EAST CHESHIRE NHS TRUST

MEETING OF THE TRUST BOARD

NOT FOR PUBLICATION BEFORE

Thursday 6th September 2018

3.00 PM

Boardroom 1, New Alderley House, Macclesfield District General Hospital

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Date: 31st August 2018

To: All Directors of East Cheshire NHS Trust

Dear Colleague

TRUST BOARD MEETING

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

Yours sincerely

Lynn McGill
Chairman

The Board encourages members of the public to attend when Board meetings are taking place. The public are observers of the proceedings not participants, however, the Chairman will provide an opportunity for members of the public to seek clarification on any matter discussed. The Chairman will not allow members of the public to express opinions or arguments which seek to bias or unduly influence the decision-making process of the Board.

There are a number of opportunities for members of the public to contribute. If you are unaware of these, please ask a member of staff before or after the Trust Board meeting and they will be happy to advise you.

TRUST BOARD – SEPTEMBER 2018 AGENDA

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Story</td>
<td>Director of Nursing, Performance and Quality</td>
<td>15 mins</td>
<td></td>
</tr>
<tr>
<td>2. Apologies:</td>
<td>Chairman</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>- Declared interest agenda</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitality and Gifts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Register Declaration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Minutes of the July 2018 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 18 (59)</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 (no open actions)</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>7. Verbal update:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SQS Committee</td>
<td>Ms A Harrison</td>
<td>15 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>FPW Committee</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. Petition regarding Congleton War Memorial Hospital</td>
<td>Chief Executive</td>
<td>10 mins</td>
<td>TB 18 (60)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Chief Executive’s Report</td>
<td>Chief Executive</td>
<td>30 mins</td>
<td>TB 18 (61)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>10. Board Assurance Framework &amp; Corporate Risk Register</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>15 mins</td>
<td>TB 18 (62)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>11. IT Strategy Update</td>
<td>Director of Finance</td>
<td>10 mins</td>
<td>TB 18 (63)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>12. Agenda Item Not Used</td>
<td></td>
<td></td>
<td>TB 18 (64)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>13. Standing Agenda Item: Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register</td>
<td>Chief Executive</td>
<td>5 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
</tr>
</tbody>
</table>
## ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Public Trust Board Agenda – November 18</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 18 (65)</td>
</tr>
</tbody>
</table>

### CONSENT ITEMS

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

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>REF. NO.</th>
<th>REASONS FOR PRESENTING</th>
<th>LINKED TO TRUST OBJECTIVE ON</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Chairman's Commentary</td>
<td>TB 18 (66)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>16. Controlled Drugs Annual Report</td>
<td>TB 18 (67)</td>
<td>For assurance</td>
<td><strong>PATIENTS</strong> - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
<tr>
<td>17. Bi-Annual Safer Staffing Levels Report</td>
<td>TB 18 (68)</td>
<td>For assurance</td>
<td><strong>PATIENTS</strong> - Provide the best services to our population through improvements to safety, productivity and patient experience <strong>STAFF</strong> - Empower, develop and value staff in providing innovative patient focused care</td>
</tr>
<tr>
<td>18. Safer Staffing Exception Report</td>
<td>TB 18 (69)</td>
<td>For assurance</td>
<td><strong>PATIENTS</strong> - Provide the best services to our population through improvements to safety, productivity and patient experience <strong>STAFF</strong> - Empower, develop and value staff in providing innovative patient focused care</td>
</tr>
<tr>
<td>19. Guardian of Safe Working Annual Report</td>
<td>TB 18 (70)</td>
<td>For assurance</td>
<td><strong>STAFF</strong> - Empower, develop and value staff in providing innovative patient focused care</td>
</tr>
<tr>
<td>AGENDA TOPIC</td>
<td>REF. NO.</td>
<td>REASONS FOR PRESENTING</td>
<td>LINKED TO TRUST OBJECTIVE ON</td>
</tr>
<tr>
<td>-------------</td>
<td>---------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
</tbody>
</table>

**Date and Time of Next Meeting:**

Date: Thursday 1st November 2018
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
DECISIONS MADE BY THE BOARD AT TODAY’S MEETING

1. Subject to one change the Committee approved the Complaints Policy.

<table>
<thead>
<tr>
<th>Agenda No</th>
<th>Agenda Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Staff Stories</td>
<td></td>
</tr>
</tbody>
</table>

Hospital Transfusion Committee Update

The Chair welcomed Mr Smart and Ms Gould to the meeting to provide an update on the work undertaken by the Hospital Transfusion Committee.

Mr Smart introduced Ms Gould, noting her invaluable work and effort to support the service to ensure patient safety for giving and receiving of blood.
Ms Gould highlighted the following:

- The Transfusion Committee provides assurance to the trust that transfusions are provided safely and within guidance. The Transfusion Committee meets on a quarterly basis with membership including representatives from all departments that use blood products.
- Transfusion is a life-saving treatment. Transfusing incorrect blood is classified as a Never Event.
- The trust uses Bloodhound, an electronic tracking system, to maintain safety throughout the transfusion process. The trust also participates in SHOT (Serious Hazards of Transfusion), a national scheme linked to the MHRA (Medical Health Regulatory Authority). Annual reports of learning are produced and used for teaching purposes.
- The transfusion department tests approximately 50-60 transfusion samples per day (circa 1500 per month). The trust administers approximately 250 units of red cells per month.
- A number of significant changes have been introduced over the last two years, to support improved processes and patient safety.
- A zero tolerance policy for sample rejection was implemented in the lab following near misses identified at the trust. Any sample with incomplete information will not be processed. A check process is in place to ensure that the blood and sample bottle are from the same patient through a secondary sample confirmation, either via an additional sample or historic data. An incident has been detected via this two sample rule, avoiding harm.
- A new request form has been implemented, which includes screening questions to identify additional blood requirements. The form has raised awareness with staff and there are increased conversations on the wards regarding additional requirements.
- A Prothrombin Complex Concentrate (PCC) flowchart has been implemented to support the reversal of warfarin. This has proved useful in clinical areas as a reference for clinicians; it was noted that there is no reversal for other anti-coagulants.
- The revised prescription pathway has been simplified providing additional prescribing advice including; smaller observation charts, a reaction chart and a consent section. Recognised as good practice, the document was shared at a regional meeting and is being used by 3 trusts as a basis for their documentation.
- Three joint consent audits were undertaken with junior doctors to determine how well consent discussions are documented. Following the first audit, compliance increased to 36%. Once the process was incorporated into the new document this increased further to 64%. These audits will be undertaken annually.
- The ‘Massive Haemorrhage protocol’ has been updated in line with national guidance, and a smaller telephone prompt card implemented. The revised process has been positively received, particularly in theatres.
- Future developments include the paediatric protocol for neonatal transfusion, upgrading the electronic system and presenting at a Grand Round with medical peers to share learning from the consent audits.

The Chair thanked Ms Gould for attending the meeting and updating on this service. She commended the hard work undertaken in a highly regulated area.
Junior Doctors – IT Improvements

The Chair welcomed Dr Biart and Dr O'Brien to the meeting to present on the IT Improvements project undertaken by the Junior Doctors.

Mr Smart shared a number of concerns raised through the Junior Doctor forum around IT and asked a number of members to review the issues raised and identify any potential solutions. This will be an ongoing piece of work by Junior Doctors coming through the trust. Junior Doctors have engaged well with this work and produced high quality surveys, reviews and results.

Dr Biart and Dr O'Brien provided an update on the work undertaken, highlighting the following.

- A survey was sent to all doctors, with 97 responses received across all grades. The survey links to the NHS Digital Maturity Assessment goals, and requested feedback on challenges faced for both software and hardware systems on frontline medicine.
- Dr Biart presented a mock patient journey, noting the various points at which IT is required to support a patient's care including a number of different software packages required which are accessed via computers.
- The LabCentre software has been raised as a particular issue by clinicians and the survey asked staff how often this has caused delays. The majority of clinicians highlighted they have been delayed more than 10 times when trying to access blood results. This causes a significant impact on a daily basis. A new piece of software, ICE, has been brought in to replace LabCentre which has significantly improved the process and given clinician's faster access to results. Positive feedback has been received since its implementation.
- The CSC software was implemented during the survey and it was noted that this has significantly improved on the previous system.
- The Up-To-Date online resource funded through the Staff Library was noted as a good support for clinicians to access evidence based information. This has been positively received and is well used by staff.
- Challenges remain regarding hardware and iPads, particularly relating to access in acute areas. Clinicians have expressed frustration at being unable to access computers in their current workplace. The iPads have improved access when available on Ward Rounds.
- MAU have recently purchased an additional computer which has improved delays; 60% of staff reported 5 or more delays when accessing a computer.
- A targeted investment proposal was made, to have 6 desktop computers and one computer on wheels (removing 5 old computers on wheels), at a projected cost of £6850.
- In summary it was noted that two problematic software programmes have been replaced with positive impact, however there remains limited access to computers and strategies are being reviewed to support.

The Chair thanked Dr Biart and Dr O'Brien for their hard work on this project during a busy time, and the positive engagement from clinicians to support this work. The Chair noted the importance in investing in the appropriate IT provision and the support of the Executive team in these pivotal improvements.
2 Apologies:

Apologies were noted from the Director of Nursing Performance and Quality; the DDO and DDNQ attended the meeting on her behalf. Charan Martin was welcomed to the meeting to observe as a trainee Non-Executive Director.

---

3 Register of Interests:

Declared Interest Agenda
There were no interests declared at the meeting.

Hospitality and Gifts Register Declaration
The Chair reminded members of the Board to ensure accurate and up to date declarations against the hospitality and gifts register.

---

4 Minutes of the June 2018 meeting

Ms Harrison noted agenda item 14 makes an incorrect reference to minutes and should read annual reports. Ms Harrison also noted that the dates for the minutes under agenda item 17 were incorrect. Following these changes, the minutes were agreed as an accurate record.

---

5 Matters Arising

There were no matters arising.

---

6 Action Log

9769 – Complete. Action Closed.
9770 – Complete. Action Closed.
9771 – Complete. Action Closed.

---

7 Verbal update:

SQS Committee
Ms Harrison provided an update from the SQS Committee on 3rd July.

Points for Assurance
• The Committee were assured in relation to the learning from the recent independent Gosport War Memorial Hospital report. External assurance has been provided from the recent CQC inspection in relation to the areas highlighted around use of controlled medicines.
• The Committee received positive assurance from the recent Inpatient Survey where all areas of the Trust are performing in line with or better than expected.
• Positive assurance was received from the recent Healthwatch ‘enter and view’ inspections of Wards 9 and 10.
• The Committee received the bi-annual SIRI update and noted assurances in relation to learning leading to practice changes including audit evidence.
• The Committee agreed with the recent additions, amendments and
priorities for next 3 months to the assurance framework and corporate risks allocated for SQS oversight.

- The Committee noted the positive assurance and progress made on the Improving Outcomes component of the Quality Strategy.
- A Spotlight in relation to the Diabetes service was received (including diabetes in pregnancy). The Committee were assured that positive actions taken in relation to specialist nurse recruitment and partnership working for the consultant element (due to a single handed consultant service) is ongoing in order to further reduce the risk level and support compliance with guidance in this area.
- The Committee received the Annual Organ Donation report confirming that the trust is compliant with all relevant legislation. The Trust continues to support local transplant referrals above the UK average.
- The Committee received assurance from the Annual Medicines Management report. Clarifications and assurances were provided specifically in relation to the use of controlled drugs.
- The Committee ratified the updated Complaints policy for subsequent Board approval. Post meeting note: The policy will be updated to ensure reference to adjusting clinical practice is included in line with learning from the most recent external reports.

Emerging Risks & Mitigating Actions

- The Committee were alerted to the challenges in meeting the 6 week diagnostic and 62 day cancer standards. Action plans are in place to address the diagnostic backlogs including interface with commissioners to better understand the recent surge in urgent referrals.
- The recent halt in non-urgent elective procedures due to winter pressures has resulted in unavoidable cancellations. Action plans are underway to enhance productivity.
- The Committee heard the challenges of sickness absence and maternity leave on small teams which has a disproportionate effect.

FPW Committee

Mr Wildig provided an update from the FPW Committee on 5th July.

Corporate Risk Register and Board Assurance Framework

- The Corporate Risk Register and Board Assurance Framework were reviewed and the strategic and corporate risks assigned to FPW were agreed as appropriate; there is one additional corporate risk expected on community care QIPP (Quality, Innovation, Productivity & Prevention).

Finance

- The trust was £160k better than plan in May. Mr Wildig cautioned that this includes STF (System Transformational Funding) funding for two months of £556k, which is dependent on achieving the quarter 1 ED 4 hour access target.
- The QIPP target for 2018/19 is £5m, with £2m identified to date as blue schemes. Executive Directors were challenged to achieve the remaining £3m. The Planned Care and Acute & Integrated Community Care directorates are behind plan for two months and are being challenged through the performance meetings to improve their position.
- A spotlight on the Acute & Integrated Community Care directorate highlighted that only amber and green QIPP schemes have currently been identified. It was agreed that a further update would be provided at
the next meeting.

Performance
- The ED (Emergency Department) 4 hour access target achieved 87% in May which is ahead of the trust’s trajectory but below the national target of 95%. ED performance has improved over the last few months with a lot of work taking place to support. May recorded the highest number of attendances for 12 months.
- There were no breaches of the 12 hour standard in May.
- RTT achieved 85% in May; 8 specialties did not achieve their target. RTT remains a concern with further work to maintain and reduce waiting lists.
- Diagnostics achieved the recovery plan for the last financial year however has declined in April and May. There is a focus on recovering this position.
- The 62 day cancer target was not achieved in May.
- The DTOCs (delayed transfers of care) trajectory has improved with work ongoing to achieve the 3.5% target.
- Emerging risks were noted on the winter plan, the criteria for allocating STF funding and improving productivity for block contracts.

Workforce
- Resourcing and overall vacancy rates have reduced however there remains a high level of acute nursing vacancies. Community nursing is fully established. Recruitment initiatives are underway.
- Medical staff vacancies have increased in May.
- Paybill and agency costs have decreased in May.
- Engagement and wellbeing absence rates for the whole workforce have decreased with continued support to staff for mental health issues and stress.
- Government compliance targets have been largely met.
- Slow progress was noted on appraisals and training.
- The levy funded apprenticeships continue to grow in line with targets.

The Chairman left the meeting to attend an NHS 70th Anniversary event and Mr Goalen acted as Chair for the remainder of the meeting.

<table>
<thead>
<tr>
<th>STRATEGIC/GOVERNANCE/ASSURANCE ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

The CEO presented the Chief Executive’s Commentary, noting the following.
- Improvements have been made in ED on the 4 hour access target achieving 87.1% which is ahead of the trust’s trajectory. Performance continues to improve in June.
- There has been a slight increase in the number of patients on the outpatients waiting list. The target set is to have no more patients on the waiting list at March 2019 compared to March 2018. The Executive team will be reviewing June’s figures to determine if there are systematic issues and how to recover the position. Validation is required on whether referrals from local GPs are increasing or decreasing.
- The 2 week cancer target is compliant. Performance on other cancer waiting times standards is mixed with variable levels of achievement.
- An external assessment has taken place on the aseptic preparation service. Low risks were identified and assurance provided.
• The trust position at the end of May was a deficit of £3.9m; this is £200k better than plan.
• The CEO highlighted the national financial settlement, advising it is unclear at this stage how it will affect the trust and local system.
• The trust received an additional £900k which has been allocated to capital funding to support a refurbishment of the outpatients department. This will aim to improve the environment and support the layout for any future potential changes to the service.
• The majority of staff side unions have agreed to the 2018/19 staff pay award.
• There has been significant clinical engagement with the work undertaken on the future service model for both the system and PLACE. A clinical strategy will be provided in coming months.

Mr Wildig queried the timescales for the proposed outpatient refurbishment. The DoF advised this is under discussion with the work likely to take place in quarter 4 of 2018/19 and quarter 1 of 2019/20, to provide the least amount of impact on waiting times. Estates are reviewing modern outpatients department at other trusts and linking in with primary care colleagues.

Mr Goalen requested clarification on whether the staff pay award would be cost neutral to the trust. The CEO advised that the financial plan assumes it will be cost neutral however detailed information is still to be received; there is a potential risk. The SSC added from a staff side perspective, they would expect this to be supported by central government.

Ms Harrison queried when the additional funding from the financial settlement is expected. The CEO advised this will be from 1 April 2019 however it is unclear how the allocation will come into trusts and CCGs.

The DoF requested clarification on the statement in section 3.14 and the CEO confirmed the waiting list standard target for March 2019 is to be less than or equal to the figure at March 2018.

9 Board Assurance Framework & Corporate Risk Register

TB 18 (52)

The DCAG provided an update on the Board Assurance Framework (BAF) and Corporate Risk Register.
• Both SQS and FPW Committees have reviewed their board assurance framework and corporate risk register in detail.
• At the SQS Committee, which reviews BAF 2 Quality and Compliance, a change of focus has been requested over the next 3 months to maximise productivity to ensure patients have a timely and quality experience.
• The DCAG noted on the report in section 3.2, point 3 on the table should read 25 in the second numerical column not 15 and it was agreed to update the report.
• The DCAG noted positive movement on closing risks.
• The Committee agreed the revisions to the board assurance framework and corporate risk register.

10 Standing Agenda Item:
Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register
There were no items noted.

### ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th></th>
<th>Public Trust Board Agenda – September 18</th>
</tr>
</thead>
</table>
| TB 18 (53) | The committee noted the agenda for the next meeting.  
Mr Goalen advised that the next Audit Committee may not be quorate. This will be discussed further outside of the meeting with the potential removal of the Audit Committee verbal update dependent on the revised meeting date. |

### CONSENT ITEMS

<table>
<thead>
<tr>
<th></th>
<th>Chairman’s Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18 (54)</td>
<td>The Committee received the Chairman’s Commentary and noted the contents.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Annual Review – Complaints Policy</th>
</tr>
</thead>
</table>
| TB 18 (55) | The Committee received the Complaints Policy and noted the contents and recommendations.  
The DCAG advised that the policy was discussed at the SQS Committee and it was recommended to include reference to external reviews. The DCAG will add an additional comment to the policy to ensure this is appropriately reflected. Subject to this change the Committee ratified the policy. |

<table>
<thead>
<tr>
<th></th>
<th>Safer Staffing Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18 (56)</td>
<td>The Committee received the Safer Staffing Exception Report and noted the contents.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Minutes of the committees of the Board:</th>
</tr>
</thead>
</table>
| TB 18 (57) | SQS Committee – April 18  
The Committee received the minutes from April’s SQS Committee and noted the contents. |
| TB 18 (58) | FPW Committee – April 2018  
The Committee received the minutes from April’s FPW Committee and noted the contents. |

**Date and Time of Next Meeting:**
**Date:** Thursday 6th September 2018  
**Time:** 3.00pm - **Venue:** Board Room 1, New Alderley House, Macclesfield District Hospital

Signed: ……………………………………

Name: ……………………………………

Date: ……………………………………...
<table>
<thead>
<tr>
<th>Report of:</th>
<th>Responsible Officer: Chief Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Officer:</td>
<td>John Wilbraham, Chief Executive</td>
</tr>
<tr>
<td>Author of Report:</td>
<td>John Wilbraham, Chief Executive</td>
</tr>
<tr>
<td>Subject/Title</td>
<td>Petition re Congleton War Memorial Service Provision</td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
<td>None</td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>To understand the context to the petition and to agree future actions</td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>The Board are asked to: • Receive the petition • Accept the recommendations about further discussions with parties</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>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>Link to Care Quality Commission Domain</td>
<td>Choose one of the following: Safe Caring Responsive Effective Well-led</td>
</tr>
<tr>
<td>Link to:</td>
<td>Trust’s Strategic Direction Corporate Objectives</td>
</tr>
<tr>
<td></td>
<td>Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
<tr>
<td>Legal implications - (identify)</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>N/A</td>
</tr>
</tbody>
</table>
Avoid acronyms or abbreviations - if necessary list:

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>MP</td>
<td>Member of Parliament</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
</tbody>
</table>
Petition regarding Congleton War Memorial Service Provision

This paper represents the formal acceptance of a petition from residents of Congleton and highlights issues of concern from the local Congleton population.

1 INTRODUCTION

1.1 A petition has been presented to the Trust Board via Cheshire East Council raising concerns about the regrettable short term closures of the Minor Injury Unit at Congleton War Memorial Hospital.

1.2 In addition, an open letter has been written by the Cllr Suzie Akers Smith, Chairman of Congleton’s Health and Well–Being Working Group of Congleton Town Council about service provision in the town and asking Cheshire East Council to look at ways to sustain the site. This letter is attached at Appendix A.

1.3 Fiona Bruce M.P and a number of local councillors have also raised their concerns with the trust about future health service provision at the War Memorial site.

1.4 The Board have already been made aware of the reasons for closure especially over the winter period.

2 THE PETITION

2.1 The petition reads as follows:

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

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

2.2 A covering note to the petition focuses on the recent closures of the Minor Injury Unit at Congleton and was addressed to Cheshire East
Health and Wellbeing Board and contained the following questions:

- Can you give an indication of the number of unfilled vacancies at Macclesfield Hospital that would need to be filled before the Minor Injuries Unit and Congleton War Memorial would be unaffected by these staffing challenges
- What active steps are being taken to address these staffing challenges
- Would this committee please accept submission of this petition on behalf of the people of Congleton?

2.3 As CEO I have acknowledged receipt of the petition.

3 MINOR INJURY UNIT

3.1 The Board has made no decisions about any service reductions at the Congleton War Memorial site.

3.2 The Board are aware that operational pressures at the Macclesfield site have led to the redeployment of staff to Macclesfield resulting in short notice closures of the Minor Injury Unit. Appendix B is a paper that was sent to the Health and Adult Social Care and Communities Oversight and Scrutiny Committee which gives further background to the position.

3.3 Whilst activity numbers are reduced due to closures there has been a steady decline in numbers of people using this service over a number of years. This is in part due to the fact that the service offered is also provided within Primary Care and other community settings.

On average the unit is seeing 2 people per hour.

3.4 The clinical and financial viability of this service needs to be considered as part of the wider sustainability work for the trust and for Cheshire East and this will be done in collaboration with Eastern Cheshire Clinical Commissioning Group and other partners within the Cheshire East Transformation programme.

4 CONGLETON WAR MEMORIAL SITE

4.1 There are a range of services provided on the Congleton site including the minor injury service, out-patient appointments and intermediate care beds. Colleagues from other organisations such as Cheshire and Wirral Partnership Trust also provide services from this site.

4.2 Whilst Congleton residents use these services they are not exclusively for Congleton residents and c.50% of the beds have been occupied by people who do not live in the town and outpatient appointments are also accessed by people outside of the town.

4.3 The Cheshire East Partnership is currently looking at developing Care Communities across Cheshire East where out of hospital services health and care will be delivered in a more integrated fashion. Congleton will be one of these Care Communities.

4.4 As part of the development of the Congleton Care Community it will be important to agree from where services in the town will be provided.
and these discussions will include discussions about how the War Memorial Site will play a part in the future service delivery.

5 RECOMMENDATION

5.1 It is recommended that:

- The CEO meets with the member of the public who presented the petition to hear in detail the concerns and to ensure there is a joint understanding of the position.
- The CEO meets with the Chairman of Congleton’s Health and Well-Being Working Group of the Congleton Town Council to discuss their concerns.
- The CEO ensures discussion about the future of the site into the wider discussions with partners of the Cheshire East transformation programme.
- The CEO and Chairman continue to have dialogue with Fiona Bruce M.P.

John Wilbraham
Chief Executive
OPEN LETTER REGARDING THE CONGLETON WAR MEMORIAL HOSPITAL

In the month that the National Health Service celebrates its 70th anniversary, we in Congleton would like to congratulate the NHS on all that they have achieved and to say how much we appreciate the health care services that are provided, in particular by the Congleton War Memorial Hospital which has benefited the residents of Congleton since 1924.

We are looking for support from Cheshire East Council, the East Cheshire NHS Trust and other health and well-being partners to ensure that these vital services continue to be provided in the growing town of Congleton especially in light of the predicted population growth in the very near future.

Congleton currently has a population of around 27,000 and planned development for around 4,000 more homes will increase the population by around 10,000 people over the next 15 years. This is the biggest increase in the town’s growth in its history. This increase in population means there will be an even greater demand for the services provided by the War Memorial Hospital in the future.

To reduce services now will not only increase demands on the current GP practices who are already under pressure to deliver healthcare but if services were moved to Macclesfield, travelling to use alternative facilities will have a real cost for local people both in terms of time and money. In addition the inconvenience or inability to travel could lead to people not attending appointments or being seen by minor injuries, leading to deterioration in their condition, and in the longer term higher costs for the NHS. It would also increase congestion on the Macclesfield Road.

We have an above average percentage of older residents who require a greater need for health service provision, this is not going to diminish with the population living longer. Not having the provision of services provided by the Congleton War Memorial will seriously impact the residents who live in and around Congleton.

Along with local residents we are seeking reassurance that Cheshire East Council will support local people in lobbying for the vital services provided at Congleton War Memorial Hospital. Any reduction in these services would leave the residents with many issues to contend with.
As a town we are in the top quintile nationally for admissions for injuries and emergencies for 0-4 year olds, hospital stays for self-harm, new admissions for bowel cancer and hip fractures. At the War Memorial Hospital Congleton residents benefit from a Minor Injuries Unit, X-ray and physiotherapy departments, blood clinics, numerous specialist clinics and meetings with consultants.

In addition the hospital has a 28 bed intermediate care ward, enabling people who still need a hospital bed to move out of a more acute hospital and recover closer to home where it is easier for friends and family to visit and aid their recovery. We believe that there is scope to further improve health services in Congleton, possibly by delivering more services across the adult social care sector at The War Memorial Hospital site.

We know that the War Memorial Hospital is a very important part of the health service for the people of Congleton and the surrounding parishes, in recent months there has been a reduction in the opening hours of the Minor Injuries Unit which means that residents are travelling to Macclesfield for these services or waiting until the following week to see their doctor. A recent Freedom of Information request revealed that the Minor Injuries Unit had been closed for 1,725 hours or 21% of the time over the past three years. This is on top of a reduction in advertised weekend opening times of 36%. This is a concern for local people and a trend that we would like to see reversed.

We are aware of the pressures on the NHS and the challenges facing our local health trust and although there is no current public consultation on the future of the War Memorial Hospital, as a town we believe that any changes for local health care provision needs to consider both the current and future needs of our growing community.

Healthcare provision changes that have happened in neighbouring towns such as Knutsford have had a detrimental impact on the residents, so that Congleton does not suffer in the same way we would welcome the opportunity to work with Cheshire East Council and members of the Health and Wellbeing group to look at innovative ways to enhance the use of the War Memorial Hospital site to further benefit our community and secure the future of health services for residents in Congleton and the surrounding parishes.

Yours sincerely

Cllr Suzie Akers Smith

Chairman of Congleton’s Health and Well-Being Working Group
Minor 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>
<td>2</td>
<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

Chairman: Lynn McGill
Chief Executive: John Wilbraham
# Agenda Item Number 9: TB 18 (61)

<table>
<thead>
<tr>
<th>Report of:</th>
<th>Chief Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Officer:</td>
<td>John Wilbraham, Chief Executive</td>
</tr>
<tr>
<td>Accountable Officer:</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Subject/Title</td>
<td>Chief Executive’s commentary for the period ending 31st July 2018</td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
<td>N/A</td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>To highlight performance issues and areas of risk to the delivery of the trust’s objectives</td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>No decisions are required of the Board</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Corporate Risk Register</td>
<td>Links to all risks identified within the Assurance Framework and the Corporate Risk Register</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Assurance Framework</td>
<td></td>
</tr>
</tbody>
</table>
| Link to Care Quality Commission Domain | Safe ✓  
Caring ✓  
Responsive ✓  
Effective ✓  
Well-led ✓  |
| Link to: | Trust's Strategic Direction  
Corporate Objectives | Links to all strategic objectives |
| Legal implications - (identify) | None |
| Impact on quality | Increasing risk to patient experience due to operational pressures |
| Resource impact | None |
| Impact of equality/diversity | None |

**Avoid acronyms or abbreviations - if necessary list:**  
ASI – Appointment Slot Issues  
CCG – Clinical Commissioning Group  
ED – Emergency Department  
NHS I – NHS Improvement  
NHS E – NHS England  
QIPP – Quality Innovation Productivity & Prevention
Chief Executive’s Commentary for the Period Ending 31st July 2018

1 INTRODUCTION

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

Below

1.2 Appendix A summarises the performance of the key indicators.

2 KEY ISSUES

The Board are asked to note the following issues

2.1 • Pressure on waiting times and the number of patients on the waiting list for treatment which has led to a decision to temporarily restrict new referrals from out of area CCG’s in selected specialities

• The outcome of the mental health consultation will take longer than originally expected

• The positive, though fragile, financial performance

• The positive external assessment of the 7 day working audit undertaken in the spring

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

Waiting times at the trust are deteriorating and action has been taken to seek to reduce demand from out of area CCG’s

3.1.1 The trust’s performance on ED waiting times has deteriorated. The number of patients admitted, transferred or discharged within 14 hours was 3,955 in July (87.9%). This has deteriorated from the June position when the 95% standard was achieved. The year to date position at the end of July was 89.4%. The volume of patients arriving at the department is 1.6% less than the period in the last financial year.

3.1.2 Whilst the percentage of people treated within 18 weeks has been relatively consistent over the first 4 months of the year we are seeing the number of people on the waiting list growing. There are concerns about the length of wait for some follow-up appointments which are being lengthened to accommodate urgent new referrals.

3.1.3 Trusts are required to have no more patients on the waiting list at 31st March
2019 as there were on 31st March 2018 and at the current time the position at East Cheshire has shown a reduction of 172 (2.3%) on the patient administration system. There are however a number of patients referred to the trust which are not automatically entered into the PAS (ASI – Appointment Slot Issues) and there is significant growth in these numbers of 1314.

3.1.4 The Executive Team is focused on this issue both in terms of patient experience but also safety and reluctantly, given the excess demand over capacity, it has been agreed with our host CCG that we will not accept referrals from other CCG’s in certain specialities for a period of time. In addition a number of waiting list initiatives are being undertaken which will add to the financial risk of the organisation.

3.1.5 Despite this pressure in the system the positive patient family and friends test remains high.

3.1.6 The length of stay of patients is being scrutinised by regulators across all providers to ensure that there is a continual focus on length of stay. The ambition is to ensure length of stay is a short as possible so as to reduce bed occupancy which in turn speeds up flow of patients through the ED and onto wards where appropriate. This is an area where we are already focusing however we have seen little improvement in our position and the winter pressures will need to be managed with lower bed occupancy rates that are currently being experienced by the trust.

3.2 Seven Day Service Audit

An audit of 7-day service standards was undertaken in the Spring and the trust has performed well when compared with other Trusts

3.2.1 The trust has received positive feedback from NHSI and NHSE following the audit of performance against four of the 7 day clinical service standards undertaken in the spring.

3.2.2 The trust data showed the following compliance rates:

<table>
<thead>
<tr>
<th>Clinical Standard</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 – time to first consultant review</td>
<td>82</td>
</tr>
<tr>
<td>5 – access to diagnostic tests</td>
<td>91</td>
</tr>
<tr>
<td>6 – access to consultant-directed interventions</td>
<td>89</td>
</tr>
<tr>
<td>8 – on-going review by consultant twice daily if high dependency patients, daily for others</td>
<td>91</td>
</tr>
</tbody>
</table>

Clinical Standard Target = ≥90%

3.2.3 The table below shows comparative data for Trusts in the North
4 FINANCIAL STABILITY

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

4.1 Income and Expenditure

The trust remains ahead of its financial plan although the in-month position has shown a small deterioration

4.1.1 The monthly position was a deficit of £43k reducing the current positive variance to plan to £243k. The position is welcomed however it is clear that this is a small positive variance which could be lost if there is any loss of financial control.

4.1.2 The tables below shows both the summary Income and Expenditure position for the Trust as well as the position by Directorate

4.1.3 Income & Expenditure Statement table - Month 4 2018/19

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Favourable/Adverse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£49,050</td>
<td>£50,309</td>
<td>£-1,259</td>
<td>Favourable</td>
</tr>
<tr>
<td>Pay Expenditure</td>
<td>£35,808</td>
<td>£36,236</td>
<td>£428</td>
<td>Adverse</td>
</tr>
<tr>
<td>Non-Pay Expenditure</td>
<td>£19,002</td>
<td>£19,621</td>
<td>£619</td>
<td>Adverse</td>
</tr>
<tr>
<td>Total Operating Expenditure</td>
<td>£54,810</td>
<td>£55,856</td>
<td>£1,046</td>
<td>Adverse</td>
</tr>
<tr>
<td>Operating (deficit)/Surplus</td>
<td>£5,760</td>
<td>£5,548</td>
<td>£-212</td>
<td>Favourable</td>
</tr>
<tr>
<td>Interest Rec'd/Paid/Gain on disp.</td>
<td>£344</td>
<td>£313</td>
<td>£-31</td>
<td>Favourable</td>
</tr>
<tr>
<td>Capital Charges &amp; Adjustment for donated assets</td>
<td>£1,133</td>
<td>£1,132</td>
<td>£0</td>
<td>Favourable</td>
</tr>
<tr>
<td>Trust (deficit)/Surplus</td>
<td>£7,237</td>
<td>£6,993</td>
<td>£-244</td>
<td>Favourable</td>
</tr>
</tbody>
</table>
4.2 QIPP

4.2.1 There is a high level of risk that the trust will not achieve its savings target in the current year. It is possible that good financial control may offset the shortfall however the non-delivery of recurrent savings builds pressure on the financial requirements of the trust in 2019/20.

The table below shows the current QIPP performance:

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Contract Income</th>
<th>Direct Income</th>
<th>Pay Cost</th>
<th>Non Pay Cost</th>
<th>Operational Variance</th>
<th>Favourable/Adverse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute and Integrated Care</td>
<td>(91)</td>
<td>(50)</td>
<td>725</td>
<td>131</td>
<td>715</td>
<td>Adverse</td>
</tr>
<tr>
<td>Allied Health and Clinical Support Services</td>
<td>0</td>
<td>9</td>
<td>(203)</td>
<td>(88)</td>
<td>(285)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Planned Care Services</td>
<td>322</td>
<td>60</td>
<td>322</td>
<td>226</td>
<td>812</td>
<td>Favourable</td>
</tr>
<tr>
<td>Contract Income</td>
<td>(1,245)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(1,245)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>0</td>
<td>(196)</td>
<td>(49)</td>
<td>(60)</td>
<td>(305)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Trustwide</td>
<td>0</td>
<td>53</td>
<td>(368)</td>
<td>409</td>
<td>94</td>
<td>Favourable</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>(1,011)</strong></td>
<td><strong>(248)</strong></td>
<td><strong>428</strong></td>
<td><strong>619</strong></td>
<td><strong>(212)</strong></td>
<td><strong>Favourable</strong></td>
</tr>
</tbody>
</table>

**FINANCE Quality, Innovation, Productivity and Prevention (QIPP)**

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

<table>
<thead>
<tr>
<th>Forecast / Actual QIPP delivered by Service Line at Month</th>
<th>2018/19 YTD</th>
<th>2019/20 YTD</th>
<th>2020/21 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute and Integrated Care</strong></td>
<td>£355k</td>
<td>£802k</td>
<td>£553k</td>
</tr>
<tr>
<td><strong>Allied and Clinical</strong></td>
<td>£331k</td>
<td>£741k</td>
<td>£245k</td>
</tr>
<tr>
<td><strong>Planned</strong></td>
<td>£325k</td>
<td>£339k</td>
<td>£741k</td>
</tr>
<tr>
<td><strong>Corporate</strong></td>
<td>£317k</td>
<td>£333k</td>
<td>£771k</td>
</tr>
<tr>
<td><strong>Trust Wide</strong></td>
<td>£312k</td>
<td>£855k</td>
<td>£1,060k</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£2,602k</td>
<td>£3,187k</td>
<td>£4,818k</td>
</tr>
</tbody>
</table>

**Percentage of Target Achieved**

- Acute and Integrated Care: 77%
- Allied and Clinical: 77%
- Planned: 77%
- Corporate: 77%
- Trust Wide: 77%
- Total: 77%

**% of Target Achieved**

- Acute and Integrated Care: 27%
- Allied and Clinical: 45.8%
- Planned: 72.7%
- Corporate: 99.2%
- Trust Wide: 99.2%
- Total: 99.2%

**FYE Black**

- Acute and Integrated Care: £239k
- Allied and Clinical: £309k
- Planned: £521k
- Corporate: £716k
- Trust Wide: £1,403k
- Total: £3,187k
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  Workforce Performance

The workforce performance is stable with no issues to draw to the Boards attention

5.1.1  The performance metrics for workforce are broadly positive and sickness absence levels remain below the planned levels.

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  Mental Health Consultation

The CCG have issued a statement saying that there is further work to be done following response to the recent consultation exercise

The following statement has been made by the CCG in respect of Mental Health Service provision. The CCG statement reads as follows:

“As a valued partner we wanted to contact you to update you on the next steps in relation to the recent public consultation regarding proposals to redesign adult and older people’s specialist mental health services in Eastern Cheshire, South Cheshire and Vale Royal.

These important services serve a population of 480,000. At the very heart of what we are aiming to achieve, through our proposals, is to improve the health and wellbeing of people with severe mental health problems. There is an absolute commitment to have available to our local populations services and support that enable our patients “to thrive, not just to survive.”

We would like to thank everyone who either took part in or supported the delivery of our three-month public consultation. We ran a very comprehensive consultation process. All 7,000 patients across Eastern Cheshire, South Cheshire and Vale Royal who are currently supported by, or accessing, adult and older people’s specialist mental health services received a personal copy of the consultation document. We held seven public engagement consultation meetings and 26 community events with over 700 attendees. We were also successful in gaining widespread print and social media coverage which helped to further encourage people to #JoinTheConversation.
All of the feedback that was received throughout the consultation period has been analysed independently. Given the breadth and depth of feedback from patients, the public and organisations, it is vital that we now have time to fully consider this before making any decisions. As such, no decision has been made or will be made until later this year.

The full consultation report will be made publicly available in early September on the websites of each Clinical Commissioning Group (CCG), and we will also attend the local authority’s health scrutiny meeting to present the findings of the consultation. A decision-making business case will then be prepared and brought to a meeting in public of the three CCGs before the end of the year when a decision will be made with regards how to progress.

We will continue to keep patients and the wider public informed of our next steps.”

## USE OF TRUST SEAL

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

## SUMMARY

### 8.1
The trust is facing significant operational pressure within ED and bed occupancy levels are higher than levels consistent with efficient patient flow.

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

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q1</th>
<th>Jul</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Adjusted Mortality Index 2017 - Latest Peer (88.68)</td>
<td></td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>Summary Hospital Mortality Indicator (HSCIC)</td>
<td>1.070</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital MRSA bacteraemia</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Infection</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecoli - includes hospital and community</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Acquired Clostridium Difficile 18/19 Avoidable</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 3 pressure ulcers - hospital</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 4 pressure ulcers - hospital</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 3 pressure ulcers - out of hospital</td>
<td>9</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 4 pressure ulcers - out of hospital</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Incidents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication errors causing serious harm</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Never Events</td>
<td>1.7</td>
<td>1.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Patient Safety: Falls resulting in patient harm per 1000 Occupied bed days</td>
<td>7745</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Complaints</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. complaints with HSO Recommendations</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of complaints</td>
<td>26</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Ward Family and Friends Test % response</td>
<td>44.2%</td>
<td>56.8%</td>
<td>56.8%</td>
</tr>
<tr>
<td>ED Family and Friends Test % response</td>
<td>24.0%</td>
<td>20.5%</td>
<td>20.5%</td>
</tr>
<tr>
<td><strong>Experience</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed Sex Accommodation breaches</td>
<td>35</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>18 week - Incomplete Patients</td>
<td>84.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to Treatment Waiting list Total</td>
<td>91.7%</td>
<td>80.9%</td>
<td>80.9%</td>
</tr>
<tr>
<td>ED: Diagnostic 6 week access standard</td>
<td>91.7%</td>
<td>80.9%</td>
<td>80.9%</td>
</tr>
<tr>
<td>ED: Maximum waiting time of 4 hours</td>
<td>89.9%</td>
<td>87.9%</td>
<td>87.9%</td>
</tr>
<tr>
<td>ED: The recording of a completed handover, (HAS)</td>
<td>87.9%</td>
<td>80.4%</td>
<td>80.4%</td>
</tr>
<tr>
<td>2 Weeks maximum wait from urgent referral for suspected cancer</td>
<td>91.4%</td>
<td>97.1%</td>
<td>97.1%</td>
</tr>
<tr>
<td>2 Weeks maximum wait from referral for breast symptoms</td>
<td>46.3%</td>
<td>90.7%</td>
<td>90.7%</td>
</tr>
<tr>
<td>31 days maximum from decision to treat to subsequent treatment - Surgery</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>31 day wait from cancer diagnosis to treatment</td>
<td>99.4%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>62 day maximum wait from urgent referral to treatment of all cancers</td>
<td>75.2%</td>
<td>72.1%</td>
<td>72.1%</td>
</tr>
<tr>
<td>62 days maximum from screening referral to treatment</td>
<td>97.3%</td>
<td>95.7%</td>
<td>95.7%</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delayed transfers of care - Acute</td>
<td>3.0%</td>
<td>4.4%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Bed days lost through delays - Acute</td>
<td>659</td>
<td>345</td>
<td>345</td>
</tr>
<tr>
<td>Delayed transfers of care - Non Acute</td>
<td>11.3%</td>
<td>12.7%</td>
<td>12.7%</td>
</tr>
<tr>
<td><strong>DTOC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Staff in Post (FTE)</td>
<td>2170.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Staff (FTE)</td>
<td>2393.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness Absence - monthly</td>
<td>4.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness Absence - Rolling year</td>
<td>4.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory and Mandatory Training - Rolling 3 year period</td>
<td>85.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate Induction attendance - Rolling year</td>
<td>91.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisals and Personal Development Plans - Rolling year</td>
<td>86.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Governance training</td>
<td>68.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding - Level 1 Compliance</td>
<td>93.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children - Level 2</td>
<td>87.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults - Level 2</td>
<td>90.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children - Level 3</td>
<td>92.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Pay Expenditure (£000)</td>
<td>£27,047k</td>
<td>£9,188k</td>
<td>£9,188k</td>
</tr>
<tr>
<td>Bank Staff Expenditure (£000)</td>
<td>£1,411k</td>
<td>£493k</td>
<td>£493k</td>
</tr>
<tr>
<td>Agency Staff Expenditure (£000)</td>
<td>£1,650k</td>
<td>£473k</td>
<td>£473k</td>
</tr>
<tr>
<td>Cash (£000's)</td>
<td>£10,690k</td>
<td>(£5,548k)</td>
<td>(£5,957k)</td>
</tr>
<tr>
<td>EBITDA (£000)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative Deficit</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Agenda Item Number 10: TB 18 (62)

**Report of:**
- **Responsible Officer:** Deputy Director of Corporate Affairs and Governance
- **Accountable Officer:** Director of Corporate Affairs and Governance

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

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

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

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

**Mitigates Risk Number:**
- (identify) On Corporate Risk Register
- (identify) On Assurance Framework

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

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

**Link to:**
- All Objectives

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

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

**Resource impact:**
- There are no resource implications

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

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

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

1 INTRODUCTION

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

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

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

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

2 STRATEGIC RISKS

The strategic risks remain unchanged in 2018/19

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

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

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

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

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

5. If the Information Technology/Information Systems and Estate infrastructure are not sufficiently invested in and adapted to align with the health economy strategy then there will be an impact on the quality of the delivery of clinically & financially sustainable services
The level of risk recorded in the Board Assurance Framework remains unchanged from the previous report; although assurances have been strengthened and action taken which enabled two gaps in control and assurance to be closed. Key areas included:

- Compliance with safeguarding training is now in line with target
- The level of appraisals due and undertaken is now in line with trajectory

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

- Contract income performance is below plan and therefore affecting the financial position
- Cancer targets are not consistently met
- The level of apprentices employed at the trust is currently below the national standard level.

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

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

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

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Monitoring Committee / Board</th>
<th>Focus over next 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leadership of Strategic Transformation</td>
<td>Clinical Management Board</td>
<td>Continue to work with partners to agree clinical models for East Cheshire.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continue with clinical engagement to ensure consensus is achieved relating to future service model</td>
</tr>
</tbody>
</table>
### Strategic Risk Monitoring Committee / Board

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Monitoring Committee / Board</th>
<th>Risk Rating without controls</th>
<th>Current Risk Rating</th>
<th>Target Risk Rating</th>
<th>Focus over next 3 months</th>
</tr>
</thead>
</table>
| 2. Quality & Compliance: patient safety, patient experience and effectiveness | Safety, Quality & Standards Committee | 16 | 12 | 8 | Maximise productivity to ensure patients have a timely & quality experience  
Embedding of the Safecare audit tool to monitor patient acuity, allowing redeployment of staff to areas of need. |
| 3. Financial stability | Finance, Performance and Workforce Committee | 25 | 25 | 15 | Focus on identification of QIPP schemes for 2018/19  
Further monitoring of control over agency spend due to continued challenge in recruiting staff.  
Delivery of the planned financial position in the quarter |
| 4. People | Finance, Performance and Workforce Committee | 20 | 16 | 8 | Continued focus on recruitment programme for consultant and middle grade staff  
On-going work to address future staff recruitment within acute nursing to cover existing vacancies and address mature workforce profile; and staff turnover. |
| 5. Infrastructure | Clinical Management Board | 16 | 12 | 8 | Continue the Estate Rationalisation programme in the community  
Continue to implement the agreed IT transformation plan. |

#### 3.2.2

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

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

#### 3.2.3

A rolling committee work programme is in place to ensure the Committees of the Board review their delegated strategic risks four times a year.
3.3 The complete Board Assurance Framework is included at Appendix 2

4 CORPORATE RISK REGISTER

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

4.1 There are currently 27 red risks included on the risk register, which is a net increase from the previous report of 6 risks, although the risks will not be identical to those in the previous report. A comparison of the current risk register and the previous reported risk register shows that eight risks have been added or had their risk scores increased, whilst two risks have either been closed or had their risk score reduced (Appendix 1 refers). This includes reported Serious Incidents Requiring Investigation.

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

4.1.2 There are a further 11 risks which are currently rated 15+, which are going through the formal approval process.

4.1.3 The table below shows the total number of risks contained on the risk register in each of the quarters reported in 2017/18 (which is specific to the time of the report being run from the risk management system).

<table>
<thead>
<tr>
<th>Movement in Corporate Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Number of risks</td>
</tr>
<tr>
<td>Risks closed</td>
</tr>
<tr>
<td>Risk score reduced to below 15</td>
</tr>
<tr>
<td>Existing risks with scores increased to 15+</td>
</tr>
<tr>
<td>New risks added</td>
</tr>
</tbody>
</table>

4.2 The 27 red rated Corporate Risks have been delegated as follows (nine risks are monitored by more than one committee, so a total of 40 risk entries appear when the risks are split by monitoring committee / board):

<table>
<thead>
<tr>
<th>Committee / Board</th>
<th>Number of Red Rated Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety, Quality and Standards Committee</td>
<td>16 (includes 3 serious incidents which have been reported on the National Strategic Executive Information System (StEIS))</td>
</tr>
<tr>
<td>Finance, Performance and Workforce Committee</td>
<td>13</td>
</tr>
<tr>
<td>Clinical Management Board</td>
<td>11</td>
</tr>
</tbody>
</table>
4.2.1 The Safety Quality and Standards Committee and Finance, Performance and Workforce Committee are scheduled to review the red rated risks delegated to them at their September 2018 meetings. Clinical Management Board will also review its delegated red risks in September 2018. Details of these risks are included at Appendix 1.

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

4.3 The complete Risk Register is included at Appendix 3.

5 RECOMMENDATION

5.1 The Board is asked to:

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

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

The following eight risks (including one which has been redacted in line with our agreed governance processes) have been added to the Corporate Risk Register or had their risk score increased since the last report (this compares with three risks which were added in the previous report)

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2797</td>
<td><strong>Risks Monitored by Safety, Quality &amp; Standards Committee</strong></td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td></td>
<td>If staff do not have the standard and competence to manage long lines (internally or from an external source) (Mid-line/PICC/CVC) then patient outcome will be affected. This Risk covers all clinical areas from ED to wards clinics, and discharged patients with long lines. Utilisation of lines that are unlicensed</td>
<td></td>
</tr>
<tr>
<td>2842</td>
<td><strong>Risks Monitored by Finance, Performance and Workforce</strong></td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td></td>
<td>A Serious Incident relating to a Delay or Failure in Treatment or Care on Ward 8 /MAU has been reported on the Strategic Executive Information System (2018/18440 Web-54202).</td>
<td></td>
</tr>
<tr>
<td>2820</td>
<td><strong>Risks Monitored by Clinical Management Board</strong></td>
<td>Newly approved risk – current score 20</td>
</tr>
<tr>
<td></td>
<td>If the Acute &amp; Integrated Care Directorate is unable to operate within the 2018/19 financial plan and achieve the relevant income and QIPP, there is a risk that the trust will not achieve the financial target</td>
<td></td>
</tr>
<tr>
<td>2834</td>
<td><strong>Risks Monitored by Finance, Performance &amp; Workforce Committee and Safety, Quality and Standards Committee</strong></td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td></td>
<td>IF there is no planning in place for the replacement of end of life hardware THEN devices may not be fit for purpose and direct patient care will be affected.</td>
<td></td>
</tr>
<tr>
<td>2810</td>
<td><strong>Risks Monitored by Clinical Management Board; Finance, Performance &amp; Workforce Committee; and Safety, Quality &amp; Standards Committee</strong></td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td></td>
<td>If cancer patients with complex pathways are not treated in a timely and coordinated way, there is a risk that the trust will not achieve 85% compliance with the 62 day standard from referral to treatment standard and patient care will be affected.</td>
<td></td>
</tr>
<tr>
<td>2817</td>
<td>If the inpatient 18 week backlog for ENT continues to increase, then there may be an impact on patient safety &amp; experience due to delays in treatment.</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td>2788</td>
<td>If the out of hours rota for FY2 doctors continue to cover across Surgery and Orthopaedics, then there is a risk that during busy shifts the doctors may be stretched too thinly and unable to provide safe care, resulting in a clinical incident or omission of care.</td>
<td>Newly approved risk – current score 16</td>
</tr>
</tbody>
</table>
The following two risks have been either closed or downgraded since the last report and are therefore no longer showing on the high level corporate risk register (this compares with 13 risks which were closed or downgraded in the previous report):

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Description</th>
<th>Status</th>
<th>Additional detail</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2565</strong></td>
<td>If the existing consultants continue to cover the gaps in the oncall rota, this will have an impact on increased workload and provide an increased financial pressure of approx £5000 per month.</td>
<td><strong>Reduction in risk score – current score 12</strong></td>
<td>Risk score downgraded due to gaps in junior doctor rota reduced.</td>
</tr>
<tr>
<td><strong>2578</strong></td>
<td>If the patient beds are not upgraded to the new electric beds with integrated safety sides then there is a potential risk of harm to the patient from falls, discomfort from not being able to manoeuvre patients into a comfortable position. Potential risk of musculoskeletal harm to staff with regard to manual handling of patients and safe manoeuvring around the organisation</td>
<td><strong>Reduction in risk score – current score 12</strong></td>
<td>Risk score reduced due to completion of capital works</td>
</tr>
</tbody>
</table>
### Report of: Responsible Officer: Accountable Officer:
Mark Ogden
Director of Finance

### Author of Report:
Ian Curr
Interim Digital Lead

### Subject/Title
IM&T Strategy 2018-23

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

### Purpose of Paper
To update on the activities of Informatics

### Action/Decision required
To Approve the Five Year IM&T Strategy

### Mitigates Risk Number: (identify)
#### On Corporate Risk Register
2059 – Lack of investment to meet the Trusts strategic objectives and national statutory requirements

#### On Assurance Framework
BAF 5 – If the Information Technology/Information Systems and Estate infrastructure are not sufficiently invested in and adapted to align with the health economy strategy then there will be an impact on the quality of the delivery of clinically & financially sustainable services

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

### Link to: Trust’s Strategic Direction Corporate Objectives
Improve the efficiency and effectiveness of the organisation through optimisation of estate and use of technology to improve patient care. As measured by a reduction in available benchmark costs.

### Legal implications - (identify)
No legal implications

### Impact on quality
Assures continuity of Trust’s IT Systems and therefore supports direct patient care

### Resource impact

### Impact of equality/diversity

### Avoid acronyms or abbreviations - if necessary list:
- CCG - Clinical Commissioning Group
- CDMS - Clinical Document Management System
- CQC - Care Quality Commission
- DMA - Digital Maturity Assessment
- ECT - East Cheshire NHS Trust
- ePMA - Electronic Prescribing Medicine Administration
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPR</td>
<td>Electronic Patient Record</td>
</tr>
<tr>
<td>eRS</td>
<td>Electronic Referral Service</td>
</tr>
<tr>
<td>MLCSU</td>
<td>Midlands &amp; Lancashire Commissioning Support Unit</td>
</tr>
<tr>
<td>PC</td>
<td>Personal Computer</td>
</tr>
<tr>
<td>PRSB</td>
<td>Professional Records Standards Body</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Programme</td>
</tr>
<tr>
<td>VDI</td>
<td>Virtual Desktop Infrastructure</td>
</tr>
<tr>
<td>XDS</td>
<td>Cross Document Sharing</td>
</tr>
</tbody>
</table>
1 Executive Summary
2 Introduction
3 The Role of IT in the delivery of quality services
4 Our vision
5 Current position
6 Modernise, simplify, share
7 Electronic patient records
8 Relationships with Health & Social Care partners
9 The financial challenge
10 Information Technology Governance
11 Next steps
**Executive Summary**

1. The Trust has a good track record of working with partners and contracting out service provision in IM&T. But the emphasis is also likely to change as more IT infrastructure is hosted and managed by external suppliers in ‘the cloud’. The NHS is also focusing on improved sharing of data, hence the need for better interoperability between systems and organisations.

2. Looking internally, the Trust’s strategy is to reduce the complexity of both our applications and the way we access them. Like much of the NHS, the use of systems has evolved in a piecemeal fashion, driving the national ambition for an electronic patient record (EPR) for all organisations. To realise this, the affordability challenge is as much a constraint as the technology challenge to making progress on this critical enabler.

3. The CQC identified the need to improve IT systems for clinicians in April 2018. While there is capital investment to bring the PC estate up to a reasonable specification in readiness for Windows, a more strategic approach to the delivery of desktop computing needs to be found. Assessment of desktop virtualisation (VDI) as an alternative is being considered this financial year. This has potential for external hosting which would mitigate some of the risks (listed on risk register) we currently run.

4. The key to simplifying our IT estate is to move as much as possible in to cloud hosted services and remove the need for data centre investment that we have experienced up to now. Achieving this will allow the Trust to consider how it purchases infrastructure support in the future, perhaps managing in-house some technical leadership to act as a buffer between us and our key suppliers. Our support contract with MLCSU which expires in March 2021 and costs £1m per year could be re-focused into an alternative approach to support.
There is a need to reduce complexity

The focus of the IM&T agenda for the next two years is to simplify and rationalise our infrastructure and systems. We have a complex mix of systems and supporting infrastructure much of which is ageing, sometimes unfit for purpose, lacking interoperability and in need of constant investment to remain up-to-date.

Some external funding is becoming available for EPR

The Trust will revisit the costs of an electronic patient record (EPR) with the knowledge that some funding for EPR and also an electronic prescribing and medicines administration system (ePMA) is being offered by NHS England. £500m has been made available for 2018-19.

Interoperability and sharing between stakeholders is a critical success

An assumption made in this strategy is that the partner for an EPR would be Mid-Cheshire Hospital Foundation Trust (MCHT) as the Cheshire and Merseyside footprint is the funding channel. New funding from NHS England will be directed through the Sustainability and Transformation (STP) route and therefore investments need to be aligned with the Digit@ll Strategy discussed later in this document.

End of life system cost pressures will create challenges

An enterprise-wide EPR shared between two organisations enables cost reduction, while the organisations retain their own identity, care plans, work flow etc, but there remains an affordability issue for all organisations.

ECT plays a vital role in the provision of Cheshire’s health services

Section 8 of this strategy focusses on the work the Trust is currently doing to embrace the opportunity of sharing data with partners. To do this not only requires pan-organisation commitment, but also to sort out some of the interoperability problems between both systems and organisations. A pre-requisite to this is effective IT governance which is covered in section 10 of the strategy.

IT will be used to transform the way we work away from a paper based operation to “Digital By Default” with an end to end digital process, allowing judgements regarding patient care to be made in a timely, robust, consistent, auditable way.

We also face some pressing issues around end of support systems including Windows 7, SharePoint 2007 and Office 2010 all of which need solutions by January 2020. The costs of these solutions (revenue) will be completely new to the Trust. The Trust will see this as an opportunity to move towards more cloud-delivered services and increase desktop productivity.

Introduction

North Cheshire NHS Trust (ECT) is an Integrated Hospital and Community provider organisation operating on the Eastern edge of Cheshire. Services are commissioned by the Clinical Commissioning Groups (CCGs) of East Cheshire, Vale Royal and South Cheshire. The area covers a population of 475,000 with an increasing ageing element of citizens – approximately 80,000 aged over 65 and 12,000 aged over 84. We provide care across the community and out of three hospital sites, the main site being in Macclesfield.
2.2 The Trust’s vision is to ensure our patients receive the best care in the right place. Our mission is to work in partnership to provide high-quality, affordable integrated services.

Our values:

- Treat each other with respect and dignity
- Commitment to quality of care
- Show compassion
- Improve lives
- Working together for patients
- Make everyone count

In April 2018 the Care Quality Commission rated the Trust ‘Good’ in an independent inspection of services.

2.3 In the current year, much emphasis has been placed on the need to understand and control our ICT operating costs and so work has been undertaken to properly baseline our supplier contracts and understand our future commitments, particularly through when and how to replace the assets we own. In doing this, there has been a desire to look at more streamlined ways of working and smart ways of support our equipment to get longer life from it.

There is a push towards shared costs as inevitably, all health and social care organisations face the same constraints and have to find better ways to do more with less. There is as a result, a mood to work at scale and share costs wherever possible. Infrastructure such as data centres will be prime candidates for externally managed services shared across boundaries. This reduces risk and has the potential to reduce operating cost by reducing support for internally hosted systems.

This report describes the IT strategy in the context of the current position and the environment we operate in.

2.4 The remainder of this report highlights the critical role IT provides in delivering quality services to our patients. It describes ECT’s vision for IT and some of the challenges we face in our current position, and the steps we intend to take to address these challenges.

2.5 An electronic patient record is a key enabler to making progress on much of the agenda, but this presents a number of affordability and technical barriers which need to be considered. As one of the Trust’s key IM&T themes is sharing with partners, the relationship with health and social care partners is also covered, in particular joint work with Mid Cheshire Hospitals Trust (MCFT)

3 The role of IT in the delivery of quality services

3.1 Information technology has an essential role in enabling safe and efficient decision-making for our clinicians.

3.2 To frontline staff, information technology improves decision-support by providing timely information about a patient’s condition especially in the case of the deteriorating patient.
3.3 Clinician time is expensive and IT, that enables the best use of that resource, is a good investment and leads to the best possible outcomes for patients. To gain the best use of resources, systems that let us schedule those resources intelligently will remove delays and waste.

3.4 The ‘clinician experience’ is an important measure of the success of our IM&T strategy. We know that from lack of investment in systems, staff become frustrated with the delays caused by sub-optimal IT. This document will emphasise the need for a good clinician experience both in the physical infrastructure and in the applications that sit upon it.

IT support to mobile working is becoming more important

3.5 The increased use of mobile devices will allow our staff to see and update information from anywhere which will lead to activities being undertaken at their earliest point. To maximise the potential of mobile computing mobile devices will depend on the underlying applications to be truly designed for mobile use.

And the way IT supports our patients is changing

3.6 Another important measure of success is how we keep our service users informed about their care. The Vision section that follows this document will refer to the need to manage engagement with patients and their carers in an efficient way so that in all communications; we are offering the best experience for them, an experience like that they have come to expect with modern on-line services such as e-banking, e-shopping and entertainment on-demand.

4 Our vision

EPR – Either a single system or more than one system that integrates to appear as one.

4.1 Our vision is for a dedicated EPR and small number of specialist clinical information systems connected together to provide the best decision support at the point of patient care – a seamless EPR. Where solutions are provided by different systems, each will interact with the other in context of the patient so that clinicians do not appear to be using, and certainly not logging in to, separate systems.

Modern and intuitive systems

4.2 Systems will be intuitive to use, with modern interfaces and as a result, used in any setting and on a broad range of devices with an emphasis on mobility, again underlining the expectation that our staff have come to expect from their use at home of the most modern and highly performing systems.

4.3 Systems will operate in a ‘real time’ proactive way to prompt clinicians about what should take place next, sometimes called ‘care pathways’, - an optimum and consistent set of activities centred on the patient’s specific needs. Clinicians will have access to the right type of user device to access systems and often this will be a device dedicated to them.

4.4 We will provide seamless wireless access at all of our sites and through the use NHS WiFi or 4G cellular (5G when available) clinicians will be able to work while on the move.
The Trust aims to go paperless over time

4.5 The Trust has a stated desire to move towards ‘digital by default’, in line with the government’s ‘Five Year Forward View’ and a way of working that recognises printed information is from a different era and not consistent with either the expectations of our staff or patients and carers. The Trust will take fully into account the method of communication that best suits the recipient’s preference. The emphasis will be on immediately available information to all who need to see it, information transferred as soon as the process is complete.

4.6 Our systems will allow us to meet national standards for the collection of data as a by-product of everyday system use and will enable us to measure and respond to time critical events in patient care. Our vision is to remove dependence on paper by having fully integrated, always available digital systems.

Sharing data with other partners is being pursued

4.7 In building a new IT future, our systems will be able to exchange information with other care systems using open standards, in particular, the XDS (Cross Document Sharing) standards described in the ‘Digit@ll’ strategy created with our Sustainability and Transformation Programme (STP) area partners.

4.8 This will enable real time sharing of data across different health providers so that patient records are routinely available within each other’s IT solutions. This new approach to sharing across boundaries will equally benefit ECT when patients from out of area require our services.

Technology enablers are and will continue evolve

4.9 Speech

Speech recognition has continued to mature and offers the possibility of replacing keyboard input with spoken language to improve the speed of data entry. This will result in “front line” clinicians updating IT systems at the point of care, building on role modelling provided by radiologists. Significantly enabling more efficient document management, shared digitally and stopping printing and posting and thereby reducing reliance on administrative support and the delays that implies.

4.10 Video

The Trust will revisit the potential of “remote assistive care” with telemedicine. Video consultations offer the opportunity for communication with patients without them having to leave their home. This is beneficial for patients who will save on travel expense and time. Where a patient is in a care setting, the savings will be significantly more if the interaction avoids the need for ambulance transport.

Carers can also be more involved in the care process through this technology. While this will not be suitable for all occasions, anything that improves the experience for patients and clinicians and makes better use of our resource, is a positive move.
5 Current position

5.1 The Trust’s infrastructure has received some significant investment over recent years but that investment hasn’t kept pace with the requirement to maintain and renew on a typical five year refresh cycle.

5.2 Consequently, more than three quarters on the Trust’s desktop PCs and laptops are more than five years old. This problem presents itself as poorly performing end user devices and applications which are slow to boot up and slow to load functionality, overall leading to a poor user experience.

5.3 An end user device technical refresh planned for the second half of 2018 will address the issues caused by the oldest desktops we have and a further batch of devices will receive extended life through other upgrades.

5.4 The Trust’s on-site data centre has also received capital investment to refresh equipment but requires an almost constant cycle of expenditure to remain fit for purpose diverting much of the Trust’s capital in to maintenance rather than investing in more modern IT systems for frontline clinicians.

5.5 Our technical IT support is currently supplied by the Midlands and Lancashire CSU under an SLA that expires in March 2021. This support comprises first line activities (call logging and telephone fixes), 2nd Line (dealing with end user equipment issues), 3rd Line (Data Centre and Networking support) and project planning and implementation. This is a largely reactive service with some support for planned infrastructure changes in coordination with the Trust’s small team. This service costs the Trust almost £1m per year.

5.6 The two year period afforded by the MLCSU contract extension to 2021 will allow the Trust to transition to a new type of managed service.

5.7 The Trust has an extensive range of IT systems; clinical applications for direct patient care, management systems for operational support and infrastructure-related systems to underpin the working of the user-facing applications.

5.8 There are over 150 applications used by our staff every day, some are organisation-wide patient systems but others much smaller departmental or very specialist systems. Support for these systems is extremely varied with many being run with no official support or by ‘goodwill’ support from staff involved in delivering the clinical service.
But there are improvement opportunities

5.9 The fragmented dis-jointed complexity lacking integration/interoperability of this application landscape leads to information being entered multiple times in to different systems which is time-consuming for staff, prone to errors and often not timely and therefore not suitable for true clinical decision support.

5.10 Simplifying the number of applications we have will lead to reduced supplier costs and reduced system management costs and support the case for a whole-system EPR that will replace the majority of this complexity.

5.11 In the first half of 2018, the Trust started the process of cataloguing these systems so that we could fully understand the interdependencies and costs associated with operating these systems.

The Trust’s digital maturity is improving

5.12 In 2015/16, the Trust submitted a self-assessment ‘digital maturity assessment’ (DMA) to NHS Digital which benchmarked our IT systems maturity against other Trusts.

5.13 The DMA consists of 15 themes. The region scored high for strategic alignment, leadership and governance but low for themes such as medicines management, asset, resource management and remote and assistive care.

5.14 East Cheshire scored poorly in its first maturity assessment compared to other Trusts. Overall we were in the lower 13% and on a local comparison (Cheshire & GM) we were ranked last.

5.15 The audit was repeated in 2016/17 and there were notable improvements for East Cheshire although the national comparator data has not been published so therefore our ranking is unclear for this assessment.

And a number of key improvements have been made

5.16 The implementation of ‘Single Sign-on’, enabling clinicians to use a smart card to access IT systems automatically, the introduction of more sophisticated laboratory results viewing, wider deployment of public and staff free WiFi and further rollout of the community systems utilising mobile apps has significantly lifted our capabilities in the last twelve months. Extending deployment of Cheshire Care Record has also been significant in past 12 months help by the introduction of single sign-on.

The Trust is also evaluating the potential for a modern electronic document management system

5.17 Hand in hand with the nationally mandated e-Referral Service (eRS), Our current project to provide the Trust with a modern Clinical Document Management System (CDMS) will further enhance our capability and digital maturity as we develop a system to remove paper processes and replace with an end to end digital work flow. The outputs from this digital work flow will be supplied to patients through a number of mobile apps including the NHS’s patient on-line project which ECT has elected to work with.
This modernisation of our document management will significantly improve how our clinicians and administrator collaborate resulting in an end to end digital experience, taking in documents from external systems such as eRS (GP Referrals) and automatically presenting them to the correct clinical group for prioritisation. At the end of the process, a seamless message will be delivered to the recipient (Health/Social Care/Patient) in a digital format unless otherwise specified.

Our clinicians will have instant access to a very comprehensive clinical record that we will also be able to share over a wider footprint through the proposed XDS open standards approach described in the Digit@ll Strategy.

6 A planned IT future – modernise, simplify, share

Simplified infrastructure management will be sought through ‘cloud’ hosting

6.1 The Trust will reduce the complexity of its internal IT infrastructure through the use of more cloud hosted managed services reducing the risks around provision of complex IT infrastructure. This will be undertaken incrementally, reducing dependence on data centre hosting and the associated management cost and investment cycle while maximising previous investments made in existing infrastructure – a phased approach.

6.2 The Trust will take a proactive stance on collaborating with other health and social care organisations in our region for the purchase at scale of common infrastructure thereby leveraging the benefits of procuring with others.

Hosted solutions are becoming the standard

6.3 Services hosted by specialist data centre providers will offer increased resilience, the ability to flex capacity up and down as required and provide guarantees of availability.

6.4 The hosted solution journey has already begun. Email services (NHS Mail) is a hosted solution that serves the Trust well and we no longer have the complexities of managing an on-site mail service and all the associated security backup and recovery processes that come with that. This is a model that will be extended to other systems. The Trust’s electronic staff rostering service is another example of a ‘Software As a Service’ (SAAS) model.

Telephony services will become part of the ICT offer

6.5 The Trust will look at moving away from its analogue telephone and paging system to a unified communications solution. The Trust will bring in specialists in this technology to help us understand the options, benefits and costs.
6.6 Similarly, more software solutions are being provided under SAAS agreements, most noticeably, Microsoft’s Office suite of applications, Office365. The trend is towards subscription based services where incremental updating of the software is managed by the software provider and the Trust just consumes the service over the web. This has the added benefit of always having the latest software version installed as it becomes available. The Trust will move away from a project based approach to bigger system upgrades. Incremental updates are smaller steps, the impact of change is more manageable and costs more easily forecast.

6.7 There are also more ‘productivity tools’ included with subscription-based office software which would allow the Trust to consider new ways of working, transforming the way staff engage and share/collaborate on documents including in digital only meetings.

6.8 ECT has benefitted from the government’s Enterprise Wide Agreement set up in 2010 which provided free of charge licenses for popular Microsoft products to trusts. From January 2020, trusts will have to fund this new approach to software, a cost the Trust has not previously encountered (estimated at circa £377k per annum)

6.9 The Trust will plan a move to a new future where the majority of our systems are externally hosted and in doing so reduce the need for complex internal data centre facilities, requiring a high level of technical expertise.

6.10 The Trust will explore the opportunities offered by virtual desktop infrastructure (VDI) to improve the performance of end user devices. In this model, the PC on the desktop acts as a terminal with the application loading, (normally happening on the PC), taking place on a server in a data centre.

6.11 This model allows older PCs to be used in a less demanding role which in turn means they have a useful extended life beyond the point where they would be replaced. The Trust will produce a business case to demonstrate the relative costs of each approach of providing desktop computing over a five year period.

6.14 The Trust has chosen to be in the first wave to transition to the HSCN network and away from the NHS (N3) network operated by BT. This will start in the Autumn of 2018 and will allow the Trust to reduce its leased data line operating costs through improved pre-negotiated contracts.

6.15 The £180k per year that the Trust currently pays for dedicated leased lines between its sites has the potential to reduce by up to half although some funding provided centrally has already been reduced hence why it is important we are engaged in this move early.

6.16 The ability to provide the business managers with the means to report performance and use predictive analytics should always be a by-product of day-to-day operations.
6.17 The Trust needs to move to a solution that provides web-based dashboards of performance and allows managers to change date parameters to see the data they need for specified periods.

6.18 Real time graphical tools should be the means by which managers at all levels can have access to immediate information whether that be current bed states, numbers waiting in A&E, early views of which A&E patients are likely to require inpatient admissions or more normalised date for contract monitoring returns.

7  Electronic patient records

7.1 An EPR is either a single clinical system or more than one system that integrates to appear as one. In either form, EPR provides a one-stop solution for clinicians to be guided in making and recording clinical decisions. It is more sophisticated than digitised paper clinical hospital notes.

7.2 The Trust’s current clinical systems landscape consists of a range of IT systems from different suppliers, with various levels of integration, ranging from no integration to seamless integration; but skewed towards limited integration.

7.3 There is a need and desire for a cohesive clinical record that embraces referral from primary care, intuitively guides clinical decision-making in secondary care, enabling onward journey to tertiary or back to primary care.

7.4 The Trust has previously approved the clinical rationale for an EPR but analysed the costs and benefits of an EPR and concluded at that time that such a solution was unaffordable to the Trust, echoed by external auditor feedback.

7.5 Since then, the Trust has continued to evaluate its underlying clinical systems and the contracts associated with the range of applications we host and therefore how those solutions may be phased out to offset the cost of a whole system EPR.

7.6 NHS England is supportive of the need for Trusts to have a full EPR. Global Digital Exemplars (Trusts that were deemed to have the best level of EPR maturity) have been at the forefront of clinical system expertise and have received funding to develop their models and for others who are less mature to follow - ‘Fast-Followers’.

7.7 NHS England announced in July 2018 (matched) funding rounds for e-Prescribing implementations and further funding for full EPRs, totalling together £500m and to be distributed through the STP regions.

7.8 ECT has previously discounted the EPR option because of unaffordability issues but the opportunity to share costs across more than one Trust and with additional funding from central government the Trust will evaluate this option as it offers the best possible opportunity for high quality, consistent patient care.
But the Trust’s strategy for sustainability reasons is to collaborate with other organisations’ EPR solutions

The Trust has looked at installations where EPRs have been deployed across two organisations and the benefits of combining expertise and resources to achieve common goals should not be underestimated. It is possible for two organisations to share an EPR while maintaining their own configurations, patient data bases and organisation identities but working together on shared functionality such as processes and pathways.

There would be benefits to patients...

Patient Centric
- Improved care for patients through agreed care plans and better decision support
- Faster alerting of deteriorating patients and therefore earlier interventions
- More streamlined use of resources through better resource planning
- Improved medicines management and reduced risks of clinical incidents
- Support for Multidisciplinary Teams (MDTs)
- Improved handover at shift changes leading to seamless care
- Fewer clinical applications and reduced system management overhead, fewer IT system contracts

...and the organisation

Provider Centric
- Hosted off-site infrastructure thereby simplifying the Trust’s system complexities
- Shared costs around system implementation and management (if undertaken as a shared EPR)
- Reduced costs of consumables and messaging
- High quality business continuity systems

The Trust is looking into the potential for a collaborative procurement with MCFT

Procuring an EPR alongside another Trust would allow for the best possible cost of ownership compared to buying alone. Implementation and operational support models and costs could be shared and would provide the added benefit of consistency.

There are costs savings included in shared approaches:
- IT training
- System configuration
- EPR support desk
- Development of clinical pathways.

The Trust is seeking funding from the national programme alongside MCFT as joint bids represent the best opportunity to secure funds. Once the availability of funds is clarified, a business case will be presented to the Board.
8 Relationships with health and social care partners

8.1 In terms of IT collaboration, ECT has historically had relationships with other healthcare providers across Cheshire, Wirral and Merseyside (The Cheshire and Merseyside Health and Care Partnership). This grouping has strengthened in recent months particularly with the moves towards a common EPR solution across Cheshire & Wirral and an open standards approach to information sharing born out of innovation in Merseyside.

8.2 The Cheshire and Wirral collaboration has resulted in the ‘Cheshire Care Record’ (CCR) supplied by System C, formerly Graphnet. This solution provides a view of data sourced from primary and secondary care across Cheshire and Wirral, a partnership of 11 healthcare providers jointly funding this service.

8.3 CCR is based on proprietary standards (ie standards that prevent other suppliers from interacting) rather than the more modern open standards approach. There is a push to move away from proprietary standards towards solutions that are supplier agnostic. The cross document sharing (XDS) pilot being trialled in Merseyside is seen as a potential challenger or replacement to the Cheshire Care Record.

8.4 A bid called ‘Share2Care’ proposed a joint operation between health and social care organisations in the North West Coast to enable open standards data sharing across the region. The bid was to the Local Health Care and Record Exemplar (LHCRE) scheme for digital transformation and the bid received initial funding of £2m in July 2018 with promise of more in years two and three.

8.5 This approach would see data remaining in the owning organisation but enable a view of that data to other members such that the extended data appear in context with a variety of internal systems. This would facilitate a real time approach to sharing data across a broad range of systems.

8.6 ECT is committed to supporting this vision of data sharing and effectively creating a wider net of connected systems. We will do this by specifying systems that can be interoperable with these open standards and where practical, extend our existing system’s functionality.

8.7 Digit@ll is the digital strategy for Cheshire and Merseyside and replaces the original (4) local strategies called LDR’s (Local Digital Roadmaps). It describes a joined up approach to sharing information across Cheshire, Merseyside and the Northwest coast and there are five key transformation themes:

- Empowering patients to take care of their own health and wellbeing
- Allow staff access to high quality information
- Connect systems through interoperability, use of technical standards
- Become a region of innovators in health IT
- Make our systems cyber secure.
East Cheshire CCG and East Cheshire Council are jointly working on an electronic patient portal called ‘Patient Passport’ or ‘Personal Care Record’. ECT has actively sought to collaborate on this project in order to use the development involved as a means to provide our clinical information on-line for patients. This joint working started in July 2018 and will culminate with shared record access for patients using mobile Apps in 2019.

This will be another significant step in our digital maturity as we seek to go paperless for our patient communications.

The benefits of documents on-line for patients, particularly in the shape of a mobile App, are;

- Much quicker (real time) availability of information
- The ability for carers (elderly and vulnerable to become involved in assisting with care (taking to appointments for example)
- Availability of their record in a form that they can share with other clinicians and family members
- Improved efficiency and reduced costs in the delivery of information for patients
- Opportunities to target relevant information for patients with particular clinical problems
- Opportunity for two way interactions for patients and hospital services
- Self-check-in at hospital appointments using the patient App on arrival
- A tool to enable video conferencing between a patient and a clinician
- Gathering patient feedback

The financial challenge

The pace at which digital technology is evolving is ever increasing, as is organisational and individual reliance on IT. In that context, the Trust plans to invest similar sums of capital and revenue currently, pending any business case for an EPR.

The Trust faces pressure from end of life systems, mostly from systems that were centrally procured for the NHS by the government in or around 2010. These systems were cost-free to the Trust but from 2020 will have to be paid for by the Trust.

New licenses will need to be procured to replace these end of life solutions and this will commit the Trust to a revenue (subscription) based model in the future which will prove challenging to afford.
9.4 The Trust will modernise its desktop operating systems by implementing Windows 10 in 2019/20. In preparation for that, older PC’s are being replaced or upgraded to cope with the new operating system.

9.5 The Trust will replace its end of life Intranet solution in 2019 and consideration will be given to the SharePoint offering that comes bundled with Office 365 as a possible replacement for our existing out of support Intranet product.

9.6 In summary, our current position and immediate challenges are;

- Ageing infrastructure organically grown
- No EPR or electronic medicines management
- No electronic medicines management
- No effective real time management of patients (except in one or two instances such as bedside observations)
- Outsourced IT Support with little cloud-based offering
- A number of variously supported IT systems without the interoperability required in the future

This is similar to many other trusts, but nevertheless represents a significant local challenge.

On a positive note, the EMIS community EPR has been well received and provides this staff group with a competent electronic record. The Trust will continue to offer this solution to departments that can benefit from what could be described as ‘an interim EPR’ such as our therapy teams.

9.7 The case for an EPR is compelling as highlighted earlier in this report. In 2015 when the Trust put an EPR investment on hold, the cost was estimated at £19m which was clearly unaffordable. The price of EPRs has reduced and some organisations are starting to produce business cases. A business case will be prepared for the Board in 2019.

9.8 Capital funds for EPR are becoming available but these appear to be significantly below what is required. Although an EPR would provide some efficiency benefits, these are often not of a scale in cash releasing terms to be able to afford the extra software licensing costs.

10 Information technology governance

10.1 Healthcare is a highly regulated area where the balance between sharing and protecting confidentiality often results in information being out of reach of those who might benefit the most. The Trust has a mature Information Governance function that oversees all areas of IM&T and sees its role as enabling as much as protecting.

10.3 The Trust will work with partners to adopt standardised data sharing agreements so the greatest value from important health care data can provide the best service.
Internal governance processes are sound

10.4 The approval committee for investments in IM&T is the ‘Digital Transformation Group’ chaired by the Executive Director of Finance. This group oversees progress of the IM&T agenda and has representation from the CCIO and a cadre of clinicians from various services, aligned to the Wachter Report ‘Making IT Work’; (Digital change in health & social care Kings Fund June 2018).

10.5 The management of IM&T’s capital allocation is reported to the Capital and Planning Group. Here monthly updates on allocated spending are reported and monitored.

10.6 CMB is the Clinical Management Board chaired by the Chief Executive. This group receives feedback and gives direction to the IM&T programme through its connections with frontline clinical staff.

10.7 The IM&T Strategy will be reviewed annually by the Digital Transformation Group to ensure its objectives are shaped by national guidance and still appropriate.

Next steps

11 The external landscape is becoming clearer

11.1 ECT has embraced partnership working for many years both locally and with other organisations for the provision of important clinical services. The Trust has also done this in IT as exemplified with the Cheshire Care Record and commissioning our IT support alongside the Cheshire CCGs. More recently, the opportunity for IT collaboration and improvement in the acute provider landscape across Cheshire and Merseyside has become more compelling.

11.2 This document outlines the Trust’s five year strategy, but much of the important change needs to take place over the next two years. The recent improvements made in IT such as cyber security, WiFi, and ‘single sign on’ have created a momentum which the Trust can build on through the four themes described in this document.

The Trust’s roadmap is ambitious

11.3 Appendix 1 shows a road map of Informatics activities that will underpin the modernisation of systems. While there is a logical order to this modernisation, many improvements will happen in parallel. The logical timeline for these improvements takes into account interdependencies between each change.

11.4 This strategy outlines the direction of travel and framework within which the Trust will progress its IT improvements. Many of the important initiatives, most notably EPR, will require much more work and for detailed business cases to be presented to the Board. But IT will become an even more critical enabler to the provision of high quality care to our patients in the future.

Recommendation

Mark Ogden
Director of Finance
August 2018
Appendix 1

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2019-20</th>
<th>2020-21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EPR (Data Sharing)</strong></td>
<td>Benchmark Current Systems to understand cost and functionality</td>
<td>Review EPRs and make Business Case to Engage with neighbour Trust, work across Cheshire &amp; Wirral, Secure National Funding</td>
<td>Develop Business Case / Existing System Rationalisation</td>
</tr>
<tr>
<td><strong>CDMS (Data Sharing)</strong></td>
<td>Make Business Case and Secure Development Partner</td>
<td>Design &amp; Build Clinical Document Management System, include Patient Passport delivery of documents</td>
<td></td>
</tr>
<tr>
<td><strong>e-Prescribing (Data Sharing)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Passport (Data Sharing)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Centre Simplification</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interfacing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VDI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unified Comms (UC)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PAS to V6 for Win10</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office 365 Licensing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intranet Replacement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Cloud Readiness Assessment of Current Applications in our Data Centre, Explore off-site Options for hosting**
- **Server Upgrade, OpenShift, Upgrades with VMAX**
- **Implement VDI Solution**
- **DMS to be Upgraded to v6 so that it can be delivered over Windows 10**
- **Determine approach: Hosted licensing or operate SP in Office 365**
- **Latest Date to issue new Office 365 Licence Model**
- **Design Intranet in Office 365 SharePoint**
Agenda Item Number 14: TB 18 (65)

Our Ref: LM/FB/Meetings01/TB/Agenda

Date: 25th October 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 1st November 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 – NOVEMBER 2018 AGENDA

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff Stories:</td>
<td>Director of Nursing, Performance and Quality</td>
<td>15 mins</td>
<td></td>
</tr>
<tr>
<td>2. Apologies:</td>
<td>Chairman</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Declared interest agenda</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitality and Gifts Register Declaration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Minutes of the September 2018 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 18 (75)</td>
<td>-</td>
</tr>
<tr>
<td>5. Matters Arising</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Action Log</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7. Verbal update:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SQS Committee</td>
<td>Ms A Harrison</td>
<td>15 mins</td>
<td>Verbal (supported by formal minutes when available)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>FPW Committee</td>
<td>Mr M Wildig</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit Committee</td>
<td>Mr I Goalen</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Chief Executive’s Report</td>
<td>Chief Executive</td>
<td>30 mins</td>
<td>TB 18 (76)</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 (77)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>10. Annual Audit Letter</td>
<td>Director of Finance</td>
<td>10 mins</td>
<td>TB 18 (78)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>11. Estates Strategy Update</td>
<td>Director of Finance</td>
<td>10 mins</td>
<td>TB 18 (79)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>12. Quality Strategy Update</td>
<td>Director of Nursing Performance and Quality</td>
<td>10 mins</td>
<td>TB 18 (80)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>13. Learning from Deaths Quarterly Report – Quarter 1</td>
<td>Medical Director</td>
<td>10 mins</td>
<td>TB 18 (81)</td>
<td>All corporate objectives</td>
</tr>
</tbody>
</table>
14. **Standing Agenda Item:**
   Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register
   
   **Presented by:** Chief Executive
   **Time Allocation:** 5 mins
   **Verbal:**
   **All corporate objectives**

### ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Public Trust Board Agenda – December 2018</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 18 (82)</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>16. Chairman’s Commentary</td>
<td>TB 18 (83)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
</tbody>
</table>
| 19. Safer Staffing Exception Report               | TB 18 (84)   | 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
<p>| 21. Minutes of the committees of the Board:       |              | Information             |                              |</p>
<table>
<thead>
<tr>
<th>Report of: The Responsible &amp; Accountable Officer</th>
<th>The Chairman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author of Report:</td>
<td>Lynn McGill, Chairman</td>
</tr>
<tr>
<td>Subject/Title</td>
<td>Chairman’s Commentary</td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
<td>None</td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>The purpose of this report is to provide a summary of many of the extra-curricular activities during July 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.</td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>To note</td>
</tr>
<tr>
<td>Link to Care Quality Commission Domain</td>
<td>Safe Caring Responsive Effective Well-led</td>
</tr>
<tr>
<td>Link to:</td>
<td>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</td>
</tr>
<tr>
<td>Legal implications - (identify)</td>
<td>None</td>
</tr>
<tr>
<td>Impact on quality</td>
<td>Positive impact</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>NHS – National Health Service CCG – Clinical Commissioning Group</td>
</tr>
</tbody>
</table>
Chairman’s Commentary  Thursday 6th September 2018

1 Introduction

A positive impact on quality by mitigating identified Corporate Risks and links to each of the 5 Care Quality Commission Domains of:-

- Safe
- Caring
- Responsive
- Effective
- Well Led

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

2 NHS Providers

Attended and contributed to the North West Chairs and Chief Executive forum on 12th July 2018 where topics discussed included capital funding; the joint working between NHS England and NHS Improvement coupled with the forthcoming regional changes and the impact for all; the importance of Non-Executive Director engagement at place system level, the incoming Secretary of State for Health, the intent for the next 10 year NHS plan and the role of digital technologies; the significance of community service development, social care and associated resources; the key messages within the recent National Audit Office paper and the continued recruitment for healthcare professionals.

3 Cheshire East Single Partnership Board

The Programme Board met on Wednesday 1st August 2018 and heard from Senior Responsible Officers, the outcome of a significant piece of work and next steps. This was followed by a workshop with core members to plan ahead.

For regular updates, please continue to see http://www.caringtogether.info

4 In support of strong partnership relationships I continue to meet informally with the Eastern Cheshire CCG Chair; this took place on Thursday 9th August 2018.

Chairman: Lynn McGill
Chief Executive: John Wilbraham
I also meet informally on occasion with the Chair of South Cheshire CCG and did so on Thursday 7th August 2018.

In addition, discussing succession to the Single Partnership Chairmanship on behalf of partners, The Chair of South Cheshire CCG and I have prepared a paper for the September Single Partnership Board; this follows initial conversations with all core partners.

5. Chair to Chair conversations
I was pleased to meet with the Chair of Mid Cheshire NHS Trust on 3rd August to explore how we might benefit from a closer working relationship. This will be further explored by our two Chief Executive Officers as part of a wider review of strategic partnership working.

6. Aspirant Chair Programme Participation
As part of NHS Improvement’s Aspirant Chairs Programme, spent a large part of Tuesday 14th August with the Chair of Sherwood Forest NHS Foundation Trust at Kings Mill Hospital, where we met with five aspirant Chairs. This will culminate in the coaching of one of these aspirants, whilst recognising the readiness or otherwise of all aspirants.

7. Freedom to speak up
The Trust has developed a strategy for Freedom to Speak up as a means to ensure we continue to strengthen transparency, openness and fairness that is embedded through our values in the way we work throughout the Trust.

8. Trust Board Business
Having agreed a programme of development offering wide exposure to the Trust’s activity, I am pleased to have received feedback from our current Insight Programme Placement whom has found this to be most helpful, informative and educational. By mutual agreement, I have extended her schedule with the Trust until the end of September 2018.

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

Chairman: Lynn McGill
Chief Executive: John Wilbraham
being that the Learning from Deaths Quarter 1 report has been deferred to our November meeting due to the lack of availability of the required data.

Due to the new timings of our Trust Board meetings, the Trust Board Programme will be revised and presented at our November meeting.

Lynn McGill
Chairman
<table>
<thead>
<tr>
<th>Report of:</th>
<th>Responsible Officer: Medical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accountable Officer: Controlled Drugs Accountable Officer</td>
</tr>
<tr>
<td>Author of Report</td>
<td>Kashif Haque - Controlled Drugs Accountable Officer</td>
</tr>
<tr>
<td>Subject/Title</td>
<td>Controlled Drugs Annual Report 2017/18</td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
<td>N/A</td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>To inform the Trust Board of the management of Controlled Drugs</td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>For information and assurance</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify)</td>
<td>BAF 2: Quality and Compliance</td>
</tr>
<tr>
<td>On Corporate Risk Register</td>
<td></td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify)</td>
<td>On Assurance Framework</td>
</tr>
<tr>
<td>Link to Care Quality Commission Domain</td>
<td>Safe</td>
</tr>
<tr>
<td>Link to:</td>
<td></td>
</tr>
<tr>
<td>Trust’s Strategic Direction</td>
<td>Continuously improve quality, safety and the patient experience</td>
</tr>
<tr>
<td>Corporate Objectives</td>
<td></td>
</tr>
<tr>
<td>Legal implications - (identify)</td>
<td>N/A</td>
</tr>
<tr>
<td>Impact on quality</td>
<td>Continuously improve quality, safety and the patient experience</td>
</tr>
<tr>
<td>Resource impact</td>
<td>Nil</td>
</tr>
<tr>
<td>Impact of equality/diversity</td>
<td>Nil</td>
</tr>
</tbody>
</table>

Avoid acronyms or abbreviations - if necessary list:
- CD Controlled Drug
- AO Accountable Officer
- ECT East Cheshire Trust
- LIN Local Intelligence Network
1 Introduction

This report provides the Trust Board with an overview of Controlled Drug (CD) activity during the year April 2017 – March 2018.

2 Background

2.1 In response to the Shipman Inquiry, the Government introduced a range of measures to strengthen the systems for managing CDs and to minimise the risks to patient safety as a result of inappropriate use. The new arrangements are underpinned by the Health Act 2006 and The Controlled Drugs Regulations 2006. One of the requirements is to have an Accountable Officer (AO) who has responsibility for the safe use and management of controlled drugs. The Accountable Officer works in accordance with legislation regarding the role and in line with the Handbook for Controlled Drugs Accountable Officers in England and keeps up to date from the national quarterly newsletter for Accountable Officers. At East Cheshire NHS Trust the AO is the Chief Pharmacist.

3 Controlled Drug Incidents

80% of controlled drug incidents recorded as very low and 20% graded low

3.1 There were 149 incident reports that involved CDs across ECT during this period (compared with 150 16/17). 80% (119) were graded as very low with the remaining 20% (30) graded low.

The graph below shows the top 10 categories of CD incidents that have been reported.
Governance issues - failure to follow CD SOP 21 (14%)
Governance issues – documentation 20 (13%)
Losses - Stock reconciliation issue - unaccounted for losses 17 (11%)
Losses - Stock reconciliation issue – resolved 14 (9%)
Governance issues - wrong storage 12 (7%)

These 5 categories account for 56% of all CD incidents.

3.3 Further review of the category ‘Losses – unaccounted for losses’ show that 7 of these relate to stock reconciliation issues related to liquid preparations. These losses are small and most probably due to the fact that there are sometimes bottles not filled to correct volume (can be up to 1% discrepancy in volume of new bottle) and also that there are small losses every time a dose is poured into a container to allow it to be drawn up into an oral syringe. When the excess is poured back there will be small losses in volume. As this is done multiple times these small loses add up. A further 4 relate to missing tablets of codeine or co-codamol. These have been investigated and no concerns have been raised and have been isolated incidents.

3.4 All CD incidents are reported via the Datix system and highlighted to the Trust Accountable Officer for CDs and reviewed. In addition, incidents are submitted to the Local Intelligence Network for review across the health economy on a quarterly basis, which is attended by the Trust CD Accountable Officer.

3.5 For the period of this report (April 2017 – March 2018) all incidents were reported to the LIN; there were no incidents where patient harm has occurred. No concerns have been raised by the LIN about our management of or reporting of CD incidents.

4 Assurance Audits

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

The Trust is fully compliant with legislation in relation to the management and supply of Controlled drugs

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

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

6 Summary

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

Sign off  Kashif Haque

Role title  Controlled Drug Accountable Officer
**Public Trust Board**  
**Thursday 6th September 2018**

**Agenda Item Number 17: TB 18 (68)**

| Report of: Responsible Officer Accountable Officer | Kath Senior  
Director of Nursing, Performance and Quality |
|---|---|
| Author of Report: | Jeanette Sarkar  
Head of Nursing, Quality |
| Subject/Title | Bi Annual Report: Safer Staffing: Safer Nursing Care Acuity and Dependency Audit |
| Background papers (if relevant) | “How to ensure the right people with the right skill are in the right place at the right time”  
Chief Nursing Officer for England & National Quality Board  
November 2013  
| Purpose of Paper | The purpose of this paper is to provide assurance on staffing levels and capacity in order to provide safe, sustainable, productive staffing and high quality, patient centred compassionate care across all acute wards at East Cheshire NHS Trust |
| Action/Decision required | To note the contents of the report and the assurance provided |
| Mitigates Risk Number (identify) 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, responsive and well lead.  
BAF 5: If the Trust does not have a high quality workforce who are engaged and motivated, then staff behaviours may not be aligned with the Trust values and this will have a negative impact on patient experience  
1406: If there are inadequate core staffing levels on acute in patient wards it will compromise the delivery of high quality care impacting on harm free care and patient safety. This will result in poor patient/carer experience and potential outcomes, recruitment and retention, staff morale, increased sickness and absence rates, non-compliance with statutory and mandatory staff training, an increase in staffing incidents and complaints resulting in financial implications |
| Link to Care Quality Commission Outcome Number (identify) | Safe  
Caring  
Responsive  
Effective  
Well Led |
| Link to: Trust’s Strategic Direction Corporate Objectives | Provide the best services to our population through improvements to safety, productivity and patient experience  
Getting it right first time |
<p>| Legal implications - (identify) | No legal implications |
| Impact on quality | May potentially impact upon quality of care, patient experience, patient outcome, recruitment, retention and staff well-being however mitigating actions are put in place to reduce the level of impact |
| Resource impact | Identified gaps in funded establishments due to wte substantive and temporary nurse staffing vacancies may impact on an increase in payroll costs in relation to paid additional hours, overtime and bank/agency expenditure in order to mitigate risks associated with patient safety and delivering high quality, compassionate care |</p>
<table>
<thead>
<tr>
<th>Impact of equality/diversity</th>
<th>No impact on equality and diversity</th>
</tr>
</thead>
</table>
| Avoid acronyms or abbreviations - if necessary list: | NQB  National Quality Board  
NICE National Institute for Health and Care Excellence  
DoH Department of Health  
CQC Care Quality Commission  
CHPPD Care Hours Per Patient Day  
SNCT  Safer Nursing Care Tool  
NMC Nursing and Midwifery Council  
WTE whole time equivalent  
HR Human Resources  
L&D Learning and Development  
AED Accident and Emergency Department  
ITU Intensive Care Unit  
CCU Coronary Care Unit  
EWTD European Directive Working Time  
NIV Non-invasive ventilation  
RN Registered Nurse  
HCA Healthcare Assistant |
Bi-Annual Report: Safer Staffing: Safer Nursing Care
Acuity and Dependency Audit

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

1 INTRODUCTION

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

2 SUMMARY OF KEY ACTIONS AND PROGRESS SINCE JANUARY 2018 SNCT AUDIT

**Recruitment and training meetings for both Registered Nurses (RN) and Healthcare Assistants (HCA) now occur monthly**

Recruitment and training meetings scheduled within HR as part of the Trust’s 2018 Recruitment and Training plan for both Registered Nurses (RN) and Healthcare Assistants (HCA) now occur monthly. This reflects the extensive pre-work undertaken in this area over the past 12 months. Conversations also occur outside of this meeting between group members to ensure that any issues that may arise are being effectively managed.

**RN Monthly rolling recruitment campaigns continue**

In line with these plans, monthly rolling recruitment campaigns for RN’s and HCA’s, with separate adverts for Bank, Pool (HCAs only) and substantive staff have remained in place since the last bi-annual report. Interviews for all adverts take place on the same day wherever possible facilitated by staff volunteering to support weekend or evening events.

**HCA rolling recruitment campaigns changed to quarterly**

However, due to successful regular recruitment campaigns, over recent months substantive HCA vacancies have become minimal. Therefore there has been no requirement to hold monthly HCA recruitment events. The next interviews are scheduled to take place in September with a proposal to hold quarterly HCA recruitment campaigns thereafter. This is dependent on the number of HCA vacancies which will continue to be assessed on a regular basis.

**Pending successful qualification 6 student nurses have accepted substantive posts**

A recruitment pipeline report is maintained by the Recruitment Team in order to track progress on all aspects of recruitment process. The recruitment team also has a specific register nurse recruitment tracker in order to capture student nurse cohorts. This is shared on a monthly basis with the Heads of Nursing which supports ongoing engagement with the Universities, student cohorts, HR, Learning and Development teams to secure potential candidates on successful
qualification as their preferred employer. Pending successful qualification 6 student nurses have accepted RN positions later in the year.

A new Face book page ‘Careers at East Cheshire NHS Trust’ was launched at the end of July 2018 with the aim to advertise hard to fill vacancies under the heading ‘Job of the Week’ increasing the level of advertisement exposure and building on the Trust’s social media presence. It is also anticipated that the page will be fully utilized to add attraction material such as good news stories about the Trust, career opportunities and forthcoming events.

11 international nurses have successfully passed their OSCE examination and gained NMC registration

Implementation of weekly pay for substantive staff undertaking shifts via nurse bank has been successfully applied. In addition, the majority of new employees to nurse bank prefer and choose this weekly pay option.

A total of 11 international nurses from the Philippines have successfully passed their OSCE examinations and subsequent NMC registration.

3 international nurses arrived in May 2018 and unfortunately were unsuccessful in their first OSCE examination attempt. However, 2 candidates are expected to pass their resit in September and the third international nurse by the end of the year. Any further nurses from this campaign are yet to be confirmed.

Despite initial benefits seen in the reduction of registered nurse vacancies following recruitment campaigns, service re-design, bed reconfiguration and staff re-alignment, substantive registered nurse vacancies continue to rise and the Trust remains challenged in its efforts to sustain safe staffing levels. Identified gaps, particularly in acute ward based areas impacts upon staff resilience and increasing levels of long term sickness patterns and maternity leave were observed during July’s audit.

During the time of July’s SNCT acuity and dependency audit registered nurse vacancies were 46.96 wte compared to January’s SNCT audit of 41.46 wte rising to 63.38 wte inclusive of Maternity Leave (11.78 wte) and long term sickness (5.64 wte).

Increases seen in staff uptake with regards to flexible retirement options are supported where possible to maintain business continuity and retain experienced staff members. To date 9 staff members have successfully applied for flexible retirement based on individual service need.

A number of staff and well-being initiatives are available and accessible to staff. In particular, the mindfulness course continues to attract and support a number of staff members.

9 trainee nursing associates have commenced the second year of the programme. Substantive posts upon successful completion are currently being scoped in liaison with the Directorates.

Further trainee nursing associate cohorts will require agreement.

The introduction of a rolling monthly advertisement for Community Nursing which cites the introduction of an incentive payment (NMC fee £120) continues to secure a higher number of applicants and appointments than previously seen.

Apprenticeship roles continue to be explored although the ability to
apply the levy to enable monies to be used for backfill remains under discussion nationally. However, an Assistant Practitioner who usually works within ITU is being supported to undertake an Open University RN apprenticeship Programme with the intention of returning to ITU on successful completion.

2.17 L&D continue to work in collaboration with Macclesfield College to progress apprenticeship roles and further roll out of the Care Certificate to existing HCA’s. This provides the HCA workforce with a solid foundation from which to develop further.

2.18 The Clinical workforce deployment project programme which was established to review staffing establishments, skill mix, alignment with ESR, financial ledgers and HR metrics has been suspended. This is due to pending service redesign, bed reconfiguration and implementation of SafeCare.

3 METHODOLOGY: SAFER NURSING CARE TOOL (SNCT) SEE APPENDIX 1

3.1 Since 2012 the Trust continues to use the evidence based, validated Shelford Safer Nursing Care Tool and as recommended data analysis is triangulated with professional judgement models. This underpins and supports a consistent approach to ensure adult inpatient ward staffing levels remain in line with funded establishments. These tools are evidence based and adhere to national recommendations which include NICE guidance to determine optimal nurse staffing levels based upon patient dependency and acuity.

3.2 From Monday 2nd July 2018 patient acuity and dependency data was collected for each day of the week for a period of 4 weeks across all adult in patient ward areas as per guidance. In order to maintain consistency data collection occurred at the same time each day over a seven day period for 4 weeks.

4 RESULTS: HIGH LEVEL SUMMARY AND DATA COMPARISON

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

4.2 Overall analysis demonstrates that in the majority of inpatient wards case mix and patient care delivery rose in the Level 1b care category compared to previous audits with the exception of Coronary Care and Intensive Care Units which illustrate Level 2 and Level 3 care delivery and provision. This reflects the peaks of acuity and dependency seen throughout July depicting complex case mix and fluctuations seen in operational and capacity pressures.
4.3 Overall analysis also demonstrates that in the majority of inpatient wards case mix and patient care delivery in the Level 1a care category compared to previous audits was slightly lower with the exception of Ward 4 which demonstrates a higher proportion of Level 1a care delivery.

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

4.5 It is important to note that the majority of elective activity cancelled throughout January following NHSE directives has since been resumed. The conversion of 13 surgical day case beds to accommodate acute in-patient admissions reverted back during March and April 2018.

4.6 To support peaks in operational pressures on occasions during July it was necessary to flex capacity. This resulted in in-patients residing in AAU and following risk assessment the placement of +1 beds on acute wards as part of the Trust response to Escalation Policy. These areas were de-escalated as quickly as possible to support safe staffing levels, safety and patient experience.

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

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

5 ACUTE AND INTEGRATED COMMUNITY CARE DIRECTORATE - MEDICAL SPECIALTIES

Wards 3, 4 and 7 current funded establishment aligns with expected acuity and

5.1 Overall

Acute medical specialty SNCT acuity and dependency analysis

A total of 977 Registered Nurse shifts were requested during July of which 829 were filled and 148 remained unfilled

Although 977 nurse bank and agency requests to support safe staffing levels during July were sought a total of 148 Registered Nurse shifts requested were not filled during this period compared to 103 in January’s audit which places additional pressure on front line staffing and delivery of high quality care. 42 unfilled requests fell within the urgent care footprint. 31 unfilled requests fell within the surgical footprint and 23 unfilled requests within medical specialties and 20 unfilled requests within older people’s integrated care.

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

A 3rd HCA has been required overnight to mitigate risks to patient safety

A review of core staffing levels, skill mix is recommended within CCU to future proof a sustainable workforce

All adult inpatient areas continue to demonstrate a high level of acuity and dependency particularly in Level 1b care

The largest proportion of patients on Ward 3 during July required Level 1b care reflecting case mix complexities

National shortage of Intravenous Tazocin resolved releasing a proportion of nursing time in the preparation of antibiotics

A Medical Nurse Practitioner has been aligned to Ward 3 which demonstrates improved senior decision making and

demonstrates that Ward 3, 4, and 7’s current funded establishment on the whole aligns with expected acuity and patient dependency to deliver high quality, safe patient care although a third HCA overnight on the acute medical wards has been consistently required to support patient safety and mitigate risk.

Based on SNCT analysis and application of senior nurses professional judgment it is recommended that a review of core staffing levels and skill mix within CCU is undertaken to build capability and capacity in view of the ageing workforce.

This approach will support wider professional context knowledge, ensuring sustainable staffing levels, appropriate skill mix and alternative roles align with NQF guidance in getting it right first time to deliver the right staff, with the right skills, in the right place at the right time is fully considered.

Application of professional judgement suggests that inter-ward transfers are increasing to support operational pressures. This impacts upon patient continuity of care, effective communication, increases length of stay and reduces patient or carer experience.

Staff continue to work flexibly across all areas and are deployed between clinical settings to support patient care based on case mix complexities and maintenance of appropriate staffing levels.

All adult inpatient ward areas continue to demonstrate a high level of acuity and dependency coupled with case mix and discharge planning complexities. Bed occupancy throughout July exceeded 95%. It is also important to note that historically funded establishments are based on 85% bed occupancy.

5.2 Ward 3

Demonstrates a slight increase in the daily average of patients who required Level 1a care during July compared to January. The largest proportion of patients required Level 1b care. This reflects the patterns seen in case mix complexities, complex intravenous drug regimes, patient supervision to prevent harm, higher levels of emotional and psychological patient support, enhanced 1:1 care, co-ordination of complex discharges, management of non-compliant patient cohorts and end of life care.

Since January’s audit the national shortage of intravenous Tazocin (antibiotic) and the impact on nursing time in administrating 3 separate intravenous antibiotics has improved. Intravenous Tazocin is now available and dispensed on a case specific recommendation which clinically is considered to be more appropriate in the management of infection and prevention, releasing some nursing time in the preparation of intravenous antibiotics.

To support patient safety, enhanced 1:1 care and cohort nursing was required in order to mitigate risks to patient harm or patient’s absconding. An additional third healthcare assistant was consistently applied overnight to maintain patient safety. This has resulted in no injurious falls and an overall reduction in slips, trips and falls year to date.

Application of professional judgement demonstrates that the deployment of a Medical Nurse Practitioner (MNP) to Ward 3 Monday-Friday from 8-4 has significantly enhanced senior decision making, timely patient diagnostic reviews, EDNF completion and has
provided nursing staff with the clinical input and support required to care for case mix complexities. This in turn demonstrates increases seen in the daily average number of patients admitted and discharged to Ward 3 compared to January 2018 audit. Additional Consultant support has also enabled the Senior Sister to appropriately redirect her energy and focus to the management of the nursing workforce and quality standards.

Professional judgement also indicates that currently the funded WTE establishment and skill mix between the ratio of registered and unregistered staff meets patient cohort care needs with the exception of a 3rd HCA overnight. Bed occupancy % during July remained at 98%.

5.3 Ward 4

Demotrates a similar and comparable pattern seen in previous biannual audits that illustrate an even split between the daily average number of patients that require Level 1a and Level 1b care.

The daily average of patients who require Level 2 care also remains comparable to January’s audit although it is important to note changes in classification between those patients who are in receipt of non-invasive ventilation (NIV) or high flow oxygen therapy denotes whether the care level category assigned is Level 1a or Level 2. The daily average number of patients in receipt of NIV care is 2 with a further 2 patients in receipt of high flow oxygen therapy.

Overall, this reflects the incremental increases seen over time in the management of complex oxygen therapy regimes and the provision of nursing care for complex, specialist respiratory interventional therapy for chest conditions. Each of these patient groups are subject to rapid deterioration and require a competent skill set and workforce to care for their individual needs.

On occasions, the daily average level of care exceeded safe staffing levels due to the re-provision of 6 closed beds from Ward 7 to the flexed area adjoining Ward 4 during the completion of estates work. Although Ward 7 staff predominantly staffed this area it is important to note that Ward 4 staff were required to support with the checking and administration of controlled drugs, intravenous therapy and patients who deteriorated in view of the skill mix (1 RN and 1 HCA).

The occasional deployment of staff back to Ward 7 to support unforeseen sickness overnight in addition to shortfalls in other areas necessitated Ward 4 staff to extend their footprint to support clinical need and facilitate the delivery of care which based on the proportion of Level 1a and Level 2 patients was at times challenging and stressful.
5.4 Ward 7

Demonstrates a reduction in the daily average of patients who require Level 1a and Level 1b care compared to January’s audit.

Although the daily average of Level 1b care illustrates a slight decrease compared to January’s audit, seasonal variation remains comparable with July 17 data analysis. Application of professional judgement, however, expected to see an increase in the Level of 1b care during July owing to the number of patients with heart failure, pressure ulcers developed on caseload and increasing slips, trips and falls associated with case mix complexities. This reflects in part the longer lengths of stay seen for patients with heart failure that require prolonged intravenous therapy and a reduction in overall admission and discharge rates.

Safe staffing levels challenged in view of re-provision of 6 closed beds within Ward 4 footprint to enable completion of flooring work – diluted Ward 7’s skill mix in staffing two areas

Throughout July six cardiology beds were re-provided within Ward 4’s flex capacity footprint to enable flooring works to be completed. Staffing this separate location was maintained through deployment of Ward 7 staff which challenged staffing levels, adequate skill mix and ward management capacity throughout this period. The re-provided beds required 1RN and 1 HCA. One additional HCA was requested via nurse bank to facilitate both areas staffing levels overnight. However, this was absorbed during the day within the current funded wte establishment by the senior sister stepping down into core numbers. It is important to note that this also impacted upon CCU staffing levels due to the inability to safely rotate staff from Ward 7 to support unfilled CCU vacancies. Mitigation was reduced by staff undertaking additional shifts and utilization of bank and agency to maintain safe staffing levels.

5.5 CCU

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

It is important to note that the Band 7 Senior Sister from Ward 7 continues to oversee management support to both areas. Although Staff Nurses have previously rotated through from Ward 7 to CCU to facilitate developmental opportunities Ward 7’s diluted skill mix, number of vacancies and planned support previously provided to Wards 3 & 4 has ceased. This in turn has necessitated the booking of a regular bank nurse with extensive CCU experience 3 days per week in addition to existing substantive staff undertaking additional shifts on a regular basis. Despite efforts to recruit to substantive vacancies within CCU recruitment has been unsuccessful.

It is recommended that a review of the staffing model, skill mix and competency set required is undertaken to build capacity and capability to sustain delivery of Level 2 care in order to future proof workforce requirements. Currently 2 staff members have flexible retirement options in place with a further expected early next year.
There is an overall upward trend in the daily average of patients who require Level 1b care compared to fluctuating Levels of 1a care.

Current funded staffing establishments are considered adequate with the exception of Day Case Unit.

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

Revised workforce model for Ward 10 agreed pending successful recruitment and implementation of HR management of change.

Ward 2 has seen an increase in substantive RN vacancies impacting upon staffing levels and skill mix.

6.1 Overall

SNCT analysis demonstrates an overall shift in patient acuity and dependency within the footprint of the surgical and orthopaedic ward areas. It illustrates a lower daily average of patients who require Level 1a care and a significant increase in the daily average of patients who require Level 1b care. This, in part reflects the number of medical outliers residing in surgical specialties and cohort 1:1 nursing within orthopaedics. The daily average of patients requiring Level 0 care remains the same compared to previous audits.

Staff work flexibly across all areas and are deployed between clinical settings to support patient care based on case mix complexities and maintenance of appropriate staffing levels. On the whole the current core staffing establishments are considered adequate when fully recruited to with the exception of changes in service design and case mix within the surgical day case unit. To date this remains unfunded although discussions via Directorate and Performance meetings are expected to resolve the funding gap.

In view of changes to case mix the senior nursing team closely monitor the effects and impact on clinical pathways, skill mix, nurse sensitive metrics, patient experience and clinical outcomes.

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

Although recruitment and retention within Orthopaedics has significantly improved compared to previous audits 4 RN wte substantive posts remain vacant necessitating continued use of bank and agency staff. Expenditure for temporary staff to support patient safety, management of elective and trauma case mix and delivery of care remains high (20-25K per month). It has also been agreed to increase the ward footprint from 30 to 32 beds.

Subsequently, as part of the 90 day improvement methodology a review of workforce requirements, skill mix and roles has been completed. An option appraisals paper with associated costs have been presented to Board and revised to progress and implement staffing levels and role recommendations. This will facilitate an effective and productive workforce to enable delivery of high quality, patient centred care and good clinical outcomes and a reduction in temporary staff expenditure.

Ward 2’s large geographical footprint and number of beds coupled with increasing vacancy levels (4.42 wte) and changes to case mix is a challenging area to co-ordinate to ensure staffing levels and skill mix are appropriate. A high proportion of substantive staff regularly undertakes additional shifts to support safe staffing levels, patient care and their colleagues.

It is important to note that the majority of elective activity cancelled throughout January following NHSE directives has since been resumed. The conversion of 13 surgical day case beds to accommodate acute in-patient admissions reverted back during March and April.
Patient acuity and dependency levels continue to demonstrate a changing pattern which show consistent increases in the daily average of patients who require Level 1b care.

Although current funded staffing establishments meet the needs of patient care observed incremental changes in case mix are assessed daily to support safe staffing levels.

Ward 1:

Continues to demonstrate a changing pattern compared to previous SNCT audits over time. Data analysis again illustrates incremental rises seen in patients requiring level 1b care, increasing on average by 2-3 patients daily with fluctuating levels of patients that require 1a care. This reflects changes to both surgical and medical case mix, discharge complexities, patient cohorts who require 1:1 enhanced care. Mitigating actions include flexible staff deployment across planned care, utilization of bank/agency staff whilst acknowledging that Ward 1 has a more senior, experienced and stable workforce compared to other areas which at times enabled staff to absorb nursing workloads on an ad hoc basis since January’s audit. However, July’s position also indicates subtle changes in that vacancy, maternity and long term sickness levels are increasing.

The data also illustrates a consistent pattern with regards to inter ward transfers and nurse escorts on site. This is due to patients requiring CT scans and other diagnostic tests. The 50/50 split between registered and unregistered staff appears to meet the needs of individual patients although careful monitoring is recommended to ensure that the fluctuations in case mix are manageable and staffing levels are able to sustain the level of nursing care delivery required.

Ward 1a

Demonstrates a consistent daily average of Level 0 care patients which is comparable with previous bi-annual audits. However, data analysis demonstrates a slight decrease in the daily average of patients who require Level 1a care and a slight increase in Level 1b care. This is in keeping with fluctuations seen in case mix complexities within planned care. Application of professional judgment aligns with expected case mix although more complex and generally dependent patients were seen in both Ward 1 and 1a during July. The split between registered and unregistered is considered appropriate.

It is important to note that the footprint of Wards 1 and 1a is a 35 bedded area and it remains challenging to co-ordinate elective activity supporting patient and team observation in addition to medical outlier management to support patient flow.

Ward 2

Demonstrates similar position in the daily average of patients who require Level 0 and 1a care compared to previous bi-annual SNCT audits. However, data analysis demonstrates a significant increase in patients who require Level 1b care on average increasing by 4 patients daily. Application of professional judgement explains this by changes in case mix - more complex bowel surgery, management of trauma orthopaedic pathways and patient co-morbidities. Previously, patients who require a high level of observation and nursing input would have been transferred to Ward 1 opposed to residing on Ward 2.

It is also important to note that the conversion of 13 day case beds to inpatient beds to create additional flex capacity to meet increased unplanned service demand during January reverted back to day case beds during March and April. Subsequently, daily increases in
A new treatment area created within Surgical Treatment Unit to optimize elective activity is in the pilot phase – current staffing model will be subject to review to support new initiative.

Despite mitigating actions taken, skill mix dilution and the split between substantive and bank/agency staff remains challenged on ward 2 due to level of vacancies, maternity leave (6.95 wte) and pathway changes within the footprint.

Ward 10 demonstrates a significant decrease in the daily average number of patients who require Level 1a care and further increases in Level 1b care.

Patient admissions and discharges were seen throughout July’s audit which aligns with the reinstatement of elective activity and changes made within elective activity clinical pathways.

Since the last bi-annual report estates work has been completed to provide a new treatment area within STU. This change redirects surgical activity from the endoscopy unit and theatre to maximise the Directorates opportunities to increase capacity to meet clinical demand. This model is currently being piloted and a permanent workforce model will be required to support changes to elective flow and safe staffing levels.

It is important to note that the staffing establishment for Ward 2 also provides staff to the Day Case Unit and Surgical Treatment Unit and has the largest footprint of all inpatient ward areas. The above pilot requires even more effective co-ordination and deployment of appropriately competent staff to care for variable case mix and compliance with same sex accommodation guidance. This will be considered in the workforce model once the output from the Trust’s bed reconfiguration proposal is known.

Despite mitigating actions taken throughout July skill mix dilution and the split between substantive and bank/agency staff was challenged due to the level of substantive RN vacancies (4.42 wte) and maternity leave (2.53 wte). The senior sister stepped down into core numbers and on occasions undertook night duty to support identified shortfall in knowledge and experience. A number of substantive staff regularly undertakes additional shifts to support staffing levels and safe delivery of care.

Previous changes made within the roster templates and skill mix for Wards 1, 1a and 2 support a reduction in 1 RN overnight. However, on occasions during July staff from Ward 2 were deployed to other areas during the night to support identified shortfall in knowledge and experience. This impacted upon the surgical footprint’s ability to manage fluctuating case mix and sustain safe staffing levels in terms of working with a diluted skill mix and below core minimum numbers. Mitigating actions to support the staffing levels and delivery of safe care includes daily risk assessment of staffing levels, deployment of staff from other areas within surgery and utilization of temporary staff via nurse bank or agency.

Ward 10

Demonstrates a significant decrease in the daily average number of patients who required Level 1a care compared to all previous bi-annual audits which is offset by continuing increases seen in patients who require Level 1b care.

The complexity of the case mix and care delivered during July particularly denotes the increase seen in the daily average of patients requiring 1:1 enhanced care and patients living with dementia. Where possible patient cohort nursing was implemented although this has proved challenging owing to the safe management of patient placement within the ward footprint to maximise patient observation. To support the management of patient care, maintain patient safety continuity of care and skill set bank and agency nurses are secured via block booking as far as possible.

Application of professional judgment aligns with the increases seen in complex discharge planning and overview assessment of individual patient profiles. The majority of patient cohorts were frail.
Overall Ward 10’s substantive RN vacancies have reduced – currently 4.0 wte

Workforce development and proposed funded establishment staffing model agreed subject to successful recruitment

and elderly or living with dementia and as such the window of opportunity to expedite discharge and manage elective activity is small.

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

Previously Ward 10 has been extremely challenged in relation to staff recruitment and retention. This position has significantly improved since the last SNCT audit. Currently Ward 10 has 4 wte RN substantive vacancies.

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

A review of staffing levels, roles and workforce modelling has been completed and aligned with service design. As such, the footprint has increased from 30 to 32 beds with a planned reduction in bed base and staffing levels during each weekend period due to cessation of elective activity.

The revised staffing model and proposed funded establishment has been agreed. The overall investment and uplift in the wte funded establishment will support an effective and productive workforce to enable the delivery of high quality, safe care.

A HR management of change will be required to fully implement the agreed changes which entail disestablishment of the Rehabilitation Assistant role, introduction of Nursing Associate roles, a generic role Monday-Friday 10.00-18.00 and a developmental Band 6 role within the team structure. This approach will support recruitment and retention whilst reducing bank and agency expenditure.

ACUTE AND INTEGRATED COMMUNITY CARE

7 DIRECTORATE - INTEGRATED CARE

7.1 Overall

Integrated care wards SNCT data analysis demonstrates a reduction in Level 1a care on Ward 9, 11 and Aston compared to January’s audit and an overall increase in the daily average number of patients who require Level 1b care were seen during July’s audit. Aston Ward demonstrates the most equal split between Level 0 and Level 1b care.

The most significant rises in Level 1b care were seen on Wards 9 and 11 which explains the decreases seen in Level 1a care which is more in keeping with the expected speciality and case mix. However, the increasing number of Level 1b care denotes the high level of nursing input required to care for this patient cohort. Throughout July a number of patients required 1:1 enhanced care and cohort nursing was also required to support challenging behaviours, cognitive impairment and complex discharge planning.

Current funded establishments on the whole are considered adequate although a review of Ward 11 staffing is recommended in view of
SNCT data analysis, trends and a staffing model that is based on an intermediate care facility that may no longer apply due to the sub-acute and acute case mix.

7.2 Ward 9

Demonstrates a significant decrease in the daily average of patients who require Level 1a care (from 8.6 to 1.6) compared to the audit undertaken in January 2018 which illustrated a significant increase. July’s audit is more representative of the case mix and care level categories expected – Level 1b.

Application of professional judgement and triangulation of metrics illustrates that acuity and dependency changed during July 2018 due to an altered ratio of patients with behavioural or challenging cognitive aggressive manifestations and discharge complexities. On a number of occasions cohort nursing and 1:1 enhanced care was required during July and 2 nurses to support individual patient personal care, mobility, de-escalation techniques and reminiscence activities.

Alignment with professional judgement also indicates that a number of patients admitted from residential care or home were too ill to return to their normal place of residence. This impacted on staffing levels and workload as complex discharge planning, 24 hour profiling and multi professional referral, therapeutic interventions and care planning was sought inclusive of DoLS application. As a consequence the daily average discharge rate also shows a reduction.

In addition, professional triangulation cites that the administration of antipsychotic medication, pain relief and daily checking of controlled drug ward stock was hindered due to the shared Mediwell dispenser between Ward 9 and MAU. This results in staff queuing to access the Mediwell causing delays in both the administration of critical medication which constitutes a NICE red flag and reduces nursing productivity.

To mitigate risks to patient safety options are being sought to remove the Mediwell and relocate to a more suitable area – cost implications inhibit removal off site. A risk assessment is in place and staff between MAU and Ward 9 attempt to reduce risks as far as possible by agreeing and prioritising essential medication. This however is not always possible in view of the nature and complexity of each specialty requirements.

Since the last bi-annual report the outstanding Band 6 junior sister role was internally seconded to on the basis of professional development. Unfortunately, due to personal circumstances unforeseen absence has depleted skill mix and Band 7 support. The senior sister and matron stepped down into core numbers to support junior members of staff and case mix complexities. The Band 6 post is currently in the process of being recruited to. Substantive RN vacancies in July are 4.75 wte.

Other mitigating actions include staff deployment, utilization of nurse bank and agency to ensure patient safety and staffing levels are maintained. However, a number of shifts (10) fell below the core minimum staffing levels in July despite shift requests to bank and agency which remained unfilled.

7.3 Ward 11
A further interim audit was undertaken on Ward 11 following recommendations in January’s audit to establish if staffing levels safely met clinical need.

July’s audit demonstrates a 98% decrease in the daily average number of patients requiring level 1a care whilst significant increases in Level 1b care.

It is recommended that Ward 11’s workforce staffing model is reviewed to support the team to deliver and sustain safe patient care.

The recommendation outlined in January’s 2018 bi-annual report suggested that if case mix, acuity and dependency continued to demonstrate a higher proportion of Level 1a and Level 1b than expected in an intermediate rehabilitation care setting to undertake an interim SNCT audit. The aim to sense check and provide assurance that the levels of patient acuity and dependency align to the funded workforce model to ensure delivery of safe patient care.

An interim 2 week audit was undertaken Monday-Sunday during April. Data analysis demonstrates a significant decrease in the daily average number of patients who require Level 1a compared to the high levels seen in January. The majority of patients required Level 1b care with a more proportionate Level 0 care expected case mix. However, the last three audits continue to demonstrate a consistent number of patients (17-21) who require Level 1b care compared to earlier bi-annual audits reflecting a shift in case mix and complexities.

July’s audit demonstrates a comparable picture to that of the interim audit. The daily average of patients who require Level 1a care remained lower although a consistent upward shift and the majority of patients in receipt of Level 1b care were again evident during July. This in part reflects the case mix seen and the number of patients who require 1:1 enhanced care, cohort nursing and complex discharge management. Increases in patient escorts and inter-ward transfers were also evident which concurs with the step changes seen in Level 1b denoting more nursing input, nurse escorts, departmental X-rays, diagnostic tests, clinic attendances and management of orthopaedic transitional care.

Maintaining safe staffing levels based on this acuity and dependency is challenging. A vacant Rehabilitation Assistant post has enabled the monies to be used differently in order to support nursing workload. Currently, the Band 3 role focuses on the coordination of complex discharge processes. In real terms this facilitates completion of overviews, commencement of individual profiles, prompts EDNF completion and onward referral.

However, in view of the case mix, geographical ward footprint, reduced patient observation coupled with 4.9 wte RN vacancies, the intermediate care based staffing model does not appear to reflect the sub-acute nature and safe staffing levels required. Currently, staffing rosters identify that only 2 substantive RN’s can be rostered on each shift which necessitates the use of existing staff undertaking additional shifts or utilizing bank or agency impacting on skill mix and competency. Patient to RN ratio increases to 1:15 overnight.

It is recommended that Ward 11’s workforce model is reviewed to reflect service and care delivery requirements in view of the changing patterns and themes emerging in successive SNCT bi-annual audits.
7.4 Aston Ward

Demonstrates the expected proportion and split seen between the daily average of patients who require Level 0 and Level 1b care. Funded wte establishment and staffing levels are considered appropriate for the care setting. However, at times of unforeseen sickness and absence or shift cancellations Aston ward may potentially become vulnerable and isolated in terms of adequate and safe staffing levels. Every attempt is made to mitigate risk and lone working by staff redeployment, pool allocation and bank/agency utilization as required. The senior sister regularly stepped down into core staffing numbers during July to support patient care. Patient observation overnight remains challenging in view of funded staffing establishment. In order to maintain patient safety and reduce risks to inpatient falls application of professional judgement considers that 3 HCA are required overnight. This corroborates with increases seen in the number of patient slips, trips and falls seen in Q1.

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

Skill mix is utilized flexibly to support daily changes to meet individual patient needs and the additional dementia care training staff received facilitates cohort nursing, 1:1 enhanced care and reminiscence therapy. During July one bay was subject to cohort nursing to support 1:1 enhanced care to minimize risks to patient safety.

It was recommended in the last bi-annual audit that a review was undertaken of patient beverage and meal services in view of the different arrangements at Aston ward to support productive ward ‘releasing time to care’. The business case submitted was not approved due a number of factors including complete kitchen refurbishment, substantial investment and associated costs. It has been proposed that a cooked-chilled service is approved which will continue to rely on nursing staff time to plate and serve.

8 ACUTE AND INTEGRATED COMMUNITY CARE DIRECTORATE - URGENT CARE

8.1 Overall

Urgent Care analysis demonstrates that on the whole current staffing levels, funded establishments and skill mix is appropriate based on current data, specialty bed configuration and consistency with regional network critical care guidance.

However, it is important to note ITU has been subject to a staffing model and shift pattern review since the previous audit in view of increases seen in demand and capacity for ITU beds. The new workforce model converted 2 healthcare assistant posts into 1 Band 5 RN post to enable safe staffing levels overnight.
The sustainability of safe staffing levels within MAU is expected to be challenging in view of the level of vacancies and maternity leave going into the winter months.

Outputs from the MAU sustainable workforce project continue to utilize dedicated pharmacy technician support to facilitate administration of medications which enables some nursing resource to be re-directed to front facing patient care.

Since the last bi-annual SNCT audit the pilot of additional Band 6 roles to provide senior cover for each shift to support patient safety, clinical practice and enhance patient flow was successfully implemented. However, in order to sustain this staffing model MAU’s funded establishment will require further review and agreement for 7 days per week.

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

Urgent care has also been challenged with high level of vacancies, maternity leave and diluted skill mix within MAU and ITU since the last bi-annual report. MAU remains an area for concern going into the winter months. Current trajectories indicate a 50% vacancy rate in October/November due to forthcoming maternity leave and outstanding vacancies.

ITU

Demonstrates a similar position in the daily average number of patients who require Level 2 care and a reduction in Level 3 care provision compared to January’s audit. A small rise in Level 0 care was observed. Application of professional judgement confers that a cohort of patients resided in ITU for a longer period of time due to dependency moving from Level 3 to Level 2 care as the patient’s clinical status improves.

Comparable data analysis also demonstrates a similar pattern seen in the small daily average increase of patients who require Level 0. This reflects and aligns with prolonged delays to step down or transfer from ITU due to lack of side room capacity or requests for specialty based beds. On occasions, patients were discharged directly from ITU.

This subsequently impacts upon the management of Same Sex Accommodation and infection control measures which is monitored closely. Mitigating risks are proactively managed as far as possible by utilizing side room capacity within ITU flexibly dependent upon case mix.

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

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

Occurrences in Same Sex Accommodation breaches continue to remain high within ITU due to case mix and delays in transfer to a ward based bed due to operational capacity pressures.

ITU staffing levels reflect critical care network and national guidance.
Higher than normal levels of vacancies within ITU – this will improve in September owing to successful recruitment of 5 RN's supervision to more junior staff. The senior sister also spends 23% of her substantive hours supporting front facing clinical patient care.

However, ITU too has been challenged with nurse vacancies since the last bi-annual audit. The senior sister and practice educator facilitator also stepped down into core numbers. This position is expected to improve in September owing to successful recruitment of 5 RN’s of which a proportion are newly qualified.

The implementation of SafeCare measures for acuity and dependency have been adjusted to represent network and national guidance using colour codes to further denote levels of patient dependency. For example – green status represents that the patient is fit for discharge to the ward but not a delayed discharge whereas red plus indicates 2 nurses are required to support one patient who may require ventilation and filtration simultaneously.

A 50% increase in the daily average number of patients who require Level 1b care was observed during July which is significantly higher than the normal case mix trends

MAU demonstrates much higher admission, discharge and transfer rates than other areas

Recruitment is challenged within MAU – 50% vacancy level by October/November is forecast

An agreement to undertake a role and skills review across ECT community nursing has been reached

Work remains ongoing to review community nurse roles to prepare the workforce for the increasing demand and acuity across the community footprint to support the shift from secondary to primary care. This has also been designed to align to the parallel development
been reached of the integrated teams across the 5 care communities.

9.3 2 Specialist Practitioner District Nurse students are due to commence in September to support the ongoing professional development of staff to facilitate specialist clinical knowledge and leadership skills to support service improvement and delivery.

9.4 A successful ECNT bid has secured 2 places on the Health Education England - Skills for Health Advanced Clinical Practitioner (ACP) apprenticeship programme which commences in September 2018. This will support the development of advanced practice roles across the community setting.

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

10.1 Since the last SNCT acuity and dependency audit the Trust has embedded a number of service model redesign programmes and progressed transformation projects. Capital estates work to facilitate emergency care streaming, integration between primary and secondary care settings and establishment of a new treatment area within the Surgical Treatment Unit is complete.

Further review of specialty services, overall bed stock and potential bed reconfiguration is currently being undertaken pending definitive Directorate and Board approval. Strong multiagency, partnership working and improved outputs linked to service transformation will support the Trust’s ability to respond consistently to demand on services.

11 Quality & Safety - delivering safe care

11.1 To support the delivery of safe and effective care the Trust invested in Allocate’s SafeCare software tool which informs real time patient acuity and dependency. This enables appropriate decision making, supports workforce deployment, mitigation of risks and professional judgement to support clinical care. SafeCare was fully implemented within the acute hospital setting in May 2018 and continues to be embedded. Further evaluation and assessment of additional report functionalities are being explored.

Over the past 6 months the majority of supervisory senior sister ward status has improved and adjusted to either a 70/30 or 60/40 split. However, this is heavily dependent upon operational pressures, current level of vacancies and skill mix dilution which necessitates senior sisters to regularly step down into core staffing numbers to support patient care.

It is anticipated that following successful recruitment supervisory status will be reinstated where possible to allow closer management and monitoring of quality standards, patient experience, completion of staff appraisal, clinical training and coaching more junior members of staff. Equally important is enabling the senior Band 7 sister to have capacity to oversee inpatient flow, pulling through patients requiring admission from MAU/ED to the right specialty and supports effective patient centred safe discharge. The senior sisters continue to spend a significant amount of time in supporting this function and
The “Matron of the Day” rota consists of a designated matron to oversee and support decision making in relation to patient safety, effective and appropriate workforce deployment.

Currently, staffing levels and patient safety continue to be overseen, risk assessed and resolved on a daily basis by the Clinical Matron team and Senior Nurse central to nurse bank staffing. Concerns or risks that remain unresolved are escalated to the corporate nursing team in as real time as possible to facilitate resolution.

Where ward staffing levels fall below their core funded establishment or below acceptable safe staffing levels in any shift period, a senior professional risk assessment is undertaken based on acuity, patient dependency, skill mix, and levels of enhanced 1:1 care. This overview is supported by reviewing census data from SafeCare to prioritize workforce deployment and aid decision making in order to maintain patient care, professional standards and safety.

The use of SafeCare and SBAR enables consistent application of care parameters, clear documentation, audit trails in relation to decisions and actions taken to facilitate safe staffing levels. Bed capacity meetings are in the process of being strengthened to ensure that staffing, patient safety and subsequent actions are appropriately managed.

However, the ability to redeploy staff effectively remains challenging in view of the impact on already stretched staffing levels when carrying a RN vacancy of 46.96 wte and bed occupancy levels exceeding 85%.

The implementation of SafeCare enables the measurement of real time patient acuity and dependency to further inform safe staffing levels.

Identified nurse staffing shortfalls continue to be discussed daily and escalated as per Trust guidance and policy in conjunction with utilization of SafeCare, patient safety huddles, daily board rounds and professional judgement. A matron of the day rota supports the decisions taken with regards to staff deployment and escalation.

All reasonable steps and measures with regards to forward planning are proactively managed to support safe staffing levels as far as possible. This includes ensuring that identified gaps are met in the first instance by allocating any unused nursing hours accrued by substantive staff within the roster, cancellation of non-essential study leave, temporary staff utilization via nurse bank, existing ward staff working additional hours, staff redeployment, senior nurses stepping down into core numbers and booking of agency staff in line with staff escalation systems and processes.

On occasions during July non-clinical front facing staff and additional volunteers were drafted in to support staffing levels at times of peak operational pressures to mitigate risks to patient safety.

Further recruitment strategies and initiatives for attracting registered nurses to join the Trust substantively or through the nurse bank have been strengthened via social media, refer a friend scheme and access to weekly pay for nurses who work additional shifts or employed by nurse bank.

A clear focus to further develop and strengthen staff retention in view of the Trust’s demographic profile of the nursing workforce is in progress. This forms part of the NHSi 90 day improvement methodology.

Regular student nurse focus group meetings facilitated by Practice Educator Facilitators and Heads of Nursing are in place to engage with students at an earlier point in their training. This aims to discuss their placement experience and provide strong links to support and
convey job opportunities on qualification. 6 student nurses have been secured on successful qualification.

It is also anticipated that further, smaller cohorts of Trainee Nursing Associates will be agreed pending programme evaluation, national directives and confirmation of funding streams.

11.5 Any adverse clinical incidents relating to nurse staffing levels, patient safety, patient harm, patient complaints or staff concerns are reported and investigated via Datix Clinical Incident Management system. The Trust also actively promotes a designated, named lead in relation to ‘Freedom to Speak Up’ to raise concerns.

The triangulation of nurse sensitive and workforce metric indicators are reported against each individual acute in patient ward and presented monthly via the safe staffing exception Trust Board report, Ward Quality Dashboards and Directorate SQS exception reports. Ward quality dashboards are visible and shared with all in-patient ward teams.

**Directorates continue to review risks pertaining to nurse staffing levels**

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

11.7 In addition, ‘Did You Know’ Boards, Sign up to Safety, Safety Thermometer, ‘Open and Honest’ Care, Ward Quality Dashboards, RADaR reports, Mortality/Morbidity data and the ability to robustly record red flags on SafeCare are closely monitored. Actions are taken as appropriate to support mitigation of risks to patient and staff safety.

Patient experience and patient outcomes are continually monitored and actioned upon through various assurance meetings in addition to PaLS in reach to AED and in patient areas.

12 **TRUST POSITION AGAINST NICE & NATIONAL GUIDANCE**

12.1 The Trust continues to work and align staffing levels in line with NICE guidance recommendations. ‘Red flag events’ which are defined as ‘events that prompt an immediate response by the registered nurse in charge of the ward’ has previously been challenging to robustly record in real time due to the absence of electronic infrastructures and software tools.

However, the implementation of SafeCare provides staff with IT access to robustly and consistently select and apply Red flags. It is important to note that this functionality is not fully embedded as the tool itself remains in the early stages of full implementation. Further training and evaluation is required to full embed all functionalities to ensure all acuity and dependency activity is captured and accurate.

Relatively new NHSI resource guidance and collation of evidence based tools specifically in relation to Paediatric and Accident and Emergency Departments is available. The new set of resource tools aims to improve and inform safe, sustainable and productive workforces in these clinical areas which are excluded from the SNCT Shelford model. The guidance is currently being appraised to consider the recommendations therein.
13 CARE CONTACT TIME (CHPPD)

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

13.2 The Trust is compliant with reporting measures.

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

14 CHALLENGES AND MITIGATION

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

14.2 National indications continue to demonstrate that the removal of student bursaries in England has had a detrimental effect on the number and quality of students who apply to undertake nurse training. In the early years of implementation this may impact upon the Trust’s ability to recruit and attract staff. Both local and national trajectories identify a significant workforce shortfall to meet current demand coupled with the impact of lower birth rates in the UK and nurse retention. A number of peer organisations have offered and implemented incentive packages to attract and retain staff which poses ECT with additional challenges. Mitigating actions include developmental opportunities, flexible retirement options, return to practice and the piloting of new roles to support the workforce. Health and well-being continue to work with Directorates and partners in Learning and Development to explore new initiatives.

14.3 Demographic profiling demonstrates that the Trust has an ageing experienced workforce with an increasing number of staff eligible and applying for early retirement. 9 staff members within the acute in patient ward areas have been supported to secure flexible retirement options in order to maintain key skill sets and competency.

14.4 Robust staff development and succession planning is required to
ensure that key critical posts are recruited to in order to mitigate risks associated with patient safety and business continuity. Emerging patterns and themes since the last bi-annual report reveal that specialist nurse practitioner and critical care areas are more likely to attract and secure prospective employees than general wards. Mitigating actions to date include HR work stream alignment to recruitment, retention, attraction strategies to facilitate workforce sustainability.

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

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

14.6 During July nursing and midwifery long term sickness and absence is 5.64 wte which illustrates a worsening position compared to previous months. Year to date maternity leave in now calculated per directorate as ‘all staff groups’ opposed to nursing and midwifery groups. In month, nursing and midwifery data with regards to Maternity leave in July is 11.78 wte in acute ward settings and 5.9 wte within community.

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

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

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

15 NEXT STEPS

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

15.2 Liaise with Directorates, HRBP and L&D to review workforce plans and succession planning models in view of demographic profile of the nursing workforce; inclusive of consideration re: apprenticeship roles, nursing associates placement on completion of Year 2, return to practice placements, development opportunities and rotational roles.

15.3 Undertake a staffing review on Ward 11 in view of the changes seen in level of care categories and monitor metrics via directorate SQS meetings and escalate by exception.

15.4 Agree and confirm the number of future trainee nursing associate cohort and participate in the ongoing evaluation of the pilot group.

15.5 Review nurse bank function, systems and processes in conjunction with “matron of the day”, bed and site management roles to streamline communication, provide role clarity and prevent duplication of efforts.

15.6 Continue to monitor and improve e-rostering compliance by working with ward areas and HR to reflect accurate templates and resolve anomalies. Pilot SafeCare audit tools to capture and provide assurance re: compliance in relation to quality and standards of care e.g. hand hygiene, documentation.

15.7 Recruit to and implement recommendations in relation to Ward 10 agreed workforce model. Plan to commence Ward 2’s workforce review following definitive outputs from bed reconfiguration project

15.8 Complete retention strategy to support workforce development, succession planning and reduce agency expenditure.

15.9 Evaluate MAU Band 6 roles to support 24 hour 7 days a week cover and confirm identified funding stream.

15.10 Appraise NHSI resource information guidance re: Paediatrics and Accident and Emergency in relation to safe, sustainable and productive staffing to help guide workforce planning

15.11 Progress consistent application of NICE Red Flags on SafeCare to further inform staffing levels based on acuity and dependency, triangulation with nurse sensitive indicators linked to CHPPD ‘model hospital’ intelligence.

15.12 A further SNCT acuity and dependency audit will be undertaken in January 2019 to enable regular comparable acuity and dependency data analysis to inform safe staffing levels for acute in patient areas.

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

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

16 RECOMMENDATIONS

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

Safer Nursing Care Tool Example:

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

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

Example:

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

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

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

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

The tool recommends 22.6% – 25% uplift for annual leave, study leave and sickness.
<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>Author of Report:</td>
<td>Jeanette Sarkar</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) On Corporate Risk Register</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>Mitigates Risk Number: (identify) On Assurance Framework</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>Link to Care Quality Commission Domain</td>
<td>Safe, Caring, Responsive, Effective, Well-led</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>No legal implications</td>
</tr>
<tr>
<td>Corporate Objectives</td>
<td>May potentially impact upon the quality of care, patient experience, patient outcomes and staff well being</td>
</tr>
<tr>
<td>Legal implications - (identify)</td>
<td>Identified gaps in funded establishments due to wte</td>
</tr>
<tr>
<td>Impact on quality</td>
<td>Identified gaps in funded establishments due to wte</td>
</tr>
<tr>
<td>Impact of equality/diversity</td>
<td>No impact on equality and diversity</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------</td>
</tr>
</tbody>
</table>

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

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

This report provides a high level summary of Safe Staffing levels on all inpatient wards across the Trust 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 acute ward areas were above the 95% safe staffing threshold during July 2018, with the exception of Aston, Paediatrics, Post Natal and Labour Ward, Ward 2, 4, 7, MAU and Ward 9.

2.2 Healthcare assistant actual fill rates during the day for Aston Ward were 85.8% compared to 90.1% in June. 18 unfilled HCA nurse bank requests impacted upon fill rate. Mitigating actions to maintain safe staffing levels included senior sister stepping down to support clinical care and facilitate safe admission and discharges.

2.3 Healthcare assistant actual fill rates during the day for Paediatrics were 91.5%. The number and dependency of paediatric patients was lower in month which enabled HCA allocation of AL and short term sickness was not covered in view of lower acuity. Staffing levels remained safe.

2.4 RN actual fill rate during the day for Ward 2 were 89.8% and 91.7% overnight. This is due to the level of vacancies and maternity leave. Mitigating actions to maintain patient safety included deployment of staff from surgical footprint, senior sister stepping down into core shifts and substantive staff undertook additional shifts on a regular basis.

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Higher levels of vacancy and maternity leave in acute ward areas impacted upon RN actual fill rates

Mitigating actions to support safe staffing levels were deployed – however a number of areas remained below core minimum staffing levels

Patient complexities, acuity, dependency and enhanced 1:1 care is reflected in HCA fill rates exceeding 130%

SafeCare (Allocate) live acuity and dependency tool continues to be embedded

3 RECRUITMENT

Registered Nurse acute vacancies in month rose to 46.96 wte

Registered Nurse recruitment event held in July resulted in 7 RN job offers of which 5 were student nurses

3.1 In month registered nurse vacancies across all acute in-patient ward areas were at 46.96 wte compared to the previous month 43.82 wte. This excludes Maternity Leave and Long Term Sickness. Inclusion of Maternity Leave (11.78 wte) and Long Term Sickness (5.64 wte) increases the overall registered nurse gap to 63.38 wte.

3.2 A registered nurse recruitment event was held on Saturday 7th July which resulted in 7 RN posts being offered of which 5 were to students pending qualification. Currently, 21 Acute and 4 Community nurse posts are subject to pre-employment checks.
Community vacancies are fully recruited to (-2.62wte) although maternity leave (5.9) and long term sickness (3.71) challenges district nursing teams – the overall gap 6.99 wte. Mitigation includes utilization of bank where possible.

3.4 No Healthcare Assistant interviews were held during July owing to the successful recruitment event held in April subject to satisfactory pre-employment checks.

3.5 9 staff members are currently in their second year of the Trust’s Nursing Associate Pilot training programme. Preliminary discussions are currently being held with the individuals, directorates, learning and development to identify final substantive placement upon successful completion of the course.

### 4 RETENTION

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

4.2 The Trust NHSI 90 day retention programme project plan has been drafted and an onsite visit from NHSI is now expected in the Autumn.

### 5 STAFF TURNOVER

5.1 In month staff turnover is 0.66% compared to 0.37% the previous month. YTD rolling staff turnover is 9.68% compared to 11.05% 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
<table>
<thead>
<tr>
<th>ServiceLine</th>
<th>Specialty</th>
<th>Ward</th>
<th>Expected RN</th>
<th>Actual RN</th>
<th>Expected HCA</th>
<th>Actual HCA</th>
<th>Percent RN</th>
<th>Percent HCA</th>
<th>Care Hours Per Patient Day (CHPPD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Care</td>
<td>Rehabilitation</td>
<td>Aston</td>
<td>935.89</td>
<td>968.08</td>
<td>2230.14</td>
<td>1913.00</td>
<td>101.7%</td>
<td>106.1%</td>
<td>92.00%</td>
</tr>
<tr>
<td></td>
<td>Medical Specialties</td>
<td>Cardiology</td>
<td>930.00</td>
<td>705.00</td>
<td>2395.00</td>
<td>1620.00</td>
<td>109.5%</td>
<td>96.9%</td>
<td>83.00%</td>
</tr>
<tr>
<td></td>
<td>Women's &amp; Children's</td>
<td>Paediatrics</td>
<td>1146.55</td>
<td>1096.00</td>
<td>372.00</td>
<td>146.33</td>
<td>92.8%</td>
<td>90.5%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Women's &amp; Children's</td>
<td>Obstetrics</td>
<td>797.01</td>
<td>764.35</td>
<td>900.00</td>
<td>713.00</td>
<td>99.8%</td>
<td>97.3%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Women's &amp; Children's</td>
<td>Obstetrics</td>
<td>2439.16</td>
<td>2360.42</td>
<td>870.00</td>
<td>743.93</td>
<td>96.9%</td>
<td>95.7%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>General Surgery</td>
<td>Ward 1</td>
<td>1878.60</td>
<td>1857.00</td>
<td>1965.40</td>
<td>2300.08</td>
<td>95.9%</td>
<td>117.0%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Medical Specialties</td>
<td>General Medicine</td>
<td>1532.64</td>
<td>1534.12</td>
<td>1589.68</td>
<td>2341.50</td>
<td>100.1%</td>
<td>147.3%</td>
<td>98.00%</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>Trauma &amp; Orthopaedics</td>
<td>Ward 10</td>
<td>1917.50</td>
<td>1843.67</td>
<td>1907.58</td>
<td>2067.00</td>
<td>98.5%</td>
<td>107.2%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Surgical Specialties</td>
<td>General Surgery</td>
<td>1112.16</td>
<td>1085.05</td>
<td>1196.30</td>
<td>2538.30</td>
<td>93.5%</td>
<td>108.2%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Medical Specialties</td>
<td>General Medicine</td>
<td>1515.78</td>
<td>1506.70</td>
<td>1524.01</td>
<td>1398.83</td>
<td>98.7%</td>
<td>109.2%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>General Surgery</td>
<td>Ward 2</td>
<td>1512.80</td>
<td>1485.42</td>
<td>1552.55</td>
<td>2128.55</td>
<td>95.4%</td>
<td>104.5%</td>
<td>100.9%</td>
</tr>
<tr>
<td></td>
<td>Medical Specialties</td>
<td>Respiratory Medicine</td>
<td>1564.88</td>
<td>1479.00</td>
<td>1594.64</td>
<td>1702.25</td>
<td>96.3%</td>
<td>106.2%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>General Surgery</td>
<td>Ward 3</td>
<td>1512.00</td>
<td>1500.02</td>
<td>1592.16</td>
<td>2174.52</td>
<td>99.5%</td>
<td>106.2%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>Integrated Care</td>
<td>General Medicine</td>
<td>1567.56</td>
<td>1530.92</td>
<td>1592.40</td>
<td>2322.28</td>
<td>98.6%</td>
<td>108.2%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

| Day | Day | Day | Day | Day | Night | Night | Night | Night | Care Staff | Overall | Total Slips, Trips & Falls | Falls (mod and above) | Cold | MSSA | ST | Pressure Ulcers | Sickness & Absence | % Stat & Mand | % IPR |
|-----|-----|-----|-----|-----|-------|-------|-------|-------|------------|---------|--------------------------|---------------------|------|------|----|----------------|-------------------|--------------|------|------|
|     |     |     |     |     |       |       |       |       |            |         |                          |                     |      |      |    |                 |                   |              |      |      |
### Agenda Item Number 19: TB (70)

**Report of:**
**Responsible Officer:**
**Accountable Officer:**

| Medical Director |

**Author of Report:**
Dr John Hunter, Medical Director
Mr Chris Smart, Guardian of Safe Working Hours

**Subject/Title**
Guardian of Safe Working Hours Annual Report

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

**Purpose of Paper**
To provide assurance to the Committee on the work undertaken by the Guardian of Safe Working Hours during the last 12 months.

**Action/Decision required**
For assurance.

**Mitigates Risk Number:**
- **On Corporate Risk Register**
  - Risk 2565: If we are unable to cover/mitigate gaps in junior doctor rota there is a risk to patient safety, quality of care and patient experience (patient flow)
- **On Assurance Framework**
  - BAF 4: If the trust does not attract, develop and retain a resilient and adaptable workforce with the right capabilities and capacity then there may be an impact on achieving mandatory service standards and delivering an integrated system

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

**Link to:**
- Trust’s Strategic Direction
  - Patients: to provide safe, effective personal care in the right place
  - People: to build, value and develop a motivated and sustainable workforce

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

**Impact on quality**
Potential impact on staff and patients if there is a breach in the terms and conditions of services for doctors in training.

**Resource impact**
Financial implication if fines are levied.

**Impact of equality/diversity**
N/A

**Avoid acronyms or abbreviations - if necessary list:**
- TCS: Terms and Conditions of Service
- DRS: Doctors rostering system
- HENW: Health Education North West
- FY: Foundation year
- StR: Specialty registrar
- DME: Director of Medical Education
- JDF: Junior Doctor Forum
- ER: Exception report
The Guardian of Safe Working Hours has been introduced to protect patients and doctors by making sure doctors aren’t working unsafe hours. The Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service for doctors in training.

This report will:

- Briefly outline the roles and responsibilities of the Guardian
- Summarise exception reporting
- Highlight the key achievements over the last 12 months

1 BACKGROUND

1.1 TCS 2016 applies to doctors and dentists in approved postgraduate training programmes under the auspices of Health Education England (HEE). Health Education North West (HENV) oversees this Trust.

1.2 The Trust has appointed a Guardian of Safe Working Hours (GoSW) who will:
   i) Act as the champion of safe working hours
   ii) Receive exception reports and record and monitor compliance against the TCS 2016
   iii) Escalate issues to the relevant Executive Director, or equivalent for decision and action
   iv) Intervene to reduce any identified risks to the doctor or patient’s safety
   v) Undertake a work schedule review where there are regular or persistent breaches in safe working hours
   vi) Distribute monies received as a consequence of financial penalties, to improve training and service experience

1.3 Chris Smart, Consultant Colorectal Surgeon, was appointed after competitive interview as the Guardian of Safe Working Hours on 1st July 2016.

1.4 Quarterly written reports are provided by the Guardian to the trust’s Finance, Performance and Workforce Committee (FPW) which summarise all exception reports, work schedule reviews and rota gaps. This report provides assurance on compliance with safe working hours by both the employer and doctors in approved training programmes. The Guardian has also attended the Committee in person to give assurance that issues of compliance with safe working hours will be addressed as they arise.

2 EXCEPTION REPORTING

2.1 The exception reporting system is vital in ensuring doctors are encouraged and feel able to highlight times when their working hours and shift patterns are non-compliant and potentially unsafe.

2.2 Doctors Reporting System 4 (DRS4) is used at the trust for exception reporting. No app for mobile devices is currently available.
2.3 The Guardian has explained exception reporting to colleagues and ensures that all junior staff are encouraged and supported to use exception reporting where day-to-day work varies from that set out in the work schedule either in hours of work (including rest breaks) or the agreed working pattern, including the educational opportunities made available.

During 2017/18, 88 exception reports were completed. In line with other organisations, the vast majority (97%) were filed by foundation doctors.

2.4 Between 1st April 2017 and 1st April 2018, 88 exception reports were filed.

Exception reporting by Grade
- FY1: 72
- FY2: 13
- StR: 3

Exception reporting by Specialty
- General Medicine: 40
- General Surgery: 37
- Traumatic and Orthopaedic Surgery: 9
- Accident and Emergency: 1
- Paediatrics: 1

3 FINES

The Guardian can levy a fine for the breach of a 48 hour average week, a breach of the maximum 72 hour week, or where the 11 hour rest requirement has been reduced to fewer than 8 hours.

3.1 The whole point of the exception reporting system is to allow employers to address issues and concerns as they arise, in ‘real time’, and to keep doctors’ working hours both rostered and actual, within safe working limits. In anything other than truly exceptional circumstances, the levying of a fine indicates that the system has failed and that someone has failed to discharge their responsibilities appropriately.

3.2 No fines were levied during the reporting period.

4 KEY ACHIEVEMENTS

The Guardian has been able to effectively discharge his duties and provide assurance to the Board.

4.1 Exception reporting is now firmly embedded at the trust.

4.2 All exception reports concerning training hours, as set out in the work schedule, are sent to the trainees educational supervisor and the Director of Medical Education (DME).

4.3 No fines have been levied.

4.4 A Junior Doctor Forum (JDF) has been established with the Director of Medical Education. Attendance and engagement has been good and several members of the Executive team have been invited attendees.

4.5 The Trust Board has received assurance on safe working hours via quarterly written reports submitted to the FPW Committee by the Guardian. The Guardian has also updated the Board in person.

4.6 Junior doctors have attended a Public Board meeting to highlight their quality improvement activity.

4.7 A number of work schedule reviews have been successfully completed.
5 RECOMMENDATION

5.1 The Board are asked to note the contents of the report.

<table>
<thead>
<tr>
<th>Name</th>
<th>John Hunter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Title</td>
<td>Medical Director</td>
</tr>
</tbody>
</table>
### Agenda Item Number 20: TB 18 (71)

#### SAFETY, QUALITY AND STANDARDS COMMITTEE

**Meeting Chair:** Ali Harrison  
**Meeting Secretary:** Gareth Rydings

#### MINUTES OF MEETING HELD ON:

Tuesday 5th June, 12:00 – 14:00

**Venue:** Boardroom 1

### PRESENT

<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</td>
<td>Ms Harrison</td>
</tr>
<tr>
<td>Dr Peter Madden</td>
<td>Non-Executive Director</td>
<td>Dr Madden</td>
</tr>
<tr>
<td>Brian Green</td>
<td>Deputy Director of Nursing &amp; 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>Julie Green</td>
<td>Director of Corporate Affairs and Governance</td>
<td>DCAG</td>
</tr>
<tr>
<td>Dr John Hunter</td>
<td>Medical Director</td>
<td>MD</td>
</tr>
<tr>
<td>Kath Senior</td>
<td>Director of Nursing, Performance &amp; Quality</td>
<td>DNPQ</td>
</tr>
<tr>
<td>Kashif Haque</td>
<td>Chief Pharmacist</td>
<td>CP</td>
</tr>
<tr>
<td>Rachael Charlton</td>
<td>Director of HR</td>
<td>DHR</td>
</tr>
</tbody>
</table>

### IN ATTENDANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Abb.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lynda Moorcroft</td>
<td>Head of Midwifery</td>
<td>HoM</td>
</tr>
<tr>
<td>Lisa Minshall</td>
<td>Head of Nursing</td>
<td>HoN</td>
</tr>
<tr>
<td>Lutfi Sulaiman</td>
<td>Consultant Anaesthetist,</td>
<td>Dr</td>
</tr>
<tr>
<td></td>
<td>Specialist Dietitian</td>
<td>Sulaiman</td>
</tr>
<tr>
<td>Karen Allsopp</td>
<td>Specialist Dietitian</td>
<td>KA</td>
</tr>
<tr>
<td>Lynn McGill</td>
<td>Chairman</td>
<td>Chairman</td>
</tr>
</tbody>
</table>

#### Agenda Item 18/47: Patient Story

The DNPQ presented a patient story relating to a 87 year old patient who had developed an unstageable pressure injury to their right heel in a residential home whilst on the caseload of the Poynton District Nursing Team. The patient was on the caseload for treatment of a moisture lesion to sacrum and had significant co-morbidities. The patient had full mental capacity and was mobile around the care home with a frame. On examination the patient was found to be wearing inappropriate footwear. Their slippers were too tight for their feet due to oedema and they were not wearing socks. The patient was not concordant with advice and wanted to wear tight slippers despite being advised not to. The patient also wanted to remove dressings after they had been applied. On identification of deterioration in skin condition to unstageable pressure ulcer, the team reported the incident on DATIX and the tissue viability team verified the ulcer as a stage 3.

**What went well**

- NICE guidelines were followed and appropriate and timely risk
assessments were undertaken.
- Good advice was given to patient and careers on how to re-distribute pressure on the heel.
- Specialist shoes were ordered and the patient was referred to the podiatry department.
- Pressure relieving information leaflet was given to the patient.
- Nutritional and hydration needs were assessed using the MUST tool and Food First leaflet as shared with the patient.
- Good sharing of information between relevant professional colleagues and patient and careers were made aware of the need to be concordant with the care plan and possible adverse impact of not doing so.
- Patient and careers offered advice around the importance to elevate the legs and not to wear tightly fitted slippers.
- All referrals to tissue viability and podiatry were made in a timely manner and no delays in response times were identified.
- All documentation as in line with required standards.

Discussion took place around promoting the importance of wearing supportive footwear and it was noted that there may be scope to do this in the community through the #ENDPJPARALYSIS campaign.

<table>
<thead>
<tr>
<th>18/48</th>
<th>Apologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>John Wilbraham – Annual Leave</td>
</tr>
<tr>
<td>2.</td>
<td>Mark Ogden – Off site commitments</td>
</tr>
<tr>
<td>3.</td>
<td>Lorraine Jackman – Attending the Freedom to Speak up North West Annual meeting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18/49</th>
<th>Conflict of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>None raised.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18/50</th>
<th>Matters Arising</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Year at a Glance</td>
</tr>
<tr>
<td></td>
<td>GR to update the year at a glance to reflect current trust objectives.</td>
</tr>
<tr>
<td>b)</td>
<td>SQS Committee Minutes – April 2018</td>
</tr>
<tr>
<td></td>
<td>The minutes were agreed as accurate pending some minor changes agreed by the committee.</td>
</tr>
<tr>
<td></td>
<td>Page 6 – Cancer standards – CP to phrase a paragraph to be added to the minutes and send through to GR.</td>
</tr>
<tr>
<td>c)</td>
<td>Action Log</td>
</tr>
<tr>
<td></td>
<td>9768 – CP informed The Greater Manchester Cancer Network (GMCN) are changing the way breaches are allocated to bring it in line with the National Cancer Breach Allocation Guidance. This will go live in Q3 of 2018/19. One of the main changes is the requirement for the first trust to refer out by day 38 (currently it is day 42). An update on the impact will come back to a future SQS meeting once it has been worked through.</td>
</tr>
<tr>
<td></td>
<td>It was noted that Greater Manchester is still developing the software. It was noted that Christies are changing their process and this may impact the figures. This is currently being monitored. Action remains open.</td>
</tr>
</tbody>
</table>
9769 – Action completed and closed. Further assurance to be provided at the November meeting. Rolling programme to reflect this update

d) Collection of Any Other Business
none raised
e) Formal Request for Removal of Items from Consent Agenda
None

### ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>18/51</th>
<th>Integrated Quality &amp; Governance Report including</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Quality Indicator Exceptions</td>
</tr>
<tr>
<td></td>
<td>• Detentions under MHA</td>
</tr>
<tr>
<td></td>
<td>• Saving Babies Lives Update</td>
</tr>
<tr>
<td></td>
<td>• Complaints (April 2018) and Annual Complaints Report</td>
</tr>
<tr>
<td></td>
<td>• Risk Assessed Data Report (RADaR)</td>
</tr>
<tr>
<td></td>
<td>• Professional Standards Authority NMC Learning Review</td>
</tr>
<tr>
<td></td>
<td>• Quarterly complaints Incidents Claims and Patient Experience Report</td>
</tr>
<tr>
<td></td>
<td>• Risk Management Sub-committee Update</td>
</tr>
</tbody>
</table>

The report was taken as read and the following areas highlighted

- The endoscopy unit is facing further patient backlog and this has been due to an influx of unplanned urgent 4 week referrals. It was noted an action plan has been put in place to ensure that the 99% diagnostic compliance trajectory can be back on track within the next few months.
- There is a risk identified to JAG accreditation if the 99% endoscopy standard is not consistently achieved.
- The Saving Babies Lives care bundle implementation with the exception of an annual assessment of Cardiotocography (CTG) and auscultation competency being implemented by the trust and it was noted that the Greater Manchester and East Cheshire strategic clinical network are in the process of developing a competency based assessment. This will be implemented once complete.
- Plans are in place to complete the bundle when the CTG competency assessment tool is implemented. Audits of clinical care will continue to ensure adherence to policy with action plans as appropriate.
- Stillbirths will never be fully eradicated nationally however the implementation and embedding of the saving babies lives care bundle will assist in achieving the reduction of avoidable stillbirths (ECT currently have lower than national rate of still births) Work will continue to embed in practice the elements of the bundle and to share findings of good practice and lessons learned to influence the achievement of reducing national stillbirths by 50% by 2025.

Discussion took place and it was noted that the trust had not received any high profile claims in relation to stillbirths. It was noted that there have been no intrapartum stillbirths at the Trust for over 5 years which provides assurance that staff possess the relevant competency based skills to provide effective care.

The HoM provided assurance that all staff participating in the ‘buddy system’ for ‘fresh eyes’ review of CTG interpretation are up to date with their competencies; have all undertaken the CTG training and are experts in providing patient care. HoM provided assurance on compliance training rates for midwives is 98% and for doctors is 96%. The only gaps in compliance are due to maternity leave and sickness and these will be addressed in appropriately timely manner.
It was noted that ECT has the lowest stillbirth rates in the region and areas of best practice are shared through the Greater Manchester and Eastern Cheshire monthly meeting.

The Committee were assured that all maternity investigations come to Check and Challenge process and to the SIRI committee ensuring connection to Board and Executive level.

The Committee were in approval and noted the following

- Exceptions to the Quality Indicators and improvement actions.
- Progress towards implementation of Saving Lives Care Bundle
- Assurance in relation to the trust’s responsiveness to complaints.
- The update on detentions under the MHA
- There is one community team triggering on RADaR in April 2018, the remedial action taken to support staff and that action plans to improve are in place.
- Learning identified for regulators from Kirkup related NMC Review
- The new edition of the Learning in to Practice bulletin
- The Q4 report, assurance provided; improvement action identified and the changes in practice made as a result of findings.
- Noted the update of the Risk Management Sub-committee including terms of reference

### 18/52 CQC Action Plan

The DCAG highlighted the following

- Noting the achievement of ‘good’ overall rating for the Trust awarded by CQC, ten areas of work have been identified for focus to address the 3 regulated activities where the trust is not currently fully compliant with CQC essential standards.
- Each area has an allocated Executive lead as well as a supporting officer with a set time frame for completion.
- The Action Plan has been submitted to the CQC
- Quarterly engagement sessions with the CQC will commence and evidence/updates to each area will be submitted to SQS on a quarterly basis. Any exception with concerns will be escalated through the SQS Committee.

**Action** – GR to update the rolling programme to include quarterly CQC Action Plan updates.

- No feedback will be provided to the trust by CQC and responsibility to test out the action plans is the trust’s own.
- The trust could be subject to an unannounced CQC visit within the normal timeframes of organisations rated as ‘Good’.

### 18/53 Clinical Negligence Scheme for Trusts (CNST)

The report was taken as read and the HoM highlighted the following key points

- NHS Resolution and the national maternity safety champions have joined to support the delivery of safer maternity care through the introduction of an incentive element to the contribution to CNST.
- The trust is required to demonstrate compliance against ten actions which will recover elements of their contribution relating to the CNST
maternity incentive fund and a share of any unallocated funds up to 10%.

- It was noted that making insufficient progress may benefit from a lesser sum to help them improve their position against any elements not compliant with.
- Sufficient assurances were received to the Committee that 9 out of 10 of the CNST standards are in place.
- The outstanding requirement by the trust is compliance with all 4 elements of the Saving Babies Life care bundle.
- The one non fully compliant area is the annual assessment of competency in relation to cardiotocography assessment and interpretation. This is a regional issue and a working group has been set up to develop an annual competency assessment tool for cardiotocograph (CTG) competencies and training.
- The Committee agreed that the standard is only partial compliant until implementation of the competency assessment framework is in place. This is expected to be Quarter 3.
- The HoM assured the Committee that all clinical staff have received the relevant CTG training including annual update training on CTG assessment & interpretation and that controls are in place to provide additional safety check.

The committee reviewed and accepted the evidence provided to be submitted to NHS Resolution, continuing to provide assurance in relation to the safety of mothers and babies at the trust.

### STRATEGIC ITEMS

#### 18/54 Harm Free Care Spotlight Falls

The committee noted the following:

- The 2017/18 reduction target for falls was achieved.
- The target for 18/19 falls per 1000 bed days will remain the same.
- 18/19 will focus on a 10% reduction from 17/18 in the total number of injurious falls.
- Focus on achieving a 10% reduction over 17/18 in severe harms reported

The HoN informed that future work is required to ensure that falls risk assessments for all injurious falls are taking place and a consistent and embedded approach is implemented trust wide.

#### 18/55 Harm Free Care Spotlight Pressure Ulcers

**The HoN presented highlighting the following.**

- Risk 2252: If the process of investigation of Stage 3 and Stage 4 pressure ulcers is not adequate and improvement actions not implemented in a timely way, then there is a risk that the Trust will not reduce the prevalence of avoidable pressure ulcers to our patients.
- Tissue Viability Incidents were the highest reported patient incidents across ECNHST 2017-18.
- Pressure Ulcer reduction trajectory target for 2017-18 has not been met
- There have been a total of 621 Pressure Ulcers reported
  - Stage 2 pressure ulcers reported = 540
  - Stage 3 & 4 = 30
- Stage 3 & 4 categorised as avoidable = 8
- Unstageable = 51
  - Hospital and community areas have seen an increase in stage 2 however there has been a decrease in stage 3 and 4 pressure ulcers which is a positive development.
  - ‘Hot spots’ are identified through the Harm free care group monthly to react and support clinical areas where identified.
  - There were a total of 28 medical device related pressure ulcers across the trust during 2017-18

Mitigating actions.

- Improved uptake & use of photography/digital imaging
- React to Red (R2R) champion role has been replaced by the Tissue Viability team engaging proactively with all clinical areas
- Face to Face Pressure ulcer training replaced e-learning as part of clinical stat & mand. training
- Bespoke work /training – e.g. ED / ITU &HDU/ Maternity
- ‘Learning from practice’ is ongoing e.g. mini RCA
- ‘Shared Care’ - pressure ulcer care plan implemented across Community teams
- Collaborative Approach - started by the Knutsford community nursing team/local nursing home now being adopted across Care Community Teams
- Implementation of Safeguarding adults Pressure Ulcer Protocol
- Care agency staff now contractually required to receive pressure ulcer care training on induction

Ambitions for 18/19

- Stage 2 Pressure ulcers’- 10% reduction across hospital & community.
- Stage 3 Pressure ulcers hospital = less than 6 across year
- Stage 3 Pressure ulcers community = less than 20 across year
- Stage 4 Pressure ulcers – for both hospital and community = ZERO tolerance

The committee noted the positive assurance received in the reduction of avoidable grade 3 and 4 pressure ulcers and supported the action plan in relation to targets for overall avoidable pressure ulcer reduction.

18/56 Harm Free Care Spotlight Nutrition

Dr Sulaiman presented the spotlight and highlighted the following

- Policies have been reviewed and updated to ensure the trust is up to date with new national guidance. These include the Enteral Feeding Policy, Nasogastric Feeding Policy and the Parenteral Nutrition Policy
- The Refeeding policy is due to be updated with the new guidance due out in November
- A baseline audit of junior doctors has been undertaken which reinforced the findings of previous audits in consistently showing:
  - A poor knowledge base of NG insertion technique,
  - Poor Monitoring of position methods,
  - Poor documentation and x-ray interpretation.

Discussion took place and Dr Sulaiman noted that the lack of improvement in
Audit results is largely due to the movement of junior doctors and rotas. It was noted that ongoing teaching sessions are in place for junior medical staff but are often poorly attended. There is opportunity for free online learning to be accessed. The DHR agreed to put Dr Sulaiman in touch with the North West Streamlining network to look at the possibilities of partnership training for junior doctors across the Cheshire and Mersey patch.

- Safety Stickers have been introduced to promote appropriate position checking are available on all wards and screensavers have been developed to promote use of the stickers.
- The annual parenteral nutrition (PN) audit has been remodelled against the NCEPOD national standards.
- Out of hours PN requests are an ongoing issue especially with bank holiday weekends.
- Emergency PN kits are now located on ICU with accompanying SOP.
- The audit also highlighted some failures of biochemical monitoring following commencement of PN and stickers have been developed for blood forms and approved at MMG.
- The Nutritional Support Team (NST) meets on an ad hoc basis to screen all new PN referrals and the NST review all patients every 2 weeks on PN to monitor their progress from a clinical, dietetic and biochemical perspective.
- A gap analysis was conducted around the Food and Hydration Strategy Standards and highlighted a good compliance with standards throughout the trust.
- The patients meals group has made significant strides in the quality of its provision for patients and positive feedback has been received.

It was noted that the NST group is struggling with a lack of senior nurse input and guidance.

**Action** – The DDNQ to resolve and identify a Senior Nurse to attend future NST groups in order to provide assurances to the Quality Forum and to ensure that any risks or concerns can be escalated through to SQS.

<table>
<thead>
<tr>
<th>ANY OTHER BUSINESS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>18/57</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Points for Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The Committee received sufficient assurances on behalf of the Trust Board for 9/10 of the Clinical Negligence Scheme for Trusts (CNST) standards in order for these to be submitted to NHS Resolution (and hence obtain recovery of % of CNST financial contribution). The final standard was 'Compliance with all 4 elements of 'Saving Babies Lives' Bundle' (against which the Trust is currently very well positioned) has one outstanding requirement via an associated action plan to address annual review and maintenance of cardiotocograph (CTG) competence. This is consistent with the situation for all members of the wider Greater Manchester &amp; Cheshire Paediatric network. All clinical staff are confirmed as having received relevant CTG training including annual update training on CTG assessment &amp; interpretation. The Head of Midwifery confirmed controls are in place which includes hourly review of CTGs by a second...</td>
</tr>
</tbody>
</table>
practitioner known as ‘fresh eyes’ approach, which provides an additional safety check. For this standard therefore only partial compliance was agreed until implementation of the competency assessment framework is in place, indicative timescale for compliance is Q3

The Committee received updates and assurances following discussion on nutrition policies and practice within the Trust which included good compliance with Department of Health Food & Hydration standards and positive feedback in relation to provision of patient meals. Further work (including re audit and selection & introduction of e-learning) is underway in relation to junior doctor knowledge of optimised Nasogastric tube insertion. Ongoing mitigations and actions following audit are also in place in relation to parenteral nutrition processes

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

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

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

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

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

The Committee noted that avoidable grade 3/4 pressure ulcers reduced from 17 to 8. (however note emerging risks below)

**Emerging Risks and Mitigating Actions**

- Pressure ulcer targets trajectory for 17-18 across in patient and community areas have not been met due to increase in stage 2 ulcers (although as stated above there has been a reduction in the number of avoidable category 3 & 4 ulcers). Actions underway to address target reductions for 18-19 including a zero tolerance target for stage 4 avoidable pressure ulcers include: 'shared care' working with partners (including care homes) ; e-learning as part of stat & mand training and mandatory for all care agency staff on induction ; work with all clinical teams to ensure accurate staging and focus on best use of aids/equipment to avoid device induced ulcers.

- The endoscopy unit having cleared backlog as planned by end March 18 is now facing further patient backlog, principally arising from
unplanned urgent 4 week referrals. A plan has been put into place to ensure that the 2018-19 99% diagnostic access target can be met within the next few months in order not to potentially jeopardise recent JAG accreditation.

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

<table>
<thead>
<tr>
<th>18/58</th>
<th>Any Other Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>None raised.</td>
<td></td>
</tr>
</tbody>
</table>

**CONSENT ITEMS**

<table>
<thead>
<tr>
<th>18/59</th>
<th>Quality Forum Sub-Committee Annual Report and Self-Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The DDNQ informed that the low attendance rate for theatres does not affect the quoracy of the group and that currently membership is under review.</td>
<td></td>
</tr>
<tr>
<td>The Committee noted and approved the contents of the report.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18/60</th>
<th>Quarterly CARE Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee acknowledged the volume and breadth of work completed and overseen by the Clinical audit, Research and Effectiveness (CARE) subcommittee including progression to compliance with NICE guidance; learning from local and national audits and registration &amp; recruitment to clinical trials.</td>
<td></td>
</tr>
<tr>
<td>The Committee noted</td>
<td></td>
</tr>
<tr>
<td>• Timely responses are provided to NICE guidance</td>
<td></td>
</tr>
<tr>
<td>• Areas of partially compliant NICE guidelines, where appropriate, are progressing</td>
<td></td>
</tr>
<tr>
<td>• Progress against the approved clinical audit plan</td>
<td></td>
</tr>
<tr>
<td>• Research targets and recruitment figures are achieved</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18/61</th>
<th>Clinical Nutrition Steering Group Annual Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee noted the contents of the report.</td>
<td></td>
</tr>
</tbody>
</table>

**FOR INFORMATION**

<table>
<thead>
<tr>
<th>18/62</th>
<th>Chairman’s Confirmation of Agenda items for July meeting (not standing items):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organ Donation Sub-Committee Annual Report</td>
<td></td>
</tr>
<tr>
<td>• Quarterly Quality Strategy Update – Improving Outcomes</td>
<td></td>
</tr>
<tr>
<td>• Bi-Annual SIRI Update Report</td>
<td></td>
</tr>
<tr>
<td>• BAF / CRR reports</td>
<td></td>
</tr>
<tr>
<td>• Annual Medicines Management Annual Report and Self-Assessment</td>
<td></td>
</tr>
<tr>
<td>• Radiation Sub-Committee Annual Report</td>
<td></td>
</tr>
<tr>
<td>• Spotlight Diabetes</td>
<td></td>
</tr>
</tbody>
</table>

**Date and Time of Next Meeting**
Tuesday 3rd July 2018
12:00 – 14:00
Boardroom 1, NAH
Agenda Item Number 20: TB 18 (72)

SAFETY, QUALITY AND STANDARDS COMMITTEE

Meeting Chair: Ali Harrison
Meeting Secretary: Gareth Rydings

MINUTES OF MEETING HELD ON:
Tuesday 3rd July, 12:00 – 14:00

Venue:
Boardroom 2, Second Floor, New Alderley House

PRESENT

<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</td>
<td>Ms Harrison</td>
</tr>
<tr>
<td>Dr Peter Madden</td>
<td>Non-Executive Director</td>
<td>Dr Madden</td>
</tr>
<tr>
<td>Julie Green</td>
<td>Director of Corporate Affairs and Governance</td>
<td>DCAG</td>
</tr>
<tr>
<td>Kath Senior</td>
<td>Director of Nursing, Performance and Quality</td>
<td>DNPQ</td>
</tr>
<tr>
<td>Brian Green</td>
<td>Deputy Director of Nursing and Quality</td>
<td>DDNQ</td>
</tr>
<tr>
<td>Kashif Haque</td>
<td>Chief Pharmacist</td>
<td>CP</td>
</tr>
<tr>
<td>Lorraine Jackman</td>
<td>Deputy Director of Corporate Affairs and Governance</td>
<td>DDCAG</td>
</tr>
<tr>
<td>Mark Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
</tr>
<tr>
<td>Dr John Hunter</td>
<td>Medical Director</td>
<td>MD</td>
</tr>
<tr>
<td>Rachael Charlton</td>
<td>Director of HR</td>
<td>DHR</td>
</tr>
<tr>
<td>Dr Susan Knight</td>
<td>Associate Medical Director for Clinical Effectiveness</td>
<td>AMDCE</td>
</tr>
</tbody>
</table>

IN ATTENDANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mike Wildig</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Charan Martin</td>
<td>Trainee Non Executive (Observing)</td>
</tr>
<tr>
<td>Lisa Kirkup</td>
<td>General Manager, Acute Care</td>
</tr>
</tbody>
</table>

Agenda No 18/63 Agenda Item Patient Story

The DDNQ presented a patient story relating to 11 year old patient taken to the Emergency Department (ED) by mum following advice from NHS 111. The patient had a medical history of asthma and was suffering from an asthma attack. The patient was very short of breath with low oxygen saturation levels. The patient was transferred to ED via the primary care streaming system, where he was treated with a nebuliser, steroids and monitored for 1 hour prior to being discharged.

What went well

Primary Care Streaming - worked really well. The patient was quickly assessed by the streaming nurse, registered by the receptionist and escorted to ED

ED - patient was treated appropriately with a nebuliser and steroids, although continued with a mild wheeze. The consultant discussed with mum the potential to admit the patient overnight for further treatment.

Mum explained that she was extremely experienced in treating asthma
symptoms – having been asthmatic since childhood herself, and discussed the treatment options with the consultant and how they would differ if the patient was discharged.

The consultant and mum agreed together that the patient would be best at home and agreed a treatment plan. It was agreed that if the patient worsened at all, he would be brought straight back to ED by mum.

The consultant checked that the patient had enough asthma medication at home and prescribed a course of steroids.

Mum felt respected and trusted to make the right decision for her son with full support of the consultant.

What did not go well

Primary Care Streaming - There was some confusion amongst arriving patients as to whether they go first to the streaming nurse or to the reception desk. There is no formal waiting list in the centre which meant that the order in which people were seen by the streaming nurse relied on the goodwill of patients to ‘wait their turn’.

Action – The DDNQ to identify a way of solving the waiting issues and priorities in the triage and reception area.

The Committee noted overall that the patient and parent had a very positive experience.

18/64 Apologies
1. John Wilbraham

18/65 Conflict of Interest
None raised

18/66 Matters Arising

a) Year at a Glance
   Agreed.
   Board objective to be updated.

b) SQS Committee Minutes – June 2018
   The minutes were agreed as accurate subject to a small number of administration changes to aid clarity.

c) Action Log
   9768 – Action remains open. CP to follow up with Greater Manchester and provide the Committee with an update between meetings.
   9858 – Action completed and closed.
   9859 – Action completed and closed.
   9860 – Action completed and closed.
   6861 – Action completed and closed.

d) Collection of Any Other Business
Formal Request for Removal of Items from Consent Agenda

Medicines Management Annual Report and Self-Assessment

It was noted that the wording of one the action plans in relation to an incident involving opioid analgesics appeared potentially as rather ‘weak’ and clarity was sought...

Assurance was received from the CP of the actions taken following the incident and the control processes in place which include pharmacy intervention audit. The CP agreed the wording of the action plan did not incorporate all the actions that were taken and would feed that back for inclusion. The CP also agreed to amend the Annual Pharmacy plan to include future audits.

Gentamicin Audit – it was noted from the audit that 6 patients had experienced deterioration in renal function but it was not clear if any harm had come to the patients. The CP has requested the information from the author. Both the MD and AMDCE commented that the patients in which gentamicin is used are generally unwell and renal dysfunction can be a result of a number of factors, and not necessarily directly attributable to gentamicin. The MD also commented that renal function deterioration with gentamicin is usually transient in nature and that ototoxicity is of greater concern and usually more permanent. The CP stated that following the audit a patient information leaflet was being developed for patients.

ASSURANCE ITEMS

18/67 Integrated Quality & Governance Report including
- Quality Indicator Exceptions
- Report on Gosport War Memorial Hospital
- Detentions under MHA
- NRLS Report
- Inspection Report for Unlicensed Aseptic Preparation
- Complaints (May 2018), PHSO investigation outcome and Complaints Policy
- National Adult Inpatient Survey
- Risk Assessed Data Report (RADaR)
- Healthwatch Enter and View Feedback
- CQC Should Dos
- Freedom to Speak up Update

The paper was taken as read and following was noted

- In month registered nurse acute in-patient vacancies were 42 wte compared to the previous month 41.67 wte across all acute in patient ward areas.
- There are currently 4 wte registered nurse vacancies within the community setting.
- There were no cases of Clostridium difficile reported in May 2018. For 2018/19 the trajectory has been reduced to 13.
- The Trust is now part of a whole system collaborative approach to reduce the number of gram-negative bloodstream infections (BSIs). The initial focus is on E.coli bloodstream infection. In May 2018 there were
no cases of E.Coli reported in the hospital.

- The falls rate per 1000 occupied bed days in May was achieved at 1.7 against a target of 2.5. The total number of falls reported in month was 55. Of these falls 18 were categorised as injurious falls – all at low harm
- There were no moderate or severe injuries due to falls reported in month
- There were 15 mixed sex accommodation breaches in May 2018 due to operational and capacity pressures
- There was one complaint received in May from a lady who has had a long wait for a hip replacement due to her elective procedure being cancelled 7 times. The first 2 cancellations were due to the lady having a UTI but the following 5 cancellations between were due to bed pressures. The lady finally received her surgery in April 2018.
- SAFER flow principles continue to be embedded within operational practice and wards continue to support the #endpj paralysis 70 day challenge.
- The Committee ratified the updated Complaints policy for subsequent Board approval. Post meeting note - the policy will be updated to ensure reference to adjusting clinical practice in line with learning from most recent external reports will be included
- The Committee noted and were assured in relation to the learning from the recent independent Gosport War Memorial Hospital report. External assurance has been provided from the recent CQC inspection in relation to the areas highlighted in the Gosport report around use of controlled medicines and the Annual Medicine Management report highlighted positive assurances from standard practice which helped to identify any potential medication errors
- The 62 day cancer standard has not been achieved in month at 70.7%. Performance in May has dropped due to multiple reasons and across multiple tumour groups. Delays in diagnostics, histology reports and the CT scanner being unavailable throughout the month have all had an impact on performance.

Discussion took place around the challenges in endoscopy and it was noted that a recent increase in cancer referrals, 4 week urgent and annual leave have all impacted performance in month. It was noted that diagnostics performance will continue to reduce due to annual leave and this has been identified as an emerging risk. Action plans are in place to address the diagnostic backlogs including interface with commissioners to better understand the recent surge in urgent referrals. Clinical prioritisation is in place to address urgent cancer cases

**Action** - It was agreed a spotlight on diagnostics will come to the August SQS meeting.

The Committee noted the following:

- Exceptions to the Quality Indicators and improvement actions.
- Assurance in relation to the trust’s responsiveness to complaints.
- The update on detentions under the MHA
- The assurance of the trust responsiveness to complaints, learning from HSO investigation and endorse the revisions to the Complaints Policy.
- The positive assurance from the Inpatient Survey and that in all areas the trust is performing in line with or better than expected.
- The three teams triggering on RADaR in May 2018, the remedial action
taken to support staff and that action plans to improve are in place.

- The positive feedback from Healthwatch and actions taken
- Directorates are leading on action plans to address 'should dos' identified by CQC inspection
- The Freedom to Speak up Update and proposed actions for Q2

18/68 Bi-Annual SIRI Update Report

The report was taken as read and the following was highlighted

- Of the 40 serious incidents reported 20 have been undeclared by the CCG as there were no lapses in care identified. These referred to 13 stage 3 pressure ulcers and 7 falls.

Discussion took place and it was noted that any new learning identified that leads to changes in practice is monitored through internal and external auditing processes to ensure that new learning is embedded.

It was agreed that any evidence and examples of learning identified will be reported back to the meeting through further updated reports.

The Committee noted the positive assurance in relation to the twenty incidents subsequently deemed not to have been caused by lapses in care and also noted the positive assurance in the embedding of eLearning and changes in practice.

18/69 Assurance Framework and Corporate Risk Register

The report was taken as read and the following area highlighted

- Risk 2801 – An increase in referrals for cardiology has seen the level of risk increases within the speciality. Weekly meetings with the clinicians are in place to help establish additional actions to mitigate the risk.

Discussion took place and it was noted that the level of risk will be taken through the Clinical Management Board; seeking assurance that all senior clinicians are sighted on actions to maximise productivity opportunities and to enable discussions around clinical priorities and further actions required to maintain patient safety. Further assurance to be provided at September SQS meeting.

The Committee noted the key areas of focus in relation to the Corporate Risk Register and Assurance Framework for the next 3 months to reduce the level of risk and asked for changes to the wording on the quality focus to say: “maximise productivity to ensure patients have a timely and quality experience”

The DCAG agreed to make these changes. The committee confirmed they were assured all the Red Rated risks currently held on the corporate risk register are being reviewed by committees of the Board.

STRATEGIC ITEMS

18/70 Quarterly Quality Strategy Update – Improving Outcomes

The DDNQ presented the report highlighting the progress made in quarter 1.

Embedding of personalised care plans

- Dementia Care Bundle reviewed and evaluated and has been implemented in A&E and the Pre-Operative Assessment Unit
- Business Case has been developed in partnership with Dementia UK to facilitate the appointment of Admiral Nurse which would be a new post for the trust.

**Timely review of IV antibiotics by a senior clinician**

- A Consultant Microbiologist attended and presented at Grand round in May which included a section on red flag sepsis and the importance of reviewing antibiotics

**Improved patient understanding of possible side effects of medications**

- A Webpage has been created on the Trust website explaining the commitment to patient centred care and a link is available to patient decision aids
- A Webpage has been created on the Trust infonet for clinicians to access patient decision aids

**Improved patient flow and discharge**

- The role of Integrated Discharge Team nurse has been realigned to focus on trusted assessment in hospital
- Proof of concept East Cheshire ‘Discharge to Assess’ pathway is now underway and social workers are now completing assessments in the community rather than on acute wards
- Nursing and Residential Home portal is now operational and this allows for real time bed capacity to be viewed

Discussion took place and it was agreed that evidence/data demonstrating improvements will be establish in order for metrics to be identified and aligned with the Trust Quality Account.

The Committee noted the positive assurance and progress made on the Improving Outcomes component of the Quality Strategy.

<table>
<thead>
<tr>
<th>18/71 Spotlight Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>LK presented the spotlight on diabetes highlighting the following</td>
</tr>
</tbody>
</table>

Risk number 2427

If there is no commissioned diabetes specialist nursing service for Eastern Cheshire then there is a significant clinical risk that pregnant women that require support with optimising their glycaemic control will not be managed appropriately

Current Risk Score : 4 x 4 = 16

Diabetes is a single handed consultant speciality. If the Trust does not have the required specialist consultant support within diabetes / endocrinology it will be unable to deliver the service and achieve the expected quality standards and performance. Patient care will be compromised

Current Risk Score : 3 x 4 = 12
**Current Performance**

It was noted that the trust has a vacancy in specialist nursing and has been unable to recruit.

The trust has recruited a specialist consultant endocrinologist in a part-time role. A diabetes outpatient service is being provided by Vernova Healthcare.

The trust is currently not fully compliant with NICE guidance:

- NG3 Diabetes in Pregnancy: management from preconception to the postnatal period due to lack of specialist nursing team
- NG17 Type 1 diabetes in adults: diagnosis and management and NICE Quality Standard 6 Diabetes in Adults due to the lack of specialist nurse team
- Endocrinology achieved 98.5% RTT incomplete for May 2018
- Currently 178 patients are due/overdue their follow-up appointments and clinic templates have been adjusted to address and reduce this figure.

**Controls in place**

- Antenatal Clinic/Early Pregnancy Assessment Unit Manager has received additional training on advising newly diagnosed gestational diabetic women
- A Consultant from Wythenshawe specialising in Diabetes/Endocrinology delivers the weekly Antenatal Clinic within Maternity
- Cross cover provided by Acute Physician for urgent patients during periods of absence
- Ward staff have enhanced skills to deliver patient education and staff on ward 7 have all been upskilled.

**Gaps in Control**

- Risk of not recruiting suitable Clinical Specialist Nurse Practitioner.

Recruitment has been difficult and it was noted that there is a potential interested party for the role who may be appointable at a band 6 level with progression to band 7.

- There is no commitment from Wythenshawe to formalise a service level agreement for the visiting consultant supporting Antenatal clinics.
- Substantive consultant recruited to part-time leaving gap Thursday and Friday each week for senior ward cover and urgent referrals

**Positive assurance**

- RTT performance is achieving
- Funds have been obtained from CCG to recruit a Clinical Specialist Nurse Practitioner and vacancy has been approved.
- Monitoring of complaints and incidents via SQS sub-committee showed no related issues or trends
- Appropriate escalation process is embedded.

**Gaps in assurance**

- Funding from National Diabetes Treatment and Care programme not obtained
- Clinical Specialist Nurse Practitioner vacancy not yet recruited to.

**Mitigating actions.**

- Strengthen opportunities for recruitment of Clinical Specialist Nurse Practitioner
- Secure funding from National Diabetes Treatment and Care programme, dependent upon recruitment
- Support the development of diabetes pathways for type 1/2 DM, complex patients and paediatric patients including transition

The Committee were assured that positive developments were anticipated in relation to specialist nurse recruitment and partnership working for consultant element was ongoing in order to further reduce risk level and support compliance with clinical guidance in this area.

### ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>18/72</th>
<th>Key Items for the Chair to be reported to the Board</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Points for Assurance</strong></td>
<td></td>
</tr>
<tr>
<td>- The Committee were assured in relation to the learning from the recent independent Gosport War Memorial Hospital report. External assurance has been provided from the recent CQC inspection in relation to the areas highlighted in the Gosport report around use of controlled medicines and the Annual Medicine Management report highlighted positive assurances from standard practice which helped to identify any potential medication errors</td>
<td></td>
</tr>
<tr>
<td>- The Committee received positive assurance from recent Inpatient survey where all areas of the Trust are performing in line with or better than expected</td>
<td></td>
</tr>
<tr>
<td>- Positive assurance received from recent Healthwatch 'enter and view' inspections of wards 9 &amp; 10.</td>
<td></td>
</tr>
<tr>
<td>- The Committee received the bi annual SiRI update and noted assurances in relation to learning leading to practice changes including audit evidence. This evidence together with further examples of embedding of learning will be reported in future updates.</td>
<td></td>
</tr>
<tr>
<td>- The Committee agreed with the recent additions, amendments and priorities for next 3 months to the assurance framework and corporate risks allocated for SQS oversight.</td>
<td></td>
</tr>
<tr>
<td>- The Committee noted the positive assurance and progress made on Improving Outcomes component of the quality strategy. Suggestion for additions of relevant metrics to appear in annual Quality Account were made</td>
<td></td>
</tr>
</tbody>
</table>
- A Spotlight in relation to diabetes service was received (including diabetes in pregnancy). The Committee were assured that positive developments were expected in relation to specialist nurse recruitment and partnership working for consultant element (due to single handed consultant) were ongoing in order to further reduce risk level and support compliance with guidance in this area.

- The Committee received the Annual Organ Donation report confirming that the trust is compliant with all relevant legislation and were assured that referrals process was effective.

- The committee received assurance from the annual medicine management report in relation to new drug applications; policies and guidelines; medication related incidents; use of controlled drugs and antibiotic stewardship. Clarifications & assurances were provided specifically in relation to use of controlled drugs.

- The Committee ratified the updated Complaints policy for subsequent Board approval. Post meeting note - the policy will be updated to ensure reference to adjusting clinical practice in line with learning from most recent external reports will be included.

**Emerging Risks & Mitigating Actions**

- The Committee were alerted to the challenges in meeting the 6 week diagnostic and 62 day cancer standards. Action plans are in place to address the diagnostic backlogs including interface with commissioners to better understand the recent surge in urgent referrals. Clinical prioritisation in place to address urgent cancer cases.

- The recent halt in non-urgent elective procedures due to winter pressures has resulted in unavoidable cancellations. Action plans are underway to enhance productivity. Response has been provided to the recent complaint concerning the unfortunate multi cancellation of an orthopaedic procedure (which has now been completed successfully).

- The Committee heard the challenges of sickness absence and maternity leave on small teams such as Community nursing together with anticipated staff vacancies. A spotlight will be taken on this topic at October SQS however priority spotlight on challenges faced due to acute nurse staffing shortages will be taken in August.

**Any Other Business**

| 18/73 | None raised. |

**CONSENT ITEMS**

<table>
<thead>
<tr>
<th>18/74</th>
<th>Organ Donation Sub-Committee Annual Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Committee received the Annual Organ Donation report confirming that the trust is compliant with all relevant legislation and were assured that referrals process was effective</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18/75</th>
<th>Annual Medicines Management Annual Report and Self-Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The committee received assurance from the annual medicine management report in relation to new drug applications; policies and guidelines; medication related incidents; use of controlled drugs and antibiotic stewardship. Clarifications &amp; assurances were provided specifically in relation to use of</td>
</tr>
</tbody>
</table>
controlled drugs.

<table>
<thead>
<tr>
<th>FOR INFORMATION</th>
</tr>
</thead>
</table>
| Chairman’s Confirmation of Agenda items for August meeting (not standing items):
  - Duty of Candour – Being Open Update (via Governance report)
  - Quarterly Mortality Report
  - Freedom to Speak Up (via Governance Report)
  - Spotlight Acute nursing
  - Spotlight MIAA WHO Checklist
  - Radiation Sub-Committee Annual Report |

**Date and Time of Next Meeting**
Tuesday 7th August
12:00 – 14:00
Boardroom 1, NAH
PUBLIC TRUST BOARD
Thursday 6th September 2018

Agenda Item Number 20: TB 18 (73)

FINANCE, PERFORMANCE & WORKFORCE COMMITTEE

MINUTES OF MEETING HELD ON:
Thursday 7th June 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>
</tr>
</thead>
<tbody>
<tr>
<td>Mike Wildig</td>
<td>Non-Executive Director</td>
<td>DoF</td>
</tr>
<tr>
<td>Ian Goalen</td>
<td>Non-Executive Director</td>
<td></td>
</tr>
<tr>
<td>Dr Anthony Coombs</td>
<td>Non-Executive Director</td>
<td></td>
</tr>
<tr>
<td>Mark Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
</tr>
<tr>
<td>Julie Green</td>
<td>Director of Corporate Affairs and Governance</td>
<td>DCAG</td>
</tr>
<tr>
<td>John Hunter</td>
<td>Medical Director</td>
<td>MD</td>
</tr>
<tr>
<td>Rachael Charlton</td>
<td>Director of Human Resources and Organisational Development</td>
<td>DHR</td>
</tr>
<tr>
<td>Kath Senior</td>
<td>Director of Nursing</td>
<td>DNPQ</td>
</tr>
</tbody>
</table>

IN ATTENDANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Peter Madden</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Emma Newton</td>
<td>Head of HR</td>
</tr>
<tr>
<td>Dr Chris Smart</td>
<td>Guardian for Safe Working Hours</td>
</tr>
</tbody>
</table>

Agenda No 18/38 Apologies

- Steve Redfern (annual leave)
- John Wilbraham

Agenda No 18/39 Minutes of meeting held 26th April 2018

Agenda Item no. 18/34 page 3 para 5 was amended at the DNPQ’s request and Committee’s agreement.

The DNPQ referred to Agenda Item no. 18/34 page 4 para 3 and noted that ‘non-elective’ should read ‘elective’.

Agenda No 18/40 Declarations of Interest

None declared.

Agenda No 18/41 Matters arising

The DNPQ advised the Committee that since the last meeting, clarity had been obtained in respect of A&E performance STF funding – the requirement is to achieve 90% during Q1, Q2 and Q3 and January and February in Q4, with 95% required for March.

Agenda No 18/42 Action points from previous meeting
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9699</td>
<td>action carried forward to next meeting.</td>
</tr>
<tr>
<td>9738</td>
<td>completed, action closed</td>
</tr>
<tr>
<td>9739</td>
<td>completed, action closed</td>
</tr>
<tr>
<td>9740</td>
<td>completed, action closed</td>
</tr>
<tr>
<td>9741</td>
<td>completed, action closed</td>
</tr>
<tr>
<td>9742</td>
<td>completed, action closed</td>
</tr>
<tr>
<td>9743</td>
<td>completed, action closed</td>
</tr>
<tr>
<td>9744</td>
<td>completed, action closed</td>
</tr>
</tbody>
</table>

### 18/43 Annual work plan

The Committee noted the revised Annual Workplan for 2018/19.

### 18/44 Workforce Report

The DHR presented the report highlighting:

- April’s vacancy rate increased compared to March due to a combination of an increase in establishment and a higher than average number of leavers, including a significant number of retirees.
- There is an emerging risk relating to the development of the Cheshire and Wirral joint payroll initiative as not all organisations have committed to join the new service in April 2019. The DHR has written formally to the executive sponsor at COCH requesting confirmation of the impact on the project and price quoted.
- Local implementation of the NW streamlining project is resulting in a productivity improvement as a result of staff not having to repeat training they have completed elsewhere. Approximately 117 clinical hours were saved in Feb/March.

The Chair asked whether a reduction in the number of vacancies remains a priority for the organisation. The DHR agreed and noted that improving retention was a key enabler to this. The Chair asked that the trajectory and position is included as a % and a number in next month’s report.

**Action:** DHR to include vacancies trajectory and position as a percentage and number in the monthly report.

Mr Goalen asked which areas had received increased paybill budgets. The DHR replied this related to a total of 14.98FTEs and was across a number of corporate and clinical areas.

The DNPQ noted that acute nurse ward vacancies remain of concern at 15% and this was leading to the use of high cost agencies. She welcomed the recent recruitment of some newly qualified and overseas nurses but noted their limited experience. In inducting new staff to the wards, teams need to feel supported and trainers need to be highly visible.

The Chair noted that agency spend was £611k which is a significant reduction.
from March. The DHR confirmed that a look back at the March position had identified a significant increase in annual leave and extra beds resulting in higher use of agency staff for unsocial hours and long days. The Chair asked where is the foresight to stop this happening again. The DHR confirmed that the DDON is reviewing this as part of the rostering work eg leave over Christmas. The DoN confirmed staff can only c/f 5 days and that she is personally assessing all high cost agency spend eg Thornbury.

The Chair questioned the high number of hours owed by some staff on e-roster. The DHR and DNPQ both agreed this was too high, noting full time staff are contracted to work 37.5 hrs per week. The DNPQ confirmed that line managers have been challenged to reduce this position. The DNPQ noted the significant assurance on the recent e-rostering audit undertaken by MIAA. The Chair noted that e-rostering appears more under control and the committee agreed that future e-roster reports should provide a spotlight on any concerns.

The Chair noted that in terms of triangulation, the latest fit & proper person review was Jan 18 not January 2016. The DCAG confirmed this point and the DHR agreed to update the paper.

Staff retention
The Head of HR (HoHR) was welcomed to the meeting to present the retention spotlight. She noted that improved retention is a trust objective for 2018/19 and that the trust has been invited to take part in an NHSI retention improvement programme. In summary this includes:

- 90 day facilitated programme (cohort 3)
- 1st 30 days involves analysis of data. Initial findings include:
  - A high turnover of admin and clerical and HCA staff in 1st 12 months, reflected in staff survey. Also other staff groups. Contact 6 weeks after starting has been implemented
  - ESR data gaps including ‘not known’ as reason for leaving. Process improvements in place and exit interview process relaunched, not being taken up by leavers. DDON doing stay interviews
- The project team have visited Tameside (cohort one) to learn from their experience. Tameside focused on ‘what matters to staff’, engaging clinical leaders and engagement in clinical areas using an appreciative enquiry approach.
- Next 60 days requires the development of an action plan due end June, focusing on the key themes from conversations. Key issues include line manager development and apparent lack of flexible working patterns.

The DoF noted the importance of line managers in retaining staff and the DHR emphasised the need for line manager training across all staff groups. In response to a question from the DNPQ, the HoHR noted the emergency department and the AICC directorate as having the highest levels of turnover. She referred to the work Tameside are undertaking to move staff around the organisation in order to provide additional development experience

Mr Goalen suggested exit interviews should be used to support future recruitment - ie ensure the door is left open. Dr Madden asked whether contacting staff 6 weeks after they start is too short and whether 3 or 6 months would be better. The HoHR acknowledged the suggestions and agreed to
review this as a part of her action plan.

The Chair asked for clarification of the ambition for 18/19 turnover and the HoHR noted a rolling position of 12% by March 2019 (an average improvement of 1% per month).

The Chair thanked the HoHR for attending the meeting.

Guardian for Safe Working quarterly update

The Guardian for Safe Working Hours (GfSWH) was welcomed to the meeting to present the quarterly report, highlighting:

- F2 rota - provides cross cover to the surgical rota, OOH and at weekends (orthopaedics and general surgery). In response to concerns raised in exception reports, the GfSWH has met with junior doctors (JDs) and senior staff within the directorates, who are exploring solutions to address issues raised such as JDs feeling that cover is stretched and this may affect patient safety.
- Investigations regarding 3 possible fines:
  - Working hours – 2 instances where 48 hour week was nearly breached, 1 of which has been declared as a near-miss but could have been prevented as this was cover for planned sick leave.
  - lack of natural breaks – no more than 25% of breaks to be missed, this is an issue within surgical in particular. 1 near miss has been reported. A solution has yet to be identified.

The Chair acknowledged the positive progress being made so far and the MD noted that splitting rotas would be costly. The GfSWH commented that front-loading services with extra staff at weekend peak times could be a solution.

In response to further questions from the Committee, the GfSWH gave the following assurances:

- Morale amongst junior doctors fluctuates, but the forum is working well and the formula has been adopted by other trusts in the region
- There was no suggestion of frustration regarding cancelled theatres earlier in the year – junior doctors are not relied on for clinical activity in this area.
- Overall, consultants are engaged with the new contract.
- The GfSWH is seen as an approachable alternative to supervisors. In August, a monthly surgery will be established to allow junior doctors to discuss any concerns on a ‘drop-in’ basis
- At this time there were no concerns requiring further support from the Committee or the Executive team.

The Chair thanked the GfSWH for attending the meeting.

18/45 Finance Report

The DoF presented the report, highlighting:

- Income and expenditure is on target
- The balance sheet is on target
- There is currently a focus on QIPP performance

The DoF confirmed to the Chair that £85k A&E provider sustainability funding has been assumed in respect of Q1 performance. Current performance QTD is
87%. The STF funding for 2018/19 is £5.7m in total, of which approx. £1.7m is for A&E performance (Q1 being approx. £250k of the total).

In terms of the request for additional capital spend; no formal confirmation has been received to date.

The Chair asked why the planned reported cash position at Month 2 was lower than expected at £3m and the DoF replied that this was because although the trust was in deficit, cash loans would be drawn down in the first quarter.

Mr Goalen queried non-pay spend on Supplies and Services, this having reduced significantly to £86k compared with at least £400k per month for each of the last 12 months. The DNPQ also asked for an explanation concerning the variances in figures for ‘Supplies and Services’ and ‘Medical and Surgical Supplies’ and the DoF agreed to reassess.

**Action:** DoF to confirm the reason for the variances and report back to the Committee

The DoF also noted the drop in income during April due to cancellations over Bank Holidays.

Mr Goalen referred to the trust wide-variances and queried the ‘Reserves eg pay award’ of (£356k) and the DoF confirmed that as the pay award had yet to be received and allocated to directorates, this was an assumptive provision made.

Mr Goalen highlighted that the I&E run rate for April 2017 was £2.047m, but is £2.067m for April 2018 (the average run rate being £1.5m). The DoF referred to the previously circulated monthly run rate positions for the previous 12 months, and that April was usually a higher deficit than the average monthly position due to the reduction in activity and income over the Easter period.

The Chair referred to Planned Care income being behind plan by £356k and the DoF replied that this related to activity carried out outside of the block contract eg for North Staffs and North Derbys. This would be expected to be around £1m a month but has been impacted by the delay in commencement of the elective orthopaedic programme to May. It is anticipated that the trust will underperform against the block contract and performance will continue to be monitored by comparing activity against PBR numbers. The committee agreed that this information would be useful if included in the monthly report going forwards. No financial penalties are likely unless the trust were to transfer or cease a particular service.

**Action:** DoF to incorporate an accumulative PBR comparison on activity carried out under the block contract in the monthly report.

The DoF gave assurance to the Committee that QIPP performance was being managed through the monthly Recovery Programme Board meetings.

The Chair asked whether the DoF could provide the Committee with a monthly plan relating to the financial control total deficit of £19.5m

**Action:** The DoF to circulate the plan to the Committee prior to the next meeting.
The Chair asked whether key indicator figures from the last 5 years would be available for context and for comparison with current figures so that overall trend could be considered.  
**Action: DNPQ to present one-off spotlight at next meeting to include high level indicators and short commentary.**

The DNPQ presented the report, highlighting:

- **A&E performance** - above trajectory at 86.7% in month. There was 1 x 12hr breach relating to a CWP patient transfer.
- **RTT performance** was behind trajectory at 84.7% and targeted action is being undertaken to improve productivity in certain areas, in particular gastroenterology, cardiology and surgical specialties. The position is expected to improve during May.
- **Diagnostic performance** declined to 95.4% with further challenges during the month linked to increases in cancer and urgent referrals. Actions to mitigate this include better cross-cover to improve back-fill rates and increased sessional capacity i.e. booking to 12 points where job plans include 4 hour sessions.
- The 2 week cancer standard was not met, mainly due to an increase in referrals and loss of capacity due to Easter Bank Holidays. The service continues to be pressured.
- There was 1 x 52 week breach in Ophthalmology due to a coding error. A further breach is expected in T&O during May due to the patient declining the date offered.

The DNPQ advised the Chair that a reply from NHSI concerning the proposed ED performance improvement trajectory (90%) had yet to be received. The DNPQ confirmed that an over-performance would be required during June to compensate for under-performance during April and May if the 90% trajectory were to be achieved.

Regarding RTT performance, Mr Goalen noted a concern in being able to manage the backlog without WLIs if it were to continue to increase and the DNPQ agreed this was a challenge and although the team are expecting performance to improve in June and that it will be monitored closely.

The Chair asked for clarity on the difference between the admitted backlog of 794 at the end of April and inpatient PTL number of 462.  
**Action: DNPQ to clarify PTL numbers and circulate response.**

The Chair went on to ask about the timescale for recovering diagnostics performance and the DNPQ replied that there is an ongoing challenge relating to loss of dropped lists that were previously picked up through WLIs. However, managers are being challenged on how to provide operational capacity over the month and a recovery plan is being developed. It is not yet clear when 99% performance will be achieved.

In response to a question from Mr Goalen concerning consultants not booking 12 points per session, the DNPQ noted that some sessions are booked to 10 points, which is not acceptable. Other lists are booking 10 but actually undertaking 12. The data quality requires work as there is no line of sight on the actual activity, only the scheduled activity.

The Chair asked for clarity on the Care Communities funding issue and the
DNPQ responded that the joint partnership board haven't agreed the funding for the Clinical Leads from June onwards which may impact future scale and pace of change. This has been escalated accordingly.

<table>
<thead>
<tr>
<th>18/47</th>
<th>Any other business</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None raised.</td>
</tr>
</tbody>
</table>

**Date and Time of Next Meeting:**
Thursday 5th July 2018
08:30-10:30,
Boardroom 1 NAH
### Agenda Item Number 20: TB 18 (74)

**FINANCE, PERFORMANCE & WORKFORCE COMMITTEE**

**MINUTES OF MEETING HELD ON:**
Thursday 5th July 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>
</tr>
</thead>
<tbody>
<tr>
<td>Mike Wildig</td>
<td>Non-Executive Director</td>
<td></td>
</tr>
<tr>
<td>Ian Goalen</td>
<td>Non-Executive Director</td>
<td></td>
</tr>
<tr>
<td>Dr Anthony Coombs</td>
<td>Non-Executive Director</td>
<td></td>
</tr>
<tr>
<td>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>John Wilbraham</td>
<td>Chief Executive</td>
<td>CEO</td>
</tr>
</tbody>
</table>

### IN ATTENDANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Abb.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steve Redfern</td>
<td>Deputy Director of Operations</td>
<td>DDO</td>
</tr>
<tr>
<td>Charan Martin</td>
<td>Trainee NED</td>
<td>CM</td>
</tr>
<tr>
<td>Emma Newton</td>
<td>Acting Deputy Director of Human Resources</td>
<td>ADDHR</td>
</tr>
</tbody>
</table>

### Agenda

<table>
<thead>
<tr>
<th>Agenda No</th>
<th>Agenda Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>18/48</td>
<td>Apologies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Kath Senior</td>
<td></td>
</tr>
<tr>
<td>18/49</td>
<td>Declarations of interest</td>
<td>None declared.</td>
</tr>
<tr>
<td>18/50</td>
<td>Minutes of meeting held 7th June 2018</td>
<td>The minutes of the June meeting were declared as an accurate record.</td>
</tr>
<tr>
<td>18/51</td>
<td>Matters arising</td>
<td>None.</td>
</tr>
<tr>
<td>18/52</td>
<td>Action points from previous meeting</td>
<td>9699 – completed, action closed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9856 – completed, action closed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9857 – completed, action closed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6862 – completed, action closed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6863 – completed, action closed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6864 – completed, action closed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6870 – completed, action closed.</td>
</tr>
</tbody>
</table>
### Annual work plan

The Annual Plan was reviewed and no changes made.

### Risk and Assurance

#### Board Assurance Framework

The DCAG referred to the Board Assurance Framework and asked for the Committee’s agreement that ‘Financial Stability’ remains risk rated at 25 and that ‘People’ remains risk rated at 16.

Mr Goalen queried whether ‘Financial Stability’ should remain on the framework as whatever action is taken, the score needs to be taken in this context. The DCAG noted that its inclusion is important as an acknowledgement that the trust cannot be assured that the score will change despite the action around financial controls and it was important that the Committee and Board were sighted on all action possible is being taken to meet the trust’s control total and aware of anything which could impact on non delivery.

The DCAG confirmed that the BAF relating to ‘People’ supported the Board’s priorities of recruitment and retention.

The Committee agreed that both scores were appropriate and papers being presented were in line with gaps in assurance and controls and actions being taken to mitigate the risks.

#### Corporate Risk Register

There are seven risks currently on the register, with an eighth relating to Acute and Integrated Community Care (AICC) QIPP 2018/19 in the process of being added.

The DCAG asked the Committee whether any further risks should be included.

The Chair asked about gaps in nursing and the DCAG confirmed that this was already an entry but would report back on when the next review was due. The CEO confirmed to the Chair that the risk rating reflected whether vacancies affect provision of a safe service; the DCAG added that assurance is provided via the Safe Staffing report to the Board and further discussion through spotlight presentation to SQS relating to safety and retention and recruitment focus discussed at FPW.

With regards to the Winter Contingency Plan, the DCAG noted that this is recognised as a control and would be added to the register if under delivering.

### Finance Report

The DoF presented the report, highlighting:
- The trust was marginally better than plan YTD
- The cash position is good
- QIPP is behind plan, with recurrent directorate QIPP a concern. The ECCCG block contract has generated an extra £1m but there are limited further opportunities as a result for income QIPP.
The Chair queried whether the income and expenditure position was correct to include £170k provider sustainability funding (PSF) for 4 hour A&E performance.

The DoF replied that as at Month 2, the trust was still expecting to achieve this target. Actual performance was 89.77% (16 breaches) which is to be reviewed and challenged. The CEO added that there is zero tolerance and performance has to be 90% and won’t be rounded up; the PSF funding is not based on trajectory. The DoF clarified to Mr Goalen that in effect removing the PSF funding for non-achievement would result in a break even position as the trust is £160k ahead of plan at Month 2.

The Chair asked for clarity concerning ‘old year invoice provision’ and the DoF explained that provision is made at the end of the year for invoices due but not yet received. So far, half of this contingency has been used in the first two months and further provision is being planned for the end of this year, which will neutralise the position.

It was noted that were the trust on a PBR arrangement the income position reported at Month 2 would be £271k higher as there is over-performance on the ECCCG block contract.

In response to a question from the CEO, the DoF advised that direct credit income is £282k better than plan. Some of this will be recurrent eg car parking income, which is will result in QIPP during Quarter 3.

The Chair questioned whether cancelled elective activity had contributed to underperformance within the Planned Care directorate and the DoF confirmed that activity was down in T&O and Gynaecology. There is still an income target for activity and it was agreed that this would be discussed further outside of the meeting as the Directorate is £311k behind plan.

Mr Goalen added that it would be useful if the ‘Contracted Income’ column were amended to show the split between the block contract, other organisations and direct income to highlight the variance.

**Action: DoF to amend the Operational Summary for future meetings.**

The Chair asked whether funding for the pay award had been confirmed and the DHR replied that no formal announcement had been made. The CEO noted a potential risk if the award was based on the number of staff in post and didn’t take into account vacancies.

The DHR added that a further risk would be if funding were based on salary mid-points as there are a high percentage of ECT at the top of the bands.

With regards to QIPP, the DoF summarised that the Corporate function was expected to have identified schemes in full by Month 4. There are no major concerns with Allied Health and Community Support Service, whose performance is increasing monthly and the directorate has a good track record. There is a risk associated with the Acute and Planned Care directorates and performance is monitored through the Recovery Programme Board and Directorate Performance meetings.

The Chair welcomed the Associate Director for Acute and Integrated Community Care (AD, AICC) to the meeting who gave a short presentation on
the Directorate’s QIPP, highlighting:
• £313k recurrent QIPP identified against target of £1.3m.
• Using Model Hospital workshops to identify opportunities.
• Check and challenge all budget lines to identify savings for ‘10 Post Challenge’.
• Staff focus groups are to identify opportunities to minimise waste and improve processes in non-pay areas.
• Continued focus on WLI, productivity and achieving the ED 4 hour standard.
• QIPP review meetings are being held fortnightly.

The CEO asked whether involving different people would benefit from a fresh approach. The AD, AICC replied that as well as KIT meetings, a specialist has recently finished working with the Directorate and there are the focus groups previously mentioned. Clinician engagement remains a challenge. The DoF also stated that he and the Clinical Lead for ED would be visiting other organisations to review and understand their approaches.

The AD, AICC confirmed to the CEO that a £300k overspend is apportioned mainly to managing gaps and operational pressures with bank and agency. The CEO noted a further concern regarding the financial control.

The DoF commented that Harrogate hospital has been identified as having similar footfall to ECT but significantly lower costs and a visit is being planned. He went on to confirm that savings such as WLIs were monitored through directorate performance meetings and the Recovery Programme Board with financial management meetings looking at other specific savings. The colour of schemes then reflect performance.

The Chair thanked the AD, AICC for attending the meeting.

The Chair remarked that he was not assured that the Directorate’s QIPP target would be met and the DCAG confirmed that it was rated 16 on the risk register. The Committee agreed that this needs to be changed to 20.

The DoF added that he does not believe the full QIPP will be found and this should be taken into account when QIPP allocation is being discussed next year.

18/56 Performance Report

The DDO presented the report, highlighting:
• ED 4 hour performance continued to improve during Month 2; the decision on trajectory resubmission is still outstanding.
• The winter plan for the system was submitted on 30th April.
• RTT - 1 x 52 week breach relating to cessation of Quarter 4 elective programme and patient subsequently declining the date offered.
• Diagnostics – performance issues in endoscopy and echocardiograms are being worked through.
• DTOC performance has improved, reducing to 5.2% at Month 2. Eastern Cheshire system are committed to deliver 3.5% by December. The main challenge has been non-acute delays due to home care availability.

The CEO confirmed to Mr Goalen that the ED trajectory was resubmitted due to inconsistencies. The original submission of 95% had not been signed off. The revised trajectory of 90% is far more likely to be achieved given the type of
service provided at ECT. This will assist in future STF discussions. The funding would be based on achieving 90%.

The DHR asked about the impact of mental health breaches and minor breaches on ED performance. The DDO replied that there were approx. 70 in mental health over the last three months which were a contributory factor and the trust is working closely on breach analysis with Cheshire and Wirral Partnership. Minor breaches were a similar figure.

Total A&E attends and admissions increased to 4471 during Month 2, stabilised during Month 3 but started to rise again this month and the DDO cited co-morbidities as a possible reason for this.

The Chair queried whether the ‘End PJ Paralysis’ scheme would be embedded once the challenge ends. The DDO replied that overall it was and a reduction in LOS is expected; a report is due at ORG later in the month. The CEO added that this should now be business as usual and suggested an audit later in the year.

**Action:** CEO to discuss the approach to monitoring embedded practice with the DON.

Dr Coombs questioned whether the Cancer 62 day trajectory performance should read 66% or 70% and the DDO confirmed the correct figure was 70%. There are issues in endoscopy and the General Manager, Allied Health is carrying out a review on performance and risk issues within a number of specialties.

**Action:** Update to be provided at the next meeting.

With regards to RTT performance, the DDO confirmed to the Chair that ‘Total PTL’ is the number of actual patients and ‘Submitted Total’ is the submitted plan figure. The waiting list is expected to be back on trajectory by the end of July and a plan is in place to help achieve this.

The CEO added that the commitment to reduce GP referrals has not happened. Waits are being managed by focusing on non-routine activity, and SBARs are now being received and reviewed with the consultants who believe there to be a clinical risk without WLIs. Analysis on GP referral numbers during Quarter 1 is being obtained before further discussions happen with the CCG. With regard to WLIs, permission was given for some WLIs to go ahead but there is still opportunity to improve productivity.

The DoF remarked that the financial impact of 20 WLIs would equate Medicine QIPP being reduced by approximately £12.5k.

The Chair asked whether solving productivity issues would ensure RTT performance is achieved and the CEO responded that concerns with GP referrals and Outpatients throughput would still remain.

The Chair referred to integrated community services and questioned when feedback from monitoring outcomes would become available and the DDO replied that the metrics should be available for the August meeting.

**Action:** DDO to liaise with the Associate Director, Service Transformation to provide an update for the next meeting.
It was noted that the Venn Group have been commissioned to carry out a system-wide capacity and demand study in respect of winter planning for 2018/19, with the results due in September.

**Action:** To be added to the Rolling Programme for discussion at October's meeting.

The ‘Spotlight on key indicators – 5 year performance review’ was not discussed and will be carried forward to the next agenda.

### 18/57 Workforce Report

The DHR presented the report, highlighting:

- The trust vacancy rate has decreased to 5.76% in month.
- Appraisals and annual clinical compliance continues to be impacted by operational pressures (in context, ECT is performing better than neighbouring trusts).
- EMT agreed to progress with the collaborative payroll service.
- Staff turnover rate has fallen in month due to fewer retirements.

The DHR confirmed to the chair that acute nursing vacancy rates had been benchmarked and the trust's performance echoed that in Countess of Chester Hospital, Cheshire & Wirral Partnership and Wirral community.

The CEO asked what plans were in place with regards to appraisals and the DHR replied that additional sessions had been booked externally due to pressures on space.

The Chair welcomed the Acting Deputy Director of Human Resources (ADDHR) to the meeting to present the spotlight on temporary staffing and agency spend.

The ADDHR summarised as follows:

- Significant decreases within Allied Health and nurse agency spend but a slight increase in medical agency spend.
- Focus on Allied Health using TempRE, saving £13,988
- High bank turnover is being investigated
- Embedding of SafeCare to help redeployment and reduce agency spend
- Lack of middle grades on bank – work to be done with lead employer
- Nursing agency spend is predominantly overnight – reviewing e-rostering with Deputy Director of Nursing and Quality
- A new Operational Agency Reduction working Group has been set up to monitor trends in staff deployment and agency use and develop operational process controls.

The Chair referred to the vacancy position appendix and asked why agency spend had increased if vacancy rates had improved. The ADDHR replied that junior doctors are not employed by the trust and therefore not part of the establishment. However, the trust has to meet the cost of covering gaps in rotas with bank or agency.

### 18/58 Any other business

None raised.
<table>
<thead>
<tr>
<th>Date and Time of Next Meeting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday 3\textsuperscript{rd} August 2018, 08:30-10:30</td>
</tr>
<tr>
<td>Boardroom 1 NAH</td>
</tr>
</tbody>
</table>