EAST CHESHIRE NHS TRUST

MEETING OF THE TRUST BOARD

NOT FOR PUBLICATION BEFORE

Thursday 7th June 2018
3.00 PM

Boardroom 1, New Alderley House, Macclesfield District General Hospital

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Our Ref:  LM/FB/Meetings01/TB/Agenda

Date:  31st May 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 7th June 2018 in Board Room 1, New Alderley House, Macclesfield District General Hospital, Victoria Road, Macclesfield, SK10 3BL.

Yours sincerely

Lynn McGill
Chairman

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

TRUST BOARD – June 2018 AGENDA

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<td>1. Patient Story:</td>
<td>Director of Nursing, Performance and Quality</td>
<td>10 mins</td>
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<td>2. Apologies:</td>
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## ASSURANCE ITEMS

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<td>3. Register of Interests:</td>
<td>The Chairman</td>
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<td>- Declared interest agenda</td>
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<td>4. Minutes of the April 2018 meeting</td>
<td>The Chairman</td>
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<td>7. Verbal update:</td>
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<tr>
<td>SQS</td>
<td>Ms A Harrison</td>
<td>15 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
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<td>FP&amp;W</td>
<td>Mr M Wildig</td>
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<td>(supported by formal minutes when available)</td>
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<td>Audit</td>
<td>Mr Ian Goalen</td>
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## STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

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<tr>
<td>8. Chief Executive’s Commentary</td>
<td>Chief Executive</td>
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<td>10. Learning from Deaths – Q4</td>
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<td>11. Standing Agenda Item:</td>
<td>Chief Executive</td>
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<td>Does the Board wish to add</td>
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### ANY OTHER BUSINESS

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<tr>
<td>11. Public Trust Board Agenda – July 18</td>
<td>The Chairman</td>
<td>5 mins</td>
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### CONSENT ITEMS

(All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting).

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<td>13. Annual report Infection, Prevention and Control</td>
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<td>For assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
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<tr>
<td>14. Annual reports of the Committees of the Board</td>
<td>TB 18 (46)</td>
<td>For assurance</td>
<td>All corporate objectives</td>
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| 15. Annual Safeguarding report | TB 18 (47) | 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 |
| 16. Safer Staffing Exception Report | TB 18 (48) | Assurance | PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience  
STAFF - Empower, develop and value staff in providing innovative patient focused care |
| 17. Minutes of the committees of the Board:  
SQS – March 18  
FP&W – March 18 | TB 18 (49)  
TB 18 (50) | Information | |

**Date and Time of Next Meeting:**

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

MINUTES OF MEETING HELD ON:
26th April 2018, 3.00pm

Meeting Chair: Lynn McGill
Meeting Secretary: Bethan Rimmer

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

Voting Members

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

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<thead>
<tr>
<th>Name</th>
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<tr>
<td>Mrs J Green</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>DCAG</td>
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In Attendance

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Bethan Rimmer</td>
<td>Executive PA / Minutes</td>
<td>✓</td>
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<tr>
<td>Peter Madden</td>
<td>Non-Executive Director</td>
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DEcISIONs MADE BY THE BOARD AT TODAY’S MEETING

1. The Board agreed to delegate oversight of the CQC action plan to the SQS Committee.

2. The Board approved the 2018/19 Operational Plan.

Agenda Item: Patient Story:

The DNPQ presented a complaint response letter following concerns raised by a patient’s relative for the delay in their orthopaedic surgery. The response provided apologies for the delay and outlined the reasoning, due to cancellation of elective procedures during the winter period, operational pressures and the need to prioritise urgent elective appointments. KS noted disappointment at being unable to provide this patient with a confirmed date for their appointment.

Dr Coombs queried what other options have been reviewed, such as referral to another hospital. The DNPQ advised discussions are taking place with commissioners, as patients have the right to request the surgery at another hospital. Waiting times are being continually discussed with commissioners through contract and quality meetings.

Dr Coombs requested clarity on the assignment of urgent and non-urgent cases. The DNPQ confirmed this is determined by the clinician. The majority of orthopaedic surgery is not clinically urgent and therefore more likely to be postponed. The operational pressures during quarter 4 have impacted on the use of elective beds for non-elective patients. Work is ongoing with clinicians to review the workload and more effective management.

Agenda Item: Apologies:

Apologies were received from Ali Harrison and Peter Goman.
The Chair formally welcomed Dr Peter Madden to the meeting as the new Non-Executive Director.

The Chair wished to place on record our thanks to Dianne Prescott for her valued contributions as Interim Strategy Advisor.

### Assurance Items

3. **Register of Interests:**

   **Declared Interest Agenda**
   There were no interests declared.

   **Hospitality and Gifts Register Declaration**
   The Chairman reminded Board members to ensure the hospitality and gift register remains up to date.

4. **Minutes of the March 2018 meeting**

   **TB 18 (28)**
   The minutes of the March 2018 meeting were declared a true and accurate record and duly signed by the Chairman.

5. **Matters Arising**

   Dr Coombs queried the current position of the 6% NHS Staff pay award. The DNPQ advised this is currently still at the consultation stage. The CEO noted funding has not yet been clarified.

6. **Action Log**

   9508 – The CEO has been requested to provide an update at the June Overview and Scrutiny Committee. The Major Injuries Unit (MIU) was opened approximately 50% during December 2017 – March 2018. There are discussions on whether the service offers value for money given patients are being treated through primary care services. **Action Closed.**

7. **Verbal update:**
   - SQS Committee
   - FP&W Committee

   The Chairs of the trust’s Committees of the Board gave an overview of the assurance and risks from their recent meetings.

### Safety, Quality and Standards Committee

**Points for Assurance**

- 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 & Responding; Integrated Care), reflected in the draft Quality Account which was reviewed.

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 2018/19.

- 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 & 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.

- The Committee reviewed the 2018/19 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 2017/18 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.

- The Committee were pleased to note the reduction in total cases of clostridium difficile (total 9 cases versus trajectory of 14). A further reduction is sought for 2018/19.

- 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.

- The trust has been shortlisted in the Changing Culture category of the Health Service Journal 2018 Patient Safety Awards (judging May 2018, awards July 2018).

- 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.

- The Committee received assurance on delivery of the Equality Objective Plan for 2017/18 and approved the proposed plan for 2018/19.

**Emerging Risks & Mitigating Actions**

- In line with national experience, there has seen a marked increase in the number of deaths recorded at the trust in Quarter 4 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.

The DNPQ noted the positive meeting, including the attendance of the Consultant Nurse for ICU who provided the update on Sepsis showing clear understanding for the Committee and the actions behind the work.
**Finance, Performance and Workforce Committee**

### Finance
- The yearend position shows the trust at a deficit of £18.9m against the target of £20.2m, an improved position.
- Income was favourable by £2.6m. The Paybill was adverse by £1.8m. Various non-pay categories were favourable by £0.5m.
- There was mixed performance at directorate level with a shortfall in Planned Care and Acute & Integrated Community Care directorates.
- The QIPP target was achieved at £6.25m, of which £6.1m are recurrent savings.
- The capital spend was behind in month however all capital money has been spent (£3m). In addition, a successful bid was received for £1.5m to support the Primary Care Streaming estates work. The total to be recorded in the accounts will therefore be £4.5m.
- Cash management was consistently positive all year with a balance of £7m. All entitled loans were drawn.
- The repayment of loans is to commence in 2018/19, with £8.5m due for repayment by February 2019. The DoF is managing this position. This has moved to current liabilities in the balance sheet.
- It was confirmed that all repeating representations for the warranties were appropriate for the year.

### Performance
- The ED 4 hour standard target achieved 72% in March. Mr Wildig noted there was no assurance gained for the achievement of targets in 2018/19. A national target has been set for trusts to achieve 95% by March 2019.
- There were 4 12 hour trolley wait breaches in March.
- The RTT standard achieved 85% against a target of 92%. There were 10 specialties that did not achieve the target. Target actions have been set to improve productivity in outpatients, endoscopy and theatres.
- There was one 52 week breach in March, with initial findings showing this was an historic error in coding.
- The RTT trajectories for 2018/19 have not yet been agreed. It is expected the trust will be required to maintain and improve on the waiting list number from 2017/18 with no deterioration.
- The Diagnostics recovery plan was achieved in March for both the month and the year. Actions will be maintained going forward.
- The cancer target achieved in March.
- DTOCs are continuing to improve and sustain improvements.
- Emerging risks were noted against winter planning for 2018/19. There is uncertainty relating to the allocation of the STF funding. Improving productivity on block contracts was noted as a risk.

### Workforce
- Overall agency rates have reduced, achieving 4.52% (a 2% reduction from March 2017).
- Nursing vacancies remain high at 6%, with acute nursing at 13%, though this is a reduction on February’s position. There are high levels of sickness and maternity and ongoing mitigations are being put in place.
- The total Paybill for the year was in excess of the plan by £1.8m, with an increase noted during March 2018. This position is below the national trajectory for the year. The trend was noted as a concern and directorates
are being challenged on their agency spend.

- Sickness absence was 5% for March which was an improvement on February, however above the target of 4.4%. The team continue to support staff sickness, particularly relating to mental health and stress.
- Operational pressures and sickness have impacted on training compliance. Managers have been requested to reschedule training and appraisals as soon as possible to meet compliance. Positive developments have occurred with streamlining the induction processes.
- Approximately 1000 members of staff took part in the Staff Survey 2017 (circa 40% of the workforce), which is in line with last year’s average. Mr Wildig thanked all staff who took part in the survey. Feedback from NHS Employers stated positive achievement for the trust to hold their position during operational pressures. The survey was positive overall however there were issues identified and action plans are in place.

The CEO assured that the 52 week breach reported at the meeting had experienced no harm due to the delay.

The Chairman queried whether there are any concerns with maintaining the financial balance in the bank. The DoF confirmed there are currently no concerns and any loans that the trust is entitled to will be requested. Mr Wildig agreed this is the correct approach to follow.

The Chairman noted the work to improve bullying and harassment cases and enquired as to the action plans. The DHR highlighted there has been a national increase in these types of cases and NHS Employers are leading on work to address. It was noted that the Allied Health and Clinical Support Services directorate received the poorest feedback from the staff survey however achieved their metrics. The CEO recommended ensuring staff are not being pushed too hard to achieve the metrics at the expense of their wellbeing. It was added that this directorate is the interface for additional services and the workload has been increasing in recent months.

STRATEGIC/GOVERNANCE/ASSURANCE/FINANCIAL ITEMS

8. Chief Executive’s Commentary

TB 18 (29) The CEO presented the Chief Executive’s commentary, highlighting the following:

- The trust received a ‘Good’ rating following the CQC re-inspection in January 2018, with Community End of Life care receiving an ‘Outstanding’ rating for Caring. The CEO noted positive feedback from staff following announcement of this rating and this should be built on. An action plan on areas that still require work is due to be submitted to the CQC in May. The Board is asked to accept delegation of the CQC Action Plan oversight to the SQS Committee.
- The Chairman formally thanked all teams for their hard work to support and achieve this improved CQC rating.
- The CEO noted a number of areas which are still rated as ‘requires improvement’, adding that some of these areas were not re-inspected and therefore maintain their current rating. There were no areas that decreased in rating, with the majority showing improvement.
- The ED 4-hour standard and RTT standard were not achieved, impacted by winter pressures. There is a trajectory in place for achievement of the ED standard to 95% by March 2019. The CEO confirmed despite pressures,
patient safety was maintained in ED.

- The trust has been shortlisted for a national patient safety award by the Health Service Journal. The team will present to the award panel in May with the award ceremony taking place in July.
- The trust was awarded Level 3 of the Disability Confident Award scheme, the first in the Northwest to receive this award.
- In a recent BMJ poll, the trust has been ranked one of the best trusts in England for transparency.
- The trust achieved its 2017/18 financial control total and QIPP targets.
- The transformation work and development of service proposals is on track for 20th July 2018 and progressing well.

Dr Coombs queried whether the positive successes have been communicated to external stakeholders. The CEO advised he has personally written to stakeholders following the announcement of the CQC rating. Achievement of the awards is being communicated via Staff Matters and trust screensavers. The DCAG advised displays are being created for the hospital and the CEO noted discussions regarding the possibility of an awards cabinet in main reception.

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.

The DNPQ acknowledged the level of work staff have been undertaking, given the recent operational pressures and high agency usage. Improvements have been seen in the last few weeks, particularly following receipt of the CQC results which has boosted staff morale.

Mr Wildig queried, for areas maintaining their historic CQC rating, whether this will remain until the next full inspection. The DCAG advised that the trust provided the CQC with a large amount of data across all services prior to the re-inspection. The CQC could re-inspect other services at any point. Further meetings with the CQC will be taking place to discuss the new action plan.

Mr Wildig enquired as to the ambition for the next inspection. The DCAG and DNPQ will be meeting with directorates to discuss improvements on the results and maintaining quality services. The CEO added that it would be ideal to have no areas of ‘requires improvement’ and increase the level of ‘outstanding’ services.

The Board agreed to delegate oversight of the CQC action plan to the SQS Committee.

**Finance Update**

The DoF provided an update on the financial position, highlighting the following:

- An additional £2.7 million of incentive funding has been received for 2017/18. This updates the actual year end position to £16.2m which will be reported in the accounts.
- £1.5m QIPP savings have been secured for ‘blue’ schemes. A number of schemes are currently going through the QIA and assessment processes. This will increase the total to £3.9m. There remains £1.1m to be identified.
- The Recovery Board continues to meet on a monthly basis and the DoF and
DNPQ meet each of the directorates monthly to discuss their position and progress. Work is ongoing on outpatient productivity however no savings have yet been identified. A 10 post challenge has been issued to the directorates, which is subject to QIA.

- The DCAG queried the position of the corporate services. The DoF advised there is a target for 12 corporate posts in their schemes. It is expected that the majority of requirements will have been identified by month 2.

**9. Chairman’s Commentary**

**TB 18 (30)** The Chairman presented her Commentary report, requesting discussion on the Board objectives outlined in the report and the following was noted:

- A piece of work has taken place around culture and, given the awards the trust has received, the Chairman queried whether the objectives can be further aligned to culture and progressing cultural maturity. The DCAG suggested this is covered under the objective on retaining staff, noting if demonstrating the desired behaviour and culture will encourage staff to stay.

- The Chairman noted that culture should be seen across all objectives with measurable metrics that maintain oversight.

- The DNPQ added that the values and behaviours of the trust are what dictate the culture and the Executive team hold responsibility for ensuring this is embedded. Feedback is showing this is not always seen through paths such as staff surveys.

- Dr Coombs noted there is nothing specific in the objectives around effective care or developing more localised care. The DCAG advised that effective care is a regulated requirement from the CQC. The DNPQ added the ‘Patients’ strategic objective focuses on the provision of effective care.

- Dr Coombs queried specific work around the development of the integrated hubs. The CEO advised this would be a subset for fully engaging the wider partnerships which would come through the DNPQ’s specific objectives.

- The Chairman requested that each of the objectives reflect a cultural element and the Board agreed to sign up to these objectives subject to the discussions at this meeting. It was recognised this may require a little time to work through.

- The Chairman updated on additional items to add to the commentary, noting the appointment of Dr Peter Madden to the vacant Non-Executive Director post. The Chairman also attended a volunteer’s thank you event led by the League of Friends in Knutsford noting the positive feedback in relation to fundraising and work achieved.

**10. 2018-19 Operational Plan**

**TB 18 (31)** The DoF presented the Operational Plan for 2018/19, highlighting the following:

- There have been no major changes since circulation of the draft plan.

- There is an update on a plan that has been submitted including £0.9m in 2018/19 for investment in improvements to cancer services and outpatients. This is awaiting approval following review in context with wider plans.

- The outturn has been amended to £16.2m following receipt of the additional £2.7m funding.

Mr Wildig noted the plan was based on month 10’s forecast outturn and queried whether there would have been any fundamental changes if assumptions had
been based on month 11 or 12. The DoF confirmed the plan would be the same, the issues in the latter months were around agency challenges and it is believed this position can be recovered.

The MD noted the aspiration from the CCG to reduce referrals by 8% which is not included in the plan. The DoF advised if this position is achieved, waiting list numbers and times should reduce.

Mr Wildig noted the national metric from NHS England to reduce DTOCs to 3.5%. The DoF confirmed agreement was made between the ECCC and NHS England of a target of 5.2% by March 2018. The intention is now to aim to achieve the 3.5% though the CEO advised this is an aspiration not a target.

The Board approved the 2018/19 Operational Plan.

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The DNPQ presented the Bi-Annual Safer Staffing Report, highlighting the following:

- This is largely aimed at the acute hospital ward areas. The methodology follows the ‘Safer Nursing Care Tool’ which supports allocation of the level of nursing needs against the number of patients. The methodology is based on the level of care that patients received in a set period of 1 week twice a year. This is consistent with allocation in other trusts.
- There has been an increase in level 1B patients, with the level of dependency increasing for 1:1 care and HCAs. This has been impacted by additional beds in the system.
- Ward 11 (intermediate care) has seen an increase in Level 1B patients which is outside the skill mix; this ward is for medically optimised patients for discharge who require intermediate care. The Level 1B patients should be on a medical ward however the beds have not been available. This will be kept under review; it also forms part of the wider skill mix review and bed reconfiguration work currently underway.
- Ward 4 has also triggered with a high level of vacancy, sickness and agency usage. The DNPQ noted this has resolved in recent weeks. The ward was impacted by additional beds during the winter period.
- The trust has invested in an Allocate Safer Care Module system which will allow electronic monitoring of dependency moving forward.
- Work is ongoing with HR, Heads of Nursing and the directorates to review staffing figures for each ward to ensure they are appropriately aligned to the number of beds.

The DoF expressed concern around supporting the request for £200k to support the future nursing associates programme when there remains QIPP savings to be allocated. 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.

Dr Coombs acknowledged support for future nursing associate programmes, should the funding be available. The DHR agreed advising this is part of the career development programme through the Retention Strategy. The current programme has proved successful with 9 out of the 10 involved working towards becoming registered nurses.
12. **Standing Agenda Item:** Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register

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.

Mr Wildig queried the implication of not achieving the agency targets. The CEO confirmed there will be no financial penalty but there may be a reputational impact with non-achievement of an NHS Improvement target. The CEO agreed the need to maintain focus and ensure this risk does not develop.

The CEO noted a potential risk around the increase in referrals due to the block contracts coming into effect.

The DNPQ noted a risk for the pace of productivity, which is being highlighted through the FPW Committee.

**ANY OTHER BUSINESS**

13. **Public Trust Board Agenda – June 18**

| TB 18 (33) | The Board agreed the Public Trust Board agenda for June 2018 with no changes. |

**CONSENT ITEMS**


The Board noted the contents of the Equality, Diversity and Human Rights Annual Review.

15. **Safer Staffing Exception Report**

The Board noted the contents of the Safer Staffing Exception Report.

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

- **SQS Committee – February 2018**  
  The Board noted the contents of the minutes of the SQS Committee.

- **FPW Committee – February 2018**  
  The Board noted the contents of the minutes of the FPW Committee.

**Date and Time of Next Meeting:**

Date: Thursday 7th June 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>Kath 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 Executives Report to Trust Board for the Period to 30th April 2018

Background papers (if relevant) N/A

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

Action/Decision required

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

Mitigates Risk Number: (identify)
On Assurance Framework

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

Link to:
➢ Trust's Strategic Direction
Links to all strategic objectives
➢ Corporate Objectives

Legal implications - (identify)
None

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

Resource impact
None

Impact of equality/diversity
None

Avoid acronyms or abbreviations - if necessary list:
Chief Executive’s Commentary for the Period Ending 30th April 2018

1 INTRODUCTION

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

2 KEY ISSUES

The Board are asked to note

- The endoscopy unit has achieved full accreditation from the Joint Advisory Group on GI Endoscopy
- The trust has received a number of awards both for patient care and staff wellbeing
- The pressure on the delivery of waiting time standards for patients has eased and performance has improved but not to the required standard
- The delivery of the planned financial position in April but also the risk about QIPP not yet identified
- The satisfactory overall performance delivered in April (Appendix 1)

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

The trust has not achieved the 4 hour standard in ED however performance in 2018/19 is improved over 2017/18

- The trust admitted, discharged or transferred 86.7% (3,481) of its patients within 4 hours during April 2018. Whilst not achieving the 95% standard this performance is some 10% better than April of the preceding year and exceeds the internal trajectory set by the trust as it moves towards achievement of the standard.

- In comparative terms the trust was the second highest performing trust in Cheshire and Merseyside.

5 of the 7 cancer waiting time standards have been met in April

- The trust failed to achieve the standards for 2 week waits for suspected cancer and 2 week wait for breast symptoms. 75 patients were not seen within 2 weeks and 23 patients were not seen for breast symptoms; there is no indication that this has led to patient harm.

The number of patients on the waiting list has grown in April

- The trust is required to ensure there are no more people on the waiting list in March 2019 as there were in March 2018. April has seen the list size grow from 7,545 to 7,815. In addition the length of time patients are waiting for their first appointment is growing in certain specialities.
The Executive team are working with clinical colleagues to maximise productivity within the core service offer to ensure the maximum number of patients can be treated.

In addition there is a review taking place about the consistency of approach on the “Did Not Attend” (DNA) policy being taken by specialities. The trust policy is that when a patient does not attend an appointment the clinician will review the notes and will take a clinical decision if the patient should be offered another appointment or if they should be returned to the care of their GP. It is unfair on patients waiting to be seen if capacity is lost by people not attending clinics.

The Trust DNA rate is good when compared to benchmarks however there is variation between clinicians and this variation needs to be explored.

Infection and mortality rates remain favourable

3.1.4 The mortality of the trust remains “as expected” when compared to peers and there have been no cases of hospital acquired clostridium difficile and MRSA bacteraemia.

3.2 JAG Accreditation

3.2.1 In April and October 2017 the endoscopy self-assessment of the Global Rating Scale (GRS), showed that the service was not achieving the GRS Levels required to renew JAG Accreditation for 2018.

The Board is aware that the Trust’s accreditation status was ‘Assessed: improvements required’ with the award of accreditation deferred until April 2018.

In April 2018 the service submitted the April 2018 GRS, and the submission showed that the service was now meeting all requirements to be awarded JAG accreditation and this has been confirmed by JAG.

3.3 Breast Screening

3.3.1 East Cheshire NHS Trust is one of 79 local NHS breast screening services across the country. Women are routinely screened every three years.

Public Health England (PHE) who manages the process reported a national complex IT problem with the breast screening invitation system leading to some women not being invited for their final screen between their 68th and 71st birthdays. They have carried out urgent work to identify the problem and have resolved it. Additional failsafe systems have also been introduced to ensure the problem does not reoccur.

PHE with the support of NHS Digital is writing to all women who have been affected by this incident. All women registered with a GP will have received a letter by the end of May outlining how they can access the helpline and take up the screening offer if they wish.

Nationally more than 206,000 women will receive a letter telling them about the issues and it has been identified that approximately 2,500 women within east Cheshire were not called for their final screening and the trust has identified that additional capacity is required to ensure that screening appointments are scheduled. The Trust has been informed that all additional costs will be met.
3.4 Congleton Minor Injuries Unit

The Unit has been closed at short notice over the winter period which has caused concern for some members of the public.

The Board are aware of pressure faced by urgent care services over the winter period. The Trust had to ensure it utilised its staffing resource in the best way to meet the demands being placed upon it.

This led to the staff at Congleton being redeployed into the main ED at Macclesfield. The Trust attempted to minimise the closure but as this was done on a day to day basis closures were made at short notice. The Trust had mechanisms to ensure the public could be made aware however these systems did not stop some people arriving at Congleton to find the service closed.

I apologise to people who have been inconvenienced.

Appendix 2 is a copy of a paper that is being presented to the Health and Adult Social Care and Communities Overview and Scrutiny Committee on 14th June for information.

3.5 NHS Smoke Free Pledge

The Trust has committed to support Action on Smoking and Health (ASH), who have written to NHS Trusts to request support to reduce smoking rates for both Patients and Staff.

ASH has written to NHS Trusts to gain support for their ambition to reduce smoking rates in patient and staff. The 5 objectives are:

- Treat tobacco dependency among patients and staff who smoke as set out in the Tobacco Control Plan for England
- Ensure that smokers in the NHS have access to the medication they need to quit in line with NICE guidance on smoking in secondary care
- Create environments that support quitting through implementing smokefree policies as recommended by NICE
- Actively work with Local Authorities and other stakeholders to reduce smoking prevalence and health inequalities
- Join the Smokefree Action Coalition

These requests are consistent with our own internal policies as smoking remains the lead cause of preventable deaths in the UK.

The Chairman, Medical Director and myself have signed their pledge on 31st October which was World No Tobacco Day.

3.6 CKKS Top Hospital Award

The Trust has received two awards from CHKS as part of their Top Hospitals programme.

East Cheshire NHS Trust was again presented with one of the Top 40 Hospital awards from CHKS, the 8th year in succession.

In addition, the Trust was recognised as one of the most improved Trusts in 2017/18 taking into account a range of indicators These indicators include clinical outcomes such as mortality and readmission rates as well as information from the staff survey and CQC inspections.

4 FINANCIAL STABILITY

Risk: If the trust cannot meet requisite financial regulatory standards and operate within agreed financial resources and transformation schemes do not deliver sufficient savings, then the proposed health economy wide service model will not be fully or effectively implemented.
The Trusts income and expenditure position is on plan at the end of April.

The Trust has generated a deficit of £2.1m at the end of April which is the planned position. The Trust is required to achieve a financial control deficit of £18.9m during 2018/19.

4.2 The table below gives a summary of income and expenditure for the month.

Cost reduction is required for the trust to achieve its financial control total.

As the Trust has a block contract for acute and community activity in 2018/19 there is limited scope to increase income and as such the QIPP programme must be delivered by increased productivity and cost reduction.

At the present time the QIPP target of £5m for the year has significant risk in delivery with £1.3m identified as “amber” or “red” in terms of delivery.

Agency Expenditure has reduced in April.

The Board are aware that costs of agency staffing had increased significantly during the last quarter of the year. £611k was spent in April compared to £1m in March.

Agency expenditure must be minimised as the year progresses and the Trust is required to ensure that expenditure does not exceed £7.3m in 2018/19.

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 Staff Wellbeing Award

The Trust has received an award from MIND for the work it has done for staff health and wellbeing.

5.1.1 The Trust has been awarded a Bronze Achieving Change award from MIND, and included in Mind’s Workplace Wellbeing Index 2017-2018.

The award is given to employers who have committed to a journey on improving mental health in the workplace by implementing initiatives to promote mental health for staff.

5.2 Workforce Metrics

April performance is consistent with plan in most areas however staff turnover is higher than expected.

The workforce metrics are generally positive in April although there has been a higher turnover rate in April than we would expect. On review this appears to be due to a higher number of people retiring in the month that the average.

This would therefore be expected to be an isolated issue however the position will be monitored. It is a reminder however that one of the strategic workforce issues faced by the Trust is an aging workforce.
5.3 Freedom to Speak Up

The Trust welcomes members of staff raising issues of concern they may have in order that patient safety and staff wellbeing is not compromised.

The Board is asked to note the guidance issued in May 2018 relating to Freedom to Speak Up. The Board will be undertaking a self-review in the coming weeks using the tool issued by NHS Improvement and the National Guardian’s Office. The outcome from the review will inform areas of further focus going forward.

Appendix 3 sets out the guidance and expectation.

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 Cheshire East Transformation Board

A decision has been taken confirming the partners for the “place” and a memorandum of understanding between the partners is being progressed.

A decision has been taken to include the following statutory organisations as part of the Cheshire East “place” within the Health and Care Partnership of Eastern Cheshire.

- Cheshire East Council
- Cheshire and Wirral Partnership NHS Foundation Trust
- East Cheshire NHS Trust
- Eastern Cheshire Clinical Commissioning Group
- Mid Cheshire Hospitals NHS Foundation Trust
- South Cheshire Clinical Commissioning Group
- South Cheshire and Vale Royal GP Alliance and
- Vernova Healthcare CIC.

Partners have received a draft memorandum of understanding to set out the way we will work together which is anticipated to be signed in June.
6.2 ECT Transformation

The work to assess how clinical services will be sustained in East Cheshire continues with good clinical engagement

6.2.1 The Trust is recognised as providing good quality services however the desire is to ensure these constantly meet the needs of patients in a sustainable fashion.

The Trust faces many challenges that are not unique to ECT such as workforce and finance. Given the relative size of the some of the services provided by the Trust it does have challenges of “critical mass”.

The “Case for Change” is in draft form and will be brought to the Board in the coming weeks alongside options that would deliver more sustainable services in the future. A workshop attended by ECT clinical leaders and invited external guests was useful in starting to set out how some of these challenges can be overcome.

It is continually stressed that no decisions have been taken about future service delivery as the focus is about assessing what is the best strategy for the Trust and its partners in providing care to the right standard as locally as possible. The Clinical Management Board is overseeing the process which is led by the CEO and Medical Director.

6.3 Mental Health Service Consultation

The consultation on the mental health service provision and the use of the Trusts Millbrook building has closed and the Trust has asked for assurance from partners on certain issues

6.3.1 The Consultation has closed and the Board will be aware of significant issues raised in public meetings surrounding the potential relocation of some inpatient services in Chester.

The response made on behalf of the Board is attached at Appendix 4 and is written from the perspective on the impact on ECT and the patients for whom we provide care.

The proposals align with the strategy of the health and care partnership in that all organisations are seeking to provide care out of hospital wherever possible whilst ensuring in hospital services are of a high standard when needed.

The major interaction with mental health services by ECT relates to joint working for patients attending ED who have mental health needs as well as physical.

The Trust is seeking assurance that any change in service delivery on the Macclesfield site does not lead to a reduction in service and speed of service for patients in ED.

In addition there are some financial consequences to the trust should the unit no longer be occupied and the Trust is seeking confirmation that the trust will not be left with a deficit in line with capped expenditure principles.
7 USE OF TRUST SEAL

The seal has been used once since the last meeting.

<table>
<thead>
<tr>
<th>Date</th>
<th>Seal Number</th>
<th>Name</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>17th May 2018</td>
<td>458</td>
<td>James Mercer Group</td>
<td>Minor works building contract – Pharmacy replacement scheme</td>
</tr>
</tbody>
</table>

8 SUMMARY

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

Sign off  John Wilbraham
Role title Chief Executive
<table>
<thead>
<tr>
<th>Metric</th>
<th>Apr</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td></td>
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<tr>
<td>Risk Adjusted Mortality Index 2017 - Latest Peer (88.77)</td>
<td>91</td>
</tr>
<tr>
<td>Summary Hospital Mortality Indicator (HSCIC)</td>
<td>Oct 16 - Sep 17</td>
</tr>
<tr>
<td>Ecoli - includes hospital and community</td>
<td>1</td>
</tr>
<tr>
<td>Hospital MRSA bacteraemia</td>
<td>0</td>
</tr>
<tr>
<td>Hospital Acquired Clostridium Difficile 18/19 Avoidable</td>
<td>0</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 3 pressure ulcers - hospital</td>
<td>3</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 4 pressure ulcers - hospital</td>
<td>0</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 3 pressure ulcers - out of hospital</td>
<td>1</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 4 pressure ulcers - out of hospital</td>
<td>1</td>
</tr>
<tr>
<td><strong>Infection</strong></td>
<td></td>
</tr>
<tr>
<td>Medication errors causing serious harm</td>
<td>0</td>
</tr>
<tr>
<td>Never Events</td>
<td>0</td>
</tr>
<tr>
<td>Patient Safety: Falls resulting in patient harm per 1000 Occupied bed days</td>
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</tr>
<tr>
<td><strong>Incidents</strong></td>
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</tr>
<tr>
<td>No. complaints with HSO Recommendations</td>
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</tr>
<tr>
<td>Never Events</td>
<td>0</td>
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<tr>
<td><strong>Complaints</strong></td>
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<tr>
<td>Number of complaints</td>
<td>5</td>
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<tr>
<td><strong>Experience</strong></td>
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</tr>
<tr>
<td>Ward Family and Friends Test % response</td>
<td>42.2%</td>
</tr>
<tr>
<td>ED Family and Friends Test % response</td>
<td>23.4%</td>
</tr>
<tr>
<td>Mixed Sex Accommodation breaches</td>
<td>20</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td></td>
</tr>
<tr>
<td>Referral to Treatment Waiting list Total</td>
<td>7815</td>
</tr>
<tr>
<td>ED: Maximum waiting time of 4 hours</td>
<td>86.7%</td>
</tr>
<tr>
<td>ED: The recording of a completed handover, (HAS)</td>
<td>90.4%</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
</tr>
<tr>
<td>2 Weeks maximum wait from urgent referral for suspected cancer</td>
<td>87.0%</td>
</tr>
<tr>
<td>2 Weeks maximum wait from referral for breast symptoms</td>
<td>67.3%</td>
</tr>
<tr>
<td>31 days maximum from decision to treat to subsequent treatment - Surgery</td>
<td>100.0%</td>
</tr>
<tr>
<td>31 day wait from cancer diagnosis to treatment</td>
<td>100.0%</td>
</tr>
<tr>
<td>62 day maximum wait from urgent referral to treatment of all cancers</td>
<td>92.9%</td>
</tr>
<tr>
<td>62 days maximum from screening referral to treatment</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>DTOC</strong></td>
<td></td>
</tr>
<tr>
<td>Delayed transfers of care - Acute</td>
<td>4.2%</td>
</tr>
<tr>
<td>Bed days lost through delays - Acute</td>
<td>310</td>
</tr>
<tr>
<td>Delayed transfers of care - Non Acute</td>
<td>9.5%</td>
</tr>
<tr>
<td><strong>Staff</strong></td>
<td></td>
</tr>
<tr>
<td>Core Staff in Post (FTE)</td>
<td>2170.9</td>
</tr>
<tr>
<td>Total Staff (FTE)</td>
<td>2420.7</td>
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<tr>
<td>Sickness Absence - monthly</td>
<td>4.38%</td>
</tr>
<tr>
<td>Sickness Absence - Rolling year</td>
<td>4.93%</td>
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<tr>
<td>Statutory and Mandatory Training - Rolling 3 year period</td>
<td>92.8%</td>
</tr>
<tr>
<td>Corporate Induction attendance - Rolling year</td>
<td>96.8%</td>
</tr>
<tr>
<td>Appraisals and Personal Development Plans - Rolling year</td>
<td>87.0%</td>
</tr>
<tr>
<td>Information Governance training</td>
<td>21.7%</td>
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<tr>
<td>Safeguarding - Level 1 Compliance</td>
<td>92.8%</td>
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<tr>
<td>Safeguarding Children - Level 2</td>
<td>84.9%</td>
</tr>
<tr>
<td>Safeguarding Adults- Level 2</td>
<td>87.9%</td>
</tr>
<tr>
<td>Safeguarding Children - Level 3</td>
<td>92.6%</td>
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<tr>
<td><strong>Finance</strong></td>
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<tr>
<td>Total Pay Expenditure (£000)</td>
<td>£9,125k</td>
</tr>
<tr>
<td>Bank Staff Expenditure (£000)</td>
<td>£427k</td>
</tr>
<tr>
<td>Agency Staff Expenditure (£000)</td>
<td>£611k</td>
</tr>
<tr>
<td>Cash (£000's)</td>
<td>£9,680k</td>
</tr>
<tr>
<td>EBITDA (£000)</td>
<td>(£1,711k)</td>
</tr>
<tr>
<td>Cumulative Deficit</td>
<td>(£2,067k)</td>
</tr>
</tbody>
</table>
Major Injury Unit at Congleton Hospital

This report gives the Health and Adult Social Care and Communities Overview and Scrutiny Committee an overview of the service offered and the issues that have led to the unit being closed on a number of occasions in recent months.

1 INTRODUCTION

The Trust is aware of the impact for residents of Congleton and surrounding areas given the Congleton Minor Injury unit has been closed on a number of occasions over recent months due to pressures at the Macclesfield Emergency Department.

1.1 The trust is aware of some patient dissatisfaction due to the intermittent closure of the Minor Injury Unit at Congleton. It is important to note that there are no reported cases of harm to patients due to the closure but the Trust recognises the inconvenience to patients.

1.2 Congleton hospital provides a number of services including 28 rehabilitation beds, outpatient facilities, x-ray and a minor injury unit (MIU).

1.3 This report focuses only on the MIU.

1.4 The trust manages the Congleton Minor Injury Unit as part of the overall urgent care service to the public and works in partnership with the main Emergency Department at Macclesfield. The winter pressures felt across the country as well as locally have led to the MIU not being open consistently. Due to staff being redeployed top the Macclesfield Emergency Department (ED).

2 SERVICE PROVIDED

The number of patients treated at Congleton is low in comparison to the Macclesfield ED and it is not a 24 hour service.

2.1 The MIU is planned to be open at the following times:

- Weekdays: 10am – 6pm
- Weekends: 8:30am – 4:30pm
- Bank Holidays: 8:30am -4:30pm

It is staffed by 1 Emergency Nurse Practitioners (ENP)

The types of conditions treated at the MIU include burns, cuts, sprains, splinter removal and minor finger dislocations. Some of these can also be treated by primary care and other health care professionals.

c.1,800 patients were treated at the MIU during 2017/18 which compares to c 49,000 patients at the Macclesfield ED.

On average the unit sees 8 patients per day with a range of 4 to 16 per day (April 2018 data).

It is worthy of note that the numbers of people using the service has reduced significantly over the past few years as more care is available through primary care and other services.
In 2015/16 c. 5,700 patients used the services; this had reduced to c. 3,700 in 2016/17 and is less than 1,800 in 2017/18.

During the winter period of 2017/18 additional appointments in general practice and Out-of-hours were provided in evenings and weekends to provide patients with additional alternatives to attending the MIU or ED.

### 3 DAILY CLOSURES

The staff in the MIU have been redeployed to the Macclesfield ED over the winter period to maximise staffing levels to the volumes of patients during the winter period there was significant pressure on the Macclesfield ED and the trust has redeployed staff to where the greatest clinical need has been.

This has, on a number of occasions, led to the nurse at Congleton becoming part of the staffing rostered at the Macclesfield ED leading to the closure of the Unit.

This has been done on a day by day basis in an attempt to provide as much service as possible to Congleton.

This has led to confusion for some members of the public about when the unit is open or closed. The trust has tried to ensure it communicates with partners and the public (via the website) on a daily basis. Action taken included:

- Highlighting the closure on the Trust’s website
- Informing NHS 111 so they could divert patients to other solutions
- Informing the CCG
- Ensuring other internal departments were aware so they could also advise patients

The NHS Choices website cannot be changed at short notice so a message was posted to ask patients to check the trust website before setting off for the MIU.

The trust did consider closing the facility for a definite period of time but on balance, it was believed better to try to staff the unit when able.

The table below shows the number of days the unit has been closed by month over the last 6 months:

<table>
<thead>
<tr>
<th>Month</th>
<th>Days Open</th>
<th>% Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>16</td>
<td>41.9%</td>
</tr>
<tr>
<td>April</td>
<td>20</td>
<td>33.3%</td>
</tr>
<tr>
<td>March</td>
<td>12</td>
<td>61.3%</td>
</tr>
<tr>
<td>February</td>
<td>13</td>
<td>53.6%</td>
</tr>
<tr>
<td>January</td>
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<td>93.5%</td>
</tr>
<tr>
<td>December</td>
<td>11</td>
<td>64.5%</td>
</tr>
<tr>
<td>November</td>
<td>19</td>
<td>36.7%</td>
</tr>
</tbody>
</table>
The position at the current time is leading to weekend closures as the nurse is being routinely employed at the Macclesfield site.

4 Urgent Treatment Centres – Principles and Standards

There is a national review of urgent care services with a required specification of service standards for the provision of facilities

4.1 NHSE published a document in July 2017 entitled Urgent Treatment Centres – Principles and Standards. Eastern Cheshire Clinical Commissioning Group will be expected to respond to this which will include the Congleton MIU.

It has already been agreed with NHS England that the Congleton MIU, would not comply with the required standards to become a wave 1 or wave 2 Urgent Care Treatment Centre. A decision on all remaining sites that will become Urgent Care Treatment Centres must be made by December 2019. Eastern Cheshire Clinical Commissioning Group will produce a formal response to this publication including its impact on the Congleton MIU in the Autumn of 2018. The review will also include the expected benefits of the new extend hours primary care which will be implemented by October 2018.

The trust will work alongside the CCG to agree how this is delivered in the future and further dialogue with Health and Adult Social Care and Communities Overview and Scrutiny Committee will take place in the coming months.

5 SUMMARY

5.1 The OSC are asked to note that the pressure on the ED at Macclesfield required the redeployment of Nursing Staff from Congleton to Macclesfield in line with activity volumes and staffing requirements.

The availability of the unit has improved since January.

Continued staff challenges during the weekends in Macclesfield is leading to the routine closure of the MIU at the weekends and this is expected to continue.

The trust wished to maintain the Congleton service when possible but this has led to intermittent closure of the MIU made at short notice; this has caused concern for patients especially those who have arrived at the facility to find it closed.

Sign Off

John Wilbraham
Chief Executive
Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

May 2018
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Introduction

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led trust.

This guide sets out our expectations of boards in relation to Freedom to Speak Up (FTSU). Meeting the expectations set out in this guide will help a board to create a culture responsive to feedback and focused on learning and continual improvement.

This guide is accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to FTSU will help boards to identify areas of development and improve.

The Care Quality Commission (CQC) assesses a trust’s speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with inspectors as part of the CQC’s assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the trust’s speaking up culture is.
About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian’s Office and represents current good practice.

We want boards to treat this guide as a benchmark; review where they are against it and reflect on what they need to do to improve. We expect that the board, and in particular the executive and non-executive leads for FTSU, will complete the review with proportionate support from the trust’s FTSU Guardian.

The good practice highlighted here is not a checklist: a mechanical ‘tick box’ approach to each item is not likely to lead to better performance.

The attitude of senior leaders to the review process, the connections they make between speaking up and improved patient safety and staff experience, and their judgements about what needs to be done to continually improve, are much more important.

Key terms used in this guide

- **The board**: we use this term when we mean the board as a formal body.

- **Senior leaders**: we use this term when we mean executive and non-executive directors.

- **Workers**: we use this term to mean everyone in the organisation including agency workers, temporary workers, students, volunteers and governors.

We will review this guide in a year. In the meantime, please provide any feedback to enquiries@improvement.nhs.uk
Our expectations

Leaders are knowledgeable about FTSU

Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian’s Office. Senior leaders can readily articulate the trust’s FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. Senior leaders can describe the part they played in creating and launching the trust’s FTSU vision and strategy.

Leaders have a structured approach to FTSU

There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement. There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian). It aligns with existing guidance from the National Guardian. Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.

Leaders actively shape the speaking up culture

All senior leaders take an interest in the trust’s speaking up culture and are proactive in developing ideas and initiatives to support speaking up. They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian. Senior leaders model speaking up by acknowledging mistakes and making improvements. The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.
Leaders are clear about their role and responsibilities

The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility. They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support. Other senior leaders support the FTSU Guardian as required. For more information see page 8 below.

Leaders are confident that wider concerns are identified and managed

Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.

Leaders receive assurance in a variety of forms

The executive lead for FTSU provides the board with a variety of reliable, independent and integrated information that gives the board assurance that:

- workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process
- steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers
- speak up issues that raise immediate patient safety concerns are quickly escalated
- action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority
- lessons learnt are shared widely both within relevant service areas and across the trust
- the handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented
- FTSU policies and procedures are reviewed and improved using feedback from workers.
In addition the board receives a report, at least every six months, from the FTSU Guardian. For more information see page 11 below. Boards should consider inviting workers who speak up to present their experience in person.

Leaders engage with all relevant stakeholders

A diverse range of workers’ views are sought, heard and acted on to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.

The organisation is open and transparent about speaking up internally and externally. Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals). The trust’s annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. Reviews and audits are shared externally to support improvement elsewhere.

Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust’s speaking up culture. Likewise, senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians. Senior leaders request external improvement support when required.

Leaders are focused on learning and continual improvement

Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers’ experience. Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn’t; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.

The FTSU policy and process are reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. A sample of cases is audited to ensure that:

- the investigation process is of high quality; outcomes and recommendations are reasonable and the impact of change is being measured
- workers are thanked for speaking up, are kept up to date throughout the investigation and are told of the outcome
- investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored.

Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. This is demonstrated in organisational data and audit.
Individual responsibilities

Chief executive and chair

The chief executive is responsible for appointing the FTSU Guardian and is ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. The chief executive and chair are responsible for ensuring the annual report contains information about FTSU and that the trust is engaged with both the regional Guardian network and the National Guardian’s Office.

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.

Executive lead for FTSU

The executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian’s Office
- overseeing the creation of the FTSU vision and strategy
- ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- ensuring that the FTSU Guardian has a suitable amount of ringfenced time and other resources and there is cover for planned and unplanned absence.
- ensuring that a sample of speaking up cases have been quality assured
- conducting an annual review of the strategy, policy and process
- operationalising the learning derived from speaking up issues
- ensuring allegations of detriment are promptly and fairly investigated and acted on
- providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.
Non-executive lead for FTSU

The non-executive lead is responsible for:

• ensuring they are aware of latest guidance from National Guardian’s Office
• holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy. Where necessary, they should robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement
• role-modelling high standards of conduct around FTSU
• acting as an alternative source of advice and support for the FTSU Guardian
• overseeing speaking up concerns regarding board members – see below.

We appreciate the challenges associated with investigating issues raised about board members, particularly around confidentiality and objectivity. This is why the role of the designated non-executive director is so important. In these circumstances, we would expect the non-executive director to take the lead in determining whether:

• sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and
• if so, whether an investigation is proportionate and what the terms of reference should be.

Depending on the circumstances, it may be appropriate for the non-executive director to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive director does take the lead, they should inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive director should inform NHS Improvement and CQC that they are overseeing an investigation into a board member. NHS Improvement and CQC can then provide them with support and advice. The trust would need to think about how to enable a non-executive director to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the
confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Human resource and organisational development directors

The human resource (HR) and/or organisational development (OD) directors are responsible for:

- ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up
- ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers’ experience is disseminated across the trust
- ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.

Medical director and director of nursing

The medical director and director of nursing are responsible for:

- ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues
- ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up
- ensuring learning is operationalised within the teams and departments they oversee.
FTSU Guardian reports

Reports are submitted frequently enough to enable the board to maintain a good oversight of FTSU matters and issues, and no less than every six months. Reports are presented by the FTSU Guardian or a member of the trust’s local Guardian network in person.

Reports include both quantitative and qualitative information and case studies or other information that will enable the board to fully engage with FTSU in their organisation and to understand the issues being identified, areas for improvement, and take informed decisions about action.

Data and other intelligence are presented in a way that maintains the confidentiality of individuals who speak up.

Board reports on FTSU could include:

**Assessment of issues**
- information on what the trust has learnt and what improvements have been made as a result of trust workers speaking up
- information on the number and types of cases being dealt with by the FTSU Guardian and their local network
- an analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of concern, particular groups of workers who speak up, areas in the organisation where issues are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up (professional background, protected characteristics)

**Potential patient safety or workers experience issues**
- information on how FTSU matters relate to patient safety and the experience of workers, triangulating data as appropriate, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built
Action taken to improve FTSU culture

- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of action taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up
- details of any assessment of the effectiveness of the speaking up process and the handling of individual cases
- information on any instances where people who have spoken up may have suffered detriment and recommendations for improvement
- information on actions taken to improve the skills, knowledge and capability of workers to speak up and to support others to speak up and respond to the issues they raise effectively

Learning and improvement

- feedback received by FTSU Guardians from people speaking up and action that will be taken in response
- updates on any broader developments in FTSU, learning from case reviews, guidance and best practice

Recommendations

- suggestions of any priority action needed.
Resources


NHS Improvement (2017): Creating a vision https://improvement.nhs.uk/resources/creating-vision/


Our Ref: jw/ltrs/ECCCG/Hawker/2018/04

30th May 2018

Mr Jerry Hawker
Chief Officer
ECCCG

Dear Jerry

Re: Consultation on the proposed redesign of specialist mental health services for adults and older people experiencing severe or mental ill-health across community and hospital care settings

Thank you for the opportunity to comment on the above consultation.

The trust has reviewed the consultation document and as a key partner within the transformation programme understands the context in which service redesign is being considered. The strategy of care out of hospital where appropriate, is consistent with the strategy of the trust and our partners in East Cheshire. In this regard the development of a new dementia outreach service to support patients remain in their homes is welcomed and the trust acknowledges the importance of supporting patients at home.

The need for clinical and financial sustainability is also understood and aligns to work being undertaken by ECT.

There are some areas where the Board seek further assurance as you consider responses to the consultation. In the main these focus on ensuring that any changes following consultation do not have any adverse impact on the timeliness of care for patients whilst in our care. I believe we would all agree once the physical ailments of patients has been resolved the Emergency Department is not the best place for mental health patients to wait for ongoing care. These patients when in the department do attract ED nursing resource which impacts on the ability to provide treatment to other patients and their conditions can be distressing for other patients to observe.

The clinicians at the trust would seek clarity on how the 24 hour local crisis care service will prevent ED attendances as there is concern that patients could bypass
this system and simply attend ED. Is there evidence from other areas where this service exists that demonstrates a reduction of attendances?

In similar vein the current psychiatric liaison service within ED is an important part of the care pathway in ensuring timely care is provided to patients. The trust seeks confirmation that there will be no erosion of this service and indeed discussions are required to ensure that we have a consistent service each and every day.

You will be aware that the ED at Macclesfield is a place of safety under the 1983 Mental Health Act which is not the case at Leighton Hospital. Should the police continue to designate the Macclesfield ED as a place of safety the trust needs clarity about how responsive mental health services will be to ensure patients are in the department for the shortest time possible?

Further assurance is required on patients who are within ED who subsequently need admission to an in-patient bed in a remote location. The trust will require assurances that the transport for these patients will be consistent with the waiting time standard within ED and that there will be no requirement for ECT staff to travel with patients.

From a financial perspective there are two issues for the Board; firstly should the consultation result in the refurbishment of Millbrook at a cost of £7m, the trust seeks clarity that as the owner of the building there will be no requirement for the trust to fund the capital resources and would welcome an understanding of how capital funding would be secured.

Likewise should the consultation result in the closure of the Millbrook Unit the trust is seeking confirmation that under the capped expenditure programme the negative financial impact on the trust will be neutralised.

Whilst the consultation will be closed by the time the ECT Board next meets in public (7th June) these issues will be discussed at the meeting.

I trust these comments are clear and helpful but if there is anything further you require please feel free to contact me.

Yours sincerely

John Wilbraham
Chief Executive

Cc: mlcsu.consultation@nhs.net
<table>
<thead>
<tr>
<th>Report of:</th>
<th>Director of Finance</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Mark Cusworth - Senior Financial Accountant</td>
</tr>
<tr>
<td>Subject/Title</td>
<td>2018/19 Capital Programme and Principles</td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>To set out the key principles which have been used to develop the 2018/19 capital programme for the Trust.</td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>Note the principles and process used in determining the 2018/19 capital programme. Approve the capital programme for 2018/19, and high level five year plan. Delegate approval of any further changes to the 2018/19 capital programme to the Director of Finance and the Capital and Space Planning Group.</td>
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<td>Mitigates Risk Number:</td>
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<tr>
<td>Risk 587</td>
<td>If the Trust is not able to operate within the agreed financial envelope then there is a risk of non-delivery of the Trust financial and non-financial targets and objectives.</td>
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<tr>
<td>Mitigates Risk Number:</td>
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<tr>
<td>Risk 39</td>
<td>If the Trust cannot identify a clinically and financially sustainable business model, the trust will fail to remain an independently viable proposition</td>
</tr>
<tr>
<td>Link to Care Quality Commission Domain</td>
<td>Well-led</td>
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<tr>
<td>Link to:</td>
<td>Trust’s Strategic Direction, Corporate Objectives</td>
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<tr>
<td>➢</td>
<td>Continuously improve quality, safety and the patient experience</td>
</tr>
<tr>
<td>➢</td>
<td>Achieve financial sustainability</td>
</tr>
<tr>
<td>➢</td>
<td>Working with our partners to provide an integrated health service for our local population</td>
</tr>
<tr>
<td>➢</td>
<td>Encouraging staff to be innovative when delivering and planning services</td>
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<tr>
<td>Legal implications</td>
<td>The proposed schemes include work that is statutory and mandatory.</td>
</tr>
<tr>
<td>Impact on quality</td>
<td>A risk based assessment is used in prioritising which schemes are approved.</td>
</tr>
<tr>
<td>Resource impact</td>
<td>The delivery of operational (and therefore financial plans) requires adequate and appropriate resources.</td>
</tr>
<tr>
<td>Impact of equality/diversity</td>
<td>Potential impact dependent on the scheme. This is considered as part of the risk based assessment.</td>
</tr>
<tr>
<td>Avoid acronyms or abbreviations - if necessary list:</td>
<td>CRL Capital Resource Limit, MES Managed Equipment Service, STF Strategic Transformation Fund, PDC Public Dividend Capital, CMB Clinical Management Board, OMT Operational Management Team</td>
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</table>
2018/19 Capital Programme and Principles

This paper sets out the key principles which have been used to develop the 2018/19 capital programme for East Cheshire NHS Trust ("the Trust"). The Board is asked to approve the 2018/19 capital programme.

1 INTRODUCTION

1.1 This paper sets out the key principles which have been used to develop the 2018/19 capital programme for East Cheshire NHS Trust ("the trust").

2 CAPITAL RESOURCES FOR 2018/19

2.1 The trust's capital programme is funded by internally generated resources. The trust submitted its plan to NHS Improvement in April which included a CRL (Capital Resource Limit – i.e. the amount it can spend) of £4,349k. A request to spend some of the ‘cash generated’ for the improvement made on the financial control target has been made. Formal notification of the trust’s CRL for 2018/19 has not yet been received.

2.2 The trust’s CRL consists of:

<table>
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<tr>
<th>Description</th>
<th>£'000</th>
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</thead>
<tbody>
<tr>
<td>Internally generated resources (i.e. depreciation)</td>
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<tr>
<td>Radiology MES – to be funded by finance lease</td>
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<tr>
<td>Capital resource limit submitted in 2018/19 plan</td>
<td>4,349</td>
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Note: The trust’s planned internally generated capital resource through depreciation for 2018/19 is £3,397k. However, the current Radiology MES scheme, which is funded through a finance lease utilises £448k of this resource, leaving £2,949k available to fund 2018/19 capital schemes (as detailed above).

3 KEY PRINCIPLES IN DETERMINING THE 2018/19 CAPITAL PROGRAMME

3.1 The capital programme aims to utilise the full amount of capital available in a given year and allocates funding for:

- Estates maintenance and infrastructure
- Accommodation issues
- Information Technology infrastructure
- Medical equipment priorities

3.2 All potential capital schemes are risk assessed and because of the level of funding available those assessed at a level 16 or above are prioritised. Once a scheme or item has been risk assessed and determined a priority for the trust to progress, the trust then undertake an
evaluation of the funding options to identify whether it is most economic to purchase it through the capital programme, lease or consider a Managed Equipment Service (MES). Generally this will result in it being a capital purchase.

4 MANAGEMENT OF THE 2018/19 CAPITAL PROGRAMME

4.1 The trust’s Capital and Space Planning Committee is a sub-committee of the Clinical Management Board and oversees the capital programme. It is chaired by the Director of Finance and has representation from both clinical and corporate departments. A sub-group, the Space Utilisation Group, meets bi-monthly to review accommodation issues and consider how best to make use of the space at the trust’s disposal. The outcomes are reported to the Capital and Space Planning Committee.

4.2 Each of the key areas identified in Section 3 is led by a senior member of staff. These are:

<table>
<thead>
<tr>
<th>Area</th>
<th>Responsible Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates</td>
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<td>Accommodation</td>
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<tr>
<td>IT</td>
<td>Head of Informatics</td>
</tr>
<tr>
<td>Equipment</td>
<td>Deputy Director of Operations</td>
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</table>

4.3 The plan for equipment is developed with Heads of Service through the Operational Management Team.

4.4 The plan at the start of the year utilises the full allocation and no contingency fund is created. Inevitably schemes/plans are delayed or fall behind, while other risks emerge in the year such as equipment failure or emergency estates work. This requires some re-prioritisation within the year and this is managed through the Capital and Space Planning Committee within the overall capital envelope. This will be reported to the Board through the Finance, Performance and Workforce Committee paper via quarterly updates.

5 2018/19 CAPITAL SCHEMES BY AREA

5.1 Estates

5.1.1 As usual the focus is on maintaining the fabric and safety of the main hospital site. All efforts are being made to programme the work in the first two quarters of the year and not undertake work which impacts on bed capacity during the December to March period.

The main improvement scheme is a £500k investment in refurbishing two of the main theatres. This requires detailed planning to ensure capacity loss is minimised but the trust will need to engage with clinicians and operational managers to achieve some flexibility to ensure overall activity and waiting levels are maintained as waiting list initiatives aren’t an option in 2018/19.

5.2 Accommodation

5.2.1 A separate capital budget will also be included for site accommodation in addition to the capital for Estates infrastructure mentioned above.

This budget will address any accommodation alterations/improvements which arise during the financial year, with the budget being allocated on a risk assessment basis. Accommodation request forms will be submitted by service lines to the monthly Space Utilisation Group (SUG) for further consideration/prioritisation. Bids approved by the
SUG will then be tabled as part of the monthly SUG update at the Capital and Space meetings.

5.3 IT

And investment in IT remains a key priority

5.3.1 The focus this financial year continues to be to ensure the organisation has fit for purpose, robust and secure IT in place, so investment is going into replacing end of life kit as well as providing additional kit in places that need it. The two big schemes are to replace the end of life core switch infrastructure which allows all staff to access the network and its applications; to replace the end of life network switches and firewall ensuring protection for the trust against cyber incidents. The remaining schemes are to provide new replacement PCs or tablet devices where most needed.

5.4 Medical Equipment

OMT prioritises medical equipment expenditure

5.4.1 Operational equipment is prioritised via risk assessment by the senior operational teams and OMT on an annual basis; with review in year to ensure emerging risks are accounted for. In this financial year the prioritised spend has focussed on two cross trust schemes. Firstly the replacement of defibrillators, the existing equipment cannot be supported and Medical Engineering have confirmed that they are unable to repair the existing units as parts are no longer available. Secondly the giving sets for the Infusion pumps will not be available from April 2019 and therefore replacement of trust infusion pumps and syringe drivers is required. The anticipated roll out programme is 6 months, with lead time of 12 - 16 weeks for the pump acquisition. A third priority is to complete the replacement programme of ECG machines, four units were approved for purchase in 2017/18, with the purchase of two units deferred until 2018/19. There is a small residual capital allocation for equipment for which the remaining purchasing priorities will be confirmed shortly.

It should be noted that there is currently a contingency of £80k to be allocated to the areas. This allocation will be discussed and agreed at the Capital and Space Planning meeting during the course of the year.

5.5 Proposed 2018/19 Capital Plan

The managers responsible for each area prioritise and risk rate their planned schemes and it is proposed that the 2018/19 capital plan is allocated as follows:
6  FIVE YEAR PLAN SUMMARY

6.1 In the submission of the plan to NHS Improvement, the trust submitted a high level five year capital plan. This is detailed below.

<table>
<thead>
<tr>
<th></th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
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<td>732</td>
<td>717</td>
<td>702</td>
<td>685</td>
<td>3,636</td>
</tr>
<tr>
<td>Equipment</td>
<td>600</td>
<td>513</td>
<td>498</td>
<td>483</td>
<td>466</td>
<td>2,560</td>
</tr>
<tr>
<td>Other</td>
<td>225</td>
<td>145</td>
<td>145</td>
<td>145</td>
<td>145</td>
<td>805</td>
</tr>
<tr>
<td>Total</td>
<td>2,949</td>
<td>2,645</td>
<td>2,599</td>
<td>2,556</td>
<td>2,505</td>
<td>12,045</td>
</tr>
</tbody>
</table>
6.2 Note: The 2018/19 split is based on the proposed capital plan detailed in Section 5.1.

The table above shows the constraints that the trust will experience over the next five years on capital resources and highlights the need for detailed risk assessments for each proposed project to ensure that the expenditure is being allocated to those areas with the highest risk.

7 FURTHER EXTERNALLY FUNDED CAPITAL OPPORTUNITIES

7.1 The commentary above describes how we will spend the capital for which we have local discretion. During the course of the year, opportunities may arise which the trust could bid for. During 2017/18 for example, the trust received £1,475k of Public Dividend Capital (PDC) to fund capital expenditure which comprises; £879k to enable the creation of primary care streaming services, £570k cyber security and £26k cancer transformation fund. The trust is also discussing with NHS Improvement the potential to utilise some of the cash generated from the improvements the trust has made over the last two years against its financial control target.

8 RECOMMENDATION

8.1 • Note the principles and process used in determining the 2018/19 capital programme

Mark Ogden
Director of Finance
May 2018
<table>
<thead>
<tr>
<th>Report of:</th>
<th>Medical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Officer:</td>
<td>Dr John Hunter, Medical Director</td>
</tr>
<tr>
<td>Accountable Officer:</td>
<td>Andy Chambers, Head of Safety and Risk</td>
</tr>
<tr>
<td>Author of Report:</td>
<td>Dr John Hunter, Medical Director</td>
</tr>
<tr>
<td>Subject&gt;Title</td>
<td>Learning from Deaths – Quarterly Mortality Report (Quarter 4)</td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
<td>N/A</td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>To assure the Board that the trust is learning from deaths and using that learning to support quality improvement</td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>To note the contents of the report</td>
</tr>
<tr>
<td>Mitigates Risk Number:</td>
<td>BAF 2.</td>
</tr>
<tr>
<td>On Corporate Risk Register</td>
<td>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.</td>
</tr>
<tr>
<td>Mitigates Risk Number:</td>
<td>(identify)</td>
</tr>
<tr>
<td>On Assurance Framework</td>
<td>(identify)</td>
</tr>
<tr>
<td>Link to Care Quality Commission Domain</td>
<td>Choose one of the following:</td>
</tr>
<tr>
<td></td>
<td>• Safe</td>
</tr>
<tr>
<td></td>
<td>• Caring</td>
</tr>
<tr>
<td></td>
<td>• Effective</td>
</tr>
<tr>
<td></td>
<td>• Responsive</td>
</tr>
<tr>
<td></td>
<td>• Well led</td>
</tr>
<tr>
<td>Link to:</td>
<td>To ensure our patients receive the best care in the right place</td>
</tr>
<tr>
<td></td>
<td>• Commit to quality of care</td>
</tr>
<tr>
<td></td>
<td>• Improve lives</td>
</tr>
<tr>
<td>Legal implications</td>
<td>None</td>
</tr>
<tr>
<td>Impact on quality</td>
<td>None</td>
</tr>
<tr>
<td>Resource impact</td>
<td>None</td>
</tr>
<tr>
<td>Impact of equality/diversity</td>
<td>None</td>
</tr>
<tr>
<td>Avoid acronyms or abbreviations - if necessary list:</td>
<td>SMR Standardised Mortality Ratio</td>
</tr>
<tr>
<td></td>
<td>RAMI Risk Adjusted Mortality Index</td>
</tr>
<tr>
<td></td>
<td>SHMI Summary Hospital Mortality Index</td>
</tr>
<tr>
<td></td>
<td>SBAR Situation, Background, Assessment, Recommendations</td>
</tr>
<tr>
<td></td>
<td>RCA Root Cause Analysis</td>
</tr>
<tr>
<td></td>
<td>LeDeR Learning Disabilities Mortality Review</td>
</tr>
</tbody>
</table>
Learning from Deaths – Quarterly Mortality Report
(Quarter 4)

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

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

1 INTRODUCTION

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

2 CONTEXT

It is now recognised that the review of mortality statistics can give an indication of quality and safety.

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

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

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

There are lessons to be learned from the review of deaths in respect of care delivery, treatment outcomes and local variables in care organisations and patient pathways.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 MORTALITY DASHBOARD FOR QUARTER

3.1 Refer to Appendix 1.

3.2 During Quarter 4, 237 patients died at the trust. There was a marked increase in mortality at the trust in Quarter 4. During the first three quarters there was an average of 52 in-patient deaths per month compared with an average of 73 per month in Quarter 4. This increase in mortality in early 2018 has been observed nationally. 101 deaths underwent a two stage retrospective case record review; no deaths were thought to have been avoidable.

3.3 2 patients with learning disabilities died at the trust during Quarter 4. The 2 deaths were reviewed using the LeDeR methodology and were found to be unavoidable.

3.4 One death was reported under the serious incident framework and is under investigation.

3.5 The average crude mortality for Quarter 4 was 2.54%.
3.6 The standardised mortality ratios for the quarter are as follows:
- Summary hospital mortality index - 1.04 (as expected range)
- Risk adjusted mortality index (RAMI) – 100.53

4 OUTCOMES OF REVIEWS

4.1 Positive:
- All deaths of patients with learning disabilities thoroughly reviewed using the LeDER methodology.
- No deaths were identified as avoidable.
- A review of deaths for patients in the diagnostic group ‘acute cerebrovascular disease’ was performed after an increase in mortality for this group of patients was noted by the Mortality Governance Sub-Committee. The investigation concluded that no death was avoidable. A significant number of the deaths were in patients admitted after having suffered a severe cerebro-vascular accident with low conscious levels and a poor prognosis; factors which usually preclude transfer to a neurosurgical or stroke unit.
- A concise review of patients dying with ‘acute or non-specific renal failure’ did not reveal any specific issues.

4.2 Improvements required:
- Accuracy of coding could be improved with more robust note keeping.
- Gaps in clinical documentation often preclude assessment of whether care bundles, e.g. sepsis, are being followed appropriately.
- Inconsistent use of the end of life care plans.

5 ACTIONS UNDERWAY IN RESPONSE TO LEARNING

A number of actions are underway to improve the management of seriously unwell patients at the trust.

5.1 Although not specifically identified as an issue in mortality reviews we know that overcrowding in the Accident and Emergency Department has the potential to increase mortality. To improve patient flow and prevent exit block from A&E we have been heavily promoting and embedding the SAFER initiative over the last quarter to reduce delays for our patients. The five elements of the SAFER patient flow bundle are:
- S – Senior review
- A – All patients will have an estimated discharge date
- F – Flow of patients will commence at the earliest opportunity
- E – Early discharge from the ward
- R – Review of patients with length of stay > 7 days

5.2 A vital sign recording system (VitalPac®) is now fully embedded at the trust and alerts appropriate staff when a National Early Warning score is exceeded. This supports the early identification and management of the deteriorating patient.

5.3 Patients at risk of deteriorating are regularly supported and reviewed by skilled critical care outreach practitioners.

5.4 A sepsis e-learning package has been developed by the sepsis group to assist clinicians to identify and manage the septic patient.
6 SUMMARY

A significant number of deaths undergo case record review, the purpose of which is to identify problems with the quality of care so that common themes and trends can be identified. This assists with focusing quality improvement initiatives.

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

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

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

7 RECOMMENDATION

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

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

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

<table>
<thead>
<tr>
<th>Time Series: Start Date 2011-10 GT</th>
<th>End Date 2016-12 GT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)</td>
<td></td>
</tr>
<tr>
<td>Total Number of Deaths in Scope</td>
<td>Total Deaths Reviewed</td>
</tr>
<tr>
<td>This Month</td>
<td>Last Month</td>
</tr>
<tr>
<td>53</td>
<td>53</td>
</tr>
<tr>
<td>This Quarter (Q1)</td>
<td>Last Quarter</td>
</tr>
<tr>
<td>63</td>
<td>200</td>
</tr>
<tr>
<td>This Year (YTD)</td>
<td>Last Year</td>
</tr>
<tr>
<td>63</td>
<td>0</td>
</tr>
</tbody>
</table>

Total Deaths Reviewed by RCP Methodology Score

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Definitely avoidable</th>
<th>Score 2</th>
<th>Strong evidence of avoidability</th>
<th>Score 3</th>
<th>Probably avoidable (more than 50%)</th>
<th>Score 4</th>
<th>Probably avoidable but not very likely</th>
<th>Score 5</th>
<th>Slight evidence of avoidability</th>
<th>Score 6</th>
<th>Definitely not avoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Month</td>
<td>0</td>
<td>-</td>
<td>This Month</td>
<td>0</td>
<td>-</td>
<td>This Month</td>
<td>0</td>
<td>-</td>
<td>This Month</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>This Quarter (Q1)</td>
<td>0</td>
<td>6.0%</td>
<td>This Quarter (Q1)</td>
<td>0</td>
<td>0.0%</td>
<td>This Quarter (QTD)</td>
<td>0</td>
<td>0.0%</td>
<td>This Quarter (QTD)</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>This Year (YTD)</td>
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<td>6.0%</td>
<td>This Year (YTD)</td>
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<td>0.2%</td>
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<td>This Year (YTD)</td>
<td>1</td>
<td>6.2%</td>
</tr>
<tr>
<td>Score 7</td>
<td>Definitely not avoidable</td>
<td>Score 8</td>
<td>Slight evidence of avoidability</td>
<td>Score 9</td>
<td>Probably avoidable but not very likely</td>
<td>Score 10</td>
<td>Strong evidence of avoidability</td>
<td></td>
<td></td>
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<tr>
<td>This Month</td>
<td>0</td>
<td>-</td>
<td>This Month</td>
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<td>This Month</td>
<td>0</td>
<td>-</td>
<td></td>
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</tr>
<tr>
<td>This Quarter (Q1)</td>
<td>0</td>
<td>6.0%</td>
<td>This Quarter (Q1)</td>
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<td>0.0%</td>
<td>This Quarter (QTD)</td>
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</tr>
<tr>
<td>This Year (YTD)</td>
<td>0</td>
<td>6.0%</td>
<td>This Year (YTD)</td>
<td>1</td>
<td>0.2%</td>
<td>This Year (YTD)</td>
<td>0</td>
<td>0.0%</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Time Series: Start Date 2011-10 GT</th>
<th>End Date 2016-12 GT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities</td>
<td></td>
</tr>
<tr>
<td>Total Number of Deaths in Scope</td>
<td>Total Deaths Reviewed</td>
</tr>
<tr>
<td>This Month</td>
<td>Last Month</td>
</tr>
<tr>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>This Quarter (Q1)</td>
<td>Last Quarter</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>This Year (YTD)</td>
<td>Last Year</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>
Our Ref:  LM/FB/Meetings01/TB/Agenda

Date:  07th 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 5th July 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 – July 2018 AGENDA

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

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>- Declared interest agenda</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Hospitality and Gifts Register Declaration</td>
<td></td>
<td></td>
<td></td>
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</tr>
<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>
</tr>
<tr>
<td>6. Action Log</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>7. Verbal update:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SQS</td>
<td>Ms A Harrison</td>
<td>15 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>FP&amp;W</td>
<td>Mr M Wildig</td>
<td></td>
<td>(supported by formal minutes when available)</td>
<td></td>
</tr>
</tbody>
</table>

## STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Chief Executive’s Commentary</td>
<td>Chief Executive</td>
<td>40 mins</td>
<td>TB 18 (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>
</tr>
</tbody>
</table>

## ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Public Trust Board Agenda – September 18</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>
</tr>
</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>
</tbody>
</table>
| 15. Safer Staffing Exception Report     | TB 18 (57) | For assurance           | PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience
STAFF - Empower, develop and value staff in providing innovative patient focused care |
| 17. Minutes of the committees of the Board: | TB 18 (58) | Information             |                               |
| SQS – June 18                           | TB 18 (59) |                         |                               |
| FP&W – June 18                          | TB 18 (60) |                         |                               |

Date and Time of Next Meeting:

Date: Thursday 6th September 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 May 2018 that form part of the network and relationship development which support the Trust and its ambassadors in achieving its vision and corporate objectives. It is not intended as an exhaustive summary.

## Action/Decision required
To note

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

## Link to:
- **Trust’s Strategic Direction**
  - 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
- CEC Cheshire East Council
- CCG Clinical Commissioning Group
- ECT East Cheshire NHS Trust
- CHKS Capita Knowledge Healthcare Systems
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.

1.1

Recognised as one of the Top 40 Hospitals for the 8th time in as many years

CHKS* Healthcare National Awards

I travelled to London on Wednesday 15th May 2018 to join peers in recognition of outstanding performance for provider trusts.

This year’s competition increased with wider inclusion across England, Wales and Northern Ireland, where previously this had included only English providers.

The top 40 Hospital awards reflect performance across 22 indicators in clinical effectiveness, health outcomes, efficiency, patient experience and quality of care, all of which makes for great patient care and experience.

As most improved hospital within the Top 40, East Cheshire NHS Trust has demonstrated it is able to hold its own in a difficult climate, whilst focusing on what it does best for patients.

Congratulations to a great team trust wide.

*Capita Knowledge Healthcare Systems
2.1 **NHS Providers**

As part of the membership body represented by NHS Providers, the trust was approached for a ballot of members to represent specific provider services, including election to the Acute and Community Network Board.

Members may be interested to note that on behalf of the Board, I have made a decision and returned a completed Ballot to meet the timescale for voting.

2.2 **Mayor's Prayer Breakfast**

Attending morning prayer on Friday 11th May was a meaningful way to stay in touch with our local communities, represented on the day with a breadth of volunteer organisations making a huge impact on homelessness, supporting teenagers, those with dependencies at difficult moments in their lives, together with how our spiritual community works together. This was a time for reflection and celebration.

It is this celebration that has served to aid the trust to find new and different ways of supporting our local community. In recent years we have developed relationships with many of these local organisations. Following this heartfelt event, I hope to see opportunities for refugees realised through either apprenticeships or volunteer links.

3 **Cheshire East Partnership Board**

The Programme Board met on Wednesday 2nd May 2018 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 more focused and progressive.

For regular updates, please continue to see [http://www.caringtogether.info](http://www.caringtogether.info)

In support of strong partnership relationships I continue to meet informally with the Eastern Cheshire CCG Chair; this took place on Thursday 24th May 2018. I also meet informally on occasion with the Chair of South Cheshire CCG and did so on 1st May 2018.
We celebrate our Healthcare Assistants & their significant contribution

3.1 Healthcare Assistant Open Event
I was pleased to attend the open event on Tuesday 1st May 2018 which showcased both the resources available to support our Healthcare Assistants and the impact they have on the patient care and experience we provide. The event attracted the highest attendance at such an event and enjoyed by all who came.

Shared learning on an international footprint for better Patient Care

3.2 Celebrating International Midwives Day
Celebrating International Midwives day early, I was pleased to join our Director of Nursing, Performance and Quality in judging a cake bake of topical inventive design. The more serious side of the celebrations saw midwives around the world recognising achievements and support for women across the globe and connecting this locally, with enthusiastic and capable teams; this was evidenced recently by the CQC review of maternity services across England reflecting our strong performance as one of the four best performing against standards nationally.

Public engagement and support, ‘self-help’ and prevention

3.3 Health Matters
These events have been developed and have run for many years with the intention of sharing both how treatments are provided and how we as individuals can self-help, recognise early signs so we might take preventative action wherever possible.

This month’s Health Matters on Tuesday 1st May 2018 focused on ‘Recent advances in knee surgery’, led by one of our consultant orthopaedic and lower limb surgeons: https://www.youtube.com/watch?v=drmpMCWxMhY

Our Volunteers continue to add real value for patients and staff

3.4 A Huge Thank You to our Volunteers
In recognition of the importance and value the trust places on the contribution made by our increasing numbers of volunteers, I was delighted alongside executive colleagues to celebrate over afternoon tea. Also evident was the growing diversity of our volunteer teams.

The highlight of the afternoon is a free raffle, with gifts donated by the leadership team and members of staff; so many gifts and a genuine testament to the impact of our volunteering team.

Thank you to all those involved in making this event such a success and to all whom volunteer.
Trust Board Business

It was a pleasure to meet with our new Insight Placement whom joined us at the start of May 2018. She will be with us until the end of August and use this time to broaden her understanding of the role of a non-executive director.

The Programme is designed to support and develop aspiring non-executive directors from a broader representative of our population.

The Trust Board Delivers as Planned

As planned. There have been no changes.

Board Development

As planned, with an emphasis on how the NHS has made difficult decisions in the past, together with our priorities through communications.

Lynn McGill
Chairman
## Agenda Item Number 13: TB 18 (45)

**Report of:**

**Responsible Officer:** Kath Senior  
Director of Nursing, Performance and Quality  
Director of Infection Prevention and Control  

**Accountable Officer:**  
Kath Senior  
Director of Infection Prevention and Control  

**Author of Report:** Anita Swaine  
Head of Nursing Infection Prevention and Control  

**Subject/Title**  
Infection Prevention and Control Annual Trust Report  

**Background papers (if relevant)**  
None  

**Purpose of Paper**  
To provide Trust board members with assurance across a range of infection Prevention and Control areas supporting the delivery of the Trust objectives.  

**Action/Decision required**  
To note the contents of the Infection Prevention and Control Annual Trust Report and assurance provided.  

**Mitigates Risk Number: (identify)**  
On Corporate Risk Register  
BAF 2: If the quality of services provided is not at the required standard then there is a risk that the trust may fail to safeguarding 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  

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

**Link to Care Quality Commission Domain**  
Safe  
Responsive  
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)**  
None  

**Impact on quality**  
This report provides assurance in relation to key quality Infection Prevention and Control issues.  

**Resource impact**  
None  

**Impact of equality/diversity**  
None
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CDI</td>
<td>Clostridium difficile Infection</td>
</tr>
<tr>
<td>PIR</td>
<td>Post Infection Review</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin Resistant Staphylococcus Aureus</td>
</tr>
<tr>
<td>MSSA</td>
<td>Methicillin Sensitive Staphylococcus Aureus</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>VRE</td>
<td>Vancomycin Resistant Enterococci</td>
</tr>
<tr>
<td>SSI</td>
<td>Surgical Site Surveillance</td>
</tr>
<tr>
<td>HCAI</td>
<td>Health Care Associated Infections</td>
</tr>
<tr>
<td>ANTT</td>
<td>Aseptic Non Touch Technique</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
</tbody>
</table>
Infection Prevention and Control Annual Trust Board Report

The purpose of this report is to detail progress against Infection, Prevention and Control achievements and objectives during the period April 2017 - March 2018. The Director of Nursing Performance and Quality is the Director of Infection Prevention and Control (DIPC), and has responsibility for assurance on the progress against the HCAI agenda including monitoring of the trajectories set internally and externally.

1 INTRODUCTION

1.1 East Cheshire NHS Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 (Department of Health 2015). The Health Act (2008) is a legislative framework required for the Care Quality Commission (CQC) registration. As part of this process the trust is committed to providing safe effective and personal care in the right place by staff with the right skills and knowledge.

2 EXECUTIVE SUMMARY

2.1 This report provides assurance on the trusts performance against the key Infection, Prevention and Control indicators and identifies actions taken to ensure that there are robust and effective measures in place to minimise the risk of infection to patients, public and staff within the care of East Cheshire Trust.

The report is prepared in accordance with the Care Quality Commission standards for registration as designated in the Department of Health guidance for infection control annual reports. This report has been prepared for public release as per the Health and Social Care Act 2008 Code of practice for health and adult social care on the prevention and control of infections (Department of Health 2015).

The report seeks to demonstrate an organisational approach to reducing avoidable Health Care Associated infections (HCAI) and the provision of a clean and safe environment with associated evidence of improvement.

- In 2017-18 the Trust reported 9 cases of Clostridium difficile infection against a PHE trajectory of 14 cases.
- As part of the Quality Account assurance process an external audit by Grant Thornton Associates was undertaken to provide assurance that the documentation for post infection Clostridium difficile review meetings was comprehensive and accurate, with demonstrable engagement from both the trust and the CCG.
- There were two cases of Methicillin Resistant Staph Aureus (MRSA BSI) blood stream infection reported against an objective of 0.
- Estates delivered a planned programme of work on Fire Precaution improvement, which enabled joint working to improve the environment by undertaking decorating works and an integrated deep clean process.
- 2017/18 has seen a decrease in the number of cases of Norovirus resulting in no closures of clinical areas, despite these infections circulating in the wider community.
- Staff flu immunisation uptake during 2017/18 was 70.58% of frontline staff (as of 9.2.18), which compares favourably to 2016/17’s 62.2% compliance rate. This also means that the trust has passed the 70% threshold to achieve the CQUIN.
- Following the implementation of the new PCR testing machine in Pathology, results from patient’s with suspected Influenza were expedited earlier. Overall the trust had 104 patients testing positive for influenza.
3 TRUST STRATEGY

3.1 The trust strategy for infection prevention and control encompasses the following key aspects:

3.2 Antimicrobial resistance to new and emerging diseases continue to require organisations to implement strategies and controls to manage cases. A national shortage of Piperacillin/Tazobactum (Tazocin) meant changes to the antibiotics used in practice and required a review of the Antibiotic policy for both adults and Paediatrics in May 2017.

The Point prevalence audit in January 2018 on all antibiotics identified found 39% of patients were on antibiotics. 32% were initiated 48 hours or later after admission suggesting they were hospital acquired infections.

Analysis of the data demonstrated the following results for the Trust KPI's (number of scripts analysed = 188):

- One KPI target was met for no missed doses overall the figures for the first three KPIs had improved since 2017.
- ASG (Antimicrobial Stewardship Group) are due to review the results and agree on recommendations to improve performance.

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Result 2018</th>
<th>Result 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indication documented on antibiotic prescription</td>
<td>100%</td>
<td>75%</td>
<td>66%</td>
</tr>
<tr>
<td>Stop or review date documented on prescription</td>
<td>100%</td>
<td>71%</td>
<td>71%</td>
</tr>
<tr>
<td>Choice of appropriate antibiotic</td>
<td>100%</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Number of antibiotics with no missed doses</td>
<td>&gt;90%</td>
<td>90.4%</td>
<td>87%</td>
</tr>
</tbody>
</table>

The Antibiotic CQUIN was in 2 parts. The first part looked at the review of patients with red flag sepsis to determine whether their antibiotics had been reviewed by a senior doctor (registrar or above), a consultant microbioiologist or antibiotic pharmacist between 24 to 72 hours. The table below shows the CQUIN targets and results for percentages of antibiotics which had been reviewed. The trust achieved the CQUIN targets for the first 2 quarters but failed for quarters 3 and 4.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Target</th>
<th>Result</th>
<th>CQUIN achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>25%</td>
<td>73%</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>50%</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>75%</td>
<td>74%</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>90%</td>
<td>81%</td>
<td>No</td>
</tr>
</tbody>
</table>

The second part of the Antibiotic CQUIN for 2017-2018 was to achieve a 2% reduction of usage for all antibiotics, piperacillin/tazobactam and the carbapenems. However defined daily doses (DDD) per 1000 admissions for antibiotic data submitted have not yet been calculated by PHE so the results for this part of the CQUIN are expected.

3.3 Managing patients with multidrug resistant organisms remains a challenge to the Trust. Patients transferred from other organisations are screened in line with Public Health guidance for Carbapenemase
patients with multidrug resistant organisms (CPE). At present the Trust has been successful in limiting transmission of CPE which is testament to good Infection Prevention and Control. The increase in antimicrobial resistance presents challenges across the NHS as it becomes increasingly more difficult to treat these patients.

Although there is no national requirement to screen patients for Vancomycin Resistant Enterococci (VRE), all patients who are admitted to ICU are screened on admission in accordance with best practice guidance by the ICU network.

Gram negative bacteraemia data both nationally and locally indicates that a more focused approach is needed and to implement changes this approach must be health economy based. The data for ECOLI blood stream infections currently collated is indicative that patients are predominantly admitted to the Trust with this organism.

3.4 IPC continue to deliver training and updates in clinical practice to meet service needs, this is supported by the Link practitioners. The IPCT continue to be allocated to clinical areas where they work with the teams to ensure high standards of IPC. This includes supporting the management of patients, 1-1 support for individual staff.

The Operational Infection Prevention and Control group consisting on IPCN, Matron, Estates, Facilitates, ISS (with other members co-opted as required), meet bi-monthly to support the delivery and embedding of IC into practice. The group review Datix incidents relating to IPC, planned programme of works including cleaning, PIR, estate issues.

3.5 Work has continued to facilitate and ensure optimal cleaning of the environment and equipment. The IPCT, Matrons and estates continue to work closely with the contracted cleaning service to improve and maintain standards. The Fire Precautions work has enabled a focused and proactive approach on decoration and deep cleaning clinical areas.

To strengthen and underpin this approach, fortnightly meetings of the Infection Control Committee Operational sub-group bring together representatives from IPCT, ISS, Estates, Soft FM and wards to identify and coordinate responses to infection control related issues

4 INFECTION CONTROL FUNCTION AND REPORTING

4.1 The DIPC is responsible for providing assurance and reporting to the Trust Board on progress against the HCAI agenda, including

- Progress against the CDI objective
- Outbreaks of Infections
- Untoward incidents
- Initiatives to reduce risk of infection to patients, staff and visitors.
- Ensuring Standards of Cleanliness

The DIPC chairs the Infection, Prevention and Control Subcommittee which maintains an overview of infection control priorities within the Trust, ensuring appropriate management of improvement initiatives and any associated risks within the organisation.

The Subcommittee reports to the Safety Quality Standards Committee. Key objectives and action plans are monitored including any exception reporting for non-achievement. The members review the TOR and undertake self-assessment annually to ensure the Subcommittee’s functions are reflective of the organisations requirements.

An Operational Infection Prevention and Control sub-group was formed in April 2016 with core
membership from operational and corporate services. The purpose of the group is to:

- Monitor and implement actions identified by the Infection Prevention and Control Committee
- Undertake all Post Infection Reviews (PIR) on cases of CDI, MRSA BSI, outbreak or specific incidents and establish if there has been any ‘Lapses in Care’.

This sub-group reports into the Infection Control Committee via the performance report, and regular dedicated agenda items.

The Infection Control Teams role and responsibility for East Cheshire NHS Trust

4.2 The infection control service is delivered by the infection control team in conjunction with staff in different disciplines across the health economy. The team uses a proactive and reactive approach, working collaboratively and positively engaging with Trust staff, and services in the wider health economy. Establishing and maintaining positive working relationships with teams to provide safe quality care to our patients and their families.

Currently the Lead Nurse is on a secondment initially until November 2018 as Head of Nursing across East Cheshire NHS Trust and Mid Cheshire Hospital Foundation Trust.

5 HEALTHCARE ASSOCIATED INFECTIONS

HCAI Performance standards are closely monitored

5.1 All cases of CDI and MRSA are subject to a Post Infection Review to establish if any “Lapse in Care” has occurred. The term ‘Lapses in Care’ relates to reviewing the patients journey to identify if any care or process should have been managed differently, and whether all appropriate policies were followed. This enables teams to identify areas requiring a change to process which in turn promotes patient safety.

There were two cases of Methicillin Resistant Staph aureus Blood Stream Infections against ambition of zero

5.2 The Trust recorded two new cases of MRSA BSI (Blood Stream Infections) during the period 2017-18; the last reported case prior to these was in November 2015. Against a national ambition of 0.

Case 1 (May 2017) - Post Infection Review (PIR) process identified this as an avoidable BSI and that the likely source of the BSI was the multiple invasive devices inserted although it was recognised that it was not possible to state equivocally which specific instance caused the BSI.

Case 2 (November 2017) - The PIR group agreed this is an avoidable BSI and that the likely source of the bacteraemia was from MRSA Pneumonia.

The group concluded that the cause of the MRSA bacteraemia could not be conclusively proven, but upon basis of evidence availability it was felt probable that lapses in hand hygiene and/or environmental cleaning had resulted in potential transmission occurring.

A 90 improvement programme will commence in June 2018 focusing on Peripheral line management, staff training and policy development.

MRSA screening in line with National Parameters

5.3 There is an established rolling programme for screening of elective and emergency admissions. As part of the ongoing process of improving data capture a review of MRSA screening data was undertaken. In relation to the elective process the timing of screening in relation to actual admission varies and therefore this data is only an indication and not an actual reflection. The IPCT have continued to support the emergency floor to improve the process including strengthening the screening process by clear identification of the sites requiring screening.

The last national figures relating to MRSA screening were produced by DoH within the report ‘implementation of modified admission MRSA screening guidance for NHS’ (2014). East Cheshire Trust participated in this data collection, and from the benchmarking against these figures show ECT performing at a comparable / favourable level to national averages.
<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective %</td>
<td>96.27</td>
<td>96.39</td>
<td>95.94</td>
<td>96.72</td>
<td>95.48</td>
<td>95.97</td>
<td>96.05</td>
<td>95.44</td>
<td>97.59</td>
<td>97.43</td>
<td>96.21</td>
<td>95.62</td>
</tr>
<tr>
<td>Emergency %</td>
<td>77.81</td>
<td>78.44</td>
<td>83.66</td>
<td>84.93</td>
<td>83.56</td>
<td>78.53</td>
<td>87.01</td>
<td>80.23</td>
<td>75.54</td>
<td>75.94</td>
<td>74.46</td>
<td>76.09</td>
</tr>
</tbody>
</table>

**Increase in year of MRSA New Isolates**

MRSA new isolates are identified through the screening programme and from specimens taken if there are signs of clinical infection. This year the Trust has recorded 102 new isolates from admission screens. Screening identifies MRSA carriers, enabling application of topical decolonisation or suppression treatment if appropriate.

**Improvement in Clostridium difficile Infections (CDI) against national ambition**

Clostridium difficile is a type of bacterium found in the gut that can cause diarrhoea in certain circumstances and can be a potentially severe or fatal infection in vulnerable patient groups, especially if they have been exposed to antibiotic treatments.

NHS England maintained East Cheshire Trusts annual trajectory for 2017-18 at 14 cases (rate 13.6 per 100,000 bed days, NHS England 2015/16). The number of cases identified by the end of the year was 9. Of these cases none identified a Lapse in Care.

The average patient age of CDI toxin positive patients has increased from 78 in 2016/17 to 83 in 2017/18.

Post Infection Review conclusions from 7 cases explicitly highlighted extensive (though clinically justified) antibiotic exposure as being contributory towards the patients subsequent infection.

As part of the surveillance process all cases of CDI are followed up at 30 days, as part of the surveillance process all CDI deaths are monitored by the IPCT.

During 2017/18 there was one case where CDI Colitis was listed on part 1A of the death certificate, one case with unresolved CDI infection listed on part 1B, and no cases with CDI listed on part 2. This compares to 2 primary attributed deaths identified during 2016/17.

**Collaborative work to reduce**

Each CCG has been given an ambition to reduce ECOLI bacteraemia across the Health Economy by 50% by 2021. The Trust is participating in this campaign as a key stakeholder. During the period April 2017-March 2018 there were 139 cases reported, compared to 147 during 2016/17. These figures related to all
Escherichia coli Bacteraemia (ECOli) across the Health Economy.

There were 25 cases directly attributable to ECNHST (cultures taken after 48hrs of admission), this is an overall health economy reduction of 15%.

As part of the Stakeholder function an analysis of the data has been undertaken, this indicated no particular themes or trends and that the Health economy were within the same demographic picture across the country including patients with urinary tract infections as the highest number of cases.

The group have agreed that moving forward the focus will be a hydration campaign for patients in the community (predominantly their own home) to support a reduction in UTI’s, development of a catheter passport, and continuation on the focus of antimicrobial stewardship.

MSSA like MRSA, bacteraemia can be particularly serious, although the majority of these cases are community acquired during 2017/18 there were 48 Trust-apportioned Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, compared to 38 during 2016-17.

There is no national benchmark or annual threshold set for MSSA bacteraemia rates. Each case is subject to a post infection review based on the mandatory data collection forms. Individual cases are reviewed by the Consultant Microbiologist and the clinical teams responsible for the patient.

The IPCT patient management system is ICNET; this is a system commissioned by Cheshire East Council to ensure that patients with infection control restrictions can be monitored across the whole health
This system provides demographic information which can be used as a tool in outbreak management and assist in tracking the patient journey for post infection reviews.

This is a joint system used in conjunction with Cheshire East Council Public Health Infection Prevention and Control team, and Mid Cheshire Foundation Trust.

### Participation in PHE mandatory Surgical Site Surveillance (SSI)

5.11 The Trust participates in the national mandatory Surgical Site Infection (SSI) surveillance programme led by PHE. Currently East Cheshire Trust submits patient data relating to Hip replacements, and repairs to neck of Femur.

A review with the Clinical Lead for orthopaedics agreed that the data collection period would reduce to one quarterly surveillance period annually (rather than the previous regime where SSI were monitored continuously), covering Hip Replacement and Repair to Neck of Femur surgeries this is in line with the minimum requirements for PHE. However it was agreed that if there was any indication of increased infections then increased surveillance would be recommenced This is in line with the GRIFT recommendation to ensure surgeons have information on their infection rates.

Accordingly SSI cases for April-June 2017 were collated and submitted with no cases of SSI identified.

<table>
<thead>
<tr>
<th></th>
<th>Hip</th>
<th>Repair to Neck of Femur</th>
</tr>
</thead>
<tbody>
<tr>
<td>number of ops</td>
<td>number of SSI’s</td>
<td>% SSI</td>
</tr>
<tr>
<td>Q1 Apr-Jun 2017</td>
<td>74</td>
<td>0%</td>
</tr>
</tbody>
</table>

### No ward closures relating to Norovirus

5.12 Although Norovirus was circulating in the wider community, impacting on local care homes and schools the Trust had no reported ward closures.

### Targeted screening for Vancomycin Resistant Enterococcus (VRE), in particular the ICU

5.13 VRE is a type of Enterococcus that has become resistant to the antibiotic Vancomycin, patients are required to have a rectal screen taken with any patients subsequently identified as positive nursed in Isolation or if appropriate cohort nursed. There is no national requirement to screen for VRE however; in line with recommended best practice from the ICU network all patients admitted to ICU are screened on admission.

Dependent on the length of time patients remain in the unit this can have an impact on patient flow in other ward areas when positive results are returned as the patient may have been discharged from the unit prior to the result being received. The IPCT work with the clinical areas to ensure all controls are in place this is often based on a risk assessment process however as far as practicable the objective is to ensure that the impact on the patient and the clinical area is minimised. and that the impact on the patient

Overall during the period April 2017-March 2018 there were

- 362 admissions into the HDU / ITU
- 30 positive VRE results.
- Of these 30, 14 patients tested positive for VRE on their admission screen to the unit.
- 16 patients tested negative on admission to ITU however had contact with a confirmed case of VRE, so therefore had a contact screen which then tested positive.

This equates to

- 9% of patients had VRE either on or during their stay in ITU / HDU.
• 4.5% were admitted with VRE
• 4.5% may have acquired VRE during their admission to ITU/HDU.

ICU have in collaboration with the IPCT reviewed and improved their cleaning schedules for managing patients with VRE.

CQUIN achieved for staff Seasonal Influenza vaccination

The Staff Seasonal Influenza Campaign commenced in October 2017 this was facilitated by:

• Peer to Peer Vaccination
• Drop in sessions in Occupational Health
• The flu stop based at the Costa Café and Statutory and Mandatory training sessions
• Specific sessions were also undertaken in various clinics across the community.

All staff who were vaccinated were entered into a prize draw and in addition, the Peer to Peer vaccinator who administers the most vaccines received a bottle of champagne.

The overall compliance this year was 70.58% meaning that the trust has successfully realised the CQUIN threshold of 70%. Lessons learnt from this year’s campaign will continue to be used to inform practice changes in the 2018-19 campaign.

The Impact of increased influenza circulating in the Health economy

During February 2018 the trusts Microbiology department purchased a PCR testing machine. This enabled results from swabs to be received within hours, enabling a more proactive management of cases by IPCN and medical teams. Accordingly this reduced the number of bay closures and potentially contributed to the fact that no wards were closed, unlike other hospitals within the local health economy.

However, there were some local care homes closed due to influenza which potentially delayed patients discharges.

Reflecting national patterns, the trust identified multiple patients with influenza commencing in late December and peaking during February 2018. Overall 104 positive cases were confirmed.

Planned programme of Education to support IPC in practice

Focused training has continued during this period delivered predominantly by the dedicated Infection Prevention and Control trainer supported by the Infection Prevention and Control nurses this included.

Building upon existing educational programmes, new initiatives during 2017/18 have included:

• Continued development of input into the HCA training programme. IPC now have a dedicated morning session on day 3 of the HCA training programme which incorporates Essential Clinical Skills for Bank HCA’s and the Aware to Care courses.
• Spoke Placement days continue to be offered to general nursing students and students of other disciplines. The uptake of these days has been regular and the feedback has been positive.
• The Link Nurse group has been developed into the Link Practitioner Group in an effort to be more inclusive. Following consultation with Matrons group the duration of meetings has been condensed to 1 hour to make it easier for staff to be released from wards to attend
• Two Link Practitioner study days were delivered in October 2017. The feedback from these days was very positive, with staff feeling supported and invested in; and accordingly planning is now well advanced for the next study day which is scheduled for July 2018.

6. AUDIT

6.1 NHS organisations are required to implement an audit programme of key policies and procedures to provide assurance that practice is effective and in line with the criterion of the Health and Social Care Act (revised 2015).

This is undertaken by a planned programme of audit and spot audits in relation to service needs, or critical incidence.
Hand hygiene audit indicates overall compliance

This is a two tiered process with the clinical areas submitting monthly audits, with IPCT undertaking verification audits of all clinical areas on a quarterly basis. The overall compliance for clinical areas submission in 2017/18 was 99.21% (from a total of 2769 individual audits of staff members) with a verification compliance of 94.12% (284 staff members audited to derive this figure).

RADaR

Performance is monitored by the Directorates as part of the RADAR dashboards and the Infection Prevention and Control bi-monthly Performance report. Non-compliance is addressed at the time of audit with additional support offered to the clinical areas as required.

Community based teams have started a self-assessment process, with verification undertaken by the Team leaders; both these results are currently reporting 100% compliance. It should be recognised that undertaking hand hygiene auditing in the community is challenging as many of the staff are lone workers. As part of the development of this process a verification process will be explored by the IPCT.

Clinical and Environmental Audits to ensure clinical areas are reflective of IPC standards:

A planned programme of environmental audits has been undertaken including some auditing of community clinic premises using a multidisciplinary team approach including Matrons, Clinical managers and ISS representatives.

Following initial verbal feedback formal reports and action plans are disseminated to the Ward/Departmental managers.

THE IPCT continue to work with the clinical areas to improve issues highlight and ensure patient safety is maintained by reducing the risk of transmission of infection.

An external audit on Peripheral cannulation was undertaken by B Braun as part of the company support to the Trust. The audit focused on areas of high cannulation A&E, MAU, CT. The audit identified areas relating to compliance with ANTT, documentation and training. The outcomes of the report have been reviewed and will be incorporated into the IPC Service Plan for 2018-19.

7 ESTATES

Decontamination monitoring

- Annual validation of the HSDU ultrasonic washer-disinfector against HTM01-01 is complete has been signed off by theAE(D) with some minor remedial actions for the Competent Person to address.
- Major building works of the new ETU decontamination facility are complete and the room is now in use whilst minor snagging works are undertaken.

Water Quality planned programme of works

Over the past eighteen months, the Trust’s Strategic Water Safety Group (SWSG) continues to provide a strategic approach to address the changes and subsequently provide advice and assurance relating to Approved Code of Practice L8 & Health Technical Memorandum 04-01.

- There is a planned preventative maintenance based on Statutory & Mandatory requirements.
- All recommended Health and Safety Commission good practice guidance is reviewed, with subsequent recommendations and actions implemented.
- Specific risk assessments and procedures have been evaluated and updated specifically in relation to Legionella and Pseudomonas Aeruginosa.
- A programme of water quality testing against augmented care areas found no major issues relating to water quality.

Fire Precaution

As part of the planned fire precaution work, redecoration and deep cleaning of the clinical areas has been
undertaken. The joint approach and planning by clinical staff, estates and ISS has proven successful in ensuring that standards are maintained, with minimal disruption to patients, and has demonstrated good collaborative working.

8 SOFT FM

Monitoring of Cleaning standards

8.1 The Trust cleaning service is provided by external contractors ISS. As part of the contract ISS are required to self-monitor the standards of cleaning against agreed performance indicators and report to the Trust.

During 2017-18 additional measures have been put in place to further strengthen the audit process, with ward staff now routinely invited to accompany the ISS auditor. This has evidenced an improved standard of cleanliness both in the acute hospital and at the various community sites.

Collaborative working has continued between ISS, IPCT and the clinical areas, which has helped foster more resilient and effective relationships. Improved communication has resulted in early notification of upcoming enhanced and deep cleaning requirements, resulting in reduced delays in reopening areas.

This has been led by the DIPC, and monitored via the Infection Prevention and Control committee to ensure sustainable improvements are made. Actions relating to cleaning standards are reviewed at the fortnightly operational Infection Prevention Committee Operational sub-group meeting.

9 POLICIES

Reviewed policies to reflect changes locally and nationally

9.1 The IPC team in collaboration with colleagues from other specialist services have reviewed all the required Infection Prevention and Control policies as part of an ongoing review process.

To support staff access to policies and other key information the IPCT continue to refresh the Infection Prevention and Control page on the infonet.

Challenges identified for 2018-19 within the Service Plan (appendix 1)

9.2 • Reduction of avoidable MRSA BSI
• Reduction in ECOLI BSI as part of health economy stakeholder working group
• Improve management of Peripheral lines utilising 90 day improvement methodology
• GAP analysis of Community training to ensure IPC knowledge and Skills reflective of their clinical environment.
• Production of Blood Culture training package supported by updated policy.

11 SUMMARY

11.1 • Multidisciplinary working to further reduce the risk of transmission of infection to maintain the safety and quality of patient care is clearly demonstrated within the outcomes in the report.
• Performance against the HCAI CDI objective has continued to improve year on year
• Infection Prevention and Control remain the clinical experts of IPC service delivery throughout the Trust. The team continue to strive to develop new and innovative ideas to improve patient care demonstrating an open and transparent learning culture.
• Trust Board are asked to note the assurance provided within the report.
Appendix 1

EXECUTIVE SUMMARY

The Infection Prevention and Control (IPC) team are based at Macclesfield District General Hospital. The service provides IPC advice, support and guidance to the three Clinical directorates of East Cheshire NHS Trust.

Service provision is provided from Monday to Friday 8am-5pm. Calls for advice and support should be made via 01625 661597 or using the hospital bleep system bleep 3449, 3034, 3085. Out of hours support is provided by the on call microbiologist via switchboard.

The IPCT have been aligned to specific clinical areas / directorates in order to facilitate excellent working relationships with staff, and enable them to work clinically with their colleagues to embed high standards of Infection Prevention practice in clinical practice.

Currently the Head of Nursing Infection Prevention and Control is undertaking a secondment covering the Infection Control service at Mid Cheshire Trust and East Cheshire Trust this is a 12 month secondment with a review at the end to evaluate the sustainability of this post.

The Infection Prevention and Control team focus this year will include:

- Working across the Health Economy to implement initiatives to support the reduction in ECOLI BSI as part of the continued focus to reduce Gram- negative bloodstream infections by 2021.
- Undertake a 90 day improvement project relating to Peripheral cannulation and ANTT this will include looking at Practice, Policy and Equipment.
- Deliver the annual staff Influenza campaign in accordance with the national CQUIN requirements.
- Review the training programme for Blood cultures in conjunction with Clinical training team and staff involved in taking blood cultures.
- Undertake a training needs analysis for community clinical staff to ensure Infection Prevention and control training is reflective of their care provision.
- Undertake quarterly prevalence studies against NHS Improvement High Impact Interventions on Urinary Catheters and IV peripheral lines in quarter 3 and 4.

Monitoring of this plan will be through the Infection Prevention and Control Group as an inclusion in the Bi monthly Performance report.
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Key Priorities</th>
<th>Start Date</th>
<th>Finish Date</th>
<th>Lead</th>
<th>Risks</th>
<th>RAG Priority</th>
<th>Assessment of Achievement</th>
<th>Key Factors/Cross Divisional Impacts</th>
<th>Status</th>
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<tbody>
<tr>
<td>Harm Free Care incorporating Sign up to Safety</td>
<td>Participate as a stakeholder in the HE working group</td>
<td>April 2018</td>
<td>31st March 2019</td>
<td>Wendy Morris</td>
<td>Lack of clinical ownership due to other competing pressures.</td>
<td></td>
<td>HE action plan Epidemiology reports from PHE detailing reduction in ECOLI Audit actions from Prevalence study</td>
<td>Identification of Trends to enable a targeted approach in implementing preventive measures</td>
<td></td>
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<tr>
<td>Reducing avoidable hospital acquired ECOLI BSI</td>
<td>Complete extended RCA in line with PHE guidance</td>
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<td>RCA on any deaths relating to ECOLI BSI.</td>
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<td></td>
<td>Undertake prevalence study against HII as a benchmark</td>
<td>September 2018</td>
<td>January 2019</td>
<td></td>
<td>Increased rates of ECOLI</td>
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<tr>
<td>Objectives</td>
<td>Key Priorities</td>
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<tr>
<td>Ensure that the standards for Blood cultures are reflective of national standards</td>
<td>Identify training needs with Professional Practice team Benchmark process with other Trusts</td>
<td>July 2018</td>
<td>January 2019</td>
<td>Wendy Morris</td>
<td>Lack of clinical engagement due to other competing pressures</td>
<td>Red</td>
<td>Blood Culture training package/Video Blood Culture policy</td>
<td>Standard practice across Trust Reduction in contaminants including MRSA BSI.</td>
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<tr>
<td>Integrated Care</td>
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<tr>
<td>Ensure that care of IV lines and cannulas are carried out in line with evidence based guidance in order to enhance patient care and</td>
<td>90 day improvement programme to Standardise practice Deliver key training Develop policy in</td>
<td>August 2018</td>
<td>February 2019</td>
<td>Abigail Paterson</td>
<td>Failure to engage clinical staff due to other service pressures</td>
<td>Red</td>
<td>Robust training programme Standard practice and agreed documentation across Trust</td>
<td>Standard documentation across the organisation No MRSA BSI related to line sites</td>
<td></td>
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<tr>
<td>Objectives</td>
<td>Key Priorities</td>
<td>Start Date</td>
<td>Finish Date</td>
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<tr>
<td>reduce harm</td>
<td>line with EPIC/ HII</td>
<td>September 2018</td>
<td>March 2019</td>
<td>Helen Dobson Infection Prevention and Control Trainer</td>
<td>In practice, Limited resources to deliver level of training required</td>
<td>Red</td>
<td>Policy in place reflective of EPIC, HII, ANTT standards, Policy and care plans available on the intranet</td>
<td>Robust policy and care plans reflective of Service needs</td>
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<tr>
<td>Develop bespoke IC training for Community staff</td>
<td>GAP analysis to establish current provision, Identify what community practitioners required</td>
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<td>Bespoke training package in place, Training days completed and evaluated by Community practitioners</td>
<td>Standard training package for community staff relevant to their role</td>
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<td></td>
<td>Deliver bespoke Community training</td>
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<td>Listening and Responding</td>
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<tr>
<td>FLU CQUIN 75% of clinical staff vaccinated</td>
<td>Identify why staff didn't have flu vaccine using survey in conjunction with HR Wellbeing team.</td>
<td>1st June 2018</td>
<td>31st March 2019</td>
<td>Anita Swaine Head of Nursing</td>
<td>Clinical staff reluctant to have flu vaccine therefore unable to achieve CQUIN</td>
<td>Staff uptake figures provided by Occupational Health</td>
<td>Workforce protected against Flu CQUIN achieved</td>
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<td></td>
<td>Establish Flu group including Representation from all Directorates Health and Wellbeing, HR</td>
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<tr>
<td>lead and Occupational to improve uptake 2019-8</td>
<td>Review with Occupational Health potential for engagement with local pharmacies for community staff vaccine</td>
<td>Achievement of 75% trajectory for staff uptake of flu vaccine</td>
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Appendix 1

MRSA BSI

- All cases to have PIR within 10 working days. The Trust responsible will be allocated via the electronic system once the PIR is complete.
- Action plans to be implemented as appropriate and monitored via Directorates Safety Quality Standards groups supported by the Infection Prevention Team.
- Corporate actions to be monitored by Infection Prevention and Control Group.
- Reporting on Datix and StEIS by ICT.
- Deliver identified training to clinical staff supporting changes to practice as appropriate.

CDI

- PIR on all cases within 10 working days, including GP’s as appropriate.
- Action plans relating to Lapses in Care to be implemented as required and monitored via the Directorates Safety Quality Standards groups supported by the Infection Prevention Team.
- Corporately monitored by Infection Prevention and Control Group
- 30 day follow up of all cases by the IPCT
- Deliver identified training to clinical staff supporting change to practice as appropriate.
- Antimicrobial compliance monitored by Antimicrobial stewardship programme

CPE

- PIR on all cases identified as positive during inpatient admission
- Deliver training to clinical staff re the management of CPE
- All cases reported to PHE Liverpool for epidemiology

ECOLI

- Identify key themes, implement actions to reduce as appropriate using the process of Lapse in Care
- PIR on all cases reported on Death certificates whilst Hospital inpatient
Report of: 
Responsible Officer: 
Accountable Officer: Mr I Goalen - Non-Executive Director

| Author of Report: | Chair of Committee 
| | Director of Corporate Affairs and Governance |
| Subject/Title | Annual Report 2017-18 |
| Background papers (if relevant) | N/A |
| Purpose of Paper | To summarise the work of the Committee from April 2017 to March 2018 |
| Action/Decision required | Approve the report |
| Mitigates Risk Number: (identify) 
On Corporate Risk Register | Links to all risks on Board Assurance Framework and Corporate Risk Register |
| Mitigates Risk Number: (identify) 
On Assurance Framework |  |
| Link to Care Quality Commission Domain | Safe 
| | Caring 
| | Responsive 
| | Effective 
| | Well-led |
| Link to: 
➢ Trust’s Strategic Direction 
➢ Corporate Objectives | Continuously improve quality, safety and the patient experience 
Trust Objectives 
Patients: Provide the best services to our population through improvements to safety, productivity & patient experience 
People: Empower, develop & value staff in providing innovative patient focused care. 
Partnerships: Actively develop sustainable services through effective partnerships 
Resources: Effectively provide services that are sustainable both now & in the future |
| Legal implications - (identify) | N/A |
| Impact on quality | N/A |
| Resource impact | N/A |
| Impact of equality/diversity | N/A |
| Avoid acronyms or abbreviations - if necessary list: | MIAA – Mersey Internal Audit Agency |
Audit Committee Annual Report 2017-18

1. Purpose

1.1 The following Annual report summarises the Audit Committees’ work for the twelve month period between 1st April 2017 and 31st March 2018.

1.2 The Annual report provides an overview of how the Committee has discharged its duties in line with the terms of reference as delegated by the East Cheshire NHS Trust Board.

2. Background

2.1 The purpose of the Audit Committee, as outlined within the Terms of Reference, is as follows:-

The Audit Committee will have primary responsibility for monitoring and reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust’s activities (both clinical and non-clinical), that supports the achievement of the Trust’s objectives.

The Committee’s duties and delegated authority from the Board are contained within the terms of reference (attached as Appendix 1).

3. Constitution and Achievements

3.1 During 2017/18, the membership of the Committee was comprised of three Non-Executive. Quoracy is achieved with the attendance of two Non-Executive Directors.

3.2 Internal and external auditors were invited to attend, together with the Anti-Fraud Specialist.

3.3 There is an open invitation to the Chairman and Chief Executive to attend; other Executive Directors attend as required.

3.4 A schedule of attendance at meetings is maintained which demonstrates full compliance with quoracy requirements. The attendance at the Committee was as follows:

<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Position</th>
<th>Individual attendance rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ian Goalen</td>
<td>Meeting Chair, Non-Executive Director</td>
<td>100%</td>
</tr>
<tr>
<td>Mike Wildig</td>
<td>Non-Executive Director</td>
<td>100%</td>
</tr>
<tr>
<td>Jane Cowan (April 17 to Dec 17)</td>
<td>Non-Executive Director</td>
<td>100%</td>
</tr>
</tbody>
</table>

3.5 Four meetings were held during the twelve month period from April 2017 – March
2018.
1. 23rd May 2017
2. 29th August 2017
3. 28th November 2017
4. 27th February 2018

3.6 In line with good practice, the Committee has an Annual Work Plan with meetings timed to consider and act on specific issues within that plan. Please refer to Appendix 2.

3.7 Due to the timing of the meetings, the Chair of the Committee has provided verbal reports to the Trust Board, providing items for assurance, emerging risks and mitigating actions. Final minutes are then submitted to the Trust Board.

3.8 The Audit Committee has fulfilled its duties through self-assessment and review, requesting assurances from trust Directors, Chairs of other Board Committees and directing and receiving reports from the auditors and counter fraud specialists. During the year the Committee has complied with ‘good practice’ recommend through:-

3.8.1 The review of Terms of Reference of the Audit Committee;
3.8.2 Development of an annual work programme for 2017 - 2018;
3.8.3 Agreement of Internal and External Audit plans;
3.8.4 Discussions with the Internal and External Auditors without management present between Audit Committee meetings;
3.8.5 Continued review of the implementation audit actions;
3.8.6 Review of progress and outcomes i.e. risks identified and action plans agreed via an action log at each Committee meeting
3.8.7 Consideration of the Annual Governance Statement, Final Accounts, Annual Report and Quality Account
3.8.8 Receiving and reviewing annual reports from Board committees
3.8.9 Scrutiny of Audit Reviews with particular focus on areas linked to the Assurance Framework.
3.8.10 Scrutiny of the Assurance Framework and Corporate Risk Registers, seeking further assurance on the understanding of risks that have been on the register for longer than a year to determine rationale for any extension of target dates and requested that the reports include additional information on risks removed and any scores reduced.

4. **Self-Assessment – Summary**

4.2 A self-assessment exercise has been carried out and is attached as Appendix 3 . The Audit Committee recognise the important role it undertakes as part of the overall governance framework at the Trust. The self-assessment concluded that the Audit Committee is delivering its core duties effectively and has continued to develop and embed the actions associated with its wider remit.

4.3 Internal Processes - The Chair of the Audit Committee has reviewed the Committee’s annual work plan and four meetings per year were agreed.

5. **Independent Assurances / External Audit**
5.1 The External Audit services for 2017 - 2018 was delivered by Grant Thornton and included audit of the financial statements and provision of an opinion thereon; and to form an assessment of our use of resources and value for money.

5.2 The Committee approved the Annual Audit Plan/Fees and has received regular updates on the progress of work. In addition, reports and briefings have been received (as appropriate) from the External Auditors.

5.3 A formal opinion on the 2017-2018 accounts will be received and discussed at the May 2018 Audit Committee meeting.

6. Independent Assurances / Internal Audit

6.1 During 2017-2018 the Internal Audit service was provided by Mersey Internal Audit Agency (MIAA), an independent NHS organisation. MIAA has demonstrated their compliance with Public Sector Internal Audit Standards (as reported within their Head of Audit Opinion and Annual Report).

6.2 The Audit Committee contributed to the risk assessment and subsequently recommended to the Board the content of the 2017/18 Internal Audit Plan. Outputs from the approved audit plan in the form of reports and progress report were received and discussed by the Audit Committee. All reports received were presented with high or significant assurance. The Committee asked the Safety, Quality and Standards Committee to seek additional assurance on the compliance with the one element of the WHO checklist.

6.3 The Head of Internal Audit Opinion and Annual Report for 2017-18, concluded that ‘Substantial Assurance’ was given that there is a generally sound system of internal control designed to meet the organisation’s objectives and that controls are generally being applied consistently.

7. Anti-Fraud

7.1 As with the Internal Audit Service, Anti-Fraud was provided by Mersey Internal Audit Agency.

7.2 To meet mandated requirements an Annual Report was provided outlining the delivery of the Anti-Fraud Plan. The Committee approved the plan and received updates as appropriate on each of the issues during the course of the year.

7.3 During 2017-2018 there were no frauds identified that would have a material impact on the trust's financial position.

8. Forward Look 2018-19 (please refer to Year at a Glance Appendix 2)

8.1 Over the coming months the Committee will:-

8.1.1 Maintain and adhere to an annual work plan which is informed by strategic risks identified on the Board Assurance Framework and Corporate Risk Register, including requests for ‘spotlights’ when necessary. This includes any
further delegated areas of focus from the Board.

9. **Committee Members Training**

9.1 During the months April 2017 to March 2018 Members of the Committee have continued to maintain and update their skills to support their work within the Committee. This has been done through various methods including the Board development sessions.

10. **Recommendations**

   Agree the annual report which will be submitted to the Trust Board.
<table>
<thead>
<tr>
<th>Title:</th>
<th>Audit Committee - Terms of Reference</th>
</tr>
</thead>
</table>
| Authors Name: | Ian Goalen - Non Executive Director  
Chair of Audit Committee |
| Scope: | Trust Wide |
| Classification: | Trust Organization Structure and Minutes |
| Replaces: | Previous Terms of Reference approved February 2017 |

To be read in conjunction with the following documents:
The Trusts Standing Orders and other Committees of the Board Terms of Reference

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<td>February 2019</td>
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<td>February 2018</td>
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<tr>
<td>Authorised by:</td>
<td>Trust Board</td>
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<td>Authorisation Date:</td>
<td>February 2018</td>
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Document for Public Display: Yes

After this document is withdrawn from use it must be kept in an archive for 6 years.

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<td>Date added to Archive:</td>
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| Officer responsible for archive: | Head of Integrated Governance |
1. **Constitution**

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee), which is directly accountable to the Board.

The Terms of Reference shall be as set out below, subject to amendment at future Board meetings. The Committee shall not have executive powers in addition to those delegated in these Terms of Reference.

2. **Definition**

The Audit Committee will have primary responsibility for monitoring and reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

3. **Membership**

3 Non-Executive Directors will be members of the Audit Committee excluding the Chairman of the Trust.

4. **Quorum**

The quorum shall be a minimum of two members present.

5. **Attendance**

Members of the Committee should make every effort to attend meetings in person. There may be circumstances where members join by telephone. The Chair should be notified of members wishing to join by telephone at least 24 hours in advance of the meeting.

The Chief Executive should be invited to attend each meeting and other Executive Directors requested to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director.

The Chief Executive shall be invited to attend to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement and when the Committee considers the draft internal audit plan and the annual accounts.

Representatives from Internal and External Audit, and the local Counter Fraud Service will be invited to attend meetings.

Members of the Audit Committee must achieve a minimum of 75% meeting attendance. Nominated deputies may attend, but their attendance will not count towards the members attendance levels.
6. **Chairmanship**

   The Committee will appoint one of the members to Chair of the Committee. The Chairman of the Trust shall not be a member of the Committee.

7. **Minutes**

   The minutes of the meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

8. **Frequency of Meetings**

   The Committee shall meet a minimum of four times a year.

8.1 **Emergency Powers**

   Where an urgent decision needs to be made in between scheduled meetings, the Chair, External Auditor or Head of Internal Audit can convene an Extra-ordinary meeting to discuss a particular issue, quorum rules as stated in paragraph 4 still apply. If it is not practicable to meet in person, matters can be dealt with through telephone or the exchange of emails. The exercise of such powers shall be reported and minuted at the next Committee meeting.

9. **Authority**

   The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

   The Committee is authorised by the Board to obtain external legal or other independent professional advice. The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

10. **General Responsibilities and Principles**

    The duties of the Committee can be categorised as follows:

10.1 **Governance, Risk Management and Internal Control**

    The Committee shall seek assurance that an effective system of integrated governance, risk management and internal control, is established and maintained across the whole of the organisation’s activities, both clinical and non-clinical which supports the achievement of the organisation’s objectives.
In particular, the Committee will seek assurance on the adequacy of:

- all risk and control (in particular the Annual Governance Statement) with related disclosure statements, and any accompanying Head of Audit statement, external audit opinion or other appropriate independent assurance, prior to endorsement by the Board;
- the risk management report as part of the Trust’s internal control arrangements contained in the Annual Report
- the management of risks
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal, code of conduct and NHSLA requirements and related reporting and self certification; and
- the policies and procedures for all work related to fraud, bribery and corruption as set out within the NHS Standards Contract and as required by NHS Protect’s Standards for Providers.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of effectiveness.

This will be evidenced through the Committee’s use of an effective Assurance Framework to guide its work and that of the audit and assurance function that report to it.

10.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal;
- review and approval of the internal audit strategy, operational plan and programme of work in the context of the Assurance Framework;
- consideration of the major findings of internal audit investigations (and management’s response), and ensure co-ordination between the Internal and External Auditors; and
• ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

• Receipt of an annual review of the effectiveness of Internal Audit

10.3 External Audit

The Committee shall seek assurance on the work and findings of the External Auditor and consider the implications and management’s responses to their work. This will be achieved by:

• consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit;

• discussion and agreement with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the Trust Plan (formally Annual Plan), and ensure co-ordination, as appropriate, with other External Auditors in the local health economy; and

• review of all External Audit reports, including the report to those charged with governance and agreement of the annual audit letters before submission to the Board and any work carried out which is outside the Trust Plan (formally Annual Plan), together with the appropriateness of management responses.

10.4 Other Assurance Functions

The Committee shall review the findings of the other assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by the Department of Health arm’s length bodies or regulators/inspections for example the Care Quality Commission, NHS Resolution Authority and professional bodies with responsibilities for the performance of staff or functions.

The Committee will review the updated Assurance Framework on 3 occasions during the year, as well as a full annual review, provided by the trust’s Internal Auditors to gain assurance on the robustness of the process.

10.5 Reporting Arrangements of other Committees and Groups

In order to comply with the requirement that the Audit Committee is responsible for providing the Board with assurance that an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), the following arrangements have been put in place:

Although the Safety, Quality and Standards Committee, and the Finance, Performance and Workforce Committee report directly to the Trust Board, the Audit Committee will receive formal feedback on the work of these committees particularly
where their work can provide relevant assurance to the Audit Committees own scope of work.

In receiving feedback on the work of the Safety, Quality and Standards Committee and issues around clinical risk management the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

In addition, the Committee will seek assurance on the work of other committees within the organisation, which fall within the Audit Committee’s own scope of work.

10.6 Anti Fraud

The Committee shall seek assurance that the organisation has adequate arrangements in place for countering fraud, bribery and corruption and shall review the outcomes of the anti-fraud work programme. This will include receipt of the Anti-Fraud Work Plan with progress reports provided on a recurring basis, plus the Anti-Fraud Annual Report, to ensure that the Committee is satisfied with action taken throughout the year and that significant losses have been properly investigated and reported to the internal and external auditors and relevant external bodies including NHS Protect.

10.7 Management

The Committee shall seek assurance through reports and updates from Directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Members of the Audit Committee will meet with External Auditors at least once a year.

10.8 Financial Reporting

The Committee shall seek assurance on the integrity of the financial statements of the Trust and any formal announcements relating to the Trust’s financial position.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control are subject to review as to completeness and accuracy of the information provided.

The Committee shall review the Annual Report and Financial Statements before making recommendations for submission to the Board, focusing particularly on:

- changes in, and compliance with, accounting policies and practices;
- major judgmental areas in preparation of the financial statements;
• Un-adjusted mis-statements in the financial statements;
• significant adjustments resulting from the audit;
• letter of representation;
• qualitative aspects of financial reporting; and
• the wording in the Annual Governance Statement and other disclosures relevant to
  the Terms of Reference.

The Committee shall review the quality account before submission to the Board.

10.9 Other Matters

To identify risks arising from the issues before the Committee. The Chair of the Committee will draw these to the attention of the Trust Board issues which require disclosure to the full Board or require executive action

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, risk management in the organisation, the integrated governance arrangements and the robustness of the processes behind the accounts.

11. Conduct of Meetings

• Agendas will normally be prepared and circulated 5 days in advance.
• Any member or attendee may request an item for the agenda through the Chair.
• Members will have the right to speak and if necessary vote at meetings of the Committee. Attendees may speak and their opinions may be sought but they will not participate in any formal vote.
• Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The person declaring an interest will withdraw whilst the issue is being discussed.
• In the event of a formal vote, a simple majority will prevail. In the event of a tied vote the Chair will have a deciding vote, provided that nothing in the way business is conducted is prohibited in Standing Orders of the Trust.

12. Reporting

Reports to the Board will be made as follows:

• The minutes of Audit Committee meetings shall be formally recorded and submitted to the Trust Board by the Chair and/or lead Executive of the Committee. In limited circumstances as covered in the Freedom of Information Act, e.g. where confidential personal information is involved, a summary or suitably edited minutes will be presented.
• Due to the timing of the Committee meetings, a verbal update, providing items for assurance and emerging risks and mitigating actions will be given to the trust board following meetings on matters that were discussed at Audit Committee meetings

• An Annual Report of the Audit Committee

• The External Audit Annual Report.

13. **Annual Review of the Audit Committee**

The Committee will undertake an annual self assessment on their effectiveness and performance to:

• Review its own performance to ensure it is operating effectively;
• Determine whether its planned activities and responsibilities for the previous year have been sufficiently discharged; and
• Recommend any changes and/or actions it considers necessary, in respect of the above.

An annual written report will be provided to the Board which will provide details of the outcome of an annual self-assessment.

14. **Monitoring Compliance**

As part of the annual self assessment referred to in paragraph 13 which will be reported in the annual report, the Committee will review that the terms of reference have been complied with and whether they remain fit for purpose. As a minimum, the terms of reference must include:

a) Duties
b) Reporting arrangements to the board
c) Membership, including nominated deputy where appropriate
d) Required frequency of attendance by members
e) Reporting arrangements into the Audit Committee
f) Requirements for a quorum
g) Frequency of meetings
h) Process for monitoring compliance with all of the above

15. **Terms of Reference**

These Terms of Reference were approved by the Trust Board at its meeting in February 2018. Any variation, including to the membership, will require the approval of the Trust Board.

The Trust Board may formally change the Terms of Reference at any time, either at its own initiation or following a request for variation submitted by the Committee.
The Committee will review the Terms of Reference annually for resubmission to the Trust Board.

The Trust Board will review the Terms of Reference submitted in the light of the wider requirements of the Trust and may amend them before approval.

The terms of reference will be reviewed in February 2019 (unless required to be reviewed earlier).

These terms of reference may be subject to further amendment following a deep dive review of the outcomes of the recent self assessment on committee effectiveness, which is still being worked through.
### Board Objectives

**PATIENTS** – Provide safe, effective personal care in the right place

**PEOPLE** – Build, value and develop a motivated and sustainable workforce

**PARTNERSHIPS** – Work within the Caring Together Framework to deliver our vision

**RESOURCES** – To deliver services that are clinically and financially sustainable

<table>
<thead>
<tr>
<th><strong>February 2018</strong></th>
<th><strong>February 2018</strong></th>
<th><strong>May 2018</strong></th>
<th><strong>May 2018</strong></th>
<th><strong>August 2018</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Board Assurance</strong></td>
<td><strong>Internal Audit report:</strong></td>
<td><strong>Audit Committee Annual Report 2017/2018</strong></td>
<td><strong>Internal Audit:</strong></td>
<td><strong>Board Assurance Framework and Corporate Risk Register</strong></td>
</tr>
<tr>
<td><strong>Framework</strong></td>
<td><strong>- Progress Report</strong></td>
<td></td>
<td><strong>- Director of Audit Opinion</strong></td>
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<tr>
<td><strong>Corporate Governance</strong></td>
<td><strong>- Draft Audit Plan 18/19</strong></td>
<td></td>
<td><strong>- Final Audit Plan</strong></td>
<td></td>
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<tr>
<td><strong>Manual</strong></td>
<td><strong>Anti-Fraud:</strong></td>
<td><strong>Annual Report</strong></td>
<td><strong>Anti-Fraud:</strong></td>
<td><strong>Internal Audit:</strong></td>
</tr>
<tr>
<td><strong>Draft Annual Governance Statement</strong></td>
<td><strong>- Progress Report</strong></td>
<td><strong>– SQS Committee 2017/2018</strong></td>
<td><strong>Annual-Fraud Annual report 2017/2018</strong></td>
<td><strong>- Review Audit Progress plan</strong></td>
</tr>
<tr>
<td><strong>Anti-Fraud Draft Workplan 2018/19</strong></td>
<td><strong>- Draft Workplan 18/19</strong></td>
<td><strong>Annual report</strong></td>
<td><strong>- Costing Assurance Review 2017/2018</strong></td>
<td><strong>- Exception reports</strong></td>
</tr>
<tr>
<td><strong>Review Committee Terms Of Reference</strong></td>
<td><strong>- Draft Self-Assessment</strong></td>
<td><strong>- FPW – 2017/2018</strong></td>
<td><strong>- Going Concern Statement</strong></td>
<td><strong>- Annual Audit Letter</strong></td>
</tr>
<tr>
<td><strong>November 2018</strong></td>
<td><strong>External Audit report:</strong></td>
<td><strong>Trust Annual Report</strong></td>
<td><strong>- Management Response</strong></td>
<td><strong>External Audit:</strong></td>
</tr>
<tr>
<td><strong>Corporate Governance Manual including:</strong></td>
<td><strong>- Final Audit plan</strong></td>
<td><strong>Annual Governance Statement</strong></td>
<td><strong>- Draft Accounting Policies</strong></td>
<td><strong>- Audit Progress Report</strong></td>
</tr>
<tr>
<td><strong>- Review of Standing Orders</strong></td>
<td><strong>- Audit Assurance letter</strong></td>
<td><strong>Quality Account</strong></td>
<td><strong>- Annual Audit Letter</strong></td>
<td><strong>- Annual Audit Letter</strong></td>
</tr>
<tr>
<td><strong>and Changes to Financial Instructions / Scheme of Delegation</strong></td>
<td><strong>Losses and Compensations</strong></td>
<td><strong>Audit Opinion on Quality Account</strong></td>
<td><strong>Review of Losses and Compensations</strong></td>
<td><strong>Review of Losses and Compensations</strong></td>
</tr>
<tr>
<td><strong>Board Assurance Framework</strong></td>
<td><strong>Internal Audit report:</strong></td>
<td><strong>Final Accounts Memorandum</strong></td>
<td><strong>External Audit:</strong></td>
<td><strong>Final Accounts Memorandum</strong></td>
</tr>
<tr>
<td><strong>Corporate Governance</strong></td>
<td><strong>- Progress Report</strong></td>
<td></td>
<td><strong>- Audit Findings including Audit Opinion, Value for Money</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Manual</strong></td>
<td><strong>- Draft Audit Plan 18/19</strong></td>
<td></td>
<td><strong>- Receive letter of Management Representation</strong></td>
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</tr>
<tr>
<td><strong>February 2019</strong></td>
<td><strong>External Audit report:</strong></td>
<td><strong>Review of Losses and Compensations</strong></td>
<td><strong>February 2019</strong></td>
<td><strong>Review Committee Terms Of Reference</strong></td>
</tr>
<tr>
<td></td>
<td><strong>- Final Audit plan</strong></td>
<td></td>
<td><strong>Board Assurance Framework</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>- Audit Assurance letter</strong></td>
<td></td>
<td><strong>Corporate Governance Manual</strong></td>
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<tr>
<td></td>
<td><strong>Losses and Compensations</strong></td>
<td></td>
<td><strong>Draft Annual Governance Statement</strong></td>
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</tbody>
</table>

### Standing Committee Agenda Items

**Declaration of Interests**
## AUDIT COMMITTEE: SELF ASSESSMENT CHECKLIST

**May 2018**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Evidence to Support Action (E)/Action Required (A) – Please indicate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMPOSITION, ESTABLISHMENT AND DUTIES</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Does the Committee have written terms of reference that adequately and realistically define the Committee’s role in accordance with Department of Health guidance?</td>
<td>X</td>
<td></td>
<td></td>
<td>Terms of reference align to Delegated Authority and the Audit Handbook.</td>
</tr>
<tr>
<td>Have the terms of reference been approved by the Board?</td>
<td>X</td>
<td></td>
<td></td>
<td>Corporate Governance Manual submitted to Trust Board May 2018.</td>
</tr>
<tr>
<td>Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?</td>
<td>X</td>
<td></td>
<td></td>
<td>February 2018.</td>
</tr>
<tr>
<td>Has the Committee established a plan for the conduct of its own work across the year so it is clear about its purpose?</td>
<td>X</td>
<td></td>
<td></td>
<td>The Committee has with the Chair agreed its work programme.</td>
</tr>
<tr>
<td>Has the Committee been provided with sufficient membership and authority to perform its role effectively and independently?</td>
<td>X</td>
<td></td>
<td></td>
<td>There are three Non-Executive Directors who act independently requesting information from Executives.</td>
</tr>
<tr>
<td>Are changes to the Committee’s current and future workload discussed and approved at Board Level?</td>
<td>X</td>
<td></td>
<td></td>
<td>As part of the Board review of the Terms of Reference.</td>
</tr>
<tr>
<td>Does the Committee report regularly to the Board?</td>
<td>X</td>
<td></td>
<td></td>
<td>Following each meeting.</td>
</tr>
<tr>
<td>Are members, particularly those new to the Committee, provided with training?</td>
<td>X</td>
<td></td>
<td></td>
<td>There is a briefing to support new members.</td>
</tr>
<tr>
<td>Does the Board ensure that members have sufficient knowledge of the organisation to identify key risk areas?</td>
<td>X</td>
<td></td>
<td></td>
<td>Via Board Development / papers from Board / Committees / Board Walkabouts</td>
</tr>
<tr>
<td>Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the board, which would then form the basis for the focus the following year?</td>
<td>X</td>
<td></td>
<td></td>
<td>The Board will receive an annual report in June 2018.</td>
</tr>
<tr>
<td><strong>COMPLIANCE WITH THE LAW AND REGULATIONS GOVERNING THE NHS</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?</td>
<td>X</td>
<td></td>
<td></td>
<td>Via the Director of Finance and the Director of Corporate Affairs and Governance.</td>
</tr>
<tr>
<td><strong>INTERNAL CONTROL AND RISK MANAGEMENT</strong></td>
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</tr>
<tr>
<td>Has the Committee formally considered how it integrates with other committees that are reviewing risks e.g. risk management and clinical governance to ensure it does not miss anything relevant?</td>
<td>X</td>
<td></td>
<td></td>
<td>Assurance from Chairs of Committees of the Board. Assurance from CEO as Chair of Clinical Management Board. Board Assurance Framework.</td>
</tr>
<tr>
<td>Has the Committee formally considered how its work integrates with wider performance management and standards of compliance?</td>
<td>X</td>
<td></td>
<td></td>
<td>Via Assurance from Finance, Workforce and Performance Committee, and Safety Quality and Standards Committee.</td>
</tr>
<tr>
<td>Has the Committee been briefed on its assurance responsibilities with regard to the Assurance Framework and essential quality and risk standards of the CQC?</td>
<td>X</td>
<td></td>
<td></td>
<td>Via the Board agreement of Audit Plan. Review of Assurance Framework. Delegated authority from the Board on any additional areas of focus not included within the Terms of Reference.</td>
</tr>
<tr>
<td>Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?</td>
<td>X</td>
<td></td>
<td></td>
<td>An agreed timeframe in place to support papers being sent out in a timely manner.</td>
</tr>
<tr>
<td>Is the Committee satisfied that the Board has been advised that assurance reporting in respect of Quality</td>
<td>X</td>
<td></td>
<td></td>
<td>Reports to Audit Committee, Board Assurance Framework, SQS Committee, Quality Account reviewed</td>
</tr>
<tr>
<td>Issue</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Evidence to Support Action (E)/Action Required (A) – Please indicate</td>
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<tr>
<td>----------------------------------------------------------------------</td>
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<td>---------------------------------------------------------------------</td>
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<tr>
<td>Governance is in place?</td>
<td></td>
<td></td>
<td></td>
<td>by External Auditors.</td>
</tr>
<tr>
<td><strong>ADMINISTRATIVE ARRANGEMENTS</strong></td>
<td></td>
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</tr>
<tr>
<td>Does the Committee meet the appropriate number of times to deal with planned matters?</td>
<td>X</td>
<td></td>
<td></td>
<td>The Chair assesses the work of the Committee and agrees 4 meetings during the year.</td>
</tr>
<tr>
<td>Is the timing of Committee meetings discussed with all the parties involved?</td>
<td>X</td>
<td></td>
<td></td>
<td>Members attendance.</td>
</tr>
<tr>
<td><strong>OTHER ISSUES</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Does the Committee assess its own effectiveness periodically to identify gaps and development needs?</td>
<td>X</td>
<td></td>
<td></td>
<td>Via self-assessment, annually.</td>
</tr>
</tbody>
</table>
**Agenda Item Number 14: TB 18 (4)**

**Report of:**

**Responsible Officer:**

**Accountable Officer:** Committee Chair, Non-Executive Director

**Author of Report:** SQS Committee Meeting Secretary

**Subject/Title**

SQS Committee Annual Report 2017-18
Revised Terms of Reference

**Background papers (if relevant)**

N/A

**Purpose of Paper**

To summarise the work of the Committee from April 2017 to March 2018

**Action/Decision required**

The committee are asked to approve the Annual Report, Terms of Reference, Self-Assessment and Year at a Glance

**Mitigates Risk Number: (identify)**

On Corporate Risk Register

**Mitigates Risk Number: (identify)**

On Assurance Framework

**BAF 2: Quality and Compliance**

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.

Due to (Causes):

- Poor professional practise
- Inappropriate behaviours
- Inadequate or inappropriate staffing levels
- Inadequate infection, prevention controls
- Sub-standards estate/facilities
- Poor systems and processes
- Failure to learn from mistakes

Resulting in (Effects):

- Compromised standards of care
- Poor patient experience
- Regulatory intervention
- Reputational damage

**Link to Care Quality Commission Domain**

Safe
Caring
Responsive
Effective
Well-led

**Link to:**

- **Trust’s Strategic Direction**
- **Corporate Objectives**

Continuously improve quality, safety and the patient experience

Trust Objectives

**PATIENTS** – Provide safe, effective personal care in the right place

**PEOPLE** – Build, value and develop a motivated and sustainable workforce

**PARTNERSHIPS** – Work within the Caring Together Framework to deliver our vision
<table>
<thead>
<tr>
<th><strong>RESOURCES</strong> – To deliver services that are clinically and financially sustainable</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal implications - (identify)</td>
<td>N/A</td>
</tr>
<tr>
<td>Impact on quality</td>
<td>N/A</td>
</tr>
<tr>
<td>Resource impact</td>
<td>N/A</td>
</tr>
<tr>
<td>Impact of equality/diversity</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Avoid acronyms or abbreviations - if necessary list:**
- NHS National Health Service
- SQS Safety, Quality & Standards
- STP Sustainability and Transformation Plan
- HR Human Resources
- JAG Joint Advisory Group
- AQuA Advancing Quality Alliance
SQS Committee Annual Report 2017-18

1. Purpose

1.1 The following Annual Report summarises the Safety, Quality and Standards Committee's work for the twelve month period between 1st April 2017 and 31st March 2018.

1.2 The Annual report provides an overview of how the Committee has discharged its duties in line with the terms of reference as delegated by the East Cheshire NHS Trust Board.

2. Background

2.1 The purpose of the Safety, Quality and Standards Committee, as outlined within the Terms of Reference, is as follows:-

This Committee is established as a Standing Committee of the Trust Board of East Cheshire NHS Trust to provide the Trust Board with assurance of clinical and non-clinical safety, quality and standards of practice throughout the trust.

2.2 As defined within the agreed terms of reference, the Committees' duties are:

- to contribute to and promote the vision, values and culture of governance, safety, quality and standards across the Trust
- to assess and provide assurance on strategic risks in relation to safety, quality and standards and monitor progress
- to oversee an effective system for delivering a safe high quality experience for all patients and service users, including carers, with particular focus on involvement and engagement for the purposes of learning and making improvement
- to ensure that lessons are learned across the organisation from patient feedback
- to oversee an effective system for monitoring clinical outcomes and clinical effectiveness; with particular focus on ensuring patients receive the best possible outcomes of care across the full range of trust activities
- to receive internal and external reports and guidance and where relevant and appropriate ensure implementation of associated recommendations
- to review the annual quality account, and provide assurance on outcomes and priorities to the Trust Board
- to agree an annual programme of work for the Committee and produce an annual report on the progress against the work plan for submission to the Trust Board
- to approve the following strategies/strategic plans, as and when required, for the following areas of service:
  - Risk Management (Maternity)
  - Clinical Audit
  - Research Governance
  - Quality (agreement prior to presenting to the Trust Board for approval)
  - Nursing, Midwifery and Therapies Professional Practice
  - Medicines Optimisation
  - Engagement and Involvement

Chairman: Lynn McGill
Chief Executive: John Wilbraham
2.3 Appendix 1 provides the revised Terms of Reference for the Committee to review and confirm accuracy.

3. Constitution

3.1 During 2017-18, the membership of the Committee comprised of Non-Executive Directors, Executive Directors, Chief Pharmacist, responsible officers for reporting sub Committees and key senior officers within the trust who are responsible for aspects of clinical governance, quality and risk.

3.2 During 2017-18 there was one change to the membership for the SQS Committee. Due to ongoing work on the STP programme, the Chief Executive agreed with the Chair for the Director of HR and Organisational Development to be relieved from attendance at SQS Committee meetings to support this work on his behalf. The Chair agreed to this change. The Director of HR and Organisational Development continues to be provided with the paperwork for all meetings and provides comments to the Chair prior to the meeting.

3.3 From April 2017, the membership consists of:-
- 2 Non-Executive Directors (one of which will Chair)
- Executive Directors (or nominated deputies)
- Associate Medical Director for Clinical Effectiveness
- Chief Pharmacist
- Deputy Director of Nursing and Quality
- Deputy Director of Corporate Affairs and Governance

3.4 The consent agenda has been utilised effectively with a number of items included under this section and the opportunity for members to seek clarity prior to the meeting. This process will continue to be used going forward.

3.5 A copy of the meeting papers and minutes are shared, for information purposes only, with the Clinical Directors, Heads of Service, Deputy Directors and Managers within the Corporate Affairs and Governance Directorate to ensure information and lessons learnt are being cascaded in a timely manner.

3.6 Meetings are scheduled for the last Tuesday in the Month. Eleven meetings have been held during the period from April 2017 – March 2018.

- Tuesday 25th April 2017
- Tuesday 30th May 2017
- Tuesday 27th June 2017
- Tuesday 25th July 2017
- Tuesday 29th August 2017
- Tuesday 26th September 2017
- Tuesday 31st October 2017
- Tuesday 28th November 2017
- Tuesday 19th December 2017
- Tuesday 30th January 2018
• Tuesday 27th February 2018
• Tuesday 27th March 2018

3.7 Due to the timing of the meetings, the Chair of the Committee provides verbal reports to the Trust Board, providing items for assurance, emerging risks and mitigating actions. Final minutes are then submitted to the Trust Board.

3.8 A schedule of attendance at meetings is maintained to demonstrate compliance with quoracy requirements.

3.9 *Table 1* shows committee members individual attendance rates for April 2017 – March 2018. 9 members of the committee have achieved the 75% attendance target including the Committee Chair, Non Executive Director, Director Nursing Performance and Quality, Chief Executive Officer, Chief Pharmacist, Medical Director, Director of Corporate Affairs and Governance. Where members have not attended the Chief Executive and Committee Chair have approved and the reason for non-attendance has been recorded in the minutes. Members who are unable to attend contribute virtually to agenda items as appropriate.

<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Position</th>
<th>Individual Attendance Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Cowan (<em>April 17 – Dec 18</em>)</td>
<td>Non-Executive Director</td>
<td>88</td>
</tr>
<tr>
<td>Julie Green</td>
<td>Director of Corporate Affairs and Governance</td>
<td>83</td>
</tr>
<tr>
<td>Kashif Haque</td>
<td>Chief Pharmacist</td>
<td>83</td>
</tr>
<tr>
<td>Ali Harrison</td>
<td>Meeting Chair, Non-Executive Director</td>
<td>100</td>
</tr>
<tr>
<td>John Hunter</td>
<td>Medical Director</td>
<td>100</td>
</tr>
<tr>
<td>Lorraine Jackman</td>
<td>Deputy Director of Corporate Affairs and Governance</td>
<td>75</td>
</tr>
<tr>
<td>Susan Knight</td>
<td>Associate Medical Director, Clinical Effectiveness</td>
<td>50</td>
</tr>
<tr>
<td>Mark Ogden</td>
<td>Director of Finance</td>
<td>58</td>
</tr>
<tr>
<td>Carol Seddon (<em>April 17 – July 17</em>)</td>
<td>Deputy Director of Nursing and Quality</td>
<td>75</td>
</tr>
<tr>
<td>Brian Green (<em>August 17 onwards</em>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kath Senior</td>
<td>Director of Nursing, Performance and Quality</td>
<td>83</td>
</tr>
<tr>
<td>John Wilbraham</td>
<td>Chief Executive</td>
<td>92</td>
</tr>
</tbody>
</table>

4. **Annual Work Plan**

4.1 In line with good practice, the Committee has an Annual Work Plan with meetings timed to consider and act on specific issues within that plan. *Appendix 2* provides the Annual Work Plan (Year at a Glance) for 2017-18 and the proposed Work Plan for 2018-19.
4.2 For the forward year ahead, the proposal is;
- To continue to address the key priorities in our Trust Quality Strategy; Harm-free Care, Improving Outcomes, Listening and Responding, Integrated Care. The Year at a Glance will schedule quarterly updates on the Quality Strategy, with topics addressing each of these 4 key priorities.
- To continue to focus on key safety and quality risks in the Trust’s Assurance Framework & Risk Register to drive our forward agendas. The Committee will continue to scrutinise information and data provided, requesting ‘deep dives’ or ‘spotlights’ where appropriate in order to seek & ultimately gain assurances on these key risks and associated mitigation plans.
- The Committee will continue to receive proactive reviews of external legislative developments which impact on our activities and external reports and/or events which may help develop patient care in our Trust to further improve patient safety, patient experience and clinical outcomes.
- To seek assurances on ongoing safety, quality and effectiveness of our services as we engage with partners in transition planning.

5. Achievements which Provide Assurance

5.1 The Safety, Quality and Standards Committee has fulfilled its duties through self-assessment, requesting and receiving assurances from Trust Directors and directing and receiving reports from Chairs of reporting sub Committees. During the year, the Committee has:
- Complied with the agreed Terms of Reference
- Adhered with the agreed work plan for 2017/18 making strategic changes where necessary and with full approval from the Chair
- Addressed strategic risks within the corporate risk register assigned to SQS oversight
- Reviewed the effectiveness of implemented action plans aimed at improving standards and quality
- Monitored progress and outcomes i.e. through formal minutes and the maintenance of an action log at each Committee meeting.

5.2 Self-Assessment

5.2.1 The self-assessment exercise has been completed by members and the results are detailed in Appendix 3.

5.2.2 The committee has made effective use of the consent agenda which was instigated in September 2015 and continues to further improve the quality and assurance of papers placed on the consent agenda to allow time for more detailed discussion on key risks and issues in the main agenda. An example has been the introduction of the combined quality and governance report initiated in November 2017.
5.3 Governance & Risk Management

5.3.1 Monthly Quality Governance Reports have been received and include information on potential organisational risk issues in terms of relevant external regulatory or statutory issues. The Committee also received the monthly Risk Assessed Data Report (RADaR), which presents members with the findings of a retrospective review of services against an agreed data set of quality risk indicators and provides assurance and commentary from service areas in relation to the previous month’s risk profile.

5.3.2 Monthly reports on the Quality Dashboard are received by the Committee and where targets are consistently not being met, ‘Spot light’ investigations are commissioned and reviewed and assurance provided to the Board on action taken. Examples this year include 12 Hour Psychiatric Breaches, A&E Claims, Falls Strategy and Action plan update, General Surgery Claims, Correspondence, Community Nursing, Acute Nursing, Overcrowding in ED and Medical Staffing.

5.3.2 From November 2017 a revised combined quality and governance report has been produced and well received by the Committee. The report covers each of the CQC 5 domains – Safe; Effective; Responsive; Caring and Well led.

5.3.3 Quarterly reviews are undertaken on the Assurance Framework and Risk Register to gain assurance that the risks faced by the Trust are being appropriately reviewed and that the necessary controls and risk mitigations are in place.

5.3.4 Freedom to Speak Up updates have been provided and included summaries of concerns, raised via the Executive Lead for raising concerns and the trust’s Freedom to Speak Up Guardian, investigation outcomes and learning.

5.4 Patient Experience

5.4.1 The focus on patient care and experience is foremost at each Committee meeting, which includes the presentation of a ‘Patient Story’ by the Director of Nursing, Performance & Quality, for members to discuss. These included positive and negative stories and were presented via verbal updates and invited attendees. Areas covered include ‘what went well’ and ‘what could have been better’ and associated learnings and actions.

5.4.2 Through the Quarterly Quality Strategy Updates, the Committee was provided with updates on ongoing work for the four key areas within the strategy; Harm Free Care, Improving Outcomes, Integrated Care and Listening and Responding. These updates were provided in June 2017, September 2017 and December 2017 and March 2018. A refresh on the Quality Strategy was presented at the February 18 SQS meeting.

5.4.3 Quarterly reports have been received on complaints, incidents, claims and patient experience. This has provided evidence of lessons learned and actions taken to prevent re-occurrence. In addition any trends or themes have been identified. The trust’s Annual Complaints Report for 2016/17 was received in May 2017.
5.4.4 Quarterly Progress Reports have been provided on delivery of the trust’s Equality Plan as well as the outcomes of patient experience surveys and associated action plans.

5.5 Internal Processes

5.5.1 Responsible Officers have provided assurance reports to the Committee in relation to the activity during the year of the following sub-committees:
- Quality Forum Sub-Committee
- Clinical Audit and Research Effectiveness Sub-Committee
- Risk Management Sub-Committee (including Health and Safety)
- Organ Donation Sub-Committee
- Medicines Management Sub-Committee
- Human Tissue Authority Sub-Committee
- Safeguarding Sub-Committee
- Serious Incident Review Sub-Committee
- Radiation Sub-Committee
- Mortality Sub Committee
- Infection, Prevention and Control Sub-Committee
- Clinical Directorate SQS Sub-Committees

6. Recommendations

6.1 The recommendations from the annual report are;
- To agree the annual report. This will be submitted to the Trust Board and Audit Committee.
- To agree the Terms of Reference (Appendix 1). This will be recommended to the Trust Board.
- To note and approve the proposed Annual Work Plan (Year at a Glance) for 2018/19 (Appendix 2).
- To note the outcome of the Self-Assessment (Appendix 3).

7. Appendices

   Appendix 1   SQS Committee Terms of Reference for 2018/19
   Appendix 2   SQS Annual Work Plan (Year at a Glance) for 2017/18 and proposed Work Plan for 2018/19
   Appendix 3   SQS Committee Self-Assessment for 2017/18
1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Safety Quality and Standards Committee (the Committee), which is directly accountable to the Board.

2. Definition

This Committee is established as a standing Committee of the Trust Board of East Cheshire NHS Trust in order to provide the Trust Board with assurances of clinical and non-clinical safety, quality and standards of practice throughout the Trust.
3. **Membership**

- 2 Non-Executive Directors (one of which will Chair)
- All Executive Directors (or nominated deputies)
- Associate Medical Director for Clinical Effectiveness
- Chief Pharmacist
- Deputy Director of Nursing and Quality
- Deputy Director of Corporate Affairs and Governance

4. **Quorum**

- A Non-Executive Director will Chair the meetings

  and;

- 2 Executives – one of whom is the Medical Director or Director of Nursing, Quality & Performance.

- If both these 2 Executives are unable to attend, then both the Associate Medical Director for Clinical Effectiveness and Deputy Director of Nursing and Quality must attend

5. **Attendance**

- Members of the Committee should make every effort to attend meetings in person. There may be circumstances where members join by telephone. If members are on annual or sick leave, deputies who have the appropriate level of authority should attend but their attendance will not count towards the member’s attendance levels. The Chair should be notified of members wishing to join by telephone and the attendance of deputies at least 24 hours in advance of the meeting.

- Members of the SQS Committee must achieve a minimum of 75% meeting attendance. Nominated deputies attendance will not count towards the member’s attendance levels.

6. **Chairmanship**

- The Chair of the Committee will be a Non-Executive Director.

- The Chair may invite other senior employees, particularly when the Committee is discussing an issue that is the responsibility of that employee.

7. **Minutes**

- The minutes of the meeting shall be drawn up and submitted for agreement at the next ensuing meeting.
8. **Frequency of Meetings**

- The Committee shall meet each month, a minimum of ten times per annum

- **Emergency Powers**
  - Where an urgent decision needs to be made in between scheduled meetings, the Chair of the committee can convene an Extra-ordinary meeting to discuss a particular issue, quorum rules as stated in paragraph 3 still apply.
  - If it is not practicable to meet in person, matters can be dealt with through telephone or the exchange of emails.
  - The exercise of such powers shall be reported and minuted at the next Committee meeting.

9. **Authority**

- Responsibility for all decisions relating to the clinical governance and non-clinical risk management activities lies entirely with the Trust Board of East Cheshire NHS Trust. The Safety, Quality and Standards Committee may act with such authority delegated to it by the Trust Board to oversee, coordinate, review and assess the effectiveness of clinical governance and non-clinical risk management arrangements and activities within the Trust. This includes detailed strategies/plans.

- The Committee is authorised by the Board to seek the information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

10. **General Responsibilities and Principles**

- The general responsibilities and principles are:
  - Contribute to and promote the vision, values and culture of governance, safety, quality and standards across the Trust;
  - assess and provide assurance on strategic risks in relation to safety, quality and standards and monitor progress
  - oversee an effective system for delivering a safe high quality experience for all patients and service users, including carers, with particular focus on involvement and engagement for the purposes of learning and making improvement
  - ensure that lessons are learned across the organisation from patient feedback;
  - oversee an effective system for monitoring clinical outcomes and clinical effectiveness; with particular focus on ensuring patients receive the best possible outcomes of care across the full range of trust activities
  - receive and where relevant and appropriate ensure and implement any recommendations from internal and external reports and guidance;
  - approve the following strategies/strategic plans, as and when required, for the following areas of service:
    - Risk Management (Maternity)
    - Clinical Audit
    - Records Management
    - Research Governance
    - Quality (agreement prior to presenting to the Trust Board for approval)
    - Nursing, Midwifery and Therapies Professional Practice
11. **Conduct of Meetings**

- The agenda and papers will be prepared and circulated 7 days in advance of a Committee meeting.

- An action log of open and closed actions will be produced.

- Any member may request an item for the agenda through the Chair.

- Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The person declaring an interest will withdraw whilst the issue is being discussed.

- In the event of a formal vote, a simple majority will prevail. In the event of a tied vote the Chair will have a deciding vote, provided that nothing in the way business is conducted is prohibited in Standing Orders of the Trust.

12. **Reporting**

- Reports to the Board will be made as follows:

  - Following each Committee meeting, the minutes shall be drawn up and submitted to the Chair in draft format. The draft minutes will then be presented at the next Committee meeting (see 'Minutes' above) for approval. The minutes of the SQS Committee shall be recorded and submitted to the Board.

  - Due to the timing of the Committee, a verbal update, providing items for assurance and emerging risks and mitigating actions will be given to the trust board following SQS meetings to ensure timely assurance and escalation of risks.

- Reporting arrangements of other Committees and Groups

  - In order to comply with paragraph2, in that the SQS Committee is responsible for providing assurance on clinical and non-clinical safety, quality and standards of practice throughout the Trust, the following Sub-Committees and Groups will provide a written report to the SQS Committee on at least an annual basis, in line with agreed Terms of Reference:

    1. Quality Forum Sub-Committee
    2. Clinical Audit and Research Effectiveness Sub-Committee
    3. Risk Management Sub-Committee
    4. Organ Donation Sub-Committee
    5. Medicines Management Sub-Committee (to include the report of the Controlled Drugs Accountable Officer)
    6. Human Tissue Authority Sub-Committee
    7. Integrated Safeguarding Sub-Committee
8. Serious Incident Review Sub-Committee
9. Mortality Review Sub Committee
10. Infection, Prevention and Control Sub-Committee
11. Safety Quality & Standards Sub-Committees of Clinical Directorates x3
12. Radiation Protection Sub-Committee

- The committee will review and provide recommendations to the Board of any changes to the sub committees reporting to SQS. Reports by exception may take place, where necessary, to escalate significant issues / risks outside of the regular scheduled reporting.

- The committee will receive Annual Reports from Sub-Committees, which will include their self-assessments, as appendices to their reports. A schedule will be shared with the Sub-Committee Chairman

13. Annual Review of the SQS Committee

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

- An annual written report will be provided to the Board, via the Audit Committee which details the outcome of the self-assessment.

14. Monitoring Compliance

- As part of the annual self-assessment referred to in paragraph 13 which will be reported in the annual report, the Committee will review that the terms of reference have been complied with and whether they remain fit for purpose. As a minimum, the terms of reference must include:
  - Duties
  - Reporting arrangements to the board
  - Membership, including nominated deputy where appropriate
  - Required frequency of attendance by members
  - Reporting arrangements into the SQS Committee
  - Requirements for a quorum
  - Frequency of meetings
  - Process for monitoring compliance with all of the above

15. Terms of Reference

- These will be reviewed in February 2019 (annually) or as required.
### Board Objectives

**VISION**: To ensure our patients receive the best care in the right place

**MISSION**: Work in partnership to provide high quality affordable integrated services

<table>
<thead>
<tr>
<th>April 2017 (Q4 / year end)</th>
<th>May 2017</th>
<th>June 2017</th>
<th>July 2017 (Q1 report)</th>
<th>August 2017</th>
<th>September 2017</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>October 2017 (Q2 report)</th>
<th>November 2017</th>
<th>December 2017</th>
<th>January 2018 (Q3 report)</th>
<th>February 2018</th>
<th>March 2018</th>
</tr>
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<tbody>
<tr>
<td>Quarterly Mortality Report</td>
<td>Spotlight – Community Nursing</td>
<td>Spotlight - Overcrowding in ED</td>
<td>Freedom to Speak Up (via Governance Report)</td>
<td></td>
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<tr>
<td>Spotlight – Community Nursing</td>
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</table>

### Board Assurance Framework

**Board Assurance Framework**

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

### Standing Committee Agenda Items

- Patient Story
- Quality Dashboard
- Quality Governance Report
- Risk Assessed Data Report (RADaR)
- Deep Dive

### Quarterly Quality Strategy Updates

- Harm Free Care
  - Sign Up to Safety
  - Improving Outcomes
  - Care Bundles
- Listening and Responding
  - Patient Surveys
- Integrated Care
  - Releasing Time to Care
## VISION
To ensure our patients receive the best care in the right place

## MISSION
Work in partnership to provide high quality affordable integrated services

### Board Objectives

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

### Board Assurance Framework

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

### Standing Committee Agenda Items

- Patient Story
- Integrated Quality & Governance Report
- Risk Assessed Data Report (RADaR)
- Spot Light

### Quarterly Quality Strategy Updates

- Harm Free Care
  - Sign Up to Safety
- Improving Outcomes
  - Care Bundles
- Listening and Responding
  - Patient Surveys
- Integrated Care
  - Releasing Time to Care

### Table: Meeting Bundle Page 114 of 165

<table>
<thead>
<tr>
<th>Month</th>
<th>Senior Leadership Meeting Activities</th>
<th>Board Assurance Framework</th>
<th>Standing Committee Agenda Items</th>
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<tr>
<td>April 2018 (Q4 / year end)</td>
<td>Quality Account&lt;br&gt;Quarterly Mortality Report&lt;br&gt;Bi-Annual QIPP QIA Report&lt;br&gt;Freedom to Speak Up Annual Report (via Governance Report)&lt;br&gt;Falls &amp; Pressure Ulcers</td>
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<tr>
<td>June 2018</td>
<td>Quarterly CARE Report</td>
<td>-</td>
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<tr>
<td>July 2018 (Q1 report)</td>
<td>SIRI Annual Report and Self-Assessment&lt;br&gt;Quarterly Quality Strategy Update – Harm Free Care&lt;br&gt;Bi-Annual SIRI Update Report&lt;br&gt;Medical staffing.</td>
<td>Infection, Prevention and Control Sub-Committee Annual Report and Self-Assessment&lt;br&gt;Duty of Candour – Being Open Update (via Governance Report)&lt;br&gt;SQS Terms of Reference AndSelf-Assessment&lt;br&gt;Quarterly Mortality Report Inc. Self Assessment&lt;br&gt;Quarterly CARE Report</td>
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</tr>
<tr>
<td>August 2018</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>September 2018</td>
<td>HTA Sub-Committee Annual Report and Self-Assessment&lt;br&gt;Bi-Annual QIPP QIA Report&lt;br&gt;Quarterly Quality Strategy Update – Listening and Responding&lt;br&gt;Assurance Framework and Risk Register (for Cmte only)</td>
<td>-</td>
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</table>

### October 2018 (Q2 report)

- Midwifery Staffing Levels
- Clinical Directorate SQS Sub-Committee Annual Reports And Assessments
- Bi-Annual QIPP QIA Report
- Patient Safety Culture Update (via Governance Report)
- Freedom to Speak Up (via Governance Report)
- Quarterly Mortality Report
- ED Pressures

### November 2018

- Risk Management Sub-Committee Annual Report And Self-Assessment
- Assurance Framework and Risk Register (for Cmte only)
- Quarterly CARE Report
- Freedom to Speak Up – Raising Concerns Update (via Governance Report)

### December 2018

- SIRI Annual Report and Self-Assessment
- Quarterly Quality Strategy Update – Harm Free Care
- Bi-Annual SIRI Update Report
- Medical staffing.

### January 2019 (Q3 report)

- Infection, Prevention and Control Sub-Committee Annual Report and Self-Assessment
- Duty of Candour – Being Open Update (via Governance Report)
- SQS Terms of Reference And Self-Assessment
- Quarterly Mortality Report Inc. Self Assessment
- Quarterly CARE Report
- Freedom to Speak Up (via Governance Report)

### February 2019

- Quality Strategy – Annual Refresh
- SQS Committee Annual Report and Self-Assessment

### March 2019

- Integrated Safeguarding Sub-Committee Annual Report and Self-Assessment
- Quarterly Quality Strategy Update – Integrated Care
- Assurance Framework and Risk Register (for Cmte only)

### Appendix 2

**SQS 2018/19 – Annual Work Plan - a Year at a Glance**

**East Cheshire NHS Trust**

<table>
<thead>
<tr>
<th>Month</th>
<th>Senior Leadership Meeting Activities</th>
<th>Board Assurance Framework</th>
<th>Standing Committee Agenda Items</th>
</tr>
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### October 2018 (Q2 report)

- Midwifery Staffing Levels
- Clinical Directorate SQS Sub-Committee Annual Reports And Assessments
- Bi-Annual QIPP QIA Report
- Patient Safety Culture Update (via Governance Report)
- Freedom to Speak Up (via Governance Report)
- Quarterly Mortality Report
- ED Pressures

### November 2018

- Risk Management Sub-Committee Annual Report And Self-Assessment
- Assurance Framework and Risk Register (for Cmte only)
- Quarterly CARE Report
- Freedom to Speak Up – Raising Concerns Update (via Governance Report)

### December 2018

- SIRI Annual Report and Self-Assessment
- Quarterly Quality Strategy Update – Harm Free Care
- Bi-Annual SIRI Update Report
- Medical staffing.

### January 2019 (Q3 report)

- Infection, Prevention and Control Sub-Committee Annual Report and Self-Assessment
- Duty of Candour – Being Open Update (via Governance Report)
- SQS Terms of Reference And Self-Assessment
- Quarterly Mortality Report Inc. Self Assessment
- Quarterly CARE Report
- Freedom to Speak Up (via Governance Report)

### February 2019

- Quality Strategy – Annual Refresh
- SQS Committee Annual Report and Self-Assessment

### March 2019

- Integrated Safeguarding Sub-Committee Annual Report and Self-Assessment
- Quarterly Quality Strategy Update – Integrated Care
- Assurance Framework and Risk Register (for Cmte only)
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<th>STATUS</th>
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<th>No</th>
<th>N/A</th>
<th>Evidence to Support Action (E)/Action Required (A) – Please indicate</th>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Does the Committee have written terms of reference that adequately and realistically define the Committee’s role in accordance with Department of Health guidance?</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Terms of Reference in place.</td>
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<tr>
<td>1</td>
<td>Have the terms of reference been approved by the Board?</td>
<td>Yes</td>
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<tr>
<td>2</td>
<td>Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?</td>
<td>Yes</td>
<td></td>
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<tr>
<td>2</td>
<td>Has the Committee established a plan for the conduct of its own work across the year so it is clear about its purpose?</td>
<td>Yes</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1</td>
<td>Has the Committee been provided with sufficient membership and authority to perform its role effectively and independently?</td>
<td>Yes</td>
<td></td>
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<tr>
<td>2</td>
<td>Are changes to the Committee’s current and future workload discussed and approved at Board Level?</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Does the Committee report regularly to the Board?</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Every Board meeting</td>
</tr>
<tr>
<td>2</td>
<td>Are members, particularly those new to the Committee, provided with training?</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Generally new members come with relevant experience and knowledges</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>In general members are selected by virtue of their expertise which includes an understanding of the issues pertinent to the function of SQS. Requirements for additional training will depend on the background of the individual and tailored to their requirements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The Committee has developed an induction pack to support new members to the Committee.</td>
</tr>
<tr>
<td>2</td>
<td>Does the Board ensure that members have sufficient knowledge of the organisation to identify key risk areas?</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the board, which would then form the basis for the focus the following year?</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMPLIANCE WITH THE LAW AND REGULATIONS GOVERNING THE NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Senior executive members of SQS are briefed on these issues as part of their role in the trust. Relevant matters are cascaded.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Triangulation with other committees and knowledge of Executive team contributions to maintaining awareness.</td>
</tr>
<tr>
<td>INTERNAL CONTROL AND RISK MANAGEMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Has the Committee formally considered how it integrates with other committees</td>
<td></td>
<td></td>
<td></td>
<td>Regular reports from relevant</td>
</tr>
<tr>
<td>STATUS</td>
<td>Issue</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Evidence to Support Action (E)/Action Required (A) – Please indicate</td>
</tr>
<tr>
<td>--------</td>
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<td>----</td>
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<td>------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
|        | that are reviewing risks e.g. risk management and clinical governance to ensure it does not miss anything relevant? | Yes |     |     | committees per ToR and incorporation into the annual plan.  
The Audit Committee seeks assurance from Committee chairs on review of the Assurance Framework and Corporate Risk Register.  
There are some risks which overlap into other Committees, however the focus for each Committee is dependent on the areas delegated from the Board. |
| 1      | Has the Committee formally considered how its work integrates with wider performance management and standards of compliance? | Yes |     |     | Monthly Integrated Quality and Governance Reports have been developed and regular incorporation of strategic items into agenda are part of the mechanism by which this assurance is obtained |
| 1      | Has the Committee been briefed on its assurance responsibilities with regard to the Assurance Framework and essential quality and risk standards of the CQC? | Yes |     |     | Regular input from Director of Corporate Affairs and Governance. |
| 2      | Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged? | Yes |     |     | Annual plan and requirements for timely submission of reports. Periodic review/discussion of format/quality/regularity of reports. |
| 2      | Is the Committee satisfied that the Board has been advised that assurance reporting in respect of Quality Governance is in place? | Yes |     |     | The Chair provides an overview to the Board following Committee meetings. The Audit Committee seeks assurance annual from review of annual reports and confirmation from Committee Chairs |

**ADMINISTRATIVE ARRANGEMENTS**

| 2      | Are papers circulated in good time and are minutes received as soon as possible after the meetings? | Yes |     |     |
| 2      | Does the Committee meet the appropriate number of times to deal with planned matters? | Yes |     |     |
| 2      | Is the timing of Committee meetings discussed with all the parties involved? | Yes |     |     |

The Chair seeks advice from members of the best time to hold the Committee meetings.

**OTHER ISSUES**

| 2      | Does the Committee assess its own effectiveness periodically to identify gaps and development needs? | Yes |     |     |

**ADDITIONAL COMMENTS**

A well organised Committee with appropriate agenda items and the right level of challenge and scrutiny.
**PUBLIC TRUST BOARD**
**Thursday 7th June 2018**

**Agenda Item Number 14: TB 18 (46)**

| Report of: | Mike Wildig  
| Responsible Officer: | Non-Executive Director  
| Accountable Officer: |  
| Author of Report: | Janine Homer  
| Executive PA |  
| Subject/Title | Annual Report of the Finance, Performance & Workforce Committee  
| Background papers (if relevant) | n/a  
| Purpose of Paper | To provide assurance that the Committee has undertaken a self assessment and demonstrated how it has discharged its responsibilities in line with their agreed terms of reference.  
| Action/Decision required | To receive and note the annual report  
| Mitigates Risk Number: (identify) On Corporate Risk Register |  
| Mitigates Risk Number: (identify) On Assurance Framework |  
| • If the trust cannot identify sufficient QIPP/additional income it will fail to achieve break even position.  
| • If we fail to achieve national and local quality standards it will impact on the trust's ability to improve the quality for patients.  
| • If the trust cannot put systems and processes in place to avoid contract penalties with its main commissioners it will have a material impact on its ability to achieve its financial targets.  
| • If the trust cannot identify a clinically and financially sustainable business model, the trust will fail to remain an independently viable proposition which will impact the local provision of care for our patients.  
| • If we do not connect effectively with our staff and engage them in sustaining an appropriate service for the people of East Cheshire we risk a deterioration of Employee Relations and the ensuring consequences including unrest, increase in sickness absence rates and general demotivation and disengagement.  
| • If leadership and/or clinical development opportunities are reduced, mid to long term workforce redesign and transformation opportunities will be constrained and we will fail in our corporate objective.  
| • If the trust does not have robust governance arrangements in place which hold up to external scrutiny and demonstrate best practice the reputation of the organisation may be damaged.  
| • If we fail to align Trust Board objectives with the |
professional practice of nursing and Allied Health Professional teams, this will impact on the trust's ability to continuously improve quality, safety and the patient experience.

| Link to Care Quality Commission Domain | Safe  
Caring  
Responsive  
Effective  
Well-led |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Link to:</td>
<td></td>
</tr>
<tr>
<td>➢ Trust’s Strategic Direction</td>
<td></td>
</tr>
<tr>
<td>➢ Corporate Objectives</td>
<td></td>
</tr>
<tr>
<td>Legal implications - (identify)</td>
<td></td>
</tr>
<tr>
<td>Impact on quality</td>
<td></td>
</tr>
<tr>
<td>Resource impact</td>
<td></td>
</tr>
<tr>
<td>Impact of equality/diversity</td>
<td></td>
</tr>
<tr>
<td>Avoid acronyms or abbreviations</td>
<td></td>
</tr>
<tr>
<td>- if necessary list:</td>
<td></td>
</tr>
</tbody>
</table>

There are no legal implications

There is no impact on quality

There are no resource implications

There is no impact on equality / diversity
Annual report and self assessment of the Finance, Performance and Workforce Committee

1. Purpose of report

1.1 The following annual report summarises the Finance, Performance and Workforce Committee’s work for the twelve month period between 1st April 2017 and 31st March 2018. It provides an overview of how the Committee has discharged its duties in line with the terms of reference as delegated by the Trust Board.

2. Background

2.1 The purpose of the committee, as outlined within the Terms of Reference, is as follows:

*This Committee is established as a Standing Committee of the Trust Board of East Cheshire NHS Trust in order to provide the Trust Board with assurance that national and local standards relating to finance, performance and workforce are being met.*

2.2 As defined within the agreed terms of reference, the general responsibilities of the Committee are:

Finance
- To seek assurance that systems and controls are in place to enable the Trust to meets its statutory duty of sustaining financial balance.
- To seek assurance on the production and implementation of long term financial plans and ensure these are aligned to workforce plans.
- To provide assurance to the Board that Quality, Innovation, Productivity and Prevention (QIPP) schemes are in accordance with national best practice guidance and that clinical leadership is driving performance improvement.
- To seek assurance on the planning and implementation of tenders.
- To seek assurance on the planning and implementation of the capital programme.
- To seek assurance on the performance and associated risks of finance plan and reporting.
Workforce

- To seek assurance on the continued development and timely delivery of the workforce strategy and its supporting plans and to ensure the workforce plan is aligned with service and financial plans.

- To provide assurance that the Trust is working within legislation and a good employment framework.

- To seek assurance on the development of appropriate learning and development and receive assurance that the trust is meeting its statutory and mandatory requirements.

- To seek assurance on the performance and associated risks of workforce plans and reporting.

- To seek assurance on the production and implementation of long term workforce plans.

Performance

- To provide assurance that the organisation has quality systems and processes which underpin sound performance and workforce modelling to deliver redesigned clinical pathways.

- To seek assurance on the delivery of the key performance measures of the Trust, with a focus on sustained performance and future delivery.

- To seek assurance on the performance and associated risks of performance plans and reporting.

Other Matters

- The Finance, Performance and Workforce Committee seeks assurance from each of the Sub-Committees and in conjunction with the scope of its own work, provides assurance directly to the Board.

- This Committee will work closely with the Audit Committee in supporting their assurance function.

- The Committee will look to see how finance, workforce and performance initiatives align with those of partner organisations.

2.3 Appendix 1 provides the Terms of Reference reviewed by the Committee.
3. **Constitution**

3.1 Membership of the Committee includes:

- Minimum 2 Non-Executive Directors (one of which will Chair)
- All Executive Directors: Chief Executive Officer, Director of Nursing, Director of Corporate Affairs and Governance, Medical Director, Director of HR and Organisational Development

3.2 Meetings are scheduled for the last Thursday of the month. Ten meetings have been held in the period April 2017 to March 2018.

- Thursday 27\textsuperscript{th} April 2017
- Thursday 29\textsuperscript{th} June 2017
- Thursday 26\textsuperscript{th} July 2017
- Thursday 28\textsuperscript{th} September 2017
- Thursday 26\textsuperscript{th} October 2017
- Thursday 25\textsuperscript{th} May 2017
- Thursday 29\textsuperscript{th} November 2017
- Thursday 25\textsuperscript{th} January 2018
- Thursday 22\textsuperscript{nd} February 2018
- Thursday 29\textsuperscript{th} March 2018

3.3 Table 1 shows Committee members’ individual attendance rates for April 2017 to March 2018. To date, all eight members have achieved the 75% attendance target.

<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Position</th>
<th>Individual Attendance Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mike Wildig</td>
<td>Meeting Chair</td>
<td>91</td>
</tr>
<tr>
<td>Tony Coombs</td>
<td>Non-Executive Director</td>
<td>91</td>
</tr>
<tr>
<td>Ian Goalen</td>
<td>Non-Executive Director</td>
<td>100</td>
</tr>
<tr>
<td>John Wilbraham</td>
<td>Chief Executive</td>
<td>91</td>
</tr>
<tr>
<td>Kath Senior</td>
<td>Director of Nursing, Performance and Quality</td>
<td>100</td>
</tr>
<tr>
<td>Julie Green</td>
<td>Director of Corporate Affairs and Governance</td>
<td>91</td>
</tr>
<tr>
<td>Mark Ogden</td>
<td>Director of Finance</td>
<td>100</td>
</tr>
<tr>
<td>John Hunter</td>
<td>Medical Director</td>
<td>100</td>
</tr>
<tr>
<td>Rachael Charlton</td>
<td>Director of HR and Organisational Development</td>
<td>91</td>
</tr>
</tbody>
</table>
4. Key Outputs and Assurances received during 2017/18

4.1 Over the period, the Committee has:

- Received and reviewed risks rated 15 and above and as appropriate requested further actions to reduce the level of risk score.
- Scrutinised QIPP scheme performance through deep dives presented by Directorates and agreed further focus where services did not deliver agreed performance.
- Provided assurance to the Board on the delivery of the control total.
- Reviewed key performance indicators and monitored performance and trends against agreed finance, workforce and performance targets ensuring scrutiny of mitigating actions where slippage has occurred.
- Received reports and reviewed benchmarking in relation to Carter, agreeing further work to improve productivity.
- Gained assurance on the staff survey and subsequent action plan as well as medical appraisal, revalidation, equality and diversity and wellbeing programmes in line with the Workforce Strategy.
- Reviewed the Terms of Reference for the Committee.

4.2 Outcomes from the FPW Self-Assessment:

The self-assessment demonstrated that all elements of the framework have been successfully achieved this year. Appendix 2 details the results of this.

5. Forward Look 2018/19

5.1 In line with good practice, the Committee has an Annual Work Plan with meetings timed to consider and act on specific issues within that plan. Appendix 3 provides the Annual Workplan (Year at a Glance) for 2017-18 and the proposed Workplan for 2018-19.

5.2 Over the coming months the Committee will:

- Take account of any further developments identified from the review of the self-assessment on Committee effectiveness.
• Continue to review and agree the key performance indicators and monitor performance and trends against those targets escalating any emerging risks to the Board.

• Continue to scrutinise all financial matters, to ensure the trust is on track to deliver its agreed control total provide assurance for the Board.

• Focus on QIPP delivery via each of the Directorates, as well as key risks for each area.

• Ensure that the annual workplan is informed by risks identified on the Board Assurance Framework and Corporate Risk Register.

• Request spotlights as and when necessary.

6. Recommendation

6.1 The recommendations from the annual report are;

• To agree the annual report. This will be submitted to the Trust Board and Audit Committee.
• To agree the Terms of Reference (Appendix 1). This will be recommended to the Trust Board.
• To note and approve the proposed Annual Work Plan (Year at a Glance) for 2018/19 (Appendix 2).
• To note the outcome of the Self-Assessment (Appendix 3).

7. Appendices

Appendix 1 FP&W Terms of Reference
Appendix 2 FP&W Annual Workplan 2017/18 and proposed Workplan for 2018/19
Appendix 3 FP&W Self-Assessment 2017/18
1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Performance and Workforce Committee (the Committee), which is directly accountable to the Board.

2. Definition

This Committee is established as a Standing Committee of the Trust Board of East Cheshire NHS Trust in order to provide the Trust Board with assurance that national and local standards relating to finance, performance and workforce are being met.
3. **Membership**

- Minimum 2 Non-Executive Directors (one of which will Chair)
- All Executive Directors

4. **Quorum**

The quorum shall be at least three members, one of which shall be a Non-Executive Director.

5. **Attendance**

Members of the Committee should make every effort to attend meetings in person. There may be circumstances where members join by telephone. If members are on annual or sick leave, deputies who have the appropriate level of authority, should attend. The Chair should be notified of members wishing to join by telephone, and the attendance of deputies, at least 24 hours in advance of the meeting.

Other specialists may be co-opted to discuss specific items on the agenda.

Members of the Finance, Performance and Workforce Committee must achieve a minimum of 75% meeting attendance. Nominated deputies attendance will not count towards the member’s attendance levels.

6. **Chairmanship**

The Chair of the Committee will be a Non-Executive Director.

The Chair will nominate a member of the Committee to Chair the meeting in their absence.

7. **Minutes**

The minutes of the meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

8. **Frequency of Meetings**

The Committee shall meet a minimum of ten times per annum.

8.1 **Emergency Powers**

Where an urgent decision needs to be made in between scheduled meetings, the Chair of the committee can convene an Extra-ordinary meeting to discuss a particular issue, quorum rules as stated in paragraph 4 still apply. If it is not practicable to meet in person, matters can be dealt with through telephone or the exchange of emails. The exercise of such powers shall be reported and minuted at the next Committee meeting.
9. **Authority**

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

10. **General Responsibilities and Principles**

10.1 **Finance**

- To seek assurance that systems and controls are in place to enable the Trust to meet its statutory duty of sustaining financial balance.
- To seek assurance on the production and implementation of long term financial plans and ensure these are aligned to workforce plans.
- To provide assurance to the Board that Quality, Innovation, Productivity and Prevention (QIPP) schemes are in accordance with national best practice guidance and that clinical leadership is driving performance improvement.
- To seek assurance on the planning and implementation of tenders.
- To seek assurance on the planning and implementation of the capital programme.
- To seek assurance on the performance and associated risks of finance plans and reporting.

10.2 **Workforce**

- To seek assurance on the continued development and timely delivery of the workforce strategy and its supporting plans and to ensure the workforce plan is aligned with service and financial plans
- To provide assurance that the Trust is working within legislation and a good employment framework
- To seek assurance on the development of appropriate learning and development and receive assurance that the trust is meeting its statutory and mandatory requirements.
- To seek assurance on the performance and associated risks of workforce plans and reporting.
- To seek assurance on the production and implementation of long term workforce plans.

10.3 **Performance**

- To provide assurance that the organisation has quality systems and processes which underpin sound performance and workforce modelling to deliver redesigned clinical pathways.
• To seek assurance on the delivery of the key performance measures of the Trust, with a focus on sustained performance and future delivery.

• To seek assurance on the performance and associated risks of performance plans and reporting.

10.4 Other Matters

The Finance, Performance and Workforce Committee seeks assurance from each of the Sub-Committees and in conjunction with the scope of its own work, provides assurance directly to the Board.

This Committee will work closely with the Audit Committee in supporting their assurance function.

The Committee will look to see how finance, workforce and performance initiatives align with those of partner organisations.

11. Conduct of Meetings

• Agendas will normally be prepared and circulated 5 days in advance.

• Any member may request an item for the agenda through the Chair.

• Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The person declaring an interest will withdraw whilst the issue is being discussed.

• All meetings will be minuted and:
  - approved by the Chair before submission to the Trust Board or wider circulation
  - approved by the Committee Members at the following meeting of the Committee
  - an Action Log will be updated following each meeting which will include open and closed actions

12. Reporting

12.1 Reports to the Board will be made as follows:

• The minutes of Finance, Performance and Workforce Committee meetings shall be formally recorded and submitted to the Trust Board by the Chair and/or lead Executive of the Committee. In limited circumstances as covered in the Freedom of Information Act, e.g. where confidential personal information is involved, a summary or suitably edited minutes will be presented.

• Due to the timing of the Committee dates, a verbal update will be given to the Trust Board after every meeting on matters that were discussed at Finance, Performance and Workforce Committee meetings.
• An annual report of the Finance, Performance and Workforce Committee

12.2 Reporting Arrangements of other Committees

The Board may identify sub committees to be established to provide further assurance.

Areas of risk will be escalated in line with the trust Risk Management System.

13. Annual Review of the Finance, Performance and Workforce Committee

The Committee will undertake an annual self assessment on their effectiveness and performance to:

• Review its own performance to ensure it is operating effectively;
• Determine whether its planned activities and responsibilities for the previous year have been sufficiently discharged; and
• Recommend any changes and/or actions it considers necessary, in respect of the above.

An annual written report will be provided initially to the Audit Committee before being submitted to the Board. This will provide details the outcome of an annual self-assessment.

14. Monitoring Compliance

As part of the annual self-assessment referred to in paragraph 13 which will be reported in the annual report, the Committee will review that the terms of reference have been complied with and whether they remain fit for purpose. As a minimum, the terms of reference must include:

a) Duties
b) Reporting arrangements to the board
c) Membership, including nominated deputy where appropriate
d) Required frequency of attendance by members
e) Reporting arrangements into the Finance, Performance and Workforce Committee
f) Requirements for a quorum
g) Frequency of meetings
h) Process for monitoring compliance with all of the above

15. Terms of Reference

These Terms of Reference were approved by the Trust Board at its meeting in March 2018 and will be reviewed at the meeting in February 2019. Any variation, including to the membership, will require the approval of the Trust Board.

The Trust Board may formally change the Terms of Reference at any time, either at its own initiation or following a request for variation submitted by the Committee.
The Committee will review the Terms of Reference annually for resubmission to the Trust Board.

The Trust Board will review the Terms of Reference submitted in the light of the wider requirements of the Trust and may amend them before approval.

The terms of reference will next be reviewed in February 2019 (unless required to be reviewed earlier).
## FINANCE, PERFORMANCE & WORKFORCE: SELF ASSESSMENT CHECKLIST

Status Key:
1 = must do  
2 = should do  
3 = could do  

### Agenda item 18/26

<table>
<thead>
<tr>
<th>STATUS</th>
<th>Issue</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Evidence to Support Action (E)/Action Required (A) – Please Indicate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMPOSITION, ESTABLISHMENT AND DUTIES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Does the Committee have written terms of reference that adequately and realistically define the Committee’s role?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) TOR agreed by Trust Board</td>
</tr>
<tr>
<td>1</td>
<td>Have the terms of reference been approved by FPW members?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) See minutes</td>
</tr>
<tr>
<td>2</td>
<td>Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) See minutes. Terms of Reference included in Corporate Governance manual</td>
</tr>
<tr>
<td>2</td>
<td>Has the Committee established a plan for the conduct of its own work across the year so it is clear about its purpose?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) Annual work programme – reviewed monthly (see minutes)</td>
</tr>
<tr>
<td>1</td>
<td>Has the Committee been provided with sufficient membership and authority to perform its role effectively and independently?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) The Committee has delegated authority via the Board. Membership includes non-executives and executives as well as senior operational managers who are in attendance as required to provide assurance on agenda items</td>
</tr>
<tr>
<td>2</td>
<td>Are changes to the Committee’s current and future workload discussed and approved at Board Level?</td>
<td>X</td>
<td>X</td>
<td></td>
<td>(1) Terms of Reference are discussed at Audit Committee and the Board. The workplan is developed from the ToR and not specifically discussed at Board</td>
</tr>
<tr>
<td>1</td>
<td>Does the Committee report regularly to the Board?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) Minutes presented to Board monthly</td>
</tr>
<tr>
<td>2</td>
<td>Are members, particularly those new to the Committee, provided with training?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) As necessary as part of overall induction training.</td>
</tr>
<tr>
<td>2</td>
<td>Does the Committee ensure that members have sufficient knowledge of the organisation to identify key risk areas?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) Walkabouts, third party training add to knowledge together with reviews of BAF and internal audit reports.</td>
</tr>
<tr>
<td>2</td>
<td>Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the board, which would then form the basis for the focus the following year?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) See minutes</td>
</tr>
<tr>
<td>3</td>
<td>Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) Training and Board Development sessions. Responsibility of DCA&amp;G and DoF to advise committee of legal and regulatory issues</td>
</tr>
<tr>
<td>2</td>
<td>Has the Committee formally considered how it integrates with other committees that are reviewing risks e.g. SQS Committee?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) Discussed when ToR updated</td>
</tr>
<tr>
<td>1</td>
<td>Has the Committee formally considered how its work integrates with wider performance management and standards of compliance?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) Discussed when ToR updated</td>
</tr>
<tr>
<td>1</td>
<td>Has the Committee been briefed on its assurance responsibilities with regard to the Assurance Framework?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) See minutes - regular reviews of BAF and report to audit committee. Deep dive risks to test controls and mitigating actions.</td>
</tr>
<tr>
<td>2</td>
<td>Has the Committee reviewed whether the</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) Format and content regularly</td>
</tr>
<tr>
<td>STATUS</td>
<td>Issue</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Evidence to Support Action (E)/Action Required (A) – Please indicate</td>
</tr>
<tr>
<td>--------</td>
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<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?</td>
<td></td>
<td></td>
<td></td>
<td>challenged to ensure appropriate information to presented.</td>
</tr>
<tr>
<td>2</td>
<td>Has the Committee been assured that information provided is accurate and of the appropriate quality?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) Supported also by internal audit projects</td>
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<td>Triangulation with knowledge from other committees and internal audit reports.</td>
</tr>
<tr>
<td>2</td>
<td>Does the Committee meet the appropriate number of times to deal with planned matters?</td>
<td>X</td>
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<td>(E) Meetings are scheduled monthly</td>
</tr>
<tr>
<td>2</td>
<td>Is the timing of Committee meetings discussed with all the parties involved?</td>
<td>X</td>
<td></td>
<td></td>
<td>(E) Committees are held prior to Board meetings</td>
</tr>
<tr>
<td>2</td>
<td>Does the Committee assess its own effectiveness periodically to identify gaps and development needs?</td>
<td>X</td>
<td>X</td>
<td>(1)</td>
<td>(E) Completion of self-assessment form and discussion at Committee annually. See minutes – monthly review of forward programme</td>
</tr>
</tbody>
</table>
## EAST CHESHIRE NHS TRUST
### Finance, Performance and Workforce Committee Annual Workplan 2017/18

<table>
<thead>
<tr>
<th>No.</th>
<th>Task</th>
<th>Lead Director/ NED</th>
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<tr>
<td>1</td>
<td>Finance Report - Inclusive of the below appendicies</td>
<td>Mark Ogden</td>
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<td>Performance</td>
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<td>2.7 Operational efficiency indicators (theatres, outpatients, bed utilisation)</td>
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<td>3</td>
<td>Workforce</td>
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<td>3.1 Resourcing - Agency utilisation</td>
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<td>3.12 Outcome of Quarterly Audit around Temporary Workforce Processes</td>
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<td>4</td>
<td>Risk and Assurance</td>
<td>Julie Green</td>
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<td>Annual Self Assessment Reports</td>
<td>Mike Wildig</td>
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<tr>
<td>6</td>
<td>Review Committees Terms of Reference</td>
<td>Mike Wildig</td>
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</table>

**Finance, Performance and Workforce Committee Annual Workplan 2017/18**

- **Finance**
  - Finance Report - Inclusive of the below appendicies
  - Finance Risk Report
  - QIPP Report (including milestone delivery plan and risk register)
  - Financial Plan - Risk and Assumptions
  - Quarterly Capital Update
  - Repeating representations - Revolving Working Capital facility
  - Quarterly balance sheet report
  - Carter quarterly update
  - Procurement update
  - SLR update
  - Directorate presentation
  - Review of tenders for 2017/18

- **Performance**
  - Performance Report - Inclusive of the below appendicies
  - ED 4-hour standard
  - 18 weeks RTT standard
  - 62 day cancer standard
  - 8 week access to diagnostics
  - Community activity and outcomes including hubs
  - GP referrals profile
  - Operational efficiency indicators (theatres, outpatients, bed utilisation)

- **Workforce**
  - Workforce Risk and Mitigation Report - with monthly KPI dashboard
  - Resourcing - Agency utilisation
  - Resourcing - eRostering
  - Engagement - Sickness absence
  - Development - Apprenticeships
  - Development - Medical revalidation
  - Resourcing - Medical agency spend
  - Workforce - Staff Survey
  - Guardian of Safe Working Quarterly Update
  - Resourcing - eRostering Update
  - Resourcing - Technology Delivery Plan
  - Outcome of Quarterly Audit around Temporary Workforce Processes
  - Gender Pay Gap report

- **Risk and Assurance**
  - All Finance, CIP, Performance and Workforce Risks rated 15 and above to be reported

- **Annual Self Assessment Reports**
  - Complete Annual Self Assessment Report on the Work of the Finance, Performance & Workforce Committee

- **Review Committees Terms of Reference**
  - Finance, Performance and Workforce Committee
## EAST CHESHIRE NHS TRUST
Finance, Performance and Workforce Committee Annual Workplan 2018/19

<table>
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Agenda Item Number 15: TB 18 (47)

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

**Accountable Officer**

**Author(s) of Report:**
Chris McGinley – Names Nurse Safeguarding Adults
Heather Millward - Named Midwife

**Subject/Title**
Safeguarding Annual Report 2017-2018: Children, Young People and Vulnerable Adults

**Background papers (if relevant)**
The Care Act 2014
Statutory Guidance Working Together to Safeguard Children 2015
Statutory Guidance for Promoting the Health and Well Being of Looked after Children 2015

**Purpose of Paper**
To provide an annual update on progress in relation to Safeguarding Children, Young People and Vulnerable Adults at Risk

**Action/Decision required**
Board members to note report, achievements and progress

**Mitigates Risk Number: (identify)**
**On Corporate Risk Register**
BAF 2: If the quality of services provided is not at the required standard then there is a risk that the Trust may fail to safeguard the health and wellbeing of patients which will impact on the Trust's ability to deliver care which is safe, effective, caring, and responsive and well lead.

BAF 4 : If the Trust is not able to deliver an effective partnership framework then we will fail to deliver clinically and financially sustainable services for the local population

BAF 5 : If the Trust does not have a high quality workforce who are engaged and motivated, with the right capability and capacity, then staff behaviours may not be aligned with trust values and this will have a negative impact on patient experience

**Link to Care Quality Commission Outcome Number (identify)**
Safe
Caring
Responsive
Effective
Well-lead

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

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

**Legal implications - (identify)**
None

**Impact on quality**
This report provides assurance that the Trust has maintained quality in relation to Safeguarding Vulnerable Children, Young people and Adults at Risk.

**Resource impact**
None
Impact of equality/diversity

<table>
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<tr>
<th>Avoid acronyms or abbreviations - if necessary list:</th>
<th>Through effective implementation of our Safeguarding arrangements patient choice and human rights will be respected.</th>
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<td>CCG</td>
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<td>Independent Management Review</td>
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<td>WRAP</td>
<td>Workshop to Raise Awareness of Prevent</td>
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</table>
The Trust is committed to the safeguarding and welfare of children, young people and vulnerable adults, emphasising that ALL staff have a duty to uphold the values of the trust and ensuring that safeguarding is everyone’s business. The purpose of this report is to update and provide a high level summary of safeguarding children, young people and vulnerable adults, in relation to the local and national agenda.

1. INTRODUCTION

This report highlights the progress being made to build on, further develop and strengthen the operational and strategic structures which support the requirement of our services users both within the acute and community setting. The trust continues to work collaboratively with partner organisations ensuring that all commissioning requirements as per Local Safeguarding Adults and Children’s Boards are met in relation to children, young people and vulnerable adults.

The safeguarding team continues to encourage all staff to think and take a ‘Think Family’ and ‘Making Safeguarding Personal’ approach for each person.

2. Training

<table>
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<th>Safeguarding compliance of 80% attained for level 1 and 2 training for Adults and level 1, 2 &amp; 3 for children.</th>
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<tr>
<td>Level 1 adult training has met the compliance requirement at 92.62%</td>
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<td>Level 1 children’s training has met the compliance requirement at 92.6%</td>
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<td>Level 2 adult training has met the requirement at 87.19%</td>
</tr>
<tr>
<td>Level 2 children’s training has met the compliance requirement at 83.8%</td>
</tr>
<tr>
<td>Level 3 children’s training has met the compliance requirement at 81.2%</td>
</tr>
<tr>
<td>Note the standard is to increase to 85% from April 2018.</td>
</tr>
</tbody>
</table>

Workshop to Raise Awareness of Prevent (WRAP) training, national requirement of 85% compliance. The Trust started from a 0% base line in July 2017 with an agreed trajectory of 85% compliance with the commissioners by June 2018.

2.2 A total of 2956 staff required WRAP training, 2294 staff were trained to end of March 2018 giving 77.60% compliance. The trust is currently ahead of its training trajectory to meet the overall 85% compliance by June 2018. A new e-learning module was introduced in March 2018. Face to face training will be offered once per quarter from April 2018 (Appendix 2). The Prevent lead and NNSA attend the Regional meetings and attended the NHS England Prevent/WRAP National Conference.
704 staff trained in Mental Capacity and Deprivation of Liberty Safeguards

A total of 690 of the required 704 staff have been trained either via e-learning or face to face sessions. The training has met the Training Needs Analysis (TNA) for 2017-18 which had an 80% compliance target which has been exceeded with an overall compliance of 98% of the required staff being trained.

522 health professionals trained in Independence Domestic Violence

IDVA training was provided to 522 health professionals, including A&E and paediatric professionals (as part of the paediatric essentials training) A&E induction, A&E junior doctors, GP registrars and midwives.

The IDVA contributed to the LSAB peer review training which considered the overall provision of domestic abuse training throughout Cheshire East.

Bespoke training:
- 3 multi agency training sessions were delivered for the LSAB. This was a collaborative training with SMART with 20 participants on each course including health care professionals
- Student social workers and General Practitioners (GP), F2 registrars
- Speaker at the Cranage Hall Safeguarding study day
- Speaker at the Change Conference on domestic abuse. This highlighted the work of hospital IDVAs, particularly in relation to the work being undertaken at Macclesfield hospital with older clients.

Training delivered in Female Genital Mutilation

The NW delivered 3 two hour training sessions. To support staff in developing skills to identify and onward report issues of FGM.

3. Partnership Working

The trust safeguarding team works collaboratively with all partner organisations contributing to multi-agency training, investigations, reports and audits.

Trust represented by safeguarding team at Cheshire East and Cheshire West & Chester Local Safeguarding Boards (LSAB/LSCB) meetings and sub-group meetings

3.1 The Director of Nursing Performance and Quality is the trust representative at the East & Cheshire West & Chester LSAB/LSCB meetings.

3.2 The Named Nurses and Midwife represent the trust at the following LSAB/LSCB sub groups.

- Learning & Development
- Policy & Practice
- Serious Cases Review
The trust submits information as required in support of these meetings. Any actions are monitored by the safeguarding team and appropriate/timely responses actioned.

### Proposed changes to Multi Agency Risk Assessment Conference (MARAC)

3.3 MARAC – a change in process has been discussed on a multi-agency level whereby it is proposed the current monthly meetings will be replaced by email requests for information as the referrals are made into MARAC. It is proposed that the turnaround response time to requests for information will be 3-4 working days. A pilot of this new scheme will commence in May with the meetings running concurrently until the pilot outcome is reviewed and final recommendations made.

### No referrals made to Channel Panel during 2017-2018

3.4 The trust is represented at the quarterly Regional Prevent meetings and bi-monthly Channel Panel meetings by the Prevent Lead or NNSA. The trust responds to requests for information on persons referred to Channel Panel from a health perspective.

### Adults safeguarding partnership referrals received by trust

3.5 First Account Form (FAF) referrals/concerns & complaints received were from: Cheshire East local Authority Social Care, North West Ambulance Service (NWAS), Care Quality Commission (CQC), Clinical Commissioning Group (CCG). The NNSA and hospital social work team met and reviewed the 322 FAF referrals received during 2017-2018 for acute services.

It should be noted that Skilled Multi Agency Response Team (SMART) referrals are not reviewed as part of this process. They are reviewed by the adult safeguarding team only.

In total 27 referrals/complaints relating to the organisation (acute and community) were received and reviewed by the relevant ward/team. The referring organisation was notified of the outcome of the investigation. Lessons learnt were used as shared learning and if required action plans developed which are held by the area concerned and monitored through local SQS.

### Contribution by Vulnerable Families Midwife (VFM)

3.6 The VFM has improved multi agency working, information
recognised by Local Authority

Child Protection Sharing Information (CP-IS), successfully implemented in acute services

The trust has worked with the National Child Information Sharing Project which will allow the identification of children who are looked after, or who are subject to, a child protection plan when they present to our Emergency Department or Maternity Services. CP-IS has been successfully implemented within the ED, the Minor Injuries Unit and Paediatric Unit and Maternity Department.

4. AUDIT

Audit provides a clear focus on reviewing staff knowledge and patient records to give assurance of compliance with training, documentation and onward referral.

Successful audit completion against agreed audit programme

4.1 The following audits were successfully completed:

- Quarterly knowledge audit (combined adults and children), 40 staff audited, no significant issues or concerns in relation to the audit outcome were highlighted.
- Safeguarding patient’s records, 10 sets of patient records audited.
- Mental Capacity and Deprivation of Liberty Safeguards (MCA/DoLS), 10 sets of patient records audited

4.2 The Commissioners annual adult self-assessment action plan developed from feedback from the Commissioners was completed and action plan developed on their feedback. The remaining amber action will be addressed in the Q1 (2018-19) review of the Safeguarding strategy.

4.3 The section 11 audits for Cheshire East and West have been completed and actions have been included in the training and supervisions sessions.

4.4 The trust has participated in a number of LSCB multi-agency audits specifically in relation to sexual abuse and neglect.

Any issues or concerns highlighted during audits were immediately fed back; actions were developed and monitored through the safeguarding integrated group.
5. SERIOUS CASE REVIEW (SCR), LEARNING REVIEW (LR) & DOMESTIC HOMICIDE REVIEW (DHR)

The trust participated fully in any Serious Case Reviews (SCR) and Learning Reviews (LR) or Domestic Homicide (DHR) as required.

Safeguarding participation in external reviews

5.1 The outcomes of the two adult learning reviews held by local authority in relation to a vulnerable adult were completed. An action plan was developed in relation to the first LR with all actions completed and shared learning from the review fed back to staff within the trust. There was no specific learning or actions identified for the trust from the second LR. However, there was an overall recommendation that all partners look at any situation and consider all aspects in a wider perspective to identify other potential safeguarding issues and vulnerable adults at risk and not to pre-judge any situation.

5.2 Three reflective children’s learning reviews were completed. ECNHST staff had significant involvement in one of the cases and the NM completed an RCA which fed into the LR.

5.3 A Cheshire West and Chester Domestic Homicide Review required the NNSC to complete an Independent Management Review (IMR) as part of the DHR investigation and the NNSC participated as a member of the review panel.

All action plans from SCR, LR and DH cases are included in the safeguarding work plans and monitored via the integrated safeguarding group. Any learning from these is included in training and distributed throughout the organisation via SQS to support staff learning, change in policy or practice.

6. DEPRIVATION of LIBERTY SAFEGUARDS (DoLS) APPLICATIONS

The trust remains a medium priority area but patient applications will be reviewed on an individual basis.

6.1 The trust made 398 DoLS applications to LA

Legal services submit and monitor all applications and email the LA DoLS team to highlight the outstanding applications that exceed 14 days. (Appendix 3)

7. Female Genital Mutilation (FGM)

FGM cases reported

7.1 The Named Midwife represents the trust as the lead for FGM. The trust is compliant with the mandatory reporting requirements for FGM and for 2017-18, 3 cases were reported.
8. SUPERVISION

Effective supervision resulting in change

8.1 Through reflective supervision, training has been updated and the policy now incorporates the ‘Signs of Safety’ model which Local Authority (LA) adopted.

9. INDEPENDENT DOMESTIC VIOLENCE ADVOCATE (IDVA)

Success of onsite hospital IDVA

9.1 The trust hosts the IDVA as part of the safeguarding team the post is jointly funded by the Cheshire Police Commissioner and CCG. This post enables direct referral and access for patients and staff in the acute setting. 156 referrals were made to the IDVA from various sources (Appendix 4)

Clients referred to IDVA were either supported directly or through Cheshire East DV services (if already known to them).

Identified high risk cases were appropriately referred to MARAC.

10. INSPECTIONS

The safeguarding team fully participated in all inspections by external organisations

10.1 Between 25-29/09/2017 Ofsted, CQC, HMI Constabulary and HMI Probation undertook a Joint Targeted Area Inspection (JTAI) of the Multi-agency response to abuse and neglect in Cheshire West and Chester. The focus was on response to children experiencing neglect and included ECNHST staff. The feedback from the inspection was very positive in relation to health

10.2 During the Care Quality Commission Inspection (CQC), the children’s safeguarding team were interviewed, supplied information and documentation in support of the inspection. One area was highlighted as requiring action the level 3 children’s safeguarding training for midwifery bank and medical staff. An action plan has been developed and is monitored through the NNSC/NM and integrated safeguarding group.

11. SAFEGUARDING RELATED DOCUMENTS, GUIDELINES & LEGISLATION

Information, documents, legislation and guidance received and reviewed by the safeguarding team

11.1 Safeguarding guidelines, changes to legislation and any other safeguarding related documents received into the trust are reviewed by the Named Nurses/Midwife. The NN’s/NW advice if any action required by the trust or whether it is for
information only. If required the NN's/NM will make relevant recommendations to the integrated safeguarding group.

12. RECOMMENDATION

12.1 The Board is asked to note the content of the report, achievements and progress made.

13. LIST of ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CP-IS</td>
<td>Child Protection Sharing Information</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>DH</td>
<td>Domestic Homicide</td>
</tr>
<tr>
<td>DoLS</td>
<td>Deprivation of Liberty Safeguards</td>
</tr>
<tr>
<td>ECNHST</td>
<td>East Cheshire NHS Trust</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>FAF</td>
<td>First Account Form</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>HMI</td>
<td>Her Majesties Inspector</td>
</tr>
<tr>
<td>IDVA</td>
<td>Independent Domestic Abuse Advocate</td>
</tr>
<tr>
<td>IMR</td>
<td>Independent Management Review</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority</td>
</tr>
<tr>
<td>LR</td>
<td>Learning Reviews</td>
</tr>
<tr>
<td>LSAB</td>
<td>Local Safeguarding Adults Board</td>
</tr>
<tr>
<td>LSCB</td>
<td>Local Safeguarding Children’s Board</td>
</tr>
<tr>
<td>MARAC</td>
<td>Multi Agency Risk Assessment Conference</td>
</tr>
<tr>
<td>MCA</td>
<td>Mental Capacity Assessment</td>
</tr>
<tr>
<td>NM</td>
<td>Named Midwife</td>
</tr>
<tr>
<td>NNSA</td>
<td>Named Nurse Safeguarding Adults</td>
</tr>
<tr>
<td>NNSC</td>
<td>Named Nurse Safeguarding Children</td>
</tr>
<tr>
<td>NWAS</td>
<td>North West Ambulance Service</td>
</tr>
<tr>
<td>RCA</td>
<td>Route Cause Analysis</td>
</tr>
<tr>
<td>SCR</td>
<td>Serious Case Reviews</td>
</tr>
<tr>
<td>SMART</td>
<td>Skilled Multi Agency Response Team</td>
</tr>
<tr>
<td>SQS</td>
<td>Safety, Quality Standards</td>
</tr>
<tr>
<td>JTAI</td>
<td>Joint Targeted Area Inspection</td>
</tr>
<tr>
<td>TNA</td>
<td>Training Needs Analysis</td>
</tr>
<tr>
<td>VFM</td>
<td>Vulnerable Families Midwife</td>
</tr>
<tr>
<td>WRAP</td>
<td>Workshop to Raise Awareness of Prevent</td>
</tr>
</tbody>
</table>
## Appendix 1

### Adult and children's training compliance

#### Level 1 Adult and Children

<table>
<thead>
<tr>
<th>Service Line</th>
<th>% Level 1 Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute &amp; Integrated Community Care</td>
<td>90.67%</td>
</tr>
<tr>
<td>Allied Health &amp; Clinical Support</td>
<td>95.36%</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>100.00%</td>
</tr>
<tr>
<td>Corporate Affairs &amp; Governance</td>
<td>95.35%</td>
</tr>
<tr>
<td>Facilities</td>
<td>100.00%</td>
</tr>
<tr>
<td>Finance</td>
<td>97.10%</td>
</tr>
<tr>
<td>Human Resources</td>
<td>99.19%</td>
</tr>
<tr>
<td>Medical Bank</td>
<td>N/A</td>
</tr>
<tr>
<td>Nurse Bank</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing and Quality</td>
<td>95.74%</td>
</tr>
<tr>
<td>Planned Care Services</td>
<td>89.30%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>92.62%</strong></td>
</tr>
</tbody>
</table>

#### Level 2 Adult safeguarding training compliance by service line

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Total Staff Requiring Level 2</th>
<th>Does not meet requirement</th>
<th>Meets Requirement</th>
<th>% Compliance</th>
<th>Headcount Required To Meet Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute &amp; Integrated Community Care</td>
<td>800</td>
<td>76</td>
<td>724</td>
<td>90.50%</td>
<td>0</td>
</tr>
<tr>
<td>Allied Health &amp; Clinical Support</td>
<td>492</td>
<td>40</td>
<td>451</td>
<td>91.85%</td>
<td>0</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>100.00%</td>
<td>0</td>
</tr>
<tr>
<td>Corporate Affairs &amp; Governance</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>100.00%</td>
<td>0</td>
</tr>
<tr>
<td>Facilities</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>100.00%</td>
<td>0</td>
</tr>
<tr>
<td>Human Resources</td>
<td>35</td>
<td>2</td>
<td>33</td>
<td>94.29%</td>
<td>0</td>
</tr>
<tr>
<td>Medical Bank</td>
<td>48</td>
<td>31</td>
<td>17</td>
<td>35.42%</td>
<td>22</td>
</tr>
<tr>
<td>Nurse Bank</td>
<td>211</td>
<td>55</td>
<td>156</td>
<td>73.93%</td>
<td>13</td>
</tr>
<tr>
<td>Nursing and Quality</td>
<td>38</td>
<td>2</td>
<td>36</td>
<td>94.74%</td>
<td>0</td>
</tr>
<tr>
<td>Planned Care Services</td>
<td>555</td>
<td>74</td>
<td>481</td>
<td>86.67%</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>2185</strong></td>
<td><strong>280</strong></td>
<td><strong>1905</strong></td>
<td><strong>87.19%</strong></td>
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#### Level 2 Children's safeguarding training compliance by service line

<table>
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<tr>
<th>Directorate</th>
<th>Total Staff Requiring Level 2</th>
<th>Does not meet requirement</th>
<th>Meets Requirement</th>
<th>% Compliance</th>
<th>Headcount Required To Meet Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute &amp; Integrated Community Care</td>
<td>800</td>
<td>131</td>
<td>669</td>
<td>83.63%</td>
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<tr>
<td>Allied Health &amp; Clinical Support</td>
<td>492</td>
<td>61</td>
<td>431</td>
<td>87.60%</td>
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</tr>
<tr>
<td>Chief Executive</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>100.00%</td>
<td>0</td>
</tr>
<tr>
<td>Corporate Affairs &amp; Governance</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>100.00%</td>
<td>0</td>
</tr>
<tr>
<td>Facilities</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>80.00%</td>
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</tr>
<tr>
<td>Human Resources</td>
<td>35</td>
<td>8</td>
<td>27</td>
<td>77.14%</td>
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<tr>
<td>Medical Bank</td>
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<td>25</td>
<td>52.08%</td>
<td>14</td>
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<tr>
<td>Nurse Bank</td>
<td>211</td>
<td>61</td>
<td>150</td>
<td>71.09%</td>
<td>19</td>
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<tr>
<td>Nursing and Quality</td>
<td>38</td>
<td>2</td>
<td>36</td>
<td>94.74%</td>
<td>0</td>
</tr>
<tr>
<td>Planned Care Services</td>
<td>555</td>
<td>67</td>
<td>488</td>
<td>87.93%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>2186</strong></td>
<td><strong>354</strong></td>
<td><strong>1832</strong></td>
<td><strong>83.81%</strong></td>
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</table>
Level 3 Children’s safeguarding training compliance by service line

<table>
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<tr>
<th>Directorate</th>
<th>Total Staff Requiring Level 3</th>
<th>Does not meet requirement</th>
<th>Meets Requirement</th>
<th>% Compliance</th>
<th>Headcount Required To Meet Compliance</th>
</tr>
</thead>
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<td>Allied Health &amp; Clinical Support</td>
<td>54</td>
<td>4</td>
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<td>Nurse Bank</td>
<td>20</td>
<td>10</td>
<td>10</td>
<td>50.00%</td>
<td>6</td>
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<tr>
<td>Nursing and Quality</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>100.00%</td>
<td>0</td>
</tr>
<tr>
<td>Planned Care Services</td>
<td>210</td>
<td>38</td>
<td>172</td>
<td>81.90%</td>
<td>0</td>
</tr>
<tr>
<td>Grand Total</td>
<td>470</td>
<td>88</td>
<td>382</td>
<td>81.28%</td>
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</table>

Appendix 2

WRAP training compliance

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Total Staff Requiring WRAP Training</th>
<th>Meets Requirement</th>
<th>Does Not Meet Requirement</th>
<th>% Compliance</th>
<th>Headcount required to be compliant (this month)</th>
</tr>
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<tbody>
<tr>
<td>Acute &amp; Integrated Community Care</td>
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<td>693</td>
<td>206</td>
<td>77.09%</td>
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<tr>
<td>Allied Health &amp; Clinical Support</td>
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<td>686</td>
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<td>Chief Executive</td>
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<td>5</td>
<td>2</td>
<td>71.43%</td>
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<td>Corporate Affairs &amp; Governance</td>
<td>44</td>
<td>42</td>
<td>2</td>
<td>95.45%</td>
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<tr>
<td>Facilities</td>
<td>46</td>
<td>42</td>
<td>4</td>
<td>91.30%</td>
<td>0</td>
</tr>
<tr>
<td>Finance</td>
<td>71</td>
<td>59</td>
<td>12</td>
<td>83.10%</td>
<td>0</td>
</tr>
<tr>
<td>Human Resources</td>
<td>127</td>
<td>114</td>
<td>13</td>
<td>89.76%</td>
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</tr>
<tr>
<td>Medical Bank</td>
<td>48</td>
<td>19</td>
<td>29</td>
<td>39.58%</td>
<td>14</td>
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<td>Nurse Bank</td>
<td>238</td>
<td>141</td>
<td>97</td>
<td>59.24%</td>
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<td>Nursing and Quality</td>
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<td>11</td>
<td>76.60%</td>
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<td>Grand Total</td>
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<td>2294</td>
<td>662</td>
<td>77.60%</td>
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</table>

Appendix 3

Annual DoLS activity

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<thead>
<tr>
<th>Month</th>
<th>Submitted</th>
<th>Granted</th>
<th>Not Granted</th>
<th>Discharged Prior to Review</th>
<th>Deceased Prior to Review</th>
<th>Regained Capacity Prior to Review</th>
<th>Other</th>
<th>Awaiting Outcome</th>
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<tr>
<td>Q1</td>
<td>85</td>
<td>7</td>
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<td>60</td>
<td>10</td>
<td>4</td>
<td>3</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Q2</td>
<td>93</td>
<td>7</td>
<td>-</td>
<td>66</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Q3</td>
<td>108</td>
<td>7</td>
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<td>84</td>
<td>11</td>
<td>5</td>
<td>-</td>
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<td>Q4</td>
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<td>11</td>
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<tr>
<td>TOTAL</td>
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<td>9</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>
### IDVA breakdown of referral source

<table>
<thead>
<tr>
<th>Department</th>
<th>Number</th>
<th>Department</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; E</td>
<td>92</td>
<td>Child safeguarding</td>
<td>7</td>
</tr>
<tr>
<td>Adult safeguarding</td>
<td>14</td>
<td>Midwife/maternity</td>
<td>9</td>
</tr>
<tr>
<td>Psychiatric liaison</td>
<td>5</td>
<td>Alcohol Liaison</td>
<td>5</td>
</tr>
<tr>
<td>MacMillan Nurses</td>
<td>1</td>
<td>Self-referral</td>
<td>6</td>
</tr>
<tr>
<td>CWP</td>
<td>6</td>
<td>Integrated Discharge Team</td>
<td>3</td>
</tr>
<tr>
<td>Gastro Medicine</td>
<td>3</td>
<td>Physiotherapist</td>
<td>1</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>3</td>
<td>Children’s Ward</td>
<td>1</td>
</tr>
</tbody>
</table>

**Over all TOTAL = 156**
<table>
<thead>
<tr>
<th>Report of:</th>
<th>Director of Nursing, Performance &amp; Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Officer:</td>
<td>Jeanette Sarkar</td>
</tr>
<tr>
<td>Accountable Officer:</td>
<td>Head of Nursing, Quality</td>
</tr>
<tr>
<td>Subject/Title</td>
<td>EXCEPTION REPORT – SAFE STAFFING LEVELS</td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
<td>“How to ensure the right people with the right skill are in the right place at the right time”, Chief Nursing Officer for England &amp; National Quality Board November 2013</td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>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 &amp; National Quality Board November 2013</td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>To note the contents of the report and the assurance provided</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify)</td>
<td>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</td>
</tr>
<tr>
<td>On Corporate Risk Register</td>
<td>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</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify)</td>
<td></td>
</tr>
<tr>
<td>On Assurance Framework</td>
<td></td>
</tr>
<tr>
<td>Link to Care Quality Commission Domain</td>
<td>Safe</td>
</tr>
<tr>
<td>Caring</td>
<td></td>
</tr>
<tr>
<td>Responsive</td>
<td></td>
</tr>
<tr>
<td>Effective</td>
<td></td>
</tr>
<tr>
<td>Well-led</td>
<td></td>
</tr>
<tr>
<td>Link to:</td>
<td>Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
<tr>
<td>Trust’s Strategic Direction</td>
<td></td>
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<tr>
<td>Corporate Objectives</td>
<td></td>
</tr>
<tr>
<td>Legal implications - (identify)</td>
<td>No legal implications</td>
</tr>
<tr>
<td>Impact on quality</td>
<td>May potentially impact upon the quality of care, patient experience, patient outcomes and staff well being</td>
</tr>
<tr>
<td><strong>Resource impact</strong></td>
<td>Identified gaps in funded establishments due to WTE substantive and temporary nurse staffing vacancies will necessitate an increase in payroll costs in relation to paid additional hours, overtime and bank/agency expenditure in order to mitigate risks associated with patient safety and quality of care</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Impact of equality/diversity</strong></td>
<td>No impact on equality and diversity</td>
</tr>
</tbody>
</table>
| **Avoid acronyms or abbreviations** | **DoH**  Department of Health  
**YTD**  Year to Date  
**WTE**  Whole time equivalent  
**RAG**  Red Amber Green  
**NMC**  Nursing Midwifery Council  
**HRBP**  Human Resource Business Partner |
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 April 2018, with the exception of Post Natal and Labour Ward, Aston Ward and Paediatrics.

Healthcare Assistant actual fill rate of 92.1% during night time hours. Safe staffing levels maintained

2.2 Post-natal and labour ward shows an actual healthcare assistant fill rate of 91.5% overnight which demonstrates an improved position compared to previous months (80.1%)

2.3 The variance in actual fill rate is due to 2.0wte vacancies subject to sourcing an appropriate apprenticeship course programme that enables workforce development.

Mitigating actions included daily monitoring of staffing levels, clinical caseload and risk assessment. Non clinical midwifery staff, 2 on call midwives available and flexing management support 12-8 were in place to ensure safe staffing levels were maintained.

Improved healthcare assistant daytime fill rate of 87.5% on Aston Ward

2.4 Aston ward healthcare assistant actual fill rate in month was 87.5% during the day which demonstrates an improved position compared to the previous month (80.1%)

Ward 4 exceeded 134% actual fill rates for registered nurses

2.5 Ward 4 registered nurse fill rate during the day was 134% and 125% overnight. However, this demonstrates an improved
position compared to the previous month. This in part is due to the closure of the 6 additional beds on Ward 4 from mid-April. Other reasons for the variance were due to registered nurse vacancy levels, skill mix dilution, increased acuity and patient dependency e.g. NIV patients.

A number of wards actual fill rate for unregistered staff exceeded 125% during the night particularly Wards 2, 3, 4, 7 and 10. This variation reflects the increase in patient cohort complexities and enhanced 1:1 care, in addition to increases in flex bed capacity and sustained patient dependency as evidenced in the SNCT tool. Mitigating actions include rostering a 3rd HCA overnight.

Increased patient complexities, acuity, dependency and enhanced 1:1 care is reflected in the overall HCA fill rates

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. This also includes a review of skill mix.

### 3 RECRUITMENT

Excluding maternity leave and long term sickness registered nurse vacancies within acute inpatient areas demonstrates a less favourable position 41.67 wte compared to last month - 34.37 wte.

In month registered nurse vacancies within acute in-patient shows a less favourable position; 41.67 wte compared to the previous month 34.37 wte across all acute in patient ward areas. This excludes Maternity Leave and Long Term Sickness. Inclusion of Maternity Leave (5.12 wte) and Long Term Sickness (4.23 wte) increases the overall registered nurse gap to 51.02 wte compared to 44.08 wte the previous month.

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

Recruitment campaign continues

A staff nurse recruitment event was held on 21st April resulting in 10 job offers

Following registered nurse interviews held on 20th April 2018, 1 registered nurse was offered a substantive post. A total of 9 acute and community registered posts offered the previous months are going through pre-employment checks – 5 for Acute and 4 for Community. 3 registered nurses commenced in post during April for Community, 1 for nurse bank and 2 for Ward 2

The next cohort of 3 international nurses is due to arrive 18th May 2018.

A staff nurse recruitment event was held on Saturday 21 April 2018 which resulted in 10 job offers of which the majority were
to student nurses. A communication plan has been implemented to ensure regular dialogue between the prospective students and senior sister is maintained until qualification has been attained and commenced in post.

17 Healthcare Assistant posts offered following interviews held in April

Following interviews held 30th April 2018, 17 Healthcare Assistant posts were offered; 2 substantive ward posts; 6 to pool; 9 nurse bank pending satisfactory pre-employment checks. From the previous month’s interviews, 10 healthcare assistants commenced in post of which the majority were for nurse bank

All outstanding community vacancies have been successfully recruited to

There are currently no registered nurse vacancies within the community setting.

9 out of the 10 trainee nursing associate roles have moved through into their 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.

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 increased in April to 1.60%

5.1 In month staff turnover is 1.60% compared to 0.62% the previous month. YTD rolling staff turnover is 11.61% compared to 11.46% 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
## Monthly Safe Staffing Report - April 18

### Care Hours Per Patient Day (CHPPD)

<table>
<thead>
<tr>
<th>ServiceLine</th>
<th>Specialty</th>
<th>Ward</th>
<th>Expected RN</th>
<th>Actual RN</th>
<th>Expected HCA</th>
<th>Actual HCA</th>
<th>Percent RN</th>
<th>Percent HCA</th>
<th>Percent RN</th>
<th>Percent HCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Care</td>
<td>Rehabilitation</td>
<td>Aston</td>
<td>905.70</td>
<td>925.42</td>
<td>2158.20</td>
<td>2187.50</td>
<td>102.2%</td>
<td>97.5%</td>
<td>66.00</td>
<td>66.00</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>Cardiology</td>
<td>ECU</td>
<td>900.00</td>
<td>900.00</td>
<td>2158.20</td>
<td>2187.50</td>
<td>102.2%</td>
<td>97.5%</td>
<td>66.00</td>
<td>66.00</td>
</tr>
<tr>
<td>Women's &amp; Children's</td>
<td>Pediatrics</td>
<td>Childrens</td>
<td>1192.50</td>
<td>1217.50</td>
<td>660.00</td>
<td>614.40</td>
<td>102.2%</td>
<td>93.7%</td>
<td>303.00</td>
<td>304.00</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Critical Care Medicine</td>
<td>Intensive Care Unit</td>
<td>1800.00</td>
<td>1800.00</td>
<td>492.00</td>
<td>492.00</td>
<td>100.0%</td>
<td>100.0%</td>
<td>1380.00</td>
<td>1380.00</td>
</tr>
<tr>
<td>Women's &amp; Children's</td>
<td>Obstetrics</td>
<td>Neo Natal Unit</td>
<td>773.30</td>
<td>773.30</td>
<td>208.00</td>
<td>208.00</td>
<td>77.9%</td>
<td>77.9%</td>
<td>66.00</td>
<td>66.00</td>
</tr>
<tr>
<td>Women's &amp; Children's Obstetrics</td>
<td>Obstetrics</td>
<td>Post Natal and Labour Ward</td>
<td>2468.70</td>
<td>2464.75</td>
<td>804.15</td>
<td>852.75</td>
<td>107.1%</td>
<td>93.9%</td>
<td>3070.00</td>
<td>3097.00</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>General Surgery</td>
<td>Ward 5</td>
<td>1818.00</td>
<td>1796.00</td>
<td>1922.17</td>
<td>1931.30</td>
<td>98.4%</td>
<td>98.8%</td>
<td>990.00</td>
<td>990.00</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>Trauma &amp; Orthopaedics</td>
<td>Ward 10</td>
<td>1875.00</td>
<td>1818.33</td>
<td>2412.89</td>
<td>2412.89</td>
<td>98.0%</td>
<td>98.0%</td>
<td>990.00</td>
<td>990.00</td>
</tr>
<tr>
<td>Integrated Care Rehabilitation</td>
<td>Ward 11</td>
<td>1000.80</td>
<td>1092.08</td>
<td>1857.00</td>
<td>1933.42</td>
<td>100.1%</td>
<td>104.1%</td>
<td>990.00</td>
<td>990.00</td>
<td></td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>General Surgery</td>
<td>Ward 2</td>
<td>1121.40</td>
<td>1097.75</td>
<td>1281.30</td>
<td>1251.30</td>
<td>97.9%</td>
<td>99.8%</td>
<td>990.00</td>
<td>990.00</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>Respiratory Medicine</td>
<td>Ward 4</td>
<td>1464.00</td>
<td>1467.83</td>
<td>1552.40</td>
<td>1590.00</td>
<td>99.0%</td>
<td>97.8%</td>
<td>660.00</td>
<td>660.00</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>General Medicine</td>
<td>Ward 7</td>
<td>1514.40</td>
<td>1498.08</td>
<td>1568.80</td>
<td>1591.40</td>
<td>98.9%</td>
<td>99.8%</td>
<td>990.00</td>
<td>990.00</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>General Medicine</td>
<td>Ward 9 (Egerton)</td>
<td>1516.80</td>
<td>1511.75</td>
<td>1512.00</td>
<td>1977.75</td>
<td>102.0%</td>
<td>108.8%</td>
<td>660.00</td>
<td>660.00</td>
</tr>
</tbody>
</table>

Note: Ward 10 moved to Ward 11 1st October 2016, Ward 5 moved to Ward 10 1st November 2016
## Agenda Item Number 17:  TB 18 (49)

### SAFETY, QUALITY AND STANDARDS COMMITTEE

**Meeting Chair:** Ali Harrison  
**Meeting Secretary:** Gareth Rydings  
**Venue:** Boardroom 1, First Floor, New Alderley House

### MINUTES OF MEETING HELD ON:  
Tuesday 27th March, 12:00 – 14:00

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Abb.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ali Harrison</td>
<td>Non-Executive Director (Chair)</td>
<td>Ms Harrison</td>
</tr>
<tr>
<td>Kash Haque</td>
<td>Chief Pharmacist</td>
<td>CP</td>
</tr>
<tr>
<td>Brian Green</td>
<td>Deputy Director of Nursing and Quality</td>
<td>DDNQ</td>
</tr>
<tr>
<td>Dr Susan Knight</td>
<td>Associate Medical Director for Clinical Effectiveness</td>
<td>AMDCE</td>
</tr>
<tr>
<td>Dr John Hunter</td>
<td>Medical Director</td>
<td>MD</td>
</tr>
<tr>
<td>John Wilbraham</td>
<td>Chief Executive</td>
<td>CEO</td>
</tr>
<tr>
<td>Kath Senior</td>
<td>Director of Nursing, performance and Quality</td>
<td>DNPQ</td>
</tr>
<tr>
<td>Lorraine Jackman</td>
<td>Deputy Director of Corporate Affairs and Governance</td>
<td>DDCAG</td>
</tr>
<tr>
<td>Julie Green</td>
<td>Director of Corporate Affairs and Governance</td>
<td>DCAG</td>
</tr>
<tr>
<td>Rachael Charlton</td>
<td>Director of HR</td>
<td>DHR</td>
</tr>
<tr>
<td>Mark Ogden</td>
<td>Director of Finance</td>
<td>Dof</td>
</tr>
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</table>

### IN ATTENDANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Abb.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mike Wildig</td>
<td>Non-Executive Director</td>
<td>Mr Wildig</td>
</tr>
<tr>
<td>Lynn McGill</td>
<td>Chairman</td>
<td>Chairman</td>
</tr>
<tr>
<td>Dr Tony Coombs</td>
<td>Non-Executive Director</td>
<td>Dr Coombs</td>
</tr>
<tr>
<td>Karen Clayton</td>
<td>Cancer Nurse Specialist</td>
<td>KC</td>
</tr>
</tbody>
</table>

### Action

#### Agenda Item 18/22: Patient Story

The DNPQ presented a patient story provided by a District Nurse regarding end of life care for a patient who had been referred into the service by their GP. The patient was a carer for his wife and was reluctant to have any input from the nurses. The patient had been diagnosed with advanced bowel cancer and a palliative care pathway was agreed with him and his family.

In terms of 'what went well', the relationship between the nurses and patient was very good, and it was noted the patient looked forward to the nurses visiting. The district nurses were able to identify when to commence with the syringe driver and trust was built between the patient and family. There was good communication with the GP and the GP relied on the nurses sharing information to help with symptom management.

In terms of 'what did not go well', patients pain symptoms were not initially controlled effectively due to a prescribing issue out with the control of the
nurses. This was resolved through contact with the GP out of hour’s service.

Discussions are ongoing with GPs regarding the ‘blue books’ concerning prescribing for end of life care being completed to include titration ranges.

Overall the patient received outstanding care at the end of their life and the family were able to spend valued time together. Due to the experience of the nurses the family were extremely happy with the treatment received and any problems faced were dealt with efficiently and effectively.

<table>
<thead>
<tr>
<th>1823</th>
<th>Apologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>None received</td>
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</table>

<table>
<thead>
<tr>
<th>1824</th>
<th>Conflict of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>None raised</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1825</th>
<th>Matters Arising</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Year at a Glance</td>
<td></td>
</tr>
<tr>
<td>Spotlight on sepsis to be added to April Falls spotlight to be moved to May</td>
<td></td>
</tr>
<tr>
<td>WHO checklist reviews to be added to April. (Spotlight) – Post meeting note: this will be moved to June to allow sufficient WHO checklist data to be collected from planned procedures for the internal audit</td>
<td></td>
</tr>
<tr>
<td>b) SQS Committee Minutes – February 2018</td>
<td></td>
</tr>
<tr>
<td>The minutes were agreed as accurate</td>
<td></td>
</tr>
<tr>
<td>c) Action Log</td>
<td></td>
</tr>
<tr>
<td>9620 – Comments received from the CCG. Currently considering how these comments can be applied to the Quarterly Strategy. Action closed.</td>
<td></td>
</tr>
<tr>
<td>9621 – Meeting scheduled to discuss future spotlights. Action closed.</td>
<td></td>
</tr>
<tr>
<td>d) Collection of Any Other Business</td>
<td></td>
</tr>
<tr>
<td>There was no AOB raised.</td>
<td></td>
</tr>
<tr>
<td>e) Formal Request for Removal of Items from Consent Agenda</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
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</tbody>
</table>

ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>18/27</th>
<th>Integrated Quality &amp; Governance Report including</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quality Indicator Exceptions</td>
<td></td>
</tr>
<tr>
<td>• Detentions under MHA</td>
<td></td>
</tr>
<tr>
<td>• Surgical Safety Checklist Audit Findings</td>
<td></td>
</tr>
<tr>
<td>• Complaints (February 2018)</td>
<td></td>
</tr>
<tr>
<td>• Risk Assessed Data Report (RADA)</td>
<td></td>
</tr>
<tr>
<td>• Kirkup Report - Independent Review of Liverpool Community Health NHS Trust</td>
<td></td>
</tr>
</tbody>
</table>

The report was taken as read and the DNPQ highlighted the following key areas:

- A wrong site surgery never event was reported by the Community Dental Service in February 2018. This is currently under investigation and the root cause analysis report will be subject to executive check and challenge and review by Serious Incident Review Sub-committee within the relevant timescales.
- Three dental never events have been reported between December 2016-February 2018, however there are no common factors identified.
- The Serious Incident Review Sub-committee will be meeting with the relevant Associate Directors in April 2018 to seek assurance on the implementation of Local Safety Standards.
- It was noted that there has been no breach of regulations and the community dental service has been recommissioned by ECCCG.
- There were 9 12 hour breaches in month and 61 mixed sex accommodation breaches were recorded. However no patient harm has resulted due to these breaches and root cause analysis investigations have been undertaken in relation to the 12 hour breaches.
- It was noted that the level of breaches were unusual for ECT and were symptomatic of the operational pressures within the system. No concerns had been reported regarding safety.
- The trust achieved all cancer standards apart from the 62 day maximum wait cancer standard in February 2018.
- It was noted that from April, the process for breach allocation is changing from April with the GM&EC Cancer Network having to adopt the national breach allocation framework. The full implications of this have not been worked through and both processes will run in parallel for April. This change may have the potential to create increase in missed 62 day cancer targets for ECT. The impact of this will be notified to the Committee as soon as known.
- The trust did not achieve the diagnostic waiting standard but the endoscopy action plan is on track for compliance with target by end March.
- The trust did not achieve the 4 hour ED standard of 95%. This had been due to the large shift seen in increased majors. It was agreed that the model in place works but is dependent on the right case mix of patients.
- The trust did not achieve the average length of stay target for either elective care or non-elective stay during February 2018.
- Average length of stay (LOS) in February for non-elective care was 5.9 against a standard of 4.7 bed days and elective care was 4.0 against a standard of 2.8 bed days.
- The directorates are undertaking monthly reviews to understand variances in LOS and identify where corrective action can be undertaken to improve.
- Delayed transfer of care (DTOC) is on trajectory and the trust continues to report fewer than 20 DTOCs.

### STRATEGIC ITEMS

**18/28 Quality Strategy - Integrated Care**

The DDNQ presented the Quality Strategy on Integrated Care and highlighted that progress has been made in all elements associated.

- Improved relationships with local nursing and residential homes has been developed and a reduction in admission to hospital has been achieved.
- External frailty training has been delivered across health and social care systems and has been well received.
- Roll out of the Cheshire Care record has started. However it has been recognised that more work is required in terms of making sure staff have access to the benefits.

Discussion took place regarding the barriers faced for the roll out of the Cheshire Care record. It was agreed that the DoF would provide an update on progression and timescales for implementation to the April SQS. It was also agreed that the Cheshire Care Record would be discussed at CMB.
The paper was taken as read and the following key areas were discussed:

- The DCAG informed that the results for the National Staff Survey have now been published and a revised report will be provided for the Finance, Performance and Workforce Committee.
- The Audit Committee agreed a planned audit of high rated risk target dates in March 2018 and highlighted 11 risks with a revised target date. The DCAG confirmed that target dates are only moved or revised if there is good rationale provided with Executive agreement.
- All risks highlighted in red are being reviewed by Committees of the Board.

It was noted that the Assurance Framework and Risk Register are ‘live’ documents and continually in a position of review. The Committee were in agreement with the risks allocated to SQS and noted the key areas of focus required. The ‘clear’ content and format of the report presented to the SQS Committee was noted and commended.

The CP and KC presented a spotlight on End of Life (EOL) Care and highlighted the following:

- Risk currently sits at 12 on the risk register.
- Risk description – If patients are not seen by the Specialist Palliative Care Team then they may not have their individual needs managed appropriately.
- Service runs Monday to Friday and the current workforce equates to
  - 0.7 WTE Medical Consultant time in Trust
  - 0.4 WTE Band 8a (Management)
  - 5.3 WTE Band 7
  - 1 WTE medical secretary Band 4
  - 0.5 WTE EOL educator / facilitator
- Number of Inbound Referrals to Specialist palliative care (SPC) increased by 26% from last year
- New referrals for home visits have increased.
- The number of follow up reviews has decreased. It is thought that this is to do with capacity issues and therefore the follow up reviews have been replaced by phone calls. It was noted that from a quality perspective this is not ideal.
- Inpatient visits by the team has increased significantly for both new and review patients.

Current controls in place

- Integrated Specialist Palliative Care MDT Meeting takes place monthly and is well attended and all patients are discussed.
- New Referral Criteria for specialist palliative care has been developed.
- New integrated Referral Form for all SPC services in East Cheshire
- Development of the use of EMIS Web to manage workload
- Improvements in coding and colour coded stickers are being assigned to record for easier identification,
• The team are working closely with the Link Nurses on Wards
• End of Life Care Resource Folders are continually updated and being used.
• Currently there is a review of locality documents for End of Life Care with focus on the care plan for end of Life and the blue prescribing booklet

Gaps in control

• The team is under resourced in terms of consultant resources and this may be compromising patient care/experience
• Unmet need of the non-cancer population
• Staff health and wellbeing is being affected and staff are often working additional unpaid hours.
• All focus is on immediate patient needs and as a result there is no time for team development and training requirements.

It was noted that there is a risk to nurse revalidation if time is not identified for training to be completed.

Positive assurance

• East Cheshire CCG has a target of 51% of patients dying in their usual place of residence. The trust currently stands at 49.2%.
• Improvement in leadership has been made since the CQC 2014 visit.

Gaps in assurance

• The national End of Life Care Audit – Dying in Hospitals has indicated the trust is below the national average in 3 out of 5 Quality Markers. These are:
  1. Is there documented evidence within the last episode of care that health professional recognition that the patient would probably die in the coming hours or days (imminent death) had been discussed with a nominated person(s) important to the patient?
  2. Is there documented evidence that the needs of the person(s) important to the patient were asked about?
  3. Is there documented evidence in the last 24 hours of life of a holistic assessment of the patients’ needs regarding an individual plan of care?
• Awaiting current CQC outcomes.

Mitigating Actions

• Greater emphasis on Education on Training
• Re-instated Palliative and EOLC locality meeting
• Practice Educator - 2.5 days dedicated to Trust Priorities for End of Life Care – Started January 2018

On behalf of the Board the CEO thanked the team for the dedication and commitment.

It was noted that additional support is required by the trust to increase and support end of life training for staff.
It was agreed that the risk would be monitored at Directorate SQS and will come back to Board SQS if the risk increase to 16 or above.

### ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>18/31</th>
<th>Key Items for the Chair to be reported to the Board</th>
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#### Points for Assurance

- The Committee received the annual report and self-assessment for the Integrated Safeguarding Adult & Children's sub committee & noted the achievements and assurances provided in relation to the Trust's compliance with statutory and mandatory safeguarding requirements.
- The Committee received the biannual review of the QIA Process providing an overview of all open & approved schemes, ongoing and planned checks on effectiveness of risk mitigation and assurances in relation to closed schemes with no unforeseen impacts on quality during the reporting period.
- Assurance Framework & Corporate Risk Register - The Committee reviewed the allocation of strategic risks to be overseen by SQS and concurred with these and areas of focus for next 3 months.

#### Emerging Risks & Mitigating Actions

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>18/32</th>
<th>Any Other Business</th>
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<td>None raised</td>
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**CONSENT ITEMS**

<table>
<thead>
<tr>
<th>18/33</th>
<th>Integrated Safeguarding Sub-Committee Annual Report and Self-Assessment</th>
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<tbody>
<tr>
<td>The Committee received and approved the annual report and self-assessment for the Integrated Safeguarding Adult &amp; Children's sub-committee &amp; noted the achievements and assurances provided.</td>
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<tr>
<th>18/34</th>
<th>Bi-Annual QIPP QIA Report</th>
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<tr>
<td>The Committee received and approved the biannual review of the QIA Process.</td>
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**FOR INFORMATION**

Chairman’s Confirmation of Agenda items for April meeting (not standing items):
- Quality Account
- Quarterly Mortality Report
- Freedom to Speak Up Annual Report (via Governance Report)
- Spotlight Sepsis

**Date and Time of Next Meeting**

Tuesday 24th April 2018
12:00 – 14:00
Lecture Theatre, MDGH
## Agenda Item Number 17: TB 18 (50)

**FINANCE, PERFORMANCE & WORKFORCE COMMITTEE**

**MINUTES OF MEETING HELD ON:**
Thursday 29th March 2018, 0830 – 1030

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

### PRESENT

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

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<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Abb.</th>
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<tbody>
<tr>
<td>Steve Redfern</td>
<td>Deputy Director of Operations</td>
<td>DDO</td>
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<tr>
<td>Lynn McGill</td>
<td>Chairman</td>
<td></td>
</tr>
<tr>
<td>Anne Marriott</td>
<td>Associate Director, Acute and Integrated Community Care Services</td>
<td>AM</td>
</tr>
<tr>
<td>Jacqui Williams</td>
<td>Associate Director, Service Transformation</td>
<td>JW</td>
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### Agenda No. 18/18

**Apologies**

None received.

### Agenda No. 18/19

**Minutes of meeting held 22nd February 2018**

Agenda item no. 18/14 page 5 of 131, para 6 should read ‘Chair’ rather than ‘Chairman’

Agenda item no. 18/16 page 9 of 131, para 2 should read ‘90% target’

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

### Agenda No. 18/20

**Declarations of Interest**

None declared.

**Matters arising**

None.
### 18/21 Action points from previous meeting

9507 – The DNPQ and DHR have met. To reduce sickness and absence rates to meet the public sector average would require a run rate of 3% which is not achievable in the next three months. The trajectory has yet to be agreed. Action closed.

9529 – Item added to agenda, action closed.

### 18/22 Annual work plan

No changes made.

### 18/23 Finance Report

The DoF presented the report, highlighting:

- The Trust is on target to achieve £19.1m deficit on Income and expenditure account, with the possibility of bonus funding if less than £19m;
- QIPP - £6.3m recurrent delivered;
- Capital – £616k behind plan at month 11 (delays due to Estates schemes) but plan in place to achieve budgeted spend by the end of March. Also, £570k of Public Dividend Capital has been awarded for cyber security expenditure;
- The debtor position has improved from Month 10;
- A strong cash position is reported as all permissible loans have been taken. A more detailed cash report will be presented mid-year.

In response to questions from the Committee, the DoF confirmed that unspent capital cannot be carried over to next year and also that the year-end settlement with the CCG had been agreed.

The CEO noted that if additional investment into the transformation agenda is required then there will need to be an increase in QIPP.

The Chair referred to the Operating Expenditure and queried the £1m variance YTD for staff costs. The DoF acknowledged overspends within Medical and Dental and Agency but that within Admin and Estates and Social workers, this is likely to be an offset against income for recharges. The Chair asked whether the fluctuation in the pay line is attributable to quality of planning and the DoN commented that a 1% variance in sickness could affect a change of circa £1m. The DDO noted that the medical variance would be offset by payment received for winter pressures. However, the CEO commented that an executive discussion will be held about allocation of these funds.

The DoF confirmed to the Chair that the agency costs referred to within ‘2017/18 Actual versus plan: key variances as at Month 11’ is the variance against NHSI planned agency target. The DoN added that A&E medical staffing costs required review as it had previously been agreed to do whatever necessary to keep the department running at safe levels and the DoF reported an improvement...
following tighter controls and negotiations with agencies.

With reference to the balance sheet and schedule of DoH loans, it was noted that, historically, when a loan becomes due, it is rolled over to new terms and that this would be the intention during 2018/19.

Procurement update
The business case outlining the operating model for a potential Cheshire Wirral procurement cluster was presented at the end of January. This was not successful due to the level of investment for staffing required. It was agreed to continue to work together to amalgamate purchasing power. The option of costs staying with individual trusts was not put forward and it was agreed that the CEO would discuss the matter with the DoF and report back.

As yet, there is no indication of a formal QIPP target allocated to Procurement. During 2017/18, £234k savings were delivered.

The Board noted that the ECT Procurement department achieved Towards Excellence level 1 accreditation for staff development and are working towards level 2.

Tenders update
The DoF confirmed that tendering activity is in line with ECT clinical policy and commented that there had been less activity in this area during 2017/18. The main outstanding tender at the present time was the sexual health re-tender for CWAC which has recently commenced.

18/24 Performance Report

The DoN presented the report, highlighting:
- The four key performance standards were not met during February. It is expected that Cancer will achieve during March and for the year;
- A&E continues in a state of operational escalation (OPEL 3);
- The focus remains on the SAFER principles in ward areas, real time escalations, and discharge planning on ward rounds;

In respect of the 62 day cancer standard, it was noted that referrals for tertiary treatments are currently 42 days within the Manchester area (38 nationally). Delays occur as a result of bank holidays affecting clinics, loss of capacity and patient choice.

The CEO commented that no assurance can be currently given to the Board that the 95% target for the ED 4 hour standard can be achieved. The number of elective/non-elective beds have been reviewed, but increasing bed volumes has financial and staffing implications. If more beds are required, this will require discussion at Board before the end of April, as there is likely to be an impact on the control total.

Community hubs update
The Chair welcomed Anne Marriott and Jacqui Williams to the meeting to present the update:
- Operational “managers” have been replaced by “coaches” in a
move to empower and enable staff to make their own informed decisions;

- The workforce is being aligned to the local population and more structure will be evident by the end of July;
- Community nurses should be appointed by November, followed by therapies and intermediate care;
- Following a visit to the Netherlands to look at the Buurtzorg model, some of these principles will be adopted;
- There will be more focus on what is best for the patient and consideration given to the wider elements of patient care;
- A reduction in the number of care hours is expected as efficiency improves, with one point of contact for each patient;
- There has been an invitation for the team to speak at a national event in May which demonstrates some recognition for the work which has been undertaken so far.

The following points were clarified in response to questions from the Committee:

- The shared vision is a work in progress - decision-making and information system are not always aligned;
- The five hubs will cover the full footprint for East Cheshire;
- The patient pathway has yet to be communicated;
- The development investment strategy is being modelled and a leadership development programme has been commissioned with AQUA;
- The outcomes framework is being developed and led by the CCG;

The Chair thanked the presenters for their presentation and for all the work that has been done in delivering the new hubs to date.

Emerging risks include:

- Winter planning for 2018/19 has to be finalised by 30th April for submission to NHS England
- The Trust's ability to achieve operational delivery during 2018/19 in line with national guidance
- The Trust's ability to improve productivity within a new block contract

18/25 Workforce Report

The DHR presented the report, highlighting:

- The overall reduction in vacancy rate since April 2017 is being driven by improved levels in medical staffing. Nursing vacancies remain a concern;
- Sickness rates have improved since January but are still above in-month target, however, benchmarking reveals similar results for other trusts in Cheshire;
- A number of training and development metrics remain impacted by operational pressures and work is underway to re-schedule dates for non-compliant staff.

The DHR commented that sickness and vacancy rates within recruiting
personnel are impacting progress in improving nursing vacancy rates. The market overall is challenging and applications from Europe have reduced greatly.

The DoN noted that there are gaps in deployment due to sickness and maternity leave but these are being managed wherever possible ahead of using agency staff.

Following discussion last month, further analysis has taken place in relation to the gender pay gap assessment and initial reporting assumptions are correct.

ECT is the first trust in the North West region to be awarded Level 3 “leader status” for the national Disability Confident scheme.

Guardian of Safe working update

The MD presented the quarterly update, highlighting:
- Issues remain with the functionality of the doctor’s rostering system;
- Exception reports increased to 35 during the last quarter, with the majority in General Surgery. All reported by F1/F2s;
- The last Junior Doctors’ Forum took place 6th March and was attended by the Chairman of the Trust, as well as nurses and ward managers.

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<tr>
<th>18/26</th>
<th><strong>Annual Report and Self-Assessment</strong></th>
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<tr>
<td></td>
<td>The DCAG referred to the Self-Assessment and requested the following amendments:</td>
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<td>- <em>Does the Committee assess its own effectiveness periodically to identify gaps and development needs?</em> Remove first comment;</td>
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<td>- <em>Are changes to the Committee’s current and future workload discussed and approved at Board level?</em> The Terms of Reference are discussed at both Audit Committee and Board.</td>
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<td>Within the Annual Report – Purpose of Report, it was noted that paras 1.1 and 1.2 were repetitive, therefore 1.2 should be deleted. A correction to the members’ attendance rate was highlighted, amending the CEO’s attendance from 100% to 90% and the MD’s from 90% to 100%.</td>
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<td>The Annual Report and Self-Assessment were approved by the Committee subject to the above changes.</td>
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<th>18/27</th>
<th><strong>Risk and Assurance</strong></th>
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<td>The DCAG presented the review of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) and drew attention to the</td>
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Committee’s areas of focus which had been highlighted in blue.

Both the BAF and CRR were reviewed at the Audit Committee meeting in February 2018.

The DCAG gave assurance that all risks had been discussed and debated as appropriate.

In response to a question from the Chair regarding risk no. 2663 inpatient 18-week backlog, the CEO clarified that an increase would impact patient experience but increase the risk to patient safety.

It was agreed that the Committee’s agendas would be re-ordered to discuss this report first when it is presented at future meetings.

<table>
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<th>For Information:</th>
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<tr>
<td><strong>Date and Time of Next Meeting</strong></td>
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<tr>
<td>Thursday 26th April 2018</td>
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<td>08:30-10:30,</td>
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<td>Boardroom 1 NAH</td>
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