EAST CHESHIRE NHS TRUST

MEETING OF THE TRUST BOARD

NOT FOR PUBLICATION BEFORE

Thursday 5th July 2018

3.00 PM

Lecture Theatre, First Floor, Main Hospital
Macclesfield District General Hospital

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Our Ref: LM/FB/Meetings01/TB/Agenda
Date: 29th June 2018
To: All Directors of East Cheshire NHS Trust

Dear Colleague

TRUST BOARD MEETING

A meeting of the Trust Board will be held at 3.00pm on Thursday 5th July 2018 in the Lecture Theatre, First Floor, 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 – July 2018 AGENDA

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
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</table>
| 1. Staff Stories: Junior Doctors – IT Improvements  
Specialist Nurse for Blood Transfusion | Director of Nursing, Performance and Quality | 15 mins  
15 mins |

The Chairman's Office
East Cheshire NHS Trust
THQ, New Alderley House
Macclesfield District General Hospital
Victoria Road
Macclesfield
Cheshire
SK10 3BL

Direct Line: 01625 66 1501
Email: fionabaker@nhs.net
http://www.eastcheshire.nhs.uk
### 2. Apologies:
Director of Nursing Performance and Quality

<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>
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<tbody>
<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>-</td>
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<tr>
<td>- Declared interest agenda</td>
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<tr>
<td>- Hospitality and Gifts Register Declaration</td>
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<tr>
<td>4. Minutes of the June 2018 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 18 (50)</td>
<td></td>
</tr>
<tr>
<td>5. Matters Arising</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td></td>
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<tr>
<td>6. Action Log</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td></td>
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<tr>
<td>7. Verbal update:</td>
<td></td>
<td></td>
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</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>FP&amp;W Committee</td>
<td>Mr M Wildig</td>
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### STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

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<tr>
<th>AGENDA TOPIC</th>
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<tbody>
<tr>
<td>8. Chief Executive’s Report</td>
<td>Chief Executive</td>
<td>40 mins</td>
<td>TB 18 (51)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Board Assurance Framework &amp; Corporate Risk Register</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>15 mins</td>
<td>TB 18 (52)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>10. 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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<th>TIME ALLOCATION</th>
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<tbody>
<tr>
<td>11. Public Trust Board Agenda – September 2018</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 18 (53)</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>
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</thead>
<tbody>
<tr>
<td>12. Chairman’s Commentary</td>
<td>TB 18 (54)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>13. Annual Review – Complaints Policy</td>
<td>TB 18 (55)</td>
<td>For assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
<tr>
<td>14. Safer Staffing Exception Report</td>
<td>TB 18 (56)</td>
<td>For assurance</td>
<td>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</td>
</tr>
<tr>
<td>15. Minutes of the committees of the Board:</td>
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<tr>
<td>SQS – April 2018</td>
<td>TB 18 (57)</td>
<td>For information</td>
<td></td>
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<tr>
<td>FP&amp;W – April 2018</td>
<td>TB 18 (58)</td>
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Date and Time of Next Meeting:

Date: Thursday 6th September 2018
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
PUBLIC TRUST BOARD

MINUTES OF MEETING HELD ON:
Thursday 7th June 2018, 3.00 PM

Meeting Chair: Lynn McGill
Meeting Secretary: Bethan Rimmer

Venue: Board Room 1, First Floor, New Alderley House

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 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>✓</td>
</tr>
<tr>
<td>Mr I Goalen</td>
<td>Non-Executive Director</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Peter Madden</td>
<td>Non-Executive Director</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Mr J Wilbraham</td>
<td>Chair Executive</td>
<td>CEO</td>
<td>×</td>
</tr>
<tr>
<td>Mrs K Senior</td>
<td>Deputy Chief Executive &amp; Director of Nursing, Performance and Quality</td>
<td>DCEO/DONPQ</td>
<td>✓</td>
</tr>
<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>
</tr>
<tr>
<td>Mr M Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
<td>✓</td>
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Non-Voting Members

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<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Present</th>
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<tbody>
<tr>
<td>Mrs J Green</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>✓</td>
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In Attendance

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Present</th>
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<tbody>
<tr>
<td>Josie Nosworthy</td>
<td>Executive PA / Minutes</td>
<td>✓</td>
</tr>
<tr>
<td>Peter Gorman</td>
<td>Staff Side Chair</td>
<td>✓</td>
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DECISIONS MADE BY THE BOARD AT TODAY’S MEETING

1. The Board accepted the recommendation that the trust is compliant in 9 out of 10 criteria of the Clinical negligence Scheme for Trusts and compliance in the final criteria will be in place by Q3.

2. The board ratified the Capital Programme for 2018/19.

Agenda Item

<table>
<thead>
<tr>
<th>Agenda No</th>
<th>Patient Story</th>
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<tr>
<td>1</td>
<td>The DoNPQ presented the patient story which described an 84 year old patient who was admitted following an episode of confusion, aggression and violence. A month following admission, the patient became increasingly confused and suffered a fall, sustaining a fractured neck of femur and a fractured left wrist. The DoNPQ states that risk assessments were undertaken, identifying the patient as being at risk of fall, however the patient got out of bed without assistance. Following internal and external CCG scrutiny, the fall was deemed unavoidable and this story highlights the complexity of some patients and the challenges around managing confusion. The Chairman queried whether RCA findings indicated any staffing capacity issues and the DoNPQ confirmed that this was not highlighted as a contributory factor.</td>
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2 | Apologies: |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1. John Wilbraham – as a consequence of changes to Board Diary dates.</td>
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</table>
2. Tony Coombs – apologies as a consequence of changes to Board diary dates.

### ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>3</th>
<th>Register of Interests:</th>
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<tbody>
<tr>
<td></td>
<td><strong>Declared interest agenda</strong></td>
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<tr>
<td></td>
<td>None declared.</td>
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<tr>
<td></td>
<td><strong>Hospitality and Gifts Register Declaration</strong></td>
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<td></td>
<td>None declared. The Chairman reminded members to ensure this is updated regularly.</td>
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<table>
<thead>
<tr>
<th>4</th>
<th>Minutes of the April 2018 meeting</th>
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<tbody>
<tr>
<td>TB 18 (39)</td>
<td>The minutes were agreed as an accurate record of the April 2018 Trust Board meeting.</td>
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<thead>
<tr>
<th>5</th>
<th>Matters Arising</th>
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<tbody>
<tr>
<td></td>
<td>No matters arising identified.</td>
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<table>
<thead>
<tr>
<th>6</th>
<th>Action Log</th>
</tr>
</thead>
<tbody>
<tr>
<td>9769</td>
<td>Complete, action closed</td>
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<tr>
<td>9770</td>
<td>Complete, action closed</td>
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<tr>
<td>9771</td>
<td>Complete, action closed</td>
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<table>
<thead>
<tr>
<th>7</th>
<th>Verbal update:</th>
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<tr>
<td></td>
<td><strong>SQS</strong></td>
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<tr>
<td></td>
<td>- The Committee received sufficient assurances on behalf of the Trust Board for 9/10 of the Clinical Negligence Scheme for Trusts (CNST) standards in order for these to be submitted to NHS Resolution (and hence obtain recovery of % of CNST financial contribution). The final standard was 'Compliance with all 4 elements of 'Saving Babies Lives' Bundle' (against which the Trust is currently very well positioned) has one outstanding requirement via an associated action plan to address annual review and maintenance of cardiotocograph (CTG) competence. This is consistent with the situation for all members of the wider Greater Manchester &amp; Cheshire Paediatric network. All clinical staff are confirmed as having received relevant CTG training including annual update training on CTG assessment &amp; interpretation. The Head of Midwifery confirmed controls are in place, which include hourly review of CTGs by a second practitioner known as ‘fresh eyes’ approach, which provides an additional safety check. For this standard therefore only partial compliance was agreed until implementation of the competency assessment framework is in place, indicative timescale for compliance is Q3.</td>
</tr>
<tr>
<td></td>
<td>The Board accepted the recommendation that the trust is compliant in 9 out of 10 criteria and compliance in the final criteria will be in place by</td>
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Q3.
- The Committee received updates and assurances following discussion on nutrition policies and practice within the Trust which included good compliance with Department of Health Food & Hydration standards and positive feedback in relation to provision of patient meals. Further work (including reaudit and selection & introduction of e-learning) is underway in relation to junior doctor knowledge of optimised Nasogastric tube insertion. Ongoing mitigations and actions following audit are also in place in relation to parenteral nutrition processes.

- The committee noted the Trust's positive achievement in relation to injurious falls rate at 2.0% vs 2.5% per 1000 occupied bed days. This has been as a result of intensive work to, inter alia, update & embed effectiveness of new falls policy (including potential inclusion in statutory & mandatory training); use of sensor equipment and audit of bed rails. Target for coming year includes further 10% reduction in total number of injurious falls including those resulting in severe harm.

- The Committee received the action plan relating to CQC inspection outcome and were assured of all planned actions and timelines. Future reviews will occur on quarterly basis to monitor progress and ensure all regulated standards are met.

- The Committee acknowledged the volume and breadth of work completed and overseen by the Clinical audit, Research and Effectiveness (CARE) sub-committee including progression to compliance with NICE guidance; learning from local and national audits and registration & recruitment to clinical trials.

- The Committee has previously received, reviewed & assured alignment of Trust practice with the recommendations from the Kirkup reports and noted the recent review issued by the Professional Standards Authority on the role of the Nursing & Midwifery Councils handling of Fitness to Practice allegations.

- The committee received an annual report on complaints providing assurance on positive handling of complaints and PALs outreach services.

- The Committee noted that avoidable grade 3/4 pressure ulcers reduced from 17 to 8, noting emerging risks below.

**Emerging Risks and Mitigating Actions**

- Pressure ulcer targets trajectory for 17-18 across in patient and community areas have not been met due to increase in stage 2 ulcers (although as stated above there has been a reduction in the number of avoidable more serious category 3 & 4 ulcers). Actions underway to address target reductions for 18-19 including a zero tolerance target for stage 4 avoidable pressure ulcers include: 'shared care' working with partners (including care homes); e-learning as part of statutory & mandatory training and mandatory for all care agency staff on induction; work with all clinical teams to ensure accurate staging and focus on best use of aids/equipment to avoid device induced ulcers.
- The endoscopy unit having cleared backlog as planned by end March 18, although is now facing further patient backlog, principally arising from unplanned urgent 4 week referrals. A plan has been put into place to ensure that the 2018-19 99% diagnostic access target can be met within the next few months in order to maintain JAG accreditation.

- The DCEO/DoNPQ noted that operational managers within the unit have committed to improving the number of points per session.

- No hospital service areas have triggered on RADAR during April in line with recent months however selected community nursing teams have triggered and a comprehensive risk assessment covering gaps in staffing; sickness levels; capacity & demand; equipment and training & admin staff has been completed with a resultant action plan being put into place monitored by the Associate Director of Acute & Integrated Community Care. The SQS Committee will seek further information and assurances if action plans do not deliver intended improvements.

### FP&W

#### Finance

- Month one position is in line with the 2018/19 plan.

- The trust is assuming provider sustainability funding (formerly STF) of £5.7m for the year. £1.7m is allocated for A&E and the remaining £4m for the national control target.

- The block contract is in place and in line with the plan.

- Capital spend is slightly behind target for month 1 and a request has been made to NHSI that an element of the cash ‘generated’ for the improvement made on the financial total target, to spend this on additional capital.

- Interim Revenue Support Loan (IRSL) is due for repayment by February 2019 and the assumption is that this will roll over on a like for like basis.

- There is sufficient cash to meet requirements, therefore no draw down for Q1 is necessary.

#### Performance

- It was agreed that additional historical key performance data will be included in the July report to provide further context to the monthly report.

- Performance has declined in month 1, with only 1 standard being achieved.

- Comparative data with trusts in Cheshire and Merseyside showed Cheshire East was the best performance in Type 1 ED, exceeding the average regional performance.
There was one breach of the 12-hour standard for which an investigation has been completed.

- The 92% RTT standard was not achieved at 84.7%, the elective programme continuing to be affected by emergency pressures. Targeted action is being taken to improve productivity in outpatients and theatres.

- The Ophthalmology patient recorded as a breach in March was admitted in April and is therefore reported as a breach in April also.

- RTT performance trajectories are to be submitted for the forthcoming year.

- The 6/52 diagnostic access standard performance has fallen to 95.4%. A number of actions are in place to mitigate challenges affecting the standard.

- The 62 day cancer standard has been achieved in month at 92.9%.

- Progress has been made with the Outcomes Framework and this will be tested between June and July which will provide key reporting information. There remains a significant challenge with funding to support the Clinical Lead resource and without resolution will start to impact scale and pace of change from June 2018 onwards.

- The draft Winter Plan developed with partners for 2018/19 was submitted to NHS England on 30 April 2018.

- NHSI has determined the allocation of the Sustainability and Transformation funding in relation to A&E performance for 2018/19 at 90%, rising to 95% by March 2019.

Workforce

- The trust vacancy rate has increased in month as a result of a higher than average number of staff retirement.

- Nursing vacancies remain high with an overall rate of 7.2%. The number of acute nursing vacancies has risen to 15% and a number of recruitment initiatives are scheduled for July and October 2018.

- Medical staff agency spend has decreased significantly from the March position.

- Community nursing is fully established.

- Agency spend for March increased significantly which can be attributed to an increase in annual leave and additionally the number of higher cost shifts undertaken by agency staff. All agency spend has seen a significant reduction on the March figure.

- The shared payroll service with Cheshire and Wirral is at risk as not all organisations have committed to the new service. This has been
escalated to the Chief Executive of the host payroll provider.

- Absence rates have decreased and are below the in-month trajectory.

- Trust awarded bronze status award from MIND charity for well-being at work.

- Compliance targets have been met in-month and levy-funded apprenticeships continue to grow.

- The streamlining of induction and new starter training is saving clinical time and reducing duplication.

- A spotlight on retention was presented as this has been identified as a key strategic priority for 2018/19. An NHSI 90 day improvement programme commenced in May 2018 and the trust ambition is to reduce staff turnover to 1% on average per month.

The Chairman noted that the trust has an aging workforce and queried whether a robust plan is in place to mitigate this risk. The DHR advised that work is taking place across the Place in terms of the working longer project, but advised that more work needs to be undertaken, given the recruitment challenges.

- The Report of the Guardian of Safeworking Hours was presented, highlighting that Overall the level of junior doctor staffing within the trust remains at an unfavourably low level and there is very little slack in the system, particularly in General Surgery at present. The cross cover rota with Orthopaedics remains an issue requiring escalation at present. The Committee received assurance from the Guardian of Safeworking Hours that actions and next steps are in place to address these issues.

**Audit**

The Committee received the year end reports as follows:

- Antifraud annual report concluded that strong systems of control are in place throughout the trust.

- All Committee annual reports were presented (with the exception of the Remuneration Committee), setting out the work undertaken over the last 12 months, ToRs, proposed work programmes and outcomes of self-assessment. No issues were raised.

In addition, the CEO was asked to report on the Clinical Management Board (CMB) consideration of risks. A short report was received from the CEO providing assurance around the role of CMB in the management of high level risks.

- The Director of Audit Opinion and Annual report provided substantial assurance to the Committee. The audit of the Managing Conflict of Interest system identified a small number of incidents whereby staff were only partially compliant. This has been actioned appropriately.
- The Annual Accounts together with the Going Concern statement confirmed that NHS guidance will be followed to prepare on a going concern basis.

- The Annual Governance statement was presented to the Committee and is recommended to the Board for approval.

- It was noted during presentation of the External Audit findings that there is an incorrect categorisation of a specific sum of money. Whilst this is a significant amount and should be recognised as being incorrect, the Committee recognised why and agreed that this does not need to be adjusted within the accounts.

- The Quality Account was received and approved by the Committee subject to minor adjustments.

Mr Goalen advised the Board that no significant issues were found in the annual reports submitted to the Committee and noted the compliments of Mersey Internal Audit Agency on the quality and timeliness of work carried out by the trust.

The Audit Committee recognised and thanked the finance team, the Head of Communications and Engagement and the Deputy Director of Nursing and Quality for their hard work in producing annual accounts and the Quality Account.

The Chairman asked Mr Goalen to confirm that the Audit Committee had delegated authority to sign off the annual accounts.

Mr Goalen confirmed this, noting that this decision then needs to be ratified by the Board.

The Board ratified the annual accounts.

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<tr>
<th>STRATEGIC/GOVERNANCE/ASSURANCE ITEMS</th>
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<tr>
<td>8 Chief Executive’s Report</td>
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<tr>
<th>TB 18 (40)</th>
<th>The DCEO/DoNPQ presented the Chief Executive’s Commentary on behalf of the CEO, highlighting the following:</th>
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<tr>
<td></td>
<td>- The trust has not achieved the 4 hour standard in ED however performance in 2018/19 is improved over 2017/18. Performance needs to increase further to 90% in order to secure STF funding.</td>
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<td></td>
<td>- Income and expenditure position is on plan for April 2018. There is a significant risk associated with QIPP schemes; with £1.3m of the £5m target identified as ‘amber’ or ‘red’ in terms of delivery.</td>
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<td>- The trust has received full JAG accreditation; diagnostic performance will require improvement in order to retain this status upon reassessment in 2018.</td>
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<td>- Public Health England have identified an error in the national system used to invite women between the ages of 68-71 for breast screening.</td>
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2000 women locally have been affected by this and have now been invited for screening by Public Health England in conjunction with NHS Digital. Additional capacity is required to ensure screening appointments are scheduled; Public Health England have informed the trust that all additional costs will be met.

- The Congleton Minor Injuries Unit has been closed at short notice a number of times over the winter period in order to utilise the staffing resource to meet demands.

Mr Goalen referred to page 24 of the bundle which notes the declining numbers of patients attending the unit and asked that this be clarified to ensure that it reflects patient numbers per day and not absolute patient numbers as closure of the unit will impact this.

The DCEO/DoNPQ advised that numbers reduced initially following investment in primary care services via the CCG and further reduced due to weekend closure of the unit.

Mr Wildig queried the remit of the Overview and Scrutiny Committee in this process. The DCEO/DoNPQ advised that a paper with proposed changes will be submitted for scrutiny by the Committee to identify the impact of changes to the service. The Committee will act as an advocate for the public and provide feedback accordingly.

- The Mental Health Service consultation has now closed and saw significant issues raised in public meetings relating to the potential relocation of inpatient services from the Millbrook Unit to an alternative site provided by Cheshire and Wirral Partnership.

The trust has written to the Chief Executive Officer, ECCCG outlining the trust’s comments and questions; a position statement will be released following a review of feedback undertaken by ECCCG. Timescale for publicised outcome of the consultation is approximately 8-10 weeks.

The DCEO/DoNPQ advised that a letter has been written to the Director of Operations, ECCCG to highlight the risk associated with delivering the 90% target for the 4hr standard; the DCEO/DoNPQ is awaiting a response.

Mr Goalen queried the proposed refurbishment cost of £7m as detailed in the letter and the DoF advised that this was Cheshire & Wirral Partnership Trusts estimated cost of upgrading the currently facility to modern standards.

- The DCAG advised of the board’s commitment to undertake a self-review in the coming weeks using the Freedom to Speak Up assessment tool issued by NHS Improvement and the National Guardian’s office. The tool will be prepopulated and submitted for review at the July trust board meeting.

- Transformation work is ongoing, with the MD leading work with clinicians and key stakeholders to develop the Case for Change and a range of
scenarios to sustain clinical services. Discussions have taken place with the Clinical Management Board, Clinical Directors and Clinical Leads, alongside commissioner and partners to ensure the best possible outcome and keep as many services as local as possible.

<table>
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<th>Capital Programme</th>
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<tr>
<td><strong>TB 18 (41)</strong></td>
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<td>The DoF presented the Capital Programme, noting that this has been reviewed and approved by the Clinical Management Board and is submitted to the Board for ratification.</td>
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The board discussed the following:

- The areas for allocated funding remain the same as the previous year, these being:
  - Estates maintenance and infrastructure
  - Accommodation issues
  - Information Technology infrastructure
  - Medical equipment priorities

- The trust has been successful over the last year in securing additional capital funding comprising £879k for creation of primary care streaming services, £570k for cyber security and £26k for cancer transformation fund.

- Mr Wildig queried the level of risk associated with the £500k capital for theatres refurbishment. The DoF advised that this is being managed in conjunction with the operational team and timings have been planned according to bed pressures during the winter plan, avoiding these times.

The board ratified the Capital Programme for 2018/19.

<table>
<thead>
<tr>
<th>Learning from Deaths – Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TB 18 (42)</strong></td>
</tr>
<tr>
<td>The MD presented the Learning from Deaths Q4 report, highlighting the following:</td>
</tr>
</tbody>
</table>

- Rising standardised mortality can be an indicator of a reduction in quality and therefore monitoring deaths in hospital has become a standard part of assessing performance and quality.

- There was a marked increase in mortality at the trust in Q4, with an average of 73 inpatient deaths per month in comparison to 52 inpatient deaths per month during Q1-3.

- 101 deaths underwent a two stage mortality review; no deaths were identified as avoidable.

- Two patients with learning disabilities died at the trust during Q4, both were reviewed using the LeDeR methodology and found to be unavoidable.

- One death has been investigated under the serious incident framework and was found to be unavoidable.

- Crude mortality rate is higher than average 2.54%.
A review of all deaths of patients suffering from acute cerebrovascular disease concluded that no death was avoidable.

A concise review of patients dying of renal failure did not reveal any issues.

Accuracy of coding could be improved with more robust note taking.

End of life care plans are being inconsistently implemented.

Learning from deaths has resulted in a number of actions to improve management of seriously ill patients at the trust, including:

- Implementation of the SAFER Care bundle.
- Vital signs recording system is now fully embedded and alerts clinicians when the national early warning score is exceeded.
- A Sepsis elearning package has been developed and promoted throughout the trust.

The DCEO/DoNPQ noted the recent media interest around organisations that are investigating the avoidability of deaths, particularly the criticism of trusts that conclude no avoidable deaths and the associated rigour of the assessment process.

The MD advised that a specific challenge is around the definition of avoidability due to the complexity of patients.

Assurance was provided that the trust uses methodology and processes consistent with the Royal College of Physicians guidance and an appropriate policy is in place throughout the organisation.

The Chairman queried whether there is opportunity for a regional, anonymised group activity in order to provide further rigour to the process.

The DCEO/DoNPQ highlighted the resource intensity of this approach and the MD advised that mortality notes are shared with other organisations if it is felt that further challenge and scrutiny are needed.

The Board noted the contents of the report.

<table>
<thead>
<tr>
<th>11</th>
<th>Standing Agenda Item: Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No further agenda items noted.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11</th>
<th>Public Trust Board Agenda – July 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18 (43)</td>
<td>The Board agreed the agenda for the July 2018 trust board meeting.</td>
</tr>
</tbody>
</table>

CONSENT ITEMS

<table>
<thead>
<tr>
<th>12</th>
<th>Chairman’s Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18 (44)</td>
<td>The Chairman advised the Board that a hand-signed letter from the Secretary of State was received, recognising the improvement in A&amp;E and diagnostic</td>
</tr>
</tbody>
</table>
performance. This will be circulated to Board members.

<table>
<thead>
<tr>
<th>13</th>
<th>Annual report Infection, Prevention and Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18 (45)</td>
<td>The Board noted the contents of the Infection Prevention and Control Annual report.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14</th>
<th>Annual reports of the Committees of the Board</th>
</tr>
</thead>
</table>
| TB 18 (46) | SQS Committee – May 2018, June 2018  
The Board noted the contents of the annual report of the SQS Committee. |
| | FPW Committee – May 2018, June 2018  
The Board noted the contents of the annual report of the FPW Committee. |

<table>
<thead>
<tr>
<th>15</th>
<th>Annual Safeguarding report</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18 (47)</td>
<td>The Board noted the contents of the Equality, Diversity and Human Rights Annual Review.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16</th>
<th>Safer Staffing Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18 (48)</td>
<td>The Board noted the contents of the Safer Staffing Exception Report.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>17</th>
<th>Minutes of the committees of the Board:</th>
</tr>
</thead>
</table>
| TB 18 (49) | SQS Committee – March 2018  
The Board noted the contents of the minutes of the SQS Committee. |
| TB 18 (50) | FPW Committee – March 2018  
The Board noted the contents of the minutes of the FPW Committee. |

Date and Time of Next Meeting:
Date: Thursday 5th July 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>9769</td>
<td>Trust Board</td>
<td>26/04/2018</td>
<td>8</td>
<td>Chief Executive's Commentary</td>
<td>Mr Goalen recommended clearer sight of the CQC rating on the website. The Chairman agreed noting the website is a key tool for recruitment. Action: The DCAG agreed to discuss this with the Communications team and update the website.</td>
<td>Julie Green</td>
<td>Jun-18</td>
<td>Complete, recommend action closed.</td>
<td>Open</td>
</tr>
<tr>
<td>9770</td>
<td>Trust Board</td>
<td>26/04/2018</td>
<td>11</td>
<td>Bi-annual report - Safer Staffing</td>
<td>The DNPQ clarified that the next steps outlined are for the team to consider and not for the Board's agreement at this time. Action: It was agreed the wording within the report is misleading and the DNPQ agreed to amend to provide further clarity.</td>
<td>Kalih Senior</td>
<td>Jun-18</td>
<td>DNPQ confirmed wording has been amended within the Bi-Annual report and this will be uploaded to the intranet with the full Public Board papers. Recommend action closed</td>
<td>Open</td>
</tr>
<tr>
<td>9771</td>
<td>Trust Board</td>
<td>26/04/2018</td>
<td>12</td>
<td>Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register</td>
<td>Mr Wildig queried whether the increase in agency cost is included as a risk. Action: The DCAG agreed to review and check the risk scoring.</td>
<td>Julie Green</td>
<td>Jun-18</td>
<td>DCAG has checked and agency cost is included in the corporate risk register. 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 Report to Trust Board for the Period to 31st May 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**
Mitigates Risk Number: (identify) 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
- Corporate Objectives
Links to all strategic objectives

**Legal implications - (identify)**
None

**Impact on quality**
Increasing risk to patient experience due to operational pressures

**Resource impact**
None

**Impact of equality/diversity**
None

**Avoid acronyms or abbreviations - if necessary list:**
- ED Emergency Department
- WLI Waiting List Initiative
- PN Parenteral nutrition
- CEC Cheshire East Council
- NHS National Health Service
- UK United Kingdom
- NHSI NHS Improvement
- CEO Chief Executive Officer
Chief Executive’s Commentary for the Period Ending 31st May 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.

2 KEY ISSUES

The Board are asked to note

2.1 • The positive improvement in waiting times for patients being treated in ED
• The satisfactory financial position
• The concerns from Congleton residents about the future of the Congleton War Memorial Hospital
• The progress being made on the sustainability assessment of the trust

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 Patient Access

There has been an improvement in the time patients are waiting to be seen in ED

3.1.1 The number of patients being treated and discharged, admitted or transferred from the ED has improved further in May; 3,896 people were treated within 4 hours (87.1%) with 575 people waiting longer. This position is better than the agreed improvement trajectory set by the trust and performance is continuing to improve through June.

3.1.2 Given the improved performance the regulators have asked the trust to resubmit an improvement trajectory and this will be included in the next performance pack produced for the end of Quarter 1.

3.1.3 The improvement in performance comes alongside a reduction in the level of bed occupancy. The trust is already planning for winter and a plan is being developed to generate reasonable levels of bed occupancy by the potential replacement of elective and intermediate care beds with medical beds; the Board will be briefed next month on this plan.

There is a small increase in the numbers of people waiting for treatment at the Trust

3.1.4 The number of patients on the waiting list at 31st May was 7,836 compared to 7,815 at the end of April 2018. The trust is aiming to have the same number at the end of March 2019 as at March 2018 which was 7,540. The current increase is almost entirely on the outpatient waiting list.
3.1.5 The numbers on the list continue to grow and this adds pressure to the number of patients treated within 18 weeks. The performance against this standard has been c.85% for the last few months however there is a risk this will deteriorate.

3.1.6 The executive team are aware of concerns from some clinicians about the impact on patient safety with increasing waiting times and a number of specific specialities are being reviewed to ensure maximum productivity is being achieved in these areas.

3.1.7 One area which has been reviewed is gastroenterology outpatients and I have sanctioned some additional clinics to be undertaken using the trusts Waiting List Initiative (WLI) policy. The financial position has been based on no WLIs being undertaken this year and therefore this balance of clinical and financial risk is being closely monitored.

3.1.8 Whilst more people are being added to the trust’s waiting list the trust is meeting its standard for seeing patients within 2 weeks for suspected cancer. Performance on the other cancer waiting time standards is mixed with some being achieved and some not.

3.1.9 There are no specific issues of patient harm; however the position needs to be closely monitored.

3.2 An EL(97)52 Audit of Unlicensed Aseptic Preparation Services was undertaken on 9th May

3.2.1 NHS Executive Letter, EL(97)52 ASEPTIC DISPENSING IN NHS HOSPITALS, was issued in August 1997 which identified that all such units were to be inspected every 12-18 months, and the:

“results of the inspections to be made known to Trust Chief Executives and to those commissioning health services, so that standards are maintained”.

3.2.2 The aseptic preparation of chemotherapy doses, a small range of monoclonal antibodies and additions to licensed adult parenteral nutrition (PN) bags at Macclesfield District General Hospital was audited in accordance with EL(97)52 and the report shared with the staff.

3.2.3 The finalised report follows consultation and agreement with the service leads within the Pharmacy Department and has raised some concerns regarding the facility and management arrangements; however given the current level of activity and the number of personnel working in the unit at this time, and the commitment to continue to develop the quality system, the inspection team has assessed this particular service to be Low Risk.

3.3 Congleton Hospital

3.3.1 The Board are asked to note the intention for a petition to be presented to Cheshire East Council (CEC). It is possible that this has been issued in light of the recent presentation by the trust to the CEC Health and Adult Social Care and Committees Overview and Scrutiny Committee about the reduced service offered at the Minor Injuries Unit over winter and the reference to a national specification for future service provision.

3.3.2 The petition reads:

Save Congleton War Memorial Hospital

Congleton’s War Memorial Hospital, which was opened in 1924 with money from local benefactors as a memorial to those who gave their lives in the First World War. Easy access to both physical and mental health-
care needs are vital for the residents of Congleton. We are concerned that a reduction of services at our much-loved hospital will have a detrimental effect upon the health and well-being of residents in the town.

We believe that the Congleton War Memorial Hospital provides a vital service for residents. We therefore call on Cheshire East NHS Trust and the UK Government to provide the funding it requires and deserves in order that it may remain open and able to serve the people of Congleton.

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 National Financial Settlement

The Prime Minister made a speech on the 18th June about a funding commitment to the NHS

4.1.1 The Prime Minister made a speech outlining a 5 year funding settlement for the NHS and a requirement for a 10 year plan for the NHS.

4.1.2 The NHS will receive an average uplift of 3.4% above inflation for a 5 year period from 2019/20. The uplift is front loaded with the annual uplifts being 3.6%, 3.6%, 3.1% 3.1% & 3.4%. This equates to £20.5bn more revenue when compared to 2018/19 funding levels. A further £1.25bn will be used to meet increased pension costs associated with the new Agenda for Change pay deal.

4.1.3 In return, a 10 year plan will be developed and submitted later this year via an “assembly” convened by national leaders and with a strong clinical input.

5 priorities were highlighted:

- Putting the patient at the heart of how care is organised
- A workforce empowered to deliver the NHS of the future
- Harnessing the power of innovation
- A focus on prevention, and
- True parity of care between mental and physical health

4.1.4 This increase in funding is clearly welcomed and the executive team will work with local partners and regulators to understand how this national settlement will play out locally and further information will be brought to the Board in due course.

4.2 Financial Performance

The Trust is on track against its financial plan

4.2.1 At the end of May the trust had generated a deficit of £3.9m, £200k better than plan. The major risk is the level of savings identified which at present are £1m short of the £5m required and only £2m currently delivered.
4.2.2 The table below shows the Income and Expenditure summaries:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Favourable/Adverse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>24,276</td>
<td>24,507</td>
<td>(231) Favourable</td>
</tr>
<tr>
<td>Pay Expenditure</td>
<td>18,146</td>
<td>18,116</td>
<td>(30) Favourable</td>
</tr>
<tr>
<td>Non-Pay Expenditure</td>
<td>9,536</td>
<td>9,646</td>
<td>110 Adverse</td>
</tr>
<tr>
<td>Total Operating Expenditure</td>
<td>27,682</td>
<td>27,761</td>
<td>79 Adverse</td>
</tr>
<tr>
<td>Operating (deficit)/Surplus</td>
<td>(3,406)</td>
<td>(3,254)</td>
<td>(152) Favourable</td>
</tr>
<tr>
<td>Interest Rec'd/Paid/Gain on disp.</td>
<td>168</td>
<td>159</td>
<td>(9) Favourable</td>
</tr>
<tr>
<td>Capital Charges &amp; Adjustment for donated assets</td>
<td>567</td>
<td>566</td>
<td>(11) Favourable</td>
</tr>
<tr>
<td>Trust (deficit)/Surplus</td>
<td>(4,141)</td>
<td>(3,980)</td>
<td>(161) Favourable</td>
</tr>
</tbody>
</table>

4.3 Outpatient Capital

4.3.1 The Trust has received additional capital which it proposes to use on the redevelopment of the outpatient facility. The Board will be aware that the trust performed better than plan last year and the regulators have recognised this by uplifting the capital limit for the trust by £900k. This resource must be spent in this financial year.

4.3.2 The executive team are proposing that this resource is used to redevelop the outpatient area at the Macclesfield site. It is some time since this department was established and it is the intention of the team to seek to create a space that is good for both patients and staff but also to ensure technology is utilised to ensure an efficient and effective service is delivered and maximise opportunity for future delivery models.

4.3.3 The executive team will be discussing the opportunity and who should be involved in the development during July.

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 2018/19 Pay Award

5.1.1 Agenda for Change Pay Award has been accepted by Staff Side Organisations. The pay award offer made by NHS Employers for staff working on Agenda for Change contracts has been accepted by the staff side organisations although not all individual unions were in agreement. The costs of this are assumed to be neutral in the trust’s financial plan and the payroll team will calculate the costs when the detailed information is received. It was anticipated that new pay rates would be in place for July payslips but there is a risk this will be delayed. The executive team will work closely with staff side colleagues and others to ensure staff are kept up to date with progress.
5.2 Workforce Performance

The workforce key performance indicators are being achieved

5.2.1 The performance metrics are being achieved with the exception of the rolling 12 month average sickness absence rate. The in-month sickness absence rate is 0.5% better than plan.

5.2.2 Agency expenditure has reduced again in May and the trust is under the maximum level set by NHSI. The regulator recently sent out direction on sign-off processes for agency expenditure reducing the value that requires CEO approval. The executive team discussed these new directions and have communicated them to managers within the trust.

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 FUTURE SUSTAINABILITY

The production of the “Case for Change” has been prepared with clinical engagement

6.1.1 The East Cheshire Sustainability programme has been underway for a number of months and a key element of this work was to understand the issues facing the trust in the delivery of clinically and financially sustainable services. It is fair to say that a number of the issues being faced are those faced by many organisations across the country and not unique to East Cheshire.

6.1.2 The trust is recognised as providing good care, a position supported by the recent Care Quality Commission inspection however the case for change challenges the trust to think about how it will meet higher expectations and standards as it moves into the future. In summary the trust can be said to be “sub scale, not sub-standard” and the challenge is to ensure the trust and its staff can continue to provide this level of care.

6.1.3 The issues faced are largely a function of the small size of the organisation which causes issues about economies of scale and resultant value for money alongside some small volume services which poses challenges in maintaining clinical skills for patients.

6.1.4 The next step is to consider some “what if” scenarios and how they would offset the issues raised in the case for change. The trust has invited consultants from other organisations to the workshop to ensure other clinical perspectives are taken into account. In addition the Nuffield Trust also presented some work they are undertaking about the future of District General Hospitals.

6.2 CHESHIRE AND MERSEYSIDE HEALTH AND CARE PARTNERSHIP

The Partnership has launched a website

6.2.1 The trust is a member of this partnership and there is now a website available to help communicate the work being undertaken. The address is: www.cheshireandmerseysidepartnership.co.uk.
### USE OF TRUST SEAL

7.1 The Trust Seal has not been used since the last meeting.

### SUMMARY

8.1 The trust has made a good start to the 2018/19 financial year from an operational perspective and is actively engaging in developing the future clinical service strategy.

<table>
<thead>
<tr>
<th>Sign off</th>
<th>John Wilbraham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role title</td>
<td>Chief Executive</td>
</tr>
</tbody>
</table>

**PUBLIC TRUST BOARD**  
Thursday 5th July 2018

<table>
<thead>
<tr>
<th>Agenda Item Number 9: TB 18 (52)</th>
</tr>
</thead>
</table>
| **Report of:**
| **Responsible Officer** | Deputy Director of Corporate Affairs and Governance |
| **Accountable Officer** | 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** | All domains |
| **Link to Care Quality Commission domain** | All Objectives |
| **Link to:** |
| | Trust’s Strategic Direction  
| | Corporate 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 reviewed the Board Assurance Framework and Corporate Risk Register at their meetings in February 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, and provides assurance against these to the Audit Committee.

2 STRATEGIC RISKS

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

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

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

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

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

5. If the Information Technology/Information Systems and Estate infrastructure are not sufficiently invested in and adapted to align with the health economy strategy then there will be an impact on the quality of the delivery of clinically & financially sustainable services.
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 14 gaps in control and assurance to be closed. Key areas included:

- Gaps in assurance relating to the 2015 CQC Inspection report; positive external assurance received from CQC following their recent Inspection.
- Gaps in control relating to winter pressures impact on training attendance in 2017/18
- The fact that the QIPP schemes were delivered in 2017/18 and control total met provided assurance at year end.
- A strengthened process to ensure the waiting list initiative policy is being applied consistently across all areas of the trust.
- Effective management of the agency cap spend and impact of IRS35 regulations

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

- Strengthened process in place for Clinical Effectiveness action plans however not yet fully embedded in practice across all directorates.
- 2018/19 QIPP schemes still to be identified and delivered
- Annual Plan submitted to NHSI but not yet finalised by regulators
- Bed reconfiguration not yet finalised
- Final Plan for winter 2018/19 still to be agreed (although within timescales)

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.

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Monitoring Committee / Board</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>
</tr>
<tr>
<td></td>
<td></td>
<td>Continue to work with partners to agree clinical models for East Cheshire. Ensure clinical engagement and consensus is achieved relating to future service model</td>
</tr>
</tbody>
</table>
### Full Compliance was achieved following assessment of the Board Assurance Framework

3.2.1 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
- 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

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Monitoring Committee / Board</th>
<th>Focus over next 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Quality &amp; Compliance: patient safety, patient experience and effectiveness</td>
<td>Safety, Quality &amp; Standards Committee</td>
<td>Maximise productivity to ensure maximum numbers of patients are treated Provide assurance against the implementation of the CQC action plan</td>
</tr>
<tr>
<td>3. Financial stability</td>
<td>Finance, Performance and Workforce Committee</td>
<td>Focus on identification of QIPP schemes for 2018/19 Delivery of the planned financial position in the quarter</td>
</tr>
<tr>
<td>4. People</td>
<td>Finance, Performance and Workforce Committee</td>
<td>Continued focus on recruitment programme for consultant and middle grade staff Continued focus on implementing the retention programme with the aim of continued reduction of agency spend</td>
</tr>
<tr>
<td>5. Infrastructure</td>
<td>Clinical Management Board</td>
<td>Continue the Estate Rationalisation programme in the community Continue to implement the agreed IT transformation plan.</td>
</tr>
</tbody>
</table>

3.2.2 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

Corporate Risk Profile – overall reduction in the total number of red rated risks since the previous report

4.1 There are currently 19 red risks included on the risk register, which is a net reduction from the previous report of 10 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 three risks have been added or had their risk scores increased, whilst 13 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 quarters reported in 2017/18 (which is specific to the time of the report being run from the risk management system).

<table>
<thead>
<tr>
<th>Movement in Corporate Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of risks</td>
</tr>
<tr>
<td>Q2</td>
</tr>
<tr>
<td>35</td>
</tr>
</tbody>
</table>

4.2 The 19 red rated Corporate Risks have been delegated as follows (four risks are monitored by more than one committee, so a total of 25 risk entries appear when the risks are split by monitoring committee / board):

<table>
<thead>
<tr>
<th>Committee / Board</th>
<th>Number of Red Rated Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety, Quality and Standards Committee</td>
<td>11 (includes 2 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>7</td>
</tr>
<tr>
<td>Clinical Management Board</td>
<td>7</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 July 2018 meetings. Clinical Management Board will also review its delegated red risks in July 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 three risks have been added to the Corporate Risk Register or had their risk score increased since the last report (this compares with 11 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>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>Newly approved risk – current score 15</td>
</tr>
<tr>
<td>2806</td>
<td>If the Planned Care Directorate is unable to operate within the financial plan and achieve the relevant income and QIPP, there is a risk that the trust will not achieve the financial target</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td>2801</td>
<td>If the current cardiology back log of new and follow up patients cannot be managed within current job plans of existing cardiology clinicians, then the back log of patients will continue to rise. This would increase waiting times for some patients with potential impact on quality of care</td>
<td>Newly approved risk – current score 20</td>
</tr>
</tbody>
</table>
The following 13 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 12 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>2674</td>
<td>If the Trust does not adequately manage winter pressures with system partners then this will impact on patient care and delivery of key national standards</td>
<td>Risk closed</td>
<td>Risk closed due to the end of 2017/18 winter pressures</td>
</tr>
<tr>
<td>2422</td>
<td>If the existing consultants continue to cover the gaps in the oncall rota, this will have an impact on increased workload and provide an increased financial pressure of approx £5000 per month.</td>
<td>Reduction in risk score – current score 12</td>
<td>Likelihood reduced due to 2 x substantive consultants now being in post</td>
</tr>
<tr>
<td>2522</td>
<td>If the Planned Care Directorate is unable to operate within the financial plan and achieve the relevant income and QIPP, there is a risk that the trust will not achieve the financial target</td>
<td>Risk closed</td>
<td>Risk relates to 2017/18 – new risk opened for 2018/19</td>
</tr>
<tr>
<td>2535</td>
<td>If the patient beds are not upgraded to the new electric beds with integrated safety sides then there is a potential risk of harm to the patient from falls, discomfort from not being able to manoeuvre patients into a comfortable position. Potential risk of musculoskeletal harm to staff with regard to manual handling of patients and safe manoeuvring around the organisation</td>
<td>Risk closed</td>
<td>One of a number of bed risks merged into one overarching risk</td>
</tr>
<tr>
<td>2684</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Ward 2 has been reported on the Strategic Executive Information System (2017/29893 Web-49343).</td>
<td>Risk closed</td>
<td>All actions complete. Closed by CCG</td>
</tr>
<tr>
<td>2628</td>
<td>A Serious Incident relating to a Fetal Death in Utero on the Labour Ward has been reported on the Strategic Executive Information System (2017/22694 Web-47520).</td>
<td>Reduction in risk score – current score 5</td>
<td>RCA complete, approved at check and challenge and sent to CCG</td>
</tr>
<tr>
<td>2728</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Ward 9 has been reported on the Strategic Executive Information System (2018/2344 Web-50693).</td>
<td>Risk closed</td>
<td>No actions identified – undeclared by CCG</td>
</tr>
<tr>
<td>2672</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Ward 8 / MAU has been reported on the Strategic Executive Information System (2017/29097 Web-49192).</td>
<td>Risk closed</td>
<td>All actions complete. Closed by CCG</td>
</tr>
<tr>
<td>2690</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Aston Unit has been reported on the Strategic Executive Information System (2017/31156 Web-49787).</td>
<td>Risk closed</td>
<td>Undeclared as a SIRI by CCG</td>
</tr>
<tr>
<td>2691</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Ward 11 Intermediate Care has been reported on the Strategic Executive Information System (2017/31265 Web-45995).</td>
<td>Risk closed</td>
<td>Undeclared as a SIRI by CCG</td>
</tr>
<tr>
<td>2637</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Aston Ward has been reported on the Strategic Executive Information System (2017/25701 Web-48270).</td>
<td>Risk closed</td>
<td>Undeclared as a SIRI by CCG</td>
</tr>
<tr>
<td>2641</td>
<td>A Serious Incident relating to an Unexpected Death in Cardiology has been reported on the Strategic Executive Information System (2017/26164 Web-44148).</td>
<td>Risk closed</td>
<td>RCA complete, approved at check and challenge and sent to CCG</td>
</tr>
<tr>
<td>Risk No.</td>
<td>Description</td>
<td>Status</td>
<td>Additional detail</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>2543</td>
<td>If we are unable to achieve our financial control total then there is a risk to the reputation and sustainability of the organisation</td>
<td>Risk closed</td>
<td>Financial risk for previous year – new risk in place for 2018/19</td>
</tr>
</tbody>
</table>
Date: 30th August 2018

To: All Directors of East Cheshire NHS Trust

Dear Colleague

TRUST BOARD MEETING

A meeting of the Trust Board will be held at 3.00pm on 6th September 2018 in Board Room 1, New Alderley House, Macclesfield District General Hospital, Victoria Road, Macclesfield, SK10 3BL.

Yours sincerely

Lynn McGill
Chairman

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

TRUST BOARD – SEPTEMBER 2018 AGENDA

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff Stories:</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>
</tr>
</tbody>
</table>
### ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. <strong>Register of Interests:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Declared interest agenda</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>- Hospitality and Gifts Register Declaration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. <strong>Minutes of the July 2018 meeting</strong></td>
<td>The Chairman</td>
<td>-</td>
<td>TB 18 (59)</td>
<td></td>
</tr>
<tr>
<td>5. <strong>Matters Arising</strong></td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>6. <strong>Action Log</strong></td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>7. <strong>Verbal update:</strong></td>
<td>Ms A Harrison</td>
<td>15 mins</td>
<td>Verbal (supported by formal minutes when available)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>- SQS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- FP&amp;W</td>
<td>Mr M Wildig</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Audit</td>
<td>Mr I Goalen</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. <strong>Chief Executive’s Report</strong></td>
<td>Chief Executive</td>
<td>40 mins</td>
<td>TB 18 (60)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. <strong>Board Assurance Framework &amp; Corporate Risk Register</strong></td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>15 mins</td>
<td>TB 18 (61)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>10. <strong>IT Strategy Update</strong></td>
<td>Director of Finance</td>
<td>10 mins</td>
<td>TB 18 (62)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>11. <strong>Winter Plan</strong></td>
<td>Director of Nursing Performance and Quality</td>
<td>10 mins</td>
<td>TB 18 (63)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>12. <strong>Learning From Deaths Quarterly Report – Q1</strong></td>
<td>Medical Director</td>
<td>10 mins</td>
<td>TB 18 (64)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>13. <strong>Standing Agenda Item:</strong></td>
<td>Chief Executive</td>
<td>5 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>- Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Public Trust Board Agenda – November 18</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 18 (65)</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>15. Chairman’s Commentary</td>
<td>TB 18 (66)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>16. Controlled Drugs Annual Report</td>
<td>TB 18 (67)</td>
<td>For assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
</tbody>
</table>
| 17. Bi-Annual Safer Staffing Levels Report | TB 18 (68)| 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 |
| 18. Safer Staffing Exception Report   | TB 18 (69)| For assurance          | PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience  
<p>|                                      |           |                        | STAFF - Empower, develop and value staff in providing innovative patient focused care |
| 19. Guardian of Safe Working Annual Report | TB 18 (70)| For assurance          | STAFF - Empower, develop and value staff in providing innovative patient focused care |</p>
<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>20. Minutes of the committees of the Board: SQS – June 2018, July 2018</td>
<td>TB 18 (71) TB 18 (72) TB 18 (73) TB 18 (74)</td>
<td>Information</td>
<td></td>
</tr>
<tr>
<td>FP&amp;W – June 2018, July 2018</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date and Time of Next Meeting:
Date: Thursday 1st November 2018
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
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 June 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: | 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
| NHSI: National Health Service Improvement
| CCG: Clinical Commissioning Group
| WRES: Workforce Race Equality Standard
| HR&OD: Human Resources and Organisational Development
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 broaden engagement.

NATIONAL, REGIONAL AND LOCAL CONTEXT

I attended this event, on Wednesday 20th June 2018 in Leeds, where we heard of the developments across the North and in particular the inroads made in planning for integrated organisations, the most progressed across England. It was encouraging to hear of other health economies dealing with similar issues to our own.

The Chair of NHS Improvement gave an update with regards to plans to bring NHS Improvement and NHS England closer together in terms of making best use of resource, with feedback from Chairs and some helpful points noted for all.

She shared the three things she keeps in mind at all times;

i) The NHS on aggregate offers the best healthcare system in the world, hugely supported by the public and we should be proud of this

ii) Whilst innovation, significant inefficiencies remain, with variation no longer acceptable, referencing the Carter work, all of which seeks to improve patient experience and outcomes

iii) Even with the variation significantly improved, there is a recognition that funding would have to change
The Chair of NHS Improvement noted seven key strands to her approach to support the necessary changes and improvements.

Wider discussions also touched on performance and appraisal; the importance of digital adoption; local adaption of good practice in leveraging improvements; developing the roadmap to make best use of the new, recently announced resources; the implications following the most recent Kirkup reviews; the contribution of social care; the importance of strengthened clinical leadership; the public’s preference of NHS priorities, and the value of engaging with the voluntary and third sector in developing the ‘Place’ offer.

Chairs then heard presentations from three Strategic Transformational Partnerships (STPs); representatives from Cumbria and the North East discussed staff engagement; Humber Coast and Vale discussed their journey to date; South Yorkshire and Bassetlaw discussed service reconfiguration and hospital services review; each talked of how they had approached their ‘Place’ based plans.

Whilst many trusts had improved performance in the first part of the new year, there remains an emphasis on winter planning for 2018-2019 across the region and England.

Following the meeting NHS England have published a briefing about integrated care and the positive impact this can and is having across the country. Please see: 

A copy is attached for your reference.

The Prime Minister has announced new funding for the NHS as part of a broader collaborative approach to provision and prevention. See: 
A voice in forums that influence regionally through strong representation

2.2 Health and Care Partnership, Cheshire and Merseyside

This event, held on the afternoon of Tuesday 19th June 2018 in Widnes, titled ‘Maximising the economic and social value of the Cheshire and Merseyside NHS pound’.

Led by the Implementation Director for the region, guest speakers contributed their perspectives. Key messages included:

i) A recognition of the importance of People and Places, two of the five ‘foundations’ outlined by the government in Britain’s Industrial strategy and how this links locally

ii) the role of health, wellbeing and care linked to the industrial strategy for East Cheshire to harness a population fit for the future to aid economic vitality, recognising mental, physical and spiritual aspects

iii) the importance of supporting individuals and making it easier to make healthy choices about lifestyle and the role of technology and Artificial Intelligence as an enabler

And one of the four ‘grand challenges’ :-

iv) Harnessing the power of innovation to help meet the needs of an aging society; for example, working differently, harnessing data and technology and engaging with a successful charitable sector where they have been seen to improve outcomes

In addition, we discussed having the conversation with our local communities to ensure successful adoption of plans for ‘Place’, coupled with engaging schools and colleges for early sight of and developing ambitions for careers in the sector.

Working with local Partners to ensure better patient experience, outcomes and make our resources go further as we seek to future proof local services

2.3 Cheshire East Partnership Board

The Programme Board met on Wednesday 6th June 2018; I was pleased to Chair the meeting in the absence of our Independent Chair and heard from several Senior Responsible Officers, together with how plans might align with the regional and national timescales currently being discussed. These discussions continue to become increasingly ‘Place’ focused and progressive.

For regular updates, please continue to see: http://www.caringtogether.info
In support of strong working relationships I continue to meet informally with local Chairs; I did so on Thursday 25th June 2018 with the Chair of Eastern Cheshire CCG.

**Local actions are improving diversity and inclusion**

2.4 **Workforce, Race and Equality Standard forum (WRES)**

I was pleased to participate in this event, on Thursday 14th June 2018 in Manchester, sharing our own success and learning from others.

Having recognised the value of data, in recent years regulators have provided resource to support the measurement of diversity of workforce and have developed an indicator framework that determines the level of WRES maturity.

As diversity lead I am pleased to note that East Cheshire NHS Trust has made progress, achieving in four of the eight measures. Whilst we have made significant progress, there is still work to do, not least of which is broadening Board diversity. It is with this in mind I am aware that our Director of Human Resources and Organisational Development (HR & OD) has embraced this as part of her planning and activity throughout the coming year. I look forward to continued improvement.

In addition, members will be aware of the choice to participate in the Insight Programme for aspirant Non-Executive Directors, specifically to support diversity and inclusion. This will add value and richness to Board discussions and decisions.

In addition, I have been asked by our regulator to mentor aspirant Chairs, previously done informally or through the NW Leadership Academy.

3. **LOCAL CONTEXT**

**Recognising Local commitment to the NHS, our patients and communities**

3.1 **Long Service Awards**

On Friday 15th June 2018, it was a pleasure to celebrate the contribution of a group of long serving people with 20 or 25 years local service to our patients and their team colleagues. I was joined by our Deputy Chief Executive/Director of Nursing, Performance and Quality to share this recognition and
celebration event. Listening to individual stories, the changes they have introduced and the improvements made for patients was a genuine source of pride.

**Public engagement and support, ‘self–help’ and prevention**

**3.2 Health Matters**

These events have been developed, shared with members of the public and have run for many years with the intention of showcasing how treatments are provided and what our professional and individual citizenship responsibilities are; in this way we can assist as individuals to enable self-help, by recognising early signs so we each might take preventative action wherever possible.

This month’s Health Matters on Tuesday 5th June 2018 focused on the A-Z of Respiratory disease, led by one of our clinical directors and lead for the Respiratory service. Amongst the information shared were some key tips for everyone. To find out more, please see:

https://www.youtube.com/watch?v=drmpMCWxMhY

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**4. TRUST BOARD**

**4.1 Board Business**

I can confirm that the Remuneration Committee met on the afternoon of Thursday 21st June 2018.

**4.2 The Trust Board Programme of Work**

As planned.

**4.3 Board Development**

Largely as planned, with one item to be rearranged.

Lynn McGill
Chairman
Breaking down barriers to better health and care

The journey from fragmented services to local partnerships and integrated care systems, designed to meet our needs today and tomorrow
Changing health and care needs

Our health and care needs today are different from those the current health and care system was designed to address. People are living longer and society is getting older overall. New technologies are being discovered and more people are living with long-term conditions such as diabetes and asthma. Health services set up in a different era must adapt to these changes.

Old divides between health and social care, between physical and mental health, and between GPs and hospitals mean that too many people experience disjointed care. For example, they may have to repeat the same details to several people in different parts of the system. This is bad for them and not a good use of staff’s time. People also want more personalised care and greater support to live their lives independently.

How our health and care needs are changing

- The number of people aged over 65 in England rose by 21 per cent between 2005 and 2015, and is expected to do so again between 2015 and 2025. There are half a million more people aged over 75 than there were in 2010 – and there will be two million more in 10 years’ time.

- People are living in ill health for longer – 65 per cent of people admitted to hospital today are 65 or older. Between 2015 and 2035, the number of older people with four or more diseases will double, and at least two-thirds of the extra time people live beyond 65 will be spent with four or more diseases.

- More and more people are living with more than one long-term condition – 15 million now and a further three million by 2025. Treating these conditions accounts for around £7 out of every £10 of total health and care spending in England, half of all GP appointments, almost two-thirds of outpatient appointments and seven out of ten inpatient bed days.

- Around 30 per cent of all people with a long-term physical condition in England also have a mental health concern such as anxiety or depression.

- In 2015, 58 per cent of women and 68 per cent of men were overweight or obese, with obesity rates increasing from 15 per cent in 1993 to 27 per cent in 2015.

- There is a nearly 20-year difference in healthy life expectancy between people living in the most deprived and the least deprived areas.

For these reasons, NHS organisations and local councils in England are joining forces to integrate services and to invest in ways to prevent illness and keep people out of hospital. Their aim is that people can live healthier lives and get the care and treatment they need, in the right place, at the right time. For people with multiple and long-term conditions, this means enhancing the care provided by GPs and community based services and helping people to manage their own health and to maintain their independence.
Working in partnership

To make this happen, all parts of local systems – such as GPs, care homes and home care, hospitals, community and mental health services – are working together more closely than ever before. They have come together to form local ‘sustainability and transformation partnerships’ in every part of England, to run services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents’ day-to-day health.

In some places the areas covered by these partnerships reflect established local government boundaries, although this is not always practical because of how people use health services. A large hospital may serve residents in several council areas, and centres of excellence for specialist services – such as cancer, trauma or stroke – often need to be planned on a wider scale.

By ensuring decisions are made at the most appropriate level, and empowering local leaders to plan around the long-term needs of the people they serve, health and care systems can make simple, practical improvements for local communities. These could include ensuring that those who regularly rely on both NHS and home care services see a single team, or making it easier to access a range of services and treatments in one place.

Often, they will do this by incorporating and expanding ideas that worked well in one place, such as in the 50 ‘vanguard’ sites that developed new models of care across England. These areas helped, for example, to expand the support given in care homes and supported living facilities, and reduced unnecessary trips to hospital.

Crucially, partnerships include people outside traditional care services whose work has an impact on day-to-day health and wellbeing. Services such as public health, housing and leisure can prevent or delay the onset of ill health and enable people to live longer, happier lives. The partnerships build on strategic plans to improve health and wellbeing that local councils have drawn up in every area.

Although partnerships published their initial proposals in 2016, these have substantially evolved to reflect views from people who use and provide services, elected representatives and local voluntary organisations. Each is at a different stage of its journey, and local priorities understandably vary.
The road to better coordinated health and care

- **2014**: the NHS Five Year Forward View set out a national vision for collaboration
- **2015**: ‘vanguards’ in 50 areas began to develop and test new models of integrated care
- **2016**: NHS organisations and many local councils came together to form partnerships covering all of England, to consider local health and care priorities and to plan services together
- **2017**: areas refined initial proposals, drawing on engagement with frontline staff, local residents and others in the community
- **2018**: some partnerships began to take on more responsibility by becoming ‘integrated care systems’

Giving more power to local areas

From April 2018, a group of the most mature partnerships evolved to become ‘integrated care systems’. In these areas, NHS organisations are taking shared responsibility for managing overall resources and using these to improve quality of care and health outcomes for their local population, working in close partnership with local government and others in the community. Other areas will follow in future, learning from the experience of the first group.

**Integrated care systems will improve health and care by:**

- supporting the coordination of services, with a particular focus on those at risk of developing acute illness and being hospitalised
- providing more care in a community- and home-based setting, including in partnership with council social care, and the voluntary and community sector
- ensuring a greater focus on population health and preventing ill health
- allowing systems to take collective responsibility for how they best use resources to improve health results and quality of care, including through agreed cross-system spending totals.

This group includes health and care systems in Manchester and Surrey that received new devolved health and care powers as part of wider devolution agreements. National regulators will further streamline their support for, and oversight of, these systems as they develop.
Some examples

Moving services closer to local communities

In Frimley (on the borders of Berkshire, Hampshire and Surrey), people are supported to manage their own care and to get more treatment in the local community instead of hospitals. For example, Aldershot residents with mental health needs now have an alternative to A&E if in crisis. They can visit the ‘Time Out’ café seven days a week, without an appointment, to get support from staff, learn self-management skills and use community resources such as peer support and advice on mental health and wellbeing.

People with urgent medical needs can also get same-day appointments at new centres that bring GPs, nurse practitioners, orthopaedic practitioners, paramedics and other relevant care professionals under one roof. GP practices are informed of all A&E attendances so they can help patients get the care and treatment they need more locally in future, reducing the risk of unnecessary hospital admissions.

Feedback shows that local residents value being able to access help when they need it. The changes have also helped to avoid trips to A&E where there is a better alternative, and cut the amount of time people unnecessarily spend in a hospital bed. Those with complex conditions have gained too as their GPs now have more time to dedicate to their care and treatment.

Improving day-to-day health and wellbeing

Health in Lancashire and South Cumbria is much worse than the national average, with higher rates of heart disease, high blood pressure, asthma and depression.

To address this, the local partnership has fostered schemes to improve day-to-day health and wellbeing, including the ‘Run-a-Mile Challenge’ in which children, teachers and others commit to run a mile a day regularly, and community-led creative activities that help to avoid social isolation and improve the local environment.

Technology is also helping people to become more able and confident to manage their health. NHS patients can record readings of their pulse, oxygen level and blood pressure, and receive text messages with tailored health advice and reminders. People over 60 with two or more long-term conditions may be referred by their GP to an ‘extensivist’ team with a range of clinical and support skills. They will develop a personalised care plan which is revisited at regular meetings with the same wellbeing support worker.

Doctors and nurses can see more patients overall, and residents receive continuity whether on the ward or at home. People are less likely to become acutely ill, and can avoid unnecessary hospital visits and stays. Emergency admissions among patients in Fylde Coast have fallen by up to 28 per cent.
Expanding and improving hospital services

Dorset’s main hospitals provide many of the same services – for example, all three provide maternity and A&E – but they sometimes struggle to meet demand and quality varies. Dorset’s clinicians want to have consultants available 24 hours a day, seven days a week, and significantly improve quality of care by ensuring each major hospital specialises in a particular area.

One aim is to provide more easily accessible local care by extending community-based services to all Dorset residents. Local centres bring together staff with different areas of expertise, allowing residents to see GPs, specialist doctors, nurses, physiotherapists, social care professionals and others in one place. They also offer blood tests, X-rays and screening, saving those in more rural parts of the county costly hospital trips.

If spread across Dorset, this model would mean less travel for 100,000 people, with outpatient appointments provided closer to home. The proposals for hospital services to specialise further received more than £100 million in 2017 and are expected to save 60 extra lives every year.

Find out more

To keep up to date about how health and care are changing:
www.england.nhs.uk/integratedcare

Subscribe to NHS England’s fortnightly bulletin, Future Health and Care:
### Report of Responsible Officer: 
**Accountable Officer:**
Deputy Director of Corporate Affairs and Governance  
Director of Corporate Affairs and Governance

### Author of Report:
Deputy Director of Corporate Affairs and Governance

### Subject/Title
Complaints Policy (Listening, Responding and Learning from Complaints and Concerns)

### Background papers (if relevant)
None

### Purpose of Paper
To provide Board members with the revised Complaints Policy

### Action/Decision required
Members are asked:
To note and approve the amended policy

### Mitigates Risk Number: (identify) On Corporate Risk Register
CRR 341 Score 9: If the trust does not assess and monitor the quality of service provision then this could lead to restrictions on service provision and financial penalty

### Mitigates Risk Number: (identify) On Assurance Framework
AF 2 Score 12: If the Quality of services provided is not at the required standard then there is a risk the Trust may fail to safeguard the health and wellbeing of patients which will impact on the Trust’s ability to deliver care which is safe, effective, caring, responsive and well led.

### Link to Care Quality Commission Domain
Well led  
Responsive

### 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)
None

### Impact on quality
A key control in ensuring that the trust is effective and responsive to quality issues, including patient experience

### Resource impact
None

### Impact of equality/diversity
None

### Avoid acronyms or abbreviations - if necessary list:
EXECUTIVE SUMMARY

1.0 The purpose of this paper is to present Board members with a revised Complaints Policy for approval.

2.0 The proposed amendments made have been highlighted and are summarised as:

- Foreword: Reference to target for communication complaints removed
  “Working in collaboration with independent advocates acting on behalf of complainants”
- Section 4: addition of ‘their relatives and carers’
- Section 5: ‘or they have valid Lasting Powers of Attorney’.
- Section 7: reference to GDPR
- Section 8: Associate Directors have overall responsibility for the investigation…”
- Added “they will promote good practice through the trust’s PALS outreach service”.
- Section 9: Change to ‘this is reported through the directorate Safety, Quality and Standards Sub-committees…”
- Expanded; ‘the local target of either 25 or 45 days or, if the investigation is managed via the Serious Incident Framework, then 60 working days may apply depending on the complexity of the concern raised”.
- Section 12; Removed ‘Number of complaints linked to communication relating to clinical care’.
- Added; ‘Number of initial complaints and reopened complaints responded to within local standards’
- Full title added: Parliamentary and Health Service Ombudsman
- KPI removed and express as: “Examples of learning from complaints which have resulted in a change of practice, policy or procedure will also be reported”.
- Added: Number of complaints relating to the care of patients with dementia and learning

3.0 It is recommended that Board members:
- Note the amendments to the policy
- Approve the policy

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Complaints Policy
(Listening, Responding and Learning from Views and Concerns)
<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Complaints Policy (Listening, Responding and Learning from Views and Concerns)</th>
</tr>
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<tbody>
<tr>
<td>Executive Summary:</td>
<td>This policy outlines the processes followed by East Cheshire NHS Trust in dealing with any complaints received, which relates to services provided by East Cheshire Trust</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>East Cheshire NHS Trust Customer Care Policy V10</td>
</tr>
</tbody>
</table>
| Description of Amendment(s): | Foreword: Reference to target for communication complaints removed “Working in collaboration with independent advocates acting on behalf complainants”  
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Added: Number of complaints relating to the care of patients with dementia and learning |
| This policy will impact on: | All staff and service users |
| Financial Implications: | Limited |
| Policy Area: | Corporate Affairs and Governance |
| Document Reference: | ECT002839 |
| Version Number: | 11 |
| Effective Date: | August 2018 |
| Issued By: | Deputy Director of Corporate Affairs and Governance |
| Review Date: | August 2019 |
| Author: | Deputy Director of Corporate Affairs & Governance |
| Impact Assessment Date: | June 2018 |
| APPROVAL RECORD |  |
| Consultation | Deputy Director of Corporate Affairs and Governance | July 2018 |
| Oversight | Safety, Quality and Standards Committee | July 2018 |
| Approved by: | Trust Board | July 2018 |
East Cheshire NHS Trust business is managed through directorates, supported by corporate functions. Integral to business delivery is effective handling of complaints and concerns.

The Trust will manage complaints in accordance with our statutory and contractual obligations; our stated vision, values, and objectives. This policy sets out the scope of the complaints procedure within East Cheshire NHS Trust and the steps that will be followed. Details relating to how this policy will be implemented operationally across the Trust will be contained within complaints procedural and guidance documents.

This policy takes into account the learning and recommendations from external reports including Francis, Keogh, Berwick and Clwyd Hart reviews. The governance arrangements of the complaints handling process and clinical engagement have been strengthened through:

- Engagement of ward managers, matrons and clinicians in the local resolution process.
- Board level and senior management review of complaints responses and patient stories.
- **Working in collaboration with independent advocates acting on behalf of complainants**
- Root cause analysis methodology applied to complex complaints.
- Complainant satisfaction survey in relation to complaints handling and whether resolution was achieved.
- External review with patient and public representatives of complaints where complainant is not satisfied with the trust’s response.

The Board has delegated responsibility to the Safety, Quality and Standards Committee for ensuring complaints are handled effectively, any learning is identified and changes in practice implemented.

John Wilbraham  
Chief Executive

Julie Green  
Director of Corporate Affairs and Governance
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**Appendix A** Management of complaints

**Appendix B** Complaints management process
1. Introduction

In April 2009, a single approach was introduced for dealing with complaints about NHS and adult social care services. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 allow commissioners and providers of healthcare the flexibility to adopt a patient focussed approach.

East Cheshire NHS Trust is committed to proactively building continuous and meaningful engagement with the public and patients to shape services and improve health. We view complaints as a positive opportunity to learn from and improve the way in which we carry out our functions and improve patient experience.

2. What our commitment means

We are committed to managing complaints in accordance with our statutory and contractual obligations, our stated vision, values, and objectives. This policy takes in to account the learning and recommendations from external reviews including Francis, Keogh, Berwick and Clwyd Hart reviews and governance arrangements in terms of the complaints handling process and clinical engagement has been strengthened.

We will ensure that complaints are managed promptly and efficiently, are properly investigated and that the complainants are treated with respect.

We will comply with the Health Act 2009 and the NHS Constitution and ensure that patients have the right to:

- Independent Complaints Advocacy Service and Healthwatch;
- have any complaint about NHS services dealt with efficiently and to have it properly investigated;
- know the outcome of any investigation into their complaint;
- take their complaint to the independent Parliamentary and Health Service Ombudsman, if they are not satisfied with the way their complaint has been dealt with by the NHS.

In accordance with our registration with the Care Quality Commission, we will ensure that there are systems in place to ensure patients, relatives and carers:

- Have suitable, accessible information about and clear access to procedures to register formal complaints and feedback on the quality of services;
- Are not discriminated against when complaints are made;
- Are assured that we act appropriately on any concerns, and where appropriate, make changes to ensure improvements in service delivery.

The above requirements form our obligations on which to ensure good complaint handling, promoted by the Parliamentary and Health Service Ombudsman.
3. **Scope and purpose of the Policy**

The purpose of this policy is to outline the way in which complaints will be handled, it does not duplicate issues, which are clearly set out in the guidance and legislation, but adapts and supplements these to meet local needs. This policy sets out the scope of the complaints procedure within East Cheshire Trust and the steps that will be followed.

This policy has two aims:

- to resolve complaints more effectively by responding personally and positively to individuals who are unhappy;
- to ensure that opportunities to learn and improve are not lost

The scope of this policy does not apply to, amongst others, any complaint:

- made by one NHS organisation against another NHS organisation;
- made by an employee of an NHS organisation relating to any matter relating to their employment;
- which is being, or has been investigated, by the Parliamentary and Health Service Ombudsman

4. **What is a complaint?**

A complaint is an expression of dissatisfaction and East Cheshire NHS Trust utilises the Customer Care Team to provide patients, their relatives and carers with advice on how to complain.

5. **Who can complain?**

(a) A person who receives or has received services from a responsible body;

(b) A person who is affected, or likely to be affected, by the action, omission decision of the responsible body which is the subject of the complaint, or their representative.

(c) A person acting on behalf of the patient provided that appropriate consent is given by the patient for them to do so or they have valid Lasting Powers of Attorney.

6. **Time limit for making a complaint**

The time limit for making a complaint is normally within 12 months of the incident. However discretion can be applied to vary this time limit where it is considered appropriate.
7. **Management of complaints**

Complaints will be managed in accordance with the national best practice flowchart (Appendix A).

The management of complaints will be sensitive to individual complainants needs and in line with the spirit of the Health Service Ombudsman principles of Good Administration, Good Complaints Handling and Remedy:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and appropriately
- Putting things right
- Seeking continuous improvement

The trust’s Duty of Candour Policy, which is located on our website, outlines individual roles and responsibilities in relation to statutory and regulatory requirement to comply with Duty of Candour for complaints and incidents.

The trust’s Fair Processing Notice, available on our website, sets out the lawful basis for processing personal data in accordance with the provisions of the General Data Protection Regulation, to enable complaints to be investigated.

8. **Responsibilities for complaints arrangements**

It is the responsibility of all staff to be receptive to all forms of customer feedback, including complaints and recognise that such information is an essential element of clinical governance.

The **Chief Executive** is the Accountable Officer for ensuring complaints within East Cheshire NHS Trust are managed effectively and has delegated this responsibility to the Director of Corporate Affairs and Governance.

The **Director of Corporate Affairs and Governance** as the nominated lead director will ensure that there are robust systems in place to manage complaints and that action is taken in light of investigations. The Director of Corporate Affairs and Governance is responsible for reporting information on complaints to the Trust Safety Quality and Standards Committee, and the Board and ensuring duty of candour is applied.

All **Executive Directors** will support the implementation of the complaints policy and ensure their staff abides by best practice through listening, responding and learning from complaints and concerns raised.

The **Trust Board** will ensure there is a culture of learning from complaints throughout the organisation.

The **Deputy Director of Corporate Affairs and Governance** has overall line management responsibility for the complaints function and will implement the complaints policy, with staff within the directorate. This includes authorisation of requests for extensions in complaint response times. The Deputy Director will provide reports on the performance indicators relating to this policy to the Trust Safety Quality and Standards Committee and working in collaboration with relevant senior managers will ensure any improvement plans are developed and implemented.

The **Customer Care Manager** will be responsible for the administrative arrangements of handling and co-ordinating the complaints in line with good practice. The Customer Care Manager will provide expertise and training on customer care and complaints handling across the organisation and develop procedures to ensure the Customer Care Team and those involved with complaints investigations are clear regarding their roles and responsibilities. The Manager is responsible for escalating concerns relating to the complaints process and taking real time action to resolve barriers to achieving a comprehensive response to complainants within agreed timescales.

The **Customer Care Officer (including Patient Advice and Liaison Service (PALS))** will assist in resolving patient and customer concerns before they become a formal complaint, and will liaise with service areas to support timely resolution of concerns, they will promote good practice through the trust’s PALS outreach service.
Customer Care Officers are also responsible for the compilation of response letters from investigation reports and ensuring that concerns raised by complainant(s) have been addressed and that any improvement actions as a result of lessons learned are articulated.

**Associate Directors** have overall responsibility for the investigation and management of complaints within their service areas, and ensure that a co-ordinated and timely investigation and response is provided. In the first instance they will support managers to resolve concerns locally.

The roles and responsibilities of **Clinicians, Senior Managers** and **Investigating Managers** will be outlined within the complaints guidance. This will provide support through the complaint handling process.

### 9. Stages in the complaints procedure

#### Local Resolution

To achieve our first aim which is to resolve complaints more effectively by responding more personally and positively to individuals who are dissatisfied; we will make every effort to ensure that:

- staff who discover that a patient or their family members have concerns take real time local action to resolve the issue.
- the complaint cannot be resolved immediately, staff in the Customer Care Team will discuss with the complainant the most appropriate way forward.

#### Formal Resolution

- all complainants are offered an opportunity to discuss their complaint and asked what they think needs to happen to resolve it (the ‘desired outcome’);
- complaints are dealt with flexibly, with the aim of achieving the desired outcome if that is possible within the local target of either 25 or 45 days; if the investigation is managed via the Serious Incident Framework then 60 working days may apply depending on the complexity of the concern raised.
- timescales for dealing with complaints are agreed with the complainant are as short as realistically possible and complainants are kept informed of progress.
- Unresolved complaints may be re-opened for review and will be responded to within 25 working days of being re-opened. However, if new information is received this may be considered as a new complaint and logged accordingly.

To achieve the second aim which is to ensure that opportunities to learn and improve are not lost, we will ensure that:

- concerns that are resolved immediately are recorded and resolutions shared at both trust and directorate Safety, Quality and Standard meetings.
- every complaint is scrutinised so that we understand what did not go well and how we can do better next time;
- outcomes from complaints are discussed at senior management level. Patient stories are shared at Board meetings.
- where formal complaints have been made members of the Safety Quality and Standards Committee receive a report on responses and outcomes of complaints. These reports are also reviewed at the Quality Forum and by Eastern Cheshire NHS Clinical Commissioning Group.
- complaints data is analysed and themes and trends are reviewed four times a year at the Safety Quality and Standards Committee, Risk Management Sub-committee and by senior managers within operational service meetings;
- senior managers identify improvements following complaint investigation outcomes and ensure actions are followed through and can demonstrate changes in practice.
- As part of the monthly directorate Quality Governance Data Pack, the Customer Care Team provides a report detailing information from the previous month including; complaints received, complaints
responded to and outstanding actions from previous complaints. This is reported through the directorate Safety, Quality and Standards Sub-committees and the Trust Board Safety, Quality and Standards Committee.

10. Health Service Ombudsman

If the complainant remains dissatisfied with the actions undertaken following the investigation/response received they have the right to ask the Health Service Ombudsman to review their complaint. The Health Service Ombudsman is independent of the NHS.

11. Unreasonably persistent and unreasonable complainant behaviour (Vexatious complaints)

Unreasonable and unreasonably persistent complainants are complainants who, because of the frequency or nature of their contacts, hinder the consideration of theirs or other people’s complaints. These complainants should be escalated to senior managers and if appropriate a letter sent to the complainant from the Chief Executive or an appropriate Executive Director.

12. Key Performance Indicators

The following performance indicators will be monitored via the Complaints, Claims, Incidents and Patient Experience Report to the Safety Quality and Standards Committee.

- Number of complaints acknowledged in 3 working days – to achieve 100%.
- Number of complaints responded to within timescale agreed with complainant – to achieve 100%.
- Number of initial complaints and reopened complaints responded to within local standards.
- Number of Parliamentary and Health Service Ombudsman investigations that have resulted in recommendations in relation to complaints handling – nil.
- Number of complaints where discriminatory practice has been identified as an issue.
- Number of complaints relating to the care of patients with dementia and learning.

Examples of learning from complaints which have resulted in a change of practice, policy or procedure will also be reported.

13. Implementation and monitoring

The key performance indicators within this policy will be monitored by the Customer Care Manager and reported by the Director of Corporate Affairs and Governance to Safety Quality and Standards Committee in the Quality Governance Report.
Customer care and communications skills are included within the learning needs analysis of the organisation. Training is also available on investigations and root cause analysis for managers and lead clinicians who investigate and prepare responses to complaints.

Appendix B contains a flow chart outlining the process, through which the Trust receives, acknowledges and responds to formal complaints.

This document has been produced with reference to the following documents:

The Local Authority Social Service Complaints (England) Regulations 2009
http://www.opsi.gov.uk/si/si2009/uksi_20090309_en_1

Guidance to the Regulations: Listening, responding, and improving: a guide to better customer care.

Ombudsman’s Principles for: Good complaint handling -

Good Administration -
http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-of-good-administration

Remedy -
http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-for-remedy

Health and Social Care Act 2008
http://www.legislation.gov.uk/ukpga/2008/14/contents

National Patient Safety Agency – Being Open Guidance

Essential Safety and Quality Standards
http://www.cqc.org.uk/

Fair Processing Notice
http://www.eastcheshire.nhs.uk/

Information Commissioner’s Office
https://ico.org.uk/
**MANAGEMENT OF COMPLAINTS**

1. **Can the complaint be resolved straight away? (within 24 hours)**
   - **YES**
   - **NO**

2. **Acknowledge the complaint within three working days, following the flow chart.**
   - **YES**
   - **NO**

3. **Does the complaint fall in the list of exclusions (for example, is it an employment matter?)**
   - **YES**
   - **NO**

4. **Does the complaint involve more than one health or adult social care provider?**
   - **YES**
   - **NO**

5. **Ensure that the complainant is offered the opportunity to meet and discuss their complaint with a senior manager of clinician.**

6. **If East Cheshire NHS Trust is managing the Complaint, notify the complainant, receive consent if appropriate. Offer discussion with the complainant and agree an action plan, how the complaint will be handled and the expected timescale.**

7. **Investigate the complaint. Is the investigation concluded within the agreed timescales?**
   - **YES**
   - **NO**

8. **Review the case**

9. **Send the final response, from the Chief Executive; signed off by the Associate Director. Include the conclusion of the investigation & organisational learning. Include recourse to the Ombudsman if the complainant is not happy.**

10. **Notify the complainant, in writing, explaining the delay. Resolve the complaint as soon as possible.**

11. **Throughout the complaint process ensure the complainant is kept informed.**

12. **The organisations must agree which will take the lead in responding and communicating with the complainant.**

13. **Contact the complainant as soon as possible to explain the decision.**

14. **The complaint falls outside complaints arrangement. Good practice to note any learning for organisation.**

15. **APPENDIX A**

Complaints Policy July 2018 V11
Appendix B - Complaints management process – 25 day response

Timeframe Guidance for 25 working days

Days 0 - 3

- Complaint received and telephone contact made with complainant. Written acknowledgement sent. Complaint details logged on DATIX.
- Customer Care Officer completes Section 1-4 of the investigation template and sends this and the complaint via Datix to the relevant Directorate(s) for investigator to be nominated.

Days 4-13

- On confirmation of lead investigator(s) – Customer Care to update DATIX with details. Investigation takes place.
- 5 working days prior to the return of the investigation template to Customer Care Team, directorate to confirm that they are on track to deliver the completed investigation documentation.
- Investigation documentation returned to Customer Care Officer who will confirm all issues have been addressed.
- Customer Care to formulate draft response letter. Customer Care Manager to quality check and approve. Letter sent to directorate for review and sign off by Directorate Manager and clinician if required.

Days 14-17

- Complaint letter to be sent via Datix to Director of Corporate Affairs and Governance for review and approval.
- Director of Corporate Affairs and Governance for approval, which may include review by another Executive Director.
- Chief Executive for review and approval.
- Chief Executive approves and signs final letter. Response letter sent, including complainant feedback survey.

Days 18-20

- Director of Corporate Affairs and Governance for approval.
- Director may return to Customer Care Team to address areas for improvement.

Days 21-23

- Chief Executive may return draft to Customer Care Team to address areas for improvement.

Days 24-25

- Chief Executive’s Administration Assistant uploads letter to DATIX and completes sent date. Final letter sent to Directorate for information and sharing with key parties.
- When a complaint is re-opened, it should be acknowledged verbally or in writing within 3 working days with the aim of responding within 25 working days.

Customer Care Team to ensure:
- Meeting offered
- Preferred method of Communication confirmed
- Consent obtained, if required
- Customer Care Team will contact any outside agencies involved in the complaint

Customer Care Manager to monitor progress and escalate to relevant Directorate Manager(s) if response is likely to breach response deadline. Deputy Director of Corporate Affairs and Governance to be notified of all suspected breaches.

Deputy Director of Corporate Affairs and Governance to discuss with relevant manager and escalate to Director if required.

Director of Corporate Affairs and Governance for approval, which may include review by another Executive Director.

Chief Executive approves and signs final letter. Response letter sent, including complainant feedback survey.

Customer Care Team implements complaints closure process, including logging actions required on DATIX and communicated to owners and drafting patient story.

Complaints Policy July 2018 V11
Appendix C - Complaints management process – 45 day response

Timeframe Guidance for 45 working days

Days 0 - 3
Complaint received and telephone contact made with complainant. Written acknowledgement sent. Complaint details logged on DATIX.

Days 1-4
Customer Care Officer completes Section 1-4 of the investigation template and sends this and the complaint via Datix to the relevant directorate manager for investigator to be nominated.

Days 5-29
5 working days prior to the return of the investigation template to Customer Care Team, service area to confirm that they are on track to deliver the completed investigation documentation

Days 30-35
Investigation documentation returned to Customer Care Officer who will confirm all issues have been addressed.

Days 36-38
Customer Care to formulate draft response letter. Customer Care Manager to quality check and approve. Letter sent to service for review and sign off by Directorate Manager and clinician if required.

Days 42-45
Complaint letter to be sent via Datix to Director of Corporate Affairs and Governance for review and approval.

When a complaint is re-opened, it should be acknowledged verbally or in writing within 3 working days with the aim of responding within 25 working days
**Report of:**
**Responsible Officer:** Director of Nursing, Performance & Quality  
**Accountable Officer:** Jeanette Sarkar  
**Head of Nursing, Quality**

**Subject/Title:** EXCEPTION REPORT – SAFE STAFFING LEVELS

**Background papers (if relevant):**
“How to ensure the right people with the right skill are in the right place at the right time”, Chief Nursing Officer for England & National Quality Board November 2013

**Purpose of Paper:**
To provide the Trust Board with an interim exception report in line with the requirements of: “How to ensure the right people with the right skill are in the right place at the right time”, Chief Nursing Officer for England & National Quality Board November 2013

**Action/Decision required:**
To note the contents of the report and the assurance provided

**Mitigates Risk Number: (identify)**  
**On Corporate Risk Register:** BAF 2: If quality is not maintained in line with regulatory standards during and after transition then this could impact on services the trust provides and ability to provide services that are caring, safe and responsive and safeguard the health and wellbeing of the local population  
**BAF 4:** If the trust does not attract, develop and retain a resilient and adaptable workforce with the right capabilities and capacity then there may be an impact on achieving mandatory service standards and delivering an integrated system

**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.

**Impact of equality/diversity**

No impact on equality and diversity

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

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<td>NHSI</td>
<td>National Health Service Improvement</td>
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<td>YTD</td>
<td>Year to Date</td>
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<td>WTE</td>
<td>Whole time equivalent</td>
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<tr>
<td>RAG</td>
<td>Red Amber Green</td>
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<td>HCA</td>
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<td>TUPE</td>
<td>Transfer of Undertaking (Protection of Employment) regulations</td>
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<td>OSCE</td>
<td>Objective Structured Clinical Examination</td>
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<tr>
<td>RN</td>
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</table>
Safe Staffing Levels – Exception Report

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

1 INTRODUCTION

1.1 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 ward areas were above the 95% safe staffing threshold during May 2018, with the exception of Aston, Paediatrics, Post Natal and Labour Wards.

2.2 Healthcare assistant actual fill rates during the day for Aston Ward were 87.4%. Mitigating actions to maintain safe staffing levels included senior sister stepping down to support clinical care.

2.3 Paediatric ward healthcare assistant actual fill rates were 81.4% during the day demonstrates a less favourable position compared to the previous month (93.7%).

2.4 Post-natal and labour ward showed an actual healthcare assistant overnight fill rate of 94.4%

2.5 A number of wards actual fill rate for unregistered staff exceeded 120% during the night particularly Wards 2, 4, 7 and 10.

2.6 Daily staffing requirements are assessed prior to each bed capacity meeting and staffing concerns are escalated in real time as appropriate. Professional judgement based on clinical need is applied to support safe patient care, co-ordinating staff deployment from other areas or bank/agency utilisation to support acuity and patient dependency. Decisions to redeploy staff are now based on and supported by the utilization of live acuity and dependency data via SafeCare and clinical judgement.

Chairman: Lynn McGill
Chief Executive: John Wilbraham
3 RECRUITMENT

Registered Nurse acute vacancies
42 wte in month compared to last month – 41.67 wte

Long term sickness and absence rates demonstrate a more favourable position - 1.6 wte

In month registered nurse vacancies within acute in-patient were at 42 wte compared to the previous month 41.67 wte across all acute in patient ward areas. This excludes Maternity Leave and Long Term Sickness. Inclusion of Maternity Leave (6.78 wte) and Long Term Sickness (1.6 wte) reduces the overall registered nurse gap from 50.39 wte compared to 51.02 wte the previous month due to staff members returning to work from long term sickness and absence.

Vacancy trajectories do not take into consideration the number of actual staff members recruited to who to date have not commenced in post. It is anticipated that some post holders will commence during June-August dependent upon satisfactory pre-employment checks and notice periods.

No Registered Nurse recruitment event held in May due to non-availability of panel members

23 Acute and 3 Registered Nurse Community posts are currently subject to pre-employment checks

There were no registered nurse recruitment events held in May due to the non-availability of panel members. A new date has been set for Saturday 7th July. 23 Acute and 3 Community Nurse posts are currently subject to pre-employment checks. 23 acute posts offered include; 15 RN's, 1 ED triage RN, 1 ED Sister, 1 Associate Respiratory Specialist Practitioner, 1 midwife, 1 chemotherapy RN and 3 bed managers. 3 Community posts subject to pre-employment checks include 1 Specialist Practitioner and 2 RN's.

3 international nurses commenced the training programme on Monday 21st May 2018 in preparation for OSCE examination.

All acute ward Healthcare Assistant vacancies recruited to

Following interviews held 30th April 2018, 15 Healthcare Assistant posts are currently subject to pre-employment checks. 2 substantive ward posts; 5 to pool; 8 nurse bank. No interviews were held during May in view of all posts being fully recruited to in the April campaign.

2 1.0 wte Band 6 Registered Nurse posts within the community are subject to re-advertisement

There are currently 4 wte registered nurse vacancies within the community setting – 3.0 wte Band 6 and 1.0 wte Band 5. 2 of the Band 6 roles have been re-advertised following unsuccessful recruitment.

9 trainee nursing associate roles continue with the second year of the programme

Ten staff members have completed the first year of the Trust’s Nursing Associate Pilot training programme with 9 moving through to the second year. Preliminary discussions are currently being held with the individuals, directorates, learning and development to identify final substantive placement upon successful completion of the course.

Chairman: Lynn McGill
Chief Executive: John Wilbraham
4 RETENTION

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

4.2 The trust is currently taking part in a NHSI 90 day improvement programme to focus on local profiling to consider initiatives and workforce development, with a particular emphasis on nurse retention.

5 STAFF TURNOVER

Staff turnover decreased in May to 0.49%

5.1 In month staff turnover is 0.49% compared to 1.6% the previous month. YTD rolling staff turnover is 11.64% compared to 11.61% the previous month. This excludes TUPE’d staff.

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

6 RECOMMENDATION

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

Appendix 1: Safer Staffing Metrics

Chairman: Lynn McGill
Chief Executive: John Wilbraham
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Ward</th>
<th>Expected RN</th>
<th>Actual RN</th>
<th>Expected HCA</th>
<th>Actual HCA</th>
<th>Percent RN</th>
<th>Percent HCA</th>
<th>Expected RN</th>
<th>Actual RN</th>
<th>Percent RN</th>
<th>Percent HCA</th>
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<tr>
<td>Rehabilitation</td>
<td>Int 1</td>
<td>935.99</td>
<td>906.90</td>
<td>2230.14</td>
<td>1948.92</td>
<td>102.1</td>
<td>87.4%</td>
<td>462.00</td>
<td>462.40</td>
<td>100.0%</td>
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<tr>
<td>Children's</td>
<td>Int 2</td>
<td>930.00</td>
<td>930.00</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Pediatrics</td>
<td>Int 3</td>
<td>1233.25</td>
<td>1244.75</td>
<td>682.00</td>
<td>555.17</td>
<td>101.0%</td>
<td>81.4%</td>
<td>1043.17</td>
<td>306.50</td>
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<td>Critical Care</td>
<td>Int 4</td>
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<td>1880.00</td>
<td>504.00</td>
<td>504.00</td>
<td>100.0%</td>
<td>100.0%</td>
<td>1426.00</td>
<td>1426.00</td>
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<td>Obstetrics</td>
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<td>826.87</td>
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<td>Women's &amp; Children's</td>
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<td>830.66</td>
<td>669.03</td>
<td>97.8%</td>
<td>87.1%</td>
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<td>713.00</td>
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<td>Sur 1</td>
<td>1878.60</td>
<td>1875.75</td>
<td>1965.40</td>
<td>2163.82</td>
<td>99.8%</td>
<td>111.1%</td>
<td>1512.00</td>
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<td>Trauma &amp; Orthopaedics</td>
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<td>1937.50</td>
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<td>1582.50</td>
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<td>833.58</td>
<td>97.5%</td>
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<td>1447.50</td>
<td>1550.48</td>
<td>967.42</td>
<td>95.7%</td>
<td>121.3%</td>
<td>1523.00</td>
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<td>1534.25</td>
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<td>958.75</td>
<td>95.7%</td>
<td>121.3%</td>
<td>1523.00</td>
<td>1089.50</td>
<td>69.7%</td>
<td>177.0%</td>
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<tr>
<td>General Surgery</td>
<td>Sur 4</td>
<td>1823.00</td>
<td>1823.25</td>
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<td>96.8%</td>
<td>97.5%</td>
<td>121.3%</td>
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<td>95.3%</td>
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<td>3954.97</td>
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<td>1887.41</td>
<td>21714.30</td>
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<td>1117.45</td>
<td>1887.41</td>
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<td>1380.53</td>
<td>11424.02</td>
<td>3920.00</td>
<td>1408.00</td>
<td>97.2%</td>
<td>121.9%</td>
<td>1479.00</td>
<td>1442.48</td>
<td>97.2%</td>
<td>121.9%</td>
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</table>

| Total                      |             | 21722.32    | 21714.30  | 1380.53      | 11424.02   | 97.2%      | 121.9%      | 1479.00     | 1442.48   | 97.2%      | 121.9%      |

Public Trust Board
Thursday 7th July 2018

Agenda Item Number 15: TB 18 (57)

Present

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

IN ATTENDANCE

Andrew Jones | Deputy Director of HR Services | DDHR
Mike Wildig | Non-Executive Director | Mr Wildig
Heather Cooper | Consultant Nurse Critical Care | CNCC

Agenda

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<tr>
<th>Agenda No</th>
<th>Agenda Item</th>
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<td>18/35</td>
<td>Patient Story</td>
<td>Covered under agenda 18/42 Sepsis spotlight.</td>
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<td>18/36</td>
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<td>1. Rachael Charlton (External meeting)</td>
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<td>2. Julie Green (Annual Leave)</td>
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<td>18/37</td>
<td>Conflict of Interest</td>
<td>None raised</td>
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<td>18/38</td>
<td>Matters Arising</td>
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<td>a)</td>
<td>Year at a Glance</td>
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<tr>
<td>b)</td>
<td>SQS Committee Minutes – March 2018</td>
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<tr>
<td>c)</td>
<td>Action Log</td>
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<tr>
<td>d)</td>
<td>Collection of Any Other Business</td>
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</tr>
<tr>
<td>e)</td>
<td>Formal Request for Removal of Items from Consent Agenda</td>
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</table>

a) Year at a Glance
The Year at a Glance was confirmed as accurate. It was noted that the Annual Medicines report will incorporate the annual controlled drugs report.

b) SQS Committee Minutes – March 2018
The minutes were agreed as accurate.
c) Action Log
9650 – Action will be covered at the May Clinical Management Board (CMB). Action closed.

9651 – Action will be covered at the May Clinical Management Board. Pending recommendations from CMB update to be provided at July SQS meeting. Action closed.

d) Collection of Any Other Business
None raised.

e) Formal Request for Removal of Items from Consent Agenda
None

Assurance Items

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<thead>
<tr>
<th>18/39</th>
<th>Integrated Quality &amp; Governance Report including</th>
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<td>Quality Indicator Exceptions</td>
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<td>Detentions under MHA</td>
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<td>Complaints (March 2018)</td>
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<td>Equality Update</td>
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<td>National Maternity and Perinatal Audit (NMPA)</td>
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<td>Risk Assessed Data Report (RADaR)</td>
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<td>Just Culture Guide</td>
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<td>Annual Freedom to Speak Up Report 2017/18</td>
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The report was taken as read highlighting the following key points:

- The trust achieved its annual target for the reduction in formal complaints to 140 against a target of 200 or below. There was also a reduction in complaints where communication regarding clinical care being the main focus of concern. This has reduced to 8 from a target of 20 or below.

- It was agreed for 18/19 that the target for next year should be to maintain or improve on the overall number of complaints received in 17/18. Trends in complaints will continue to be monitored with links to claims. Any concerns/trends identified will be subject to future spotlights.

- The annual Freedom to Speak up report highlighted between April 2017 and March 2018 15 concerns raised with the Guardian in comparison to 5 raised between 2016/17. This provides positive assurance that staff are speaking up, however it was noted that over half of the concerns raised were anonymous and therefore indicates that there is still reluctance from staff.

- There has been an improvement in registered nurse vacancies in both acute and community settings. There are currently nil registered vacancies within the community setting and acute has seen an improvement in 34.37 whole time equivalent (wte) compared to last month’s 40.77 wte.

- There was one clostridium difficile case reported in March and end of year position is below trajectory for infection control and has been further reduced to 13 for 18/19.

- The falls rate per 1000 occupied bed days in March was achieved at 2.1 against a target of 2.5 and no falls were resulted in severe harm.

- The trust has been shortlisted in the Changing Culture category of the Health Service Journal 2018 Patient Safety Awards

- The trust did not achieve the 4 hour standard of 95% or the
improvement trajectory of 95% in March with 72.1% patients seen within 4 hours

- Three 12 hour breaches were recorded in March and root cause analyses have been undertaken in relation to all three.
- The trust achieved all cancer standards in March 2018.
- The trust achieved all diagnostic waiting time standards for the month. The committee noted the excellent work being done in order to achieve this standard in month.

It was confirmed that there is a plan in place to maintain the diagnostic standard, however the main risk associated with this maintenance of the standard is 'urgent 2 week waiters' and these are unpredictable to plan against.

CP informed The Greater Manchester Cancer Network (GMCN) are changing the way breaches are allocated to bring it in line with the National Cancer Breach Allocation Guidance. This will go live in Q3 of 2018/19. One of the main changes is the requirement for the first trust to refer out by day 38 (currently it is day 42). An update on the impact will come back to a future SQS meeting once it has been worked through.

Action : CP to confirm date for impact availability

Discussion took place regarding clinical activity lost due to bank holidays throughout the year and whether the trust needs to look at re-scheduling appropriately. It was confirmed that this work is currently being addressed throughout the Outpatient Study Group and will be picked up by the Finance, Performance and Workforce Committee.

- Work is currently ongoing in maternity regarding caesarean sections on patients less than 39 weeks. The trust has introduced the growth assessment programme (GAP) to help reduce still birth rates. An update will come back to a future meeting.

Action: DNPQ to confirm date of update

The Committee approved and received assurance against the following

- Exceptions to the Quality Indicators and improvement actions.
- Assurance in relation to the trust’s responsiveness to complaints
- The update on detentions under the MHA
- The trust has been shortlisted for the Health Service Journal 2018 Patient Safety Awards.
- The assurance on delivery of the Equality Objective Plan and EDS (2) for 2017/18 and approve the proposed plan for 2018/19.
- There is one community team (Congleton & Holmes Chapel) triggering in March 2018, the remedial action taken to support staff and that action plans to improve are in place.
- The new Just Culture Guide that the trust will be implementing in relation to safety incidents.
- The proposed areas of focus to support staff to raise concerns during 2018/19.
The Quality Account was taken as read with the DDNQ highlighting the following key areas:

- The Quality Account will be signed off by the Audit Committee in May before going into the public domain.
- The four priority domains of harm free care, improving outcomes, listening and responding and integrated care all achieved against their 2017/18 priorities.
- There has been significant progress made on reducing falls and pressure ulcers and this work will continue to ensure the processes are fully embedded throughout the trust.
- Priorities for 18/19 have been confirmed by Board.
- The trust was rated ‘Good’ by the Care Quality Commission (CQC) following inspections of the trust’s services and leadership during January and February 2018.
- It was noted that the CQC specific action plan on areas that require improvement will be implemented once issued. It was agreed that the Committee recommends that these actions are interwoven into the trust quality priorities for 18-19.
- It was noted that the Commissioning for Quality and Innovation (CQUIN) that are on target are 2 yearly CQUINs and have achieved for this year but will roll over into next.
- CQUINs achieved in year are as follows
  1. Improving the uptake of flu vaccinations for front line staff within Providers
  2. Improving the assessment of wounds
  3. Improving services for people with mental health needs who present to A&E
  4. E-Referrals-relates to GP referrals to consultant 1st outpatient services
  5. Reduction in antibiotic consumptions per 1,000 admissions
- There are three partially achieved CQUINs. These are
  1. Timely identification of sepsis in emergency departments and acute inpatient settings
  2. Timely treatment of sepsis in emergency departments and acute inpatient settings
  3. Antibiotic review for sepsis

The Committee noted the achievements and performance in the four priority elements of the trust quality strategy which are all rated as having been achieved and reflected in the draft Quality Account which was reviewed.

The MD presented the report highlighting the following

- There has been a rise in mortality in quarter 4. The trust recorded an average of 73 inpatient deaths per month for Q4 compared to 53 over the past three quarters and has resulted in an increase in Risk Adjusted Mortality Index (RAMI) to 102.60

The MD informed that the increase in mortality rates is national and no official explanations or direct factors have been established.
• It was noted that the increase in RAMI is still within expected rates and is still below peer rates.
• The three (Clinical Classification Software) CCS groups with the highest volumes of deaths are as follows:
  1. Pneumonia (except that caused by TB or STD)
  2. Septicaemia (except in labour)
  3. Congestive heart failure; non-hypertensive
• There is no weekend trend effect associated with the trust.
• It was noted that one mortality review is currently subject to an RCA in line with the serious incident framework and will be reviewed at the Serious Incident Committee meeting.
• There has been an increase in coding diagnosis per FCE and the trust recently underwent an external coding audit which provided positive assurance and resulted in the trust being awarded level 3 accreditation.
• Coding accuracy has increased in year and the trust has a good coding structure in place and is progressing with a clinical engagement programme to cover all specialties.
• It was noted that the trust PAS operating system does not support a validation programme for coders.
• No mortality alerts have been received from the Dr Foster unit at Imperial College. However the Mortality Governance Sub-Committee meeting on 16 April has flagged that for the CCS Group Acute Renal Failure, as having higher than expected mortality and will be monitored closely.
• There has been a change in the trusts mortality review process and a minimum of 20% of deaths will be subject to review from selected cohorts rather than 100% previously. The criteria has been amended to reflect this change and is in line with national guidelines.
• The Mortality policy is currently being updated to reflect the changes in the review process.

The Committee were in agreement to align mortality reviews with national guidance with the proviso that a review is brought back to SQS in 6 months' time.

The committee noted the significant increase in mortality over the last four months.

Sepsis Annual Report

The CNCC highlighted the following:

• A significant amount of work has gone into improving the recognition and management of sepsis at the trust.
• There is a national requirement that the recognition and response to sepsis be improved.
• In 2015 the trust nominated a Sepsis lead and a Sepsis steering group was established to drive the change required for quality improvement.
• In 2016/17 a national sepsis CQUIN was introduced by NHS England.
• Sepsis management is time critical and in septic shock there is an increase in mortality by 8% per hour of delay in parenteral antibiotic
A 'sepsis 6' bundle has been introduced that provides medical therapies required to reduce the mortality of patients with sepsis.

Sepsis care bundles proforma’s have been developed to support the national sepsis definition.

Stickers have been developed and are being used as part of best practice in ED to help indicate that sepsis screening has been undertaken.

Antibiotic administration in ED has been improved and sepsis patients are being prioritised in triage with consultant agreement to allow sepsis to take priority.

Sepsis mortality has plateaued in the trust and the trust continues to remain lower than peer organisations.

Focus remains on the recognition and management of sepsis and will be monitored thought the Sepsis Steering Group.

The patient story was presented by means of a trailer from the film Starfish depicting the life changing impact sepsis has on a patient and his family.

The CNCC presented the Spotlight on Sepsis and highlighted the following:

- Sepsis is a dysregulated response to an overwhelming infection
- Risk 2752: If health care professionals do not comply with national sepsis guidance then patient safety may be compromised
- Current risk score is 16 with mitigated action in place risk score is lowered to 12. Target score is 6.

Current performance

- Performance does not reflect the work being done to achieve the targets set by the national CQUIN.
- Currently the trust is seeing a reduction in achievement vs target
- This is largely due to medical outliers and a delay in patient reviews.

Mitigating controls in place

- Development of Sepsis Policy
- Bi-monthly Sepsis Steering group meetings
- Consistent approaches and documentation have been implemented across the trust
- Sepsis care bundles and screening stickers have been developed for coding recognition and are available in all ward areas and ED to help screen patients.
- Statutory Mandatory training and 1:1 education sessions being provided
- Mandated e-learning
- Monthly CQUIN meetings with Associate Directors

Current gaps in control

- Process for communication with microbiology
- Medical outliers
- New Starters
- Lack of Auditor
- Overcrowding in ED
- Variable compliance to standard
- Variable engagement with clinicians
- Lack of digital Sepsis pathway
- Nurse Vacancy and heavy reliance on agency staff

**Positive assurance**
- Implementation of evidence based tools
- Clinical consistency of critical care outreach
- Outreach sepsis Champion
- Red Sepsis Grab boxes
- Mandated e-learning
- Named sepsis nurse per shift in ED
- Mortality figures
- Nice Guidelines
- Data Vs Done
- ED Sepsis champion

**Gaps in assurance**
- Availability of documentation
- Clinical Champions : Ownership
- National Updates : Frequent changes
- No additional resources
- Sepsis trollies not yet implemented
- Consistency vs compliance
- Maternity leave for sepsis champion

**Next steps**
- Engage Clinicians & seek champions
- Emulate the recent success of ED in the ward areas
- Implement ED sepsis Trollies
- Agree a trajectory for successful achievement
- Expedite mandated learning
- Steering group
- Agree focussed auditor
- Update Statutory and Mandatory training with patient stories
- Monthly Sepsis Operational Delivery Group, commencing May with Matrons, Directorate general managers, senior sisters and Clinical champions
- Consider Sepsis as a Quality Dashboard criteria
- SOP for coders

It was noted that the trust is not unique in addressing Sepsis in ED and the problem has been identified in peer organisations.

It was suggested that workscreens in ward areas that display alerts in real time would help staff improve recognition and increase response times to patients. The DoF informed that this could be addressed by the Digital Transformation Group.

The Committee noted the excellent progress made under guidance of the
Sepsis Steering Group and the nominated Sepsis lead. The Committee accepted the risk classification as 'medium' (score 12) based on all mitigating activities.

Any Other Business

18/43 Key Items for the Chair to be reported to the Board

<table>
<thead>
<tr>
<th>Points for Assurance</th>
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<tbody>
<tr>
<td>• The Committee noted the achievements and performance in the four priority elements of our trust quality strategy which are all rated as having been achieved (Harm Free Care; Improving Outcomes; Listening &amp; Responding &amp; Integrated Care), reflected in the draft Quality Account which was reviewed.</td>
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<td>• The Committee noted the recent CQC Well Led inspection outcome rating the Trust as 'Good' overall. The associated improvement plan will be brought back to the next Committee meeting (if delegated authority is received from the Board) the committee would recommend actions are interwoven in the trust quality priorities for 18-19.</td>
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<td>• A 'Spotlight' on sepsis was discussed (Risk # 2752 on the risk register). The excellent progress made (under guidance of the Sepsis Steering Group) in terms of engagement of all staff; embedding the sepsis policy and implementation of mandated training &amp; e-learning and evidence-based tools was noted. The patient story shared at the meeting demonstrated the life changing impact that sepsis can have if prompt identification and treatment is not available. The Committee accepted the risk classification as 'medium' (score 12) based on all mitigating activities.</td>
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<td>• The Committee reviewed the 18/19 target for reduction in number of formal complaints. It was agreed that the target should be maintenance or improvement in the overall number of formal complaints compared to 17/18 levels (achieved reduction to 140, 20% less than 2016/17) and no specific target in relation to type of complaint. The Committee acknowledges the importance of receiving feedback and learning from complaints. Trends in complaints and reduction of repeat subject of complaints will continue to be monitored</td>
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<td>• The Committee were pleased to note the reduction in total cases of clostridium difficile (total 9 cases versus trajectory of 14). The allocated trajectory has been reduced to 13 for 18.</td>
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<td>• The Falls rate target at the trust per 1000 occupied bed days has been achieved (a 20% reduction versus 2017-18 levels) which demonstrates the effectiveness of falls reduction policies and action plans</td>
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<td>• No falls resulted in severe harm in month.</td>
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<td>• The trust has been shortlisted in the Changing Culture category of the Health Service Journal 2018 Patient Safety Awards (judging May 18, awards July 18)</td>
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<td>• The Committee were pleased to receive assurance of the effectiveness of recent action planning in relation to diagnostics (in particular endoscopy) and all cancer targets were achieved in March.</td>
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<td>• The committee received assurance on delivery of the Equality Objective Plan for 17/18 and approved the proposed plan for 18/19</td>
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Emerging Risks & Mitigating Actions
In line with national experience, there has been a marked increase in number of deaths recorded at the trust in Q4 with no official explanations found, nor any direct causal factors established for the trust locally. During this period there have been no Dr Foster mortality alerts and any potential trends locally have been reviewed. Investigation of trust mortality rates for patients in CCS group 'acute cerebrovascular disease' concluded no death was avoidable. Investigational review will be conducted for potentially increased mortality rates in acute/unspecified renal failure patients.

The Committee supported the proposal to align mortality reviews with national guidance and criteria (as opposed to conducting full reviews for all deaths at the trust) with the proviso of a review in 6 months time. This will release resource to help embed learning gathered from reviews to date.

Any Other Business

None raised.

Consent Items

None

For Information

Chairman’s Confirmation of Agenda items for June meeting (not standing items):
- Quality Forum Sub-Committee Annual Report and Self-Assessment
- Radiation Sub-Committee Annual Report
- CQC Assurance Plan
- Risk Management Sub-Committee Bi-annual Report (via Governance Report)
- Spotlight on Harm free care including
  - Falls & pressure ulcers
  - Nutrition
- Spotlight MIAA internal audit outcomes

Date and Time of Next Meeting
Tuesday 7th June 2018
12:00 – 14:00
Boardroom 1
Agenda Item Number 15: TB 18 (58)

FINANCE, PERFORMANCE & WORKFORCE COMMITTEE

Meeting Chair: Mike Wildig
Meeting Secretary: Janine Homer

MINUTES OF MEETING HELD ON:
Thursday 26th April 2018, 0830 – 1030

Venue: Boardroom 1

PRESENT

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

IN ATTENDANCE

Agenda No | Agenda Item | Action
--- | --- | ---
18/28 | Apologies | 
  - Steve Redfern (Annual Leave)
18/29 | Minutes of meeting held 29th March 2018 | The minutes of the March meeting were declared as an accurate record.
18/30 | Declarations of Interest | None declared.
18/31 | Matters arising | Mr Goalen referred to page 5 of the March minutes – agenda Item 18/24 para 3 and queried that the papers circulated for April’s Board meeting did not include a discussion on the requirement for extra beds. The CEO responded that the control total has been agreed to and that work is still ongoing regarding the potential extra beds.
18/32 | Action points from previous meeting | 9699 – Update not due until June meeting. Action to remain open.
18/33 | Annual work plan | The Chair requested a review of the frequency and timings of work plan items and the DCAG agreed to liaise with the other Executive Directors accordingly.
**Action:** The DCAG is to coordinate a review of the annual work plan for 2018/19

### Performance Report Inclusive of the below appendices

| 18/34 |  
|-------|---|
| • ED 4 Hour standard |  
| • 18 Weeks RTT standard |  
| • 62 Day Cancer standard |  
| • 6 week access to diagnostics |  
| • Community activity and outcomes including hubs |  
| • Operational efficiency indicators (theatres, outpatients, bed utilisation) |  

The Committee noted that ED 4 hour target performance for week ending 22nd March was 94%

The DoN presented the report, highlighting:
- The 99% diagnostic standard has been achieved in line with plan. Work is ongoing to move clinicians to 12 points per list;
- The improvement in DTOC performance has been sustained;
- The trust continued to be in operational escalation during March with four 12 hour trolley waits reported.

The DoN went on to highlight three emerging risks:
- There is as yet no clarity on the terms for STF funding in relation to A&E performance for 2018/19;
- Winter planning continues with submission to NHSE due by 30th April;
- There are concerns regarding backlog in certain clinics such as Gastro (SBARs have been competed). DNAs are not routinely booked and job plans are being challenged. Overall clinics are being well utilised but productivity improvements are slow.

The CEO noted the added clinical risk of an increase in routine backlogs if urgent cases are being treated first.

The DoN replied that the challenge is being able to close the gap; the Gastro backlog extends to January 2017 and the DoF added that there is evidence of caution in gastroenterologists discharging patients back to their GPs.

In response to a question from the Chair regarding the RTT trajectory, the DoN confirmed that outpatients/inpatients/day case waiting lists need to be managed to ensure there is no further increase at the year end. The trajectory has been submitted to NHSI.

The CEO added that this will be a performance indicator included in the pack. Lists will be validated and outpatient productivity reviewed. He also intends to write to the CCG regarding the management of GP referrals.

The DHR noted the importance of engaging clinicians when considering annual work plans.

Dr Coombs noted a concern that GP referrals had been highlighted as a concern in the past but no remedial action had been taken.

The DoN circulated an activity summary relating to the Bollington, Disley and Poynton community hub. This demonstrated a good understanding of demography to help target activity accordingly. The data set also includes primary care home information.
The Congleton and Holmes Chapel hub is currently testing the Buurtzorg principles ahead of rollout. The DoN reported that traditional roles and responsibilities within district nursing and practice nursing are being challenged and this has on occasion created some tension. District Nurses in Knutsford had become disengaged with practices but that this situation was now improving. Issues had also been reported concerning the community psychiatric nurse resource but this has now been reinstated from CWP back to the GPs.

The DoN confirmed to the Chair that the figure 23% of patients attending A&E who were admitted was the daily average and that the ophthalmology patient breaching 52 weeks relates to a coding issue, for which an RCA is underway.

Dr Coombs asked about the resilience of diagnostics performance and the DoN replied that risks included an increase in patients waiting two weeks. There are also opportunities to create more space and this is being reviewed.

Dr Coombs went on to query the month on month variation within non-elective LOS and the DoN clarified that elective performance is distorted by the cancellation of inpatients in favour of complex cancer patients.

Mr Goalen referred to the decline in performance of 'Utilisation of Original Planned Hours' within theatres and asked whether the trend would reverse. The MD replied that as dropped lists are now not allocated as WLIs, there are now gaps within the theatre template. Job plans make this a challenge and performance may worsen before it improves. The CEO added that if job plans were to be annualised, the expectation would be that theatre utilisation would reduce over the winter months and therefore staff should not be paid where a list is dropped or a theatre closed.

The Chair queried the value of having carried out a theatre efficiency review earlier in the year given that overall performance is below target. The DoN noted that the gap in control on the indicator is bed availability and the MD confirmed that start times are affected by bed availability.

Dr Coombs asked whether the trajectories would be affected by moving to a block contract and the DoN responded these were based on 2016/17 performance.

The CEO commented that if a theatre is not running there should be no cost wastage and asked for evidence that this would be the case.

**Action:** The DoN to review the indicators included in the Performance Report to provide assurance to the Committee that theatre utilisation is maximised for day cases.

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### Workforce Report Inclusive of the below appendices

<table>
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<th>18/35</th>
<th>Risk and mitigation report – with monthly KPI dashboard</th>
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<td>Staff Survey</td>
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The DHR presented the report, highlighting:

- The trust-wide annual priority to reduce the overall vacancy rates over the year has been achieved (2% improvement from March 2017 to March 2018);
- Operational pressures have impacted on training metrics and appraisal compliance, however, the safeguarding target has been achieved in recent years;
The streamlined model for induction and new starter training has been implemented.

The MD asked whether the development of the Cheshire and Merseyside collaborative Bank was solely in relation to nursing. The DHR replied that this will ultimately cover medical too but nursing is the first wave.

The DoN queried the possibility of incentivising staff to go on Bank; other organisations doing so have noticed a reduction on agency spend as a result. The DHR noted that the focus for 2018/19 is retention of staff and this would form part of that, but the financial impact would need to be reviewed.

The CEO asked whether an increase to hourly rates will mean an increase in total Bank costs.

**Action:** The DHR to review financial impact and report back to the Committee.

The DoF highlighted that although vacancies across the trust are at their lowest, agency spend had increased significantly during Q4. A discussion followed about the likely causes for this and the Chair asked for an explanation to be included in the report at the next meeting.

**Action:** The DHR to include an explanation for the increase in agency spend in next month’s report

The Chair questioned the increase to e-rostering trust hours owed and the DHR responded that more staff took annual leave during March. The Chair asked about the profile of the hours owed and the DHR agreed to investigate further.

**Action:** The DHR to provide a breakdown at next meeting

The DHR confirmed that sickness rates have reduced but are slightly higher than MCHFT and COCH, although lower than the average for the North West region.

**Staff survey**

The DHR presented the findings, noting that Steven Weeks from NHS Employers had identified the trust as having performed very well in relation to the national position.

A discussion followed about the bottom five ranking scores and it was noted that some areas need further work to understand the perceptions behind the scores given.

Issues within the AHCSS directorate seem to be at the interface with other services and not internal, and this is being reviewed.

The DCAG reported that approximately 50% of the potentially harmful errors reported as seen by Community relate to other care providers and these are being passed on to the appropriate organisations. The trust’s approach to reporting all patient safety irrespective of who they are aligned to was considered very positive.

The CEO commented that some results had not changed from the last year’s survey and that consideration to this needs to be given when agreeing Board objectives around staff retention. Further triangulation would provide a better
understanding of what is considered an acceptable score.

Mr Goalen noted that a good performance in workforce metrics might suggest staff in some areas are more challenged and this may reflect negatively in their survey results.

### Finance Report Inclusive of the below appendices

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<th>18/36</th>
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<tr>
<td>• Finance risk report</td>
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<tr>
<td>• QIPP report (including milestone delivery plan and risk register)</td>
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<tr>
<td>• Repeating presentations – Revolving Working Capital facility</td>
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The DoF presented the report, highlighting (in relation to the year to 31st March 2018):

- The trust received an extra £2.7m of STF funding on 20th March. This reduced the deficit at year end from £18.9m to £16.2m;
- Capital spend was achieved;
- All cash was drawn down;
- Drew down all cash;
- £6,259k QIPP was achieved against £6,000k target;
- There was a M12 impairment of £951k for A&E, however, this does not impact on the financial control target.

The Committee noted thanks to the Finance department for their hard work in completing the year-end submission.

In response to questions from Dr Coombs, the DoF confirmed that the capital spend was achieved through expediting orders and slippage in Estates being transferred to medical equipment. He went on to confirm that the car parking contract generated £53k income from patient and visitor charges and the contract had been extended last year by two years.

The Chair referred to the trust-wide variances and asked whether the plan would have been achieved if the risk accruals relating to data challenges had not been released. The DoF commented that it is usual practice to release the previous year’s provisions at year end and then create further provision to build this back up when fresh data challenges are made during the course of the year. The CEO noted that there will be no requirement for this when the trust moves to a block contract.

Mr Goalen referred to page 48 notes 1 and 3 and the £840k deficit for plan v actual on page 41 and asked what the underlying position would be for Month 12 without these funds being released.

**Action:** The DoF agreed to provide analysis of the normalised run rate for Month 12.

Mr Goalen then asked whether most of the QIPP achieved during the year was as a result of cost reduction and the DoF replied that it was mostly relating to income gain. Before QIPP has been identified at the start of the year, it is added to non-pay and reallocated once it is delivered.

It was noted by the Chair that overall performance was very close to plan but that there were significant variances in individual directorate performances and...
he questioned the effectiveness of our planning. The DoF responded that these are regularly scrutinised within directorate performance meetings. The Planned Care underperformance could be attributed to £3m in income and £2m expenditure and Acute and Integrated underperformance relates to net adverse expenditure control.

The CEO challenged the meaning of ‘trust-wide’ and queried whether in 2018/19 funds should be reallocated back to divisions where appropriate eg funds released for data challenges.

Mr Goalen asked whether the trust is breaking the statutory duty to break even over a period of three years and both the DoF and CEO were of the opinion that this had been extended to five years but that clarity was required. **Action: The DoF to clarify whether the statutory requirement to break even has been extended from three to five years.**

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<tr>
<th>18/37</th>
<th>Any other business</th>
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<td>None raised.</td>
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Date and Time of Next Meeting:
Thursday 7th June 2018
08:30-10:30,
Boardroom 1 NAH