EAST CHESHIRE NHS TRUST

MEETING OF THE TRUST BOARD

NOT FOR PUBLICATION BEFORE

Thursday, 30th November 2017

15.00

Board Room 1, New Alderley House
Macclesfield District General Hospital
Our Ref: LM/FB/Meetings01/TB/Agenda

Date: 24th November 2017

To: All Directors of East Cheshire NHS Trust

Dear Colleague

TRUST BOARD MEETING

A meeting of the Trust Board will be held at 3.00pm on 30th November 2017 in Board Room 1, New Alderley House, Macclesfield District General Hospital, Victoria Road, Macclesfield, SK10 3BL.

Yours sincerely

Lynn McGill
Chairman

The Board encourages members of the public to attend when Board meetings are taking place. The public are observers of the proceedings not participants, however, the Chairman will provide an opportunity for members of the public to seek clarification on any matter discussed. The Chairman will not allow members of the public to express opinions or arguments which seek to bias or unduly influence the decision-making process of the Board. There are a number of opportunities for members of the public to contribute. If you are unaware of these, please ask a member of staff before or after the Trust Board meeting and they will be happy to advise you.

TRUST BOARD – November 2017 AGENDA

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REFERENCE</th>
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<tbody>
<tr>
<td>1. Patient Story :</td>
<td>Director of Nursing</td>
<td>10 mins</td>
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<tr>
<td>2. Apologies:</td>
<td>Chairman</td>
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## ASSURANCE ITEMS

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<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
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<tbody>
<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
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<tr>
<td>- Declared interest agenda</td>
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<td>- Hospitality and Gifts Register Declaration</td>
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<tr>
<td>4. Minutes of the September 2017 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 17 (65)</td>
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<tr>
<td>5. Matters Arising</td>
<td>The Chairman</td>
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<tr>
<td>6. Action Log</td>
<td>The Chairman</td>
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<tr>
<td>7. Verbal update:</td>
<td>Ms A Harrison Mr M Wildig Mr Goalen</td>
<td>10 mins</td>
<td>Verbal (supported by formal minutes when available)</td>
<td>All corporate objectives</td>
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<tr>
<td>SQS</td>
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<td>FP&amp;W</td>
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<td>Audit</td>
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## STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

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<th>AGENDA TOPIC</th>
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<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
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<tbody>
<tr>
<td>8. Chief Executive’s Commentary</td>
<td>Chief Executive</td>
<td>45 mins</td>
<td>TB 17 (66)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Learning from Deaths</td>
<td>Medical Director</td>
<td>20 mins</td>
<td>TB 17 (67)</td>
<td>PATIENTS - Provide safe, effective personal care in the right place</td>
</tr>
<tr>
<td>10. Estates Strategy Update</td>
<td>Director of Finance</td>
<td>20 mins</td>
<td>TB 17 (68)</td>
<td>All corporate objectives</td>
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<tr>
<td>11. Agenda Item not used</td>
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<tr>
<td>12. Board Assurance Framework and Corporate Risk Register</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>20 mins</td>
<td>TB 17 (70)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>13. Standing Agenda Item: Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register</td>
<td>Chief Executive</td>
<td>5 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
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ANY OTHER BUSINESS

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<tr>
<th>AGENDA TOPIC</th>
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<th>TIME ALLOCATION</th>
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<tbody>
<tr>
<td>14. Public Trust Board Agenda – January 18</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 17 (71)</td>
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</tbody>
</table>

CONSENT ITEMS

(All 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, any such items will be made clear at the start of the meeting).

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>REF. NO.</th>
<th>REASONS FOR PRESENTING</th>
<th>LINKED TO TRUST OBJECTIVE ON</th>
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<tbody>
<tr>
<td>15. Chairman's Commentary</td>
<td>TB 17 (72)</td>
<td>Information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>16. Safer Staffing Exception Report</td>
<td>TB 17 (73)</td>
<td>Assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
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<td>STAFF - Empower, develop and value staff in providing innovative patient focused care</td>
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<td>17. Minutes of the committees of the Board:</td>
<td>TB 17 (74)</td>
<td>Information</td>
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<td>SQS – September 17</td>
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<td>FP&amp;W – September 17</td>
<td>TB 17 (75)</td>
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Date and Time of Next Meeting:

Date: Thursday 25th January 2018
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
Agenda Item Number 4: TB 17 (65)

MINUTES OF A MEETING OF
THE PUBLIC TRUST BOARD MEETING
HELD ON THURSDAY 28th SEPTEMBER 2017
BOARDROOM 1, MDGH, MACCLESFIELD SK10 3BL

Voting Members

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>ABBREVIATION</th>
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<tr>
<td>Mrs L McGill</td>
<td>Chairman</td>
<td></td>
<td>✓</td>
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<tr>
<td>Ms A Harrison</td>
<td>Non-Executive Director</td>
<td></td>
<td>✓</td>
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<tr>
<td>Mr M Wildig</td>
<td>Non-Executive Director</td>
<td></td>
<td>✓</td>
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<tr>
<td>Dr A Coombs</td>
<td>Non-Executive Director</td>
<td></td>
<td>x</td>
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<tr>
<td>Mr I Gaolen</td>
<td>Non-Executive Director</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Dr J Cowan</td>
<td>Non-Executive Director</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Mr J Wilbraham</td>
<td>Chief Executive</td>
<td>CEO</td>
<td>✓</td>
</tr>
<tr>
<td>Mrs K Senior</td>
<td>Director of Nursing, Performance and Quality</td>
<td>DoN</td>
<td>✓</td>
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<tr>
<td>Dr J Hunter</td>
<td>Medical Director</td>
<td>MD</td>
<td>✓</td>
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<tr>
<td>Ms R Charlton</td>
<td>Director of HR &amp; Workforce</td>
<td>DHR</td>
<td>✓</td>
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<tr>
<td>Mr M Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
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Non-Voting Members

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<tr>
<th>NAME</th>
<th>TITLE</th>
<th>ABBREVIATION</th>
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<tbody>
<tr>
<td>Mrs J Green</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>DCAG</td>
<td>x</td>
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<tr>
<td>Ms L Jackman</td>
<td>Deputy Director of Corporate Affairs &amp; Workforce</td>
<td>DDCAG</td>
<td>✓</td>
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<tr>
<td>Mrs F Smith</td>
<td>Meeting Secretary</td>
<td>FS</td>
<td>✓</td>
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<tr>
<td>Mr P Goman</td>
<td>Staff Side Chairman</td>
<td>PG</td>
<td>x</td>
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<tr>
<td>Mrs A Cadiou-Heaver</td>
<td>Head of Informatics</td>
<td>ACH</td>
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In Attendance

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<tr>
<th>NAME</th>
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<tr>
<td>Mrs J Green</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>DCAG</td>
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DECISIONS MADE BY THE BOARD AT TODAY’S MEETING

1. The Board approved the executives’ decision to bring the Handforth Clinic outpatient services back on to the main hospital site.
<table>
<thead>
<tr>
<th>AGENDA No</th>
<th>SUBJECT</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>1.</td>
<td>Patient Story:</td>
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<td></td>
<td>The DoN presented the patient story which relates to a patient with learning disabilities who is a tenant at a residential home and attended the trust for day case surgery. A Senior Support Worker at Cheshire East Council contacted the trust to bring to our attention the care that they had received during the visit. The patient had attended for an endoscopy &amp; colposcopy and during the visit received patient centred care, porters chatted to them and music was played to put them at ease. A capacity assessment was undertaken at home by Mr Ward and Ruth Peacock. As a result of pre-planning by the team and the reasonable adjustments made the patient had a better experience and clinical outcome. This patient story has also been shared with the Safety, Quality and Standards Committee.</td>
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2. Apologies:

- Dr A Coombs, Non-Executive Director
- Mrs J Green, Director of Corporate Affairs and Governance

3. Register of Interests:

- Declared interest agenda
  
  There were no declared interests.

- Hospitality and Gifts Register Declaration
  
  There were no declared receipts of hospitality or gifts.

  The Chairman reminded the board members that the electronic declaration system is now operational and asked that all members complete their declaration on-line.

4. Minutes of the July 2017 meeting

- The percentage response rate for Friends & Family test in the Emergency Department was corrected from 5% to 15%.

  The minutes were accepted as a true record and duly signed by the Chairman.

5. Matters Arising

- There were no matters arising.
6. **Action Log**

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<tr>
<th>Action Log</th>
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<tr>
<td>8851 – action closed</td>
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<td>9150 – action closed</td>
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<tr>
<td>9196 – action closed</td>
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7. **Verbal update, Committees of the Board:**

**SQS, FP&W and Audit**

The Chairs of the trust’s Committees of the Board gave an overview of the assurances and risks from their recent meetings, highlighting the following:

**Safety, Quality & Standards Committee (SQS)**

**Points for Assurance**

- All cancer targets were achieved in August
- **Critical Care service specification:** The committee were provided with evidence and assurances in relation to compliance, improvement plans and risk mitigation plans with the relevant standards. The committee approved the trust's action plan associated with the recommendations made by Cheshire & Merseyside critical care network team
- The trust has completed all actions to schedule for the PHE Quality Assurance review of the Cervical Screening service.

**Mortality**

Review and analysis has been conducted following receipt of the Dr Foster alert indicating a higher than average mortality rate for skin and subcutaneous tissue infections (March 2016 - Jan 2017 data) within the trust. No themes or specific causes for concern in the care of these patients were found from the mortality governance reviews. There were however primary diagnosis errors due to the sequencing of the diagnosis codes (rather than incorrect codes being assigned for these episodes. No death was found to be considered a result of problems in care. An action plan has been produced for submission to CQC addressing the correct primary diagnosis and death certification (which has been recognised nationally as an area which needs further action). The Chairman asked whether the board is assured that there are no issues arising out of the Dr Foster alert. Ms Harrison confirmed that there were no deficiencies in care resulting in death and there were no specific trends / themes identified. The Chairman asked whether there is peer review as well as local report for neonatal / stillbirth. Ms Harrison confirmed the trust is looking at associated specialties.

- **Quarterly review of PALS & complaints** indicates the number remains reasonably steady month on month, and reduced versus the same period last year. The main themes in both are communications (written/documentation & verbal); waiting times; and clinical treatment. There has been learning arising from an existing complaint which was referred to PHSO due to the introduction of a new topic which should have been raised as a new complaint and would therefore have avoided any breaches in initial response time).
The Committee received its third review into claims, with this month’s spotlight being on general surgery - reviewing data and outcomes covering 2014-17. No specific themes/trends have emerged. There are 11 pending claims referred to NHS Resolution which include complications arising from complex cholecystectomy cases; infection following surgery and missed diagnosis of breast cancer (2 claims in each). Where appropriate, actions to mitigate risks and changes in practice have been made which are regularly monitored. Whilst seeking the best possible outcome, the Committee also noted that there was no financial risk to the trust as any payments are covered through the Clinical Risk Scheme via NHS Resolution.

**Neonatal deaths and Stillbirth rates at the trust** - in line with national ambitions to further reduce neonatal deaths and stillbirths the trust carefully reviews all such cases for further learning. The trust’s stillbirth rate for 2016-17 was 4.7 per 1000 total births (slightly above crude national average level) and neonatal death rate is 1.78 per 1000 total births (below crude national average). Representatives are involved in the Greater Manchester & East Cheshire strategic clinical network special interest group to ensure currency of knowledge and learning.

**Emerging Risks and Mitigating Actions**

- Diagnostic target (99%) continues to be missed primarily due to challenges in endoscopy provision but the backlog is stabilising following implementation of associated action plans. All patient breaches are reviewed by the clinical teams. No serious incidents have been reported during this period.
- A 12 hour trolley wait was reported in August but no harm occurred as a result of the delay in transfer - this incident will be reviewed by the SIRI committee.
- Improvements in clinical correspondence performance have resulted in 14, 21, and 28 day targets now being met, however, 24hr turnaround deadlines are missed. The Executive team will follow through with the clinical directorate to support timed delivery of the action plan and junior doctor & clinician engagement with the processes. At this time the trust is not aware of any harm coming to patients as a consequence of delays in correspondence reaching the GP.
- Following review of the Human Tissue annual work report, where 2 incidences of incorrect/duplicated identification bands being located on a deceased patient, a number of immediate actions have been taken for implementation and reinforcement across all in patient areas.
- Although no hospital areas triggered in August, community nursing in Knutsford triggered - primarily due to staff absence (sickness and maternity) within a relatively small team. Overall the number of vacancies in community nursing meaning short term staff transfers from other areas are challenging. The Theatres area is close to triggering however a comprehensive action plan is in place covering facilities, staffing and culture.
- The Committee reviewed the assurance framework and risk register.
including addition of new risks. It was agreed that a check and challenge on risk number 2578, concerning a number of hospital flooring areas in relation to infection control and falls risks, should be brought to the next committee given that an executive investment decision to address priority areas needs to be made imminently.

Finance, Performance & Workforce Committee (FPW)

Finance

- The trust continues to perform well, at the end of month 5 the deficit was £183k better than plan.
- £6.3m of the £6m QIPP target has been identified, of which £5m are blue schemes and most are recurrent. Work is starting on identification of 2018/19 schemes. Acute & Integrated Care and Planned Care Directorates have a shortfall in schemes. Assurance was provided to the committee that plans are in place within the Planned Care Directorate to meet the target going forward. No assurance was provided that the shortfall of £500k within Acute & Integrated Care would be closed and the directorate is looking for extra help to achieve.
- The STF funding penalty for non-achievement of targets was appealed but was not successful and therefore £90k has been paid. There is a £240k penalty if quarter two is not achieved.
- A quarterly update on Carter was received. More information has been received on benchmarking which is being investigated. To date there is no evidence / actions for cost savings so we have requested more action focussed information going forward.
- Procurement savings 2017/18 – staff consultation underway and for larger scale goods and services the trust is using the purchase price benchmark
- CWP collaboration memorandum of understanding has been signed

Performance

- A&E performance against the 4-hour standard has not been achieved this month and assurance has not been received around whether the trust will achieve the trajectory. Work is on-going on the ECIP 5 key drivers.
- Referral to Treatment (RTT) performance against the 18 week standard was not achieved for diagnostics. Actions to mitigate associated risk are in place. RTT was primarily achieved in August, however risk remains.
- Cancer targets have been achieved.
- Delayed Transfers of Care have improved during August.

Workforce

- Staffing in A&E has improved but remains fragile. All shifts have been covered
- Apprenticeships – ECT funding has not been allocated
- Guardian of safe working – Systems are embedded and all junior doctors are now on the new contract. Rostering systems in place and exception reports are produced on a timely basis.
The Board Assurance Framework / Corporate Risk Register was deferred until the next meeting

Dr Cowan asked whether the missed ED target has resulted in patient harm. DoN advised that one incident is being investigated through the Serious Incident process. Higher risk patients are being prioritised accordingly and patient safety is not compromised.

Audit Committee

- The Board Assurance Framework / Corporate Risk Register was received and was confirmed to be aligned to information received by the committee
- Internal Audit progress report received showing a number of audits completed and five currently in progress
  - Agency/locum audit had significant shortcomings in policies / controls. The key factor for the committee is the sustainability of actions. A quarterly review to take place by DHR and report back to audit
  - The committee was advised that e-rostering will be fully automated by the end of September 2017
  - Delayed Transfers of Care received high assurance rating, with the only areas of weakness identified outside the trust’s control
  - Cyber Security audit identified weak controls in user access, malware and patch management. The auditors advised the committee that the trust is at a similar level to other trusts. A presentation of IT business continuity is to take place at the next meeting
- External Audit reported that all deadlines had been met and that the Charitable Funds audit is to be carried out in the near future. For the 2017/18 final accounts no changes were expected
- The losses & compensations register was reviewed and nothing untoward was identified. The committee asked for the date of occurrence of loss to be added going forward
- Amendments to the overpayments policy were reviewed and noted.

STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

8. Chief Executive’s Commentary

The CEO presented the report and highlighted the following points:

Quality and Compliance

- The 4-hour access trajectory of 90% has not been achieved in August or for the quarter and so this will directly affect STF funding. Whilst this is an economy wide target it is only this trust that has a financial impact.
- The medical staffing position has improved with an A&E consultant appointed. A further middle grade has been appointed to but however 4/5 remain vacant. Unfilled shifts are currently being filled by agency / locum.
- The winter plan was submitted last week, with sign off from partner organisations due next week. The plan sets out the interventions and
changes needed for Q3.

- Delays in the system have meant that the clinical risk is now out of balance and mortality and patient experience could be affected. Delayed Transfers of Care in month have gone up recently to 30 in total and so for patient safety reasons, 12 unfunded beds have been purchased and discussions are now taking place with our partners. Additionally, there have been 8/9 patients from Staffordshire this week where hospital beds have been closed but processes are not in place to manage those patients.

The DoN advised the board of the positive Internal Audit report received, showing controls and processes are in place for DTOCs. However, she added that continuing health care needs and dependency of patients impacts the flexibility to respond, resulting in a backlog in A&E.

Mr Wildig asked whether the CEO being Chair of the A&E Delivery Board was a conflict of interest. CEO responded that this is not the case as the DoN attends the meeting as the ECT representative.

Financial Stability

- The potential penalties for non-achievement of the 4 hour wait target are £360k in quarter 3 and £428k in quarter 4, which have not been accrued for.
- Waiting List Initiatives are taking place to ease the Referral to Treatment target but the trust is being asked to pay more than the agreed level per session. At present the trust is saying no to the request.

It was agreed that WLI payments would be added to the risk register.

Leadership and Strategic Transformation

- The trust has been asked to pay additional rent for the provision of services at Handforth Health Centre. A six week consultation for the local population showed a preference to leave services in the health centre and incur a £60/£65k annual increase in cost. A review of patient transport options identified that most patients arrive by car to the Handforth Health Centre. This led to the Executive decision that the services would be brought into the MDGH site. No MP feedback has been received to date.

The Board approved the executives’ decision to bring the outpatient services back on to the main hospital site

9 IT Strategy – Progress Report

The DoF presented the IT Strategy, informing the Board that £1.1m has been spent on infrastructure and IT improvements, resulting in benefits to patients and the public. Work on patient and public Wi-Fi has commenced and the trust is adopting a single sign-on approach which will also benefit clinicians.

There has been good progress on the Five Year Forward View, particularly around e-rostering; patient level costing; e-procurement; and electronic health records in the community.
The DoN queried whether the implementation of the IT infrastructure and improvements reduces business continuity risks in the event of system failure. The Head of informatics noted that clinical workstations remain unsupported and therefore electronic requests have been replaced with patient centre. This gives resilience in terms of housing all requests and results in a central location.

The MD noted the benefit of a single sign-on system and it is expected that this system will be implemented in February 2018.

Dr Cowan asked whether the electronic transfer to pharmacies presents a risk to patient sensitive information. The CEO asked that governance processes are reviewed.

Dr Cowan referred to the Cheshire Care Record and asked whether community staff can access GP records. Head of Informatics confirmed and information sharing agreement is in place and that view only access is available.

DHR stated that the mini iPods have resulted in online training issues. The Head of Informatics confirmed that any new iPods purchased are full size and have been enabled to allow training, subject to connection.

The Chairman noted that some digitally mature organisations are awarded funding and asked whether the trust can link into these organisations and any associated AHS network funding.

The Head of Information responded that a digitally mature organisation is identified and then a fast follower is given funding to replicate systems. Funding is provided via the STP.

The Chairman summarised that good progress had been made with limited resources.

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<th>10. Winter Plan</th>
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<tr>
<td>The DoN presented the winter plan, informing the Board that East Cheshire’s Winter Plan sets out the arrangements to manage surges in demand and capacity and associated risks to delivery. This includes a trajectory to deliver the 95% 4h emergency access standard by March 2018.</td>
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<td>The winter plan incorporates initiatives across five workstreams:</td>
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<tr>
<td>• System leadership</td>
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<td>• Assessment prior to admission</td>
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<tr>
<td>• Doing todays work today</td>
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<tr>
<td>• Frailty model</td>
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<td>• Home first/discharge to assess</td>
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<td>The winter plan takes account of predicted activity levels and risks to capacity. Acute core bed capacity is limited to 232 beds. The plan is primarily focussed on whole system initiatives to reduce general...</td>
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and acute demand through:

- Admission avoidance
- Proactive bed management to reduce acute bed occupancy for:
  - routine discharges (high volume, short length of stay)
  - complex discharges (low volume, long length of stay)

Based on 2016/17 Winter performance, the DoN set out the national and local context and the demand and capacity assumptions over the 2017/18 winter period and specifically over the Christmas period.

The wider considerations for demand and capacity and the challenge of having a maximum 15 Delayed Transfer of Care patients by March 2018 were explained.

The DoN outlined the main issues and risks:

- Winter Plan still ‘health sector’ focussed. Further engagement with partners prior to deadline (end Sep)
- Workforce availability and resilience
- Performance & operational delivery
- Sustaining A&E performance from March 2018

In Summary:

- The winter plan must deliver 95% A&E standard by March 2018
- Patient safety is paramount
- The plan is not yet fully funded
- Non-delivery of the A&E access standard would also impact the financial control target due to loss of STP funding
- The plan does not include additional acute beds other than those identified within the escalation policy
- Further analysis is required to inform community bed assumptions
- Staff engagement is critical to delivery
- The commitment of all partners is required
- The improvement Trajectory will be signed off at A&E Delivery Board on 4 October

The DHR queried whether primary care streaming would take place 24 hours a day and if so, have staff been identified.

The DoN responded that streaming will take place only during the day. Patients will be expected to be seen within 4 hours but not seen by a medic. This has been flagged as a risk as 10% reduction in A&E numbers is a significant assumption.

Mr Goalen queried how the result of primary care streaming and not admitting patients would reduce the extent of the problem. The CEO explained that this will free up capacity to treat the patients that need to be treated in the hospital environment. Dr Cowan noted the potential improvement in patient experience.

The CEO stated that the plan is fragile and needs further resilience.
Responsiveness of partners is key, as is better planning to guard against using flex beds for delayed transfers of care.

Ms Harrison asked whether the trust can insist on out of hospital bed flex from partners. CEO explained that this would need to be escalated to the regulators if the plan is likely to fail.

11. Board Assurance Framework and Corporate Risk Register

The DDCAG presented the report and noting that both the Safety, Quality and Standards committee and the Finance, Performance and Workforce Committee have reviewed the relevant associated risks.

DDCAG referenced the earlier IT Strategy update informing the board that risk number 2418 has reduced in score from 16 to 12

Dr Cowan noted that risk number 2578 should be split into two separate risks. The DDCAG acknowledged these changes.

The CEO stated that gaps in control for the 18 week (RTT) standard risk should be amended.

12. Standing Agenda Item: Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register

No further risks identified.

ANY OTHER BUSINESS

13. Public Trust Board Agenda – October 17

The agenda for the September Trust Board meeting was noted.

CONSENT ITEMS

14. Chairman’s Commentary

The Board received and noted the content of the Chairman’s commentary.

15. Annual Report – Controlled Drugs

The Board received assurance on the following aspects of the Controlled Drugs Annual Report 2016/17:

Incidents
- There were 150 incident reports that involved CDs across ECT between April 2016 and March 2017 (compared with 140 in 2015/16). 64% (96) were graded as low with the remaining 36% (54) graded very low.
- The top 5 categories of incidents are:
  o Correct procedure not followed 25 (17%)
  o Losses – unaccounted for losses 18 (12%)
  o Governance - documentation 13 (9%)
  o Losses - resolved 12 (8%)
  o Losses – spillage/spoilage 9 (6%)
- All CD incidents are reported via the Datix system and are highlighted to the Trust Accountable Officer for CDs and reviewed. In addition,
incidents are submitted to the CD Local Intelligence Network (LIN) for review across the health economy on a quarterly basis, which is attended by the Trust CD Accountable Officer.

- For the period of this report (April 2016 – March 2017) all incidents were reported to the LIN. There were no incidents where patient harm has occurred and no concerns were raised by the LIN about the management of or reporting of CD incidents.

Assurance Audits

- It is a requirement of the Department of Health Safer Management of CDs Guidance that pharmacy staff regularly check records of CD stocks held on every ward or department against actual stock. At ECT these checks are carried out quarterly by the pharmacy teams. No major concerns have been reported following completion of these audits. Any actions identified are actioned immediately.

Compliance with Legislation

- The Controlled Drugs (Supervision of Management and Use) Regulations 2006 were revised as a consequence of an enactment of the Health and Social Care Act to reflect the new architecture for the NHS. The Regulations came into force in April 2013. One of the major changes was the requirement for the Trust to hold a Home Office Licence to allow the supply of CDs to other legal entities (e.g. East Cheshire Hospice).

- The Trust is fully compliant with this and is in possession of a Home Office licence to allow us to possess and supply schedule 2, 3, 4 & 5 controlled drugs in accordance with the Misuse of drugs Act 1971.

The management of CDs continues to be monitored by the Trust AO and reported via the Trust incident reporting system. There are no areas of concern to be raised with the Trust Board.

16 Bi-Annual Safer Staffing Report

The Board received assurance on the following aspects of the bi-annual review of nurse staffing:

Methodology

- Since 2012 the trust has used the validated Safer Nursing Care Tool (SNCT) and professional judgement models to underpin and guide adult inpatient ward staffing levels in line with funded establishments. The Board receives assurance via a bi-annual report which includes details on how the tool calculated the WTE, using acuity and dependency measurements.

Summary of Key Outcomes

- Overall the outcome from the July 2017 audit using the SNCT and professional judgement aligns with the expected funded establishment.

- Due to operational pressures AAU (which is a non-inpatient area) has accommodated patients overnight and the acute directorate is
currently reviewing staffing levels based on internal tools to measure acuity and dependency. The outcome will form part of the trusts escalation process.

- Additional healthcare assistants have been requested and utilised to support 1:1 care.
- Further actions have included re-deployment of staff from other areas.
- The supervisory status of senior sisters was previously adjusted to provide a 50/50 split working clinically within the rotas. Over the past six months the majority of ward areas have seen an improved position and senior sisters are now working to a 60/40 split supervisory/clinically.
- Nurse staffing in acute and community areas continues to be discussed daily and shortfalls are escalated as per trust guidance and policy in conjunction with safety huddle briefings and daily board rounds.

Addendum
The Board will receive further assurance on community nursing services and acute nurse staffing at its November meeting.

17. Safer Staffing Exception Report

The Board received the August 2017 Safer Staffing Exception Report submitted by the DoN. Members noted its content and the following exceptions:

- Post-natal and labour ward illustrates an actual registered midwife fill rate of 92.7% during the day which demonstrates a slight decline compared to the previous month. Mitigating actions include the utilisation of midwives via nurse bank.
- Post-natal and labour ward illustrates an actual healthcare assistant fill rate of 84.4% during the day and 62.9% overnight which demonstrates a worsening position for actual fill rates overnight compared to the previous month. Mitigating actions include the use of 2 on call midwives for homebirths who can if required be called to support the unit at times of increased workload to ensure safe staffing levels are maintained.
- Paediatrics ward illustrates an actual registered nurse fill rate of 91.5% during the night which remains an equivocal position compared to the previous month. Paediatrics ward illustrates an actual healthcare assistant fill rate of 53.3% during the day and 93.5% overnight which illustrates an improved position compared to previous months during the day although a worsening position overnight. In view of lower than normal patient numbers and patient dependency during August the number of healthcare assistants has been reduced which is reflected in nurse bank utilization.
- Aston Ward illustrates an actual healthcare assistant rate of 83% during the day and 92.6% overnight which demonstrates an equivocal position during the day compared to previous months although a worsening position overnight.
- In month registered nurse vacancies within the acute in-patient wards

Chairman: Lynn McGill
Chief Executive: John Wilbraham
illustrate an increased position - 38.77 wte compared to 35.62 from the previous month. This excludes Maternity Leave and Long Term Sickness. Inclusion of Maternity Leave and Long Term Sickness increases to 53.15 wte. Pending satisfactory pre-employment checks the majority of roles successfully recruited to are registered midwives and nurse specialist substantive roles in addition to 8 ward based staff nurse roles.

- Four international overseas nurses have recently passed their OSCE’s and are awaiting NMC registration. A further 2 international nurses are expected to arrive in October with 3 more in the pipeline.
- Following interviews held in July 2017, 12 Healthcare Assistant posts have been appointed to of which 10 will be aligned to Nurse Bank and 2 substantive ward posts pending satisfactory pre-employment checks. In addition, 11 HCA’s are due to attend corporate induction on Monday 18th September 2017.
- Rolling registered nurse recruitment campaigns continue and interviews had been scheduled during early August. In addition, the Trust participated in the RCN job fair in Liverpool during September to promote the organisation as an ‘employer of choice’ which included information regarding professional development, support and accommodation incentives.

18. Mortality – Learning from Deaths Policy

The new Mortality Governance policy sets out clear roles and responsibilities to ensure the trust meets obligations to review and understand information relating to mortality, act on that information to support quality improvement and to undertake robust structured mortality reviews of a consistent quality.

Clinicians (including doctors, nurses and allied health professionals) should systematically use mortality reviews to provide assurance that the care provision within their service is of high quality and safe and where feasible implement lessons learned from these reviews to improve patient outcomes. This policy will describe the process for mortality reviews.

The Board noted the content of the policy.

18. Minutes of the committees of the Board:
SQS – June 17
FP&W – June 17

The minutes of the June 2017 Finance, Performance & Workforce and Safety, Quality & Standards Committees were shared with Board members and the content noted.

Any Other Business
The Chairman confirmed the non-executive Board Champion for Emergency Preparedness was Ian Goalen

Date and Time of Next Meeting:
Date: Thursday 30th November 2017
Time: 3pm
Venue: Board Room 1, New Alderley House, Macclesfield District Hospital

Chairman: Lynn McGill
Chief Executive: John Wilbraham
<table>
<thead>
<tr>
<th>Action Log No.</th>
<th>Committee</th>
<th>Date Presented</th>
<th>Agenda Item</th>
<th>Action Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9361</td>
<td>Trust Board</td>
<td>28/09/2017</td>
<td>8 Chief Executive’s Commentary</td>
<td>It was agreed that WLI payments would be added to the risk register.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fiona Smith</td>
</tr>
<tr>
<td>9362</td>
<td>Trust Board</td>
<td>28/09/2017</td>
<td>9 IT Strategy - Progress Report</td>
<td>Dr Cowan asked whether the electronic transfer to pharmacies presents a risk to patient sensitive information. The CEO asked that governance processes are reviewed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Julie Green</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nov-17</td>
</tr>
<tr>
<td>9363</td>
<td>Trust Board</td>
<td>28/09/2017</td>
<td>11 Board Assurance Framework and Corporate Risk Register</td>
<td>Dr Cowan noted that risk number 2578 should be split into two separate risks. The DDCAG acknowledged these changes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lorraine Jackman</td>
</tr>
<tr>
<td>9364</td>
<td>Trust Board</td>
<td>28/09/2017</td>
<td>11 Board Assurance Framework and Corporate Risk Register</td>
<td>The CEO stated that gaps in control for the 18 week (RTT) standard risk should be amended.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lorraine Jackman</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Response required by</th>
<th>Comment/Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiona Smith</td>
<td>Nov-17</td>
<td>Complete. Recommend action closed.</td>
</tr>
<tr>
<td>Julie Green</td>
<td>Nov-17</td>
<td>Complete. Recommend action closed.</td>
</tr>
<tr>
<td>Lorraine Jackman</td>
<td>Nov-17</td>
<td>Complete. Recommend action closed.</td>
</tr>
<tr>
<td>Lorraine Jackman</td>
<td>Nov-17</td>
<td>Complete. Recommend action closed.</td>
</tr>
</tbody>
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**PUBLIC TRUST BOARD**  
**Thursday 30th November 2017**  

**Agenda Item Number 8: TB 17 (66)**

<table>
<thead>
<tr>
<th>Report of:</th>
<th>The Chief Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Author of Report:</strong></td>
<td>John Wilbraham, Chief Executive</td>
</tr>
<tr>
<td><strong>Subject/Title</strong></td>
<td>Chief Executives Report to Trust Board for the Period to 31st October 2017'</td>
</tr>
<tr>
<td><strong>Background papers (if relevant)</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Purpose of Paper</strong></td>
<td>To highlight performance issues and areas of risk to the delivery of the trusts objectives</td>
</tr>
<tr>
<td><strong>Action/Decision required</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mitigates Risk Number: (identify)</strong></td>
<td>Links to all risks identified within the Assurance Framework and the Corporate Risk Register</td>
</tr>
<tr>
<td><strong>On Corporate Risk Register &amp; Assurance Framework</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Link to Care Quality Commission Domain** | Safe ✓  
Caring ✓  
Responsive ✓  
Effective ✓  
Well-led ✓ |
| **Link to:** |  
➢ Trust’s Strategic Direction  
➢ Corporate Objectives |
| | Links to all Strategic Objectives |
| **Legal implications - (identify)** | None |
| **Impact on quality** | Increasing risk to patient experience due to operational pressures |
| **Resource impact** | None |
| **Impact of equality/diversity** | None |
| **Avoid acronyms or abbreviations - if necessary list:** | ED – Emergency Department  
A&E – Accident & Emergency  
IV – Intravenous  
ECIP – Emergency Care Improvement Programme  
TUPE – Transfer of Undertakings (Protection of Employment) regulations 2016  
CQC – Care Quality Commission  
SSB’s – Sugar sweetened beverage  
NHS – National Health Service  
NHS E – National Health Service England |
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS I</td>
<td>National Health Service Improvement</td>
</tr>
<tr>
<td>STF</td>
<td>Sustainability Transformation Fund</td>
</tr>
<tr>
<td>CCG’s</td>
<td>Clinical Commissioning Groups</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability Transformation Programme</td>
</tr>
<tr>
<td>IBCF</td>
<td>Integrated Better Care Fund</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention</td>
</tr>
<tr>
<td>AICC</td>
<td>Acute and Integrated Community Care</td>
</tr>
<tr>
<td>MSK</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>ECT</td>
<td>East Cheshire NHS Trust</td>
</tr>
</tbody>
</table>
Chief Executive’s Report to the Trust Board
For the Period Ended October 2017

1. **PURPOSE**

1.1 This report is to inform the Board on the position of the trust as at the end of October 2017 in relation to the strategic risks faced including a view on operational performance against key indicators.

2. **KEY ISSUES**

2.1 The Board are asked to note:

- Building pressure on services as the winter approaches in terms of ED throughput times and staff vacancies on wards
- Receipt of additional funds to assist in developing services over the winter period and the increase in the number of beds out of hospital which are key for managing patient demand during the winter months
- The trust committing to a voluntary scheme to reduce sugar sweetened beverages available on its premises
- A positive, though small, variance on the financial plan
- The CCG are making proposals to its Governing Body on 29th November which may have an impact on the waiting times for patients and the financial position of the Trust
2.3 **KEY METRICS**

2.3.1 The table below gives a summary of the position at the end of October.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q1</th>
<th>Q2</th>
<th>Oct</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Adjusted Mortality Index 2016 - Latest Peer ()</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary Hospital Mortality Indicator (HSCIC)</td>
<td>1.027</td>
<td>1.056</td>
<td></td>
</tr>
<tr>
<td><strong>Infection</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecoli - includes hospital and community</td>
<td>39</td>
<td>41</td>
<td>11</td>
</tr>
<tr>
<td>Hospital MRSA bacteraemia</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospital Acquired Clostridium Difficile 17/18 Avoidable</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 3 pressure ulcers - hospital</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 4 pressure ulcers - hospital</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 3 pressure ulcers - out of hospital</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 4 pressure ulcers - out of hospital</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Incidents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication errors causing serious harm</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Never Events</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Incident reported rate per 1000 occupied bed days</td>
<td>65.4</td>
<td>66.3</td>
<td>64.2</td>
</tr>
<tr>
<td><strong>Complaints</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of investigations with Ombudsman</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Experience</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward Family and Friends Test % response</td>
<td>41.4%</td>
<td>34.2%</td>
<td>39.9%</td>
</tr>
<tr>
<td>ED Family and Friends Test % response</td>
<td>22.3%</td>
<td>20.3%</td>
<td>21.1%</td>
</tr>
<tr>
<td>Mixed Sex Accommodation breaches per 1000 FCE’s</td>
<td>0</td>
<td>4</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 week - Incomplete Patients</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>18 Week - Admitted Backlog</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>ED: Maximum waiting time of 4 hours</td>
<td>83.9%</td>
<td>67.0%</td>
<td>89.9%</td>
</tr>
<tr>
<td>ED: The recording of a completed handover, (HAS)</td>
<td>88.5%</td>
<td>88.5%</td>
<td>89.1%</td>
</tr>
<tr>
<td>2 Weeks maximum wait from urgent referral for suspected cancer</td>
<td>98.2%</td>
<td>97.8%</td>
<td>98.2%</td>
</tr>
<tr>
<td>2 Weeks maximum wait from referral for breast symptoms</td>
<td>92.5%</td>
<td>97.1%</td>
<td>96.2%</td>
</tr>
<tr>
<td>31 days maximum from decision to treat to subsequent treatment - Surgery</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>31 day wait from cancer diagnosis to treatment</td>
<td>98.5%</td>
<td>98.1%</td>
<td>98.0%</td>
</tr>
<tr>
<td>62 day maximum wait from urgent referral to treatment of all cancers</td>
<td>87.1%</td>
<td>91.8%</td>
<td>85.2%</td>
</tr>
<tr>
<td>62 days maximum from screening referral to treatment</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay - non elective</td>
<td>5.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay - elective</td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delayed transfers of care - Acute</td>
<td>5.3%</td>
<td>5.5%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Bed days lost through delays - Acute</td>
<td>1261</td>
<td>1361</td>
<td>468</td>
</tr>
<tr>
<td>Delayed transfers of care - Non Acute</td>
<td>28.0%</td>
<td>25.8%</td>
<td>25.3%</td>
</tr>
<tr>
<td><strong>LoS</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Core Staff in Post (FTE)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Staff (FTE)</td>
<td>2122.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness Absence - monthly</td>
<td>4.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness Absence - Rolling year</td>
<td>4.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory and Mandatory Training - Rolling 3 year period</td>
<td>92.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate Induction attendance - Rolling year</td>
<td>98.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisals and Personal Development Plans - Rolling year</td>
<td>89.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Governance training</td>
<td>78.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding - Level 1 Compliance</td>
<td>92.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children - Level 2</td>
<td>70.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults - Level 2</td>
<td>75.4%</td>
<td></td>
<td></td>
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<tr>
<td>Safeguarding Children - Level 3</td>
<td>80.3%</td>
<td></td>
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<tr>
<td><strong>Finance</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Total Pay Expenditure (£000)</td>
<td>£26,583k</td>
<td>£26,304k</td>
<td>£8,675k</td>
</tr>
<tr>
<td>Bank Staff Expenditure (£000)</td>
<td>£1,131k</td>
<td>£1,134k</td>
<td>£354k</td>
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<tr>
<td>Agency Staff Expenditure (£000)</td>
<td>£1,268k</td>
<td>£1,265k</td>
<td>£489k</td>
</tr>
<tr>
<td>Cash (£000's)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>EBITDA (£000)</td>
<td></td>
<td></td>
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<tr>
<td>Cumulative Deficit</td>
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</tbody>
</table>

4
3. **QUALITY AND COMPLIANCE – PATIENT SAFETY, PATIENT EXPERIENCE AND EFFECTIVENESS**

*Risk: If quality is not maintained in line with regulatory standards during and after transition then this could impact on services the trust provides and ability to provide services that are caring, safe, and responsive and safeguard the health & wellbeing of the local population*

3.1 **Winter**

3.1.1 The Eastern Cheshire Health and Care economy has received £183k from Cheshire and Merseyside STP to assist in the delivery of safe, effective and timely care over winter. There were a number of options for the use of this resource however the Operational Resilience Group ranked the potential schemes with those most improving patient flow.

3.2.2 The A&E Delivery Board reviewed the proposals and Cheshire East Council have agreed to use IBCF resources to match fund the first scheme adding a further £82.5k. This will allow the following initiatives to be put in place from 1 December to 31st March:

- Rapid Access Domiciliary Care which will enable support to be put into people’s homes to allow them to be discharged from hospital
- IV Therapy Service which will allow more activity to be undertaken in hospital beds and the assessment areas

3.2.3 The building work within the ED continues and remains on track to be completed before Christmas which will also further increase the number of patients who can be assessed at any one time.

3.2.4 The Board are aware that the winter plan is dependent upon a good flow of patients in and out of the hospital and whilst there are escalation procedures there is no plan to increase the number of acute beds. The plan centred therefore on increasing the number of out of hospital beds and 90 beds have been commissioned.

3.2.5 The trust has embarked on a flu vaccination programme for staff to seek to minimise any disruption in service delivery over the period. The current level of take up from staff is c44% and trust leaders are seeking to impress the importance of having the vaccination in terms of protecting themselves and their families, their patients and their colleagues. The Executive team will continue to take every opportunity to publicise the programme and maximise take up.

3.2 **Emergency Care Improvement Programme (ECIP)**

3.2.1 It is with disappointment that I have to advise the Board that the ECIP team who have been helping with the economy to improve our processes both in and out of hospital have been requested to support other Trusts and as such will be ceasing their work here imminently.

3.2.2 NHSI are providing support to the trust to continue the work however this will be less than the resource of the ECIP team. Despite the disappointment, ECIP have assisted
the trust to create a base from which we can continue to work to improve both the care our patients receive as well as improving the speed of the care.

3.3 **Care Quality Commission (CQC)**

3.3.1 I can confirm that CQC will be undertaking our “well led” inspection during 30\textsuperscript{th} January to 1\textsuperscript{st} February 2018. During the year the trust’s senior leaders undertook a self-assessment against the key lines of enquiry and we have been focused on further improvement in the following areas:

- **Strategy** - Further clarity and communication regarding the trust’s vision and strategy and how this links to Caring Together, supporting high quality sustainable care
- **Productivity** - Identify opportunities to further maximise operational productivity for example job planning, e-rostering systems, out-patients
- **Leadership Development** – review capacity and capability to deliver high quality, sustainable care assessing how we use our workforce to maximum patient benefit including succession planning and having systems and processes in place for learning, continuous improvement and innovation

3.3.2 The Board should note that prior to the “well led” inspection, the CQC will undertake an announced inspection and a short notice inspection. This is a follow up from the inspection carried out in December 2014 following which the trust implemented a quality improvement plan.

3.4 **Reduction of Sugar Sweetened Beverages within the NHS**

3.4.1 Obesity is a major issue for the health of the population and NHSE have recently consulted on ways to approach this issue.

3.4.2 NHSE and NHSI have written to Trusts to sign up to a voluntary scheme to reduce the sale of sugar-sweetened beverages (SSBs) on NHS premises. The trust should be working with partners to try to reduce the incidence of obesity with patients, staff and members of the public and this scheme offers an opportunity to do so. In addition to Trusts, a number of NHS suppliers have also agreed to work on this initiative.

3.4.3 Through the voluntary scheme we will be are asking our suppliers to:

- Commit to the definition of sugar-sweetened beverages (as set out in Annex B of the NHSE Guidance)
- Reduce the total monthly volume of sugar-sweetened beverage sales per NHS outlet, reaching a target of 10\% or less of total volume of drinks sales for the whole month of March 2018 and continuing thereafter and in future contracts

3.4.4 As the provider, we will provide NHSE with self-reported data on a quarterly basis, comprising total monthly beverage sales by volume (litres), including the total volume of sugar-sweetened beverage sales.
3.5 **Operational Performance**

**4 Hour Emergency Department Standard**

3.5.1 More people were treated in less than 4 hours in October with an improved performance of 89.9%. This is clearly a positive position however the fragility of the system remains and the performance in November has reduced to c.82% at the time of writing.

3.5.2 The requirement to achieve 90% for the quarter, whilst mathematically possible, would require a consistent performance of c.93% for the rest of November and all of December. This level of performance has not been achieved for a considerable time and as such the Q3 STF is at risk (c£350k).

3.5.3 Longer waiting times clearly affect patient experience and it is interesting to note the improved Friends and Family test in ED showing an increased satisfaction rate of 92.1% during October.

3.5.4 In addition, the trust has received the outcome from the national survey of Accident and Emergency undertaken in 2016 which also demonstrates good and improving experience.

3.5.5 The trust was classed as performing ‘better than other trusts’ for six categories enough time to discuss health problem with doctor/nurse:

- Doctors and nurses not talking to each other as if you weren’t there
- Family / someone close having opportunity to speak to a doctor
- Member of staff saying one thing and another saying something different
- Hospital staff do everything they could to control pain
- Not feeling threatened by other patients / visitors

3.5.6 The trust was also classed as performing 'better than other trusts' in relation to the overall section score for care and treatment.

3.5.7 The trust was not classed as performing 'worse than other trusts' for any categories.

3.5.8 Whilst there is clearly an associated clinical risk with patients waiting for long periods in emergency departments close monitoring of patient safety has not identified any specific patient safety concerns.

3.5.9 The trust has also received a report from Health Voice who visited a number of Trusts in Cheshire and whilst this is a relatively small sample of patients it does give positive feedback from patients.

3.5.10 The trust is working with partners in Cheshire and Merseyside to look at producing an app for the public which will allow them to see waiting times at emergency departments in their locality. It is hoped that when waiting times are long this may prompt members of the public to consider other options for seeking treatment in a timely way e.g. pharmacies.
Cancer Standards

3.5.7 It is pleasing to report that again all cancer standards were achieved in month. The Board are aware of increased pressure on diagnostic waiting times and work continues to identify how this issue can be addressed with a focus on productivity.

3.5.8 The Clinical Management Board reviewed work from the Model Hospital and Clinical Directors and leaders were shown the data for the Trust and how to interrogate the data for their specialities to assist with productivity gains.

3.5.9 There was positive interest from the clinicians and the Director of Finance and Director of Nursing, Performance and Quality will be seeking to assist the clinical teams in improving their performance to the benefit of both the patients and the financial position of the trust.

Delayed Transfers of Care

3.5.10 The level of delays has plateaued and whilst there has been a significant reduction from last year it is critical that these do not grow over the winter period. The CCG have agreed to commission more beds out of hospital and Council colleagues are seeking to increase capacity and improve processes for patients to access domiciliary care.

3.5.11 This remains a key risk to the delivery of safe care over the winter period.

4. **FINANCIAL STABILITY**

*Risk: If the trust cannot meet requisite financial regulatory standards and operate within agreed financial resources and transformation schemes do not deliver sufficient savings, then the proposed health economy wide service model will not be fully or effectively implemented.*

4.1 Income and Expenditure

4.1.1 The trust effectively broke even in the month of October and remains ahead of plan by £182k posting a deficit of £11.8m. Whilst this positive variance is welcome it remains a small positive balance and the fact that the month was a breakeven shows the fragility of the position. It is clear any small change in the financial control within the organisation could have significant impact on the delivery of the trusts financial control limit.
4.1.2 The tables below summarise the position;

**Summary Income and Expenditure Position:**

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Favourable/Adverse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>85,615</td>
<td>85,018</td>
<td>597</td>
<td>Adverse</td>
</tr>
<tr>
<td>Pay Expenditure</td>
<td>61,945</td>
<td>61,562</td>
<td>(383)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Non-Pay Expenditure</td>
<td>33,304</td>
<td>32,762</td>
<td>(543)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Total Operating Expenditure</td>
<td>95,249</td>
<td>94,324</td>
<td>(926)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Operating (deficit)/Surplus</td>
<td>(9,634)</td>
<td>(9,305)</td>
<td>(328)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Interest Rec'd/Paid/Gain on disp.</td>
<td>458</td>
<td>416</td>
<td>(42)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Capital Charges &amp; Adjustment for donated assets</td>
<td>1,899</td>
<td>1,899</td>
<td>0</td>
<td>Favourable</td>
</tr>
<tr>
<td>Adjustment for 2016/17 additional sustainability &amp; transformation funding</td>
<td>0</td>
<td>189</td>
<td>189</td>
<td>Adverse</td>
</tr>
<tr>
<td>Trust (deficit)/Surplus</td>
<td>(11,991)</td>
<td>(11,809)</td>
<td>(182)</td>
<td>Favourable</td>
</tr>
</tbody>
</table>

**Position by Service Line:**

<table>
<thead>
<tr>
<th>Income &amp; Expenditure Statement by Service Line</th>
<th>Contract Income</th>
<th>Direct Income</th>
<th>Pay Cost</th>
<th>Non Pay Cost</th>
<th>Operational Variance</th>
<th>Favourable/Adverse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute and Integrated Care</td>
<td>(323)</td>
<td>(180)</td>
<td>862</td>
<td>433</td>
<td>792</td>
<td>Adverse</td>
</tr>
<tr>
<td>Allied Health and Clinical Support Services</td>
<td>(127)</td>
<td>(57)</td>
<td>(526)</td>
<td>(154)</td>
<td>(864)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Planned Care Services</td>
<td>1,318</td>
<td>(67)</td>
<td>816</td>
<td>441</td>
<td>2,508</td>
<td>Adverse</td>
</tr>
<tr>
<td>Contract Income</td>
<td>494</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>494</td>
<td>Adverse</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>(7)</td>
<td>(233)</td>
<td>(1)</td>
<td>(241)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trustwide</td>
<td>17</td>
<td>(471)</td>
<td>(1,302)</td>
<td>(1,262)</td>
<td>(3,018)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Sub Total</td>
<td>1,379</td>
<td>(782)</td>
<td>(383)</td>
<td>(543)</td>
<td>(329)</td>
<td>Favourable</td>
</tr>
</tbody>
</table>

**QIPP Position:**

**FINANCE**

**Quality, Innovation, Productivity and Prevention**

*Provide the best services to our population through improvements to safety, productivity and patient experience*

<table>
<thead>
<tr>
<th>Forecast / Actual QIPP delivered by Service Line at Month 7</th>
<th>2017/18 YTD</th>
<th>2017/18 YTD</th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£3,164k</td>
<td>£3,132k</td>
<td>£32k</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Blue</th>
<th>Green</th>
<th>Amber</th>
<th>Red</th>
<th>Total In Year Forecast / Actual</th>
<th>% of Target Achieved</th>
<th>FYE of Recurrent Schemes</th>
<th>YE Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute and Integrated Care</td>
<td>£372k</td>
<td>£54k</td>
<td>£8k</td>
<td>£214k</td>
<td>£648k</td>
<td>56.0%</td>
<td>782</td>
<td>£100k</td>
</tr>
<tr>
<td>Allied and Clinical</td>
<td>£464k</td>
<td>£11k</td>
<td>£114k</td>
<td>£590k</td>
<td>£701k</td>
<td>84.1%</td>
<td>560</td>
<td>£110k</td>
</tr>
<tr>
<td>Planned</td>
<td>£235k</td>
<td>£8k</td>
<td>£31k</td>
<td>£608k</td>
<td>£881k</td>
<td>100.2%</td>
<td>872</td>
<td>£200k</td>
</tr>
<tr>
<td>Corporate</td>
<td>£382k</td>
<td>£84k</td>
<td>£55k</td>
<td>£130k</td>
<td>£663k</td>
<td>98.2%</td>
<td>813</td>
<td>£100k</td>
</tr>
<tr>
<td>Trust Wide</td>
<td>£3,992k</td>
<td>£3,992k</td>
<td>£2,600k</td>
<td>153.5%</td>
<td>£3,992k</td>
<td>£2,600k</td>
<td>113%</td>
<td>£0k</td>
</tr>
<tr>
<td>Total</td>
<td>£5,445k</td>
<td>£5,445k</td>
<td>£2,600k</td>
<td>108.7%</td>
<td>£5,445k</td>
<td>£2,600k</td>
<td>113%</td>
<td>£7,019k</td>
</tr>
<tr>
<td>Percentage of Target Achieved</td>
<td>118.7%</td>
<td>17.9%</td>
<td>23.7%</td>
<td>108.2%</td>
<td>113%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Recurrent</td>
<td>98.0%</td>
<td>92.9%</td>
<td>89.2%</td>
<td>90.5%</td>
<td>97%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.1.3 The CCG’s financial position remains of significant concern and proposals are being put to their Governing Body on 29th November which may have an impact on the trusts financial outturn. I will apprise the Board of the CCG’s position at the meeting when there is clarity on what the CCG governing body have agreed.

5. **WORKFORCE**

*Risk: If the trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity then there may be an impact on achieving mandatory service standards, and delivering an integrated system.*

5.1 **Staffing Levels**

5.1.1 The Executive are seeking to reduce the number of vacancies within the organisation during the financial year. The position is variable between staff groups.

5.1.2 The trust has been successful in recent consultant recruitment with posts offered in the emergency department, gastroenterology, paediatrics and endocrinology. In addition the filling of shifts for middle grades in the emergency department has improved significantly from April. The department ran with 45.6 middle grade shifts not covered in April but this has reduced to just 1.7% in October. This position clearly offers a better service to patients as well as making the department a better place to work in.

5.1.3 Nurse vacancies remain a cause for concern with 13.6% of acute nursing posts vacant. When adding to this maternity and sickness rates the rate increases to nearer 20%. The trust continues with recruitment activity however it is clear that we are reliant on bank and agency staff to provide care on our wards. As winter approaches there is a risk that this is insufficient to maintain staffing levels on wards, especially if we have flu within this workforce.

5.2 **Metrics**

5.2.1 It is pleasing to see a 5% improvement to 89% in the volume of appraisals that have taken place within the trust and that the majority of workforce indicators are being achieved. The staff survey is currently live and will be due to close in December. The Executive team have stressed the importance of staff taking time to tell us what their positive and negative issues are about working at East Cheshire. At the present time the response rate is c.35% which is in line with the national average but it is hoped we can improve on this before the survey closes.

5.3 **TUPE**

5.3.1 43 staff were TUPE’d to other organisations during October.

5.3.2 The 0-5 Years’ Service (Health Visitors) transferred from the trust to Cheshire & Wirral NHS Partnership Trust. Approximately forty members of staff transferred from the AICC Directorate to the new provider under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE)
5.3.3 The MSK Service transferred from the Allied Health and Clinical Support Directorate to In Health. Three members of staff transferred to the new provider under TUPE.

5.3.4 Both TUPE’s progressed efficiently and no issues were raised as part of the transfer process.

5.4 **Staff Awards**

5.4.1 The annual staff awards event was held on 17\textsuperscript{th} November and was an enjoyable evening with the opportunity to thank all staff for the contribution they have made during the last 12 months.

5.4.2 Congratulations go to all staff nominated for awards as well as the award winners.

5.4.3 It is also important to put on record our thanks to the sponsors of the event without whom the event would be unlikely to happen.

6. **LEADERSHIP AND STRATEGIC TRANSFORMATION**

*Risk: If the collective leadership across the integrated care system is not well led and unable to effect the changes required with pace and support of key regulators and stakeholders then there is a risk to the sustainability of the trust and the wider Health and Social Care economy.*

6.1 **Caring Together Integrated Teams**

6.1.1 The Caring Together Programme Board have again recognised the importance of the development of these teams to affect changes in the way care is given leading to more preventative care and more patients managing their own conditions in a way that minimises their need for hospital treatment.

6.1.2 ECT has started to collect base information so the teams are able to demonstrate how their input will affect activity at hospital. The baselines will also give an indication of usage per head of population of East Cheshire however it will not demonstrate activity sent to other Trusts.

6.1.3 This information will need to be developed further and will need to align with other data indicators to give an overall picture of delivery.
7. **USE OF TRUST SEAL**

7.1 The trust seal has been used as below since the last meeting:

<table>
<thead>
<tr>
<th>Date</th>
<th>Seal Number</th>
<th>Name</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>18&lt;sup&gt;th&lt;/sup&gt; October 2017</td>
<td>456</td>
<td>Cheshire West and Chester Council</td>
<td>Contract Deed of Termination (0-5 Years Healthy Child Programme)</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; November 2017</td>
<td>457</td>
<td>Primary Health Investment Properties Ltd</td>
<td>Deed of Covenant</td>
</tr>
</tbody>
</table>

John Wilbraham  
Chief Executive
### Report of:
**Responsible Officer:** Medical Director
**Accountable Officer:** Medical Director

### Author of Report:
Dr John Hunter, Medical Director
Andy Chambers, Head of Safety, Risk and Resilience

### Subject/Title
Learning from Deaths – Quarterly Mortality Report

### Background papers (if relevant)
N/A

### Purpose of Paper
To provide assurance to the Board that the trust is learning from deaths and using that learning to support quality improvement

### Action/Decision required
To note the contents of the report

### Mitigates Risk Number: (identify)
BAF 2. If quality is not maintained in line with regulatory standards during and after transition then this could impact on services the trust provides and ability to provide services that are caring, safe and responsive and safeguard the health and wellbeing of the local population.

### Link to Care Quality Commission Domain
- Safe
- Caring
- Effective
- Responsive
- Well led

### Link to:
- Trust’s Strategic Direction
- Corporate Objectives
  - To ensure our patients receive the best care in the right place
  - Commit to quality of care
  - Improve lives

### Legal implications - (identify)

### Impact on quality

### Resource impact

### Impact of equality/diversity

### Avoid acronyms or abbreviations - if necessary list:
- SMR Standardised Mortality Ratio
- RAMI Risk Adjusted Mortality Index
- SHMI Summary Hospital Mortality Index
- SBAR Situation, Background, Assessment, Recommendations
- RCA Root Cause Analysis
- LeDeR Learning Disabilities Mortality Review
1.0 **Background**

1.1 Monitoring deaths in hospital has become a standard part of assessing the performance of our hospitals and the quality of their care.

1.2 There are two ways to consider in-hospital mortality rates. It can be done by looking at either crude mortality rates or standardised mortality ratios (SMRs). Both measures are a valid measure of mortality and both are constructed from numbers of deaths.

1.3 Regular examination and better understanding of hospital mortality can potentially improve the way care is delivered by identifying problems with the quality of care and help focus the hospital’s quality improvement work.

1.4 In general terms, the rationale for calculating death rates in hospital is that they can be used to measure hospital quality in some way, and therefore help trusts:
- Reduce mortality rates
- Improve patient safety
- Reduce avoidable variation in care and outcomes

1.5 Crude mortality is a simple analysis of the percentage of patients who die against the number of admissions to hospital and makes no adjustment for complexity. A hospital standardised mortality ratio is calculated by counting the number of actual (observed) deaths in a trust and comparing it with the number of expected deaths. The difference between the expected number of deaths and the observed number is often called ‘excess deaths’. In this case the word *excess* is a technical term, but is sometimes interpreted by the media as deaths which were avoidable (i.e. that they should not have happened at all), unexpected, or attributable to failing in quality of care. None of these can be directly inferred from an SMR – it can only signal that further investigation may be required. The standardised mortality ratios used at the trust are RAMI (risk adjusted mortality ratio) and SHMI (summary hospital mortality ratio). The expected mortality in the standard population is set at 100 (RAMI) or 1 (SHMI).

1.6 It is likely that the frequency of risk groups (populations grouped by age / gender / diagnoses / admission type / deprivation) vary widely between trusts and local weightings may therefore be very different. While hospital standardised mortality ratios, for example, are valid for comparing trusts to the national average (the standard population) they are less useful for comparing between trusts. This means that ranking hospitals on the basis of their SMRs is misleading.

1.7 Hospitals are required to estimate the number of ‘preventable deaths’ – deaths that were reviewed / investigated and as a result considered more likely than not to be due to problems in care – based on case record reviews of deceased patients. Nearly a quarter of all NHS hospital admissions are aged over 75 years, and more than 40% of deaths occur in those older than 80 years. Moreover, half the UK population end their lives in hospital, with the actual number varying substantially between hospitals depending on local alternatives for provision of end of life care. Thus, expected deaths as a result of underlying disease account for a large proportion of mortality, making it difficult to identify a signal of preventable deaths due to problems with care. Even when errors of commission or omission do occur, establishing the degree to which healthcare has contributed to death amongst very elderly, frail patients with
serious illness and multiple comorbidities towards the end of their natural lifespan and with just days or hours to live is difficult.

1.8 The principal approach to measuring preventable deaths involves detailed retrospective case record review (RCRR) by trained reviewers. This has clinical credibility in terms of taking account the complexity of patients’ conditions and care and indicating whether or not poor care was responsible for any death. However data generated from case record reviews and investigations, for example estimates of the number of deaths thought more likely than not to be due to problems in care, are subjective and so not useful for making external judgements about the safety of trusts.

1.9 Case record review assessment is finely balanced and subject to significant inter-reviewer variation. It does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.

1.10 Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems, none of which would be likely to have caused the death in isolation but which in combination can contribute to the death of a patient.

1.11 The largest RCRR study of deaths in England identified a preventable death rate of 3.6% and no significant variation in the proportion of avoidable deaths between hospitals.

2.0 Situation

2.1 The National Guidance on Learning from Deaths: National Quality Board 2017 stipulated that as from April 2017 all NHS trusts and foundation trusts must collect and publish, on a quarterly basis, specified information on deaths, including those that are assessed as more likely than not to be due to problems in care, and evidence of learning and action that is happening as a consequence of this information.

2.2 All patients who die at the trust undergo a two stage retrospective case record review as detailed in the Mortality Governance Policy [Appendix 1].

2.3 Reviewers are asked to judge whether there were any problems in care that had contributed to the patient’s death. The judgement is framed by a six point scale:

<table>
<thead>
<tr>
<th>Avoidability of death scale</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Score 1</td>
<td>Definitely avoidable</td>
</tr>
<tr>
<td>Score 2</td>
<td>Strong evidence of avoidability</td>
</tr>
<tr>
<td>Score 3</td>
<td>Probably avoidable (more than 50:50)</td>
</tr>
<tr>
<td>Score 4</td>
<td>Possible avoidable, but not very likely (less than 50:50)</td>
</tr>
<tr>
<td>Score 5</td>
<td>Slight evidence of avoidability</td>
</tr>
<tr>
<td>Score 6</td>
<td>Definitely not avoidable</td>
</tr>
</tbody>
</table>

2.4 Problems in care are defined as patient harm resulting from acts of omission (inactions such as failure to diagnose and treat according to evidence based
3.0 Mortality Dashboard for Quarter

3.1 Learning from deaths dashboard

Chairman: Lynn McGill
Chief Executive: John Wilbraham
3.2 During Quarter 1, 153 patients died at the trust. All deaths underwent a two stage retrospective case record review; one death was thought to have been potentially avoidable.

3.3 One patient with learning disabilities died at the trust during the first quarter. The death was reviewed using LeDeR methodology and found to be unavoidable.

3.4 The average crude mortality for Quarter 1 is 1.77%.

3.5 The standardised mortality ratios for the quarter are as follows:
   - Summary hospital mortality index – 1.139 (as expected range)
   - Risk adjusted mortality index (RAMI) – 90.23

4.0 Root Cause Analysis Conducted into Patient Deaths for Quarter

4.1 One death has being investigated under the Serious Incident Framework and was declared as an unexpected death following a root cause analysis (RCA) investigation.

4.2 The RCA concluded that the death was more likely than not to have resulted from problems in care/service provision. Learning from the RCA has been identified and shared and actions implemented to reduce the likelihood of recurrence. The trust has complied with its duty of candour responsibilities.

5.0 Lessons Learned

5.1 153 deaths were reported on Datix (computer based incident reporting system) in Quarter 1. Actions are assigned on Datix to individual doctors and nursing staff who are required to provide feedback when policies or processes have not been followed. Issues identified from the mortality reviews include:
   - SBAR (situation / background / assessment / recommendations) verbal handover documents were not all present for all transfers and some were not fully completed
   - Not all sections were fully completed on the End of Life Care Plan
   - After death care of the family and patient is not always clearly documented
   - On occasion it is evident from the notes that although pathways are being implemented, the care bundle documentation is not always present (e.g. community acquired pneumonia, sepsis, acute kidney injury)
   - Nursing assessments and care planning standards not always achieved. Legibility and identity of staff was variable
   - Fluid balance monitoring remains variable with compliance

5.2 Examples of good practice highlighted by the mortality reviews include:
   - Evidence of good, timely management and care planning by the clinical team
   - Risk assessments completed on admission
   - The majority of nursing care documentation and formulation of care plans are clear and legible. Nursing risk assessments are regularly updated
   - Prompt medical review and treatment for raised National Early Warning Scores (NEWS)
   - Good documentation of discussions with relatives and patients
   - Good communication between teams evident
• Timely referrals to the Palliative Care Team and excellent plans formulated when reviewed by the team.

6.0 Summary

6.1 All patient deaths at the hospital are subject to retrospective case record review using a two stage process.

6.2 Lessons learned from these reviews are shared with the teams.

6.3 Recurrent themes identified from the mortality reviews are used to identify areas for quality improvement.

7.0 Recommendations

7.1 The Board is asked to note the contents of this report.
MORTALITY GOVERNANCE POLICY
**Executive Summary:**
For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However, some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures.

NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths where problems in care might have contributed is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon (National Quality Board, 2017). This policy sets out the mortality governance framework for East Cheshire NHS Trust.

**Supersedes:**
Not applicable

**Description of Amendment(s):**
New Policy

**This policy will impact on:**
- All trust staff

**Financial Implications:**

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<tr>
<td>Issued By:</td>
<td>Julie Green, Director of Corporate Affairs and Governance and John Hunter, Medical Director Dr Susan Knight, Associate Medical Director (Chair Trust Mortality Sub-committee)</td>
<td>Review Date:</td>
<td>July 2020</td>
</tr>
<tr>
<td>Author:</td>
<td>Andy Chambers, Head of Safety, Risk and Resilience</td>
<td>Impact Assessment Date:</td>
<td>April 2017</td>
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**APPROVAL RECORD**

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<tr>
<td>Mortality Sub-Committee Director of Corporate Affairs and Governance</td>
<td>June 2017</td>
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Table of Contents

1. Introduction
   Page 4
2. Purpose
   Page 4
3. Roles and Responsibilities
   Page 5
4. Governance Arrangements
   Page 7
5. Process
   Page 8
6. Monitoring Compliance
   Page 9
7. References
   Page 9

Appendices

Appendix 1: Mortality Sub-committee Terms of Reference
1. Introduction

1.1 Background

Research suggests that approximately 3-5% of in-hospital deaths in England are due to a problem in care and are therefore potentially avoidable. The only way to determine if a death is potentially avoidable is through the process of retrospective case record review (RCRR). In order to detect and reduce the level of avoidable deaths an NHS organisation needs to have robust governance arrangements for reviewing the care of patients and analysing mortality data.

Whilst only a small proportion of patients who are admitted to hospital die, scrutinising the care they received during the admission provides an opportunity to identify factors which may have contributed to their death. Mortality reviews are an established part of the provision of high quality clinical care and the lessons learned and actions taken from these reviews may impact positively on all patients, reducing complications, length of stay and readmission rates. Such actions may include improving pathways of care, reducing variability of care delivery through the use of care bundles, and early recognition and escalation of care of the deteriorating patient. Mortality reviews will identify examples where these and other clinical processes can be improved.

Mortality reviews are a systematic activity designed to enable clinicians and managers at any level in the Trust to understand the underlying circumstances and culture that may lead or contribute to the death of patients.

Learning from a review of the care provided to patients who die should be integral to a provider’s clinical governance and quality improvement work. This policy has been written following recommendations from the publication “National Guidance on Learning from Deaths”, (National Quality Board, March 2017).

1.2 Review

This policy will be reviewed on a three-yearly basis by the Mortality Sub-Committee or in response to local or national changes in guidance or policy.

2. Purpose

The aim of this policy is to set out clear roles and responsibilities to ensure, as a Trust, we meet our obligations to review and understand information relating to mortality, act on that information to support quality improvement and to undertake robust structured mortality reviews of a consistent quality.

Clinicians (including doctors, nurses and allied health professionals) should systematically use mortality reviews to provide assurance that the care provision within their service is of high quality and safe and where feasible implement lessons learned from these reviews to improve patient outcomes. This policy will describe the process for mortality reviews.

The mortality review process will enable data from a large number of deaths to be analysed and interrogated to identify those areas where there may be systematic and correctible shortcomings in care that contribute to preventable deaths. Analysis will support quality improvement programmes as well as permitting contemporaneous feedback and actions...
following individual case reviews. This approach will provide assurance that the Trust is doing all it can to identify and learn from episodes of care where harm may have occurred. It also provides an opportunity to identify pathways of care ranging across health and social care providers which may be in need of collaborative review in order to improve patient outcomes. These reviews will be conducted in line with current agreed protocols for interface incidents and investigating serious incidents requiring investigation.

The information collected from mortality reviews will be presented at Public Board alongside data on crude, standardised and national mortality rates.

### 3. Roles and Responsibilities

#### 3.1 Chief Executive

The Chief Executive is the Accountable Officer of the Trust and as such has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to national guidance on learning from deaths issued in respect of Governance.

#### 3.2 Medical Director

The Medical Director has delegated accountability for mortality at board level and has responsibility to monitor, review and receive assurance on the effective implementation of national and local strategies targeted at reducing preventable mortality in accordance with patient choice, reducing adverse events, improving outcomes and quality of care for patients. The Medical Director will provide the quarterly mortality dashboard to the trust board and, in conjunction with the Chair of the trust Mortality sub-committee, a quarterly mortality report to trust SQS.

#### 3.3 Director of Nursing, Performance and Quality

The Director of Nursing, Performance and Quality has delegated accountability for patient safety and has a responsibility to use data and information from mortality sub-committee to inform patient safety improvements.

#### 3.4 Non-Executive Director

Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support in line with the guidance set out in the National Guidance on Learning from Deaths.

#### 3.5 Director of Corporate Affairs and Governance

The Director of Corporate Affairs and Governance has delegated accountability for governance and risk management across the Trust and for working in collaboration with the Medical Director to ensure the Board and relevant committees receive appropriate assurance with regard to the implementation of this policy.

#### 3.6 Associate Medical Director for Clinical Effectiveness

The Associate Medical Director for Clinical Effectiveness has delegated accountability to lead on mortality governance and operational implementation across the trust. The Associate Medical Director chairs the mortality sub-committee and is responsible for the
committee’s work plan, ensures all mortality data/information is appropriately reviewed and actioned and contributes to the quarterly SQS assurance report. They will make sure that the trust fulfils its statutory and contractual duties to report and investigate all deaths that occur in the organisation and provide expert advice to investigation leads.

3.7  Deputy Director of Corporate Affairs and Governance

The Deputy Director of Corporate Affairs and Governance will provide specialist advice across the organisation in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and nonclinical risk and governance.

3.8  Head of Safety, Risk and Resilience

The Head of Safety, Risk and Resilience has operational responsibility for the implementation and monitoring of the mortality review process in place in the trust as well as managing the mortality review nurses. The Head of Safety, Risk and Resilience has responsibility to provide information and analysis of data collected as part of the mortality review process.

3.9  Mortality Review Nurses

The mortality review nurses will undertake all stage 1 mortality reviews of patients that have died at East Cheshire NHS Trust. The mortality review nurses are responsible for managing the mortality review process and ensuring that stage 2 reviews are completed and appropriately identify lessons learned and good practice. The mortality review nurses will provide information and data compiled from the mortality reviews for inclusion in reports to the mortality sub-committee and the board. Where concerns are identified they will be escalated through the standard incident reporting process (Datix®).

3.10  Clinical Directors

Clinical Directors have the responsibility to ensure that mortality reviews and data from mortality reviews are reviewed at Directorate/Service mortality and morbidity meetings and/or Directorate SQS. They are responsible for ensuring that actions are implemented and sustained and this can be evidenced.

3.11  Consultants

It is the duty of all registered medical practitioners to understand the outcomes of their clinical practice. Consultants have a responsibility to analyse the information contained within mortality reviews pertaining to their clinical work and to work collaboratively and proactively to implement actions or learning. Individual consultants are responsible for examining the information collated in each stage 1 mortality review and appending their comments and feedback. To improve the objectivity of the stage 2 process, in cases where possible deficiencies of care have been identified in stage 1 the second stage of the mortality review will be completed by a consultant who was not directly involved in that patients care. It is expected that consultants will engage their team in this process and will discuss the findings/lessons learned with the team including the trainees for whom they are responsible. The consultants also have a responsibility to help identify changes in practice and work towards implementation of the changes required.
3.12 Associate Directors

The Associate Directors in each directorate have operational responsibility for ensuring staff within their respective directorate adheres to this policy and associated procedures. The Associate Directors are responsible for embedding individual and systemic learning as a result of mortality reviews reported within the trust.

3.13 All Staff

All staff employed by the trust have a legal, professional and moral duty to assist in any investigations or implementing improvement actions within their sphere of responsibility.

Staff will be informed if they are needed to participate in a mortality review or complete any actions by the mortality review team and/or by the Mortality sub-committee.

4. Governance Arrangements

4.1 Trust Board

Mortality reporting will be provided to the Trust board by the Medical Director on a quarterly basis as a dashboard identifying the total number of inpatient deaths (including Emergency Department deaths), those deaths that the trust has subjected to case record review, an estimate of how many deaths were judged more likely than not to have been due to problems in care and the number of patients with a learning disability who have died whilst receiving inpatient care. The Non-Executive Director for mortality will provide assurance that the detailed quarterly report has been reviewed at the Trust Safety, Quality and Standards (SQS) Committee and the trust is meeting its requirements.

Information on mortality will be summarised and published in the trusts quality account in line with national guidance, including evidence of learning and action as a result of this information and an assessment of the impact of actions that have been taken.

4.2 Trust Safety, Quality and Standards Committee

The Trust Safety, Quality and Standards (SQS) Committee receive assurance from the Mortality Sub-committee on a quarterly basis in a report from the Medical Director/ Associate Medical Director for Clinical Effectiveness. SQS will approve the Mortality Sub-committee terms of reference.

4.3 Mortality Sub-committee

The Mortality Sub-committee has oversight of data and information relating to mortality at East Cheshire NHS Trust. The purpose of the sub-committee is set out in the sub-committee’s terms of reference (Appendix 1):

- The purpose of the Mortality Sub-Committee is to monitor, review and receive assurance on the effective implementation of national and local strategies targeted at reducing preventable mortality in accordance with patient choice, reducing adverse events, improving outcomes and quality of care for patients.
4.4 Reporting

A quarterly analysis of the data collected from mortality reviews is presented to the Mortality Sub-committee for discussion and is then shared throughout the organisation via the Clinical Directors (Directorate Safety, Quality and Standards meeting) and Heads of Nursing (Harm Free Care Group).

5. Process

5.1 Mortality Reviews

Mortality reviews are undertaken for all patients who die either as an inpatient or in the Emergency Department at East Cheshire NHS Trust. The process for the mortality reviews is set out in the Mortality Governance Standard Operating Procedure available via the trust Infonet. The mortality review process and development of this policy has been reviewed and approved by the mortality sub-committee following the publication of the National Guidance on Learning from Deaths. The proforma for mortality reviews has been assimilated into the Datix® Integrated Risk Management system and is used to collect data on all inpatient deaths.

5.2 Mortality Support Nurses

Two mortality support nurses are in post to ensure consistency in completing mortality reviews and to support the clinical teams in completing stage 2 of the review process. The mortality support nurses have the appropriate skills through specialist training and protected time as part of their contracted hours to review and support the investigation of deaths.

5.3 Learning Disability

A patient with a learning disability who dies as an inpatient will also have a proforma completed from the Cheshire learning disability mortality group. This is shared with the Learning Disabilities Mortality Review Programme (LeDeR) and discussed as part of a multi-agency case review.

5.4 Maternal Death

All maternal deaths investigated as a serious incident as part of the serious incident process.

5.5 Child Death/ Stillbirth and Neonatal death

All child deaths are reported from the organisation to the Child Death Overview Panel for review. The link to details can be found in the references section below.

5.6 Responding to a mortality alert

Organisations will receive mortality alerts from the Dr Foster Unit at Imperial College when it is identified that significantly more than expected deaths have occurred in a specific diagnostic group. The mortality reviews completed are used to inform the response to Dr Foster alerts. The investigation and response will be discussed and reviewed at the Mortality Sub-committee and at trust SQS before sharing with the Care Quality Commission (CQC).
5.7 **Bereavement Services**

Relatives are signposted to Macclesfield Bereavement Services following a death in hospital. Information on bereavement services are provided in a booklet given to all families when they collect the death certificate at the trust’s general office.

5.8 **Duty of Candour**

Where a significant failure of care is identified this will sensitively be shared with the next of kin as part of the duty of candour process. A mortality review will be graded to identify if any harm has been caused to the patient. In accordance with the duty of candour policy any mortality review flagging moderate or severe harm or indicating that the patient’s death has been caused by the organisation, then duty of candour will be applied.

6. **Monitoring Compliance**

6.1 **Measuring performance and audit**

As reported on the mortality dashboard to the Trust Board
- Number of Deaths
- Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (not including patients with identified learning disabilities)
- Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities
- Perinatal/child/ maternal/ stillbirth deaths – quarterly reporting from April 2017
- Duty of Candour monitored at Serious Incidents Requiring Investigation Sub-committee and is meeting the required standards.

Evidence will be sought that Directorate Specialities are learning and changing practice from mortality reviews (e.g. outcome from audit of mortality and morbidity audit meetings).

7. **References**

Further guidance and information


- Learning candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. Care Quality Commission (CQC) 2017


- Mortality Review Standard Operating Policy.
http://www.eastcheshire.nhs.uk/About-The-Trust/policies/M

- East Cheshire Child Death Overview Panel
# APPENDIX 1

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<thead>
<tr>
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<tr>
<td>Medical Director</td>
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<tr>
<td>Director of Corporate Affairs and Governance</td>
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To be read in conjunction with the following documents:

Terms of Reference for the Safety, Quality and Standards Committee of the Board

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Document for Public Display: Yes

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Officer responsible for archive: Chair of Sub-Committee
1. **Definition**

- The purpose of the Mortality Sub-Committee is to monitor, review and receive assurance on the effective implementation of national and local strategies targeted at reducing preventable mortality in accordance with patient choice, reducing adverse events, improving outcomes and quality of care for patients.

2. **Membership**

- Associate Medical Director for Clinical Effectiveness (Chair)
- Medical Director (Deputy Chair)
- Director of Corporate Affairs and Governance
- Principle Information Analyst
- Chief Pharmacist or Deputy Chief Pharmacist
- A senior clinical representative from the Surgical, Medical and Urgent Care Service Lines
- Palliative care consultant
- Clinical Coding Manager
- Head of Nursing – individual attendance as dictated by agenda items
- Director of Nursing, Performance & Quality
- Head of Safety, Risk and Resilience
- ‘Representative' Doctor in Training
- Mortality Review Nurse

- Other members will be co-opted as required in accordance with the Sub-Committees' work plan.
- Deputies to attend meetings where members are unable to do so.

3. **Quorum**

- The group will be considered quorate if either the Chair or Vice Chair is present, plus one senior clinical representative and a representative from Corporate Affairs and Governance.
- Virtual meetings may be held where required and an audit trail maintained of decision making.

4. **Chairmanship**

- Associate Medical Director for Clinical Effectiveness will Chair the group. The vice chair will be the Director of Corporate Affairs and Governance.

5. **Frequency of Meetings**

- The Group will meet monthly; ad hoc meetings may also be required.

6. **Operational Duties of the Sub-Committee**

- To work towards the elimination of all potentially preventable in-hospital mortality.
- To review on a monthly basis, the benchmarked mortality rates of the Trust, including the previous months’ data.
• To consider the mortality data in conjunction with other qualitative clinical data and identify areas for future investigation. To facilitate the increased use of Clinical databases, run by various bodies including professional societies in the fuller assessment of in-hospital mortality.
• To investigate any alerts received from the Care Quality Commission (CQC) or identified by the Mortality monitoring information systems e.g. Dr Foster, HED, etc.
• To develop data collection systems to ensure the Trust’s mortality data is timely verifiably accurate and in line with national and international best practice.
• To ensure mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of clinical excellence.
• To develop an annual mortality clinical coding improvement plan and receive regular reports on its implementation.
• To assign clinical leads to address raised mortality in particular clinical areas by the deployment of strong evidence based interventions such as care bundles. The Mortality Sub-Committee will receive regular reports on implementation and the measurable impact of these interventions on hospital mortality.
• To work with established groups to ensure each junior doctor intake receives the latest guidelines on care protocol implementation and clinical coding best practice.
• To review and monitor compliance with other Hospital policies including DNACPR and Death Certification Policy.
• To monitor and consider the information from the electronic review of all in hospital deaths.

7. Strategic Duties of the Sub-Committee

• To act as the strategic hospital Mortality Overview Sub-Committee with senior leadership and support to ensure the alignment of the hospital departments for the purpose of reducing all avoidable deaths.
• Strategic oversight of extant mortality review committee(s).
• To produce a Mortality Reduction Strategy that aligns hospital systems such as audit, information services, training and clinical directorates. This strategy will be reviewed on an annual basis by the Medical Director.
• Sign off of action plans and methodologies that are designed to reduce morbidity and mortality across the trust.
• Sign off of all regulatory mortality responses.
• To report on Mortality performance to the Board.

8. Reporting Arrangements

• The group will provide reports to the Safety Quality and Standards Committee with additional escalation of concerns/ issues as required to the Trust Board.

9. Annual Review of the Committee

• The Committee will undertake an annual self-assessment on their effectiveness and performance to:-
Review its own performance to ensure it is operating effectively;
Determine whether its planned activities and responsibilities for the previous year have been sufficiently discharged; and
Recommend any changes and/or actions it considers necessary, in respect of the above

- A quarterly written report will be provided to the Trust Board Safety, Quality & Standards Committee, which details the Self-Assessment as an appendix

10. Monitoring Compliance
- As part of the annual self-assessment referred to in Paragraph 9, which will be reported in the annual report, the Committee will review that the terms of reference have been complied with and whether they remain fit for purpose.
  - Duties
  - Reporting arrangements to the Trust Board Safety, Quality & Standards Committee
  - Membership, including nominated deputy where appropriate
  - Required frequency of attendance by members
  - Requirements for a quorum
  - Frequency of meetings
  - Process for monitoring compliance with all of the above

11. Terms of Reference
- Terms of Reference and membership will be reviewed annually.
**Report of:**

**Responsible Officer:** Head of Estates

**Accountable Officer:** Director of Finance

**Author of Report:**

Robert Few, Head of Estates
Mark Ogden, Director of Finance

**Subject/Title:**

Estate Strategy Update 2017

**Background papers (if relevant):**

Estate Strategy 2012/13 to 2017/18.

**Purpose of Paper:**

To update the Board on progress made to date against the strategy.

**Action/Decision required:**

To note.

**Mitigates Risk Number: (identify)**

Datix no: 1334. If the Estate infrastructure is not sufficiently invested in and adapted to align with the health economy strategy then there will be an impact on the quality of the delivery of clinically & financially sustainable services.

**Link to Care Quality Commission Domain**

Safe ✓
Caring
Responsive
Effective ✓
Well-led

**Link to:**

- Trust’s Strategic Direction
- Corporate Objectives

Continuously improve quality, safety and patient experience. Achieving financial sustainability within an effective governance framework. Contributing to our local communities and being considerate to the environment.

**Legal implications - (identify):**

The Trust must meet a number of statutory requirements for the quality and safety of its’ Estate department.

**Impact on quality:**

N/A

**Resource impact:**

N/A

**Impact of equality/diversity:**

N/A

**Avoid acronyms or abbreviations - if necessary list:**

ECT – East Cheshire Trust
CEF - Carbon Energy Fund
QIPP - Quality, Innovation, Productivity & Prevention
MDGH - Macclesfield District General Hospital
NHSPS – NHS Property Services
ATC – Adjusted Treatment Cost
ERIC - Estate Return Information Collection
PCT – Primary Care Trust
STP – Sustainability Transformation Programme
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Chairman: Lynn McGill
Chief Executive: John Wilbraham
Estate update – November 2017

1 Introduction and strategic context

This report provides an update for the Board on the latest position regarding the Estate Strategy.

The existing Estate strategy covers the period 2012-2017

The purpose of this paper is to update the Board on progress made on the estate strategy. It describes the background to the current estate strategy and how the Trust is performing against this. It highlights the drivers of the strategy going forward and how the Trust compares to the national Model Hospital benchmarks and its peers, and includes in appendix 1 a list of all sites at which staff are based.

The 2012-2017 estate strategy was created to align with the Trust’s five year integrated business plan covering the same period. The main objectives identified in the strategy were to focus on statutory requirements, and the Trust’s service strategy to meet long-term local and national objectives for providing local healthcare.

In order meet these objectives the following was taken into consideration:

1. The long term strategies for providing local healthcare services and the Trust’s strategy to meet them;
2. estate performance criteria based on performance indicators, benchmarks such as Estate Return Information Collection (ERIC) data and ‘Estatecode’ guidance to measure:
   - improvements in the quality of the operational estate over time measured through reductions in backlog maintenance;
   - improvements in statutory compliance and reduction in risk measured through reductions in non-compliance with statutory legislation and incident rates;
   - improvements in energy performance to meet the NHS Carbon Reduction Strategy;
   - reductions in the revenue cost of the operational estate over time measured by mapping trends in overall maintenance costs, utilities costs and income-to-asset value ratio;
   - improvements in the use of the estate over time by eliminating under-used and surplus assets measured by comparing the building floor area against total site area and by income-to-asset value ratio.

The performance of the ECT estate is subsequently highlighted in section two (and appendix 2) of this report.
The organisation's strategic direction means there will be changes across the hospitals and community estate

The Trust’s updated strategic organisational direction will inform the Estate strategy for the next period, 2018 to 2021. Although capital projects have already commenced at the Macclesfield Hospital site:

1. building an extension to facilitate the streaming of patients more effectively through the Accident and Emergency Department;
2. upgrading the Endoscopy Department so the Trust can achieve compliance targets and enable the department to be more productive;
3. maintaining patient safety by continuing with the fire precaution programme.

One enabler identified within the Caring Together programme is to make best use of the estate across Cheshire. This will bring changes across community settings to meet the requirement to have a local model allowing the community based workforce to co-locate and share knowledge and best practice from different organisations.

Changes must ensure the estate remains fit for purpose, safe, functional, effective and efficient across both the acute and community settings. The Trust will use the Lord Carter Report 2016 and Model Hospital metrics to ensure the requirements above are monitored so that unwarranted variation in productivity and efficiency are avoided. The Model Hospital metrics relating to the estate are reported later in this report.

Focus is on the operational estate

In the last three years, NHS Property Services (NHSPS) has been through a period of sustained change, with the ultimate goal of building a portfolio of property that is fit for purpose, efficient and cost effective. An important part of achieving their goal has been the introduction of market rent based charging on all of their freehold properties.

NHSPS will charge tenants market value for property as it moves them away from the ‘cost recovery’ approach they had used previously, where the cost of running each building was been split between the occupants in proportion to the space they occupied.

NHSPS property charges may not necessarily be any higher than at present as the Department of Health has agreed with NHS England that it will meet any increase in property costs at a national level. The mechanism for compensating commissioners and providers of NHS services at a local level is the responsibility of NHS England.

The current risk to the Trust therefore is that should commissioners take the opportunity to withdraw some subsidy payments it could eventually result in a significant cost pressure to the Trust. This has been the case recently at Handforth Heath Centre whereby commissioners withdrew the subsidy relating to the acute services operating from that property.

A list of sites where East Cheshire NHS Trust has a formal arrangement with NHSPS is listed in appendix 1, section 5.
Other non NHSPS sites (GP’s, private Landlords etc):
The Trust will work towards vacating properties where there is an
opportunity to do so but it is essential for the Trust to be working
with commissioners and other providers to ensure cost pressure or
cost avoidance are mitigated in the future.

In addition to the NHSPS leases, the Trust inherited forty sites where
there have been no formal arrangements in place; this goes back to
the demise of the PCT 2012/13. The Estate team have already
undertaken numerous surveys across the East Cheshire patch to
identify which sites our services are working from. It is important to
continue working with clinical managers to reduce the community
footprint and to ensure future cost pressures are avoided at these
sites.

Rationalisation of the estate is an important theme of the Caring
Together strategy

Caring Together was developed as a programme in response to a
number of significant challenges facing health and social care
services, including the rapidly increasing older population,
increasing life expectancy, high levels of demand on care services,
increasing complexity in people’s needs, and at the same time limited
funding for health and social care.

East Cheshire NHS Trust is an integrated Trust with both acute and
community settings. Therefore, for the Trust to align with the Caring
Together programme and STP strategies, the Estate rationalisation
programme will continue in the community. East Cheshire NHS
Trust will work with other partners and providers within the area to
support the vision of co-location of five neighbourhood integrated
care teams in Eastern Cheshire. It requires the Trust to adapt an agile
working approach within the community. This will bring about less
desks, more hot desks and working with the CCGs and Local
Authorities in one ‘public estate’.

Although there aren’t many new buildings, the Trust benchmarks
favourably on estate’s metrics

The Model Hospital metrics have been used to demonstrate and
update the board on performance of the estate. East Cheshire NHS
Trust metrics for the Model Hospital dashboard are shown in
appendix 2.

The dashboard identifies the major metrics trusts need to consider
when reviewing their estate. The metrics provided in this section are
based on data provided by trusts through data collection systems,
mainly the Estate Return Information Collection (ERIC) and the
Patient Led Assessment of the Care Environment (PLACE) system.

The previous 2016 Strategy update paper reported on the 2014-15
Lord Carter Dashboard and it used the Adjusted Treatment Cost
(ATC) metric to compare estate and facilities data with the clinical
activity using that estate, especially in terms of productivity metrics.
However, to be consistent with the rest of the Model Hospital
initiative, the Weighted Activity Unit (WAU) has been used in the
2015-16 Dashboards.

Metrics using the WAU are important as they relate estate and
facilities elements to the activity taking place in them. This is
effectively how “productive” the estate is, as opposed to how
“efficient” it is in terms of the costs related to its provision. For
instance, two trusts could have exactly the same size hospitals costing

Chairman: Lynn McGill
Chief Executive: John Wilbraham
the same in terms of estate and facilities to run i.e. they would have the same levels of efficiency. However, the Trust with the greater activity moving through their hospital would be more productive. An explanation of each domain is reported in more detail in appendix 2.

3 Investing in our estate

Capital investment is focused on the owned estate

2016 / 17 estate capital expenditure has focused on delivering the Trust’s strategic projects and reducing backlog maintenance to ensure the estate remains fit for purpose. A summary of the main elements of the capital programme is provided below.

This has meant significant investment in A&E

A&E Primary Care Streaming, cost £879k:
Improvement of patient flow through A&E with patients initially being reviewed by a triage nurse who will assess whether the patient requires GP Out of Hours or A&E input. This process will:

- ensure that patients are directed to GP services or A&E accordingly, which will assist in managing demand / pressures on A&E,
- enable patients to be signposted to the correct location considering their clinical need,
- increase GP Out of Hours service provision with two additional GP consulting rooms being in place,
- increase waiting area space / capacity for GP and A&E,
- provide flexible space in GP out of hours to accommodate a training room for A&E staff (when the consulting room is not in use).

Upgrading the endoscopy unit

Endoscopy Treatment Unit Improvements, cost £475k:

- To expand / improve the current accommodation for endoscopy washing / disinfection in order to meet the requirements for JAG accreditation.
- To implement best practice from an infection prevention/control perspective.
- A clear pathway / flow for the processing of endoscopes from the washer / disinfection area to the clean area to satisfy infection control requirements,
- Enables the current washer disinfector machines to be utilised as pass through machines (from the disinfection area to the clean area).

And continuing with improvements across the hospital site

Backlog maintenance projects:

- Continuation of the fire precaution work project (set to start 1st April 2018), cost £196k,
- New flooring installations, cost £87k,
- Essential maintenance in theatres 1 to 4, cost £170k,
- New pharmacy air conditioning system, cost £270k,
- Roof repairs, cost £25k,
- Legionella avoidance work, £10k,
- New signage across the Trust, cost £40k.

The main focus for 2018 is to continue with the Operating Theatres upgrades along with continuing to offset Estate related backlog maintenance.
4 Next Steps

Millbrook represents a potential estate development opportunity

4.1 The Model Hospital metrics show the Trust’s space utilisation is good when compared against the national benchmark and our peers. The amount of underutilised space is currently 0.6% which is well within the Lord Carter recommendations.

4.2 The Trust has a number of opportunities both at the hospital and within the community to rationalise the estate further to ensure patients receive the right care at the right place regardless of its high occupancy levels. The Millbrook building presents an opportunity for the Trust to consolidate the estate or improve services should the current tenant, Cheshire & Wirral Partnership (CWP), vacate the building in 2018.

There is a need to refresh Estate Strategy for 2018 - 2021

4.3 The Estate Strategy will be updated in 2018 and will cover the period to 2021.

4.4 The refreshed strategy will be aligned to:

1. be consistent with the Model Hospital metrics allowing for improvements where necessary,
2. identify capital projects plans in order to offset and manage backlog maintenance and Critical Infrastructure Risk (CIR) risk effectively,
3. the Sustainable Transformation Plan (STP) and Caring Together programme.
4. remain fit for purpose, safe, functional and effective & efficient,
5. reduce occupancy cost in the community estate and/or mitigate cost pressures where historical peppercorn rents exist.

Recommendation

5.1 1. To note.

Sign off Role title

Mark Ogden
Director of Finance
Appendix 1

Assets, Landlord & Tenant Property Management

The list below identifies the Trust’s property portfolio across Cheshire. The property portfolio has been split into the following categories:

1. East Cheshire Freehold Sites
2. Formal MDGH Lease Arrangements – East Cheshire NHS Trust as tenant
3. Formal Community Lease Arrangements – East Cheshire NHS Trust as tenant (non NHSPS)
4. Informal Community Site Accommodation (no lease or licence in place and no accommodation costs)
5. NHS Property Services Leases

1. East Cheshire Freehold Sites
   1. Macclesfield District General Hospital (MDGH)
   2. Congleton War Memorial
   3. Knutsford and Community District Hospital
   4. Pavilion House

2. Formal MDGH Lease Arrangements
   1. New Alderley House
   2. Silk House
   3. Hope House
   4. Henbury House
   5. Ingersley
   6. Gawsworth House
   7. Blue Zone Land
   8. Macclesfield Conservative Club (Parking Only)
   9. Macclesfield Cricket Club (Parking Only)

3. Formal Community Lease Arrangements (non NHSPS)
   1. Health Hub
   2. Eagle Bridge (Sexual Health)
   3. Fountains in Chester (Sexual Health Unit)

4. Informal Community Site Accommodation Arrangements (no accommodation costs for the Trust, to date)
   1. East Cheshire Hospice
   2. Festival Hall GP Practice
   3. David Lewis Centre
   4. West Cheshire College Health & Wellbeing Centre
   5. Green Moss Medical Centre
   6. Bollington Medical Centre
   7. Meadowside Medical Centre
   8. Chelford Surgery
   9. Kenmore Medical Centre

Chairman: Lynn McGill
Chief Executive: John Wilbraham
10. Poynton Clinic (GP side)
11. Handforth Clinic (GP side)
12. The Schoolhouse Surgery
13. Manchester Road Medical Centre
14. Toft Road Surgery
15. Annandale Medical Centre
16. Mcilvride Medical Centre
17. Hulme Hall Health Centre
18. Lawton House Surgery
19. Readesmoor surgery
20. Northwich Sauna
21. Park Lane Special School
22. Neston Clinic
23. Ashgrove Children's Centre
24. Congleton & Holmes Chapel Children's Centre
25. Oakenclough Children's Centre
26. Oak Tree Children's Centre
27. Macclesfield Leisure Centre
28. Congleton Leisure Centre
29. Manor Park Children's Centre
30. Congleton Children's Centre
31. Poynton Children's Centre
32. Hurdsfield Children's Centre
33. Broken Cross Children's Centre
34. Audley Health Centre
35. Rode Health Surgery
36. Oaklands Medical Centre
37. Breast Screening Mobile Unit
38. Leek Cottage Hospital

5. NHSPS Property Services Leases

1. New Alderley House (part)
2. Handforth Medical Centre
3. Wilmslow Medical Centre
4. Sanders Square
5. Weston Clinic
6. Priorsleigh Medical Centre
7. Holmes Chapel Health Centre
8. Kingsmead Medical Centre
9. Eagle Bridge Health & Wellbeing Centre (not Sexual Health)
10. Church View Primary Care Centre
11. Dene Drive Health Centre
12. Wharton Primary Healthcare Centre
13. Weaverham Clinic
14. Ashfields Health Centre
15. Alsager Health Centre
16. Stanney Lane Clinic
17. Blacon Church Hall

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Appendix 2

East Cheshire NHS Trust

Estates & Facilities

Robert Few

Tuesday, November 7, 2017

Model Hospital

https://model.nhs.uk

nhs.i.modelhospital@nhs.net
## Estates & Facilities, Trust Level

### Cost Efficiency

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>Year</th>
<th>Trust Actual</th>
<th>Peer Median</th>
<th>Benchmark Value</th>
<th>Info</th>
<th>Variation</th>
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<td>Estates &amp; Facilities Cost (£ per m2)</td>
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### Productivity

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<th>Benchmark Value</th>
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<th>Variation</th>
<th>Trend</th>
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<td>Amount of empty space <em>NEW</em></td>
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<td>Amount of under utilised space <em>NEW</em></td>
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<td>Occupied Floor Area (1,000m2 per WAU)</td>
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<td>Critical Infrastructure Risk (L per m²)</td>
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<td>Total Critical Infrastructure Risk &quot;NEW&quot;</td>
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<td>Total Backlog Maintenance (L per m²)</td>
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<td>Cleanliness - Patient Led Assessment Score</td>
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<td>Food - Patient Led Assessment Score</td>
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<td>Privacy, Dignity &amp; Wellbeing - Patient Led Assessment Score</td>
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<td>Condition, Appearance &amp; Maintenance - Patient Led Assessment Score</td>
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<td>93.8%</td>
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<td>Dementia Environment - Patient Led Assessment Score</td>
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<td>89.8%</td>
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<td>Disability - Patient Led Assessment Score &quot;NEW&quot;</td>
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<td>96.1%</td>
<td>74.5%</td>
<td>78.4%</td>
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</tbody>
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Chairman: Lynn McGill
Chief Executive: John Willbraham
Using peer list: My Peers

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George Eliot Hospital NHS Trust (R LT)
Harrogate and District NHS Foundation Trust (RCD)
Mid Essex Hospital Services NHS Trust (ROB)
Northern Lincolnshire and Goole NHS Foundation Trust (RNL)
Rotherham NHS Foundation Trust (RRF)

South Tyneside NHS Foundation Trust (R T9)
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East Cheshire NHS Property Portfolio.

Estate & Facilities Costs (£ per WAU)
When compared to the national benchmark the Trust is slightly above the recommended level. However, compared to our peer median we are slightly below suggesting our productivity is superior. The cost per WAU will shift towards the recommended benchmark once the adjustments noted within the £ per m² section in the main report have been made.

Hard Facilities Management (FM) Cost (£ per m²)
Hard FM costs show the Trust is cost efficient when compared against the national benchmark and its peers.

Building & Engineering Maintenance Costs (£ per m²)
Maintenance costs show the Trust is cost efficient when compared against the national benchmark and its peers. The Estate team are due to implement a Measured Term Contract (MTC) in early 2018 which should enable the Trust to make savings across both revenue and capital projects.

The Estate Help desk will also be enhanced to allow clinical services to report issues on site quicker and more effectively. Services will be able to track their requests in future with clear communications. The maintenance team will be adapting handheld devices for undertaking work priorities with the additional benefit of good asset management control.

Energy Cost (£ per m²)
Trust energy performance has improved dramatically over the past 5 years by partnering with the NHS SBS Carbon Energy Fund (CEF) to deliver guaranteed energy and carbon savings over a 15 year term. The CEF scheme provides a Combined Heat and Power (CHP) plant at MDGH and many side measures including a Trust wide Light Emitting Diode (LED) lighting upgrade, new refrigeration plant, pumps, motors and radiators. The CEF scheme in combination with other environmental and sustainability schemes has reduced carbon emission output by over 3,000 tCO2e per year which is the equivalent consumption of 600 large family homes. The Trust is on track to exceed the national 2020 NHS carbon reduction target by 34% against the 1990 baseline. The unit cost of energy is showing the Trust that is it cost efficient when compared against the national benchmark and its peers.

Water & Sewage Cost (£ per m²)
Water and sewage costs are set to reduce once the adjustments noted in Estate & Facilities costs (£ per m²) are made.

Soft Facilities Management (FM) Cost (£ per WAU)
These standards are delivered in line with legislative requirements (eg waste regulations, environmental health, Department of Health guidance (national standards of cleanliness, car parking management) and statutory regulations. Soft FM functions with a mix of contracted services but also operates some services 'in house', for example printing services and residential accommodation management. The Trust pays a premium for contracted out services but this reduces the level of financial risk to the Trust and enables greater flexibility in managing and changing services.

Cleaning Cost (£ per m²)
Compared with both peer median and benchmark values, the Trust is clearly operating with a higher weighted activity unit. The Trust's internal monitoring revealed a lowering of cleanliness.
standards in 2015 which fell below the acceptable level of infection control in 2015/2016. Standards of cleanliness in the hospital are fiercely protected in order that the risk of hospital acquired infections is reduced to an absolute minimum. This is monitored through the SQS Committee. In addition to the general cleaning there is an active bed management cleaning programme, enhanced cleaning, Infection cleaning and deep cleaning. This will explain why MDGH WAU costs are higher than the median.

**Food cost £ per meal**
Food is 1p more than the benchmark value and 1p less than the median, so closely compares with performance indicators. Patient menus offer porridge or cereal at breakfast with fruit juice, toast and preserves. At lunchtime a traditional two course meal with a roll or a salad or sandwich with a sweet. In the evening, fruit juice, choice of hearty soup, filled jacket potato, quiche, sandwich or salad with a sweet are available for patients. A snack item is provided later in the evening. A minimum of seven hot drinks are offered during the day and water throughout. The Trust prides itself on the quality of food, the provision of which is monitored closely to ensure the quality and consistency is of a good standard and patient comments are acted upon, as appropriate, to improve the provision when at all possible.

**Laundry & Linen Cost (£ per Item)**
The laundry and linen costs compare favourably with the benchmark value which is mirrored. The Trust actual cost is 2p less than the median. The contract was negotiated through the north west procurement hub 10 years ago in 2016/7 and is a collaborative agreement between a number of Trusts. The contact is currently being market tested and the procurement process is being managed through SBS and ECT Procurement with a view to securing a competitive and efficient quality service for patients.

**Special & Clinical Waste Cost (£ per Tonne)**
The reported special and clinical waste per tonne is more than double the benchmark and median figures. On investigation of the ERIC data submitted, it appears that the cost per tonne of incinerated waste used on the ERIC return had to be estimated as the information was not available from the provider due to commercial sensitivity. The mix, collection and disposal of waste at ECT will be representative of other similar Trusts. The estimated costs used in for calculations were considerably over estimated, so the figures will be adjusted accordingly in the 2016/2017 return; they will prove to be much more closely aligned to benchmark.

**Portering (£ per m2) *NEW* *
Portering at Macclesfield Hospital incorporates postroom duties which may account for the higher Trust WAU costs against benchmark/median cost. There is a relatively high dedicated departmental portering ratio to pool portering which will attract a higher cost due to fluctuating levels of efficiency. The requirement for bespoke portering is high. Previous moves to create a central pool of porters experienced a high level of resistance despite the increased use of communication and recording technology. Further research is being undertaken to progress different and more efficient ways of working using knowledge and experience of the service provider operating throughout the country in a range of hospitals.

**Amount of Non-clinical Space (%)**
The amount of non-clinical space has reduced again in 2015-16 leaving the Trust well within the recommendation of the Model Hospital requirements (The Lord Carter Review suggest no more than 35% non-clinical space with a Trust). The 4.3% empty space relates to the closed nursing accommodation at Congleton War Memorial which cannot be used due to its current condition and is ready for demolishing.

**Critical Infrastructure Risk (£ per m²)**
Critical infrastructure risk (CIR) is the total cost for eliminating high and significant risk backlog maintenance. It represents the amount of capital investment needed to eliminate safety and resilience risks from the operational estate. The risks are made up of three categories:
i. Non-compliance with statutory and mandatory requirements;
ii. Patient, staff and visitor safety issues; and;
iii. Infrastructure works to ensure continuity of services.

It is expected that NHS trusts undertake enough capital investment to keep CIR levels as close to zero as practicable possible.

The higher this metric the greater the relative risk to patients, visitors and staff from safety and resilience problems. As CIR is a sub-set of backlog maintenance, it can be eliminated by either capital investment or disposal of the relevant building.

The 2015 / 16 cost to eliminate CIR is below the national benchmark and the Trust’s peers. The cost of CIR is due to increase as the Trust has recently updated the six facet survey in line with best practice. However, it is not expected to increase CIR above the national benchmark or its peers.
### Report of:
**Responsible Officer**
Director of Corporate Affairs and Governance

**Accountable Officer**

### Author of Report:
Head of Integrated Governance

### Subject/Title
Review of Assurance Framework and Corporate Risk Register

### Background papers (if relevant)
Assurance Framework and Corporate Risk Register

### Purpose of Paper
This report is to provide the Board with an opportunity to review and discuss the Board Assurance Framework and actions which have taken place since the previous meeting.

### Action/Decision required
The Board is asked to:
- Review and discuss the content of the Board Assurance Framework and Corporate Risk Register
- Note the key areas of focus for the next 3 months to reduce the level of risk
- Confirm that the risks identified are consistent with reported information about the organisation

### Mitigates Risk Number: (identify)

**On Corporate Risk Register**

**Mitigates Risk Number: (identify)**
On Assurance Framework

This paper relates to the Assurance Framework and Corporate Risk Register and therefore is linked to all risks.

### Link to Care Quality Commission domain
All domains

### Link to:
- **Trust’s Strategic Direction**
- **Corporate Objectives**

All Objectives

### Legal implications - (identify)
There are no legal implications

### Impact on quality
This review ensures that appropriate systems are in place for the Board to understand the controls relating to any impact on the quality of services

### Resource impact
There are no resource implications

### Impact of equality/diversity
There is no impact on equality/diversity

### Avoid acronyms or abbreviations - if necessary list:
- CQC – Care Quality Commission
- RTT – Referral to Treatment
- QIPP – Quality, Innovation, Productivity and Prevention
- ED – Emergency Department
- STP – Sustainability and transformation plan
1. PURPOSE

This report is to provide the Board with an opportunity to review and discuss the risks contained in the Board Assurance Framework and Corporate Risk Register and to note the key areas of focus for the next 3 months to reduce the level of risk.

2. EXECUTIVE SUMMARY

Board Assurance Framework

The level of risk recorded in the Board Assurance Framework remains unchanged from the previous report, however, the number of gaps in assurance has increased in month by 4. The Board will continue to focus on improving controls linked to the following areas:

– Ensuring patient safety
– Maintaining patient satisfaction
– Achieving the 4-hour operational standard by March 2018
– Producing a regulator approved plan for the future delivery of sustainable services
– Delivering the agreed financial control target
– Reducing the level of vacancies within the workforce and meet the regulators agency spend target
– Continuing to improve staff engagement especially in the area of our future strategy

Corporate Risk Register

The Corporate Risk Register is a living document in which risks are added and removed on an on-going basis. The overall number of risks reported in this report has increased by eight from the previous report in September. Risks have been added and removed during the period as demonstrated in the graph below.

The table below shows the total number of risks contained on the risk register in quarters 1, 2 and 3 and compares the number of risks which have been added and removed during the first three quarters of the 2017/18 financial year.
The information in this report provides the Board with a detailed position statement and includes the areas of priority over the coming months.

3. BACKGROUND

The Board has accountability to ensure there are effective systems and processes in place to manage risk and East Cheshire NHS Trust has set this out within its Risk Management Strategy 2017 to 2018, which was approved by the Board at its January 2017 meeting.

The assurance framework and corporate risk register forms part of the Risk Management Strategy and has been developed to identify risks which could significantly impact on the organisation's ability to deliver its organisational objectives and key work-streams.

Reflecting current thinking and good practice over the management of the Board Assurance Framework the overall number of risks within its Board Assurance Framework have been reduced to provide a more strategic focus on risk. The Audit Committee reviewed the Assurance Framework and Corporate Risk Register at its meeting in August 2017. The Clinical Management Board reviewed the Assurance Framework and Corporate Risk Register in July 2017.

4. STRATEGIC RISKS

At the April 2016 meeting of the Board, the following Strategic risks were reviewed and approved:

1. If the collective leadership across the integrated care system is not well led and unable to effect the changes required with pace and support of key regulators and stakeholders then there is a risk to the sustainability of the trust and the wider Health and Social Care economy.
2. If quality is not maintained in line with regulatory standards during and after transition then this could impact on services the trust provides and ability to provide services that are caring, safe, and responsive and safeguard the health & wellbeing of the local population.
3. If the trust cannot meet its requisite financial regulatory standards and operate within agreed financial resources and transformation schemes do not deliver sufficient savings then the proposed health economy wide service model will not be fully or effectively implemented.
4. If the trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity then there may be an impact on achieving mandatory service standards, and delivering an integrated system.
5. If the Information Technology/Information Systems and Estate infrastructure are not sufficiently invested in and adapted to align with the health economy strategy then there will be an impact on the quality of the delivery of clinically & financially sustainable services.
5. POSITION REPORT

Assurance Framework

The following table shows how the Strategic Risks included in the Board Assurance Framework were split using the Red, Amber, Yellow, Green rating. The target level for those Strategic Risks has also been included to show how the risks are expected to move over time.

<table>
<thead>
<tr>
<th>RAG rating</th>
<th>Risk Rating without controls</th>
<th>Current Risk Rating</th>
<th>Target Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>5 (2x25; 1x20; 2x16)</td>
<td>3 (1x25; 1x20; 1x16)</td>
<td>1 (1x15)</td>
</tr>
<tr>
<td>Amber</td>
<td>0</td>
<td>2 (2x12)</td>
<td>1 (1x10)</td>
</tr>
<tr>
<td>Yellow</td>
<td>0</td>
<td>0</td>
<td>3 (3x8)</td>
</tr>
<tr>
<td>Green</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The table below shows the key areas of focus within each strategic risk area, which aim to reduce the level of risk:

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Area of focus over the last 3 months:</th>
<th>Areas of focus going forward:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leadership of Strategic Transformation Clinical Management Board)</td>
<td>• Set out the Strategic Vision and communicate to staff • Continue to work with partners to agree economy wide service model</td>
<td>• Provide further clarity to staff on the strategic direction of the trust • Continue to work with partners to agree economy wide service model</td>
</tr>
<tr>
<td>2. Quality &amp; Compliance: patient safety, patient experience and effectiveness (Safety, Quality &amp; Standards Committee)</td>
<td>• Delivery of agreed trajectory for 4 hour standard including embedding of SAFER bundle • Continue Board walkabouts and engagement of staff to ensure readiness for CQC re-inspection</td>
<td>• Roll out of winter plan • Delivery of agreed trajectory for 4 hour standard including embedding of SAFER bundle • Delivery of Referral To Treatment waiting time target • Continue to ensure safety and standards of care met • Sustain an open and transparent culture</td>
</tr>
<tr>
<td>3. Financial stability (Finance, Performance and Workforce Committee)</td>
<td>• Identification of remaining QIPP schemes • Continued delivery of agreed financial plan &amp; good budgetary management</td>
<td>• Continued delivery of agreed financial plan &amp; good budgetary management</td>
</tr>
<tr>
<td>4. People (Finance, Performance and Workforce Committee)</td>
<td>• Improve staff engagement particularly around our future strategy • Focus on recruitment programme for consultant and middle grade staff</td>
<td>• Continued focus on recruitment programme for consultant and middle grade staff • Focus on Acute nursing vacancies</td>
</tr>
</tbody>
</table>
Strategic Risk | Area of focus over the last 3 months: | Areas of focus going forward:
--- | --- | ---
5. Infrastructure (Clinical Management Board) | - Continue to reduce agency spend | - Continue to reduce agency spend
 | - Estates work within ED, following successful bid for additional capital funding | - Progress roll out of patient centre ordering application (Radiology)
 | - Progress roll out of patient centre ordering application (Radiology) | - Provide wi-fi for patients

The monitoring of each of the Strategic Risks has been delegated as follows:

<table>
<thead>
<tr>
<th>Committee / Board</th>
<th>Number of Strategic Risks</th>
<th>Current Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety, Quality and Standards Committee</td>
<td>1</td>
<td>1 x 12</td>
</tr>
<tr>
<td>Finance, Performance and Workforce Committee</td>
<td>2</td>
<td>1 x 25; 1 x 16</td>
</tr>
<tr>
<td>Clinical Management Board</td>
<td>2</td>
<td>1 x 20; 1 x 12</td>
</tr>
</tbody>
</table>

The Safety Quality and Standards Committee and Finance, Performance and Workforce Committee are scheduled to review their risks at their September 2017 meetings. Clinical Management Board last reviewed its risks in July 2017.

Corporate Risk Register

There are currently 30 red risks included on the risk register, which is an increase from the previous report of 8 risks. This includes reported Serious Incidents Requiring Investigation.

The 30 red rated Corporate Risks have been delegated as follows (4 risks are monitored by more than one committee, so a total of 37 risk entries appear when the risks are split by monitoring committee / board):

<table>
<thead>
<tr>
<th>Committee / Board</th>
<th>Number of Red Rated Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety, Quality and Standards Committee</td>
<td>19 (includes 5 incidents which have been reported on the National Strategic Executive Information System (StEIS))</td>
</tr>
<tr>
<td>Finance, Performance and Workforce Committee</td>
<td>8</td>
</tr>
<tr>
<td>Clinical Management Board</td>
<td>10</td>
</tr>
</tbody>
</table>

There are currently no red risks in the holding area of DATIX awaiting approval.

The Corporate Risks which are scored between 9 and 12 are reviewed through the risk Management Sub-committee and Operational Management Group and escalated accordingly to the relevant identified committee.

The following 15 risks have been added to the Corporate Risk Register or had their risk score increased since the last report (this compares with 4 risks which were added in the previous report)
<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2389</td>
<td>If the trust does not have appropriate plans in place to upgrade the Intensive care unit, this will impact on the ability to comply with Health Building Note (HBN) 04-02.</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td>2536</td>
<td>If the environmental upkeep of Minor Injuries Unit and Congleton War Memorial Hospital is not repaired / updated there is a potential risk of poor patient experience and patient safety</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td>2610</td>
<td>If the Trust does not meet the diagnostic target standard of &gt;1% of patients waiting more than 6 weeks (ie 99% of patients are seen within 6 weeks), then this may impact on patient care, patient experience and Trust reputation</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td>2427</td>
<td>Diabetes is a single handed consultant specialty. If the Trust does not have the required specialist Consultant support within diabetes/endocrinology it will be unable to deliver the service and achieve the expected quality standards and performance. Patient care will be compromised.</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td>2535</td>
<td>If the patient beds are not upgraded to the new electric beds with integrated safety sides then there is a potential risk of harm to the patient from falls, discomfort from not being able to manoeuvre patients into a comfortable position. Potential risk of musculoskeletal harm to staff with regard to manual handling of patients and safe manoeuvring around the organisation</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td>2633</td>
<td>If the Urodynamic analyser unit based in the Endoscopy Treatment Unit continues to fail and EBME are unable to make any further repairs this will impact on patients care and delivery of the 6 week diagnostics target. An obsolete notification has been issued by the manufacturers.</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td>2624</td>
<td>If the number of intermediate care support workers is reduced from 10wte to 7wte in the SLA for 2017/18 there is a risk of negative impact on patient flow and the ability of the trust to meet key access targets and 3.0wte support workers will be at risk of redundancy</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td>2647</td>
<td>If the Endoscopy and Treatment service are dependent on one room alone having a scope guide there is an inequality of care to patients undergoing (colon) procedures and an increased risk of perforation to patients and the procedure time is increased, meaning longer time on examination table for patients.</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td>2628</td>
<td>A Serious Incident relating to a Fetal Death in Utero on the Labour Ward has been reported on the Strategic Executive Information System (2017/22694 Web-47520).</td>
<td>Newly approved risk – current score 15</td>
</tr>
<tr>
<td>2637</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Aston Ward has been reported on the Strategic Executive Information System (2017/25701 Web-48270).</td>
<td>Newly approved risk – current score 15</td>
</tr>
<tr>
<td>2640</td>
<td>A Serious Incident relating to the management of a child with mental health on general Paediatric Ward has been reported on the Strategic Executive Information System (2017/26036 Web-48361).</td>
<td>Newly approved risk – current score 15</td>
</tr>
<tr>
<td>2641</td>
<td>A Serious Incident relating to an Unexpected Death in Cardiology has been reported on the Strategic Executive Information System (2017/26164 Web-44148).</td>
<td>Newly approved risk – current score 15</td>
</tr>
<tr>
<td>2643</td>
<td>A Serious Incident relating to a Slip, Trip, Fall resulting in a Fractured Neck of Femur on Ward 7 has been reported on the Strategic Executive Information System (2017/26583 Web-48361).</td>
<td>Newly approved risk – current score 15</td>
</tr>
</tbody>
</table>
If the street lighting at Congleton War Memorial Hospital is not improved, then there is a risk to patients and staff from trips and falls due to the street lighting not being in a serviceable condition.  
Increase in risk score from 12 to 16

If the inpatient 18 week backlog continues to increase, there will be an impact on delays in treatment for patients due to the constraints around volume of 18 week plus patients treated per month, a reputational risk and a potential financial impact.  
Increase in risk score from 12 to 16

The following ten risks have been either closed or downgraded since the last report and are therefore no longer showing on the high level corporate risk register (this compares with six risks which were closed or downgraded in the previous report):

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2156</td>
<td>If there is a delay in expediting emergency patient transfers for specialist treatment within 8 minutes, then there is a risk that patient safety and clinical outcome may be compromised.</td>
<td>Reduction in risk score – current score 10</td>
</tr>
<tr>
<td>1724</td>
<td>If pathology (histopathology) attendance at MDT does not happen then there is a risk that we will fail to meet the peer review target of 95% attendance.</td>
<td>Reduction in risk score – current score 12</td>
</tr>
<tr>
<td>2119</td>
<td>If cancer patients with complex pathways are not treated in a timely and coordinated way, there is a high risk that the Trust will not achieve the 62 day standard from referral to treatment of 85%.</td>
<td>Reduction in risk score – current score 12</td>
</tr>
<tr>
<td>1783</td>
<td>If the number of trained nurse vacancies within MAU does not decrease, then there is a risk that patient safety will be compromised, poor patient experience, potential impact on staff morale, sickness, staff training, incidents and complaints and there will also be a resultant impact on financial balance.</td>
<td>Reduction in risk score – current score 12</td>
</tr>
<tr>
<td>2425</td>
<td>If ECT cannot agree to the GP’s lease renewal terms at Handforth Clinic, ECT may need to vacate the site with potential disruption to patient services and reputation of the trust.</td>
<td>Risk closed</td>
</tr>
<tr>
<td>2533</td>
<td>If the IOL Master, which is over 12 years old, breaks down then this may cease the cataract service at East Cheshire until a replacement is sourced.</td>
<td>Risk Closed</td>
</tr>
<tr>
<td>2588</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Ward 3 has been reported on the Strategic Executive Information System (2017/17745 Web-46227).</td>
<td>Risk closed</td>
</tr>
<tr>
<td>2601</td>
<td>A Serious Incident relating to a Slip, Trip Fall resulting in fractured Neck of Femur on Aston Ward has been reported on the Strategic Executive Information System (2017/18819 Web-46545).</td>
<td>Risk closed</td>
</tr>
<tr>
<td>2053</td>
<td>If agency staff are unavailable due to the revision of agency rates this may impact on the Trust being able to deliver services in some areas.</td>
<td>Risk closed</td>
</tr>
<tr>
<td>292</td>
<td>If the Trust does not effectively control use of agency staff this will have an impact on financial delivery, continuity of care and may impact on the quality of service provision.</td>
<td>Risk closed</td>
</tr>
</tbody>
</table>
Of the 30 Risks currently on the Corporate Risk Register all have documented plans attached to the risk register identifying actions / plans to be taken and timescales for delivery.

6. RECOMMENDATIONS

The Board is asked to:

- Review the content of the Board Assurance Framework
- Note the key areas of focus for the next 3 months to reduce the level of risk
- Note that the Red Rated risks currently held on the corporate risk register are being reviewed by committees of the Board
APPENDIX 1

<table>
<thead>
<tr>
<th>Risk Area ID</th>
<th>Date</th>
<th>Description</th>
<th>Risk Status</th>
<th>Action/Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>2389</td>
<td>18/11/2016</td>
<td>If the existing facilities do not comply with the Critical Care Health Building Note (HBN) 04-02 service specification, then there is a risk to patient safety and experience, an increase in required staffing levels and to staff wellbeing.</td>
<td>Risk remains unchanged. Action plan in place and space utilisation request made.</td>
<td>Risk remains unchanged. Action plan in place and space utilisation request made.</td>
</tr>
<tr>
<td>2463</td>
<td>15/02/2017</td>
<td>If the HSDU Autoclaves, Washer Disinfectors (the R.O. equipment or the Clean Steam Generators) are not replaced, they will become increasingly unreliable and if they were to fail may not be able to be repaired.</td>
<td>No movement in risk scores since being added. Mitigation relies upon successful capital funding.</td>
<td>No movement in risk scores since being added. Mitigation relies upon successful capital funding.</td>
</tr>
<tr>
<td>2422</td>
<td>07/12/2016</td>
<td>If Consultants continue to cover the gaps in the on-call rota, this is becoming unsustainable with the increased workload. Additionally the cost of covering internally equates to approx £5000 per month whilst externally covered equating to approx £8000. This is a financial risk to the Trust.</td>
<td>Risk remains. No movement in risk score since risk added in December 2016.</td>
<td>Risk remains. No movement in risk score since risk added in December 2016. Sugar Contingency Plan and Service Level Agreement in place. Capital bid pro-forma uploaded to risk.</td>
</tr>
<tr>
<td>2486</td>
<td>21/03/2017</td>
<td>If persistent gaps in the middle grade rota are not addressed then there is a risk the emergency department does not have safe staffing levels and safe standards may not be maintained.</td>
<td>Risk score reduced from 20 to 15 due to recruitment and changes to pay cap.</td>
<td>Risk score reduced from 20 to 15 due to recruitment and changes to pay cap. Sugar Contingency Plan and Service Level Agreement in place. Capital bid pro-forma uploaded to risk.</td>
</tr>
</tbody>
</table>

Full Bundle Page 78 of 112
## Progress on Risk Areas Identified Prior to 2017/18

<table>
<thead>
<tr>
<th>Action Plans in Place and Uploaded</th>
<th>July &amp; August 2017, set out risks, actions and next steps have been uploaded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2455</strong> 30/01/2017</td>
<td>If the street lighting at Congleton War Memorial Hospital is not improved, then there is a risk to patients and staff from trips and falls due to the street lighting not being in a serviceable condition.</td>
</tr>
<tr>
<td></td>
<td><strong>2427</strong> 30/12/2016</td>
</tr>
<tr>
<td></td>
<td><strong>2269</strong> 20/07/2016</td>
</tr>
<tr>
<td></td>
<td><strong>2272</strong> 20/10/2016</td>
</tr>
<tr>
<td></td>
<td><strong>1766</strong> 17/03/2015</td>
</tr>
<tr>
<td>Progress on Risk Areas Identified Prior to 2017/18</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Action Plans in Place and Uploaded</strong></td>
<td></td>
</tr>
<tr>
<td>Level Agreement in place. Capital bid pro-forma uploaded to risk.</td>
<td></td>
</tr>
<tr>
<td>Plan being presented to November OMT</td>
<td></td>
</tr>
</tbody>
</table>
Dear Colleague

TRUST BOARD MEETING

A meeting of the Trust Board will be held at 3.00pm on 25th January 2018 in Board Room 1, New Alderley House, Macclesfield District General Hospital, Victoria Road, Macclesfield, SK10 3BL.

Yours sincerely

Lynn McGill
Chairman

The Board encourages members of the public to attend when Board meetings are taking place. The public are observers of the proceedings not participants, however, the Chairman will provide an opportunity for members of the public to seek clarification on any matter discussed. The Chairman will not allow members of the public to express opinions or arguments which seek to bias or unduly influence the decision-making process of the Board. There are a number of opportunities for members of the public to contribute. If you are unaware of these, please ask a member of staff before or after the Trust Board meeting and they will be happy to advise you.

TRUST BOARD – January 2018 AGENDA

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Story</td>
<td>Director of Nursing</td>
<td>10 mins</td>
<td></td>
</tr>
<tr>
<td>2. Apologies</td>
<td>Chairman</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>- Declared interest agenda</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitality and Gifts Register Declaration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Minutes of the November 2017 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 18 (01)</td>
<td></td>
</tr>
<tr>
<td>5. Matters Arising</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>6. Action Log</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>7. Verbal update:</td>
<td>Ms A Harrison</td>
<td>10 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>SQS</td>
<td></td>
<td></td>
<td>(supported by formal minutes when available)</td>
<td></td>
</tr>
<tr>
<td>FP&amp;W</td>
<td>Mr M Wildig</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Chief Executive’s Commentary</td>
<td>Chief Executive</td>
<td>45 mins</td>
<td>TB 18 (02)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Learning from Deaths</td>
<td>Medical Director</td>
<td>20 mins</td>
<td>TB 18 (03)</td>
<td>PATIENTS - Provide safe, effective personal care in the right place</td>
</tr>
<tr>
<td>10. Risk Management Strategy</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>20 mins</td>
<td>TB 18 (04)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>11. Standing Agenda Item:</td>
<td>Chief Executive</td>
<td>5 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Public Trust Board Agenda – March 18</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 18 (05)</td>
</tr>
</tbody>
</table>
CONSENT ITEMS

(All 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, any such items will be made clear at the start of the meeting).

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>REF. NO.</th>
<th>REASONS FOR PRESENTING</th>
<th>LINKED TO TRUST OBJECTIVE ON</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Chairman's Commentary</td>
<td>TB 18 (06)</td>
<td>Information</td>
<td>All corporate objectives</td>
</tr>
</tbody>
</table>
| 14. Safer Staffing Exception Report    | TB 18 (07) | Assurance              | PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience
|                                       |          |                        | STAFF - Empower, develop and value staff in providing innovative patient focused care |
| 15. Minutes of the committees of the Board: | TB 18 (08,09) | Information             |                              |
| SQS – October, November 17             |          |                        |                              |
| FP&W – October, November 17            |          |                        |                              |
| Audit - September 17                   |          |                        |                              |
|                                       | TB 18 (10,11) |                        |                              |
|                                       | TB 18 (12) |                        |                              |

Date and Time of Next Meeting:

Date: Thursday 29\textsuperscript{th} March 2018
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
<table>
<thead>
<tr>
<th>Report of: The Responsible &amp; Accountable Officer</th>
<th>The Chairman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author of Report:</td>
<td>Lynn McGill, Chairman</td>
</tr>
<tr>
<td>Subject/Title</td>
<td>Chairman’s Commentary</td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
<td>None</td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>To note</td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>To note</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Corporate Risk Register</td>
<td>If we fail to contribute to sustainability and improvement of local communities, then we risk the loss of organisational reputation and loss of confidence by stakeholders.</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Assurance Framework</td>
<td>If we fail to achieve effective communications with partners this will impact on the ability of the Trust to ensure we are financially sustainable and can deliver our clinical strategy.</td>
</tr>
</tbody>
</table>
| Link to Care Quality Commission Domain          | • Safe  
• Caring  
• Responsive  
• Effective  
• Well-led |
| Link to:                                        | Supporting and developing staff to enable them to achieve their best  
➢ Trust’s Strategic Direction  
➢ Corporate Objectives |
<p>| Legal implications - (identify)                  | None |
| Impact on quality                               | Positive impact |</p>
<table>
<thead>
<tr>
<th>Resource impact</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of equality/diversity</td>
<td>None</td>
</tr>
</tbody>
</table>
| Avoid acronyms or abbreviations - if necessary list: | NHS – National Health Service  
NHSI – National Health Service Improvement  
C&M 5YFV - Cheshire and Merseyside 5 year Forward View (formally STP)  
ECT - East Cheshire NHS Trust  
HFMA – Healthcare Financial Management Association |
1 NATIONAL, REGIONAL AND LOCAL CONTEXT

New Legislation

1.1 I am mindful of new legislation being introduced from 11th December 2017 amending the Mental Health Act 1983 which alters Police Powers in relation to detention. This is likely to have an impact and we are preparing for this and its impact. Assurance is being provided through the Safety, Quality and Standards Committee which will be on the agenda during November.

1.2 Cheshire and Merseyside Strategic Partnership

The membership group met on Wednesday 15th November 2017 to hear of progress in developing plans and how progress would be measured and managed through individual organisations and programme boards. It was also an opportunity to showcase successful examples of integration.

1.3 Healthcare Financial Management Association (HFMA) - Non Executive and Lay Member Faculty Forum

Attended the event on Wednesday 11th October 2017, at which there was a focus on the developments of ‘Place based’ health and social care, with examples from the work undertaken across Manchester and Wales. There were reflections from a governance and Chair perspective, together with feedback from the Medical Director of a Welsh Health Board and the impact of whole system, Place based integration. These themes were mirrored through the ‘Success Regime’ led by NHS Improvement.

1.4 NHS Providers Forum

Attended this event in the North West on Thursday 19th October 2017, where topics included the challenges of increased demand on the NHS and performance, workforce, changes to the leadership of NHS Improvement, together with models of care for social care and GP colleagues in primary care.

LOCAL CONTEXT

1.5 Chair to Chair

On 7th November, I took the opportunity to meet with the Chair of Mid Cheshire NHS Foundation Trust informally to catch up on recent developments.

1.6 Macclesfield for Business Steering Group

This group has met on a number of occasions, recognising the value of local employers and their views on the Macclesfield Town Strategy plans currently out for consultation. I attended the meeting on Monday 13th November to offer a health
perspective and will do so too on 24th November 2017. The trust has also made the 
link visible for staff via ‘Staff Matters’ to make comments directly, should they wish to 
do so. Business views are being collected and supported by a survey, will be fed 
back collectively to Cheshire East Council.

2.  **PARTNERSHIPS**

2.1 **Caring Together Programme Board**

The Caring Together Programme Board (CTPB) met on 11th October and 8th 
November 2017. The Programme Board continues to focus on optimum models of 
primary and community care, which are progressing well, together with sustainability 
and the need to balance short term needs with mid to long term population and 
service requirements. This has broadened to encapsulate a larger footprint and any 
developments will be included as part of Board business and papers for 
consideration.  For regular updates, please see [http://www.caringtogether.info](http://www.caringtogether.info)

In support of strong partnership relationships I continue to meet informally with the 
CCG Chair; this took place on 3rd October and 14th November 2017.

2.2 **Joint Caring Together and Connecting Care Programme Boards**

This group met on the afternoon of 9th November 2017, the focus of which 
was a joint discussion to explore the opportunities and risks of working more closely 
together across a wider geographical footprint. These discussions will be 
encapsulated via board papers for discussion and any decisions.

2.3 **Partner Support**

I was pleased to offer support as Independent Chair to Cheshire and Wirral 
Partnership NHS Foundation Trust and the appointment of a Non-Executive Director.

2.4 **Celebrating Achievements; Staff Awards**

It was a pleasure to celebrate with our colleagues the tremendous work and 
achievements our people have delivered for patients.

With 210 nominations and more than 7,000 on line and postal votes this year, this 
represents one of the most popular events to date. Of particular interest was the 
increasing numbers of nominations and support for staff from partner organisations.

We know this is a reflection of the care received based on the huge numbers of 
patient and family/carer feedback which continues to demonstrate the amount of care 
and compassion shown whilst delivering care and how this has been experienced. 
This is something we can all be proud of.

It was a time to celebrate personal and team achievements at a time of improved 
service delivery, structural changes and in the face of unrelenting demand.

Most inspirational.  A real tribute to all, thank you.
2.5 A New Compassion Award

I am also pleased to share the announcement of a new award, to be introduced quarterly, the Compassion Award. Borne out of patient and family experience and a donation by one of our Board team and reflected in these heartfelt words:-

I would like to give my deepest thanks to everybody on Ward 1A who cared for my mum in the last week of her life. I’m not sure how I would have got through this painful time without your support as medical professionals and compassionate human beings. We are really grateful for the kindness, patience and compassion showed by the staff at the hospital - it made a huge difference for us during a very difficult and sad time. We hope this Compassion Award will help to reinforce the wonderful work that is done every day at the trust.

2.6 Harvest Festival

It was a pleasure to attend the Harvest festival on 12th October 2017, which brings together patients, staff and the chaplaincy team, most of whom are volunteers.

We also celebrated DIVALI, the Hindi New Year festival during October.

2.7 Health Matters

This month’s topic focused on the work of the Pharmacy team and how they work to benefit patients across all service areas. They take an important lead role in patient safety through prescribing, patient drug reviews at home as well as through ward or community based care episodes, take home medicines, managing controlled drugs and the importance of using antibiotics prudently and wisely. To find out more information, please see


3 TRUST BOARD

3.1 The Trust Board Programme of Work is as planned.

3.2 Board Development

As planned with a focus on sustainability across the local health economy and understanding how we are able to better support our primary care colleagues together with a reflection and update on cyber security.

3.3 Board Walkabouts

The programme for Board walkabouts is as planned. These are supplemented by walkabouts in areas of increased risk which aids triangulation of information for greater assurance.
Board members continue to attend ad hoc SIRI meetings to be assured of the Trust’s handling of incidents.

3.4 NED Appointments

I am pleased to confirm the following reappointments:

- Michael Wildig for a four year appointment until 6th November 2021
- Dr Jane Cowan for a four year period until 6th November 2021
- Dr Anthony Coombs for a two year period until 30th November 2019

All three have been appointed following an independent process led by NHS Improvement. Each has confirmed they meet the Fit and Proper Persons requirements, checked annually. To find out more about their profile please see the Trusts web site http://www.eastcheshire.nhs.uk/

I look forward to their contribution, challenge and leadership throughout their tenure.

3.4 Encouraging Board level Diversity

The trust is participating in the Insight Programme, run by a third party in support of NHS Improvement ‘Diversity on Boards’ programme, aimed at supporting aspirational directors to develop and hone their skills and experience in readiness for future leadership and board roles. I am pleased to note that we have supported our Insight Programme member to attend public board meetings; the Safety, Quality & Standards committee; the Finance Performance and Workforce committee; ECHO, the Trust’s Charity; coupled with board development discussions and by month end, will have also included the Organ Donation committee and Audit Committee.

Lynn McGill
Chairman
## Trust Board
### Thursday 30th November 2017

Agenda Item Number 16: TB 17 (73)

| Report of: Responsible Officer | Kath Senior  
Author of Report: | Director of Nursing, Performance & Quality  
Subject/Title | EXCEPTION REPORT – SAFE STAFFING LEVELS  
Background papers (if relevant) | “How to ensure the right people with the right skill are in the right place at the right time”,  
Chief Nursing Officer for England & National Quality Board November 2013  
Purpose of Paper | To provide the Trust Board with an interim exception report in line with the requirements of: “How to ensure the right people with the right skill are in the right place at the right time”,  
Chief Nursing Officer for England & National Quality Board November 2013  
Action/Decision required | To note the contents of the report and the assurance provided  
Mitigates Risk Number: (identify) On Corporate Risk Register | BAF 2: If quality is not maintained in line with regulatory standards during and after transition then this could impact on services the trust provides and ability to provide services that are caring, safe and responsive and safeguard the health and wellbeing of the local population  
Mitigates Risk Number: (identify) On Assurance Framework | BAF 4: If the trust does not attract, develop and retain a resilient and adaptable workforce with the right capabilities and capacity then there may be an impact on achieving mandatory service standards and delivering an integrated system  
Link to Care Quality Commission Domain | Safe  
Responsive  
Effective  
Well Led  
Link to: | Provide the best services to our population through improvements to safety, productivity and patient experience  
Legal implications - (identify) | No legal implications  
Impact on Quality | May potentially impact upon the quality of care, patient experience, patient outcomes and staff well being

Chairman: Lynn McGill  
Chief Executive: John Wilbraham
<table>
<thead>
<tr>
<th>Resource impact</th>
<th>Identified gaps in funded establishments due to substantive and temporary nurse staffing vacancies will necessitate an increase in payroll costs in relation to paid additional hours, overtime and bank/agency expenditure in order to mitigate risks associated with patient safety and quality of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on equality/diversity</td>
<td>No impact on equality and diversity</td>
</tr>
<tr>
<td>Avoid acronyms or abbreviations - if necessary list:</td>
<td>DoH  Department of Health  YTD   Year to Date  WTE   Whole time equivalent  RAG   Red Amber Green</td>
</tr>
</tbody>
</table>
1.0 Background

1.1 This report provides a high level summary of Safe Staffing levels on all inpatient wards across the Trust. It provides a high level exception report in relation to the actual fill rate for registered and unregistered staff during the day and night and highlights where this falls below a 95% threshold using a RAG system.

1.2 Actual staff numbers compared to planned staffing numbers are collated for each adult and paediatric inpatient area. This is collected in line with the requirements of the DoH Unify reporting process and the data extract is attached (Appendix 1). Nurse sensitive indicators and workforce metrics have been applied against each inpatient ward area to further inform and provide assurance in terms of adequate staffing levels and harm free care.

2.0 October 2017 Position – Exception by RAG status only

2.1 Ward Staffing:

2.1.1 Post-natal and labour ward illustrates an actual registered midwife fill rate of 90.2% during the night which demonstrates an improved position compared to the previous month. The reason for this variance is due to 2.6 wte vacancies which have been successfully recruited to pending satisfactory pre-employment checks. It is anticipated that new post holders will commence in November. Mitigating actions include the utilization of midwives via nurse bank.

2.1.2 Post-natal and labour ward illustrates an actual healthcare assistant fill rate of 75.8% during the day which demonstrates a worsening position compared to the previous month although an improved position overnight. The reason for this variance is due to 7.4% sickness and absence rates and 1.9 wte vacancies. The vacant posts have been successfully recruited to and pending satisfactory pre-employment checks anticipated commencing in post during December/January. Mitigating actions include the use of 2 on call midwives for homebirths who can if required be called to support the unit at times of increased workload to ensure safe staffing levels are maintained.
2.1.3 Aston ward illustrates an actual healthcare assistant fill rate during the day of 83.7% which demonstrates an improved position during the day compared to the previous month. The reason for this variance is due to 1.0 wte long term sickness and 4.4 wte staff members who are in the process of phased return to work management plans. This includes working reduced contracted hours or undertaking administrative duties. Mitigating actions include robust management of sickness and absence rates. In addition, daily risk assessment of staffing requirements has been undertaken to support safe staffing levels, facilitated staff deployment or utilization of nurse bank. On occasions bank request shifts have remained unfilled particularly for 1:1 enhanced care support.

2.1.4 Paediatrics ward illustrates an actual registered nurse fill rate of 91.9% during the day. The reason for this variance is due to 0.6 wte vacancy, 4 wte Maternity Leave and 1 wte long term sickness. Recent recruitment has been unsuccessful. Mitigating actions include the senior sister and matron regularly stepping down into core staffing numbers in addition to community nurses covering outstanding shifts at short notice to support safe staffing levels. Bank and agency staff has been utilized where necessary to maintain required dependency ratios.

2.1.5 Paediatrics ward illustrates an actual healthcare assistant fill rate of 79.9% during the day and which illustrates an improved position compared to the previous month. The reason for this is due the paediatric unit piloting a new shift pattern to reflect fluctuating demand and capacity requirements. Evaluation of the pilot is due in November 2017 to further inform and reflect a proposed new staff model.

2.1.6 Ward 9 illustrates an actual registered nurse fill rate of 93.9% during the day which illustrates a worsening position compared to the previous month. The reason for this variance is due to 5 wte registered nurse vacancies, short and long term sickness. Despite utilization of nurse bank 15 registered nurse core shifts remained unfilled during October. Mitigating actions include healthcare assistant deployment to support enhanced 1:1 and personal care.

3.0 Recruitment and Retention

3.1 Recruitment:

3.1.1 An evening recruitment event was held on 11th October 2017 which led to 9 registered nurse job offers being made out of which 7 have returned their signed offer letters. The majority of applicants were students who qualify next year.

3.1.2 In month registered nurse vacancies within the acute in-patient wards illustrate an equivocal position – 37.8 wte. This excludes Maternity Leave and Long Term Sickness. Inclusion of Maternity Leave (3.63 wte) and Long Term Sickness (3.17 wte) increases the overall registered nurse role gaps to 44.6 wte. However, this demonstrates an improved position compared to the previous month by 8.55 wte as a number of staff members have returned to work.

3.1.3 1 further international nurse is expected to arrive early November 2017. 5 overseas nurses remain in the pipeline although no agreed timescales as yet have been confirmed as they are at different stages of the process.
3.1.4 Following interviews held in September 2017, 28 Healthcare Assistant posts were offered of which 22 have accepted subject to satisfactory pre-employment checks. It is anticipated that 12 will commence in post on the 10th November and 10 on the 20th November. 18 of the posts recruited to are aligned to the ward areas, 3 to nurse bank and 1 to the virtual pool.

3.1.5 Currently, in month registered nurse vacancies within the community setting is 5.3 wte in addition to 8 wte Maternity Leave and 6.3 wte sick leave. Mitigating actions and options to support depleted community teams is currently being managed by deployment between community teams based on daily RAG status risk assessment. In addition, part time staff may undertake ad hoc additional hours to support staffing levels, Healthcare Assistant bank utilization to support phlebotomy services and occasional agency utilization.

3.1.6 The Trust’s Nursing Associate Pilot continues. Currently 10 staff members are in the process of a 2 year training programme.

3.2 **Retention:**

A clear focus is required on staff retention and succession planning in view of the demographic profile of the nursing workforce, risks to business continuity, local and national shortfall forecasts.

A new clinical workforce deployment group has been established to facilitate and review staffing models inclusive of nursing and medical roles. It is anticipated that this will further inform and take action with regards to recruitment and retention strategies coupled with safe staffing levels, skill mix and appropriate funded whole time equivalent establishments.

Other potential solutions to support workforce retention include consideration of apprenticeship roles, newly qualified rotational posts with bespoke placements, return to practice and flexible retirement campaign options. However, it must be realised that these are medium to long term solutions opposed to improvements required in the management and mitigation of the Trust’s short term position and operational challenges this poses.

In order to meet practice, training and student placement standards careful consideration is required as part of workforce analysis to ensure that the correct infrastructure enables adequate and safe supervision in practice to support to new and existing roles. The current level of vacancy within the acute setting challenges this mentorship requirement. Mitigating actions include liaison between senior sisters and practice educator facilitators to agree and co-ordinate the maximum number of student nurse placements per clinical area that may be accommodated at any one time to enable mentorship requirements to be met.

3.3 **Staff turnover:**

3.3.1 In month staff turnover is 0.63% compared to the previous month of 5.24%. YTD 13.05%

3.3.2 Please refer to appendix 1 for a breakdown of each individual in-patient ward area metrics which includes the total number of slips, trips and falls, pressure ulcer and injurious falls incidence in month.

Chairman: Lynn McGill
Chief Executive: John Wilbraham
4.0 Recommendation

4.1 The Board is asked to note the content of the report.

Appendix 1 – Safer Staffing Metrics:
### Monthly Safe Staffing Report - September 17

<table>
<thead>
<tr>
<th>ServiceLine</th>
<th>Specialty</th>
<th>Ward</th>
<th>Expected RN</th>
<th>Actual RN</th>
<th>Expected HCA</th>
<th>Actual HCA</th>
<th>Percent RN</th>
<th>Percent HCA</th>
<th>Percent RN</th>
<th>Percent HCA</th>
<th>Care Staff</th>
<th>Overall</th>
<th>Falls (mod and above)</th>
<th>Cdiff</th>
<th>MRSA</th>
<th>ST</th>
<th>Pressure Ulcers</th>
<th>grade 2-4</th>
<th>Sickness &amp; Absence</th>
<th>% Stat &amp; Mand</th>
<th>% IPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Care</td>
<td>Rehabilitation</td>
<td>Aston</td>
<td>905.70</td>
<td>910.08</td>
<td>2158.20</td>
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<td>102.0%</td>
<td>600.00</td>
<td>649.00</td>
<td>810.00</td>
<td>763.50</td>
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<td>1.9</td>
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<td>100.0%</td>
<td>600.00</td>
<td>600.00</td>
<td>600.00</td>
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<td>100.0%</td>
<td>100.0%</td>
<td>89</td>
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<td>Women's &amp; Children's</td>
<td>Paediatrics</td>
<td>Children</td>
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<td>1035.00</td>
<td>933.97</td>
<td>345.00</td>
<td>325.08</td>
<td>97.6%</td>
<td>94.2%</td>
<td>217</td>
<td>9.3</td>
<td>3.4</td>
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<td>Urgent Care</td>
<td>Critical Care Medicine</td>
<td>Intensive Care Unit</td>
<td>1800.00</td>
<td>1800.00</td>
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<td>100.0%</td>
<td>118</td>
<td>26.9</td>
<td>7.3</td>
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<td>Neonatal Unit</td>
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<td>100.0%</td>
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<td>91.6%</td>
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<td>95.9%</td>
<td>92.6%</td>
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<td>1856.00</td>
<td>1902.00</td>
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<td>114.3%</td>
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<td>951</td>
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<td>990.00</td>
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<td>110.6%</td>
<td>660.00</td>
<td>680.50</td>
<td>990.00</td>
<td>1131.58</td>
<td>103.1%</td>
<td>132.5%</td>
<td>893</td>
<td>2.0</td>
<td>3.8</td>
<td>5.8</td>
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<td>100%</td>
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<td>1127.00</td>
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<td>1464.00</td>
<td>1477.50</td>
<td>1562.60</td>
<td>1692.67</td>
<td>100.0%</td>
<td>112.9%</td>
<td>990.00</td>
<td>1072.08</td>
<td>680.00</td>
<td>981.25</td>
<td>98.2%</td>
<td>144.8%</td>
<td>877</td>
<td>3.0</td>
<td>3.2</td>
<td>6.2</td>
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<td>1114.40</td>
<td>1148.58</td>
<td>1543.20</td>
<td>1545.50</td>
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<td>100.0%</td>
<td>990.00</td>
<td>1061.50</td>
<td>660.00</td>
<td>1070.00</td>
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<td>153.2%</td>
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<td>6.2</td>
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<tr>
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<td>1393.00</td>
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<td>0</td>
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<tr>
<td>Integrated Care</td>
<td>General Medicine</td>
<td>Ward 9 (Egerton)</td>
<td>1516.00</td>
<td>1464.08</td>
<td>1512.00</td>
<td>1749.15</td>
<td>95.3%</td>
<td>110.0%</td>
<td>660.00</td>
<td>682.75</td>
<td>1320.00</td>
<td>1527.25</td>
<td>102.8%</td>
<td>115.7%</td>
<td>720</td>
<td>3.0</td>
<td>4.6</td>
<td>7.6</td>
<td>0</td>
<td>0</td>
<td>74%</td>
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Agenda Item Number 17: TB 17 (74)

**SAFETY, QUALITY AND STANDARDS COMMITTEE**

**MINUTES OF MEETING HELD ON:**
Tuesday 26th September, 12:00 – 13:30
Boardroom 1, 1st Floor, New Alderley House

**COMMITTEE CHAIR:** Ms Ali Harrison, Non-Executive Director

**MEETING SECRETARY:** Bethan Rimmer, Executive PA/Meeting Secretary

**PRESENT:**
- Kath Senior, Director of Nursing Performance and Quality
- John Hunter, Medical Director
- Dr Jane Cowan, Non-Executive Director
- John Wilbraham, Chief Executive
- Mark Ogden, Director of Finance
- Lorraine Jackman, Deputy Director of Corporate Affairs and Governance
- Kashif Haque, Chief Pharmacist

**IN ATTENDANCE:**
- Jeanette Sarkar, Head of Nursing Quality
- Vicky Bond, Outpatient Service Manager

<table>
<thead>
<tr>
<th>AGENDA NO</th>
<th>SUBJECT</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>17/105</td>
<td>Patient Story</td>
<td>This item was deferred due to time constraints.</td>
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</table>
| 17/106    | Apologies     | 1. Julie Green – Annual Leave  
2. Brian Green – Annual Leave  
3. Sue Knight – Annual Leave |
| 17/107    | Matters Arising | Year at a Glance  
The Chair noted there is no deep dive topic for October’s meeting and requested that members provide suggestions from today’s discussions. The year at a glance was confirmed and agreed.  

**SQS Committee Minutes – August 2017**
The Chair highlighted on page 6, agenda item 17/100, bullet 3, 4th sentence should read ‘…discharge information to GP have not been met’. The Chair also noted some formatting changes required in agenda item 17/100 which have been outlined to the meeting secretary and will be amended. There was no change to the content.  
The Chair requested a clarification on page 2 (agenda item 17/095) where the action advises the DDNQ and DDCAG would provide a draft report at October’s meeting.

Chairman: Lynn McGill  
Chief Executive: John Wilbraham
however the action log states November. The DDCAG confirmed that a template will be brought back to October’s meeting for comment and the report will be provided in November.

The minutes were agreed with the discussed amendments.

Action Log

9236 – To be taken to October’s CMB. The CP advised there has been a request from the CCG for a Recovery Plan with a deadline of 13th October. Changes have been made to the booking process which has shown improvement and the in-month position has held. The CP provided context on capacity concerns, advising between August and September there have been 50 additional 2 week patients which have had to be accommodated. The CP confirmed all 2 week patients have been accommodated however there is a risk for surveillance patients who have had to be delayed. The CP to provide a further update at the next meeting.
9238 – Complete. Action Closed.
9239 – Not due at this meeting.
9237 – Not due at this meeting.

Collection of Any Other Business

There were no items of any the business.

Formal Request for Removal of Items from the Consent Agenda

The Chair noted the HTA Annual Report advising 2 incidents were identified where deceased patients in the mortuary were incorrectly identified. The DDCAG provided clarity on these cases outside of the meeting advising immediate action was taken and updated that the Head of Safety, Risk and Resilience is liaising with relevant staff on the post death procedure and raising awareness. The Chair confirmed assurance has been provided.

ASSURANCE ITEMS

17/108 Quality Dashboard – Report by Exception – August 2017

The DNPQ presented the Quality Dashboard report highlighting the following:
- A sustained position continues for ED performance and the diagnostic standard.
- There was a 12 hour trolley wait in August; an RCA is being completed and will be taken to the SIRI Sub-Committee.
- DTOCs increased in August which has caused an increase in the number of bed days lost; this has continued into September. This position is being scrutinised through the performance meetings and the A&E Delivery Board.
- The DNPQ noted concerns regarding clinical correspondence however advised there have been no reported issues of harm. The risk relates to patient information being efficiently communicated to GPs.
- The C-difficile standard is on track.

The Committee noted the following:
- The Chair commented the addition of the quality impact in the report is very helpful.
- The CEO noted the issues regarding DTOCs, also advising there were 12
additional unfunded beds in September and 6 in August. The CEO is in discussions with colleagues from partner organisations highlighting the need for further out of hospital capacity.

- The CEO highlighted the potential quality impact associated with the increase in endoscopy waiting times which needs to be monitored and any mitigating actions taken.
- The CP acknowledged the increased DNA (did not attend) rate in endoscopy however additional support has been provided through the implementation of a new booking process and incorporation of the ETU booking team into the wider booking team.
- An error was highlighted in the report and the DNPQ provided assurance that all cancer standards have been met.
- An error was highlighted in the ‘effective’ commentary on the dashboard highlighting the 95.8% against GP should refer to the inpatient discharging position.
- It was agreed that the narrative sections will be removed from the dashboard with relevant information being provided through the accompanying report.
- The Chair highlighted in the CQUIN summary, the achievement stated for the diabetic eye adult screening programme review. The narrative alongside this relates to staff stress which appears unrelated. The DNPQ agreed to review and amend this section accordingly.
- It was noted that the format of the report will be reviewed and presented to the October SQS meeting.

<table>
<thead>
<tr>
<th>17/109</th>
<th>Risk Assessed Data Report (RADaR) – August 2017 Data</th>
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The DDCAG presented the RADaR Report highlighting the following:

- Positive assurance was noted on unavoidable incidents that have been undeclared.
- No acute areas triggered in August.
- Two community teams triggered; Knutsford and Waters Green. It was noted that long term sickness has been a challenge for these teams.
- A piece of work is being undertaken on bank supply for the community and what additional support can be provided.
- The DHR provided an update outside of the meeting advising that the community doesn’t currently have any vacancies, the gaps relate to sickness and maternity and for smaller teams this does have a big impact. The situation is being monitored.
- Newly qualified nurses are being provided with a ‘buddy’ to support. This initiative has been positively received with improvements seen for cross covering.

The Committee noted discussed and noted the following:

- Theatres are close to triggering and the HoNQ confirmed there are staff shortages of approximately 8wte vacancies. It was noted that there is currently a national shortage of theatre scrub nurses. A rotational post is being reviewed which has been successful in other areas and the workforce plan will form part of the recovery plan being produced. The Chair advised that the CQC previously highlighted theatre infrastructure and queried whether there is anything more that can be done to mitigate the risk. The DNPQ advised focused work has taken place on theatres including
environmental work and the lighting and storage in theatres is being upgraded. There are no concerns regarding patient safety and this is monitored through the WHO checklist. The DNPQ advised there have been no serious incidents or unexpected deterioration of patients within theatres.

- The DNPQ advised that theatre staffing is on the risk register with a score of 15 and the DDCAG agreed to confirm the risk rating.

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<thead>
<tr>
<th>17/110 Bi-Annual QIPP QIA Report</th>
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<tbody>
<tr>
<td>Following an update from the DHR, the Chair advised QIA 2529 relating to the HR management of change is now complete. This will be monitored for impact as per policy and will be reviewed.</td>
</tr>
<tr>
<td>The Chair highlighted under ‘future development’ that work will be undertaken to provide a strategic overview of schemes and queried whether this has been happening to date. The DDCAG and DDNQ will link with the CCG to discuss the QIPP schemes across the system to assure oversight of any change that may impact on trust services The DNPQ confirmed that there are no quality and governance issues.</td>
</tr>
<tr>
<td>The DoF highlighted QIA 2506 commenting this seems a high risk for 0.5 WTE of a member of staff. The DDCAG advised a QIA is completed for all skill mixes; this QIA relates to is a small team where there could be a significant impact. The DDCAG advised all QIA risks are reported to SQS, regardless of risk level, and are reviewed through the Risk Management Sub-Committee.</td>
</tr>
<tr>
<td>The Chair noted assurance has been provided that mitigations are in place and the QIA risks remain low. It was agreed that this report would be brought as a consent item moving forward.</td>
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<table>
<thead>
<tr>
<th>17/111 Assurance Framework and Risk Register (for Committee only)</th>
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<tbody>
<tr>
<td>The DDCAG presented the Assurance Framework and Risk Register report noting two new risks added which relate to falls resulting in harm and a number of risks that have reduced from high to moderate level.</td>
</tr>
<tr>
<td>Dr Cowan queried the concerns regarding risk 2578 relating to flooring. The DNPQ advised there is a risk relating to the MAU flooring which is lifting in some areas and required replacement. This would require relocating patients during this work which would take a significant amount of time and cause disruption. There is currently no area identified to move these patients to during this work. Remedial work is not possible at this stage. The CEO advised replacement of this floor is not feasible going into the winter period given the additional operational pressures on the system. The CEO advised that he would discuss this concern with the Board and request they accept the risk at this time.</td>
</tr>
<tr>
<td>The DNPQ noted an additional risk regarding flooring relates to ward areas with the wrong flooring in place which has been identified as an infection control risk as they cannot be cleaned to the level required without significant disruption to patients. The CEO requested information on how the decision was made to install this flooring and what was the cost. The DNPQ agreed to look into this issue.</td>
</tr>
</tbody>
</table>
The Chair requested that the DNPQ provide an assurance report to the next meeting on the Executive decision made to mitigate and resolve the risks relating to flooring for the SQS Committee to scrutinise the decision.

Following a query from the DNPQ, the DDCAG agreed to review whether there should be two separate risks regarding flooring; one relating to falls and the other to infection control.

The DNPQ confirmed these risks remain accurate regarding the two single handed consultant services.

The Chair queried whether risk 2156 regarding ambulance transfers is a trust risk. The DDCAG advised this was escalated by consultants and while it does sit with NWAS, how to manage the acutely ill patient is our risk until the transfer takes place. The DNPQ noted that an action was previously taken to reduce the risk score to 10 and the DDCAG agreed to look into this and update accordingly.

The DNPQ highlighted the ED risk score at 20 advising while the situation has improved there continues to be a risk. It was agreed by the Executive team to maintain the current risk score.

### STRATEGIC ITEMS

<table>
<thead>
<tr>
<th>17/112</th>
<th>Quarterly Quality Strategy Update – Listening and Responding</th>
</tr>
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<tbody>
<tr>
<td>The Quality Strategy Update was deferred to the next meeting.</td>
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<table>
<thead>
<tr>
<th>17/113</th>
<th>Deep Dive: Correspondence</th>
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<tbody>
<tr>
<td>The CP presented the Deep Dive on Correspondence, supported by the Outpatient Service Manager, highlighting the following;</td>
<td></td>
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<tr>
<td>• Risk 780 is currently at a risk score of 12 and relates to correspondence targets and the financial impact of non-achievement.</td>
<td></td>
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<tr>
<td>• Provisional review of August’s data for 14 and 21 days shows the target has been met.</td>
<td></td>
</tr>
<tr>
<td>• Controls: Following a review of the outpatient team, additional supervisor support has been provided to the Transcription Suite and bank staff are being utilised where appropriate. Lower level line management has undergone a restructure and medical secretary support is being utilised.</td>
<td></td>
</tr>
<tr>
<td>• Gaps in Control: A high turnover of staff and high level of sickness has been seen within the team. Additional clinics have increased the workload, there is a lack of clinician sign off and no consistent approach to letter templates. It was noted that the position of ‘dictated not signed’ has not been previously agreed however is present in some specialties.</td>
<td></td>
</tr>
<tr>
<td>• Positive Assurance: A recent restructure has provided additional support and the team is fully established.</td>
<td></td>
</tr>
<tr>
<td>• Gaps in Assurance: There is limited experience within the team and currently no facility to outsource letters to support. The team are reviewing outsourcing options. Advice is being sought from the Information Governance team and the team will look to pilot in one area to determine effectiveness. In terms of technology advancements, Medisec, which is used for outpatient letters, is...</td>
<td></td>
</tr>
</tbody>
</table>
working on voice recognition software. The team will continue to look at viable options as this will support team resilience however it will require financial input.

• A number of consultants work for other trusts but undertake clinics at this trust through SLAs. For those consultants, the team have trialled live typing which has worked well for some services. The MD queried the resistance for undertaking this process in all specialties. The OSM advised this relates to time constraints as some clinics have a quick throughput of patients.

The MD noted the resistance for 'dictated not signed' relates to clinicians wanting to check all the information is correct. It was agreed that the CP and MD would meet with clinical directors and clinical leads to provide a proposal for agreeing timelines for improvement on these issues and undertake a check and challenge process.

The CEO commented that there needs to be a process in place to support when there is sickness in the team and prevent the position from deteriorating. The CP advised that the possibility of outsourcing would support team resilience.

The CEO asked the CP to thank his team for achievement of the correspondence targets. The Chair agreed and acknowledged the positive work taking place and the recommendations for supporting the process moving forward.

Dr Cowan queried when the standard hasn’t been met whether there has been any patient harm. The CEO advised there has been no reported patient harm. The Chair advised the Committee will monitor this in relation to complaints procedures and PALS and identify any themes through that process. The DNPQ advised there are monthly meetings with the commissioners that include GP representative and any issues would be raised through this forum.

### ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>17/114</th>
<th>Key Items for the Chair to be reported to the Board</th>
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**Points for Assurance**

- The Quality Dashboard data & reporting format will be reviewed and revised with a draft presented back to the SQS Committee in October in order to give improved assurance on quality indicators (stronger focus on the specific safety, quality and standards elements) and continuous improvement of the trusts performance against targets.
- All cancer targets were achieved in August.
- Biannual Quality Impact Assessment process covering all QIPPs confirmed all assessments and actions in place with strategic overview for cross QIPP linkages being provided by DDNQ and DDCAG.
- Critical Care service specification: The committee were provided with evidence and assurances in relation to compliance, improvement plans and risk mitigation plans with the relevant standards. The committee approved the trust's action plan associated with the recommendations made by Cheshire & Merseyside critical care network team.
- The trust has completed all actions to schedule for the PHE QA review of our Cervical Screening service.

**Emerging Risks and Mitigating Actions**

- Diagnostic targets (99%) continue to be missed primarily due to challenges in endoscopy provision but backlog stabilizing following implementation of
associated action plans. All patient breaches are reviewed by the clinical teams. No serious incidents have been reported during this period.

- A 12 hour trolley wait was reported but no harm occurred as a result of the delay in transfer - this incident will be reviewed by the SIRI Sub-Committee.
- Improvements in clinical correspondence performance have resulted in 14, 21, and 28 day targets now being met however 24 hour turnaround deadlines are missed. The Executive team will follow through with the clinical directorate to support timed delivery of the action plan and junior doctor & clinician engagement with the processes. At this time the trust is not aware of any harm coming to patients as a consequence of delays in correspondence reaching the GP.
- Although no hospital areas triggered this month, community nursing in Knutsford triggered - primarily due to staff absence (sickness and maternity) in a relatively small team and overall number of vacancies in community nursing meaning short term staff transfers are challenging. The Theatres area is close to triggering however a comprehensive action plan is in place covering facilities, staffing and culture.
- Following review of the HTA annual work report, where 2 incidences of incorrect/duplicated identification bands were located on a deceased patient, a number of immediate actions have been taken for implementation and reinforcement across all in patient areas.
- The Committee reviewed the assurance framework and risk register including addition of new risks. It was agreed that a check and challenge on risk # 2578 concerning a number of hospital flooring areas in relation to infection control and falls risks should be brought to the next committee given that an executive investment decision to address priority areas needs to be made imminently. Future deep dives/spotlights will focus on risks relating to resourcing risks concerning middles grade rotas # 2486, junior doctors rotas # 2565, and on call consultants # 2422.

17/115 Any Other Business

There were no items of any other business.

**CONSENT ITEMS**

(These items have been read by Committee members and the minutes will reflect recommendations, unless an item has been requested for removal from the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting)

17/116 Quality Governance Report Including:
  a) Complaints responded to in August 2017
  b) Cervical Screening Quality Assurance Review Action Plan

The committee received the Quality Governance Report noting the complaints in August 2017 and the Cervical Screening Quality Assurance Review Action Plan and accepted the contents and recommendations.

17/117 Critical Care Action Plan

The Committee received the Critical Care Action Plan, noting and accepting the contents and recommendations.

17/118 HTA Sub-Committee Annual Report and Self-Assessment
The Committee received the HTA Sub-Committee Annual Report and Self-Assessment noting and accepting the contents and recommendations. Further comments were discussed under agenda item 17/107.

<table>
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<tr>
<th>FOR INFORMATION</th>
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<tbody>
<tr>
<td><strong>Chairman's Confirmation of Agenda items for October meeting (not standing items):</strong></td>
</tr>
<tr>
<td>1. Midwifery Staffing Levels</td>
</tr>
<tr>
<td>2. Service Line SQS Sub-Committee Annual Reports And Self-Assessments</td>
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<tr>
<td>3. Patient Safety Culture Update (via Governance Report)</td>
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<td>4. Quarterly Mortality Report</td>
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<thead>
<tr>
<th>Date of Next Meeting</th>
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<tbody>
<tr>
<td>Tuesday 31st October 2017, 12:00 – 14:00</td>
</tr>
<tr>
<td>Boardroom 1, First Floor, New Alderley House</td>
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<td><strong>Paper deadline: 23rd October 2017, 5pm</strong></td>
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</table>
**FINANCE, PERFORMANCE & WORKFORCE COMMITTEE**

<table>
<thead>
<tr>
<th>Meeting Chair: Mike Wildig</th>
<th>MINUTES OF MEETING HELD: Thursday 28th September 2017</th>
</tr>
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<tbody>
<tr>
<td>Meeting Secretary: Janine Homer</td>
<td>Venue: Boardroom 1, First Floor, New Alderley House</td>
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**PRESENT:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>Mike Wildig</td>
<td>Non-Executive Director</td>
<td>Mr Wildig</td>
</tr>
<tr>
<td>Ian Goalen</td>
<td>Non-Executive Director</td>
<td>Mr Goalen</td>
</tr>
<tr>
<td>Rachael Charlton</td>
<td>Director of HR and Organisational Development</td>
<td>DHR</td>
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<tr>
<td>Dr John Hunter</td>
<td>Medical Director</td>
<td>MD</td>
</tr>
<tr>
<td>Mark Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
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<tr>
<td>Kath Senior</td>
<td>Director of Nursing, Performance and Quality</td>
<td>DNPQ</td>
</tr>
<tr>
<td>John Wilbraham</td>
<td>Chief Executive</td>
<td>CEO</td>
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**IN ATTENDANCE:**

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<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Janine Homer</td>
<td>Meeting Secretary</td>
</tr>
<tr>
<td>Michael Brown</td>
<td>Associate Director, Planned Care</td>
</tr>
<tr>
<td>Anne Marriott</td>
<td>Associate Director, Acute and Integrated Community Care</td>
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**AGENDA ITEM**

<table>
<thead>
<tr>
<th>Item</th>
<th>Subject</th>
<th>Action</th>
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<tbody>
<tr>
<td>17/78</td>
<td>Apologies</td>
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<td></td>
<td>• Julie Green – Annual Leave</td>
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<td></td>
<td>• Dr Tony Coombs – Non-Executive Director</td>
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<tr>
<td>17/79</td>
<td>Minutes of meeting held July 2017</td>
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<td></td>
<td>The minutes of the July meeting were agreed as an accurate record.</td>
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<tr>
<td></td>
<td>The Chair noted that no meeting had been held in August because of annual leave. However, a full set of papers was produced and circulated to the Committee and the CEO offered to respond to any questions that committee members wanted to raise. The Chair noted that one member had raised questions and that these had been dealt with.</td>
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<tr>
<td>17/80</td>
<td>Matters arising</td>
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<td></td>
<td>The Chair referred to page 5 of the July minutes and asked whether the winter plan had been submitted. The CEO confirmed that it had and that it was to be discussed as part of the Trust Board agenda later in the day.</td>
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<tr>
<td>17/81</td>
<td>Action points from previous meeting</td>
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<td></td>
<td>8896 - The Chair agreed prior to this meeting that the item would be deferred until October’s meeting. Action to remain open.</td>
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</table>
8897 - The DoF confirmed that all associated risks relating to the non-approve capital priority list had been added to the risk register. **Action closed.**

9186 – The DHR confirmed that the information requested by the CEO had now been added to the summary page of the workforce report. **Action closed.**

9188 – Item not due until October.

9189 – The DoF confirmed that the extra column will be added to the report from next month. **Action closed.**

9190 - Risks on the Corporate Risk Register that have reduced in score are now included in the report. **Action closed.**

9229 – The DoF confirmed that the planned work is underway. **Action closed.**

17/82 **Annual work plan**

Mr Goalen asked when the Capital update would be presented to the Committee. The DoF confirmed that it was included the Finance report to follow.

The Chair referred to ‘Community activity and outcomes’ and asked whether this included hubs. The DNPQ replied that it was too early to build this in. The CEO added that reporting on Q2 would start in October. The Chair asked that the description on the work plan be amended to include hubs going forward.

**Action: Annual work plan description for ‘Community activity and outcomes’ to be amended to ‘Community activity and outcomes including hubs’.**

The Chair then referred to ‘Development – Nurse Revalidation’ and the DNPQ noted that the risk score associated with this is 6, and it was agreed that this would be removed from the work plan unless escalation was required.

**Action: Remove ‘Development – Nurse Revalidation’ from the annual work plan.**

17/83 **Finance Report**

**Finance Report**

The DoF highlighted the following:

- Overall, the trust was ahead of plan with a £60k improvement in August.
- QIPP is on track, however there are concerns with the delivery within Planned Care (PC) and Acute and Integrated Community Care (AICC)
One area of challenge is PC income, which is behind plan but being offset by AICC A&E income. Work is required particularly within General Surgery and Orthopaedics.

It is not anticipated that the four hour A&E target will be achieved for Q2 as the 90% trajectory has not been met during September.

In response to questions raised by the Committee, the DoF provided clarity on the following:

- Trauma and Orthopaedics (T&O) electives and General Surgery were not on plan and work is underway around Theatre productivity and Endoscopy. The Carter model hospital suggests that there is more opportunity to increase work through existing capacity; improvements in the booking process will increase work within Endoscopy.

  **Action:** The CEO asked for further detail on what is driving the reduction in income to be included in next month's report.

- Direct credit income was ahead of plan due to monies received from HENW, where expenditure had been matched to cover accordingly.

- The CEO noted that high cost drugs are both unusually under planned income and under planned expenditure and the DoF responded that this was being investigated.

- There has been extra consultancy expenditure within the Theatres utilisation project and medical specialties and additional cover for sickness within Finance and HR. Medical staffing costs are below plan following improved controls on agency spend.

  **Action:** More detail on the overall performance of ‘Contracted Income – Other’ is to be provided in next month’s income report.

- Mr Goalen referred to AICC pay being £590k adverse due to agency costs and challenged whether this statement was correct as previously the committee had been assured that agency costs had minimal impact.

  **Action:** The DoF agreed to validate this and report back.

- Several income schemes were negotiated at the start of the year e.g. community care. To date, a lot of the QIPP has been income-generated, but there are opportunities in productivity.

- ‘Property, plant and equipment’ is down by a variance of £1.67m and capital expenditure is £670k below plan and the DoF advised that the difference of £1m is an element of £1.4m being carried forward from previous years. A large proportion of this relates to plans to purchase a second CT scanner, the business case for which is still in progress.

  **Action:** Intangible assets have not reduced from £973k to £594k as planned and the DoF agreed to investigate and report back.

- The position with Mid Cheshire NHS Foundation Trust has been resolved based on ECT calculations and £198k has been received so far.
• Action: Mr Goalen noted that in section 3.3.1 of the report concerning pre-payments ‘revised accounting’ should read ‘revised payment’.
  - The DoF will seek clarity on the statement that the reduction in Month 5 accrued income was largely a result of data and drugs challenges and CQUIN.
  - With regards to loan funding and being £6m under what was asked for, the balance would be requested by the end of the year, dependent on when STF funding would be paid.

Carter Update
The DoF provided a brief summary of the report including:
  - Procurement is referred to in a separate report.
  - The trust and Mid Cheshire have been put into a footprint with north Midlands for Pathology services.
  - A further presentation regarding Carter will be made to the next Clinical Management Board.

The Committee agreed that a shift from analysis to actions was required with the next update reflecting a more action-orientated approach.

The CEO commented that with regards to Pathology, it is the opinion of Tracy Bullock (CEO, Mid Cheshire) that the savings assessed have been overstated.

Procurement
The DoF presented an update on Procurement, highlighting the following:
  - A business case is being developed for the Cheshire and Wirral footprint.
  - A Memorandum of Understanding (MOU) has been signed to commit to work being completed within the next six months.
  - A further MOU is underway, however, two trusts have not accepted this.
  - The appendix to the report indicates that suppliers offer differing prices to other trusts
  - There is opportunity to make savings if ECT were to buy products at the median prices within the Purchasing Price Index Benchmark (PPIB)
  - A staff consultation process is underway for the ECT Procurement department, intending to make some savings and also some restructuring of the department.

Directorate Presentation – Planned Care
The Associate Director for Planned Care was welcomed to the meeting to update the committee on the Directorate’s QIPP position including:
  - QIIPP target is £880k recurrent;
  - 5 post challenge - £288k;
• Theatre productivity review - £252k through General Surgery, Ophthalmology, Gynae and T&O;
• Sexual Health retraction of vacancies - £128k;
• £214k renegotiating of SLAs in Sexual Health and buying-in consultant services;
• £14k through a reduction some surgical practitioner hours in general surgery.

The AD for Planned Care provided clarity on the following points following questions from the Committee:
• Theatre productivity is delivering but is being offset by the shortfall in income, which creates a potential risk. If productivity increased within T&O; one additional case onto an all-day list would require four extra beds.
• Once the theatre refurbishment is complete, a review of vacancies will be undertaken.
• Changes in Endoscopy bookings are enabling three weeks' notice which should reduce DNA rates. Whilst bookings are currently being made to 10 points, work is required around consultant job plans and capital investment in additional scope guides is being considered.
• Out Of Area charging for Sexual Health relates to East and West Cheshire and also Staffordshire; an invoice has been raised for last year and they are now being charged monthly.

**Directorate Presentation – Acute and Integrated Community Care**

The Associate Director for Acute and Integrated Community Care was welcomed to the meeting to update the committee on the Directorate's QIPP position including:
• Target £1156k; £527k identified, gap £656k;
• The schemes underway that will achieve across areas in Urgent Care, community, a small amount in Medicine;
• Additional schemes identified include – Cardiology £26k, Gastro and Respiratory both increased productivity by IYE £100k, ED, patient flow and Outpatient productivity – amount to be confirmed;
• Further work is required to address the remaining shortfall of £430k.
• The non-patient transport savings relate to the re-negotiated contract following the SVR exit; this has not impacted on the service.

The AD for Acute and Integrated Community Care provided clarity on the following points following questions from the Committee:
• Further schemes would involve improving productivity and the challenge faced is in consultants changing the way that they work and benchmarking with Stockport and South Manchester shows that comparisons aren't always favourable. The MD noted that The Royal College have standards for consultants' patient numbers within clinics which are used as guidance but not mandatory. Peripheral clinics are not efficient and are currently under review and cancelled clinics are being
challenged. These issues are not prescriptive of all consultants, but are significant to influence overall results.

- With regards to the £2k in-month underspend and where the year-end forecast would be if this continued, the AD for Acute and Integrated Community Care and the DoF reported that there is a planned decreased within Month 5, therefore this would not be a continuing trend.

The ADs for Planned Care and Acute and Integrated Community Care were thanked for their attendance.

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<tr>
<th>17/84 Performance Report</th>
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**Performance**

The DNQP presented the Performance report highlighting the following:

- ED Performance did not improve during July/August (85.2%) and is at 83.7% MTD for Sept (86.9% QTD), therefore additional funding is at risk. An increase in acute and non-acute DTOCS have driven this, along with a 12 hour trolley wait on 29th August;

- Diagnostics have deteriorated to 90% and will become a risk if not brought back on track as it is starting to impact on other areas (eg routine colonoscopies) – to be discussed in more detail at next month’s meeting. Cancer patients are being prioritised and long waits are being micro-managed to avoid harm occurring;

- 18 Weeks RTT is being delivered on aggregate but under performing in areas such as General Surgery where diagnostics delays are impacting performance.

- Ophthalmology is above plan for activity. WLIs are under negotiation as double the WLI rate of £500 per session is being requested; activity being carried out elsewhere is being investigated.

- A backlog exists within T&O; clinicians are reluctant to carry out WLIs; capacity at Mid Cheshire is being explored.

- Work is ongoing on the winter plan, which will be shared in more detail at the Trust Board meeting.

In response to questions raised by the Committee, the DNQP provided clarity on the following:

- DTOCS impacted by community beds are split one third social care and two thirds health care. Some are Out Of Area as a result of bed closures in Staffordshire. Bed rounds and stranded patients are reviewed daily. The CEO commented that whilst ECT is proactive, there are no clear plans from the CCG and this will be raised at the next A&E Delivery Board.

- With regards to the 4 hour ED standard being met if DTOCs were lower, the DNQP noted there were other contributory factors such as complex discharges and routine short stays, which are being reviewed e.g. pre-noon discharges.

- A draft winter plan has been submitted to NHSE for delivering
90% in Q3 and 95% in March including monthly trajectories.

- The CEO referred to patient flow and added that there were a number of breaches in mental health, with each breach representing 0.75%. The trust is being asked to admit to a further 12 beds from September but funding hasn’t yet been established.
- The CEO observed that although exceeding 90% was achievable, lack of assurance in getting to 95% relates back to the trust’s partners, which presents an operational, financial and reputational risk to the trust itself.
- The MD confirmed that although theatre 3 had been out of commission for refurbishment as planned, consultant leave had also contributed to cancelled lists.
- The drop in diagnostic standard performance was more than expected; a trajectory is being developed and will be ready for inclusion in next month’s report for further discussion.

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<tr>
<th>17/85 Workforce Report</th>
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<td>The DHR presented the workforce report highlighting the following:</td>
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<td>- A significant improvement in A&amp;E staffing, as a result of leadership focus and improved medical staffing, with zero unfilled bank and agency shifts in September, similar is expected for October;</td>
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<td>- Training is behind trajectory due to operational pressures; work has been carried out to improve this with focus needed on core clinical, annual clinical, safeguarding and appraisals;</td>
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<td>- There are concerns with the predicted balance in terms of the trust’s digital apprenticeship account;</td>
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<td>- The off-framework agency bookings were 84; this figure has reduced over the last four months;</td>
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<td>- The number of over-pay cap bookings is reported back to NHSI weekly; however, the trust is under the overall agency pay cap issued by NHSI.</td>
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In response to questions raised by the Committee, the DNPQ provided clarity on the following:

- Improved performance around safeguarding training and ongoing IT issues.
- Operational pressures continue to impact staff training. The DNPQ confirmed that she had written to the ADs to express disappointment; the CEO expressed concern that commitments have not been met and that more consideration needs to be given to how this can be delivered.
- Following a government-wide strategy, all organisations employing more than 500 people pay into an apprenticeship account, from which they can then draw down funds to pay for the education part of training. At present, the trust pays approximately £31k, the Government contributes £3k and the trust currently draws down £1k monthly. This year, funds will be carried over but going forward, what is not used will be transferred into a national fund. There is scope to provide funding to future trainee Nursing Associates; however, this is...
under discussion as there is a cost pressure in providing backfill. Further work to explore this is being undertaken by the DoF and DNPQ.
- The trust vacancy rate is currently 7.02% compared with 7.4% 12 months ago.

Guardian of Safe Working
The MD presented the quarterly update provided by Dr Chris Smart:
- Junior doctors are engaged and there are a number of trainees now on the new contract;
- A junior doctors' forum takes place monthly; the primary issue is gaps in rotas;
- Chris Smart to attend the December meeting of FP&W to update the committee further.

The committee agreed that medical revalidation be added to the annual work plan for discussion in July 2018.

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<th>17/86</th>
<th>Risk and Assurance</th>
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<td>The Chair proposed that this item be deferred until October’s meeting.</td>
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<th>17/87</th>
<th>Any Other Business</th>
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<td>None raised.</td>
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**Future Meetings:**

- 26th October 2017, 08:30-10:30, Boardroom 1 NAH
- 30th November 2017, 08:30-10:30, Boardroom 1 NAH
- 21st December 2017, 08:30-10:30, Boardroom 1 NAH