EAST CHESHIRE NHS TRUST

MEETING OF THE TRUST BOARD

NOT FOR PUBLICATION BEFORE

Thursday 26th April 2018

3.00 PM

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

Date: 26th April 2018

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 26th April 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 – April 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, Performance and Quality</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></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Declared interest agenda</td>
<td>The Chairman</td>
<td>5 mins</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 March 2018 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 18 (28)</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></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SQS</td>
<td>Ms A Harrison</td>
<td>10 mins</td>
<td></td>
<td>Verbal (supported by formal minutes when available)</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/FINANCIAL 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>40 mins</td>
<td>TB 18 (29)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Chairman’s Commentary</td>
<td>Chairman</td>
<td>10 mins</td>
<td>TB 18 (30)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>10. 2018-19 Operational Plan</td>
<td>Director of Finance</td>
<td>15 mins</td>
<td>TB 18 (31)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>11. Bi-annual Report - Safer Staffing</td>
<td>Director of Nursing, Performance &amp; Quality</td>
<td>10 mins</td>
<td>TB 18 (32)</td>
<td><strong>PATIENTS</strong> - Provide the best services to our population through improvements to safety, productivity and patient experience <strong>STAFF</strong> - Empower, develop and value staff in providing innovative patient focused care</td>
</tr>
</tbody>
</table>
12. **Standing Agenda Item:**
   Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register

   **Presented by:** Chief Executive
   **Time Allocation:** 5 mins
   **Verbal:** All corporate objectives

---

### ANY OTHER BUSINESS

---

### 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>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Public Trust Board Agenda – June 18</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 18 (33)</td>
</tr>
</tbody>
</table>

**AGENDA TOPIC**

**REF. NO.**

**REASONS FOR PRESENTING**

**LINKED TO TRUST OBJECTIVE ON**


   TB 18 (34)

   Assurance

   All corporate objectives

15. **Safer Staffing Exception Report**

   TB 18 (35)

   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

16. **Minutes of the committees of the Board:**

   SQS – February 18
   FP&W – February 18

   TB 18 (36)
   TB 18 (37)

   Information

---

**Date and Time of Next Meeting:**

Date: Thursday 7th June 2018
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
The Board agreed the Corporate Governance Manual update.

The Director of Nursing, Performance and Quality (DNPQ) presented a patient story taken from a letter which was originally sent to the Secretary of State for Health and Social Care, Jeremy Hunt by the relative of a patient.

The letter confirmed a patient was admitted into ward 3 seriously ill and difficult conversations were undertaken with the family around a completing a Do Not Resuscitate Form. This was understandably a distressing time for the family however the ward staff on ward 3 was acknowledged to be extremely professional, caring and warm. The daughter of the patient encouraged Mr Hunt to attend Macclesfield Hospital with a view of visiting ward 3 to see how professional and compassionate the staff were.

The DNPQ confirmed further work is being undertaken within the Trusts Quality Strategy Priorities 2018/2019 to continue to develop and improve end of life care.
<table>
<thead>
<tr>
<th>2.</th>
<th><strong>Apologies</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No apologies were noted</td>
</tr>
</tbody>
</table>

**ASSURANCE ITEMS**

<table>
<thead>
<tr>
<th>3.</th>
<th><strong>Register of Interests:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Declared interest agenda</td>
</tr>
<tr>
<td></td>
<td>No interests were declared</td>
</tr>
</tbody>
</table>

**Hospitality and Gifts Register Declaration**

The Chairman reminded Board members to ensure the hospitality and gift register remains up to date.

<table>
<thead>
<tr>
<th>4.</th>
<th><strong>Minutes of the January 2018 meeting</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18 (11)</td>
<td>Amendment to the previous minutes to be documented as:</td>
</tr>
<tr>
<td></td>
<td>• Page 13 of the papers, item 11; to be amended from ‘delegation of private account’ to be amend to ‘delegation of annual accounts’</td>
</tr>
<tr>
<td></td>
<td>The minutes of the January 2018 Trust Board meeting, with the amendment documented above, were declared a true and accurate record and duly signed by the Chairman</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.</th>
<th><strong>Matters Arising</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No matters arising were identified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6.</th>
<th><strong>Action Log</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9508 – The Chief Executive (CEO) has undertaken further discussions with the Chief Officer, Eastern Cheshire CCG around the position of usage within Congleton War Memorial Hospital. The Board noted the Minor Injuries Unit (MIU) was closed for much of January 2018 however this has improved throughout the last 2 months with MIU remaining closed over the weekend. Staff are being utilised with supporting MIU 50% and supporting Macclesfield hospital 50% to ensure there is adequate cover on each site. Recommend action closed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.</th>
<th><strong>Verbal update:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Chairs of the trust’s Committees of the Board gave an overview of the assurances and risks from their recent meetings and the Board noted there have been two Safety, Quality and Standards Committee and Finance, Performance and Workforce Committee meetings taking place in February 2018 and March 2018 since the last Public Trust Board therefore updates provided by AH, MW and IG will consist of both meetings.</td>
</tr>
</tbody>
</table>

**Safety, Quality and Standards Committee**

Points for Assurance

- The Committee received the annual report and self assessment for the Integrated Safeguarding Adult & Children's sub committee & noted the achievements and assurances provided in relation to the Trust's
Agenda item No.4: TB 18 (28)

compliance with statutory and mandatory safeguarding requirements

- The Committee received the biannual review of the Quality Impact Assessment (QIA) Process providing an overview of all open & approved schemes, ongoing and planned checks on effectiveness of risk mitigation and assurances in relation to closed schemes with no unforeseen impacts on quality during the reporting period

- Assurance Framework & Corporate Risk Register - The Committee reviewed the allocation of strategic risks to be overseen by SQS and concurred with these and areas of focus for next 3 months.

Emerging Risks & Mitigating Actions

- A Spotlight on corporate risk concerning end of life care and access to the Specialist Palliative Care team was presented & discussed. The dedication of the team in the face of significantly growing referrals and associated workload was noted, particularly given local (& national) shortfall in Palliative Medicine consultant. Support needed for trust wide End Of Life (EOL) training was recognised including consistent completion of EOL documentation. The risk will continue to be monitored via Directorate SQS, returning to main SQS if risk increases to >15

- Never events - 3 dental never events have occurred (one arising from retrospective 2014 report) in period Dec 16-Feb 18 with a further potential historical case to be confirmed post RCA. There appear to be no common factors beyond human error, however the SIRI committee will be seeking assurances on implementation of Local Safety Standards for invasive procedures with dental and ortho-dentistry services. It is to note that the community dental service has recently been recommissioned by ECCCG

- WHO Checklist - further to the receipt of ‘significant assurance’ outcome by Audit Committee on the Trusts compliance with the WHO checklist, several recommendations were made to further strengthen controls particularly in relation to debrief processes. Actions have been instigated and another internal audit outcome will be presented to SQS in April

- There were 9 patients waiting more than 12 hours from decision to admit to admittance to a ward in February. This is a reflection of ongoing significant operational pressures. No patient harm has been identified arising from the delay and no serious incidents associated with Emergency Department (ED) overcrowding have been reported during this period. No complaints relating to the access standard have arisen this month.

- A further increase in mixed sex accommodation breaches was noted for February (61 vs 39 in January). These arose due to operational pressures and all efforts were made to support privacy & dignity. The situation will be monitored very carefully particularly over the forthcoming Easter period

- The trust did not achieve the diagnostic waiting standard however, the
action plan is on track for compliance with target by end March. All other cancer standards were met save for the 62 day cancer standard arising from a smaller number of treatments this month. The process for breach allocation is changing from April with the Greater Manchester (GM) & East Cheshire (EC) Cancer Network having to adopt the national breach allocation framework. The full implications of this are being worked through and both processes will run in parallel for April. This change may create a short term increase in missed 62 day cancer targets for ECT. The impact of this will be notified to the Committee as soon as known.

- The Q4 Quality Strategy update focusing on Integrated Care was presented. Progress has been made on all elements and learning was discussed and agreed in relation to recording progress in form of specific outcomes for next year’s strategy. It was agreed further work would be taken up by CMB to evaluate and address some of the challenges faced in maximising the potential of the Cheshire Care Record.

**Finance, Performance and Workforce Committee**

- The Trust continues to be better than predicted plan and positive assurance has been noted.
- QIPP target of £6m for the Trust has been achieved however the Board noted 1 out of 3 Directorates have achieved their QIPP target.
- Staff consultations within the Procurement department have now been finalised with all staff receiving updated job descriptions and new working ways aligned with the Carter Report.
- The Trust have expressed an interest in bidding for Cheshire West and Chester (CWAC) Sexual Health tender and will inform the committee of outcome when confirmed.
- Operational pressures remain high with 2 months noted as red in 4 areas within the performance metrics.
- RTT has further decreased and it was noted the trust is unable to meet the set target. 22 breaches have been confirmed however there is a recovery action plan in place, the success of which may be impacted by continued operational pressures.
- The trust wide vacancy rate has decreased with the Board noting 4.3% to date. Acute nursing was highlighted as an area of concern however ongoing promotion is being undertaken. Agency spend is noted as above the agreed quarter however overall year to date, the trust is under the cap for NHSI plan.
- East Cheshire NHS Trust is the first trust in the North West region to be awarded Level 3 of the Disability Confident Leader scheme.
- Operational pressure has been a challenge with ensuring the workforce is compliant with training however an action plan has been implemented to achieve the targets set.
- The annual self-assessment and annual report was approved at FPW February meeting.

**Audit**

- The Committee reviewed and approved the Board Assurance
Framework and Corporate Risk Register for the trust.
- The terms of reference (ToR) were reviewed and approved. It was noted risks are owned by the Clinical Management Board (CMB) however this is not documented within the ToR.
- Concerns were raised around the conflict of interest bi annual report with Theatres Procurement Group not achieving full compliance with declarations.
- The Committee approved the increase of declarations to be from a grade 8C as opposed grade 8B.
- Internal audit report was received and concerns were raised with the sign out of medical instruments after surgery and the lack of debriefing with theatre lists.
- The payroll report was presented with 1 staff member under investigation with counter fraud.
- The internal audit plan was presented and the Committee approved the same.
- The external audit was presented alongside the draft assurance letters from the Director of Finance (DoF) and Information Governance (IG) and the Board noted these were accepted as final with no amendments.
- Losses and compensation paper was reviewed and noted

### STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>8.</th>
<th>Chief Executive’s Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18 (12)</td>
<td>The CEO presented the Chief Executive’s Commentary, highlighting the following:</td>
</tr>
<tr>
<td></td>
<td>• The Board is asked to accept the deficit control total for 2018/19 of £19.2m and related plan accepting that there is £1.9m of QIPP yet to be identified</td>
</tr>
<tr>
<td></td>
<td>• Continued pressure on urgent care has continued to necessitate the cancelation of elective in-patient operations with a resultant deterioration in waiting times.</td>
</tr>
<tr>
<td></td>
<td>• The agreement of a block contract with NHS Eastern Cheshire for 2018/19.</td>
</tr>
<tr>
<td></td>
<td>• The delivery of the 2017/18 financial position as at the end of February.</td>
</tr>
<tr>
<td></td>
<td>• The commencement of engaging clinical and non-clinical staff in developing service proposals for consideration in July 2018.</td>
</tr>
<tr>
<td></td>
<td>• The Board understood that the 6% pay increase for NHS over a 3 year period will be fully funded however formal confirmation is still awaited.</td>
</tr>
<tr>
<td></td>
<td>• CQC full report is awaiting to be received and is noted to be due in April 2018</td>
</tr>
<tr>
<td></td>
<td>• Performance within our A&amp;E department remains challenging and the annual plan will be submitted to the Board in April 2018 for final sign off. The DoF confirmed this has been accepted in principle however formal acceptance will be noted in April.</td>
</tr>
<tr>
<td></td>
<td>• The DoF confirmed flu vaccinations have been achieved at 70% with the target for 2018/2019 confirmed as 75%. This compared favourably with the national position.</td>
</tr>
<tr>
<td></td>
<td>• Concerns were raised with achieving 95% Emergency Department (ED) performance target due to current pressures. The CEO praised the staff currently working above and beyond their hours and their dedication to ensuring patient safety is maintained. There is significant work going into patient flow.</td>
</tr>
</tbody>
</table>
Transformations work is being undertaken with the trust currently in week 5 of a 28 week service proposal. Any major service change would be subject to a consultation and be financially stable.

Positive feedback has been received via the staff survey with a score noted as 3.8 out of 5 which is above the national average.

9. Corporate Governance Manual Update

The Director of Corporate Affairs and Governance (DCAG) presented the Corporate Governance Manual update and requested the Board agree the amendments.

The Board agreed the Corporate Governance Manual update.

10. Financial Update (budgets)

The DoF presented the financial budget paper and the following was noted:

- A block contract has been agreed with the East Cheshire CCG (ECCCG) however additional commissioner agreements will be placed onto a cost and volume contract as no agreement has been reached.
- The submitted financial plan for 2018/19 is a deficit of £19.2m, after assuming delivery of a recurrent 3.5% cost reduction target totalling £5.0m. The Trust had previously accepted a target of £19.4m in September 2017 and this is therefore only a small change.
- As a result of accepting the control total, the Trust is able to assume that it will be eligible for the Sustainability & Transformation (S&T) Funding payment of £5.7m; £4m for financial achievement and £1.7m for A&E delivery.
- The NHS staff pay award has been increased from 1% to 6% over a period of 3 years for Agenda For Change staff groups.
- The Staff Side Chair (SSC) confirmed full support that the increase will be entirely funded as the trust would be unable to achieve any additional cost. This is currently in the consultant stage and a full announcement is expected in July 2018.
- The winter planning risk is to be shared with the ECCCG and the budget to be approved in April 2018.

11. Annual Review – Carter

The DoF presented the Carter annual review and the following was noted:

- The Pathology Quality Assurance Dashboard (PQAD) hosted by NHSI to provide assurance that the pathology services provided are of appropriate quality and safety and the Cheshire pathway services scored 16 indicator reference as follows:
  - 8 indicator references - fully compliant
  - 6 indicator references - partially compliant
  - 2 indicator references – not compliant
- The Trust continues to implement the procurement transformation plan and there are 3 areas of risk which are being evaluated following a bid for funding with Mid Cheshire.
- In line with Carter recommendations, ECT is working on collaborative savings with other trusts through the development of aggregate sourcing work plans. The Trust’s detailed work plan will be in place by May 2018.
- The Trust has utilised the Model Hospital tool to benchmark against the operational activity and a number of staff access this regularly.
### Agenda item No.4: TB 18 (28)

The Director of Nursing, Performance & Quality (DNPQ) confirmed that further opportunity is available for the trust to secure a link with nursing and medical partnership working. East Cheshire NHS Trust currently have nurses in post where other trusts have doctors. The skill mix of nurses remains high against doctors employed.

The Chairman celebrated the positive work which is ongoing, the continued dedication of staff and noted the contents of the report.

<table>
<thead>
<tr>
<th>12.</th>
<th>Learning from Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TB 18 (16)</strong></td>
<td>The Medical Director (MD) presented the Learning from Deaths paper and the following was noted:</td>
</tr>
<tr>
<td></td>
<td>• The trust undertook a review of 20 deceased patients using a recognised clinical approach and confirmed, no deaths were found to be avoidable.</td>
</tr>
<tr>
<td></td>
<td>• All deaths of patients with learning disabilities were thoroughly reviewed using the LeDER methodology</td>
</tr>
<tr>
<td></td>
<td>• Good input from the palliative care team</td>
</tr>
<tr>
<td></td>
<td>• Evidence throughout the reviews of good communication with relatives and patients at the end of life</td>
</tr>
<tr>
<td></td>
<td>• No deaths were reported under the serious incidents framework</td>
</tr>
<tr>
<td></td>
<td>• Accuracy of coding has improved, although could be improved further with more consistent note keeping</td>
</tr>
<tr>
<td></td>
<td>• Gaps in clinical documentation can preclude assessment of whether care bundles are being followed appropriately</td>
</tr>
<tr>
<td></td>
<td>• There was inconsistent use of the end of life care plans</td>
</tr>
<tr>
<td></td>
<td>• Themes remain consistent and assurance will be delivered via learning for staff.</td>
</tr>
</tbody>
</table>

The board noted the contents of the report.

<table>
<thead>
<tr>
<th>13.</th>
<th>GIRFT Update</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TB 18 (17)</strong></td>
<td>The MD confirmed GiRFT is an anagram for Getting It Right First Time and this was piloted in Orthopaedic Surgery and is currently led nationally by Orthopaedic surgeon Professor Tim Briggs.</td>
</tr>
<tr>
<td></td>
<td>To date 4 specialties have been visited at ECT by the GIRFT team over the past year: orthopaedics, general surgery, ophthalmology and obstetrics &amp; gynaecology. Engagement is noted as excellent at all the meetings with consistent presence of senior managers, consultants and nursing staff.</td>
</tr>
<tr>
<td></td>
<td>Mortality is noted with low levels of length of stay and infection rate is low within the trust. No safety issues were noted and the trust was praised by the GIRFT team.</td>
</tr>
<tr>
<td></td>
<td>No formal feedback has been received by the trust however this will be shared with the Board by the MD upon receipt.</td>
</tr>
</tbody>
</table>

The Board noted the contents of the report.

<table>
<thead>
<tr>
<th>14.</th>
<th>Board Assurance Framework &amp; Corporate Risk Register</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TB 18 (18)</strong></td>
<td>DCAG confirmed all Committees have reviewed all risks.</td>
</tr>
</tbody>
</table>
The Board confirmed that the information received and discussed in meetings is consistent with risks on the Corporate Risk Register.

<table>
<thead>
<tr>
<th>15.</th>
<th><strong>Standing Agenda Item:</strong> Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No further agenda items noted.</td>
</tr>
</tbody>
</table>

**ANY OTHER BUSINESS**

<table>
<thead>
<tr>
<th>16.</th>
<th><strong>Public Trust Board Agenda – April 18</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18</td>
<td>The Board agreed for the Annual Plan to be added to April 2018 Trust Board meeting agenda.</td>
</tr>
</tbody>
</table>

**CONSENT ITEMS**

<table>
<thead>
<tr>
<th>18.</th>
<th><strong>Chairman’s Commentary</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18</td>
<td>The Board noted the contents of the Chairman’s commentary.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>19.</th>
<th><strong>Corporate Governance Manual</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18</td>
<td>The Board noted the contents of the Corporate Governance Manual and approved the changes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>20.</th>
<th><strong>Safer Staffing Exception Report</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18</td>
<td>The Board noted the contents of the Safer Staffing Exception report.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>21.</th>
<th><strong>Minutes of the committees of the Board:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18</td>
<td>SQS – December 17, Jan 18</td>
</tr>
<tr>
<td></td>
<td>The Board noted the contents of the minutes of the SQS committee.</td>
</tr>
<tr>
<td>TB 18</td>
<td>FP&amp;W – November 17, Jan 18</td>
</tr>
<tr>
<td></td>
<td>The Board noted the contents of the minutes of the FPW committee.</td>
</tr>
<tr>
<td>TB 18</td>
<td>Audit - November 17</td>
</tr>
<tr>
<td></td>
<td>The Board noted the contents of the minutes of the Audit committee.</td>
</tr>
</tbody>
</table>

**Date and Time of Next Meeting:**
Date: Thursday 26th April 2018
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital

Signed: ..............................................
Name: ..............................................
Date: ..............................................
<table>
<thead>
<tr>
<th>Action Log No</th>
<th>Committee</th>
<th>Date Presented</th>
<th>Paper Reference</th>
<th>Agenda Item</th>
<th>Action Description</th>
<th>Action Owner</th>
<th>Response required by</th>
<th>Comment/Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>9508</td>
<td>Trust Board</td>
<td>25/01/2018</td>
<td>8</td>
<td>Chief Executive’s Commentary</td>
<td>CEO &amp; DoN to liaise with CEC and CCG regarding MIU at Congleton War Memorial</td>
<td>John Wilbraham / Kath Senior</td>
<td>Feb-18</td>
<td></td>
<td>Open</td>
</tr>
</tbody>
</table>

The Chief Executive (CEO) has undertaken further discussions with the Chief Officer, Eastern Cheshire CCG around the position of usage within Congleton War Memorial Hospital. The Board noted the Minor Injuries Unit (MIU) was closed for much of January 2018 however this has improved throughout the last 2 months with MIU remaining closed over the weekend. Staff are being utilised with supporting MIU 50% and supporting Macclesfield hospital 50% to ensure there is adequate cover on each site. Recommend action closed.
| **Report of:** | Chief Executive |
| **Responsible Officer:** | |
| **Accountable Officer:** | John Wilbraham, Chief Executive |

**Subject/Title**
Chief Executives Report to Trust Board for the Period to 31st March 2018

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

**Purpose of Paper**
To highlight performance issues and areas of risk to the delivery of the trusts objectives

**Action/Decision required**
Agree oversight on delivery of the CQC action plan is delegated to the SQS Board Committee.

**Mitigates Risk Number: (identify) On Corporate Risk Register**
Links to all risks identified within the Assurance Framework and the Corporate Risk Register

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

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

**Link to:**
- Trust’s Strategic Direction  
  Links to all strategic objectives
- Corporate 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:**
CQC – Care Quality Commission  
QIPP - Quality, Innovation, Productivity and Prevention  
HSCA – Health & Social Care Act  
CEO – Chief Executive  
SQS – Safety, Quality & Standards Committee  
ED – Emergency Department  
NNAP – Neo-natal National Audit Programme  
NHS E – National Health Service England  
ANNP – Advanced Neo-natal Nurse Practitioner  
Fol – Freedom of Information  
BMJ – British Medical Journal
Chief Executives Commentary for the Period Ending 31st March 2018

1 INTRODUCTION

The paper gives an overview of performance of the trust for the period and provides assurance and areas of risk around the delivery of the Boards objectives.

2 KEY ISSUES

The Board are asked to note

- The “Good” rating for services and well led following the recent Care Quality Commission (CQC) Inspection
- The non-achievement of the 4-hour and referral to treatment standards due to winter pressure activity
- The delivery of the diagnostic waiting standard in line with the recovery plan
- The delivery of the 2017/18 financial control total and QIPP savings but significantly increasing expenditure on agency staff

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

The Trust has received a “Good” rating from the Care Quality Commission (CQC) following their inspection in January 2018

3.1 Care Quality Commission Inspection

The Board has accountability to ensure there are effective systems and processes in place which can demonstrate compliance with the Health and Social Care Act including effective leadership.

3.1.1 The trust was notified by CQC that it would be assessed against the “Well Led” framework which would take place over a four day inspection timeframe commencing January 2018. This was to be preceded by a short notice and no notice inspections carried out within core service areas.

Outcome from the Inspection

The Trust was rated as “Good” overall

3.1.2 The outcome from the inspection was very positive with the overall rating of “Good”. Community end of life care were rated “Outstanding” for caring. Not all the core services were inspected and this is in line with the CQC Inspection regime; they have taken account of this as part of their judgement.
Community End of Life Care assessed as “Outstanding” for caring  

Of the core services inspected CQC considered whether the service was Safe, Effective, Caring, Responsive and Well-led (known as the domains). The ratings for effective, responsive and well-led have all improved from requires improvement to good. The rating for caring remains the same at good. The rating for safety remains at requires improvement.

There were several areas of “outstanding practice” noted

- Within the community end of life care, CQC saw numerous examples that demonstrated staff consistently treated patients in a compassionate, dignified and respectful way.
- In surgery, staff worked with local members of the public with learning disabilities to produce pictorial information booklets for patients who helped prepare them for surgery.
- The frailty service had developed to provide “wrap-around” treatment to support patients at home before and after hospital admission. The service linked with local care homes and meant that, for example, a podiatrist could refer patients to physiotherapy for a formal fall assessment if the patient was thought to be at potential risk of falling.
- Boxes containing local memorabilia such as local history books were available for patients living with dementia. Nurses sourced these items themselves from charity shops.
- The children’s ward was especially responsive to children and young people with learning disabilities and others on the autism spectrum. The National Autistic Society had accredited the children’s ward.
- The nurses had developed special recreational bags for children with mental health issues. These bags contained a stress ball, fidget spinner and ear plugs to minimise noise from younger children.
- For children with food aversions the play team worked with the speech and language therapist to develop therapeutic food play.
The Trust was assessed as not meeting three regulated activities

There were three regulated activities which the trust was assessed as not meeting these were:

- Regulation 15 of the Health and Social Care Act (HSCA); relating to premises and equipment
- Regulation 12 of the HSCA relating to safe care and treatment
- Regulation 9 of the HSCA relating to person centred care

The trust will implement an action plan and test that changes in practice are embedded. This will form part of the organisation’s audit review process.

The Trust will continue its regular meetings with CQC

In line with usual practice, the CEO and executives will be meeting with CQC throughout the year.

CQC have set out guidance on the maximum time limits for inspections set out below; they will use a trust’s previous ratings and the latest information they have to decide which “services” to inspect alongside its annual inspection of the well-led key question. The maximum intervals for re-inspection being:

- one year for core services rated as inadequate
- two years for core services rated as requires improvement
- three and a half years for core services rated as good
- five years for core services rated as outstanding

Full report can be located here.

3.1.7 Next Steps

The Board is asked to delegate authority to the SQS Board Committee to oversee the implementation of the trust’s quality improvement action plan.

3.2 Performance Standards

3.2.1 Appendix A summarises the performance for March, quarter 4 and the year. It can be seen that the impact of winter has meant that the trust did not meet its waiting time targets for patients moving through ED in 4 hours and the number of people treated who had waited more than 18 weeks. Further impacts were seen on the number of patients who were awaiting admission from ED for more than 12 hours and there have also been ward bays which have had both male and female patients being nursed together.

It is pleasing to note that the diagnostic waiting time was achieved in March in line with the recovery plan for this standard.
3.2.2 The Executive Team are in discussion regarding the bed configuration for 2018/19 to mitigate future impacts of winter conditions and pressures. This needs to be achieved within the financial resources available to the organisation and will look to balance the number of medical and surgical beds to the demand being faced.

3.3 Patient Safety Award

The Trust has been shortlisted in a national patient safety award process

3.3.1 I am pleased to report that the trust has been shortlisted by the Health Service Journal in its national safety awards programme. The submission in the changing culture category was entitled:

*Maintaining Patient Safety in times of Escalation - An Organisational Approach*

The team will be presenting to the award panel in May with the award ceremony taking place on the 9th July 2018.

3.4 External Reviews

This national audit demonstrates the trust is operating as expected in 4 of the five areas and exceeding the standard in one area.

3.4.1 Lung Cancer

The results of a national lung cancer audit undertaken by Healthcare Quality Improvement Partnership have been published and the trust performance is positive.

3.4.2 The slide below shows the outcomes for the trust and also refers to the CQC domains:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude proportion of patients seen by a Cancer Nocc Speci</td>
<td>84.9%</td>
<td>92.4%</td>
<td>NA</td>
<td>90%*</td>
<td>Meets the national minimum standard of 90%</td>
</tr>
<tr>
<td></td>
<td>Case note adjusted one year relative survival rate</td>
<td>Effective</td>
<td>Not significantly different from the national level</td>
<td>39.6%</td>
<td>37.0%</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Case note adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery</td>
<td>Effective</td>
<td>Significantly better than the national level</td>
<td>16.3%</td>
<td>17.5%</td>
<td>11%*</td>
</tr>
<tr>
<td></td>
<td>Case note adjusted percentage of patients with advanced Non Small Cell Lung Cancer (NSCLC) receiving Systemic Anti-Cancer Treatment</td>
<td>Effective</td>
<td>Not significantly different from the national level</td>
<td>61.9%</td>
<td>62.0%</td>
<td>65%*</td>
</tr>
<tr>
<td></td>
<td>Case note adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy</td>
<td>Effective</td>
<td>Not significantly different from the national level</td>
<td>76.3%</td>
<td>60.0%</td>
<td>70%*</td>
</tr>
</tbody>
</table>

3.5 Neo Natal Critical Care
3.5.1 The trust has also undergone a peer review on neonatal critical care undertaken by the Quality Surveillance Programme of NHSE. There were no serious concerns or immediate risks with a number of significant achievements, namely:

- Term admission review template
- Dissemination of lessons learnt via the directorate newsletter
- Improved family facilities on unit including refurbished accommodation
- High proportion of mother’s milk at discharge as evidenced by NNAP data
- Committed and motivated ANNP/lead nurse
- Nominated as patient choice best team in 2016
- Team awarded the best team for infection control in 2017
- Attempts to keep mums and babies together which has impacted on the low term admission rate
- Training programme for nurse members

3.5.2 There are a number of areas for development which will be taken forward by the neonatal team.

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.

The Trust has achieved its 2017/18 financial control target and achieved its QIPP savings target

4.1 The trust, subject to annual accounts audit, will declare a deficit of £18.9m for 2017/18 which is £1.3m better than the control total accepted by the trust of £20.2m.

4.2 QIPP savings in year totalled £6.2m against a target of £6m with this value confirmed in recurrent terms. The position is summarised below:

4.3 Summary Income and Expenditure Position for 2017/18:

<table>
<thead>
<tr>
<th>Income &amp; Expenditure Statement table - Month 12 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan</strong></td>
</tr>
<tr>
<td>Income</td>
</tr>
<tr>
<td>Pay Expenditure</td>
</tr>
<tr>
<td>Non-Pay Expenditure</td>
</tr>
<tr>
<td>Total Operating Expenditure</td>
</tr>
<tr>
<td>Operating (deficit)/surplus</td>
</tr>
<tr>
<td>Interest Rec'd/Paid/Gain on disp.</td>
</tr>
<tr>
<td>Capital Charges &amp; Adjustment for donated assets</td>
</tr>
<tr>
<td>Adjustment for 2016/17 additional sustainability &amp; transformation funding</td>
</tr>
<tr>
<td>Trust (deficit)/surplus</td>
</tr>
</tbody>
</table>
Growth in agency expenditure is a cause for concern

The level of expenditure has increased significantly in recent months with the March position being £1m compared to £630k in March 2017. It is recognised that the trust has had additional beds open for winter pressures but this was also the case in the winter of 2016/17.

The executive team have scheduled to discuss this at a team meeting to review the position and to ensure that controls are in place to minimise the expenditure made.

The trust has maintained expenditure below the “capped” level in 2017/18 however the current level is not consistent with achieving the 2018/19 cap of £7.3m

The Financial outlook for 2018/19 is challenging with a control total of £19.2m

The annual plan sets out the financial requirement to have a deficit of no more than £19.2m. The Board are aware that the main contract in 2018/19 is a block arrangement and therefore cost control and productivity will be key in the delivery of this financial objective.

QIPP delivery is of concern with £1.5m secured against a £5m requirement.

The 2017/18 annual plan submission is presented in a separate agenda item.

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.

Disability Confident Scheme

The Trust is the only health organisation in the NW to be awarded the nationally recognised Disability Confident Award

East Cheshire is one of only six health organisations nationally and the first trust in the NW region to be awarded Level 3 of the Disability Confident Scheme. The scheme is designed to help employers make the most of the opportunities provided by employing people with disabilities. The trust is now known as a ‘Disability Leader’. This ‘Leader’ status reflects the work the trust has done to support disabled people who are seeking work experience or volunteering opportunities at the trust and our commitment to championing this work both internally and across local business communities.
5.1.2 This award recognised the development of our work experience pathways for applicants with disabilities; where a number of placements have been made as a result. The award also took into account the range of support we offer to disabled staff through our Health & Wellbeing service and our commitment that should a member of staff become disabled during their employment, every effort is made to support them to continue working. Health & Wellbeing questions form part of the annual appraisal process and the HR team offer coaching to managers to understand and implement reasonable adjustments where required.

5.1.3 The trust was proud to have been selected to be an NHS Employers Diversity & Inclusion Partner for 2017 / 2018 and over the course of the year, this has involved working with NHS employers and other national bodies to support the robust measurement of diversity and equality across the healthcare system. This pioneering and championing work helped the trust meet some of the local challenges in support of integrated diversity and inclusion, with the aim of making measurable improvements relating to the experience of staff. As part of this work, the trust is part of the NHS employers Workforce Disability Advisory Group (Disability Pioneers), set up to help shape and communicate the introduction of the Workforce Disability Equality Standard.

5.2 Openness

5.2.1 East Cheshire has been ranked as one of the best Trusts in England for transparency in relation to clinicians’ conflict of interest disclosures by a study in the BMJ. The study was based on a FoI request sent out in July 2016 which asked for gifts and hospitality registers from 2015/16.

5.2.2 The full league table can be viewed at - coi.theycarenforyou.org – and the full paper in the BMJ can be viewed at http://bmjopen.bmj.com/content/8/3/e019952

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 ECT Service Proposals

6.1.1 The clinical engagement in the development of the proposals is continuing following the launch event with Clinical Leads and Directors. Currently individual meetings are taking place with clinical directors and clinical leads to refresh the “case for change” i.e. setting out the challenges that each service area faces.

6.1.2 Three workshop sessions have been established during May and June where this work will be brought together such that the clinicians and senior managers understand the challenges across the organisation as a base for the development of the proposals.
6.1.3 The second session will bring colleagues from the Nuffield Trust who have been undertaking work on how District General hospitals may look in the future.

7 USE OF TRUST SEAL

7.1 The trust seal has not been used since the last meeting.

8 SUMMARY

2017/18 has been a challenging but in many ways a successful year

8.1 The winter pressures have impacted the trust in line with many NHS organisations and it is clearly disappointing that patient experience was affected by long waits in ED and cancelled operations.

8.2 This should not undermine the successes delivered in the year and the improved rating from the CQC, nor the improved outcomes within harm free care such as the reduction in the number of falls and the delivery of our financial objectives; these are all outcomes which should be celebrated.

Sign off
John Wilbraham
Role title
Chief Executive
## Appendix A

### Mortality

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Adjusted Mortality Index 2017 - Latest Peer (91.35)</td>
<td></td>
<td></td>
<td></td>
<td></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>
<td>Oct 16 - Sep 17</td>
<td>1.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecol - includes hospital and community</td>
<td>39</td>
<td>41</td>
<td>30</td>
<td>10</td>
<td>11</td>
<td>8</td>
<td>29</td>
</tr>
</tbody>
</table>

### Infection

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital MRSA bacteraemia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</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>4</td>
<td>0</td>
<td>1</td>
<td>0</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>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 3 pressure ulcers - out of hospital</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 4 pressure ulcers - out of hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Incidents

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication errors causing serious harm</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</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>65.0</td>
<td>65.4</td>
<td>67.6</td>
<td>55.0</td>
<td>62.5</td>
</tr>
<tr>
<td>Patient Safety - Falls resulting in patient harm per 1000 Occupied bed days</td>
<td>8.2</td>
<td>8.0</td>
<td>8.2</td>
<td>9.0</td>
<td>9.2</td>
<td>9.1</td>
<td>9.7</td>
</tr>
</tbody>
</table>

### Complaints

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints with HSO Recommendations</td>
<td>30</td>
<td>38</td>
<td>36</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>92</td>
</tr>
<tr>
<td>Ward Family and Friends Test % response</td>
<td>41.4%</td>
<td>34.2%</td>
<td>37.4%</td>
<td>38.2%</td>
<td>39.7%</td>
<td>36.9%</td>
<td>37.8%</td>
</tr>
<tr>
<td>ED Family and Friends Test % response</td>
<td>62.3%</td>
<td>59.6%</td>
<td>57.8%</td>
<td>62.4%</td>
<td>58.2%</td>
<td>54.7%</td>
<td>34.5%</td>
</tr>
<tr>
<td>Med ICU Accommodation breaches per 1000 FCE's</td>
<td>0.4</td>
<td>0.9</td>
<td>1.9</td>
<td>0.4</td>
<td>0.2</td>
<td>0.6</td>
<td>0.1</td>
</tr>
</tbody>
</table>

### Experience

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Week - Incomplete Patients</td>
<td>88.6%</td>
<td>87.9%</td>
<td>85.7%</td>
<td>71.2%</td>
<td>70.2%</td>
<td>72.5%</td>
<td>84.2%</td>
</tr>
<tr>
<td>18 Week - Admitted Backlog</td>
<td>543</td>
<td>489</td>
<td>745</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED: Maximum waiting time of 4 hours</td>
<td>63.9%</td>
<td>67.0%</td>
<td>61.6%</td>
<td>71.2%</td>
<td>70.2%</td>
<td>72.5%</td>
<td>84.2%</td>
</tr>
<tr>
<td>2 Weeks maximum wait from urgent referral for suspected cancer</td>
<td>98.9%</td>
<td>98.6%</td>
<td>98.2%</td>
<td>98.6%</td>
<td>98.5%</td>
<td>98.6%</td>
<td>98.5%</td>
</tr>
<tr>
<td>2 Weeks maximum wait from referral for breast symptoms</td>
<td>92.5%</td>
<td>97.1%</td>
<td>96.9%</td>
<td>96.9%</td>
<td>96.8%</td>
<td>96.4%</td>
<td>96.6%</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>
<td>100.0%</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>98.9%</td>
<td>98.9%</td>
<td>98.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>62 day maximum wait from urgent referral to treatment of all cancers</td>
<td>97.1%</td>
<td>97.7%</td>
<td>94.3%</td>
<td>96.6%</td>
<td>95.0%</td>
<td>97.2%</td>
<td>98.5%</td>
</tr>
</tbody>
</table>

### Access

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED: The recording of a completed handover - (HAS)</td>
<td>96.8%</td>
<td>98.6%</td>
<td>98.6%</td>
<td>98.6%</td>
<td>98.6%</td>
<td>98.6%</td>
<td>98.6%</td>
</tr>
<tr>
<td>2 Weeks maximum wait from urgent referral for suspected cancer</td>
<td>98.9%</td>
<td>98.6%</td>
<td>98.8%</td>
<td>98.6%</td>
<td>98.5%</td>
<td>98.5%</td>
<td>98.5%</td>
</tr>
<tr>
<td>2 Weeks maximum wait from referral for breast symptoms</td>
<td>92.5%</td>
<td>97.1%</td>
<td>96.9%</td>
<td>96.9%</td>
<td>96.8%</td>
<td>96.4%</td>
<td>96.6%</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>
<td>100.0%</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>98.9%</td>
<td>98.9%</td>
<td>98.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>62 day maximum wait from urgent referral to treatment of all cancers</td>
<td>97.1%</td>
<td>97.7%</td>
<td>94.3%</td>
<td>96.6%</td>
<td>95.0%</td>
<td>97.2%</td>
<td>98.5%</td>
</tr>
</tbody>
</table>

### Staff

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Staff in Post (FTE)</td>
<td>2164.2</td>
<td>2155.5</td>
<td>2179.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness Absence - monthly</td>
<td>6.8%</td>
<td>6.0%</td>
<td>5.10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness Absence - Rolling year</td>
<td>4.79%</td>
<td>4.87%</td>
<td>4.91%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate Induction attendance - Rolling year</td>
<td>93.3%</td>
<td>93.8%</td>
<td>94.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Governance training</td>
<td>88.3%</td>
<td>88.0%</td>
<td>86.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding - Level 1 Compliance</td>
<td>93.5%</td>
<td>93.8%</td>
<td>94.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children - Level 2</td>
<td>78.1%</td>
<td>78.1%</td>
<td>78.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children - Level 3</td>
<td>76.8%</td>
<td>77.1%</td>
<td>80.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Pay Expenditure (£000)</td>
<td>£26,583k</td>
<td>£26,304k</td>
<td>£26,949k</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank Staff Expenditure (£000)</td>
<td>£1,133k</td>
<td>£1,139k</td>
<td>£1,252k</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Governance training</td>
<td>89.29%</td>
<td>92.4%</td>
<td>95.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding - Level 1 Compliance</td>
<td>93.2%</td>
<td>93.8%</td>
<td>94.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children - Level 2</td>
<td>78.1%</td>
<td>78.1%</td>
<td>78.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children - Level 3</td>
<td>76.8%</td>
<td>77.1%</td>
<td>80.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Finance

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Pay Expenditure (£000)</td>
<td>£26,583k</td>
<td>£26,304k</td>
<td>£26,949k</td>
<td>£9,403k</td>
<td>£9,338k</td>
<td>£9,633k</td>
<td>£28,374k</td>
</tr>
<tr>
<td>Bank Staff Expenditure (£000)</td>
<td>£1,133k</td>
<td>£1,139k</td>
<td>£1,252k</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Staff (FTE)</td>
<td>2407.8</td>
<td>2437.4</td>
<td>2501.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency Staff Expenditure (£000)</td>
<td>£1,268k</td>
<td>£1,272k</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash (£000's)</td>
<td>£3,224k</td>
<td>£5,387k</td>
<td>£7,314k</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory and Mandatory Training - Rolling 3 year period</td>
<td>93.3%</td>
<td>93.8%</td>
<td>94.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Governance training</td>
<td>88.3%</td>
<td>88.0%</td>
<td>86.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding - Level 1 Compliance</td>
<td>93.5%</td>
<td>93.8%</td>
<td>94.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children - Level 2</td>
<td>78.1%</td>
<td>78.1%</td>
<td>78.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children - Level 3</td>
<td>76.8%</td>
<td>77.1%</td>
<td>80.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Pay Expenditure (£000)</td>
<td>£28,374k</td>
<td>£28,374k</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank Staff Expenditure (£000)</td>
<td>£1,133k</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Staff (FTE)</td>
<td>2407.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency Staff Expenditure (£000)</td>
<td>£1,268k</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash (£000's)</td>
<td>£3,224k</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory and Mandatory Training - Rolling 3 year period</td>
<td>93.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Governance training</td>
<td>88.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding - Level 1 Compliance</td>
<td>93.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children - Level 2</td>
<td>78.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children - Level 3</td>
<td>76.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TRUST BOARD  
Thursday 26th April 2018  
Agenda Item Number 9: TB 18 (30)

<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 agree the strategic and annual objectives for 2018-19</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-lead |
| Link to:                                         | Supporting and developing staff to enable them to achieve their best  
Working with our partners to provide an integrated health service for our local population |
<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
A&E – Accident and Emergency
CCG – Clinical Commissioning Group
IT – Information Technology
1 NATIONAL, REGIONAL AND LOCAL CONTEXT

1.1 NHS Providers regional forum

1.1.2 The Vice Chair attended this meeting on behalf of the trust; discussions focused around the reduced level of public satisfaction with the NHS coupled with the recognition of how hard the whole system is working for patients; the financial position nationally, how this is influencing organisations and what this means for government policy; the importance of ensuring social care is recognised as a priority for funding alongside health, given their symbiotic relationship.

1.1.3 Workforce and the impact of Brexit, together with the volume of regulation were also on the agenda.

1.1.4 It is increasingly acknowledged that patients presenting at A&E departments have multiple co-morbidities and complex needs and there is a growing conversation about how this impacts across the system together with the need to take a longer term view of funding.

1.2 Provider Summit, Modernising Healthcare

I attended this event which focused on several key areas of interest including innovation, digital technology and the significance of data on service transformation. Learning from others with shared experiences will also help inform our own service innovation.

2 LOCAL CONTEXT

2.1 Chair to Chair meetings

2.1.1 I was pleased to invite and host the Chair of The Christie on Thursday 5th April to discuss all things cancer. She was pleased to visit the site and see first-hand the friendly staff, warm reception and enjoyed the site walk about.

2.2 Health Matters

2.2.1 This month’s Health Matters focused on frailty; recognising the signs, how to help ourselves, as well as what assistance is available to avoid hospital admission. When this is necessary, it is so important to recognise both the impact of getting dressed when in hospital to be more like your normal self and how keeping mobile can make such a difference and avoid muscle wastage.

2.2.2 To see this and previous topics and video presentations, please use this link.
http://www.eastcheshire.nhs.uk/News-Events/Health-matters.htm

Chairman: Lynn McGill
Chief Executive: John Wilbraham
3    PARTNERSHIPS

3.1 Central and East Cheshire Joint Programme Board

3.1.1 The Joint Programme Board met on Wednesday 4th April 2018 and heard from several senior responsible officers. Plans and discussions are at an early stage of development although shaping up and aligning regionally. For regular updates, please continue to see http://www.caringtogether.info

3.1.2 In support of strong partnership relationships I continue to meet informally with the Eastern Cheshire CCG Chair; this took place on both 8th February and 8th March 2018.

4    TRUST BOARD

4.1 Trust Board Business

4.1.1 I was pleased to welcome the Chair of Mid-Cheshire Hospitals NHS Foundation Trust to support the recruitment of a non-executive director to bring the Board back to full membership. This is work in progress and I will be pleased to share the outcome with members when completed.

4.2 Strategic and Annual Objectives

4.2.1 The Board are required to set objectives for the financial year 2018-19; below are the proposed strategic and annual objectives for approval by the Board.

Patients - To provide safe, effective personal care in the right place

People - Build, Value and develop a skilled, motivated and sustainable Workforce

Partnerships - To build strong relationships with partners in Cheshire East and Greater Manchester to Deliver our vision

Resources - To deliver services that are clinically and financially sustainable

4.2.2 The Board’s priorities for 2018/19 are:

- To ensure patients are safe
- To deliver timely urgent care for patients
- To retain and develop skilled and motivated staff who support our ambition to be the local employer of choice
- To engage staff in developing our clinical strategy
- To develop strategic proposals for future sustainable services
- To fully engage in wider partnership working for the benefit of the local population
- To deliver the financial control total through improved productivity and strong financial control
- To further develop IT systems to support staff in providing good quality care

Chairman: Lynn McGill
Chief Executive: John Wilbraham
4.2.3 Once agreed, these will be set as objectives for the Chief Executive.

4.3 **Board Attendance**

4.3.1 Each year, the trust publishes Board members attendance at each of its key meetings by way of demonstrating commitment and contributions to the trust and the NHS. Please find attendance for 2017-18 attached at Appendix 1.

4.4 **Clinical Excellence Awards Committee**

I am pleased to note that this committee which reached its decisions on Tuesday 10\textsuperscript{th} April 2018 has discharged its responsibilities in line with policy and good practice.

4.5 **The Trust Board Programme of Work** is as planned.

4.6 **Board Development**

4.6.1 As planned with a focus on broadening a more diverse culture through continued effective leadership and which is everyone’s business.

Lynn McGill
Chairman
<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Percentage Attendance</th>
<th>Percentage Attendance</th>
<th>Percentage Attendance</th>
<th>Percentage Attendance</th>
<th>Percentage Attendance</th>
<th>Percentage Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>McGill, Lynn</td>
<td>Chairman</td>
<td>100%</td>
<td>100%</td>
<td>Not a member</td>
<td>Not a member</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Goalen, Ian</td>
<td>Deputy Chair &amp; Non-Executive Director</td>
<td>100%</td>
<td>86%</td>
<td>100%</td>
<td>100%</td>
<td>Not a member</td>
<td></td>
</tr>
<tr>
<td>Coombs, Dr Anthony</td>
<td>SID &amp; Non-Executive Director</td>
<td>91%</td>
<td>86%</td>
<td>Not a member</td>
<td>90%</td>
<td>Not a member</td>
<td></td>
</tr>
<tr>
<td>Cowan, Dr Jane</td>
<td>Non-Executive Director</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>Not a member</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Harrison, Ali</td>
<td>Non-Executive Director</td>
<td>91%</td>
<td>100%</td>
<td>Not a member</td>
<td>Not a member</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Wildig, Mike</td>
<td>Non-Executive Director</td>
<td>91%</td>
<td>86%</td>
<td>100%</td>
<td>90%</td>
<td>Not a member</td>
<td></td>
</tr>
<tr>
<td>Wilbraham, John</td>
<td>Chief Executive</td>
<td>100%</td>
<td>100%</td>
<td>Not a member</td>
<td>90%</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Senior, Kath</td>
<td>Deputy CEO &amp; Director of Nursing, Performance and Quality</td>
<td>100%</td>
<td>100%</td>
<td>Not a member</td>
<td>100%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>Ogden, Mark</td>
<td>Director of Finance</td>
<td>100%</td>
<td>100%</td>
<td>Not a member</td>
<td>100%</td>
<td>58% (pre-approved)</td>
<td></td>
</tr>
<tr>
<td>Charlton, Rachael</td>
<td>Director of HR &amp; Operational Development</td>
<td>91%</td>
<td>86%</td>
<td>Not a member</td>
<td>90%</td>
<td>33% (pre-approved)</td>
<td></td>
</tr>
<tr>
<td>Green, Julie</td>
<td>Director of Corporate Affairs and Governance</td>
<td>91%</td>
<td>86%</td>
<td>Not a member</td>
<td>90%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>Hunter, Dr John</td>
<td>Medical Director</td>
<td>100%</td>
<td>100%</td>
<td>Not a member</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
Report of:  
Responsible Officer: Accountable Officer: Director of Finance  

Author of Report: Deborah Bennett  
Head of Strategic Planning  

Subject/Title ECT 2018/19 Plan  

Purpose of Paper To seek Board approval of the annual plan to be submitted to NHSI by 30 April 2018  

Action/Decision required To approve  

Mitigates Risk Number: (identify)  
On Corporate Risk Register Corporate Risk 2342:  
If the planned process and budget control process are not robust then there is a risk that the Trust will not achieve the financial control total.  

Mitigates Risk Number: (identify)  
On Assurance Framework  

Link to Care Quality Commission Domain Choose one of the following:  
Safe  
Caring  
Responsive  
Effective  
Well-lead ✓  

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

BAF – 3 – Financial Stability  
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  

Legal implications - (identify) N/A  

Impact on quality See contents  

Resource impact See contents  

Impact of equality/diversity N/A
<table>
<thead>
<tr>
<th>Acronyms or Abbreviations</th>
<th>Full Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEP</td>
<td>Capped expenditure process</td>
</tr>
<tr>
<td>CNST</td>
<td>Clinical negligence scheme for trusts</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for quality and innovation</td>
</tr>
<tr>
<td>DTOC</td>
<td>Delayed transfer of care</td>
</tr>
<tr>
<td>ECCCG</td>
<td>Eastern Cheshire CCG</td>
</tr>
<tr>
<td>FTE</td>
<td>Full time equivalent</td>
</tr>
<tr>
<td>GAM</td>
<td>Group accounting manual</td>
</tr>
<tr>
<td>GIRFT</td>
<td>Get it right first time</td>
</tr>
<tr>
<td>HSCA</td>
<td>Health and Social Care Act</td>
</tr>
<tr>
<td>iBCF</td>
<td>Improved Better Care Fund</td>
</tr>
<tr>
<td>QIA</td>
<td>Quality impact assessment</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity, Prevention</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement</td>
</tr>
<tr>
<td>OSCE</td>
<td>Objective structured clinical examination</td>
</tr>
<tr>
<td>RADaR</td>
<td>Risk assessed data reports</td>
</tr>
<tr>
<td>RMS</td>
<td>Referral management system</td>
</tr>
<tr>
<td>RTT</td>
<td>Referral to treatment</td>
</tr>
<tr>
<td>SQS</td>
<td>Safety, quality and standards</td>
</tr>
<tr>
<td>S&amp;T</td>
<td>Sustainability and transformation</td>
</tr>
</tbody>
</table>
East Cheshire NHS Trust
2018/19 Plan

April 2018
## Contents

1. Introduction .................................................................................................................................. 3  
2. Health and Care Partnership for Cheshire and Merseyside .......................................................... 3  
3. Approach to Activity Planning....................................................................................................... 3  
4. Approach to Quality Planning ....................................................................................................... 7  
    4.1 CQC Feedback ...................................................................................................................... 7  
    4.2 Quality Priorities .................................................................................................................. 7  
    4.3 Monitoring Arrangements ................................................................................................... 8  
    4.4 Triangulation of Quality with Workforce and Finance ........................................................ 8  
5. Approach to Workforce Planning .................................................................................................. 9  
    5.1 Workforce Availability ......................................................................................................... 9  
    5.2 Recruitment and Retention ................................................................................................. 9  
    5.3 Organisational Change ...................................................................................................... 10  
    5.4 Agency Spend .................................................................................................................... 10  
6. Approach to Financial Planning ................................................................................................... 11  
    6.1 Efficiency Savings ............................................................................................................... 11  
    6.2 Capital ................................................................................................................................ 12  
    6.3 Loan funding ...................................................................................................................... 12
1. Introduction
This narrative outlines any changes from the plan published in December 2016, covering 2017/18 and 2018/19 in terms of:

- activity;
- quality;
- workforce; and
- finance.

The document mirrors the headings within the 2017/18-2018/19 narrative for ease of cross-referencing.

2. Health and Care Partnership for Cheshire and Merseyside
Building on the approach outlined in the 2017/18-2018/19 plan, the Trust is committed to delivering sustainable services that provide the best care for local people. The need to think differently about how services are delivered to meet the changing needs of our population is recognised. The Trust acknowledges the need to use its limited resources wisely, to meet the demands on the system, and stay within its allocated budgets.

As part of the Health and Care Partnership for Cheshire and Merseyside, the Trust is engaging with The Nuffield Trust and Kings Fund to understand their thinking on the key clinical, operational and financial factors that could support the sustainability of small providers; those which serve populations of less than 200,000 and have a turnover of less than £200 million.

Acute sustainability across Cheshire and Merseyside is complex. There is one programme, nine places and five emerging acute care collaborations all at various stages of their development. The position for the Eastern Cheshire footprint is even more complex as patient flows for East Cheshire NHS Trust and Mid Cheshire NHS Foundation Trust also impact on Greater Manchester (for East Cheshire) and Staffordshire (for Mid Cheshire).

The purpose of the work with the acute sustainability programme in East Cheshire NHS Trust is to produce a service proposal. The proposal will set out the options for the acute sustainability of services for the local population and, as a result of that, the next steps for how East Cheshire NHS Trust will agree and implement a clinically sustainable, operationally practical and financially affordable solution for acute services. The timescale for the development of options is by July 2018.

3. Approach to Activity Planning
This financial year sees the Trust moving to a block contract arrangement with our lead commissioner based on the following:

- forecast outturn at month 10; plus
- the national planning guidance assumptions of:
  - Elective – 3.6%
- Non elective – 2.3%
- A&E – 1.1%
- Outpatients – 4.9%

For Eastern Cheshire CCG, elective activity was reduced to approximately 1% growth and outpatient activity reduced to 2% to reflect their referral management scheme. Non elective growth was capped at below 1% and A&E attendances are forecast to reduce to reflect ECCC demand management plans.

This approach fits with the principles of the NHS Capped Expenditure Programme where the Eastern Cheshire Health Economy is being required to reduce the levels of budgetary overspend in the local health system. The block contract also gives the Trust the freedom to innovate its approach to patient care and promote productivity while maintaining the financial stability of the local health economy.

Two of the Trust’s commissioners, North Staffordshire and North Derbyshire, have not contracted with the Trust to forecast outturn or additional growth leading to an expectation that the Trust will be above plan for these commissioners.

The net impact of these activity assumptions is set out in the table below and reflects a materially steady state position for the year:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Forecast Out-turn 31/03/2018</th>
<th>Full Year Plan 31/03/2019</th>
<th>Planned change between 2017/18 and 2018/19</th>
<th>Percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total referrals</td>
<td>55,718</td>
<td>56,164</td>
<td>446</td>
<td>0.8%</td>
</tr>
<tr>
<td>Consultant led first outpatient attendances</td>
<td>46,655</td>
<td>47,507</td>
<td>852</td>
<td>1.8%</td>
</tr>
<tr>
<td>Consultant led follow up outpatient attendances</td>
<td>71,570</td>
<td>72,945</td>
<td>1,375</td>
<td>1.9%</td>
</tr>
<tr>
<td>Total elective admissions spells (ordinary and day case admissions)</td>
<td>17,388</td>
<td>17,564</td>
<td>176</td>
<td>1.0%</td>
</tr>
<tr>
<td>Total non-elective admissions</td>
<td>14,453</td>
<td>14,588</td>
<td>135</td>
<td>0.9%</td>
</tr>
<tr>
<td>Total A&amp;E attendances excluding planned follow ups</td>
<td>51,613</td>
<td>51,246</td>
<td>(367)</td>
<td>-0.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral to Treatment</th>
<th>Forecast Out-turn 31/03/2018</th>
<th>Full Year Plan 31/03/2019</th>
<th>Planned change between 2017/18 and 2018/19</th>
<th>Percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of incomplete RTT pathways &lt;=18 weeks</td>
<td>6,374</td>
<td>6,374</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Number of incomplete RTT pathways &gt;18 weeks</td>
<td>943</td>
<td>943</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Number of incomplete RTT pathways &gt;52 weeks</td>
<td>1</td>
<td>0</td>
<td>(1)</td>
<td>-100.0%</td>
</tr>
<tr>
<td>Number of completed admitted RTT pathways</td>
<td>8,095</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Number of completed non-admitted RTT pathways</td>
<td>29,338</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Number of New RTT pathways (clock starts)</td>
<td>37,500</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The Trust’s lead commissioner, NHS Eastern Cheshire CCG, have procured a Referral Management System (RMS) for implementation in 2018/19. Whilst the CCG has a lower than average referral rate per head of population and generally submits high quality referrals, it has assessed that an 8% reduction in referrals is a realistic estimate of the likely reductions. The CCG are aiming to introduce the RMS into the following specialties:

- Cardiology
- General Surgery
- Orthopaedics
- Gastroenterology
- Ophthalmology
- Paediatrics
In addition, the Trust will be implementing the advice and guidance module of the e-Referral system in a group of specialties to be agreed between the Trust and CCGs. The impact of ‘Advice and Guidance’ has yet to be fully developed across the health economy but appears to be minimal at present.

In reviewing the planning assumptions, it should be noted that the Trust can evidence a reduction in ‘zero day’ non-elective spells which is contrary to the national trend of 7.3% growth as outlined in Figure 2 below.

In addition, the Trust has a lower than average non-elective admission rate as shown in Figure 3 below.
In 2018/19, the Trust will significantly reduce the use of waiting list initiatives by improving productivity in outpatient services and theatres; reducing cost without reducing headcount by increasing productivity in line with outputs from the Model Hospital, Getting It Right First Time (GIRFT), the 10 Point Efficiency plan.

Whilst NHS England has set a challenging national metric to reduce DTOCs nationally to 3.5%, NHS Eastern Cheshire CCG had separately agreed with the Trust a figure of 5.2% to be achieved by March 2018, which has been calculated into the wider Cheshire East Council trajectory. The Trust, in partnership with Cheshire East Council and Eastern Cheshire CCG, is undertaking a considerable programme of activity to meet this target.

The Delivering Better Care Fund Plan in Cheshire East 2017-19 was submitted to NHS England in September 2017, who formally accepted the proposed DTOC trajectory, recognising the scale of ambition across the Cheshire East health and social care economy. The DTOC trajectory is monitored by all partners through the A&E Recovery Board which is chaired by the Trust’s Chief Executive Officer.

East Cheshire Trust plans to deliver the requirements of minimising 52 week RTT breaches and ensure that the RTT waiting list is no higher in March 2019 than March 2018. The Trust is currently developing its ophthalmology and urology daycase facilities to maximise productivity and activity for these specialties to help facilitate these planning aims. The extension to urology facilities will create further capacity in endoscopy, which will support the delivery of the diagnostics target and cancer 62 day standard.

The Trust is working with colleagues across the Eastern Cheshire health and care system and also across Cheshire and Merseyside in the development of the system winter plan for 2018/19. The Trust participated in the Cheshire and Merseyside NHS England sponsored Winter Planning workshop on 21 March 2018. The workshop provided opportunities for joint learning from Q4 2017/18 along with specific activities including the development of system capacity and demand modelling, including acute and community bed requirements. The provision of additional community beds in Eastern Cheshire was material in maintaining the
DTOC position for the system during Q4 2017/18. It was one of the initiatives funded by NHSE through the local iBCF (Improved Better Care Fund). The A&E Delivery Board has reviewed these winter initiatives and is awaiting confirmation of funding through the iBCF for 2018/19.

4. Approach to Quality Planning

The Trust will continue to embed quality initiatives that support the improvement of the Emergency Access standard, working with partners to further strengthen clinical outcomes.

4.1 CQC Feedback

Following a CQC Inspection for Well Led and inspection of the majority of our Core Services the trust has been rated ‘Good’. The community end of life care was rated Outstanding in ‘Caring’.

The CQC identified the following areas of outstanding practice:

- Within the community end of life care, they saw numerous examples that demonstrated staff consistently treated patients in a compassionate, dignified and respectful way.
- In surgery staff worked with local members of the public with learning disabilities to produce pictorial information booklets for patients which helped prepare them for surgery.
- The frailty service had developed ‘wrap-around’ treatment to support patients at home before and after hospital admission. The service linked with local care homes which meant that, for example, a podiatrist could refer patients to physiotherapy for a formal falls assessment if the patient was thought to be at potential risk of falling.
- Boxes containing memorabilia such as local history books were available for patients living with dementia. Nurses sourced these items themselves from charity shops.
- The children’s ward was especially responsive to children and young people with learning disabilities and on the autism spectrum. The National Autistic Society has accredited the children’s ward.
- The nurses had developed special recreational bags for children with mental health issues. These bags contained a stress ball, fidget spinner and ear plugs to minimise noise from younger children.
- For children with food aversions the play team worked with the speech and language therapist to develop therapeutic food play.

There are three areas of regulated activity which the trust was assessed as not meeting expectations. These were:

- Regulation 15 of the Health and Social Care Act (HSCA); relating to premises and equipment
- Regulation 12 of the HSCA relating to safe care and treatment
- Regulation 9 of the HSCA relating to person centred care

The Trust will implement an action plan and test that changes are embedded as part of the organisation’s audit review process.

4.2 Quality Priorities
For East Cheshire NHS Trust, quality encompasses four elements. This year, the priorities under each element are:

**Harm Free Care**
Care that is safe
- Management of IV lines
- Falls prevention
- Pressure ulcer prevention
- Improved risk assessment/care planning
- Sepsis Bundle

**Improving Outcomes**
Care that is clinically effective
- Personalised care plans
- Patients understanding of possible side effects of medications
- Inpatient flow and discharge planning including electronic discharge notifications

**Listening and Responding**
(Staff and Patients)
- Care environment within medical wards
- Outpatient clinic cancellations
- Safe staffing and skill mix

**Integrating Care**
Care that is co-ordinated and based around individual need
- Community hub outcomes framework
- Partnership working with residential and Nursing Home providers
- End of Life Care pathway in hospital and community

The Trust is fully committed to delivery of CQUINs against both 2017/18 standards and the new standard for 2018/19, ‘Preventing ill health by risky behaviours – alcohol and tobacco CQUIN indicator for NHS Trusts’. The Trust is also committed to the achievement of standards relating to best practice tariffs.

4.3 **Monitoring Arrangements**
The Trust has a robust mechanism in place to monitor performance against quality priorities. Appropriate indicators are sourced based on national best practice and benchmarked against current performance. Where possible, previous performance is mapped to identify areas of seasonality or unplanned variance. Trajectories for achievement are then agreed accordingly.

Any area subject to material change is subject to a Quality Impact Assessment (QIA). QIAs are monitored on a monthly basis by the Deputy Director of Corporate Affairs and Governance and the Deputy Director of Nursing. A bi-annual review of QIAs is submitted to the Trust’s Safety, Quality, and Standards Committee.

4.4 **Triangulation of Quality with Workforce and Finance**
Performance against quality indicators is monitored monthly via the Safety, Quality and Standards Board Committee (SQS) who have delegated authority to oversee the implementation of the quality strategy and annual quality priorities set out within the Quality Account. Quality priorities are agreed following triangulation of information via complaints, incidents, claims and other patient experience data from surveys and external audits, which are reviewed by the SQS Committee quarterly. The Committee
also reviews risks from the Board Assurance Framework and Corporate Risk Register delegated by the Board. Where there is an overlap and potential impact for performance and workforce the Finance, Performance, and Workforce Board Committee oversee the performance. Both committees report assurance and emerging risk issues to the Board. Directorates receive monthly governance data packs and review the quality indicators at their own SQS sub committees. Monthly Executive performance meetings are held with Directorates and action plans are implemented where appropriate to mitigate risks. Finally, Risk Assessed Data Reports (RADaR) are presented to the Board monthly through the Safety, Quality, and Standards Committee. The RADaR has 24 indicators, which support the triangulation of workforce and quality information. Action plans are developed to mitigate any risks highlighted by the RADaR.

5. Approach to Workforce Planning

Within the local system, the Trust is working with partner organisations to deliver integrated services across health and social care and over the planning period expects to see a move to more agile working aligned to ‘place based care’.

The workforce plan has been developed in conjunction with Associate Directors for each of the three directorates to ensure accurate inclusion of service specific intelligence and plans. The HR team has worked in conjunction with finance and have predicted forecast changes in full time equivalents (FTEs) informed by QIPP project mandates, local intelligence and agreed working assumptions that are utilised in general planning.

5.1 Workforce Availability

The workforce plan highlights a current staffing gap with a number of vacancies, particularly acute nursing and consultants in ortho-geriatrics and emergency care. High sickness levels are also impacting on overall workforce availability particularly across acute areas.

The impact of this is a continued (and increasing over quarter four) reliance on temporary staff - including bank, fixed term appointments, and agency workers - in order to maintain safe staffing levels across the organisation. The Trust is collaborating in regional and national initiatives to address workforce supply issues.

5.2 Recruitment and Retention

Due to forces outside the Trust’s control the cohort of qualified nurses that were expected from the Philippines will no longer be joining the Trust. This is due to difficulties with previous cohorts passing the OSCE (Objective structured clinical examination, based on UK pre-registration standards). The Trust has been selected to participate in the NHSI Retention Direct Support Programme. The retention support is being targeted at improving nursing turnover rates in acute and community trusts and will be led by the Deputy Director of Nursing and Quality.
A cohort of nine Nurse Associates undertaking training as a part of a Cheshire and Wirral pilot are due to qualify in January 2018. The Trust is currently looking at potential future ward models to incorporate the nurse associate role into skill mix.

5.3 Organisational Change

Expected changes in 2018 include a transfer out of the Child Information Health Service administration staff in April 2018 (4.09 FTE) and a transfer out of an occupational therapist to East Cheshire Hospice in April 2018 (0.4 FTE).

A number of corporate services will be subject to restructuring in 2018/19 which will result in a reduction of 3.5% of pay (approx. 12 FTE) as part of the organisations QIPP scheme’s from July 2018.

The Trust is focussing on how our staff will work differently as the community hubs are developing. More partnership working with neighbouring trusts is also being pursued particularly in areas where there are service resilience opportunities.

5.4 Agency Spend

The 2017/18 NHSI agency ceiling was set at £8.441m. The Trust is forecast to be below the agency ceiling in 2017/18 by approximately £1.5m. The trajectory increased sharply in the last quarter of 2017/18; an agency recovery plan is being developed which builds on existing work to reduce agency expenditure such as increased recruitment of bank staff and weekly pay for bank staff. NHSI have reduced the agency ceiling to £7.325m for the 2018/19 plan.

![Figure 1: Actual Agency Spend 2017/18](image)

![Figure 2: Planned Agency Spend 2018/19](image)

<table>
<thead>
<tr>
<th>2017/18</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental</td>
<td>189</td>
<td>176</td>
<td>146</td>
<td>127</td>
<td>208</td>
<td>111</td>
<td>218</td>
<td>277</td>
<td>206</td>
<td>315</td>
<td>313</td>
<td>325</td>
<td>2,642</td>
</tr>
<tr>
<td>Non-medical clinical staff</td>
<td>243</td>
<td>230</td>
<td>205</td>
<td>179</td>
<td>209</td>
<td>286</td>
<td>215</td>
<td>352</td>
<td>280</td>
<td>410</td>
<td>428</td>
<td>590</td>
<td>4,642</td>
</tr>
<tr>
<td>Non-medical non clinical</td>
<td>13</td>
<td>38</td>
<td>55</td>
<td>46</td>
<td>51</td>
<td>54</td>
<td>67</td>
<td>55</td>
<td>76</td>
<td>95</td>
<td>64</td>
<td>100</td>
<td>714</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>445</strong></td>
<td><strong>413</strong></td>
<td><strong>409</strong></td>
<td><strong>353</strong></td>
<td><strong>469</strong></td>
<td><strong>432</strong></td>
<td><strong>501</strong></td>
<td><strong>684</strong></td>
<td><strong>562</strong></td>
<td><strong>820</strong></td>
<td><strong>805</strong></td>
<td><strong>1,015</strong></td>
<td><strong>6,928</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2018/19</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental</td>
<td>214</td>
<td>203</td>
<td>191</td>
<td>166</td>
<td>176</td>
<td>175</td>
<td>175</td>
<td>180</td>
<td>260</td>
<td>260</td>
<td>260</td>
<td>223</td>
<td>2,488</td>
</tr>
<tr>
<td>Non-medical clinical staff</td>
<td>402</td>
<td>382</td>
<td>342</td>
<td>259</td>
<td>268</td>
<td>286</td>
<td>313</td>
<td>370</td>
<td>378</td>
<td>378</td>
<td>378</td>
<td>411</td>
<td>4,137</td>
</tr>
<tr>
<td>Non-medical non clinical</td>
<td>113</td>
<td>68</td>
<td>68</td>
<td>57</td>
<td>57</td>
<td>54</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>40</td>
<td>690</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>800</strong></td>
<td><strong>703</strong></td>
<td><strong>602</strong></td>
<td><strong>499</strong></td>
<td><strong>500</strong></td>
<td><strong>500</strong></td>
<td><strong>500</strong></td>
<td><strong>500</strong></td>
<td><strong>500</strong></td>
<td><strong>500</strong></td>
<td><strong>500</strong></td>
<td><strong>500</strong></td>
<td><strong>7,725</strong></td>
</tr>
</tbody>
</table>

Table 2: Agency Spend 2017/18 and Planned Spend 2018/19
6. **Approach to Financial Planning**

In 2017/18, the Trust was set a control total by NHS Improvement of a £20.2m deficit, after receipt of an assumed £4.0m Sustainability and Transformation Funding. At year end, the Trust achieved a deficit of £18.9m, £1.3m better than plan. The Trust’s QIPP planning was also successful delivering £6.3m of savings (£6.2m recurrently) in 2017/18, against a target of £6m.

NHS Improvement has issued a control total to the Trust for 2018/19 which is £19.2m; this requires delivery of £5m QIPP. The Trust has assumed 1% pay inflation in line with national guidance. Non-pay expenditure modelling has taken account of known contractual inflation uplifts such as the outsourced soft facilities management provider ISS. The Trust has been notified of a £1.8m increase in CNST premium that has been included in the financial modelling. The Trust has utilised NHS Improvement non-pay inflation assumptions for any remaining material inflation pressures.

### Table 3: 2017/18 and 2018/19 Income and Expenditure Plan

During 2017/18, the Trust reached a net liability position on its Statement of Financial Position. In accordance with guidance from the 2017/18 Department of Health Group Accounting Manual (‘GAM’), the Trust has prepared its 2017/18 accounts on a going concern basis. The Trust has extended this assumption to the preparation of the 2018/19 plan submission, in accordance with the draft 2018/19 GAM.

#### 6.1 Efficiency Savings

The Trust achieved its QIPP requirement for 2017/18 of £6m savings recurrently in line with the previous plan. This means the target for 2018/19 remains the same as the previous plan at £5m. Historically, in the delivery of QIPP, the Trust has secured extra
income to maintain service levels rather than implement cost reductions to align expenditure budgets with income being received. This year the Trust is entering into a block contract arrangement with its main commissioner in line with the capped expenditure process (CEP) philosophy of system working to reduce cost. The value of QIPP unidentified has reduced from £2.8m in the initial plan submission to £1.1m in the revised plan. The Trust has established mechanisms for monitoring delivery and will be continuing to develop plans to bridge the gap during 2018/19.

6.2 Capital
The Trust is operating in a constrained capital environment. The Trust’s internally generated capital resource for 2018/19 is £2.9m. The Trust keeps its estate asset lives under review as part of its valuation process. An interim valuation of the estate is currently being undertaken and will be reflected in the resubmission in April 2018. It is currently utilising a significant number of fully depreciated assets and replaces these on a risk based approach.

The leads for each area have prioritised and risk rated their planned schemes for 2018/19 and it is proposed that the 2018/19 draft capital plan is split as follows:

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and accommodation</td>
<td>1.4</td>
</tr>
<tr>
<td>IT</td>
<td>0.8</td>
</tr>
<tr>
<td>Equipment and Contingency</td>
<td>0.7</td>
</tr>
<tr>
<td>Cancer / Outpatients</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>3.8</strong></td>
</tr>
<tr>
<td>Equipment - Finance Lease</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5.2</strong></td>
</tr>
</tbody>
</table>

**Table 4: Draft capital plan 2018/19**

The Trust still intend to progress the extension to the Radiology Managed Equipment Service for a CT scanner, originally planned for 2016/17, and this is included in the capital programme outlined above.

The Trust is in discussion with NHS Improvement about the scope to utilise the cash generated by improvements in its financial control target over the last two years, as capital schemes. In the submitted plan, the Trust has included £0.9m in 2018/19 (£2.9m over three years) for improvements to cancer services and outpatients.

6.3 Loan funding
The plan assumes that the Trust will continue to receive interim revenue loan support from the Department of Health to fund the 2018/19 planned deficit of £19.2m, which is in line with the control total set by NHSI.
In addition, it has been assumed that the interim revenue support loan which falls due for repayment in 2018/19, amounting to £8.5m, will be replaced with a support loan with the same terms and conditions.
**TRUST BOARD**  
**Thursday 26th April 2018**

Agenda Item Number 11: TB 18 (32)

| Report of: Responsible Officer | Kath Senior  
| Accountable Officer | Director of Nursing, Performance and Quality |
| Author of Report: | Jeanette Sarkar  
| | Head of Nursing, Quality |
| Subject/Title | Bi Annual Report : Safer Staffing: Safer Nursing Care Acuity and Dependency Audit |
| 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 | The purpose of this paper is to provide assurance on staffing levels and capacity in order to provide safe, sustainable, productive staffing and high quality, patient centred compassionate care across all acute wards at East Cheshire NHS Trust |
| Action/Decision required | To note the contents of the report and the assurance provided |
| Mitigates Risk Number: (identify) | BAF 2: If the quality of services provided is not at the required standard, then there is a risk that the Trust may fail to safeguard the health and wellbeing of patients which will impact on the Trust’s ability to deliver care which is safe, effective, caring, responsive and well lead. |
| On Corporate Risk Register | BAF 5: If the Trust does not have a high quality workforce who are engaged and motivated, then staff behaviours may not be aligned with the Trust values and this will have a negative impact on patient experience |
| Mitigates Risk Number: (identify) | 1406: If there are inadequate core staffing levels on acute in patient wards it will compromise the delivery of high quality care impacting on harm free care and patient safety. This will result in poor patient/carer experience and potential outcomes, recruitment and retention, staff morale, increased sickness and absence rates, non-compliance with statutory and mandatory staff training, an increase in staffing incidents and complaints resulting in financial implications |
| On Assurance Framework | |
| Link to Care Quality Commission Outcome Number (identify) | Safe  
| | Caring  
| | Responsive  
| | Effective  
| | Well Led |
| Link to: | Provide the best services to our population through improvements to safety, productivity and patient experience  
| Trust’s Strategic Direction | Getting it right first time  
| Corporate Objectives | |
| Legal implications - (identify) | No legal implications |
| Impact on quality | May potentially impact upon quality of care, patient experience, patient outcome, recruitment, retention and staff well-being however mitigating actions are put in place to reduce the level of impact |
| Resource impact | Identified gaps in funded establishments due to wte substantive and temporary nurse staffing vacancies may impact on 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 delivering high quality, compassionate care |
| Potential increase in substantive wte to reflect and re-align baseline ward establishments in line dependency, nurse sensitive indicators and workforce metric evidence |

| Impact of equality/diversity | No impact on equality and diversity |
| Avoid acronyms or abbreviations - if necessary list: |  |
| NQB  National Quality Board |  |
| NICE National Institute for Health and Care Excellence |  |
| DoH Department of Health |  |
| CQC Care Quality Commission |  |
| CHPPD Care Hours Per Patient Day |  |
| SNCT  Safer Nursing Care Tool |  |
| NMC Nursing and Midwifery Council |  |
| WTE whole time equivalent |  |
| HR Human Resources |  |
| L&D Learning and Development |  |
| AED Accident and Emergency Department |  |
| ITU Intensive Care Unit |  |
| CCU Coronary Care Unit |  |
| EWTD European Directive Working Time |  |
| NIV Non-invasive ventilation |  |
| RN Registered Nurse |  |
| HCA Healthcare Assistant |  |
Bi-Annual Report : Safer Staffing: Safer Nursing Care Acuity and Dependency Audit

This paper forms the bi annual review of nurse staffing in line with the commitments outlined by the National Quality Board (NQB 2013) and DoH (2014) ‘Hard Truth’s’ document – The Journey to Putting Patients First. The guidance refers to the optimisation of nursing, midwifery and care nurse staffing capacity and capability. This in turn forms part of CQC’s Intelligent Monitoring for all NHS providers.

1 INTRODUCTION

1.1 This paper describes the Trust's progress, compliance against national guidance and delivery of safe care. A summary of key actions and recommendations since the last bi-annual report is provided and high level narrative with regards to the results of the SNCT acuity and patient dependency audit undertaken in January 2018.

2 SUMMARY OF KEY ACTIONS AND PROGRESS SINCE JULY 2017 SNCT AUDIT

Recruitment and training plans for both Registered Nurses (RN) and Healthcare Assistants (HCA) have been established

Weekly Staff Nurse and HCA Recruitment and Training meetings are scheduled within HR and as an output of these meetings, a 2018 Recruitment and Training plan for both Registered Nurses (RN) and Healthcare Assistants (HCA) has been established, with the purpose of implementing a planned approach to inform HR teams of each stage of the recruitment process each month.

The above plan supports HR recruitment teams to identify when influxes of RN's and HCA's are expected and to inform Learning and Development (L&D) to ensure sufficient training dates are available to meet demand.

Monthly rolling recruitment campaigns for RN's and HCA's are scheduled

In line with these plans, monthly rolling recruitment campaigns for RN's and HCA's are scheduled, with separate adverts for Bank, Pool (HCAs only) and Substantive staff. Interviews for all adverts take place on the same day wherever possible.

Recruitment pipeline report is maintained by the Recruitment Team in order to track progress on all aspects of recruitment process. The recruitment team also has a specific register nurse recruitment tracker in order to capture student nurse cohorts. This is shared on a monthly basis with HoN.

Recent RN recruitment campaigns include; launch of targeted Facebook campaign in conjunction with social media experts

As part of the 12 month recruitment campaign, open days/evenings are booked quarterly. Recent RN recruitment campaigns include; launch of a targeted Facebook campaign in conjunction with social media experts. Recruitment events also take place in different geographical locations e.g. Stoke.

Regular engagement has been maintained with Leek Moorlands Hospital whilst staff were undergoing transformational change; this resulted in the appointment of 6 HCA and 1 RN.

Weekly engagement with Derbyshire Community NHS Foundations Trust who are also undergoing organisational change; weekly ECT vacancy bulletin is sent to the Trust.
Nine international nurses from the Philippines have successfully passed their OSCE examination.

Implementation of weekly pay for staff undertaking shifts via nurse bank will be relaunched in April 2018.

A total of 9 (+3 since the previous SNCT audit) international nurses from the Philippines have successfully passed their OSCE examinations and subsequent NMC registration.

3 international nurses are expected to arrive in April 2018 with a further 3 in the summer.

Despite initial benefits seen in the reduction of registered nurse vacancies following service re-design, bed reconfiguration and staff re-alignment, substantive registered nurse vacancies continue to be challenging, impacting on staff resilience and increasing stress related long term sickness, as observed during January.

During the time of January’s SNCT acuity and dependency audit registered nurse vacancies were 41.46 wte rising to 49.22 wte inclusive of Maternity Leave (3.55 wte) and Sickness and Absence (long term sickness 7.11 wte).

Increases seen in staff uptake re: flexible retirement options is supported where able to maintain business continuity and retain experienced staff members.

A number of staff and well-being initiatives are available and accessible to staff.

Ten Nursing Associate roles have commenced training and further HCA apprenticeship roles are being explored.

10 nursing associate roles commenced training and bespoke placements although one candidate has since withdrawn from the programme.

Further trainee nursing associate cohorts will require agreement.

Introduction of rolling monthly advert for Community Nursing advert in January 2018 which cites the introduction of an incentive payment (NMC fee £120) secured a higher number of applicants than previously seen.

HCA apprenticeship roles are being explored and one staff member within ITU is due to commence the programme.

L&D continue to work in collaboration with Macclesfield College to progress apprenticeship roles and further roll out of the Care Certificated to existing HCA continues. This provides the HCA workforce with a solid foundation from which to develop further although it is more on an ad hoc basis.

Retrieval team pilot implementation between AED and ITU.

Clinical workforce deployment project programme commenced to review staffing establishments, skill mix, alignment with ESR, financial ledgers and HR metrics in view of changing acuity and dependency coupled with challenges re: recruitment, retention and succession planning.

Increases in visibility of senior managers on call on site during weekend to support safe staffing and patient flow during time of peak operational pressures.
Since 2012 the Trust has used the validated Shelford Safer Nursing Care Tool and as recommended triangulated with professional judgement models to underpin and guide adult inpatient ward staffing levels in line with funded establishments. These tools are evidence based and adhere to national recommendations which include NICE guidance to determine optimal nurse staffing levels based upon patient dependency and acuity.

From Monday 8th January 2018 patient acuity and dependency data was collected for each day of the week for a period of 4 weeks across all adult in patient ward areas as per guidance. In order to maintain consistency data collection occurred at the same time each day over a seven day period for 4 weeks.

Delays in data inputting owing to sickness and absence resulted in the SNCT analysis being undertaken a month later than usual.

January’s 2018 acuity and dependency audit was consistently high with complex case mix and more poorly patients

SNCT analysis, metrics triangulation and application of senior nurse professional judgement indicates that January’s 2018 acuity and dependency audit was consistently high with complex case mix and sicker patients. With the exception of Ward 2, 3, 4, 9, 10 and 11 staffing levels align with the expected funded establishment, appropriate skill mix and staff competency required to enable the delivery of high quality, safe and sustainable productive staffing for adult inpatient areas. It is recommended that in view of SNCT analysis that a review of staffing models for the exception areas is undertaken. It is also recommended that the third HCA that is consistently requested in the majority of clinical areas to support safe care during the night is included in the review of skill mix.

Overall analysis demonstrates that in the majority of inpatient wards case mix and patient care delivery rose in the Level 1b care category compared to previous audits with the exception of Coronary Care and Intensive Care Units which illustrate Level 2 and Level 3 care delivery and provision. This reflects the increased acuity and dependency seen throughout January, case mix complexities and peaks in operational pressures.

Overall analysis also demonstrates that in the majority of inpatient wards case mix and patient care delivery in the Level 1a care category compared to previous audits remain equivocal with the exception of Ward 1, 7, 9 and Medical Assessment Unit who demonstrates an increase.

More detailed SNCT analysis summaries for each Directorate ward specialty are explained from section 5 to 8.

It is important to note that since the last bi annual report the additional flex beds that were opened on Ward 5 from January 2017 to support demand, capacity, patient flow and operational pressures which closed in April 2017 follow a similar pattern seen during January’s SNCT audit. Within the Surgical Treatment Unit (STU) 7 day case beds were converted to inpatient beds from the beginning of January 2018 and remain open.

Latterly to support completion of estates work on STU 6 inpatient flex beds were re-provided on Ward 5 from March 2018. In addition, 6 flex beds opened on Ward 4 from 27th October 2017 to support patient
A total of 103 Registered Nurse shift requests were not filled during January 2018 despite agency and bank requests.

The impact of additional flex capacity and ability to maintain safe patient care, safe staffing levels, staff competency, appropriate skill mix and staff resilience cannot be underestimated. Daily risk assessments and review of staffing levels were maintained during January and overseen within the Trust’s bed capacity meetings to mitigate risks to patient safety and patient experience as far as possible. A bed reconfiguration review is currently being undertaken to support and robustly inform 2018’s winter planning process and the management of peak operational pressures. It is anticipated that this will reduce patient transfers between areas to enable and improve patient care continuity, patient experience, reduce mixed sex accommodation breaches and support safe staffing levels whilst responsive to demand and capacity pressures.

Although nurse bank and agency requests to support safe staffing levels during January were sought a total of 103 Registered Nurse shifts requested were not filled during this period which places additional pressure on front line staffing and delivery of high quality care. 44 unfilled requests fell within the urgent/integrated footprint. 38 unfilled requests fell within the surgical footprint and 12 unfilled requests within medical specialties.

Although AAU is excluded from the SNCT audit in view of it being a non-designated inpatient area, operational pressures have necessitated its utilization to accommodate patients overnight. On a number of occasions AAU supported in-patient capacity and was bedded during January’s audit. The acute and integrated directorate review staffing levels on a daily basis for this area based on internal tools to measure acuity and dependency. To facilitate consistent leadership and continuity of patient care a Band 7 Sister is aligned to this area within the Urgent Care footprint. This in turn helps to support and inform safe staffing levels are appropriate to maintain patient safety if this area is used in this way as part of the escalation policy process.

5 ACUTE AND INTEGRATED COMMUNITY CARE DIRECTORATE - MEDICAL SPECIALTIES

Overall

Acute medical specialty SNCT acuity and dependency analysis demonstrates that Ward 7, Medical Assessment Unit, Coronary Care and Intensive Care Unit’s current funded establishment aligns with expected acuity and patient dependency to deliver high quality, safe patient care although a third HCA overnight on Ward 7 has been consistently required to support patient safety.

However, based on SNCT analysis and application of senior nurses professional judgment it is recommended that a review of core staffing levels, skill mix, case mix and supporting infrastructure roles in acute respiratory, gastroenterology, care of the elderly and intermediate care wards (Wards 3, 4, 9, 10 and 11) is undertaken. Preliminary work commenced in February via the clinical deployment workforce project group programme.

The outputs, however, of this preliminary work have been temporarily suspended to prevent unnecessary duplication in the light of new work streams that are inextricably linked to workforce models and potentially will impact upon we ward funded
All adult inpatient areas continue to demonstrate a high level of acuity and dependency. It is proposed that final alignment of staffing models and skill mix will be consulted in liaison with senior directorate and corporate nursing colleagues as the outputs from bed reconfiguration, service redesign and implementation of Allocate’s safer care software tool are realised. This approach will support wider professional context knowledge, ensure sustainable staffing levels and that appropriate skill mix and alternative roles which aligns to NQB guidance, getting it right first time to deliver the right staff, in the right skills, in the right place at the right time is fully considered.

All adult inpatient ward areas continue to demonstrate a high level of acuity and dependency coupled with case mix and discharge planning complexities. Bed occupancy throughout January exceeded 98% and in the majority of wards the number of admissions, discharges and patient transfers reduced due to exit block. It is also important to note that historically funded establishments are based on 85% bed occupancy.

During January, at least half of the patients on Ward 3 were reviewed as ‘stranded patients’ with a length of stay exceeding 7 days. Demonstrates a comparable significant increase and recurring pattern in the daily average of patients requiring Level 1b care during the month of January on Ward 3. At least half of the patient cohort during January was in receipt of intravenous antibiotics that impacted upon staff time. A minimum of 8 hours per day was observed in the reconstitution of antibiotic preparation in view of the impact of local and national shortages of intravenous Tazocin. This shortage has necessitated a change in prescribing recommendations which is monitored through the medicines management antibiotic steering group. In clinical practice terms this translates to a twice a day intravenous antibiotic being converted to the administration of 3 different antibiotics 3-4 times a day placing additional pressure on staffing levels.

To support patient safety, enhanced 1:1 cohort nursing and prevent the risk of patient falls an additional third healthcare assistant has been consistently requested and utilized overnight.

Application of professional judgement suggests that a small proportion of patients require Level 2 care which reflects the complex needs of the patients on this ward in relation to acute transfers to and from ITU or ETU. Professional judgement also suggests that changes to services and redesign within Cheshire and Wirral Partnership Foundation Trust has, in real terms reduced alcohol liaison services with regards to the provision of in-reach to Ward 3 which impacts upon the level of patient acuity and dependency seen. This in turn increases length of stay, enhanced 1:1 care and necessitates hospital admission opposed to avoidance. This is particularly evident for patient cohorts that require alcohol detoxification management regimes. During January at least half of the patients on Ward 3 were reviewed as ‘stranded patients’ with a length of stay exceeding 7 days and the continued emotional, psychological and complex drug regimes challenged.
adequate staffing levels.

In order to address the impact and mitigate risks to patient care, staffing levels and patient flow the Directorate is benchmarking with peer organisations. Temporary increases in medical staffing to support senior decision making in response to nurse staffing concerns is in place and planned deployment of staff from within the directorate supported skill mix and staffing levels during January.

5.3 Ward 4

Demonstrates a similar and comparable pattern seen in previous biannual audits that demonstrates the daily average and majority of patients require Level 1a and 1b care over the last 12 months with the exception of Level 2 care.

A significant increase in the daily average of patients who require Level 2 care was seen in January’s audit compared to previous audits. The daily average increase seen for this cohort of patients was 2.4 compared to 1.0 previously. This reflects the increase and frequency seen in the use of non-invasive ventilation (NIV), complex oxygen therapy regimes and the provision of nursing care for complex, specialist respiratory interventional therapy for chest conditions.

On occasions, this daily average exceeded safe staffing levels based on Level 2 care. The flexing and deployment of staff from other areas staffing was required to help support clinical need in order to facilitate the delivery of safe, patient care. However, due to the volume of vacancies on Ward 4, junior skill mix, split between nurse bank and agency utilization coupled with the additional 6 beds safe staffing levels during January remained extremely challenging. Mitigating actions included daily staffing risk assessment, utilization of bank/agency nurses, staff deployment from other areas (usually ITU or Ward 7), matron stepping down the majority of January to support Ward 4 in addition to corporate nursing stepping down to support teams and patient care during peak pressures. Temporarily, staffing numbers were agreed to be increased to support substantive team members, co-ordination and safe patient care. On 2 occasions during January patients were either admitted or transferred to ITU for NIV in view of Ward 4’s depleted skill mix to ensure patient safety and safe staffing levels met individual patient needs.

Application of professional judgement also indicates that a reduction in senior staff skill mix coupled with release of more experienced staff to secondment opportunities, unforeseen senior sister long term sickness and absence and a higher than average level of vacancies seen in this area resulted in skill mix dilution and a change in substantive to temporary staffing ratios. On occasions this was as high as a 70/30 split or 60/40. In order to meet clinical case mix complexities and patient care needs mitigation included planned staff deployment from other acute medical areas and daily risk assessment to facilitate the delivery of safe care. However, it is acknowledged that this redistribution of skill mix left other areas below their core numbers and the skill set of staff deployed were unable to be utilized to care for patients on NIV or high flow oxygen interventional therapy. It also places staff under extreme pressure and increases in stress related illnesses, anxiety and reduced staff morale was seen during January.
The daily average of Level 1b care on Ward 7 remains consistent.

On a planned basis, Ward 7 substantive staff rotated temporarily to Wards 3 and 4 to support skill mix dilution and level of vacancies.

A fifth flex bed on CCU was provided within the pacing room to accommodate additional patients posed pressures and risk to cardiology patients requiring access to emergency pacing facilities.

There is an overall shift in patient acuity and dependency within the footprint of the surgical and orthopaedic ward areas.

### 5.4 Ward 7

Demonstrates a further shift and increase in the daily average of patients who require Level 1a care compared to previous audits. This reflects complex diabetic ulcer management, increased observations for those patients triggering early warning scores, increased therapeutic and intravenous drug therapy regimes inclusive of antibiotics.

However, the daily average of Level 1b care remains reasonably consistent although each biannual audit illustrates an incremental daily average rise of 1.0 compared previously. This reflects in part the treat and return angiography patient cohorts seen and longer lengths of stay seen for patients with heart failure that require prolonged intravenous therapy. In addition, throughout January two 6 bedded bays required cohort nursing to support confused patients, patients living with dementia, DoLS applications and end of life care.

Application of professional judgement confers with the above and cited that the daily average of patients who required Level 1a care was absorbed within the current staffing establishment or by the senior sister stepping down into core numbers although as with other acute medical wards a third healthcare assistant was required to support patient safety and care overnight.

In addition, on a planned basis Ward 7 substantive staff rotated temporarily to Wards 3 and 4 to support skill mix dilution and level of vacancies necessitating backfill with Bank staff. This also impacts upon a reduced skill set of competency on Ward 7.

### 5.5 CCU

Demonstrates a consistent level of acuity and dependency in keeping with professional judgement – Level 2 care. An increase in patients who require complex heart failure management, haemodynamic support and therapeutic interventions was also evident.

In order to support increases seen in demand and capacity for CCU beds a 5th flex bed was provided within the pacing room to accommodate additional patients requiring acute cardiology care. However, on occasion non-cardiology patients resided in the pacing room (5th bed) due to trust wide demand and capacity operational pressures. This posed additional pressures and risk to cardiology patients who potentially require access to emergency temporary pacing facilities. Mitigating actions include risk assessment and de-escalation as quickly as possible.

It is important to note that the Band 7 substantive Senior Sister role stepped down through personal choice although her knowledge, experience and skills have been retained as a Band 6 sister within CCU. The Band 7 Senior Sister from Ward 7 currently oversees and provides management support to both areas with further evaluation in March.

### 6 PLANNED CARE SERVICES DIRECTORATE - SURGICAL SPECIALTIES

Overall

SNCT analysis demonstrates an overall shift in patient acuity and dependency within the footprint of the surgical and orthopaedic ward areas. It illustrates a lower daily average of patients who require Level 0 care to a mixture of Level 1a and Level 1b care. This,
Current staffing establishments are considered adequate when fully recruited to, with the exception of Ward 2.

A risk assessment is in place with regards to the management of medical outliers.

Retention within Orthopaedics has improved, although a number of substantive posts remain unfilled necessitating the continued use of bank and agency staff.

Ward 1 has seen an average increase of 2 patients per day requiring level 1b care.

Staff work flexibly across all areas are deployed between clinical settings to support patient care based on case mix complexities and maintenance of appropriate staffing levels. On the whole the current core staffing establishments are considered adequate when fully recruited to with the exception of Ward 2. In view of changes to case mix the senior nursing team closely monitor the effects and impact on clinical pathways, skill mix, nurse sensitive metrics, patient experience and clinical outcomes. It is recommended that any permanent change to case mix, bed reconfiguration or consistently elevated acuity and dependency analysis is subject to workforce model review in this area in order to agree proposed safe staffing levels going forward.

A directorate risk assessment is in place with regards to the management of medical outliers, staffing levels and skill mix dilution. This is monitored via the Directorate’s governance assurance framework and exception reporting.

Although recruitment and retention within Orthopaedics has improved significantly compared to previous audits a number of substantive posts remain unfilled necessitating continued use of bank and agency staff. Expenditure for temporary staff to support patient safety and delivery of care remains high. In addition, the ward footprint has also seen an increase from 30 to 32 beds. Subsequently, as part of the 90 day improvement methodology and clinical deployment group, a review of workforce requirements, skill mix and roles has been undertaken. An option appraisal and associated costs are due to be presented by the Directorate to the Board in order to progress and implement staffing level and role recommendations. This will facilitate an effective and productive workforce to enable delivery of high quality, patient centred care and good clinical outcomes.

Ward 2’s large geographical footprint and number of beds coupled with increasing vacancy levels and flex capacity is a challenging area to co-ordinate to ensure staffing levels and skill mix are appropriate. A high proportion of substantive staff regularly undertakes additional shifts to support safe staffing levels, patient care and their colleagues.

It is important to note that the majority of elective activity was cancelled during January as advised by NHSE in response to national operational demand and capacity pressures seen within AED. This in turn challenges staffing levels, skill set competency and staff morale in caring for more medical patients opposed to surgical patients. The effects and potential impact on recruitment and retention are being closely monitored.

Ward 1:

Demonstrates a changing pattern compared to previous SNCT acuity and dependency audits. January 2018 SNCT data analysis demonstrates incremental rises seen in patients requiring level 1b care, increasing on average by 2 patients daily and a decrease in level 1a care. This reflects changes to case mix, discharge complexities,
In comparison with other areas, Ward 1 has a more senior, experienced and stable workforce in place. Due to the number of patients requiring CT scans and diagnostic tests, Ward 1 has seen an increase in the number of nurse escorts on site.

Ward 1a has seen a slight increase in the daily average of patients requiring level 1b care. Despite mitigating actions taken, skill mix dilution and the split between substantive and bank/agency staff remains a challenge on ward 2.

Management of medical outlier patient cohorts’ who require 1:1 enhanced care and an increase in DoLS application and overviews which led to increased staff workload. Mitigating actions include flexible staff deployment across planned care, utilization of bank/agency staff whilst acknowledging that Ward 1 has a more senior, experienced and stable workforce compared to other areas which at times enabled staff to absorb on an ad hoc basis fluctuations in case mix and the placement of + 2 beds. However, during January a number of substantive registered and unregistered staff sustained injuries outside of work which impacted upon skill mix.

The case mix and management of surgical patients and medical outliers influences the increases seen in the average level of 1b patients especially in relation to patients who require full assistance, prolonged intravenous therapy, enhanced 1:1 care and complex discharge arrangements. The data also illustrates a consistent pattern with regards to increases in nurse escorts on site. This is due to patients requiring CT scans and other diagnostic tests. The 50/50 split between registered and unregistered staff appears to meet the needs of individual patients although careful monitoring is recommended to ensure that the fluctuations in case mix are manageable and staffing levels are able to sustain the level of nursing care delivery required.

The changing case mix and number of medical outliers observed within Ward 1 during January impacted upon staff morale and potentially identifies risks to recruitment and retention in view of changing skill set requirements and personal preference to surgical speciality nursing.

Ward 1a Demonstrates a consistent daily average of Level 0 and 1a care patients which is comparable with previous bi annual audits. However, data analysis demonstrates a slight increase in the daily average of patients who require Level 1b care. This is in keeping with fluctuations seen in case mix complexities and the placement of additional +1 to flex bed capacity. Application of professional judgment aligns with expected case mix although more complex patients were evident through January’s audit again reflective of medical outliers. This was perceived to impact upon the privacy and dignity of patients awaiting gynaecology or breast procedures. The split between registered and unregistered is considered appropriate. However, it is important to note that the footprint of Wards 1 and 1a is a 35 bedded area and remains challenging to co-ordinate elective activity supporting patient and team observation.

Ward 2 Demonstrates a reduction in the daily average of patients who require Level 1a care compared to previous bi annual SNCT audits although data analysis demonstrates an increase in patients who require Level 1b care on average by 3 patients daily. This reflects the changes made to bed configuration in that 7 day case beds were converted to inpatient beds during January to create additional flex capacity to meet increased unplanned service demand. An increase in patient admissions and transfers within STU were also seen which is aligns with the increases seen in the number of medical outlier patients.

Application of professional judgement explains changes seen in case mix with more complex major bowel surgery and patients with
The staffing for Ward 2 also provides staff to the Day Case Unit and Surgical Treatment Unit. In addition, during January Ward 2 received sicker patients from medicine and direct admissions for Accident and Emergency which impacts upon staffing levels and skill mix. The management of elective activity, patient flow and case mix which includes orthopaedic trauma pathways also altered due to cancellation of elective activity during January as advised by NHSE and the placement of medical outliers on Ward 10. Professional judgement also perceives that continuity of care and medical oversight of patients was disrupted impacting upon length of stay and reduced discharges. Mitigating actions include daily board rounds, escalation of care as per policy. Skill mix dilution was supported by regular staff working additional shifts in addition to bank and agency utilization. Despite mitigating actions taken skill mix dilution and the split between substantive and bank/agency staff remains challenged. Senior sister stepped into numbers and on occasions undertook night duty to support identified shortfall in knowledge and experience.

Previously, patients who require a high level of observation and nursing input would have been transferred to Ward 1 opposed to residing on Ward 2.

It is important to note that the staffing establishment for Ward 2 also provides staff to the Day Case Unit and Surgical Treatment Unit and has the largest footprint of all inpatient ward areas. Work is also underway to provide a new treatment area within STU which will redirect surgical activity from the endoscopy unit and theatre to maximise opportunities to increase their capacity to meet clinical demand. This will require even more effective co-ordination and deployment of appropriately competent staff to care for variable case mix. Currently staff are utilized flexibly between all 3 areas to provide safe staffing levels.

Previous changes made within the roster templates and skill mix for Wards 1, 1a and 2 supported a reduction in 1 trained staff overnight. However, during January staff from Ward 2 were deployed to other areas during the night to support identified, ad hoc staffing gaps. This impacts upon the surgical footprint’s ability to manage fluctuating case mix and sustain safe staffing levels in terms of working with a lower skill mix and below core minimum numbers. Mitigating actions to support the staffing levels and delivery of safe care includes daily risk assessment of staffing levels, bank/agency utilization in addition to regular staff working additional shifts.

Ward 10 has seen the most significant shift within the Planned Care Directorate, with an increased daily average of 4.3 patients requiring level 1b care.

Ward 10

Demonstrates the most significant shift seen within the Planned Services Directorate. The daily average number of patients who require Level 1a illustrates a slight reduction compared to previous SNCT audits although Level 1b care demonstrates a further daily average increase of 4.3 patients. This reflects changes to case mix and the cancellation of elective orthopaedic activity during January impacting upon acuity and dependency.

The complexity of the case mix and care delivered during January particularly denotes the increase seen in the daily average of patients requiring 1:1 enhanced care and patients living with dementia. Where possible patient cohort and nursing has been implemented although this has proved challenging owing to the safe management of patient placement within the ward footprint to maximise patient observation. To support the management of patient care continuity and shortfall in core staffing bank and agency nurses are secured via block
In addition, SNCT analysis and application of professional judgment aligns with complex discharge planning and prolonged overview individual patient profiles. The frequency of inpatient transfers and medical outliers received from other areas poses challenges and difficulties in staff completing complex overview assessments in the absence of knowing the patient or requests to repeat the process in view of changes to individual patient status increased staff workload. This change to case mix also demonstrates a reduction in admission rates and increases in patients waiting for intermediate care or transitional care beds. The majority of patient cohorts were frail and elderly or living with dementia and as such the window of opportunity to expedite assessment and discharge was reduced.

Ward 10 demonstrates a slightly higher Level 1a acuity and patient dependency compared to national SNCT benchmark analysis which probably reflects the combination of elective, trauma and medical outlier case mix bed and the fact that it is 32 beds. Room 14 is being used flexibly to accommodate trauma patients from AED to maintain segregation of case mix. Increased recording of observations, administration of intravenous therapies and effective patient pain control also impacts upon staffing levels. Mitigating actions include the co-ordinator role supporting preparation of intravenous drugs and administration of analgesia.

The impact of managing elective and trauma activity within one area impacts upon the effective management of infection and prevention control measures which in turn requires more nursing time to support the triple clean of side rooms to ensure patient safety and mitigate infection risk.

Previously Ward 10 has been extremely challenged in relation to staff recruitment and retention. This position has significantly improved since the last SNCT audit.

In part this improvement has been seen as a result of the proactive 90 day improvement programme implemented by the senior nursing team which provides focus, scope and progress seen in several key areas of identified work streams and proactive staff engagement.

A review of staffing levels, role changes and workforce modelling has been completed and recommendations submitted subject to approval. Proposals include a change in skill mix and role profiles with the introduction of nursing associates to the team. Overall investment is required to uplift the wte funded establishment to support effective, productive and delivery of high quality safe care and positive health gains. It is anticipated that a significant reduction in bank 1:1 enhanced care and agency expenditure will be offset by proportionate investment to support adequate and safe staffing levels.

Increased patient observations on Ward 9 is influenced by the shift in patient acuity and dependency

Overall

Integrated care wards SNCT data analysis demonstrates a reduction in Level 1a care on Ward 11 and Aston but shows a significant increase on Ward 9 from a daily average of nil level 0 care to a daily
average of 8.6 patients who require Level 1a care compared to previous audits. This reflects a shift in acuity and dependency on Ward 9 in view of increased patient observations, early warning score triggers and escalation of care inclusive of patients who required interventional therapy. Application of professional judgment also informs that a higher proportion of patients required escort on and off site to attend diagnostic investigations such as CT scans.

Changes to the daily average of patients who require Level 1b care also demonstrates a different pattern showing a significant increase on Ward 11 and a reduction on Wards 9 and Aston compared to previous audits. Current funded establishments and staffing levels are considered appropriate for Aston Ward although based on current bed configuration and level of care requirements on Wards 9 and 11 a review of the funded WTE establishment and workforce model is recommended to support safe staffing levels and care.

Current funded establishments and staffing levels are considered appropriate for Aston Ward

Ward 9 has seen an increase in the daily average of patients requiring level 1a care and a 50% decrease in patients requiring level 1b care

Ward 9

Demonstrates a significant increase in the daily average of patients who require Level 1a care compared to previous bi annual audits and a 50% reduction in patients who require Level 1b care.

Application of professional judgement and triangulation of metrics illustrates that acuity and dependency changed during January 2018 due to an altered ratio of patients with behavioural or challenging cognitive aggressive manifestations compared to July 2017 audit. This aligns with the split seen with regards to the increase of patients requiring Level 1a care which is reflective of acute care case mix complexities.

Alignment with professional judgement also indicates that throughout January the vast majority of patients admitted from residential or home were too ill to return to their normal place of residence. This impacted on staffing levels and workload as complex discharge planning, 24 hour profiling and multi professional referral, therapeutic interventions and care planning was sought. On occasion’s rapid changes to individual patient status necessitated further overview re-assessment which also increases staff workload. A reduced proportion of patients required full support with activities of daily living, enhanced 1:1 care owing to variable levels of dementia, cognitive impairment and mental capacity assessments (DoLS) coupled with complex discharge planning and reminiscence therapy.

Since the last bi annual report the outstanding Band 6 junior sister role has been recruited to from within the existing team as an opportunity for personal and continued professional development.

Due to changes in case mix complexities and patient vulnerability a review of workforce modelling has commenced. It is anticipated this will help to inform and deliver appropriate skill mix from Monday-Sunday to facilitate appropriate application and adherence to mental capacity act requirements, DoLS assessment, reminiscence therapy and proactive personalised care planning for patients and carers living with dementia. Further interim senior sister and matron assurance audits are recommended to sense check and inform if the daily average of patients who require Level 1a care remains elevated and escalated by exception via Directorate governance frameworks. Mitigating actions include staff deployment, utilization of nurse bank
and agency in conjunction with senior sister and matron stepping down to support clinically to ensure patient safety and staffing levels are maintained. However, a number of shifts fell below the core minimum staffing levels despite shift requests to bank and agency which remained unfilled.

Whilst there has been a decrease in the daily average of patients requiring level 1a care, the proportion of patients requiring level 1b care has significantly increased.

Ward 11

Demonstrates a decrease in the daily average of patients who require Level 1a care compared to previous audits and the proportion of 1b Level care illustrates a significant increase.

The shift seen demonstrates a significant decrease by almost 50% in the daily average of patients who require Level 0 care compared to previous bi annual reports moving from a daily average of 11 patients in receipt of Level 0 care to an average of 5.9 patients per day in January’s audit.

This change reflects the changes seen to case mix, frequency of patient observations, intravenous therapy interventions and fluctuations in the number of medical outliers and acute medical patient transfers that required escalation of care within an intermediate care bed based model. This was also observed via NHSI and Fusion2 who aligned Ward 11 to a sub-acute medical ward footprint.

Indications suggest that if case mix, acuity and dependency continue to demonstrate a higher proportion of Level 1a than expected in an intermediate rehabilitation care setting coupled with sustained significant increases in the daily average number of patients who require Level 1b care (from 9.3 to 17.5), urgent review of the core funded staffing establishment, skill mix and staff competency assessment is required to mitigate risks.

Bed head services, bathroom facilities and space requirements should be prioritised in view of the 6 additional funded beds within the paediatric ward footprint.

In view of the six additional funded beds placed within the paediatric ward footprint and reduced patient observation it is recommended that bed head services, bathroom facilities and enough space to navigate essential moving and handling equipment should be prioritised to support the delivery of safe care. Mitigation includes risk assessment and monitoring via directorate SQS risk register, clinical incidents and key metrics along with bank and agency utilization following daily review of staffing levels.

It is also important to note that since the last bi annual audit the secondment of the Band 7 integrated discharge team leader has proved successful. The seconded post has been converted into a substantive senior sister Band 7 role which provides ward 11 with consistent and effective leadership.
**Aston Ward**

Demonstrates the expected proportion and split seen between the daily average of patients who require Level 0 and Level 1b care. Funded WTE establishment and staffing levels are considered appropriate for the care setting. However, at times of unforeseen sickness and absence or shift cancellations Aston ward may potentially become vulnerable and isolated in terms of adequate and safe staffing levels. Every attempt is made to mitigate risk and lone working by staff redeployment, pool allocation and bank/agency utilization as required.

There has been a slight increase in the number of escorts off site due to orthopaedic changes made to satellite clinics previously based at Congleton War Memorial Hospital. Fracture clinics are re-provided on the main Macclesfield site and often require a healthcare assistant to accompany patients on escort duty impacting upon core staffing levels for a period of time. Mitigating actions include pool allocation and booking of bank staff to support escort duties.

Skill mix is utilized flexibly to support daily changes to meet individual patient needs and additional specialist dementia training has been put in place to facilitate cohort nursing and 1:1 enhanced care. During January one bay was subject to cohort nursing to support 1:1 enhanced care to minimize risks to patient safety.

During January two patients regularly attended the ward for body brace checks to ensure correct fitting and skin integrity assessment. This flexible approach to meet patient need impacts upon staffing levels as each visit requires support from nursing, physiotherapy and occupational therapy as the brace is removed in a specific way. Although staff worked flexibly to support and expedite discharge ward attendees divert staff away from core frontline ward based duties.

It was recommended in the last bi-annual audit that a review was undertaken of patient beverage and meal services in view of the different arrangements at Aston ward to support productive ward ‘releasing time to care’. Preliminary discussions between the Directorate and ISS have to date found no solution to moving towards a ‘plating service’.

---

**ACUTE AND INTEGRATED COMMUNITY CARE DIRECTORATE - URGENT CARE**

**Overall**

Urgent Care SNCT data analysis demonstrates that on the whole current staffing levels, funded establishment and review of skill mix is appropriate based on current data, specialty bed configuration and consistency with regional network critical care guidance. However, it is important to note ITU has been subject to a staffing model and shift pattern review since the previous audit in view of increases seen in demand and capacity for ITU beds which was also seen in January.

Outputs from the MAU sustainable workforce project continue to utilize dedicated pharmacy technician support to facilitate administration of medications which supportive productive nurse staffing. During the last bi-annual SNCT audit consideration to increase skill set and shift leaders was proposed. Subsequently,
additional Band 6 roles have been recruited to that not only provides Band 6 cover for each shift to support patient safety and clinical practice but also positively impacts upon staff retention by providing opportunities for continuing professional development to existing staff. It also extends senior nurse presence and visibility over a seven day period to facilitate co-ordination and effective patient flow.

Although a two year rotational staff nurse programme was previously implemented between ITU, ED, AAU and MAU completion of full rotation is sporadic in view of staff preferences to permanently stay in one of the areas opposed to rotating through. Rotational opportunities, however, remain in place to attract and incentivise recruitment, retention and sustainable staffing levels.

**ITU**

Demonstrates a significant increase in the daily average of patients who require Level 2 and Level 3 care provision compared July 2017’s audit. This equates to an additional daily average of 3 patients which require the unit to flex staffing levels to support 6 patients, invasive monitoring and interventional therapy. Application of professional judgement confers that a cohort of patients resided in ITU for a longer period of time due to dependency and case mix complexities. On a couple of occasions during January theatre recovery space was also utilized to support increases seen in demand and capacity.

Comparable data analysis also demonstrates a similar pattern seen in the small daily average of patients who require Level 0 or Level 1a care. This reflects and aligns with prolonged delays to step down or transfer from ITU due to lack of side room capacity or requests for specialty based beds. On occasions, patients were discharged directly from ITU. This was seen to impact upon the management of Same Sex Accommodation and infection control measures which is monitored closely. Mitigating risks are proactively managed as far as possible by utilizing side room capacity within ITU flexibly dependent upon case mix. However, due to increases seen in case complexity and infection control measures during January one side of the unit environmentally becomes more overcrowded which restricts adequate bed space and elimination of mixed sex breaches. Mitigating actions include robust de-cluttering and storage of unused equipment and deep cleaning processes are adhered to. This places additional pressure on staffing levels and response times to support demand and capacity.

Since the last bi-annual audit a ‘retrieval team’ between ITU and AED was implemented to support and expedite transfers from AED to ITU to help create resuscitation capacity within AED. Appropriateness is based on individual patient assessment and early intervention to support positive clinical outcomes especially in the management of Sepsis and Acute Kidney Injury. However, the increases seen throughout January in acuity and dependency in ITU necessitated staff to remain on the unit to support safe staffing levels.

Staffing levels for ITU are appropriate and reflect critical care network guidance and align to the commissioned service specification. Staffing levels and patient dependency are risk assessed daily to ensure that 4 Level 3 and 2 Level 2 care patients may be accommodated at any one time which reflects their number of commissioned critical care beds. However, application of professional judgement infers that the unit should be placed in a

A ‘retrieval team’ between ITU and AED has been implemented to support and expedite transfers, however an increase in acuity and dependency in January in ITU necessitated that staff remain on the unit

**There has been a significant increase in the daily average number of patients requiring Level 2 and 3 care provision in ITU**
A management of change proposal has been submitted facilitating a supervisory co-ordinator role on early shift.

Since the last SNCT acuity and dependency audit a management of change proposal has been implemented that facilitates a supervisory co-ordinator role on the early shift. The changes to skill mix and workforce modelling also ensures 2 Band 6 staff members work clinically and on shift 7 days a week to support safe staffing levels sharing knowledge, skills, experience and a level of clinical supervision to more junior staff.

The senior sister also spends 23% of her substantive hours supporting front facing clinical patient care.

The skills mix dilution and high level of vacancies on Ward 4 impacted upon ITU acuity and dependency.

It is also important to note that Ward 4’s skill mix dilution and high level of vacancies impacted upon ITU acuity and dependency. Patients who would normally receive NIV or high flow interventional oxygen therapy care were, on 2 occasions during January transferred to ITU to support patient safety and correct staffing ratios. This indirectly places additional pressure on ITU’s ability to flex staffing levels in a timely manner.

The daily average number of patients requiring level 1a and level 1b care has increased on MAU.

Data analysis also demonstrates that the daily average of patients who require Level 1a and Level 1b care increased compared to the previous audit. On a daily average this translates to an increase of 2.6 patients for Level 1a and 3.5 for Level 1b care. This change reflects case mix complexities and increases seen in immediate interventional therapeutic treatment coupled with patient cohorts who remained on MAU longer than 48 hours due to exit block to facilitate patient transfers to specialty wards. Increases were seen in the number of patients who required 1:1 enhanced nursing and constant supervision.

Data analysis and application of professional judgement also correlates to a reduction in admissions, patient transfers and number of patients discharged directly home from MAU. This demonstrates as seen in other areas prolonged length of stay due to case mix complexities, increases in patient dependency and co morbidities. Staff reported that they felt under more pressure in view of increasing levels of intravenous therapies, cardiac monitoring and unstable diabetic patients that under normal circumstances would have been transferred sooner to specialty based wards.

MAU demonstrates much higher admission, discharge and transfer rates than other areas although this reduced in January.

MAU widely demonstrates much higher admission, discharge and transfer rates than other areas, on average receiving 17 admissions per day, 7 discharges and 6 transfers opposed to other areas. This is consistent with rapid assessment and the management of patient flow. However, during January the patterns normally seen altered and admissions reduced on average to 14 per day and discharges to 4.5 per day indicative of consistent operational pressures that impacted upon patient flow throughout the whole of the hospital.
Safe staffing levels were maintained and at times of peak pressure flexible staff deployment between areas and utilization of bank and agency to support external escort duties.

Mitigating actions also include the stepping down of the co-ordinator role to support the delivery of safe patient care.

9 COMMUNITY SETTING

9.1 Although previously SNCT data collection and preliminary analysis as part of a pilot project was undertaken by community teams the tool is no longer recommended nationally and is not being taken forward.

9.2 Following discussions with senior community nurses and managers about future nursing requirements proposed in The Five Year Forward View 2020, as well as current and future service/caseload demands (e.g. increasing acuity and dependency of patients - local integrated team development) agreement to undertake a role and skills review across ECT community nursing was reached.

9.3 Subsequent developments and outcomes of any changes will be aligned to the principles outlined in NQB guidance: An improvement resource for district nursing services in relation to safe, sustainable and productive staffing which incorporates characteristics of what constitutes good quality care in district nursing.

9.4 Work has commenced to gain a local consensus and agree key principles with regards to roles and clarity for any future community nursing model. This work includes benchmarking across other organisations and District Nursing Service Education and Career framework.

10 CURRENT NURSING ESTABLISHMENT – CHANGES TO SERVICE MODEL AND BED BASE

10.1 Since the last SNCT acuity and dependency audit the Trust has embedded a number of service model redesign programmes following service provision review in relation to bed reconfiguration. Capital estates work to strengthen and facilitate emergency care streaming and integration between primary and secondary care settings is now complete. It is anticipated that a further review of overall bed stock and reconfiguration will be necessary to enable the Trust to respond consistently to demand on services which impacts upon safe staffing levels and patient experience.

11 Quality & Safety - delivering safe care

11.1 The supervisory status of the senior sisters was previously adjusted for them to provide a 50/50 split working clinically within the rota. Over the past 6 months this position in the majority of ward areas has improved and adjusted to a 60/40 split. However, in view of the unprecedented operational pressures seen throughout January, current level of vacancies and diluted skill mix, enhanced level of 1:1 care and case mix complexities necessitated senior sisters to continually step down into core numbers to support safe staffing levels. It is anticipated that following successful recruitment supervisory status will be reinstated where possible to allow closer
management and monitoring of quality standards, patient experience, completion of staff appraisal, clinical training and coaching junior staff within the ward environment. Equally important is enabling the senior Band 7 sister to have capacity to oversee inpatient flow, pulling through patients requiring admission from ED and supporting more timely discharge for patients going home or to more appropriate care settings. The senior sisters continue to spend a significant amount of time in supporting this function and management of activity as part of the SAFER project.

Pressures were seen in January in relation to the volume of patients requiring 1:1 enhanced care, mental capacity and DoLS assessment. Currently, staffing levels and patient safety continue to be overseen, risk assessed and resolved on a daily basis by the Clinical Matron team and Senior Nurse central to nurse bank staffing. Concerns or risks that remain unresolved are escalated to Senior Nurses in real time as required. Where wards fall below their core funded establishment or below acceptable staffing levels in any shift period, a senior professional assessment is made based on acuity, patient dependency, skill mix, enhanced 1:1 care and decisions made to move staff from other areas to mitigate risk are implemented. The use of SBAR facilitates clear documentation and provides an audit trail in relation to decisions taken. In addition, the bed capacity meetings have been strengthened to ensure that staffing, patient safety and subsequent actions are appropriately managed. This, however, has been challenging due to fluctuating demand, capacity and increasing numbers of mixed sex accommodation breaches during January compromising patient privacy and dignity. Further pressures were seen during January in relation to the volume and number of patients who required 1:1 enhanced care, mental capacity and DoLS assessment, complex discharge planning and the impact on staffing levels when carrying an RN vacancy rate of 41.46 excluding Maternity and Long Term Sickness leave.

Non-clinical front facing staff and additional volunteers were drafted to support staffing levels at time of peak operational pressures. Identified nurse staffing shortfalls continue to be discussed daily and escalated as per Trust guidance and policy in conjunction with safety huddle briefings and daily board rounds. All reasonable steps and measures with regards to forward planning are also made in advance to support safe staffing levels as far as possible which include any identified gaps being met by using any unused nursing hours accrued by substantive staff, cancellation of non-essential study leave, temporary staff via nurse bank, existing ward staff working additional hours, staff redeployment, increased clinical placement of senior sister and matron roles and booking of agency staff. On occasions non-clinical front facing staff and additional volunteers were drafted in to support staffing levels at times of peak operational pressures to mitigate risks to patient safety.

Further recruitment strategies and initiatives for attracting registered nurses to join the Trust substantively or through the nurse bank are in the process of being further developed and strengthened via Directorate and HR workforce development plans. There is also a requirement to strengthen staff retention and succession planning in view of the demographic profile of the nursing workforce. In addition, regular student nurse focus group meetings facilitated by Practice Educator Facilitators and Heads of Nursing are in place to engage with students at an earlier point in their training to discuss their placement experience and provide strong links to support and convey job opportunities on qualification. The first cohort of Trainee Nursing Associates is also half way through their training programme.

Any adverse clinical incidents relating to nurse staffing, patient safety, patient harm, risks, patient complaints or staff concerns are reported and investigated via Datix Clinical Incident Management system, HR
policy inclusive of raising concerns with the Trust’s identified named lead. The triangulation of nurse sensitive and workforce metric indicators are reported against each individual acute in patient ward and presented monthly via the safe staffing exception Trust Board report, Ward Quality Dashboards and Directorate SQS exception reports. Ward quality dashboards are shared with ward teams. 

Directorates continue to review risks pertaining to nurse staffing levels

Risks pertaining to nurse staffing levels are reported and form part of the Datix Risk Register which are subject to discussion and regular review within Directorates and form part of the Trust’s Governance assurance frameworks.

In addition, ‘Did You Know’ Boards, Sign up to Safety, Safety Thermometer, ‘Open and Honest’ Care, Ward Quality Dashboards, RADaR reports, Mortality/Morbidity data and development of red flags are monitored robustly and actions taken as appropriate to mitigate risks to patient safety and inadequate staffing levels to support triangulation. Patient experience and patient outcomes are continually monitored and actioned upon through various assurance meetings in addition to PaLS in reach to AED and in patient areas during January.

12 TRUST POSITION AGAINST NICE GUIDANCE

The Trust continues to work and align staffing levels in line with NICE guidance recommendations. ‘Red flag events’ which are defined as ‘events that prompt an immediate response by the registered nurse in charge of the ward’ can be challenging to record in real time. This in part is due to diluted skill mix and substantive nurse to bank/agency ratios. The absence of electronic infrastructure and software upgrade presents frontline staff with a challenge to collate accurate and robust data consistently with regards to ‘missed breaks’ and staff ‘working over the duration of their rostered shift’. Proposals in relation to improvement in IT infrastructure and supporting safe staffing resource tools are currently in discussion.

13 CARE CONTACT TIME (CHPPD)

In February 2016 the Carter report provided further guidance with regards to improving measures aligned previously to care contact time. It recommends that CHPPD (Care Hours per Patient Day) is calculated to describe both the staff required and staff available in relation to the number of patients requiring direct nursing care to help Trust’s provide high quality care, efficiency savings and improvements in productivity. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing by the total number of in-patient admissions in a 24 hour period at the midnight bed count for each ward area.

The Trust is compliant with reporting measures.

Further work is currently be undertaken utilizing ‘model hospital’ intelligence to facilitate rigorous interpretation and consistent application of guiding principles with other sources of data such as professional judgement to ensure the complexities of patient care and staffing numbers reflect appropriate skill mix and competency.
14 CHALLENGES AND MITIGATION

14.1 European and International recruitment trajectories and start dates have been subject to change which has resulted in a significant decrease in the number of international nurses initially recruited to. This has been compounded by the candidate’s unsuccessful completion of IELTS examination, regulatory requirements, candidate withdrawal or loss to larger peer organisations. Mitigating actions include partnership working with the agency, colleges and universities including closer working with candidates to assess and facilitate their competencies in the clinical setting.

14.2 Early, national indications demonstrate that the removal of student bursaries in England has had a detrimental effect on the number and quality of students who apply to undertake nurse training. In the early years of implementation this may impact upon the Trust’s ability to recruit and attract staff. Both local and national trajectories identify a significant workforce shortfall to meet current demand coupled with the impact on nurse retention in view of the 1% pay cap for public worker sectors. A number of peer organisations have offered and implemented incentive packages to attract and retain staff which poses ECT with additional challenges. Mitigating actions include developmental opportunities, flexible retirement options, return to practice and the piloting of new roles to support the workforce.

The trust has an ageing experienced workforce with an increasing number of staff eligible and applying for early retirement

14.3 Demographic profiling demonstrates that the Trust has an ageing experienced workforce with an increasing number of staff eligible and applying for early retirement. A number of are supported to secure flexible retirement options in order to maintain key skill sets and competency.

14.4 Robust staff development and succession planning will be required to ensure that key critical posts are recruited to in order to mitigate risks associated with business continuity. Mitigating actions to date include HR work streams alignment to recruitment, retention, attraction strategies to facilitate workforce sustainability.

14.5 Increased sickness and absence rates within some areas has impacted on safe staffing levels and skill mix dilution. The management of this in addition to a number of gaps due to maternity leave is an additional pressure on an already challenged workforce. Operational pressures continue to be mitigated through agreed escalation processes and managed on a daily basis.

The trust saw a less favourable position in nursing and midwifery long-term sickness and absence during January

14.6 During January nursing and midwifery long term sickness and absence is 7.11% which illustrates a worsening position compared to the previous audit. Year to date maternity leave in now calculated per directorate as ‘all staff groups’ opposed to nursing and midwifery groups. In month, nursing and midwifery data with regards to Maternity leave in January is 3.55 wte

14.7 The opening of additional flex capacity or utilization of AAU as an in-patient area to support the management of patient flow, patient safety and operational pressures has presented staff with many challenges during January and has required staff resilience and flexibility.
Mitigating actions include a planned and co-ordinated approach to deploy staff from all other areas to support safe staffing levels and skill mix. However, this coupled with the current level of vacancies and early indications of winter pressures may further impact upon the Trust’s ability to provide adequate staffing levels and skill mix across all in patient ward areas necessitating backfill with bank and agency staff.

14.8 Controls to support a reduction in agency expenditure have been consistently applied to ensure a trust wide approach is adopted for all staff groups. The impact of these measures are monitored weekly against nurse sensitive and workforce metrics to ensure patient safety, staff wellbeing and operational delivery is effectively addressed and managed to support safe staffing levels. The DNP&Q maintains oversight on all over cap nurse agency requests and a robust approval process is in place in and out of normal working hours. Despite these measures, on a number of occasions throughout January staffing levels have been below core minimum staffing levels due to non-availability of bank or supply of agency staff.

14.9 Identified gaps in medical staffing may further impact upon nurse staffing and the delivery of safe patient care. Mitigating actions include review of job plans, substantive and locum recruitment with clear escalation processes in place.

15 NEXT STEPS

15.1 Share outputs from SNCT with Directorates and where recommended review wte funded establishment and staffing models to support safe, sustainable and productive staffing levels align particularly in relation to overnight HCA requirements

15.2 Liaise with Directorates, HRBP and L&D to review workforce plans and succession planning models in view of demographic profile of the nursing workforce; inclusive of consideration re: apprenticeship roles, nursing associates, return to practice placements, development opportunities and rotational roles.

15.3 Undertake an interim acuity and dependency audit on Ward 9 and Ward 11 in view of significant changes seen in level of care categories and monitor metrics via directorate SQS meetings and escalate by exception.

15.4 Agree and confirm future trainee nursing associates programme as part of the ongoing evaluation of the pilot cohort.

15.5 Review nurse bank function, systems and processes inclusive of roll out of re-rostering implementation to other teams to support effective management, staff deployment and utilization.

15.6 Improve e-rostering compliance and IT infrastructure and consider investment in SafeCare to support health-roster systems and real time nurse staffing metrics to support safe patient care delivery.

15.7 Agree and implement recommendations in relation to Ward 10
proposed workforce model.

15.8 Review recruitment and retention strategies to support workforce development and reduce agency expenditure.

15.9 Complete consensus and benchmarking exercise to help inform future community staffing models and roles

15.10 Progress application of CHPPD to further inform staffing levels based on acuity and dependency, triangulation with nurse sensitive indicators and ’model hospital’ intelligence.

15.11 A further SNCT acuity and dependency audit will be undertaken in July 2018 to enable regular comparable acuity and dependency data analysis to inform safe staffing levels for acute in patient areas.

15.12 Any exception identified in the interim will be managed appropriately within set timescales, discussed and escalated through the Trust’s established performance and governance assurance frameworks.

16 **RECOMMENDATIONS**

16.1 The Board is asked to note the contents and recommendations contained within the report.
Appendix 1:

Safer Nursing Care Tool Example:

Multipliers can be used to set nursing establishments allied to acuity and dependency measurement. The multipliers agreed for each level of patients on inpatient wards are:

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Adult Inpatient Wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>0.99 WTE per bed</td>
</tr>
<tr>
<td>Level 1a</td>
<td>1.39 WTE per bed</td>
</tr>
<tr>
<td>Level 1b</td>
<td>1.72 WTE per bed</td>
</tr>
<tr>
<td>Level 2</td>
<td>1.97 WTE per bed</td>
</tr>
<tr>
<td>Level 3</td>
<td>5.96 WTE per bed (1-1)</td>
</tr>
</tbody>
</table>

Example:

If a 28 bedded ward has 12 patients at Level 0, 7 patients at Level 1a, 8 patients at Level 1b and 1 patient at Level 2, a total of 37.24WTE nursing staff should be required. This figure is a baseline against which to set nurse staffing levels.

Additional factors as outlined in Appendix 1 may also need to be considered as wards have different activity and dependency.

Professional judgment is required to ensure that establishments are adjusted appropriately under these circumstances. Nurse sensitive indicators can also be used at this stage to ascertain the impact of acuity, dependency and activity on quality outcomes.

<table>
<thead>
<tr>
<th>Number of patients/Level of Care</th>
<th>Adult inpatient ward area</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 patients at Level 0</td>
<td>0.99 x 12 = 15.24</td>
</tr>
<tr>
<td>7 patients at Level 1a</td>
<td>1.39 x 7 = 9.73</td>
</tr>
<tr>
<td>8 patients at Level 1b</td>
<td>1.72 x 8 = 13.76</td>
</tr>
<tr>
<td>1 patient at Level 2</td>
<td>1.97 x 1 = 1.97</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37.34 WTE</strong></td>
</tr>
</tbody>
</table>

The tool recommends 22.6% – 25% % uplift for annual leave, study leave and sickness.
Dear Colleague

TRUST BOARD MEETING

A meeting of the Trust Board will be held at 3.00pm on 7th June 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.

---

<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, Performance and Quality</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 April 2018 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 18 (39)</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>15 mins</td>
<td>Verbal (supported by formal minutes when available)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>SQS</td>
<td>Mr M Wildig</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FP&amp;W</td>
<td>Mr Ian Goalen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit</td>
<td></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>40 mins</td>
<td>TB 18 (40)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Capital Programme</td>
<td>Director of Finance</td>
<td>15 mins</td>
<td>TB 18 (41)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>10. 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>11. Public Trust Board Agenda – July 18</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 18 (42)</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>12. Chairman’s Commentary</td>
<td>TB 18 (43)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>13. Annual report Infection, Prevention and Control</td>
<td>TB 18 (44)</td>
<td>For assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
<tr>
<td>14. Annual reports of the Committees of the Board</td>
<td>TB 18 (45)</td>
<td>For assurance</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>15. Annual Safeguarding report</td>
<td>TB 18 (46)</td>
<td>For assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>STAFF - Empower, develop and value staff in providing innovative patient focused care</td>
</tr>
<tr>
<td>16. Safer Staffing Exception Report</td>
<td>TB 18 (47)</td>
<td>Assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>STAFF - Empower, develop and value staff in providing innovative patient focused care</td>
</tr>
<tr>
<td>17. Minutes of the committees of the Board:</td>
<td></td>
<td>Information</td>
<td></td>
</tr>
<tr>
<td>SQS – March 18</td>
<td>TB 18 (48)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FP&amp;W – March 18</td>
<td>TB 18 (49)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date and Time of Next Meeting:

Date: Thursday 5th July 2018
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
**TRUST BOARD**  
April 2018

**Agenda Item No 14: TB 18 (34)**

<table>
<thead>
<tr>
<th>Report of:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible Officer:</strong></td>
<td>Deputy Director of Corporate Affairs and Governance</td>
</tr>
<tr>
<td><strong>Accountable Officer:</strong></td>
<td>Director of Corporate Affairs and Governance</td>
</tr>
</tbody>
</table>

| Author of Report: | Equality & Patient Experience Manager |
| Subject/Title | Equality and Human Rights Update Q4 2017-2018 |

**Background papers (if relevant)**
- Equality Act 2010
- Equality Delivery System 2 (EDS2)
- Eastern Cheshire Clinical Commissioning Group (CCG) quality schedule

**Purpose of Paper**
To provide assurance to the Board in relation to trust compliance with the requirements of the Equality Act (2010), the Equality Delivery System, the Workforce Race Equality Standard (WRES) and progress on learning disabilities and autism.

**Action/Decision required**
The Board is asked to note the report, the assurance provided and the planned action for 2018-2019.

**Mitigates Risk Number: (identify)**
**On Corporate Risk Register**
- CRR 38 Score 12: If the Trust does not have robust governance arrangements which hold up to external scrutiny in relation to CQC standards, the reputation of the organisation may be damaged with loss of confidence from stakeholders.

**Mitigates Risk Number: (identify)**
**On Assurance Framework**
- AF 2 Score 12: 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.

**Link to Care Quality Commission Domain**
Responsive  
Well-lead

**Link to:**
**Trust’s Strategic Direction**
Board Objective: Patients: Provide safe, effective personal care in the right place

**Corporate Objectives**

**Legal implications - (identify)**
The trust has a duty to remain compliant with requirements under the Equality Act (2010)

**Impact on quality**
Provides positive assurance in relation to compliance with the NICE Quality Standard for Patient Experience 2012 including requirements around learning disabilities

**Resource impact**
None

**Impact of equality/diversity**
Provides assurance of compliance with the Equality Act 2010  
Provides assurance of achievement against the Equality Delivery System 2.

**Avoid acronyms or abbreviations - if necessary list:**
- EIA – Equality Impact Assessment
- CCG – Clinical Commissioning Group
- NAS – National Autistic Society
- BSL – British Sign Language
- EDS – Equality Delivery System
Report on Equality and Diversity

The purpose of this paper is to provide assurance to the Board on the trust’s annual compliance with statutory requirements for equality and diversity as a provider of health services and as an employer. The report includes information on:

- Delivery of the Equality Objective Plan 2017/18
- Assurance on the completion of the Quality Schedule requirements
- Positive assurance on workforce equality and diversity
- Achievement of the Equality Delivery System framework
- Evidence of good practice achieved in relation to learning disabilities

1  INTRODUCTION

Positive assurance on legislative requirements and good practice.

1.1 The trust continues to be focussed on delivering accessible services for all in a non-discriminatory way. The commitment to developing a workforce that is valued and diverse will enable the trust to deliver the best possible healthcare to the communities it serves.

1.2 The trust is compliant with the requirements of the Equality Act (2010) and has delivered the equality components of the Quality Schedule 2017/18.

1.3 The 2017 Workforce Race Equality Standard (WRES) analysis demonstrated improvement in engagement with Black and Minority Ethnic (BME) staff.

1.4 The trust achieved Disability Confident level 3 leader status in 2018.

2  PROGRESS UPDATE

Equality Objective plan fully delivered

2.1 The Safety, Quality and Standards Committee approved the 2017-2018 Equality Objective Plan in July 2017 and received assurance on progress throughout the year. The key objectives of this plan have been achieved.

2.2 All key performance indicators of the Quality Schedule requirements on equality have been assessed and met.

2.3 The Finance, Performance and Workforce Committee has received positive assurance regarding equality and diversity as part of their oversight remit for workforce.

The 2017 analysis against the WRES demonstrated that the relative likelihood of white staff being appointed from shortlisting compared to BME staff, is 1.65 times greater however the gap has reduced so this is an improved position.

First trust in the region to achieve Disability Confident Leader status.

2.4 The trust continues to take positive action in relation to applicants who declare a disability and was successful in achieving Disability Confident Leader status (Level 3) in March 2018. The trust has defined pathways to support applicants who are seeking work experience or volunteering opportunities at the trust and some success has been seen during 2017/18 identifying suitable work placements.
3 EQUALITY DELIVERY FRAMEWORK

**Trust is ‘achieving’ across all Equality outcomes**

3.1 The trust met the requirement for an annual stakeholder assessment of performance on equality using the Equality Delivery System framework in March 2018. The trust was assessed in 12 of the 18 outcomes and was classed as ‘achieving’ in all outcomes assessed.

Highlights of the assessment included:
- the developments in caring for people on the autistic spectrum
- recognition from Body Positive of the work undertaken around lesbian, gay, bisexual and transgender (LGBT) which was seen as changing the image of the trust to be LGBT friendly
- performance in the CQC national maternity survey 2017 where the trust was named as just one of four trusts nationally which performed ‘better than expected’ across all areas of the survey
- achievement of Disability Confident level 3 leader status
- the development of multi-faith prayer facilities.

3.2 Overall the trust is now ‘achieving’ in 17 of 18 outcomes (one outcome has not yet been reassessed). In 2016, the trust was assessed as ‘developing’ in outcome 1.3, Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed. This element will be reassessed in 2019.

4 LEARNING DISABILITIES COMPLIANCE

**Evidence of good practice in relation to learning disabilities**

4.1 The trust continues to perform well against the elements of the learning disabilities compliance framework based on recommendations set out in Healthcare for All (DH, 2008). Good practice includes:
- flagging and alert system in place and monitored
- reasonable adjustments are made for patients and their carers are supported
- photo journeys are available on the trust website
- in addition to e-learning, face to face refresher training has been implemented
- the trust learning disabilities and autism group includes representation from local organisations caring for people with learning disabilities and autism
- practice is evaluated via surveys and patient stories
- there is a learning disability support function in the trust and access to local health facilitation.
5 HOSPITAL ACCREDITATION VISITS

**Commendation by National Autistic Society**

5.1 The trust has undergone three successful visits as part of the National Autistic Society’s Hospital Accreditation; these have been in pre-op assessment, A&E and the Children’s Ward.

The trust was commended on promotion of the Open2Autism approach to patients and carers, staff awareness and flexibility, reasonable adjustments made and patient and carer support.

---

6 EQUALITY OBJECTIVE PLAN 2018-2019

**Equality Objective Plan 2018/19 approved**

6.1 The plan was approved by the Safety, Quality and Standards Committee in April 2018. Objectives are derived from national requirements, trust priorities and issues raised in the Equality Delivery System stakeholder assessment 2018.

---

7 FUTURE FOCUS

7.1 Work towards completion of the NAS Hospital Accreditation for autism.

7.2 Implement actions following the WRES analysis and the findings of the staff survey relating to staff with disabilities.

7.3 Looking forward to the implementation of the national Workforce Disability Equality Standard (WDES) the trust has identified, through the latest staff survey, areas of poorer satisfaction when compared against the general trust working population. Specific actions have been set to address these issues in the coming year. The WDES will form part of the standard contract and the first report is set to be published in 2019.

7.4 Prepare for engagement with Macclesfield PRIDE 2018.

---

8 RECOMMENDATION

To note the contents of the report and the positive assurance with regard to the trust meeting its statutory and mandatory obligations in relation to equality.

**Sign off**

Julie Green - Director of Corporate Affairs and Governance
### Agenda Item Number 15: TB 18 (35)

**Public Trust Board**  
**Thursday 26th April 2018**

**Report of:** Kath Senior  
**Responsible Officer:** Director of Nursing, Performance & Quality  
**Accountable Officer:**

| Author of Report: | Jeanette Sarkar  
| Head of Nursing, 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  
**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

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

**Link to Care Quality Commission Domain:**  
Choose one of the following:  
Safe  
Caring
<table>
<thead>
<tr>
<th>Link to:</th>
<th>Provide the best services to our population through improvements to safety, productivity and patient experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust’s Strategic Direction</td>
<td>No legal implications</td>
</tr>
<tr>
<td>Corporate Objectives</td>
<td>Impact on quality: May potentially impact upon the quality of care, patient experience, patient outcomes and staff well being</td>
</tr>
<tr>
<td>Legal implications - (identify)</td>
<td>Resource impact: Identified gaps in funded establishments due to WTE 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</td>
</tr>
<tr>
<td>Impact of 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</td>
</tr>
<tr>
<td>YTD Year to Date</td>
<td>WTE Whole time equivalent</td>
</tr>
<tr>
<td>WTE Whole time equivalent</td>
<td>RAG Red Amber Green</td>
</tr>
<tr>
<td>NMC Nursing Midwifery Council</td>
<td>HRBP Human Resource Business Partner</td>
</tr>
</tbody>
</table>

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Safe Staffing Levels – Exception Report

This report provides a high level summary of Safe Staffing levels on all inpatient wards across the Trust and an overview of community nurse vacancy positions. It provides a high level exception report in relation to the actual fill rate for ward in patient registered and unregistered staff during the day and night, highlighting where this falls below a 95% threshold using a RAG system.

1 INTRODUCTION

1.2 Actual staff numbers compared to planned staffing numbers is 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 WARD STAFFING

Registered midwife fill rate of 92.1% during daytime hours.

Safe staffing levels maintained

2.1 Post-natal and labour ward shows a registered midwife fill rate of 92.1% during the day, with in month sickness and absence rates and 2.0 wte vacancies responsible for this variance.

Safe staffing levels were maintained overnight through changing shift patterns and use of bank staff or community midwife teams flexibly

2.2 The average actual healthcare assistant fill rate of 80.1% overnight shows a slightly improved position compared to the previous month (78.5%).

Short term sickness and absence coupled with a staff member returning mid-month on a phased return from long term sickness contributed towards this variance.

In addition, 2.0wte vacancies are subject to final confirmation of the ability to support an apprenticeship course programme prior to recruitment.

Mitigating actions included daily monitoring of staffing levels, clinical caseload and risk assessment. Non clinical midwifery staff, 2 on call midwives available and flexing management support 12-8 were in place to ensure safe staffing levels were maintained. Community midwife teams also worked flexibly to support the maternity unit dependent upon demand and capacity.
Reduced healthcare assistant daytime fill rate of 80.1% on Aston Ward.

2.3 Aston ward healthcare assistant fill rate in month was 80.1% during the day, demonstrating a worsening position compared to the previous month (91.1%).

The reasons for the variance were due to 8 unfilled healthcare assistance bank shifts, long term sickness and uncovered 1:1 enhanced nursing requests to support cohort nursing. Mitigating actions included all staff stepping into core numbers.

Ward 4 exceeded 128% actual fill rates for registered nurses due to the impact of additional beds, vacancy level, skill mix dilution and case mix acuity and dependency. Mitigating actions included temporary increase of trained staff to Ward 4 to maintain patient safety.

2.4 Ward 4 registered nurse fill rate during the day was 158% and 128.9% overnight. The reasons for the variance were due to higher registered nurse vacancy levels, skill mix dilution, increased acuity and patient dependency, additional bed capacity (6) and concerns raised from staff in terms of professional registration and their perceived inability to safely supervise agency/bank staff. Short and long term sickness also contributed towards this variance.

Mitigating actions included internal staff deployment, bank and agency utilisation and senior sister stepping down into core numbers to support and maintain patient safety. In addition, agreement was reached to temporarily increase registered staffing levels whilst proactively recruiting to vacant posts to ensure patient safety was maintained and that supervision of temporary agency staff was adequate. This has now improved.

Increased patient complexities and enhanced 1:1 care is reflected in some overall fill rates exceeding 110% during the day and 130% during the night.

Additional bed capacity has an impact on the fill rate returns.

A number of wards actual fill rate for unregistered staff exceeded 110% during the day and in excess of 130% during the night. This variation reflects the increase in patient cohort complexities and enhanced 1:1 care, in addition to increases in flex bed capacity. The conversion of six day case beds to inpatient beds also remained open throughout March on Ward 5 to support clinical need and emergency activity in addition to AAU and +1 bed on acute wards following risk assessment. Wards 2 and Ward 4 actual fill rates for both registered and unregistered staff appear high on the unify return, however this reflects the flexed bed capacity and dilution of skill mix.

A significant number of staff stayed beyond their duration of shifts and worked ad hoc additional hours to support patient safety, care and their colleagues.

Professional judgement and staff deployment based on clinical need supported maintenance of patient safety although diluted skill mix remains challenged.

Daily staffing requirements are assessed prior to each bed capacity meeting and staffing concerns are escalated in real time as appropriate. Professional judgement based on clinical need is applied to support safe patient care, co-ordinating staff deployment from other areas or bank/agency utilisation to support acuity and patient dependency.
Some core and enhanced 1:1 care shifts remained unfilled despite going out to agency and bank but staff worked additional hours or stepped down to support patient safety.

On a number of occasions throughout March, outstanding core shifts and 1:1 enhanced care remained unfilled via nurse bank, agency shifts and requests to respective agency tiers. Mitigating actions included staff working additional hours, senior sisters, matrons and corporate nursing teams ‘stepping down’ to support patient safety and maintain an overview of the completion of risk assessments. All non-urgent clinical meetings were cancelled to support.

3 RECRUITMENT

Excluding maternity leave and long term sickness registered nurse vacancies within acute inpatient areas has improved and is currently 34.37 wte.

It is important to note however that the majority of new staff members have not commenced in post to date and are going through pre-employment checks.

1 registered nurse was offered a substantive post following interviews held in March. Of which 1 was to nurse bank.

3.1 In month registered nurse vacancies within acute in-patient shows an improved trajectory; 34.37 wte compared to the previous month of 40.77 wte which converts to a 15% vacancy rate across all acute in patient ward areas. This excludes Maternity Leave and Long Term Sickness. Inclusion of Maternity Leave (5.07 wte) and Long Term Sickness (4.64 wte) increases the overall registered nurse gap as to 44.08 wte compared to 51.45 wte the previous month.

Please note however that although vacancy trajectories demonstrate an improved position, actual staff members have not yet commenced in post to date subject to pre-employment checks and ward confirmation of start dates. It is anticipated that staff will commence in post in May 2018.

3.2 Following registered nurse interviews held on 16th 2018, 1 registered nurse was offered a substantive post. A total of 9 acute and community registered posts offered the previous months are going through pre employment checks – 5 for acute and 4 for Community. 3 registered nurses commenced in post during March.

The 3 overseas nurses who arrived in the autumn who partially failed their final OSCE have now successfully passed their OSCE and await NMC registration.

8 Healthcare Assistant posts offered following interviews held in March.

13 Healthcare Assistants offered posts the previous month are going through pre employment checks.

8 Healthcare Assistant posts were offered; 2 substantive ward posts and 2 to pool pending satisfactory pre-employment checks. From the previous month’s interviews, 13 healthcare assistants are currently going through pre employment checks; 7 ward based substantive roles, 4 candidates to nurse bank and 2 to pool. 4 ward based HCA commenced in post during March.

Registered nurse vacancies within the community setting are nil. Previous outstanding Band 6 posts have been recruited to via implementation of a Band 5 to 6 development programme as recruitment to Band 5 community posts has proved more successful. Temporary fixed term contracts remain in place to...
cover 2.7 wte maternity leave and 1.0wte remains on long term sickness.

Mitigating actions in the interim period to support depleted community teams in the short term is managed by deployment between teams based on daily RAG status risk assessment. In addition, part time staff have undertaken ad hoc additional hours to support staffing levels and utilisation of bank and agency as required.

Nine staff members have completed the first year of the two-year Trust’s Nursing Associate Pilot training programme. Preliminary discussions are currently being held with the individuals, directorates, learning and development to identify final substantive placement upon successful completion of the course.

4 RETENTION

The Trust’s demographic workforce profile and succession planning requires robust plans to support business continuity of key critical posts

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

4.2 A retention strategic steering group has been established to drive and focus local profiling and to consider initiatives and workforce development, with a particular emphasis on nurse retention.

The Clinical Workforce Deployment Group review of ward staffing model timescales have been integrated into new work streams aligned to bed reconfiguration and Safecare tool implementation

4.3 The clinical workforce deployment group was established to facilitate and review ward staffing models inclusive of nursing and medical roles. It was anticipated that this work stream would inform actions around recruitment and retention strategies that take into account safe staffing levels, skill mix and appropriately funded whole time equivalent ward establishments based upon acuity, dependency, patient safety, nurse sensitive quality indicators and patient outcomes.

In the light of new work streams that are inextricably linked to workforce review and development (bed reconfiguration and implementation of safe care software e-rostering tool) original work undertaken by this group has now been integrated into the Safecare project group workstream.

A further cohort of Trainee Nursing Associates has been proposed for September 2018 and January 2019 intakes

4.5 Other potential solutions to support workforce retention include consideration of apprenticeship roles, offer newly qualified staff a rotational post with bespoke placements to support development, access to return to practice courses and support flexible retirement applications. A further 2 cohorts of trainee nursing associates in September 2018 and January 2019 has been proposed to support workforce development.
Recruitment event to take place 21st April at the Moathouse Hotel, Stoke

4.6 A further registered nurse recruitment open event is scheduled to take place on the 21st April at the Moathouse Hotel in Stoke. This is being supported by a Facebook campaign and promotional activity.

4.7 Although the actual fill rate % for ward areas in most cases remains above 95%, signs of skill mix dilution are evident and are being closely monitored against patient safety incidents and nurse sensitive indicators.

Important focus is placed on skill mix to ensure appropriate supervision for newly qualified staff and student nurse training

4.8 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 new and existing roles. The current level of vacancy within the acute setting challenges this mentorship requirement. Mitigating actions include liaison between senior sisters, practice educator facilitators and the universities. Collective agreement and coordination with regards to the maximum number of student nurse or return to practice placements per clinical area is proactively managed to ensure mentorship requirements can be met. Student nurse focus groups are held monthly to support learners in practice and escalation of concerns raised are dealt with in as real time as possible by the learning and development team in liaison with senior sisters, matrons and Heads of Nursing.

5 STAFF TURNOVER

5.1 In month staff turnover is 0.62% compared to 0.37% the previous month. YTD rolling staff turnover is 11.46% compared to 12.40% the previous month. This excludes TUPE’d staff.

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.

6 RECOMMENDATION

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

Appendix 1: Safer Staffing Metrics

March Safe Staffing Report final.xlsx

Chairman: Lynn McGill
Chief Executive: John Wilbraham

The Information Standard Centre
Top hospitals Programme
Health and care information you can trust
Confident Employer
## Monthly Safe Staffing Report - March 18

<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>Expected RN</th>
<th>Actual RN</th>
<th>Expected HCA</th>
<th>Actual HCA</th>
<th>Percent RN</th>
<th>Percent HCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Care</td>
<td>Rehabilitation</td>
<td>Anton</td>
<td>935.09</td>
<td>955.58</td>
<td>2230.14</td>
<td>1872.50</td>
<td>100.6%</td>
<td>84.1%</td>
<td>682.00</td>
<td>671.00</td>
<td>847.00</td>
<td>814.52</td>
<td>98.3%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>Cardiology</td>
<td>CCA</td>
<td>1830.40</td>
<td>1900.00</td>
<td>1040.00</td>
<td>520.00</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98</td>
<td>10.8</td>
<td>0</td>
<td>18.8</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Women's &amp; Children's</td>
<td>Paediatrics</td>
<td>Children</td>
<td>1252.25</td>
<td>1272.58</td>
<td>682.00</td>
<td>690.50</td>
<td>80%</td>
<td>100%</td>
<td>1009.50</td>
<td>1099.50</td>
<td>316.50</td>
<td>364.50</td>
<td>107.5%</td>
<td>102.5%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Critical Care Medicine</td>
<td>Intensive Care Unit</td>
<td>1860.00</td>
<td>1860.00</td>
<td>504.00</td>
<td>504.00</td>
<td>100.0%</td>
<td>100.0%</td>
<td>1860.00</td>
<td>1860.00</td>
<td>504.00</td>
<td>504.00</td>
<td>100.0%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Women's &amp; Children's</td>
<td>Obstetrics</td>
<td>New Natal Unit</td>
<td>797.01</td>
<td>826.83</td>
<td>312.21</td>
<td>326.83</td>
<td>100%</td>
<td>100%</td>
<td>797.01</td>
<td>797.01</td>
<td>326.83</td>
<td>326.83</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>General Surgery</td>
<td>Ward 1</td>
<td>1875.06</td>
<td>1873.17</td>
<td>7265.40</td>
<td>7174.10</td>
<td>100.0%</td>
<td>100.0%</td>
<td>1021.00</td>
<td>1026.75</td>
<td>1384.00</td>
<td>1387.60</td>
<td>100.0%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>Trauma &amp; Orthopaedics</td>
<td>Ward 10</td>
<td>1937.50</td>
<td>1917.50</td>
<td>1927.58</td>
<td>1947.50</td>
<td>99.9%</td>
<td>99.9%</td>
<td>1023.00</td>
<td>1145.75</td>
<td>1559.50</td>
<td>1172.00</td>
<td>92.2%</td>
<td>92.2%</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>Rehabilitation</td>
<td>Ward 11</td>
<td>1177.16</td>
<td>1160.05</td>
<td>1910.93</td>
<td>2345.42</td>
<td>103.9%</td>
<td>127.3</td>
<td>682.00</td>
<td>683.50</td>
<td>1021.00</td>
<td>1355.00</td>
<td>103.9%</td>
<td>135.4%</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>General Surgery</td>
<td>Ward 2</td>
<td>1118.79</td>
<td>1123.05</td>
<td>1124.03</td>
<td>1150.75</td>
<td>100.6%</td>
<td>100.6%</td>
<td>682.00</td>
<td>693.50</td>
<td>824.00</td>
<td>854.00</td>
<td>104.6%</td>
<td>104.6%</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>General Medicine</td>
<td>Ward 3</td>
<td>1532.64</td>
<td>1539.08</td>
<td>1589.67</td>
<td>1733.33</td>
<td>100.4%</td>
<td>114.6%</td>
<td>1023.00</td>
<td>1026.52</td>
<td>1244.00</td>
<td>1147.00</td>
<td>104.5%</td>
<td>116.7%</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>Respiratory Medicine</td>
<td>Ward 4</td>
<td>1531.04</td>
<td>1536.42</td>
<td>2305.32</td>
<td>2335.42</td>
<td>118.4%</td>
<td>118.4%</td>
<td>1034.00</td>
<td>1319.00</td>
<td>824.00</td>
<td>1075.00</td>
<td>128.6%</td>
<td>128.6%</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>General Medicine</td>
<td>Ward 7</td>
<td>1564.88</td>
<td>1563.65</td>
<td>1594.64</td>
<td>1587.50</td>
<td>79.3%</td>
<td>90.7%</td>
<td>1021.00</td>
<td>1046.00</td>
<td>682.00</td>
<td>1023.55</td>
<td>102.7%</td>
<td>102.7%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>General Medicine</td>
<td>Ward 7BMAU</td>
<td>1922.00</td>
<td>1826.00</td>
<td>1392.16</td>
<td>1890.08</td>
<td>95.0%</td>
<td>118.1%</td>
<td>1364.00</td>
<td>1376.50</td>
<td>1364.00</td>
<td>1388.00</td>
<td>100.0%</td>
<td>101.9%</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>General Medicine</td>
<td>Ward 9 (Neonatal)</td>
<td>1048.43</td>
<td>1050.00</td>
<td>1674.00</td>
<td>1850.50</td>
<td>97.0%</td>
<td>113.5%</td>
<td>682.00</td>
<td>684.25</td>
<td>1364.00</td>
<td>1482.84</td>
<td>100.0%</td>
<td>107.3%</td>
</tr>
</tbody>
</table>

### Care Hours Per Patient Day (CHPPD)

- RN Expected: Registered Nurses
- RN Actual: Registered Nurses
- HCA Expected: Health Care Assistants
- HCA Actual: Health Care Assistants

### Percent RN

- Percent RN: Percentage of RNs to total staff
- Percent HCA: Percentage of HCAs to total staff

### Percentiles

- <80%
- 80% - 95%
- >95%

### Notes

- Percentage count over the month of patients
- Registered nurses/nurses
- Care Staff
- Overall
- Total
- Falls
- % Staff & Mandal
- Sidelines
- Absence

### Specific Units

- Urgent Care: Critical Care Medicine
- Integrated Care: Rehabilitation
- Surgical Specialties: General Surgery
- Medical Specialties: General Medicine
- Medical Specialties: Respiratory Medicine
- Medical Specialties: General Medicine
- Medical Specialties: General Medicine
The DCAG presented the patient story relating to a complaint letter received regarding the cancellation of an appointment. The complaint letter highlighted the following areas of concern:

- The patient received no apology at the time of cancelling their appointment, and was incorrectly informed they would have to go back on the 14 week waiting list.
- The patient felt no care or compassion from the hospital.

Discussion took place between the Committee and it was confirmed that appointments are often cancelled at short notice due to clinical priority. However it was noted that the patient would not have gone back onto a 14 week waiting list and that communication between staff and patient needs to be clear and precise.

As a result of the miscommunication the patient took their business elsewhere.

It was agreed that caring and compassion should always be the top priority when staff are liaising with patients and that staff are clear on the values and behaviours the trust represents. The DCAG informed that this message has been relayed back to staff.

18/13 Apologies
1. Kath Senior – annual leave
2. Dr Susan Knight – annual leave

18/14 Conflict of Interest
None declared.

18/15 Matters Arising

a) Year at a Glance

Agreed as accurate.

b) SQS Committee Minutes – January 2018

CP to be added to the attendance list for January 18 meeting.
Typo to be corrected in patient story.

Minutes agreed as accurate after the minor amendments have been made.

c) Action Log

Action 1 – Action completed and closed.
Action 2 – Action completed and closed
Action 3 – Action completed and closed. The MD informed that that an external audit has just been performed and the Coding department have now attained level 3 in the IG audit and depth of coding is consistently above peer organisations. Very positive achievement.
Action 4 – Action completed and closed.
Action 5 – Action closed.
Action 6 – Action closed.

d) Collection of Any Other Business

None

e) Formal Request for Removal of Items from Consent Agenda

None

ASSURANCE ITEMS

18/16 Integrated Quality & Governance Report including

The DCAG introduced the report and acknowledged the work of the DDCAG and DDNQ who were asked to present the key areas for noting

- In month saw an improvement (94.46%) in the Safety Thermometer performance (Harm Free Care).
- The falls rate per 1000 occupied bed days in January was achieved at 1.3 against a target of 2.5. January saw the lowest reported number of falls resulting in harms year to date.
- There was one case of Clostridium difficile reported in January 2018. This brings the total to eight cases year to-date which remains below the trajectory of 14 for 2017/18
- There were 32 mixed sex accommodation breaches in January 2018 due to operational and capacity pressures. Patient safety and privacy and dignity have been maintained throughout.
- The 4 hour ED access standard had not been achieved. In January 2018 a total of 39 patients waited more than 12 hours from the decision to admit to actually being admitted to the ward. There was no patient harm associated with any of these breaches; however their patient experience was not as we would wish.
- The CQC published the results of the national Maternity Survey, in which the trust’s Maternity Department were endorsed very positively by service users. The department was one of just four nationally which performed ‘better than expected’. The Committee noted the very positive feedback and ratings for the trust.
- RADaR - Four community nursing teams were triggering in month. It was confirmed action plans are in place for each community team as well as applying the recently issued national community nursing dependency tools. Progress is being monitored by the appropriate directorate and the DNQP and DDNQ continue to undertake their programme of visits.
- There has been an improvement in Q3 Complaints, Incidents, Claims and Patient Experience and the Committee noted the improvements made in name band incidents and confidentiality breaches.
- Endoscopy unit plan - Additional activity is being undertaken by an external company over the weekends and the expected time frame to be back on track is the end of March 2018. It was noted that the average waiting time is now 5 weeks but some waiting times are showing as over 5 weeks due to patient choice.

The Chair acknowledged and recognised the achievements made by the trust and the standards and quality maintained though the current challenging periods.

<table>
<thead>
<tr>
<th>18/17</th>
<th>SQS Committee Annual Report and Self-Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Committee approved the updated SQS terms of reference &amp; annual report for 2017-18 and agreed initial priorities for the 2018-19 annual work plan.</td>
</tr>
</tbody>
</table>

**STRATEGIC ITEMS**

<table>
<thead>
<tr>
<th>18/18</th>
<th>Quality Strategy – Annual Refresh</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The DDNQ presented the report highlighting the achievements made across the four 17/18 Quality Strategy domains. These are:</td>
</tr>
</tbody>
</table>

- Harm Free Care
- Improving Outcomes
- Listening and responding
- Integrating Care

The Committee acknowledge the progress made across the four domains and made reference to the following areas in particular:

- The improvement in avoidable stage 3 pressure ulcers and falls approved by the CCG and the reduction in Clostridium difficile cases.
- Mortality governance framework has revised to reflect national guidance.
- The reduction in formal complaints by 10% and implementation of public Wi-Fi across the hospital site.
- The embedded partnership approach to DTOC’s and the significant impact seen in year reduction in bed days lost

Further acknowledgement was noted by the Committee regarding the achievements made in year against the backdrop of significant winter pressures experienced by the trust.

Discussion took place regarding the proposed 12 high level priorities recognised. It was agreed that the Committee supported the proposed priorities identified within the strategy domains for 18/19. However target trajectories need to be confirmed at the Quality Forum after external input has been sought from the CCG.
**Action** – DDNQ to seek external input from the CCG regarding the 12 priorities identified.

Once agreed, these priorities will be reflected in the Trust Annual Accounts.

Discussion took place regarding the identified priorities being subject to spotlight topics throughout the year in order to track the progress being made against each priority.

**Action** – Ms Harrison to speak with the DNPQ regarding a spotlight schedule and the priorities listed within the strategy.

### ANY OTHER BUSINESS

**18/19**

**Key Items for the Chair to be reported to the Board**

**Points for Assurance**

- The Committee approved the updated SQS terms of reference & annual report for 2017-18 and agreed initial priorities for 2018-19 annual work plan
- The Committee acknowledged progress made in 4Q across the four 2017-18 Quality Strategy domains and in particular advances made in harm free care across Acute and Community services (e.g. reduction in Clostridium difficile cases and avoidable pressure ulcers and falls); improving outcomes (e.g. updated mortality governance); listening & responding (e.g. reduction in complaints and introduction of Wi-Fi) and Integrating Care (e.g. embedded partnerships to reduce delayed transfers of care). it was noted that these achievements have been made against a backdrop of significant winter pressures.
- The Committee supported the proposed high level priorities across the four Quality Strategy domains for 18-19, noting that trajectory targets need to be confirmed by the Quality Forum (once CCG input has been taken account of) and that these priorities will be reflected in the Trusts Quality Account
- The national maternity survey issued by CQC in January confirmed the very positive feedback and ratings for the trust.
- The trust achieved all cancer standards including the 62 day maximum wait in January.
- The Q3 Complaints, incidents, claims and patient experience report was reviewed and the committee noted the improvements made in name band incidents and confidentiality breaches as a result of actions taken on these areas. End of Life care documentation will be prioritised for similar review and action as part of the 2018/19 Quality Strategy

**Emerging Risks & Mitigating Actions**

- Acknowledging the public consultation due imminently for Millbrook Unit closure, the relevant Trust team members will be meeting with Cheshire & Wirral Partnership colleagues in relation to the ongoing and future provision of the Mental Health Act administration arrangements and associated service level agreement.
- There were 32 mixed sex accommodation breaches in January due to operational and capacity issues. Staff made all efforts to ensure privacy and dignity were maintained
- 39 patients waited more than 12 hours from decision to admit to being admitted to the ward in January. No patient harm has been identified arising from these delayed ward admittances. No serious incidents associated with
ED overcrowding have been reported demonstrating all ongoing mitigation and escalation actions have proved effective to aid patient flow but RCAs have been undertaken for all cases and any learning will be shared and applied. There were no complaints relating to the 4 hour ED access standard in this month.

- Community nursing teams continue to trigger and Waters Green triggered in January. In addition to ongoing action plans, the teams are applying the recently issued national community nursing dependency tools and are reaching out to other community nursing teams who have applied new care models.

<table>
<thead>
<tr>
<th>18/20</th>
<th>Any Other Business</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There was no any other business raised.</td>
</tr>
</tbody>
</table>

**CONSENT ITEMS**

| 18/21 | None |

**FOR INFORMATION**

Chairman’s Confirmation of Agenda items for March meeting (not standing items):
- Integrated Safeguarding Sub-Committee Annual Report and Self-Assessment
- Quarterly Quality Strategy Update – Integrated Care
- Assurance Framework and Risk Register (for Cmte only)
- Spot Light- End of life care

**Date and time of next meeting:**
Tuesday 27th March 2018
12:00 – 14:00
Boardroom 1
## Agenda Item 16: TB 18 (37)

**FINANCE, PERFORMANCE & WORKFORCE COMMITTEE**

**MINUTES OF MEETING HELD ON:**
Thursday 22nd February 2018
8.30 – 10.30

**Meeting Chair:** Mike Wildig  
**Meeting Secretary:** Janine Homer  
**Venue:** Boardroom 1

### PRESENT

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Abb.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Mike Wildig</td>
<td>Non-Executive Director</td>
<td></td>
</tr>
<tr>
<td>Mr Ian Goalen</td>
<td>Non-Executive Director</td>
<td></td>
</tr>
<tr>
<td>Dr Anthony Coombs</td>
<td>Non-Executive Director</td>
<td></td>
</tr>
<tr>
<td>Mr John Wilbraham</td>
<td>Chief Executive Officer</td>
<td>CEO</td>
</tr>
<tr>
<td>Mr Mark Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
</tr>
<tr>
<td>Julie Green</td>
<td>Director of Corporate Affairs and Governance</td>
<td>DCAG</td>
</tr>
<tr>
<td>John Hunter</td>
<td>Medical Director</td>
<td>MD</td>
</tr>
<tr>
<td>Rachael Charlton</td>
<td>Director of Human Resources and Organisational Development</td>
<td>DHR</td>
</tr>
<tr>
<td>Kath Senior</td>
<td>Director of Nursing</td>
<td>DNPQ</td>
</tr>
</tbody>
</table>

### IN ATTENDANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Abb.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steve Redfern</td>
<td>Deputy Director of Operations</td>
<td>DDO</td>
</tr>
<tr>
<td>Anne Marriott (for part of Agenda Item no. 18/15 only)</td>
<td>Associate Director for Acute and Integrated Community Care</td>
<td>AM</td>
</tr>
<tr>
<td>Wendy Barker (for part of Agenda Item no. 18/14 only)</td>
<td>Education Business Manager</td>
<td>WB</td>
</tr>
<tr>
<td>Ruth Knighton (for part of Agenda Item no. 18/14 only)</td>
<td>Workforce Lead for Engagement, Wellbeing &amp; Inclusion</td>
<td>RK</td>
</tr>
</tbody>
</table>

### Agenda

<table>
<thead>
<tr>
<th>Agenda No</th>
<th>Agenda Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>18/09</td>
<td>Apologies</td>
<td>None received</td>
</tr>
<tr>
<td>18/10</td>
<td>Minutes of meeting held 25th January 2018</td>
<td></td>
</tr>
</tbody>
</table>

It was noted that this month's agenda referred to the minutes of the previous meeting being November rather than January.

Mr Goalen referred to item number 18/06 Performance Report, page 4 para 2 and the following amended statement was agreed:

*The DNPQ responded that there are still processes that require improvement, despite improvement in DTOC. The Trust has had some days where there has been improved ED flow but overall performance is very fragile and with the current case mix does not provide assurance that the standard is achievable in*
the foreseeable future.

Following these amendments, the minutes were agreed as an accurate record.

<table>
<thead>
<tr>
<th>18/11</th>
<th>Matters arising</th>
</tr>
</thead>
<tbody>
<tr>
<td>None.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18/12</th>
<th>Action points from previous meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>9507 – The DNPQ and DHR met 21/02 and a report is due back at the March meeting. Action to remain open.</td>
<td></td>
</tr>
<tr>
<td>9525 – completed, action closed.</td>
<td></td>
</tr>
<tr>
<td>9526 – completed, action closed.</td>
<td></td>
</tr>
<tr>
<td>9527 – completed, action closed</td>
<td></td>
</tr>
<tr>
<td>9528 – completed, action closed.</td>
<td></td>
</tr>
<tr>
<td>9529 – Action not due until March meeting.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18/13</th>
<th>Annual work plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>No amendments made.</td>
<td></td>
</tr>
</tbody>
</table>

**Workforce Report Inclusive of the below appendices**

<table>
<thead>
<tr>
<th>18/14</th>
<th>Workforce Risk and Mitigation Report – with monthly KPI dashboard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Development – Apprenticeships</td>
</tr>
<tr>
<td></td>
<td>Gender Pay Gap Report</td>
</tr>
<tr>
<td></td>
<td>HEE Consultation approach</td>
</tr>
</tbody>
</table>

The Chair welcomed Wendy Barker, Education Business Manager, to the meeting to present the spotlight on apprenticeships, who highlighted:

- The apprenticeship levy was introduced in April 2017;
- There are 22 levy-funded apprenticeships at ECT against a forecast of 44. This is on track to be achieved by May;
- Two thirds of apprentices are non-clinical;
- Approximately 90% are existing staff, with the majority below degree level;
- it is unlikely that the full levy amount will be spent;
- Collaboration with Macclesfield College has been a success, a good example of this is the bespoke programme the College is developing for the new Maternity Care Assistant role.

In response to questions from the Committee the following points were clarified:

- The relationship with Macclesfield College is reciprocal and ECT is looking to take on work experience learners from the College;
• The Trust is already working with other institutions such as Edge Hill, Chester, South Cheshire College and Manchester Metropolitan University and also hosts pre-registration students;
• The Trust is not an outlier in not fully utilising the levy;
• Currently the monthly cost of £33k could fund between 50-60 individuals at £600 per person per month;
• The NMC recognise that not being able to use the levy to pay for backfill is an issue within the health sector. The cost of backfill is typically £40k per person over two years in the case of Nursing Associates.

The DNPQ acknowledged the positive contribution that WB has made to support the scheme – noting that there is no pipeline for nursing.

WB noted that Whiston hospital are putting 10 HCAs through the degree nursing apprenticeship with Edgehill.

The DHR presented the workforce report, highlighting:
• The national workforce strategy consultation is being responded to;
• Deployment gaps (sickness, maternity leave) are now impacting on training, temporary staff spend and staff resilience. Nursing vacancies remain a concern; Dr Coombs noted the negative impact of development and engagement and the DHR confirmed this is being closely monitored by the DDO;
• Sickness rates increased during January;
• Agency spend was higher than the trajectory for the first month this year, however, the Trust will achieve its plan.

In response to a question from the chairman, the DNPQ confirmed that the consultation regarding the implementation of the community hubs would take place over two weeks with no reduction in workforce.

The CEO referred to the improvement in Trust total vacancies from 5.86% in April 2017 to 4.9% in Jan 2018 and also Nursing and Midwifery Registered vacancies from 10.3% in April 2017 to 6.85% in Jan 2018. Although acute nursing vacancies remain unchanged, it is noted that the overall position has improved.

The Chair welcomed Ruth Knighton to the meeting to present the Gender Pay Gap report as follows:
• The report forms part of the ESR-published NHS Workforce Profile dashboard and is uploaded to the Trust website;
• It is expected that the report will be in line with other organisations;
• The average pay findings are affected by the percentage of males in the Medical and Dental (58%) and Consultants (69%) profiles;
• Agenda for Change requires an audit to make sure that hourly rates align.

Mr Goalen asked about the purpose of the scheme in particular from a national perspective and the DHR responded that this has been issued from the Government’s Equalities Office in order to provide a better understanding on workforce diversity.
It was noted that the pay gap is minimal in all areas with the exception of ‘medical and dental’ and ‘personal salary’ categories.

In response to a comment from Dr Coombs, the DHR acknowledged that more work is required around Clinical Excellence Awards, where 22% of males are in receipt of awards compared to 9% female.

The DDO asked whether Waiting List Initiative payments are taken into account as it is nationally reported that these are more likely to be taken up by men and RK clarified that this would be classed as part of pay rather than bonuses.

Mr Goalen noted that employing more men would reduce the gender pay gap and RK confirmed that this is being taken into account in resourcing plans.

The DNPQ mentioned the issues of attracting more men into nursing and the DHR replied that school-based initiatives are targeting this issue.

### Finance Report Inclusive of the below appendices

<table>
<thead>
<tr>
<th>18/15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Finance Risk Report</strong></td>
</tr>
<tr>
<td><strong>QIPP Report (including milestone delivery plan and risk register)</strong></td>
</tr>
<tr>
<td><strong>Repeating representations – Revolving Working Capital facility</strong></td>
</tr>
<tr>
<td><strong>Financial Plan – Risks and Assumptions</strong></td>
</tr>
<tr>
<td><strong>Quarterly Capital Update</strong></td>
</tr>
<tr>
<td><strong>Directorate Presentation – Acute and Integrated Community Care</strong></td>
</tr>
</tbody>
</table>

Anne Marriott, the Associate Director for Acute and Integrated Community Care (AM) was welcomed to the meeting and presented the Directorate’s QIPP report:

- Target £1.156m, achieved £650k ytd;
- £503k of schemes are recurrent;
- All key schemes have been completed;
- Remaining schemes underway at Month 10 are –
  - Review of Paediatrics SLAs
  - Increased activity from Respiratory
  - Best practice tariff
  - Cardiology loop device
  - Virtual respiratory clinics
  - Endoscopy Gastro activity
- The target of £1.730m for 2018/19 includes the unachieved QIPP from 2017/18
- The recent QIPP workshop identified several area for next year which are already in progress as follows:
  - Outpatients and Community – focusing on the most productive specialties such as respiratory and gastro;
  - The epilepsy, rheumatology and Parkinson’s services are under review;
  - Development of virtual respiratory clinics;
  - ‘Right care, right place’ eg consider transferring rheumatology clinics to GPs;
  - Reduction in peripheral work;
  - Intermediate care review;
  - Optimise best practice tariff for Inpatients;
Utilise model hospital data around specialties with low activity volumes;
LoS drivers – a Multi-Disciplinary Discharge Event (MADE) is being held week commencing 26th February;
Some estates opportunities exist in Congleton and Knutsford but these would require CCG agreement.

In response to a question from Dr Coombs, AM clarified that work is ongoing to establish how much the reduction in fixed costs as a result of removing peripheral clinics.

The Chair asked about the overall QIPP total if all schemes were achieved; AM could not confirm an overall figure, noting that significant work up was required, particularly for more strategic schemes. She added that the QIPP target remains a significant challenge, as does identifying areas where costs could be taken out.

It was noted that the only clinical lead at the workshop was the Clinical Director and AM commented that learning from this year’s planning means a structured approach in working up viable plans and holding people to account.
The CEO stated that more focus is required on what can be achieved during 2018/19 as well as longer term plans.

Mr Goalen asked for clarity regarding the cost reduction of £310k and why it was not QIPP and the DoF replied that QIPP can be either income or cost reduction.

When the transfer of services from South and Vale Royal took place, the Trust was required to find £310k.

The DoF continued with the Finance Report, highlighting:

- **Income and Expenditure**
  - The Trust is in a ‘break even’ at Month 10;
  - Pay expenditure is £630k adverse variance against plan with agency increasing from £562k in Month 9 to £820k in Month 10;
  - Elective income at Month 10 was £115k adverse to plan and non-elective income £200k better.

- **Capital**
  - £853k behind plan but being closely monitored;
  - The profile has changed to take into account winter pressures;
  - £130k has been reallocated to medical equipment to absorb some of the slippage and there is confidence that the full capital spend will be achieved.

- **Financial Control Target 2018/19 (FCT)**
  - In September 2017, the Trust accepted a FCT deficit of £19.4m for 2018/19;
  - A similar target exists for A&E however RTT is based on list numbers rather than waiting times;
  - The agency ceiling cap has been reduced by £1m;
  - The FCT has been adjusted for any failure in A&E performance;
  - The CNST changes allowance looks understated;
  - The National risk reserve of £0.3m is helpful;
  - £5m QIPP requirement is challenging;
QIPP is a varying percentage across the Directorates – key areas are AICC and PC due to non-delivery this year.

In response to a question from the Chair, the DoF confirmed the adverse impact of the unmet £1m A&E funding during Q2 and Q4 would be met through reserves and CQUINs.

It was noted that whilst Trust-wide had over-achieved, overall Directorate performance was behind plan and the DoF commented that income had underperformed, requiring better controls on expenditure and a focus on productivity.

The CEO suggested consideration be given to the principles of central releasing ‘in month’ as part of the Board’s budget setting. The DNPQ said that results were based on both planning and delivery; discussions are ongoing in certain specialties to avoid rolling over plans that will not be achieved in the next year.

With reference to a question from Mr Goalen about non-pay expenditure ‘other’, the DoF confirmed that £183k has been released, including some from CQUIN reserve and £36k from a tribunal provision.

The CEO noted that more clarity is being sought from NHSI regarding the changes to the RTT target and that the A&E target is 90% by September 2018 and 95% by March 2019.

Mr Goalen queried increasing elective admissions when bed occupancy is 150% of actual and the impact this would have on LoS performance. The CEO responded that more scrutiny is required, taking into account the risk of the CCG not continuing to fund the extra community beds.

A further discussion took place about QIPP targets for 2018/19 and the following points were noted:
- It was decided at EMT not to load QIPP to areas that over achieved in 2017/18;
- Historically, QIPP has always been allocated equally;
- Allied Health has been allocated a lower target as an effective reward for over-achieving during 2017/18;
- To give a higher target to areas that have over-achieved ultimately risks disengagement;
- Within the model hospital, surgery is the most efficient nationally;
- Extra support is being provided where necessary;

Performance Report Inclusive of the below appendices

18/16
- ED 4-hour standard
- 18 weeks RTT standard
- 62 day cancer standard
- 6 week access to diagnostics
- Community activity and outcomes including Hubs
- Operational efficiency indicators (theatres, outpatients, bed utilisation)
- GP referrals profile
The DNPQ presented the performance report highlighting:
- A&E performance has plateaued since December and is 70.2% MTD with increasing attendance levels of majors such as pneumonia and respiratory;
- DTOC numbers change daily but averaged 12 during January;
- LoS increased slightly to 6%.

The CEO commented that although ED performance will not achieve plan this quarter, the Trust’s activity is reasonable when compared to other Type 1 trusts.

Dr Coombs asked whether the A&E Delivery Board are clear on what changes are required to increase performance from 70% and the DDO referred to the MADE event which will receive input from across all of the Eastern Cheshire system and aims to independently challenge patient LoS, identify themes and agree real time actions.

The DNPQ added that the current focus in ED is on proactively sending patients to the Discharge Lounge and turning beds around within 30 minutes. It is accepted that ED cubicle space is manageable if patients are moved to inpatient beds but if the overall system is congested then exit from ED becomes an issue.

The Chair asked whether the 90% target could be achieved next year and the DNPQ replied that September is the target for this.

The DNPQ commented that the Trust is utilising Medinet at weekends and is on target to achieve the diagnostic standard recovery plan by the end of March. Medinet are carrying out routine not complex work. The majority of lists are now achieving 12 points and most of the challenges that the consultants raised have been resolved.

The Chair queried the residual risk of non-delivery of the RTT standard into 2018/19 and the DNPQ noted that a specialty-level trajectory has been put in place.

The DDO added that restarting the elective programme fully after January will provide an additional challenge as treating patients chronologically means that lists going forward will be subject to delays.

The Chair queried the success of the winter plan and whether any learning had been identified. The DDO replied that the extra beds in community had been the equivalent of opening ward 5 last year, therefore capacity had been maintained, however the types of patients and levels of complexity had impacted this year.

The CEO remarked that the level of discussion at A&E Delivery Board had also contributed as had the escalation policy. The challenge lies in achieving 85% bed occupancy.

<table>
<thead>
<tr>
<th>18/17</th>
<th>Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>The DCAG referred to the Terms of Reference and asked the Committee whether any further delegated authorities should be included for recommendation to the Board.</td>
<td></td>
</tr>
</tbody>
</table>
The Chair referred to 10 General Responsibilities and Principles specifically Workforce 10.02 ‘To provide assurance that the Trust is working within legislation and a good employment framework’ and the DHR confirmed that this forms part of the workforce strategy and assurance is provided through the monthly workforce report.

The DCAG suggested strengthening the annual workplan to include key issues following monthly review. It was recommended that the phrase ‘To seek assurance on the risks associated with…’ should be also applied to Finance and Performance and the CEO recommended a further change to ‘To seek assurance on the performance and associated risks…’

In response to a question from the Chair regarding ‘Any interest in the matter under discussion (as defined in Standing Orders) will be declared’, the DCAG confirmed that going forward this has now been added to the agenda for all decision-making committees.

1. The Chair queried inclusion of the phrase ‘These terms of reference may be subject to further amendment following a deep dive review of the outcomes of the recent self-assessment on committee effectiveness, which is still being worked through’ and it was noted that the annual self-assessments form part of the annual report and are previously referenced under ‘13 - Annual Review of the Finance, Performance and Workforce Committee’.

Mr Goalen queried whether the finances relating to the Healthcare Partnership should be delegated to this committee and the DCAG drew his attention to 10.4 Other Matters ‘The Committee will look to see how finance, workforce and performance initiatives align with those of partner organisations’. It was agreed that this could be reviewed again if that delegation were made.

The Committee approved the Terms of Reference subject to the above amendments.

Date and Time of Next Meeting:
Thursday 29th March 2018
08:30-10:30,
Boardroom 1 NAH