Mid Cheshire Hospitals NHS Foundation Trust

Board of Directors

Thursday 30 September 2021, 9.30am
Ibis Crewe, CW1 6BD

AGENDA

No	BAF Risk	Item
PRELIMINARY BUSINESS		
1 9:30		**Apologies (v)** Chair
2 9:32		**Declarations of Interest (v)** Chair To receive declarations of interest in agenda items and / or any changes to the register of directors' declarations of interest pursuant to Section 8 of Standing Orders
3 9:35		**Patient Story (v)** Executive Director To note
4 9:45		**Draft Minutes of the Last Meeting - 29 July 2021 (d)** Chair To approve the draft minutes of the last meeting of the Board of Directors, discuss any matters arising and review the action log
CONTEXT / OVERVIEW		
5 09.48		**Chair's Report (v)** To note • Chair's Actions
6 09:55		**Chief Executive's Report (d)** Chief Executive • Digital Clinical System Programme Board - 16 August 2021 • Hospital Redevelopment Programme Board - 12 August & 16 September 2021 To note
7 10.05		**Board Assurance Framework (BAF) Heatmap 2021/22 (d)** Chief Executive To note

No	BAF Risk	Item
8 10.05		**Integrated Performance Report Month 5 - (August 2021) (d)** Chief Executive To note
QUALITY - Patient Safety, Clinical Effectiveness & Patient Experience		
9 10:05		**Quality & Safety Committee Chair's Assurance Reports - 18 August & 22 September 2021 (d)** Committee Chair To note
	BAF3	• **Safeguarding Annual Report (d)** Director of Nursing & Quality To note
	BAF3	• **Serious Incidents Report (d)** Medical Director To note
PERFORMANCE & FINANCE		
10 10:30		**Performance & Finance Committee Chair's Assurance Reports - 17 August & 23 September 2021 (d)** Committee Chair To note
WELL LED		
11 10:50		**Workforce & Digital Transformation Chair's Assurance Reports - - 16 August & 20 September 2021 (d)** Committee Chair To note
	BAF9	• **Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES) Annual Submissions (d)** Director of Workforce and OD To approve

CONSENT AGENDA

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, these items will be identified at the start of the meeting

- **Bribery Act Compliance Review (d)**
  To note
- **Medical Revalidation Annual Report 2020/21 (d)**
  To approve
- **Expressions of Interest for Hospital Redevelopment (d)**
  To note
- **Violence Reduction Strategy and Policy (d)**
  To approve
- **Request to Use Trust Seal (d)**
  To approve

CONCLUDING BUSINESS

12 11:10 **Any Other Business (v)**
Chair
To consider any other matters of business

13 11:15 **Items for the Risk Register/Changes to the Board Assurance Framework (BAF) (v)**
Chair
To identify any additional items for the Risk Register or changes to the BAF arising from discussions at this meeting

14 11:17 **Key Messages from the Board (v)**
Chair
To agree

Resolution

The Board is asked to resolve that in accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudiced to the public interest.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**6**	Date of Meeting: 30/09/2021
Report Title	**Chief Executive's Report September 2021**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Caroline Keating, Company Secretary	
Action Required	To note	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Update on A&E New Build including latest communications
- Current position in relation to Covid patients
- Update on key challenges (operational performance; finance; workforce) within the Trust

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

-

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Provide safest and best care ☐	• Be the best place to work ☐
• Become a leading and sustainable health care system ☐	• Push boundaries in clinical, technology and digital innovation ☐

Impact *(is there an impact arising from the report on the following?)*

• Quality ☐	• Compliance ☐
• Finance ☐	• Legal ☐
• Workforce ☐	• Risk/BAF Click here to select relevant risk
• Equality ☐	

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Board of Directors	Monthly	CEO Report	Chief Executive	Noted

Chief Executive's Report
Board Meeting – 30 September 2021

Key Highlights

National / Regional Update

Integrated Care System (ICS)

1. Various guidance has now been published (interim governance; development of provider collaboratives; development of place-based partnerships) and work is proceeding at pace to consider the implications of these and how the April 2022 deadline of the new legislation is met.

2. I had an introductory meeting with David Flory, Interim Chair of the C&M ICS on 22 September – this was a helpful meeting to understand the direction of travel for the ICS and also to introduce Mid Cheshire and our successes and challenges.

Trust Update

3. A&E New Build – The new build is progressing well, despite delays caused by availability of materials which have been well mitigated. The current planned opening date is 1 December 2021. I met with Edward Timpson, MP for Eddisbury on 3 September 2021 and showed him the A&E site. It was a positive visit and he was very impressed with the build and also supportive of our new build ambitions. I am due to have a site visit with Kieran Mullan, MP for Crewe and Nantwich on 1 October 2021 to discuss the same.

4. New Build communications – A very successful communications campaign around our application to be one of 8 new hospitals has been running during the last week in September. Alongside lots of social media and news reporting, I was interviewed by BBC Radio Stoke and Signal Radio, a commercial radio station in Staffordshire, to discuss the proposals. The details of the new build led BBC bulletins throughout the afternoon and early evening on those days. We also shared our new build video on social media channels and with staff. So far, it has had more than 5000 views and our social media campaign has reached over 33,000 people to date.

5. We are expecting a visit from Professor Jacqueline Dunkley-Bent, Chief Midwifery Officer at NHSE/I and England's first Chief Midwifery Officer and Professor of Midwifery at King's College London and London South Bank University. She will meet with Julie Tunney, Director of Nursing & Quality; Murray Luckas, Medical Director and myself. Further details will be advised once known.

Covid-19

6. At 23 September, there were 31 confirmed positive COVID-19 patients in the hospital (20 reported in my last CEO report in July). However, the numbers of hospitalisations are starting to fall, but it is expected that children returning to school will likely have an impact and the local

infection rate is rising. Critical Care has seen a reduction in the number of COVID-19 patients, down to four at the time of writing, which is around half what it was early September.

Vaccination Programme

7. The Trust has now received national guidance on the delivery of the 'booster' COVID-19 vaccination and the administration of the booster to staff has commenced. We have also this month started the Flu vaccination programme.

Service Restoration

8. The recovery and restoration of core clinical services and activity remain a priority for the Trust. Waiting lists, however, continue to grow and the focus remains on patients with the highest clinical need and those that have waited the longest. We are meeting the standard for patients who require an operation within one month for nearly eight in every ten patients.

9. The backlog of patients waiting over one year for treatment continues to reduce and is currently ahead of trajectory. The resumption of daycase activity, driven mainly by issues in Endoscopy, remains one of the main challenges, and we are delivering around 70% of pre-pandemic levels, which is below the Cheshire & Merseyside average. An endoscopy improvement plan has been agreed, overseen by the Chief Operating Officer (COO). Gaps in the anaesthetic workforce are also a contributory factor and a robust action plan is being implemented, again overseen by the COO.

Trust 'Business as Usual'

Urgent and Emergency Care Pressures

10. Levels of attendances and emergency admissions continue to be significantly higher than pre-pandemic. This is obviously having an impact on the waiting times in the Emergency Department and has required more escalation beds to be opened due to the higher numbers of emergency admissions. This has in turn has now impacted on the delivery of the orthopaedic elective programme as beds normally reserved for surgery have needed to be used for Urgent Care pressures. Work is ongoing to release these beds and catch up on the Orthopaedic programme and a Plan B solution for Orthopaedic surgery has been identified and will provide some resilience during winter should beds be used again for urgent care pressures. This, however, is a sub-optimal solution.

11. The Executive Team also met on 17 September to review the existing winter plans and identify solutions for additional capacity over and above the norm due to the considerable pressures already being experienced showing no signs of abatement. These are being costed and developed further at present.

12. The focus nationally remains on ambulance handover times in excess of 60 minutes and the number of patients waiting a total time in the Emergency Department (ED) in excess of 12 hours. The Trust performs well against the >60-minute ambulance handover standard and this is, therefore, not a concern; however, approximately 5% of patients in ED are waiting over 12 hours which is a significant increase compared to pre-pandemic levels. The Executive Team

has recently supported the new Urgent and Emergency Care Improvement Plan which will be presented to the Performance and Finance Committee in October.

Finance

Current position

13. The position at the end of month 5 (June) of the financial year is a £0.4m deficit. This has resulted from the current urgent care pressures which has led to a further ward being opened during August. The changes to the Elective Recovery Fund (ERF) thresholds have also meant that, whilst originally the Trust was planning on a £0.6m 'contribution' from restoration towards its bottom-line expenditure, this has been reduced to a £0.1m forecast for H1.

Forecast for H1 (April -September)

14. As a result of the current position and with the two factors above unlikely to change in September, the Trust no longer expects to be able to deliver a balanced position for H1. A £0.9m deficit has, therefore, been forecast (£0.5m due to reduced contribution from ERF).

In line with previous system discussions across Cheshire & Merseyside every organisation is being supported to achieve breakeven for H1, it has been agreed that surpluses at other organisations will be used to support the deficits in other Trusts including MCHFT. Consequently, the Trust will receive a further £0.9m system funding to achieve breakeven at the end of H1 (September 2021). This support is non-recurring while the expenditure being incurred is likely to have a more recurring impact on our cost base.

H2 Financial Regime (October – March)

15. At the time of writing, guidance for the second half of the year has still to be received (due 16 September). The national headlines are that the settlement is better than previously anticipated but there is a general efficiency requirement of circa 2% and a reduction in COVID funding, non-NHS income and an assumption that H1 efficiency was delivered recurrently, all of which will result in an overall efficiency requirement in the region of 2.5% - 3% (£3.8m-£4.6m).

16. There will be a continuation of the block payment arrangements and the Elective Recovery Fund and Hospital Discharge Funding, although the details of the requirements are not yet known. Undoubtedly, given the operational pressures faced by Cheshire & Merseyside in comparison with other areas of the country, the allocation settlement will be a significant financial challenge across the whole of the HCP.

2022/2023 Timelines

17. As I mentioned in my July report, guidance on next year is not expected until December 2021 at the earliest but, nationally, they are reviewing the NHS block payment and system top-up baselines by the end of November in time for the spending review in December. 2022/23 planning will be during the period January-March 2022.

Workforce

People Recovery Plan

18. As part of the People Recovery Plan, the Trust has continued to develop its Wellbeing offer. In addition to a Wellbeing Week starting on 27 September 2021 with events and a presence at VIN and CCICP, we are also launching a Wellbeing calendar in October. The team

continues to promote the Forward Together resources documentation which was created as part of the People Recovery Plan. The Forward Together documentation will act as the "wellbeing conversation" and will encourage individuals to have conversations to ensure they are accessing any personalised support that may be required.

19. Although the sickness rate for August 2021 was 5.2% which reflects a decrease since July (5.8%), it remains higher than this time last year. The main reason for absence is anxiety and stress which is reflective of the ongoing pressures the hospital faces as a result of the COVID-19 pandemic. We are continuing to work hard to provide support mechanisms to all our staff during this time to prevent a continued increase in sickness rates.

Staff Networks

20. Following a staff survey and benchmarking exercise, the Trust has established two new staff networks - Disability and Carers and LGBT+. The initial meetings for both networks took place during September. Although the Trust already has a well-established Black & Minority Ethnics (BAME) network, the establishment of these networks ensures we are on track to deliver the national equality objective of 'implementing high performing staff networks'. The workforce team will work closely with the networks supporting them to become fully established and able to advise and influence decision making in the future.

BAME Leadership Programme

21. Following a joint bid with the Countess of Chester Hospital NHS Foundation Trust to the Cheshire and Merseyside People Board, we have been successful in receiving funding to implement a BAME Leadership Programme. This is a programme of positive action, designed and structured to challenge and overcome the main contributing factors limiting BAME progression. A dedicated BAME Leadership course demonstrates a strong commitment to the development of BAME staff and helps to put the spotlight on managers to encourage BAME staff in realising their career aspirations and full potential.

Staff Consultation and engagement: Offsite office moves

22. The consultation and engagement exercises regarding the off-site office move to Infinity House on the Crewe Business Park have continued throughout the summer and into September. A managers' briefing session was held on 22 September and there is a dedicated move page on the Trust intranet with a number of resources in place to help teams and individuals plan for the move on w/c 11 October. The consultation is due to end on 30 September after which formal contractual change letters will be issued.

Digital Clinical System (DCS) Update

23. The Assurance Report from the meeting held in August is attached at Appendix I.

(Leighton) Hospital Redevelopment Programme Board (HRPB)

24. The HRPB met in August and September. The Chair's Assurance Reports for both meetings are appended to my report (Appendix II).

James Sumner, Chief Executive
September 2021

Digital Clinical System
DCS Transformation Board Assurance Report
September 2021

Report to	Board of Directors
Date	September 2021
Report from	James Sumner, DCS Programme SRO
Report prepared by	Phill James – DCS Programme Director
Executive Lead/s	Dylan Williams – Chief Information Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

The Best And Final Offer process completed in July. A procurement report is seeking preferred supplier approval with robust process assurances being sought by Transformation Board attendees.

An informal NHS Digital TSSM (Trust System Support Team) heath check in June recorded an Amber status that stated “success was not guaranteed but was possible is a range of measures were acted upon”. An assurance report was noted and reported the vast majority of recommendations acted upon and a small number of longer term actions work in progress, with support agreed where required. A formal (OGC Gateway 3) Programme Assurance Review (PAR) was undertaken 7th, 8th and 9th September 2021 and will report late September.

A Communications and Engagement Plan was approved. The board noted that a dedicated lead has been recruited.

The Transformation Board requested future confirmation of executive level sign-off of all programme benefits.

The Transformation Board approved financial support for current fixed term commitments including core membership of the Clinical Advisory Group.

KEY CONCERNS / RISKS

Approval of the procurement report and thus preferred supplier requires robust process assurances.

DECISIONS MADE

The Transformation Board did not approve the procurement report and requested further assurances.

The Transformation Board approved funding for core Clinical Advisory Group membership and fixed term appointments to support ongoing programme activities.

RECOMMENDATION

- To note

Leighton Hospital Redevelopment Programme Board (HRPB)
Chair's Assurance Report
August 2021

Report to	Board of Directors
Date	12 August 2021
Report from	James Sumner, Chief Executive
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executives	Russell Favager, Deputy Chief Executive Clare Hammell, Deputy Medical Director *(representing Medical Director)*
Meeting quoracy	Yes ☐ No ☒

KEY AREAS OF ASSURANCE

- Governance and risk reporting arrangements – **acceptable assurance**: arrangements reflect widened scope of HRPB:
  - Development of Outline Business Case for Leighton Hospital redevelopment, if successful in joining the national Hospital Improvement Programme (HIP)
  - Leighton Hospital Phased Redevelopment (also known as 'Plan B')
  - Partnership Working with the other four significantly RAAC impacted Trusts
  - Victoria Infirmary Northwich (VIN) redevelopment - progress with Council offsite plan and phased redevelopment of VIN
  - Terms of Reference to be revised before onward submission to Board for approval
- Expressions of Interest for HIP reviewed ahead of Performance and Finance Committee and approval by Board
- RAAC plank inspection work in Ward 10 and South Cheshire site will not be completed before Spring 2022; risk accepted by Executive Safe and Sustainable Group and Executive Risk and Assurance Group
- Archus contracted to produce a spatial review and plan for the redevelopment of the Victoria Infirmary site in Northwich.
- ED completion date for handover from contractor had been delayed until 1 November 2021, with a commissioning period to follow. Commissioning Plan to be reviewed at next meeting

KEY CONCERNS/RISKS

- RAAC plank inspection work in Ward 10 and South Cheshire site (as outlined above)
- Planning permission for new ED still not been granted

Priority Areas: DECISIONS MADE (not quorate)

None

RECOMMENDATION

To note

Leighton Hospital Redevelopment Programme Board (HRPB)
Chair's Assurance Report
September 2021

Report to	Board of Directors
Date	16 September 2021
Report from	James Sumner, Chief Executive
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executives	Russell Favager, Deputy Chief Executive
Meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

- Update on migration plan for new Emergency Department (ED) received; ED to be operational from early December
- Changes to lease terms made since Board approval and signing of Infinity House lease reviewed and accepted. Board of Directors to be advised

Strategic Outline Case for Leighton Hospital Redevelopment

- Phased redevelopment approach discussed
- Engagement and Communications plan in progress with stakeholders and public

RAAC Plank Works

- Work for 2021/22 £22m project continues on time and to forecast budget, noting majority of programme spend is backended. Plans in place to ensure two areas where work was delayed and therefore currently off budget are completed on time
- Processes for design of 4 Ward Block and business case development to secure funding for construction agreed

KEY CONCERNS/RISKS

- A number of competing bids from the North West for new hospital redevelopment submitted as part of the initial expressions of interest process
- Victoria Infirmary redevelopment plan remains financially challenging; alternative options are also being explored

Priority Areas: DECISIONS MADE (to be ratified as not quorate)

- Agreed proposal for Archus to develop a business case for the 4 Ward Block (2022/23)
- Agreed to appoint a designer for the 4 Ward Block from national procurement framework
- Updated governance structure for HRPB/ Steering Groups approved.

RECOMMENDATION

To note

BAF heatmap showing current scores and change (Impact x Likelihood) 2021-22

SO1: Patient Experience & Quality of Services Provide safest and best care which is equitable and centred on the patient and their family's health, well-being and care needs	**SO2: New Ways of Working** Become a leading and sustainable health care system, providing seamless care to our local population in collaboration with our partners	**SO3: Best Place to Work** Be the best place to work, where our staff are empowered to innovate and provide consistently excellent care	**SO4: Build for the Future** Push boundaries in clinical, technology and digital innovation to provide the tools and infrastructure to deliver best possible care
BAF1: IF demand exceeds operational capacity while the Trust adapts to the 'new normal', THEN service restoration may be ineffective and impact negatively on patient care, outcomes and experience **= 4 x 5 = 20**	**BAF5:** IF we fail to establish formal place-based partnerships with good governance and assurance, THEN we are unlikely to deliver new ways of working across the health and social care system **= 4 x 3 = 12**	**BAF8:** IF we fail to develop the capacity and capability to deliver a consistent and coordinated continuous improvement methodology, THEN we will not deliver our strategic ambitions **= 3 x 4 = 12**	**BAF11:** IF our estate, infrastructure and equipment are not fit for the future, THEN we will fail to achieve our strategic ambitions **= 5 x 4 = 20**
BAF2: IF our workforce wellbeing and resilience are reduced, THEN our capacity to restore services and adapt to future challenges will be compromised **= 4 x 4 = 16**	**BAF6:** IF we are unable to achieve a sufficient level of influence within the ICS, THEN commissioning decisions may prevent us from achieving our strategic aims **= 4 x 3 = 12**	**BAF9:** IF the conditions for shaping leadership and organisational culture are sub-optimal, THEN our strategic ambitions will not be realised **= 4 x 3 = 12**	**BAF12:** IF a major incident occurs as a result of RAAC plank failure, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation **= 5 x 4 = 20**
BAF3: IF we do not maintain a robust and consistent focus on the quality of care, THEN there may be a negative impact on patient safety, outcomes and experience **⇧ 3 x 4 = 12***	**BAF7:** IF we are unable to agree a financial control total, THEN it could jeopardise delivery of strategy **= 3 x 3 = 9**	**BAF10:** IF we are unable to harness data to understand the needs of our population and inform our decisions, THEN we will fail to improve healthcare outcomes and address health inequalities **= 3 x 4 = 12**	**BAF13:** IF we fail to deliver the technological and people aspects required to implement Digital Clinical System, THEN intended benefits for patients may not be realised and the financial investment would be wasted **= 4 x 3 = 12**
BAF4: IF a significant H&S incident occurs within the Trust, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation **= 5 x 3 = 15**			**BAF14:** IF workforce plans do not align with the future operating model, THEN it is likely that there will be increased costs and workforce gaps that could affect standards of care **= 3 x 4 = 12**

***BAF3 score increase to be approved at September 21 Trust Board (current 3x3=9)**

Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors
Integrated Performance Report

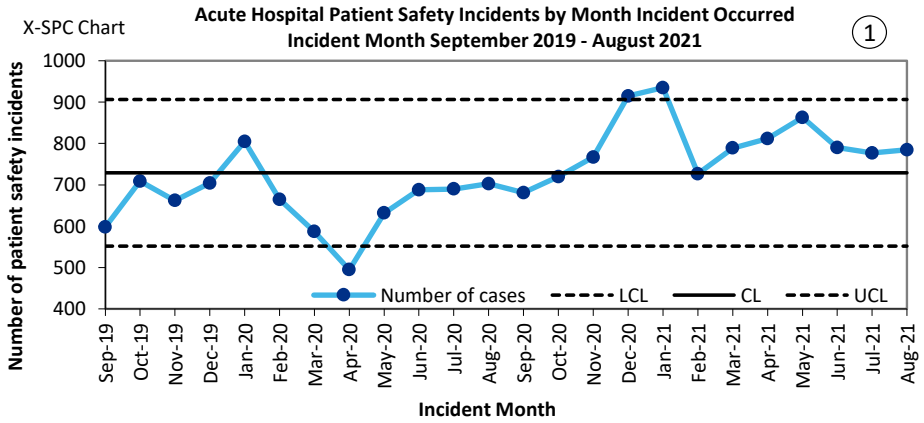
August 2021

"To Deliver Excellence in Healthcare through Innovation & Collaboration"

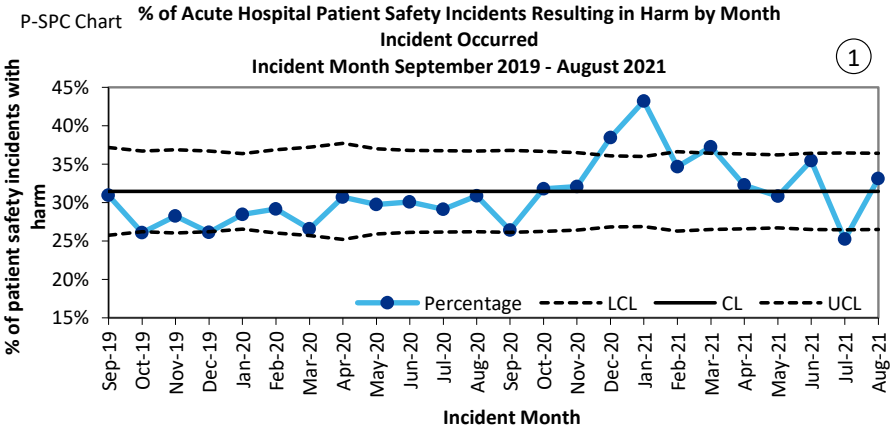
Quality, Safety & Patient Experience

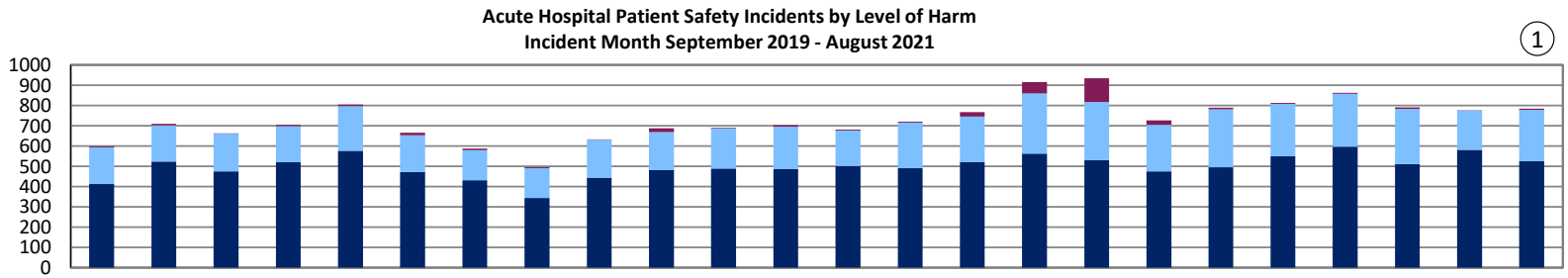
Acute Hospital Patient Safety Incidents (Excludes CCICP)

X-SPC Chart



P-SPC Chart





	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Moderate and Above	5	7	2	6	9	12	8	5	1	20	2	8	5	5	22	56	118	23	8	5	5	7	2	7
Low Harm	180	178	185	178	220	182	148	147	187	187	199	209	175	224	224	296	286	229	286	257	261	273	194	253
No Harm	413	524	475	520	576	471	431	343	444	481	489	486	501	491	521	563	531	475	495	550	597	510	581	525

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

Key Narrative: 785 incidents are currently shown for August 2021 of which 33.1% resulted in harm.

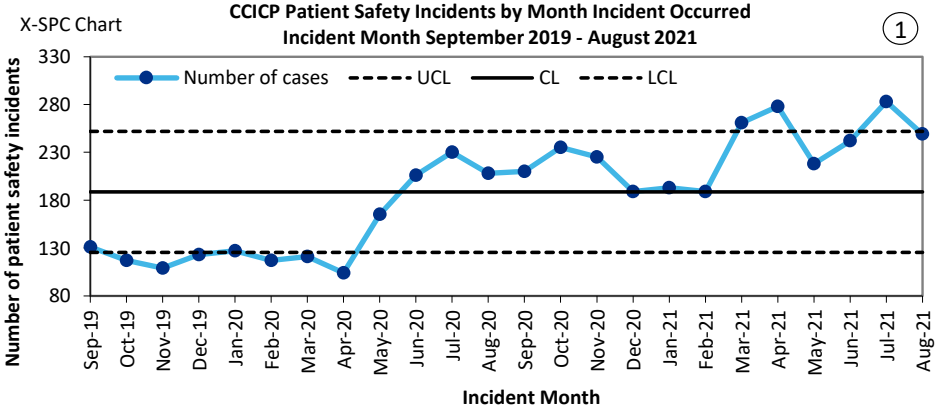
Low Harm 253, Moderate Harm 7, Serious Incident 0

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

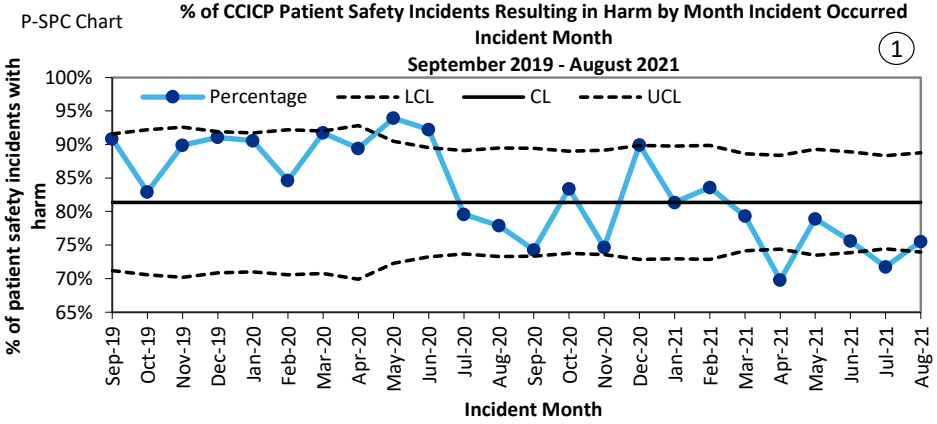
Quality, Safety & Patient Experience

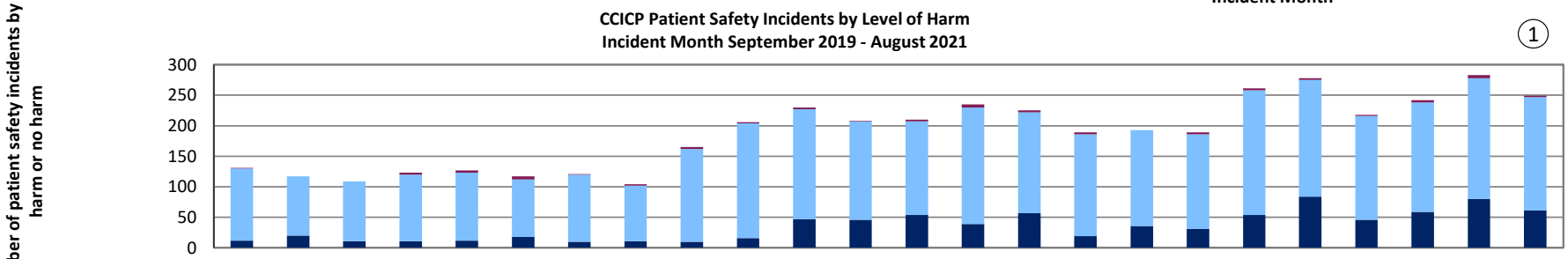
Central Cheshire Integrated Care Partnership (CCICP) Patient Safety Incidents

X-SPC Chart



P-SPC Chart





	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Moderate and Above	1	-	-	3	4	5	1	2	3	2	3	1	3	5	3	3	-	3	3	3	2	4	5	2
Low Harm	118	97	98	109	111	94	110	91	152	188	180	161	153	191	165	167	157	155	204	191	170	179	198	186
No Harm	12	20	11	11	12	18	10	11	10	16	47	46	54	39	57	19	36	31	54	84	46	59	80	61

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

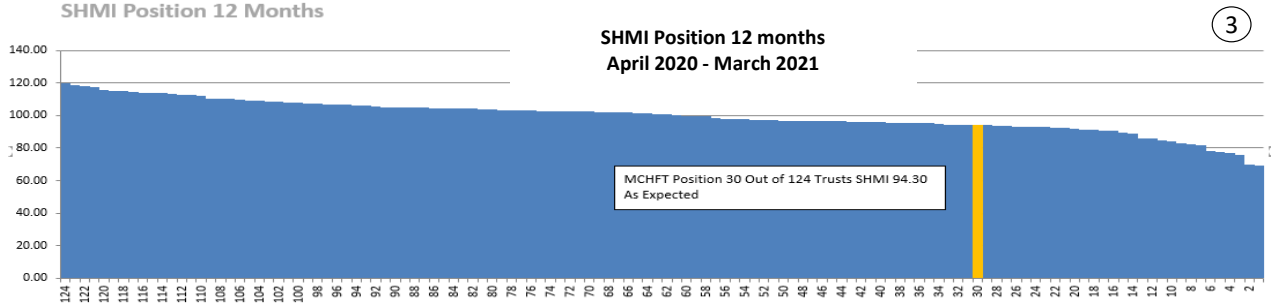
Key Narrative: 249 CCICP patient safety incidents are currently shown for August 2021 of which 75.5% resulted in harm. There was a step change in March 2020 where CCICP introduced incident reporting awareness sessions and this increased incident reporting from May 2020.

Low Harm 186, Moderate Harm 2, Serious Incident 0

Quality, Safety & Patient Experience

Mortality

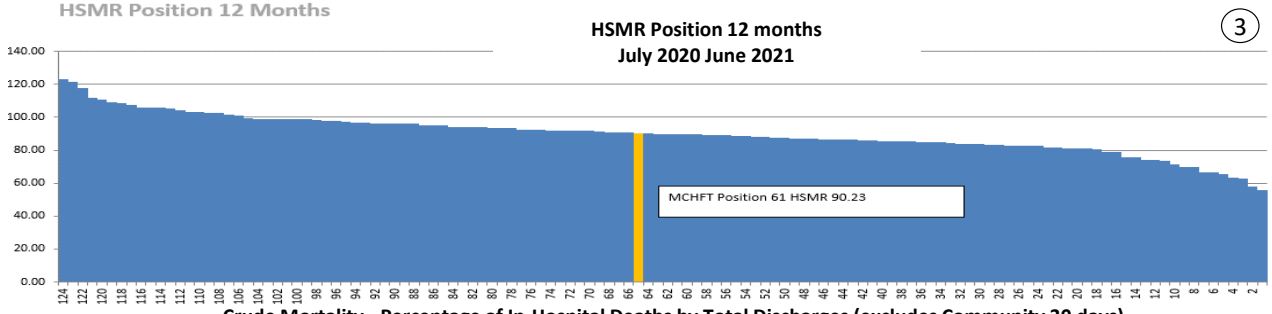
SHMI Position 12 Months



③

Key Narrative: The latest release of SHMI is 94.30 (rank 30) against the previous value of 93.11 (rank 23). This is still in the 'as expected' range. Please note that the number of submitting Trusts has dropped from 129 to 124 due to Trust mergers that is now reflected in the data.

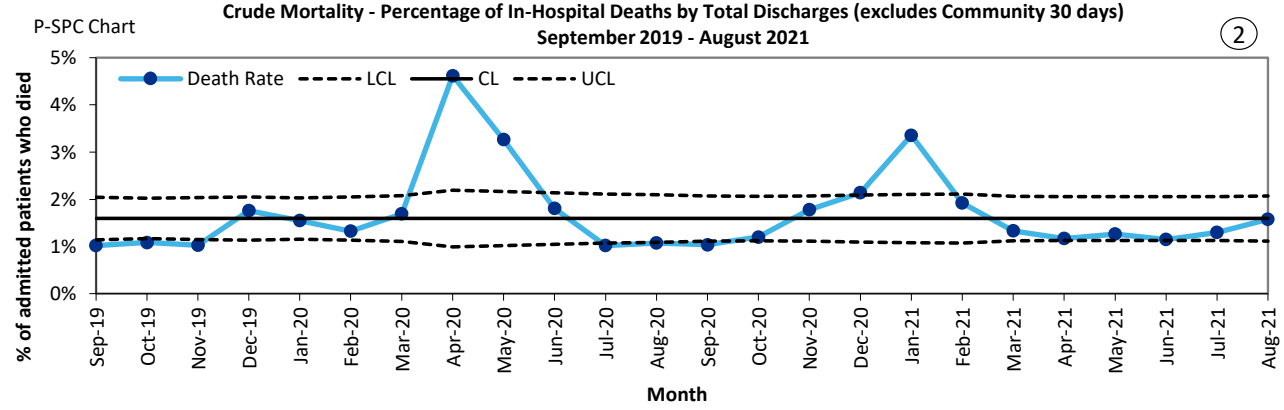
HSMR Position 12 Months



③

Key Narrative: The latest HSMR release is 90.23. Recent releases had shown an improvement in HSMR which is likely to be the result of improving rates of palliative coding (still low compared to other Trusts). This release shows another slight improvement. Please note that the Trust mergers in SHMI are reflected in this data.

P-SPC Chart



②

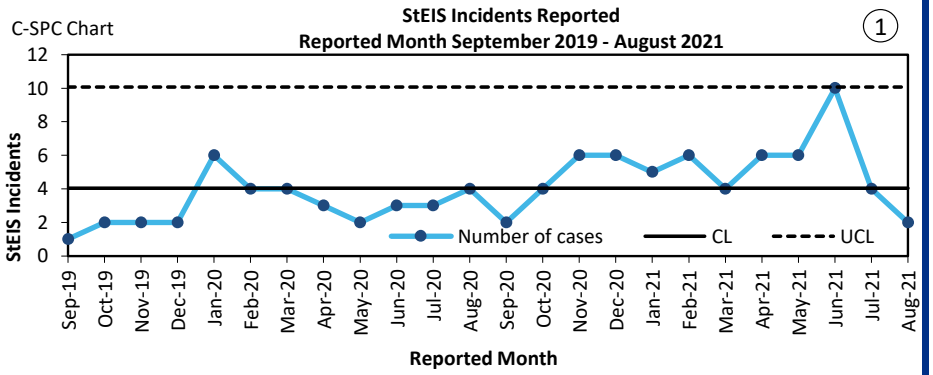
Key Narrative: Crude mortality has remained largely consistent over the time period except for peaks seen in April 2020, May 2020 and January 2021 related to an increase in COVID-19 patients within the Trust. August 2021 continues to show a return to pre-covid levels but is higher than August 2020, with more deaths & discharges recorded than in August 2020. August 2021 shows an increase from July 2021.

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Quality, Safety & Patient Experience

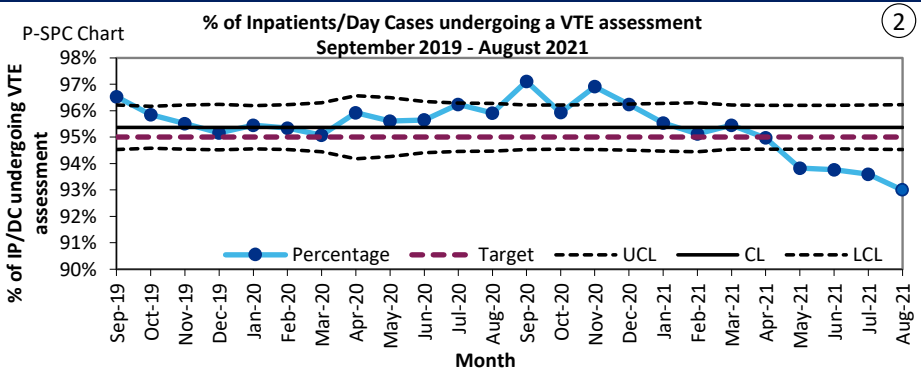
StEIS Incidents - Trust Total



Accountable: Medical Director **Data Owner:** Quality Governance

Key Narrative: There were 2 serious incidents reported to StEIS in August 2021. There were 2 patients from different wards that sustained a fractured neck of femur, there were no lapses in care.

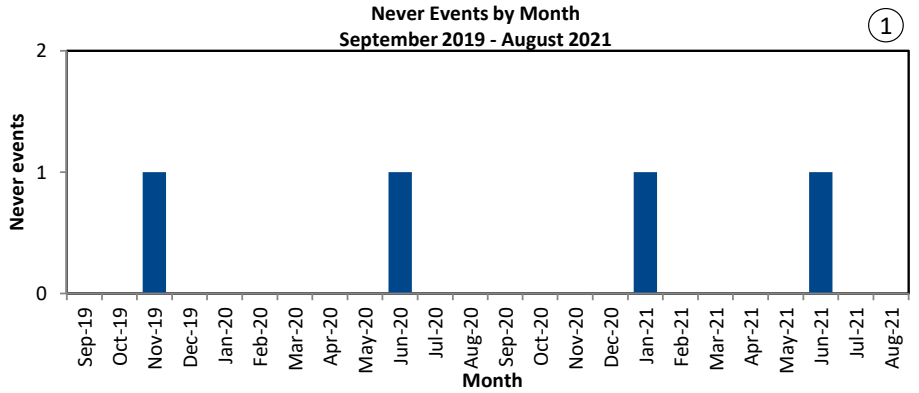
VTE



Accountable: Medical Director **Data Owner:** Information Services

Key Narrative: The percentage of VTE assessments remains below target in July 2021 achieving 93.0%. The P-SPC charts adjust the control limits to take into account each month's denominator.

Never Events - Trust Total



Accountable: Medical Director **Data Owner:** Information Services

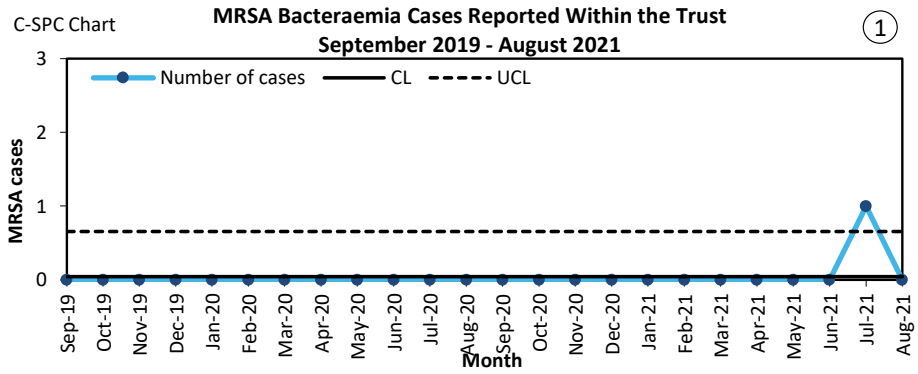
Key Narrative: There were no never events reported in August 2021.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Quality, Safety & Patient Experience

MRSA

C-SPC Chart

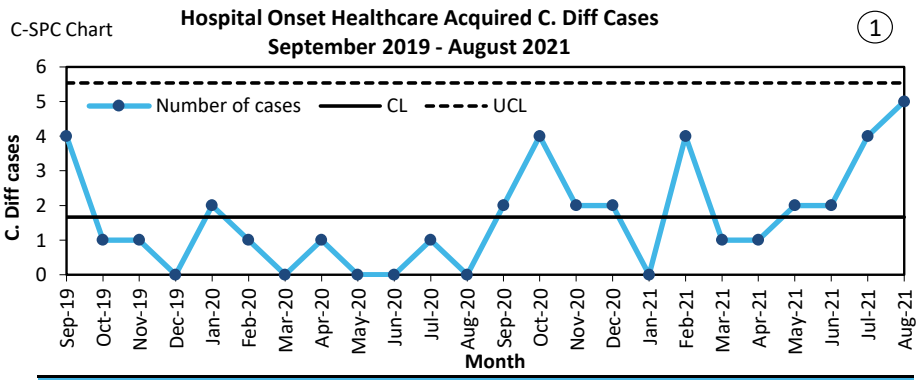


Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team

Key Narrative: There were no MRSA bacteraemia cases reported in August 2021.

C. Diff Positive Cases

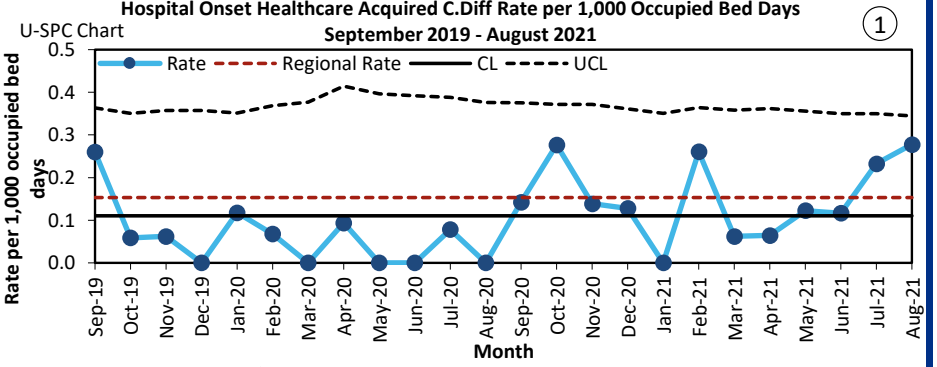
C-SPC Chart



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Avoidable	0	0	0	0	0	0	0	0	0	0	1	0
Unavoidable	1	4	1	0	0	1	1	0	1	0	2	3
Awaiting Confirmation	1	0	1	2	0	3	0	1	1	2	1	2

Hospital Onset Healthcare Acquired C.Diff Rate per 1,000 Occupied Bed Days

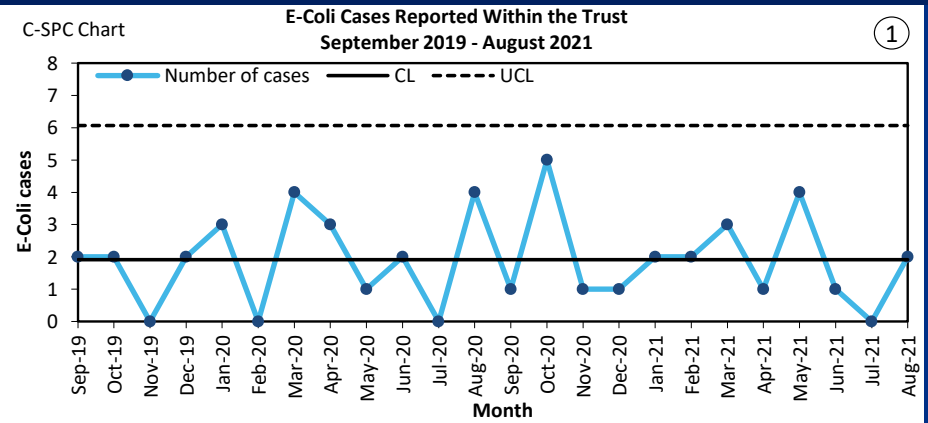
U-SPC Chart

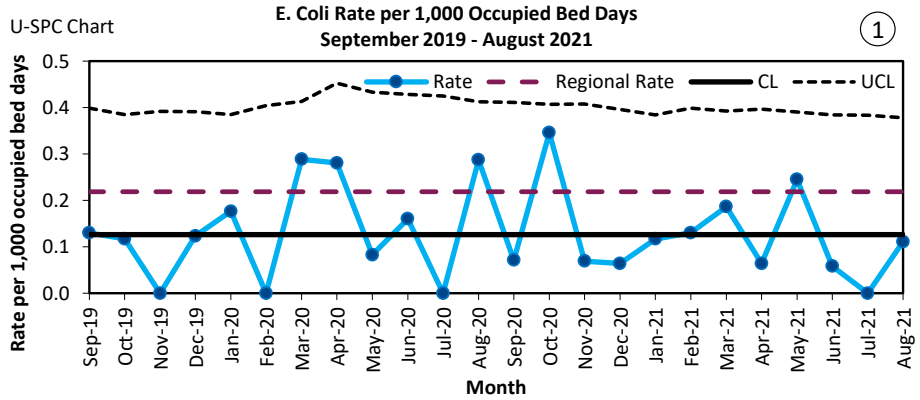


Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: Five hospital onset healthcare acquired C.Diff cases were recorded in August 2021 with a rate of 0.28 per 1,000 occupied bed days, above the regional rate for the month. The P-SPC charts adjust the control limits to take into account each month's denominator.

Quality, Safety & Patient Experience

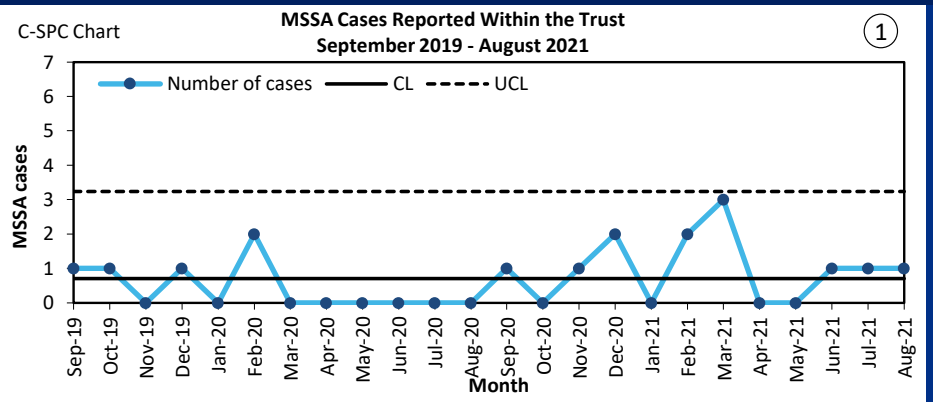
E-Coli Cases

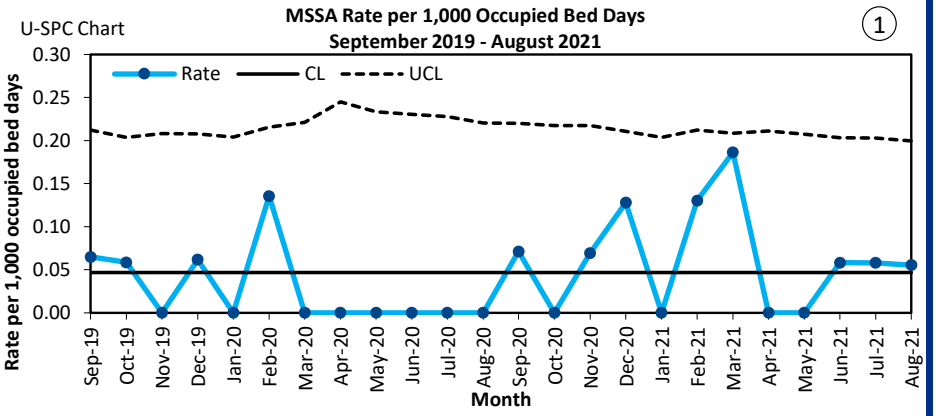




Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: Two E-Coli cases were recorded in August 2021 with a rate of 0.11 cases per 1,000 occupied bed days, below the current regional rate. The U-SPC chart adjusts the control limits to take into account each month's denominator.

MSSA





Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: There was one MSSA case reported in August 2021 with a rate of 0.06 per 1,000 occupied bed days. The U-SPC chart adjusts the control limits to take into account each month's denominator.

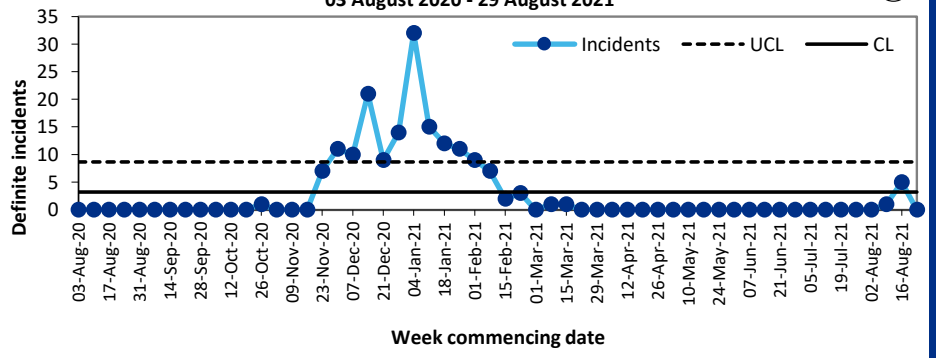
Quality, Safety & Patient Experience

COVID-19 Healthcare Acquired Infections

C-SPC Chart

MCHFT Definite COVID-19 Incidents by Result Week
03 August 2020 - 29 August 2021

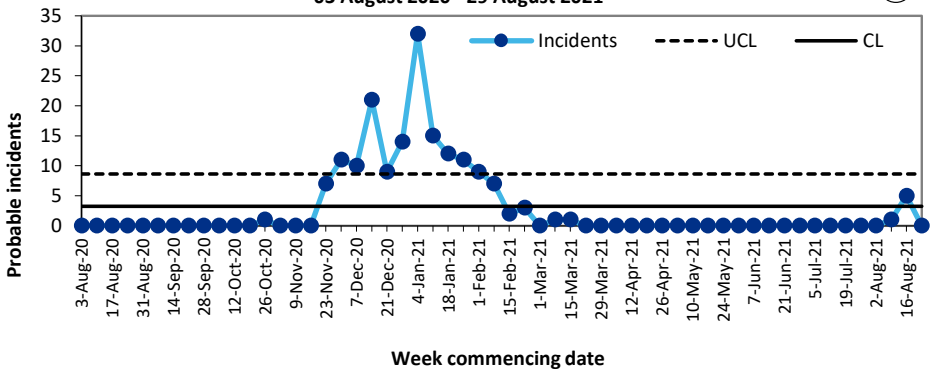
①



C-SPC Chart

MCHFT Probable COVID-19 Incidents by Result Week
03 August 2020 - 29 August 2021

①

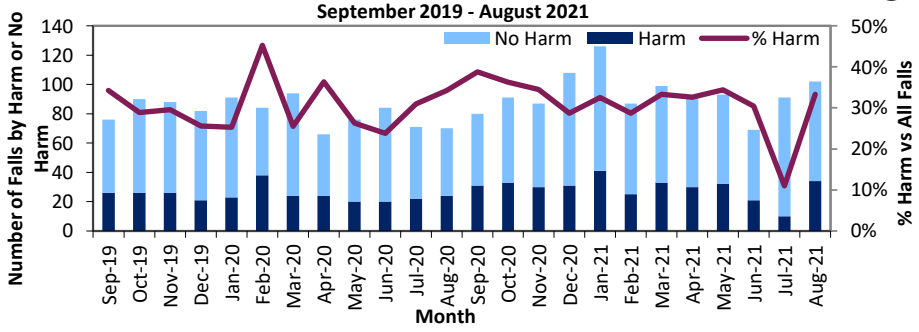


Accountable: Director of Nursing and Quality **Data Owner:** Information Services
Key Narrative: The latest week reported, week commencing 23rd August 2021, shows 0 definite incidents and 0 probable incidents.

Falls

Falls Rate Harm Vs No Harm
September 2019 - August 2021

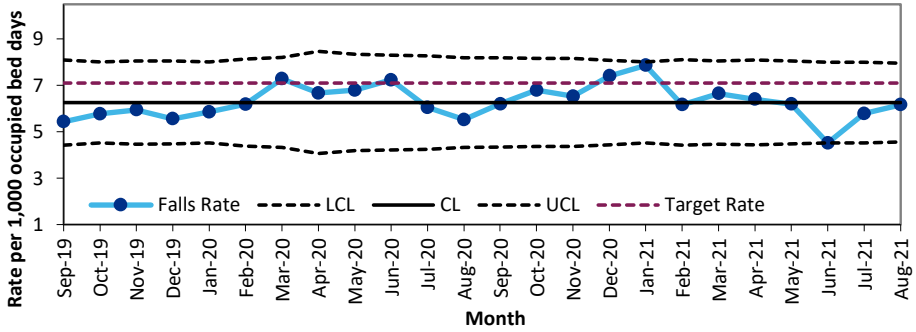
②



U-SPC Chart

Falls Rate per 1,000 Occupied Bed Days
September 2019 - August 2021

②

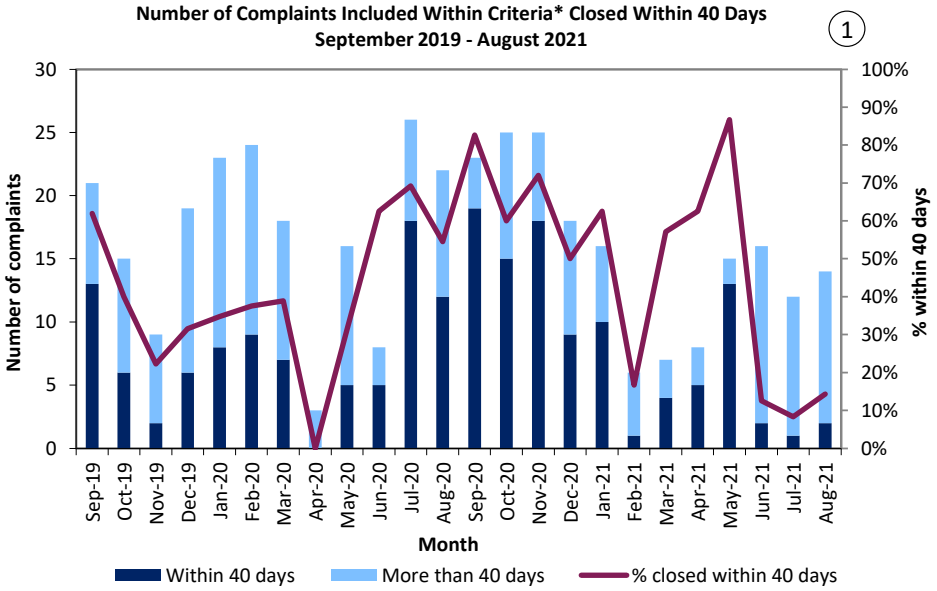


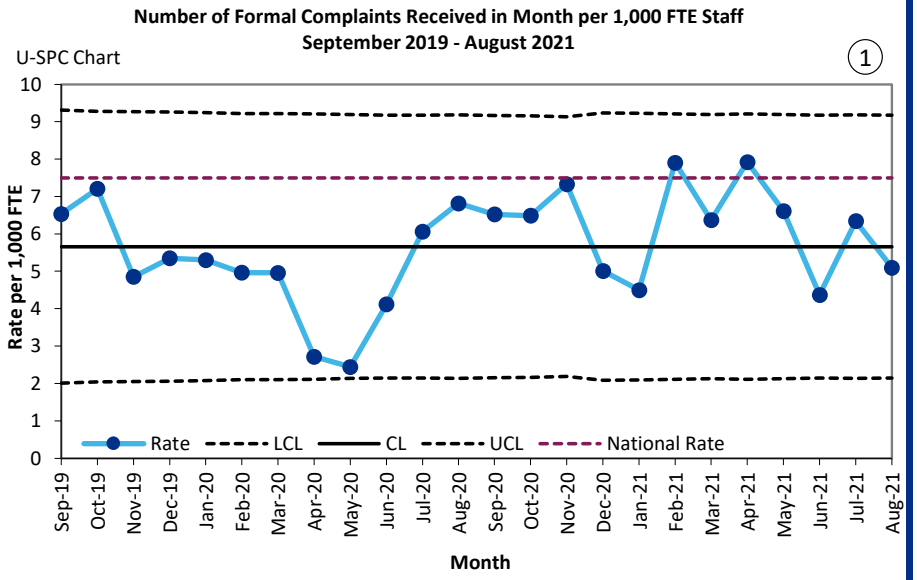
Accountable: Director of Nursing and Quality **Data Owner:** Nursing Quality Team
Key Narrative: 102 falls were reported in August 2021 with a rate of 5.7 per 1,000 occupied bed days, which is better than the target rate of 6.6. 34 falls resulted in harm (33%). The U-SPC chart adjusts the control limits to take into account each month's denominator.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Quality, Safety & Patient Experience

Formal Complaints





Accountable: Director of Nursing and Quality
Data Owner: Customer Care Team

Key Narrative: 14 complaints were closed in August 2021, of which 2 were closed within 40 days (14.3%). The rate of formal complaints received in August 2021 was 5.1 per 1,000 FTE staff, below the national rate.

Due to the second wave of the covid pandemic, complaint responses were stood down from November 2020 and recommenced in March 2021.

**exclusion criteria includes, for example: complaints linked to an investigation, multi-agency and cross-divisional and complaints, withdrawn complaints, complaints put on hold during the COVID-19 period.*

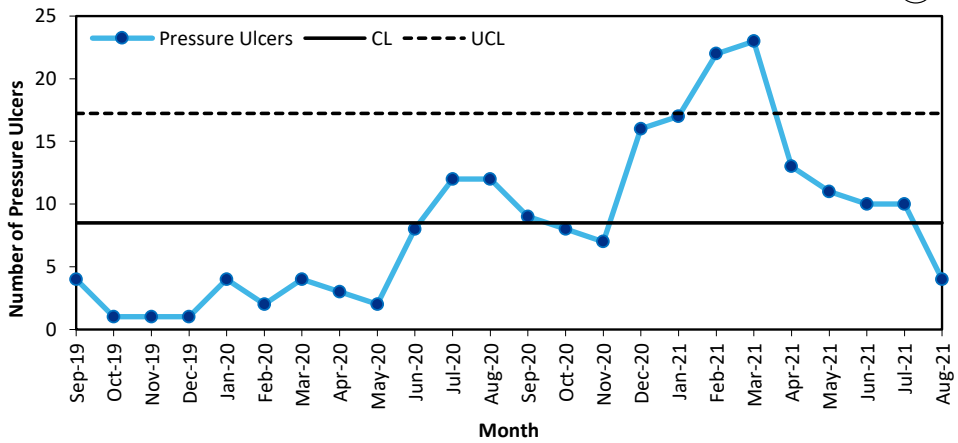
Quality, Safety & Patient Experience

Acute Hospital Pressure Ulcers

C-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Identified
September 2019 - August 2021

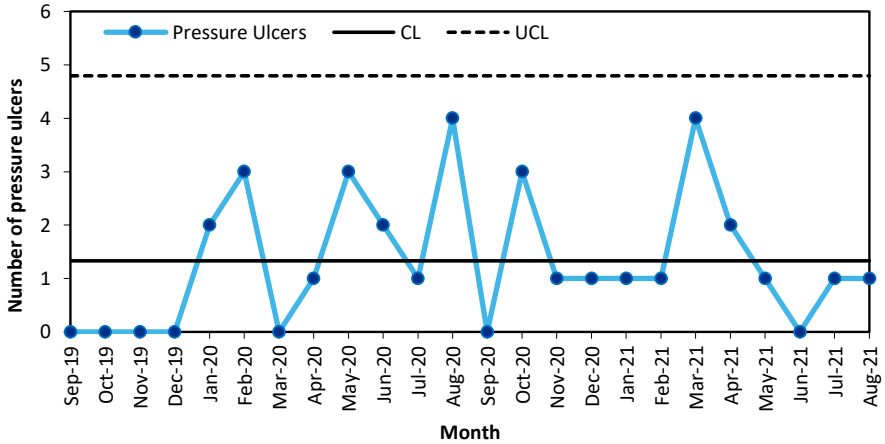
①



C-SPC Chart

Community Pressure Ulcers - Lapses in Care Identified
September 2019 - August 2021

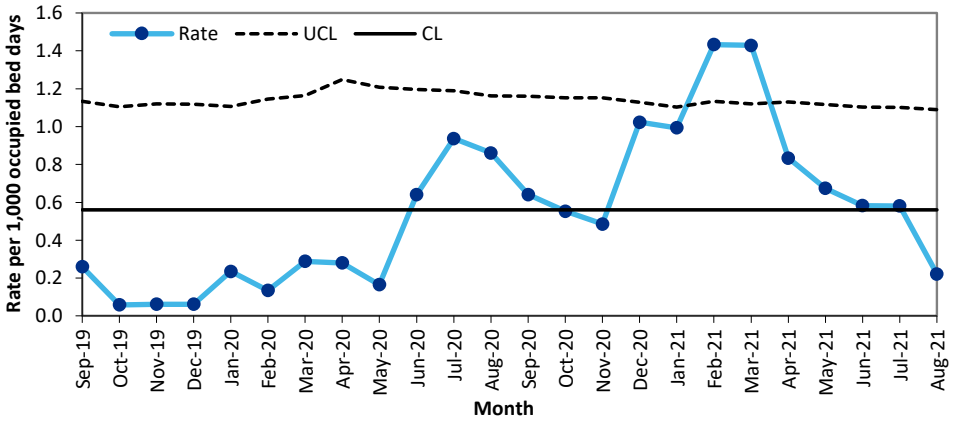
①



U-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Rate per 1,000 Occupied Bed Days
September 2019 - August 2021

①



To note: U-SPC charts adjust the control limits to take into account each month's denominator.

Accountable: Director of Nursing and Quality
Data Owner: Nursing Quality Team

Key Narrative:

Acute: Four acute hospital lapses in care have currently been identified in August 2021 with a rate of cases per 1,000 occupied bed days of 0.22. Latest months data correct at time of reporting, however, will increase as the validation process for August 2021 data continues.

Community: Currently one community lapse of care has been identified in August 2021. There have been 5 community lapses of care reported in the current financial year.

Current financial year reported cases subject to validation.

Quality, Safety & Patient Experience

Safer Staffing Divisional Analysis

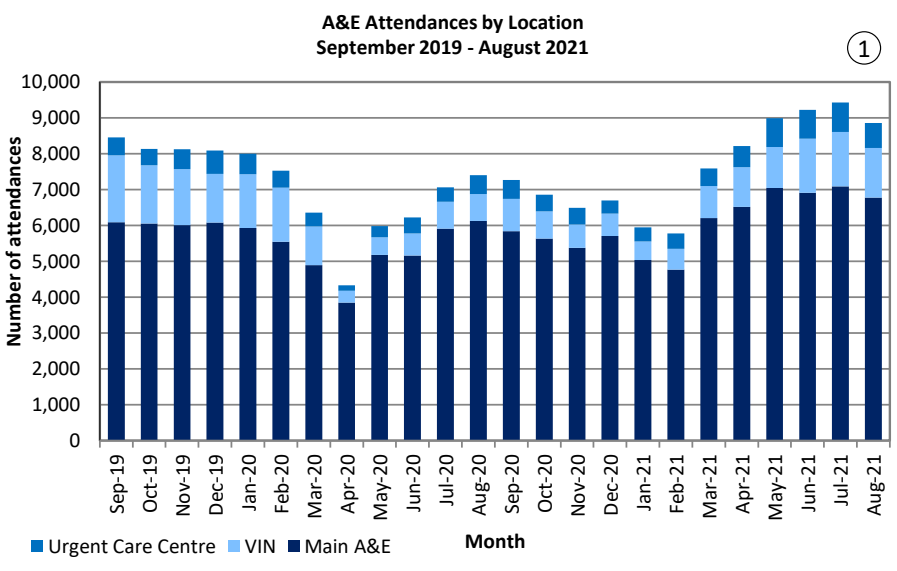
①

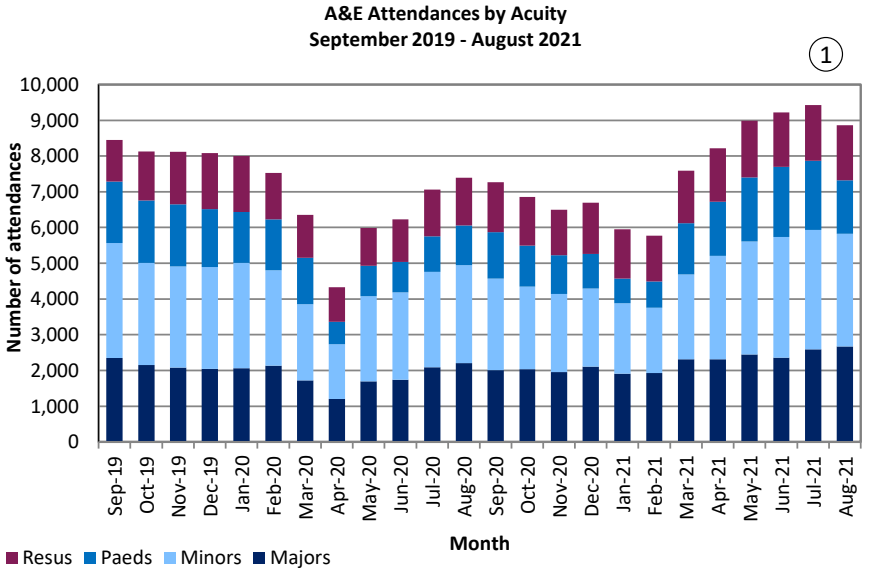
Ward Name	Day				Night				Day		Night	
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate
MCHFT	50388.5	43357.2	42961.4	35001.6	37573.3	33427.0	32421.0	28598.3	86.0%	99.1%	89.0%	97.0%
Acute Medical Unit	2040.8	2009.8	1673.5	1586.8	1908.0	1728.0	1500.0	1428.0	98.5%	94.8%	90.6%	95.2%
Child & Adolescent Unit	3335.9	2693.4	1394.5	1091.0	1931.0	1818.0	408.0	334.8	80.7%	78.2%	94.1%	82.0%
Critical Care Unit (HIGH)	4832.0	3415.3	602.8	530.8	4836.0	3529.0	744.0	240.0	70.7%	88.1%	73.0%	32.3%
Elmhurst	746.0	750.3	2495.0	2263.5	744.0	734.5	1884.0	1800.0	100.6%	90.7%	98.7%	95.5%
South Cheshire Surveillance (HIGH)	2392.5	2029.0	2716.7	2073.2	2232.0	1932.0	2544.0	2228.8	84.8%	76.3%	86.6%	87.6%
Ward 1 Cardiology Coronary Care	2131.5	2010.5	1260.0	1150.5	1524.0	1452.0	832.5	804.0	94.3%	91.3%	95.3%	96.6%
Ward 10 Orthopaedic Trauma	2812.5	2370.5	3698.5	3041.4	1620.0	1548.0	2484.0	2314.5	84.3%	82.2%	95.6%	93.2%
Ward 11 Surgical/Gynae	2112.5	2034.5	1872.0	1765.1	1248.0	1187.5	1536.0	1488.0	96.3%	94.3%	95.2%	96.9%
Ward 12 SAU	1288.5	1187.5	942.3	857.8	756.0	733.8	804.0	768.0	92.2%	91.0%	97.1%	95.5%
Ward 12 Surgical Specialties	1300.0	1216.0	814.8	734.8	754.0	706.0	744.0	684.0	93.5%	90.2%	93.6%	91.9%
Ward 13 Medical Escalation	2035.0	1718.0	1926.0	1436.3	1248.0	1045.0	1769.5	1493.5	84.4%	74.6%	83.7%	84.4%
Ward 14 Gastroenterology	1363.5	1324.5	1763.0	1584.5	1164.0	1116.0	1368.0	1308.0	97.1%	89.9%	95.9%	95.6%
Ward 15 Medical Escalation	2131.5	1681.0	1900.0	1766.8	1476.0	1176.0	1764.0	1620.0	78.9%	93.0%	79.7%	91.8%
Ward 18 Elective	1381.0	1006.5	1362.0	917.8	756.0	744.0	804.0	660.0	72.9%	67.4%	98.4%	82.1%
Ward 19 Winter	1738.5	1670.0	2024.5	1523.3	1212.0	1176.0	1692.0	1491.0	96.1%	75.2%	97.0%	88.1%
Ward 21b Rehabilitation	1356.5	1236.3	2649.5	2374.3	1164.0	1089.0	1728.0	1584.0	91.1%	89.6%	93.6%	91.7%
Ward 22 NICU	1641.1	1661.4	1174.9	502.4	1330.3	1307.7	666.5	290.3	101.2%	42.8%	98.3%	43.5%
Ward 23 Maternity	1376.7	1175.3	814.5	780.2	744.0	725.0	756.0	741.5	85.4%	95.8%	97.4%	98.1%
Ward 26 Labour	2783.3	2360.5	703.6	685.6	2226.0	2104.6	372.0	372.0	84.8%	97.4%	94.5%	100.0%
Ward 3 Respiratory	2497.8	2301.0	1765.0	1434.0	1740.0	1619.8	924.0	903.0	92.1%	81.2%	93.1%	97.7%
Ward 4 Care of the Elderly	1547.0	1416.0	2167.5	1821.0	1176.0	1068.0	1864.5	1806.0	91.5%	84.0%	90.8%	96.9%
Ward 5 Covid (HIGH)	2847.5	1909.8	1505.5	764.0	2184.0	1620.0	1440.0	1080.0	67.1%	50.7%	74.2%	75.0%
Ward 6 Stroke / Rehab	1781.0	1572.0	2459.5	2079.4	1560.0	1356.7	1404.0	1239.0	88.3%	84.5%	87.0%	88.2%
Ward 7 Diabetes / General Medicine	1752.0	1694.3	2370.0	1726.0	1248.0	1152.5	1596.0	1512.0	96.7%	72.8%	92.3%	94.7%
Ward 9 Orthopaedic Elective	1164.0	914.0	906.0	511.5	792.0	758.0	792.0	408.0	78.5%	56.5%	95.7%	51.5%

Accountable: Director of Nursing and Quality
Data Owner: Information Services
Key Narrative: The highlighted cells reflect wards where the qualified staffing rate is below 85% of planned levels.

Performance

A&E Activity





Accountable: Chief Operating Officer
Data Owner: Information Services

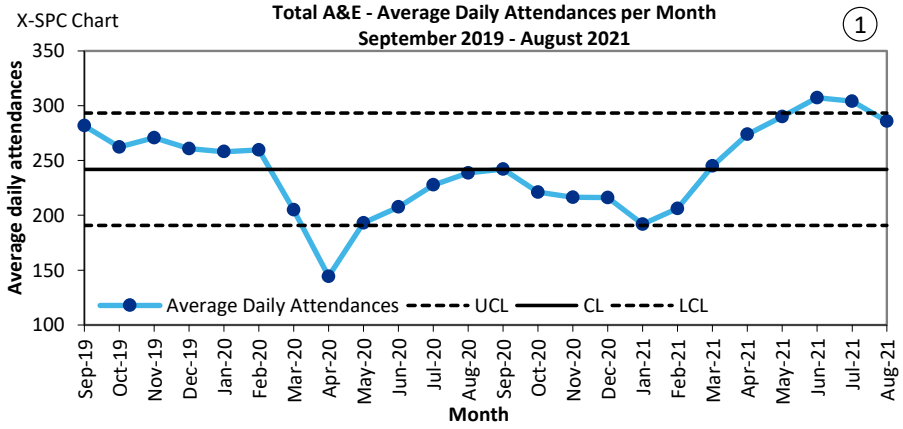
Key Narrative: There were a total of 8,858 A&E attendances across all locations in August 2021, a 6.0% decrease on the previous month.

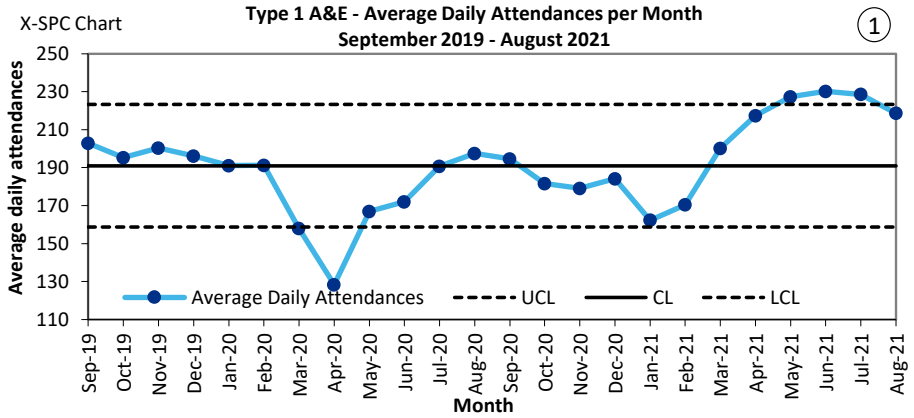
There were 6,777 attendances reported in August 2021 for the main A&E department at Leighton Hospital (type 1), higher than pre-pandemic levels, but fewer than the 7,086 attendances in July 2021.

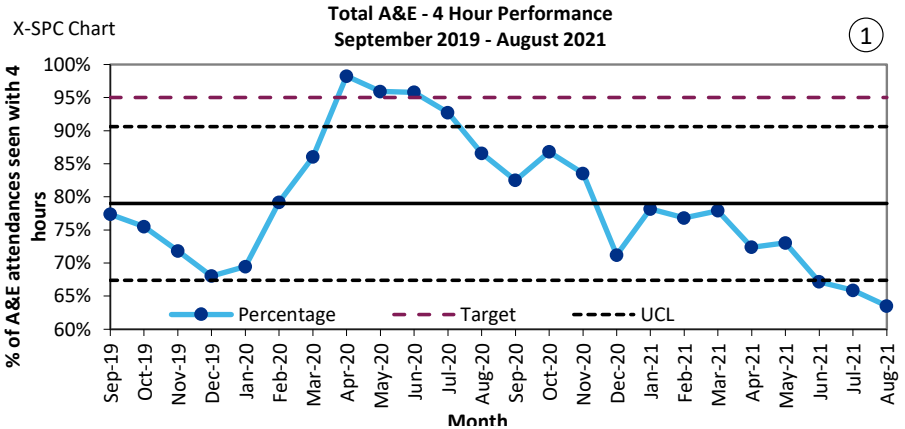
August 2021 activity variance compared to previous month by acuity: Majors +83, Minors -190, Paeds -439, Resus -22.

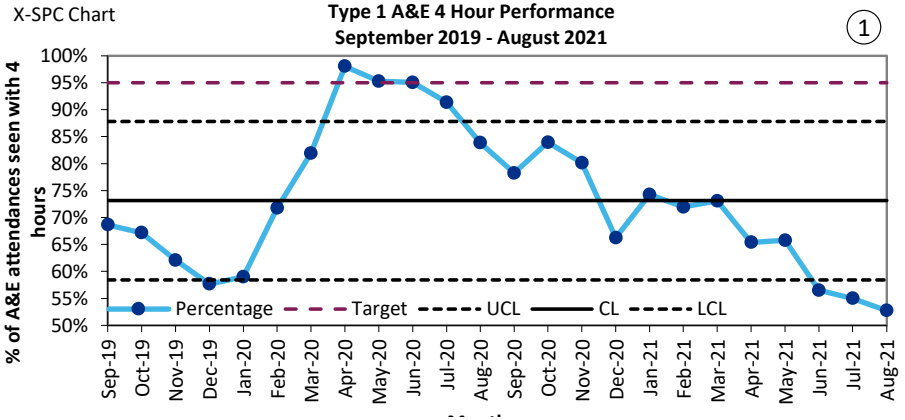
Performance

A&E Performance









Accountable: Chief Operating Officer

Data Owner: Information Services

Key Narrative: The average total daily A&E attendances for August 2021 was 286, lower than the July 2021 rate of 305, but remaining above the pre-pandemic attendance rates. The average daily attendances for Type 1 follows a similar pattern with August 2021 rate of 219, lower than the July 2021 rate of 229. As activity rates have remained high there is a corresponding reduction in performance, with Total A&E Attendances achieving 63.5% and Type 1 achieving 52.7% in August 2021, which is lower than the previous month and for several months.

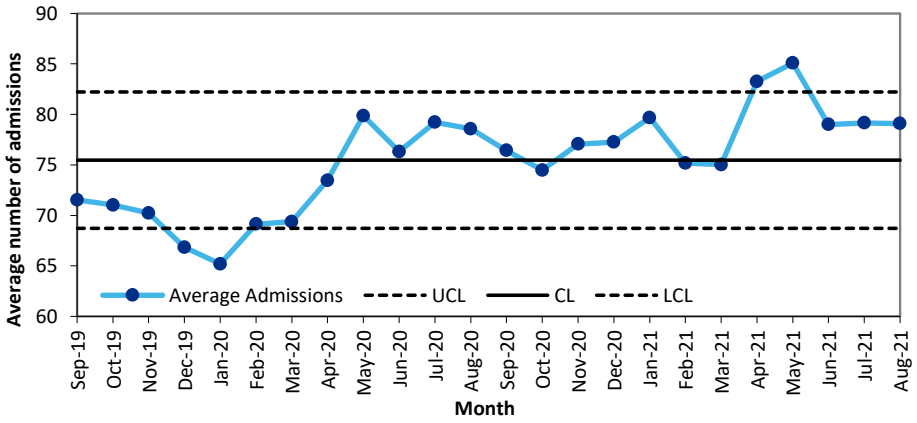
Performance

Unplanned Admissions

X-SPC Chart

Average Daily Admissions from A&E
September 2019 - August 2021

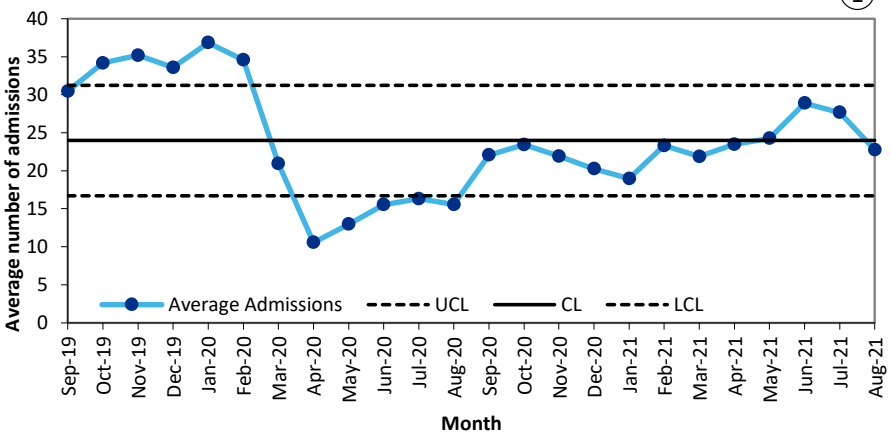
1



X-SPC Chart

Average Daily Admissions per Month - GP Referred
September 2019 - August 2021

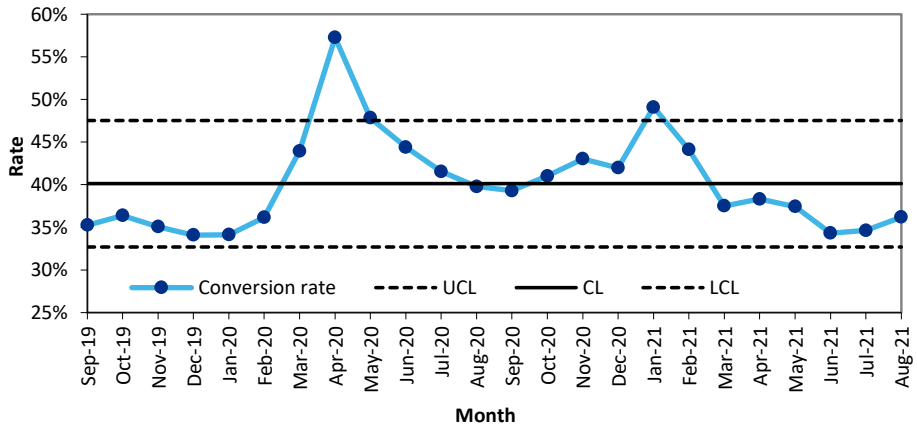
1



X-SPC Chart

Type 1 Attendance to Admissions Conversion Rate - Overall
September 2019 - August 2021

1



Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: Activity between March 2020 and March 2021 included admissions to RAU reflecting a pathway designed to support the covid pandemic which has now closed and averaged 214 admissions per month during the period.

The average daily admissions from A&E for August 2021 was 79, in line with the rate shown for July 2021 (79), above pre-pandemic levels.

The average daily admissions for GP-referred patients in August 2021 was 23, a decrease against the average admission rate for July 2021 (28). The reduction in GP referred admissions (compared to pre pandemic) is due to stricter admission criteria, based on Covid pathways, directing more patients to ED/RAU and a change in how patients present to ED following virtual GP appointments.

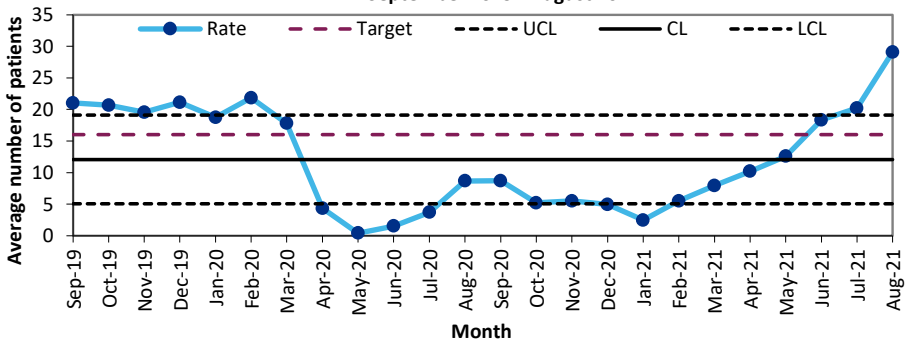
The type 1 admission conversion rate for August 2021 was 36.2%, higher than the previous two months.

Performance

Inpatient Metrics

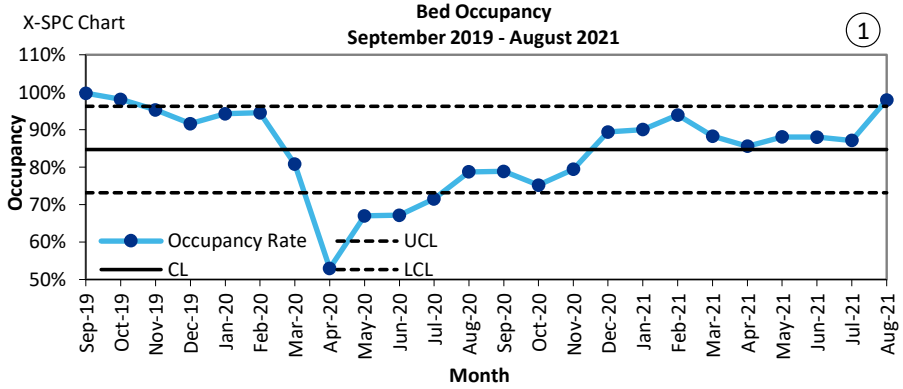
X-SPC Chart

Average Number of People Delayed per Day
September 2019 - August 2021



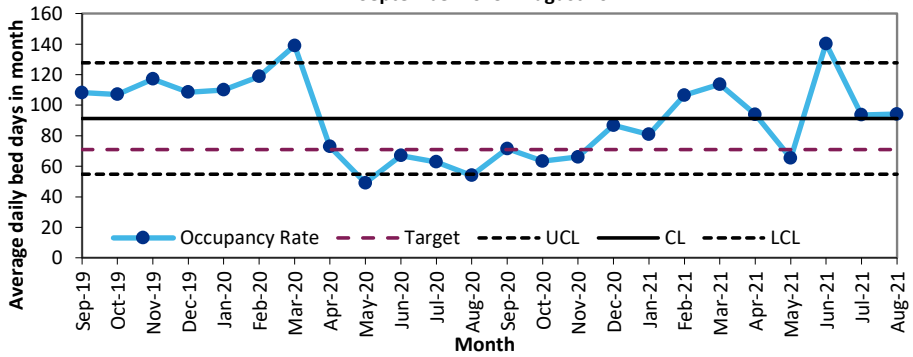
X-SPC Chart

Bed Occupancy
September 2019 - August 2021



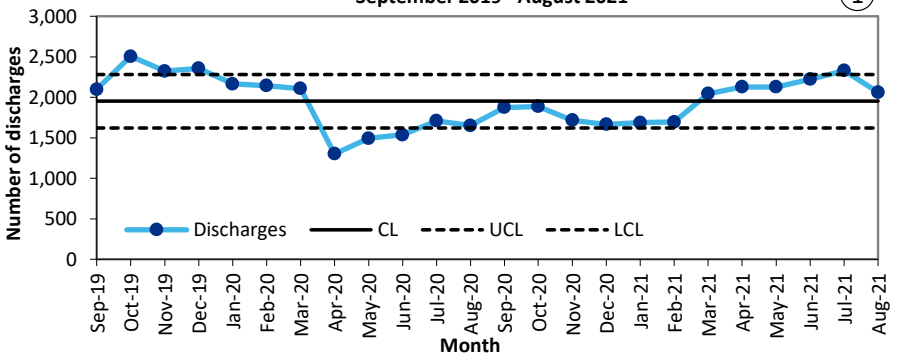
X-SPC Chart

Super Stranded Patients
September 2019 - August 2021



X-SPC Chart

Discharges from G&A Bed (Adult and Paeds) per Month
September 2019 - August 2021



Accountable: Chief Operating Officer **Data Owner:** Information Services

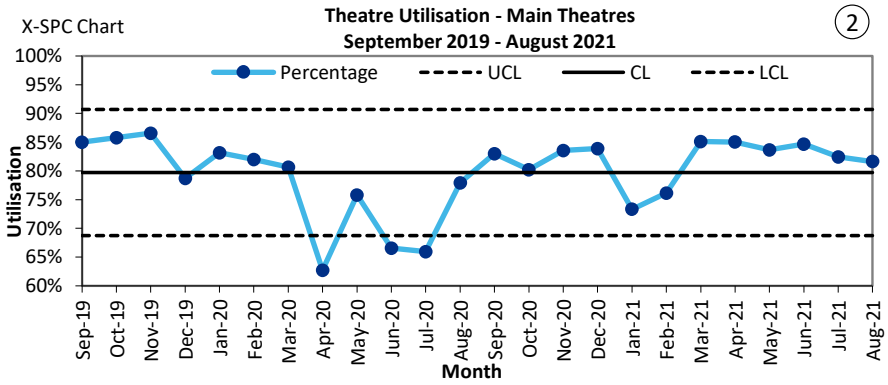
Key Narrative: The average number of people delayed per day during August 2021 was 29, an increase on July (20) and above the target. The average number of super stranded patients delayed per day in the hospital remained static between August and July. The percentage bed occupancy rate for August 2021 was 97.9%, an increase on the July 2021 occupancy rate of 87.1%. The bed occupancy figure reported does not exclude lost beds that are not suitable for patient admissions for infection prevention and control (IPC) reasons. There were 2,062 discharges from G&A beds in August 2021, which is a small decrease on the previous month.

** bed stock numbers used to calculate the bed occupancy rate have been updated from July 2020 to reflect covid ward changes*

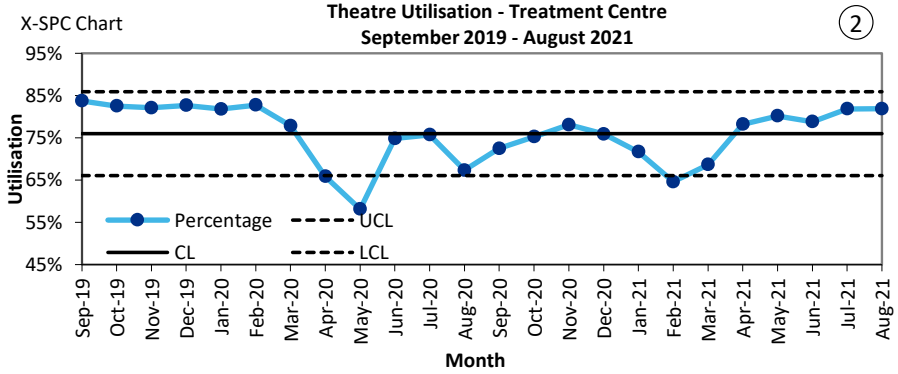
Performance

Theatre Utilisation

X-SPC Chart



X-SPC Chart

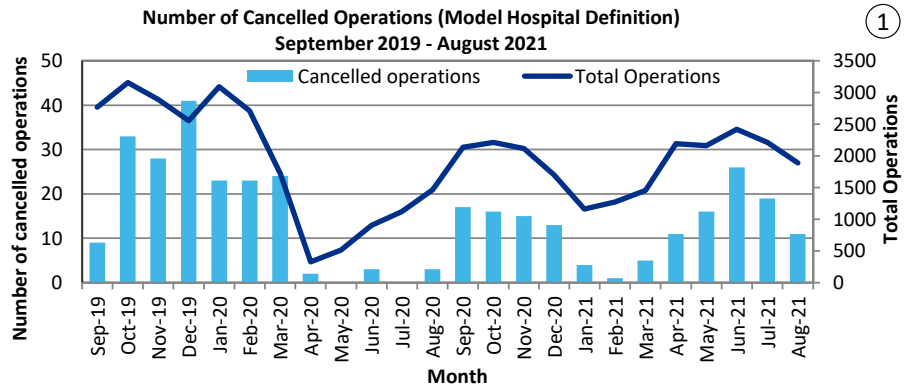


Accountable: Chief Operating Officer **Data Owner:** Information Services

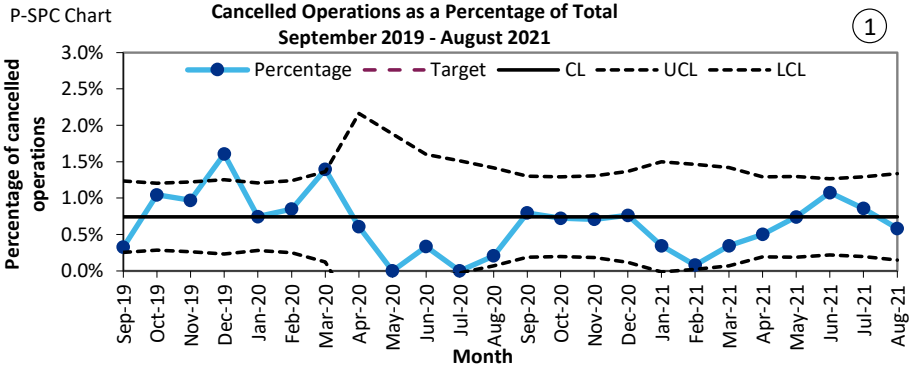
Key Narrative: Theatre utilisation rate for August 2021 was 81.6% in Main Theatres, similar to the July 2021 position of 82.4%.

Theatre utilisation rate for the Treatment Centre in August 2021 was 81.9%, in line with the July 2021 position of 81.8%.

Cancelled Operations



P-SPC Chart



Accountable: Chief Operating Officer **Data Owner:** Information Services

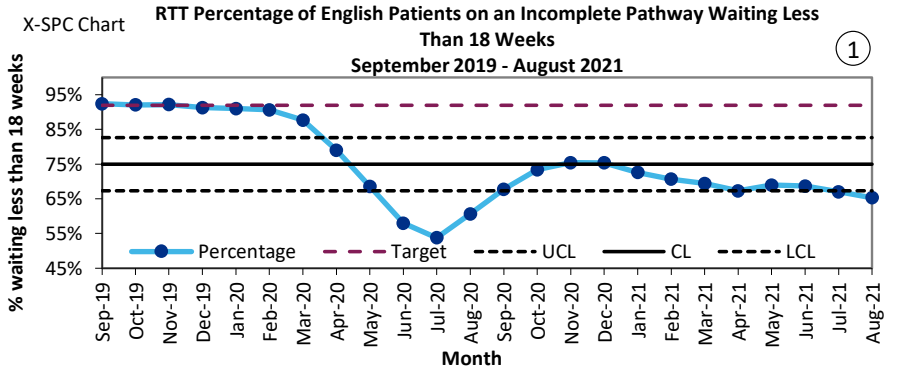
Key Narrative: 11 operations were cancelled on the day of admission by the hospital for non-clinical reasons in August 2021 (0.6%), an improvement on the percentage of cancellations in July 2021 (0.9%).

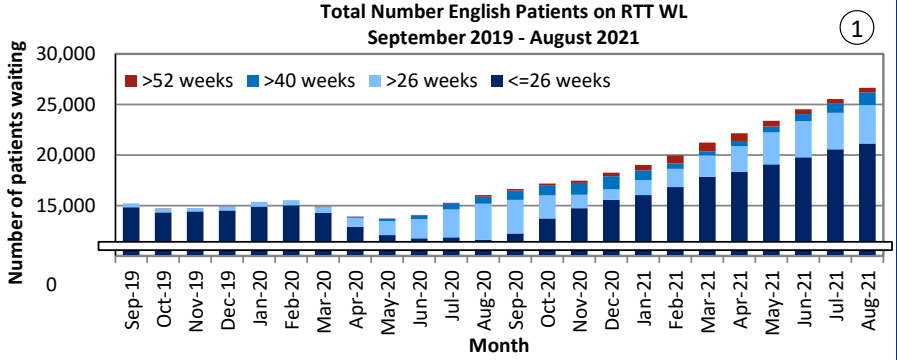
The P-SPC chart adjusts the control limits to take into account each month's denominator.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Performance

Referral to Treatment Waiting Times (RTT)





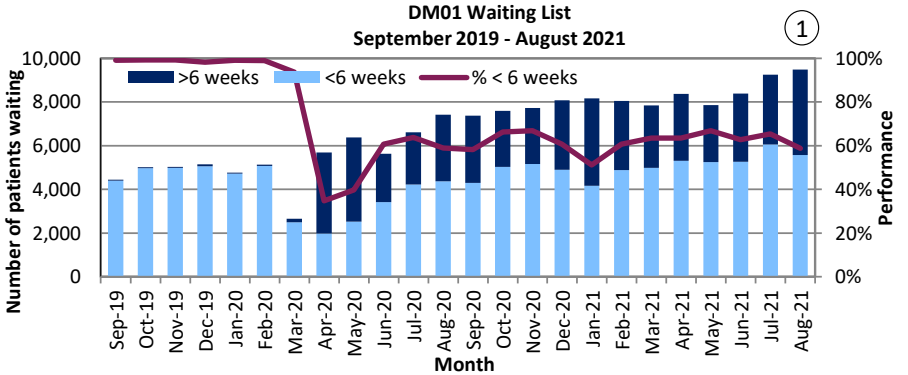
Accountable: Chief Operating Officer **Data Owner:** Information Services

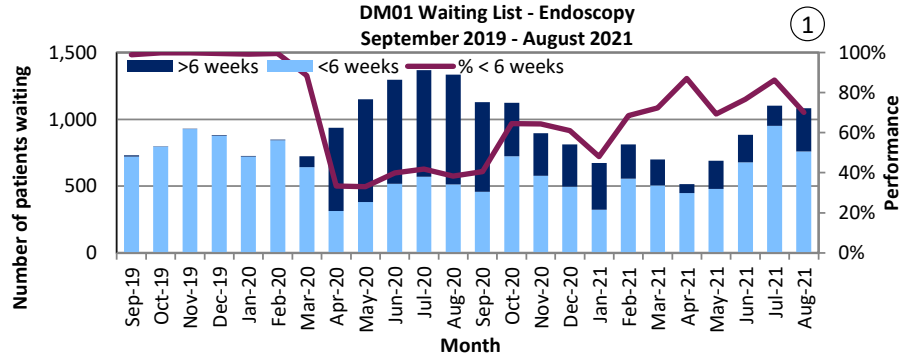
Key Narrative: The total number of patients on the RTT WL continues to grow with 26,622 patients waiting at the end of August 2021, of which 424 patients were waiting for more than 52 weeks, 4 fewer than reported in July 2021.

August 2021 RTT performance shows 65.3% of patients waiting less than 18 weeks, a decrease to the performance in July 2021 (67.0%).

Latest month's data provisional

Diagnostic Waiting Times





Accountable: Chief Operating Officer **Data Owner:** Information Services

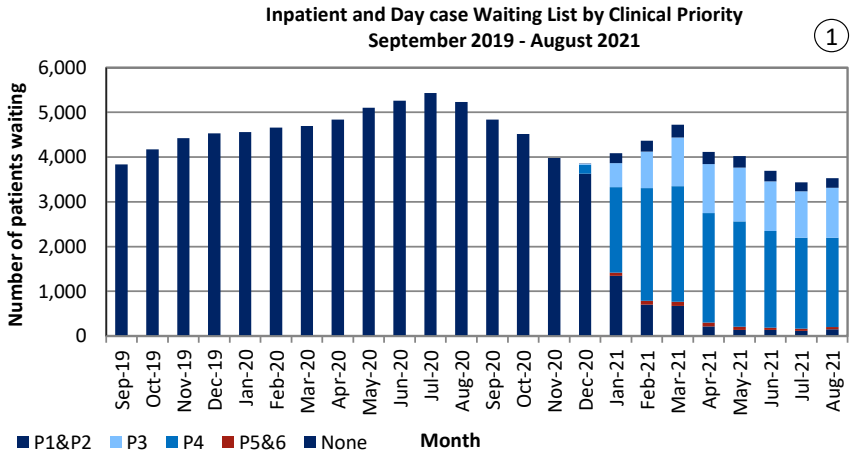
Key Narrative: Following a review of the DM01 guidance, there have been changes to the reporting logic from June 2021, which has led to an increase in the number of DM01 waiters reported alongside some waiting list growth.

The total number of patients on the DM01 diagnostic waiting list for August 2021 was 9,479 and performance against the 6 week diagnostic standard in August 2021 was 58.8%. Performance for the Endoscopy DM01 modalities reduced from 86.3% in July 2021 to 70.1% in August 2021.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Performance

Inpatient and Day Case Clinical Prioritisation

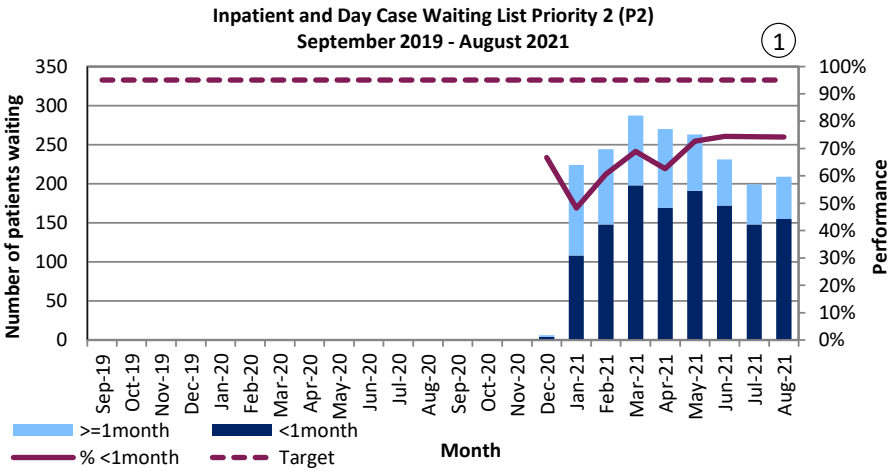


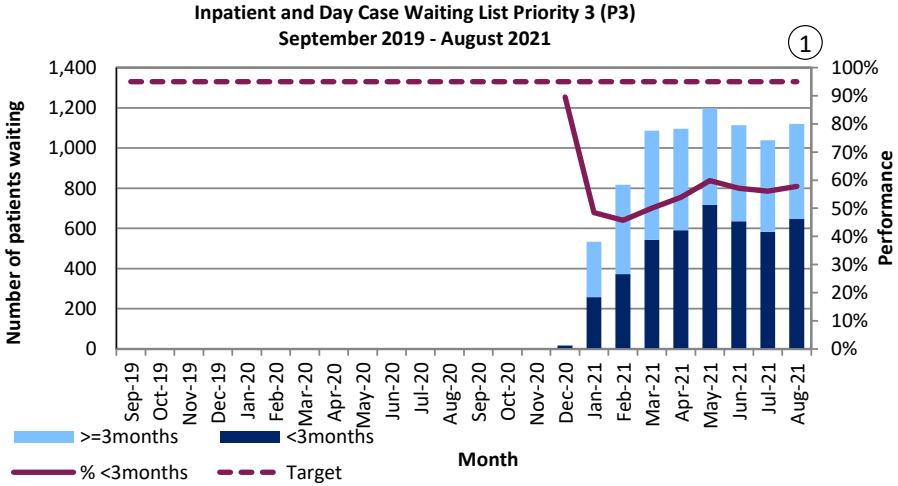
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: From December 2020, all patients on the inpatient waiting list are assigned a clinical priority code defining when they should undergo their operation. P1: 1-3 days, P2: <1 month, P3: <3 months. P5 and P6 relate to patients choosing to delay treatment for covid and non-covid reasons.

The waiting list at the end of August 2021 showed 209 patients had been categorised as P1 and P2; 1,119 as P3; 2,001 as P4.

In August 2021 the percentage of patients classified as P2 and currently waiting less than 4 weeks for treatment was 74.2%, similar to the previous month. The patients classified as P3 and waiting less than 3 months at the end of August 2021 was 57.8%.

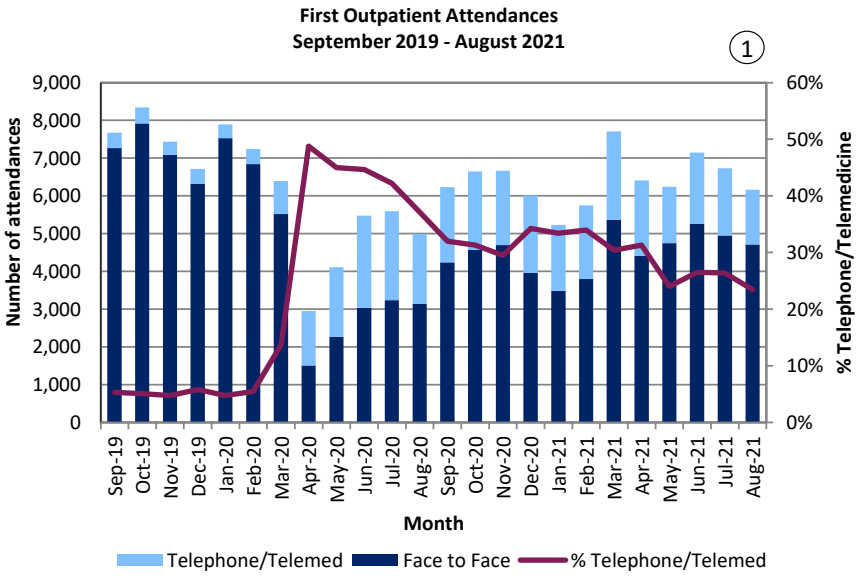


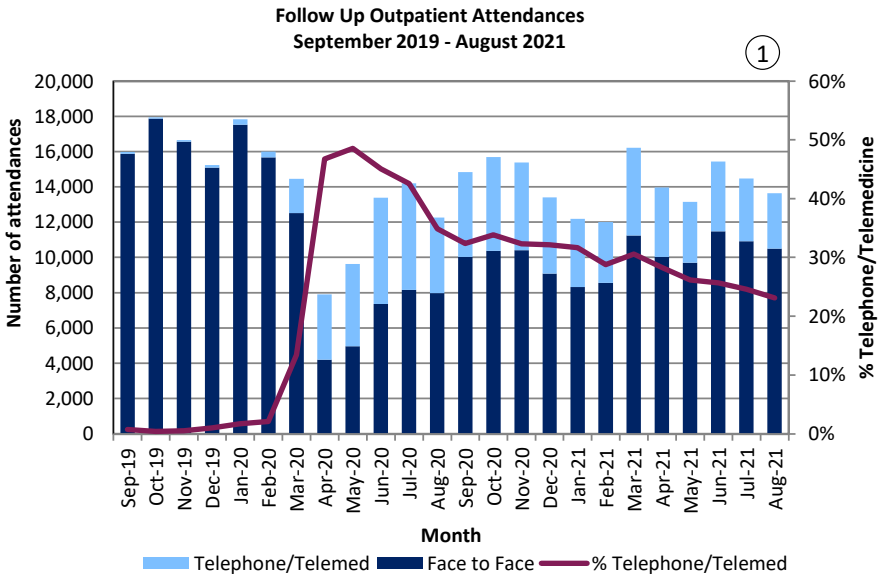


Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Performance

Outpatient Activity





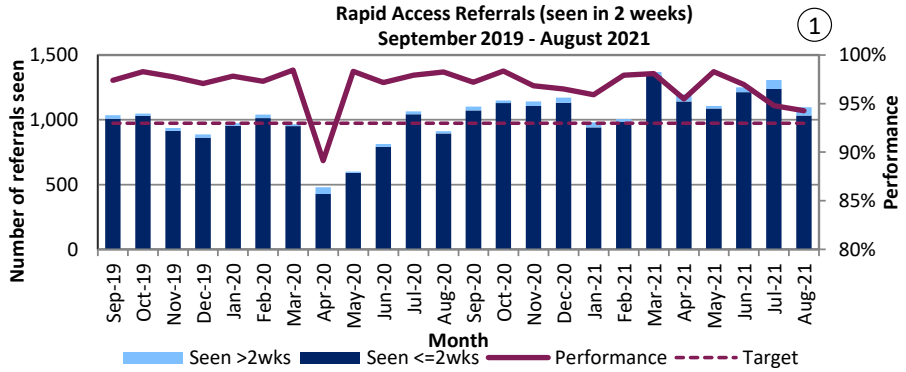
Accountable: Chief Operating Officer **Data Owner:** Information Services

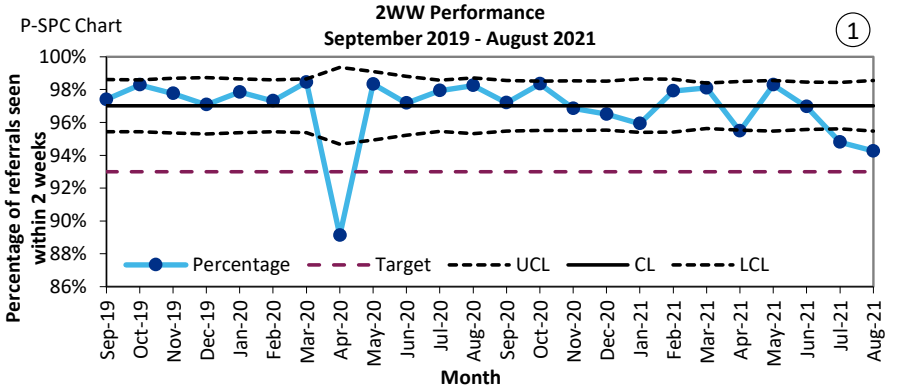
Key Narrative: 6,106 total first outpatient appointments were attended in August 2021, a decrease of 8.5% of activity compared to July 2021. The proportion of non face to face appointments for August 2021 was 23.4%, below the rate seen in July 2021 (26.4%).

There were 13,646 total follow up outpatient appointments attended in August 2021, a decrease of 5.8% of the activity compared to July 2021. The proportion of non face to face appointments for August 2021 was 23.1%, below the rate seen in July 2021 (24.6%).

Performance

Rapid Access Referrals





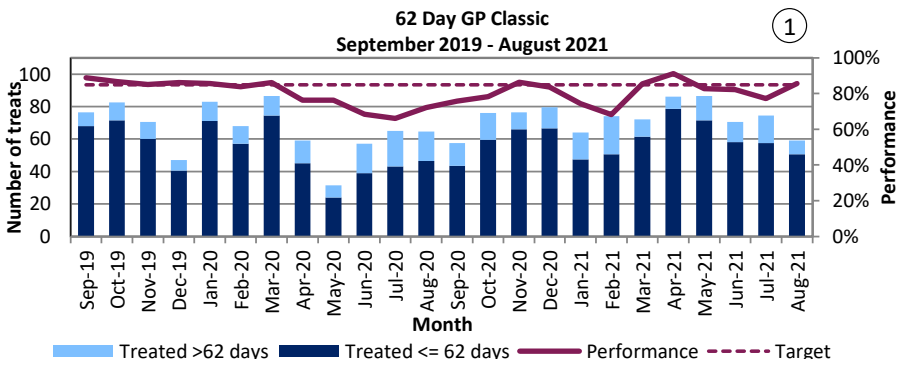
Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

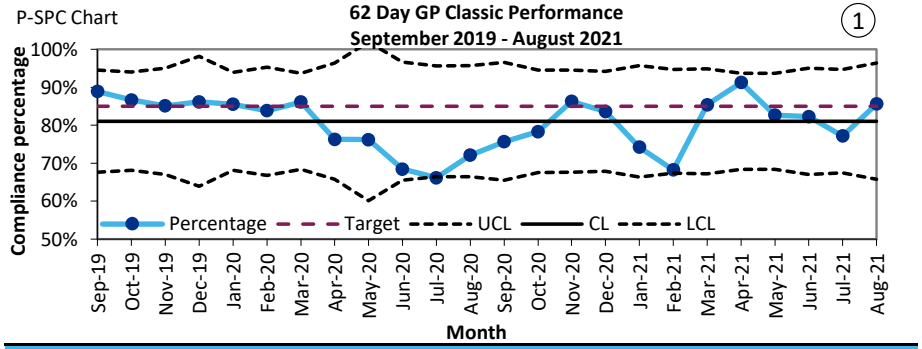
Key Narrative: 1,097 rapid access referrals were seen in August 2021, an decrease of 16.1% from the previous month but in line with the 24-month average.

The 2 week wait performance has consistently delivered above the 93% standard. August 2021 performance was 94.2%. The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

62 Day





	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
104+day Confirmed Cancer	2	3	3	5	4	2	1	0	2	1	2	2

Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

Key Narrative: Provisional performance against the 62-day standard for August 2021 currently reported at 85.6% and is above target. This is subject to validation of tertiary referrals and transfer dates, this is likely to improve.

The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

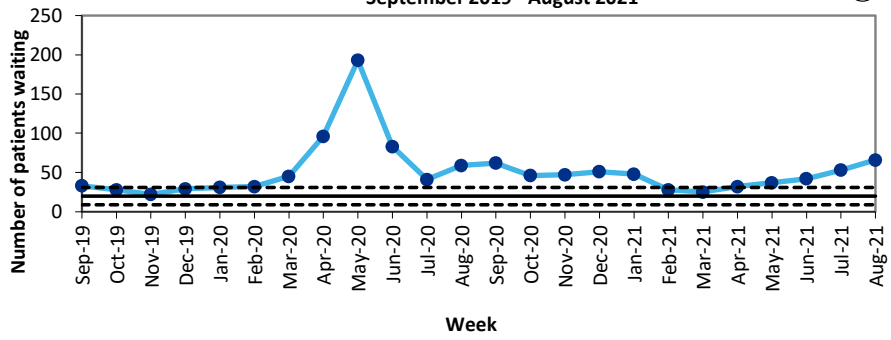
Performance

Cancer Waits Without DTT

X-SPC Chart

Rapid Access GP Referrals waiting 63-104 days without a decision to treat
September 2019 - August 2021

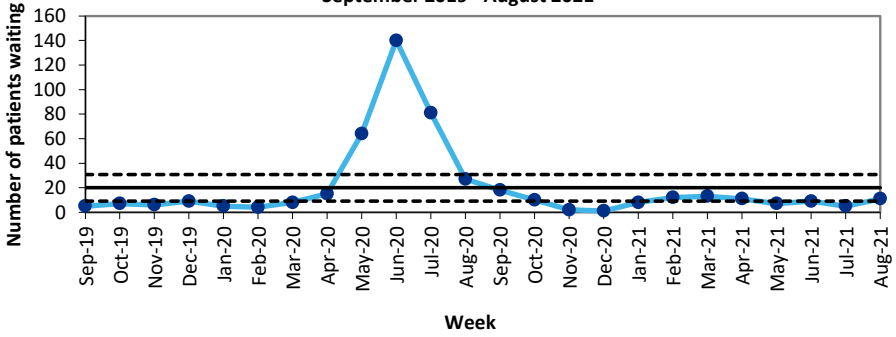
①



X-SPC Chart

Rapid Access GP Referrals waiting more than 104 days without a decision to treat
September 2019 - August 2021

①



Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

Key Narrative: There were 66 patients waiting between 63 and 104 days without a decision to treat (DTT) at the end of August 2021, and 11 patients waiting more than 104 days, which is a rising trend.

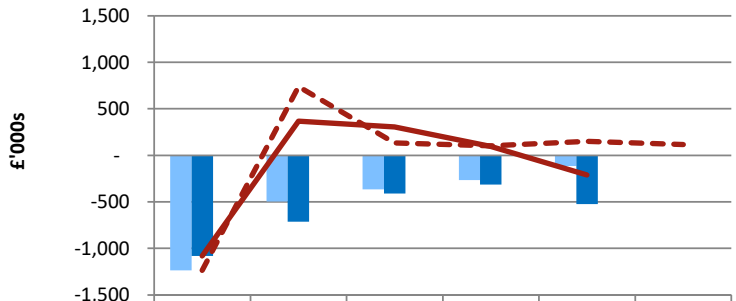
Data based on the last Monday of the month

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Finance

Financial Performance

Financial Performance 2021/22



	Apr	May	Jun	Jul	Aug	Sep
Cumulative Plan	-1,235	-497	-366	-266	-116	-1
Cumulative Actual	-1,081	-715	-409	-313	-525	
Cumulative Variance	154	-218	-44	-47	-408	1
In Month Plan	-1,235	737	132	100	149	115
In Month Actual	-1,081	366	306	97	-212	
In Month Variance	154	-371	174	-4	-361	-115

Month

	YTD Rating		YE Rating	
Indicator	**Plan**	**Actual**	**Forecast**	**Status**
Finance				
Use of Resource Rating				
Capital Service Capacity				
Liquidity				
I&E Margin				
Distance from Financial Plan				
Agency Spend				

Accountable: Director of Finance **Data Owner:** Finance Department

Current view

The cumulative actual position at the end of August was a £0.5m deficit, which is over plan by £0.4m. An additional covid positive ward, over and above the 2 escalation wards, was fully operational in August contributing to the adverse variance.The additional unfunded ward pressure, which is expected to remain open in September, together with the anticipated contribution from Elective Recovery Fund not materialising will make it difficult to achieve a balanced position for H1. It is expected for H1 that the Trust will have a deficit of £0.9m against a break even financial plan.

As part of forecast discussions within the Healthcare Partnership (HCP), it has provisionally been confirmed that the surpluses elsewhere within other organsiations within the system will be moved to support the Trusts deficit in order to achieve an overall balanced position for the HCP.

Forward view

The escalation beds are expected to remain open beyond H1 into Q3 & 4. The planning for Winter/surge capacity indicates that there will be further pressures to come to support key areas such as paediatrics, and additional escalation capacity.

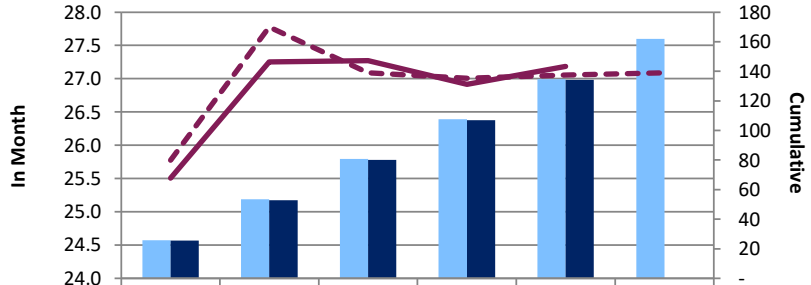
Planning guidance for H2 (October-March) is expected on 16 September 2022 although it has been confirmed it will be a continuation of system envelopes and block contract payments will remain in place.

It is expected to be be a challenging second half of the year, with an increased efficency expectation offset by relentless unplanned care pressures. H1 and H2 will be treated as a single financial period with organisations expected to achieve financial balance for the whole year.

Finance

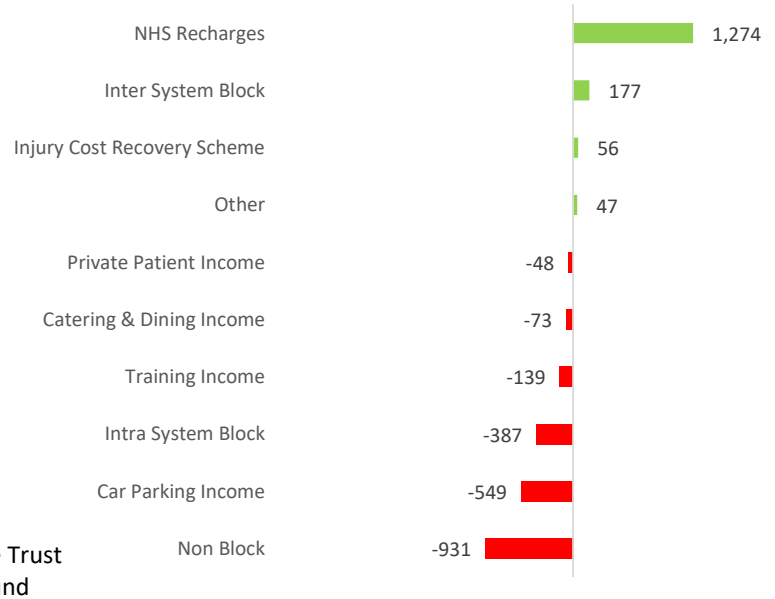
Income

Contract Income Performance 2021/22 £'m ②



	Apr	May	Jun	Jul	Aug	Sep
Cumulative budget	26	54	81	108	135	162
Cumulative actual	26	53	80	107	134	
In month budget	26	28	27	27	27	27
In month actual	26	27	27	27	27	

Variance £'000s ②



Accountable: Director of Finance **Data Owner:** Finance department

Current View:

Overall income is under budget by £1m. Predominately this is due to reduced income from the Elective Recovery Fund (ERF) due to reduced elective activity taking place. The consequences of this are that the Trust planned to deliver a £0.6m contribution to the Trust position however this is now more likely to be around £100k. The data issue relating to April and May ERF has now been resolved and payment of the balance is now expected.

There is also an under performance due to delays to services change eg East Cheshire Dermatology – which are offset by recharges above the plan associated with the vaccination, testing and final year student nurse placement funding.

Forward View:

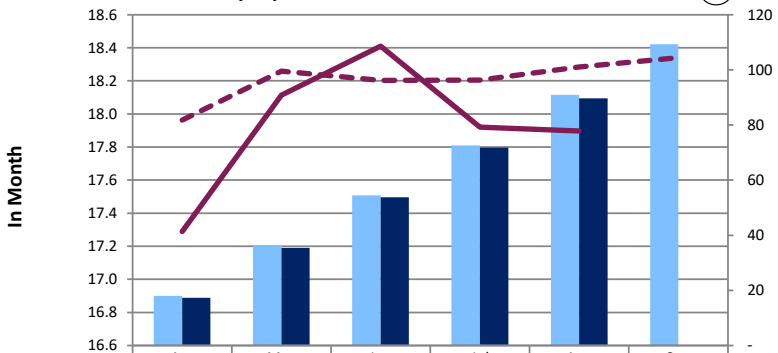
The funding and payment mechanism arrangements for H2 will be broadly in line with H1, with some adjustments for higher efficiency requirements, inflationary impacts and expansion of services for example maternity services resulting from the Ockendon report.

Finance

Pay

Pay Expenditure 2021/22 £'m

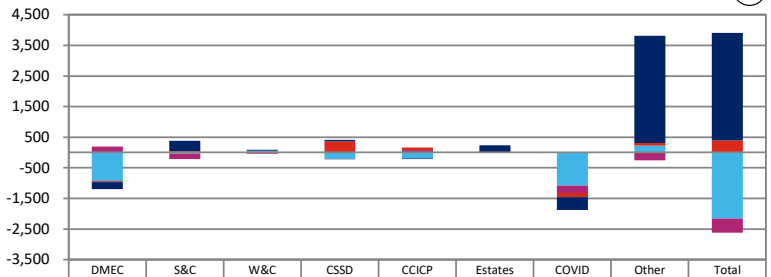
②



	Apr	May	Jun	Jul	Aug	Sep
Cumulative budget	18	36	54	73	91	109
Cumulative actual	17	35	54	72	90	
In month budget	18	18	18	18	18	18
in month actual	17	18	18	18	18	

Pay Variances by Staff Group and Division £'000s

②



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	-998	168	55	186	-55	240	-1,872	3,562	1,285
Infrastructure Support Staff	-227	345	34	54	-30	240	-417	3,512	3,511
Non Clinical Staff	-33	33	-1	361	87	-	-129	78	397
Medical Staff	195	-174	-34	-15	76	-	-250	-258	-461
Nursing Staff	-933	-36	56	-214	-188	-	-1,077	229	-2,162

Accountable: Director of Finance **Data Owner:** Finance Department

Current View:

Pay is under budget YTD (£1.3m). Costs continue to be high in month reflecting the continuation of the existing escalation wards and the further increase in month of an additional ward during August. This in turn increased the number of additional nurse/HCA shifts required, however, this has been offset in part by the annual leave accrual being released from reserves.

Bedwatch security costs have risen in month as the number of additional beds increases.

Forward View:

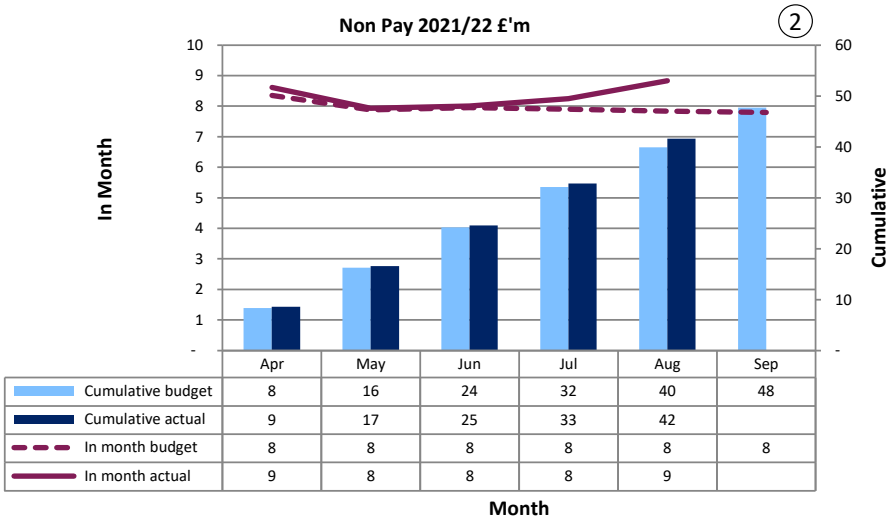
The pay bill will come under significant pressure particularly in H2 if the current levels of bed occupancy continue, whilst the Trust has forward planned with the international nurse recruits - the level of demand caused by further opening of a ward is such, that there will remain a high dependency on agency to staff wards within the hospital this Winter.

Escalation beds that were expected to close at the end of June 2021 remain open at a financial pressure to the Trust and are expected to be open for September and beyond. In additional there are emerging pressures being identified as part of the Winter/surge planning which are likely to see a further increase in cost.

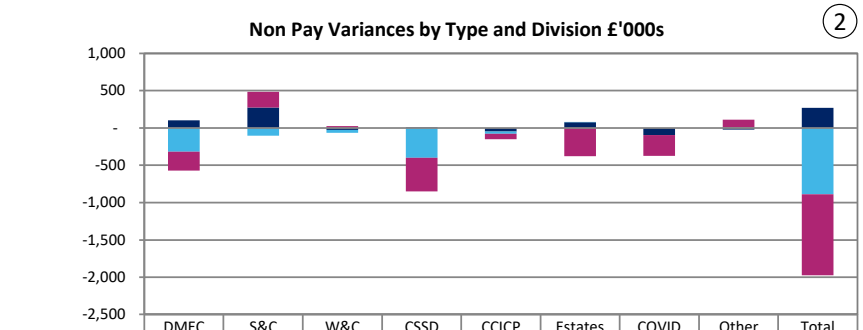
In response to this the Trust is supporting several strategies aimed at improving the urgent care flow – which is at an unprecedented level for a Summer period.

Finance

Non-Pay



	Apr	May	Jun	Jul	Aug	Sep
Cumulative budget	8	16	24	32	40	48
Cumulative actual	9	17	25	33	42	
In month budget	8	8	8	8	8	8
In month actual	9	8	8	8	9	



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	-467	383	-40	-845	-150	-301	-374	92	-1,702
Other Non Pay	-252	213	27	-452	-72	-378	-279	108	-1,086
Drugs	-317	-103	-38	-400	-32	0	-	4	-887
Clinical Supplies	103	273	-28	7	-46	77	-95	-20	271

Accountable: Director of Finance **Data Owner:** Finance Department

Current View:

Non-Pay is over budget YTD by £1.7m and has seen a steep increase in month.

The largest area of overspend is within the area of high cost drugs, which is linked to an increase in activity – where those drugs are commissioned by NHSE, the Trust has seen a corresponding increase income.

Outsourcing costs and Clinical supplies have seen increases in month which is anticipated as part of the restoration recovery plan.

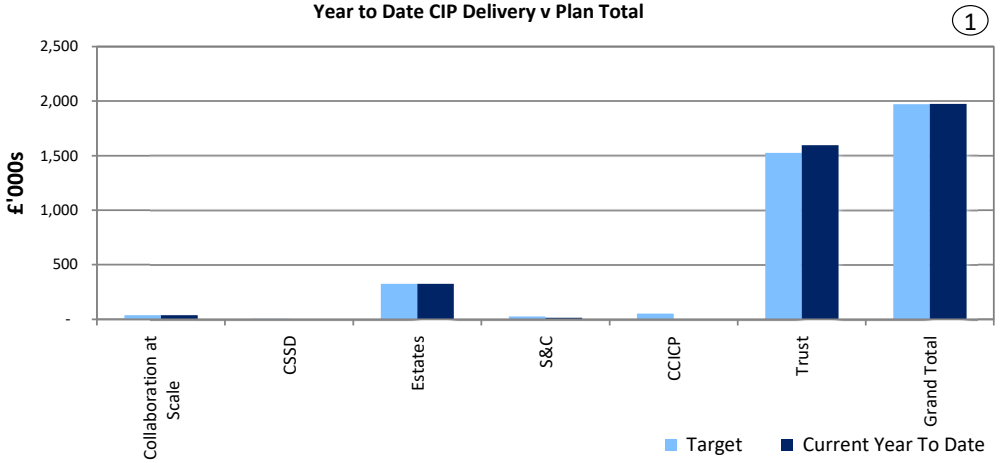
International Recruitment costs have also risen as staff have started to join the Trust from overseas.

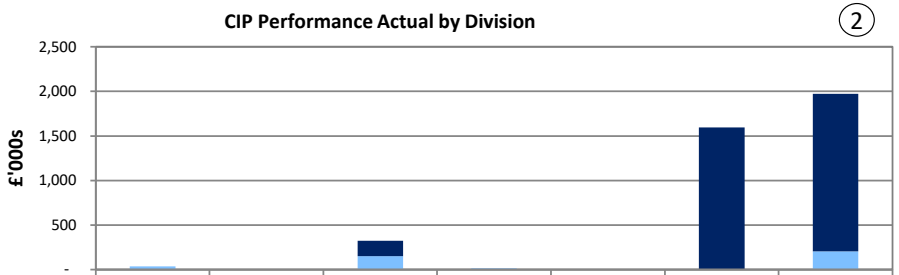
Forward View:

In the coming months it is anticipated that there will be an increase in the use of alternative providers as part of the restoration programme commences, which will be primarily sourced via the increasing capacity framework - particularly within diagnostics as Q2 progresses.

Finance

Cost Improvement Programmes (CIP)





	Collaboration at Scale	CSSD	Estates	S&C	CCICP	Trust	Grand Total
Current Year To Date	38		325	15		1,596	1,973
Pay			173			1,596	1,768
Non pay	38		152	15			205

Accountable: Director of Finance **Data Owner:** Finance Department

Current View:
The national efficiency expectation for H1 was set at 0.28% (£0.4m), in addition the Trust has a C&M system efficiency target of £1.9m, giving a total target of £2.3m for H1. To date the CIP plan is being met, with the largest savings relating to the procurement of laundry services, with additional savings on recruitment delays and phasing difference in expected cost pressures.

The Trust is continuing to look to support either existing schemes or new schemes that can progress in areas of the hospital that have capacity to support focus around this, which is being managed via the monthly finance meetings, with a particular focus on collaboration schemes that can be progressed.

Saving schemes that will be progress this year, at present are focussed on having no or little patient impact.

Forward View:
It is expected that there is likely to be a minimum 2% Costing imporvement requirement for H2, based on the early themes of the H2 guidance discussed.

Early indications are that for Cheshire & Merseyside healthcare partnership (HCP) there is likely to be a significant financial challenge to deliver a balanced system position for H2. The expectation is that there will be an increasing focus on Trust efficiency schemes with an expected efficiency target set above the national one, which would be on top of the 3% (£4.6m) indicated above.

Finance

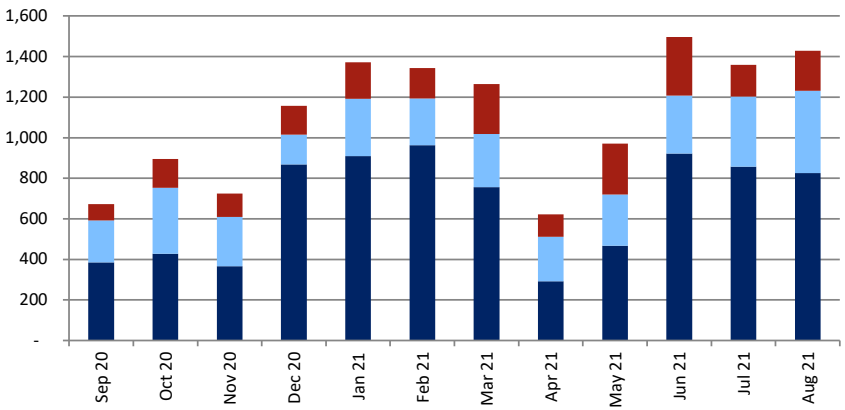
Income and Expenditure

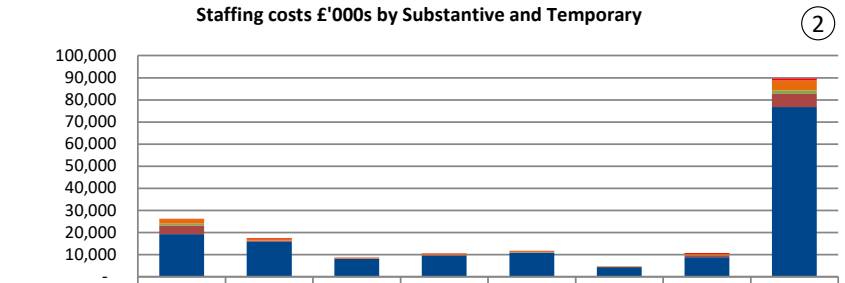
(2)

Budget H1		Month			Year to Date			Forecast H1
2021/22 (£'000)		Plan Aug (£'000)	Actual Aug (£'000)	Variance Aug (£'000)	Plan April to Aug (£'000)	Actual April to Aug (£'000)	Variance April to Aug (£'000)	2021/22 (£'000)
	Operating							
	Operating Income							
	Commissioning Income							
151,309	Inter System Block	1,467	1,475	8	7,234	7,411	177	151,309
0	Intra System Block	19,072	19,133	61	95,459	95,072	(387)	0
0	Non Block	4,779	4,828	48	23,297	22,365	(931)	0
407	RTA and Private Patient	68	65	(3)	339	347	7	407
0	*Other Operat* Donations of Purchased Assets	0	0	0	0	0	0	0
10,066	Other Operating Income	1,668	1,683	15	8,376	8,936	560	10,066
161,782	**TOTAL OPERATING INCOME**	**27,054**	**27,183**	**129**	**134,705**	**134,130**	**(575)**	**161,782**
	Operating Expenses							
(109,534)	Employee Benefits Expenses (Pay)	(18,284)	(17,896)	388	(90,913)	(89,628)	1,285	(110,434)
(8,912)	Drugs	(1,485)	(1,637)	(152)	(7,426)	(8,313)	(887)	(8,912)
(8,311)	Clinical Supplies	(1,301)	(1,170)	131	(6,526)	(6,256)	271	(8,311)
(30,057)	Other operating expenses	(5,049)	(6,024)	(975)	(25,968)	(27,055)	(1,086)	(30,057)
(156,814)	**TOTAL OPERATING EXPENSES**	**(26,120)**	**(26,728)**	**(608)**	**(130,834)**	**(131,252)**	**(417)**	**(157,714)**
4,968	**EBITDA**	**934**	**455**	**(479)**	**3,871**	**2,879**	**(992)**	**4,068**
	Non Operating							
	Non Operating Income							
(190)	Interest	(32)	(7)	25	(158)	(55)	103	(190)
0	Asset disposal	0	0	0	0	0	0	0
	Non-Operating Expenses							
(3,522)	Depreciation & Finance Leases	(545)	(424)	120	(2,783)	(2,167)	616	(3,522)
0	Depreciation on Donated Assets	1	(26)	(27)	(0)	(135)	(135)	0
(1,256)	PDC Dividend Expense	(209)	(209)	0	(1,047)	(1,047)	0	(1,256)
0	**Net Surplus/(deficit) before Exceptional Items**	**149**	**(212)**	**(361)**	**(116)**	**(525)**	**(408)**	**(900)**
0	Remove capital donations/grants I&E impact	(1)	26	27	0	135	135	162
0	**Net Surplus/(Deficit) after Exceptional Items**	**149**	**(185)**	**(334)**	**(116)**	**(389)**	**(273)**	**(738)**

Finance

Bank and Agency





	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	26,238	17,455	8,615	10,494	11,520	4,661	10,645	89,628
Waiting List	199	280	53	62	0	-0	332	926
Bank	1,972	602	300	410	369	295	522	4,470
Locum	944	211	33	234	127	-	57	1,606
Agency	3,882	546	102	202	221	16	910	5,879
Substantive	19,241	15,817	8,126	9,585	10,804	4,351	8,824	76,748

Accountable: Director of Finance **Data Owner:** Finance Department

Current View:

Agency expenditure was £1.4m in the month of August, which is an increase on July - reflecting the additional demand in shifts required to support the escalation areas of the hospital.

The continued high levels of spend relate to the escalation beds remaining open, and also support for the restoration programme.

Forward View:

It is expected that there will be increased pressure on agency expenditure as a result of the pressures that are being experienced with unplanned care.

The Trust continues to work collaboratively across Cheshire to increase the International nurse recruitment in order to meet the key objective of minimal nurse vacancies.

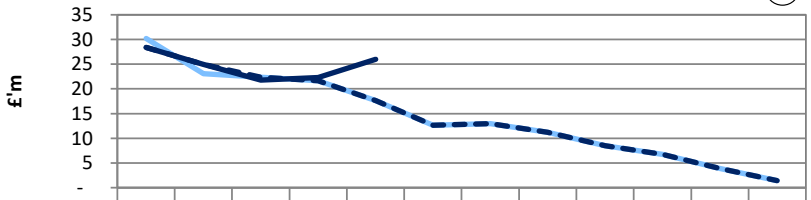
As the restoration plans progress there will be an increase in premium costs (agency/WLIs) for the medical workforce in order to support this return of planned care services.

Finance

Cash

Cash Position

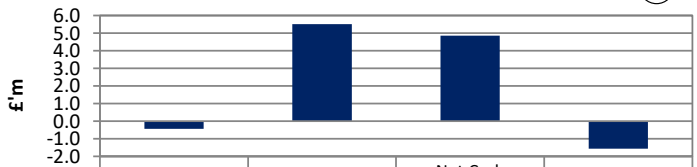
②



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	30	23	22	22	18	13	13	11	9	7	4	1
Actual	28	25	22	22	26							
Forecast	28	25	22	22	18	13	13	11	9	7	4	1

Cash Flow Movements

②



	Operating Surplus / (Deficit)	Increase / (Decrease) in Working Capital	Net Cash Inflow / (Outflow) from Capital Expenditure	Net Cash Inflow / (Outflow) from Borrowings
Variance to Opening Balance	-0	6	5	-2

Accountable: Director of Finance **Data Owner:** Financial Services

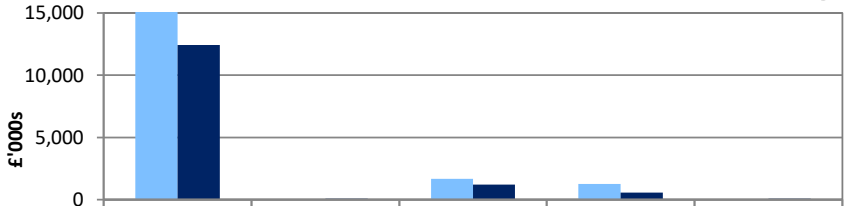
Current View: Cash is higher than plan by £8.4m due to improvements in working capital linked to higher accruals and lower creditors, and slippage in capital projects.

Forward View: The cash position remains strong, however the forecast includes £7.3m of additional capital expenditure which is funded internally.

Capital

Capital Expenditure

②



	Estates	IT	Estates	IT	Other
	NHSI Approved Plan		Additional Schemes		
Plan	18837	0	1671	1261	0
Actual	12443	72	1218	578	69

②

	Year to Date £'000s			Year End £'000s		
	Plan	Actual	Variance	Plan	Forecast	Variance
NHSI Approved Plan						
Estates	18,837	12,443	-6,394	37,909	38,947	1,038
IT	0	72	72	3,600	3,770	170
NHSI Approved Total	**18,837**	**12,515**	**-6,322**	**41,509**	**42,717**	**1,208**
Additional Schemes						
Estates	1,671	1,218	-453	3,627	3,273	-354
IT	1,261	578	-683	2,600	2,570	-30
Other	0	69	69	0	151	151
Total Capital Schemes	**21,769**	**14,380**	**-7,389**	**47,736**	**48,711**	**975**

Accountable: Director of Finance **Data Owner:** Financial Services

Current View: The capital programme is behind plan by £7.4m, due to the A&E expansion of £4.3m, RAAC Planks £1.3m and Backlog Maintenance £0.4m.

Forward View: We are currently forecasting a £1.2m overspend against the NHSI Submitted Plan. The Trust is awaiting formal recognition from the HCP for the additional capital schemes.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Finance

Statement of Financial Position August 2021

②

		Plan Apr to August (£'000)	Actual Apr to August (£'000)	Variance (£'000)
Assets	Assets, Non-Current	123,691	115,574	-8,117
	Assets, Current	33,152	42,730	9,578
ASSETS, TOTAL		**156,843**	**158,304**	**1,461**
Liabilities	Liabilities, Current	-36,317	-39,661	-3,344
	Liabilities, Non Current	-6,931	-6,960	-30
TOTAL ASSETS EMPLOYED		**113,595**	**111,683**	**-1,913**
Taxpayers' and Others' Equity				
	Taxpayers Equity	113,595	111,683	-1,913
TOTAL FUNDS EMPLOYED		**113,595**	**111,683**	**-1,913**

Accountable: Director of Finance **Data Owner:** Financial Services

Current View:
Cash is higher than plan by £8.4m mainly due to slippage on the capital programme. Trade Receivables are higher by £0.4m mainly due to Christie drugs invoices in query which are currently under review.

Trade Payables are on plan, however accruals remain high, driven by agency and drugs costs.

Public Dividend Capital is behind plan by £1.5m due to scheme slippage.

Forward View:
The Trust is due to receive PDC funding in relation to RACC Planks of £22m, and ED build £6m.

Finance

Balance Sheet

Current View:

Assets Non-Current
The capital programme is behind plan by £7.4m, due to the A&E expansion scheme of £4.3m, RAAC Planks £1.3m and Backlog Maintenance £0.4m.

Assets Current
Cash is higher than plan by £8.4m due to improvements in working capital linked to higher accruals, and slippage in capital projects.

Current Liabilities
Accruals are higher than plan due to an increase in agency and drugs costs.

Taxpayers Equity
Public Dividend Capital is behind plan, due to slippage in capital projects.

	Plan Apr to August (£'000)	Actual Apr to August (£'000)	Variance (£'000)	Forecast 2021/22 (£'000)
Assets				
Assets, Non-Current	**123,691**	**115,574**	**-8,117**	**147,436**
Assets, Current				
Trade and other Receivables	7,477	7,860	383	7,062
Other Assets (including Inventories & Prepayments)	8,075	8,896	821	6,662
Cash and Cash Equivalents	17,600	25,974	8,374	1,426
Total Assets, Current	**33,152**	**42,730**	**9,578**	**15,151**
ASSETS, TOTAL	**156,843**	**158,304**	**1,461**	**162,586**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-876	-789	87	-1,010
Loans Commercial Current	-180	-180	0	-357
Trade and Other Payables, Current	-20,962	-21,035	-73	-18,713
Provisions, Current	-514	-702	-189	-226
Other Financial Liabilities	-13,786	-16,955	-3,169	-13,475
Total Liabilities, Current	**-36,317**	**-39,661**	**-3,344**	**-33,780**
Net Current Assets/(Liabilities)	**-3,165**	**3,069**	**6,234**	**-18,630**
Liabilities, Non Current				
Finance Lease, Non Current	-2,135	-2,186	-51	-1,065
Loans Commercial Non-Current	-3,306	-3,306	0	-2,962
Provisions, Non-Current	-1,490	-1,469	21	-1,370
Trade and Other Payables, Non-Current	0	0	0	0
Total Liabilities Non-Current	**-6,931**	**-6,960**	**-30**	**-5,397**
TOTAL ASSETS EMPLOYED	**113,595**	**111,683**	**-1,913**	**123,409**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	124,832	123,332	-1,500	143,832
Retained Earnings	-23,327	-23,740	-413	-32,513
Donated asset reserve	0	0	0	0
Revaluation Reserve	12,090	12,091	1	12,090
TOTAL TAXPAYERS EQUITY	**113,595**	**111,683**	**-1,913**	**123,409**
TOTAL FUNDS EMPLOYED	**113,595**	**111,683**	**-1,913**	**123,409**

(2)

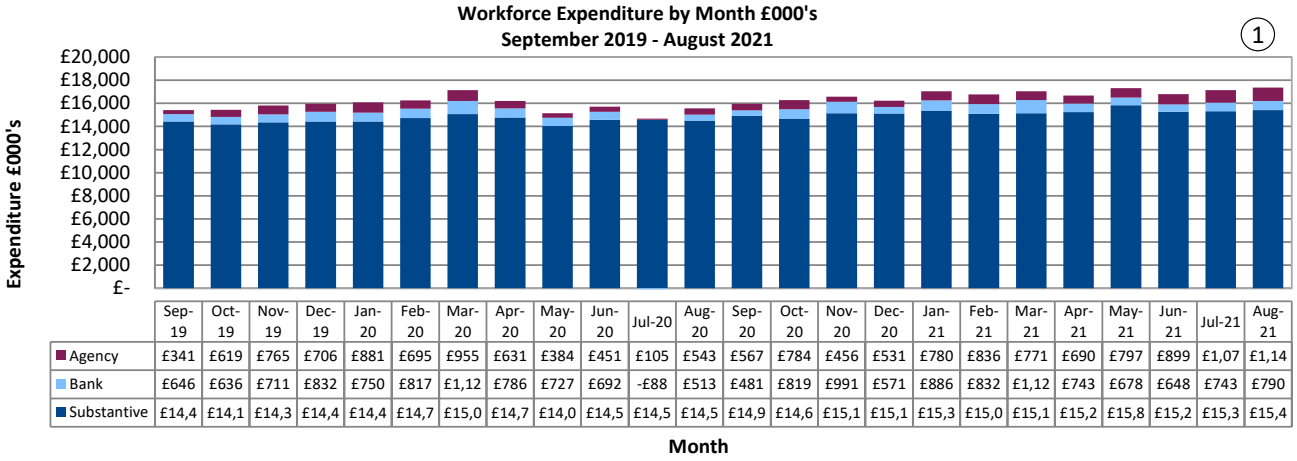
Forward View:

The forecast includes PDC funding and capital spend in relation to RACC Planks of £22m, and ED build £6m.

Cash balances are expected to reduce due to capital spends and a forecast deficit. At present, there are no plans to request cash support during the financial year.

Workforce

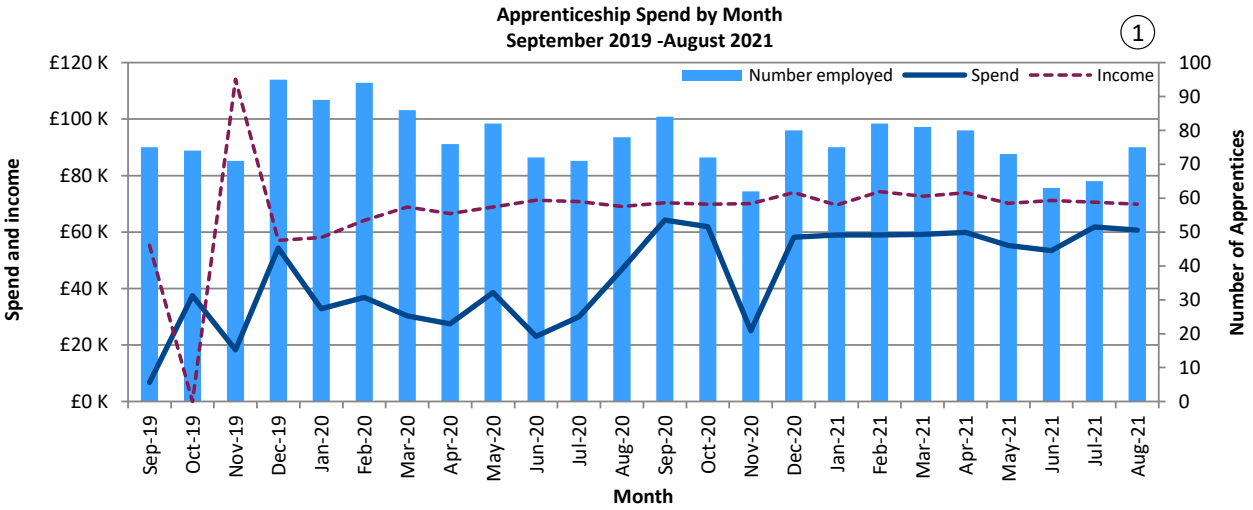
Finance and Costings



	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Agency	£341	£619	£765	£706	£881	£695	£955	£631	£384	£451	£105	£543	£567	£784	£456	£531	£780	£836	£771	£690	£797	£899	£1,07	£1,14
Bank	£646	£636	£711	£832	£750	£817	£1,12	£786	£727	£692	-£88	£513	£481	£819	£991	£571	£886	£832	£1,12	£743	£678	£648	£743	£790
Substantive	£14,4	£14,1	£14,3	£14,4	£14,4	£14,7	£15,0	£14,7	£14,0	£14,5	£14,5	£14,5	£14,9	£14,6	£15,1	£15,1	£15,3	£15,0	£15,1	£15,2	£15,8	£15,2	£15,3	£15,4

Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: Total workforce expenditure for August 2021 is £17,357k, an increase of £266k (1.3%) from the previous month and 11.5% higher than August 2020. Expenditure for August 2021 is £237k below budget (-1.3%) and £1,685k below budget (-1.9%) YTD.



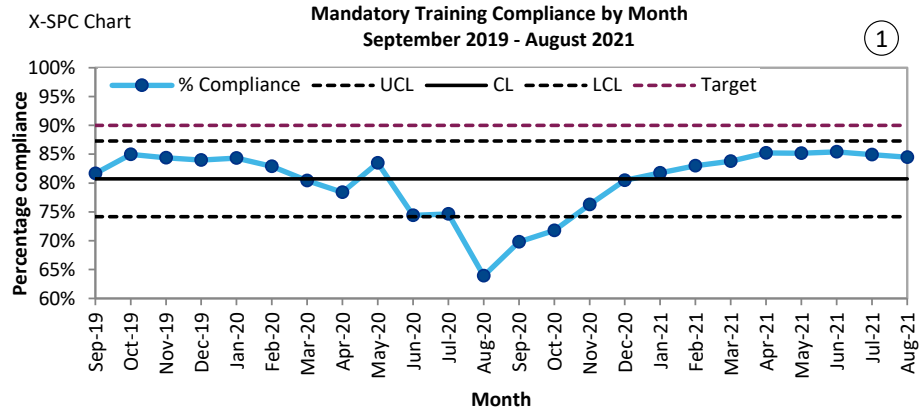
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

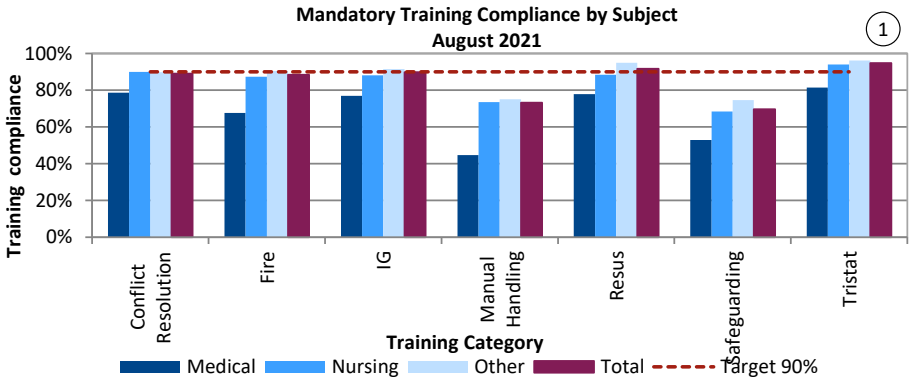
Key Narrative: The number of Apprentices employed in August 2021 was 75, 3.8% lower than the number employed in August 2020 (78).

Apprenticeship spend remains below income.

Workforce

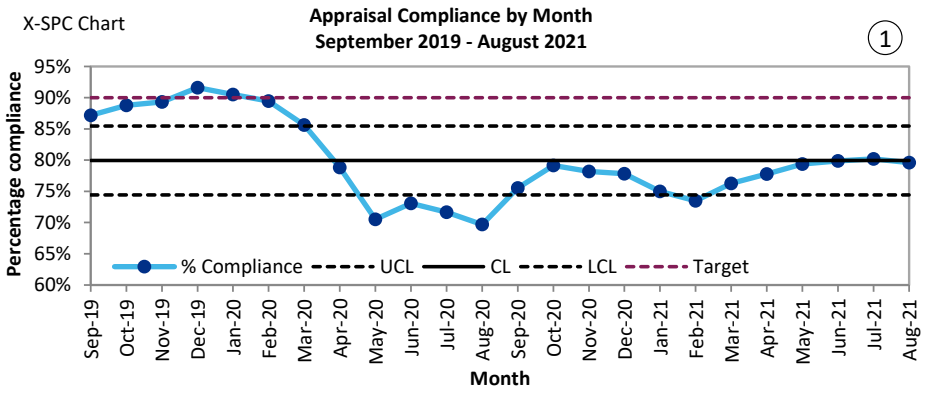
Training

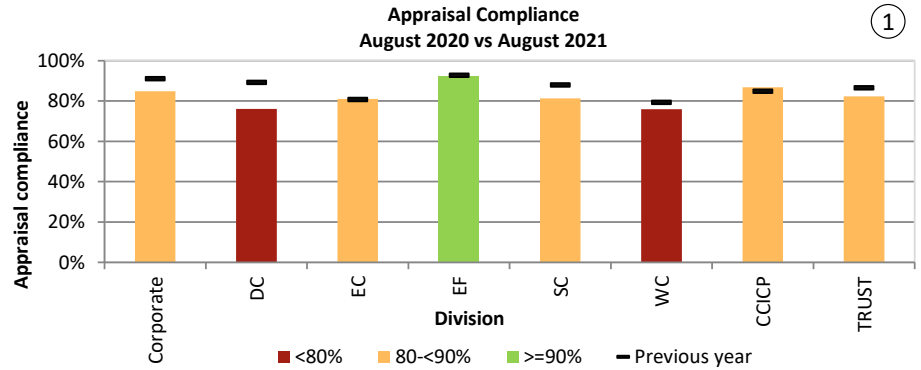




Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: Mandatory training compliance has stabilised achieving at 84.5% in August 2021 . Previously there had been a month on month improvement from the lowest compliance of 63.9% reported in August 2020. Training compliance remains below the 90% target.

Appraisals

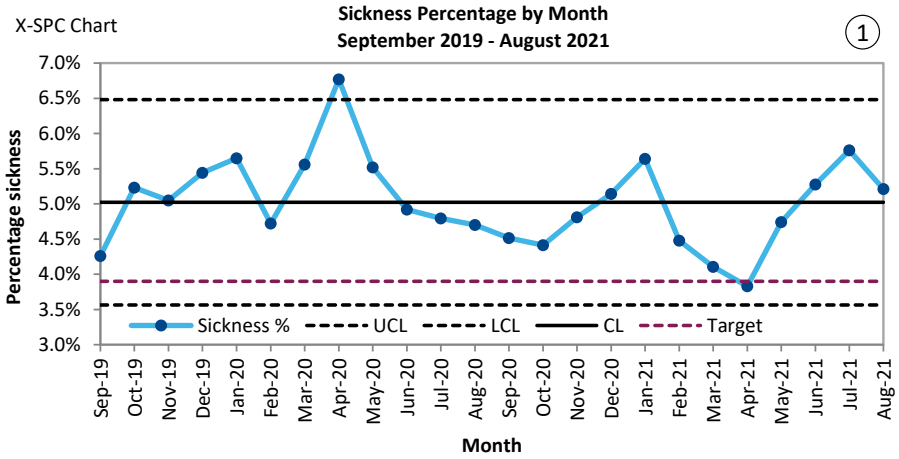




Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The reported appraisal compliance for August 2021 is 79.6%, which is in line with the 80.2% compliance reported in July 2021. Appraisal compliance remains below the target rate of 90% which was only achieved in December 2019 and January 2020 over the 24-month period shown.

Workforce

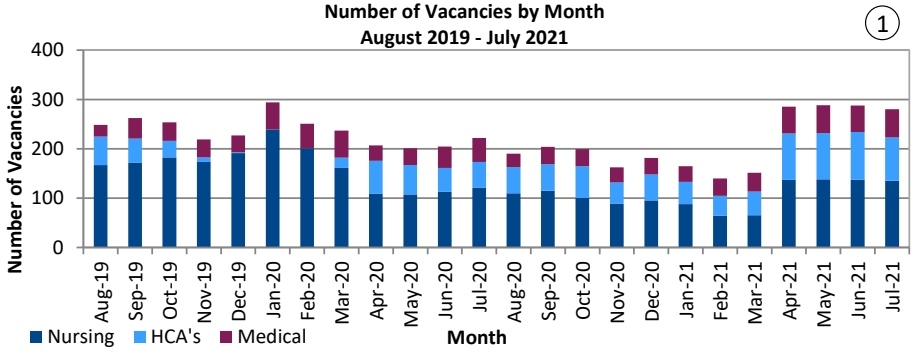
Sickness

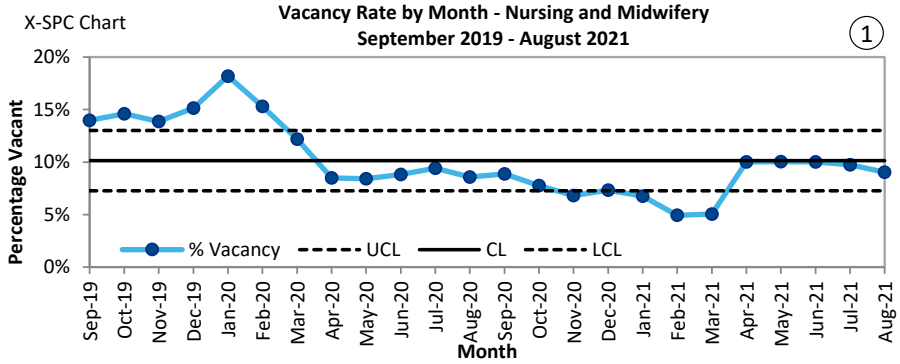


Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: The sickness rate for August 2021 was 5.2%. This is a decrease compared to the sickness rate reported for July 2021 (5.8%). The sickness rate is above that reported the previous year for August 2020 which was 4.7%.

Vacancies



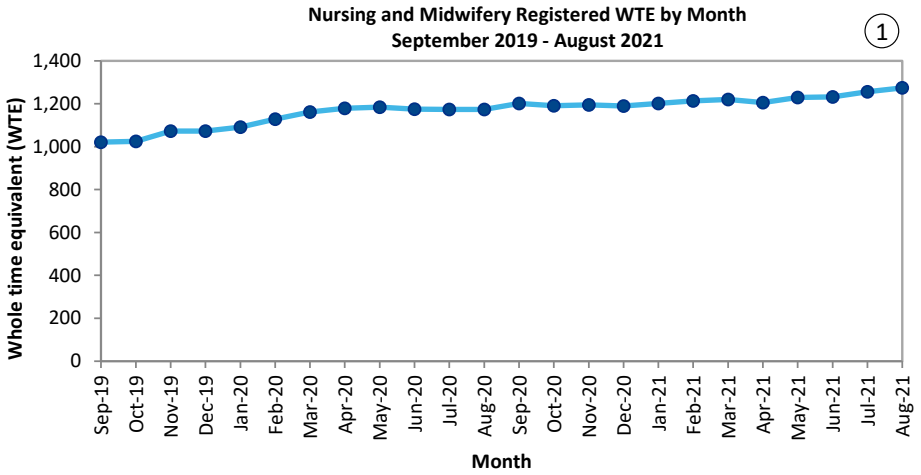


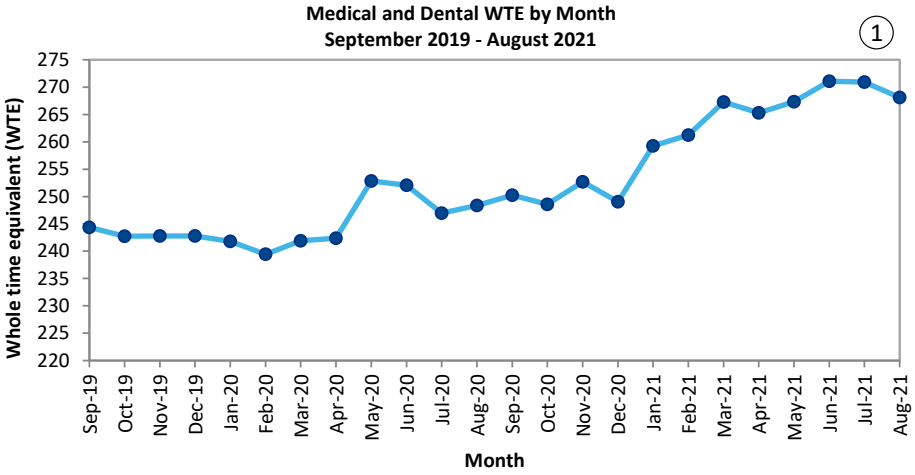
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The vacancy figures from April 2020 were restated to exclude International Recruitment, Nurse Apprentices and COVID.

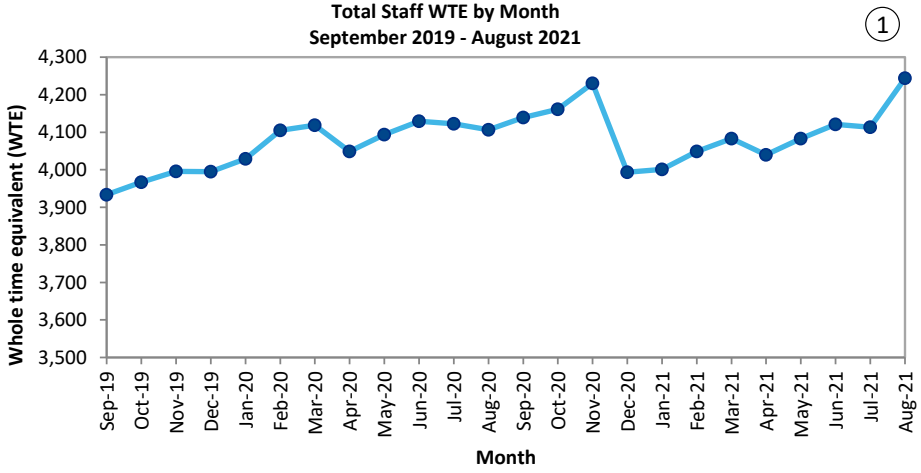
The vacancy rate forAugust 2021 has reduced slightly to 9.1% compared to previous month. The vacancy rate since the beginning of the financial year has increased, mainly as a result of investments which have been added to the Establishment at the beginning of the 2021-22.

Workforce

Total Staff Whole Time Equivalent (WTE)







Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: Nursing and Midwifery staff have increased by 252.9 WTE (25%) over the 24-month period and Medical and Dental staff by 23.8 (9.7%).

The Pathology Services (~278 staff, 243.8 WTE) transferred across to UHNM on the 1st December 2020 via a TUPE process, accounting for a drop in WTE of total staff from December 2020.

Data from ESR report: Monthly staff in post (WTE)

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Quality & Safety Committee (QSC)
Chair's Assurance Report
August 2021

Report to	Board of Directors
Date	18 August 2021
Report from	Lesley Massey, Non-Executive Director Chair
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Clare Hammell, Deputy Medical Director *(representing Murray Luckas, Medical Director)* Julie Tunney, Director of Nursing & Quality
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Covid-19:
Covid inpatient numbers increasing, planning for second ward in place if required, impact on staffing would be considerable. Ward 9 elective surgery repurposed for medical patients to manage emergency admission demand. Hospital acquired nosocomial outbreak in medical escalation ward, ward is closed with Trust outbreak measures in place.

IT Radiology Incident Update - Partial Assurance: Seven reported incidents reported from GPs, all low or no harm. No urgent referrals needed to be made as a result of the incident. Root cause analysis due to be completed jointly with Cheshire Clinical Commissioning Group.

BAF Heat Map
BAF 3 *Quality of Care* risk score of 9 reviewed, as discussed at QSC in July. New proposed score (3 Impact x 4 likelihood = 12) the likelihood has been increased to a 4 due to higher number of inpatient beds creating pressure on workforce which may lead to an increase in moderate harm. Due to this factor a new monthly report has been established to identify any areas with agency staff fill above 20%. Any area identified will undergo a care observation audit by the Quality Team.

Integrated Performance Report (IPR): Key points raised were:

- Central Cheshire Integrated Care Partnership (CCICP) patient safety incidents above upper control limit; percentage resulting in harm has decreased, reflects a positive patient safety culture
- Venous Thromboembolism (VTE) assessments sustained decline, remains at 93% of patients and no related clinical incidents. Staff reminded of requirement, compliance to be monitored via Trust Patient Safety Group
- One avoidable MRSA Bacteraemia case reported, review identified a lack of evidence that correct procedures were followed for the use of an invasive device. Increase in C-Difficile infections, reflective of increase in infections in the community since lockdown eased as rates rising across Cheshire and Merseyside (C&M). No trends identified in ongoing rapid reviews and actions taken. Increased vigilance noted in terms of other organisms aside of Covid 19.
- Safe staffing rates remain challenging, with increase of inpatient beds, agreed agency block booking for vacancies/ maternity cover in some areas. Additional support staff used when

Registered Nurse rate falls below expected 85% fill rate. Robust and embedded system in place to review staffing daily to ensure areas are utilising all roles and therefore as safe as possible. QSC **partially assured,** recognised actions in place to address staffing levels. Sustaining additional beds on existing workforce was challenging across all staff groups.

Executive Quality Governance Group (EQGG) Chair's Report

All risks scoring 15 or over reviewed. Key highlights of discussions were:

- Increase in skin damage incidents attributed to growth in patient numbers and higher acuity
- Healthcare Assistant (HCA) recruitment and retention work on supply, induction capacity and support of new staff. New role of Pastoral Support HCA being advertised
- Changes to divisional governance structures not yet fully embedded
- Deteriorating patient risk score reduced to 15
- Two new operational risks identified, lack of Tuberculosis service (TB) in Cheshire and Gynaecological Oncology failsafe
- Wellbeing Squads being well received, working in evenings as well as days to provide support
- Clinical Haematology risk. Improved engagement with supplier of service to support the review.

High quality annual reports received from the following services/ areas:

- **Clinical Audit and Effectiveness Report 2020/21 - Partial Assurance:** National and local audits stood down in March 2020 due to Covid, team flexed to support Covid work. Action plan and recruitment underway to achieve acceptable assurance following review of team to support new governance structures
- **Director of Infection Prevention & Control (DIPC) Annual Report 2020-21 - Acceptable Assurance:** Challenging and high-profile year for IPC, met objectives and Terms of Reference and provided pivotal support service during Covid. Trust approach implemented and recognised nationally. Next steps and challenges for 2021/22 outlined.
- **Annual Learning from Clinical Incidents, Inquests & Complaints Report - Partial Assurance:** Significant number of sources e.g. Post Infection Reviews (PIR), Structured Judgement Reviews (SJR), providing data to identify common elements of learning. Strong framework in place, levels of Clinical Harm Reviews and PIR need to improve to achieve acceptable assurance.
- **Annual Safeguarding Report 2020/21- Acceptable Assurance:** All statutory and regulatory requirements fulfilled against 52% increase in referrals. Appointment of named doctor for Adults Safeguarding would support team further.
- **Trust Patient Experience Group Annual Report and Summary 2020-21 - Acceptable Assurance:** First iteration of report combining patient experience, external engagement and complaints reflecting revised governance structure. Duties and Terms of Reference achieved.

Serious Incidents July 2021 – Acceptable Assurance: Four Strategic Executive Information System (StEIS) incidents recorded, one nosocomial Covid cluster identified in post-infection review. Lapse in care identified through the SJR process due to delay in treatment. Three non-linked cases of confirmed TB in Trust staff, previously working overseas and a baby born in poor condition requiring a transfer, initial 48 hour review identified some lapses in care.

Quarterly Incident Report: Quarter 1 of 2021/22 - Partial Assurance: First iteration of report to provide themes, trends and overview of safety incident processes, as recommended by internal auditors. Good reporting culture within peer averages. Clear identification of themes and trends previously reported to QSC.

KEY CONCERNS/RISKS

- Capacity of staff to manage patient care and all role requirements due to operational pressures and sustained use of escalation beds.

Priority Areas: DECISIONS MADE

- BAF 3 risk score increased from 9 to 12.

RECOMMENDATION

To note.

Quality & Safety Committee (QSC)
Chair's Assurance Report
September 2021

Report to	Board of Directors
Date	22 September 2021
Report from	Lesley Massey, Non-Executive Director Chair
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Murray Luckas, Medical Director Julie Tunney, Director of Nursing & Quality
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Covid-19: New infection prevention and control campaign to be launched to cover all organisms. QSC recommended that wider communications with the Clinical Commissioning Group (CCG) were considered as patient mask wearing compliance was low.

IT Radiology Incident Update - Partial Assurance: Root cause analysis (RCA) identified as failure of radiology department to advise IT of a system upgrade. Further meeting planned with CCG representation to agree findings. All patient impact reports to date categorised as low harm.

BAF Heat Map – BAF 3 score likelihood increased. Review of 15+risks underway to assess consistency against the risk prioritisation matrix and to identify potential impact on risk appetite.

Medical Workforce Deep Dive - Partial Assurance: Acute Medicine and Respiratory vacancies remain a concern, although services remain sustainable. Risk flagged and monitored through risk management process.

Integrated Performance Report (IPR): Key points raised were:

- Hospital Safety incidents within control limits; statistically significant change from March 2020, reflecting changes in emergency care pressures and Covid. Majority remain low or no harm
- Number of metrics deteriorated as number of patients in hospital have increased with a potential link to the number of additional escalation beds open, urgent and emergency case load and staff pressures
- Sustained positive shift in Central Cheshire Integrated Care Partnership (CCICP) incident reporting following training; increase in clinical incident reporting combined with reduction of incidents with harm
- Venous Thromboembolism (VTE) declining assessment rates, although remain above 93%; focus work has started in wards
- Review of twelve case spike in C-Difficile infections found four were avoidable due to antimicrobial prescribing; Executive Risk and Assurance Group to consider and whilst actions needed are clear, close review and focused attention will be important. Trust Infection Prevention and Control group will hold to account on actions.

- Previously reported hospital acquired Covid outbreak of ten cases was contained. One isolated case in September to date
- The percentage of harm within the number of patient falls dropped in July, possibly due to bed occupancy, however, this is under review to understand other contributory factors
- Lapses in care leading to Pressure Ulcers remain low, as a result of targeted work, however, cases for August still within the QA process
- Safe Staffing levels challenging while a high number of escalation beds open. If registered nursing ratios not met, incident raised and action taken. All areas made as safe as possible.

Hospital Metrics Development – Review of alternative methods of assessing hospital pressures concluded no easy solutions. External support from Advancing Quality Alliance (AQuA) suggested more regular rebasing of Statistical Process Charts (SPC) when changes in practice implemented.

Executive Quality Governance Group (EQGG) Chair's Report
All risks scoring 15 or over reviewed. Key highlights of discussions were:

- National Institute for Health and Care Excellence (NICE) assessment of compliance with key guidance completed with **partial assurance** as divisional governance structures not yet embedded. Completes outstanding action on key Board Assurance Framework control. Reporting to Board via QSC on areas of non-compliance to be confirmed
- Patient Safety Specialist role to be launched in conjunction with national Patient Safety Strategy
- Ward Accreditation programme commenced in CCICP
- AQuA patient safety report received, based on Trust patient safety score (second highest score in North West)
- Clarity on handling risks held by other Executive Groups provided in guide issued by Corporate Governance and Risk Assurance team.

Quality and Safety Improvement Strategy 2021-22 - Partial Assurance: Summary progress report of the four priority programmes: Sepsis – overachieving target; Medicines Safety – focused project in ED with Pharmacy Technician to reduce medical errors; End of Life Care – significant work underway; Reduction of Post-partum Haemorrhage – now in line with other Trusts.

Organ Donation Annual Report - Acceptable Assurance: Low number of potential donors this year. All appropriate next of kin were approached and two of three agreed to donation. This remains in line with national average.

Serious Incidents August 2021 - Acceptable Assurance: Two Strategic Executive Information System (StEIS) incidents recorded, both inpatient falls resulting in fractured neck of femur. Preliminary review suggests no lapses in care. CCG confirmed such falls no longer require StEIS reporting as management process is appropriate.

Care Quality Commission (CQC) - Acceptable Assurance: Actions managed by Executive Groups, Trust Quality Group providing overview of any not on track. Compliance with CQC regulatory requirements and preparation for inspection to be managed by new CQC Expert Group.

KEY CONCERNS/RISKS
Sustained pressures on Trust coupled with gaps in workforce and level of escalation beds is having a negative impact on morale

Priority Areas: DECISIONS MADE

None

RECOMMENDATION

To note.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**9.2**	Date of Meeting: 30/09/2021
Report Title	**Annual Safeguarding Report 2020/21**	
Executive Lead	Julie Tunney; Director of Nursing & Quality / Executive Safeguarding Lead	
Lead Officer	Jo-Ann Carnwell; Named Nurse for Safeguarding Children	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Safeguarding and promoting the welfare of children and adults and in particular protecting them from harm depends on a shared responsibility; a common understanding that safeguarding really is "*everyone's business.*" - no matter what your role, your level of seniority or where you are based within MCHFT
- There continues to be significant levels in safeguarding activity being addressed by the Trust Safeguarding Group. In part, this has been due to the good levels of knowledge and skills now demonstrated by frontline practitioners; in recognizing and responding to safeguarding concerns.
- The TSG members operated a *business-as-usual* approach during the Pandemic; ensuring that the Unborn, children, young people and adults that accessed MCHFT services remained protected. The challenges of the Pandemic gave TSG members the opportunity to enhance their IT solutions and adapt to a virtual environment. Monthly TSG meetings, LSAB / SCP Executive Board, Subgroups, Strategy meetings, Discharge Planning meetings all embraced Microsoft Teams, which allowed TSG members greater agency participation, improved time management and increased accountability, for the benefit of timely and proactive safeguarding decisions.
- The annual report outlines that the statutory and mandatory requirements and the annual objectives have been met, details of which are held within this report.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- N/A

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Provide safest and best care	✓	• Be the best place to work	☐
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

Impact *(is there an impact arising from the report on the following?)*

Mid Cheshire Hospitals NHS FT

• Quality ☐ • Finance ☐ • Workforce ☐ • Equality ☐	• Compliance ☐ • Legal ☐ • Risk/BAF Click here to select relevant risk
Equality Impact Assessment (*must accompany the following submissions)*	
Strategy ☐ Policy ☐ Service Change ☐	

REPORT DEVELOPMENT

Committee/ Group Name	**Date**	**Report Title**	**Lead**	**Brief summary of key issues raised and actions agreed**
Trust Safeguarding Group	15.07.21	**Trust Safeguarding Group Annual Activity Report 2020 / 2021**	Jo-Ann Carnwell; Named Nurse for SGC / TSG Chair	Report for dissemination
EQGG	02.08.21	**Trust Safeguarding Group Annual Activity Report 2020 / 2021**	Phil Pordes; SGA Lead on behalf of TSG Chair	

Trust Safeguarding Group Activity Report 2020/21

'Delivering Excellence in Healthcare through Innovation and Collaboration'

Contents

1. Forward

It is regarded as "*best practice*" and good quality governance for the Trust Safeguarding Group to report formally each year to the Executive Board and the wider trust organisation on how it has fulfilled its statutory responsibilities and duties regarding effective safeguarding processes at MCHFT.

This is the fifth annual report of the Trust Safeguarding Group and describes how it has fulfilled its statutory responsibilities and duties during the period from April 2020 to March 2021.

This report outlines the considerable amount of work undertaken by the Trust Safeguarding Group with support of colleagues across all divisions within the Trust to ensure that the unborn, children, young people and adults at risk are identified, safeguarded and supported to stay safe.

In particular, during the 2020 – 21 period the Trust Safeguarding Group has continued to work hard to strengthen collaborative working, the development of partnerships and in ensuring continuity and consistency of safeguarding practice within the Trust, CCICP, the CCG's and the wider Cheshire footprint.

The Trust Safeguarding Group strongly believe that safeguarding and promoting the welfare of children and adults and in particular protecting them from harm depends on a shared responsibility; a common understanding that safeguarding really is "*everyone's business."*

"Everyone's business" – no matter what your role, your level of seniority or where you are based within MCHFT and that's the key message the Executive Safeguarding Group at MCHFT endorses and actively promotes.

2. Safeguarding Background

Adult and Child Safeguarding in NHS organisations are statutory and regulatory requirements.

The Trust is accountable for delivery in relation to safeguarding requirements and this is monitored closely by Local Safeguarding Children and Adult Boards, Clinical Commissioning Groups (CCG) and the Care Quality Commission (CQC).

Statutory requirements relate to:

- Children Act 1989
- Children Act 2004; specifically section 11
- The Care Act 2014

It is the responsibility of every NHS funded organisation and each individual practitioner working in the NHS to ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied, with the well-being of those adults and children at the heart of what we do.

For adult safeguarding this also needs to respect the autonomy of adults and the need for empowerment of individual decision making, in keeping with the Mental Capacity Act and its Code of Practice.

3. Safeguarding Context

3.1 National Safeguarding Context

Whilst it is parents and carers who have primary care for their children, Local Authorities, working with their partner organisations and agencies have specific duties to safeguard and promote the welfare of all children in their area; through guidance such as The Children Acts of 1989 and 2004.

The Wood review (May 2016) advised there needed to be greater accountability across Local Authorities, the Police and Health. Therefore, *Working Together to Safeguard Children 2015* was updated & published in July 2018 to reflect his recommendations, changes in *Children and Social Work Act 2017* and new child death review guidance.

- Co-ordinated approach – safeguarding is everyone's business.
- Early help – identifying those in need.
- Evidence based assessments, with clear analysis.
- Child centred & focused.
- Organisational responsibilities.
- Multi agency arrangements with clear and shared responsibility of the local authority, the CCG and Police.
- Improving practice through practice learning reviews, with significant cases being referred to a National Review Panel (previously known as SCR).

3.2 Safeguarding Context across the Cheshire Footprint

Our vision for children and adult safeguarding supports the vision of our Local Safeguarding Adults Boards (LSAB) and Safeguarding Children Partnerships (SCP), previously known as Local Safeguarding Children Boards (LSCB).

Our population in Cheshire; whether that is the unborn, children, young people or adults have the right to live a life free from harm, where communities: -

- Have a culture that does not tolerate abuse.
- Work together to prevent abuse.
- Know what to do when abuse happens.

Our vision also supports the values of our organisation: -

- Commitment to quality and safety.
- Respect, dignity and compassion.
- Listening, learning and leading.
- Creating the best outcomes together.
- Every1Matters.

4. Safeguarding at Mid Cheshire Hospitals NHS Foundation Trust

4.1 Safeguarding Process

Children who are in need of help and protection deserve high quality and effective support as soon as a need is identified. MCHFT therefore promotes a safeguarding children process that effectively and efficiently responds to the needs and interests of children and their families, underpinned by sound statutory guidance and legislation.

MCHFT ensures that their practitioners are clear about what is required of them individually, organisationally, and how they need to work together in partnership. Everyone in the Trust who comes into contact with children and families has a role to play in their safeguarding: to ensure safety, welfare, and protection.

Therefore, safeguarding and promoting the welfare of **children** is defined as:

- Protecting children from maltreatment.
- Preventing impairment of children's health or development.
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care.
- Taking action to enable all children to have the best outcomes.

All **adult** safeguarding processes are based upon the 6 key principles:

- Empowerment – Personalisation and the presumption of person-led decisions and informed consent.
- Prevention – It is better to take action before harm occurs.
- Proportionality – Proportional and least intrusive response appropriate to the risk presented.
- Protection – Support and representation of those in greatest need.
- Partnership – Local solutions through services working with their communities.
- Accountability – Accountability and transparency in delivering safeguarding.

Safeguarding practice is now aligned to The Care Act (2014) and is centred on making safeguarding personal. Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) and Central Cheshire Integrated Care Partnership (CCICP) has robust processes in place to safeguard adults and our progress will now be demonstrated as part of our annual report 2020 / 21.

4.2 Safeguarding achievements in 2020/21.

Key achievements include:

1. Ensuring child protection medical examinations took place in a timely manner during the covid-19 pandemic During the peak of the pandemic, there was agreement that the community paediatrics team would provide out of hours cover temporarily, to ease pressures on the general paediatrics team. A risk assessment was completed on the potential impact of winter pressures and covid-19 on child protection medical examinations and there was agreement between community and general paediatrics on how child protection medicals would be prioritised.

2. Ensuring clinical supervision of paediatricians in relation to safeguarding children continued despite the challenges of the covid-19 pandemic The safeguarding children peer review meeting moved online via Microsoft Teams. The Named Doctor for Safeguarding Children continued to offer one to one clinical supervision sessions for paediatricians as required; by Microsoft teams, telephone and face to face with social distancing and PPE. This provided support to staff and appropriate challenge if necessary.

3. Working with partner agencies (such as Police and Children's Social Care) to understand complex issues and difficulties involving children admitted to the ward, where there have been safeguarding children concerns The Safeguarding Children Team has contributed to multidisciplinary reflective meetings with partner agencies, to understand the complex issues involved and how they might be managed differently in the future. This resulted in all agencies understanding the issues involved and considered how to manage them differently in future

4. Ensuring appropriate governance arrangements are in place for all documents which are relevant to safeguarding children The Safeguarding Children Team have produced a flowchart to clarify governance arrangements for all documents within Women's and Children's Division. This ensures that Governance arrangements are clear for such documents.

5. Working collaboratively with community teams to safeguard vulnerable adults within our Cheshire footprint.

6. Implementing of Guidelines for Risk Assessing Suicidal Adults and / or Young People in the Ward Environment.
7. The launch of the 24 hours Go To Adult Safeguarding guidelines on the intranet

8. Raising awareness of Adult Safeguarding issues during Adult Safeguarding week.

9. Level 3 Adult Safeguarding training implemented.

5. Safeguarding Training Compliance

5.1 Safeguarding Children

Mandatory Safeguarding Training adheres to the MCHT Training Matrix which is underpinned by the Safeguarding Children and Young People: Roles and Competences for Health Care Staff Intercollegiate Document Fourth edition: January 2019.

Face to face training was discontinued due to the Pandemic and so MCHFT adopted the e-Learning for Health (NHSE) packages. The training included contemporary issues such as Domestic Abuse, Child Sexual Exploitation and Grooming, Female Genital Mutilation, Trafficking and County Lines, and additional elements of safeguarding related awareness for key staff such as the Serious Case Review process and Modern-Day Slavery and Neglect.

Training evaluations provide evidence that staff feel sessions are beneficial to their practice and are familiar and confident with safeguarding referral processes and who to contact for advice and support; but found eLearning a challenging process to participate in.

The table below illustrates the current training compliance rates for safeguarding within the Trust at the end of Quarter 4 2020 / 21. These are monitored and reported quarterly internally and to commissioners. Commissioning standards require a compliance threshold of 90%, therefore the Trust Safeguarding Group have analysed this data, alongside Learning & Development and Information Services to address and ensure compliance in the forthcoming 2021 / 22 period.

Level of Safeguarding Children Training	**Acute MCHFT Training Compliance**	**CCICP Training Compliance**
Children's Mandatory Level 1 Safeguarding Training	**93.2%**	**94.9%**
Children's Safeguarding - Level 2 Training	**71%**	**67.2%**
Children's Safeguarding - Level 3 Training	**62.8%**	**82.2%**

It is indicated that Mandatory training compliance in the 20/21 period was significantly impacted upon by the Covid-19 situation. In particular, there were challenges for staff release, staff being redeployed, self-isolating or working from home, negotiating eLearning packages and extracting accurate data from the Trust Reporting Tool.

5.2 Safeguarding Adults

Mandatory safeguarding adults training has developed and changed during 2020/21. The implementation of the Intercollegiate Document which mirrors Children's Safeguarding and directs organisations in relation to which staff require which level of training has led to a review of face to face training sessions and e-learning packages.

Compliance data is recorded and shared quarterly via the adult safeguarding dashboard and the quarterly report. Issues can be escalated at the Trust Safeguarding Group as needed and we have had cause to raise concerns in 2020/21 in respect of training figures and their accuracy.

Safeguarding adults training includes Mental Capacity / Deprivation of Liberty Safeguards, Prevent, the Think Family approach and Domestic Violence.

The training uses case studies to highlight good practice and to help staff apply the theory to their practice.

All sessions are evaluated, and the training reviewed in response to any feedback given.

The table below illustrates how we share training figures currently and then how they will be collated going forward now we have the differing levels of training across the organisation.

2020/21

	MCHFT	CCICP
Adult Safeguarding Training		
Overall ASG staff training	90%	95%
Clinical staff	89%	94%
Non Clinical staff	92%	98%
Domestic Abuse		
Level 1	90%	95%
Level 2	Awaiting figures	Awaiting figures
MCA/DOLS		
Clinical Staff	90%	95%

April 2021 and onwards – Q1

	MCHFT	CCICP
Adult Safeguarding Training		
L1 Clinical	89%	95%
L1 Non-Clinical	93%	94%
L2 Clinical	67%	85%
L2 Non-Clinical	77&	80%
L3 Clinical	54%	73%
L3 Non-Clinical	33%	80%

6. Safeguarding in Midwifery

This year has seen a huge impact on maternity services due to the COVID-19 pandemic. The UK Government placed pregnant women into the group of who were considered 'vulnerable' to the severe effects of COVID-19 and that they stringently applied social distancing measures. This resulted in MCHFT adjusting pathways and guidelines to ensure careful surveillance of pregnant women's health and safeguarding responsibilities continued.

Despite these adjustments and restrictions, the team received **818** referrals throughout the year for **764** pregnant women and all safeguarding assessments were completed timely. The Enhanced team continued to provide face-to-face clinical care and ensured all levels of social needs were addressed

Antenatal care for women should begin from when a pregnancy is confirmed; ideally this should be from 6 weeks gestation. When a woman books for maternity care midwives collect information and assess the health and social needs of the women and her family. However, it must be noted that not all concerns are reported or occur in early pregnancy.

Referrals to the team are mainly received from Midwives, Social Workers and the Police. Any unborn or new-born baby can be placed at risk of neglect or abuse by their mother's or by an immediate family member's behaviour and the reasons for this are more than often extremely. complex.

If any of the following are identified whilst a woman is receiving maternity care a referral to the Enhanced Team must be made:

- Safeguarding Children:
    - Current / Previous Children's Social Care involvement
    - Unwanted ongoing pregnancy, i.e. wishing to relinquish child
    - Potential risk in the household, i.e. associated people, dangerous animals
    - Confirmed concealed pregnancy after 24 weeks gestation
    - Homelessness / transient lifestyle
    - Child / Sexual Exploitation
    - Surrogate pregnancy
- All disclosures of Female Genital Mutilation, Domestic Abuse, Stalking and Harassment, Honour Based Violence and Forced Marriage
- All problematic or continued alcohol / substance misuse
- All young people who have care leaver status (up to the age of 21)
- All young people in care
- All 16 years of age and under
- Learning difficulties / disabilities
- Non-attendance (as per MCHFT Maternity Missed Appointment Guideline)
- Unstable Mental Health concerns *(Since December 2020 this criterion no longer meets the criteria for referral to the Enhanced Team; referrals are now sent to the Perinatal Mental Health Midwife)*

It is imperative that all referrals to the team are assessed on the day they are received', those requiring immediate action are dealt with on the same day whilst other referrals are placed for the weekly allocation meeting. All referrals are allocated in accordance to the geographical area of the pregnant women and Enhanced midwife for that area. The lead midwife then assesses what package of care is required; depending on the emerging problems this can vary from Early Help to Child Protection. All assessments reflect the Child Safeguarding and Promoting Welfare Assessment Framework; the unborn development needs, the capacity of parents and the impact / influence of wider family and other adults.

The team share the responsibility of the 'Duty Midwife' role and are responsible for:

- Checking all telephone messages and communicates to team members who are off-site conducting midwifery visits or attending a meeting.
- Attending all clinical areas to liaise with shift leaders and collect any safeguarding referrals
- Printing all electronic referrals / notifications from; community midwives, MCHFT Safeguarding Team, Police, other maternity providers / units.
- Responding to any safeguarding queries throughout the day.

6.1 Safeguarding Referrals

The Enhanced Midwifery Team received **818** referrals this year.

2020-2021 referrals:

Quarter	Q1			**Total**	Q2			**Total**	Q3			**Total**	Q4			**Total**	**Total**
Month	April	May	June		Jul	Aug	Sep		Oct	Nov	Dec		Jan	Feb	Mar		
Number of referrals	55	56	62	**173**	82	64	80	**226**	68	72	76	**216**	83	57	63	**203**	**818**

As from February 2021 referrals for Perinatal Mental Health (PNH) were no longer recorded as a referral to the Enhanced Team, this data is now collected in a separate system. A total of 115 referrals were made to PNH between February and March 2021; had these changes not been implemented at the latter end of the year the total number of referrals to the Enhanced Team would have been 933.

The table below shows the number of referrals over the last eight years.

2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-2020
491	**366**	**630**	**555**	**781**	**774**	**861**	**826**

6.2 Macclesfield Hospital Notifications

The COVID-19 Pandemic had a further impact on maternity services. In March 2020 a decision was made that pregnant women would not be able to deliver their baby's at Macclesfield DG Hospital and were diverted to other local Maternity units, such as MCHFT. The reason for this decision was based on not being able to provide 24 hour anaesthetist cover for emergency caesarean sections given the expected increase in their work load due to the COVID-19 Pandemic.

During this year MCHFT received safeguarding information for **167** pregnant women from Macclesfield District General Hospital. The Named Midwives and Enhanced Midwives at both maternity units have *(and continue to)* worked closely to ensure the most vulnerable women and babies were safeguarded throughout the pregnancy continuum. A total of **37** pregnant women were allocated to the Enhanced Team, these had significant safeguarding children concerns as attendance at meetings and robust communication pathways were required.

A flowchart specific for MCHFT was developed to ensure midwives and obstetricians were aware of how to access all up-to-date safeguarding or child protection issues for women.

Macclesfield
Safeguarding Notifica

The below table is a breakdown of number of initial and updated notifications received:

Quarter	Q1			**Total**	Q2			**Total**	Q3			**Total**	Q4			**Total**	**Total**
Month	April	May	June		Jul	Aug	Sep		Oct	Nov	Dec		Jan	Feb	Mar		
Number of initial notifications and updates	50	70	83	**203**	125	110	99	**334**	119	96	102	**317**	90	60	57	**207**	**1,061**

6.3 Safeguarding Referrals

The outcome all referrals is only known once the pregnancy has ended. The following data demonstrates the outcome of women referred to the team whose expected date of delivery was during 2020-2021.

Levels of Need / Outcome of all safeguarding referrals:

Level of Need	Outcome of Safeguarding Assessment	Lead Midwife	Total
Level 1	No further action required.	Clinical care to remain with the lead community midwife	**127**
Level 2	Information needs to be shared with HV/ FNP and Named GP	Clinical care to remain with the lead community midwife	**24**
Level 3	Summary of concerns and identified risks are documented on a Child and Adult Safeguarding Notification Form also known as 'Cause for Concern'. This notification is filed in the mother records with a copy for the baby's records when they are generated at birth. A copy is shared with: LWS / NICU / Named GP for Child Protection Lead and Practice Manager /Health Visitor or FNP	Clinical care to remain with the lead community midwife.	**187**
Level 4	As above (Level 3)	Dependent on the pregnancy gestation i.e.: >34 weeks, pregnant women may continue to be seen by the lead midwife with input from the Safeguarding Midwife; this is to	**6**

		ensure pregnant women receive continuity of care.	
Level 5	As above (Level 3 and 4) Admission Plans filed in the mother and baby's records; to ensure all staff knows of what actions are required around birth and discharge from hospital.	Those who meet the criteria for case load remain under the care of a Lead Enhanced Midwife based on the geographical area where the woman lives. This includes: • Early Help / Team Around the Family • Child in Need • Child Protection • Mental health issues • Domestic Abuse • Alcohol and Substance Misuse • All young people in care / care leaver status • Young person not well supported • Homeless / supported housing / refuge/ transient lifestyle • Poor home conditions • Late bookers > 24 weeks with concerns • Trafficked • Potential risk in household; associated people/ poor conditions/ dangerous pets • Women and / or partner with learning difficulties	**152**
Level 6	As above (Level 3, 4 and 5)	Those who meet the criteria for liaison with Macclesfield Safeguarding Midwifery Team.	**23**
Level 7	Not applicable	No further action due to: • Miscarriage = 14 • Termination of Pregnancy = 2 • Not pregnant = 25 • Intra Uterine Fetal Death = 1 • Moved out area = 4	**47**
		Grand Total	**566**

6.4 Child Protection Conferences

Child Protection Plans aim to ensure children are safe from harm and to prevent any suffering from harm by supporting parents and cares, addressing vulnerabilities and risk factors to promote a child's health and development and to meet any unmet needs.

During this year The Enhanced Team attended **35** Initial Child Protection Conferences for unborn babies and **28** were babies were placed on Child Protection Plans at birth.

The below table is a breakdown of Child Protection Plans and categories of harm for Unborn babies due to be born at MCHFT:

Category of Concern for Unborn babies	Q1	Q2	Q3	Q4	Total
Physical Harm	1	0	1	1	3
Emotional Harm	3	1	0	2	6
Sexual Harm	0	0	0	1	1
Neglect	5	6	1	13	25
Total	9	7	2	17	**35**

The below table is a breakdown of Child Protection Plans and category of concerns for babies born at MCHFT:

Category of Concern for babies born at MCHFT	Q1	Q2	Q3	Q4	Total
Physical Harm	1	0	1	0	2
Emotional Harm	2	2	0	1	5
Sexual Harm	0	0	0	1	1
Neglect	7	5	2	6	20
Total	10	7	3	8	**28**

Author: Liz Thompson; Named Midwife for Safeguarding

7. Safeguarding Children

7.1 Annual Safeguarding Activity

At MCHFT, Safeguarding Notifications are generated when a member of staff within the trust identifies a safeguarding concern or issue and then formally *notifies,* informs, or escalates the concern to a member of the Safeguarding Children Team.

The level of safeguarding activity can be seen in Fig 1. Since 2009, there has virtually been a year on year increase in the level of safeguarding activity within the organisation. Upon assessment by the Trust Safeguarding Group, it would appear that this escalation is closely aligned to the increase in staff competence and confidence levels in effectively recognising and responding to safeguarding issues.

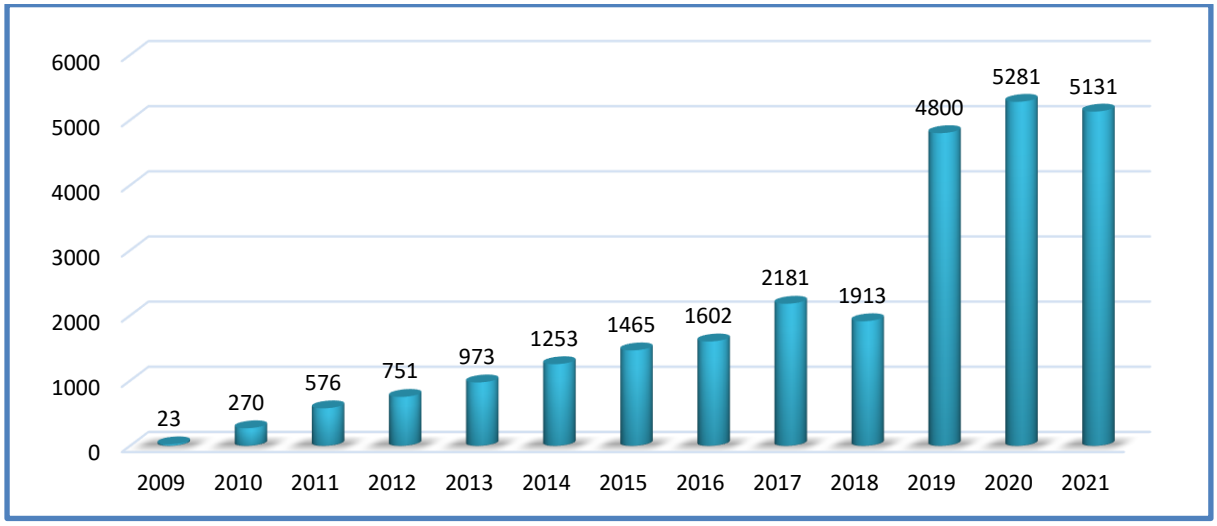


Fig1.

The last three years in particular, have seen a significant increase in safeguarding activity within the organisation. In 2020/2021, the Safeguarding Children Team generated a total of 5,131 notifications. This was a decrease of 150 from the previous year. However, given this period has also juggled the Covid-19 pandemic, a reduced patient footfall, a reduction of face to face patient contacts; this decrease appeared negligible. What is apparent is that no matter what the challenges, safeguarding recognition and response continues within MCHFT.

This data is disseminated in quarterly Safeguarding reports to assist staff in understanding the importance of their recognition and response to safeguarding concerns.

The total activity included concerns being reported, discussed with or notifying a number of professionals within the Safeguarding children Team, including the Named Nurse, Name Midwife, IDVA, Paediatric Liaison Nurse and Specialist nurse for CCICP. These individual levels of reported activity can be seen in Fig 2.

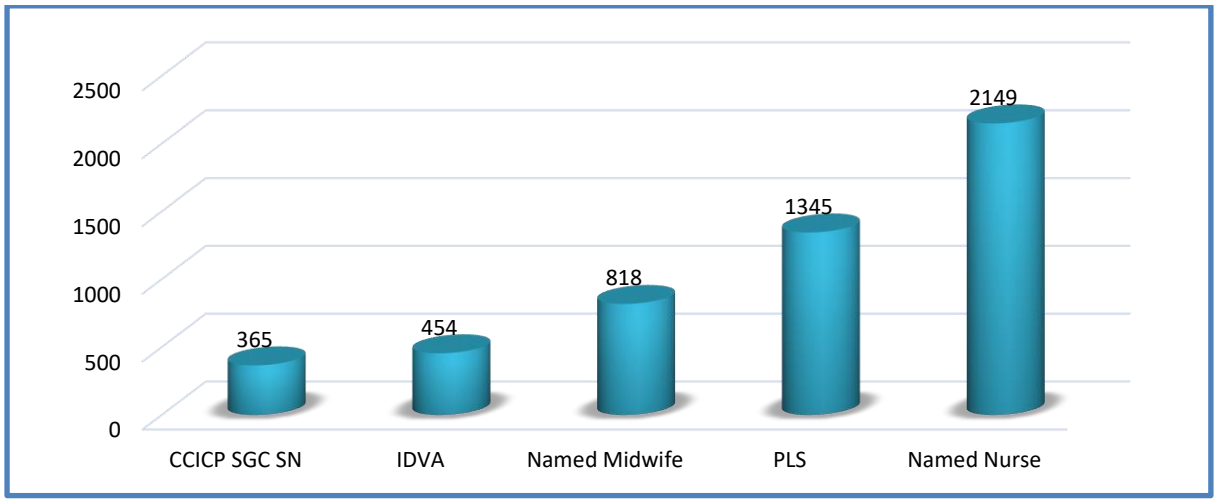


Fig 2

The 2020 / 2021 Quarter 1 period generated a total of 470 Safeguarding Notifications to the Named Nurse. This was an increase of 35, when compared to the same period last year. period generated a total of 572 Safeguarding Notifications to the Named Nurse. This was an increase of 185, when compared to the same period last year. It was also an increase of 103 notifications since the period.

The total for the Quarter 3 period was 573 Safeguarding Notifications to the Named Nurse. This was an increase of 87, when compared to the same period last year. It was also an increase of 1 since the Quarter 2 period.

The Named Nurse received a total of 535 Safeguarding Notifications. Whilst this was a decrease of 38 since Quarter 3, it was an increase of 115 from the same period last year. This brings the end of year total for the 2020 / 2021 period to the Named Nurse as 2,149, an increase of 421 from the previous year.

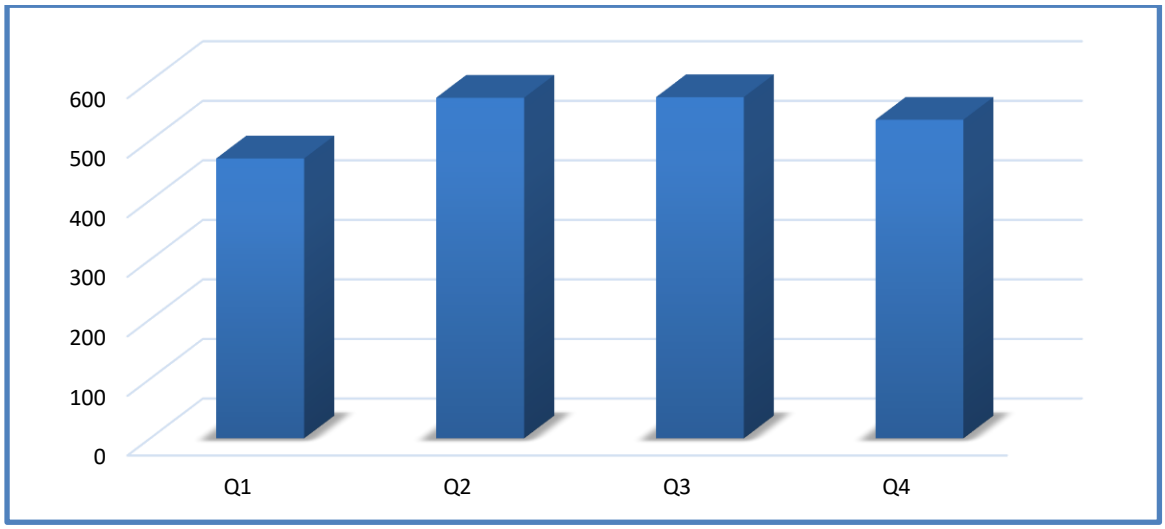


Fig 3

Fig 3 demonstrates this quarterly level of activity to the Named Nurse for Safeguarding. It is noted that activity levels have remained fairly consistent throughout; however, a slight reduction in Quarter 1 may have been due to by the emergence of the Covid-19 pandemic, lock-down restrictions and falling patient footfall / attendance numbers.

Fig 4 details the level of activity for the Named Nurse on a month by month basis throughout the year. It demonstrates the variance of safeguarding activity; although it may have also reflected the timeline of the pandemic.

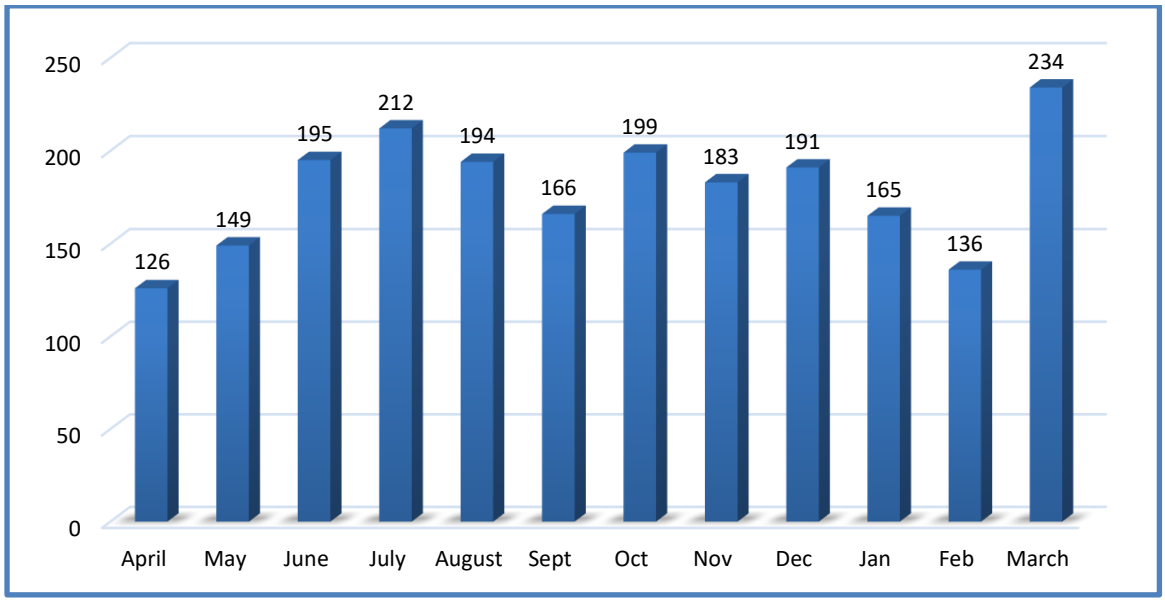


Fig 4

7.2 Divisional and departmental Safeguarding Activity

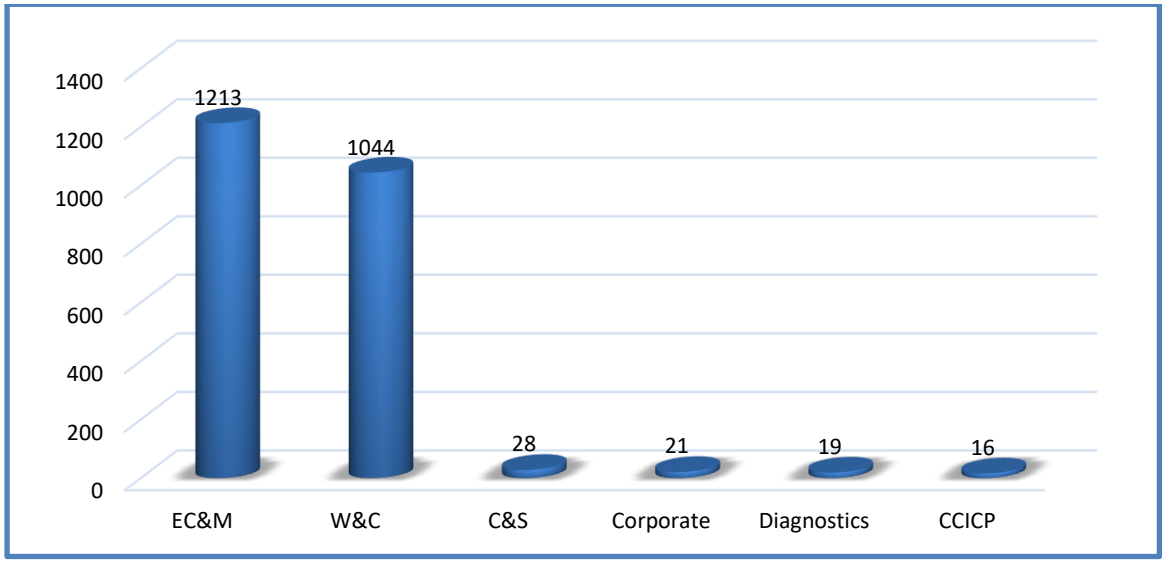


Fig 5

Fig 5 sets out where safeguarding activity has been encountered in each Division at MCHFT. It is no surprise that the majority were received from Women & Children Division and Emergency Care & Medicine. Both could be regarded as the *front door* of acute health care services and as such; are key locations in the recognition and response to safeguarding concerns. However, it is also positive that safeguarding concerns are identified in all Divisions; providing assurance that process is robust and embedded in the organisation.

Focusing on Emergency Care, the majority of safeguarding concerns were identified within the A&E Department and a smaller number of issues being recognised within the Minor Injuries Unit-Victoria Infirmary, GPOOHS or within the Urgent Care Centre. This is evidenced in Fig 6.

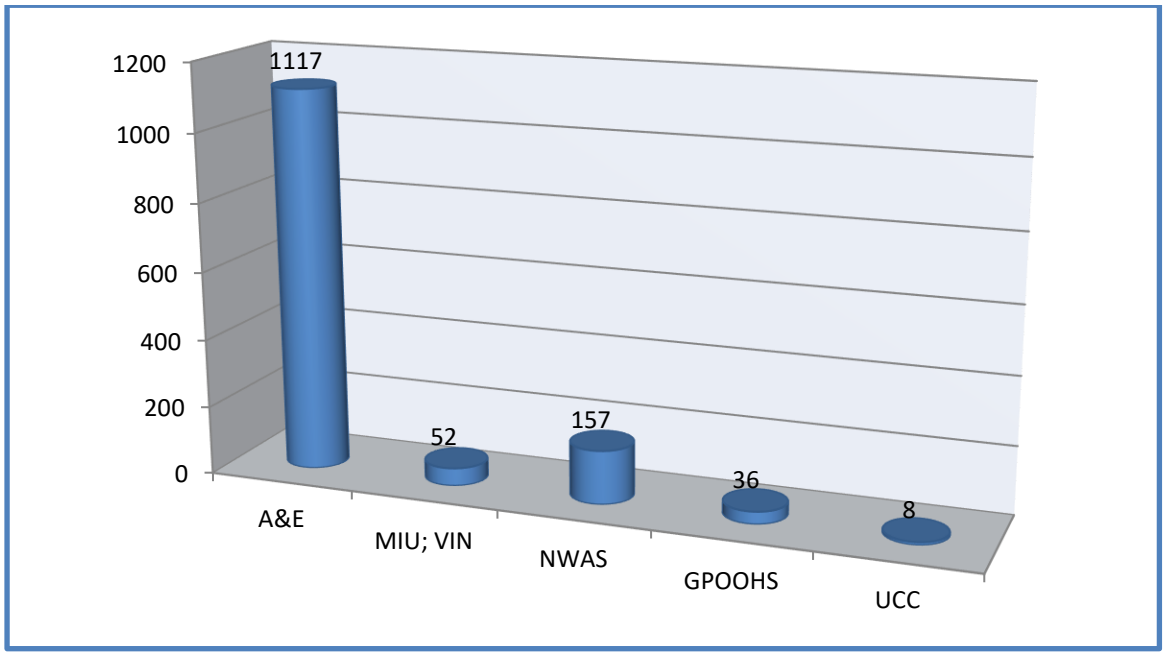


Fig 6.

Compared to previous years, there was a noticeable decline in activity in the MIU, UCC and GPOOHS locations. Anecdotal evidence would suggest this was a direct result of the Pandemic and the requirement for the organisation to change the patient access points and service responses.

It is also important to highlight the number of safeguarding referrals received from North West Ambulance Service (NWAS) over the 2020 /21 period. This evidences good levels of information sharing and communication between key agencies, such as MCHFT and NWAS.

It allows for the Named Nurse for Safeguarding Children to review the NWAS concerns and assess the impact upon the child or young person's journey at MCHFT, continue safeguarding actions throughout the patient journey and share information with relevant agencies, such as Children's Social Care.

Fig 7 evidences the safeguarding concerns identified within the Women & Children Division and this again demonstrated the impact of the Pandemic. Safeguarding activity or responses on the Child and Adolescent Units (CAU) – saw the greatest variance. This was a direct result of how Ward 16 and Ward 17 were utilised during the pandemic period; including Ward 17 being used specifically for suspected / actual paediatric Covid cases, to Ward 16 being for adult patients. There was also a decline noted in paediatric outpatient or specialities; as face to face patient contacts also reduced.

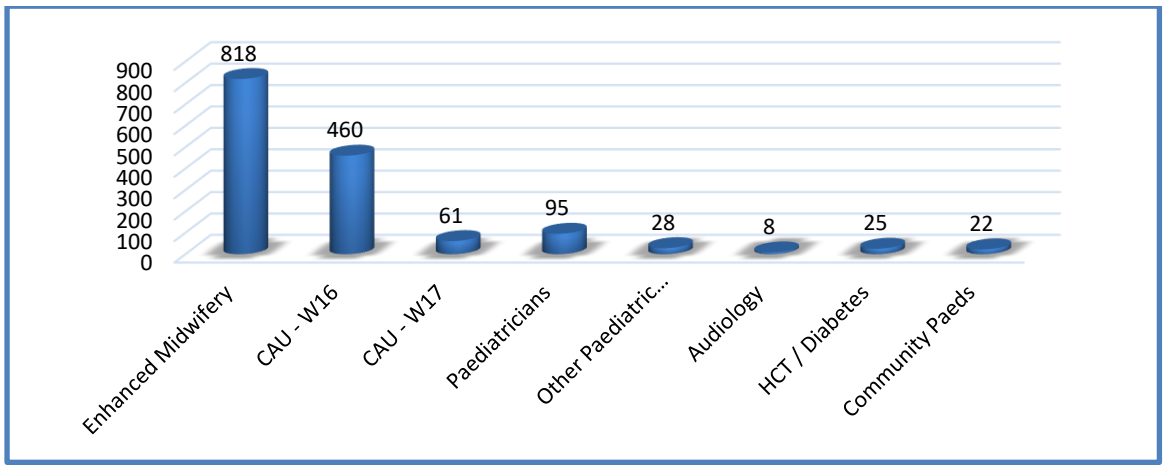


Fig 7

7.3 Statutory Categories of Harm Identified

Statutory safeguarding guidance, such as in *Working Together; HM Government (2018)* refers to the recognition of harm under four categories of abuse: emotional harm, physical abuse, neglect, and sexual harm.

The majority of safeguarding notifications, escalations or referrals to the Named Nurse are categorised under these titles. Fig 8 demonstrates the level of safeguarding activity within these categories.

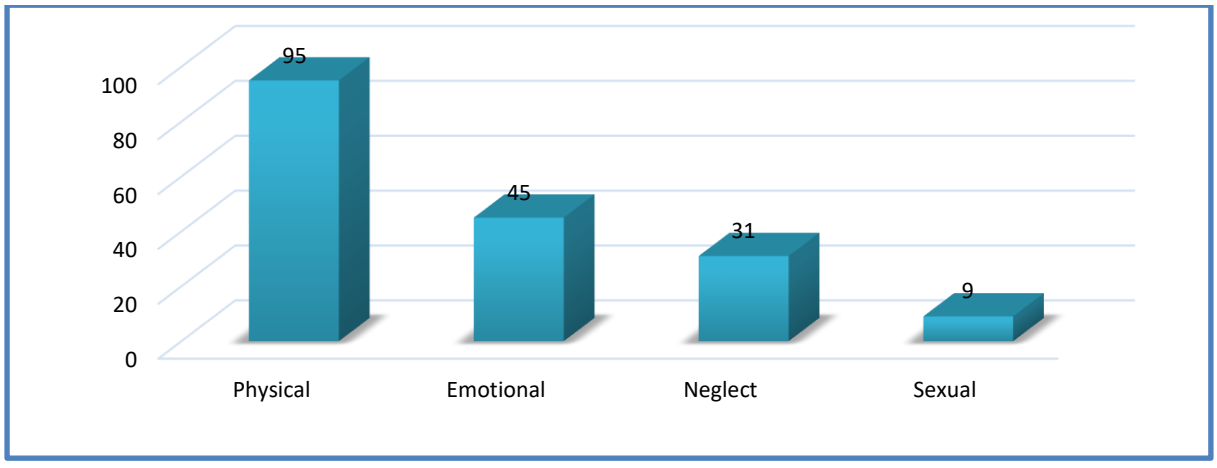


Fig 8

Physical harm was the most represented category of harm in the 2020 - 2021 period. This was a consistent pattern also identified in the quarterly safeguarding activity reports. Case examples included non-accidental injury, unwitnessed injuries, discrepancies in explanation and poor parental supervision.

Examples of emotional harm included the impact of witnessing domestic abuse, limited parental emotional warmth and reassurance towards a child or young person and conveying they are unlived, unimportant, or not valued within the family unit. Emotional harm can occur alone or intertwined with other categories of harm; but was identified on 45 occasions in the organisation.

Neglect was recognised on a total of 31 occasions. Case examples included poor presentation or hygiene, Was Not Brought (WNB), self-discharges and poor parental response to existing health needs.

Finally, sexual harm which can involve forcing or enticing a child or young person to take part in sexual activities or sexual assaults was escalated in 9 patient presentations.

7.4 Subcategories of Harm Identified

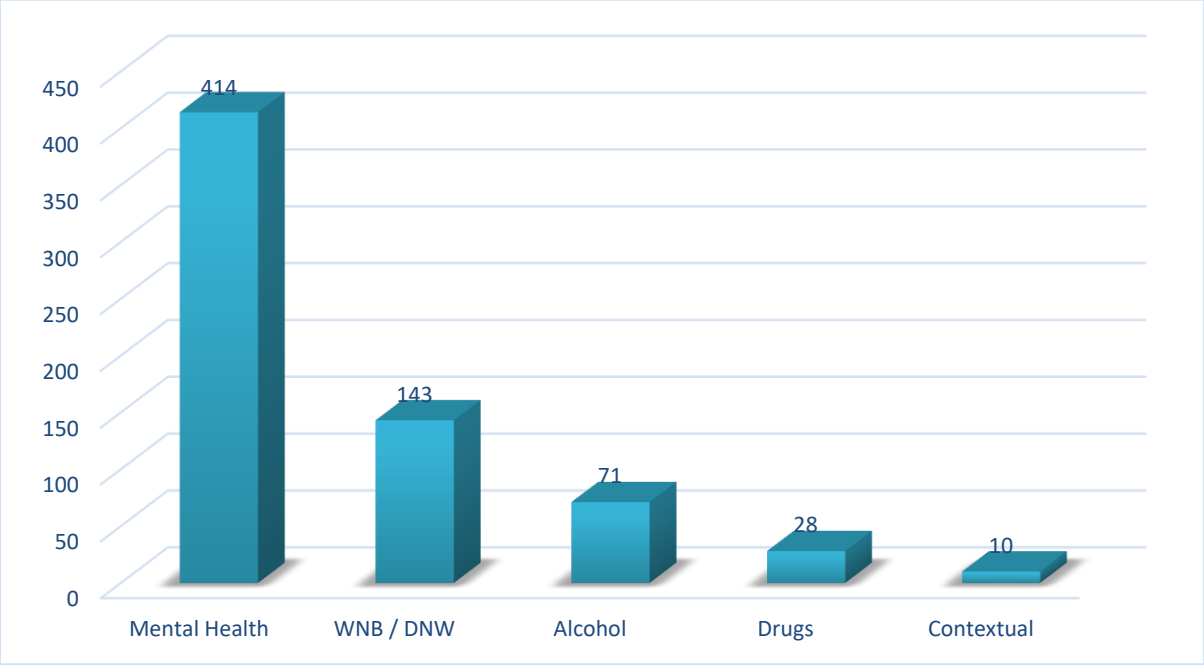


Fig 9

Fig 9 evidences other areas of safeguarding concern or issues identified by staff at MCHFT. The largest recognised group was around the emotional well-being or mental health of children and young people. This will be discussed in greater detail in section 7.5. *Was not brought / Did not wait / Self discharges* was the next significant subgroup, which identified children or young people who were not brought for appointments, left before treatment was concluded or parents wished to discharge against medical advice.

All patients attending as the result of excess alcohol / intoxication will be managed clinically, safeguarding consideration, assessment and referral is completed as required and the patient provided with the contact details of CGL and other support agencies. Fig 10 demonstrates the number of presentations for under 18's during the 2020 / 2021 period, which appeared to reflect the timeline of the pandemic.

The first lockdown was initiated in March 2020 and continued throughout April. During this time there was a "stay at home" message and a significantly reduced patient footfall in the organisation, which is reflected in the data. May introduced conditional easing of restrictions and then from June to August there was a phased reopening for the population. This could then account for the "spike" of presentations during this time. Tiered restrictions were established in September and October; but CYP were often maintaining their social interactions that had been established in the Summer months, which would explain the continuation of admissions. A decline in presentations in November coincides with the second lockdown period; before a final levelling off, of presentations heading towards and during the third lockdown.

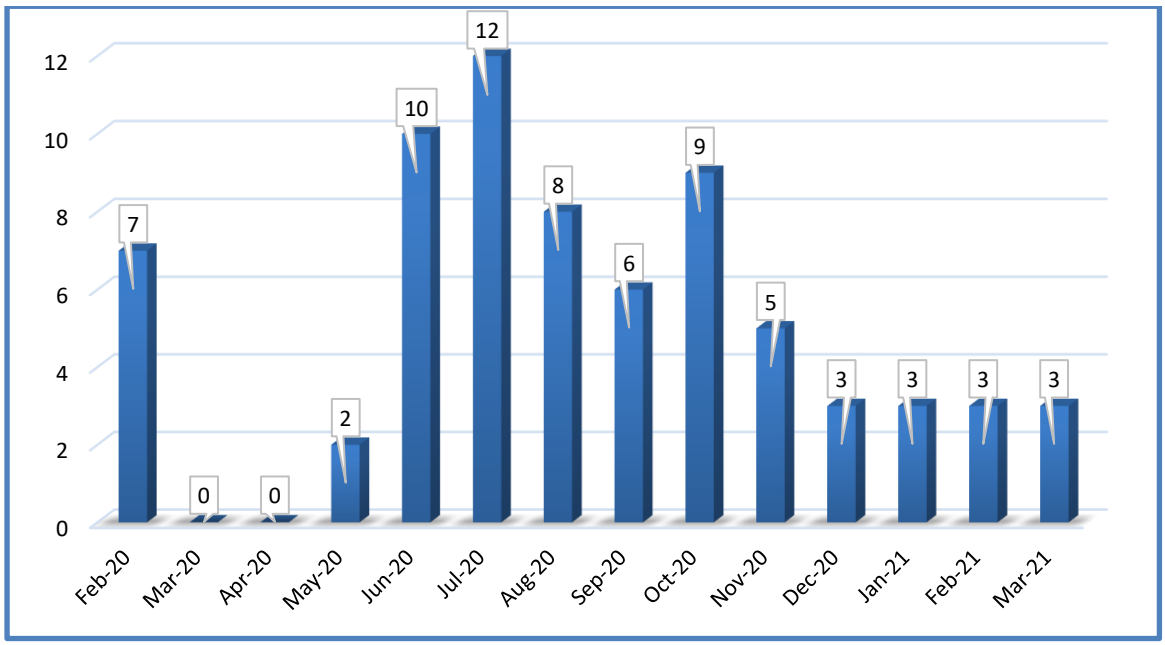


Fig 10

During the 2020 / 21 period, the Executive Safeguarding Group has been continuing to promote and embed the importance of the *Think Family* approach.

Think family is an approach whereby **all practitioners**; across all children's and adult services; **are identifying, assessing, and responding to the safeguarding needs and requirements of all family members.**

Think family places a **responsibility onto all practitioners, regardless of role; to respond to identified issues**, whether that is offering guidance, signposting, escalation, through to providing services.

Think Family requires **all practitioners to communicate with other professionals and agencies, who may be working with other family members**, to coordinate those interventions and efforts, to achieve the best outcomes possible for the whole family unit.

Fig 11 identifies parental / carers categories of harm, which includes the Think Family remit and which required multi-agency responses and interventions.

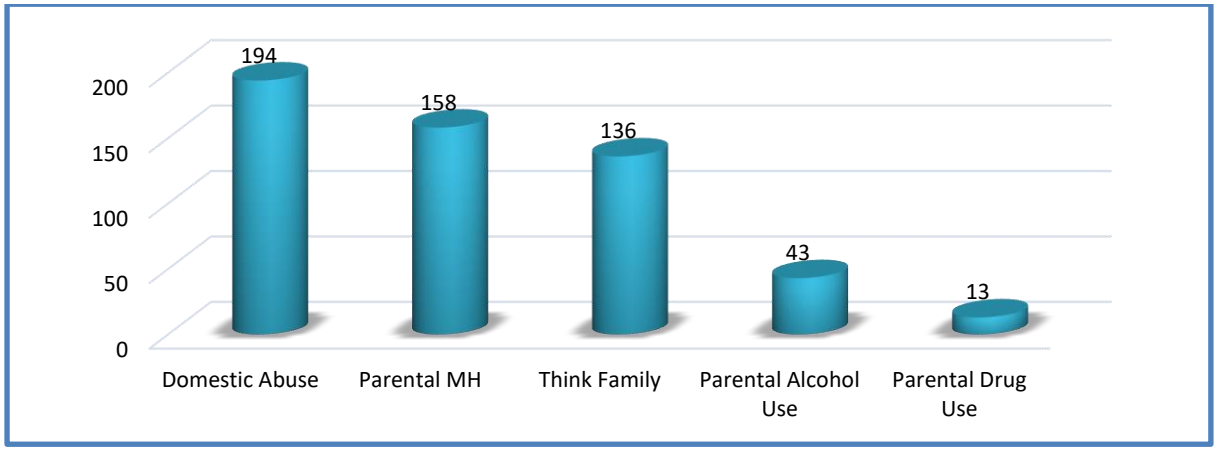


Fig 11

It is vital that practitioners are aware if a child attending the Trust is subject to a child protection plan (CPP) or care proceedings (LAC). This can be of particular importance to staff that work within the Emergency Department, as they can often be the first point of contact for vulnerable children and their families.

Fig 12 highlights the number of children and young people presenting at the organisation who are subject to either a child protection plan or care order. It also evidences which locality or Local Authority they are supported by.

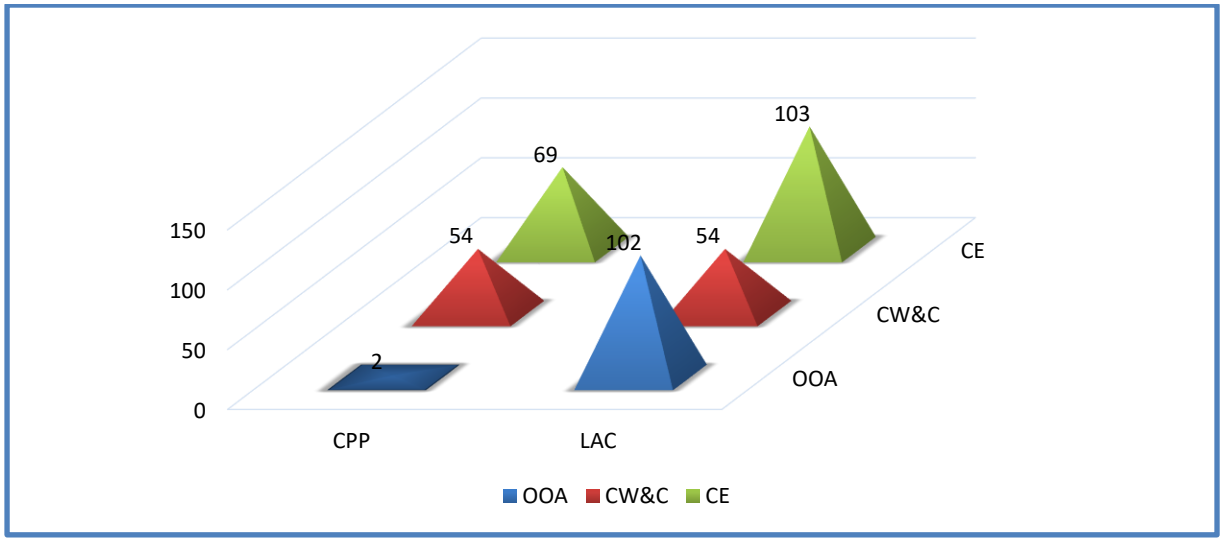


Fig 12

Anecdotal evidence indicates that practitioners recognise this additional vulnerability; predominately through the presence of PCS risk markers and then act upon the risk marker to inform the clinical plan and communicate with partner agencies.

In September 2018, the Executive Safeguarding Group completed the implementation of the Child Protection Information Sharing (CP-IS) programme. This is an NHS England programme dedicated to delivering a higher level of protection to children who visit unscheduled care settings such as Accident and Emergency, Minor Injury Units, Paediatric Assessment and Walk-in Centres. CP-IS connects a local authorities Social Care IT system with unscheduled care settings so that vital child protection information can be shared. Child Protection Information is uploaded by Local Authorities and held on the NHS Spine. This includes:

- Children on a Child Protection Plans (CPP)
- Looked After Children - full, interim, and voluntary care orders (LAC)
- Any unborn child that has a Child Protection Plan against it – (UCPP)

Anecdotal evidence suggests that since the introduction of CP-IS the recognition of additional vulnerability in children and young people has significantly improved in unscheduled care settings; and allowed for increased levels of communication and information sharing with partner agencies. the 2021 / 2022 period, it is hoped to extend CP-IS to Community Paediatrics / CCICP to enhance current safeguarding pathways.

7.5 Mental Health Presentations Identified

In the 2020 / 2021 period there were a total of 414 attendances due to a child or young person experiencing difficulties or concerns regarding their mental health or emotional well-being. This was an increase of 56 presentations, when compared to the previous year, which had recorded a total of 358 child and young people attending for support.

Fig 13 indicates the level of activity, over the past six years at the organisation, which clearly demonstrates a year on year increase.

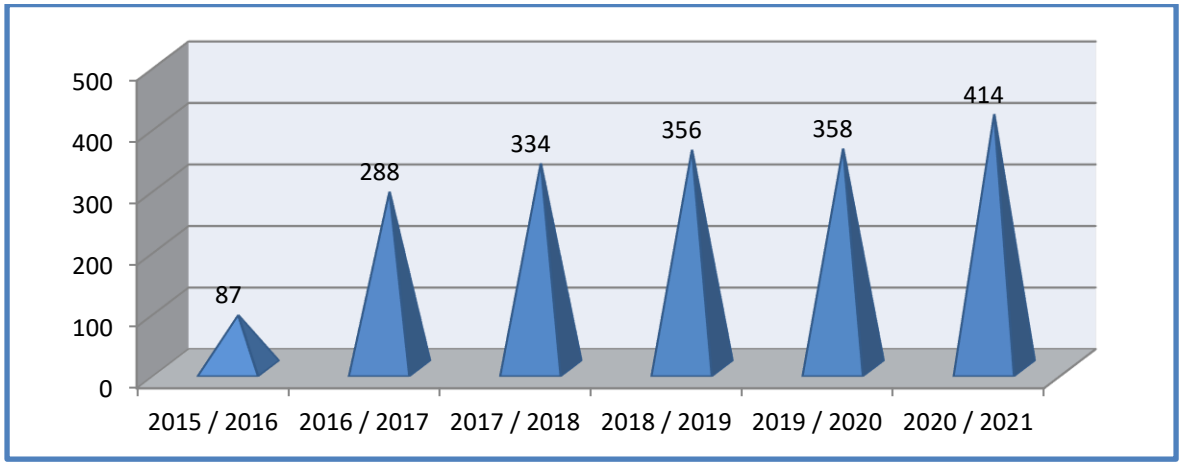


Fig 13

Fig 14 demonstrates the attendances on a month by month basis, from April 2020 through to March 2021

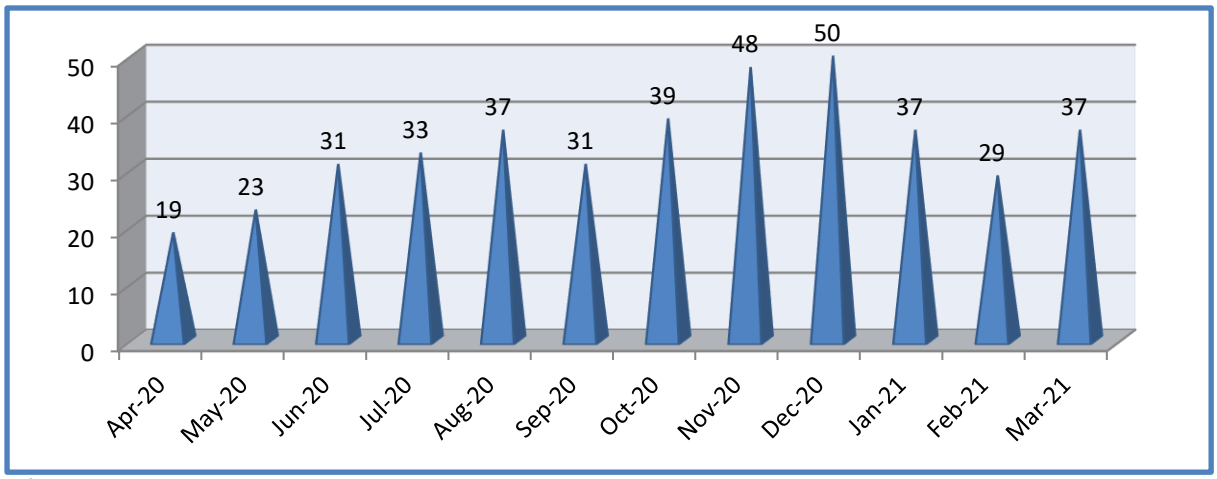


Fig 14

The data indicates the lowest number of attendances were in the months of April and May 2020, which coincided with the first lockdown and when patient footfall was at its lowest within the organisation. The highest number of presentations were seen in the months of November and December 2020, when the population had emerged out of the second lockdown period and hoped to be returning to fewer regulations and more social interactions / activities. Previous years of data collation, it was possible to attribute the lowest rate of presentations with the school holiday periods, particularly in the summer months, which was usually a time when many families travel outside their place of residence. However, in 2020 / 2021, activity was variable month by month and appeared to be dictated by the incidence, restrictions and challenges associated with the Covid-19 pandemic.

When assessing when the patient presentations to MCHFT occurred, the majority (76%) were during the working week, Monday through to Friday. In particular, attendances during the week increased on a Tuesday and a Wednesday accounting for 39% of all presentations. A smaller proportion (24%) occurred during the weekend period, with Sunday have having a slightly greater percentage at 12%.

Analysis of previous years data has attempted to establish any patterns or trends attached to the days children and young people were attending with mental health difficulties. However, due to the pandemic, changing social restrictions and academic timetables, this was not possible in the 2020 / 2021 period.

Agencies have acknowledged for some time, that if a child or young person presented during the working week / hours, they benefited from having access to the optimum number of professionals in their care journey. But consideration needed to be given to those that needed assistance outside the usual nine to five timeframes.

In 2018, a telephone helpline / Crisis Line was initiated by Cheshire Wirral Partnership (CWP) to offer an additional point of contact, support and advice to children, young people, their

families, and professionals. The helpline operated in the evenings and weekend period; although not over twenty- four hours. However, when the Covid-19 pandemic escalated, CWP extended this helpline / Crisis Line to twenty-four hours a day, seven days a week to ensure any children and young people experiencing mental health challenges could seek the support they required, at the time they needed it. This helpline / Crisis Line has become invaluable to families and professionals alike and has been utilised as part of the overall safety plans for children and young people.

Fig 15 demonstrated the time periods of presentations and this clearly reinforced why a twenty-four hours a day, seven days a week Helpline / Crisis line is required, as part of robust safety plans.

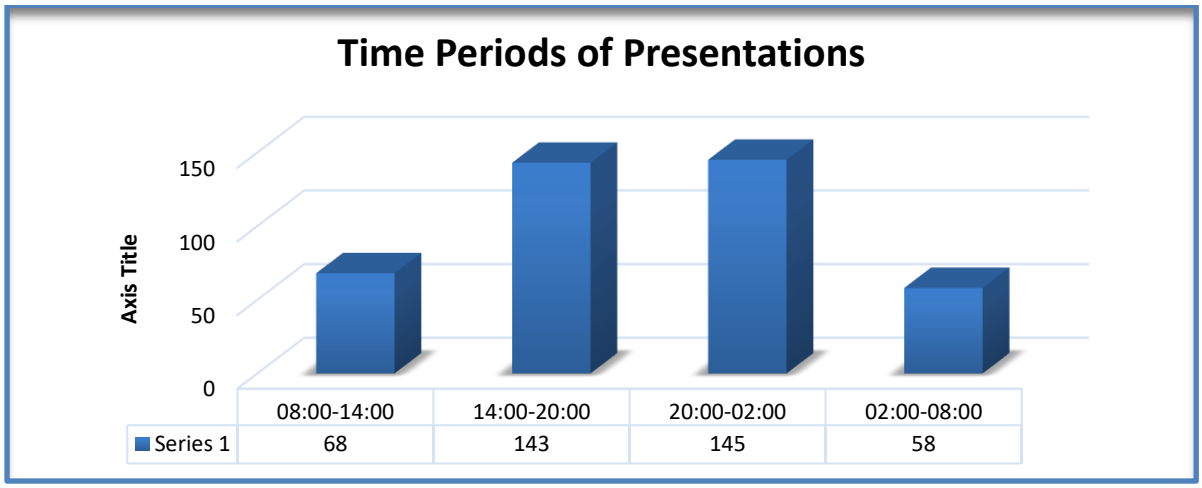


Fig 15

Fig 16 evidences the gender of patients presenting with mental health concerns. Over twice as many of the patients were female, than male. This appears to be in line with current research which indicates females are more likely to experience mental health issues and are twice as likely to be diagnosed with anxiety.

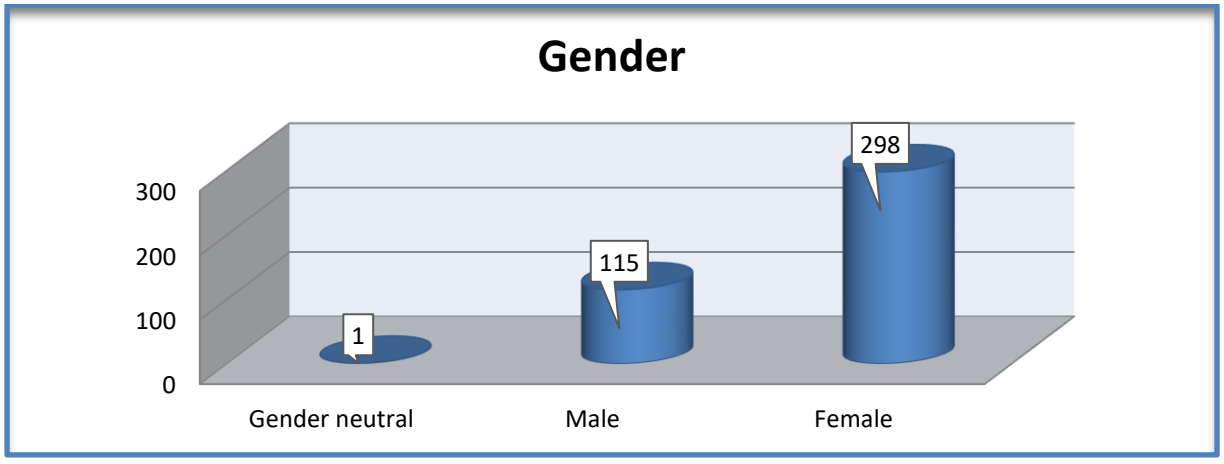


Fig 16

Fig 17 demonstrates information on the ages of patients presenting with mental health concerns and would suggest that children and young people, fifteen to seventeen are the most common age group.

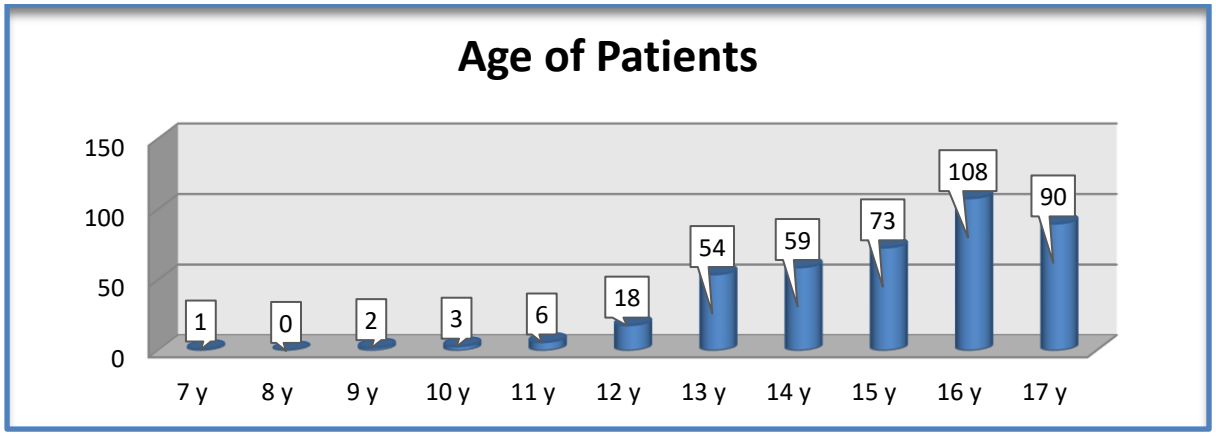


Fig 17

This trend has been replicated across the country but it is also acknowledged that there was a rise in younger children experiencing mental health concerns (anxiety, depression and emotional disorders); which MCHFT have also been able to evidence. The youngest patient presenting to the organisation was 7 years of age, who presented with evidence of self-harm, challenging behaviours and after an attempt to jump from a window.

When a child or young person presents to MCHFT with a mental health concern; the majority of patients will be admitted as a patient. This allows for clinical treatment, a comprehensive mental health assessment and appropriate safety / discharge planning.

However, it should also be acknowledged that for some patients, admission would not be beneficial and in theses case direct communication with mental health services, to agree an alternative plan, such as community follow up would be more appropriate.

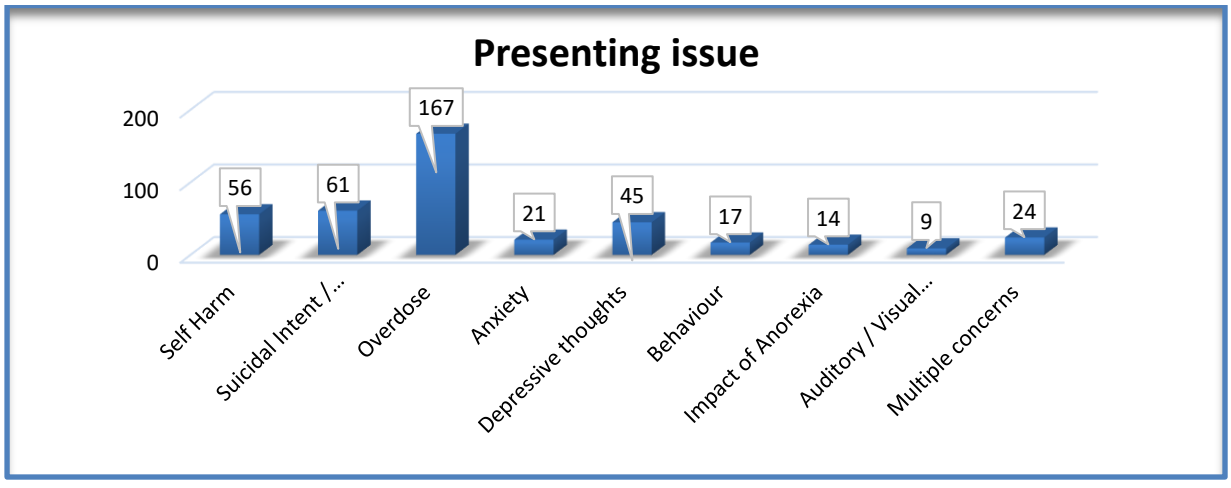


Fig 18

Fig 18 indicates how the mental health concern manifested for the child or young person. The leading issue was of a child or young person taking a deliberate / intentional overdose of medication; predominately of easily accessible medications such as paracetamol or ibuprofen or accessing their parents /carers medication.

Once a child or young person is assessed as clinically fit; they will be formally referred to either the Child and Adolescent Service (CAMHS) or Psychiatric Liaison; often dependant on their chronological age. The patient will be assessed, and this assessment will be used to inform their discharge planning; along with any support strategies / pathways.

Most of the patients were referred to CAMHS; but it was noted that there were also a small number of patients who were not referred to any mental health service. When assessing the reasons behind this data, it appeared to be as the result of the patient refusing of declining mental health services, already having a forthcoming appointment with mental health services or the treating practitioner predominately focusing upon the clinical features of the presentation.

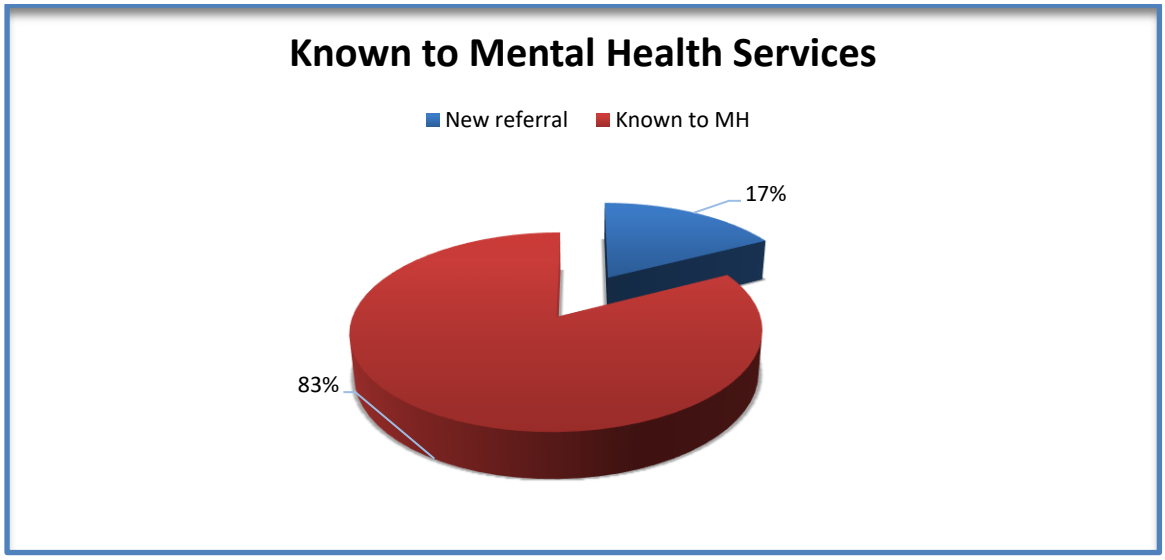


Fig 19

Fig 19 indicates if the patient is already known to mental health services or if this would be their first contact. In 342 out of a total 414 presentations, the patient had already been referred to, assessed and / or seen by / supported by mental health services.

Further analysis indicated that these MCHFT presentations may have occurred whilst they were waiting for their initial consultation with mental health services, had been triggered by an existing issue or stressor in between their mental health appointments or had been advised to attend MCHFT by their mental health practitioner.

The presentation data was also able to identify if this was the child or young person's first attendance at MCHFT for mental health concerns or if there had been previous similar episodes and admissions. For the majority of children and young people it was their first presence at MCHFT and this is perhaps reflective of the additional stress, anxiety and fear

generated from the Covid-19 pandemic period, but for 199 patients they had experienced previous admissions requiring mental health assessment and support.

As a direct result of these increased admissions, liaison has been taking place between the Executive Safeguarding Group, CWP and Cheshire Clinical Commissioning Group (CCG) to assess how the acute and community health services can work in partnership and develop more reactive, effective and efficient services in supporting the most vulnerable within our local patient population.

Since March 2017; the Named Nurse for Safeguarding Children has collated monthly data on these presentation / admissions and this information has directly influenced the CCG's and Cheshire Wirral Partnership (CWP) in identifying where future resources should be targeted. For example, funding was secured to provide mental health key workers in a number of Secondary schools in Cheshire East. The aim was to provide early help and support for the emotional health being of pupils; thereby avoiding the need for an A&E attendance or hospital admission.

This continues to be a valuable source of information and work continues to be undertaken with the other Cheshire Acute providers to ascertain if they can also replicate the same data collation.

A separate activity report focusing on mental health presentations will be produced by the Named Nurse for Safeguarding Children for the 2020 / 2021 period.

7.6 Liaison and Communication with Partner Agencies

Fig 20 reinforces the importance of how to respond to safeguarding concerns. It identifies contact, consultation, or discussion with either social care colleagues or other partner agencies.

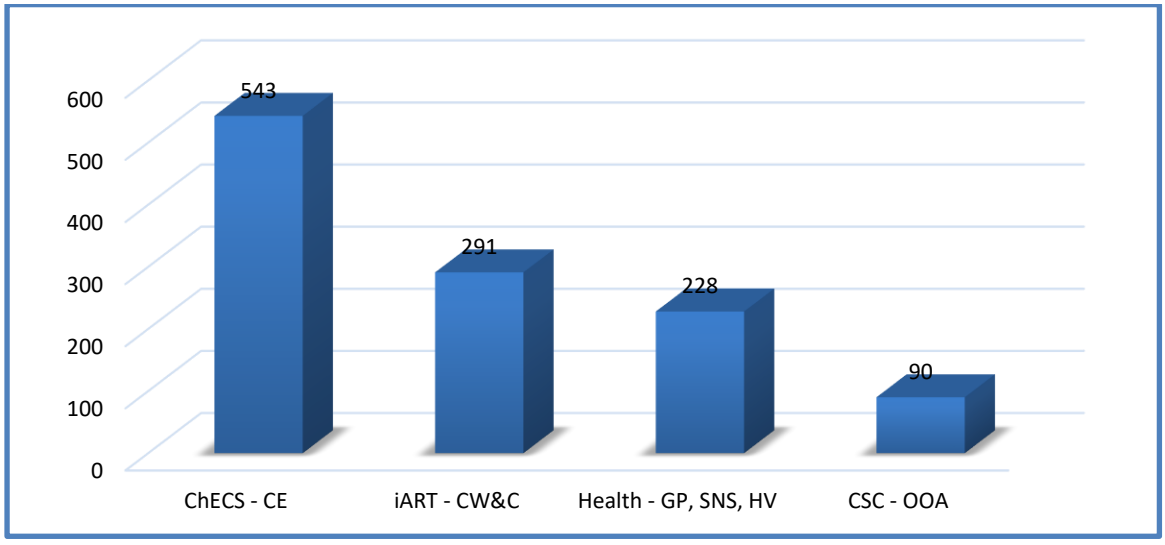


Fig 20

There was evidence of increased communication with all agencies, but in particular to social care colleagues. These contacts may have been to decide whether a formal safeguarding referral was required, but also to share information regarding a child's condition, inform on a discharge plan or to query on the safeguarding history of a vulnerable child, young person or family unit.

7.7 Referrals to Children's Social Care

Fig 21 goes on to identify the resulting referrals to social care colleagues made from those initial discussions or consultations. Referrals were required as the result of physical injury presentations, domestic abuse, intentional overdoses, neglect or the impact of poor parental responses or capacity. As a result of the submitted referrals, anecdotal evidence suggests that:

- The use of the consultation of discussion period (prior to formal referral) has led to a decrease of inappropriate or ineffective referrals.
- Further information is often submitted by MCHFT; for the purposes of Section 17 / Section 47 enquires.
- Communication is often required between the Named Nurse for Safeguarding Children and partner agencies to obtain outcome information; that provides *closure* or *resolution* for the MCHFT referrer.
- The Named Nurse for Safeguarding Children uses referral information as a basis to effective safeguarding supervision and for case discussion in mandatory training.

2020 / 21 saw a continued number of referrals to social care colleagues and also in line with partner agency developments, included a relevant, evidence-based assessment tool (where appropriate).

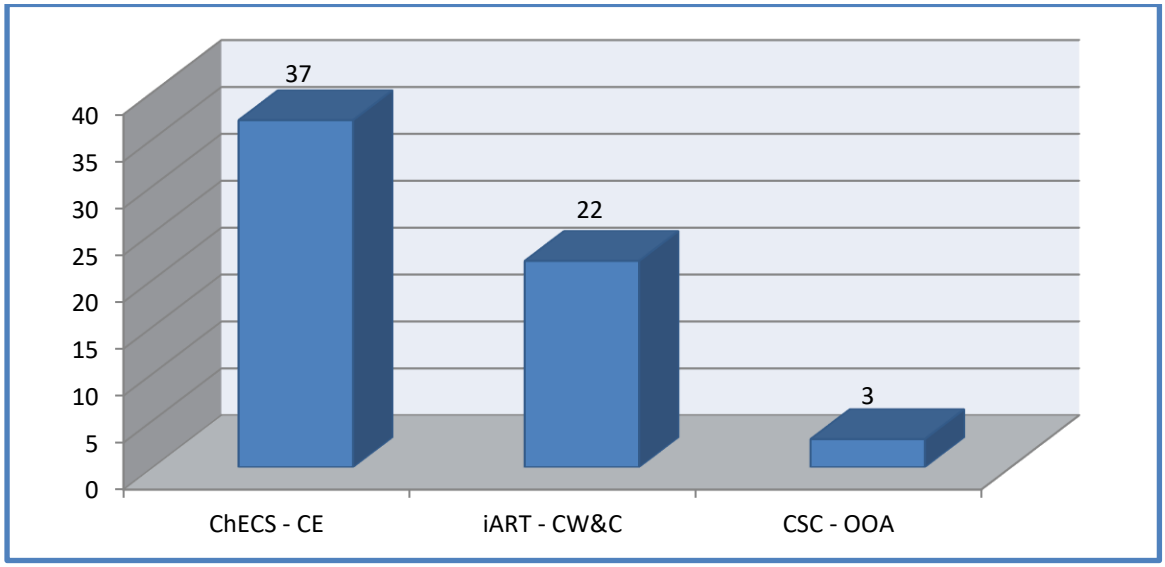


Fig 21

7.8 Quality of Referrals to Children's Social Care

The quality of our initial referral information can be vital in determining the quality of the subsequent multi agency response and support that the child and family receive.

The Trust has been working in partnership with the Local Authorities and other partner agencies to ensure an improvement in the quality of referral information, for example through the development of multi-agency practice standards and the use of common terminology and assessment.

All referrals made by practitioners at the Trust are reviewed by a member of the Safeguarding Children Team. Any discrepancies, anomalies or missing information are dealt with on a case by case basis, directly with the practitioner concerned or a member of their team. Through systematic feedback and supervision opportunities frontline staff has increased in their confidence and competence regarding the formal escalation of safeguarding concerns.

7.9 Safeguarding Supervision

Effective supervision is essential to professional development. It provides an opportunity to analyse and reflect on concerns resulting in outcome focussed action planning. This in turn enhances decision making. Supervision can be an arena for both celebration and challenge.

At MCHFT, Safeguarding supervision is co-ordinated and delivered by a member of the Safeguarding Children Team (Named Nurse / Midwife / Doctor / Specialist Nurse).

Safeguarding supervision within MCHFT is offered by the safeguarding professionals ***no less than three monthly*** but can be obtained more frequently by practitioners if it is felt to be necessary.

Staff supervision sessions are conducted in one of two formats:

- Specific staff supervision sessions, either for individuals or as a group.
- As required / requested staff supervision sessions.

Specific staff supervision sessions are conducted with those healthcare practitioners that maintain a patient caseload and / or by the nature of their roles and responsibilities; may undertake frequent safeguarding activities and / or child protection planning.

As required / requested supervision sessions are conducted for all other members of staff within the organisation.

In the 2020 / 21 period the Named Nurse for Safeguarding Children conducted both formats of safeguarding supervision. Alongside the ad hoc supervision sessions conducted for staff across the organisation; a number members of staff received a regular, specific supervision session; by the nature of their role remit and responsibility.

The quarterly analysis of 2020/21 can be found below of the specific safeguarding sessions:

Quarter 1	Quarter 2	Quarter 3	Quarter 4
66.7%	85%	76.5%	90%

It should be noted that during 2020 / 2021, safeguarding supervision moved to become a virtual meeting due to the Covid-19 pandemic and compliance rates were variable due to shielding requirements.

7.10 Managing Allegations Against Staff Who Work with Children

Where an allegation is made against a staff member that indicates that they may be unsuitable to work with children there is a requirement to notify this to the Local Area Designated Officer (LADO) employed by the Local Authority.

This occurs where a staff member works with or has contact with children under the age of 18 years and allegations suggest they may have harmed a child or that children could be unsafe in their care.

The process aims to allow full disclosure of information regarding concerns so that employers can complete a robust assessment of transferable risk with key partner agencies.

Allegations may come from a variety of sources including complaints regarding a staff member; as a result of an internal investigation as a result of information shared by other agencies in relation to a member of staff (for example the police or Children's Social Care). Allegations regarding the suitability of staff to work with children may arise as a result of the professional or personal lives of staff.

In the 2020 /21 period, the Acute Trust submitted 3 referrals to LADO.

7.11 Audit

As well as meeting the organisations statutory requirements within the Section 11 Audit completion; the Safeguarding Children team also adhere to an annual audit programme in relation to safeguarding children activity; this includes adherence to safeguarding process, training compliance and frontline staff knowledge and flowchart visibility. The findings and any recommendations from the audits are disseminated through the Executive Safeguarding group; at the time of completion; before being promoted to the wider organisation.

MCHFT also participate fully in the LSCB's Multi-Agency audit programme, completing quarterly audits on safeguarding key topics or themes such as Neglect or sexual harm.

Audit schedule 20-21.doc

7.12 Serious Case Reviews and Practice Learning Reviews

Occasionally, a child or young person dies or is seriously harmed and there are questions about how agencies supported or protected the child or young person in the events leading up to their death or harm.

Local Safeguarding Children Boards (LSCB's), along with partner agencies are currently required to produce a Serious Case Review (SCR) to consider what can be learnt from such cases and how they can be prevented again in the future.

Where a case has not met the criteria for SCR a multi-agency Practice Learning Review (PLR) can be undertaken to identify learning across the locality and agencies.

7.13 Risks

Previously, the Safeguarding Children Team experienced significant challenges due to reduced capacity and staff absence of key team members. During this period the remaining team members were supported by the Executive Team in continuing to meet their statutory safeguarding requirements such as the Section 11 Audit.

However, in the 2020 / 21 period, the Safeguarding Children Team and the wider TSG learned from the experience and ensured more robust team cover and succession planning.

There is greater shared responsibility of safeguarding commitments, such as submission of the Performance Dashboard, allocation of training session delivery and representation at external safeguarding meetings. This has helped to provide a more consistent and effective safeguarding service. A summary of key safeguarding activity is produced on an annual basis; to inform ESG and the wider organisation of what work is routinely scheduled by the Safeguarding Children Team; alongside with an annual review of the safeguarding organisational structure.

7.14 New Developments in Safeguarding

Key safeguarding documentation such as the Safeguarding notification form, Safeguarding Flowchart and Safeguarding Practice Policy have all been revised in 2020 / 21. This work ensures that safeguarding process at the organisation continues to be robust and fit for purpose; to the benefit of our service users.

Moving forward further work will continue on the development or roles and responsibilities within the team, how we adapt to key themes such as Contextual Safeguarding and how to integrate greater learning opportunities in mandatory training such as enhanced eLearning programmes alongside face to face sessions.

The challenges of the Pandemic gave agencies, including MCHFT the opportunity to enhance their IT solutions. As a result, the Safeguarding Partnerships adapted to a virtual environment. Executive Board, Subgroups, Strategy, Discharge Planning meetings all embraced Microsoft Teams as a way of conducting business as usual. This has allowed the TSG members greater agency participation, improved time management and increased accountability, for the benefit of proactive safeguarding decisions.

Author: Jo-Ann Carnwell; Named Nurse for Safeguarding Children

8. The Role of the Paediatric Liaison Specialist Nurse in Safeguarding Children

The position of Paediatric Liaison Specialist Nurse (PLS) is part of the wider safeguarding children community.

The PLS role operates full time, Monday – Friday; and is responsible for the effective co-ordination and timely communication between the acute trust and the commissioning community organisation. This is in accordance with the recommendations as set out by Lord Laming (2003).

The PLS is required to scrutinise and triage the MCHT Emergency Department paediatric attendances and proportionately share the information that is necessary to safeguard and/or promote the welfare of a child by communicating any necessary information from the hospital to the community teams.
This involves close liaison between members of the MCHT Safeguarding team (Adults and Children) and community practitioners e.g. health visitors and school nurses.

The PLS also liaises with and receives referrals from the following key locations within MCHT.

- A&E department – minors, majors, and resuscitation areas.
- Paediatric wards, CAU and Assessment area.
- Neonatal Unit.
- Fracture Clinic.
- GP Out of Hours Service.
- Urgent Care Centre
- Minor Injuries Unit; Victoria Infirmary

Referrals for the PLS are completed by staff members; within the key locations and are then electronically sent to the safeguarding team email account.

Referrers are guided by specific ‘trigger lists’ within each department to ensure that referrals are appropriate.

8.1 How the Role of Paediatric Liaison Specialist Operates

There is daily contact with the Emergency Department to review all Paediatric notes for the preceding 24-hour period to highlight children or families of concern to community practitioners and to the Named Nurse for Safeguarding Children within MCHT.

Referrals are assessed for any key health information or potential safeguarding issues; before then being disseminated to the relevant community practitioner (for example, Health Visitor or School Nurse). All referrals are forwarded electronically to avoid time delay especially where there could be a safeguarding concern.

This process also applies to children who may attend MCHFT; but reside outside of the Cheshire locality (for example, if on holiday), information is shared to counterpart Liaison Specialists in their locality for them to share with relevant agencies.

This sharing of information then allows community practitioners to arrange follow up visits, work with partner agencies, offer additional advice and support or devise appropriate care packages; dependent on why the child attended hospital initially.

The PLS role has proven to be crucial within the communication pathways that operate between the acute and community environments. Anecdotal evidence would suggest that it clearly demonstrates “best practice”.

The PLS role acts as a reliable resource to both acute and community colleagues.

The PLS maintains a daily contact with the key locations to ensure that referrals are received in a timely fashion.

8.2 Paediatric Liaison Specialist Activity

Table 1 shows the number of referrals received on a monthly basis (Blue key), and figures are compared with the preceding years’ referrals (Red key) a correlation can be seen in reduced referrals at the start of April 2020. This is in line with the onset of the Global Coronavirus Pandemic, activity within the ED and Children’s inpatient areas was dramatically reduced from March 2020. Rise and fall trends can be seen to concur with easing and implementation of restrictions/lockdowns nationally and locally during the Pandemic and its’ management.

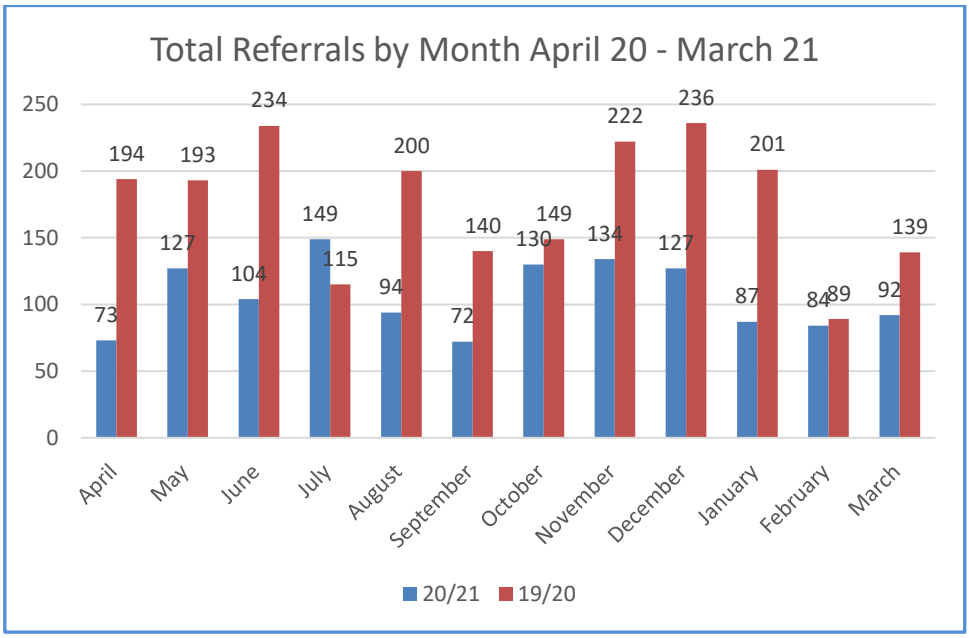


Table 2 shows the total number of referrals received by PLS broken down into Clinical Commissioning Group locality (CCG)

For the period April 2020 – March 2021, the Paediatric Liaison Specialist Nurse received ***1,345*** referrals, which were then disseminated to community practitioners for information sharing and further action as deemed necessary. The referrals are separated into CCG localities.

The service received ***767*** less referrals this year (***2112*** referrals 2019-2020), which would fit with National lockdown and accessing health provision.

	East	West
April 2020	50	23
May 2020	88	39
June 2020	61	43
July 2020	89	60
August 2020	61	33
September 2020	91	53
October 2020	74	56
November 2020	88	46
December 2020	80	47
January 2021	55	32
February 2021	53	31
March 2021	58	34
Grand Total	**848**	**497**

Table 3 shows the numbers of PLS referrals received by MCHT alert code. MCHT operates an alert system, and practitioners will refer to safeguarding children when there is an alert present on the patient record. Other presenting factors are further considered when children attend. Mental health continues to be the dominant presentation and reason for referral to the PLS. This is consistent with previous year's figures and increases year on year. Figures for children that have overdosed and self-harmed are also captured, Table 3 demonstrates that almost two thirds of the referrals received have mental health as a contributor to attendance.

- '*' indicates an active child protection plan in place under a Local Authority
- '* PRE' indicates social care activity within the past year
- 'LAC' indicates that a child is cared for, usually by a Local Authority
- 'MAC' indicates that the family have been heard at Multi Agency Risk Assessment Conference
- 'CSE' indicates child sexual exploitation

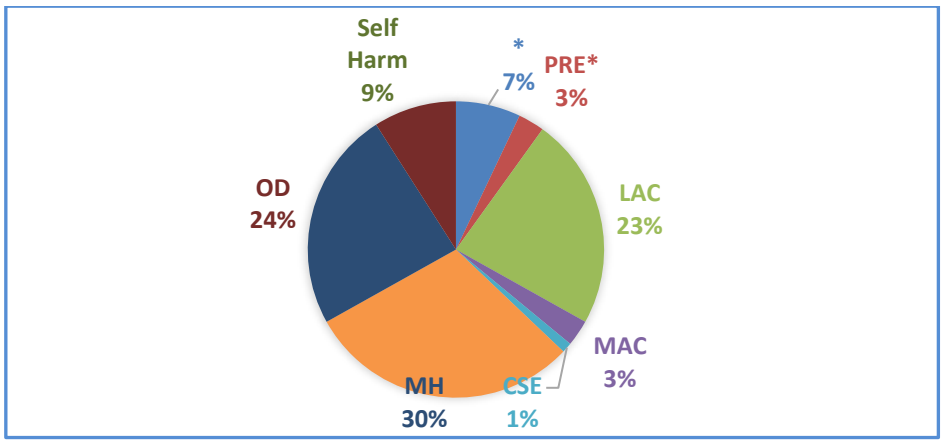
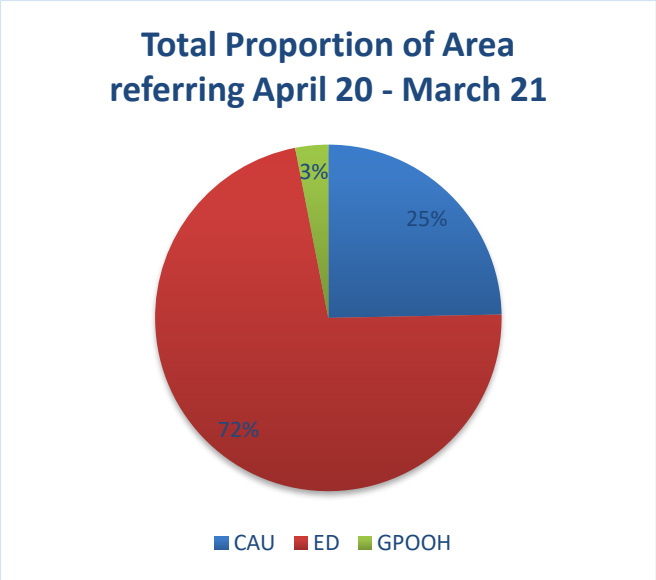
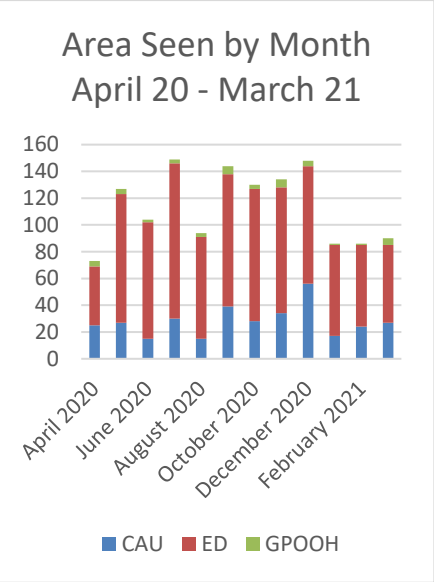
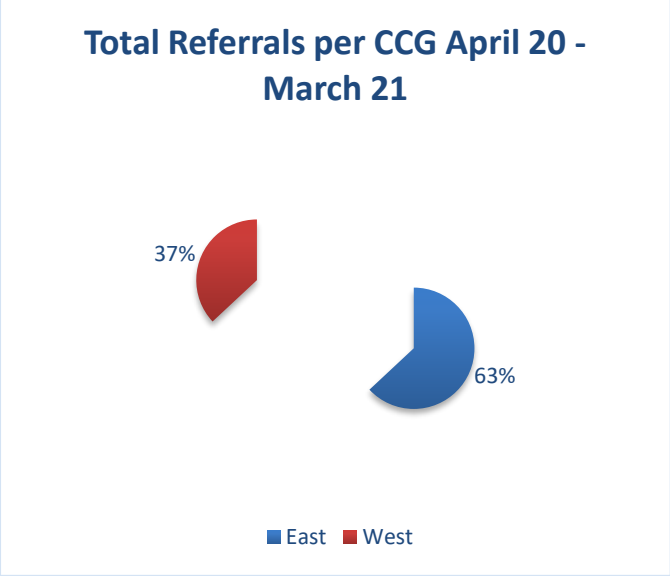
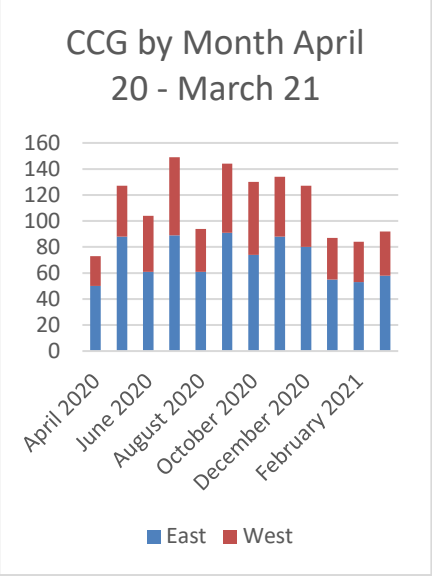


Table 4 indicates the areas where the PLS receives their referrals from, this is further broken down into CCG locality on Table 5.









Author: Mel Whalley; Paediatric Liaison Specialist Nurse

9. The Role of the Named Doctor in Safeguarding Children

The following is a summary of the clinical activity and performance figures for child safeguarding medical examinations undertaken by paediatricians within the 2020-2021 period.

9.1 Child Safeguarding Medical Examinations

A total of 67 child safeguarding medical examinations were undertaken, which is slightly more than last year, when the total number was 64. Throughout this year, 17 medicals were undertaken in quarter one, 12 in quarter two, 9 in quarter three and 29 in quarter four.

Type of abuse: Three quarters (75%) of examinations were requested due to concerns about physical abuse, 6% were requested due to concerns about neglect, with the remainder of 19% requested for sibling medicals *(Figure 1)*.

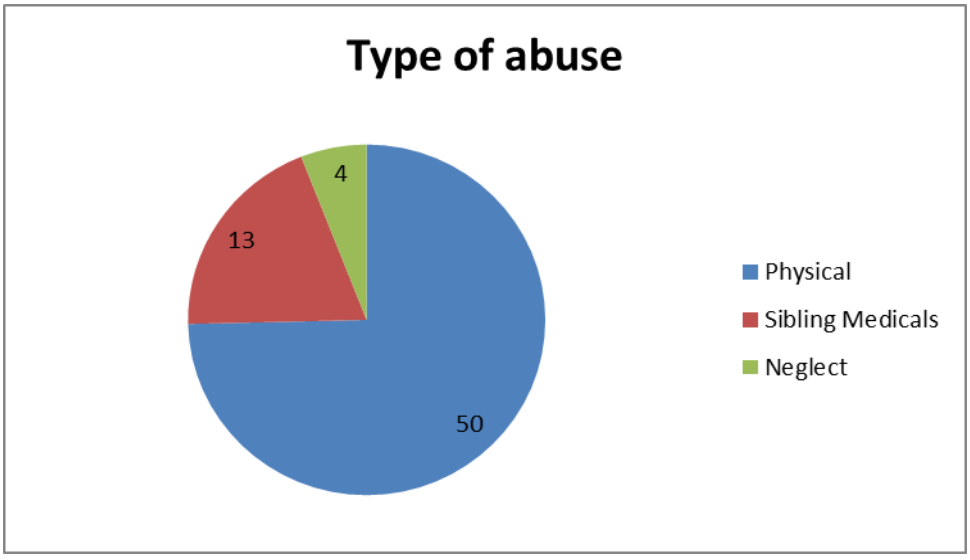
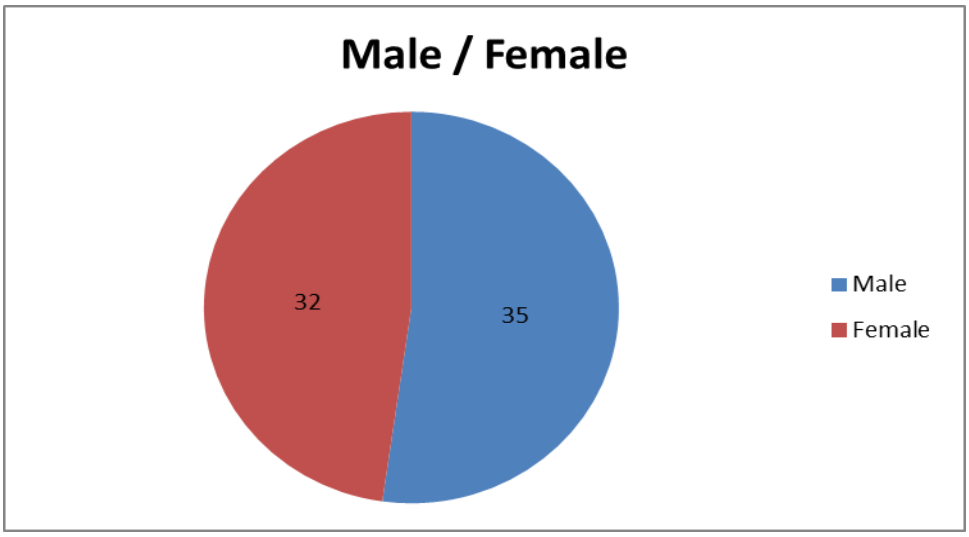


Figure 1

There is a trend of an increasing number of requests for sibling medicals; last year they comprised 6% of requests. There were no requests last year in relation to neglect; the requests this year in relation to neglect should be

considered in relation to the Covid -19 pandemic, where there has been reduced visibility of some children. Therefore, some children may have been experiencing neglect for longer periods of time before professional intervention.

Demographics: Just over half of the children seen were boys *(Figure 2)*. The ages of children seen ranged from a baby aged approximately 9 weeks old, to a teenager aged fourteen years and 11 months.



52% of examinations were for children living within the South Cheshire CCG area, with the remainder of 48% for children living within the Vale Royal CCG area (Figure 3). Last year these figures were for 66% for South Cheshire CCG and 33% for Vale Royal CCG.

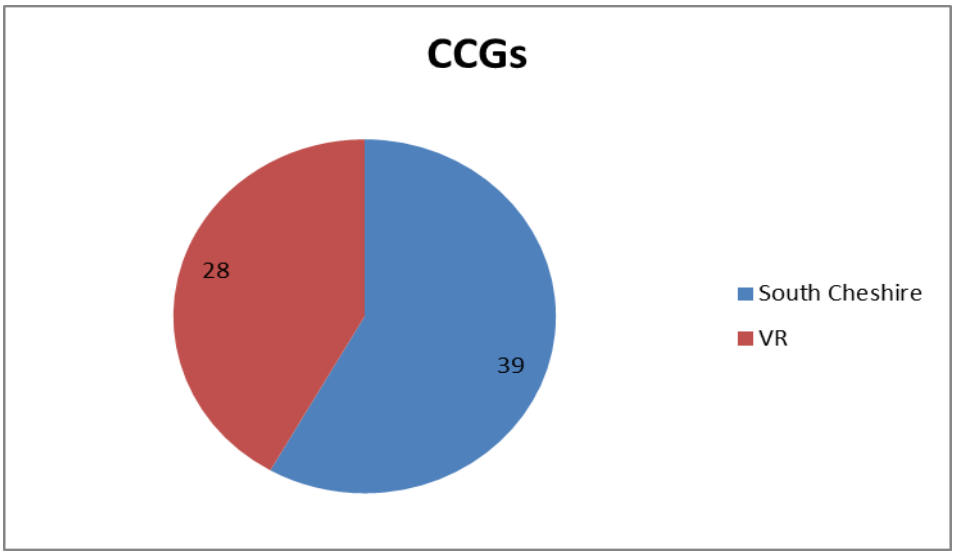


Figure 3

Source of referral: most referrals, around 80%, were from Children's Social Care. The remainder were at the request of staff in A&E, general paediatrics consultants, the Police and the Named Doctor for Safeguarding Children. In one child, the source of referral was not stated *(Figure 4).*

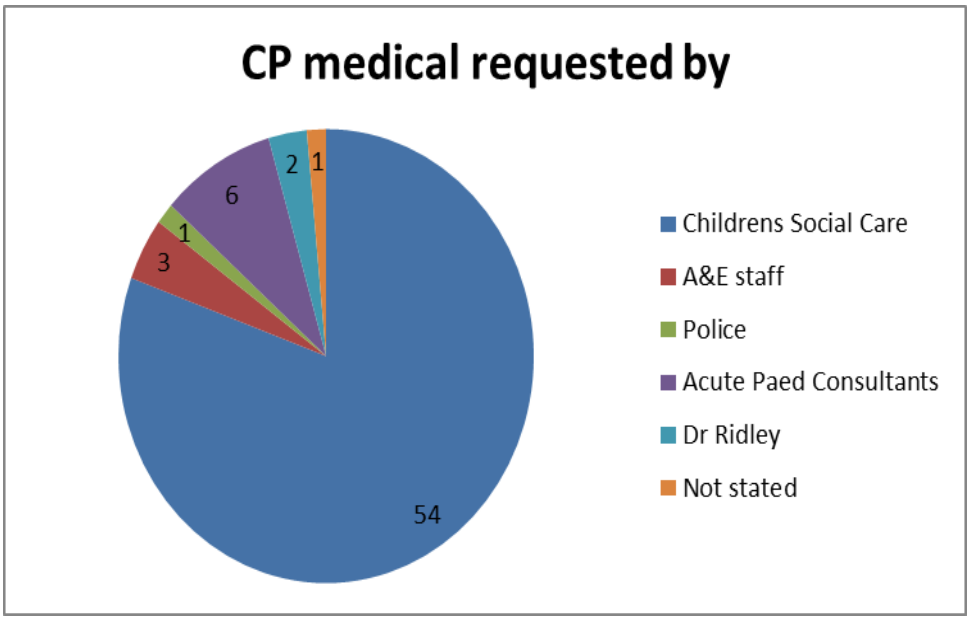


Figure 4

Details about the medical: Around of three quarters of examinations were carried out by the community paediatric team, with the remainder carried out by the general paediatric team *(Figure 5)*.

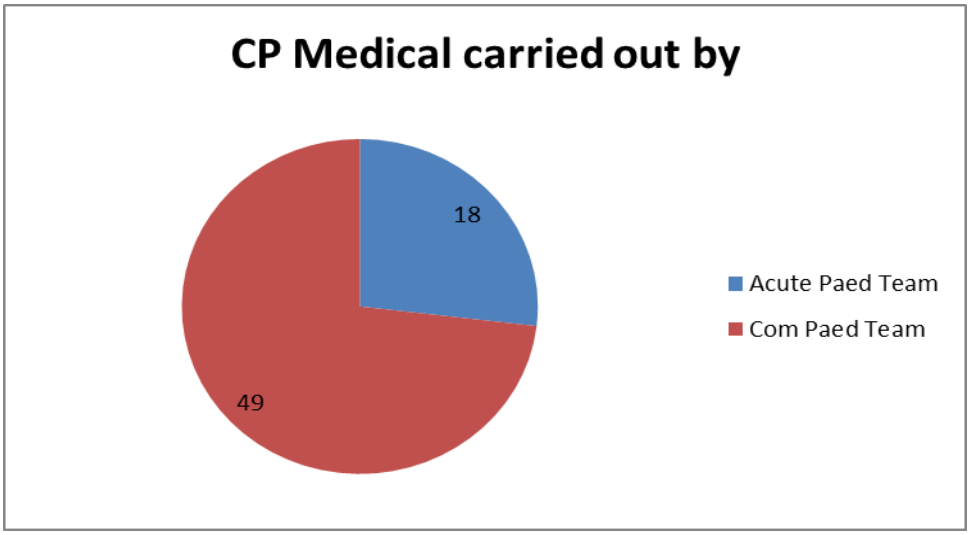


Figure 5

During the peak of the covid-19 pandemic, there was agreement that the community paediatrics team would provide out of hours cover for child protection medical examinations temporarily, to ease pressures on the general paediatrics team. A risk assessment was completed on the potential impact of winter pressures and covid-19 on child protection medical examinations and there was agreement between community and general paediatrics on how child protection medicals would be prioritised.

Most examinations took place during normal working hours i.e. Monday to Friday 09.00-17.00; however, some reports did not state the time the child was seen *(Figure 6)*.

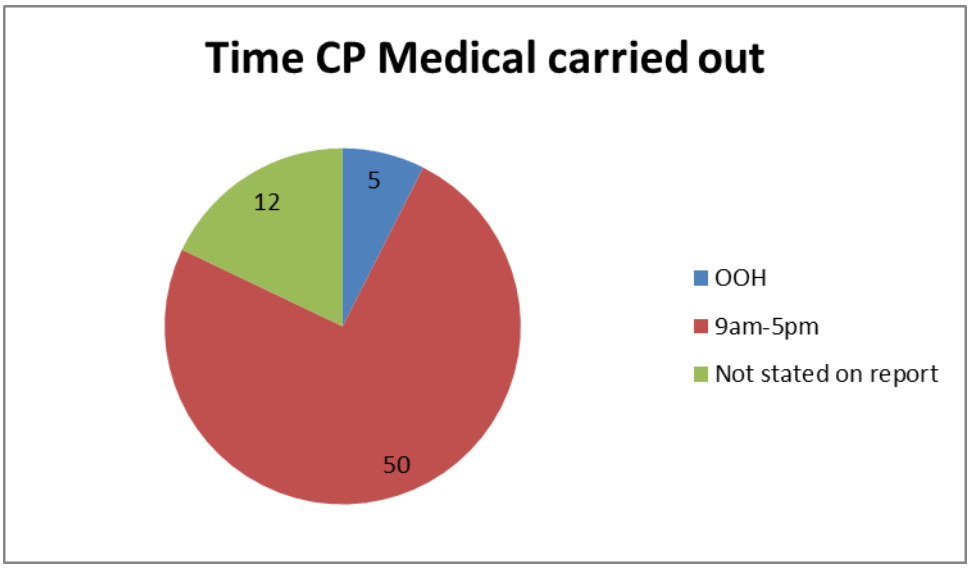
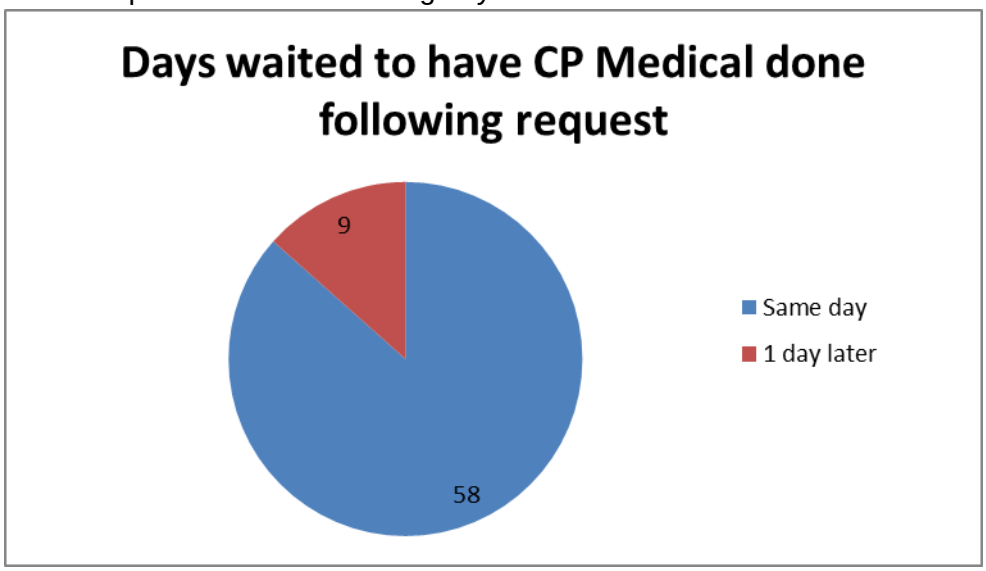


Figure 6

Around 87% of examinations occurred on the same day as the request, with the remainder taking place the following day *(Figure 7).* If an examination did not take place on the same day as the request, this was considered on a case by case basis, based on an agreed joint decision between the Paediatrician and Children's Social Care about the urgency of the request, ensuring the child was in a safe place in the interim.

It is positive that this year, all children were examined in a timely manner on the same day as the request or on the following day.



Almost 90% of all of the child protection medical reports were completed and sent out within the Safeguarding Children Partnership standard of three working days *(Figure 8).*

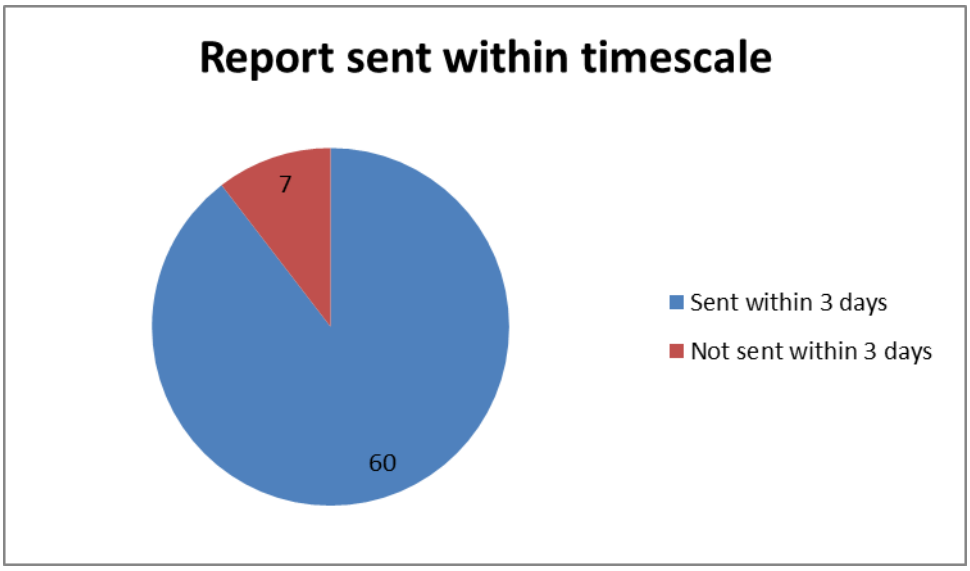


Figure 8

9.2 Safeguarding Children Supervision for Paediatricians

For the permanent members of staff within Community and General Paediatrics, group safeguarding supervision is conducted in a monthly Safeguarding Children Peer Review meeting. Trainees and medical students in paediatrics also attend. Other clinicians working within the Trust may be invited to the meeting by the Named Doctor for Safeguarding Children, particularly if there is an issue being discussed that involves them, for example staff working in A&E or midwifery. In addition, clinicians working outside of the Trust may also be invited if relevant, for example GPs and/or the Named GP for Safeguarding Children.

Individual safeguarding supervision sessions for clinicians with the Named Doctor for Safeguarding Children are also available on request. These sessions are particularly emphasised as an option for clinicians who may find it difficult to attend the peer review meetings. One to one sessions for paediatricians continued during the Covid-19 pandemic; by Microsoft teams, telephone and face to face with social distancing and PPE. This provided support to staff and appropriate challenge if necessary.

During this period, a total of ten Safeguarding Children Peer Review Sessions took place. The April 2020 session was cancelled due to the covid-19 pandemic. Prior to the covid-19 pandemic, sessions were all face to face. Sessions moved online and took place using Microsoft Teams from May 2020. The December 2020 session was cancelled in advance, due to an anticipated lack of quoracy.

The Safeguarding Children Partnership standard is that at least 80% of permanent members of staff in paediatrics should attend at least four sessions per year (i.e. an average attendance of one session per quarter). The number of permanent members of staff has varied between fourteen and nineteen. Over the year, the compliance was 87% and for all quarters, this standard was met. The figures are as follows:

- Q1 – 17/19 – 89%
- Q2 – 15/18 –83%
- Q3 – 14/17 – 82%
- Q4 – 13/14 – 93%

Compliance will continue to be monitored and scrutinized through the Trust Safeguarding Group.

As the Named Doctor for Safeguarding Children, I also receive safeguarding supervision sessions, conducted on a quarterly basis, with the Designated Doctor for Safeguarding Children.

Author: Dr Francesca Ridley; Named Doctor for Safeguarding Children & Joe Sullivan; PA

10. CCICP and Safeguarding Children

10.1 Background and Activity

Paediatric services in community consist of:

- Paediatric therapies
- Paediatric Bowel and Continence Service
- Paediatric Advanced Nurse Practitioner
- Home Care Team
- School Nurses in Special Schools
- ADHD Team

The paediatric services work in partnership across the different primary and secondary services and alongside partner agencies in Education, Early Help and Team around the Family (TAF), CAMHS, Children's Social Care, and Domestic Abuse Services within the Trust and across Cheshire East and Cheshire West

The lived experience of children has undoubtedly been impacted in the context of COVID 19 and associated restrictions to health provision, school attendance and isolation of families. This is reflected in the data for Q1 and Q2. The intervening months in Q3 and Q4 have highlighted children with complex health and development needs living in families with complex vulnerabilities such as domestic violence and abuse, poor mental health and parents with health and learning needs.

The safeguarding contacts data below arise through use of:

- safeguarding notifications,
- telephone calls
- correspondence /emails

from practitioners in community services and predominantly identify children where practitioners are working to manage processes around attendance to appointments, Early Help and partnership working with other involved agencies

Community Services Safeguarding Contacts 2020-2021

QUARTER 1 2020	10
QUARTER 2 2020	14
QUARTER 3 2020	27
QUARTER 4 2020-21	101

The paediatric services and school nurses use the Trust Safeguarding Notification Form to identify concerns related to the children they work with directly, and to identify where children meet the threshold for 'Was Not Brought'.

The information shared in the Safeguarding Notification for children triggers a search for additional information by the specialist safeguarding nurse to develop a clear understanding of any known vulnerabilities or risk factors. The detailed search includes reviewing internal health record systems in Child Protection Files, EMIS and PCS and where necessary telephone calls to partner agencies in social care such as:

- Child in Need and Child Protection Teams
- Children with Disability Team
- Looked After Children Team.

The detailed enquiry process may indicate a history of Child Protection or Child in Need Planning/Procedures, history of appointments, health problems, referrals and attendances and would include any parental vulnerabilities. In all cases the practitioner is supported with additional information, and guidance on what proportionate actions to take in response to the Safeguarding Notification and Was Not Brought information.

Invariably the children identified in this process will have vulnerabilities by virtue of their inherent health needs and it is important that they have access to necessary health appointments.

Analysis and sharing of information in case files may lead to the CCICP practitioner liaising with other agencies such as Early Help, health visitors, community paediatrics, schools, Gps and school nurses with an aim to support the child and their family in accessing appointments.

Equally within this process staff are enabled to consider the impact of the Adverse Childhood Experiences in working in Early Help, safeguarding and child protection processes and incorporate a Think Family Model to their practice. Both these models factor strongly in the Trust Safeguarding Training attended by staff

In some cases, it has been necessary to refer the child to the appropriate children's services for assessment and intervention to ensure that parents understand their parental responsibilities in meeting their child's health needs.

10.2 Safeguarding Supervision

In the period 2020 -21 the Specialist Nurse for Safeguarding Children provided mandatory Safeguarding Supervision to between 11 and 14 CCICP practitioners on 24 occasions.

This activity translates into 171 discussions regarding early help, safeguarding children, child protection and Looked After Children issues.

Safeguarding Supervision is underpinned by the Trust Safeguarding Supervision Policy 2020 and supports staff with case oversight, safeguarding leadership/ management and restorative supervision.

Safeguarding supervision is also available on an ad-hoc basis to all staff, and this has been utilised by individuals and teams to discuss cases where there are identified concerns and they require further support, analysis and guidance.

The work in paediatric community services can be very challenging and isolating for staff as it may involve providing intimate care and interventions in a family home setting and requires sensitivity and resilience to maintain appropriate and professional relationships with parents/carers.

This has been the case recently where practitioners identified concerns regarding a child with complex health needs which appeared to be unmet and the relationship had broken down with the parents. Safeguarding supervision was able to effectively support the practitioners through restorative supervision and exploring ways of successfully and sensitively mediating between parents and staff with an outcome which was child centred and where all concerned were able to recognise the positive outcome.

Author: Aliette Atkinson; Safeguarding Specialist Nurse

12. Safeguarding Adults (including CCICP)

12.1 Patient Stories

For each quarterly report, a patient story is shared to offer assurance that Adult Safeguarding keeps the person at the heart of everything we do and that we recognise and respect the voice of the adult.

The following two patient stories evidence this, both demonstrating collaborative working between primary and secondary care in order to safeguarding vulnerable adults.

Patient Story 1

Jean* had been unwell for a few days with general weakness but now could not mobilise. Her son who lives with her and is her carer, called for an ambulance.

On admission to the hospital a skin inspection took place. Extensive bruising around the buttock, top of thighs and genitalia was noted. Jean said she did not know where these bruises had come from. Concerned staff contacted the police and an incident report was logged with the safeguarding team.

Once Jean was settled on the ward the Safeguarding team visited Jean and we asked about her life, whether she was happy at home? Does she manage well? Does she have a good relationship with her son? Jean said that she was very happy, and her son looks after her well and she cannot wait to return home. It became obvious during this chat that Jean was lacking capacity. She was not orientated to place and time and could not retain information.

Photographs of her injuries were taken in her best interest and examination of the bruises was also performed. Medics felt that the bruising was not synonymous of bruising that can occur with a medical condition and could have been caused by an external trauma.

The safeguarding team liaised closely with the police and social care to ensure Jean's safety was maintained.

The police visited the home of Jean to speak to her son. They felt that her son was not coping with looking after her and as he denied knowledge of where her bruises had come from the Police could not proceed with any criminal investigation as a formal complaint has not been made.

It was then agreed between agencies that Jean should not return home. Jean remains to have fluctuating capacity and an IMCA was assigned to Jean in order to make discharge decisions. Social care met with Jean's son and explained how this decision was reached.

Patient Story 2

Rose (81), was admitted to the hospital for a planned procedure-accompanied by her daughter. During the pre-op assessment Rose disclosed she had been staying at her daughters for the past 2 days as the police had been called to her home following an altercation with her husband.

Rose then proceeded to explained that she had suffered over 50 years of domestic abuse at the hands of her husband including serious physical assault. Rose feels that she no longer has the energy to live like this however is frightened to start again at her age. She was then referred to the safeguarding team.

The disclosure of this abuse led Rose to have a period of extreme distress. During this time, the safeguarding team met with Rose and recognised her anguish and need for support. She was referred to the Mental Health Liaison. Mental Health Liaison suggested that on discharge Rose is referred to the older person's mental health team for on-going support.

Rose's case was then referred to the Domestic Violence hub and a complex IDVA was then assigned to her. They met to discuss safety planning which Rose felt if she was to return home to her husband.

The safeguarding team then referred Rose to social care to support her with her decision to either leave the marital home or be discharged to a care facility.

The safeguarding team appreciated what a difficult and complex situation this was and visited the patient daily on the ward. Rose was grateful for the support as were the staff as it was a difficult and complex situation for them to manage.

Patient's names have been changed.

12.2 Policies and Procedures

The Safeguarding Vulnerable Adults Policy is available for staff to access via the Trust's intranet site. The Policy is due to be updated in October 2021 and will include guidance in relation to care providers completing safeguaring enquiries where staff are involved. Current issues, including County Lines will be referenced and the importance of a 'Think Family' approach when addressing safeguarding adult concerns.

In June 2018 a Mental Capacity Assessment Process and Deprivation of Liberty (DoLS) Policy was introduced. The Policy provides clear guidance for staff in relation to supporting patients who lack capcity and our legal duties and requirements.

The Trust has also developed an educational DVD to provide practical support to staff who undertake capacity assessments. The DVD shows both a Dr and Nurse led capacity assessment and clearly demonstrates practical application of the Mental Capacity Act (2005).

Other policies which are part of the Adult Safeguarding remit include, the Prevent Policy and the Hand Control Mittens Policy; both of which have been updated recently.

Staff are also able to access guidance from the Local Safeguarding Adults Board including:

- Managing High Risk Self-Neglect Cases Referral Form
- Information Sharing Agreement
- Safeguarding Adults Review Form

The Adult Safeguarding Team have introduced a new Policy in November 2020, Guidelines for Risk Assessing Suicidal Adults and /or Young People in the Ward Environment. The introduction of the Policy reflects the increase in mental health presentations over the past 12 months and was guidance welcomed by staff across the organisation.

12.3 Adult Safeguarding Incident Data: Acute Hospital

Each quarter Information Governance produce a report for the Adult Safeguarding Team that gathers data in relation to:

- Number of incidents and originating department
- Incidents by cause
- Impact
- Perpetrator
- **CCICP** Incidents
- Patient Story

In addition to this Performance Dashboards are populated on a quarterly basis and provide useful statistical data for example: -

- Training figures
- Internal monitoring/audit
- DoLS referrals
- MARAC referrals
- Number of safeguarding incidents

12.3 Adult Safeguarding Incident Data: Acute Hospital & CCICP

Safeguarding Concerns (Received via incident reporting system IR1's)

Concerns are collated into two categories; those raised on admission and internal concerns. Each concern is investigated, and outcomes are recorded on the safeguarding adult trigger log.

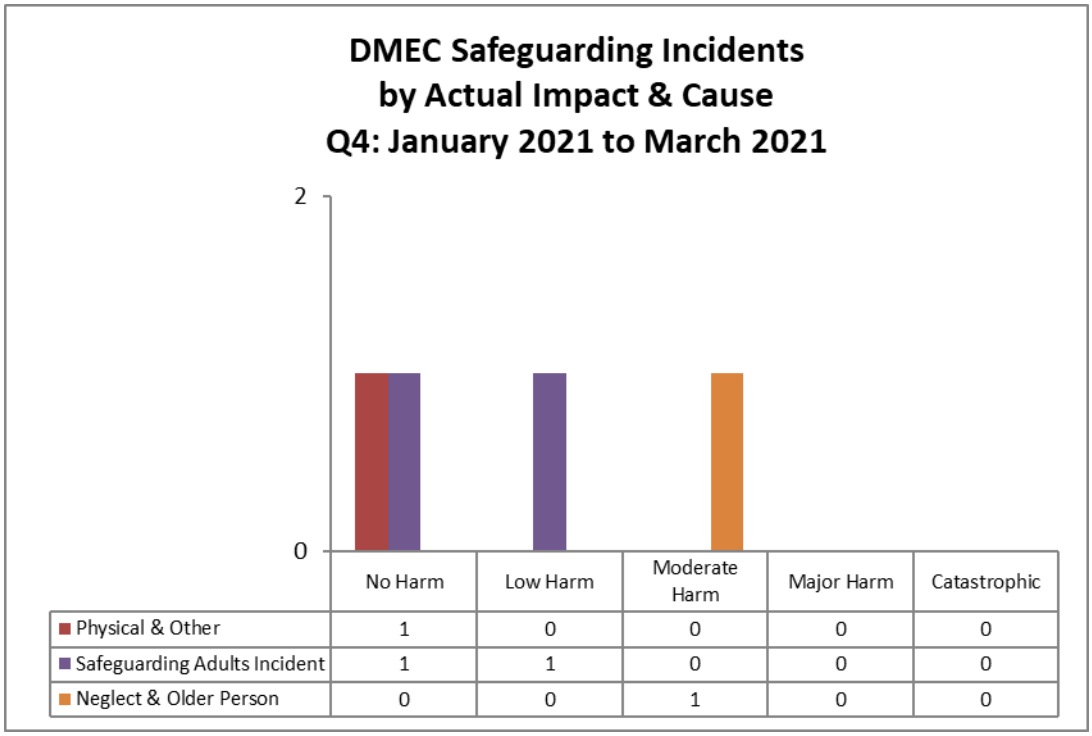
Numbers of Concerns Raised 2019 - 2020

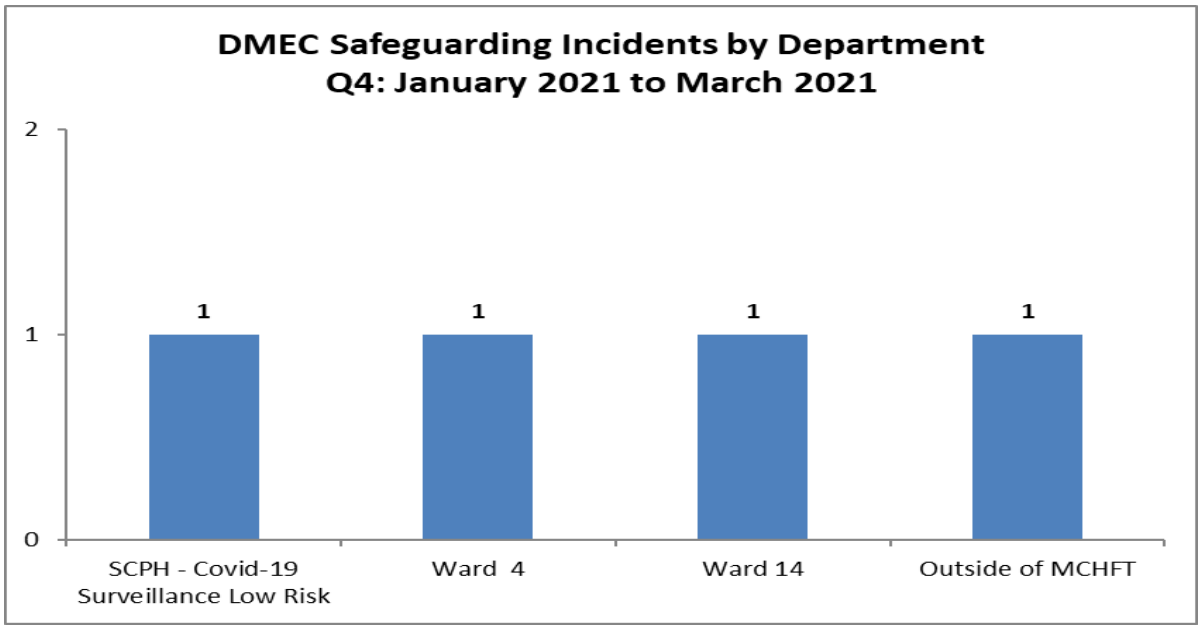
	Concerns on Admission	Internal Concerns
Q1	74	6
Q2	77	3
Q3	109	5
Q4	114	5

Incidents are broken down by cause, impact, and originating Division. All incidents with an actual impact of moderate harm or above are highlighted within the report and details of the investigation and outcome documented.

following set of graphs show the safeguarding incidents for the Division of Medicine and Emergency Care for quarter 4 as an example of the type of information shared in the quarterly reports. The graphs show the number of incidents, actual impact and the originating department:

Quarter 4





12.4 Adult Safeguarding Incident Data: MCHFT

The Safeguarding Team continue to collect more information from the Trust and community services each quarter. This information highlights referrals received that were not raised via the incident reporting route. Referrals came via first account forms, North West Ambulance Service referrals, phone calls and emails from either social care or staff within CCICP. Adult Safeguarding Team also attend pressure ulcer panels for all Cat 3 & 4 pressure ulcers developed in care within the Trust and CCICP to advise on any safeguarding concerns that may arise.

Examples of the type of data that is collated is shown below from Q4

160 care concerns/enquiries from hospital/ward/departments, social care and North West Ambulance (NWAS). All these range from phone calls emails and 1st accounts. This figure also takes into account Domestic Violence referrals that the team have dealt with in the absence of the hospital IDVA.

NWAS referrals are triaged by social care and the safeguarding team are asked to chase any actions that are required. These can range from speaking to the patient or families to collect more information, or ensuring IDT referrals, Mental Health liaison referrals & substance abuse referrals are completed with patients consent.

Number	Code	Outcomes.
123	NWAS referrals all from East Social Care.	Concerns were around patient self-neglecting/not coping; requiring input from social care for assessments when med fit if consent. In these figures there were a number of patients requiring Mental Health Liaison or substance misuse services.
14	DN	Care concerns re patients for discharge back to the community and wound care.
2	Family raising concerns	Patient was discharged late and in pyjamas
1	Homeless Support	Advice given over homeless patient
1	Consultant	Rang for advice regarding alleged sexual assault
10	Social Workers	These consist of telephone calls/emails. Providing SG team with information re inpatient. Requesting information about patient diagnosis, discharge concern Advice re-PU on discharge. Pt discharged on a DOL's Attitude of staff towards carers.
1	X-Ray Department	Patient arrived looking very unkempt
1	OT	Advice re care concern.
14	Wards - requesting advice or information re patients in their care with open SG or advice for SG referral	Information sourced from SW's, families or professionals and fed back to ward.
25	Pressure Ulcers	
67	Domestic Violence	Patients have disclosed violence within their relationships.
Total: 160		

12.5 Deprivation of Liberty (DoLS) Applications

Deprivation of Liberty Safeguarding's are a fundamental part of ensuring patients are treated respectfully, with dignity and that their rights are protected whilst in hospital. DoLS provide a legal framework to protect adults who lack capacity to make decisions for themselves in relation to their care and treatment. Where deprivation of liberty is unavoidable, DoLS ensure decisions are made in a person's best interest and with the least restriction to their rights and freedoms.

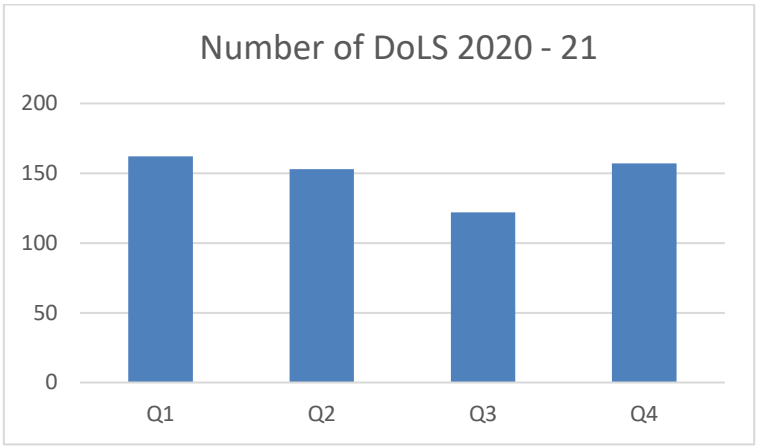
Between 1 April 2020 and 31 March 2021 MCHFT made 594 DoLS applications to either Cheshire East or Cheshire West DoLS team.

All DoLS applications are quality assured by the Dignity Matron, prior to being sent to the relevant Local Authority. This process ensures that there are as few delays as possible within the system, patient's rights are respected, and deprivations are kept to a minimum. As highlighted in last year's Activity Report, the DoLS process will be moving to Liberty Protection Safeguards (LPS).

There has been a delay in its implementation and the new date for DoLS to LPS is April 2022.

Key changes include:

- LPS will be applicable in all settings
- LPS to include 16- and 17-year olds
- New "Responsible Body" will be the Hospital Trust
- Qualified staff to undertake most of LPS assessments, to be completed as part of routine care
- Explicit duty to consult with carers and families, as well as the patient.



12.6 Themes and Lessons Learned

A high proportion of safeguarding concerns fell into the following concerns:

Quarter 1

- Safeguarding Adults Incidents
- Neglect & Other
- Psychological & Mental Health

Quarter 2

- Neglect & Older Person
- Psychological & Other
- Safeguarding Adults Incident

Quarter 3

- Physical & older person
- Discriminatory and Learning Disabilities
- Institutional & Other

Quarter 4

- Safeguarding Adults Incidents
- Neglect & Older Person
- Physical & Other

Themes and lessons learned are shared with Divisions via the quarterly reports presented at the Trust Safeguarding Groups (TSG). Domestic Violence continues to be recognised as a significant concern within the safeguarding arena, and the work of the hospital based Independent Domestic Violence Advisor (IDVA) is increasing year upon year. patient stories that are shared at the Trust Safeguarding Group contain many elements of good practice as well as lessons to learn and these are taken back to Divisions to share.

Difficult cases are used as learning opportunities, with good practice identified and areas to be developed. Staff find these cases an excellent way to learn and bridge the gap between theory and application to practice.

The Trust has taken 2 cases to the Court of Protection involving the application of Safeguarding principles and protecting the rights of patients who lack capacity to make decisions for themselves. These 2 cases have been extremely helpful in staff training and education.

12.8 Safeguarding Team Structure Job Titles

See Appendix 2

12.9 Adult Safeguarding Flowchart

See Appendix 3

Author: Phil Pordes, Vulnerable Adult Lead Nurse

13. Addressing Domestic Abuse

In December 2020, the Safeguarding Team (Children and Adults) reviewed the processes, pathways, and structures regarding Domestic Abuse responses in the Trust.

This was triggered by staff absence in the Safeguarding Team. As a result, the Named Nurse for Safeguarding Children and Vulnerable Adult Lead Nurse made the strategic decision that whilst it was important to harness the expert advice of the IDVA, a “team approach” would build resilience and consistency within the organisation.

The internal processes reviewed included:

- Referrals and how they are received within the Safeguarding Team
- Triage of referrals; to ensure timely responses and identification of how / by whom the response should be delivered i.e. the Safeguarding team, the IDVA, or the DA Hubs.
- Risk assessments using evidence-based assessment tools
- Updating the key documents utilised for the recognition / response to DA in the organisation, such as the DA Flowchart and RIC assessment tool.
- Support for staff in completing risk assessments and making referrals to services

DV Flowchart 2021 (4).doc

MARAC REFERRAL FORM Version 6 Apr

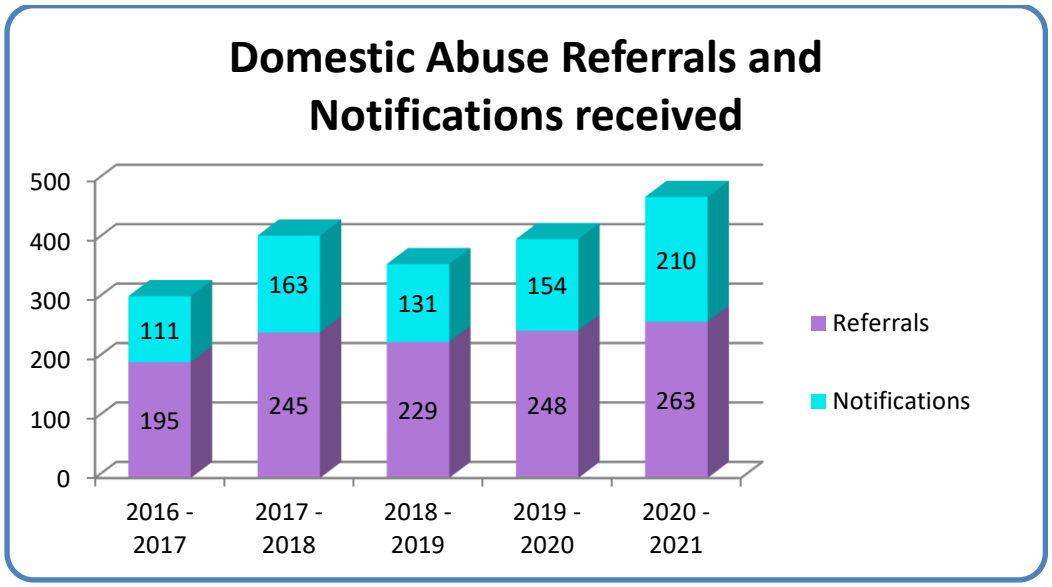
S	SPECIFIC	Details exactly what needs to be done
M	MEASURABLE	Achievement or progress can be measured
A	ACHIEVABLE	Objective is accepted by those responsible for achieving it
R	REALISTIC	Objective is possible to attain (important for motivational effect)
T	TIMED	Time period for achievement is clearly stated

Table.1

The internal methodology used is underpinned by SMART objectives (Table 1.) and provides a dataset as an evidence base for referrals, processes and outcomes for patients who have made disclosures of domestic abuse or violence to any Trust staff IN Acute or Community settings.

Further work continues with the CCG to ensure that arrangements are in place which reflect the shared working and practices across the Cheshire Partnership, and is informed by legislation Domestic Abuse Act 2021 and Pathfinder Toolkit June 2020.

13.1 Referral Data



Domestic abuse referrals are generated when a domestic abuse concern is raised and a referral is made to the Hospital IDVA to investigate further, contact the client or signpost for additional support.

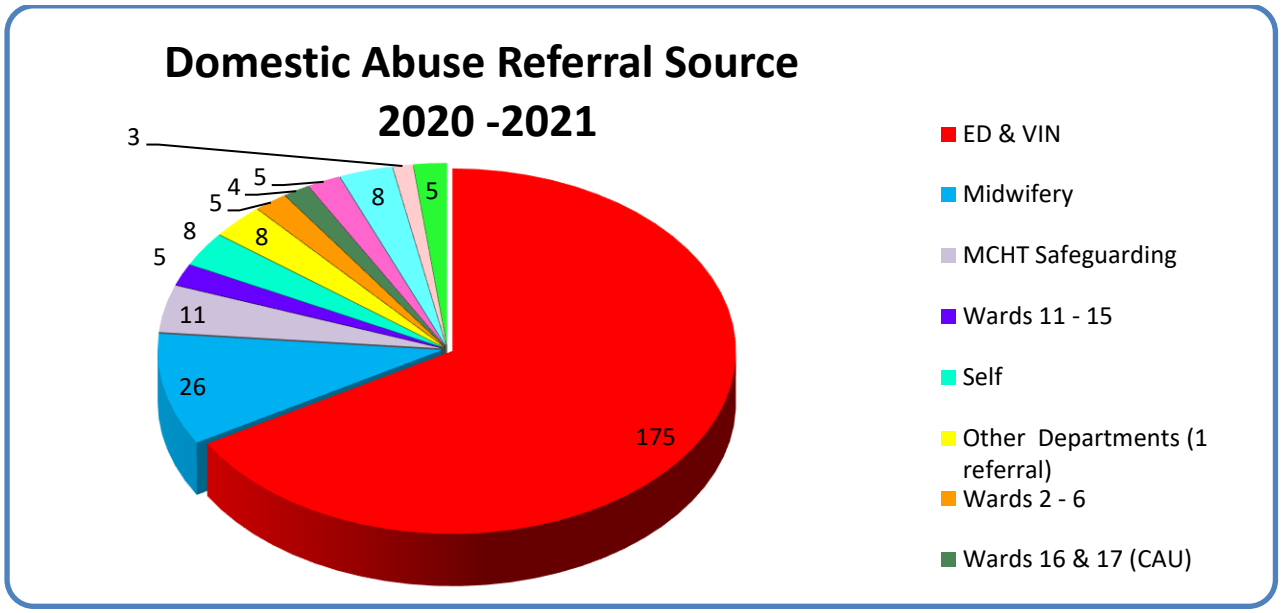
Domestic abuse notifications are generated when the Hospital IDVA is contacted in relation to general advice requests, information requests, information sharing and enquiries.

Some departments liaise closely with the Hospital IDVA to share or request information and it was felt this work was not represented by recording referral numbers alone. The recording of domestic abuse notifications commenced in Jun 2016 as it was felt necessary to record this separately.

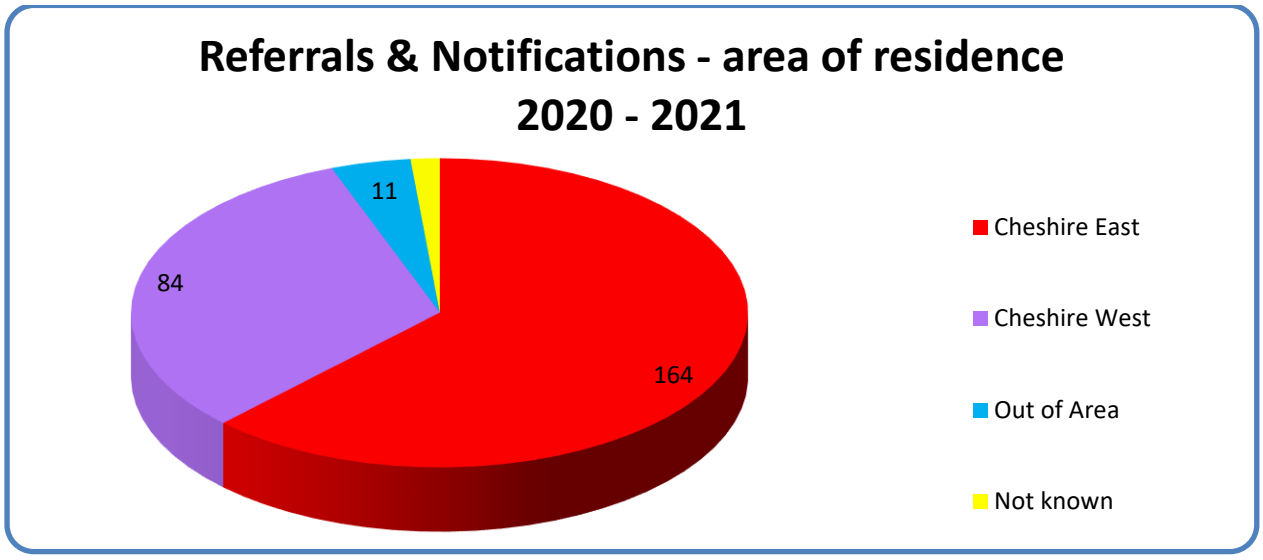
There were 263 referrals and 210 notifications made to the Hospital IDVA in the 2020/2021 period.

The 2020/2021 period saw the highest number of referrals and notifications ever recorded.

There was an 6% increase in referrals and 36% increase in notifications when compared to the previous year.



ED, Midwifery and the MCHFT Safeguarding team were the top 3 primary sources for domestic abuse referrals. This was also the case for the previous year 2019 – 2020.



62% of domestic abuse referrals and notifications related to people living in the Cheshire East area.
32% of domestic abuse referrals and notifications related to people living in the Cheshire West and Chester area
6% of referrals related to people living outside of the area or the information was not known.

Authors: Paula Gilmore; IDVA & Aliette Atkinson; Safeguarding Specialist Nurse

14. Conclusion

As a Trust Safeguarding Group, we are confident in the policies and processes that we promote within the Trust. Audit processes, governance frameworks and anecdotal evidence would suggest that the Trust Safeguarding Group is developing confident, consistent, and competent safeguarding practices.

However, we are keen to continually develop and improve our service, for the benefit of our staff and patients. The Trust Safeguarding Group operate an open-door policy; with the recognition that we "*can always do better*" therefore are always amenable to suggestions, ideas and innovations from colleagues, frontline practitioners and partner agencies alike.

There continues to be significant levels in safeguarding activity being addressed by the Trust Safeguarding Group. In part, this has been due to the good levels of knowledge and skills now demonstrated by frontline practitioners; in recognising and responding to safeguarding concerns.

The Named Nurse for Safeguarding; on behalf of the Trust Safeguarding Group would like to extend their appreciation and thanks to all MCHFT staff for helping to keep the unborn, children, young people and adults of Cheshire and its surrounding localities safe.

There is also evidence that the working relationships between MCHFT and its partner agencies are in a much more positive and stronger position in 2020 / 2021. The Trust Safeguarding Group will continue their co-operation and collaboration in maintaining these communication pathways; to achieve positive outcomes for the Cheshire population.

Finally, the Named Nurse for Safeguarding Children would like to extend her gratitude to Julie Tunney; Executive Lead, Sally Mann; Deputy Director of Nursing and all the members of the Trust Safeguarding Group for their constant commitment and dedication to their roles within safeguarding.

Jo-Ann Carnwell: Named Nurse for Safeguarding Children

Appendix 1 Dashboard SGA

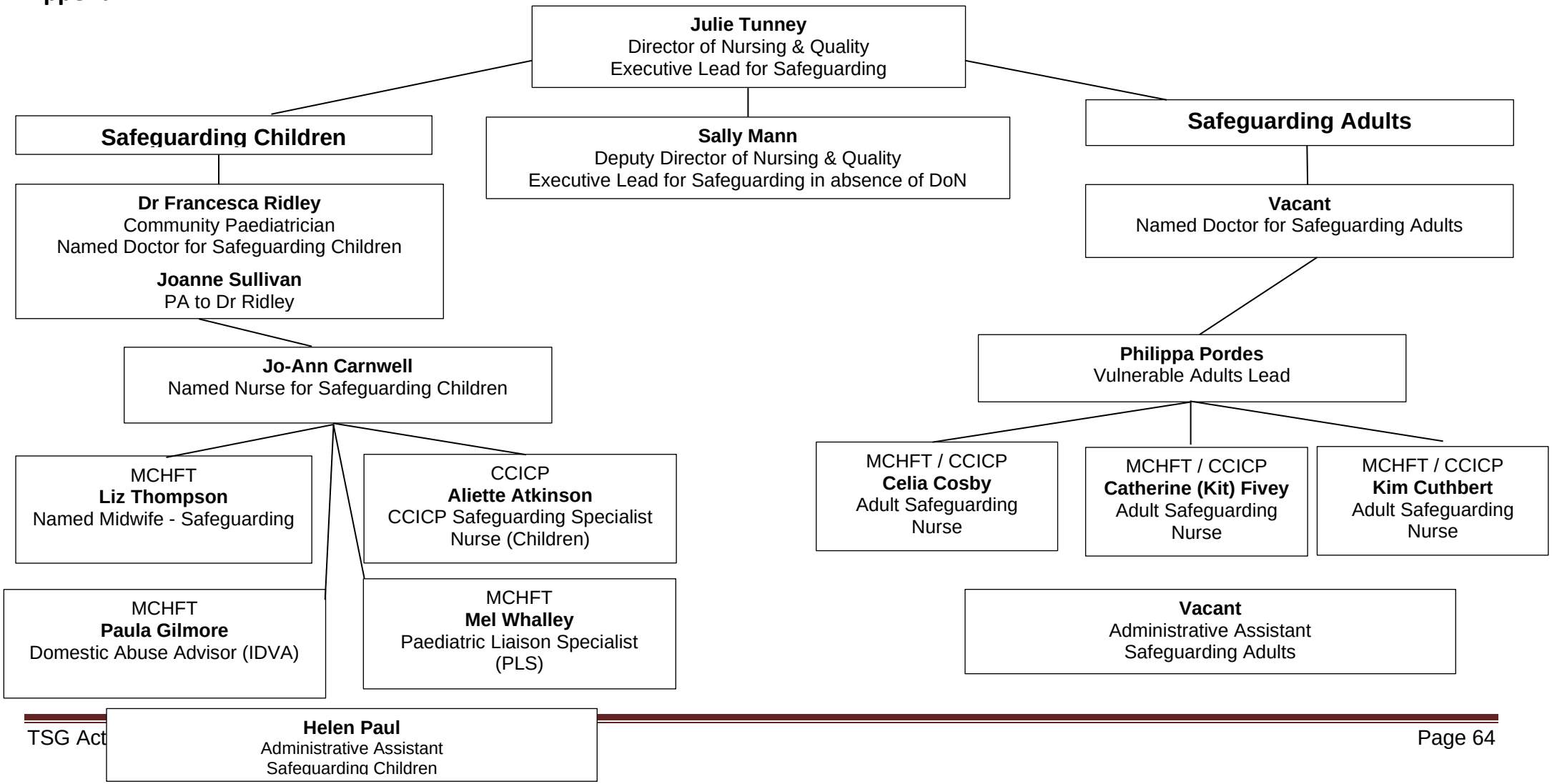
Mid Cheshire Hospital NHS Foundation Trust				
Adult Safeguarding Performance Dashboard 2020 / 21				
Indicator	**Reporting Frequency**	**Threshold**	**QUARTER 4**	**Comments relating to red / amber measures**
STAFF TRAINING				
Percentage of overall staff who have had training within the past 3 years.	Quarterly	>90%	90%	As from April 2021, adult safeguarding will be split into Levels 1, 2 and three and compliance reported accordingly. Q4 CCICP.docx
Percentage of clinical staff who have had training within the past 3 years	Quarterly	>90%	89%	
Percentage of non-clinical staff who have had training within the past 3 years	Quarterly	>90%	92%	
Domestic Abuse Training				
Level 1 – Percentage of overall staff who have had awareness training	Annual	>90%	90%	
Level 2 – Percentage of overall staff who have had awareness training	Quarterly	>90%	0%	Awaiting confirmation of training figures.
Specific Training				
Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)				
Identified MCA & DoLS Lead	Annual	Identified	✓	

MCA Lead – clinical staff who require training and target percentages in line with Training Needs Analysis (TNA) in line with Trust policy	Annual	Count	4084	CCICP - 808
Year 2 of 3, number of clinical staff to be trained on a rolling programme	Quarterly	Count	3675	CCICP – 767
Percentage of clinical staff completed MCA / DoLS training in line with policy requirements	Quarterly	50%	90%	CCICP – 95%
SAFEGUARDING ASSURANCE FRAMEWORK				
Safeguarding self-assessment framework completed and returned to Clinical Commissioning Group (CCG)	Annual	Compliance	✓	
Safeguarding Assessment framework & action plan completed and returned to CCG	Quarterly	Compliance	✓	
ADULT SAFEGUARDING INTERNAL MONITORING				
Safeguarding Adults Policy				
Adult Safeguarding Policy is current and reviewed in line with Trust compliance	Annual	Compliance	✓	
Audit of Adult Safeguarding Policy awareness, knowledge and training	Quarterly	10 Cases	100%	This quarter's audit demonstrated that all staff were aware that there is an Adult Safeguarding Policy and had received Safeguarding Adults training in the last three years. A qualified member of staff was unsure where to find the Flowchart, so a copy was provided for her, as well as where to access it. This was also raised with their Ward Manager to ensure all staff on that ward were reminded where the Flowchart is.
Mental Capacity Policy is current and reviewed in line with trust Compliance	Quarterly	Compliance	✓	
Audit of documentation of Mental Capacity Assessments undertaken	Quarterly	Count	10	Continuous monitoring of uDNACPR orders and associated Mental Capacity Assessments; particularly in respect of patients with a learning disability.

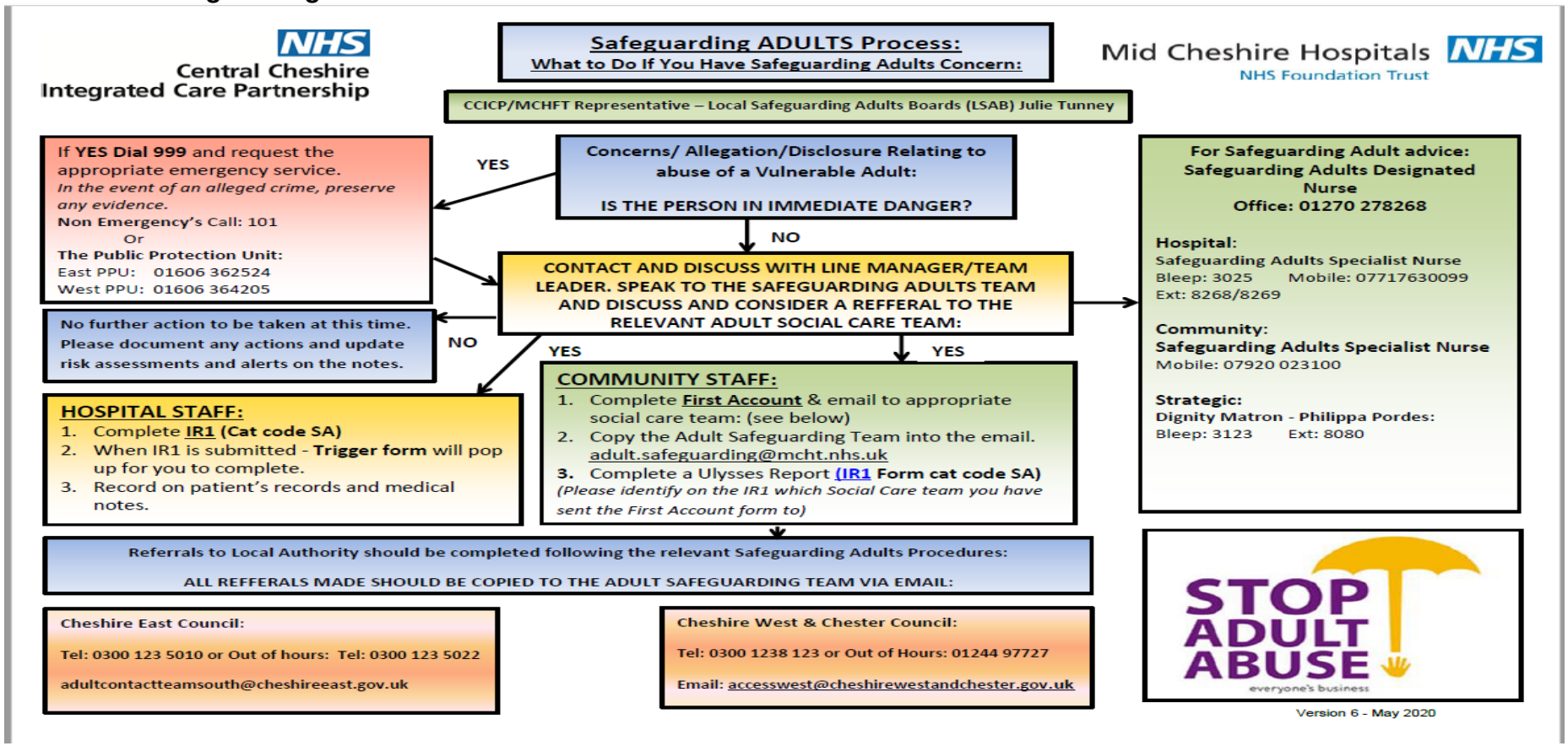
Number of Deprivation of Liberty Applications (DoLS)	Quarterly	Quarterly	157	
Numbers of adult safeguarding referrals to Local Authority of concerns on admission	Quarterly	Count	114	[Awaiting report]
Numbers of adult safeguarding internal enquiries	Quarterly	Count	4	An allegation was made that a patient was discharged from hospital with extensive bruising. This is currently being investigated by the Division, as the family have also raised this via the complaints process. An issue was raised where a patient was referred to an incorrect service. This was rectified and closed. An allegation was made where a patient who lacked capacity kissed another patient on the cheek. The patient who was kissed was very understanding and realised that the patient was unaware of what they were doing. A safeguarding was raised in relation to an unplanned admission to critical care for a vulnerable patient. An RCA is in progress, duty of candour completed with patient's advocate and the incident raised a the Patient Safety Summit. Learning will be shared across the organisation.

Appendix 2

Trust Safeguarding Group Organisational Structure



Appendix 3 Adult Safeguarding Flowchart



Appendix 4

Mid Cheshire Hospitals NHS Foundation Trust
Safeguarding Children Flowchart

What to Do If You Are Worried that an Unborn Baby, Child Or Young Person is Being Abused or Neglected

(04/2021)

If there are concerns about child's immediate safety; contact the Police

A PRACTITIONER HAS SIGNIFICANT CONCERNS ABOUT AN UNBORN BABY, A CHILD OR YOUNG PERSON'S WELFARE; OR HAS CONCERNS ABOUT AN ADULT WHICH MAY IMPACT ON A CHILD'S OR YOUNG PERSON'S WELFARE (THINK FAMILY).

↓

CHECK: IS THERE A CP-IS ALERT OR SAFEGUARDING RISK MARKER FOR THE PATIENT THAT YOU ARE CONCERNED ABOUT?

↓

Practitioner discusses their concerns with a member of the **MCHFT Safeguarding Team**. Consider the concerns using the ***Assessment Framework and the Key Questions***
*(see reverse of flowchart)

Practitioner **still** has concerns	Practitioner no longer has concerns
Contact relevant CSC and hold a verbal consultation with the Duty Social Worker to discuss / explore concerns and agree actions. Consent must be secured from families to confirm they agree with information being shared; **UNLESS** it could put a child at risk. Practitioners may be asked to put details of their concerns into a *Multi-Agency Referral Form* (MARF). These can be accessed via the CSC websites; before being submitted via secure email. (See orange box opposite)	No further immediate safeguarding action is required, but is there a need for further advice, information or support for the child / family? Consider further information sharing and / or follow up by partner agencies; such as GP or 0-19 service (Health Visitor / School Health). Consider signposting or referral to other agencies; such as CAMHS, Visyon, or Early Help Services. Verbally update the family and relevant member of the MCHFT Safeguarding Team. Complete a Safeguarding Notification form and submit to the MCHFT Safeguarding Team via e-mail. Document the concerns & outcomes in patient records.
↓	
Send a copy of the completed MARF AND a Safeguarding Notification form to the MCHFT Safeguarding Team via e-mail. If no MARF is required, a Safeguarding Notification form should still be completed and sent to the MCHFT Safeguarding Team. Verbally update the family. Document concerns & outcomes in patient records.	

Children's Social Care (CSC)
Mon – Fri: 08.30-16.30 hours.

Cheshire East
Cheshire East Consultation service (ChECS):
0300 123 5012 (opt 3)
CHECS@cheshireeast.gov.uk
www.cescp.org.uk

Cheshire West & Chester
Integrated Access and Referral Team (i-ART)
0300 123 7047
i-ART@cheshirewestandchester.gov.uk
www.cheshirewestscp.co.uk

Emergency Duty Team -
(Out of hours - after 16.30 hours or Weekends & Bank Holidays)

Cheshire East:
0300 123 5022
EDT.outofhours@cheshireeast.gov.uk

Cheshire West:
01244 977 277
EDT2@cheshirewestandchester.gov.uk

Cheshire Police - 101

For Safeguarding advice & support at MCHFT:

Jo-Ann Carnwell
Named Nurse – Safeguarding.
01270 27 8057 / Bleep 3308

Liz Thompson
Named Midwife – Safeguarding.
01270 27 3830

Dr A Thirumurugan
Designated Doctor for Safeguarding Children and Child Deaths
01270 25 5141 / Bleep 3492

Dr. F. Ridley
Named Doctor – Safeguarding.
01270 27 8294

Aliette Atkinson
Specialist Nurse (CCICP)
01270 27 8033

Paula Gilmore
Domestic Abuse Advisor (IDVA)
01270 27 8087 / Bleep 3307

Mel Whalley
Paediatric Liaison Specialist (PLS)
01270 61 2075

Safeguarding Admin
01270 27 3796

Out of hours / Weekends:
Consultant Paediatrician On-Call
01270 25 5141 (through switch)

Secure email:
safeguardingchildren@mcht.nhs.uk

safeguardingmidwifery.team@mcht.nhs.uk

Appendix 5

Key Safeguarding Children Activities: MCHFT & CCICP Overview 2020 / 2021.

Key Safeguarding Activity	Represented or Conducted By:	Frequency
Cheshire East Safeguarding Children Partnership (CESCP) Executive Board	Director of Nursing & Quality	Quarterly
Cheshire West & Chester Safeguarding Children Partnership (CW&CSCP) Executive Board	Deputy Director of Nursing	Quarterly
CESCP Quality Assurance & Scrutiny sub-group	Named Nurse for Safeguarding Children / Named Dr for Safeguarding Children	Quarterly
CW&CSCP Quality Assurance sub-group	Named Nurse for Safeguarding Children / Named Dr for Safeguarding Children	Quarterly
CESCP Learning & Improvement sub-group	Named Midwife / Safeguarding Specialist Nurse	Quarterly
CW&CSCP Practice Improvement sub-group	Named Midwife / Safeguarding Specialist Nurse	Quarterly
CW&CSCP Training & Development Hub	Safeguarding Specialist Nurse	Quarterly
CESCP Child Exploitation Operational Group	Safeguarding Specialist Nurse	Monthly
CW&CSCP Child Exploitation Operational Group	Named Nurse for Safeguarding Children	Monthly
Peer support & reflection at Cheshire Designated & Named Professionals meetings	Named Nurse for Safeguarding Children / Named Dr for Safeguarding Children Named Midwife / Specialist Nurse.	Quarterly
CESCP Task & Finish Group – Mental Health of C&YP	Named Nurse for Safeguarding Children	As required
CESCP Task & Finish Group – Sharing information of MH presentations	Named Nurse for Safeguarding Children	As required
CW&C MARAC Meetings	Hospital IDVA (Independent Domestic Violence Advisor) SGA / SGC Team	Monthly
Cheshire East MARAC Meeting	Hospital IDVA (Independent Domestic Violence Advisor) SGA / SGC Team	Fortnightly
CW&C MARAC Steering Group	Hospital IDVA (Independent Domestic Violence Advisor) SGA / SGC Team	Quarterly
Cheshire East MARAC Steering Group	Hospital IDVA (Independent Domestic Violence Advisor) SGA / SGC Team	Bi Annual
Trust Safeguarding Group Meetings; incorporating CCG Assurance	TSG Team members	Bi monthly
MCHFT Safeguarding Children Operational Group	Safeguarding Children Team	Monthly
MCHFT Professional Meeting with Head of Midwifery	Named Nurse for Safeguarding Children	Monthly

Emergency Care / Paediatrics Link Meetings	Named Doctor / Named Nurse for Safeguarding Children	Quarterly
Paediatric Governance Meeting	Named Doctor	Monthly
Community Paediatric Governance Meeting	Named Doctor	Monthly
Submission of Safeguarding Children Performance Activity MCHT Dashboard	Safeguarding Children Team	Quarterly
Submission of Mental Health Presentations for under 18's Dashboard to CCG	Named Nurse for Safeguarding Children	Monthly
Safeguarding Supervision - individual & Groups	Conducted by Named Dr, Nurse, Midwife & Specialist Nurse; specific to their roles.	Quarterly
Safeguarding Children Peer Review Meeting	Named Doctor	Monthly
Quarterly Activity Report	Completed individually by the Named Nurse, Midwife, Specialist Nurse and IDVA; specific to their roles.	Quarterly
Internal Safeguarding Notifications	Assessed and actioned by the Named Nurse, Midwife, Specialist Nurse, Liaison Nurse and IDVA; specific to their roles.	Daily
Level 2 Safeguarding Training	Conducted by the Named Nurse or Specialist Nurse; specific to their roles.	Monthly
Level 3 Safeguarding Training	Conducted by the Named Nurse, IDVA, Midwife or Specialist Nurse; specific to their roles.	Monthly
Safeguarding Children Briefing to Junior Doctors in Emergency Care	PLS	Quarterly
Safeguarding Training to Junior Doctors in Paediatrics	Named Doctor	Three times per year
Safeguarding Training for additional competencies; specific to Paediatricians	Named Doctor	Three times per year
CESCP Multi Agency Safeguarding Audit	Specialist Nurse	Quarterly
CW&CSCP Multi Agency Safeguarding Audit	Named Nurse for Safeguarding Children	Quarterly
CW&CSCP Random 20 Audits	Named Nurse for Safeguarding Children	Quarterly
Data & Information collation / report for Quality Schedule	Named Nurse for Safeguarding Children	Six monthly
CW&C MARAC Case Audits	Hospital IDVA (Independent Domestic Violence Advisor) SGA / SGC Team	Annually
Section 11 Audit	Specialist Nurse; supported by SGC Team	Annually with Quarterly Reviews
Safeguarding Children Flowchart & Visibility Audit	Safeguarding Children Team	Annually
Trust Safeguarding Group Report	TSG members	Annually

Trust Safeguarding Group Performance Activity Report	TSG Members	Annually
Safeguarding Children Training Matrix	Safeguarding Children Team	Annually
Revision of eLearning & face to face training sessions	Safeguarding Children Team	Annually
Safeguarding Children Audit Schedule	Safeguarding Children Team	Annually
Revision of Safeguarding Children flowchart	Safeguarding Children Team	Annually
Revision of Safeguarding Children Notification form	Safeguarding Children Team	Annually
Revision of Safeguarding Children Policy	Named Nurse for Safeguarding Children	Annually
Revision of Safeguarding Supervision Policy	Named Nurse for Safeguarding Children	Once every three years.
Revision of Safeguarding Children & Domestic Abuse Intranet site	Safeguarding Children Team	Annually
Revision of Domestic Abuse Policy	Hospital IDVA (Independent Domestic Violence Advisor) SGA / SGC Team	Once every two years
Revision of Domestic Abuse Flowchart	Hospital IDVA (Independent Domestic Violence Advisor) SGA / SGC Team	Annually
Revision of MCHFT MARAC Referral form	Hospital IDVA (Independent Domestic Violence Advisor) SGA / SGC Team	Annually
Revision and review of Was Not Brought (WNB) process.	Named Doctor	Annually

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**9.3**	Date of Meeting: 30/09/2021
Report Title	Serious Incidents Report August 2021	
Executive Lead	Murray Luckas, Medical Director	
Lead Officer	Sheila Kasaven, Associate Director of Quality Governance	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

There have been two StEIS (Strategic Executive Information System) reportable incidents declared.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

N/A

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Provide safest and best care	✓	• Be the best place to work	☐
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

Impact *(is there an impact arising from the report on the following?)*

• Quality	✓	• Compliance	✓
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF3 Quality of care**	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
TPSG	17/09/21	Serious Incidents August report	ADQG	Meeting yet to be held
QSC	22/09/21	Serious Incidents August report	ADQG	Noted

Serious Incident Report – August 2021

Introduction

1. This report provides the Committee with details of serious incidents declared and closed during August 2021, and an oversight of learning gained through the patient safety summit discussions.

2. The report reflects a key control for the strategic objectives to deliver outstanding care and patient experience and deliver the most effective care to achieve best possible outcomes.

Background and Analysis

3. Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. The national Serious Incident Framework (NHS England, 2015) describes the circumstances in which such a response may be required and the process and procedures for achieving it, to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

4. Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

5. There have been two serious incidents declared in August 2021.

SI 2021/16871 and SI 2021/17514 Fractured neck of femurs

Two patients suffered in-patient falls resulting in fractured femurs. These occurred on Ward 19 and Elmhurst. Preliminary investigations have not revealed any lapses in care

Conclusions

6. The Trust has declared two serious incidents; immediate actions to prevent further occurrences happening have been instigated.

7. The Trust continues to demonstrate ongoing learning from incidents and ensures these are disseminated widely within the organisation.

Recommendations

8. The Committee is asked to decide whether it is sufficiently assured that the Trust has processes in place to identify, investigate and learn from serious incidents.

Author: Sheila Kasaven, Associate Director of Quality
Governance Date: 07/09/2021

PAF Committee
Chair's Assurance Report
August 2021

Report to	Board of Directors
Date	17 August 2021
Report from	Trevor Brocklebank, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Russell Favager, Deputy Chief Executive and Director of Finance Andy Williams, Divisional General Manager Surgery and Cancer *(representing Chief Operating Officer)*
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Executive Delivery and Performance Executive Group (EDPG) Chair's Assurance Report
Two new operational risks identified: delays in the turnaround of histopathology results and lack of Anaesthetists impacting delivery of critical services. Risk assessments completed for both and actions identified.

Covid-19 cases since July have doubled, Covid ward and surveillance ward open, leading to further pressure on beds. Critical Care impact has reduced and returned to non-escalation status. Higher levels of staff annual leave impacting, will taper off from September. Preparations taking place for anticipated high levels of flu and Respiratory Syncytial Virus (RSV) in autumn/ winter on top of current high demand.

Urgent and Emergency Care (UEC) pressures significant, numbers stabilised but at a higher level than previous years. 4-hour A&E wait metric was 65.9% in July, with Type 1 falling below 50% on occasions, Trust was one of the lowest in the North West. UEC Programme Director appointed for six months to review and implement recommendations.

Restoration Plan Update
Target of 95% achieved in ordinary electives. Outpatient and day cases below target. Key drivers are number of Anaesthetists and Endoscopy, action plan has been implemented. Board to discuss planned £900k spend on restoration in August/September but due to combination of changes to Elective Recovery Fund (ERF) thresholds and less activity unlikely to receive any ERF income for this activity.

Timescale to achieve treatment of 95% of P2 patients (to be treated within one month) by June 2021, revised to June 2022. Urology a particular outlier, actions in place to address. Overall waiting list numbers grown, number of 52 week waiters continued to reduce. Diagnostic waiting list has increased, 34.6% waiting more than 6 weeks. Cancer performance is improving.

Mid Cheshire Hospitals NHS Foundation Trust

Executive Safety and Sustainable Environment Group (ESSEG) Chair's Assurance Report
Key issues highlighted:

- Emergency Department build delayed by six weeks to 1 November; key causes identified: delay in receiving steels and self-isolation of workers. Three further weeks planned for commissioning of building – to be overseen by EDPG
- Fire Alarm tender, four responses but value of work is above their limits on the framework. Plan to appoint and work at risk by compartmentalising work
- South Cheshire building and Ward 10 not available for RAAC plank inspection before Spring 2022, risk accepted by ESSEG and Executive Risk and Assurance Group (ERAG)
- Partner provider of accommodation, training rooms and travel services to clinical staff in Crewe have opened negotiations on costs of services for the Trust and individual staff members.

New Hospitals Programme – Expression of Interest (EOI) – Acceptable Assurance: Noted.

Finance

- Cumulative position small variance to plan, remain on track to achieve forecast for H1 (April-Sept 2021). No guidance received for H2 (October 21 – March 22)
- ERF potential shortfall for April/ May due to exclusion of some data by Trust to national system. Raised as an issue with NHS Improvement and Health & Care Partnership (HCP). Corrected files now submitted however period closed so opportunity to correct may not happen until May 2022. £0.8m at risk. Further review of implications taking place
- Unlikely to receive any additional ERF income due to changes in ERF thresholds
- Update on capital spending to be provided to HCP, Trust high priority for any further allocations if available due to slippage by other Trusts in HCP.

Cheshire Medical Imaging (CMI) Limited Liability Partnership (LLP)
Verbal update provided on re-awarding of work to CMI LLP in June 2020 previously agreed by the Board, following review of contract, conflicts of interest and reimbursement rates. Head of Contracts to ensure regular meetings take place to review performance and contract.

KEY CONCERNS/RISKS

- Restoration and emergency care pressures on workforce and resources remain high, with capacity struggling to meet demand. A further increase in Covid cases would be challenging.
- Restoration thresholds not being met therefore further ERF funding unlikely to be received
- £0.8m of ERF funding will potentially not be received due to data submission error
- A&E performance is one of the lowest in the North West
- Reputational and retention risk if staff based in offsite facilities are faced with increased costs
- Good progress on Radiology CMI LLP previously discussed by the Board, risk has reduced

Priority Areas: DECISIONS MADE

- Board to be asked to discuss risks and benefits of proceeding with additional restoration work following changes to ERF

RECOMMENDATION

To note

PAF Committee
Chair's Assurance Report
September 2021

Report to	Board of Directors
Date	23 September 2021
Report from	Trevor Brocklebank, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Russell Favager, Deputy Chief Executive and Director of Finance Oliver Bennett, Chief Operating Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Upper GI Bleed Update

Provision of service on Leighton Hospital site delayed pending recruitment to consultant posts to achieve minimum requirement for on call rota. Recruitment rounds to date unsuccessful, locum options being explored. Wider issue of medical workforce gaps is focus of task and finish group, with monitoring from Workforce and Digital Transformation (WDT) Committee and Executive oversight.

Executive Delivery and Performance Executive Group (EDPG) Chair's Assurance Report

- Significant steady increase of Covid positive patients over last several weeks. Despite increasing infection rates in the community, hospital admissions are now starting to fall.
- Emergency care remains under significant pressure with attendances and admissions still well above pre-pandemic levels, albeit a small drop in paediatric and minor injury attendances in August. Ambulance handovers are not a concern, the number of patients (circa. 5%) waiting >12 hours in the Emergency Dept. is and performance against the 4-hour standard is the lowest in the system because of the acute challenges
- Circa. 85 escalation beds remain open, which is more than last month, however, discharge rates overall are reasonably good, the number of delayed transfers of care and complex discharges delayed because of out of hospital system pressures especially in the domiciliary sector. PAF were alerted to a number of patients that waited over 12 hours in the ED following a decision to admit.
- The key 62 day and 2-week cancer referral standards were achieved in August. The number of patients waiting 63+ days is rising a little because we are diagnosing faster. National focus is on delivery of the faster diagnosis standard whereby patients should receive their diagnosis within 28 days; this is being achieved.
- Waiting lists for diagnosis and treatment continue to rise month on month and well above pre-pandemic levels.

PAF were concerned about the significant challenges on the urgent and emergency care (UEC) pathway and the impact this was having on performance and patient care. Robust and sustained challenge from PAF on the internal and system-wide factors impacting on UEC performance discussed in detail and actions for improvement. PAF informed that there is considerable executive oversight of the problem, a new interim programme director has been appointed and the national ECIST (Emergency Care Improvement Support Team) are supporting the improvement programme. The

Executive Team have also recently approved the new urgent and emergency care improvement plan with each workstream having an appointed Executive Sponsor, and the new ED building will be operational early December which is supported by further investment in workforce. PAF had significant concern with the provision of out of hospital capacity that would allow timely discharge of patients who needed ongoing care and currently more of these were still in hospital unnecessarily. This is the focus of the Cheshire-wide flow group and the A&E Delivery Board. PAF reassured by the responses provides by the Executive Directors to the challenges around performance.

Restoration Plan Update:

- Emergency care pressures described above having some impact on elective recovery and restoration.
- Outpatient activity delivering against local trajectory, however, elective daycase activity is behind plan with resumption just less than 70% of pre-pandemic levels. Anaesthetic workforce and issues mainly in endoscopy are driving this level of performance; both have an improvement plan agreed.
- Nearly 8 in every 10 patients who require surgery within one month is meeting that standard and remains an improving trajectory.
- The number of patients waiting >52 weeks continues to improve and is currently ahead of trajectory. However, the number waiting between 44-51 weeks is increasing because we continue to delivery less 'core' activity compared to 2019; this is being closely monitored.
- 'D-codes' are now being applied to all patients waiting a diagnostic procedure which will enable the scheduling of patients in clinical priority order.

Elective Recovery Fund (ERF) requirement likely to remain at a non-achievable 95% for the Trust. Work taking place across Cheshire & Merseyside (C&M) system about achieving system position but is going to be challenging. Lack of a green/cold site for elective operating and no close independent sector facilities makes it a greater challenge for the Trust compared to others. Recognition that only a system solution will achieve success in the short term with management maximising what can be achieved in the Trust.

BAF Heatmap: PAF challenge to whether risk score of BAF 1 (*Demand exceeds operational capacity and impacts on restoration and patient care)* is sufficiently high (20). Review of 15+ risks underway to ensure that risk prioritisation matrix is being applied consistently. Impact of BAF2 (*Workforce wellbeing and resilience)* recognised as WDT-owned risk that impacts across all areas.

Winter Plan: In progress internally and with external partners. Additional resource for Paediatrics this year but concerns additional workforce not available. Further review next month.

Executive Safety and Sustainable Environment Group (ESSEG) Chair's Assurance Report

Key messages highlighted:

- ED build on track for 1 November contractor handover, to be followed by cleaning, medical fit out and early December migration
- Refurbishment of School of Nursing building has been more significant than planned due to RAAC plank issues and asbestos delaying move by three months. Impact on demolition process is time critical due to funding requirements. Approved purchase of alternative proposal of temporary modular accommodation solution.
- Infinity House lease completed, refurbishment works underway, staff expected to move in 11 October
- Offsite accommodation provider for clinical staff agreed terms for rent increase and ongoing process for future increases
- Fire safety external review of South Cheshire block completed

Violence Reduction Strategy & Policy: New national violence reduction standards incorporated into revised Trust strategy and policy. Action plan in place to meet outstanding requirements of standards. Recommended for approval at Board.

Finance

- Off plan by £400k in month due largely to UCE pressures and opening of additional wards and reduced ERF contributions. System discussions taken place to ensure all Trusts reach balanced position; Trust expecting to receive additional £0.9m to achieve break even at the end of H1 but this is non-recurring support. Further discussions about mutual aid and impact on finance taking place around H2 (October 21 to March 22) with system approach becoming embedded.
- Draft expenditure forecast for H2 submitted to Health and Care Partnership, awaiting confirmation of allocations. Additional funding for winter pressures planned, lack of workforce will be challenging. Plan to offer substantive Nursing and Healthcare Assistant (HCA) roles to encourage interest.
- Efficiency targets likely to be in the region of 3%. H1 (April to September 21) efficiency targets achieved. Projects likely to continue into H2 but significant challenge to deliver recurring efficiencies during winter. PAF concerned regarding messaging of efficiency requirement during current operational challenges.
- Community Services sustained underspend concerns addressed, due to recruitment slippage and late delivery of additional (often non-recurring) investments.
- Data submission issue partially resolved, corrected in submission and additional ERF confirmed for May but not for all months. Root Cause Analysis underway by Chief Operating Officer.

KEY CONCERNS/RISKS

- UEC performance remains under substantial pressure and, despite significant intervention and improvements, the situation is not improving. This is impacting on services across the organisation, with some mitigation in place.
- Restoration and recovery of elective backlogs is significantly challenged and daycase activity is behind plan, for multiple reasons, which will further drive up waiting lost backlogs.
- H2 financial position remains unconfirmed but likely to be very challenging as will require circa 3% efficiency savings.

Priority Areas: DECISIONS MADE

- Violence Reduction Strategy recommended for approval to Board
- Purchase of temporary modular building to allow demolition of residencies to proceed approved

RECOMMENDATION

To note

Workforce and Digital Transformation (WDT) Committee
Chair's Assurance Report
August 2021

Report to	Board of Directors
Date	16 August 2021
Report from	Lorraine Butcher, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Heather Barnett, Director of Workforce and OD Matt Palmer, Head of Digital Services *(representing Chief Information Officer (CIO))*
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Executive Workforce Assurance Group Chair's Report

- Mandatory training compliance for Medical staff remains below target despite focus
- Risks on overtime/ annual leave payments and pension tax reviewed and risk score reduced
- Staff Wellbeing added as an operational risk
- Workforce supply work crucial part of reducing pressures on workforce:

    - **Apprenticeship Plan 2021-24 - Acceptable Assurance:** Key aims to increase expand apprenticeship uptake, align scheme to strategic priorities, improve quality and widen participation with emphasis on equality and diversity. Will align to Trust Strategy/ Workforce Strategic Plan and link to all HR plans e.g. People Plan. WDT to monitor progress / achievement of actions
    - **Medical Workforce Deep Dive - Acceptable Assurance:** Deep dive analysis with short, medium and long-term recommendations to address shortages in Acute Medicine, Anaesthetics and Respiratory medical workforce areas. National shortages and ageing workforce challenging recruitment; report demonstrated strong management grip of issues.

Staff Wellbeing - Partial Assurance: Workload, staff absences and vacancies causing ongoing pressures, reflected in sustained increase in staff absence rates in Integrated Performance Report (IPR). Task and finish group reviewing causes of short-term absence and developing measures to reduce occurrences. Wide range of management actions in place to provide support to staff, and further communications planned.

Wellbeing Guardian Update

Three priority areas identified:

- Staff networks – engaging with staff, focus on Equality, Diversity and Inclusion
- Civility Programme
- Estates & Facilities – Wellbeing Ally in Estates identified, Guardian to shadow, further actions to be agreed.

People Plan - Acceptable Assurance: New process for workforce planning approved at EWAG. A new tool supports planning at ward/ department level and at a Trust aggregated position, with defined, risks, opportunities, challenges, finances and actions. Will align to regional intelligence requirements. To be shared with Performance and Finance Committee.

Digital Transformation and Information Services (DTIS) Executive Group – Chair's Report
Digital Strategic Plan on hold until new CIO joins in September. Five new risks identified and risk assessments completed. Planning started to recruit required staff (40) for Digital Clinical System (DCS) with East Cheshire NHS Trust. Further engagement with Maternity staff required to ensure DCS system requirements meet department needs.

Digital maturity assessment baseline report confirmed at 0, full maturity score 7. "Trust ideally placed to capitalise on benefits of DCS". Actions identified to get to level 2, plan to be at level 5 at DCS implementation.

Digital Programmes - IT Projects Status Update - Acceptable Assurance:
Programme on track and exceptions noted. Update provided on Cheshire & Merseyside (C&M) Digital Programme.

Appraisal Assurance Plan - Partial Assurance: Overall position unchanged, significant improvements in Corporate and Women and Children's, balanced by decline in other divisions. Identified hotspots improved since June. Operational pressures most significant barrier. Success of focused efforts in Corporate are challenging to replicate in larger divisions. Trust figure of 79.9% is ahead of C&M average of 75%. Appraisal to be added to risk register as limited improvement made. Link between lack of appraisal and wellbeing and attrition of workforce noted.

KEY CONCERNS/RISKS

- Workforce remains under pressure due to increased demand and staff absences due to stress, anxiety and depression in particular
- Medical workforce mandatory training compliance
- Appraisal compliance levels

Priority Areas: DECISIONS MADE

- People Plan to be shared with PAF due to financial implications
- Medical Workforce deep dive to be shared with Quality and Safety Committee due to impact on quality of care

RECOMMENDATION

To note

Workforce and Digital Transformation (WDT) Committee
Chair's Assurance Report
September 2021

Report to	Board of Directors
Date	20 September 2021
Report from	Lorraine Butcher, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Oliver Bennett, Chief Operating Officer *(representing Heather Barnett, Director of Workforce and OD)* Matt Palmer, Head of Digital Services *(representing Dylan Williams Chief Information Officer (CIO))*
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Executive Workforce Assurance Group Chair's Report

- Good Resuscitation training capacity to end of year; plan for long-term capacity in progress
- Five of 24 CQC actions remain a risk. all relating to mandatory training, appraisal and turnover Work is ongoing within the relevant Executive Workforce Assurance Group (EWAG) subgroups to deliver these.
- Workforce supply under constant review, a reduction in Bank fill rates over the summer period is being examined. Executive oversight of Medical Workforce vacancies remains in place, reduction in Anaesthetist vacancies noted. Managing resilience in staffing levels current topic for Executive discussion.

Integrated Performance Report - consistent picture of sustained demand on emergency services impacting on workforce. Short-term sickness rates reduced in month, increase in long-term absence noted. Workforce Strategic Plan will identify priorities for medium/ long-term.

Flowers Update - Acceptable Assurance: Trust on track to process payments for eligible staff. Corrective payments falling outside of +/-7% national tolerance of due to payments for Waiting List Initiatives. Project to move annual leave to ESR underway to support future payment system (awaiting national guidance).

Staff Networks - Acceptable Assurance: Two further networks (Disability/Carers and LGBT+) established across Mid Cheshire Hospitals and East Cheshire NHS Trust. On target to meet required element of NHSI Equality and Diversity priorities.

Workforce Race and Disability Equality Standards (WRES/WDES) - **Acceptable Assurance:** Data uploaded as required. Generally improved position and increased representation of Black, Asian and Minority Ethnic (BAME) staff, primarily due to international nursing recruitment. Funding received for BAME leadership course to support career development. BAME and disabled staff remain more likely to be subject to bullying and harassment, so training for challenging actions/ language being implemented.

Corporate Social Responsibility Update: New environmental and social responsibility strategic plan in development. Final document to be presented to Board, following further Committee review. Application made for Cheshire and Merseyside Social Value award covering social, economic, environmental and innovation aspects; first step to achieving Social Value Mark.

Talent Maturity - Partial Assurance: Good success on leadership programme offer and completion although challenging for senior staff in particular to find time. Further work required to improve Motiv8 and career progression conversations rates, linked to appraisal conversations. Talent boards at divisional level and succession planning require embedding.

Appraisal Assurance Plan - Partial Assurance: Significant improvement in Corporate and W&C Divisions. Focus remains, acknowledging its importance as lever for staff wellbeing, development and performance.

Staff Survey - Partial Assurance: Civility group now established and action plan in place; close link to organisational culture noted. Focus on staff wellbeing this year. Results of first People Pulse Survey received, with drill down of data available from January to identify hotspots.

Staff Wellbeing - Acceptable Assurance: Wellbeing week planned w/c 27 September to raise awareness of support available and how to access it. Procurement process to commence for Earned Pay Scheme shortly for financial advice. Flu jabs start this week.

Digital Transformation and Information Services (DTIS) Executive Group – Chair's Report

- NHSx 'What Good Looks Like Framework' launched with seven success measures including levelling up agenda at Integrated Care System (ICS) level. Self-assessment against framework to be completed
- CQC action plan elements noted as in progress or complete
- Laboratory Information Management Systems (LIMS) delayed due to availability of laboratory staff to test system; completion date of March 2022 still anticipated
- Digital Clinical System - decision on preferred supplier pending

Digital Programmes - IT Projects Status Update - Acceptable Assurance:
Majority of projects on track; Radiology Information System unlikely to be complete by March 2022 as Trust move to the same system as rest of C&M; system hosting discussion causing delay.

KEY CONCERNS/RISKS

- Workforce remains under sustained operational pressure
- A small number of Medical Devices have not yet been updated from Windows 2010, despite closure of decommissioning programme; moving to the business as usual programme
- Appraisal completion rates plateaued.

Priority Areas: DECISIONS MADE

None

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**11.1**	Date of Meeting: 30/09/2021
Report Title	**Workforce Race and Disability Equality Standards**	
Executive Lead	Heather Barnett, Director of Workforce and OD	
Lead Officer	Ian Howarth – Equality, Diversity and Inclusion (EDI) Lead	
Action Required	To approve	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- The Trust has seen an increase in the overall headcount of BAME staff however there has been a reduction in the overall headcount of disabled staff
- Disabled and BAME staff still experience greater levels of bullying and harassment by patients, staff and Managers than their white and non-disabled colleagues
- An action plan has been developed to improve the Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standard (WDES) but with themes remaining similar to prior year.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- The WRES and WDES report is published on the Trust's website by 30 September 2021.
- EDI Lead to agree with Company Secretary the best approach for engaging and supporting the Trust Board in respect of item one on the WDES action plan regarding voluntary declarations in respect of protected characteristics.

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Provide safest and best care ☐	• Be the best place to work ✓
• Become a leading and sustainable health care system ☐	• Push boundaries in clinical, technology and digital innovation ☐

Impact *(is there an impact arising from the report on the following?)*

• Quality ☐	• Compliance ☐
• Finance ☐	• Legal ☐
• Workforce ✓	• Risk/BAF **BAF9 Leadership and organisational culture**
• Equality ✓	

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
BAME Staff Network	w/c 06-08-21	WRES WDES Annual Report	Ian Howarth	No surprises in data – press on with by stander training & BAME staff development
Executive Workforce Assurance Group	01-09-21	WRES WDES Annual Report	Ian Howarth	Approved for onward submission to WDT
Equality, Diversity and Inclusion Steering Group	16-09-21	WRES WDES Annual Report	Ian Howarth	TBC
Workforce and Digital Transformation Committee	20-09-21	WRES WDES Annual Report	Ian Howarth	Recommended for approval

Workforce Race and Disability Equality Standards

Introduction

1. This paper summarises the approach taken in preparing the WRES / WDES, key findings and associated action plan. The report acts as a statistical insight into the BAME (Black Asian Minority Ethnic) breakdown of our workforce thus allowing for further detailed analysis and understanding around whether we've improved.

2. Following authorisation from the Trust Board the final position has to be reported publicly via the Trust website by the 30th September.

Executive Summary

3. Overall, the Trust has seen an increase in the overall headcount of BAME staff however there has been a reduction in the overall headcount of disabled staff.

4. Findings from our WRES submission indicate that addressing recruitment, in particular increasing BAME representation in non-clinical roles, bands 5 and above and senior nonclinical roles is a priority.

5. Findings from our WDES submission also indicate recruitment as a key theme, in particular creating accessible career pathways for disabled staff into managerial roles (AfC Band 8a and above) as well as Trust action to facilitate the voices of disabled people.

6. There has been a positive change in BAME, and Disabled staffs experience of work in relation to the NHS Staff survey results and an increase in reporting of bullying and harassment. However Disabled and BAME staff still experience greater levels of bullying and harassment by patients, other staff and Managers than their white and non-disabled colleagues.

7. BAME staff remain more likely to enter a formal disciplinary process than white staff however disabled staff are not more likely than their non-disabled colleagues to go through a formal capability process.

8. There are two changes for the 2021 WRES. Metric 1 now provides a definition for 'Senior Medical Managers'. Metric 3 is now taken as the year end figure rather than an average over 2 years as in previous years submissions.

Background and Analysis

9. The reference period for the WRES and WDES is 01/04/2020 to 31/03/2021. The data is taken from ESR, Recruitment systems, learning and development and the ER Case Tracker. The WRES and WDES data is submitted annually before the end of August and the findings report must be published on the Trusts website before end of October 2021. The WDES is based on 10 metrics. The WRES is based on 9 metrics.

10. The report has driven an action plan which is closely aligned with the trusts already present strategic direction for increasing proportional representation of BAME colleagues throughout the workforce. The report also aligns with our commitments to deliver on the national EDI priorities and achievement of the Model Employer Goals, he latter of which requires the NHS as a whole to achieve 19% BAME proportional representation at all grades by 2025 and for MCHFT this translates to ensuring our overall BAME population is proportionally spread across all grades, currently a target of 9%.

Key findings

Workforce Race Equality Standards

Highlights

- BAME Representation has increased overall in the Trust accounting for 9.2% of the total workforce (7.7% in 2020); 2.5% non-clinical roles (2.38% in 2020) and 9.6% in clinical roles (7.7% in 2020).
- There has been an increase of BAME Representation at Senior Level (defined as Band 8a+) between clinical and non-clinical roles with 8 BAME staff now holding a Band 8 role in 2021 vs 5 BAME staff in 2020.
- Relative likelihood of white staff accessing mandatory training and CPD over BAME staff has decreased positively from 0.88 in 2020 to 0.83 in 2021.
- There has been an increase in BAME staff believing that the Trust provides equal opportunities for progression and promotion (68.2% in 2020 vs 72.5% in 2021).

Lowlights

- In non-clinical roles, there are more BAME staff in Bands 2 and 3 than the total number of BAME staff in Bands 4 – 9 and VSM roles.
- In clinical roles the largest proportion of BAME staff (22%) are within Band 5. The number of BAME staff in Band 5 has increased by 7% on 2020. This is likely the result of international nurse recruitment. However there has only been a 0.5% increase of BAME staff at Band 6 in clinical posts.
- The likelihood of white staff being appointed from shortlisting has effectively remained static year on year at 1.4 times more likely. The number of BAME applicants shortlisted has also remained static (18.4%).
- The likelihood of BAME staff entering formal disciplinary process has increased from 0.54 times more likely in 2020 to 1.13 times more likely in 2021.
- There are no BAME Board Members (Exec and non-Exec). This is unchanged from 2020,
- However, the recent appointment of a Non Executive Director is anticipated to reflect an improved position in the WRES 2022, and enhance the diverse talent and influences contributing to the Trust Board.

Mid Cheshire Hospitals NHS FT

Proposed Action Plan

Indicator	Action	Measure	Date
1	Develop BAME Leadership Programme to commit to the development of BAME staff (targeting AfC B5 to address the bottleneck and concentration of BAME headcount at B5 and BAME progression into B6 roles.) Programme is currently being explored with Local Trust partners.	Increase in BAME band 6 clinical and increase in BAME staff at band 8.	Jan-22
2	Introduce diverse interview panels to ensure that the panel is representative of the community we serve and of multiple protected characteristics. In Particular at B4 and B5 internal interviews, specialty Doctor and Consultant Recruitment.	Increase in BAME candidates appointed from shortlisting.	Mar-22
	Training for hiring Managers on fair and inclusive recruitment practices.	Increase in BAME candidates appointed from shortlisting. All Managers who recruit for a vacancy to have been trained (target 90% of Managers)	Mar-22
	Recruitment for 8a> hiring managers must require candidates to demonstrate EDI work/legacy during interviews	Improvement in BAME staffs experience of work i.e. reduction in bullying and harassment from Managers. Increase in BAME candidates appointed from shortlisting. Increase in internal promotions within underrepresented groups.	Oct-22
3	Just Culture Decision Tree to be followed on every occasion prior to formal disciplinary processes commencing to ensure that managers consider any cultural factors in relation to the matter to be investigated and that a decision to commence a formal process is based on the facts of the case to eliminate any subconscious bias.	Reduction in WRES Indicator 3 on likelihood of BAME staff entering the formal disciplinary process. Workforce Team to audit 25% of cases per year	Sep-22

Workforce Disability Race Equality Standards

11. **Highlights**

- There has been an increase in disabled staff's perception that we made adequate adjustments to support them in their role. This has increased from 71.6% in 2020 to 79.7% in 2021
- Disabled staff are no more likely to enter the capability process compared to non-disabled staff. This has remained static since 2020
- The relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting has decreased positively from 1.63 times more likely in 2020 to 1.34 times more likely in 2021
- There has been an increase of disabled staff in non-clinical senior roles (clusters 3 and 4)
- The staff engagement score for disabled staff has increased from 6.7 in 2020 to 7.0 in 2021.

12. **Lowlights**

- There has been an overall decline in the number of staff employed by the Trust who are disabled (3.53% in 2020 vs 3.19% in 2021)

Mid Cheshire Hospitals NHS FT

There has been no change in the number of staff who have not declared if they have a disability (15%)

- There has been a decrease in the number of disabled staff in all clinical clusters other than cluster 6 (medical and dental, non-consultant career grade). There are no disabled staff within clinical cluster 4 (bands 8c – 9 and VSM)
- During the reporting year there was no forum to facilitate the voices of disabled people. See action plan for details of Disabled and Carers Staff Network
- 5 Board Members have not declared if they have a disability or not.

Proposed Action Plan

Indicator	Action	Measure	Date
1	Address identified lowlight in respect of disability declaration rates and identify true scale of no declarations Band 8 & above by working to reduce those who report disability as unknown or null. In support of this action:	Null or undisclosed Current 15% Target 10%	Jan-22
	Trust Board will be requested to review and update their equal opportunity monitoring information through self service	Discussed in board meetings	Jan-22
	Undertake a programme of promotional activity encouraging employee declaration. This can be linked to promotional activity on ESR self-service.	Communications Plan	Jan-22
2	Training for Recruiting Managers in respect of Trust schemes for supporting disabled people into work including Disability Confident	Training session delivered	Dec-21
6	Roll out of Disability Passports to support disabled staff to feel supported within work. Training for Managers on supporting disabled staff to include consideration of reasonable adjustments and linked to Disability Passports	Passports to be rolled out Training to be delivered	Nov-21
9b	Implementation of carers and Disability Forum to facilitate the voices of disabled staff	Forum to be established	Oct-21

Conclusion

13. Mid Cheshire Hospitals NHS Trust is committed to addressing the findings of our WRES and WDES submission for 2021 and welcomes the opportunity to align an action plan with the support of colleagues from across the Trust against those areas identified for improvement.

14. The National EDI Priorities are a key focus for the Trust in 2021/2022 and we are committed to ensuring that all staff have a voice within the Trust and that our recruitment practices and processes ensure we have a workforce which is reflective and representative of our diverse community.

15. All staff should have the opportunity to develop professionally and personally within the Trust. This is reflected in our action plan and aligns to our ambition and the aims of the NHS People Plan to be an open and inclusive workplace.

16. The WDES and WRES report will be published in a PowerPoint format in 2021 in a change to the Word format. A copy for review is in Appendix 1. This includes data taken from the WRES and WDES data collection documents.

Recommendation

17. The Workforce Digital and Transformation Committee are requested to approve the findings of this report and to lend their support to endorsing the action plans ahead of onward presentation to the Trust Board.

18. Following Trust Board approval, we are required to publicly report our position to the Equality Diversity & Inclusion page on the Trust website.

Author: Ian Howarth –Equality Diversity & Inclusion Lead

Date: 10-09-21

Appendix One – Slideware summarising the key findings

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Workforce Race Equality Standard (WRES)
and
Workforce Disability Equality Standard (WDES)

Summary Findings and action plan
2020 – 2021

Annual Report prepared by
Rebecca Bather, Workforce Business Partner, Equality, Diversity and Inclusion

The slide deck uses the template framework recommended by NHS England for compiling an annual report for WRES /WDES

Executive Summary

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

- The data taken to inform both the WRES and WDES submissions is effective 31st March 2021 with the data for a number of the indicators in each report being taken from the 2020 NHS employee engagement survey.
- Overall the Trust has seen an increase in the overall headcount of BAME staff however there has been a reduction in the overall headcount of disabled staff.
- Findings from our WRES submission indicate that addressing recruitment, in particular increasing BAME representation in none clinical roles, bands 5 and above and senior none clinical roles is a priority.
- Findings from our WDES submission also indicate recruitment as a key theme, in particular creating accessible career pathways for disabled staff into managerial roles (AfC Band 8a and above) as well as Trust action to facilitate the voices of disabled people.
- There has been a positive change in BAME and Disabled staffs experience of work in relation to the NHS Staff survey results and an increase in reporting of bullying and harassment. However Disabled and BAME staff still experience greater levels of bullying and harassment by patients, other staff and Managers than their white and none disabled colleagues.
- BAME staff also remain more likely to enter a formal disciplinary process than white staff however disabled staff are not more likely than their none disabled colleagues to go through a formal capability process.
- Declaration rates have increased in 2021 in both WRES and WDES however 20% of staff have not declared their ethnicity and /or their disability status.
- There are two changes for the 2021 WRES. Metric 1 now provides a definition for a 'Senior Medical Managers'. Metric 3 is now taken as the year end figure rather than an average over 2 years as in previous years submissions.

Actions underpinning progress Over last 12 months

NHS Mid Cheshire Hospitals NHS Foundation Trust

In support of the Trusts commitment to advancing race equality and removing barriers in the workplace for disabled colleagues the following are examples of work undertaken in the last 12 months in line with our Equality and Diversity Plan.

The COVID 19 pandemic did impact the delivery of the WRES and WDES action plans published in 2020 however this has not meant that no action or work was undertaken, only that priorities were shifted during 2020 / 2021.

- The Trust introduced a requirement that all System Operating Procedures devised in response to Covid-19 had a mandatory requirement to have an associated Equality Impact Assessment in place.
- The Trust worked at pace with the support of the Equality Diversity & Inclusion Lead to prioritise risk assessments for staff identifying as Black, Asian, or Minority Ethnic, (BAME) as well as colleagues who were also in the higher risk categories on account of underlying health conditions.
- BAME colleagues were offered priority flu jabs, annual health assessments led by Occupational Health and a 3-month supply of vitamin D supplements as the Trust continually sought to seek opportunities to mitigate what at the time was an emerging picture in terms of the disproportionate impact Covid-19 was having on the BAME community.
- The Mosque, chapel and prayer room each underwent a risk assessment in light of Covid-19. The Trust was pleased to be able to keep these open with measures in place to ensure their safe use.
- Launched a BAME staff network which has helped engage colleagues in discussions around vaccine hesitancy.
- In response to the measures placed on society in response to Covid-19, specific guidance was produced in support of those suffering from or at risk of domestic abuse. The guidance identified sources of support during Covid-19 and it was agreed that staff at risk/suffering could use Trust accommodation/residences during this time if needed.
- Promotion of Freedom to Speak Up Guardian and related Trust policies.

WRES

NHS Mid Cheshire Hospitals NHS Foundation Trust

The Workforce Race Equality Standard (WRES) is a set of nine specific metrics that enable NHS organisations to compare the experiences of white and black and minority (BAME) staff.

This information is used to develop a local action plan, and enable the Trust to demonstrate progress against the indicators of race equality.

Purpose of the WRES

- To help local and national NHS organisations to review their data against the 9 WRES Indicators.
- To produce action plans to close the gaps in workplace experience between white and black and Ethnic Minority (BAME) staff.
- To improve BAME Representation at the Board Level of the organisation.

WRES 2020 – 2021

Key Observations

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Highlights

BAME Representation has increased overall in the Trust accounting for 12.8% of the total workforce (7.7% in 2020); 2.5% none clinical roles (2.38% in 2020) and 9.6% in clinical roles (7.7% in 2020).

There has been an increase of BAME Representation at Senior Level (defined as Band 8a+) between clinical and none clinical roles with 8 BAME staff now holding a Band 8 role in 2021 vs 5 BAME staff in 2020.

Relative likelihood of white staff accessing mandatory training and CPD over BAME staff has decreased positively from 0.88 in 2020 to 0.83 in 2021.

There has been an increase in BAME staff believing that the Trust provides equal opportunities for progression and promotion (an increase of 4.3% on 2020 WRES submission data)

Lowlights

In none clinical roles, there are more BAME staff in Bands 2 and 3 than the total number of BAME staff in Bands 4 – 9 and VSM roles.

In clinical roles the largest proportion of BAME staff (22%) are within Band 5. The number of BAME staff in Band 5 has increased by 7% on 2020. This is likely the result of international nurse recruitment. However there has only been a 0.5% increase of BAME staff at Band 6 in clinical posts.

The likelihood of white staff being appointed from shortlisting has increased from 1.43 times more likely in 2020 to 1.47 times more likely in 2021.

The likelihood of BAME staff entering formal disciplinary process has increased from 0.54 times more likely in 2020 to 1.13 times more likely in 2021.

There are no BAME Board Members (Exec and none Exec). This is unchanged from 2020.

WDES

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

The Workforce Disability Equality Standards (WDES) is a set of 10 specific metrics that enable organisations to compare the experiences of disabled and none disabled staff.

This information is used to develop a local action plan, and enable the Trust to demonstrate progress against the indicators of race equality.

- Introduced to make a positive impact for the benefit of disabled people.
- Used to help inform year on year improvements removing barriers impacting on workplace experiences of disabled staff.
- Mandated for all NHS Trusts and foundation Trusts since 2019.

WDES 2020 – 2021

Key Observations

Mid Cheshire Hospitals NHS Foundation Trust

Highlights

- There has been an increase in disabled staffs perception that we made adequate adjustments to support them in their role. This has increased from 71.6% in 2020 to 79.7% in 2021.
- Disabled staff are no more likely to enter the capability process compared to none disabled staff. This has remained static since 2020.
- The relative likelihood of none disabled staff compared to disabled staff being appointed from shortlisting has decreased positively from 1.63 times more likely in 2020 to 1.34 times more likely in 2021.
- There has been an increase of disabled staff in none clinical senior roles (clusters 3 and 4).
- The staff engagement score for disabled staff has increased from 6.7 in 2020 to 7.0 in 2021.

Lowlights

- There has been an overall decline in the number of staff employed by the Trust who are disabled (3.53% in 2020 vs 3.19% in 2021). The number of none clinical staff declaring they have a disability has decreased by 0.4% on 2020 and the number of clinical staff declaring they have a disability has decreased by 0.30% on 2020s submission.
- There has been no change in the number of staff who have not declared if they have a disability (15.18% in 2020 vs 15.13% in 2021).
- There has been a decrease in the number of disabled staff in all clinical clusters other than cluster 6 (medical and dental, none consultant career grade). There are no disabled staff within clinical cluster 4 (bands 8c – 9 and VSM).
- The Trust has no forum to facilitate the voices of disabled people.
- 5 Board Members have not declared if they have a disability or not.

Conclusions

Mid Cheshire Hospitals NHS Foundation Trust

Mid Cheshire NHS Trust is committed to addressing the findings of our WRES and WDES submission for 2021 and welcomes the opportunity to align an action plan with the support of colleagues from across the Trust against those areas identified for improvement.

The National EDI Priorities are a key focus for the Trust in 2021/2022 and we are committed to ensuring that all staff have a voice within the Trust and that our recruitment practices and processes ensure we have a workforce which is reflective and representative of our diverse community.

All staff should have the opportunity to develop professionally and personally within the Trust. This is reflected in our action plan and aligns to our ambition and the aims of the NHS People Plan to be an open and inclusive workplace.

Appendices

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Workforce Race Equality Standard (WRES) descriptor

Appendix one – WRES Data Report and Metrics

Workforce Disability Equality Standard (WDES) descriptor

Appendix two – WDES Data Report and Metrics

Note on the data

- The data in the graphics which follow is taken from ESR and shows the distribution of pay-grades within the staff groups as a proportion of our overall workforce who have identified as either White, BME and those who have opted not to declare.
- The data is listed in percentages in order to respect statistical integrity and to reflect best practice and to respect confidentiality.
- Metrics 4 – 9a on the WDRES and metrics 5 – 8 on the WRES are taken from the NHS Staff Survey 2020.

Appendix One

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

WRES Metrics Report 1/2

		White staff in 2020	White staff in 2021	White staff	BME staff in 2020	BME staff in 2021	BME staff	Ethnicity unknown/Null 2020	Ethnicity unknown/Null 2021	Ethnicity unknown/Null
		Percentage %	Percentage %	Percentage difference %	Percentage %	Percentage %	Percentage difference %	Percentage %	Percentage %	Percentage difference %
WRES Indicator 1 - none clinical workforce	Cluster 1 (bands 1 - 4)	23.26	24.16	0.90	0.54	0.55	0.01	0.73	0.70	-0.04
	Cluster 2 (bands 5 - 7)	3.47	3.80	0.33	0.12	0.14	0.02	0.08	0.06	-0.02
	Cluster 3 (bands 8a - 8b)	1.21	1.33	0.12	0.04	0.06	0.02	0.00	0.02	0.02
	Cluster 4 (bands 8c-9 and VSM)	0.60	0.56	-0.04	0.02	0.02	0.00	0.00	0.00	0.00
WRES Indicator 1 - clinical workforce	Cluster 1 (bands 1 - 4)	21.19	19.79	-1.41	1.63	1.41	-0.22	0.22	0.47	0.25
	Cluster 2 (bands 5 - 7)	34.47	32.50	-1.97	3.35	4.52	1.16	0.91	1.04	0.13
	Cluster 3 (bands 8a - 8b)	2.70	2.62	-0.08	0.04	0.08	0.04	0.02	0.04	0.02
	Cluster 4 (bands 8c-9 and VSM)	0.12	0.18	0.06	0.00	0.00	0.00	0.00	0.00	0.00
	Cluster 5 (Medical and Dental staff, consultants)	1.92	2.02	0.10	1.01	1.02	0.01	0.08	0.08	0.00
	Cluster 6 (Medical and Dental Staff, none consultant career grade)	0.54	0.59	0.06	0.58	0.63	0.06	0.16	0.18	0.03
	Cluster 7 (medical and dental staff, medical and dental trainee)	0.56	0.45	-0.11	0.38	0.74	0.36	0.06	0.22	0.17
	Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Appendix Two

WRES Metrics Report 2/2

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Mid Cheshire Trust Summary of 2021 WRES Findings (as of 31-03-2021)				Improvement / Deterioration
	Metric	2021 WRES	2020 WRES	Progress
1	Representation of staff across grades and bands	a. BME staff 12.8% of total workforce b. BME staff 2.5% none clinical c. BME staff 9.6% Clinical	a. BME staff 7.70% of total workforce b. BME staff 2.38 % none clinical c. BME staff 7.77% Clinical	
2	Likelihood of White staff being appointed from shortlisting	1.47 times more likely	1.43 times more likely	
3	Likelihood of BAME staff entering disciplinary process	1.13 times more likely	0.54 times more likely	
4	Likelihood of white staff accessing none-mandatory training	0.83 times more likely	0.88	
5	Percentage of staff experiencing bullying and harrassment from patients, relatives or public	26.7	28.4	
6	Percentage of staff experiencing bullying and harrassment from staff	25	22.4	
7	Percentage believing Trust provides equal opperturnties for progression or promotion	72.5	68.2	
8	Percentage experiencing discrimination from manager / team leader or colleagues	14.4	16.2	

Appendix Two

WDES Metrics Report 1/3

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

		Disabled staff in 2020	Disabled staff in 2021	Disabled staff	None disabled staff in 2020	None disabled staff in 2021	None disabled staff	unknown/Null 2020	unknown/Null 2021	unknown/Null
		Percentage %	Percentage %	Percentage difference %	Percentage %	Percentage %	Percentage difference %	Percentage %	Percentage %	Percentage difference %
WRES Indicator 1 - none clinical workforce	Cluster 1 (Bands 1 - 4)	5.20	4.90	-0.30	80.8	81.90	1.10	14.00	13.20	-0.80
	Cluster 2 (bands 5 - 7)	3.20	2.00	-1.20	82.7	86.20	3.50	14.10	11.70	-2.40
	Cluster 3 (bands 8a - 8b)	1.60	2.90	1.30	92.1	92.80	0.70	6.30	4.30	-2.00
	Cluster 4 (bands 8c-9 and VSM)	3.20	3.60	0.40	83.9	85.70	1.80	12.90	10.70	-2.20
WRES Indicator 1 - clinical workforce	Cluster 1 (Bands 1 - 4)	2.84	2.50	-0.34	83.03	83.50	0.47	14.13	14.10	-0.03
	Cluster 2 (bands 5 - 7)	3.48	3.10	-0.38	80.94	81.10	0.16	15.57	15.80	0.23
	Cluster 3 (bands 8a - 8b)	1.44	0.70	-0.74	76.26	77.60	1.34	22.30	21.60	-0.70
	Cluster 4 (bands 8c-9 and VSM)	0.00	0.00	0.00	100	88.90	-11.10	0.00	11.10	11.10
	Cluster 5 (Medical and Dental staff, consultants)	1.32	1.31	-0.01	81.58	81.05	-0.53	17.11	17.65	0.54
	Cluster 6 (Medical and Dental Staff, none consultant career grade)	0.00	1.45	1.45	59.38	65.22	5.84	40.63	33.33	-7.30
	Cluster 7 (medical and dental staff, medical and dental trainee)	2.00	1.45	-0.55	84	65.22	-18.78	14.00	33.33	19.33
	Other	0.00	0.00	0.00	0	0.00	0.00	0.00	0.00	0.00

Appendix Two

WDES Metrics Report 2/3

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Summary of 2021 WDES Findings (as of 31-03-2021)				Improvement / Deterioration	
	Metric	2021 WDES	2020 WDES	Progress	Commentary
2	Relative likehood of non disabled staff compared to disabled staff being appointed from shortlisting	1.34	1.63		A figure of below 1.00 indicates that disabled staff are more likely than non disabled staff to be appointed from shortlisting
3	Relative likehood disabled staff compared to non disabled staff entering formal capability process	0	0	No change	
4a	Percentage of disabled staff compared to non-disabled staff experiencing harrassment, bullying or abuse from patients/Services Users, their relatives or other members of the public	27.2	30.4		
	Percentage of disabled staff compared to non-disabled staff experiencing harrassment, bullying or abuse from Managers	15.9	15.1		This metric has decreased for none disabled (2019 9.2 vs 8.3 2020)
	Percentage of disabled staff compared to non-disabled staff experiencing harrassment, bullying or abuse from other colleagues	23.2	27.6		
4b	Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harrassment, bullying or abuse at work they or a colleague reported it.	44.1	39.6		

Appendix Three

WDES Metrics Report 2/3

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

	Metric	2021 WDES	2020 WDES	Progress	Commentary
5	Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal oppertunities for career progression or promotion.	87.7	79.8		
6	disabled staff saying that they have felt pressure from their manager to come into work, despite not feeling well enough to perform their duties.	29.7	28.1		Non disabled also seen an increase in this metric
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	39.2	40.1		Non disabled also seen a decrease in this metric
8	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	79.7	71.6		
9a	a. The staff engagement score for Disabled staff, compared to non-disabled staff.	7	6.7		
9b	Trust action to facilitate the voices of disabled people	No	No	No change	
	Metric 4a to 9b is based on staff survey data				

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CONSENT 1**	Date of Meeting: 30/09/2021
Report Title	**Bribery Act 2010 & Trust Anti-Bribery Strategy**	
Executive Lead	Russ Favager, Deputy Chief Executive & Director of Finance	
Lead Officer		
Action Required	To approve	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Description of Bribery Act Non-Compliance, Offences and Procedures
- Key Measures – Anti-Bribery Strategy is driven from very top of organisation with top-level commitment with respect to adopting and applying bribery counter measures
- Board to reconfirm the adoption of zero tolerance attitude towards bribery and corruption and confirm its commitment to the Bribery Act Statement on the Trust's Internet and Intranet.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- To note the paper and reconfirm zero tolerance attitude towards bribery and corruption and commitment to Bribery Act Statement

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Provide safest and best care	✓	• Be the best place to work	✓
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

Impact *(is there an impact arising from the report on the following?)*

• Quality	☐	• Compliance	✓
• Finance	✓	• Legal	✓
• Workforce	✓	• Risk/BAF Click here to select relevant risk	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
NA				

Bribery Act 2010 & Trust Anti-Bribery Strategy

Introduction and Background

1.1 Bribery is generally defined as an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another. The Bribery Act 2010, which came into force on the 1st July 2011, reformed the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors. In addition to the main offences under Sections 1, 2 and 6 of the Act, which carry custodial sentences of up to 10 years and potentially unlimited fines, it introduced a corporate offence (under Section 7), exposing commercial organisations to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

1.2 Any organisation that is incorporated under the law in the United Kingdom falls under Section 7 of the Act. NHS bodies such as CCGs, NHS trusts, foundation trusts, and special health authorities are all deemed to be relevant corporate bodies. Applicable organisations must ensure 'adequate preventative procedures' are in place for acts of bribery and corruption committed by 'persons associated' with them, in the course of their work, or else the organisation will become liable.

1.3 'Persons associated' can mean employees, temporary and agency personnel, contractors, agents, suppliers, partners and Joint Ventures, as well as other individuals or organisations (whether incorporated or not) that may provide a service.

1.4 For the purposes of the Bribery Act, a 'trade' or 'profession' is considered a business. This means that, whether individually or in partnership, GPs, pharmacists, dental practitioners, opticians, finance professionals etc. will also be subject to, and personally liable under, the Bribery Act.

Definition

2.1 Bribery is generally defined as an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another.

Risks of non-compliance

3.1 There are a number of risks entailed in breaching the Bribery Act. These include:

3.1.1 Criminal justice sanctions against directors, board members and other senior staff (under Section 14);

3.1.2 Damage to the organisation's reputation;

3.1.3 Conviction of bribery or corruption may lead to the organisation being precluded from future public procurement contracts. *[Under the Public Contracts Regulations 2006, a*

company is automatically and perpetually debarred from competing for public contracts where it is convicted of a corruption offence. There are no current plans to amend the 2006 Regulations for this to include the crime of failure to prevent bribery. Organisations which are convicted of failing to prevent bribery are not automatically barred from participating in tenders for public contracts; however, there is discretion to exclude organisations convicted of this offence if it is deemed appropriate.]

3.1.4 Potential diversion and/or loss of resources;

3.1.5 Unforeseen and unbudgeted costs of investigations and/or defence of any legal action;

3.1.6 Negative impact on patient/stakeholder perceptions.

Conclusion

4.1 In summary, there are 4 key offences under the Act:

4.1.1 **Section 1** - Offering, promising or giving a bribe to another person to perform a relevant 'function or activity' improperly, or to reward a person for the improper performance of such a function or activity.

4.1.2 **Section 2** - Requesting, agreeing to receive or accepting a bribe to perform a function or activity improperly, irrespective of whether the recipient of the bribe requests or receives it directly or through a third party, and irrespective of whether it is for the recipient's benefit.

4.1.3 **Section 6** - Bribing a foreign public official (probably of limited applicability to most NHS organisations/staff).

4.1.4 **Section 7** - Failure of a commercial organisation to prevent bribery (the corporate offence). This is a 'strict liability'* offence and an organisation can be found guilty of 'attempted' or 'actual' bribery on the organisation's behalf, even if the organisation and its officers were not aware of the bribery itself. It should be noted that a corresponding Section 1 or Section 6 offence needs to be proven for a section 7 offence to apply.

** Strict liability offences do not require proof of intention or recklessness – in other words, it is not necessary for the prosecution to show that the organisation intended to make the bribe in bad faith, or that it was negligent as to whether any bribery activity took place.*

4.2 An organisation has a defence to the corporate offence if it can show that it had in place 'adequate procedures' as part of a cohesive and integrated corporate Anti-Bribery Strategy designed to prevent bribery by, or of, persons associated with the organization.

Adequate Procedures

5.1 The Act is not prescriptive as to what constitutes 'adequate procedures', although both the Ministry of Justice (MoJ) and the NHS Counter Fraud Authority have provided guidance as to what form these procedures might take, depending on the nature, size and type of organisation. Adequate procedures need to be applied proportionally, based on the level of risk of bribery across the organisation, and form part of an NHS body's overall governance arrangements.

5.2 Adequate procedures relate to relevant compliance protocols and transparent procedures and measures which an organisation can put in place to prevent bribery by individuals associated with it. These might include training, briefings or new internal controls and procedures. Whether the procedures are adequate will ultimately be a matter for the courts to decide on a case by case basis.

5.3 The MoJ suggests that an effective Anti-Bribery Strategy framework could be informed by six principles:

5.3.1. **Principle 1 – Proportionate Procedures.** An organisation's procedures to prevent bribery by persons associated with it are proportionate to the bribery risks it faces and to the nature, scale and complexity of the organisation's activities. They are also clear, practical, accessible, effectively implemented and enforced.

5.3.2. **Principle 2 – Top-Level Commitment.** The top-level management of an organisation (be it a board of directors, the owners or any other equivalent body or person) are committed to preventing bribery by persons associated with it. They foster a culture within the organisation in which bribery is never acceptable.

5.3.3. **Principle 3 – Risk Assessment.** The organisation assesses the nature and extent of its exposure to potential external and internal risks of bribery on its behalf by persons associated with it. The assessment is periodic, informed and documented.

5.3.4. **Principle 4 – Due Diligence.** The organisation applies due diligence procedures, taking a proportionate and risk-based approach, in respect of persons who perform or will perform services for or on behalf of the organisation, in order to mitigate identified bribery risks.

5.3.5. **Principle 5 – Communication (inc. Training).** The organisation seeks to ensure that its bribery prevention policies and procedures are embedded and understood throughout the organisation via internal and external communication, including training, which is proportionate to the risks faced

5.3.6. **Principle 6 – Monitoring & Review.** The organisation monitors and reviews procedures designed to prevent bribery by persons associated with it and makes improvements where necessary. It considers independent assessment and/or certification of its arrangements.

Existing Counter Measures & Action Required

6.1 Bribery should be seen as another business risk to the organisation and should be treated accordingly. It is the responsibility of everyone in the organisation playing their part to ensure both the likelihood of bribery occurring, and its adverse impact if it does, are kept to an absolute minimum. However, as with the counter fraud strategy, the implementation of an anti-bribery agenda backed by a zero-tolerance culture should be driven from the very top of the organisation, at Board level.

6.2 MIAA's Internal Audit (IA) and Counter Fraud (CF) Services directly assist and support the Trust and its senior management with maintaining adequate procedures on an ongoing basis, primarily through existing IA and CF plans.

6.3 However, changes to the environment in which the Trust operates, such as the introduction of new legislation and global pandemics, as well as organisational and operational changes for the Trust over time, can result in alterations to risk exposure.

6.4 The most significant change to the Trust's operating environment in recent times is the COVID-19 global pandemic, which has affected all organisations, and the NHS in particular. It is therefore timely for the Trust to reflect on whether changes in recent years, particularly the response to the COVID-19 pandemic, have had any impact on the Trust's bribery risks, such as procuring PPE from non-typical sources and restricted procurement processes. From MIAA discussions with Trust management, no specific bribery issues have been identified. Nevertheless, MIAA will continue to work with the Trust to manage bribery risks.

6.5 A key step in the process of managing bribery risks is ensuring that the Anti-Bribery Strategy is driven from the very top of the organisation i.e. the Trust Board.

Recommendations

7.1 That the Board note this paper and continue to support the Trust's Top-Level Commitment with respect to adopting and applying bribery counter measures on an organisation-wide basis.

7.2 The Board reconfirm that the Trust adopts a 'zero tolerance' attitude towards bribery and corruption and does not, and will not, pay or accept bribes or offers of inducement to or from anyone, for any purpose.

7.3 The Board re-confirm its commitment to the Bribery Act Statement, recently updated and published on the Trust website and intranet (see appendix 1).

Author: **Russell Favager, Deputy Chief Executive & Director of Finance**
Date: **3 September 2021**

Appendix 1 - Zero Tolerance to Fraud, Bribery and Corruption

The Trust is responsible for the administration of public funds for the purpose of providing healthcare to the community it serves. It is recognised that the existence of fraud and corruption threaten to

prevent these funds from providing maximum benefit to patients. The Trust takes a zero tolerance approach to any incidents of fraud, bribery and corruption.

The Bribery Act 2010 was introduced to make it easier to tackle the issue of bribery, which is a damaging practice. Bribery can be defined as 'an inducement or reward offered, promised or provided to someone to perform a relevant function or activity improperly in order to gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another'.

Bribery is a criminal offence. The Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we, or will we, accept bribes or improper inducements. This approach applies to everyone who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery.

The Bribery Act creates specific criminal offences which carry custodial sentences of up to 10 years and potentially unlimited fines. It also introduces a corporate offence which means that if Mid Cheshire Hospitals NHS Foundation Trust is exposed to criminal liability, it is punishable by an unlimited fine, for failing to prevent bribery.

To limit the Trust's exposure to bribery, the organisation has in place an Anti-Fraud, Bribery and Corruption Policy, as well as a Corporate Governance Manual which includes details around managing conflicts of interest and code of conduct. These apply to all staff and to individuals and organisations who act on behalf of Mid Cheshire Hospitals NHS Foundation Trust. The Trust also has in place a nominated Local Counter Fraud Specialist who will investigate, as appropriate, any allegations of fraud, bribery or corruption. The Trust will seek the most stringent sanctions available against anyone seeking to commit bribery.

The success of the Trust's anti-bribery approach depends on its staff playing their part in helping to detect and eradicate bribery. The Trust therefore encourages staff, service users and others associated with the Trust to report any suspicions of bribery and will rigorously investigate any allegations. In addition, the Trust holds a Register of Interests for directors, staff, and Governors and asks staff not to accept gifts, hospitality or sponsorship that will compromise them or the Trust.

The Board of Directors carries out its business in an open and transparent way. The Trust is committed to the prevention of bribery, as well as to combating fraud, and expects the organisations it works with to do the same. Doing business in this way enables the Trust to reassure its patients, Members and stakeholders that public funds are properly safeguarded.

If you have any concerns or suspicions of fraud or bribery the Trust needs to know about, the Trust's nominated Local Counter Fraud Specialist can be contacted in confidence:

- By phone: 0151 285 4531 / 07721 237 352
- By email: phillip.leong@miaa.nhs.uk / phillip.leong@nhs.net

Alternatively, you can also contact the NHS Counter Fraud Authority (NHSCFA), the national authority with responsibility for fraud and other economic crime within the NHS and the wider health group, in confidence:

- Via the Fraud and Corruption Reporting Line: 0800 028 40 60 (free, 24-hour phone line)
- Through the NHSCFA website: www.cfa.nhs.uk/reportfraud

The Trust's Senior Responsible Officer for fraud, bribery and corruption is Russell Favager, Deputy Chief Executive and Director of Finance.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CONSENT 2**	Date of Meeting: 30/09/2021
Report Title	Annual Board Report and Statement of Compliance on the Appraisal and Revalidation of Medical Practitioners at MCHFT	
Executive Lead	Mr Murray Luckas, Responsible Officer/Medical Director	
Lead Officer	Miss Nikki Phillips, Revalidation Support Manager	
Action Required	To approve	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- The Trust maintains a fit for purpose appraisal system that is operating effectively and satisfies the statutory requirements around revalidation.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- To approve the signing and the submission of compliance to NHS England

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Provide safest and best care	☐	• Be the best place to work	✓
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

Impact *(is there an impact arising from the report on the following?)*

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF3 Quality of care**	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed

Appraisal and Revalidation of Medical Practitioners

Purpose of the Report

1. The purpose of this report for 2020 / 2021 is to provide assurance to the Board of Directors that the appraisal system for medical practitioners employed by Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) is robust, supports the revalidation agenda and is operating effectively.

Background

2. Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

3. Designated Bodies (which includes MCHFT) have a statutory duty to appoint a Responsible Officer (RO) and then provide the RO with sufficient funds and other resources to discharge their duties. In the case of MCHFT, the RO is the Medical Director.

4. The statutory duties of a RO include:

    - Undertaking appropriate employment checks for medical appointments
    - Maintaining a list of doctors for whom they are responsible
    - Ensuring there is an integrated system for
        - Monitoring doctor's performance
        - Encouraging and supporting development and learning
    - Ensuring that effective systems and processes for appraisal are in place
    - Taking appropriate, timely action when concerns about the performance or conduct of a Doctor is identified

5. Licensed doctors must revalidate usually every 5 years, by having an annual appraisal based on the GMC's core guidance for doctors "Good Medical Practice". The framework consists of four domains which cover the spectrum of medical practice. These are:

    1. Knowledge, skills and performance
    2. Safety and quality
    3. Communication, partnership and teamwork
    4. Maintaining trust

6. When a doctor's revalidation date arrives, that doctor's RO is asked to make an evidence-based recommendation to the GMC about the doctor's revalidation by submitting one of three formal statutory statements:

    - A recommendation that the doctor is up to date and fit to practise and should be revalidated

    - A request to defer the date of the RO's recommendation due to the doctor:

        - being engaged in the systems and processes that support revalidation, but about whom there is incomplete information on which to base a recommendation to revalidate (this will be where a doctor has not been able to gather all of the required supporting information by the time the submission date falls due)

- participating in an ongoing local human resources or disciplinary process, the outcome of which is material to the evaluation of the doctor's fitness to practice and that will need to be considered prior to making a recommendation.

- A notification of the doctor's non-engagement in revalidation, which should be made if a doctor has not engaged "sufficiently" with revalidation

The GMC then uses the RO's recommendation as the basis for its decision about the doctor's revalidation.

Governance Arrangements

7. The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process.

8. In 2019 to ensure the FQA continued to support future progress in organisations and provide the required level of assurance both within designated bodies and to the higher-level Responsible Officer, a review of the main document and its underpinning annexes was undertaken with the priority redesign of the three annexes below:

Annual Organisational Audit (AOA):

9. At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report Template

10. Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/ (Appendix I)

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the

appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

Statement of Compliance:

The Statement of Compliance has been combined with the Board Report for efficiency and simplicity as below:

Section 1 – General:

The Board of Directors of Mid Cheshire Hospitals NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: n/a **Comments:** Mr Murray Luckas – Medical Director is the Responsible Officer, Dr Clare Hammell is the Deputy Responsible officer. **Action for next year:** No changes anticipated

2. The designated body provides sufficient funds, capacity, and other resources for the responsible officer to carry out the responsibilities of the role.

Yes **Action from last year**: n/a **Comments:** At MCHFT the RO and Deputy RO roles are predominantly supported by the Revalidation Support Manager. However other members of the Medical Resourcing Team play an important role in ensuring that the RO and Deputy RO deliver their statutory duties around revalidation, particularly in relation to employing doctors and their pre-employment checks **Action for next year:** No changes anticipated

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: To maintain the systems **Comments**: The Trust uses the Allocate appraisal system for tracking and monitoring the Doctor's appraisals, alongside back-up manual processes to ensure that the system reflects the same information as held on GMC Connect. **Action for next year:** To maintain the systems

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Review and ratification of the Consultant and SAS Doctor Appraisal Policy due March 2024 **Comments:** Version 6 of the Consultant and SAS Doctor Appraisal Policy was ratified at the March 2021 Joint Local Negotiating Committee and Version 4 of the

Consultant and SAS Remediation Policy was ratified in December 2019 by the Joint Negotiating Committee with review planned for December 2022.

Action for next year: Review and ratification of the Consultant and SAS Doctor Appraisal Policy due March 2024

5. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: To give due consideration to repeating the process depending on the resolution of Covid-19

Comments: A peer review was undertaken with Bolton NHS Foundation Trust and Salford Royal Foundation NHS Trust in August 2017. Areas for consideration for the Trust were suggested and an action plan developed, and all objectives achieved by December 2017.

Action for next year: To give due consideration to repeating the process depending on the resolution of Covid-19

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To maintain the process.

Comments: Non-training grade Trust Doctors and Trust Doctors follow the same process as substantive Doctors - they are expected to undertake an Annual appraisal and have access to our appraisal system. The Medical Appraisal and Revalidation Entry Form, along with close working with Medical Resourcing means that upon starting these doctors are contacted with all the necessary information for them to carry out appraisal and 1:1 training with the Revalidation Support Manager is offered.

Agency doctors who are connected to the Agency as Designated Body – assurance of appraisal and revalidation dates on pre-employment checks.

Action for next year: To maintain the process.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: Maintain appraisal and revalidation processes during the transformation of the interim/new Senior Medical Team

Comments: The Allocate system was updated to reflect the changes made in the Appraisal 2020 model. Please see table below.

Action for next year: To maintain the processes.

Appraisal		Number
Completed – not divided into 1a/1b due to "pause" in appraisal process by GMC due to Covid-19		224
Missed / Incomplete	Approved	9
	Unapproved	10
Total		243
Appraisal Completion Rate (Category 1)		224/243 (92.1%)

The Trust's appraisal rates for the past 9 years have been:

	2012 /13	**2013 /14**	**2014 /15**	**2015 /16**	**2016 /17**	**2017 /18**	**2018 /19**	**2019 /20**	**2020 /21**
Number of Completed Appraisals (Category 1)	124	134	175	196	208	202	212	216	243
Missed / Incomplete Approved	NR	4	1	8	8	1	4	10	9
Missed / Incomplete Unapproved	NR	31	4	0	1	1	0	0	10
Total	166	169	180	204	217	204	216	226	243
Completion rate (%)	74%	79.2%	97.2%	96.1%	95.9%	99.01%	98.01%	95.6%	92.1%

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: n/a

Comments: Please see the tables below

Action for next year: To maintain the processes

Missed / Incomplete Appraisals - Approved	
No of Appraisals	**Reason**
1	Long term Sick leave
4	Overseas
4	Started with Trust too late for appraisal and not done by Previous Trust/Agency

Missed / Incomplete Appraisals - Unapproved	
No of Appraisals	**Reason**
10	Appraisals not booked/completed before end of March 2021

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: n/a

Comments: Please see Section 1.5

Action for next year: Please see Section 1.5

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To train additional appraisers and to consider bring the Appraiser Training in-house if possible

Comments: The organisation trained an additional nine Appraisers to ensure there were 37 trained Appraisers at the start of the appraisal year, however 2021 has again seen an increase in the loss of Appraisers due to turnover.

On-Line Training was sourced and has proved successful and will continue to be used in 2021 – 2022.

Action for next year: Train additional appraisers to ensure that the Trust has the required cohort of trained appraisers to manage the increased number of prescribed connections and natural appraiser turnover.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year: To maintain the process.

Comments: Appraiser Meetings are held quarterly, and the Appraisers are expected to attend two meetings per year. These meetings look at all aspects of the appraisal and revalidation processes, led by the Responsible Officer.

All appraisal summaries are reviewed by the Revalidation Support Manager using the PROGRESS tool and reports are provided to the Appraisers to include in their Appraisal, along with the electronic Appraisee Feedback Questionnaires generated by the Allocate system.

Action for next year: To maintain the process.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Collate the outcomes and actions from 2020 – 2021 appraisals to meet the new requirement of the "NHS England Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D – Annual Board report and Statement of Compliance"

Comments: As part of the quality assurance process around medical appraisals, the Revalidation Support Manager reviews all appraisals and appraisal summaries and then the RO randomly selects 20% of all medical appraisals undertaken each year for an in-depth review. The aims of this review include ensuring that the medical appraisals at the Trust are being undertaken in accordance with the Good Medical Practice framework and the Trust's Consultant and SAS Doctor Appraisal Policy. Compliance with a portfolio checklist of essential pieces of information to be discussed as part of the appraisal process is audited and the findings from this review are then presented to the Trust's appraisers as part of the drive to improve the standard of medical appraisals each year.

This board report is collated to comply with the new requirements.

Action for next year: To maintain the process.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Mid Cheshire Hospitals NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	243
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	224

Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	19
Total number of agreed exceptions	9

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: To maintain the process.

Comments: The Revalidation Overview and Assurance Committee (ROAC) meets monthly to discuss up-coming revalidation recommendations. The appraisal months for Doctors have been arranged to ensure that prior to these meetings the appraisal documentation can be quality audited by the Revalidation Support Manager to ensure, where possible, that all documentation is present and complete.

Extension of revalidation dates by the GMC due to Covid-19 has seen a reduction in deferrals for insufficient information. It is recognised that deferrals in 2021 – 2022 may rise significantly due to the difficulties in obtaining some supporting information, for example, patient feedback.

Please see table below

Action for next year: To maintain the process

Recommendation	**2020/2021**	**2019/2020**	**2018/2019**	**2017/2018**	**2016/2017**	**2015/2016**	**2014/2015**
On-Time	30	57	29	20	10	80	73
Late	0	0	0	0	0	0	0
Missed	0	0	0	0	0	0	0
Positive	30 (100%)	54 (94.7%)	26 (90%)	18 (90%)	7 (70%)	74 (92.5%)	50 (68.5%)
Defer							
• Insufficient Information	0	1 (1.7%)	3 (10%)	1 (5%)	3 (30%)	4 (5%)	15 (20.5%)
• Ongoing Process	0	2*	0	1 (5%)	0	1 (1.25%)	6 (6.9%)
Deferred for	0	0	0	0	0	1	3

insufficient Information and later revalidated						(1.25%)	(4.1%)
Non-Engagement	0	0	0	0	0	0	0
Total	30	57	29	20	10	80	73

*Same Doctor, deferred twice in appraisal year

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: To maintain the process.

Comments: All recommendations are discussed in ROAC three months in advance to ensure that all documentation is reviewed and correct for recommendations to be made and that where required discussions can be held with the Doctor by the Responsible Officer, providing an action plan for the Doctor concerned.

Action for next year: To maintain the process.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: To maintain the process.

Comments: Appropriate clinical governance systems are in place and all Doctors are provided with Appraisal Portfolio Information containing Significant Events and Clinical Incidents for discussion and reflection in their appraisal

Action for next year: To maintain the process.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: To maintain the process.

Comments: Clinical Leads hold responsibility for identifying and managing concerns about all aspects of all performance, escalating them where it is felt that they may be serious.

Action for next year: To maintain the process.

3. There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns.

Action from last year: To maintain the process.

Comments: The Trust's approach to identifying and responding to concerns includes regular case discussion meetings held by the Senior Medical Leadership Team in order to review progress on all open cases, which are also covered by the Trust's Disciplinary procedure and the Consultant and SAS Doctors Remediation Policy

Action for next year: To continue to follow our agreed policies and procedures

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

Action from last year: To maintain the process.

Comments: There is a monthly report to Trust Board of significant cases involving doctors. The process and individual significant cases are independently scrutinised via the Root Cause Analysis process.

Action for next year: To maintain the process.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year: To maintain the process.

Comments: Transfer of Information is provided when requests are received. Requests are made using the Medical Appraisal and Revalidation Entry Form for all Doctors joining the organisation.

Action for next year: To maintain the process.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: We intend to increase our numbers of trained investigators

Comments: All processes for responding to concerns are managed according to our Trust Policy. We have trained Case Investigators and Case Managers to ensure appropriate processes. Issues around potential bias and discrimination are considered by our Senior Team before any formal process is commenced. Training of new Investigators has been undertaken.

Action for next year: To maintain the process.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: To continue to monitor compliance **Comments:** All doctors employed by the Trust are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, including locum doctors by the Medical Resourcing Team **Action for next year:** To continue to monitor compliance

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of last year's actions.

Following the GMC "Pause" on appraisals during 2020-2021, the Trust decided to continue with the appraisal process, which was designed as a supportive process for Doctors, to allow Doctors to have the space to chat about their experiences.

Processes were maintained during the year and Doctors were revalidated, where appraisal and supporting information allowed, despite extensions being granted by the GMC for these Doctors.

Focus was placed on training more Appraisers for the organisation, however, once again 2020-2021 has seen a high turnover of Appraisers and this continues to be a focus going forward.

Actions still outstanding: None.

Current Issues/New Actions:

The focus in 2020-2021 will be to continue support the Doctors with the appraisal process through/following the pandemic, to increase the number of trained Appraisers and reinstitute the Quality Auditing processes for all appraisals, rather than the focus being on those due to revalidate only.

Overall conclusion: The Trust has continued to demonstrate compliance within the appraisal and revalidation processes whilst continuing to review and improve the overall quality of the appraisals and their content for the Doctors.

Section 7 – Statement of Compliance:

The Board of Mid Cheshire Hospitals NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: Mid Cheshire Hospitals NHS Foundation Trust

Name: James Sumner Signed 

Role: Chief Executive Officer

Date: 10th August 2021

Appendix I

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

Classification: Official
Publications approval reference: C1231
To: Responsible Officers and Medical Directors in England
30 April 2021
Dear colleagues,

Professional standards activities in 2021/22

Further to my letters on 19 March 2020 and 3 September 2020 I am writing about professional standards activities as we enter a new appraisal year. Thank you to you and your teams for maintaining professional standards activities and supporting the Covid response in the way that you continue to do.

I have previously recommended to aim for full participation in appraisal by April 2021, with flexibility for doctors who need to be excused, or as soon as possible for those that have not done so. The Appraisal 2020 model will remain the default model for doctors connected to NHS England and NHS Improvement. This is providing a useful development opportunity, supporting doctors through what has been a difficult time for many. I encourage responsible officers who have not yet done so to adopt it.

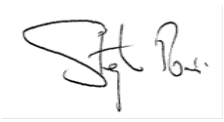
Feedback also suggests that the Appraisal 2020 model is a catalyst of professionalism as well as a vehicle for support. What comes next should therefore be a continued forward evolution to consolidate the benefits, whilst still ensuring that revalidation requirements are met. We are working on evaluation and next steps for appraisal and governance processes with partners across the UK, including the Academy of Medical Royal Colleges, GMC and BMA. We will work with you with a view to implementing these in 2022/23.

Last year we cancelled the 2019/20 Annual Organisational Audit and we are now standing down the 2020/21 exercise. However, organisations will still be able to report on their appraisal data and impact of the Appraisal 2020 model later in the year. The annual Board report and Statement of Compliance is being updated to support this. The date for submission of this report is 24 September 2021.

Because they are already covered in the annual Board report, the Framework for Quality Assurance (Annex B) Quarterly Reports will cease from 1 April 2021.

I hope this information provides a useful steer. Doctors and their colleagues in the workforce have risen magnificently to the challenges of the pandemic. By developing the Appraisal 2020 model and ensuring that the next steps consolidate its benefits we will serve not just the profession but their teams and, ultimately, patients.

Yours sincerely,



Professor Stephen Powis

National Medical Director

NHS England and NHS Improvement

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CONSENT 3**	Date of Meeting: 30/09/2021
Report Title	Expression of Interest – 8 New Hospitals	
Executive Lead	Russ Favager, Deputy Chief Executive & Director of Finance	
Lead Officer		
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

Final changes that were made to the Expression of Interest prior to submission were as follows:

- Inclusion of shared RAAC paragraph as agreed between 5 RAAC trusts
- Inclusion of summary functional content table in scheme summary section following information received that NHS England/ NHS Improvement (NHSEI) were looking for this information specifically
- Updates to incorporate feedback from (NHSEI) to strengthen community link and aid clarity of message
- Minor updates to include partner feedback and further sense, spell and grammar check
- No changes to facts or figures such as costs, savings or benefits.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Waiting for outcome of national process following submission under Chairman's Action as agreed by Board (29 July 2021).

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Provide safest and best care	✓	• Be the best place to work	✓
• Become a leading and sustainable health care system	✓	• Push boundaries in clinical, technology and digital innovation	✓

Impact *(is there an impact arising from the report on the following?)*

• Quality	☐	• Compliance	✓
• Finance	✓	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF11 Estate, infrastructure and equipment**	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

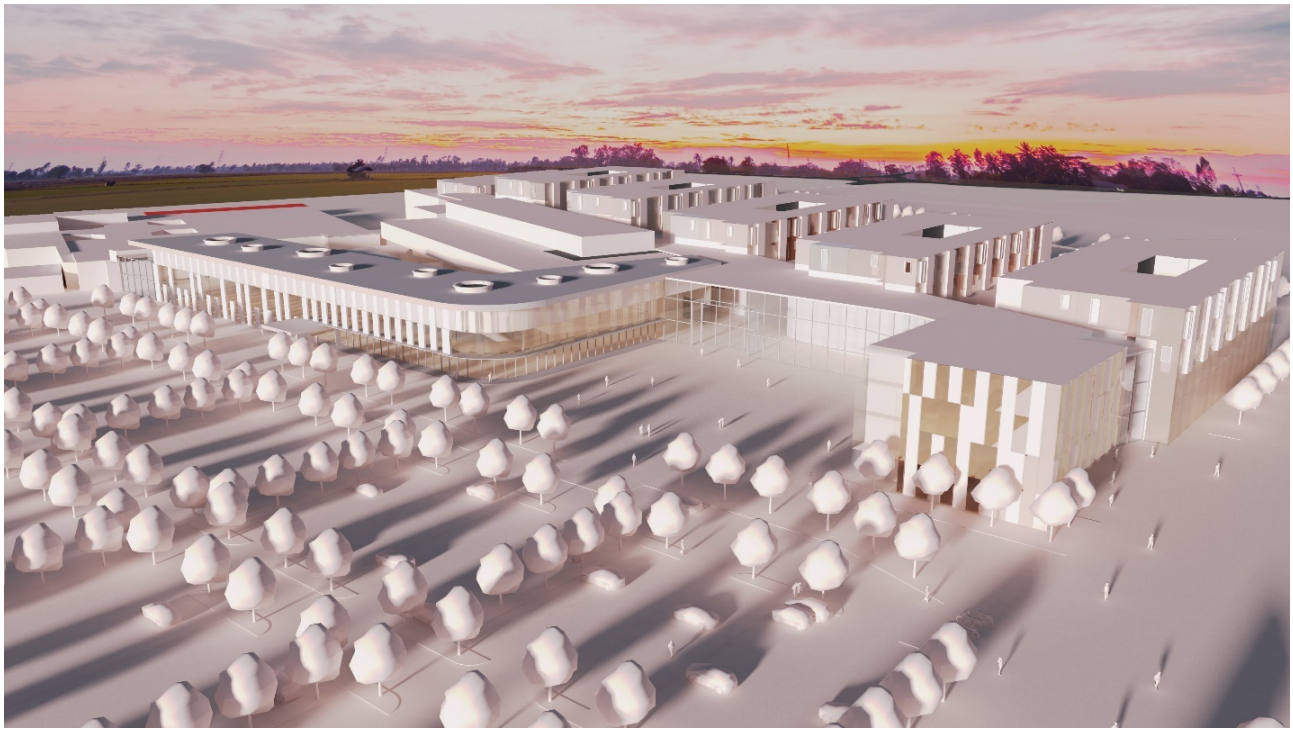
Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Hospital Redevelopment Programme Board	12/08/21	Expression of Interest – 8 New Hospitals	Russell Favager	Approved – noted work in progress
Performance and Finance Committee	17/08/21	Expression of Interest – 8 New Hospitals	Russell Favager	Approved – noted work in progress
Hospital Redevelopment Programme Board	16/09/21	Expression of Interest – 8 New Hospitals	Russell Favager	Final version noted

Department of Health & Social Care

Health Infrastructure Plan: future new hospitals – expression of interest template for NHS organisations

Published 15 July 2021

Leighton Hospital Redevelopment



Expressions of Interest

New Hospital Criteria

1. A whole new hospital site on a new site or current NHS land (either a single service or consolidation of services on a new site).

2. A major new clinical building on an existing site or a new wing of an existing hospital (provided it contains a whole clinical service, such as maternity or children's services).

Leighton Hospital Redevelopment

The Trust is submitting an Expression of Interest (EoI) for the next round of NHP funding and has been encouraged to do so by Julian Kelly and Simon Corben, with whom the Trust is working closely in relation to risk mitigation works to manage the Reinforced Aerated Autoclaved Concrete (RAAC) affected NHS estate.

The scheme proposed as part of this EoI is the redevelopment of the Leighton Hospital site in Crewe, Cheshire to eliminate RAAC planks from the estate due to the safety risks associated with this building material as per the SCOSS Alert issued in May 2019 and the NHSE&I directive to remove all RAAC by 2035.

Newer elements of the estate (approximately 15%) will be retained to ensure best value for money whilst replacing the estate affected by RAAC and/or significant and high-risk backlog maintenance, such as the five wards that are subject to a fire safety Improvement Notice from Cheshire Fire and Rescue Service.

What is the Five Hospitals Programme?

The programme is a collaboration of five NHS trusts who all have severe challenges with their estate relating to the presence of RAAC. None of these trusts is currently on the New Hospital Programme and there is currently no other source of funding available to support the wholescale eradication of RAAC from their affected hospitals.

The five trusts in the collaboration are:

- Airedale NHS Foundation Trust
- Frimley Health NHS Foundation Trust
- Mid-Cheshire Hospitals NHS Foundation Trust
- North West Anglia NHS Foundation Trust
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

How is the Collaboration Working?

The formation of the collaboration has been supported by key Senior NHS leaders including Simon Corbin, Adrian Eggleton, Julian Kelly, and Strategic Estates Directors across the affected Regions.

The five hospitals communicate regularly through Chief Executive Officer and Estates Director's meetings to discuss opportunities to work collaboratively on key areas.

The aim is to significantly reduce the total collective cost of the five hospitals' schemes by maximising value for money, reducing duplication and waste, releasing savings from at-scale procurement, sharing knowledge and best practice and identifying scalable solutions.

What is the Scope?

With guidance from NHSE&I colleagues, the collaboration is currently focusing on the following areas:

- At-scale procurement of Professional Consultancy services
- Replicable design
- Use of Modern Methods of Construction/DfMA
- Digital standardisation
- Sustainability and Environmental strategy
- Procurement

The Trusts aim to look beyond the existing requirements for MMC/DfMA and frame considerations by also targeting critical clinical and non-clinical manufactured components, assets and equipment – maximising use of digital monitoring through the operational lifecycle of the asset.

Progress to Date

The collaboration is primed and ready to respond to the opportunity to progress its work through the New Hospital Programme (or any alternative opportunity that arises) and has already begun to scope out potential workstreams and areas of focus across the partnership.

The partnership is awaiting further guidance from colleagues at NHSE&I to enable it to align its work with the national direction of travel. In the meantime, the five trusts are actively engaging in the capital strategy process, emergency capital funding programme, and RAAC research programme, as well as proactively sourcing best practice and guidance from trusts already working on the New Hospitals Programme.

The five hospitals are in a unique position, dealing with the complex risks and problems associated with RAAC alongside the everyday challenges of ageing estate and growing demand for services. By working on the NHP together in this way, the trusts will be able to effectively remove the largest estates safety risk facing the NHS nationally whilst remaining focused on cost efficiency and effectiveness and future estate requirements such as sustainability.

Trust Type

Acute

Region

North West

Trust Name

Mid-Cheshire Hospitals NHS Foundation Trust.

Site Covered

Leighton Hospital, Middlewich Road, Crewe, Cheshire, CW1 4QJ.

Indicative Cost of Scheme

£660m capital investment is required inclusive of VAT, uplifted to reflect prices at the mid-point (April 2025) of the anticipated 5-year programme. £560m of capital investment is required at April 2021 prices.

Indicative costs have been estimated based on the room-by-room Schedule of Accommodation (SoA) and 1:500 drawings developed for the preferred scheme solution. Assumptions include:

- Healthcare Premises Cost Guide (HPCG) at PUBSEC 259 index applied, plus anticipated on-costs, with a 10% allowance for professional fees.
- 5% Planning Contingency.
- 15.9% Optimism Bias reflecting the degree of uncertainty at this stage.
- 9% Net Zero Carbon premium.
- 20% VAT which, at this stage, it is assumed will only be recoverable on Professional fees.
- 11% equipment allowance.
- Additional £23m for Digital technologies.
- No costs for land acquisition or disposal required.

Opportunities for phased delivery over a number of years have been identified. It is anticipated that the initial phases of this, delivering the first two ward blocks by 2024/25, would cost £180m. This will not result in a linear reduction in the costs of the scheme as it is likely that delivering the programme in this way would result in increased capital requirements overall, estimated to be £93m. A continuous new build would eradicate RAAC in the least time, however, a phased approach may be necessary to better fit within the national funding envelope, but this approach would increase the time to eradicate RAAC and prolong the associated risk exposure.

Indicative Savings of Scheme

1. £407m (gross costs) reduced Backlog Maintenance (BM) liability i.e. 80% uplift from ERIC 2020-21 reported net works costs of £226m (which includes £34m of significant and high-risk BM), to cover VAT, decant, asbestos removal costs, plus professional fees. This is one of the largest backlogs of any similar NHS trust and includes RAAC plank removal costs for Years 1-5 only, as mandated by NHSE&I, with further works required to achieve long-term elimination of RAAC by 2035. Estimates demonstrate that the costs of incremental RAAC replacement equal the single-phase whole hospital redevelopment without any associated patient, staff and operational benefits and efficiencies.

2. £10m per annum reduction in annual operating costs:

- Increased bed capacity to meet 2029 demand, mitigating the need for temporary measures to address shortfalls, equating to c.£8m p.a.
- Investment in facilities with improved functional layout and adjacencies opportunities, improving patient flow and generating efficiencies of c.£2.5m p.a.
- Efficiency gains through digital technologies of c.£1.5m p.a.
- Offset by estimated increase in additional Facilities Management costs of £2m p.a. (due to a larger footprint to accommodate modern space standards).

Savings exclude £22m p.a. capital charges (based on total capital costs at mid-point of construction, 30% impairment, straight-line depreciation and 3.5% PDC interest).

Initial cost benefit analysis, undertaken in line with HMT Greenbook and NHSE&I guidance, incorporated wider non-cash releasing and social benefits (social value health benefits through carbon reduction) and compared to the counterfactual position (Business as Usual) generating a £190m incremental Net Present Social Value (NPSV) and 4.11 Cost Benefit Ratio.

Status of Plans and Engagement to Date with Partners

- Design: RIBA stage 1 (1:500s), plus ‘Concept’ stage DQI completed.
- Business Case: Strategic Outline Case approved by MCHFT Board April 2021 and issued to Regional NHSE&I Estates Leads and Cheshire & Merseyside Health and Care Partnership (CMHCP).
- Planning: local planner consultation undertaken confirming storey heights and high level aims of the project, and local planners are very supportive.
- Deliverability: In year financial support via NHSE&I and ICS for RAAC plank remedial work including demolition of residences and diversion of main HV incomer. These works enable immediate start on site in 2022/23 (pending funding approval and completion of business case process). Phasing and deliverability of the scheme tested with three major Contractors and feedback incorporated.
- Procurement: Current procurement strategy enables switch from multi-phase to single phased approach depending on funding secured by the Trust.
- Letters of support: received from Cheshire West and Chester Council (CWAC) and Cheshire CCG. Local MP Kieran Mullan fully supportive as are the local Community.
- Staff Engagement: Clinical engagement workshops undertaken to determine future ways of working, use of digital and system integration in the development of transformational models of care. Used to inform full SoA and associated 1:500 designs.
- Health System Engagement: Joint working with other RAAC hospitals to promote a standardised approach to risk management and RAAC plank replacement.
- RAAC Plank Research: One Residence block (vacated space) has been given to the national RAAC plank research body to enable further data to be captured.

Summary of Scheme

Leighton Hospital Redevelopment is a whole hospital scheme to demolish and replace old RAAC affected estate with new, fit for purpose buildings, whilst ensuring value for money through retention or repurposing of newer parts of the estate.

The scheme:

- Addresses 20% bed capacity shortfall to 2029 through provision of an additional 97 beds, reflecting population and demographic growth and including LoS reduction, left shift etc. assumptions.
- Addresses all extreme or high-risk critical infrastructure items in the Critical Infrastructure Review and 6 Facet Surveys undertaken by NIFES in 2020 including:
  - Removal of 32,804m^2 RAAC estate by 2028.
  - Single points of failure/resilience issues (MEP).
  - Fire compartmentation inadequacies.
  - Presence of asbestos throughout trust buildings.
- Removes £407m (gross costs) Backlog Maintenance (BM) liability.
- Comprises 73,042m^2 new build and 6,755m^2 retained estate (dark grey blocks) of which 3,515m^2 will be refurbished.
- Completes in 2028 with potential for earlier phases to be completed from 2023/24.

Service	Functional Content
ED	10 Majors 6 Minor 7 Paediatrics & Assessment Triage Decontamination Suite, Isolation Resus GP Zone, Imaging Zone Specialist Treatment Spaces 10 Place Observation Beds
Imaging	2 Plain Film 1 Bone Densitometry 3 Obstetric Ultrasound 1 EPAU Ultrasound 6 Ultrasound 5 MRI 2 Angiography / Fluoroscopy 3 Mammography 2 Ultrasound Breast Unit
Beds	416 Single Beds 32 Single Rehabilitation Beds 26 Single Paediatric Beds
Maternity	26 Single Maternity Beds 5 Place Assessment 12 Birthing / LDRP Sized Room
Paediatrics	18 NNU / SCBU

Outpatients	71 C/E rooms including 12 virtual

Expression of Interest – Statement

The plans have the overwhelming support of staff, patients and the local community, support MCHFT's ambition to be a Trust with an 'Outstanding' rating and construction can commence in Q2 2022-23.

Better Outcomes for People and Smarter Use of Infrastructure

- Provision of 100% single rooms, removal of 6 bed bays:
  - increased patient (flow) throughput.
  - improved patient experience (through improved privacy and dignity and reduction in bed moves – evidence suggests patients are moved on average 5 times in a multi-bed bay).
  - reduction in Hospital Acquired Infections (HAIs).
- Improved clinical adjacencies from a highly dispersed estate. Emergency Department is remote from Imaging and Theatres, current travel distances for abdominal pain presentation are 890m. This would be reduced to 300m in the new facilities. Travel times will reduce on average between 3-4 minutes between key departments such as ED, Theatres, Endoscopy, Medical wards and Women's and Children's.
- Care closer to home delivered through:

- PIFU and other Outpatient (OP) transformation measures – 10% reduction in FU appointments.
- 10% new, 20% FU transfer to virtual OP appointments from F2F with associated reduction in number of Consult/Exam (C/E) rooms required – c. 10 C/E rooms converted to virtual rooms which are half the size of C/E.
- Repatriation of OP to community settings, reducing acute C/E room requirement by two with no associated increase in community C/E requirement due to efficiency gains in utilisation.

- Improved outcomes, patient experience and waiting list times through:
  - 25% reduction in DNA rate.
  - 7-day imaging service.
  - Increased use of pre-habilitation and rehabilitation services to reduce surgical LoS.
- Improved and specially designed facilities for patients with dementia or disabilities. Leighton Hospital PLACE scores are poor despite Cheshire's ageing population (22.5%) being above the England average (18%) and set to increase further.
- Costed investment in digital to improve patient experience and outcomes, staff experience and efficiency and overall building management efficiency:
  - Digital bed management.
  - Hospital wide 5G, phone signal and medical grade wi-fi.
  - PIFU and clinical check in.
  - Digital wayfinding.
  - Self-check in kiosks.
  - Automated Guided Vehicles.
  - Command and Control Centre.
  - Building Management System.
  - Real time asset tracking.
  - Digital front door.
  - Connected devices.
  - Digital twin.

The application of these technologies will reduce DNA rates, reduce staff travel times, use of connected devices will predict patient deterioration enabling earlier intervention and reduced LoS.

Stronger and Greener NHS Buildings

- Remove £407m (gross works cost) of BM liability.
- Single phase investment allows removal of RAAC planks and associated risk to patients and staff in 5 years, instead of 12-15.
- Delivery of a scheme that will meet NHS Net Zero Carbon targets through ensuring buildings are lean and remove fossil fuel dependency. The scheme has an energy consumption target of 110 kWh/ m^2/year to be met through investment in solar thermal and PV panels for the provision of

hot water and electricity as well as the use of smart building controls. Current energy consumption is 163kWh/m^2/year.

- New facilities are designed to incorporate lessons from the Covid-19 pandemic including flexibility of estate to enable easy implementation of green and blue pathways.

Fairer and More Efficient Use of Resource

- The successful partnership with Central Cheshire Integrated Care Partnership (CCICP) puts the trust in a strong position to maximise opportunities to further integrate patient pathways with Community and other Health System partners.
- A new hospital offers major economic benefits, sustainable skilled jobs and cost efficiencies of 'smart' buildings to an area hit hard by economic challenges and the impact of Covid 19.
- Independent analysis demonstrates that the ongoing refurbishment of the present failing infrastructure over the next 15 years, will cost substantially more than the projected new-build costs.
- Creation of additional service capacity through the provision of a further 97 beds that will be required by 2029 to support the growing and ageing population.
- Staff training and welfare facilities are currently poor and investment will provide on-site training facilities enabling improvements in staff recruitment and retention rates.
- Enable expansion of the apprenticeship scheme allowing different routes into healthcare to support a challenged NHS workforce.
- The Trust owns the land required for development and can build the new hospital on the existing site, without disrupting current services.
- Enhancing care closer to home and delivering more in the community and primary care, using the space to enhance skills in the community to keep people away from hospital.

Declaration

I confirm that the information in this form is accurate at the time of completion and that I have appropriate executive approval from my trust to submit this expression of interest.

Yes

Name: ..... **Russ Favager**

Role:..... **Deputy Chief Executive**

Email address: ……**russell.favager@mcht.nhs.uk**

Phone Number: ……**01270 273760**

Date approved by Trust Board: ..... **28th August 2021**

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CONSENT 4.1**	Date of Meeting: 30/09/2021
Report Title	Violence Reduction Strategy	
Executive Lead	Russell Favager, Deputy Chief Executive and Director of Finance	
Lead Officer	Les Jackson, Local Security Management Specialist (LSMS)	
Action Required	To approve	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Incorporates the new national Violence Reduction standards (December 2020) to be introduced through 2021/22. The majority of the objectives are currently being met.
- A shift from violence and aggression management through a data led approach
- Emphasis on stakeholder involvement and application of a diversity lens
- Live document with strategic actions requiring regular review.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Continue to work towards the requirements of the strategy and standards
- Objectives and timescales to be managed through Violence & aggression Forum and reported through Health and Safety Group (HSG)
- Continuing work by the Violence Reduction Operational Lead and twice-yearly report to Executive Lead for Violence Reduction.
- HSG to have sight of document for discussion around resultant Violence Reduction Policy.

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Provide safest and best care	✓	• Be the best place to work	☐
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

Impact *(is there an impact arising from the report on the following?)*

• Quality	✓	• Compliance	✓
• Finance	✓	• Legal	☐
• Workforce	✓	• Risk/BAF Click here to select relevant risk	
• Equality	✓		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☒ Policy ☐ Service Change ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised, and actions agreed
Executive Safe and Sustainable Executive Group	7 September 2021	Violence Reduction Strategy	Les Jackson, LSMS (Violence Reduction Lead)	
Performance and Finance Committee	17 August 2021	Violence Reduction Strategy	Les Jackson, LSMS (Violence Reduction Lead)	Requested further clarity on recommendations
Performance and Finance Committee	23 September 2021	Violence Reduction Policy	Les Jackson, LSMS (Violence Reduction Lead)	Agreed and recommended to the Board

Mid Cheshire Hospitals NHS FT

Violence Reduction Strategy

Introduction

1. This strategy has been mandated by the Violence Prevention and Reduction Standard (December 2020). There is a requirement that a strategy is produced and then reviewed against the Standard, and board assurance provided at least twice per year that it has been met. This Strategy has been produced by the Violence Reduction Operational Lead (LSMS) who is responsible for the operational management of issues related to violence and aggression at the Trust, reporting to an appointed violence reduction executive lead. The Trust Board is overall accountable for the violence prevention and reduction strategy.

2. The violence prevention and reduction standard will be incorporated into the 2021/22 NHS Standard Contract.

3. As a minimum, the standard will be reviewed annually or following significant changes, i.e. legislative and strategic changes. It is applicable until further notice.

4. The standard has been developed with partners from the Social Partnership Forum and its subgroups, the Workforce Issues Group and the Violence Reduction Group. The standard is managed by NHS England and NHS Improvement and was endorsed by the Social Partnership Forum on **15 December 2020**.

Executive Summary

5. This Strategy has been reviewed against the violence prevention and reduction standard December 2020 (Appendix I) and has been written to provide the Trust with a risk-based framework that supports a safe and secure working environment for Trust staff, safeguarding them against abuse, aggression and violence.

6. This strategy uses the Plan, Do, Check, Act approach to set out the specific activities required to implement the Strategy and continue to evolve the Trust's Violence Prevention, Reduction and Management systems, processes, culture and competencies.

7. This Strategy document provides a detailed guidance for all staff to understand their responsibilities and the specific methodology that should be followed to ensure a consistent approach to Violence Prevention and Reduction across all areas of the Trust.

8. The following statements are not currently met by the Trust:

    - A process exists for auditing violence prevention and reduction performance and ensuring that associated systems are effectively managed and assessed regularly.
    - The audit outcomes inform a regular senior management review held at least twice a year.
    - This senior management evaluates and assesses the violence prevention and reduction programme, the findings of which are shared with the Board.

- Following this review, the violence prevention and reduction lead updates as necessary the objectives, policy, plans and supporting processes required to deliver the outcomes.
- Violence prevention and reduction forms part of the overall organisational strategy and workforce planning process and is closely aligned to the STP and ICS planning arrangements.

Background and Analysis

9. The Violence Prevention and Reduction Standard, is a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence with the emphasis on Violence Prevention and Reduction.

10. With the introduction of the standard and the requirement that it be incorporated into the 2021/22 standard contract, the initial task was to assess our current approach to violence and aggression and assess this against the new standard.

11. Using the Plan, Do, Check, Act approach, the Violence Reduction Operational Lead codified specific activities required to implement the Strategy and continue to evolve the Trust's Violence Prevention, Reduction and Management systems, processes, culture and competencies.

12. In line with the dictates of the National Standard, the initial iteration of the Violence Reduction Strategy should be seen as an assessment of current violence and aggression management practices consolidating into a practice of Violence Reduction. Using the Plan, Do, Check Act, approach, MCHFT's Violence Reduction Strategy has now been set out. The document should also be seen as a live document, updating as the data led approach as stipulated comes into clearer focus.

Plan:

13. This Strategy was reviewed against the violence prevention and reduction standard. Any future requirements or additions to the strategy or policy needs to use a data and incident led approach to identify what needs to be completed and how, who will be responsible for what, and what measures will be used to judge success.

14. Critically, this strategy is data driven. Violence and aggression incident data must continue to be rigorously interrogated on a quarterly basis at the Violence and Aggression Forum and strategies planned with the emphasis on Violence Reduction.

15. Whilst measures already in place provide detailed information around deliberate and clinical drivers of violence and aggression, and such information is critical to Violence Prevention and Reduction, there are data requirements of the new standard which need to be introduced.

16. Over the 2021/2022 data is now being collected that brings new focus of the strategy towards violence and aggression incident data towards those groups of staff, patients and visitors who have protected characteristics in order that any actions taken are driven from the data. The latest iteration of the strategy now gives greater credence to the "data led" approach to violence reduction and sets out those protected characteristics that have been a factor in incidents of violence and aggression.

17. Additionally, quarterly Violence and Aggression forum meetings have now been expanded to include the input of trade union groups in order to shed a different light on the anecdotal experience of violence and aggression from a staff perspective.

Do:

MCHFT must:

Assess and manage risks:

18. Strategies which target the reduction of violence and aggression described are well understood (and indeed have formed the "backbone" of traditional security work and violence reduction measures at MCHFT) and a **Detection**, **Sanction** and **Redress** approach is recommended. The **Sanction** and **Redress** elements are appropriate to deliberate incidents of Violence and aggression.

19. For non-deliberate (or clinical causes), detection should be followed by strategies which are aimed at the underlying causes. Again, these are well understood and relate, for example, to early identification of alcohol de-tox, understanding dementia related violence and aggression and the focusing of resource towards managing and reducing violence and aggression with clinical roots.

20. As the Violence Reduction strategy takes root, additional data garnered from the application of a diversity lens and the inclusion of anecdotal and qualitative information from staff experience has now fed into this aspect, identifying risks.

Check

21. The Violence and Aggression Reduction Lead (LSMS), on behalf of the trust must ensure that the plans are implemented successfully, assess how well the risks are controlled and determine if the aims have been achieved, i.e. via audit measures. Whilst the quarterly meeting of the violence and aggression forum addresses risks associated with violence and aggression, these have now been expanded to include protected characteristics as well as the qualitative experience of violence and aggression gained by staff representative/Trade Union input. Essentially, the data that has been collected in the planning phase should lead to strategies targeting the areas highlighted by the data. It is then important that the data is now checked for validity and an assessment made as to whether the measures have been successful.

Act:

22. The Violence Reduction Operational lead, through the Violence and Aggression forum will review its performance to enable the senior management team to direct and inform changes to policies or plans, in response to any localised lessons learnt and incident data collected in respect of violence prevention and reduction. This will take the form of the review of incident data (including any qualitative data alongside a quantitative Ulysses review) critical findings should potentially be reviewed with internal and external stakeholders.

23. There is an overarching compliance process which should be seen as a lattice around which the Plan, Do, Check Act approach is built. This has entailed:

- An initial Assessment of data in relation to violence and aggression, with the addition of a diversity lens to the data including protected characteristics as well as the subjective experience of violence and aggression.
- An Assessment validation of that data, in other words this data must be checked, shared and discussed, (The quarterly Violence and Aggression forum is the multidisciplinary vehicle for this process)
- A process of Senior management validation which will take place at least twice per year via reporting through the Violence and Aggression Reduction Operational lead (the LSMS) and the Executive Lead for Violence Reduction.
- Management and maintenance of Action Plans: Actions will be evidence based by a process of measurement and comparison with incident data as this pertains to violence and aggression. As such any actions targeting incident data will be fluid by nature and subject to validation through the quarterly Violence and aggression forum.
- Repeat Assessment as Required: In line with the standard, the data must be assessed on a twice-yearly basis and reported through the Violence Reduction Operational Lead to The Executive lead for Violence Reduction. The data will also be interrogated as an important constituent of the quarterly Violence and aggression forum. This is a continuous process which will continue after the initial assessment and should grow “organically” in line with the nature of the violence and aggression data. This should be seen as a process of continuous improvement.

Conclusion

24. In conclusion, the Trust is well set up by means of regular Violence and Aggression Forum meetings to interrogate violence and aggression data in accordance with the new standard. The completion of the strategy and Violence Reduction Policy documents sets out how this data should be used to measure where we are as a Trust.

25. The introduction of additional categories of data which are related to protected characteristics has now been collated and needs further interpretation. The important point is that the strategy is data driven and any changes are led by that data.

26. The addition of staff representation, via the attendance of trade union representatives into the violence and Aggressive forum is another important paradigm shift. Factors such as stress, can have a marked effect on how staff deal with incidents of violence and aggression and the collation of such information will continue to form an important component of the Trust posture in respect of Violence Reduction.

Recommendation

27. The Board is asked to endorse the Violence Reduction Strategy and resultant Violence Reduction Policy, both comply and are reflective of the Violence and Aggression Prevention and Reduction Standards

28. The Board is asked to endorse that the Quarterly Violence and Aggression Forum will track on-going compliance with the national Violence and Aggression Reduction Standard as data continues to be gathered, assessed and acted on.

29. The Board is asked to endorse that the Violence Reduction Operational Lead will meet with the Executive Lead for Violence Reduction at least twice per year and that the Violence Reduction lead will track progress with the national standards.

30. The Board is asked to endorse the shift in emphasis from a policy of managing violence and aggression to one of violence reduction.

31. The Board is asked to endorse that a diversity lens needs to be applied to our understanding violence and aggression, particularly as this pertains to protected characteristics.

32. The Board is asked to endorse that qualitative data obtained through staff experience of violence and aggression needs to be an important component of strategies aimed at violence reduction.

33. The Board is asked to endorse that training for Trust and community staff in respect of violence and aggression should be integral to a process of violence reduction**.**

Author: Les Jackson Violence Reduction Operational Lead

Date: 23/08/2021

Appendix I

Classification: Official

Violence Prevention and Reduction Standard

Mid Cheshire Hospital Foundation Trust Compliance and Evidence

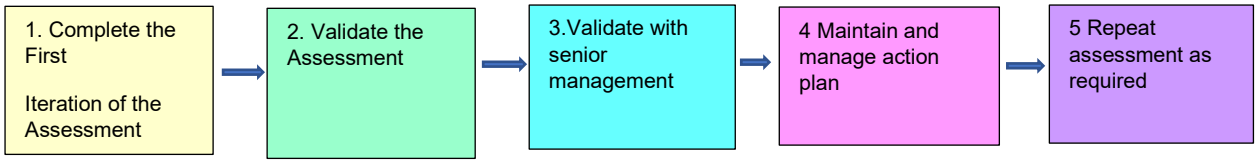
December 2020

Compliance assessment

The process outlined in Figure 1 is for NHS organisations to consider when completing the violence prevention and reduction assessment. It ensures that responses to the evaluation are valid and any required organisational actions are endorsed at senior management level in consultation with key stakeholders, via the designated internal governance routes.

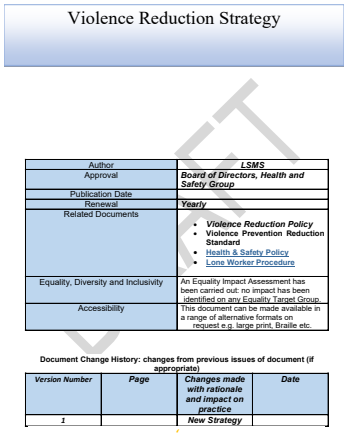
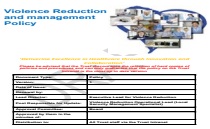
The evidence showing the criteria have been met for each indicator, or not, should be made available to essential stakeholders.

Figure 1: Violence prevention and reduction assessment process



The violence prevention and reduction lead completes the initial assessment in collaboration with key stakeholders. • The rationale, evidence and actions are recorded for each response.	Validate the recorded responses and rationale with relevant stakeholders.	Validate the findings with senior management and obtain agreed responses and actions to address any concerns.	• Ensure there is a clear plan with defined roles and responsibilities for discharging any actions identified. • Ensure appropriate timescales are assigned to each action. • The actions may include but are not limited to further investigation, improving processes, validating rationale and evidence. • Actions and risks identified should be included as part of the organisational risk assessment.	Agree the frequency with senior management and key stakeholder.

Plan

	Indicators	Compliant	Evidence
The board (non-exec and exec members) endorses the violence prevention and reduction policy	The organisation has developed a violence prevention and reduction strategy which has been endorsed by the board and is underpinned by the relevant legislation and government guidance.	Complete Requires Endorse by Board	
	The organisation has developed a violence prevention and reduction policy which has been endorsed by the board and is underpinned by workforce and workplace risk assessments	Complete Requires Endorse by Board	
	The organisation has engaged with key stakeholders, including trade unions, health and safety representatives and other appropriate stakeholders.	Yes	Union Representatives attended V/A forum; protected characteristics added to Ulysses Violence & Aggression reports (Strategy doc, page 12)
	The organisational risks associated with violence have been assessed and shared with appropriate stakeholders in the sustainability and transformation partnership (STP) or integrated care system (ICS).	Yes	Policy and strategy now complete, shared with staff side representatives and shared through ESSEG, EWAG and presented to HSG. The LSMS/EPRR Lead represents the trust at regional level at quarterly meetings chaired by NHSE/I where violence and associated risks are discussed. (Strategy doc, page 12)
	The senior management (the chief executive and the board) is accountable for the violence prevention	Yes	Senior management role, including VR Executive lead set out and included in both strategy and policy documents (Strategy doc, page 13)

	and reduction strategy and policy, and this is clearly set out in both documents.		
	Senior management is informed about any disparity trends for violence and aggression against groups with protected characteristics, and a full equality impact assessment has been developed and made available to all stakeholders.	Yes	Protected characteristics now included in Ulysses reporting system, report on potential disparity at each V/A Forum Complete: no PC Disparities of note (Age + Clinical factors aside) Equality impact assessment included in policy documents (Strategy doc, page 13)
	The violence prevention and reduction objectives and expected performance criteria outcomes have been incorporated into the policy.	Yes	Policy complete, including objectives as clarified on page 2 of the policy. Performance Criteria are set out in page 5 as a process of comparison of violence and aggression statistics from the previous quarter, setting out its performance criteria. (Strategy doc, page 13)
Clearly defined objectives and performance criteria	There are practical and efficient methods for measuring status against the objectives identified and agreed by the senior management team in consultation with key stakeholders.	Yes	Objectives checked via data at the VA forum Complete, objectives to be discussed at next meeting with VR Executive Lead All violence and aggression incidents are recorded on to Ulysses Monthly and Quarterly (VA Forum) and yearly (Security report) (Strategy doc, page 13)
	The organisation is compliant with relevant health and safety legislation and any other applicable statutory legislation, and this has been validated, i.e., via the organisation's auditors.	Yes	Complete Organisation compliant (needs regular assessment) (Strategy doc, page 13)
	Inequality and disparity in experience for any staff groups with protected characteristics have been addressed, and this is clearly referenced in the equality impact assessment.	Yes	Complete and included in policy and Strategy documents (Strategy doc, page 13)

	Plans have been developed and documented for achieving violence prevention and reduction objectives, and the outcomes are clearly set out in the policy.	Yes	Complete V/A Forum and Senior management reviews set out in policy (Strategy doc, page 13)
Violence prevention and reduction plans recorded, implemented and maintained	The plans are updated and maintained to consider improvements, lessons learnt and updated risk assessments, annually as a minimum schedule.	Yes	Complete, all risk assessments in relation to violence & Aggression are up to date Plans are included in the policy document and updated on the policy update schedule. (Strategy doc, page 14)
	Risk assessments are available to managers, their staff, trade union representatives and other relevant stakeholders.	Yes	Complete Risk Assessments are available on the system and can be viewed/reviewed by managers/staff. (Strategy doc, page 14)
	The plans are reviewed in consultation with subject matter experts pertaining to the Equality Act 2010.	Yes	Complete, the LSMS has liaised with human resources lead when developing plans and policies via VA Forum. HR lead attends HSG where policy is "operationalised" (Strategy doc, page 14)

Do

	Indicators	Compliant	Evidence
	The senior management assesses and provides the resources required to deliver the violence prevention and reduction objectives.	Yes	Funding for L/W and Breakaway training agreed, training schedule set out for Leighton & CCICP. Security and violence/aggression incident management and response are well managed by a well-trained in-house security team consisting of 12 officers, operations manager, co-ordinator, control room operator and admin support, managed by the LSMS. Additional resources will be identified by the LSMS as part of continual security risk assessments. There is an established process by which the LSMS can review and request additional resource. Security provision is by means of an in-house team for which the LSMS is accountable. (Strategy doc, page 14)
Board members approve resources	A designated board-level (director) manages the violence	Yes	Director of Finance is VR Lead and oversees the violence prevention and reduction strategy. (Strategy doc, page 15)

	prevention and reduction workstream and ensures appropriate and sufficient resources are allocated to the function (which is underpinned by an organisational risk assessment).		
	The senior management team regularly provides accessible communications on the violence prevention and reduction objectives and priorities.	Yes	LSMS has completed a newsletter for distribution, Security has a designated intranet page. Communications team supports the VR Strategy (Strategy doc, page 15)
Regular workforce engagement	Communications cover all staff groups and functions within the organisation.	Yes	Complete as above (Strategy doc, page 15)
	The recognised trade unions are consulted and involved in the development of violence prevention and reduction objectives.	Yes	Trade Union Representation at forum meetings has now taken place and contributions made. (Strategy doc, page 15)
	A diversity lens is applied to objectives development, to provide due diligence for Public Sector Equality Duty, and this is validated by the subject matter expert pertaining to the Equality Act 2010.	Yes	The Trust meets its legal duties under the equalities act 2010. Protected characteristics included in and added to Ulysses questionnaires for Violence & Aggression incidents, this is shared with HR attendee at forum meetings and HSG. (Strategy doc, page 15)
	The organisational roles and responsibilities across all levels are clearly set out in a violence prevention and reduction policy.	Yes	Roles and responsibilities set out in policy document section 5.1. (Strategy doc, page 15)
Clear roles, responsibilities and training	A training needs analysis (violence) informed by the risk	Yes	Training needs analyses included in policy document page 32, appendix B Conflict

	assessment has been undertaken, and suitable and sufficient training and support are accessible and provided to all staff.		resolution training (CRT) is in place for all staff and updated every 3 years (Strategy doc, page 15)
	Violence prevention and reduction workforce and workplace risk assessments are managed and reviewed as part of an ongoing process and documented in the appropriate organisational risk registers.	Yes	Workforce and workplace risk assessments in relation to violence and aggression are in place and up to date, managed by the LSMS and divisional compliance lead. (Strategy doc, page 16)
Regular risk assessment	Violence risks are co-ordinated across the organisation and are accessible and shared with senior management and all appropriate stakeholders.	Yes	The V/A forum identifies risk factors and risk areas for Violence and aggression, additionally Workforce and workplace risk assessments in relation to violence and aggression are in place and up to date and managed as above. (Strategy doc, page 16)
	Identified violence risks and their mitigations/controls are communicated to all staff in regular bulletins.	Yes	Newsletter and information around Violence, Aggression and security measures now completed by LSMS, and discussed with H&S manager. Security has an intranet page accessible by all staff with PC Access. (Strategy doc, page 16)

Check

	Indicators	Compliant	Evidence
	The efficiency and effectiveness of the violence prevention and reduction plans and processes are assessed and reviewed as a minimum every six months or following organisational changes or serious incidents.	Yes	Quarterly through V/A Forum and HSG and twice yearly through VR Executive lead Violence and aggression incidents are regularly reviewed by LSMS and included in monthly, quarterly and yearly assessments (Strategy doc, page 16)
Process to assess violence prevention and	The senior management is directly accountable for ensuring that the	Yes	To be confirmed by Executive lead for VR at next meeting. The processes in place to ensure that senior management are sighted on performance of the Trust in the area of Violence reduction.

reduction performance	system is working effectively and providing assurance that the violence prevention and reduction objectives are being achieved.		These include meetings with LSMS and VR Executive Lead (Strategy doc, page 17)
	Staff members are actively encouraged to report all incidents, including near misses.	Yes	incident reporting at a good standard. (Strategy doc, page 17)
	Violence data is managed in accordance with the General Data Protection Regulations (GDPR)	Yes	anonymised reporting via forum in place. The Trust also employs the services of a Data Protection officer (Head of IT and IG Security) who manages information Governance and provides advice and guidance to all staff relating to GDPR. All staff have to complete an annual training programme relating to Data Security. (Strategy doc, page 17)
Data is traceable retrievable and accessible	Violence data is frequently analysed using primary metrics to support the violence prevention and reduction assessments and inform the audit process.	Yes	metrics are regularly assessed via the V/A Forum and HSG group. Monthly breakdowns of Violence and aggression incidents are circulated to appropriate managers. Violence data is also analysed continuously and immediately utilising the Ulysses Incident Reporting System. (Strategy doc, page 17)
	Violence data is analysed using the demographic make-up of the workforce, including age, sex, ethnicity, disability, and sexual orientation.	Yes	protected characteristics now included in Ulysses questionnaire (Strategy doc, page 17)
	The protection and storage of data about violence follows the organisation's information governance policies.	Yes	Ulysses and data from forum is compliant with Governance policies. The Information Governance and Data Protection Policy covers all aspects of Data security which includes the information stored on the Ulysses system . The Ulysses system has been subjected to a data Protection impact assessment (Strategy doc, page 18)
	Data collected about violence assures that the processes are effective and identifies where lessons can be	Yes	Effective processes managed via V/A Forum, additionally, the Ulysses Incident Reporting System incorporates a lessons learnt element (Strategy doc, page 18)

	learnt and that the policy objectives are being achieved.		
	A process exists for auditing violence prevention and reduction performance and ensuring that associated systems are effectively managed and assessed regularly.	Action Required	Although V/A data is regularly assessed via the VA Forum, a regular and formal audit process needs to be established
Established audit and assurance process for violence prevention and reduction	The audit outcomes inform a regular senior management review held at least twice a year.	Action Required	As above.
	All incidents are logged, reviewed, assessed and any corrective actions are recorded within acceptable timeframes, and where this may be prolonged by investigations and or staff support, this is recorded and communicated to senior management, relevant staff and stakeholders.	Yes	Incidents effectively managed via Ulysses. LSMS regularly reviews Violence and aggression incidents, Ulysses Incident reporting System is supported by a Ulysses training programme and an Incident Management Policy. (Strategy doc, page 18)
Process for corrective and preventative actions for violence prevention and reduction	The violence prevention and reduction risk registers are updated accordingly.	Yes	July 2021 Risk assessments and risk registers are up to date. The Trust Risk register is managed to ensure that all risks on the register are subject of regular reviews. Risks are managed utilising the Ulysses incident Reporting System. (Strategy doc, page 18)

Act

	Indicators	Compliant	Evidence
	A senior management review is undertaken twice a year and **as**	Action Required	1st review to take place under new standards. The LSMS presents to Committee level at least twice per year regarding security updates as well as an annual report.

	required or requested to evaluate and assess the violence prevention and reduction programme, **the findings of which are shared with the board.**		Committee are able to review all incidents reported under the security headings which include abuse directed to staff be it physical or otherwise and the Committee may task the LSMS accordingly if required and can review all incidents under their respective headings
Board reviews the violence prevention and reduction performance	Inputs to the process include: - local risk management system (data about violent incidents) - risk registers - audit and governance reports that include violence performance - lessons learned (STP and ICS level) - review of the violence prevention and reduction processes - risk assessments (workplace and workforce) - triangulated with WRES and WDES - staff experiences (causation themes, impact on health and wellbeing, consequences, etc) - Serious Incidents - NHS Staff Survey, local or pulse surveys - local HR intelligence (staff recruitment and leavers rates, absenteeism or retention rates)		• Ulysses IR system • Ulysses risk register would be used to record and act on an incident of Violence and aggression • System allows for staff to prepare risk assessments for each patient and flag those risks to others providing care. • HSG and VA forum allows staff to raise concerns around Violence or Aggression. • All Ulysses reported incidents are rated as no, low, moderate etc. Dictating the level of response required. • NHS staff survey 2020 included questions relating to perceptions of Violence and aggression. • HR Attendance Forum & HSG to voice any concerns • Trade union attendance at forum and HSG gives voice to concerns raised. • LSMS discusses related Violence and Aggression incidents with Cheshire Police representative Incidents are discussed at the regional Cheshire and Merseyside LSMS meetings with a view to learning lessons from others (Strategy doc, page 19)

	- key stakeholders. - trade union concerns raised through the health and safety committee - meetings with chief constable or designated representative, police and crime commissioners, etc.		
 **Violence prevention and reduction policy updated with lessons learned**	Following the senior management review (twice a year) the violence prevention and reduction lead updates as necessary the objectives, policy, plans and supporting processes required to deliver the outcomes.	Action Required	1st review to take place with new standard, LSMS will update VR Executive lead regarding objectives/Policy/plans etc. the LSMS will update on advice/instruction from VR Executive Lead, Forum and HSG. The LSMS presents to Committee level regular security updates together with an annual report. Committee are able to review all incidents reported under the security headings which include Violence & Aggression incidents or abuse directed to staff be it physical or otherwise and will task the LSMS accordingly (Strategy doc, page 20)
	Senior management has enough information **from the violence prevention and reduction performance inputs** to make informed decisions about the violence prevention and reduction policy, and this information is based on credible intelligence and risk assessments	Yes/No	July 2021 (1st review to take place under new strategy) HSG through the VA forum are updated at regular intervals relating to the Violence reduction performance inputs. Violence and Aggression inputs are shared at twice yearly reviews with VR Executive lead. Updates include detail on all individual cases of violence and the actions taken in response to incidents (Strategy doc, page 20)
Informed decisions at senior management level	Violence prevention and reduction forms part of the overall organisational strategy and workforce planning process and is closely aligned to the STP and ICS	No	Awaiting evidence to rate. Sustainability & Transformation Partnerships Integrated Care Systems (ICS: Operating with partners from 2022)

	planning arrangements		
	Staff receive timely responses to incident investigations, and where this may be prolonged by process requirement, this is recorded and communicated to staff, senior management and relevant stakeholders.	Yes/No	Incident follow up and investigations effectively managed via Ulysses The Ulysses management system is utilised to record all investigations. Result of investigations are shared back with the reporter via the Ulysses system. The LSMS receives early notification of all incidents and will contact those staff that have been affected by violence. The line manager of the member of staff concerned will manage the Ulysses incident. (Strategy doc, page 21)

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CONSENT 4**	Date of Meeting: 30/09/2021
Report Title	Violence Reduction Policy	
Executive Lead	Russell Favager, Deputy Chief Executive and Director of Finance	
Lead Officer	Les Jackson, Local Security Management Specialist (LSMS)	
Action Required	To approve	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Updated policy reflects National Standards on Violence Prevention and Reduction, also incorporated into the Trust's Violence Reduction Strategy
- Traditional and legacy workstreams around the Trust's approach to violence and aggression e.g. zero tolerance, detection, sanctions and redress will still continue alongside the approach on the national standards
- A diversity and staff representation lens is applied in the strategy and policy

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Continue to work towards the requirements of the strategy and standards
- Objectives and timescales to be managed through Violence & aggression Forum and reported through Health and Safety Group (HSG)
- Continuing work by the Violence Reduction Operational Lead and twice-yearly report to Executive Lead for Violence Reduction
- HSG to have sight of document for discussion around resultant Violence Reduction Policy.

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Provide safest and best care	✓	• Be the best place to work	☐
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

Impact *(is there an impact arising from the report on the following?)*

• Quality	✓	• Compliance	✓
• Finance	✓	• Legal	✓
• Workforce	✓	• Risk/BAF Click here to select relevant risk	
• Equality	✓		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☒ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Executive Safe and Sustainable Executive Group	06/07/21	Violence Reduction Policy	Les Jackson, LSMS (Violence Reduction Lead)	
Performance and Finance Committee	17/08/2021	Violence Reduction Policy	Les Jackson, LSMS (Violence Reduction Lead)	Requested further clarity on recommendations
Health and Safety Group	September 2021	Violence Reduction Policy	Les Jackson, LSMS (Violence Reduction Lead)	
Performance and Finance Committee	23/09/21	Violence Reduction Strategy & Policy	Russell Favager, Deputy Chief Executive and Director of Finance	Agreed and recommended to the Board

Violence Reduction Policy

Introduction

1. This policy will help Mid Cheshire Hospitals NHS FT (MCHFT) to pro-actively manage violent and aggressive behaviour and provide a paradigm shift away from the management of violence and aggression towards a policy of Violence Prevention and Reduction. The policy will also be consistent with the national standard on Violence and Aggression reduction as well as the Trust's Strategy on Violence Reduction.

Executive Summary

2. The policy provides a framework for staff to respond in situations that they face with regard to violence and aggression (both where they can plan and where an incident is unforeseen), that is set firmly within a legal context and links with other policies and procedures of MCHFT. The policy is written to be entirely consistent with the Violence Prevention and Reduction Standards (December 2020), and by extension, The Trust's Violence Reduction Strategy. This document assists practitioners by promoting best practice principles and ensuring consistency across the Trust. This policy sets out specific responses required to implement the Trust's Violence Prevention, Reduction and Management Policy, processes, culture and competencies.

3. This Policy document provides a detailed guidance for all staff to understand their responsibilities and the specific methodology that should be followed to ensure a consistent approach to Violence Prevention and Reduction across all areas of the Trust. The policy also sets out guidelines for responding to violence and aggression informed by experience and good practice.

Background and Analysis

4. This Policy sets out measures and techniques that can be used by staff to respond to incidents of violence and aggression. Such measures apply across a range of context's and can include:
    - Tips for managing Violence and Aggression.
    - The correct pathway for the management of acute aggression
    - Acute Management of Aggressive patients
    - The use of sedation or rapid tranquilisation
    - Managing aggressive patients and visitors
    - The role of restraint
    - Patients who may or may not be subject to the provisions of the mental health act
    - The use of "Specialing" i.e. the addition of 1:1 healthcare support or, in cases of violence and aggression, the provision of security support. (more commonly known as Bed Watch)
    - The Sanctions and Alert Code process in respect of patients and visitors and the process to be followed which can result in exclusion.

5. Advice is given around incident reporting in respect of violence and aggression, as well as the role of reporting incidents to the police. Within the broader context of the National Violence Prevention and Reduction Standard, the link between accurate reporting and the use of the

reported data to formulate the Trust's Violence Reduction Strategy is set out. This constitutes the bulk of change to the existing policy on Managing violence and aggression at the Trust.

Incident Reporting in relation to the Violence Reduction Strategy

6. The Trust has a quarterly Violence and Aggression Forum whose stated aim is to understand violence and aggression and, in particular, the causes and drivers of violence and aggression across the Trust. Specific actions are agreed to reduce or tackle drivers of violence and aggression. This includes a detailed understanding of non-deliberate as well as deliberate causes of violence.

7. Following the production of the national Violence and Aggression Prevention and Reduction standards, it was agreed between the Chair (Wendy Astle-Roe; Head of Health and Safety) and Vice Chair (Les Jackson; Violence Reduction Operational Lead & LSMS) of the Quarterly Violence and Aggression forum that a major proportion of the forum's work would now concentrate on the national standards as well as on-going work around the Trust's Violence Reduction Strategy.

8. Violence and aggression data are gathered from the Ulysses Incident reporting system. "Traditional" data which has been gathered includes deliberate vs non deliberate violence and aggression and remains a crucial component of prevention strategies. This relates to the degree to which a perpetrator of violence and aggression has the mental capacity to be responsible for their actions. Data collection around place, cause and effect of violence and aggression, again continues to be key.

9. Participation in the forum includes clinical and dementia leads, alcohol liaison and leads from high (aggression and violence) activity areas. In line with the broader strategy aims, membership has been broadened to include Trade Union representation as well as workforce/Human Resources representation to incorporate protected characteristics. It is crucially important that a diversity lens is applied to incidents of violence and aggression in order to understand their impact on victimology, perpetration and equitable outcomes. Accurate information in terms of drivers such as mental health, alcohol & drugs or other underlying clinical factors allows the forum to formulate strategies and direct resources to understanding and ultimately reducing such incidents moving forward.

10. In order to gather the additional data, which is a requisite of the new national standards, additional categories around protected characteristics has been added.

11. In line with the Violence Reduction Strategy, the Violence Reduction Operational Lead (the LSMS) will report to the Executive Lead for Violence Reduction on a twice-yearly basis along the objectives of the strategy. This underlines the importance of identifying the drivers of violence and aggression such as criminality, protected characteristics, drugs/alcohol and clinical conditions. This reporting structure has been added to both the policy and strategy documents. Strategies which have been formulated to target these drivers are largely dependent on accurate reporting and the resultant gathering of data. It is also crucial that anecdotal or qualitative information in respect of violence and aggression is highlighted by trade union representation at the VA Forum and through the Violence Reduction Operational Lead. The importance of such staff data cannot be overemphasised. Work related or personal; stress/anxiety/depression can have a marked impact on staff ability to manage incidents of violence and aggression. Pressures on staff activity on a busy ward can result in patients

(potentially having aggression as a component of a clinical condition) acting out in a violent manner. Capturing such data, even if this is of an anecdotal or qualitative nature is key to the realisation of the Violence Reduction strategy.

12. In order that the dictates of the Violence and Aggression Prevention and Reduction standard are met, the role of the Violence Reduction Operational Lead (the LSMS) as well as the executive lead for Violence Reduction are also set out in the policy (as well as the strategy documents).

Conclusion

13. In conclusion, the existing policy on managing violence and aggression has been updated and expanded to include those elements which are a requirement of the national standard on Violence Prevention and reduction.

14. This policy provides a clear set of techniques and guidelines which can be used to manage violence and aggression, with the new strategy requiring an additional data stream to add to violence reduction strategies.

15. The introduction of additional categories of data which are related to protected characteristics and staff experience requires collating and interpreting. As data is gathered and interpreted, the existing policy documents and strategy documents will change to reflect this.

Recommendation

16. The Board is asked to endorse the Violence Reduction Policy, noting it is reflective of the Violence Reduction Strategy and the Violence and Aggression Prevention and Reduction Standards.

17. The Board is asked to agree that the Policy will be “operationalised” by Health and Safety Group

Appendix I

Violence Reduction and management Policy

'Delivering Excellence in Healthcare through Innovation and Collaboration'

Please be advised that the Trust discourages the retention of hard copies of policies and procedures and can only guarantee that the policy on the Trust Intranet is the most up to date version

Document Type:	**Policy**
Version:	**1**
Date of Issue:	
Renewal by:	
Lead Director:	**Executive Lead for Violence Reduction**
Post Responsible for Update:	**Violence Reduction Operational Lead (Local Security Management Specialist)**
Approval Committee:	**Board**
Approved by them in the minutes of:	
Distribution to:	**All Trust staff via the Trust Intranet**

Contents:

1 Introduction / Purpose

Mid Cheshire Hospitals NHS Foundation Trust (MCHFT), is committed to providing a safe environment for all its staff, patients, contractors, volunteers, and visitors. The Trust will not tolerate violence or aggression will continue to adopt a "Zero Tolerance" approach to unlawful violence and aggression. The trust, therefore, welcomes the introduction of the Violence Prevention and Reduction Standard (December 2020), a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence with the emphasis on Violence Reduction. The overall objective of Violence reduction at the trust will be a process of continuous improvement in respect of violence and aggression incidents.

The World Health Organisation defines violence as "***the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, developmental impact, or deprivation".***

This Policy will help MCHFT to pro-actively manage violent and aggressive behaviour and provide a paradigm shift away from the management of violence and aggression towards a policy of Violence Prevention and Reduction. This Policy will also be consistent with the National standard on Violence and Aggression reduction as well as the Trust's Strategy on Violence Reduction.

MCHFT recognises the management of violence and aggression from patients, particularly behaviour that is due to a clinical reason, should be managed on the advice of Senior Medical staff, Line Mangers and Mental Health Specialists.

It is the policy of MCHFT that no one will be discriminated against on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. MCHFT will provide interpretation services or documentation in other mediums as requested and necessary to ensure natural justice and equality of access.

The policy provides a framework for staff to respond in situations that they face with regards to violence and aggression (both where they can plan and where an incident is unforeseen), that is set firmly within the legal context and links with other policies and procedures of MCHFT. The policy is written to be entirely consistent with the Violence Prevention and Reduction Standards (December 2020). This document assists practitioners by promoting best practice principles and ensuring consistency across the Trust.

2 General Document Principles

Tips for managing challenging behaviour & Violence prevention & Reduction

1) **Re-orientation**: If the patient is disorientated and has very poor memory they may not know where they are and can be quite frightened, use regular reassurance e.g. 'I am Security Officer/Nurse Banks, and this is ward 14 at Leighton Hospital.' Consider writing some basic information clearly in view of the patient e.g. age, location, etc. Use Calendars, clocks and familiar artefacts and faces. Try to limit ward/bed moves.

2) **Body Language:** care needs to be taken to approach the patient in a reassuring, non-threatening way e.g. respect personal space, stand side on, palms of hands facing the patient and reassuring voice. Don't stand over a seated patient or stand directly in front of them instead try to get down to the patient's level on an angle. Avoid standing over a patient in bed in such a manner that puts you at risk of being kicked or struck. Always conduct a dynamic risk assessment prior to entering the striking distance of an aggressive patient.

3) **De-escalation:** if a confused patient is irritable, try not to take offence; it is likely exacerbated by their medical condition. Often the best way to handle this is to remain calm with a gentle tone of voice. In general, try not to confront the patient/visitor and be diplomatic, 'I can understand why you feel this way.' Training around De-escalation techniques and interpersonal skills, which is part and parcel of an overall shift towards violence prevention and reduction, can be arranged via the LSMS.

4) **Communication:** explain your actions clearly and repeatedly if necessary, encourage the person to talk, listen to the person and make conversation as best you can. Having some time to build a relationship is essential. A successful key to managing people is via the relationship that you have with them.

5) **Distraction:** If the patient is distressed by a particular topic that cannot be resolved try talking to them about an issue that they are more confident, is such as the memories of their past or something that you know they have a keen interest in.

6) **Non-Confrontation:** If the patient needs to get up and pace, if possible don't battle this need but try to provide a safe environment for them to do so. Remove any dangerous items from bed area. Activity can be useful at reducing aggression. Always remember to avoid risk, be aware of how to conduct a dynamic Risk Assessment and do not hesitate to contact your security team for support and assistance.

7) **Ward Environment:** Noise reduction and low-level lighting at night. Encourage cognitive activity and encourage and support visits.

8) **Time and Patience:** Expect and plan that the confused patient will often take more time and require more resource in order to receive their necessary care. Make best use of your time, if the patient is uncooperative now try to do other tasks and then revisit or an alternative member of staff may succeed. Appropriate levels of staffing are needed.

9) **Training:** Knowledge of policy and procedures such as Rapid Tranquilisation Missing patient procedure and "Specialing" (also known as "Bed Watch") is critical. Additionally, training around "Breakaway," Descalation and Lone Worker is available by contacting the LSMS. Such training is critical to violence reduction and advocates a process of continuous de-escalation. Familiarise yourself with the law such as the Mental Capacity Act 2005.

Problems: If a problem persists don't ignore it, plan how best to deal with it with colleagues and get assistance from other professionals when required. What are the triggers that cause the behaviour? Can the behaviour itself be made safe? What does the patient get out of the behaviour? Be alert for pain and depression. Always contact your LSMS (Violence Reduction Lead) for advice and practical solutions to managing and reducing violence and aggression.

Information required for Incident Reporting Form, Violence and Aggression Reduction:

- Ensure all relevant details are correct and all parts to the IR1 form have been completed.

- Recording of the driving factors behind the incident must be recorded for example, clinical, alcohol de-tox, dementia, deliberate/non-deliberate. This is an important distinction as it may relate to the capacity for accountable decision making.

- Victim and perpetrator details, it is important that factors such as protected characteristics are accurately noted. This is an important component of the Violence Prevention and Reduction Strategy. These are found in the questionnaire section of Ulysses, you may not see anything that is initially relevant, however **age** is a factor in many incidents of violence and aggression as this is indicated in conditions of which aggression may be a component, i.e. dementia.

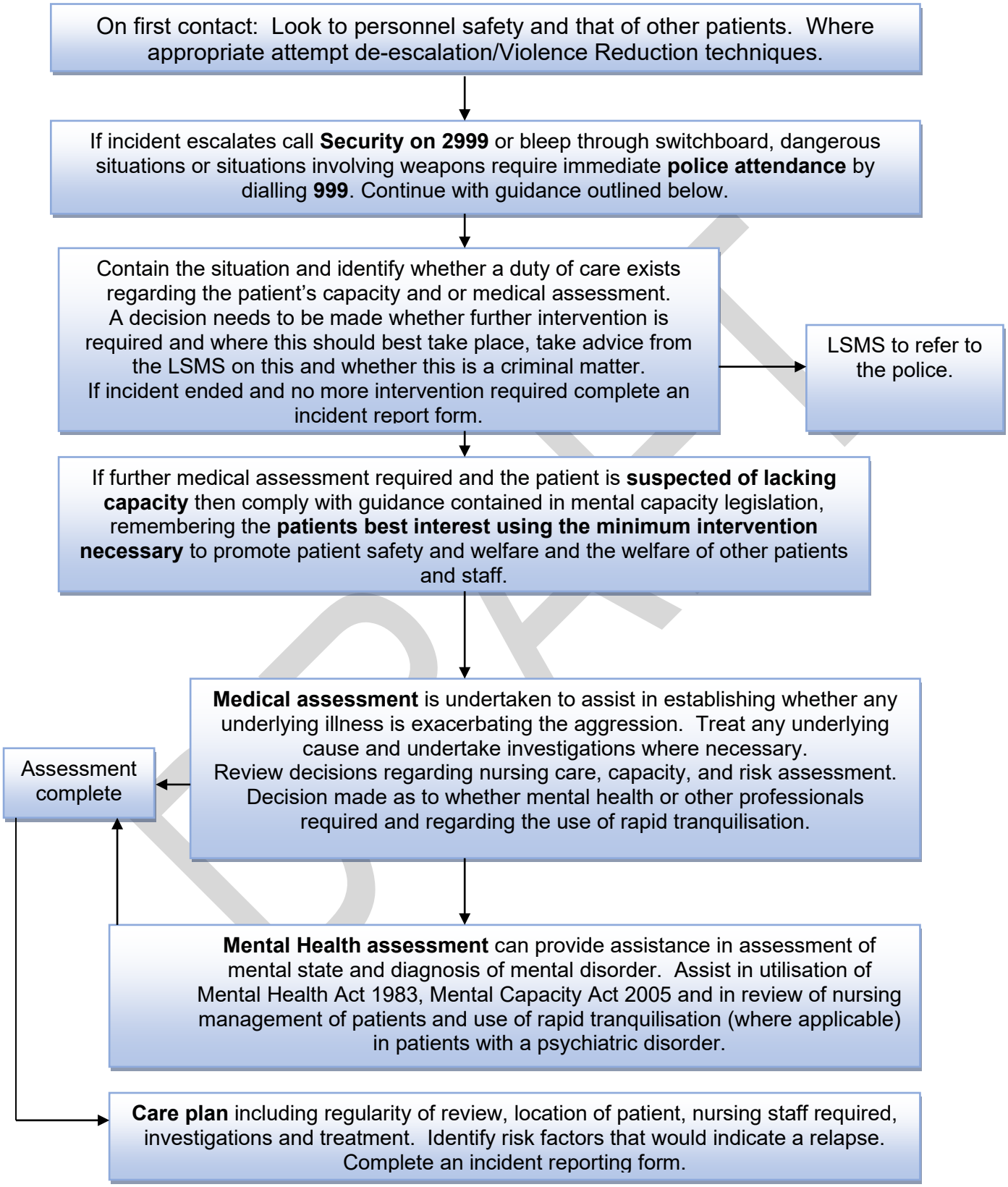
- Names/contact details of any witnesses are completed in full.

- Incident trigger code identified.
- Incident (**also known as an IML number**) or crime number if given by the police.
- Name of representative from Cheshire Constabulary if applicable.
- Number of staff on duty is recorded.
- De-escalation measures (if any) taken. This will give a clear indication of attempts made to mitigate the inherent risk present with any incident of violence and aggression, speaking to the importance of a reduction approach.
- Names of Senior Management involved in the incident.
- To assess if the victim requires further action taking on behalf of the Trust.

Incident Reporting in relation to the Violence Reduction Strategy

The trust has a quarterly Violence and Aggression Forum whose stated aim is to understand violence and aggression and in particular the causes and drivers of violence and aggression across the trust. Specific actions are agreed to reduce or tackle drivers of violence and aggression. This includes a detailed understanding of non-deliberate as well as deliberate causes of violence. This relates to the degree to which a perpetrator of violence and aggression has the mental capacity to be responsible for their actions. Participation in the forum includes clinical and dementia leads, alcohol liaison and leads from high (aggression and violence) activity areas. In line with the broader strategy aims membership has been broadened to include Trade Union representation as well as workforce/Human Resources representation to incorporate protected characteristics. It is crucially important that a diversity lens is applied to incidents of violence and aggression in order to understand their impact on victimology, perpetration and equitable outcomes. Accurate information in terms of drivers such as mental health, alcohol & drugs or other underlying clinical factors allows the forum to formulate strategies and direct resources to understanding and ultimately reducing such incidents moving forward. The Violence and Aggression Forum sets out, in detail, incidents of Violence and aggression over the quarter and compares this to the violence and aggression figures for the previous quarter and in doing so sets out performance criteria for the reduction of such incidents. In line with the Violence Reduction Strategy, the LSMS will report to the Executive Lead for Violence Reduction on a twice-yearly basis along the objectives of the strategy. This underlines the importance of identifying the drivers of violence and aggression such as criminality, protected characteristics, drugs/alcohol and clinical conditions. Strategies which have been formulated to target these drivers are largely dependant on accurate reporting. It is also crucial that anecdotal or qualitative information in respect of violence and aggression is highlighted by trade union representation.

Pathway for the Management of Acute Aggression



Acute management of an agitated or aggressive patient.

All interventions should occur simultaneously and early

Environmental interventions

- Create a calm environment
- Turn off tv/radio
- Remove other patients to another room if possible
- Remove objects that can be used as weapons, e.g. chairs
- Get help from trained staff
- Contact your Security team, fast bleep 2999

Behavioural interventions

- Talk slowly and softly
- Never turn your back to the patient
- Place yourself between the exit and the patient
- Be aware – eye contact may help establish a rapport, or may seem threatening
- Innocuous questions about sleeping and eating may prove a useful distraction
- Convey a genuine sense of concern
- Allow patient to verbalise feelings, but cut short if anger is escalating
- Restraint may be necessary with removal to a safer secluded area

Medical interventions

Consider another cause of the agitation, e.g. alcohol withdrawal, Seek advice from appropriate medical staff/doctor r/e treatment/rapid tranquilisation

Refer to Rapid Tranquilisation Pathway

Rapid Tranquilisation

Ensure that the incident is fully reported on the Incident reporting system (Ulysses) and that factors such as clinical/alcohol etc are recorded. Also ensure that protected characteristics are noted, including age.

Managing Agitated Patient Flowchart

Is your patient agitated and distressed?

↓

Have you checked precipitating factors and strategies to manage behaviour in the support plan?

↓

Liaise with family/carers and people who know the patient best.
Inform them of situation and document the conversation

↓

Refer to de-escalation techniques (see policy and procedures, management of acute aggressive behaviour, appendices F & G) → remember to use the least amount of restriction/restraint and restrictions that are proportionate to the likelihood and seriousness of the harm that may be caused. Commence Behaviour Monitoring Chart (see Frequently Used Forms – D – Dementia)

↓

Complete delirium screening tool and if positive, implement the PINCH ME care plan

↓

Nursing/Medical/Liaison Psychiatry review as needed

↓

Mental Capacity Assessment (MCA) → Decision specific and time specific

↓

Consider making a Deprivation of Liberty Safeguarding application

↓

Complete Situation, Background, Assessment, Recommendation (SBAR) Tool

↓

If 1:1 support is required – consider the following:

↓

- Who is the most appropriate person to provide the 1:1?
  - HCA ☐
  - Q RGN ☐
  - Q RMN ☐
  - MCHFT Security ☐
  - Contract Security ☐ → complete IR1 ☐
  - Combination ☐

→ Security are only to be used as a <u>very</u> last resort, once all other de-escalation measures have failed. Security can only be booked once the circumstances have been discussed with either the Director of Nursing & Quality, Deputy Director of Nursing & Quality, Dignity Matron or SMOC (out of hours).

↓

- Contact the Dementia Lead Nurse/Dignity Matron/Clinical Site Manager (out of hours) for further advice and guidance
- Refer to 1:1 guidelines (Nursing and/or Security)
- Daily review of 1:1 provision

↓

- Refer to Management of Acute Aggressive Behaviour Patient Policy / Rapid Tranquillisation Guidelines (put rapid tranquilisation into search engine – policies & procedures as needed

NB: This is only to be implemented when all other methods of de-escalation have failed

The use of sedatives on patients

The fundamental principles of English Law relating to the medical care and treatment

- In general, it is an assault to perform physically invasive medical treatment without consent.
- A mentally competent adult patient has an absolute right to refuse treatment even if that refusal might lead to his or her death.
- An incompetent patient can lawfully be given such treatment provided it is not contrary to a previously expressed competent decision, it necessary to save life or to prevent deterioration of mental or physical health and is in the patient's best interests.
- A patient lacks the relevant mental competence to make a decision if he or she is incapable of comprehending, believing and weighing information about treatment.

Best interests

Best interests (of a patient) has been defined as being treatment which is necessary to preserve the life, health or well-being of the patient or that which is to be carried out in order to save life or to ensure improvement or prevent deterioration in physical or mental health.

Restraint as last resort-Security Staff only

If a patient becomes violent the use of physical restraint is only necessary when other methods have failed. First try various interactions with the patient: -

a) Individual staff talking to the patient
b) Staff with good relationship talking to patient
c) Senior staff talking to the patient
d) Doctor talking to the patient
e) Two or more people talking to patient
f) Security officer, as an independent party, talking to the patient.

Further guidance

Alcohol Detoxification in adults

Rapid Tranquilisation

Mental Health Liaison Services

To refer a patient to Mental Health Liaison services the below form requires completing. The form can also be found by clicking on the below link and then click 'M' then Mental Health.

Mid Cheshire Hospitals NHS Foundation Trust - Frequently Used Forms

Patients and Visitors.

There are a number of causal factors which may result in a patient, visitor or colleague exhibiting aggressive or violent behaviour in the workplace. An initial assessment of work areas should be undertaken to establish the likely risk of such an event occurring. This will also assist in identifying everyday actions, which can be taken to prevent an incident. As part of the risk assessment process especially in high risk areas where there is a history of violence to ensure that all staff are appropriately trained in Conflict Resolution.

If the risk is presented by a patient; a Psychiatric/Psychological opinion should be professionally obtained at the earliest possible stage where appropriate attention should be taken in relation to any reduction/cessation of anti-psychotic drugs or alcohol withdrawal and an appropriate psychiatric opinion sought.

As part of the overall violence reduction strategy, quarterly meetings of the Violence and aggression forum will identify, by means of incident analyses, areas (such as the Emergency Department-ED) with higher numbers of incidents of Violence and aggression. Incident analyses is dependent on accurate reporting in the first instance. This allows forum member to identify higher risk areas as well as the role of clinical factors, criminality, drugs & alcohol. Importantly, the violence reduction strategy requires that a diversity lens is applied to the understanding of violence aggression. Factors relating to protected characteristics can be found in the incident questionnaire section of Ulysses.

Strategies aimed at reducing incidents of violence and aggression in higher risk areas will have a significant (positive) effect of reducing overall incidents of violence and aggression across the trust.

Security staff have already undergone training around enhanced conflict management, restraint, dementia and mental health, equipping them to deal with actual and potential violence and aggression (with a range of causes) throughout the trust. All staff are trained in Conflict resolution, however additional training will be made available on request and in higher risk areas in de-escalation and “breakaway” training. Simple techniques such as how to dynamically risk assess threats and how best to approach a potentially (be it deliberate or non-deliberate) violent patient can have a marked impact on staff safety and incident numbers. This is aimed at the overall reduction in incidents of violence and aggression across site. Such training is available via the LSMS and Trust Security department. Combination Lone Worker and Breakaway training is available via the same pathway with the emphasis on Violence Reduction, particularly in a community setting.

Information

The provision of information to patients, their friends and relatives is extremely important and can prevent the risk of violence. This is particularly the case in situations of acute distress and/or long waiting periods, and is more relevant to departments such as Accident and Emergency and Outpatients. Information in relation to patient flow through, for example, ED, should be clear and well understood in order to prevent potential misunderstandings and reduce the likelihood of violence and aggression.

Environment

Some individuals may be anxious and apprehensive about unfamiliar surroundings or procedures, in these circumstances they will be provided by staff with sufficient information to reduce any uncertainty and any misunderstanding. It is important that the workplace environment and surroundings are subject to risk assessment in respect of the prevention of violence. Some useful aspects for investigation include: -

- Keeping patients fully informed of what is happening and why.

- Giving each patient a defined personal space.
- Providing diversion activities where appropriate.
- Monitoring the mix of patients.
- Developing nurse/patient allocation systems, consistent application and monitoring any individual programme.
- Ensuring that patients' complaints are dealt with quickly and fairly.
- Removing aggressive patients to a single room or cubicle to protect both the health and safety of other patients and that of the aggressor himself/herself.
- Remove from the aggressor's access, all items such as flower vases etc. which could be used as missiles or to cause damage.
- Check personal belongings for offensive weapons and potential incendiary devices matches, cigarette lighters. Permission from the patient is required. If permission refused seek LSMS/police advice in respect of evidence required for Police to search.
- Staff to maintain regular checks on the patient's demeanour and condition.

Staff.

Keeping staff informed - Information about patients/clients who are being cared for within different departments must be communicated in both written and verbal form particularly when the following applies: -

- New members of staff are involved.
- New patients/clients are admitted.
- There has been a change in the patients/clients medical/physical state, medication, behaviour or mood, etc.
- Known violent patients/clients are being transferred from one department to another. In such cases staff should check the medical case note file for the appropriate alert codes.
- Where domiciliary visits are made to patients/clients with a known or suspected history of aggressive or violent behaviour guidelines in the Lone Worker Procedure should be adhered to.

Workload

When considering these issues it may become appropriate to refer to **Managing the risks associated with work related stress.** In accordance with the Violence Reduction Strategy, there is an important role for staff representation via, for example, trade unions at the Violence and Aggression Forum to highlight anecdotal or Qualitative information regarding the role of workload and stress in reducing violence and aggression. It remains important, however to also consider the following:

- Unpredictable and unremitting workloads which often lead to fatigue and a diminished ability, both to identify at an early stage and to subsequently cope with potentially violent situations.
- The need to provide adequate cover for nights, weekends and changeover periods between shifts.

- Individuals must not be left isolated for long periods, nor should junior or inexperienced staff have to cope alone, especially in situations where there is a recognised potential for violence, or
- Where patients may take advantage. The Trust also has a **Lone Worker Procedure** which provides further guidance.
- Where there is a well-established risk, an agreed minimum number of appropriately qualified staff should be on duty at any one time. Where appropriate nursing staff will be designated to a patient who requires 'special observation'.

Training

All areas should include in the risk assessment the risk to staff when dealing with potentially violent patients / visitors. ALL staff in high risk areas identified by role, incident reports or risk assessment must attend Conflict Resolution Training and if identified by risk assessment Breakaway training.

Management of Patients exhibiting violent behaviour in hospital

The word violence does not necessarily convey the same meaning to everyone. It is often used interchangeably with "aggression" which is the threat of violence, rather than violence itself. On occasions patients act and behave in a manner that can be challenging, common causes for this are listed below. The list is not exhaustive, and for the purpose of this document the causes have been categorized according to those that are likely to be due to a physiological illness or condition and those that are likely to occur as a result of criminality, unacceptable conduct or behaviour.

- An acute confused state or delirium, in circumstances where a patient's symptoms are likely to cause harm to self or others. Severe symptoms are deemed to be a mental health disturbance, under the Mental Health Act 1983.
- An acute or chronic illness that affects the patient's conscious level or usual state of mind, for example low blood oxygen levels, a very high temperature, neurological disorders.
- Acute mental health disturbances in patients who require hospitalization for physiological conditions.
- Patients with chronic mental health problems that may be exacerbated due to the physiological condition
- Patients who are, or are likely to withdraw from alcohol or drugs during the course of their inpatient stay
- Patients who are solvent abusers, known to be alcoholic or who have taken recreational drugs
- Patients being treated who have a history of alcohol or drug addiction that no longer have access to their drug of choice.
- Patients with a history of drug abuse should not have a vascular access device insitu unless it is absolutely unavoidable, and this must be removed at the earliest opportunity.
- Patients who are considered suicidal, i.e. violent against themselves, or destructive (i.e. violent against property) are provided with special care to minimise the risk. Similar consideration should be made when the patient's violence is likely to be directed towards other people.

Additional advice.

It can be disconcerting that often the person who is being violent is the very person for whom you are caring. Sometimes the abuse comes out if the patient is in pain or distressed. More often, anxious partners or relatives may be threatening violence. Either way you are faced with a very difficult and disturbing situation. The principal aim for staff is to establish a relationship of trust and understanding with the patient, relative, friend or visitor so that they can express tensions and anxieties before reaching a state where they release them through violent behaviour.

It is recognised that the management of such patients requires skill of a high order. Always be aware which member of staff has the best relationship with the patient. It is usually the case that if this member of staff shows an interest the patient will unburden themselves. Other staff should always be aware that this is the right person in most instances to deal with the situation initially regardless of status or seniority. However, this does not imply that only one member of the team should form a good relationship with the patient. It is obviously essential to widen the patient's contact with the staff.

Always be as straightforward as possible with the patient and never promise to do anything that cannot be carried out. If a patient asks for something to be done and it cannot be achieved, then tell the patient why. Staff must learn to recognise hostility in them towards patients and discuss this freely in the ward/department meetings as hostility in the staff may cause hostility in the patient. Patients must never be threatened in any way.

Staff should also remember that their own behaviour may, unintentionally, trigger a violent response from a patient. Understanding of models such as Betaris Box (Conflict resolution Training) play a role here. Trying to avoid aggression and violence by all possible means should not be interpreted as weakness by staff. Quite often, it may be wise to let a difficult situation quieten down somewhat and approach the patient later. Avoid violence wherever possible and always remember that any incident of violent or aggressive behaviour should be managed as a process of continual de-escalation with an overall process of violence reduction being key.

Patient's biography

Know each individual patient's biography, e.g. any likes or dislikes, associated disorder or perception difficulties. A nursing care plan should be written for every patient as soon after admission as practicable. Even though it may be brief initially, it offers a documented guide to staff on how to approach and nurse the patient. This helps prevent staff approaching a patient in ways that are known to provoke. One should not have to receive a blow to discover a patient's idiosyncrasies. Care plans must always reflect the agreed team management of each individual patient.

Try to get the patient to express their feelings. Usually this helps and results in the reduced necessity for them to resort to violence. Remember if this is a clinical issue a doctor will decide if medicines are needed.

Delegate staff:

- to be with the other patients;
- to call the senior nurse manager/bleep holder;
- to call the doctor and duty security officer
- to get medicines ready, if prescribed.

Instructions for staff dealing with violent, confused, disturbed patients and violent and abusive visitors.

Whilst it is not possible to apply rigid rules to cover all contingencies involving violent, confused, disturbed, uncooperative or missing patients and violent or abusive visitors in a busy hospital or indeed community environment the following instructions provide some basic principles which must be observed. All such incidents must be reported in detail. Such reporting should also include reference to location and factors such as clinical causes, drugs or alcohol. Also remember that the violence reduction strategy instructs us to apply a diversity lens to incidents of violence and aggression as this relates to the perpetrators or underlying victimology of the participants.

Violent patients

Where all other interventions have failed staff can call from assistance from the Security Team. This applies to incidents at Leighton, the police may have to be called for assistance in a community setting. In the event of a call for assistance from any member of staff to a violent or aggressive patient posing a potential risk of injury to self or others, the Security Officer should immediately act to de-escalate the incident. Where possible this should be achieved by means of sympathetic persuasion, tact, good humour and a display of willingness to deal with any complaint or perceived problem. This should have the effect of allaying any sense of grievance or fear which the patient may have. If all else fails and certainly before any harm can be inflicted, the use of physical intervention may become necessary. The application of physical restraint should always be lawful, safe and reasonable under the circumstances and must always be the absolute minimum force necessary. In circumstances of physical restraint, the Security Officer will be expected to act as 'Team Leader' to achieve this purpose and co-ordinate the action of the staff present. Remember that Security Officers are trained and certified to use physical restraint when no other option is available at that point in time.

In order that the patient and anybody else who may be in the vicinity understands the reason for the course of action as soon as the violent patient is restrained it is the duty of the Security Officer to clearly and distinctly tell the patient "We are restraining you to prevent you hurting yourself or anyone else". This will also have the purpose of declaring a lawful course of action which will be recorded on the Security Officer's Body Worn Video. This will allow the Trust Security Team to record the incident of physical intervention to a high evidential standard should this be required. Such recorded incidents also provide a valuable training tool for the Security team to meet the requirement of the Violence Reduction strategy and the Security department's aim of continuous improvement. If, after all efforts to calm the patient the violent behaviour continues the Security Officer must ask a member of the nursing staff to summon a doctor immediately if this has not already been done. It may become necessary to request the assistance of the police and/or meet the threshold for the procedure on **Rapid Tranquilisation**

Clinical Care

If, upon arrival, the doctor is also unable to pacify the patient, they may as a last resort acting on behalf of the consultant and in the **patient's** best interests under Common Law prescribe a sedative, see **Rapid Tranquilisation** procedure. Security Officer's are trained to a standard authorising them to assist in the administration of medication and will, if the doctor so requests, assist to restrain the patient whilst the sedative is being administered. The security officer will remain until it has taken effect, or the doctor indicates the patient to be no longer a danger to self or others. The clinical reason for administering sedation should be recorded in the patient's notes as soon as possible after the event.

If the doctor decides that sedation is inappropriate on the grounds that the violent behaviour is attributable neither to illness nor to previous medication, but rather to aggressive

personality, substance abuse or criminal intent, and if firm and compassionate persuasion or firm cautionary advice fails to persuade the patient to desist, and a breach of the peace continues, the police, as a last resort, must be called to deal with the matter. The Security Officer will remain to restrain the patient. This should be a joint decision by security and the lead clinician.

Dealing with uncooperative patients.

If called by a member of nursing staff to a patient who although not acting violently is refusing to co-operate by allowing the administration of prescribed medicine the correct procedure is for the nursing staff to enter the refusal on the patient's notes and **not** administer the medicine if reasonable persuasion is unsuccessful.

If the nursing staff indicate that they wish to administer the medication forcibly and ask for assistance in restraining the patient the Security Officer should explain that they cannot assist and call the Sister or Charge Nurse, if on duty, or the appropriate senior nurse/bleep holder.

When the appropriate manager responds and arrives, they must be informed of the circumstances and told that a Security Officer does not have power to restrain a patient who is merely being uncooperative (and is deemed to have the capacity to make decisions) and who does not wish to take the medicine or to have it administered.

In the event of a call for assistance from nursing staff for patients who are making a nuisance of themselves by wandering around the wards and inconveniencing staff and other patients with impolite or unwanted conversation, encroachment or other interference; security officers will assist nursing staff by explaining to the patient, the necessity for good order and reasonable behaviour in wards and other treatment areas, and then remain with the patient until an acceptable level of behaviour has been achieved. Persistent nuisance should be reported to the appropriate manager/bleep holder, to discuss measures to alleviate the difficulty. It is not appropriate to physically restrain the patient under these circumstances.

Guidance on the role of Security Officers called to assist with patients with a mental disorder.

The purpose of this section is to ensure that that there is a clear understanding by medical, nursing and security staff on the role of the security officers with regard to the supervision of persons awaiting psychiatric assessment and of psychiatric patients.

Whenever security staff have been called by nursing/medical staff to deal with a difficult or (potentially) dangerous individual, they should receive as full a brief as is possible with regard to:

- The mental state of the individual;
- The likely risk of self-harm or harm to others;
- The existence of any document/exercise of any power preventing the patient from leaving;
- Whether they are carrying weapons of any kind;
- Any special risks posed by the individual;
- Whether the condition is alcohol/drug induced.
- Any ICS risk codes on patients record

This list is not exhaustive and staff should not expose themselves to unnecessary risk in trying to establish all the facts, e.g. whether the individual has a weapon.

The purpose of this brief is to allow the security staff to judge how best the individual should be addressed with minimum risk to everyone involved.

Obviously in some circumstances where safety of individuals is at immediate risk it may not be possible to give a brief. Where there is sufficient time security staff should be briefed without necessarily having to compromise patient confidentiality. In all circumstances where it is necessary to restrain an individual only reasonable force may be used. Any method of restraint which involves force in excess of reasonable force after the immediate crisis is over is not justified by law.

Individuals not placed on a section of the Mental Health Act. (MHA).

Where a person is waiting to be seen by a psychiatrist and there is reason to believe that the patient may be at risk to him/herself or others but has **not** been placed on a Section 5(2) or 5(4) of the MHA then security staff may be asked to attend to ensure no-one comes to any harm.

A security officer should not in normal circumstances be left alone with a psychiatric patient. Security staff are neither trained nor qualified to observe that individual and appropriate steps should be taken to assess the patient for the purposes of placing him or her on a section.

Common Law powers.

If the same patient wishes to leave the ward, department or hospital and has still not been placed on a section then security staff may be requested under **Common Law by a nurse or doctor** to apprehend and restrain a person who is mentally disordered **and** if there are reasonable grounds to believe that they present an imminent danger to himself or others.

Security staff will confirm with the nurse or doctor that the patient is an imminent danger to himself or others before apprehending and/or restraining that person. Only 'reasonable force' may be used to restrain the patient. It may be possible for security staff to follow the person whilst on Trust Premises and around the area of the Hospital covered by CCTV whilst the police are being called. By following the person security staff can liaise with the police via radio and phone to save police time in finding the person.

Police Powers

If such a person decides to leave and it is not possible to detain that individual it is the responsibility of nursing/medical staff to contact the Police. The police will then search for the person and if necessary, take them to the police station on a Section 136 of the MHA under Police powers to remove a person to a place of safety. The designated place of safety for this area is the police station **not** the hospital. However local Place of Safety agreements may be in place between Police and NHS Trust's i.e Mental Health facility/services at a nearby Trust. Police stations and custody suites are usually used as a place of safety as a last resort when extreme violence is used, has been used or is likely to be used or a serious crime has been committed.

Mental Health Act Sections 5(2) and 5(4)

If a person is at risk to themselves or others and is wishing to leave the hospital and a Section 5(2) has been applied then security staff may be asked to attend to ensure that nursing/medical staff do not come to any harm when there are concerns for their safety. Again, a security officer is not to be left alone with a psychiatric patient. Whilst the patient is being held on a Section 5(2) security staff may be asked to detain a patient if they attempt to leave using minimum reasonable force where necessary. Security staff are to be shown the documentation to satisfy themselves that the patient has been placed on a section and that they are not being asked to do something which could be illegal. Requesting that Security Officers effectively detain a person without providing them assurance that the patient is

effectively under a section as detailed above puts them in a compromised position. Doing this does not compromise patient confidentiality.

Under a Section 5(4) of the MHA a registered nurse is allowed to informally detain a patient who is already being treated for mental disorders for up to 6 hours. A registered nurse in this context is a Mental Health Liaison Nurse. Security Officers may assist in the restraint of a patient in the same way as under a Section 5(2) of the MHA. If it is necessary to use a security officer he or she should keep as low a profile as possible in the circumstances since the presence of a uniformed security officer can exacerbate an already potentially violent situation. It is important that a professional and

"Specialling" of patients deemed to be mentally ill.

A patient will need to be 'specialled' when:

- He/she is thought to be at risk of self-harm/suicide and/or attempting to leave the ward/department.
- Other people may be placed at risk by the patient's actions.
- He/she is thought to be vulnerable for example at risk of falling over etc. due to mental state. (Please note that the inclusion of Security Presence for falls prevention is not appropriate)

Security 1 to 1 presence for violent patients.

The rules on "specialling" are to ensure that observation of a patient is carried out on a one-to-one basis by a designated nurse. If there are concerns about the safety of staff carrying out the observation, then obviously there is a role for security staff to play in protecting the staff but not "observing" the patient. Security staff are not to observe a patient because there are not enough nurses. It is the responsibility of the relevant Division to secure the appropriate level of staffing required.

It must be stressed that the in-house Security Department does not have the resources to provide a continuous presence for an in-patient being observed on a ward (i.e. special led) on the off chance that something untoward may occur. If staff or others are being threatened or attacked then the ward manager/senior staff on duty will complete the Security 1 to 1 risk assessment (available on the Trust Intranet on frequently used forms, **Security Presence Request form**) and request Security staff presence. This will be arranged by the on-duty Security Manager after agreement from the Modern Matron/Senior Manager that the presence is required. This will be provided by an Approved Security Contractor registered with the Security Industry Authority Approved Contractor Scheme and experienced in 1 to 1 or Bed-watch duties. Police assistance should only be requested in extreme instances of violence where the Security staff cannot control the incident. Security staff and the police will stay until the patient has calmed down to a state where the Police presence is no longer needed. Incidents like this will require close liaison between Police, nursing and security staff as to when it is safe for the Police to leave.

Considerations for Security Presence

Careful consideration should be given to the degree of involvement by a security officer. Some mental health patient's behaviour deteriorates when in the presence of a uniformed officer; therefore, it may be prudent in some circumstances that the security officer maintains as low a profile as possible in the circumstances. Particular care must be taken to avoid using more than reasonable force to quell a disturbance. When the Mental Health patient is female, and a male security officer is requested to attend the accompanying nurse should be female since two males left alone with a female are leaving themselves open to false

charges of sexual assault or harassment. Where male security presence is unavoidable, a male officer should not be left alone with a female patient for the same reasons and arena of safety guidelines should be followed at all times.

Reporting.

As soon as possible after an incident has concluded the Trust's Incident Report form must be completed. The form should be used to record physical and non-physical incidents. Reporting incidents which may seem minor or incidents which are deemed to be clinically induced is equally important as these can often escalate into more serious behaviour. Incident information must also include reasons for the incident such as clinical confusion, alcohol de-tox or deliberate behaviour. In line with the overall violence reduction strategy a diversity lens should be applied to all incidents of aggressive behaviour and note should be made (Questionnaire section of Ulysses) of any incident factors related to protected characteristics. It is important to note that failure to report an assault to the LSMS/Police could adversely affect any claim for compensation under the Criminal Injuries Compensation Authority Scheme. The presence of a mental illness for example should not automatically be used as a reason not to report the assault.

Support for staff.

The Trust acknowledges that its staff may be affected physically or emotionally following a violent incident. Managers need to be aware therefore that individuals will need active support and counseling especially after the incident and on resuming or returning to work. This is particularly important given the potential impact of stress on the employee's current or future health. It is therefore essential that the line manager conduct a full debriefing of all staff involved in a violent episode. This should include the arrangement of professional counselling via the Occupational Health Department for all those who wish to avail themselves of it. Staff can also contact Victim Support. The manager should also arrange a follow-up meeting within two weeks of the debriefing. If a member of staff is subject to verbal abuse, threatening behaviour or assault from a colleague then the **Trusts Equality and Diversity Policy (Dignity at Work)** should be referred to and an incident form completed. This is an important component of the trust violence reduction strategy in the application of a diversity lens to incident and post incident follow up. The attendance of staff representation (trade unions) at the violence and aggression forums as part of the trust violence reduction strategy should also be seen as an additional and important measure for highlighting the importance of staff support following incidents of Violence and aggression.

Legal action following an assault.

Where deliberate assaults with no clinical cause do take place the Trust's security officers and the police should invariably be involved with the incident either by protecting the member of staff being attacked, restraining the assailant and/or by arresting the individual. After any assault the victim may want to know what is happening to the aggressor. It is essential that the victim knows the Trust is doing all it can to help after an assault has taken place. Any incident of assault will be subject to an investigation and the LSMS and Health & Safety Lead will be part of the review team. The Civil Court Process may provide additional or alternative avenues for dealing with assailants (e.g. injunctions, claim for damages, anti-social behaviour orders etc.)

There are many instances where a referral would be appropriate. This may Include cases where:

- The police have not attended

- The police have attended but have decided not to investigate
- The police have investigated but have decided not to take the matter any further
- The police have suggested a 'civil remedy' is sought
- The CPS have had the matter referred by the police but have decided not to take any action

Options available to the victim after an assault has taken place.

The member of staff assaulted (the victim) must make a statement to the Police if they wish a prosecution to be pursued with any chance of success. When giving the statement the victim has two options on how he/she wishes to be kept informed of subsequent proceedings:

- The victim can allow the normal course of events to be followed, in which case he/she would be kept informed of proceedings by the authorities. The Trust would not be involved in any legal capacity in pursuing the prosecution nor would the Trust be allowed any access by the Police to information regarding the assault for fear of compromising the prosecution case. The member of staff if they wish may contact the LSMS who will provide appropriate support, advice and guidance if required.
- The victim can tell the police officer taking the statement that he/she wishes the Trust to act on their behalf in the matter. The LSMS would then maintain communications with the police in order to be kept fully informed of developments regarding the assault and lead on the co-ordination of the case.

Procedure to be followed after an arrest has taken place and the Trust has been appointed as agent by the victim.

- Inform Security extension and bleep 2999 if not involved already.
- Victim to complete an Incident Form, with the help of immediate line manager.

Contact the LSMS as soon as possible on ext. 2088 who will contact the Police to establish:

- if the offender has been charged or not.
- if the offender has been charged whether he/she has been bailed or is in custody.
- if the offender has been charged when he/she is due to appear in court.
- if the offender has not been charged, to establish reason why and has the offender received a caution.

The LSMS will then inform the Line Manager of the information received from the police who will then inform the staff member of these facts. Where the offender is due in court, but the victim is not required to give evidence, the Trust will give the victim the opportunity to attend court if they wish and offer that an appropriate manager will accompany them to court if requested.

Procedure to be followed after an arrest for assault has taken place and the victim does not wish the Trust to act as agent

The Trust will take no part in the subsequent proceedings but will give the victim time off to attend court if requested and offer an appropriate manager to accompany the victim to court.

NOTE: Where the assault is committed by an individual who is subsequently diagnosed as mentally ill, it is highly probable that the offender will not be prosecuted either by the CPS or by the Trust on legal and medical grounds.

The use of Control and Restraint techniques.

This section gives guidelines on dealing with incidents when it becomes necessary for staff trained in approved control and restraint techniques to restrain an individual. The emphasis is to prevent violence against staff however when the application of an approved restraint technique is carried out it must be with the use of minimum reasonable force considering all the circumstances applicable at the time of application. This must be an on-going process throughout the use of the approved technique. De-escalation should also be a continuous process with the aim of exiting from any position of restraint as soon as it is possible to do so. Every other option and means of preventing, controlling, and diffusing a situation should be attempted before there is any physical interaction with a violent person. Security Staff employing restraint techniques or staff making a request for third party restraint, on patients or visitors must be clear that they understand why they are using those techniques.

Should the occasion arise when a member of staff has reasonable grounds to believe their safety is at imminent risk from personal attack or they are being assaulted they may use minimum reasonable force to effect an escape from the situation but not to incapacitate the attacker totally, i.e. they are breaking away from the situation. The concept of reasonableness is somewhat flexible and will obviously vary with the circumstances. Once the escape is affected and the member of staff is no longer at risk then the use of physical force is no longer permissible, the use of force is an immediate reaction to risk and not a follow up process.

Any member of staff who uses physical force to protect themselves must be prepared to defend their actions in a court of law to prove that they did use minimum reasonable force against an attacker.

Examples of occasions where use of control and restraint techniques may be required are;

- Assault: There are reasonable grounds to believe that an assault is imminent if the aggressor is not restrained.
- Behaviour of an individual is such that he/she needs to be restrained until the arrival of the police
- To stop a breach of the peace
- Removal of individuals from the Trust

Where an individual's behaviour is deemed to be causing a breach of the peace, it may be necessary to remove that individual from the premises. A breach of the peace occurs whenever harm is actually done or is likely to be done to a person or in his presence to his property. It also occurs when a person is in fear of being so harmed through an assault, affray, unlawful assembly, riot or other disturbance. Where the offender is a patient then security officers must establish with the senior nurse on duty or doctor in the department or ward that there are no medical or nursing reasons why that patient cannot be removed from the premises. Only when that has been established can the security officer ask that person to leave, explaining the reasons why, i.e. their behaviour is causing distress and is unacceptable. Should the person refuse to leave the premises then security officers may physically remove that person from the premises using minimum reasonable force. Should the security officer believe that it would not be safe for him/her to remove the person or that the offender is likely to return as soon as they have been removed then the police should be contacted and asked to remove the individual. The security officer should remain with the offender until the police have arrived and the matter is resolved. Removal of persons from

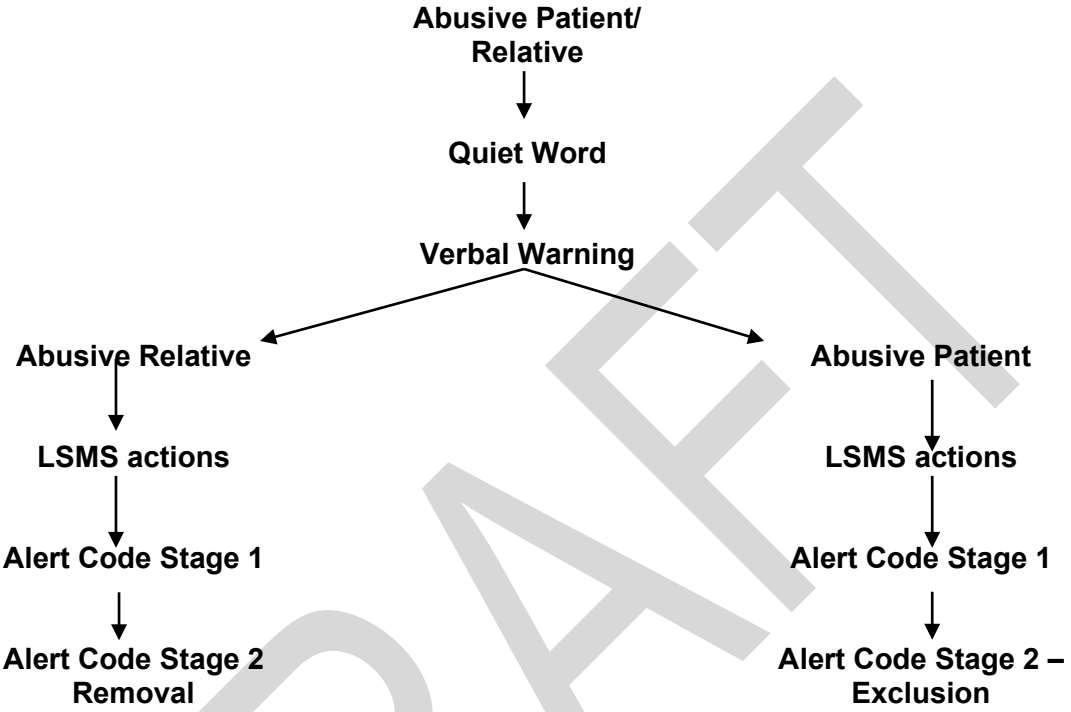
Trust Premises is largely covered by Section 119-120 of the Criminal Justice and immigration Act (CJIA) (2008) providing the rationale and legal framework for decisions around such removals.

Alert Codes and withholding of treatment.

The Trust's procedures for identifying patients and/or their relatives who have a history of verbal or physical abuse towards staff or Trust property is through the use of Alert Codes stage 1 and stage 2.

FLOW CHART FOR THE USE OF ALERT CODES TO IDENTIFY PATIENTS AND/OR RELATIVES WHO HAVE A HISTORY OF VERBAL OR PHYSICAL ABUSE TOWARDS STAFF OR PROPERTY

What to do:



Guideline for the Use of Alert Codes and Withholding of Treatment.

(for individuals who have a history of verbal or physical abuse towards staff)

Where a patient and/or relative (adult aged 16 or over) has a known history of verbal or physical abuse to staff, and/or has in the present episode of care displayed such behaviour that staff have felt their safety compromised then the following action should be taken:-

Quiet Word - The patient and/or relative should be spoken to quietly as per conflict resolution training and informed that in the interest of staff and patient safety this behaviour will not be tolerated in any area of the hospital - an investigation should be carried out by the senior staff member present to establish what is causing the abuse.

Verbal Warning - The patient and/or relative should be given a verbal warning stating that their behaviour is unacceptable and unless his/her behaviour ceases the matter will be reported to the LSMS who will consider all the evidence and take appropriate actions that may include an Alert Code Stage 1 being issued. A record of the incident will be placed within the patient's medical record if the patient is the aggressor and also a note made within the patients record if the relative is the aggressor. An investigation should be carried out by the senior staff member present to establish what is causing the abuse.

Local Security Management Specialist (LSMS) Actions. - The LSMS will review the evidence contained in the incident report forms and gather evidence from all sources to review the action to be taken. This may include writing to the patient/visitor outlining the unacceptable behaviour, arranging a meeting to discuss the incident(s), asking the

patient/visitor to sign an Acknowledgement of Reasonable Behaviour Agreement (ARA) and arranging if necessary a multi-agency meeting to agree a unified course of action/support.
If the patient and/or relative re-offend the **(LSMS)** will then consider the next course of action which may include escalating to an Alert Code Stage 1.

Relative alert code stage 1

- An incident form is completed by each member of staff involved.
- Review of the incident with ward/department manager the LSMS and the Directorate Manager and/or Clinical Director/Lead Consultant.
- Ensure that a senior member of staff witnesses the explanation to the relative.
- **The relative is then removed from the Trust premises.**
- Submit to the Chief Executive's office for signature.
- Issue the standard letter to the relative.
- The full process must be recorded in the appropriate patient's medical/nursing documentation and the ICS system.

Patient alert code stage 1

- An incident form is completed by each member of staff involved
- Inform and seek advice from the patient's consultant or senior member of the medical team their General Practitioner (G.P.) if necessary.
- Inform the patient of the ward staff's concerns and fully explain the Alert Code Stage 1 procedure, ensuring that there is no confusion as to the standard of behaviour required or the possible consequences of failure to comply.
- Complete all patient details on the confirmation of Alert Code Stage 1
- Ask the patient to sign the confirmation of Alert Code Stage 1. If the patient refuses to sign, this should be documented but explained to the patient that the document will be valid with or without the patient's agreement.
- Ensure that a senior member of staff witnesses the explanation to the patient and also signs.
- Give the patient a copy of the confirmation of Alert Code Stage 1 and a copy of the policy itself.
- Prepare a copy of the standard letter for issue to the patient's GP This letter should be signed and sent by the Directorate Manager. A copy of the policy should be attached.
- Review of the incident with ward/department manager, the LSMS and the Directorate Manager and/or Clinical Director/Lead Consultant.
- Prepare a copy of the standard letter for issue to the patient and forward to the Chief Executive's office for signature.
- Copies of the Confirmation of Alert Code Stage 1 should be inputted into the ICS system. A copy must be kept in the front of the patients notes situated on the Red Alert Card (once the ICS alert code is in place this will be used to record Yellow Card status.)

- The ICS system will be coded with a # symbol and the code will be "SOB" i.e. standard of behavior. Training will be given to the relevant staff by the IT Department.
- The full process must be recorded in the patient's medical and nursing documentation.

Patient alert code stage 2- Exclusion Checklist

- The decision to withdraw treatment can only be taken by both the relevant Divisional General Manager and the Associate Clinical Director (or, in their absence, the Medical Director), once alternate care arrangements have been made. This does not preclude the relevant clinician discharging a patient who no longer requires inpatient care in the normal manner.
- The responsible consultant must be informed and write to the patient's GP the exclusion and the reasons for it.
- The patient must be informed that they may challenge exclusion via the established complaints procedure.
- The Chief Executive must be informed who will dispatch written confirmation to the patient's home.
- The LSMS must also be informed. A detailed record of the rationale for exclusion and of the alternative arrangements for care should be kept in the patient's health records and nursing documentation.
- If an excluded individual returns in any circumstances other than a medical emergency, security staff should be called immediately. The Trust will subsequently seek legal redress to prevent the individual from returning to Trust property.
- The exclusion will last one year, subject to alternative care arrangements being made. The provision of such arrangements will be pursued with vigour by the relevant clinician. In the event of an excluded individual presenting at the Accident and Emergency Department/Minor Injuries Unit for emergency treatment, that individual will be treated and stabilised with, if necessary, security staff in attendance. Where possible, they would then be transferred immediately. However, if admission is unavoidable,
- Security staff will be informed and their attendance will be determined by a senior member of clinical staff.
- Any patient behaving unlawfully will be reported to the police and the Trust will seek the application of the maximum penalties available in law. The Trust will prosecute all perpetrators of crime on or against Trust property, assets and staff.

Alert Code Stage 2 - Exclusion Checklist – Relatives

- The decision to exclude a relative can only be taken by the Chief Executive when threatening behaviour continues to Trust staff and patients following the issue of an Alert Code Stage 1.
- An Alert Stage Code 2 will be issued to the relative from the Chief Executive.
- A note will be placed on the patient's notes regarding the relative's behaviour and this will also be noted in the ICS system.
- Staff will be advised to periodically check that the threatening relative does not attend at visiting or other times. If the relative in question continues to visit, staff are advised to contact the LSMS for further action.

- The LSMS will assess and take advice on reinforcing the exclusion and the potential of legal action taken against the aggressor.

ALERT CODE NUMBERED CODES

This Alert code should be recorded on the Alert Sticker that is kept on the front inside cover of the patient's medical case-note (please note no written text). This will inform any staff in the future that the patient has a history of such behaviour.

The following numbered codes are to be used: -

1a - Patient's relatives have a history of verbal abuse

1b - Patient has a history of verbal abuse

These codes are also used on the Trusts ICS system.

Letters.

Alert code letters will be issued through the LSMS (leslie.jackson@mcht.nhs.uk)

Clinical Review Checklist

In the event of inappropriate behaviour by a patient and following careful review by the individual's clinical team the Alert Code Stage 1 can be instigated. Those patients who in the expert judgement of the relevant clinician are not competent to take responsibility for their actions will not be subject to this procedure.

Review to include:

- Is the patient/relatives known to have a history of violence? Yes/No
- Is the patient suffering from a medical condition to cause him/her to be violent? Yes/No
- If yes, what?
- Has the patient suffered from a previous head injury? Yes/No
- Is the patient suffering from mental illness? Yes/No
- Does the patient have a history of alcohol abuse? Yes/No
- Does the patient have a history of drug abuse? Yes/No
- Agreement that the Alert Code is to be used Yes/No

WITNESS FOR THE TRUST (Initiator of Procedure, patients clinical team member)			
Name:		Name:	
DESIGNATION:		**DESIGNATION:**	
Signed:	Dated:	Signed:	Dated:

Confirmation of Alert Code Stage 1

Division _____ Ward/Dept.

Patient's Name _____

Hospital Number _____

Home Address _____

_____

Contact Next of Kin _____

Their address _____

_____

G.P.'s Name _____

G.P.'s Address & Telephone number _____

_____

The consequences of a failure to comply with the Alert Code Stage 1 have been fully explained and I understand my G.P. will be informed.

I agree to comply with the expected behaviour set out in the policy under which care will be provided at the Mid Cheshire Hospitals NHS Foundation Trust.

Signed _____ Date _____

* Delete if refused

WITNESSES FOR THE TRUST
(Initiator of Procedure)

NAME _____ NAME _____

DESIGNATION _____ DESIGNATION _____

Signed _____ Date _____ Signed _____ Date _____

Examples of appropriate members of staff able to initiate the Procedure: -

Directorate Manager, Clinical Director; Director of Nursing, Executive Director; Senior Nurse; Security Manager; Senior Clinician (registrar or above); Senior Sister/Charge Nurse
Out of Hours. Executive Director on call, Nurse Manager on Call

3 Definitions

Acute care setting: short-term (approximately 30 days) inpatient care or emergency services or other 24-hour urgent care settings (Source: NICE CG25).

Aggression: a disposition, a willingness to inflict harm, regardless of whether this is behaviourally or verbally expressed and regardless of whether physical harm is sustained (Source: NICE CG25).

Assault: an assault is "Any act which intentionally or recklessly causes another person to apprehend immediate and unlawful personal violence"

4 Associated Documents

Health & Safety Policy
Fire Safety Policy
Lone Worker Procedure
Trust Violence Reduction Strategy

5 Duties

The Trust Board is accountable for the provision of security within the Trust that provides safeguards to protect patients, staff and visitors and their property and belongings.

The Director of Finance is the designated **Executive Lead for Violence Reduction** for the Trust, however the Local Security Management Specialist (LSMS) will be the operational lead for violence Reduction. Divisional Directors and Line Managers will implement the Trusts violence Reduction strategy and will ensure that appropriate violence reduction training is provided in their areas of responsibility.

5.1 Duties within the Organisation

5.2 Security Management Specialist/Violence Reduction Operational Lead

- Responsible for the effective implementation of all security procedures.
- Takes the lead at the trust in matters relating to violence prevention and reduction
- Takes the lead on the provision of training around violence prevention and reduction.
- Responsible for providing the Executive Violence Reduction Lead with Violence Prevention and Reduction performance audits on a twice-yearly basis, or following a serious incident.
- Responsible for carrying out full investigations in line with Trust Policies and taking appropriate action with the Police, Prosecution and Legal services.
- Will review risk assessments and security incidents to identify trends / hot spots and develop a Trust wide Action Plan where necessary to address issues raised

5.3 Divisional Directors/Divisional Risk & Governance Manager / Line managers.

- Will ensure that, as far as is reasonably practicable, security and the safety of patients, visitors and staff are reflected in all appropriate departmental procedures. Such procedures will require regular monitoring, review and updating as necessary.

5.4 Wards and Departmental Managers.

- Ward and Departmental Managers are responsible for notifying all new and existing staff of how to access the current Trust Security policy document and other relevant documents.
- Ward and Departmental Managers will ensure that all staff are aware of their responsibility in maintaining compliance with the Trust Security policy document.

- Have direct accountability for the management of violence and aggression in their area of responsibility.
- Adhere to the Management of Aggression Pathway, see section 2
  Provide adequate cover for nights, weekends and changeover periods between Shifts.
- Ensure there is an appropriate skill mix on the ward and staffing levels reflect the needs of patient dependency.
- Ensure there are appropriately trained staff on duty, to de-escalate potential violent situations or cope with those that may develop
- Identify when to involve mental health professionals and who to contact
- Perform a risk assessment and include relevant information on the Ulysses risk reporting system.
- Identify any training needs of staff in respect of managing violence and aggression and control and restraint/breakaway/Lone Worker training.
- Perform a post incident review to determine any changes to a patient's care plan or to extract lessons for the future.
- Ensure that persons included in the incident are supported post incident.
- Remember that colleagues or patients who were present at the incident may all be shaken and possibly emotionally distressed. Occupational Health may well need to be contacted.
- Ensure staff receive relevant training on how to deal with aggressive patients / visitors.

5.5 Individual Staff:

- Read and comply with the Trust Security policy document.
- Read and comply with the Trust Violence Reduction Strategy
- Attend training and awareness sessions to familiarise themselves with and comply with, all Trust documents relevant to their role and responsibilities.
- Have an awareness of their own behaviour in dealing with violence and should interact with clients in a manner which minimises the likelihood of an aggressive incident occurring.
- Ensure the safety of persons receiving treatment or care in the hospital as far as is possible.
- Report identified risks to their line manager.
- Ensure that all incidents of Violence and Aggression are reported in line with trust procedures and apply a diversity lens to understanding and reporting.

- Ensure they follow guidelines and pathway put in place to minimise the risk of violent incidents occurring.
- Ensure they follow guidelines and pathways put in place to minimise the risk of violent incidents occurring and manage incidents effectively.
- Ensure they follow guidelines and pathways put in place to minimise the risk of violent incidents occurring and manage incidents effectively.
- Work in accordance with training provided

6 Consultation and Communication with Stakeholders

- Health & Safety Group
- Director of Nursing Quality
- **Quality and Governance managers**
- Estates & Facilities Divisional Senior Team
- Legal Services Manager
- Divisional General Managers
- Matrons
- Ward / Department Managers
- Governance.policies@mcht.nhs.uk

7 Implementation

This procedure will be implemented by Matrons responsible for the Division.
This document will be implemented as part of the Violence Prevention and reduction standards (December 2020) as part of the standard contract through 2021/2022
This document will be implemented by Divisional Board meetings and evidence of this can be demonstrated in the Divisional Board minutes. This document will be available on the Trust Intranet for all staff to access.
Please provide evidence of implementation as this will be required for review by external agencies e.g. the National Health Service Litigation Authority (NHSLA) standards and the Care Quality Commission (CQC).

8 Education and Training

It is the responsibility of line managers to identify any staff training needs. Any training regarding this policy will be delivered by an approved member of staff qualified to deliver such training. Staff who work in areas which have been identified as high risk will attend. Ad hoc training in areas identified as high risk by incident reporting/or the Trust risk management systems.

9 Monitoring and Review

The document will be monitored and reviewed by:

- Security Audits
- Trust Health & Safety Group
- Divisional Quality and Governance Managers

9.1 Action Plan

The MCHFT Trust Gap Analysis/Action Plan must be used to demonstrate effective monitoring of all documents. This can be found on the intranet in frequently used forms.

9.2 Audit Pro Forma

Standard/process/issue required to be monitored	Monitoring and Audit			
	Process for monitoring e.g. audit	Responsible individual /group	Frequency of monitoring	Responsible committee
Compliance with Policy & effectiveness of Guideline	Incident Investigation Ulysses monitoring	Local Security Management Specialist (LSMS)	Annually	Health & Safety Group

10 References / Bibliography

Health and Safety at Work Etc. Act 1974
Management of Health and Safety at Work Regulations 1999 as amended

11 Appendices

All Appendices must be in numerical order 1, 2, 3 etc. and positioned before the mandatory appendices below.

A Version Control Document
B Communication / Training plan
C Equality Impact and Assessment Tool

APPENIDX A - Control Sheet

This must be completed and form part of the document appendices each time the document is updated and approved.

VERSION CONTROL SHEET			
Date dd/mm/yy	**Version**	**Author**	**Reason for changes**
June 2021	1	Local Security Management Specialist. (LSMS)	"Management of Acute Aggressive Behaviour" updated to account for Violence Reduction Strategy

APPENDIX B - Training needs analysis

Communication/Training Plan (for all new / reviewed documents)	
Goal/purpose of the communication/training plan	To communicate the Trusts up to date Management of Aggressive Behaviour Procedure giving clear specific guidance on all aspects of operational and strategic procedures associated with Violence and Aggression
Target groups for the communication/training plan	• All Staff • Contractors / Stakeholders
Target numbers	• All site Users
Methodology – how will the communication or training be carried out?	Communicated plan will be: • Sent to all Wards and Departments • Uploaded onto the Trusts Intranet • Raised through awareness
Communication/training delivery	• Local Security Management Specialist • Security Operations Manager
Funding	• No Funding Required
Measurement of success. Learning outcomes and/or objectives	• Ensure compliance with document through audit. • Completion of paperwork • Comply with NHS Protect guidance.
Review effectiveness – learning outputs	• Measure against Goal/Purpose • Did it achieve what it set out to achieve? • Review of further communication or training needs
Issue date of Document	March 2019
Start and completion date of communication/training plan	
Support from Learning & Development Services	Assistance from L+D not required during communication process.

For assistance in completing the Communication / Training Plan please contact the MCHT Learning and Development Services

Mid Cheshire Hospitals
NHS Foundation Trust

APPENDIX C - Form 1

Equality Impact Screening Assessment

Please read the Guide to Equality Impact Assessment before completing this form. To be completed and form part of the policy or other document appendices when submitted to governance-policies@mcht.nhs.uk for consideration and approval or to be completed and form part of the appendices for proposals/business cases to amend, introduce or discontinue services.

Guideline- Managing Aggressive Behaviour (Patients, Visitors and Relatives)

		Yes/ No	Justification and Data Sources
A	**Does the document, proposal or service affect one group less or more favourably than another on the basis of:**		
1	Race, ethnic origins (including gypsies and travellers) or nationality	**NO**	
2	Sex	**NO**	
3	Transgender	**NO**	
4	Pregnancy or maternity	**NO**	
5	Marriage or civil partnership	**NO**	
6	Sexual orientation including lesbian, gay and bisexual people	**NO**	
7	Religion or belief	**NO**	
8	Age	**NO**	
9	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	**NO**	
10	Economic/social background	**NO**	
B	**Human Rights – are there any issues which may affect human rights**		
1	Right to Life	**NO**	
2	Freedom from Degrading Treatment	**NO**	
3	Right to Privacy or Family Life	**NO**	
4	Other Human Rights (see guidance note)	**NO**	

NOTES

If you have identified a potential discriminatory impact of this document, proposal or service, please complete form 2 or 3 as appropriate.

Date: January 2019 **Name**: Les Jackson

Signature: **Job Title: Local Security Management Specialist. (LSMS)**

Date: ……..Name: ……..

Signature: …*Les Jackson* **Job Title:……..**

Where an impact has been identified in Section A, please outline the actions that have been agreed to reduce or eliminate risks in Section B.

If there are no impacts identified in Section A, completion of Section B is not necessary.

SECTION B

Please expand tables below as necessary

SECTION B NUMBER A1-10, B1-4	NATURE OF IMPACT	EVIDENCE	STAKEHOLDER INVOLVEMENT	ACTION	COST	LEAD	TIMESCALE	RISK SCORE

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CONSENT 5**	Date of Meeting: 30/09/2021
Report Title	**Use of the Trust Seal**	
Executive Lead	Russ Favager, Deputy Chief Executive and Director of Finance	
Lead Officer	Andrew Deakin, Head of Capital Development	
Action Required	To approve	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Request to use the Trust Seal for Deed of Variation

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- To affix the seal to the contracts prior to signing in accordance with the SFIs

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Provide safest and best care ☐ • Become a leading and sustainable health care system ☐	• Be the best place to work ☐ • Push boundaries in clinical, technology and digital innovation ☐

Impact *(is there an impact arising from the report on the following?)*

• Quality ☐ • Finance ☐ • Workforce ☐ • Equality ☐	• Compliance ☐ • Legal ☐ • Risk/BAF Click here to select relevant risk

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
NA				

Estates & Facilities Division

Capital Procedures

Form CF13 – Request to affix Trust Seal
(Version 1.0 – February 2013)

In line with the provisions Trust Standing Order Section 17 (Sealing of Documents), we request approval to affix the Trust Seal to the following document –

Type of Document – Deed of Surrender

Title of Document – Deed of Surrender between Mid Cheshire Hospitals Foundation Trust and Stroke Association relating to premises at Leighton Hospital

Reason for Trust Seal – Engrossment of a Deed of Surrender. The premises is located within the 'Residences' blocks and has a gross internal area (GIA) of 58.9 square metres

Number of copies to be sealed – One copy of the Deed of Surrender

The seal is to be applied to – Page 4

Parties to Agreement - The parties are Mid Cheshire Hospitals NHS Foundation Trust and Stroke Association

Value – N/A

Andrew Deakin
Head of Capital Development

Date: 14th September 2021

To be completed by Trust Secretary

Approval minuted at Board meeting of *(date)*_____

Seal Applied *(date)*_____

Seal Number _____