EAST CHESHIRE NHS TRUST

MEETING OF THE TRUST BOARD

NOT FOR PUBLICATION BEFORE

Thursday 6th December 2018

3.00 PM

Boardroom 1, New Alderley House, Macclesfield District General Hospital

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Dear Colleague

TRUST BOARD MEETING

A meeting of the Trust Board will be held at 3.00pm on 6th December 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.

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<thead>
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<tr>
<td>1. Patient Story</td>
<td>Director of Nursing, Performance and Quality</td>
<td>15 mins</td>
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<tr>
<td>2. Apologies</td>
<td>Chairman</td>
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## ASSURANCE ITEMS

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<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
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<tr>
<td>- Declared interest agenda</td>
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<td>- Hospitality and Gifts Register Declaration</td>
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<tr>
<td>4. Minutes of the November 2018 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 18 (88)</td>
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<tr>
<td>5. Matters Arising</td>
<td>The Chairman</td>
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<td>6. Action Log</td>
<td>The Chairman</td>
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<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>
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<tr>
<td>SQS Committee</td>
<td>Mr M Wildig</td>
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<tr>
<td>FPW Committee</td>
<td>Mr I Goalen</td>
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## STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

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<tr>
<td>8. Chief Executive’s Report</td>
<td>Chief Executive</td>
<td>30 mins</td>
<td>TB 18 (89)</td>
<td>All corporate objectives</td>
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<tr>
<td>9. Board Assurance Framework and Corporate Risk Register</td>
<td>Director of Corporate Affairs and Governance</td>
<td>10 mins</td>
<td>TB 18 (90)</td>
<td>All corporate objectives</td>
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<tr>
<td>10. Learning from Deaths Quarter 2 Report</td>
<td>Medical Director</td>
<td>10 mins</td>
<td>TB 19 (91)</td>
<td>All corporate objectives</td>
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<tr>
<td>11. Standing Agenda Item: Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register</td>
<td>Chief Executive</td>
<td>5 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
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ANY OTHER BUSINESS

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<th>AGENDA TOPIC</th>
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<tr>
<td>12. Public Trust Board Agenda –</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 18 (92)</td>
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<tr>
<td>February 2019</td>
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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>
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<th>REASONS FOR PRESENTING</th>
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<td>13. Public Trust Board Year at a Glance</td>
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<td>For information</td>
<td>All corporate objectives</td>
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<td>14. Chairman’s Commentary</td>
<td>TB 18 (94)</td>
<td>For information</td>
<td>All corporate objectives</td>
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<tr>
<td>15. Fit and Proper Persons Policy</td>
<td>TB 18 (95)</td>
<td>For information</td>
<td>All corporate objectives</td>
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<tr>
<td>16. Safer Staffing Exception Report</td>
<td>TB 18 (96)</td>
<td>For assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
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<td>STAFF - Empower, develop and value staff in providing innovative patient focused care</td>
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<td>17. Minutes of the committees of the Board:</td>
<td>TB 18 (97)</td>
<td>Information</td>
<td>Information</td>
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<tr>
<td>SQS Committee</td>
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<tr>
<td>- September 2018</td>
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<td>- October 2018</td>
<td>TB 18 (98)</td>
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<td>FP&amp;W Committee</td>
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<td>- October 2018</td>
<td>TB 18 (99)</td>
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<td>Audit Committee</td>
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<td>- September 2018</td>
<td>TB 18 (100)</td>
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Date and Time of Next Meeting:

Date: Thursday 7th February 2019
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
Voting Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Abb.</th>
<th>Present</th>
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<tbody>
<tr>
<td>Mrs L McGill</td>
<td>Chairman</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>Mr I Goalen</td>
<td>Non-Executive Director</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>Mr M Wildig</td>
<td>Non-Executive Director</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>Dr A Coombs</td>
<td>Non-Executive Director</td>
<td>-</td>
<td>X</td>
</tr>
<tr>
<td>Ms A Harrison</td>
<td>Non-Executive Director</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>Dr P Madden</td>
<td>Non-Executive Director</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>Mr J Wilbraham</td>
<td>Chief Executive</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>Mrs K Senior</td>
<td>Director of Nursing, Performance and Quality</td>
<td>DON</td>
<td>✓</td>
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<tr>
<td>Dr J Hunter</td>
<td>Medical Director</td>
<td>MD</td>
<td>✓</td>
</tr>
<tr>
<td>Ms R Charlton</td>
<td>Director of HR &amp; Workforce</td>
<td>DHR</td>
<td>✓</td>
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<tr>
<td>Mr M Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
<td>X</td>
</tr>
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Non-Voting Members

| Mrs J Green         | Director of Corporate Affairs & Governance     | DCAG | ✓       |

In Attendance

| Josie Nosworthy     | Executive PA / Minutes                         | -    | ✓       |
| Mr P Goman          | Staff Side Chair                               | SSC  | ✓       |
| Ms K Mason          | Deputy Director of Finance                     | DDoF | ✓       |

#### Agenda Item

1. **Staff Stories:**

The DoN welcomed Caroline Hardy, Team Manager, Michelle Richardson, Physiotherapist and Caroline Sugden, Community Matron from the Frailty Team who presented the story of Mr J, aged 75 as follows:

- Mr J is usually mobile, and arrived at A&E with increased confusion, reduced mobility, new incontinence and a cough. Mr J also suffers with Parkinson’s disease and associated dementia.

- Doctors in A&E diagnosed Mr J with a chest and urine infection and treated him with antibiotics. Whilst there was no clinical reason for admission, Mr J had reduced mobility and presented as drowsy.

- The Frailty Team assessed Mr J in A&E. It was established that there was adequate support at home and that the family were keen to avoid admission.

- The Frailty Team commenced mobility assessments and BP checks. They engaged with Mr J, mobilising him until he was able to sit comfortably, eat and drink.

- As a result of this early intervention in A&E, Mr J was discharged home with next follow-up in place. The same Frailty Team member reviewed Mr J the following day and found the confusion to be resolving.

- Blood pressure was re-checked and the patient was referred to the GP for a medication review.

- Referrals were made for carers assessment and to the community matron, and a review with the Parkinsons Nurse was booked.
The family of Mr J felt listened to and understood, and appreciated the involvement in care arrangements.

The comprehensive and holistic assessment of patient needs and wrap around care provided by the Frailty Team enabled the patient to avoid hospital admission and gain access to a number of additional services.

Ms Harrison questioned how the process is impacted without the support of family members. Ms Richardson advised that the Frailty Team have developed good links with intermediate care and can place patients directly in an intermediate care bed. For patients without family support, the wrap around system of care in place ensures that patients are reviewed in their home environments.

The Board recognised the dedication and commitment of the Frailty Team and congratulated them on a total of 32% of avoided admissions in 2017/18.

2. Apologies:
   - Director of Finance, whom was attending a national meeting in London
   - Dr A Coombs, Non-Executive Director

3. Register of Interests:
   - Declared interest agenda
     None declared
   - Hospitality and Gifts Register Declaration
     None declared

4. Minutes of the September 2018 meeting TB 18 (75)
   True and accurate record of meeting.

5. Matters Arising
   No matters arising.

6. Action Log
   (no open actions)
   No outstanding actions

7. Verbal update:

   **Address to Board members**
   The Chairman noted that Suzie Ackers Smith, the Mayor for Congleton and Mr David Brown, Conservative Councillor for Congleton had requested the opportunity to address the Trust Board. The first 10 minutes of the trust board meeting was given over to listening to their address in relation to the petition received by the Trust and the Congleton Minor Injuries Unit.

   **SQS Committee – October 2018**
   Ms Harrison provided an update from the SQS Committee, noting that on
Points for Assurance

- **Infection Control**: single case of Clostridium difficile and three cases of E-Coli in August. The Trust remains on target for infection reduction (C.Diff ≤ 13, E.Colii 50% reduction by 2021).
- **Harm Free Care**: improvements are seen across both hospital and community (both only slightly below 95% target)
- **The number of patient falls is below anticipated numbers**
- **Positive Friends and Family test across all areas**
- **The trust met the two week wait standard for cancer**.
- **SQS committee reviewed the Assurance Framework and Risk Register and confirmed agreement of the listed risks**.
- **SQS approved the Quality Strategy update. A focus on job plans may help with capacity**.
- **Spotlight on Community Nursing and progress with Integrated Teams**: very substantial progress being made with Clinical Leads (GPs) now appointed in all five areas and a wide range of local initiatives being taken to improve care and increase efficiency. Many good examples of cross functional working and implementation of Buurtzorg principles.

Emerging Risks & Mitigating actions

- **Overall** - below target performance in August in most key areas due to increased operational pressure, in common with peers. Useful analysis of patient flow and capacity needs completed by Venn Consulting
- **A&E 4 hr performance** at 81.1%, however no complaints have been made. Actions are being maintained through A&E Delivery Board.
- **Diagnostic waiting times** have declined. Actions include out of area referrals suspended, capital approval for new equipment, priority for Echocardiography
- **62 Day Cancer Standard** was not met at 71.9%, with 5 breaches over 104 days
- **RTT standard**: Backlog of patients waiting more than 18 weeks is slightly lower than July. No 52 week breaches have occurred. Most specialties not achieving 92% standard. Action to limit referrals for three services (cardiology, gastroenterology and general surgery) and implement WLIs if there is clinical risk
- **RADAR**: One area triggering in August and being kept under observation
- **Medical consultancy shortages in haematology, cardiology and care of the elderly remain**. Partnership working / recruitment essential for long term service sustainability.
- **79 mixed sex breaches due to capacity and bed availability**. All efforts being made to retain patient privacy and dignity
- **DTOC** has increased to 5.6%
- **Key actions/factors identified to be addressed to relieve overall operational pressure**
FPW Committee – November 2018
Mr Wildig provided an update from the FPW Committee, noting the following.

**Finance**
- Result to month 6- Sept - £31k positive variance to Plan. A stable position but fragile in terms of being able to maintain it. Current month deficit of £217k is after income accrual release of £238k release and £700k STF funding.
- Original control total (before STF funding for A&E of £1.7m)) was £20.9m but we have agreed to reduce to £19.9m. We will get STF of £2m so Plan becomes £17.9m. A level of confidence expressed that, subject to the effects of winter, the Plan is achievable for the year.
- QIPP schemes, target 5m for 18/19 of which we have delivered £2.6m of Blue schemes. Not enough schemes to date, total in the pipeline is £3.8m of which £3.2m is recurrent. No real movement since last month and we will need to re-focus for next year.
- Planned Care Directorate (income) and Acute and Integrated Community Care Directorate (pay costs) are behind Plan and are receiving actions and challenges.
- Loans and Cash – Revised Plan shows cash requirement of £16.2 m for the year. Nothing drawn down to date. November draw down will be £2.2m.
- Quarterly Capital Update – Planned capex for year was £5.2m. We also have £127k for Wi-Fi expansion. £5.2m is made up of £2.9m own resources, £900k of cash balance for outpatients and £1.4m equipment finance lease for CT Scanner. Revised plan is £5.4m. Capex to Sept is £1.1m against plan to Sept of £1.5m. Slippage will catch up in November.
- Outpatients £900k. £600k deferred to next year replaced by medical equipment brought forward, subject to confirmation from NHSI.
- Includes £127k for capital element of winter plan.

**Performance**
- **ED 4 hour** performance for Sept was 81.7% - behind trajectory of 90%. In June we achieved 95.79% but dropped back to 88% in July and 81% in August.
- Operational pressures with high bed occupancy has had a significant impact on flow.
- It was noted that admissions in September were nearly 2.6% higher than previous year despite 3.5% lower attendances. This confirms that people are presenting with increased complexity and therefore more poorly.
- Large amount of activity continues to address improved flow
- Winter plan has been agreed with the A&E Delivery Board and the CEO may wish to say more about this in his report.
- No positive assurance that we will achieve the trajectory in the near future by the year end.
- No breaches of the 12 hr standard.
- **92% RTT** standard – achieved 80% in Sept. 9 specialties not achieving. Targeted action to improve performance is being undertaken.
• No 52-week breaches in August or Sept. One breach year to date.
• Requirement for 18/19 is to maintain waiting lists at the same level as March 2018, currently projecting over 400 above target for the end of March 2019. Actions are in place to reduce this level.
• **Diagnostics** – still a major challenge with performance at 81.6% in September, due to clinicians being unable to pick up dropped lists in endoscopy, although 2 week waits have been booked and standards met. A number of actions are in place to improve performance. At 81% we are an outlier so urgent action is required.
• **Cancer Targets** – did not achieve the 62 day standard in Sept 2018 at 72.16% against target of 85%. There were 9 breaches. Particularly areas causing the delays are the subject of focus.
• The 2 week wait standard was achieved.
• **GP Referrals** – some analysis of monthly referrals was received to start to build a picture of the position. More analysis is required and will be reported at a later date.
• **Emerging Risks** – include winter planning for 2018/19 with concerns over workforce availability, financial commitment and delivery of performance standards. Continued under performance against the 4 national standards and seeking to improve productivity further for diagnostics, theatres and outpatients.

**Workforce**

• **Resourcing** – Overall vacancy rates have reduced further to 4.9% which is the lowest this financial year. 12 month rolling turnover has also reduced compared to last year and turnover for ‘nursing staff at 7.86% is at its lowest point since before April 2016.
• However, we still have high levels of Acute Nursing vacancies which remain at over 15%. Recruitment initiatives continue, together with Retention strategies
• Medical staff vacancy rates have reduced to 7.02% and we are showing good progress.
• Community nursing is fully established but maternity leave (8%) and sickness (4%) have a big impact.
• **Total pay bill** has increased in month by £89k from August, due to the commencement of some new appointees. Agency spend is in line for the month with agreed actions in place to reduce spend.
• Impact of Winter Plan not factored into the agreed agency plan so extra monies are being made available from internal resources to help mitigate the cost.
• **Engagement and Wellbeing** – Sickness absence rates have increased to 4.6% against a target of 4.3%. We will have a spotlight on sickness absence next month.
• **Development** – Annual Clinical Update and Core Clinical e-Learning compliance remains below trajectory because of operational pressures although have increased in month.
• Last month, Spotlight on apprenticeships and vocational learning. Good presentation and trajectory to achieve target this year of 60 new apprenticeships for 18/19.
• Also, GMC Annual Trainee and Trainer Survey 2018 report received. A good report and generally showing an improved position compared to the previous year
• **Existing and emerging risks** – workforce demands continue to impact
on key metrics, specifically clinical training and appraisals and temporary staffing spend. Acute nurse vacancy rates remain a concern particularly with the onset of winter. To Note; vacancies within the medical workforce cause capacity issues and higher agency spend.

Audit Committee – September 2018
Mr Goalen provided an update from the Audit Committee, noting the following.

- The Committee welcomed Dr Madden as a member of audit committee.
- The BAF and CRR were considered and the Committee received assurance around the following:
  - Actions have been identified regarding the escalating risk of increased waiting times.
  - Acute nursing vacancies – current focus is on developing a retention plan and recruitment campaigns are ongoing.
- Discussion around the procedure for risks that have not achieved the target score by the specified target date. An assurance report will be provided at the next meeting.

Internal audit:
- Data Quality Review 2017/18 gained significate assurance.
- Quality Spot Checks 2018/19 gained moderate assurance, with two areas of concern highlighted – fire exits blocked by moveable equipment and temperature and location issues around medication refrigerators.
  The DCAG noted that the fire exits are now checked on a weekly basis and no further concerns have been identified. All medication refrigerators now have new thermometers in place.
- Counter fraud progress report was positive overall, the level of fraud within ECT being very low in comparison to other organisations.
- External audit – interim audits are scheduled to begin in December 2018.
- Losses and Compensations were reviewed and the Committee noted the significant loss incurred in respect of destruction of pharmacy stock. The Committee acknowledged the level of reduction over time and agreed that future reports would include five year analysis data.
- No audit recommendations were received.
- The trust Overpayments Policy was noted as updated.

STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

8. Chief Executive's Report TB 18 (76)

The Chief Executive Officer (CEO) presented his report, highlighting the following:

MIU
- It was noted that a small demonstration has taken place outside the Congleton War Memorial Hospital to show support for the continuation of the Minor Injuries Unit (MIU).
- The CEO stated that there have been no decisions made regarding the formal closure of the MIU. The MIU will continue to be closed at weekends and the CEO maintained that the unit will close on a temporary basis if patient demand in the Emergency Department (ED) dictates the need to relocate staff to utilise skills.
- The number of people accessing this service is small and reducing, with the attendees dropping from 5,704 in 2015/16 to 3,682 in 2016/17, with
the reduction seen prior to any closures as a result of flexible staffing requirements

- Numbers significantly reduce in 2017/18, however this has been attributed in part due to the closure of the service.
- Analysis of the volume of patients treated at the MIU shows that 72% of all patients were not registered with Congleton GP services.

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<th>Winter Plan</th>
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<tr>
<td>Plans are being finalised through the A&amp;E Delivery Board to prepare in the best way possible to maintain patient safety through the winter months.</td>
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<td>Two videos have been produced by the communications team entitled ‘Helping Flo’ which will be played within and outside of the organisation to help inform our local population about actions that can be taken by everyone to help with patient flow.</td>
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<td>Actions are being planned to enable the system to be proactive and not reactive during the winter period.</td>
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Measure include:-

- Utilising £300k of capital resources to move the discharge lounge to a more central location with the view that it will be easier to utilise from ED. |
- As pressure builds the trust is looking to change a surgical ward into a medical ward alongside recruiting additional medical/clinical staff to provide best possible care whilst managing in patient length of stay. |
- Emphasis will continue on the Flu vaccination campaign. The trust is currently at 32% against a national target of 70% which is an improved position in comparison to this time in 2017/18. |
- Eastern Cheshire Clinical Commissioning Group (ECCCG) is investing in additional out of hospital capacity. |
- Cheshire East Council (CEC) have received £1.45m of an allocation to Local Authorities specifically to ease winter pressures. The DoN advised that a meeting will take place between Council representatives and ECCG to determine how best to utilise the additional resource. |
- Financial risks include the control of agency spend in an increasingly pressured winter context. |
- Workforce risks are around the necessary use of agency staff to implement the winter plan. Block booking of agency staff is taking place where possible. |

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<tr>
<td>A performance notice has been received from ECCCG regarding patient access standards. A response has been issued and the trust is working constructively with ECCCG to agree how the position can be rectified.</td>
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<tr>
<td>Challenges over the last few days have resulted in a deterioration in the A&amp;E standard, with bed capacity having a major impact on performance.</td>
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<td>Opportunities for improvement include daily achievement of the Delayed Transfers Of Care (DTOC) trajectory.</td>
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<td>This is impacted by patient complexity and the number of Deprivation Of Liberty (DOLs) patients requiring a 1:1 nursing ratio.</td>
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<tr>
<td>The trust is consistently under-achieving the 62 day cancer standard, having plateaued in the last three months at around 73% against the 85% standard.</td>
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- A number of initiatives have put in place to improve the number of patients waiting to complete their cancer treatment and the length of time from first attendance.
- An additional £58k has been received to assist with the reduction of the Endoscopy backlog of follow up patients.
- Recruitment is in place for an Endoscopy Nurse and challenges addressing productivity have resulted in an increase from 8.5 to 9.5 points per list, demonstrating an improved performance.
- Despite underachieving against the standard a review of performance for the year at type 1 Emergency Departments shows the trust performing relatively well as demonstrated in the table within the report.

9. Estates Strategy Update TB 18 (77)

Rob Few, Head of Estates presented the Estates Strategy Update to the Board, asking them to note the contents and approve the strategy.

Key points were highlighted as follows:
- The trust operates across three hospital sites and the community partnership estate.
- The estate rationalisation programme has assisted in improving the delivery of clinical service and ‘critical mass’ on site.
- Metrics show good occupancy level, with a good ratio between clinical and non-clinical space.
- The trust will align its estate strategy with Cheshire and Merseyside Health and Care Partnership to give a strategic focus to estates as a key enabler to support the delivery of the best solutions to service local populations.
- Capital investment will be focused on the owned estate, including improvements to the Outpatients department and upgrading operating theatres.

The Director of HR (DHR) asked how staff are engaged and contributing to the development of the estates strategy.

Mr Few advised that assessments are undertaken which in turn informs quality metrics and stakeholders engagement and sign off is sought for proposed work.

Mr Wildig questioned whether the proposed Outpatient redesign provides an opportunity to rework processes and implement efficiencies in addition to building work.

Mr Few advised that clinician input has been pivotal to the proposed changes to working practice alongside buildings.

The Board acknowledged the updates to the proposed Estates strategy and approved the principles of the strategy, noting further information and assurance will be provided going forward and the strategy will be managed in line with service changes over the next 5 years. Mr Few confirmed that the Estates strategy will be presented to the Clinical Management Board in January 2019.

10. Learning from Deaths Quarterly Report – Quarter 1 TB 18 (78)

The Medical Director (MD) presented the Learning from Deaths Quarterly
Report – Quarter 1, highlighting the following:

- The trust undertakes a two stage mortality review involving an initial mortality nurse screening followed by referral to consultant for identification of care deficiencies.
- Historically, the trust has reviewed every death in order to identify recurrent themes. Very few areas of significance have been identified and therefore the trust will now focus on reviewing 20% of all deaths.
- There has been a marked decrease in mortality at the trust in Q1 compared with Q4.
- One death was reported under the serious incident framework. This has been appropriately investigated.
- No deaths were found to be avoidable, however one death was found to have an avoidable element. This underwent an RCA investigation in line with trust policy. It was highly unlikely this would have altered the outcome on this occasion, however offers scope for improvements to care.
- Three patients with learning disabilities died at the trust; these were reviewed using the LeDeR methodology and were found to be unavoidable.
- Improvements required were around accuracy of coding which could be improved with more robust note taking. Some inconsistencies were also found in the use of end of life care plans.
- Comprehensive quality improvement initiatives are underway to improve the management of seriously unwell patients at the trust.

The DoN asked for clarity around the timescales for undertaking mortality reviews.
The MD advised that mortality reviews are conducted within 2-3 weeks and the DCAG confirmed that this is an extremely timely process and compared very well when benchmarked.

The Chairman questioned the potential benefit of providing comparative data from the previous 5 years.
The MD advised that whilst the number of deaths is decreasing, this is in conjunction with a reduction in the number of admissions and therefore the mortality rate at the trust is gradually increasing, reflecting patients with increased complexity and whom are therefore more poorly.

**Action:** The MD agreed to investigate potentially useful comparative metrics.

---

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

None identified.

---

**ANY OTHER BUSINESS**


The Board agreed to align review of the Quality Strategy to the SQS Committee schedule and therefore this will be submitted to the board in March 2019.
### CONSENT ITEMS

<table>
<thead>
<tr>
<th></th>
<th>Public Trust Board Year at a Glance TB 18 (80)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>The Board received the Year At A Glance schedule.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Chairman’s Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>TB 18 (81) The Board received the Chairman’s Commentary. The Board noted the contents, acknowledging that the delay of both the presentation of the first compassion award and the mentorship of the Aspirant Chair Programme.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Safer Staffing Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>TB 18 (82) The Board received the Safer Staffing Exception Report and noted the contents.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Minutes of the committees of the Board:</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.</td>
<td>TB 18 (83) SQS Committee August 2018 The Committee received the minutes from the August SQS Committee meeting and noted the contents.</td>
</tr>
<tr>
<td></td>
<td>TB 18 (84) September 2018 The Committee received the minutes from the September SQS Committee meeting and noted the contents.</td>
</tr>
<tr>
<td></td>
<td>TB 18 (85) FP&amp;W Committee August 2018 The Committee received the minutes from the August FPW Committee meeting and noted the contents.</td>
</tr>
<tr>
<td></td>
<td>TB 18 (86) September 2018 The Committee received the minutes from the September FPW Committee meeting and noted the contents.</td>
</tr>
<tr>
<td></td>
<td>TB 18 (87) Audit Committee September 2018 The Committee received the minutes from the September Audit Committee meeting and noted the contents.</td>
</tr>
</tbody>
</table>

**Date and Time of Next Meeting:**

**Date:** Thursday 6th December 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>7194</td>
<td>Trust Board</td>
<td>01/11/2018</td>
<td>10</td>
<td>Learning from Deaths Quarterly Report – Quarter 1</td>
<td>The MD agreed to investigate potentially useful comparative metrics.</td>
<td>John Hunter</td>
<td>Dec-18</td>
<td>Included in Quarter 3 Mortality Report to be presented to the SDS Committee in February 2019. Recommend action closed.</td>
<td>Open</td>
</tr>
</tbody>
</table>
Report of:
Responsible Officer: Chief Executive
Accountable Officer: 

Author of Report: John Wilbraham, Chief Executive

Subject/Title Chief Executive’s commentary for the period ending 31st October 2018

Background papers (if relevant) N/A

Purpose of Paper To highlight performance issues and areas of risk to the delivery of the trust’s objectives

Action/Decision required No decisions are required of the Board

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

On Corporate Risk Register

Mitigates Risk Number: (identify) On Assurance Framework

Links to all risks identified within the Assurance Framework and the Corporate Risk Register

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 Positive impact on quality

Resource impact None

Impact of equality/diversity None

Avoid acronyms or abbreviations - if necessary list:
CQC – Care Quality Commission
SQS – Safety, Quality & Standards Committee
ED – Emergency Department
FT – Foundation Trust
NHS – National Health Service
MCFT – Mid-Cheshire Hospitals NHS Foundation Trust
UK – United Kingdom
EU – European Union
Chief Executive’s Commentary for the Period Ending 31st October 2018

1  INTRODUCTION

1.1 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 Board’s objectives.

1.2 Appendix A summarises the performance of the key indicators.

2  KEY ISSUES

The Board are asked to note the following issues

2.1 • An improvement in the number of patients on the trust’s waiting list but clinical concern regarding the length of wait in certain specialities;
• The small but positive financial variance;
• The constructive meeting with the Care Quality Commission regarding the trust’s improvement plan;
• Continued public concern regarding the Congleton Minor Injury Unit; and
• The review of possible impacts re BREXIT have been assessed as low risk to the organisation.

3  QUALITY AND COMPLIANCE – PATIENT SAFETY, PATIENT EXPERIENCE AND EFFECTIVENESS

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

3.1 Care Quality Commission (CQC) Improvement Plan

3.1.1 Following the publication of the CQC inspection report in April 2018 which rated the trust "Good", the Director of Nursing, Performance and Quality and the Director of Corporate Affairs and Governance have been leading the work on an improvement plan overseen by the Safety Quality and Standards Committee to address three areas of non-compliance.

3.1.2 A planned engagement meeting took place with the trust’s CQC Relationship Manager on Monday 19th November where positive assurance was provided on the progress of agreed actions and a proposed audit plan to ensure changes implemented are sustained.
3.1.3 Other topics discussed included:

- An update on the reviews currently underway in response to a Dr Foster Alert relating to sepsis. SQS is scheduled to receive a spotlight presentation on work throughout the trust on sepsis which was agreed will be shared with the CQC;
- An overview of the trust’s actions to improve the waiting time performance by March 2019; and
- Positive feedback from the trust on the inspection process and approach undertaken by inspectors.

The trust also received an update on the Well-Led Inspection programme going forward which is normally undertaken annually from the date of the publication of the inspection report.

3.2 Patient Access

The trust has seen a steadying of a number of access standards however there remains clinical risk for patients who are waiting for treatment

3.2.1 Performance against the ED 4-hour standard in October was 76.9% which is the lowest monthly performance in the current financial year.

3.2.2 A number of beds have not been available as fire precaution work has been undertaken in a number of bays across wards and this work will be completed in December. This together with the plans to redesignate surgical beds to medical beds and a small increase in the overall bed stock is the basis for facing the coming winter months.

3.2.3 In comparative terms the trust’s 4-hour standard compared to other Cheshire and Mersey “type 1” facilities is summarised below.

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EAST CHESHIRE NHS TRUST</td>
<td>95.26%</td>
<td>95.03%</td>
<td>95.58%</td>
<td>96.50%</td>
<td>98.40%</td>
<td>93.76%</td>
<td>90.92%</td>
<td>94.91%</td>
</tr>
<tr>
<td>2</td>
<td>78.65%</td>
<td>83.54%</td>
<td>87.26%</td>
<td>79.20%</td>
<td>84.61%</td>
<td>86.83%</td>
<td>83.83%</td>
<td>81.42%</td>
</tr>
<tr>
<td>3</td>
<td>79.07%</td>
<td>77.10%</td>
<td>82.17%</td>
<td>80.76%</td>
<td>86.11%</td>
<td>89.27%</td>
<td>81.43%</td>
<td>82.20%</td>
</tr>
<tr>
<td>4</td>
<td>76.94%</td>
<td>84.75%</td>
<td>85.11%</td>
<td>83.71%</td>
<td>78.83%</td>
<td>74.78%</td>
<td>75.32%</td>
<td>80.04%</td>
</tr>
<tr>
<td>5</td>
<td>76.64%</td>
<td>79.48%</td>
<td>74.95%</td>
<td>78.14%</td>
<td>82.54%</td>
<td>79.17%</td>
<td>80.63%</td>
<td>78.80%</td>
</tr>
<tr>
<td>6</td>
<td>72.25%</td>
<td>71.85%</td>
<td>78.69%</td>
<td>74.45%</td>
<td>80.37%</td>
<td>79.17%</td>
<td>84.13%</td>
<td>77.26%</td>
</tr>
<tr>
<td>7</td>
<td>70.77%</td>
<td>72.79%</td>
<td>75.35%</td>
<td>73.93%</td>
<td>79.98%</td>
<td>73.40%</td>
<td>78.43%</td>
<td>74.98%</td>
</tr>
<tr>
<td>8</td>
<td>71.86%</td>
<td>76.86%</td>
<td>76.80%</td>
<td>79.93%</td>
<td>77.06%</td>
<td>69.08%</td>
<td>69.50%</td>
<td>74.50%</td>
</tr>
<tr>
<td>9</td>
<td>71.88%</td>
<td>71.70%</td>
<td>68.36%</td>
<td>71.91%</td>
<td>71.44%</td>
<td>67.81%</td>
<td>68.07%</td>
<td>70.18%</td>
</tr>
</tbody>
</table>

3.2.4 Referral to Treatment Time and number of patients on the waiting list remains a challenging position

3.2.5 The numbers of patients on the waiting list has reduced from 8,695 to 8,569 during October. This reduction is welcome however there are further reductions required for the trust to meet its target of 8,197 at 31st March 2019.

Appendix B has greater detail which will be discussed at the Board meeting.
3.2.6 Each speciality is aware of the number of patients that need to be treated to achieve the required volume and their plans are reviewed weekly and areas of risk escalated to the Executive Directors.

Areas of significant concern continue in cardiology and gastroenterology, however, in recent weeks breast surgery has also become an issue as there has been an increase in the number of referrals for breast surgery which is believed to stem from Stockport FT restricting referrals for out of area CCG’s.

3.2.7 The trust has received external funding of £52k to be used to increase capacity for endoscopy patients and reduce waiting times. Plans are close to completion for additional sessions to be delivered through waiting list initiatives by our own staff. This will improve the performance against the 6 week diagnostic standard which will also improve the performance on the cancer waiting times as diagnostic treatment is a key part of the cancer pathways.

3.2.8 The focus on the numbers on the waiting list does not detract from the NHS Constitutional Standard that 90% of patients should receive their treatment in 18 weeks. Performance currently stands at 80% which is the lowest position for more than 18 months. The executive team will be reviewing this position as, to return to the 90% standard will require a significant increase in patient activity to remove the “backlog”.

The 2019/20 planning guidance is due to be issued and this is likely to set out the national expectations with regard to this position.

3.2.9 Whilst there has been a steadying of the length of time patients are waiting for treatment in certain specialities, the wait for an appointment is significantly longer than the trust would wish it to be and represents a level of clinical risk to patients.

Benchmarking with other Trusts has shown that whilst waiting times may be increasing at other Trusts we remain an outlier in a number of specialities. The executive team will be reviewing this to identify how this situation can be best managed to minimise risk to patients.

3.2.10 Due to the non-elective bed pressures orthopaedic elective activity has been restricted which has led to a number of orthopaedic patients who if not treated by the end of March 19 will have waited more than 52 weeks.

The trust has sought to work collaboratively with Mid-Cheshire Hospitals NHS Foundation Trust (MCFT) and has contacted 48 patients in this category to see if they would wish to have their treatment undertaken at MCFT.

To date only 12 patients have taken up this offer with the majority wishing to stay with the consultant they have already seen. Clearly the trust respects patient choice and will not “force” patients to be treated elsewhere.

There are also a number of patients in cardiology who are close to waiting 52 weeks and the Executive Team are also assessing how best to manage this position in the short-term and medium term.
Members of the public remain concerned about the future of the Minor Injury Unit at Congleton despite communication from the trust that no strategic decision has been taken about its future.

3.3.1 There has been a second demonstration Saturday 17th November 2018 outside Congleton War Memorial Hospital by c.50 members of the public expressing their concerns about the future provision of this service.

3.3.2 The Board discussed this at its last meeting and the position remains unchanged namely that the service is now available Monday to Friday although short notice closures remain possible should the Macclesfield ED need to utilise the members of staff rostered for Congleton.

3.3.3 The Unit has been open 17 days during October.

3.4 Chief Operating Officer

To enable the Director of Nursing, Performance and Quality more time to work alongside the Medical Director, the trust has appointed a Chief Operating Officer for 15 months reporting directly to the CEO.

3.4.1 Jayne Wood has been appointed from 2 January 2019 into the role of Chief Operating Officer replacing the current Deputy Director of Operations who retires in December.

Jayne is a pharmacist by background and has considerable Board level experience which includes Improvement Director for Emergency and Urgent Care, and Chief Operating Officer positions.

3.4.2 Jayne will report to the Chief Executive rather than to the Director of Nursing Performance and Quality to allow sufficient time to manage the busy operational agenda without impacting on the important strategic development work.

4 FINANCIAL STABILITY

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

4.1 Income and Expenditure Position

The financial position of the trust remains on plan to achieve the financial control total of £17.9m.

4.1.1 At the end of October the trust has generated a deficit of £11,129k which is £289k better than the planned position. Whilst welcome, clearly the size of the positive variance is low in terms of overall spend and will remain at risk especially dependent upon the level of operational pressure the trust will face over the winter period.

The tables below summarise the position:


### 4.1.2 Income & Expenditure Statement table - Month 7 2018/19

<table>
<thead>
<tr>
<th></th>
<th>Plan £'000s</th>
<th>Actual £'000s</th>
<th>Variance £'000s</th>
<th>Favourable/Adverse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay Expenditure</td>
<td>62,129</td>
<td>63,467</td>
<td>1,338</td>
<td>Adverse</td>
</tr>
<tr>
<td>Non-Pay Expenditure</td>
<td>32,993</td>
<td>33,869</td>
<td>876</td>
<td>Adverse</td>
</tr>
<tr>
<td><strong>Total Operating Expenditure</strong></td>
<td>95,122</td>
<td>97,336</td>
<td>2,214</td>
<td>Adverse</td>
</tr>
<tr>
<td><strong>Operating (deficit)/Surplus</strong></td>
<td>(8,814)</td>
<td>(8,603)</td>
<td>(211)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Interest Rec’d/Paid/Gain on disp.</td>
<td>623</td>
<td>545</td>
<td>78</td>
<td>Favourable</td>
</tr>
<tr>
<td><strong>Capital Charges &amp; Adjustment for donated assets</strong></td>
<td>1,982</td>
<td>1,981</td>
<td>(1)</td>
<td>Favourable</td>
</tr>
<tr>
<td><strong>Trust (deficit)/Surplus</strong></td>
<td>(11,419)</td>
<td>(11,129)</td>
<td>(289)</td>
<td>Favourable</td>
</tr>
</tbody>
</table>

### 4.1.3 The position by service area is summarised below.

<table>
<thead>
<tr>
<th>Income &amp; Expenditure Statement by Service Line</th>
<th>Contract Income</th>
<th>Direct Income £'000s</th>
<th>Pay Cost £'000s</th>
<th>Non-Pay Cost £'000s</th>
<th>Operational Variance £'000s</th>
<th>Favourable/Adverse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute and Integrated Care</td>
<td>(1,409)</td>
<td>(1,409)</td>
<td>1,359</td>
<td>515</td>
<td>1,545</td>
<td>Adverse</td>
</tr>
<tr>
<td>Allied Health and Clinical Support Services</td>
<td>(41)</td>
<td>(31)</td>
<td>(30)</td>
<td>(210)</td>
<td>(281)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Planned Care Services</td>
<td>721</td>
<td>652</td>
<td>58</td>
<td>1,663</td>
<td>Favourable</td>
<td></td>
</tr>
<tr>
<td>Contract Income</td>
<td>(2,422)</td>
<td>(2,422)</td>
<td>0</td>
<td>0</td>
<td>(2,422)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>0</td>
<td>0</td>
<td>(155)</td>
<td>(126)</td>
<td>(68)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Trustwide</td>
<td>0</td>
<td>(165)</td>
<td>461</td>
<td>295</td>
<td>Favourable</td>
<td></td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>(1,809)</td>
<td>(1,809)</td>
<td>1,359</td>
<td>515</td>
<td>1,545</td>
<td>Adverse</td>
</tr>
</tbody>
</table>

### 4.2 BREXIT

There are concerns about the financial and operational issues which may be faced by NHS organisations following the finalisation of BREXIT negotiations however the trusts assessment of its position is that there is a low risk of disruption.

#### 4.2.1 Trusts have been asked to assess any impact on supplies and services that may arise following BREXIT.

The Finance Director and procurement lead of the trust have been engaged in reviewing the position and responding to the Department of Health and Social Care.

The overall risk has been assessed as low risk to the organisation.

#### 4.2.2 A number of product lines are being assessed nationally such as the supply of medicines to reduce duplication in assessment at individual trust level but there has been a review of the local position.

#### 4.2.3 The team has reviewed some 503 suppliers with a gross value of £11.9m p.a. and has risk assessed taking into account issues such as if the supplier is UK based, if it imports from E.U and does the contract involve EU regulation.

The assessment shows the majority of suppliers are considered to be low risk.

#### 4.2.4 Of the 503 suppliers only 3 are considered to pose a high risk, two supply pathology services and one provides dental equipment maintenance. The Director of Finance will continue to work with regulators and The Department of Health to ensure these risks are managed over the coming months.

### 5 WORKFORCE

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

The trust’s flu vaccination campaign for staff has commenced and more staff are being encouraged to receive the jab. NHS staff are asked to have the flu vaccination to protect the patients they serve as well as themselves, their families and their colleagues. This is an important element of the trust’s winter plan.

At the end of October 41.5% of staff had been vaccinated. The range across the country is between 10% and 79.7% but within Cheshire and Merseyside the range is from 39% to 79% and as such we are not performing well against this important standard.

The Director of Nursing Performance and Quality along with all Executive Directors is continuing to encourage staff through the management structure and a number of communication methods are being used including use of screensavers which update by directorate each week.

5.2 Agency Expenditure

Agency expenditure is £61k higher than planned at the end of October and the level of expenditure will increase over winter and needs to be closely managed.

The agency expenditure is £3.6m for the 7 month period which is £61k higher than planned. The winter plan is predicated on significant additional agency staffing and it is important that financial control is maintained over the winter period.

The additional resources that have been built into the financial year end position.

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 Millbrook Consultation

The changes in Mental Healthcare provision increasing out of hospital care but maintaining a bed base within Macclesfield. The CCG’s met on 22 November to discuss the options for reconfiguration of local mental health services following the recent consultation exercise. A number of options were discussed in light of responses from the public and a revised offer following consultation responses was approved by all the CCG’s affected.

Some further engagement work has been agreed but there is clarity now that a significant element of the service currently housed in the Millbrook Unit on the Macclesfield site will be vacated in September 2019.

This does bring some financial risk to the trust as there will be a loss of rental income which the Finance Director will be seeking to resolve with the local CCG. The Executive Team will be bringing forward options for how the vacated accommodation will be used in January 2019.
6.2 Development of Sustainability Strategy

The Cheshire East Partnership Board is continuing to develop the strategy for integrating health and social care across the Cheshire East Place with a view to maintaining local service provision and to seek to increase care out of hospital both in terms of prevention as well as providing care in different sessions.

6.2.1 The Cheshire East Partnership Board is continuing to develop the strategy for integrating health and social care across the Cheshire East Place to develop sustainable service delivery in and out of hospital maximising local service delivery.

6.2.2 Out of hospital care is being driven through the developing care communities all of which now have designated clinical leaders from primary care. This element of the work is crucial in sizing the acute sector provision that will be required in the future.

6.2.3 In order to assess the right size for the acute services the Executive Team are meeting monthly with Mid Cheshire Hospitals NHS FT Executive Team to discuss mutual benefit in addressing challenges for both organisations.

These meetings are supplemented with a number of meetings of clinical leaders led by the ECT Medical Director with colleagues from Mid-Cheshire FT Stockport FT and Manchester FT.

7 USE OF TRUST SEAL

The Trust Seal has been used once since the last meeting.

<table>
<thead>
<tr>
<th>Date</th>
<th>Seal Number</th>
<th>Name</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>26th October 2018</td>
<td>459</td>
<td>Sarah Jane Holmes, Avant Kapoor, Megan Clare Martin, James Conrad Milligan and James Shipston and NHS Property Services Ltd</td>
<td>Agreement for lease and sub-lease relating to part of Handforth Health Centre</td>
</tr>
</tbody>
</table>

8 SUMMARY

8.1 The key concern within this report is the waiting time position in a number of specialities which is causing clinical concern and has reputational risk if not addressed. The Executive Team are focused on this to resolve the issues both in the short-term and the medium term.

Sign off
Role title: Chief Executive
## Appendix A

### Metric | Q1 | Jul | Aug | Sep | Q2
--- | --- | --- | --- | --- | ---
**Mortality**
Risk Adjusted Mortality Index 2017 - Latest Peer (88.4) | 1.070 | 89 | 92 | 91 |
Summary Hospital Mortality Indicator (HSCIC) | | | | |
EoEi - includes hospital and community | 1 | 1 | 3 | 0 | 4 |
Hospital MRSA bacteremia | 0 | 0 | 0 | 0 | 0 |
Hospital Acquired Clostridium Difficile 18/19 Avoidable | 0 | 0 | 0 | 0 | 0 |
Incidence of newly-acquired cat 3 pressure ulcers - hospital | 3 | 2 | 0 | 2 | 4 |
Incidence of newly-acquired cat 4 pressure ulcers - hospital | 0 | 1 | 1 | 0 | 2 |
Incidence of newly-acquired cat 3 pressure ulcers - out of hospital | 3 | 2 | 2 | 0 | 4 |
Incidence of newly-acquired cat 4 pressure ulcers - out of hospital | 0 | 1 | 1 | 0 | 1 |
Medication errors causing serious harm | 0 | 0 | 0 | 1 | 1 |
**Infection**
Ecoli - includes hospital and community | | | | |
**Incidents**
Patient Safety: Falls resulting in patient harm per 1000 Occupied bed days | 1 | 1 | 1 | 2 | 1 |
No. complaints with HSO Recommendations | 0 | 0 | 0 | 0 | 0 |
Number of complaints | 26 | 14 | 11 | 19 | 41 |
Ward Family and Friends Test % response | 94.2% | 94.3% | 97.5% | 94.4% | 91.0% |
ED Family and Friends Test % response | 94.6% | 94.9% | 94.3% | 94.6% | 91.2% |
Mixed Sex Accommodation breaches | 35 | 24 | 79 | 49 | 143 |
**Access**
18 week - Incomplete Patients | 94.2% | 92.4% | 80.2% | 74.9% | 81.4% |
Referral to Treatment Waiting list Total | 7745 | 7806 | 7546 | 7546 | 7546 |
Diagnostic 6 week access standard | 89.9% | 87.9% | 81.1% | 81.7% | 83.7% |
ED: Maximum waiting time of 4 hours | 94.0% | 90.4% | 90.2% | 90.2% | 90.2% |
ED: The recording of a completed handover, (HAS) | 94.3% | 94.3% | 94.3% | 94.3% | 94.3% |
2 Weeks maximum wait from urgent referral for suspected cancer | 96.1% | 96.4% | 96.4% | 96.4% | 96.4% |
2 Weeks maximum wait from referral for breast symptoms | 94.3% | 94.3% | 94.3% | 94.3% | 94.3% |
31 days maximum from decision to treat to subsequent treatment - Surgery | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
31 day wait from cancer diagnosis to treatment | 94.8% | 100.0% | 100.0% | 100.0% | 100.0% |
62 day maximum wait from urgent referral to treatment of all cancers | 72.8% | 73.3% | 73.3% | 72.8% | 73.3% |
62 days maximum from screening referral to treatment | 97.5% | 97.5% | 97.5% | 97.5% | 97.5% |
**Cancer**
Delayed transfers of care - Acute | 3.0% | 4.4% | 4.4% | 4.4% | 4.4% |
Bed days lost through delays - Acute | 659 | 345 | 323 | 312 | 980 |
Delayed transfers of care - Non Acute | 11.3% | 12.7% | 7.7% | 8.1% | 9.5% |
Core Staff in Post (FTE) | 2170.6 | 2181.4 |
Total Staff (FTE) | 2393.3 | 2414.4 |
Sickness Absence - monthly | 4.2% | 4.3% | 4.6% |
Sickness Absence - rolling year | 4.9% | 4.9% | 4.9% |
Statutory and Mandatory Training - Rolling 3 year period | 91.3% | 91.0% | 92.0% |
Corporate Induction attendance - rolling year | 91.3% | 91.0% | 92.0% |
Appraisals and Personal Development Plans - Rolling year | 86.6% | 86.6% | 85.7% |
Information Governance training | 68.3% | 73.1% | 79.9% |
Safeguarding - Level 1 Compliance | 93.1% | 93.0% | 92.5% |
Safeguarding Children - Level 2 | 97.7% | 98.2% | 98.8% |
Safeguarding Adults - Level 2 | 90.6% | 90.7% | 90.3% |
Safeguarding Children - Level 3 | 92.4% | 91.0% | 91.3% |
Total Pay Expenditure (£000) | £27,047k | £9,188k | £9,040k | £9,129k | £27,357k |
Bank Staff Expenditure (£000) | £1,411k | £493k | £592k | £541k | £1,626k |
Agency Staff Expenditure (£000) | £1,650k | £473k | £559k | £498k |
Cash (£000’s) | £10,690k | £7,927k | £6,432k |
EBITDA (£000) | (£5,548k) | (£7,261k) | (£7,617k) |
Cumulative Deficit | (£6,957k) | (£9,020k) | (£9,720k) |
<table>
<thead>
<tr>
<th>Report of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Officer</td>
</tr>
<tr>
<td>Accountable Officer</td>
</tr>
<tr>
<td>Author of Report:</td>
</tr>
<tr>
<td>Subject/Title</td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
</tr>
<tr>
<td>Purpose of Paper</td>
</tr>
<tr>
<td>Action/Decision required</td>
</tr>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Corporate Risk Register</td>
</tr>
<tr>
<td>Link to Care Quality Commission domain</td>
</tr>
<tr>
<td>Link to:</td>
</tr>
<tr>
<td>Trust’s Strategic Direction</td>
</tr>
<tr>
<td>Corporate Objectives</td>
</tr>
<tr>
<td>Legal implications - (identify)</td>
</tr>
<tr>
<td>Impact on quality</td>
</tr>
<tr>
<td>Resource impact</td>
</tr>
<tr>
<td>Impact of equality/diversity</td>
</tr>
<tr>
<td>Avoid acronyms or abbreviations - if necessary list:</td>
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</table>
Review of Referral to Treatment (RTT) Waiting Time Risks

This report is to provide the Board with an opportunity to review and discuss the current risks relating to waiting times and to note the key agreed and proposed actions to help reduce the level of risk.

1 INTRODUCTION

1.1 The Board has accountability to ensure there are effective systems and processes in place to manage risk and East Cheshire NHS Trust has set this out within its Risk Management Strategy 2018 to 2019, which was approved by the Board at its January 2018 meeting.

1.2 The Board Assurance Framework and Corporate Risk Register forms part of the Risk Management Strategy and has been developed to identify risks which could significantly impact on the organisations ability to deliver its organisational objectives and key work-streams.

2 MANAGING RISKS

Spotlight on waiting time risks

2.1 The Corporate Risk Register is a living document in which risks are added, removed and updated on an on-going basis. It is presented to the Board and Committees of the Board four times a year.

2.2 This report provides a spotlight on a specific group of risks relating to Waiting Times and the Referral to Treatment access targets (RTT).

2.3 Clinical risk as a result of increased waiting times is escalating to an unacceptable level:

- in particular where waiting times for urgent new Cardiology patients is over 6 months
- when waiting times for Cardiology patients for follow up is 17 months past the planned review date

2.3.1 There is also concern that there will be a number of 52 week waits associated with Orthopaedics.

3 RISKS RELATING TO WAITING TIMES

18 risks are included on the trust's risk register

3.1 There are currently 18 risks included on the risk register, which relate to waiting times. Of these 10 are high level risks, seven are moderate risks and one is a low level risk. There is one overarching risk and the remainder of the risks have been identified across each of the three clinical directorates as shown in the table below:

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Planned Care</th>
<th>Allied Health &amp; Clinical Support Services</th>
<th>Acute &amp; Integrated Community Care</th>
</tr>
</thead>
</table>
There are three themes within the 10 high rated risks which are Single Handed Service, Demand exceed capacity and staffing / recruitment issues

### 3.2

The overarching risk has had a risk score of 16 since it was added to the risk register in April 2017. The target score is 12, with a target date of 31 December 2018, and the Board will need to consider if this target date is achievable in the light of agreed improvement plans.

### 3.2.1

**2663** - If the inpatient 18-week backlog continues to increase, there may be an impact on patient safety due to delays in treatment (potential 52 week breaches), the NHS constitutional standard will not be achieved with associated reputational risk and potential financial impact due to loss of income or penalties.

The nine other high rated risks are detailed below and have been grouped by theme:

#### 3.2.2

**Single Handed service**

**2794** - Orthodontic is a single handed consultant led service. Service has recently closed to new referrals due to demand. Issues with frequency of follow up appointments raised by Consultant.

Actions being taken to mitigate this risk are:

- Notice served on contracts in September 2018
- New referrals are not being accepted

This risk has had a risk score of 16 since it was added to the risk register in June 2018. The target score is 12, with a target date of end of March 2019.

#### 3.2.3

**Demand exceeds capacity**

**2732** - If there is insufficient capacity to see all ophthalmology patients waiting a follow up appointment then there is a risk of patient harm and poor patient experience.

The RTT standard for this specialty is currently being achieved but continues to be monitored.

This risk has had a risk score of 16 since it was added to the risk register in February 2018. The target score is 6, with a target date of 31 December 2018.

**2681** – If the Endoscopy and Treatment Unit are not able to offer dates for required procedures within the recommended timeframes there may be a clinical risk to some patients which could mean a poor outcome due to the delayed diagnostic procedure.

Actions being taken to mitigate this risk are:

- Priority given to 2 week wait patients and urgent referrals
- Waiting List Initiatives are being undertaken which is holding the backlog
- Additional Waiting List Initiatives are being undertaken to reduce the backlog with recovery plan to deliver the RTT standard by the end of quarter
This risk has had a risk score of 15 since it was added to the risk register in December 2017. The target score is 9, with a target date of end of March 2019.

2817 – If the inpatient 18 week backlog for ENT continues to increase, then there may be an impact on patient safety & experience due to delays in treatment.

Actions being taken to mitigate this risk are:
- Priority given to 2 week wait patients and urgent referrals
- Additional Middle Grade capacity secured

This risk has had a risk score of 16 since it was added to the risk register in July 2018. The target score is 12, with a target date of 31 December 2018.

2610 – If the Trust does not meet the diagnostic target standard of <1% of patients waiting more than 6 weeks (ie 99% of patients are seen within 6 weeks), then this may impact on patient care, patient experience and Trust reputation

This risk is largely driven by delays in Endoscopy and ECHO and actions being taken to mitigate this risk are:
- Waiting List Initiatives being undertaken to the end of the year to support recovery

This risk had its original risk score of 16 increased to 20 in July 2018 to reflect current performance and lack of robust recovery plan. The target score is 6, with a target date of 31 March 2019.

2801 – If the current cardiology back log of new and follow up patients cannot be managed within current job planned capacity there is a significant clinical risk to delivery of patient care due to increasing patient backlog and longer waiting times.

Actions being taken to mitigate this risk are:
- Virtual clinics in place for follow up
- In discussions with speciality to agree additional flexible capacity through Waiting List Initiatives and the use of potential locum in the pipeline

This risk has had a risk score of 16 since it was added to the risk register in June 2018. The target score is 6, with a target date of end of March 2019.

2773 – If the Planned Care directorate does not have sufficient capacity to deliver the annual plan then this may result in a backlog of patients waiting to be treated including clinic appointments and those requiring surgery.

Actions being taken to mitigate this risk are:
- Orthopaedics remains challenged particularly with lower limbs. The focus is on treating longest waits
- A small number of patients have taken up the offer of treatment at Mid
All high level risks are presented to the Board and Committees of the Board for review and discussion.

Cheshire NHS Foundation Trust during December 2018.

- Further action required to mitigate the risk of 52 week breaches including the potential use of private providers.

This risk had its original risk score of 12 increased to 16 in May 2018 to reflect peaks in referrals affecting capacity. The target score is 12, with a target date of 31 March 2019.

**Staffing / Recruitment issues**

3.3

- 2512 – If the Cardio Respiratory Department are unable to increase staffing levels and offer more echocardiography appointments there is a risk that the 6/52 diagnostics access standard will not be achieved, leading to delays in treatment that may result in patient harm. Staff resilience is also impacted by an unsustainable workload, perceived risk to patients and inability to recruit new staff to vacant posts.

Actions being taken to mitigate this risk are:

- Waiting List Initiatives being undertaken to recover position by end of March 2019
- A number of referrals have been diverted to Wilmslow Primary Care Clinic

This risk had its original risk score of 12 increased to 16 in May 2018 to reflect decline in staffing position. The target score is 12, with a target date of 31 March 2019.

**Capacity / Staffing / Equipment Mix**

3.4

- 2810 – If cancer patients with complex pathways are not treated in a timely and coordinated way, there is a risk that the trust will not achieve 85% compliance with the 62 day standard from referral to treatment standard and patient care will be affected.

Actions being taken to mitigate this risk are:

- Action plan agreed to support transfer to tertiary providers by day 39.
- Active tracking of all cancer patients to remove barriers and prioritise diagnostic tests.
- Patient discussion at MDTs to support patient flow and timely escalation of delays

This risk has had a risk score of 16 since it was added to the risk register in June 2018. The target score is 12, with a target date of 31 March 2019.

16 of the 18 risks were added to the risk register during 2017/18, with one moderate and one low rated risk added prior to this date.

All risks are subject to regular review according to their level of risk score, with all high level risks scheduled for their next review during December and January. Each of the high level risks referred to are included in the overarching Board Assurance Framework / Corporate Risk Register report presented to the Board and Committees of the Board in December 2018.
4 AGREED & PROPOSED ACTION

**Actions have been agreed or are planned to reduce the waiting time risks, which includes an additional investment of £300k to support waiting list initiatives**

4.1 The Executive Team are involved in all high risk specialties and are briefed on the other specialties where there is an emerging risk.

4.1.1 Clinicians from key specialties have been meeting with the Chief Executive; Director of Nursing, Performance & Quality; and Medical Director to agree the approach to improve the position.

4.1.2 Action plans are in place for each specialty and weekly monitoring and management of the position takes place through Operational Performance Group and Executive Management Team.

4.1.3 Clinical reviews take place to prioritise patients.

4.1.4 Agreement has been made that £300k is made available to specific specialties to use for waiting list initiatives to reduce their backlog and manage capacity issues.

4.1.5 To return to the RTT standard will require a significant increase in patient activity and this is something that the Executive Team will be reviewing.

4.1.6 The Trust is reviewing resilience to improve clinical sustainability as part of its clinical strategy.

5 RECOMMENDATION

5.1 The Board is asked to:

- Review and discuss the content of report
- Note the key agreed and proposed actions to help reduce the risk

Kath Senior

Director of Nursing, Performance and Quality
**Report of:**  
Responsible Officer  
Accountable Officer  

Deputy Director of Corporate Affairs and Governance  
Director of Corporate Affairs and Governance  

**Author of Report:**  
Head of Integrated Governance  

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

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

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

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

**Mitigates Risk Number:** (identify)  
On Corporate Risk Register:  
This paper relates to the Assurance Framework and Corporate Risk Register and therefore is linked to all risks.  

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

**Link to Care Quality Commission domain**  
All domains  

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

**Link to:**  
All Objectives  

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

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

**Resource impact**  
There are no resource implications  

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

**Avoid acronyms or abbreviations - if necessary list:**  
CQC – Care Quality Commission  
RTT – Referral to Treatment  
QIPP – Quality, Innovation, Productivity and Prevention  
ED – Emergency Department  
STP – Sustainability and transformation plan
Review of Assurance Framework and Corporate Risk Register

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

1 INTRODUCTION

1.1 The Board has accountability to ensure there are effective systems and processes in place to manage risk and East Cheshire NHS Trust has set this out within its Risk Management Strategy 2018 to 2019, which was approved by the Board at its January 2018 meeting.

1.2 The Board Assurance Framework and Corporate Risk Register forms part of the Risk Management Strategy and has been developed to identify risks which could significantly impact on the organisation’s ability to deliver its organisational objectives and key work-streams.

1.3 The Audit Committee and Clinical Management Board last reviewed the Board Assurance Framework and Corporate Risk Register at their meetings in September 2018.

1.4 Clinical Management Board has the overarching responsibility for managing and overseeing all risks; it also has a number of risks which are not delegated to either the Safety Quality and Standards Committee or the Finance, Performance and Workforce Committee, and provides assurance against these to the Audit Committee.

2 STRATEGIC RISKS

The Board approves the Strategic Risks for Each Financial Year

The strategic risks remain unchanged in 2018/19

2.1 At the April 2017 meeting of the Board, the following Strategic risks were reviewed and approved:

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

2. Quality & Compliance: patient safety, patient experience and effectiveness - If quality is not maintained in line with regulatory standards during and after transition then this could impact on services the trust provides and ability to provide services that are caring, safe, and responsive and safeguard the health & wellbeing of the local population.

3. Financial stability - If the trust cannot meet its requisite financial regulatory standards and operate within agreed financial resources and transformation schemes do not deliver sufficient savings then the proposed health economy wide service model will not be fully or effectively implemented.

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

5. **Infrastructure** - If the Information Technology/Information Systems and Estate infrastructure are not sufficiently invested in and adapted to align with the health economy strategy then there will be an impact on the quality of the delivery of clinically & financially sustainable services

### 3 BOARD ASSURANCE FRAMEWORK

**The level of risk within the Board Assurance Framework remains unchanged**

3.1 The level of risk recorded in the Board Assurance Framework remains unchanged from the previous report; although assurances have been strengthened and action taken which enabled three gaps in control and assurance to be closed. Key areas included:

- On track to achieve the public sector apprenticeship target
- Improvement in level of participation in staff survey
- Data Security & Protection Toolkit requirements assessed and baseline assessment submitted

3.1.1 There are further gaps in controls and assurance added since the previous review, which include:

- Performance notice received regarding non delivery of a number of patient waiting standards
- One instance of MRSA was reported since the last report
- The staffing costs of the winter plan has not been factored in to the agency usage plan

The changes identified in the paragraphs above are based on information gained from the review of reports and minutes from committees of the Board; Clinical Management Board; and other reporting groups and committees.

3.2 Of the five agreed Strategic Risks, three are currently rated as high and two are rated moderate risks. The table below sets out the expected change of risk scores over time when all strategic actions have been implemented. The focus for the next three months is listed along with the responsible committee / board which have been delegated to monitor each of the risks.

3.2.1 The focus for the next three months has been identified by reviewing reports to committees of the Board and Board papers.

The Clinical Management Board is the forum with overarching responsibility for managing risks.
The strategic risk scores may not be fully reduced to their optimum score for 2 to 3 years

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Monitoring Committee / Board</th>
<th>Risk Rating without controls</th>
<th>Current Risk Rating</th>
<th>Target Risk Rating</th>
<th>Focus over next 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leadership of Strategic Transformation</td>
<td>Clinical Management Board</td>
<td>25</td>
<td>20</td>
<td>10</td>
<td>Continue to work with partners to agree clinical models for East Cheshire. Continue with clinical engagement to ensure consensus is achieved relating to future service model Recovery of the access targets performance in line with agreed trajectories</td>
</tr>
<tr>
<td>2. Quality &amp; Compliance: patient safety, patient experience and effectiveness</td>
<td>Safety, Quality &amp; Standards Committee</td>
<td>16</td>
<td>12</td>
<td>8</td>
<td>Continue to maximise productivity to ensure patients have a timely &amp; quality experience Continue to closely monitor the access targets in respect of quality and patient safety</td>
</tr>
<tr>
<td>3. Financial stability</td>
<td>Finance, Performance and Workforce Committee</td>
<td>25</td>
<td>25</td>
<td>15</td>
<td>Continued focus on identification of QIPP schemes for 2018/19 Further monitoring of control over agency spend due to continued challenge in recruiting staff. Delivery of the planned financial position in the quarter</td>
</tr>
<tr>
<td>4. People</td>
<td>Finance, Performance and Workforce Committee</td>
<td>20</td>
<td>16</td>
<td>8</td>
<td>On-going work to address future staff recruitment within acute nursing to cover existing vacancies and address mature workforce profile; and staff turnover Continue to work on retention of staff and ensure monitoring of impact of winter plan on agency staffing levels</td>
</tr>
<tr>
<td>5. Infrastructure</td>
<td>Clinical Management Board</td>
<td>16</td>
<td>12</td>
<td>8</td>
<td>Continue the Estate Rationalisation programme in the community Continue to implement the agreed IT transformation plan.</td>
</tr>
</tbody>
</table>

The Board will also continue to focus on improving controls linked to the following agreed priority areas:

- 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
3.2.3 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

A rolling committee work programme is in place to ensure the Committees of the Board review their delegated strategic risks four times a year.

4 CORPORATE RISK REGISTER

4.1 There are currently 36 red risks included on the risk register, which is a net increase from the previous report of two risks, although the risks will not be identical to those in the previous report. A comparison of the current risk register and the previous reported risk register shows that five risks have been added or had their risk scores increased, whilst three risks have either been closed or had their risk score reduced (Appendix 1 refers). This includes reported Serious Incidents Requiring Investigation.

4.1.1 The Corporate Risk Register is a living document in which risks are added and removed on an on-going basis. Therefore, the statement given above is at a specific point of time, rather than being reflective of all the changes which have happened during the period.

4.1.2 The table below shows the total number of risks contained on the risk register in each of the last four quarters (which is specific to the time of the report being run from the risk management system).

4.2 The 36 red rated Corporate Risks have been delegated as follows (17 risks are monitored by more than one committee, so a total of 57 risk entries appear...
A considerable number of serious incidents once investigated are downgraded when the risks are split by monitoring committee / board):

<table>
<thead>
<tr>
<th>Committee / Board</th>
<th>Number of Red Rated Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety, Quality and Standards Committee</td>
<td>26 (includes 5 serious incidents which have been reported on the National Strategic Executive Information System (StEIS))</td>
</tr>
<tr>
<td>Finance, Performance and Workforce Committee</td>
<td>20</td>
</tr>
<tr>
<td>Clinical Management Board</td>
<td>11</td>
</tr>
</tbody>
</table>

4.2.1 The Safety Quality and Standards Committee and Finance, Performance and Workforce Committee are scheduled to review the red rated risks delegated to them at their December 2018 meetings. Clinical Management Board will also review its delegated red risks in December 2018. Details of these risks are included at Appendix 1.

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

## 5 RECOMMENDATION

5.1 The Board is asked to:

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

Sign off
Role title
Julie Green - Director of Corporate Affairs and Governance
APPENDIX 1

The following five risks have been added to the Corporate Risk Register or had their risk score increased since the last report (this compares with 15 risks which were added in the previous report)

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2863</td>
<td>A Serious Incident relating to an Unexpected Death of an Inpatient on MAU has been reported on the Strategic Executive Information System (2018/22037 Web-52785).</td>
<td>Newly approved risk – current score 20</td>
</tr>
<tr>
<td>2877</td>
<td>A Serious Incident relating to an Unexpected Death of an Inpatient on HCU / ICU has been reported on the Strategic Executive Information System (2018/22826 Web-55377).</td>
<td>Newly approved risk – current score 20</td>
</tr>
<tr>
<td>2878</td>
<td>A Serious Incident relating to a Medication Incident on A&amp;E has been reported on the Strategic Executive Information System (2018/23052 Web-55509).</td>
<td>Newly approved risk – current score 20</td>
</tr>
<tr>
<td>2879</td>
<td>A Serious Incident relating to a MRSA Bacteraemia on Ward 3 has been reported on the Strategic Executive Information System (2018/23568 Web-55678).</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td>2853</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Aston Unit has been reported on the Strategic Executive Information System (2018/19211 Web-54481).</td>
<td>Newly approved risk – current score 16</td>
</tr>
</tbody>
</table>
The following three risks have been either closed or downgraded since the last report and are therefore no longer showing on the high level corporate risk register (this compares with two risks which were closed or downgraded in the previous report):

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Description</th>
<th>Status</th>
<th>Additional detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>2738</td>
<td>A Serious Incident relating to an Unexpected Death on Ward 4 has been reported on the Strategic Executive Information System (2018/5386 Web-51531).</td>
<td>Risk closed</td>
<td>Risk closed due to all actions being complete and SIRI closed by CCG</td>
</tr>
<tr>
<td>2740</td>
<td>A Serious Incident relating to a Fetal Death In Utero on the Labour Ward has been reported on the Strategic Executive Information System (2018/5663 Web-49665).</td>
<td>Risk closed</td>
<td>Risk closed due to all actions being complete and SIRI closed by CCG</td>
</tr>
<tr>
<td>2842</td>
<td>A Serious Incident relating to a Delay or Failure in Treatment or Care on Ward 8 /MAU has been reported on the Strategic Executive Information System (2018/18440 Web-54202).</td>
<td>Risk closed</td>
<td>Risk closed due to all actions being complete and SIRI closed by CCG</td>
</tr>
</tbody>
</table>
## Report of:
#### Responsible Officer:
Medical Director

#### Accountable Officer:

### Author of Report:
Dr John Hunter, Medical Director
Stephanie Ratcliffe, Head of Clinical Effectiveness

### Subject/Title
Learning from Deaths – Quarterly Mortality Report (Quarter 2 – July-September 2018)

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

### Action/Decision required
For assurance

### 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.

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

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

### Legal implications - (identify)
N/A

### Impact on quality
N/A

### Resource impact
N/A

### Impact of equality/diversity
N/A

### Avoid acronyms or abbreviations - if necessary list:
- SMR  Standardised Mortality Ratio
- RAMI  Risk Adjusted Mortality Index
- SHMI  Summary Hospital Mortality Index
- SBAR  Situation, Background, Assessment, Recommendations
- RCA  Root Cause Analysis
- LeDeR Learning Disabilities Mortality Review
Learning from Deaths – Quarterly Mortality Report (Quarter 2)

The CQC published its report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* in December 2016, making recommendations about how the approach to learning from deaths could be standardised across the NHS. The publication of the *Learning from Deaths* framework placed a number of new requirements on trusts, including an imperative to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to the Public Trust Board. This report includes information on the following:

- Background on measurement of mortality metrics and their utility
- Mortality metrics for the quarter including the mortality dashboard
- Themes identified from the review of deaths
- Actions being undertaken in response to learning

1 INTRODUCTION

1.1 The aim of this paper is to provide assurance to the Board of the work underway across the organisation to implement the National Quality Board’s (NQB) National Guidance on Learning From Deaths.

2 CONTEXT

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

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

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

2.4 In general terms, the rationale for calculating death rates in hospital is that they can be used to measure hospital quality in some way, and therefore help trusts:

- Reduce mortality rates
- Improve patient safety
- Reduce avoidable variation in care and outcomes

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

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

There is utility in the measurement of preventable hospital deaths to drive quality improvement, but it has to be recognised that there are significant limitations to using this metric to gauge the quality and safety of healthcare.

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

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

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

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

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

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

3.1 Using specific criteria a selection of patients who die at the trust undergo a
two stage retrospective case record review as detailed in the Mortality Policy
and Standard Operating Procedure.

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

<table>
<thead>
<tr>
<th>Avoidability of death scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score 1</td>
</tr>
<tr>
<td>Score 2</td>
</tr>
<tr>
<td>Score 3</td>
</tr>
<tr>
<td>Score 4</td>
</tr>
<tr>
<td>Score 5</td>
</tr>
<tr>
<td>Score 6</td>
</tr>
</tbody>
</table>

3.3 Problems in care are defined as patient harm resulting from acts of omission
(inactions such as failure to diagnose and treat according to evidence based
guidelines), acts of commission (affirmative action such as incorrect treatment
or management) and harm as a result of unintended or unexpected
complications of healthcare.

4 MORTALITY DASHBOARD FOR QUARTER

4.1 Refer to Appendix 1.

4.2 During Quarter 2, 143 patients died at the trust which is slightly more than
Quarter 1 when 134 deaths were recorded. The average number of deaths per
month in Q2 was 47 compared with 44 in Q1.

4.3 The average crude mortality for Quarter 2 was 1.7%.

4.4 The standardised mortality ratios for the quarter are as follows:
• Summary hospital mortality index – 1.12 (as expected range)
• Risk adjusted mortality index (RAMI) – 88.7

4.5 1 death was reported under the serious incident framework and is being
appropriately and thoroughly investigated.

4.6 2 patients with learning disabilities died at the trust during Quarter 2. The 2
deaths were reviewed using the LeDeR methodology and one was found to
be potentially avoidable.
4.7 A mortality alert from the Dr Foster Unit at the Imperial College was received in October 2018 which indicated higher than average mortality rates for Septicaemia (except in labour) at the trust. An investigation is currently underway and a response being formulated.

5 OUTCOMES OF REVIEWS

5.1 Following the recent appointment of a Head of Clinical Effectiveness, the backlog of mortality reviews has now been completed.

5.2 Positive:
- Mortality reviews are now completed in a timely manner
- Evidence of good communication with patients’ relatives
- Very few of the deaths reviewed were identified as avoidable
- No identified risk of increased mortality by day of admission (‘weekend effect’)
- Good end of life care
- The deaths of all patients with learning disabilities who died at the trust were reviewed using the appropriate methodology

5.3 Improvements required:
- Better coding of the complications associated with Type II diabetes
- Record keeping and documentation
- The accurate documentation and coding of sepsis needs focus to ensure the recently introduced sepsis coding changes are embedded
- Although discussions around end of life care are consistently clearly documented in the medical and nursing notes, problems persist with end of life documentation:
  - Records contain gaps when reviewing end of life care
  - The end of life bundle is initiated but not appropriately completed
  - There is little documentary evidence of caring for families after the patient has died

6 ACTIONS UNDERWAY IN RESPONSE TO LEARNING

6.1 The Sepsis Group meets monthly to focus on improving the management of sepsis at the trust.

6.2 The Medical Director is leading a discussion on the recognition and documentation of infection and sepsis with the physicians.

6.3 Discussions are ongoing with Head of Clinical Coding on actions to improve the coding of complications associated with Type II diabetes.

7 SUMMARY

7.1 Using specific criteria, a selection of patient deaths at the hospital are subject to retrospective case record review using a two stage process. A minimum of 20% of all deaths at the trust are comprehensively reviewed monthly.

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

7.3 When serious failing are uncovered by a mortality review a root cause analysis investigation into the death is instigated.

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

8.1 The Board is asked to note the contents of this report and be aware of the actions taken to further reduce avoidable harm.

Name: Dr John Hunter
Job Title: Medical Director
Appendix 1 – Mortality Dashboard

### Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

<table>
<thead>
<tr>
<th>Time Series</th>
<th>Start date</th>
<th>Q1</th>
<th>End date</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017-01</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

<table>
<thead>
<tr>
<th>Total Number of Deaths in Scope</th>
<th>Total Deaths Reviewed</th>
<th>Total Number of deaths considered to have been potentially avoidable (RCP&lt;3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Month</td>
<td>Last Month</td>
<td>This Month</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>This Quarter (Q1)</td>
<td>Last Quarter</td>
<td>This Quarter (Q1)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>This Year (YTD)</td>
<td>Last Year</td>
<td>This Year (YTD)</td>
</tr>
<tr>
<td>277</td>
<td>73</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Total Deaths Reviewed by RCP Methodology Score

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
<th>Score 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Month</td>
<td>This Month</td>
<td>This Month</td>
<td>This Year (YTD)</td>
<td>This Year (YTD)</td>
<td>This Year (YTD)</td>
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<tr>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>This Quarter (Q1)</td>
<td>This Quarter (Q1)</td>
<td>This Year (YTD)</td>
<td>This Year (YTD)</td>
<td>This Year (YTD)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

### Summary of total number of learning disability deaths and total number reviewed under the LeDeH methodology

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

<table>
<thead>
<tr>
<th>Total Number of Deaths in scope</th>
<th>Total Deaths Reviewed Through the LeDeH Methodology (or equivalent)</th>
<th>Total Number of deaths considered to have been potentially avoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Month</td>
<td>Last Month</td>
<td>This Month</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>This Quarter (Q1)</td>
<td>Last Quarter</td>
<td>This Quarter (Q1)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>This Year (YTD)</td>
<td>Last Year</td>
<td>This Year (YTD)</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>
Dear Colleague

**TRUST BOARD MEETING**

A meeting of the Trust Board will be held at 3.00pm on 7th February 2019 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 – FEBRUARY 2019 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>15 mins</td>
<td></td>
</tr>
<tr>
<td>2. Apologies</td>
<td>Chairman</td>
<td></td>
<td></td>
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</tbody>
</table>
## ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Declared interest agenda</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitality and Gifts Register Declaration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Minutes of the November 2018 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 19 (01)</td>
<td></td>
</tr>
<tr>
<td>5. Matters Arising</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Action Log</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7. Verbal update:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- SQS Committee</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>- FPW Committee</td>
<td>Mr M Wildig</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Chief Executive’s Report</td>
<td>Chief Executive</td>
<td>30 mins</td>
<td>TB 19 (02)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Learning from Deaths Quarter 3 Report</td>
<td>Medical Director</td>
<td>10 mins</td>
<td>TB 19 (03)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>10. Risk Management Strategy</td>
<td>Director of Corporate Affairs and Governance</td>
<td>10 mins</td>
<td>TB 19 (04)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>11. Standing Agenda Item: Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register</td>
<td>Chief Executive</td>
<td>5 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
</tr>
</tbody>
</table>

## ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Public Trust Board Agenda – March 2019</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 19 (05)</td>
</tr>
</tbody>
</table>
CONSENT ITEMS
(All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting).

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>REF. NO.</th>
<th>REASONS FOR PRESENTING</th>
<th>LINKED TO TRUST OBJECTIVE ON</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Public Trust Board Year at a Glance</td>
<td>TB 19 (06)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>14. Chairman’s Commentary</td>
<td>TB 19 (07)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>15. Major Incident Plan</td>
<td>TB 19 (08)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
</tbody>
</table>
| 16. Safer Staffing Exception Report                | TB 19 (09) | For 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 |
| 17. Minutes of the committees of the Board:        |          | Information             |                               |
| SQS Committee                                     |          |                         |                               |
| - November 2018                                   | TB 19 (10) |                         |                               |
| - December 2018                                   | TB 19 (11) |                         |                               |
| FP&W Committee                                    |          |                         |                               |
| - November 2018                                   | TB 19 (12) |                         |                               |
| - December 2018                                   | TB 19 (13) |                         |                               |

Date and Time of Next Meeting:

Date: Thursday 7th March 2019  
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
### Board Objectives

**PATIENTS** – Provide safe, effective personal care in the right place  
**PEOPLE** – Build, value and develop a motivated and sustainable workforce  
**PARTNERSHIPS** – Work within the Caring Together framework to deliver our vision  
**RESOURCES** – To deliver services that are clinically and financially sustainable

### Board Assurance Framework

1. Leadership of Strategic Transformation  
2. Quality & Compliance: patient safety, patient experience and effectiveness  
3. Financial stability  
4. People  
5. Infrastructure

### Standing Board Agenda Items

- The Patient’s Voice (Patient Story)/The Staff Voice (Staff Story)  
- Chairman’s Report (inc annual Fit & Proper person test, Rol and Gifts & Hospitality registers)  
- Chief Executive’s Report (inc. Strategy, Performance and Assurance and areas to focus as a Deep Dive)  
- Conflict of Interests  
- Committee Assurance via relevant Committee Chairs  
- Exception Report – Safer Staffing Levels

KPI’s for strategies will be overseen by committee’s. The CEO report will contain escalation issues and separate papers will be provided to the Board as appropriate.
**Report of: The Responsible & Accountable Officer**
The Chairman

**Author of Report:**
Lynn McGill, Chairman

**Subject/Title**
Chairman’s Commentary

**Background papers (if relevant)**
None

**Purpose of Paper**
The purpose of this report is to provide a summary of many of the extra-curricular activities during November 2018 that form part of the network and relationship development which support the trust and its ambassadors in achieving its vision and corporate objectives. It is not intended as an exhaustive summary.

**Action/Decision required**
To note

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

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

**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

**Legal implications - (identify)**
None

**Impact on quality**
Positive impact

**Resource impact**
None

**Impact of equality/diversity**
None

**Avoid acronyms or abbreviations - if necessary list:**
NHS – National Health Service
CCG – Clinical Commissioning Group
NHSI – NHS Improvement
NHSE - NHS England
CQC - Care Quality Commission
CPR - Cardiopulmonary Resuscitation
Introduction

Collectively, as a means of adding value through effective leadership, these activities provide context and so aid strategic challenge, seeking assurance in a supportive and collegiate manner and may be gained through key meetings of national, regional or local importance, shared learning from each other, from international examples and by making local connections to engender relationships, trust and broaden engagement.

NHS Improvement North, Chairs Forum

Attended this event, on Friday 16th November in Leeds, which included additional Non Executive board membership as part of a wider development approach. We heard of the developments across the North and in particular the inroads made related to:

- Planning for an integrated approach to regulation between NHS Improvement and NHS England; the changes to how CQC will be evaluating providers, via intelligence led model.
- Preparations for Winter 2018-19 and the significance of patient flow through assessment, diagnostic, length of inpatient stay; Lord Carter’s productivity challenge, and achievements to date.
- The improved contribution of a diverse board; regionally led talent management to aid workforce sustainability.
- How NHS Improvement and NHS England are supporting ‘Speaking Up’.
- NHS Resolution on progress, achievements and shared learning.

Cheshire & Merseyside Health and Care Partnership Forum

This event was held in Liverpool on Wednesday 20th November 2018, where we heard from the executive leadership team; The Kings Fund and their learning from first wave Integrated Care systems, one commissioning approach to integration; The
Nuffield Trust and their learning around planning at scale.

These documents are available in the public domain in support of this learning:

From the Health Foundation

From The Kings Fund

**NHS England & NHS Improvement Workshop**

My thanks to Mr Wildig, Non Executive Director for attending this workshop on behalf of the Trust. This event was led by the Chief Executive Officers of the two regulators on 29th October, one of several events being held around England and forms a part of their consultation as they develop the strategic direction for the NHS over the next 5-10 years. Aspects of the workshop covered the current challenges, including finance, equality of access, integrated care, workforce, productivity, effectiveness and how best to support people to better manage their own health. Our attendance builds on comments already shared in response to the consultation documents.

**East Cheshire leaders Contribute to the development of the NHS Plan consultation**

**Cheshire East Partnership Board**

The Programme Board met on Wednesday 7th November and heard from Senior Responsible Officers, the Programme Management Office leads, the outcome of several pieces of work and discussed next steps.

Given the pending retirement of our current Independent Chair, the Partnership Board is seeking to appoint a successor and actions are in hand to ensure the consolidation and implementation of sustainable service intentions.

**Aspirant Chairs Programme Participation**

Following discussions with recent aspirant Chairs, I have commenced time supporting a mentee. This is an important and valued contribution to developing the pipeline of Trust Chair succession.

Chairman:  Lynn McGill
Chief Executive:  John Wilbraham
Investing in local relationships for future sustainability

Chair to Chair conversations

In support of strong partnership relationships I continue to meet informally with the Eastern Cheshire CCG Chair; this took place on Thursday 8th November 2018.

Public engagement, self help and prevention

Health Matters

A part of our annual programme, these events have been developed and shared with members of the public, remain a firm favourite and showcase how treatments are provided. It is also timely to reflect on what each of our professional and individual citizenship responsibilities are. In this way we can engage individuals by supporting self-help by recognising signs early and take preventative action wherever possible.

This month’s Health Matters focused on understanding cardiopulmonary resuscitation (CPR) and what to do in the event of a cardiac arrest. We saw the techniques used for CPR safely demonstrated, a range of equipment and how defibrillation works, heard about the facts of survival and discussed an overview of the reasons when to use the techniques and why this is sometimes not appropriate. It was a most interactive session. To find out more and see a video of this and prior presentations go to:
http://www.eastcheshire.nhs.uk/News-Events/Health-matters.htm

Staff that are engaged and motivated provide better care for patients

Annual Awards Event

Research has evidenced that when people and teams are working at their best, they make a significant and measureable difference to patient care and experience.

With the aid of sponsors, we were delighted to recognise and celebrate these achievements, the result of nominations and voting by patients and colleagues from across the trust. This year we received 347 nominations and more than 7,000 votes across all seven categories.

The winners have been recognised in a number of areas and will be able to see these on the Trust’s website. http://www.eastcheshire.nhs.uk/About-The-Trust/Trust%20awards.html

Trust Board Business

Chairman: Lynn McGill
Chief Executive: John Wilbraham
The Trust Board Delivers as Planned

The Board regularly takes time out to discuss topical issues and develop our own understanding

8.1 The Trust Board Programme of Work

The programme is as planned, with the exception of the Quality Strategy update, which will be combined with a refreshed Clinical Strategy and brought to March 2019 meeting.

8.2 Board Development Programme

Members met on Thursday 15th November 2018 as part of this development programme, where we invited a partner to undertake some shared perspectives. This was an insightful use of time.

8.3 Remuneration Committee

I can confirm that the Remuneration Committee met on Tuesday 25th November 2018.

8.4 Board Walkabouts

I am pleased to confirm trust board members have undertaken a breadth of walkabouts across the Trust, noted below for information and assurance, between April 2018 and end of October 2018, as demonstrated by the table below.

<table>
<thead>
<tr>
<th>Ward 4</th>
<th>Hospital Sterile &amp; Disinfecting Unit (HSDU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Nurses, Waters Green</td>
<td>Knutsford Hospital</td>
</tr>
<tr>
<td>Human Resources (HR) Department</td>
<td>Surgical Treatment Room</td>
</tr>
<tr>
<td>Matron’s meeting</td>
<td>Ward 7</td>
</tr>
<tr>
<td>Two Grand Rounds covering topics both Ophthalmology and Coroner’s service</td>
<td>Acute and Integrated Care, both Directorate and SQS Team meetings</td>
</tr>
<tr>
<td>Finance team</td>
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<td>Customer Care/Patient Advice and Liaison (PALs) team</td>
<td>Ward 9; Special Care Unit; Medical Secretaries</td>
</tr>
<tr>
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<td>e-Rostering Team</td>
</tr>
<tr>
<td>Medical Education Team</td>
<td>Ward 4</td>
</tr>
<tr>
<td>Ward 10 x 2</td>
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</tr>
<tr>
<td>Professional Practice Team</td>
<td>Ward 8 Medical Assessment Unit (MAU)</td>
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Chairman: Lynn McGill
Chief Executive: John Wilbraham
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<td>Ophthalmology Outpatients</td>
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<tr>
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<td>Recruitment Team</td>
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<tr>
<td>Ward 11</td>
<td>Wards 1 &amp; 2</td>
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<td>‘Out of Hours’ District Nursing Team meeting</td>
<td>Theatres Team</td>
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<td>Radiology and X Ray team</td>
<td>Infection Control Team</td>
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<td>Library and Knowledge team</td>
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Lynn McGill

Chairman
Public Trust Board  
Thursday 6th December 2018

Agenda Item Number 15: TB 18 (95)

<table>
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<tr>
<th>Report of:</th>
<th>Director of Corporate Affairs &amp; Governance</th>
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<tr>
<td>Responsible Officer:</td>
<td>Fiona Baker, Corporate Affairs &amp; EPRR Manager</td>
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<td>Accountable Officer:</td>
<td></td>
</tr>
<tr>
<td>Author of Report:</td>
<td></td>
</tr>
<tr>
<td>Subject/Title</td>
<td>Fit &amp; Proper Persons Policy</td>
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<td>Background papers (if relevant)</td>
<td>Fit &amp; Proper Persons Guidance (formerly contained in the Corporate Governance Manual)</td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>To formalise the trust's Fit &amp; Proper Persons process into trust policy</td>
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<tr>
<td>Action/Decision required</td>
<td>Approval of the policy</td>
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<td>Mitigates Risk Number: (identify) On Corporate Risk Register</td>
<td>Links to all risks identified within the Assurance Framework and the Corporate Risk Register</td>
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| Link to Care Quality Commission Domain | Safe  
Caring  
Responsive  
Effective  
Well-led ✓ |
| Link to: |  
➢ Trust's Strategic Direction  
➢ Corporate Objectives |
| Legal implications - (identify) | None |
| Impact on quality | Positive Impact on Quality |
| Resource impact | None |
| Impact of equality/diversity | Positive Impact |
| Avoid acronyms or abbreviations - if necessary list: | None |
Fit & Proper Persons Policy

The attached proposed policy will ensure trust compliance with the Care Quality Commissions Regulation 5 requirements of the Fit & Proper Persons Regulations.

1 INTRODUCTION

All Board level Directors are required to participate in annual Fit & Proper Persons test

1.2 The Fit & Proper Persons regulations came into force in November 2014. These regulations require trusts to assure themselves that all Trust Board members and those individuals who perform the duties of a Trust Board member are fit and proper individuals to carry out the important role of Director.

1.2 Historically the trust has had a process in place to ensure the regulations were adhered to; this process is being extended to include those Deputy Directors that deputise for their Director at Board.

The process for ensuring compliance has been strengthened

2.2 The process has been reinforced and developed into a Fit & Proper Persons policy to strengthen the trusts compliance with the regulation.

2 RECOMMENDATION

2.1 The Board are asked to approve the new Fit & Proper Persons Policy noting the additional requirement for the following Deputy Directors to participate in an annual Fit & Proper Person’s test including a self-assessment:
- Deputy Director of Corporate Affairs & Governance
- Deputy Director of Nursing and Performance
- Deputy Director of HR and Organisational Development
- Deputy Director of Finance

Sign-off

Fiona Baker

Title

Corporate Affairs & EPRR Manager
Fit & Proper Persons
Policy
**Policy Title:** Fit & Proper Persons Policy

**Executive Summary:** This policy will ensure trust compliance with the Care Quality Commission Regulation 5 requirements of the Fit & Proper Persons Regulations. It outlines the processes the trust has in place and ensures that Trust Board members and Deputy Directors (as listed at 1.1) undertake their annual requirement to complete a self-declaration to confirm that they are of good character, possess the right competencies and skills and be physically and mentally fit to do the job in with the Equality Act 2010.

**Supersedes:** Fit & Proper Persons Test – agreed via the Corporate Governance Manual March 2018.

**Description of Amendment(s):** Updated throughout including extending the FPPR test to include Deputy Directors (those listed at 1.1) as well as Trust Board members.

**This policy will impact on:**

**Financial Implications:**

<table>
<thead>
<tr>
<th>Policy Area:</th>
<th>Board members and their deputies</th>
<th>Document Reference:</th>
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<tr>
<td>Version Number:</td>
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<td>Effective Date:</td>
</tr>
<tr>
<td>Issued By:</td>
<td>Corporate Affairs &amp; EPRR Manager</td>
<td>Review Date:</td>
</tr>
<tr>
<td>Author:</td>
<td>Corporate Affairs &amp; EPRR Manager</td>
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**APPROVAL RECORD**

<table>
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<tr>
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<td>Director of Corporate Affairs &amp; Governance</td>
</tr>
<tr>
<td>Ratified by:</td>
<td>Trust Board</td>
</tr>
<tr>
<td>Received for information:</td>
<td>Trust Board members and their deputies</td>
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</table>
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3. Responsibilities Page 5
4. Fit & Proper Persons Requirements Page 5
5. Breaching the Requirements Page 6
6. Being held to Account Page 6
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4. Outlining the Process Page 8

Appendices

Appendix A - CQC provision of information
Appendix B - Fit and Proper Persons Test – Self Declaration Form
Appendix C - Fit and Proper Persons Test – Checklist
1. Introduction and Background

1.1 The Fit & Proper Persons Regulation (FPPR) came into force for all NHS Trusts and Foundation Trusts in November 2014. The regulations require trusts to assure themselves that all Trust Board members and individuals who perform the duties of a Trust Board member are fit and proper individuals to carry out the important role of Director irrespective of their voting rights.

For East Cheshire NHS Trust this means:

**Board members** -

- Non-executive Directors (NEDs) including the Chairman
- Executive Directors

*The following Deputy Directors who represent Executives at Board:*

- Deputy Director of Corporate Affairs & Governance
- Deputy Director of Finance
- Deputy Director of Nursing & Quality
- Deputy Director of Human Resources and Organisational Development

2. Purpose

2.1 The purpose of the FPPR is not only to hold the above to account in relation to their conduct and performance, but also to instil confidence in the public that the individuals leading NHS organisations are suitable to hold their positions.

2.2 As an NHS provider, the trust is required to demonstrate that appropriate processes are in place to confirm that Trust Board members and Deputy Directors are of good character; possess the right competencies and skills and be physically and mentally fit to do the job in with the Equality Act 2010.

2.3 East Cheshire NHS Trust will undertake a FPPR test on recruitment and thereafter annually.

3. Responsibilities

3.1 **The Chairman** is accountable for discharging the requirement to ensure that all Trust Board members meet the fitness test and do not meet any of the ‘unfit’ criteria and for ensuring that the findings of the annual Fit & Proper Persons test are shared in the public domain.

3.2 **The Chief Executive** has overall accountability for ensuring that the trust has appropriate policies and robust monitoring arrangements in place.

3.3 **The Director of Corporate Affairs & Governance** has delegated accountability for ensuring that all newly appointed Trust Board members and those Deputy Directors as
noted above have undertaken the Fit & Proper Persons test on recruitment and annually thereafter. They have responsibility of discharging the requirement to ensure that Deputy Directors meet the fitness test and do not meet any of the ‘unfit’ criteria. The Director of Corporate Affairs & Governance has accountability for ensuring that the trusts Fit & Proper Persons Policy is in place.

3.4 **Trust Board members** are responsible for ensuring that they submit a Fit & Proper Persons self-declaration on an annual basis and that they adhere to the guidelines of this policy.

3.5 **Deputy Directors** namely: Deputy Director of Corporate Affairs & Governance, Deputy Director of Finance, Deputy Director of HR & OD, Deputy Director of Nursing & Quality are responsible for ensuring that they submit a Fit & Proper Persons self-declaration on an annual basis and that they adhere to the guidelines of this policy.

3.6 **The Corporate Affairs Manager** is responsible for ensuring that the Fit & Proper Persons Policy is current and reviewed as necessary including following any new guidance. They are responsible for co-ordinating the annual Fit & Proper Persons test and for ensuring all information is sourced and shared with either The Chairman or the Director of Corporate Affairs & Governance (as appropriate). The Corporate Affairs Manager is responsible for ensuring all relevant information is stored appropriately and in line with trust policies (including the DBS policy).

### 4. Fit & Proper Persons Requirements

4.1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 places a duty on Trusts to ensure that their Trust Board members and individuals who perform the duties of a Trust Board member (for East Cheshire NHS Trust this means those Deputy Directors stated at section 1.1) are not appointed or allowed to continue being employed by the trust unless they can demonstrate the below requirements:

- Are of good character – that is
  - Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence; and
  - Have been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals;
- Have the necessary qualifications, skills and experience;
- Are able to perform the work that they are employed for after reasonable adjustments are made;
- Have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;
- Can supply information as set out in Schedule 3 of the 2014 Regulations when requested by the Care Quality Commission (see Appendix A).

4.2 Categories of ‘unfitness’ that would prevent people from holding office or necessitate their removal from their position as a Board Member or Deputy Director, and for whom there is no discretion includes:

- The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy
restrictions order or an order to like effect made in Scotland or Northern Ireland;

- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40);
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
- The person is included in the children’s barred list or the adults’ barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

4.3 The regulations stipulate that a Trust Board member or Deputy Director would be considered unfit if they were included on a barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006 or on any corresponding list.

5. Breaching the Requirements

5.1 The FPPR may be breached should the trust have in place someone who does not satisfy the FPPR requirements; evidence of this could be if:

- A Board member or Deputy Director is unfit on a ‘mandatory’ ground, such as a relevant undischargeable conviction or bankruptcy; the trust will determine this;
- The trust does not have a proper process in place to enable it to make the robust assessments required by the FPPR;
- On receipt of information about a Board member or Deputy Director’s fitness, a decision is reached on the fitness of the individual that is not in the range of decisions that a reasonable person would make; and
- A Board member or Deputy Director has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere, which if provided in England, would be a regulated activity.

6. Being held to Account

6.1 The CQC holds Trusts to account in relation to the FPPR through the well-led key question of its regulatory model; during a well-led inspection the CQC will always consider FPPR issues including whether the trust has a robust system in place to ensure all relevant Trust Board members and individuals who perform the duties of a Trust Board member meet the requirement at the recruitment stage and subsequently throughout that persons employment. This may involve:

- Checking their personnel files;
- Checking information or records about appraisal rates; and
- Checking that the trust is aware of the various guidelines on recruiting Trust Board members and Deputy Directors and that the trust has implemented procedures in line with this best practice.

6.2 If the CQC is concerned that a trust is not discharging its FPPR responsibilities properly, it may take enforcement action against the trust such as cancelling the trusts registration or they may consider prosecution.
6.3 It will be the responsibility of the Chairman to discharge the requirement to ensure that all Trust Board members meet the fitness test and do not meet any of the ‘unfit’ criteria; it will be the responsibility of the Director of Corporate Affairs & Governance to ensure that all Deputy Directors (as identified in section 1.1) meet the fitness test and do not meet any of the ‘unfit’ criteria.

6.4 CQC and Trust Response to concerns about a Trust Board Member or Deputy Director

6.4.1 CQC guidance sets out how they will respond to concerning information about a Trust Board member or those Deputy Directors that perform the duties of a Trust Board member from the public or members of staff. The CQC may decide to convene a management review meeting to determine if the information indicates a potential FPPR concern and needs following up with the individual and the trust.

6.4.2 The CQC would then send all information that falls under the FPPR to the trust and ask the trust to respond with regards to intended action (within 10 days).

7.1 During recruitment and annually thereafter, Trust Board members and those Deputy Directors listed previously in section 1.1 will:

- Undertake a self-assessment of their fitness to act in their position

7.2 The FPPR test also requires the following to be undertaken during the recruitment stage and annually thereafter:

- The Insolvency, Bankruptcy and Disqualified Directors registers will be checked to ensure no Trust Board member of Deputy Director is named on them;
- A review of the trusts Conflict of Interest Database will take place to ensure compliance (on appointment Trust Board members and Deputy Directors will be asked to make a declaration within 28 days of appointment);
- Confirmation will be sought that there are no HR or Whistleblowing issues that may deem the Trust Board member or Deputy Director unfit for post;
- A review of the professional body will take place if appropriate (ie General Medical Council, Nursing & Midwifery Council); and
- Their current DBS will be reviewed to ensure compliance (it is the responsibility of the individual concerned to ensure that they have a current DBS)

7.3 The self-assessment form used by the trust can be found at Appendix B. Guidance relating to the Fit & Proper Persons test issued by the CQC can be found at Appendix C.

7.4 Good Character

7.4.1 While there is no statutory guidance on what constitutes ‘good character’, it names the following features that are ‘normally associated’ with good character that will be taken into account when assessing an individual under FPPR, these are:

- Honesty;
- Trustworthiness;
- Integrity;
- Openness;
- Ability to comply with the law;
- A person in whom the public can have confidence;
- Prior employment history, including reasons for leaving;
- If the individual has been subject to any investigations or proceedings by a professional or regulatory body;
- Any breaches of the Nolan principles of Public Life;
- Any breaches of the duties imposed on the Trust Board member of Deputy Director under the Companies Act;
- The extent to which the Trust Board member of Deputy Director has been open and honest with the trust; and
- Any other information which may be relevant, such as disciplinary action taken by an employer.

7.5 Disclosure and Barring Service (DBS):

7.5.1 A DBS provides access to information across England and Wales about criminal convictions and other police records. The check relates to the data held about an individual’s criminal history including (in most cases) cautions, convictions, reprimands and final warnings. It may also include traffic offenses such as speeding and drink driving.

7.5.2 A DBS is required for all Trust Board members and those Deputy Directors listed at section 1.1; the type of DBS required is dependent on the position held. See below:

- Non-Executive Directors including The Chairman – Standard DBS (via the trusts HR processes);
- Executive Directors – Enhanced DBS without Barred List information or with Children’s and Adult’s Barred List information (via the trusts HR processes) unless that Executive Director undertakes controlled drugs destruction and then the Capita process and application applies; and
- Deputy Directors – Enhanced DBS without Barred List information or with Children’s and Adult’s Barred List information (via the trusts HR processes) unless that Deputy Director undertakes controlled drugs destruction and then the Capita process and application applies.

7.5.3 DBS checks should be completed as part of the trusts recruitment process and then refreshed every 3 years thereafter. It is the Trust Board member and the Deputy Directors responsibility to ensure that their DBS remains current.

7.5.4 For further guidance relating to DBS, please refer to the trusts DBS Policy (which can be found on the intranet under policies); the policy explains eligibility for DBS checks and what each level covers.

7.5.5 Once a DBS has been carried out and a certificate obtained, the certificate should be brought into the Chairman’s office so that details such as the unique reference number, type of DBS (ie level) and date it was issued can be recorded. A copy of the certificate is not kept by the trust.
8. Outlining the Process

8.1 Figure 1 below outlines the process to be adopted by the trust in making new appointments to the Trust Board and for those Deputy Directors listed at section 1.1. Figures 2 and 3 outline the review process for existing Trust Board members and Deputy Directors listed at section 1.1.

---

**Figure 1: Fit and Proper Persons Test for New Appointments**

- **Application and Interview**
  - *Provisional Offer (Subject to Fit and Proper Persons Test and suitable references)*
    - **Non-Executive Directors**
      - Undertake Fit and Proper Persons Test
        - Process led by NHS Improvement but completed by Trust
          - The following checks to be carried out on behalf of NHS:
            - Self-assessment FPR
            - Search of Disqualified Director Registry
            - Search of Insolvency, Bankruptcy Register
            - Review of Professional Bodies (if relevant)
            - Occupational Health Check
            - DBS Check
          - NHS Improvement process to consider appointment
          - **No Issues**
            - Confirm Appointment
          - **Issues**
            - Consider appointment taking account of issues
            - Confirm Appointment noting why exception made (if permitted)
            - Withdraw Provisional Offer
    - **Executive/Deputy Directors**
      - Undertake Fit and Proper Persons Test
        - Process led by East Cheshire NHS Trust
          - The following checks to be completed:
            - Self-assessment FPR
            - Search of Disqualified Director Registry
            - Search of Insolvency, Bankruptcy Register
            - Review of Professional Bodies (if relevant)
            - Occupational Health Check
            - DBS Check
Figure 2: Fit and Proper Persons Annual Process for Trust Board Members

**Undertake Fit and Proper Persons Test**

*All Trust Board members: The process is lead by East Cheshire NHS Trust*

**Self-Assessment**

- Trust Board member completes FPP self-declaration form and returns it to the Chairman’s office

**Chairman’s office to check the following:**

- Regulatory bodies are checked (where relevant)
- DNA status is reviewed and renewed if necessary
- Review of suitability conducted for any potential candidates
- Check of disqualified register conducted
- Check of bankruptcy register conducted
- HR Director checks to see if there are any outstanding HR issues or concerns
- FPP process has been undertaken, there are no issues of concern
- Whistleblowing: check with trust
- Consider conflict of interest register conducted to ensure compliance

**Corporate Affairs Manager to notify Trust secretary of the outcome of the FPP Test**

**Trust Secretary to inform Chair / Senior Independent Director of the outcomes of the FPP Test**

- **No issues**
  - Confirm FPP test results

- **Issues**
  - Consider continued employment taking into account of issue(s) and regulations
    - Confirm FPP test pass noting why exception has been made
    - Undertake steps to remove from post

**Appeal Process**
8.2 Reporting on the FPPR test:

8.2.1 Annual FPPR checks will take place during January each year the outcomes of which will be reported by The Chairman in their March commentary to Trust Board.

Appendices

Appendix A - CQC provision of information
Appendix B - Fit and Proper Persons Test – Self Declaration Form
Appendix C - Fit and Proper Persons Test – Checklist
Appendix A

The CQC has the right to require the provision of information set out in Schedule 3 of the 2014 Regulations and such other information as is kept by the organisation that is relevant to the individual as follows:

- proof of identity including a recent photograph;
- where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(38), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(39);
- where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults;
- satisfactory evidence of conduct in previous employment concerned with the provision of services relating to:
  - health or social care, or
  - children or vulnerable adults
- where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P’s employment in that position ended;
- in so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform;
- a full employment history, together with a satisfactory written explanation of any gaps in employment;
- satisfactory information about any physical or mental health conditions which are relevant to the person’s capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity;
- for the purposes of this Schedule:
  - ‘the appointed day’ means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force,
  - ‘satisfactory’ means satisfactory in the opinion of the CQC,
  - ‘suitability information relating to children or vulnerable adults’ means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.
Appendix B

Fit and Proper Persons Test – Self Declaration Form

Under Regulation 5 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (and subsequent amendments), the following are expected to make a self-declaration on appointment and annually thereafter:

**Trust Board members, Deputy Directors of HR, Corporate Affairs & Governance, Nursing and Quality and Finance.**

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<thead>
<tr>
<th>DECLARATION</th>
<th>Please confirm Yes or No</th>
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<tbody>
<tr>
<td>I can confirm that I am of good character by virtue of the following:</td>
<td></td>
</tr>
<tr>
<td>I have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence</td>
<td></td>
</tr>
<tr>
<td>I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.</td>
<td></td>
</tr>
<tr>
<td>I have not been sentenced to imprisonment for three months or more within the last five years</td>
<td></td>
</tr>
<tr>
<td>I am not an undischarged bankrupt</td>
<td></td>
</tr>
<tr>
<td>I am not the subject of a bankruptcy order or an interim bankruptcy order</td>
<td></td>
</tr>
<tr>
<td>I do not have an undischarged arrangement with creditors</td>
<td></td>
</tr>
<tr>
<td>I am not included on any barring list preventing them from working with children or vulnerable adults</td>
<td></td>
</tr>
<tr>
<td>I have the qualifications, skills and experience necessary for the position I hold at the Trust</td>
<td></td>
</tr>
<tr>
<td>I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010</td>
<td></td>
</tr>
<tr>
<td>I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider</td>
<td></td>
</tr>
<tr>
<td>I am not prohibited from holding the relevant position under any other law (e.g., under the Companies Act or the Charities Act).</td>
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Signed & Name:

Position:

Date:

Date of Birth:

Home Address:
## Appendix C

### Fit and Proper Persons Test - Complying with the regulations

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<th>Evidence</th>
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<td>At appointment</td>
<td>Employment checks in accordance with NHS Employment Check Standards issued by NHS Employers including:</td>
<td>References;</td>
</tr>
<tr>
<td></td>
<td>• two references, one of which must be most recent employer;</td>
<td>Outcome of other pre-employment checks;</td>
</tr>
<tr>
<td></td>
<td>• qualification and professional registration checks;</td>
<td>DBS checks where appropriate;</td>
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<tr>
<td></td>
<td>• right to work checks;</td>
<td>Register search results;</td>
</tr>
<tr>
<td></td>
<td>• proof of identity checks;</td>
<td>List of referees and sources of assurance for FOIA purposes.</td>
</tr>
<tr>
<td></td>
<td>• occupational health clearance;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DBS checks (where appropriate);</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• search of insolvency and bankruptcy register;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• search of disqualified directors register.</td>
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</table>

1. Providers should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations.

(Sch.4, Part 2: Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.

Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.)
<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Where a provider deems the individual suitable despite not meeting the characteristics outlined in Schedule 4, Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware.</td>
<td>Report and debate at the nominations committee(s). Report and recommendation at the council of governors (for NEDs) or the board of directors (for EDs) for foundation trusts, reports to the board for NHS trusts. Decisions and reasons for decisions recorded in minutes. External advice sought as necessary.</td>
<td>Record that due process was followed for FOIA purposes.</td>
</tr>
<tr>
<td>3. Where specific qualifications are deemed by the provider as necessary for a role, the provider must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator.</td>
<td>Requirements included within the job description for all relevant posts. Checked as part of the pre-employment checks and references on qualifications. Requirements included within the job description for all relevant posts. Checked as part of the pre-employment checks and references on qualifications.</td>
<td>Person specification Recruitment policy and procedure</td>
</tr>
<tr>
<td>N.B. While this provision most obviously applies to executive director appointments in terms of qualifications, skills and experience will be relevant to NED appointments and to Deputy Directors (as identified in section 1.1)</td>
<td>Employment checks include a candidate’s qualifications and employment references. Recruitment processes include qualitative assessment and values-based questions. Decisions and reasons for decisions recorded in minutes.</td>
<td>Recruitment policy and procedure Values-based questions Minutes of board of directors.</td>
</tr>
<tr>
<td>4. The provider should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, (which may include appropriate communication and leaderships skills and a caring and compassionate nature), to undertake the role; these should be followed in all cases and relevant records kept.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>Assurance process</td>
<td>Evidence</td>
</tr>
<tr>
<td>----------</td>
<td>------------------</td>
<td>----------</td>
</tr>
<tr>
<td>5. In addition to 4 above, a provider may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe.</td>
<td>Discussions and recommendations by the nominations committee(s). Discussion and decision at board of directors meeting. Reports, discussion and recommendations recorded in minutes of meetings. Follow-up as part of continuing review and appraisal.</td>
<td>Discussions and recommendations by the nominations committee(s). Discussion and decision at board of directors meeting. Reports, discussion and recommendations recorded in minutes of meetings. Follow-up as part of continuing review and appraisal.</td>
</tr>
<tr>
<td>6. When appointing relevant individuals the provider has processes for considering a person’s physical and mental health in line with the requirements of the role, all subject to equalities and employment legislation and to due process.</td>
<td>Self-declaration subject to clearance by occupational health as part of the pre-employment process.</td>
<td>Occupational health clearance</td>
</tr>
<tr>
<td>7. Wherever possible, reasonable adjustments are made in order that an individual can carry out the role.</td>
<td>Self-declaration of adjustments required. NHS Employment Check Standards Board decision</td>
<td>Minutes of board meeting meeting</td>
</tr>
<tr>
<td>Standard</td>
<td>Assurance process</td>
<td>Evidence</td>
</tr>
<tr>
<td>----------</td>
<td>------------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| 8. The provider has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. | Consequences of false or inaccurate or incomplete information included in recruitment packs. Checks set out in 1. Above i.e. Employment checks in accordance with NHS Employers pre-employment check standards including:  
- self-declarations of fitness including explanation of past conduct/character issues where appropriate by candidates;  
- two references, one of which must be most recent employer;  
- qualification and professional registration checks;  
- right to work checks;  
- proof of identity checks;  
- occupational health clearance;  
- DBS checks (where appropriate);  
- search of insolvency and bankruptcy register;  
- search of disqualified directors register. Included in reference requests. | NED Recruitment Information pack  
Reference Request for ED/NED/Deputy Director |

('Regulated activity' means activities set out in Schedule 1, Regulated Activities, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Schedule 1 covers the provision of:
- personal care; accommodation for persons who require nursing or personal care; accommodation for persons who require treatment for substance misuse; treatment of disease, disorder or injury; assessment or medical treatment for persons detained under the 1983 Act; surgical procedures; diagnostic and screening procedures; management of supply of blood and blood derived products etc.; transport services, triage and medical advice provided remotely; maternity and midwifery services; termination of pregnancies; services in slimming clinics; nursing care; family planning services.

'Responsible for, contributed to or facilitated' means that there is evidence that a person has intentionally or through neglect behaved in a manner which would be considered to be or would have led to serious misconduct or mismanagement.

'Privy to' means that there is evidence that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed.

'Serious misconduct or mismanagement' means behaviour that would constitute a breach of any legislation/enactment CQC deems relevant to meeting these regulations or their component parts.

N.B. This provision applies equally to executives, NEDs and Deputy Directors.)
<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. The provider must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. N.B. The CQC accepts that providers will use reasonable endeavours in this instance. The existence of a compromise agreement does not indemnify the new employer and providers will need to ensure that their Core HR policies address their approach to compromise agreements.</td>
<td>Consequences of false, inaccurate or incomplete information included in recruitment packs. Core HR policies for appointments and remuneration Checks set out in Section 1 above. Included in reference requests.</td>
<td>NED, ED and Deputy Director Recruitment Information packs Core HR policies Reference Request for ED, NED and Deputy Director</td>
</tr>
<tr>
<td>10. Only individuals who will be acting in a role that falls within the definition of a ‘regulated activity’ as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS). N.B. The CQC recognises that it may not always be possible for providers to access a DBS check as an individual may not be eligible.</td>
<td>DBS checks are undertaken only for those posts which fall within the definition of a “regulated activity” or which are otherwise eligible for such a check to be undertaken.</td>
<td>DBS policy DBS checks for eligible post-holders</td>
</tr>
<tr>
<td>11. As part of the recruitment/appointment process, providers should establish whether the individual is on a relevant DBS list. Continuing provisions.</td>
<td>Eligibility for DBS checks will be assessed for each vacancy arising.</td>
<td>DBS policy</td>
</tr>
<tr>
<td>12. The fitness of Trust Board members and Deputy Directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role. Assessment of continued fitness to be undertaken each year. Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year. Chairman/DCAG review checks and agree the outcomes.</td>
<td>Continual to be assessed annually as part of the Board’s Fit &amp; Proper persons checks (January each year) Register checks if necessary Board minutes record that process has been followed.</td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>Assurance process</td>
<td>Evidence</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>13. If a provider discovers information that suggests an individual is not of good character after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter. The provider has arrangements in place to respond to concerns about a person’s fitness after they are appointed to a role, identified by itself or others and these are adhered to.</td>
<td>Core HR policies provides for such investigations. Revised contracts allow for termination in the event of non-compliance with regulations and other requirements. Contracts (for EDs and director-equivalents) and agreements (for NEDs) incorporate maintenance of fitness as a contractual requirement.</td>
<td>Core HR policies Contracts of employment (for EDs and director-equivalents) Service agreements or equivalent (for NEDs)</td>
</tr>
<tr>
<td>14. The provider investigates, in a timely manner, any concerns about a person’s fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the provider must demonstrate due diligence in all actions.</td>
<td>Core HR policies include the necessary provisions. Action taken and recorded as required</td>
<td>Core HR policies</td>
</tr>
<tr>
<td>15. Where a person’s fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users.</td>
<td>Core HR policies</td>
<td>Managerial action taken to backfill posts as necessary.</td>
</tr>
<tr>
<td>16. The provider informs others as appropriate about concerns/findings relating to a person’s fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/investigations carried out by others.</td>
<td>Core HR policies</td>
<td>Referrals made to other agencies if necessary.</td>
</tr>
</tbody>
</table>
**Report of:**
**Responsible Officer:**
**Accountable Officer:**

| Director of Nursing, Performance & Quality |

**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)**

| 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 |

**Link to Care Quality Commission Domain**

| Safe |
| Caring |
| Responsive |
| Effective |
| Well-led |

**Link to:**

- Trust’s Strategic Direction
- Corporate Objectives

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

**Legal implications - (identify)**

| No legal implications |

**Impact on quality**

| May potentially impact upon the quality of care, patient experience, patient outcomes and staff well being |

**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

<table>
<thead>
<tr>
<th>Impact of equality/diversity</th>
<th>No impact on equality and diversity</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>NHSI</td>
<td>National Health Service Improvement</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole time equivalent</td>
</tr>
<tr>
<td>RAG</td>
<td>Red Amber Green</td>
</tr>
<tr>
<td>HCA</td>
<td>Healthcare Assistant</td>
</tr>
<tr>
<td>TUPE</td>
<td>Transfer of Undertaking (Protection of Employment) regulations</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
</tbody>
</table>
Safe Staffing Levels – Exception Report

This report provides a high level summary of Safe Staffing levels on all inpatient wards across the Trust, an overview of community nurse vacancy and intermediate care 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

1.1 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

2.1 All acute ward areas were above the 95% safe staffing threshold during October 2018, with the exception of Post Natal and Labour Wards, Ward 1 and Aston.

2.2 Post-natal and labour ward Registered Midwife actual fill rate during the day was 93.8% compared to 96.5% in September. Healthcare assistant actual fill rate overnight was 93.6% compared to 85% in September. This is due to 1.6 wte midwife vacancies although 3 new midwives are due to commence in post during November. Short term sickness impacted upon HCA actual fill rate overnight. However, recent recruitment and the upskilling of staff via the maternity care assistant apprenticeship programme will support a sustainable workforce development model going forward.

Mitigating actions include utilization of midwife on call x2 overnight, use of Band 7 management support 12-8 and non-midwifery staff Monday to Friday 9-5 to maintain safe staffing levels.

2.3 Ward 1 Registered Nurse actual fill rate during the day was 80.8% compared to 98.6% in September 2018. This variance is due to the re-provision of 6 surgical beds on Ward 4 to enable fire precautions work to be completed. In effect, a registered nurse from Ward 1 was redeployed to maintain skill mix and safe staffing levels in view of the increase in Ward 4’s overall footprint.

Two out of the last cohort of 3 international nurses successfully passed...
successfully passed OSCE 2.4 Wards 3 and 4. No further international nurses are in the pipeline.

12 HCA unfilled Bank shift requests and long term sickness on Aston Ward impacted upon actual fill rate although an improved position compared to September 2.5 Aston Ward Healthcare Assistant actual fill rate during the day was 91.8% compared to 86% in September. 12 unfilled Healthcare Assistant bank requests for cohort 1:1 nursing coupled with long term sickness x 1 impacted upon actual fill rate. Mitigating actions to maintain safe staffing levels included senior sister stepping down to support clinical care and facilitate safe admission and discharges. In addition one substantive Healthcare Assistant post has successfully been recruited to pending satisfactory pre-employment checks.

Patient complexities, acuity, dependency and the opening of flex capacity is reflected in actual HCA fill rates which exceeded 125% to maintain patient safety 2.6 A number of wards actual fill rate for unregistered staff exceeded 125% during the night which is reflective of case mix complexities, patient dependency, 1:1 enhanced cohort nursing and the opening of additional flex capacity during peak operational pressures in October. Additional staff were required to enable the delivery of safe patient care and support adequate staffing levels.

SafeCare (Allocate) live acuity and dependency tool continues to be embedded and utilized to support workforce deployment 2.7 Daily staffing requirements are assessed by the ‘Matron of the Day’ 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. Decisions to redeploy staff are based on and supported by the utilization of live acuity and dependency data via SafeCare and clinical professional judgement.

3 RECRUITMENT

Registered Nurse acute vacancies in month decreased to 44.31 wte compared to 47.8 wte in September 3.1 In month registered nurse vacancies across all acute in-patient ward areas were at 44.31 wte compared to 47.8 wte the previous month. This excludes Maternity Leave and Long Term Sickness. Inclusion of Maternity Leave (14.95 wte) and Long Term Sickness (8.24 wte) demonstrates a slight decrease in the overall registered nurse gap to 67.5 wte compared to 68.92 wte during September.

Increased levels of LTS continue to impact upon the overall wte RN shortfall 3.2 A Registered Nurse recruitment event was held on Wednesday 17th October which resulted in 7 RN substantive posts being offered of which 5 were Student Nurses on successful qualification. Currently, 14 Acute and 1 Community RN posts are subject to pre-employment checks. The majority of posts recruited to are for specialist areas or teams opposed to ward based roles. Of the 5 ward based roles appointed to the majority are student nurses pending successful qualification between September 2018 and March 2019.

Chairman: Lynn McGill
Chief Executive: John Wilbraham
The overall identified shortfall within community teams demonstrates an improved position compared to the previous month. Currently, community vacancies overall are 0.78 wte although a number of teams (3) remain slightly over their funded establishment which offsets the true number of vacancies in individual teams. Inclusion of maternity leave (4.4) and long term sickness (0.9) challenges smaller district nursing teams – the overall gap however has reduced from 10.48 wte to 6.09 wte. Mitigation includes utilization of bank where possible and staff working flexibly.

Currently, intermediate care vacancies are 2.24 wte of which one has recently been recruited to pending satisfactory pre-employment checks. Inclusion of long term sickness (0.9) increases the overall gap to 3.14 wte. Delays in recruiting to the vacant posts have in part been due to additional expenditure in wraparound which resides within the intermediate care budget.

Intermediate Care vacancies currently 2.24 wte

All 9 TNA’s have secured substantive positions from January 2019 pending successful completion of the training programme.

9 staff members are currently in their second year of the Trust’s Nursing Associate Pilot training programme and are due to complete in January 2019. All 9 TNA’s have secured substantive positions aligned to service need and preferred personal choices.

A further cohort of 6 TNA commence training in December 2018 following successful recruitment and selection processes.

A further cohort of 6 trainee nursing associates commence in December 2018 following successful recruitment and selection processes.

No Healthcare Assistant interviews were held during October in view of outstanding posts being filled. Currently 14 HCA posts are subject to pre-employment checks; Wards x 5, Pool x 5 and Bank x 4.

4 RETENTION

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

As part of the NHSI 90 day improvement programme the Trust has now launched a new Retention Model “RETAIN”. An action plan is in place and working groups established to support and progress initiatives. The Trusts new Retention Model is now embedded and 12 month rolling nursing turnover in October was 9.52% which is below the 10% target set within the NHSI retention plan. Some key aspects of this include ‘buddying’ new starters with experienced nurses and ‘reconnect’ sessions with new starters – firstly at 30 days with a senior sister, then with a matron at 60 days and a further session with the Deputy Director of Nursing and Quality and Heads of Nursing at 90 days. A ‘Careers at East Cheshire NHS Trust’ twitter account has also been established to promote the opportunities available within the
Trust.

5 STAFF TURNOVER

In month staff turnover increased to 1.25%. In month staff turnover is 1.25% compared to 0.51% the previous month. YTD rolling staff turnover is 9.52% compared to 7.86% 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.

Kath Senior
Director of Nursing, Performance and Quality
Appendix 1: Safer Staffing Metrics
### Monthly Safe Staffing Report - October 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>Care Hours Per Patient Day (CHPPD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Care</td>
<td>Rehabilitation</td>
<td>Arvon</td>
<td>935.89</td>
<td>304.08</td>
<td>322.14</td>
<td>257.27</td>
<td>93.8%</td>
<td>88.9%</td>
<td>682.00</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>Cardiology</td>
<td>ECU</td>
<td>930.00</td>
<td>930.00</td>
<td>930.00</td>
<td>930.00</td>
<td>100.0%</td>
<td>100.0%</td>
<td>620.00</td>
</tr>
<tr>
<td>Women's &amp; Children's</td>
<td>Pediatrics</td>
<td>Alaska</td>
<td>2148.56</td>
<td>2148.56</td>
<td>2148.56</td>
<td>2148.56</td>
<td>100.0%</td>
<td>100.0%</td>
<td>1362.50</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Critical Care Medicine</td>
<td>Whitsune Care Unit</td>
<td>1800.00</td>
<td>1800.00</td>
<td>1100.00</td>
<td>1100.00</td>
<td>100.0%</td>
<td>100.0%</td>
<td>1426.00</td>
</tr>
<tr>
<td>Women's &amp; Children's</td>
<td>Obstetrics</td>
<td>Neo Natal Unit</td>
<td>797.01</td>
<td>794.30</td>
<td>794.30</td>
<td>794.30</td>
<td>100.0%</td>
<td>98.8%</td>
<td>713.00</td>
</tr>
<tr>
<td>Women's &amp; Children's</td>
<td>Obstetrics</td>
<td>Post Natal and Labour Ward</td>
<td>2453.10</td>
<td>2453.10</td>
<td>2453.10</td>
<td>2453.10</td>
<td>100.0%</td>
<td>100.0%</td>
<td>2000.00</td>
</tr>
<tr>
<td>General Specialties</td>
<td>General Surgery</td>
<td>Ward 1</td>
<td>1839.00</td>
<td>1577.56</td>
<td>1577.56</td>
<td>1577.56</td>
<td>86.1%</td>
<td>97.5%</td>
<td>1023.00</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>Trauma &amp; Orthopaedics</td>
<td>Ward 10</td>
<td>1907.00</td>
<td>1562.17</td>
<td>1562.17</td>
<td>1562.17</td>
<td>82.2%</td>
<td>97.8%</td>
<td>1023.00</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>Rehabilitation</td>
<td>Ward 11</td>
<td>1327.16</td>
<td>1143.81</td>
<td>1143.81</td>
<td>1143.81</td>
<td>85.8%</td>
<td>100.0%</td>
<td>682.00</td>
</tr>
<tr>
<td>General Specialties</td>
<td>General Surgery</td>
<td>Ward 12</td>
<td>1518.78</td>
<td>1384.01</td>
<td>1384.01</td>
<td>1384.01</td>
<td>90.5%</td>
<td>100.0%</td>
<td>682.00</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>General Medicine</td>
<td>Ward 13</td>
<td>3055.64</td>
<td>1613.55</td>
<td>1613.55</td>
<td>1613.55</td>
<td>100.0%</td>
<td>99.8%</td>
<td>1062.30</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>Respiratory Medicine</td>
<td>Ward 4</td>
<td>1552.88</td>
<td>1526.02</td>
<td>1526.02</td>
<td>1526.02</td>
<td>100.0%</td>
<td>99.9%</td>
<td>1062.30</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>General Medicine</td>
<td>Ward 7</td>
<td>1564.88</td>
<td>1580.83</td>
<td>1580.83</td>
<td>1580.83</td>
<td>100.0%</td>
<td>100.0%</td>
<td>1062.30</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>General Medicine</td>
<td>Ward BMAU</td>
<td>1022.00</td>
<td>1311.33</td>
<td>1311.33</td>
<td>1311.33</td>
<td>99.6%</td>
<td>112.7%</td>
<td>1364.00</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>General Medicine</td>
<td>Ward B (Breathing)</td>
<td>1564.95</td>
<td>1580.83</td>
<td>1580.83</td>
<td>1580.83</td>
<td>100.0%</td>
<td>100.0%</td>
<td>1064.00</td>
</tr>
</tbody>
</table>

**Notes:**
- CHPPD: Care Hours Per Patient Day
- Percent values indicate the percentage of target staffing
- Blue indicates > 95%
- Yellow indicates 80% < 95%
- Red indicates < 80%

Additional information and metrics are provided in the report, including RN, HCA, and other medical staff ratios and contributions to overall care and patient outcomes.
SAFETY, QUALITY AND STANDARDS COMMITTEE

Meeting Chair: Ali Harrison
Meeting Secretary: Bethan Rimmer

MINUTES OF MEETING HELD ON:
Tuesday 4th September, 12:00 – 14:00

Venue:
Boardroom 1, First Floor, New Alderley House

Present:

Name                  | Job Title                                | Abb.
----------------------|-------------------------------------------|
Ali Harrison          | Non-Executive Director                    | Ms Harrison
John Wilbraham        | Chief Executive                           | CEO
Julie Green           | Director of Corporate Affairs and Governance | DCAG
Kath Senior           | Director of Nursing, Performance and Quality | DNPQ
Dr John Hunter        | Medical Director                          | MD
Rachael Charlton      | Director of HR                            | DHR
Mark Ogden            | Director of Finance                       | DoF
Brian Green           | Deputy Director of Nursing and Quality    | DDNQ
Lorraine Jackman      | Deputy Director of Corporate Affairs and Governance | DDCAG
Dr Susan Knight       | Associate Medical Director for Clinical Effectiveness | AMDCE
Kashif Haque          | Chief Pharmacist                          | CP

IN ATTENDANCE:

Dr Tony Coombs        | Non-Executive Director                    | Dr Coombs
Bethan Rimmer         | Meeting Secretary/Minutes                 | BR

Agenda No | Agenda Item | Action
-----------|-------------|---------
18/87      | Patient Story |

The DNPQ presented a thank you letter received from a relative of a patient treated at the trust for colon cancer. Excellent care was noted from diagnosis to recovery, with good communication and quick response following the cancer diagnosis. A number of members of staff were individually thanked including the consultants, specialist nurses and staff nurses from the colorectal team and Ward 2. The patient is continuing to recover and has been given the news that they are cancer free.

The DNPQ highlighted the very positive story and the great care that was provided for this patient. The DNPQ confirmed that the letter has been shared with those members of staff highlighted.

18/88 Apologies

Peter Madden, Non-Executive Director

18/89 Conflict of Interest

There were no conflicts of interest noted.
18/90  Matters Arising

a) Year at a Glance
The updated Year at a Glance was noted by the Committee. The Chair highlighted that the Quarterly CQC Assurance Plan will be included within the Integrated Quality and Governance Report.

b) SQS Committee Minutes – August 2018
The Chair noted minor typographical errors within the minutes and agreed to provide these updates to the minute taker following the meeting.

The AMDCE highlighted one change; page 7, agenda item 18/79, 4th bullet should read ‘After the substantial rise in expected deaths in Quarter 4…’.

The Chair queried the wording on page 7, agenda item 18/80, 4th bullet point. KS confirmed this should read ‘…due to number of comorbidities with more complex discharge processes.’

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

c) Action Log

9768 – Complete. Action Closed.
7036 – Complete. Action Closed.
7037 – Action due at December’s meeting.
7038 – Complete. Action Closed.

There was one further action noted.
Action: The CP agreed to review the impact on the revised cancer breach allocation process on the trust and update the Committee outside the meeting.

CP

d) Collection of Any Other Business

None received.

e) Formal Request for Removal of Items from Consent Agenda

None received.
The DNPQ introduced the Integrated Quality and Governance Report, highlighting the following:

- Acute nurse vacancies have increased by 3wte to 47wte. Adding in long term sickness and maternity leave the level is approximately 63wte.
- There has been an increase in operational pressures in July compared to June. There were 24 mixed sex breaches in July (zero in June).
- Despite pressures, the trust has maintained positive responses through the Friends and Family tests.
- The ED 4 hour access standard achieved 87.9% against the 95% target.
- The diagnostics waiting times have deteriorated in July, largely due to cover for endoscopy lists due to annual leave. The prioritisation of urgent patients has impacted on routine cases.
- There has been a further increase in RTT and waiting list figures. Due to the elevated risk for the waiting list backlog, the risk register has been updated to a score of 20 (previously scored at 16).

The following was discussed:

- The Chair highlighted the positive work taking place and acknowledged the hard work of staff under the current pressures.
- The Chair noted despite pressures within ED there have been no complaints or incidents relating to delays in A&E. There were instances noted around communication and care coordination.
- Dr Coombs highlighted the nursing posts offered and those at pre-employment check stage and queried timeframes for completion. The DDNQ noted a number of these relate to student nurses who won’t qualify until March 2019.
- The DDNQ is leading on a retention and 90 day improvement project which is reviewing the recruitment and retention of staff. Analysis on newly qualified nurses has identified a proportion that leave within the first 12 months and work is ongoing to determine the potential cause and how those staff can be retained. The DDNQ added some new starters are lost during the recruitment stage due to other job opportunities.
- Dr Coombs queried whether there is a ‘buddy’ system for new nurses. The DDNQ advised that the Band 5 senior nurses have been identified as best placed to provide this support. The need to recognise the contribution of these senior nurses has been identified, and a change of uniform is being reviewed so they can be specifically identified.
- The DNPQ has met with the senior sisters on the wards and asked how they maintain contact with new staff going through the recruitment pipeline. There was good challenge and discussion within the meeting between staff on the level of engagement required. The DNPQ clarified it is the senior sister’s job to ensure new starters feel welcomed into the team before they start.
• Dr Coombs queried whether team leaders have retention targets within their personal targets. The DNPQ advised this is not presently in place.
• The MD queried advertisement of nursing vacancies. The DDNQ advised there are continuous recruitment adverts online through NHS Jobs and the recruitment events are run as often as possible.
• The DDNQ advised with the level of vacancies going into winter, the team are reviewing how to support on the wards through different staffing groups. The DNPQ added that meetings are taking place with ADs to ensure that mitigations were in place to manage the risk.
• The Chair queried the balance between specialist nurses and general nurses. The DNPQ advised this is being reviewed through the work on advanced clinical practice.
• The DoF noted the 22 new starters at pre-employment check stage and queried whether the trust was doing all it could to minimise delays. The DHR confirmed that the trust follows the NHS Employment pre-employment guidelines and the trust has a robust and timely process, which has been reviewed within the last couple of years. The DCAG confirmed this process has also been reviewed by the CQC. The DHR added the key is that there is engagement by the manager within the recruitment process; there is evidence that where the manager is actively engaged from interview to start date, this helps progress the recruitment more efficiently.
• The Chair queried the outcome of the two patients waiting longer than 104 days against the cancer target. The DNPQ confirmed that these patients have now been treated. The DCAG added that a check and challenge had taken place on the RCAs and confirmed that no harm was identified. Delays in diagnostics have impacted the pathway. There were areas identified within the trust’s control that can be improved upon.
• **Action:** The DNPQ agreed to review the two cases of patients with cancer pathways of longer than 104 days and confirm the total number of days prior to treatment.
• The Chair noted the approved capital request for replacement of ageing endoscopy equipment is being processed and queried whether the associated risk will reduce. The DCAG confirmed the risk is likely to decrease however this equipment is not yet in place. The Chair queried whether there is any further equipment in endoscopy that is not funded. The MD confirmed the scope guide is currently unfunded; this was due to reprioritisation of a replacement stacker.
• The DNPQ highlighted the Winter Plan is currently under discussion and development the Board will receive an update at the September Private Board meeting. A potential clinical risk for Winter is overcrowding in ED.
• The Chair highlighted a risk not reflected in the report, risk 2797, relating to long lines and requested further information. The DNPQ advised the HITS service historically supported the management of long lines for patients; this service has been decommissioned and long lines are typically covered by Consultant Anaesthetists. A long line goes from the chest into the heart. It has been identified that skill levels and competence have declined across ward staff and additional support is required. This was highlighted through Infection Control and the Acute and Integrated Community Care directorate and is being managed through the Professional Forum. The Critical Care Outreach team are currently supporting on the wards. The intention is to train up staff on the wards.
• The Chair queried how assurance will be provided to the committee that this is being managed and the risk will reduce. The DNPQ advised work is ongoing to strengthen the policy which will be taken to the Infection Control Committee for sign off. Dr Coombs queried whether this links to the community for district nurses. The DNPQ confirmed it does however patients are required to come into hospital for the lines to be fitted.

• The DNPQ noted a case within the report relating to a claim for clinical negligence due to a failure to prescribe medication for the correct length of time. On the risk assessment it states the prescription should have been for 4 weeks, not 2 weeks. The patient developed a pulmonary embolism. The DNPQ highlighted there is no further specific learning or change of process noted.

**Action:** The DDCAG agreed to review this claim and clarify if there are any procedural or practice changes to note and provide associated evidence.

### 18/92 Quarterly CARE Report

The Quarterly CARE Report was received and noted. The following was discussed.

**Compliance with NICE Guidance**

- The Chair highlighted the table in section 1.2 and reference to there being zero guidance accepted as partially or non-compliant and unlikely to change. The AMDCE advised partial compliance is work in progress or where it cannot be fully compliant due to conflicting guidelines. There are mitigations in place. The guidance is periodically reviewed.

**Audit**

- The Chair noted the number of local and national audits and queried whether there have been any concerns identified for the Trust. The AMDCE highlighted the positive work undertaken, particularly by the Blood Transfusion Nurse.

- The AMDCE advised that junior doctors are increasingly being asked to complete quality improvement projects, which has made it difficult to ‘recruit’ staff to support audit projects. This puts challenge on the clinical effectiveness team to achieve audit targets. Whilst both are relating to effectiveness and productivity, quality improvement projects don’t necessarily provide all required information for the audit forward planner.

- The CEO queried the impact of completing less ‘traditional’ audits. The AMDCE advised the Trust is required to complete the national audits; it would impact on the local audits. There will be evidence from the quality improvement projects to provide justification for a lower level of audits.

- The Chair noted on Appendix 1 the reference that compliance of VTE training is the responsibility of SQS; the CP confirmed this refers to directorate SQS meetings and is on their risk register. The DCAG confirmed that VTE compliance has been externally audited as part of the Quality Accounts data quality requirement.
### Research

- The AMDCE noted the positive work taking place.
- The MD confirmed he is currently recruiting to the vacant Clinical Lead for Research position and will update SQS once confirmed.
- Dr Coombs queried the recruitment figures under section 4.2 and queried whether this is better than expected. The AMDCE confirmed it is and added that the red areas within the chart are for recruitment that hasn’t yet taken place.

### 18/93 Board Assurance Framework & Corporate Risk Register Report

The DCAG provided an update on the Board Assurance Framework and Corporate Risk Register for risks allocated to the SQS Committee. The following were noted.

- The DCAG noted the focus on strategy risks for SQS relating to maximising productivity to ensure that patients have a timely and high quality experience. This has been noted with re-deployment of the workforce using the new SafeCare Audit Tool.
- The Chair noted that the SafeCare tool wasn’t available for ED when highlighted at the previous meeting and queried whether this has changed. The DDNQ advised there is a rolling schedule for uploading departments onto the tool; this is currently being undertaken for Maternity and Paediatrics.
- The DNPQ highlighted section 3.1.1 and the reference to an increase in harm relating to community acquired infections, querying whether this was raised through the safety thermometer metric. The DDNQ confirmed it was highlighted through this method however was this was a relatively small increase. The DNPQ confirmed this was identified via a point prevalence exercise and at that point there were a higher number of old catheters identified. It was agreed further context should be provided in future reports.
- The Chair noted the increased risk on the 18 week RTT backlog, particularly around ENT and queried the cause of the delays. The DNPQ advised for ENT it is related to the number of increased referrals. Discussions are taking place with Manchester, who provide the ENT consultants, and conversations are also taking place with the CCG around GPs and referral management. The CCG are putting actions in place.
- The Chair noted a number of areas that have been challenged as a result of changed or increased referrals patterns and queried the cause. The CEO advised a significant number of Waiting List Initiatives have ceased since last year. Work is ongoing to provide further understanding as to whether there is an increase in demand or a reduction in capacity. This is being led by the Executive team and feedback and assurance will be provided to the SQS and FPW Committees once completed.
- The Assurance Framework and Risk Register items for SQS overview were agreed.

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CEO
<table>
<thead>
<tr>
<th>STRATEGIC ITEMS</th>
<th>18/94</th>
<th>Spotlight Medical Staffing</th>
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<tbody>
<tr>
<td>The MD presented the spotlight on Medical Staffing, noting the following.</td>
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<tr>
<td>• 8 risks on the current corporate risk register relate to medical staffing; these refer to single-handed services and/or gaps within the junior doctor rotas. The Chair raised one potential further risk at 16 which is not currently included within the risk register for SQS oversight.</td>
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<td>• <strong>Action:</strong> The DCAG agreed to review the risks outlined in the medical staffing spotlight against the risk register to clarify if there was any missing information and provide assurance.</td>
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<td>• The supply of new doctors into the UK has not met the level of demand required. Brexit conversations mean that there is possibility that the UK will become less attractive for overseas recruitment. There is a national shortage in a number of specialties.</td>
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<td>• A number of vacant consultant and specialty doctor posts have been successfully recruited in recent months. There remain a number of high demand specialty consultant vacancies. The MD advised the potential to work with Stockport and the Christie Hospital Foundation Trust on particular specialties e.g. Care of the Elderly and Haematology (respectively).</td>
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<td>• Factors that are influencing the difficulties in recruitment include uncertainty on future service provision, a small specialty base limiting potential opportunity, variable trainee allocation (the Deanery prioritises specialist tertiary centres), heavy reliance on SAS (Staff and Associate Specialist) doctors and neighbouring hospitals offering recruitment premia.</td>
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<tr>
<td>• Actions put in place to reduce the risk include strengthening the medical staffing department and introducing the eRostering system, working with other Trusts for ‘difficult to recruit’ specialties and reviewing physician associate and advanced nurse practitioner roles to reduce the rota gaps. The Trust has a good medical bank supply. There has been a positive report received from the General Medical Council on trainees (this will be brought to the FPW Committee).</td>
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<td>• Bed Managers are reviewing staffing requirements daily to ensure there is an appropriate level of staffing on the wards. The Guardian of Safe Working Hours has oversight of the working hours for Junior Doctors to ensure they are managed appropriately.</td>
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<tr>
<td>The following were discussed.</td>
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<tr>
<td>• The Chair highlighted the risk relating to F2 doctors covering general surgery and orthopaedics. The MD advised that for nights and weekends, one doctor covers both areas. The Guardian of Safe Working Hours is reviewing staffing levels with the directorate to address this issue. Recruitment is ongoing which should support this risk mitigation.</td>
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<td>• The Chair highlighted risk 2801 relating to cardiology and queried the target of 16. The CEO advised the imbalance at present will take time to resolve. WLIs and virtual clinics have been initiated to support reducing the waiting list. To reduce further would require additional financial support. The DCAG confirmed acceptance that the risk will remain at this level for a period of time, and this is a subject of discussion at Clinical Management Board. The DNPQ suggested strengthening the wording of the risk to ensure it is effectively reflected.</td>
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<td>• <strong>Action:</strong> The DCAG confirmed risk 2801 will be updated with further narrative to support assurance.</td>
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- The CEO advised the cardiology consultants have raised concerns regarding the length of wait for follow up patients; this has been identified as a potential clinical risk and is being reviewed and actioned.

### ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>18/95</th>
<th>Key Items for the Chair to be reported to the Board</th>
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</table>

#### Points for Assurance
- **Infection Control:** Single case of Clostridium difficile and E-Coli in July however work is ongoing with positive initiatives across acute and community areas and the Trust remains on target for infection reduction.
- **Harm Free Care:** Improvements seen across both hospital and community (although remaining below 95% target) including Trust wide decrease in all new pressure ulcers on caseload.
- **Positive Friends and Family test across all hospital and community areas.**
- **CQC action plan:** All actions in hand and on track for completion to required timelines.
- The Committee reviewed the Assurance Framework and Risk Register and confirmed agreement to listed risks with clarification of additional risks to be agreed at next meeting.
- The Trust is well positioned in respect of compliance with the new Learning Disability improvement standards and data collection for the NHSI deadline is in hand.
- **Complaints/ incidents/ claims and patient experience:** Quarterly report confirms thorough and timely complaint resolution (with one unresolved partially upheld complaint with HSO recommendation with all action plans agreed and tracked); no trends in recent claims; feedback from local surveys, FFT validating that the Trust is delivering on positive patient experience including 2018/19 Quality Schedule components.
- **Assurance provided on robust processes opposite NICE guidance compliance with no major issues identified.**

#### Emerging Risks & Mitigating Actions
- **Increased level of acute nurse vacancies concerning ahead of any winter resilience planning.** Vigorous ongoing recruitment activities underway; use of patient acuity tool to direct resources and optimised use of bank vs agency.
- **Medical consultancy shortages in haematology (single handed); gastroenterology and care of the elderly.** Partnership working and recruitment is essential for long term service sustainability.
- **Missed RTT targets across most specialities (now including ENT) leading to potential poor patient experience although there have been no 52 week breaches.** Clinical prioritisation; temporary cessation of out of area commissioner referrals and work to enhance clarity of demand forecasts versus supply / productivity is in hand.
- **62 day cancer targets not met; linked to diagnostics and histology delays.** Work is ongoing to address short and long term solutions.
- **Mixed sex breaches due to capacity and bed availability principally in ITU and AAU.** All efforts have been made to retain patient privacy and dignity.
<table>
<thead>
<tr>
<th>18/96</th>
<th>Any Other Business</th>
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<tbody>
<tr>
<td></td>
<td>There were no items of any other business received.</td>
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**CONSENT ITEMS**

<table>
<thead>
<tr>
<th>18/97</th>
<th>CARE Sub-Committee Annual Report and Self-Assessment</th>
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<tbody>
<tr>
<td></td>
<td>The committee received the CARE Sub-Committee Annual Report and Self-Assessment noting its contents and accepting recommendations.</td>
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</table>

Chairman’s Confirmation of Agenda items for October meeting (not standing items):
- HTA Sub-Committee Annual Report and Self-Assessment.
- Bi-Annual QIPP QIA Report.
- Quarterly Quality Strategy Update – Listening and Responding
- Community Nursing Spotlight

**Date and Time of Next Meeting**
Tuesday 2\textsuperscript{nd} October 2018, 12:00 – 14:00
Boardroom 1, First Floor, New Alderley House
Agenda Item Number 17: TB 18 (98)

### SAFETY, QUALITY AND STANDARDS COMMITTEE

#### MINUTES OF MEETING HELD ON:
Tuesday 2nd October 2018, Boardroom 1, First Floor, New Alderley House, 12:00 – 14:00

**Meeting Chair:** Dr Anthony Coombs  
**Meeting Secretary:** Gareth Rydings  
**Venue:** Boardroom 1, First Floor, New Alderley House

### PRESENT

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Abb.</th>
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<tbody>
<tr>
<td>Dr Peter Madden</td>
<td>Non-Executive Director</td>
<td>Dr Madden</td>
</tr>
<tr>
<td>John Wilbraham</td>
<td>Chief Executive</td>
<td>CEO</td>
</tr>
<tr>
<td>Julie Green</td>
<td>Director of Corporate Affairs and Governance</td>
<td>DCAG</td>
</tr>
<tr>
<td>Kath Senior</td>
<td>Director of Nursing, Performance and Quality</td>
<td>DNPQ</td>
</tr>
<tr>
<td>Brian Green</td>
<td>Deputy Director of Nursing and Quality</td>
<td>DDNQ</td>
</tr>
<tr>
<td>Kashif Haque</td>
<td>Chief Pharmacist</td>
<td>CP</td>
</tr>
<tr>
<td>Mark Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
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<tr>
<td>Dr John Hunter</td>
<td>Medical Director</td>
<td>MD</td>
</tr>
<tr>
<td>Lorraine Jackman</td>
<td>Deputy Director of Corporate Affairs and Governance</td>
<td>DDCAG</td>
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<tr>
<td>Dr Susan Knight</td>
<td>Associate Medical Director for Clinical Effectiveness</td>
<td>AMDCE</td>
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### IN ATTENDANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tbody>
<tr>
<td>Jacqui Williams</td>
<td>AD Transformation &amp; Community</td>
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<tr>
<td>Jane Bayley</td>
<td>Care Community Coach</td>
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### Agenda Item

**Agenda Item Number 17: TB 18 (98) Patient Story**

The DNPQ presented the patient story relating to a letter received by a patient regarding the care received for their father by the District Nurses from the Alderley Edge Medical Practice team.

The following key messages were highlighted:

- There was a telephone call from the community nursing matron clearly explaining the Duty of Candour.
- The family were positive and confident that there were no concerns or neglect in any aspect of their father’s care by the District Nurse team.
- Pressure ulcers on the patient’s calves due to the care were eradicated with vigilance.
- The nursing team provided excellent care for the family and great support, establishing an excellent relationships.
- The family felt that the nurses respected the patient’s dignity and showed great empathy towards him at all times.
- The patient’s principal desire was to always remain and be cared for in his own home. The care that the nurses provided fundamentally allowed the patient to remain in his home and ensured that he got the correct treatment.
- The team regularly went over and beyond what they needed to do.
and the family's view was it clearly demonstrated the NHS at its best.

<table>
<thead>
<tr>
<th>18/99</th>
<th>Apologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rachael Charlton – planned sick leave</td>
<td></td>
</tr>
<tr>
<td>2. Ali Harrison – Annual leave</td>
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</table>

<table>
<thead>
<tr>
<th>18/100</th>
<th>Conflict of Interest</th>
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</thead>
<tbody>
<tr>
<td>None declared</td>
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<table>
<thead>
<tr>
<th>18/101</th>
<th>Matters Arising</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Year at a Glance</td>
<td></td>
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<tr>
<td>Patient Safety Culture update to be moved to December SQS.</td>
<td></td>
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<tr>
<td>b) SQS Committee Minutes – September 2018</td>
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<tr>
<td>Minutes agreed as accurate.</td>
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<tr>
<td>c) Action Log</td>
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<tr>
<td>7037 – Action on track and due for December update. Remain open.</td>
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<tr>
<td>7083 – Monthly reviews in place with the CEO. Action closed</td>
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<tr>
<td>7084 – 2 x 104 days breaches.</td>
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<tr>
<td>1st patient treated at 133 days. Reasons for delays were multifactorial. Patient had a declined a number of treatment dates offered and refused an MRI scan. This resulted in a CT scan being requested and further delays to treatment.</td>
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<tr>
<td>2nd patient treated at 113 days. Reason for delay was multifactorial. 31 day wait to scan colon, waits for prescription. CT scan performed on day 65. And a meeting prior to treatment was required. Action closed.</td>
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<td>7085 – Orthopaedic team to review arrangements for post-operative VTE prophylaxis. The clinical lead has agreed to take this forward via departmental meeting. Action completed and closed</td>
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<tr>
<td>7086 – Agenda item. Action closed.</td>
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<td>7119 – Action on track and due for November update. Remain open.</td>
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<tr>
<td>d) Collection of Any Other Business</td>
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<tr>
<td>None raised</td>
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<tr>
<td>e) Formal Request for Removal of Items from Consent Agenda</td>
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<tr>
<td>None raised</td>
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**ASSURANCE ITEMS**

<table>
<thead>
<tr>
<th>18/102</th>
<th>Integrated Quality &amp; Governance Report including</th>
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<tbody>
<tr>
<td>• Quality Indicator Exceptions</td>
<td></td>
</tr>
<tr>
<td>• Detentions under MHA</td>
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<tr>
<td>• Complaints (August 2018)</td>
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<tr>
<td>• Risk Assessed Data Report (RADaR)</td>
<td></td>
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<tr>
<td>• Quality Impact Assessment Update</td>
<td></td>
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<tr>
<td>• Equality Update Q1 2018/19</td>
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The paper was taken as read and the following key areas highlighted:

- For August registered nurse vacancies within acute inpatient ward areas were 49.84wte compared to the previous month 46.96wte. This excludes Maternity Leave and Long Term Sickness.
- Community vacancies overall are 1.17 wte although a number of
teams are over their funded establishment which offsets the true number of vacancies in individual teams.

It was noted that the over establishments in teams are very small parts of posts and mostly relate to historic vacancies and work is underway to realign.

- Exit interviews have been introduced as part of the work ongoing around retention and recruitment. The DDNQ noted that so far only one member off staff has requested an interview. It is too early to comment on the success of these interviews and the impact to figures.

- The current cohort of 9 trainee Nurse Associates have been offered substantive employment on completion of their course in January 2019. The Trust have agreed to support a second cohort of 6 trainee Nurse Associates who will commence their training in December 2018.

- There was one case of Clostridium difficile identified on MAU in August. This brings the total of trust cases to two, year to date. The Trust remains on to deliver the Public Health England annual trajectory of < 13.

- Falls rate per 1000 occupied bed days was achieved in August at 1.9 against a target of 2.5 and year to date the trust remains on target to achieve the 10% reduction target on injurious falls set against last year’s baseline.

Discussion took place regarding the one fall on Aston Ward that was reported as severe and resulted in a fractured neck of femur. The patient has since died. It was noted that a mortality review and investigation has been undertaken and will be taken to the Serious Incidents Committee for review. No lapses in care were identified.

- The Trust did not achieve the 95% standard in month, performance was 81.1% and it was noted that there were no complaints or incidents reported during August in relation to waiting times in A&E.

- There were 79 mixed sex breaches in August which were all largely down to capacity and bed availability.

In response to Dr Madden’s query regarding impacts to partners for not achieving targets, the CEO confirmed that it is likely the trust will receive a performance notice from the CCG; however the CCG will work closely with the trust to address the issues. There are no financial implications.

- The 62 day cancer standard of 85% has not been achieved in month at 71.9%.

Further discussion took place regarding the standard and it was noted that ECT are not alone in this and that it was a regional issue. The Trust has been asked to attend a regional meeting to address the East Cheshire Cancer pathways. Currently all pathways are being reviewed with a view to centralise and improve efficiencies. It was noted that this will not be a quick fix.

Further conversation took place regarding the trusts safety due to targets not been achieved. The CEO informed that the trust is not running unsafe services and highlighted that although the trust may not be achieving the targets set nationally/regionally the trust remains to deliver a consistent
baseline that has not deteriorated over time. The CEO did note that waiting times and follow ups are a concern and as a result waiting list initiatives have been introduced for some specialities where clinical risk has been identified.

- **RaDAR** – The DDCAG informed that there was only one area that triggered in month and that was Waters Green. There were no hospital areas that triggered.

It was noted that any area that triggers for three consecutive months will be visited by the DNPQ or DDNQ to address the issues raised.

- The number of emergency caesarean sections has increased. The DNPQ informed that this is due to variations in circumstances. All sections are reviewed and assurance is provided as to why. It was noted that the rise in sections is mainly due to the ‘gap and grow’ scheme undertaken by the trust which looks at early interventions when small to date babies are identified.
- There were two serious incidents in month and root cause analyses are underway. One incident relating to a baby who was transferred to Alder Hey after a medicine overdose and one relating to unexpected death of a patient with learning disabilities. Both incidents will be taken through the appropriate processes and be taken to the Serious Incidents Committee for review.

**18/103 Quarterly Quality Strategy Update – Listening and Responding**

The DDNQ provide updates on the following areas:

**Improving the care environment within medical wards**

- Upgrading of sluice and bathrooms to ward 7 has taken place
- Cost neutral observation and evaluation of Mediwell systems agreed with supplier. Currently looking to relocate to a more appropriate area.

**A reduction in outpatient clinic cancellations**

- Increased capacity and improved productivity - Actions are in place to address challenges on the ‘shop floor’ which have resulted in loss of clinics. Work is ongoing to review job plans to ensure that they are appropriate and signed off to deliver what is required. Annual leave and study leave polices will also be reviewed. Challenges are being reviewed by the CP as Chair of the Outpatients Productivity Group.

**Review of safe staffing and skill mix in all ward areas**

- Roster changes made in some areas as establishment realignment – Ward 10
- Introduction of ward discharge co-ordinator post – Ward 11
- SOP drafted for minimum doctor cover across all in patient areas in medicine/paediatrics
- Safer care now implemented within maternity and neonates
- TV screen now installed within Silver Command and review of Nurse Staffing Escalation guide.

**18/104 Assurance Framework and Corporate Risk Register**
The DCAG presented the report and informed that the key areas for the Committee to seek assurance were escalated risks. All such escalated risks have actions assigned which are on track in order to support de-escalation of the risk score within the appropriate time frame.

- There are three risks relating to acute nursing and have been flagged to the DNPQ and DDNQ. Actions are in place to mitigate some of the risk level.

It was noted that risks relating to waiting times are taking longer to resolve; the key issue is addressing capacity in the system, which is being reviewed weekly at EMT.

The DCAG informed that all risks and associated action plans are reviewed in line with their review dates and target dates are audited twice a year to ensure any changes are in line with agreed processes. This is reviewed by the Audit Committee.

The DCAG confirmed to the DNPQ that the risk highlighted by the CQC inspections around a band 6 overnight on the children’s ward is included with the risk around the wards (2548) and the risk itself is being addressed. Good risk assessments and mitigations have taken place to keep the risk score below 16 and are currently being managed well until substantive appointments are made.

### STRATEGIC ITEMS

<table>
<thead>
<tr>
<th>18/105</th>
<th>Spotlight Community Nursing</th>
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<td>The following was highlighted</td>
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- There are five teams within the Eastern Cheshire Care communities. These are team Macclesfield, team Bollington, Disley and Poynton, Team Knutsford, Team Congleton and Holmes Chapel and Team Chelford, Handforth, Wilmslow and Alderley Edge.
- The role of the coach is a new role to the organisation and will help support the improvement of patient and population outcomes through collaboration, relationship development, innovation and creative solutions, promoting self-management, autonomy and empowering decision making at a local level and will be working across multiple boundaries.
- Currently Community Nursing staffing remains in an “over established” position which is a result of legacy from previous years, however the position is supporting current maternity and long term sickness.
- Workforce redesign – Community nursing job descriptions are currently being reviewed and newly redesigned job descriptions are being developed. There will be a consultation process in October 2018 with the hope to have the new roles in place by December 18.
- There is a high focus on community appraisal and stat and mandatory training. There is recognition that some areas are challenged and work is ongoing regarding the importance of appraisals to ensure meaningful outcomes.

**Action** – it was agreed that an update on community nursing appraisals and stat and mandatory training will be provided to SQS in February 2019.
• Work is ongoing using the friends and family test to help identify different ways of improving the quality of services for patients.
• Improving Clinical Practice – 90 day programmes will focus on:
  - NEWS2 - Standardises the assessment of acute illness severity.
  - Pressure Area Care - To reduce the number of category 2 pressure ulcers developed on DN caseload
  - Bespoke Training for all Community Nursing Staff - Individuals with Respiratory type conditions identified across all Care Communities.
  - Nursing Home Support - Working jointly with local care homes to improve outcomes for patients, predominantly with regards to pressure ulcer care and reducing inappropriate hospital admissions.

Quality & Best Practice Initiatives have been implemented in each of the areas:

• Congleton and Holmes Chapel - Delivering care at home which focuses on the whole individual not just the task. The team are also focussing on ‘Focus on Health and Wellbeing’ for patients and staff and have purchased a team bike so staff are able to commute to appointments quickly.
• Knutsford - Team development and working together to generate ideas for improvement. Holistic assessment of patients with comorbidities and working with GPs and Practice Nurses to ensure that housebound patients get full reviews. Care homes are being supported and regular visits to care home offering advice, training and wound care. Management of wound care is being improved and implemented and a wound care process with Practice Nurses will shortly be starting at a joint clinic
• Macclesfield – Care home initiative - A Care Home initiative commenced in 1 home in September 2018 with planned roll out to others by January 2019. Focus will be on struggling residential homes and will look to provide additional support to encourage care at home.
• Chelford, Handforth, Wilmslow and Alderley Edge – Away day has been planned for the District Nurse team and areas of focus will be the Sepsis Pathway and hydration cups.
• Bollington, Disley and Poynton – Improving office environment and developing the admin role. Looking to improve access to GP EMIS to help support the team to release time to care for patients.

The transformational work throughout, especially the NEWS2 initiative was acknowledged and the work ongoing ensuring that to ensure that the right people are in the right place at the right time to make the correct decisions was noted by the Committee.

JW informed that in terms of the teams that are flagging on RaDAR that challenges have been addressed and the introduction of the new coach role has helped provide additional support to team leaders and managers to address these issues. Action plans and systems have been put in place to manage escalation processes.

Discussion took place regarding admission avoidance and JW informed that initial initiatives have been focussed on improving the quality of processes
and putting the patient first. If the quality is right then efficiency will follow. Work is ongoing regarding admission focus and over the next three months current initiatives will be reviewed. It was agreed that over the next 12 months focus needs to turn to admission avoidance.

It was noted that sharing from the local initiatives is taken to the Community Operational Delivery Group with the expectation that successful initiatives and best practices are shared and implemented across localities.

### ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>18/106</th>
<th>Key Items for the Chair to be reported to the Board</th>
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#### Points for Assurance

**Infection Control:** single case of Clostridium difficile and three cases of E-Coli in August. The Trust remains on target for infection reduction (C.Diff <= 13, E.Coli 50% reduction by 2021).

**Harm Free Care:** improvements seen across both hospital and community (both only slightly below 95% target)

**Falls:** below anticipated numbers

**Positive Friends and Family test across all areas**


**2 week wait standard for cancer was met**

**SQS committee reviewed the Assurance Framework and Risk Register and confirmed agreement to listed risks**

**SQS approved the Quality Strategy update. A focus on job plans may help with capacity.**

**Spotlight on Community Nursing and progress with Integrated Teams:** very substantial progress being made with Clinical Leads (GPs) now appointed in all five areas and a wide range of local initiatives being taken to improve care and increase efficiency. Many good examples of cross functional working and implementation of Burtzkof principles.

#### Emerging Risks & Mitigating actions

**Overall - below target performance in August in most key areas due to increased operational pressure, in common with peers. Useful analysis of patient flow and capacity needs completed by Venn Consulting**

**A&E 4 hr performance** at 81.1%, however no complaints. Actions being maintained through A&E Recovery Board

**Diagnostic waiting times** declined. Actions include out of area referrals suspended, capital approval for new equipment, priority for Echocardiography

**62 Day Cancer Standard** not met at 71.9% with 5 breaches over 104 days
RTT standard: Backlog for patients waiting more than 18 weeks at 714 slightly lower than July. No 52 week breaches. Most specialities not achieving 92% standard. Action to limit referrals for three services (cardiology, gastroenterology and general surgery) and implement WLIs if there is clinical risk

RADAR: One area triggering in August and being kept under observation

Medical consultancy shortages in haematology, cardiology and care of the elderly remain. Partnership working / recruitment essential for long term service sustainability.

79 mixed sex breaches due to capacity and bed availability. All efforts being made to retain patient privacy and dignity

DTOC increase to 5.6%

Key actions/factors identified to be addressed to relieve overall operational pressure

- bed flow
- diagnostic capacity
- Outpatient capacity

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<tr>
<th>18/107</th>
<th>Any Other Business</th>
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<td>None raised</td>
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CONSENT ITEMS

18/108 HTA Sub-Committee Annual Report and Self-Assessment.

The Committee noted and approved the content of the HTA Sub-Committee Annual Report and Self-Assessment

FOR INFORMATION

Chairman’s Confirmation of Agenda items for November meeting (not standing items):

- Maternity Staffing Levels
- Clinical Directorate SQS Sub-Committee Annual Reports and Self-Assessments
- Freedom to Speak Up (via Governance Report)
- Maternity Growth Assessment Programme update
- Quarterly Mortality Report
- Spotlight - ED Pressures including Inpatient flow and discharge assurance for winter planning

Date and Time of Next Meeting
Tuesday 6th November 2018
12:00 – 14:00
Boardroom 1
## Agenda Item Number 17: TB 18 (99)

### FINANCE, PERFORMANCE & WORKFORCE COMMITTEE

**Meeting Chair:** Mike Wildig  
**Meeting Secretary:** Janine Homer  
**Venue:** Boardroom 1, First Floor, New Alderley House

### Agenda

<table>
<thead>
<tr>
<th>Agenda No</th>
<th>Agenda Item</th>
<th>Action</th>
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<tbody>
<tr>
<td>18/80</td>
<td>Apologies</td>
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<td>• Steve Redfern</td>
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<td>• Rachael Charlton</td>
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<tr>
<td>18/81</td>
<td>Declarations of interest</td>
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<tr>
<td></td>
<td>None declared.</td>
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<tr>
<td>18/82</td>
<td>Minutes of meeting held 7th September 2018</td>
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<tr>
<td></td>
<td>The minutes of the previous meeting were agreed as an accurate record.</td>
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<td>18/83</td>
<td>Matters arising</td>
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<td></td>
<td>• The Committee to note the additional high level risks approved since September 2018</td>
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<td>Discussed under agenda item no 18/84.</td>
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<tr>
<td>18/84</td>
<td>Action points from previous meeting</td>
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7013 – Although comparative data is not shared amongst trust, the CEO agreed to speak to the CEO at MCFT with a view to comparing the two trusts. Update at next meeting.

7087 – Assurance was received that short and medium term actions are in place with long terms plans being closely monitored. Alterations to target dates are to be discussed at the next Audit Committee to understand rationales used and ensure the correct process is followed.

7088 – Further update to be provided for next meeting.

<table>
<thead>
<tr>
<th>18/85</th>
<th>Annual work plan</th>
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<td>Reviewed and no changes made.</td>
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**Performance Report**

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<th>18/86</th>
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<tbody>
<tr>
<td>• ED 4 Hour standard</td>
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<tr>
<td>• 18 Weeks RTT standard</td>
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<tr>
<td>• 62 Day Cancer standard</td>
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<tr>
<td>• 6 week access to diagnostics</td>
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<tr>
<td>• Community activity and outcomes including hubs</td>
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<td>• Operational efficiency indicators (theatres, outpatients, bed utilisation)</td>
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<td>• GP Referrals</td>
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<td>• Winter plan demand and capacity review</td>
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The DoN reported that August had been a challenging month with the Eastern Cheshire system operating at OPEL 4 several times. There has not been the expected reduction in operational pressures. However, feedback at directorate performance meetings demonstrated that staff were committed to delivering standards and were disappointed in their ability to achieve this.

Two weeks ago around 200 staff attended an event on improving patient flow; the focus was maintaining motivation and commitment to provide the right care for patients in the right place. This campaign would continue and also extended to involve patients and carers.

Diagnostics remains a concern at 74.9%. This is largely driven by Endoscopy and the overall level of throughput is insufficient to address the backlog. Some WLIs have been instigated and at this point progress remains slow. Additionally due to unsuccessful recruitment to the technician’s role echocardiograms have a backlog. A further review of how this will be improved is underway including exploring an external solution. This is impacting on cancer performance, which is at its lowest of 71.9%. Diagnostics performance is being scrutinised regionally and ECT have been asked to meet with NHSE and the commissioners regarding the action plan.

The RTT PTL continues to grow and the forecast to the end of the year is concerning, particularly the potential for 52 week breaches. Alternatives are being sought with partners to deliver work as cancellations continue, especially in Orthopaedics.

The DoN confirmed to Dr Madden that the waiting times reporting error had
been resolved, with the CEO adding that there had been no impact on the 4 hour figures, only to year-on-year. With regard to Type 1 attendances, ECT is the second-best performer after Alder Hey within Cheshire and Merseyside.

Dr Coombs asked how A&E performance was affecting staff morale and the DoN replied that optimism remains, citing the enthusiasm displayed when the target for quarter 1 was almost achieved and 95% achieved in June. Feedback from the recent Venn report indicated that there are issues compounding pressure, such as ED being too small for the volume of patients, and domiciliary care.

The MD reported positive feedback from medical staff and the DCAG added that the recent flow event was good for morale, highlighting to staff that efforts are system-wide, not just local to ECT.

With regards to August admissions from A&E being higher than last year, the DoN advised the chair that feedback from the CCG’s review had yet to be received.

Mr Goalen referred to NHS 111 online being live, noting the low take-up rate for Eastern Cheshire residents and asked whether better communication, such as a mass text, could be considered and it was acknowledged that more work on this is required, with the CEO adding that this was a matter for discussion at A&E Delivery Board.

The Chair asked about RTT performance and WLIs and the CEO commented that 25 WLIs had been agreed in Gastro and a further 25 in other specialties. 40 have been agreed in cardio virtual clinics but there is no capacity in this financial year. Having recommenced WLIs since the start of the year, some productivity improvement has been seen which is optimistic.

It was noted that 10 specialties are not currently achieving the 92% standard; the rate of 9.7% for Orthodontics was questioned and the DoN agreed to check this was accurate.

**Action: DoN to confirm the Orthodontics RTT performance for August was correct at 9.7%**

The MD confirmed to the Chair that of the 100 consultants working at the trust, the majority now have job plans in place, but there are variances in performance due to different working styles.

The CEO stated that clinics are to be evaluated, with Gastro having been identified as the most effective specialty (achieving 97.6% at end July). The lowest performing three will be reviewed to look at lost productivity. The vast majority of the waiting list lies in Outpatients. The challenge of achieving the national standard remains and the CEO could not give assurance that this was possible, particularly if patients on the ASI list are included.

Dr Madden asked whether going forward peer pressure within clinical management could be employed to improve productivity; the MD responded that the trust takes part in the Getting It Right First Time (GIRFT) programme, which provides data to benchmark against other hospitals. Visiting clinicians have not identified any issues in areas where activity levels are lower. Overall,
ECT is not a great outlier.

The DoF added that unwarranted variation is also a theme of Model Hospital and will need to be addressed and the CEO highlighted the importance of the Outpatients Productivity Group, productivity in this area being a key driver.

With regards to liaising with the CCG to reduce follow ups, discussions are taking place; there are issues with peripheral clinic utilisation and loss of activity through travel time, however, reducing these would not be a popular public decision.

The Chair referred to the Venn report and queried the ‘Proportion of Attendances that Result in Admission’ figure of 39%, believing this to be 22% and the DoN replied that this figure is being verified.

One of the outputs of the model is that Acute wards would have +6 beds and the DoN clarified that this figure assumes an average LOS of 5.6 and no DTOCs.

**Workforce Report**

| 18/87 | • Workforce risk and mitigation report – with monthly KPI dashboard  
• Apprenticeships and vocational learning  
• GMC Annual Trainee and Trainer Survey 2018 |

The DDHR presented the report, highlighting:
- Acute nursing vacancies remain a concern, having increased to 16.34%. Areas with high rates include ED, ward 9 and MAU.
- This is impacting on agency spend, which has increased to £559k in August.
- The extra capacity that may be required over winter is an emerging risk.
- There has been an increase in absence relating to stress, anxiety and depression. Where there is pressure, preventative work is ongoing.

The Chair asked whether the trust is working close to cap on agency spend and the DoF responded yes, that he had written to NHSI regarding the winter risk and was waiting for a response.

Dr Madden questioned whether stress-related absences could be reduced by eliminating work not required and the DDHR replied that HR are working with the Deputy Director of Nursing to review options on wards, such as use of therapists and bed co-ordinators to take pressure off nurses (ward 1).

The DoN agreed that more could be done – such as challenging meetings taking place when OPEL 4 had been declared. The winter plan includes meetings throughout January being cancelled.

The CEO confirmed that the winter plan will be presented to Board in November; comments from Cheshire East Council are outstanding and there are no mental health commitments yet included. ECT plans include converting a surgical ward to medical and moving the discharge lounge to create additional surgical bed capacity, however, Orthopaedic work will likely be cancelled in January.

The DDHR reported that the trust is in a better position than previous years around medical staffing gaps. ED staffing challenges are much improved as is
the medical bank, which in turn improves agency use. Work continues to attract new personnel and to maintain a flexible workforce.

The Chair welcomed the HoELD to the meeting, who presented the spotlight on apprenticeships and vocational learning, highlighting:

- The trust is on track to achieve the public sector target.
- The new, annual target of 2.3% of the workforce is ambitious.
- 23 have started, with 25-40 more due to start before end of Q4.

The HoELD acknowledged that as apprentices are part of the head count, there is a challenge in meeting the cost of clinical backfill, which isn’t covered by the levy. Around 30% of the levy is spent monthly. There may be an option to transfer part out to other organisations to keep funds within the system; unspent funds will be withdrawn after two years.

The DoF confirmed to the CEO that financial provision had been made therefore there is no impact to this year’s deficit.

The HoELD noted that work is moving towards apprenticeships being further linked to the workforce and also partnerships being explored, such as student nurses placements in care homes.

The Chair thanked the HoELD for attending.

The MD presented the 2018 GMC annual trainee and trainer survey, highlighting:

- HENW use the survey to assess the quality of training via submitted self-assessment reports
- Results are more positive overall than last year
- Imps needed in some areas, such as General Surgery, Paediatrics and Obs & Gynae
- Education leads have access to the survey results and action plans will be formulated for central monitoring

Cardiology is a negative outlier, it is thought that this is a perception issue eg training is missed when on call.

### Finance Report

| 18/88 | • Finance risk report  
• QIPP report (including milestone delivery plan and risk register)  
• Repeating presentations – Revolving Working Capital facility  
• SLR update  
• Carter update  
• Procurement update  
• QIPP presentation – Corporate |

The DoF presented the report, highlighting:

- £248k better than plan at Month 5.
- QIPP remains a challenge – particularly the performance for the Acute and Planned Care directorates. Allied Health is expected to deliver and Corporate has achieved.
The Chair referred to Income Spend By Category and observed that performance is approximately £1m better than 2016/17 for each month in 2017/18. The DoF clarified that this is as a result of the block contract but also mainly due to non-elective activity.

Dr Coombs queried whether ceasing out of area CCG referrals would present a future risk to contract income being above plan. The DoF replied that this is being closely monitored. Specialties affected are Cardiology, Gastro and General Surgery but there should be enough work until the end of the year.

The Chair asked the DoF’s opinion on the most concerning issues affecting the financial plan. The DoF cited QIPP and the necessary balance sheet provision required to cover under-performance, the impact of winter on agency spend and lack of income performance impacted by the block contract.

The DoF confirmed to Mr Goalen that the reserves set aside at the beginning of the year were yet to be released. The £700k ring-fenced for not hitting the A&E target will now be used to part fund the cost of the extra ward over winter (estimated £800k total), as the financial control target is now measured against position excluding A&E.

It was noted that loans becoming repayable were expected to be rolled over as previously.

Dr Coombs referred to Appendix 1 of the service line reporting update and questioned whether this could be split into five to represent the hubs. The DoF advised that presently budgets are not fully aligned to the five areas as some are managed centrally.

The DoN added that work has started and the CEO noted that scrutiny of the hubs’ operational budgets will become more of a focus next year.

Mr Goalen referred to Appendix 2 of the service line reporting update and commented on the reduced contribution of trust-wide income for 2017/18 (£11m) against total (£12m) compared with 2016/17 (£9m against £16m) and the DoF agreed that the trust had become less profitable.

In respect of Carter recommendations, the DoF confirmed to the Committee that there are a number of initiatives being worked on to deliver the identified productivity opportunity, including Radiology and Pharmacy and particular emphasis on Procurement. E-Prescribing (EPR) and Radio Frequency Identification (RFID) will not be implemented by the October 2018 deadline.

The CEO asked how much of the apparent lack of productivity is attributed to size – the WAU makes ECT an outlier. The DoF replied that, for example, within back office functions, ECT overheads against clinical income are approximately 7.5% compared with CWP 7.4% and Mid Cheshire 7%, which does not make the trust a significant outlier. The target/aspiration would be 6% which equates to £2.5m taken out of overheads.

Dr Coombs queried whether there was a correlation between percentage overheads and income. The DoF reported that performance is being compared with trusts of a similar size and that ECT still looks high cost.
With reference to the Procurement update, the DoF noted:
- The trust continues to make savings
- Better savings could be made by joint procurement with other trusts
- Capital savings resulted in more medical equipment being bought

Turning to the report on Corporate QIPP performance, the DoF acknowledged that more work is required within Facilities and Estates, with the latter expecting to achieve target.

It was noted that although the increase to charges for staff car parking was implemented in April, the scheme is still showing as red because it is not yet extracted from budget.

18/90 Any Other Business
None raised.

For Information
Date and Time of Next Meeting:
Thursday 1st November 2018, 08:30-10:30
Boardroom 1 NAH
### Agenda Item Number 17: TB 18 (100)

#### PUBLIC TRUST BOARD

Thursday 6th December 2018

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<tr>
<th>AUDIT COMMITTEE</th>
<th>MINUTES OF MEETING HELD ON:</th>
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<tbody>
<tr>
<td>Meeting Chair: Ian Goalen</td>
<td>Thursday 20th September 2018</td>
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<tr>
<td>Meeting Secretary: Gareth Rydings</td>
<td>Venue:</td>
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#### PRESENT

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<tr>
<th>Name</th>
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<tr>
<td>Ian Goalen</td>
<td>Chair and Non-Executive Director</td>
<td>Chair</td>
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<tr>
<td>Dr Peter Madden</td>
<td>Non-Executive Director</td>
<td>Dr Madden</td>
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#### IN ATTENDANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Details</th>
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<tbody>
<tr>
<td>Andrew Rothwell</td>
<td>Engagement Manager, Mersey Internal Audit Agency</td>
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<tr>
<td>Ian Pinches</td>
<td>Manager, Grant Thornton UK LLP</td>
</tr>
<tr>
<td>Alison Lill</td>
<td>Interim Head of Finance</td>
</tr>
<tr>
<td>Kara Mason</td>
<td>Deputy Director of Finance</td>
</tr>
<tr>
<td>Roger Causer</td>
<td>Anti-Fraud Specialist – Mersey Internal Audit Agency</td>
</tr>
<tr>
<td>Lorraine Jackman</td>
<td>Deputy Director of Corporate Affairs and Governance</td>
</tr>
<tr>
<td>Fiona Doorey</td>
<td>Head of Communications, Marketing and Engagement</td>
</tr>
<tr>
<td>Julie Green</td>
<td>Director of Corporate Affairs and Governance</td>
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<tr>
<td>Lynn McGill</td>
<td>Chairman</td>
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#### Agenda

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<th>Agenda Item</th>
<th>Action</th>
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| 18/17 | Apologies : |  
| 1. John Wilbraham |  
| 2. Kath Senior |  
| 3. Mark Ogden |  
| 4. Mike Wildig |  
| 5. John Farrar |  
| 6. Ian Pinches |  |

#### 18/17 Declaration of Interests

None declared

#### 18/18 Minutes of Meeting held on 22nd May 2018

Page 7 - Annual Accounts 2017/18 There was a query regarding the correct figure. AL to provide clarity around the correct figure outside of the meeting.

The minutes were approved subject to the above amend. AL

#### 18/19 Matters Arising:

None raised

#### 18/20 Review of Action Log

9612 – The two concerns that the Audit committee raised were presented as a spotlight at the August SQS meeting. The DCAG informed that no issues were identified in terms of responsibilities. Two areas were identified where further work is required and it was agreed that actions and recommendations to address these issues will return to the December SQS meeting. Action complete and closed.

#### 18/21 Chairman’s Introductory Comments

The Chair informed that the meeting will provide an interim update to review the governance procedures and feedback from external auditors on progress to date.
The Chairman introduced and welcomed Dr Peter Madden as a new member of the Audit Committee.

**GOVERNANCE**

18/22 Board Assurance Framework and Corporate Risk Register

The paper was taken as read and the DCAG informed that not all of the risks have been included within the report due to them being held in the holding area on the risk register.

The following themes have been identified within the corporate risk register. These are:

- Waiting times – There is concern regarding the risk escalating due to increased waiting times and higher waiting lists. Actions have been identified and are currently being addressed through Executive focus and support. Waiting list initiatives are being used in some areas and are being monitored closely by the CEO.
- Acute nursing vacancies – Current focus on developing a retention plan. Work ongoing regarding recruitment campaigns and spotlights on Acute and Community nursing will be reviewed and monitored through the SQS Committee.

Discussion took place regarding the procedure for risks that have not achieved their target score when it comes to their review date. The DCAG informed that review dates are audited twice yearly and any risk that will not achieve their expected target score will require additional rationale and reasoning as to why the risk has not lowered in score. Assurance must be provided that the risk is being managed effectively before an extension can be agreed and signed off at senior level.

It was agreed that a paper providing assurance on the recording of the rational for target date changes will be brought to the November meeting.

**INTERNAL AUDIT**

18/23 Internal Audit Progress Report

Mr Rothwell presented the report and informed that since the previous meeting of the Audit Committee the following reports have been finalised:

- 2017/18 Data Quality Review – Significant Assurance

Review of the policy confirmed that it details a clear organisation and governance chart, the roles and responsibilities of staff in relation to the data quality, along with the training and monitoring arrangements. There is clear indication that the policy works well given the scores against the national standard for data quality being higher than the standard set.

Discussion took place regarding the recent incident regarding inaccuracies in data reporting being reported to Board. The Chairman ask for assurance that the trust is doing all it can to prevent further incidents happening. The DCAG informed that a root cause analysis investigation as undertaken regarding the incident and actions have been put in place to address identified weaknesses and gaps in control. This will be tracked through the Serious Incidents

- 2018/19 Quality Spot Checks (i) – Moderate Assurance
Fire exits

As part of this review 22 wards within the trust were visited, including Aston Ward at the Congleton War Memorial Hospital. The review found that for 20 ward areas visited all main fire exits were clear of obstructions.

On ward 11, two secondary exit doors were obstructed, one with a chair and the other with bags of clean linen.

On ward 9, a workspace area was stationed in front of a secondary fire exit door.

A repeat walk around was conducted at a later date and found that all the exit areas on the 22 wards were clear of obstruction in all areas.

It was noted that appropriate notices and signs to identify emergency routes were displayed on all wards visited and also found that locks and bars were in good condition on all fire doors reviewed. All staff showed good awareness of fire precautions and displayed good knowledge with regards to fire evacuation routes.

Medicine Fridges

A spot check on the management and monitoring of appropriate temperatures was undertaken on 22 wards across the trust, including the Congleton War Memorial Hospital. The review noted that seven medicine fridges were located in a non-secure area as they were located in clinic / utility rooms which were not locked.

It was noted that when the MIAA audit was undertaken there were issues with the temperatures of fridges. It was confirmed that weekly audits are now in place to monitor temperatures and that the trust has purchased electronic thermostats to be installed in line with CQC action plans. Since the initial audit two further audits have been undertaken and assurance has been received by the Deputy Chief Pharmacist that there are no concerns.

The Committee were informed that with regards to the two fridges that provide access to emergency drugs, one of the fridges has been removed completely and it has been agreed the other one will be kept unlocked but secured in a locked room.

The DCAG to provide assurance this has happened.

Dr Madden informed that he had been on a recent walkabout in the Pharmacy area and received assurance that the real focus has been emphasised on addressing the issue raised with the medical fridges.

- 2018/19 Incident Reporting (NRLS Validation) –High Assurance

A review of the systems and processes in place relating to the validation and subsequent reporting of serious incidents via the NRLS(National Reporting and Learning System) was undertaken to confirm that controls are in place, operating effectively and sufficiently robust in order to ensure accurate reporting.
It was noted that all systems and processes in place were in line with standards and there were no further recommendations to be made.

**18/24 Internal Audit Recommendation Follow Up Report**

Mr Rothwell presented the report and informed that all outstanding recommendations are on track and looking good. It was noted that the three outstanding recommendations are not due yet.

The Governance team were thanked for all their hard work on ensuring everything is appropriately evidenced.

**18/25 Internal Audit Charter**

No changes from previous year were noted.

**18/26 Counter Fraud Progress Report**

Mr Causer presented the report noting the work undertaken during the period of April 2018 to September 2018 highlighting activities and outcomes to be brought to the Committees attention.

The following was noted

- All key messages are in progress and a full report will come back to the February 2019 meeting.
- Plan Delivery Dashboard is on track
- Current investigation activity – There are currently 4 fraud investigations ongoing within the trust are recommend to be closed and removed from the planner. One case is currently ongoing and currently under investigation by Cheshire Police. Staff member has been dismissed by the trust and is expected to get to court in Autumn. Two cases relate to false representation and are currently in the review and evidence gathering process.

**EXTERNAL AUDIT**

**18/27 Audit Progress Report**

It was noted that Ian Pinches has left Grant Thornton. A debrief meeting has been scheduled for October.

It was highlighted

- Interim audits are due to commence in December, however AL informed that they are in talks to commence in November with a hope to be able to bring the plan to November’s Audit meeting.
- Audit deliverables have not change from last year and the trust is seeking guidance with regards to implementation expectations for 18/19 accounts. It was noted that this will impact the budgeting process going forward.

**18/28 Annual Audit Letter – 2017/18**

The summary of the findings report that was approved and reviewed in the May Audit meeting were noted and AL informed that the letter will be now uploaded to the trust website.

**FINANCE**

**18/29 Review of Losses and Compensations**

The DDoF presented the report and highlighted the following key areas:

- Total payment January 2018 to March 2018 (Q4) was £15.6k (full year £55.8k) and April 2018 to August 2018 (Q1) was £14k.
It was noted that £10k of the £14k is relating to the excess paid towards an employment claim. The total claim amount was £25k.

It was also noted that a significant loss had been incurred in respect of destruction of pharmacy stock items due to uncertainty over fridge temperatures. This correlated with the findings of Internal Audit in respect of control of fridges.

- The five year trend analysis highlights the losses and compensations paid by the Trust for the last five years. This excludes the largest expenditure of Clinical Negligence.

Discussion took place and it was agreed that future reports would include five year analysis data.

The Committee acknowledged the reduction over time.

<table>
<thead>
<tr>
<th>18/30</th>
<th>Final Accounts Memorandum</th>
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<tbody>
<tr>
<td>There were no audit recommendations for 17/18 or the previous year.</td>
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<table>
<thead>
<tr>
<th>18/31</th>
<th>Overpayments Policy – Updated</th>
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<tr>
<td>The policy was submitted and signed off in August 2017 by the Audit Committee – subsequently the decision has been taken to change payroll provider to the Countess of Chester with effect from 1st April 2019.</td>
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It was noted that there are minimal changes to the policy and the policy now includes an SLA with regards to the new provider.

Specific references to disciplinary issues regarding fraud and potential court action have been included.

The DCAG confirmed the Policy has been reviewed by the Partnership Forum.

Discussion took place regarding overpayments and the DDoF confirmed that overpayments do happen frequently however meetings have been set up with relevant team mentors to review monthly and to ensure the policy is correctly adhered to. Regular meetings with SBS and the debt collector providers also occur when issues are identified.

<table>
<thead>
<tr>
<th>18/32</th>
<th>Any other business</th>
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<tr>
<td>None raised</td>
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**Next Meeting:**
Tuesday 27th November 2018