Countess of Chester Hospital NHS Foundation Trust

# Part B Pack

## Board of Directors meeting – 19th January 2021

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|---|---|---|---|---|---|---|---|---|
| **Meeting** | **19th January 2021** | | **Board of Directors** | | | | | |
| **Report** | **Agenda item 14.a** | | **Terms of Reference Quality & Safety Committee** | | | | | |
| **Purpose of the Report** | Decision | | Ratification | X | Assurance | | Information | |
| **Accountable Lead** | Keith Haynes | | | | Interim Governance Consultant | | | |
| **Author(s)** | Keith Haynes<br><br>Debbie Bryce | | | | Interim Governance Consultant<br><br>Lead for Governance Improvement | | | |
| **Board Assurance Framework** | Q1 | Quality & Safety | | | | | | |
| **Strategic Aims** | | | | | | | | |
| **CQC Domains** | Well Led | | | | | | | |
| **Previous Considerations** | Quality & Safety Committee – 15th September 2020<br>Quality & Safety Committee – 15th December 2020 | | | | | | | |

**Summary**


The purpose of this report is to provide the terms of reference of the Quality & Safety Committee, for ratification.

The terms of reference were considered at the 15th September 2020 committee meeting and there was an action agreed to consider further the balance of the membership of the Board Committee between Non-Executive Directors and Trust Executive Directors.

Further consideration of this issue was given at the December meeting, with the following observations noted:

- Whilst there is a requirement for balance of Non-Executive Directors and Executive Directors at Board level (with a specific requirement for at least half of the Board excluding the Chair to be comprised of Non-Executive Directors) there is no similar requirement for a Board Committee.
- Specifically, the primary role of a Board Committee is to provide assurance to the Board in relation to its subject area in order to ensure that the Board's agenda remains manageable and that sufficient time is devoted through the Board Committee to consideration of critically important matters such as quality and patient safety.

Consequently, no changes were ultimately proposed to the terms of reference with regards to the equivalence of membership between Non-Executive and Trust Executive Directors.

| | |
|---|---|
| | The additions made to the Quality & Safety Committee terms of reference are as follows:<br>• Addition of Chief Digital Information Officer to the membership<br>• Addition of Managing Director, Cheshire West ICP, to those in attendance<br>• New title added : Associate Director of Quality Governance<br>• New title added :Deputy Director of Nursing<br>• Change to Governor to 'attend', rather than 'observe'.<br>• Minor updates to sections 3.12, 3.13 and 4.04. |
| **Recommendation(s)** | The Board of Directors is asked to:<br>• Consider the contents of this report and ratify the revised Terms of Reference of the Quality & Safety Committee. |
| **Corporate Impact Assessment** | |
| **Statutory Requirements** | Meets regulatory requirements and supports delivery of safe care in line with CQC requirements |
| **Quality & Safety** | Supports the provision of assurance in the safe delivery of care |
| **NHS Constitution** | Report and content meets regulatory requirements |
| **Patient Involvement** | n/a |
| **Risk** | Supports compliance with NHS Standards |
| **Financial impact** | n/a |
| **Equality & Diversity** | n/a |
| **Communication** | n/a |

**COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

**QUALITY AND SAFETY COMMITTEE TERMS OF REFERENCE**

## 1.00 PURPOSE

1.01 The purpose of the Quality and Safety Committee is to support the Board in ensuring that the Trust's management, and clinical and non -clinical processes and controls are effective in setting and monitoring good standards and continuously improving the quality of services provided by the Trust in line with the principles and values of the Patient First programme.

1.02 The Committee will also support the Board in ensuring that the Trust manages comments, compliments, concerns and complaints from patients and the public in a sensitive and effective manner and that a process of organisational learning is in place to ensure that identified improvements are embedded within the organisational framework.

1.03 The Committee shall also provide information to the Audit Committee, when requested, to assist that Committee in ensuring good structures, processes, and outcomes across all areas of governance.

## 2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated Non-executive Director
- Two further nominated Non-executive Directors
- Medical Director (the joint Lead Officer for the Committee)
- Director of Nursing and Quality (the joint Lead Officer for the Committee)
- Chief Executive Officer
- Director of Finance
- Chief Operating Officer
- Director of People and Organisation Development
- Director of Pharmacy
- Divisional Medical Director, or equivalent from each Division
- Chief Digital Information Officer

2.02 Those normally in attendance at the Committee meetings shall be:

- Associate Director of Quality Governance
- Deputy Director of Nursing
- Head of Facilitates
- Head of Estates
- Managing Director, Cheshire West ICP

2.03 The Trust Chair shall propose which Non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust

Board shall approve the appointment of the Committee Chair, based on the Chair's recommendations.

2.04 Any member of the Board of Directors shall have the right to be in attendance at any meeting of the Committee by prior agreement with the Chair. An agreed named Governor may attend the Committee.

2.05 The executive members of the Committee may exceptionally send a deputy to the meeting but the deputy will not have voting rights at the meeting.

2.06 Other Trust managers and clinicians, and patients, members of the public or governors, may be invited to attend for particular items on the agenda that relate to areas for which they are responsible or on which the Committee requires advice or information.

2.07 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

**3.00 ROLE AND RESPONSIBILITIES**

**AUTHORITY**

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

**DUTIES**

**Quality strategy, targets and outcomes**

3.05 To review and recommend to the Board the Quality Strategy of the Trust, and to monitor progress against the strategy and other improvement plans such as improvement programmes within Patient First that may impact on clinical quality.

3.06 To ensure there are robust systems for monitoring clinical quality performance indicators within Divisions and to receive reports on clinical quality performance measures.

3.07 Review and Monitor Quality Impact Assessments (QIA) relating to Efficiency and Transformation programmes to gain assurance that there will be no unforeseen detrimental impact on quality of care for patients.

3.08 In response to requests from the Board, or where appropriate as decided by the Committee, monitor the implementation of action/improvement plans in respect of quality of care, particularly in relation to incidents, survey outcomes (including Staff Survey) and similar issues.

**Compliance and Regulation**

3.09 To receive and consider the necessary action in response to external reports, reviews, investigations or audits (from DH, NHSI/NHSE, CQC, other NHS bodies) which impact on clinical quality or patient safety and experience.

3.10 To monitor the Trust's responses to all relevant external assessment reports and the progress of their implementation, including the reports of the Care Quality Commission.

3.11 To receive a commentary on the CQC's insight report in respect of the Trust and consider if the Trust's quality risk profile should be amended as a result.

**Clinical governance and risk management**

3.12 Through reports from the (executive) Quality Governance Group and by other means, monitor and obtain assurance as to the effectiveness of the processes, systems and structures for good clinical governance at the Trust, and to seek their continuous improvement.

3.13 To consider reports from Divisional Governance Reviews, to ensure that the reviews are effective and that actions arising from them are addressed in a timely and appropriate manner under the management oversight of the (executive) Quality Governance Group.

3.14 To review the themes, trends, management, and improvements relating to serious untoward and other incidents, (both staff and patient).

3.15 To gain assurance that appropriate feedback mechanisms are in place for those raising incidents and that a culture of openness and transparency in respect of incident reporting is encouraged supporting the Speak Up agenda and to receive reports from the Freedom to Speak up Guardian.

3.16 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High Level Operational Risks with a significant potential for impact on the Trust's quality risk appetite, and promote

continuous quality improvement with regard to the management of clinical and non-clinical risk and the control environment throughout the Trust.

3.17 To receive and consider the Trust's clinical governance and clinical and non-clinical risk management annual reports, and agree recommendations on actions for improvement.

3.18 To ensure there is a comprehensive clinical audit programme in place to support and apply evidence-based practice, implement clinical standards and guidelines, and drive quality improvement, including through approving and monitoring progress against the Clinical Audit Strategy.

3.19 To maintain oversight of research and innovation activity, ensuring that it is well governed and is focused on and delivers improvement in respect of the Trust's clinical quality priorities.

3.20 To consider reports from the Committee's reporting groups, including the Quality Governance Group. To consider these reports in the context of quality risks and assurances over the Trust's system of internal control as reflected within the BAF.

3.21 To consider reports from the Trust's Caldicott Guardian and Data Protection Officer where quality risks have been identified by them.

3.22 To consider reports from the Guardian of Safe Working in the context of the Trust's quality, safety and patient experience processes.

3.23 To consider reports from on Health and Safety and to gain assurance of compliance and completion of action plans arising from areas of concern.

3.24 To consider reports from on Safeguarding to gain assurance of legislative compliance and completion of action plans arising from concerns.

3.25 Where appropriate, to consider reports from other operational groups addressing improvement in patient care, and to monitor the completion of action plans arising from areas of concern.

**Patient experience**

3.26 To consider reports from the Patient Experience Team, the Patient Advice & Liaison Service and other sources of feedback (such as Healthwatch) on all formal and informal patient feedback, both positive and negative, and to consider action in respect of matters of concern.

3.27 To consider the results, the issues raised and the trends in all patient surveys (including real- time patient feedback systems), of in-patients and out-patients activities and estate surveys such as PLACE that may impact on clinical quality, and to gain assurance of the development of robust improvement plans and the subsequent completion of action taken to address issues raised.

**Complaints and reviews**

3.28 To review the themes, trends, the management of, and the learning and improvements made relating to complaints.

3.29 To consider national reports from the Ombudsman, to identify matters of relevance requiring action within the Trust, and to make recommendations to the Board.

3.30 To review the complaints procedure in conjunction with the periodic review of the complaints policy.

**Development, education and training**

3.31 To consider reports on national and local surveys including the staff survey and GMC survey as they relate to clinical quality, and to monitor the implementation of action taken to address issues raised.

3.32 To ensure that medical, nursing and other staff recruitment, retention, development, education and training strategies and plans are aligned with and support the Trust's quality strategy.

3.33 To ensure that other education and training-related issues, themes and trends are addressed, to promote high standards of care quality.

**Estates strategy**

3.34 To review the estates strategy and recommend it to the Board, and to monitor progress against and risks associated with the strategy, and monitor other estates-related improvement plans.

3.35 Where appropriate, to make recommendations to the Board on necessary actions or approvals relating to the matters in this section.

**REPORTING AND RELATIONSHIPS**

3.36 The Committee shall be accountable to the Board of Directors of the Trust.

3.37 The Committee shall report to the Board after each of its meetings and make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

3.38 The Committee shall report as required to the other Trust Committees any matters that require the attention or decision of that Committee.

3.39 The Committee chair will provide annually a report to the Board detailing how the Committee has discharged its Terms of Reference. Any identified significant changes to the terms of reference must be subject to approval by the Trust Board.

## 4.00 CONDUCT OF BUSINESS

4.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

4.02 The Committee shall be deemed quorate if there are at least the Chair, one Non-executive Director, one Executive Director (which must be either the Executive Medical Director or Director of Nursing & Quality). A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

4.03 The Committee shall meet bi-monthly (at least six times) in each financial year, or additionally if required. The Chair may request an extraordinary meeting if he/she considers one to be necessary.

4.04 At the discretion of the Chair of the Committee business may be transacted through other technologies provided all parties are able to hear all other parties and where an agenda has been issued in advance, or through the signing by every member of a written resolution sent in advance to members and recorded in the minutes of the next formal meeting.

4.05 Agendas and briefing papers should be prepared and circulated five working days before each meeting, to give sufficient time for Committee Members to give them due consideration.

4.06 Minutes of Committee meetings should be formally recorded and distributed to Committee Members within 10 working days of the meetings.

## 5.00 STATUS OF THESE TERMS OF REFERENCE

**Approved by Trust Board:** 25th June 2019, and subsequent updates 24th September 2019

**Reviewed by the Quality & Safety Committee:** 15th September 2020 and 15th December 2020.

**Next Review:** September 2021

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|---|---|---|---|---|---|---|---|
| **Meeting** | **19th January 2021** | | **Board of Directors** | | | | |
| **Report** | **Agenda item 14.b** | | **Mortality Indicators Report** | | | | |
| **Purpose of the Report** | Decision | | Ratification | | Assurance | X | Information | |
| **Accountable Executive** | Darren Kilroy | | | | Executive Medical Director | | |
| **Author(s)** | Denise Wood<br><br>Michelle Greene | | | | Head of Information & Performance<br><br>Divisional Medical Director | | |
| **Board Assurance Framework** | Q1<br><br>Q5 | Quality & Safety<br><br>Patient safety -failure to identify preventable clinical harm and preventable avoidable death | | | | | |
| **Strategic Aims** | To provide assurance on the Learning from Deaths process | | | | | | |
| **CQC Domains** | Safe | | | | | | |
| **Previous Considerations** | Learning From Deaths Group – 19th November 2020<br>Quality and Safety Committee – 15th December 2020 | | | | | | |
| **Summary** | This report is intended to:<br><br>• Summarise the key mortality indicators<br>• Highlight areas of concern<br>• Assure the Board of Directors of actions in place for improvement | | | | | | |
| **Recommendation(s)** | The Board of Directors is asked to note the overall performance against all areas and actions being taken to meet targets. | | | | | | |
| **Corporate Impact Assessment** | | | | | | | |
| **Statutory Requirements** | Meets the Trust compliance with Learning from Deaths mandated reporting | | | | | | |
| **Quality & Safety** | Improve patient safety | | | | | | |
| **NHS Constitution** | Demonstrate improvements to HSMR and SHMI rates | | | | | | |
| **Patient Involvement** | | | | | | | |
| **Risk** | | | | | | | |
| **Financial impact** | | | | | | | |
| **Equality & Diversity** | | | | | | | |
| **Communication** | | | | | | | |

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# Trust Mortality Indicator Report

November 2020

## Contents

# 1. Executive Summary

| Indicator | Result | Threshold | Date range | Previous Result |
|---|---|---|---|---|
| SHMI | **106.8** | 100 | Jul 19 to Jun 20 | **105.6** |
| HSMR | **115.9** | 100 | Aug 19 to Jul 20 | **117.5** |
| Elective HSMR Admissions: Crude Mortality Rate | 0.2% | 0.1% | Aug 19 to Jul 20 | 0.2% |
| Non-Elective HSMR Admissions: Crude Mortality Rate | 6.9 % | 5.7% | Aug 19 to Jul 20 | 6.9 % |
| Mortality Reviews Completed | 18% | | Oct-19 to Sept-20 | 22% |

## Key Messages

1. **Crude Mortality Rate**: During the rolling 12 month period of August 2019 to July 2020 the Countess of Chester Hospital NHS Foundation Trust (COCH) crude mortality rate was 4.5% of HSMR admissions, which was consistent with the previous period of July 2019 to August 2020. For the same period in the previous year August 2018 – July 2019 the crude rate was 3.9%.

2. **HSMR**: The rolling 12 month HSMR is lower than the previous period, at 115.9 for August 2019 to July 2020, compared to 117.5 for the period July 2019 to June 2020. Chart 1 on page 7 illustrates the monthly relative risk over the last year. From March 2020 it should be noted that the national Covid-19 pandemic has had a significant impact on the volume of elective and non-elective hospital admissions. One of the impacts of the pandemic is a significant reduction in the HSMR denominator, which has affected both the crude and risk adjusted mortality metrics. The figures should be viewed taking into account the impact of COVID-19, including the late presentation of other non Covid-19 related acutely ill patients, who might previously have sought treatment at an earlier stage.

3. **Reporting**: A monthly report is produced for the Learning from Deaths group. The Trust moved from to the clinical benchmarking software Dr Foster on 1st October 2019. As part of the customer support we receive, our Dr Foster consultant has given specific advice and support on how to utilise the software to maximum benefit and identify areas of concern. The Trust will be implementing the Dr Foster Early Warning Mortality tool to support this. It has been agreed with Divisional Medical Directors that mortality will be discussed at every specialty meeting as a standard agenda item, and then escalated to Divisional Governance Committees.

4. **Mortality reviews:** The overall completion rate is currently 18% (October 2019 to September 2020).

5. **Palliative Care and Comorbidities**: Palliative care coding rates at 3.8% are lower than peers at 4.1% and the national rate of 4.3%. Although levels of patient comorbidity are now improving an action plan is in place and is being monitored. Further detail on this is provided in section 6.3 of the report.

6. **R codes (signs and symptoms):** The percentage of spells with an 'R' code primary diagnosis (4.6%) is lower than both peers (mortality peer group) at 5.9% and the average national value (6.2%). Although the figure is lower, analysis of primary diagnosis of deaths indicates that further work is required on this measure.

### HSMR breakdown by admission method August 2019 to July 2020

| HSMR | Latest Result | Previous Result |
|---|---|---|
| All Admissions | 115.9 | 117.5 |
| Non-Elective Admissions | 115.8 | 117.4 |
| Elective Admissions | 124.4 | 133.4 |

# 2. Introduction

This Mortality Indicators Report is produced by COCH Business Intelligence Department for the Learning from Deaths Group Meeting which is held on a monthly basis.

The aim of this report is to provide information relating to mortality both in-hospital and during the 30 days following discharge from hospital. Whilst evidence suggests a mortality ratio as a single indicator of hospital quality is, at best, akin to a smoke alarm, it has been recognised nationally that regular examination and better understanding of mortality can potentially improve the way care is delivered, recorded and coded, and in turn help improve the quality of the data used.

The majority of indicators presented in this report pertain to Standardised Mortality Ratios (SMRs). SMRs are the ratio of the number of deaths in hospital within a given time period to the number that might be expected if the hospital had the same death rates as some reference population (in this case the hospitalised population of England). As well as standardising for age, the hospital mortality measures discussed in this report, the Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Indicator (SHMI), also make adjustments for patient differences which can influence deaths in a hospital, but are ultimately outside of its control (for example deprivation and sex) . An overview of the methodology applied to each of these mortality measures (HSMR & SHMI) can be found in Appendix 2.

This report will supplement standardised mortality measures with the presentation of contextual indicators that directly impact on the mortality rates discussed, namely, clinical coding measures including:

- Palliative Care
- Depth and accuracy of clinical coding (‘Signs and Symptoms’ coding)
- Co-morbidities (Charlson Comorbidity Index)

# 3. Learning from Death Reviews (October 2019- September 2020)

The usual process for reviews is a panel of clinicians meet weekly to perform high level case note reviews for the previous month's deaths. The primary aim of these reviews is to assess the care provided but a summary of the clinical coding is also reviewed. Any concerns with primary diagnosis, Charlson co-morbidities or procedures are raised with the Clinical Coding Service Manager who attends the meeting.

COVID 19 produced some challenges for the Trust. There was less time for reviews fortunately some non-patient facing clinicians continued with the SJRs remotely. These have now restarted slowly as has the Friday morning peer review group.

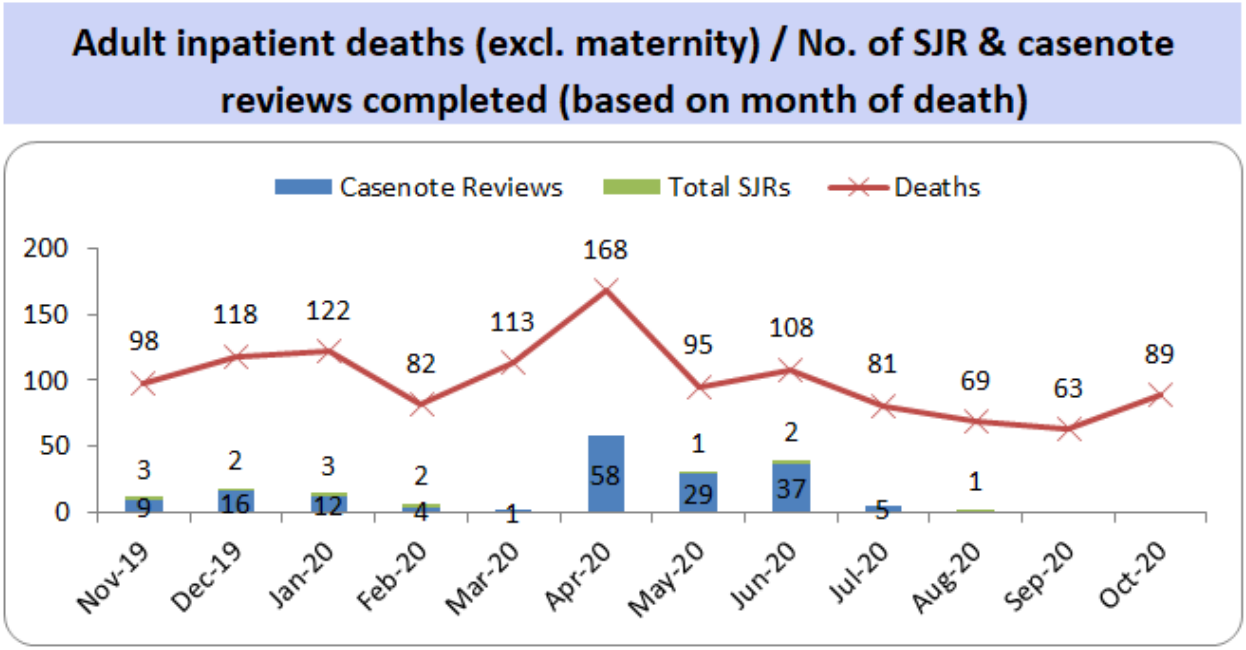
There was a commitment to review all Deaths from Covid on a Friday morning case note review group. Currently 139 patients notes have been reviewed, approximately half of the Covid deaths with plans to review the remainder.

The criteria for inclusion in the SJR process has been agreed to include, LEDER deaths, all deaths after elective surgery, any death referred by the serious incident panel, all deaths in an area where there is a low death rate and a proportion of deaths in specialities with a higher mortality rate. The medical examiner is to be appointed in October and then will feed into the Learning from death and governance. From April to March 2020 there has been 5% of the SJR which have demonstrated care scores of less than 3 requiring a further review. Nationally the 'acceptable' figure is 10%. When collating the SJR, case reviews and investigations 28% have been reviewed in some form. The aim is to ensure that all reviews moving forward make explicit comments around care scores and preventability of death.

The review of elective deaths is underway and currently 14 out of 18 for 2019/20 have been undertaken, with 5 errors in recording identified and updated to non-elective admissions. There have also been 9 LEDER death reviews.

For 2020/21 data a preventability score has been introduced for mortality reviews. This will allow visibility of all deaths within the Trust and which have been reviewed, and provide comments on the care received. This will allow more timely review of themes and learning to be disseminated.

The recent notable decline in case note reviews and SJR's is as a result of capacity issues due to current pressures the Trust is facing tackling the coronavirus.




NB. Deaths in March and April include the increased rate attributed to deaths from Covid-19

# 4. Hospital Standardised Mortality Ratio (HSMR)

HSMR is a key performance indicator for quality of care and safety. COCH receives HSMR data from Dr Foster, which utilises data from the NHS Digital Secondary Users System (SUS) and Hospital Episodes Statistics (HES) published three months in arrears.

## 4.1 HSMR: 12 Month Rolling Score at Trust Level (Aug-19 to Jul-20)

The following summary provides an overview of the Trust HSMR compared to similar acute peer groups, for the HSMR Basket of 56 Diagnosis Groups. For the 12-month rolling period August 2019 to July 2020, the Trust's score is lower at **115.9,** when compared to the 12 month rolling period between July 2019 and June 2020, at 117.5, however the **HSMR remains above the expected range**.

Table 3: HSMR for COCH sites compared to Peers August 19 – July 20

| Covid-19 Peers | Observed | Expected | Relative risk |
|---|---|---|---|
| COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST | 929 | 801.2 | 115.9 |
| ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST | 1093 | 980.0 | 111.5 |
| NORTHAMPTON GENERAL HOSPITAL NHS TRUST | 1291 | 1172.3 | 110.1 |
| NORTH WEST ANGLIA NHS FOUNDATION TRUST | 1646 | 1514.5 | 108.7 |
| MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST | 910 | 853.4 | 106.6 |
| POOLE HOSPITAL NHS FOUNDATION TRUST | 870 | 820.5 | 106.0 |
| TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST | 894 | 848.8 | 105.3 |
| GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST | 1049 | 1017.3 | 103.1 |
| MEDWAY NHS FOUNDATION TRUST | 1061 | 1073.9 | 98.8 |
| MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST | 671 | 707.2 | 94.9 |
| SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST | 675 | 820.8 | 82.2 |

Using Dr Foster to select a comparable peer group the above Trusts have a similar case mix.

Figure 1: Trust HSMR – August 2019 to July 2020

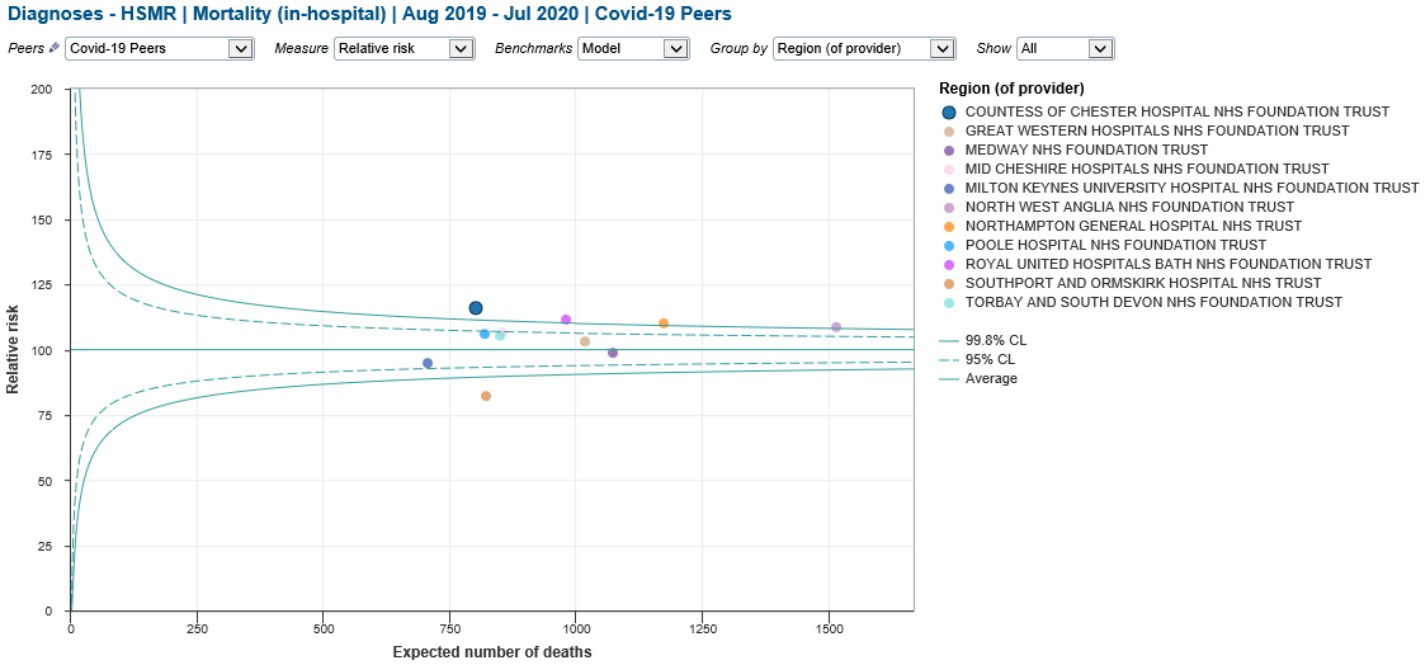
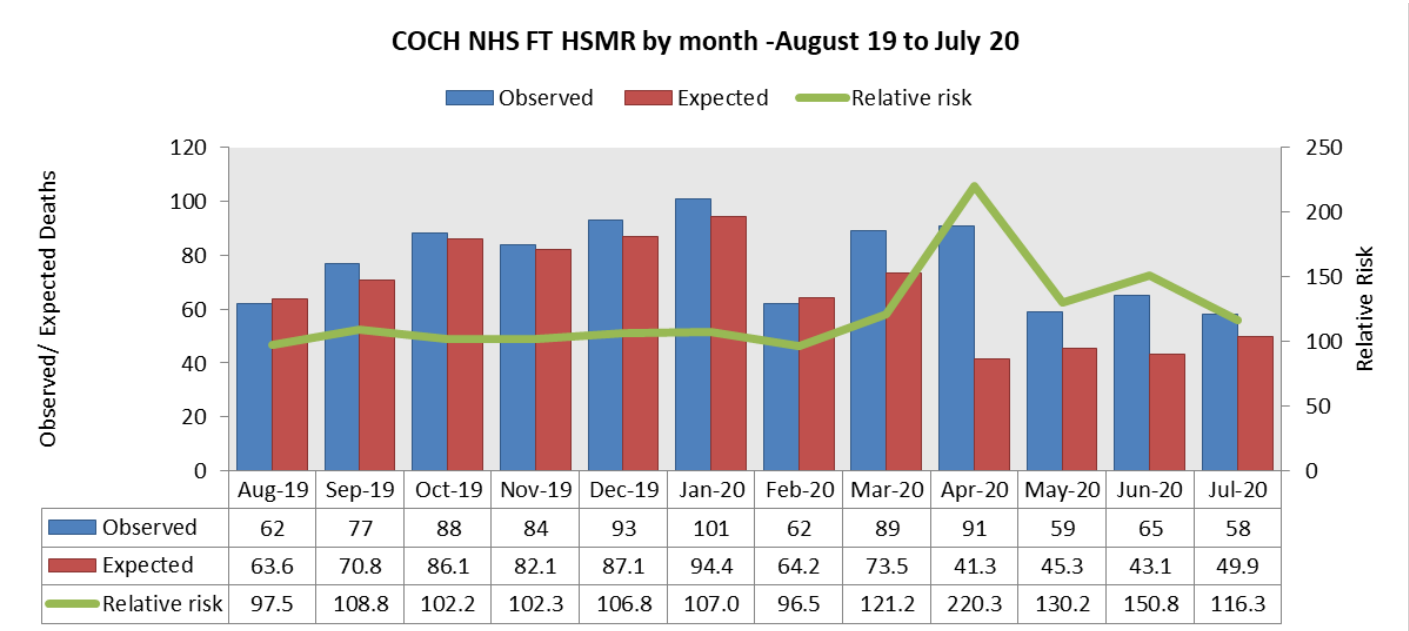



Chart 1 below provides a summary of the observed number of deaths and relative risk at Trust level by month between August 2019 and July 2020. Within the 12 month rolling period the month of April 2020, now has the highest variance between the expected and observed mortality. It is advisable to review the full rolling twelve month period rather than one month, particularly as March 2020 onwards includes Covid-19 related deaths which have impacted on the effectiveness of the relative risk model.

Chart 1: Trust HSMR by Month. August–19 to July-20 (HSMR Basket of 56 Diagnosis Groups)




| | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Observed | 62 | 77 | 88 | 84 | 93 | 101 | 62 | 89 | 91 | 59 | 65 | 58 |
| Expected | 63.6 | 70.8 | 86.1 | 82.1 | 87.1 | 94.4 | 64.2 | 73.5 | 41.3 | 45.3 | 43.1 | 49.9 |
| Relative risk | 97.5 | 108.8 | 102.2 | 102.3 | 106.8 | 107.0 | 96.5 | 121.2 | 220.3 | 130.2 | 150.8 | 116.3 |

## 4.2 Covid-19 update

This report now covers the period until the end of July 2020, so the impact of Covid-19 deaths will cover more months within the rolling 12 month date range.

From the initial analysis undertaken in September the Trust was found to have a higher number of covid-19 related deaths within the HSMR basket. The risks associated with this group of patients have a more pronounced effect on the trusts HSMR. Covid-19 patients are taken out of the basket when within the primary diagnosis because there isn't a risk model for these patients within Dr Foster. Out of 31 patients with pneumonia, 23 have subsequently been amended to Covid-19 within coding guidelines and rules, but the impact of this change will take up to 3 months to be reflected within the figure.

## 4.2 HSMR: Diagnosis groups of concern

Dr Foster provides CUSUM alerts (short for 'cumulative sum'). Alerts are designed to signal that a pattern of activity appears to have gone beyond a defined threshold and act as a smoke alarm, to inform users that something might be going wrong.

The Trust has purchased the Dr Foster Early Warning System which will support the early identification of any diagnosis groups and patients of concern. Data from the Trust will be submitted directly to Dr Foster and will provide early results without the direct peer comparison.

Initial analysis has been focused on CUSUM alerts but going forwards a process will be put in place for each specialty to review all deaths attributed to that specialty, co-ordinated by the M&M (Mortality & Morbidity) lead. The Divisional Medical Directors (DMD's) will agree this as part of the Learning from Deaths review.

| CUSUM alert | Observed deaths | Expected deaths | Relative Risk (RR) |
|---|---|---|---|
| Residual codes, unclassified | 25 | 11.2 | 223.3 |
| Fluid and electrolyte disorders | 21 | 10.1 | 208.3 |
| Acute and unspecified renal failure | 51 | 30.3 | 168.5 |
| Acute cerebrovascular disease | 89 | 67.6 | 131.7 |
| Viral infection | 98 | 82 | 119.6 |
| Pneumonia | 205 | 176.6 | 116.1 |

Source: Dr Foster Mortality Summary for 12 months to July-2020

# 5. Summary Hospital-Level Mortality Indicator (SHMI)

The following summary provides an overview of the Trust SHMI score for the period July 2019 to June 2020 sourced from NHS Digital.

## 5.1 Trust SHMI Analysis

The COCH SHMI value for the most recent reporting period is 105.6. Table 4 below provides an overview of the observed and expected deaths.

**Table 4: COCH SHMI Score Jul-19 to Jun-20**
**Figures from NHS Digital (filtered to COCH Covid-19 Peer Group)**

| Provider name | SHMI value | SHMI banding | Number of spells | Observed deaths |
|---|---|---|---|---|
| MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST | 1.1697 | 1 | 37,415 | 1,260 |
| NORTH WEST ANGLIA NHS FOUNDATION TRUST | 1.1478 | 1 | 76,935 | 2,840 |
| **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST** | **1.0681** | **2** | **43,540** | **1,380** |
| MEDWAY NHS FOUNDATION TRUST | 1.0491 | 2 | 52,980 | 1,770 |
| ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST | 1.0460 | 2 | 58,855 | 1,895 |
| SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST | 1.0399 | 2 | 36,250 | 1,310 |
| NORTHAMPTON GENERAL HOSPITAL NHS TRUST | 1.0132 | 2 | 68,320 | 1,985 |
| TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST | 1.0101 | 2 | 42,195 | 1,645 |
| GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST | 0.9998 | 2 | 55,520 | 1,735 |
| MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST | 0.9922 | 2 | 49,685 | 1,445 |
| POOLE HOSPITAL NHS FOUNDATION TRUST | 0.8577 | 3 | 47,175 | 1,485 |

The range of observed deaths at band 2 is considered to be ‘as expected’. The peer groups are consistent with the HSMR peers, for trusts with a similar case mix of patients.

## 5.2 Trust SHMI Diagnosis Groups of Concern (June-19 to May-20)

Analysis of the Trust SHMI at diagnosis level indicates the diagnosis groups in which the observed number of deaths rate was higher than the expected, but not statistically significantly high, using 95% confidence intervals.

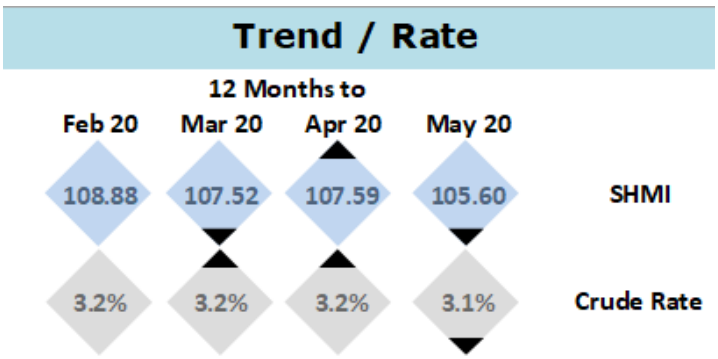
Table 5: Trust SHMI Diagnosis Groups of Concern Jun-19 to May-20

**SHMI Group - With 95% CI (Dr Foster)**

| SHMI Group | # | Obs | Exp | SHMI | Low / High |
|---|---|---|---|---|---|
| (140) Allergic reactions, Rehabilitation care, fitting of prostheses, and adjustment of | | 40 | 20 | 200.00 | 142.87 272.35 |
| (66) Acute cerebrovascular disease | | 95 | 70 | 135.71 | 109.80 165.91 |
| (75) Chronic obstructive pulmonary disease and bronchiectasis | | 40 | 30 | 133.33 | 95.24 181.57 |
| (98) Other gastrointestinal disorders | | 15 | 10 | 150.00 | 83.89 247.42 |
| (82) Influenza, Acute and chronic tonsillitis, Other upper respiratory infections, Other upper respiratory | | 15 | 10 | 150.00 | 83.89 247.42 |
| (78) Pleurisy, pneumothorax, pulmonary collapse | | 15 | 10 | 150.00 | 83.89 247.42 |
| (63) Cardiac dysrhythmias | | 15 | 10 | 150.00 | 83.89 247.42 |
| (124) Intracranial injury | | 20 | 15 | 133.33 | 81.41 205.93 |

NOTE: There have been some methodological changes with the SHMI data nationally, which now follows a methodology employed by HES (Hospital Episodes Statistics). This disclosure control methodology has been updated to a methodology based on rounding, so the number of finished provider spells and observed deaths are now displayed to the nearest five.

Table 6: Trust SHMI Trend/Rate



# 6. Clinical Coding Indicators

The following section will provide an overview of some of the factors that can influence mortality and drive performance against the HSMR and SHMI. Table 7 provides a summary for COCH between June 2019 and May 2020 for selected coding and case-mix indicators, along with a comparison against peers.

Table 7: Selected coding and case-mix indicators that can influence mortality: COCH against mortality peers (Aug-19 to Jul-20)

| Indicator | COCH value | Previous COCH value | Peer value | National value |
|---|---|---|---|---|
| % Non-elective deaths with palliative care | 30.7 | 31.4% | 36.3% | 33.8% |
| % Non-elective spells with palliative care | 3.8% | 3.8% | 5.0% | 4.3% |
| % Spells in Symptoms & Signs chapter | 4.7% | 4.6% | 6.3% | 6.5% |
| % Non-elective Spells with Charlson comorbidity score = 0 | 45.2% | 45.3% | 42.9% | 42.3% |
| % Non-elective Spells with Charlson comorbidity score = 20+ | 12.4% | 12.2% | 13.5% | 14.0% |

## 6.1 Palliative Care Coding Rates

The presence of the diagnosis code 'Z515' or the national specialty code 315 is used to denote palliative care. The coding of palliative care is one of the twelve weighting factors applied to the calculation of HSMR, however is not considered in the calculation of SHMI.

During the first wave of Covid the usual cohort of patients that the Palliative Care team would normally see were not in the hospital and referrals to the service therefore dropped. The team continued to contact and visit wards to offer support and provided a 7 day service, in addition outpatient activity remained busy. The Covid patients within our mortality data typically deteriorated very rapidly and therefore medical teams either did not have the opportunity to refer to Palliative care, or were able to manage symptoms, these findings have also been noted from the case note reviews. During the more recent period of Covid, patients with complex symptoms normally seen by Palliative care are in the hospital, so activity has increased again and is expected to be reflected in future data.

## 6.2 Signs and Symptoms Coding ('R' Codes)

Both mortality models (HSMR & SHMI) discussed in this report use the primary diagnosis of the mortality dominant episode within a spell to attribute a 'weighting' in mortality score calculations. Diagnosis codes beginning with 'R' (signs & symptoms) map to the diagnosis group 140 in the SHMI model, which has a relatively low 'expected' mortality rate, therefore the greater the number of 'R' codes present in patient's records, the higher the 'Relative Risk' score attributed to the organisation.

## 6.3 Co-Morbidity Coding

The coding of patient co-morbidities is one of the twelve weighting factors applied to the calculation of HSMR, and one of the six weighting factors applied to the calculation of SHMI. A high level of patient co-morbidities increases the 'expected' number of deaths in both methodologies, and thus reduces the relative risk rate. The Charlson Comorbidity Index is used to calculate comparative levels of co-morbidity, and consists of 17 conditions for which a 'weighting' is assigned. The higher the patient weighting, the higher the risk the co-morbidity is perceived to be as a contributing factor to a patient's health outcome, and potential risk of death. In order to calculate a patient's co-morbidity score, each spell is calculated as the

sum of the weights for each of the conditions in all secondary diagnosis fields in the first episode of the spell.

Between June 2019 and May 2020 COCH has a higher percentage of spells (54.1%) in the lowest category of patient complexity (with a Charlson score of 0) compared to both the Peer Trusts (49.7%) and all providers in England (46.6%).

COCH has a lower percentage of spells (8.5%) in the highest category of morbidity (a Charlson score of 20 or more) compared to the Peer Acute Trusts (9.7%) and all providers in England (10%).

From Dr Foster data COCH is also an outlier for elderly patients in the age range 75-84. The low morbidity associated with high elderly cohort of patients further illustrates a case mix where higher coding depth would be expected.

Clinical coding has utilised an internally developed bi-weekly mortality tool (DCM) since November 2018. The tool has been useful in improving coding depth and has delivered significant increases in tariffs since its inception (£7k YTD). A revamped tool has been launched this month with increased functionality along with additional resources from the Clinical Coding Divisional Lead. We would hope to see a positive impact on our mortality indexes once the results are visible.

The Clinical Coding Divisional Leads have continued their work within their respective divisions and implemented numerous initiatives to improve coding depth. Earlier this year we implemented comorbidity tick lists in every speciality with the aim of reaching the 50th percentile compared to our national peers on coding depth. Many of the new initiatives have been to address the tick lists within specialities where the figures haven't improved. We continue to monitor the figures monthly and would hope to see improvements across the board in the coming months.

Average coding depth is now at 3.5 from the baseline of 2.3 (based on June-May 18/19). This is slightly below the 50th percentile at 3.8, but care should be taken when interpreting this for activity from March 2020 due to lower activity levels.

The Trust continues to work with our Dr Foster consultant to understand our data, investigate areas highlighted for concern and support the implementation of the Early Warning System. Future training events will be scheduled to provide expert advice and training for clinicians and analysts.

# Appendix 1 - SHMI & HSMR Methodologies

| | Hospital Standardised Mortality Rate (HSMR) | Risk Adjusted Mortality Index (RAMI) | Summary Hospital-level Mortality Indicator (SHMI) ** |
|---|---|---|---|
| Observed | All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England* | Total number of observed in-hospital deaths | Number of observed in-hospital deaths plus deaths out of hospital within 30 days of discharge |
| Expected | Expected number of deaths | Expected number of deaths *Calculated using a 10 year data set (as of 2012) to get the risk estimate* | Expected number of deaths *Calculated using a 36 month data set to get the risk estimate* |
| Adjustments | ▪ Sex<br>▪ Age in bands of five up to 90+<br>▪ Admission method<br>▪ Source of admission<br>▪ History of previous emergency admissions in last 12 months<br>▪ Month of admission<br>▪ Socio economic deprivation quintile (using Carstairs)<br>▪ Primary diagnosis based on the clinical classification system<br>▪ Diagnosis sub-group<br>▪ Co-morbidities based on Charlson score<br>▪ Palliative care<br>▪ Year of discharge | ▪ Sex<br>▪ Age<br>▪ Clinical grouping (HRG)<br>▪ Primary and secondary diagnosis<br>▪ Primary and secondary Procedures<br>▪ Hospital type<br>▪ Admission method<br><br>Further detailed methodology information is included in CHKS products, or specific enquiries to CHKS www.chks.co.uk | ▪ Sex<br>▪ Age group<br>▪ Admission method<br>▪ Co-morbidity<br>▪ Year of dataset<br>▪ Diagnosis group<br><br>Details of the categories above can be referenced from the methodology specification document at http://www.ic.nhs.uk/services/summary-hospital-level-mortality-indicator-shmi |
| Exclusions | Excludes day cases and regular attendees | Excludes mental illness, obstetrics, babies born in or out of hospital, day cases, and patients admitted as emergencies with a zero length of stay discharged alive and spells coded as palliative care (Z515) | ▪ Specialist, community, mental health and independent sector hospitals.<br>▪ Stillbirths<br>▪ Day cases, regular day and night attenders |
| Whose data is being compared and how much data is used for comparison e.g. all trusts or certain proportion etc. | All England provider trusts via SUS<br><br>Data attributed to all Trusts within a 'super-spell' of activity that ends in death | UK database of Trust data and HES<br><br>Data attributed to Trust in which patient died | All England non-specialist acute trusts except mental health, community and independent sector hospitals.<br><br>Data attributed to Trust in which patient died or was discharged from |

*HSMR does not exclude 20% of deaths, it looks for the diagnosis groups that account for the majority of deaths, and the figure of 80% is quite variable dependent on the case mix of the trust. HSMR could just as easily cover 100% of activity. It covers 80% of activity mostly for historical reasons and the fact that you get little extra value from the other 20%.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Meeting** | **19th January 2021** | | **Board of Directors** | | | | | |
| **Report** | **Agenda item 14.c** | | **Annual Health and Safety Report April 2019 – March 2020** | | | | | |
| **Purpose of the Report** | Decision | | Ratification | | Assurance | X | Information | |
| **Accountable Executive(s)** | Alison Kelly<br><br>David Coyle | | | | Director of Nursing & Quality<br><br>Chief Operating Officer | | | |
| **Author(s)** | Michael Sturgess | | | | Health & Safety Compliance Manager | | | |
| **Board Assurance Framework** | Q1 | Quality & Safety | | | | | | |
| **Strategic Aims** | To deliver safe care and treatment | | | | | | | |
| **CQC Domains** | Safe, Effective, Caring, Responsive, Well Led | | | | | | | |
| **Previous Considerations** | Quality Governance Group – 28th October 2020<br>Quality and Safety Committee – 15th December 2020 | | | | | | | |
| **Summary** | The report provides the Board of Directors with a summary of principal activity and outcomes relating to the promotion and management of health and safety within the Trust during 2019/20.<br>The report also highlights current key priorities for the Health and Safety Group and its sub-groups for the current financial year.<br><br>The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed, and outlines the local governance arrangements that underpin health and safety management within the Trust. | | | | | | | |
| **Recommendation(s)** | The Board of Directors is asked to note the contents of the report. | | | | | | | |
| **Corporate Impact Assessment** | | | | | | | | |
| **Statutory Requirements** | Meets Health & Safety regulatory standards | | | | | | | |
| **Quality & Safety** | Supports delivery of safe care and CQC requirements | | | | | | | |
| **NHS Constitution** | Supports compliance with NHS Standards | | | | | | | |
| **Patient Involvement** | N/A | | | | | | | |
| **Risk** | Reflects key aspects of the Board Assurance Framework | | | | | | | |
| **Financial impact** | N/A | | | | | | | |
| **Equality & Diversity** | N/A | | | | | | | |
| **Communication** | Document to be published on the website and intranet | | | | | | | |

# Annual Health and Safety Report 2019 to 2020

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## 1 Introduction

This report provides analysis of standards of health and safety management throughout the Trust for the financial year 1st April 2019 to 31st March 2020.

The Health and Safety at Work etc. Act 1974 provides a legislative framework to promote, stimulate and encourage excellent health and safety at work standards with delegated responsibility through the CEO to implement systems that ensure the Countess of Chester Hospital staff and ancillary contractors, work in a safe and compliant manner to protect both themselves and other service users from significant or avoidable harm.

In particular, the act requires organisations to provide and maintain:

- A Health and Safety Policy;
- A system to manage and control risks in connection with the use, handling, storage and transport of articles and substances;
- A safe and secure working environment, including provision and maintenance of access to and egress from premises;
- Safe and suitable plant, work equipment and systems of work that are without risks;
- Information, instruction, training and supervision as necessary;
- Adequate welfare facilities.

## 2 Objectives

Health and Safety in the Trust continues to be work in progress. The Trust is compliant for the processes in place and a full policy review is currently under way. The review will include the Trust Health and Safety Policy, Risk Assessment Policy and some generic risk assessment forms which are being amended to be more user-friendly. Once reviewed, the documents will be ratified at Health and Safety Committee before they are uploaded to the Trust Intranet.

We are aiming to raise the profile of Health and Safety across the Trust to achieve a comprehensive compliance through engagement with Ward and Department Leads and improve the overall Health and Safety Culture. There has been significant change in department leaders and managers across the Trust who may or may be familiar with the Health and Safety processes i.e. carrying out risk assessments in the work areas. The Trust is in the early stages of changing this process and working with department leads.

The culture for ensuring risk assessments are in place for the tasks each department carries out need to be embedded.

Each department has an online folder for their completed assessment forms for the managers/leaders to share with their teams. The requirement for risk assessment completion will become routine practice for all departments and wards. These folders are on the shared drive (S drive).

## 3. Health and Safety Requirements 2019/20

### 3.1 Legislative changes

The legislation is enforced by the Health and Safety Executive (HSE) who have far-reaching enforcement powers. The following legislation is most relevant to the Trust and is the basis of all our policies, procedures, training and assessments;

**Health and Safety at Work Act 1974**
This is the fundamental piece of Health and Safety Law under which other legislation is made from. It places general duties on employers to ensure the health, safety and welfare of all persons at work. It also places Health and Safety duties on occupiers of buildings, contractors, manufacturers and employees.

**Assurance**: All Health and Safety policies and procedures adhere to the strict guidelines in this, the most common piece of legislation. An audit process will be put in place to audit all Health and Safety Policies and procedures, the findings of these audits will be escalated through the Health and Safety group meetings on a quarterly basis.

**Management of Health and Safety at Work Regulations 1999**
Require employers to assess the Health and Safety risks to employees and others who may be affected by work activities (Risk Assessment and Risk Management).
Arrangements must be made for the effective planning, organisation, control, monitoring and review of preventive and protective measures and Employees must be informed of protective measures and the employer must appoint one or more Health and Safety competent persons.

**Assurance**: Risk Assessments are carried out extensively across the Trust and we currently have an adequate number of trained staff.

The risk assessment performance across the Trust is currently 85%. The remaining 15% of staff will receive training via Risk Awareness training sessions which are due to recommence in September 2020. The teams can then complete their Risk Assessments.

Fig 1 Risk Assessments renewals due / current

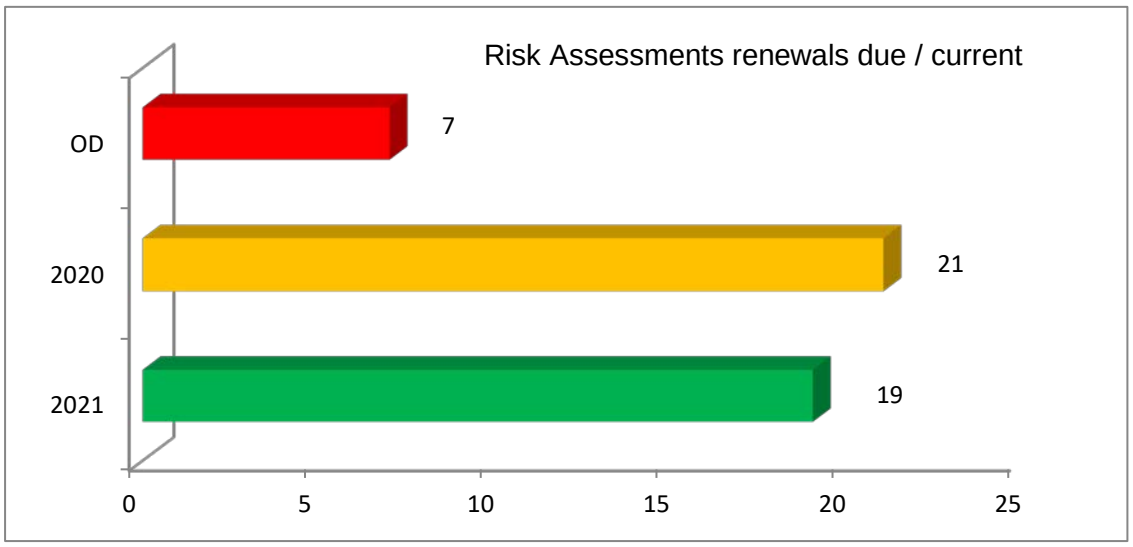


Fig 1 above shows that there are 40 Departments who have risk assessments in place and their renewal years. 7 Departments are currently being assessed and will have their Managers trained to be able to review and carry out their own risk assessments.

21 Departments have current risk assessment due for renewal by end of 2020.

19 Departments have current risk assessments due for renewal in 2021.

**Regulatory Reform (Fire Safety) Order 2005**
Places duties on employers or occupiers of buildings to make effective fire safety management arrangements; this includes carrying out a Fire Risk Assessment and establishing effective arrangements for fire detection, fire protection, fire emergency, fire prevention and fire training.

**Assurance**: Fire Risk Assessments are carried out across the Trust by the Fire Safety Officer. Fire warden Training and weekly fire alarm testing is also carried out.

All fire risk assessments are up to date and are reviewed annually by the Fire Safety Officer.

Fire Warden training is carried out several times per year and the certification lasts 2 years and reminders are sent out to attend refresher training. We are currently under staffed for Fire Wardens across the Trust with only approx. 5% of staff trained as Fire Wardens. A recruitment programme is due to recommence in September 2020.

**Workplace (Health, Safety and Welfare) Regulations 1992**
These regulations cover the need to provide a safety and healthy working environment.
The areas covered include: maintenance, ventilation, temperature, lighting, space, floors and traffic routes, sanitary conveniences, drinking water and rest facilities.

**Assurance**: Our Facilities teams ensure a clean and healthy work environment and the Estates teams are responsible for maintaining all equipment, heating and ventilation across the Trust.

The Estates team carry out regular monitoring for all water and water drinking facilities and Legionella testing is carried out as per the set timetable for the testing points around the Trust, this is currently 100% compliant.

Ventilation is also subject to annual testing by an external Consultant and is validated and verified by our Authorising Engineer and Authorised person. Testing and filter changes are subject to a timetable of when they are due to be serviced. These tests are currently 100% compliant as per the requirements of the HTM 03 (Hospital Technical Memorandum).

**Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)**
The regulations require that specified injuries, diseases and Dangerous Occurrences are reported to the Health and Safety Executive or Local Authority.

**Assurance**: All accidents and incidents which are reported through Datix are reported under the RIDDOR legislation where the criteria are met to do so (refer to point 3.5 and to incidents trends in point 6.3).

**Health and Safety (Display Screen Equipment) Regulations 1992**
These regulations cover the use of DSE at work. The primary application is the use of computer workstations. The requirements include the analysis of workstations, daily work routine, eyes and eyesight and the provision of training and information to users.

The process for having a workstation assessment completed by the Health & Safety Compliance Manager is twofold; Employees who have visited Occupational Health often have a workstation assessment carried out following a referral. Department Managers also request these to address issues raised by a member of their team.

The assessment normally results in changes to both workstation set up and posture and may, on occasion, result in a new chair being purchased for the individual (this is then subject to a second visit to ensure the chair is adjusted correctly).

**Assurance**: Workstation assessments carried out for all users as required, covered at Mandatory Training and Welcome Event.

These assessments are carried out as per the process listed above, i.e. the process for having a workstation assessment completed by the Health & Safety Compliance Manager, ensures that colleagues who may have visited Occupational Health often have a workstation assessment carried out following a referral. Department Managers also request these to address issues raised by a member of their team.

Not all staff work on computers so the actual number of computer users is around the 80% mark. Of these employees, not all require a visit from the Health & Safety Compliance Manager as there is a Workstation Assessment Form on the Trust Intranet; these forms are requested by Department Managers / Leads. If issues are raised as a result of the form being completed, then the Health & Safety Compliance Manager will visit the member of staff to address the issues raised.

**Manual Handling Operations Regulations 1992**
These regulations cover the need to assess manual handling operations and implement effective risk control measures. Risk control should first consider how the risk could be avoided and where it cannot, then risk control measures covering the load, individual, the task being carried out and the working environment.

**Assurance**: Manual Handling Assessments are carried out extensively and annually around the Trust. These are also covered at the Mandatory Training and Welcome Event.

Not all employees in the trust require a Manual Handling Risk Assessment and these are generally carried out following a general risk assessment where Manual Handling is identified as a risk. The Wards all have a Manual Handling Risk Assessment process in place which is completed annually by the ward Manager. The ward staff have also attended additional training following the Mandatory Training or Welcome event.

The Manual Handling Team assist with these risk assessments and action plans to address issues raised by colleagues. Approx. 30% of staff are required to have a specific manual handling assessment. These assessments are carried out annually.

**Personal Protective Equipment at Work Regulations 1992**
These regulations require employers to provide compatible, effective Personal Protective Equipment (PPE), maintain and replace PPE and give information, instruction and training on the use of PPE.

**Assurance**: Following risk assessments and associated guidelines around the correct PPE being made available, the Trust has ample supplies of the compatible pieces of equipment. This is especially relevant in the provision of PPE under the COVID 19 pandemic for our identified zones for Covid 19.

We have suitable and sufficient numbers in stock and processes in place for re-ordering. Training in the use of this equipment is provided as required.

The Infection Control team have a full, up to date register of all staff who have been fit tested for the masks required for their role, this register is a rolling report and the statistics below show the current standings for the testing programme up to end of March 2020

- At the 24th March 2020, the Trust had 100+ staff that were trained to carry out the Fit Testing and a good training programme was in place to increase this number.
- Up to the end of March 2020, the Trust had carried out fit testing for employees as required for their normal work.
- For staff who required the FFP3 Masks, there is a local induction checklist and all training for fit testing is captured in ESR, this programme automatically reminds Managers that they have staff that need to be re-fitted for their masks.

The Procurement team manage their stock by carrying out the following processes;

**Non PPE**

- Perpetual Inventory in place – Wards weekly stocktake, Critical Areas daily stocktake. Ward stock reviews are conducted every 6 months with Supplies and the Ward Manager
- SOP in place if products are unavailable due to various reason i.e. manufacturing issues, recall – to ensure continuity of supply – this involves Supplies staff, Clinical Procurement Specialist Nurse to advise of alternatives suitable for the Trust to use, and a member of Contracts if products fall under a Trust Contract
- In addition, External - Medical Alerts / Field Safety Notices passed to Purchase and Supply Manager (SD) to check if we use and link with end users if we do
- Internal Medical Alerts – raised by our Trust go through Clinical Procurement Specialist Nurse
- Changes to Wards / Clinical Areas or new Wards / Clinical Areas – Procurement / Supplies linked in to ensure correct stock ready to use
- Regular Supplier reviews for products, plus each Supplier who provides products / services to the Trust has provided Procurement with a Business Continuity Plan, again which is filed on the department S Drive

**PPE**

- Daily Stocktake of PPE
- Spreadsheet created to allow Trust to know how many days stock we have of each product
- Regional Meetings – were daily, now twice a week regarding PPE and regional situation
- Input onto two systems, one regional and one national of current stock situation and burn rate
- Weekly Trust meeting on PPE, again currently fortnightly

### 3.2 HSE Inspection

Following a visit from the HSE in July 2019, the Trust was issued with 4 Improvement Notices.

- **Manual handling training** for staff on Wards 50 and 51 who work with patients with Dementia. Actions Implemented and the notice was closed.

  Assurance received from Sallie Kelsey (Interim Head of Education): Manual Handling training was reviewed and a new presentation was created and rolled out to include the staff working with patients living with dementia whilst on the wards.

- **Training for staff:** Staff on Wards 50 and 51 who work with patients with Dementia Actions Implemented and the Notice Closed

  Assurance received from Sallie Kelsey (Interim Head of Education): Conflict resolution training has taken place but the specific training regarding clinical holding for the high risk areas is on hold as it involves close contact work. The manual handling requirements have continued and are still in place.

- **Radiology Department**: The Trust needed to control the extent to which employees and other persons are exposed to ionising radiation in the nuclear medicine department.

  Assurance received from Ruth Buckley (Radiology Service Manager): The recommendations required the Department to review the designation of rooms and corridors within the nuclear medicine department as well as the process for contamination monitoring paying attention to the risk of spreading radioactive contamination outside of the working area. These recommendations were put into the local rules and as such, the Department are professionally bound by them. All local rules are reviewed on an annual basis, along with our external radiation protection advisor.

- **Lone Working in the Community**: The Trust was deemed as not doing enough to protect the Lone Workers in the Community from violence and aggression in patient's homes. Actions implemented and the Notice closed**.**

  Assurance provided by Alex Holroyd (Inpatient Lead Therapist): Since the visit from HSE in autumn of last year, the Rapid Response Team (RRT) has successfully adopted the Malinko software (from January 2020). The software allows the team to schedule our daily visits to ensure maximum capacity is utilised in the system and most importantly staff safety

throughout the working day by staff checking in and out on their phones after each patient visit.

Each member of staff has their own work phone and on the whole the implementation of the new scheduling system has been welcomed by all staff, demonstrated through their compliance of using the system (this is continually audited). One caveat to all of this has to be COVID 19; The Trust had 32 therapy staff redeployed to the RRT late March through to the end of this month which will have undoubtedly skewed some of the data (in terms of check in and check out) as this group of staff had to be manually added to Malinko on a daily basis and they did not have their own devices. In the absence of the check in check out system for the redeployed staff, a buddy system was put into place.

By introducing Malinko it has allowed the Trust to see what our capacity is on a day to day basis, with up to a 5 day future view which is invaluable for planning hospital discharges whilst trying to maintain flow.

The Lone working policy is currently under review and will be reviewed and shared with the Partnership Forum and ratified at the Health & Safety Group meetings. This will then be added to the Trust Intranet.

The HSE Inspectors returned in January 2020 to review the actions implemented and were satisfied that the actions were suitable and sufficient enough for the Improvement Notices to be closed.

An official audit on the status of the actions has not yet been completed but assurances have been given by the relevant department Leads that all actions arising have been implemented into normal business as usual.

### 3.3 Covid 19 Pandemic

There is new ‘emergency legislation’ now in force to address the challenges posed by the Coronavirus outbreak. This has allowed “extraordinary measures” never seen during peacetime in the UK.

**The Coronavirus Bill** was introduced in the House of Commons on 19 March 2020 (Bill 122). It received Royal Assent on 25 March 2020 having been fast-tracked through Parliament.

The purpose of the Act is to provide ‘emergency powers’ needed to respond to the current coronavirus epidemic. Powers are for use only if needed, judged on the basis on the clinical and scientific advice.

Although there is no direct duty on the Trust, the above legislation has driven all relevant changes to all processes falling under the COVID 19 remit to which the Trust have responded.

The Health and Safety Compliance Manager was part of a strong team who helped set up and manned the Silver Control Function during the first 12 weeks of the pandemic, they

assisted with the COVID Secure Risk Assessments for Departments in facilitating teams to return to work, ensuring that offices were safe, clean and that safe distancing was observed and the wearing of masks in offices was mandatory as per the Trust guidelines.

### 3.4 Brexit

Minor amendments have been made to regulations to remove EU references. However, the legal requirements for employers remain the same as before the UK formally left the European Union on 31 January 2020. Therefore, our duties to protect the health and safety of those affected by our work have not yet changed.

The UK is now in the 'transition period', which began immediately after Brexit day and is due to end on 31 December 2020. During this 11-month period, the UK will continue to follow all of the EU's rules.

### 3.5 RIDDOR Reporting under COVID 19

The HSE introduced a change to the RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) and Covid-19 Reporting. The requirement is that the Trust must only make a report under RIDDOR when:

1. An unintended incident at work has led to someone's possible or actual exposure to Coronavirus. This must be reported as a dangerous occurrence.
2. A worker has been diagnosed as having COVID 19 and there is reasonable evidence that it was caused by exposure at work. This must be reported as a case of disease.
3. A worker dies as a result of occupational exposure to coronavirus

The Trust has put a process in place to manage the above requirements. The 3 conditions to make a report under RIDDOR listed above are still valid. Outside of these 3 categories it won't fall under the RIDDOR reporting requirements.

## 4 Health and Safety Group and Management Structure

During the COVID 19 pandemic, all meetings were paused and there are plans in place to reinstate the Health and Safety Committee meetings in September and the Terms of Reference have been revised to accommodate the current standing as we look to re-introduce the meetings. (See Appendix 1)

The Health and Safety Committee receive Assurance reports from the leads for the following functions;

- Fire safety
- Health and safety training provision
- Manual handling
- Occupational Health and Wellbeing
- Catering
- Risk management
- Security

The Health and Safety Group meetings receive these assurance reports and the leads for the relevant functions have the opportunity to present data for their areas and any associated risks arising, the number of Datix cases reported during the last quarter and any actions which may have been put in place.

The function leads also have the opportunity to share knowledge and situations they may have come across, with the other Group members, this helps in bringing discussion around possible solutions and any potential training requirements which may help raise awareness.

## 5 Risk Management and Risk Reporting

The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999.

To support the risk assessment programme, the Health and Safety Compliance Manager rolled out local and open risk assessment training promoting best practice in the completion of a Trust risk assessment and the principals of effective Risk Management within departments and in the wider Trust.

This training has been well attended by employees and the training will continue to be available to employees and refresher training is also in place.

The Health and Safety Compliance Manager continues to provide advice and guidance in the implementation of statutory risk assessments through the various sub groups.

New simplified risk assessment forms developed include;

- General Risk Assessment Form
- Service Impact Risk Assessment
- New and Expectant Mothers Risk Assessment Form
- Workstation Assessment Form
- COVID 19 Secure Area Risk Assessment

All forms have been adopted as standard practice by the Divisions with specialist risk assessments being completed by the Health and Safety Compliance Manager upon request.

## 6. Health and Safety Incident Reporting

The following data provides a detailed breakdown of the level of harm, and type of health and safety related incidents that have been reported in 2019/2020;

**Figure 1 Moderate Injuries reported incidents**

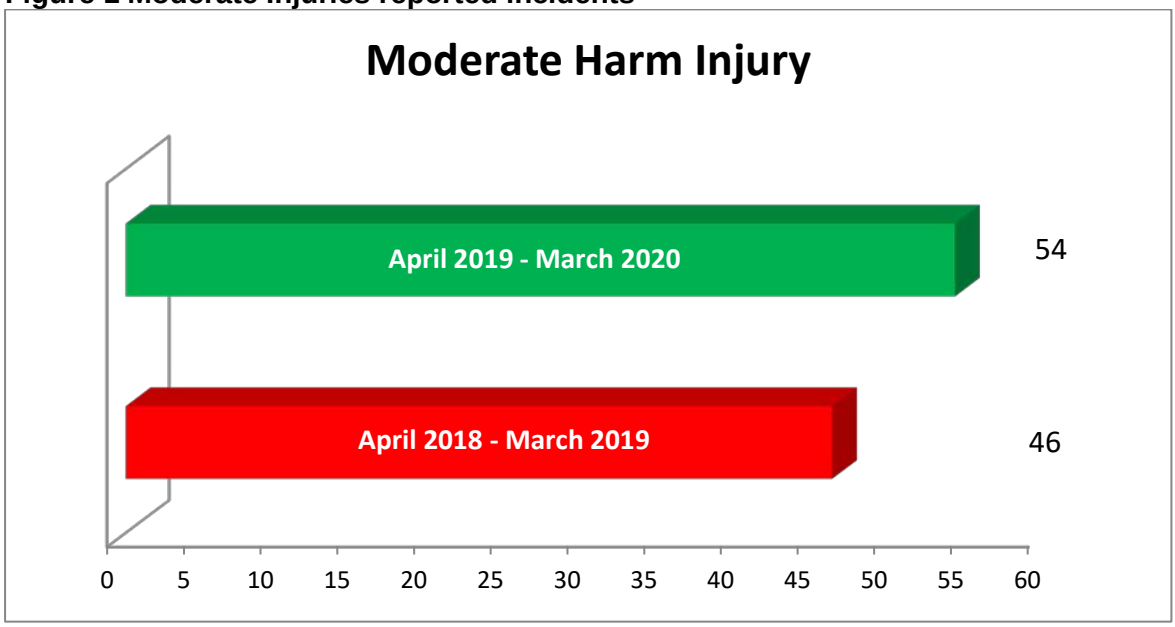



Fig 1 indicates an increase in the number of incidents over previous years which a detailed analysis has revealed this to be as a result of the improved Trust-wide awareness of the need to fully report Health and Safety incidents.

The number of reported events shows an increase from the previous year's reports as a result of this changing culture.

DATIX reporting is endorsed and promoted at all Mandatory Training Sessions and in 2020 there are plans to roll out 2 hour training sessions for all Ward Managers.

This training will be focused on the Ward Managers requirements for the correct and timely reporting of all incidents within their department.

The process for managing each Datix case raised will be clearly explained along with how the categories allocated impact on the investigation and reporting process through to the Datix case being closed off.

The training commenced mid August 2020. Dates are ongoing and the training has been well received from staff.

**Figure 2 Low Harm Injuries reported incidents**

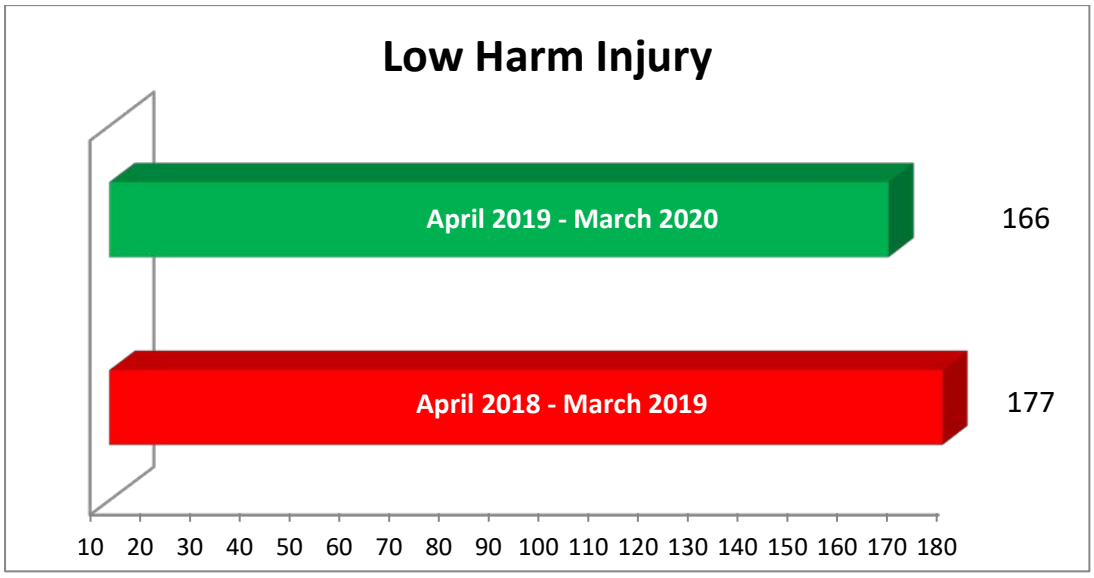
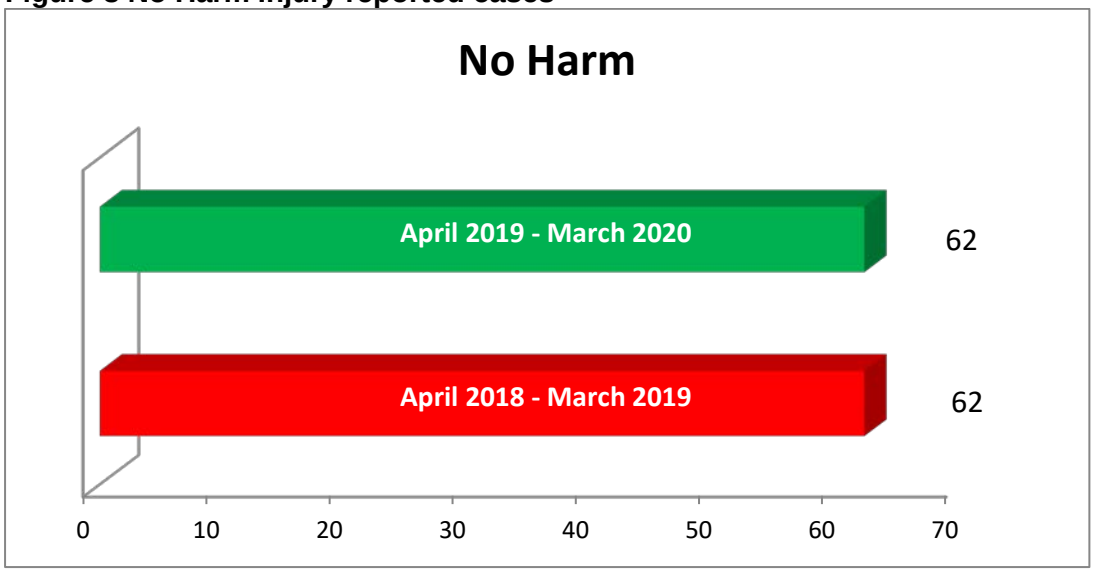



**Figure 3 No Harm Injury reported cases**

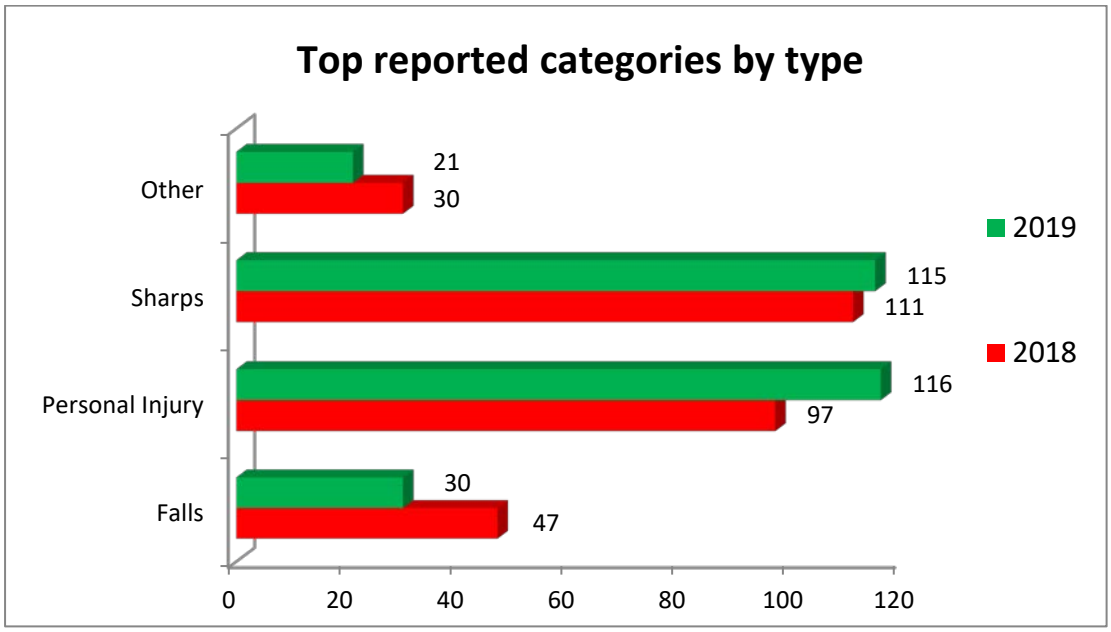



Figures 2 and 3 show the 'low harm' and 'no harm' cases from the past 2 years and these figures indicate a decrease in the number of low harm incidents over previous years. (2018 and 2019)

There is an assumption that this is attributed to an increase of reporting following Mandatory Training.

## 6.1 Health and Safety Incident themes (2019/2020)

**Fig 4 highlighting the top categories reported**




The breakdown of the "other" category in the graph above was made up of some of the following cases

- Injury to patient
- Splash of bloods
- Contamination of atmosphere
- Temperature issue
- Fire escape blocked
- Unsafe environment
- Equipment malfunction
- Chemical waste

Fig 4 indicates a rise in the past 2 years of the number of incidents over previous years. A detailed analysis has revealed this to be as a result of the improved Trust wide awareness of the need to fully report health and safety incidents.

The actual number of case rose for the reporting period are shown below and indicate a level of consistency of reporting.

**April 2018 to March 2019:** 285 incidents
**April 2019 to March 2020:** 282 incidents

### 6.1.1 Learning / changes in practice

Personal Injuries were the highest reported accident outcome as shown above; these injuries were a cross section of slips, trips, falls, manual handling injuries, needlestick injuries and inoculation injuries.
For a full breakdown of legal claims and costs, please refer to Appendix 2

We cover the need for safety awareness in the work environment at Mandatory training and it is difficult to achieve a zero reported injuries culture but by following up on Datix cases the investigations will go some way to establishing root cause to identify any common trends and sharing learning from incidents to prevent incidents in the future.

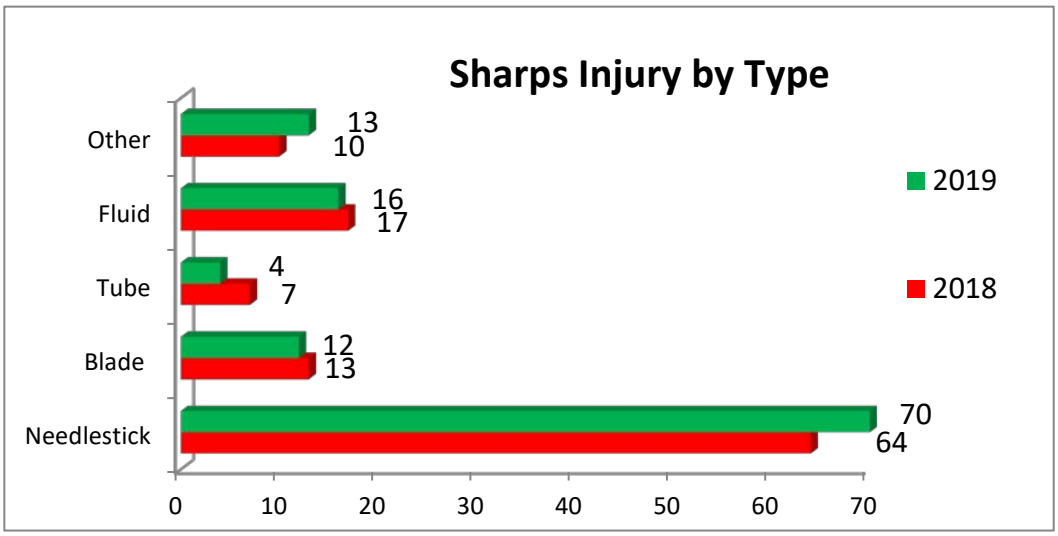
The trends may be falls in a particular area or particular work group i.e. junior doctors and nurses, these groups will receive more specific training in risk awareness to further improve their safety knowledge and this, in turn, could help to reduce the number of incidents.

## 6.2 Sharps

This area of reported incidents remains a cause for concern. However, the in-year sharps incidents were below the 4 year average with the overarching percentage of sharps incidents remaining stable. The Trust implemented 'A New, Safer Sharps Initiative in 2017' which has helped reduce the number of needlestick injuries.

### 6.2.1 Sharps Incidents

**Fig 5 Highlighting sharps injuries by type**



The data below shows the breakdown of these categories through Datix entries for the periods April 2018 to March 2019 and April 2019 to March 2020.

The category for sharps falls under Inoculation / Sharps Injury and as such has the following topics;

- Needlestick Injury
- Fluid Splash
- Blades
- Glass tubes
- Other (Wires, staples etc.)

Total Sharps / Inoculation figures for the past 2 years are;

**2018:** 111

**2019:** 115

The figures are consistent across all categories and the Sharps / Inoculation figures for the past 2 years are lower since the introduction of the New, Safer Sharps Initiative in 2017.

### 6.2.2 Learning / Changes in practice

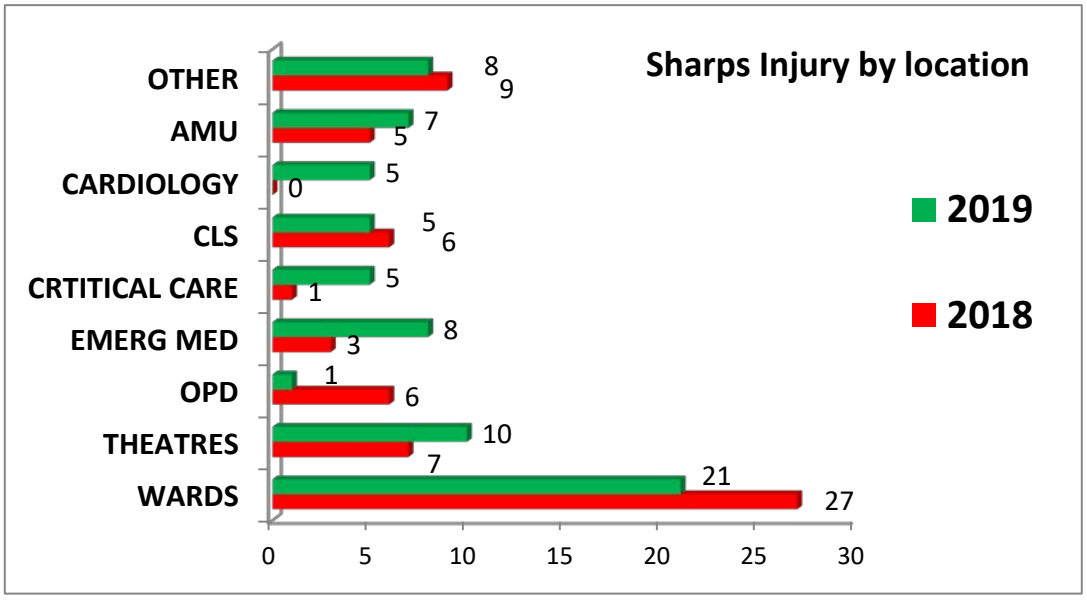
The inoculation / sharps injuries which are reported through Datix cover a cross section of types as listed in section 6.2.1; the most significant type being Needlestick injuries.

These are covered at mandatory training sessions for all groups (Clinical, Medical & Non-Clinical) this training highlights the need for greater care when handling the needles.

However, the Mandatory Training sessions are only every 2 years so it is important that we continue to promote safe practice in relation to inoculation / sharps injuries (see section 9.3 for further information).

An online E-Learning programme is being explored for sharps safety which could be carried out more frequently to the more relevant groups of staff. The aim is for the training to be every 6 months or annual and would be recorded in ESR training records. The training is to be monitored and cross-checked following any sharps incident reported to check when the individual last received this training.

**Fig 6 – Needlestick injuries by location**




The “other” category in the chart above is made up of other locations where no more than one injury had been reported for that area.

## 6.3 RIDDOR Incidents

There has been a decline in the number of RIDDOR reports over the past four years and the data in the table below is from April 2018 to March 2019 and April 2019 to March 2020;

**April 2018 to March 2019:** 10 Reports submitted to the Health and Safety Executive

**April 2019 to March 2020:** 9 Reports submitted to the Health and Safety Executive

**Fig 7 Breakdown of RIDDOR reportable injuries**

| Incident Type | 2018 | 2019 | Detail | Column1 |
|---|---|---|---|---|
| MSKD | 1 | 0 | Rapid Response staff injured when patient at home lost their balance | Apr-19 |
| Violence | 2 | 1 | Nurse assaulted by confused elderly patient on Ward 54 | Apr-18 |
| | | | Security Guard assaulted by confused patient in A&E | Dec-18 |
| | | | Nurse assaulted by elderly patient on ward 51 | Apr-19 |
| Slip | 4 | 6 | Domestic Supervisor slipped on the wet floor of the Mop Washing Room | Jul-18 |
| Slip | | | A member of the choir tripped on a pavement outside EDTC | May-18 |
| Slip | | | Employee tripped over television stand in Critical Care | May-18 |
| Slip | | | Midwife tripped over stool and fell to floor, fractured bone in hand | Oct-18 |
| Slip | | | Nurse fell from tripping over against the leg of table in D4 Theatre | May-19 |
| Slip | | | Nurse went into a bay on a ward and slipped over spilt alcohol gel | Jun-19 |
| Slip | | | More than 7 day absence for Domestic Assistant who fell down the stairs | Jun-19 |
| Slip | | | Member of public fell on a ward, no obstacles or wet floor | Jul-19 |
| Slip | | | 7 day absence through finger injury when employee tripped over green boxes | Nov-19 |
| Slip | | | Employee rehanging curtains, slipped on the step ladder, fractured ankle | Dec-19 |
| Electric Shock | 1 | 0 | Nurse received electric shock from faulty bed | Jul-18 |
| Fractured Wrist | 1 | 0 | IT Employee received fracture wrist whist loading PC's onto trolley | Aug-18 |
| Needlestick | 1 | 0 | Needlestick Injury from Patient known to be Hepatitis C positive | Mar-19 |
| Back injury | 0 | 2 | Employee injured back trying to catch falling notes - Hospital admission | Sep-19 |
| Back injury | | | More than 7 day absence through back injury caused in labour delivery | Oct-19 |

Previous Years RIDDOR Reports submitted to HSE;

**2016:** 15 Reports Submitted

**2017:** 14 Reports submitted

**2018:** 10 Reports submitted

### 6.3.1 Learning / Changes in practice

As shown in figure 7, the incidents which have been reported under the RIDDOR legislation cover a variety of topics and due to the criteria for reporting, it is vitally important that the Ward and Department Managers fully understand the criteria when they initially report a Datix incident to ensure that they complete the Datix form correctly and activate the RIDDOR check box so this is captured when any RIDDOR queries are run from within Datix.

By arranging training sessions for these managers, we can educate them on the full criteria around the RIDDOR legislation, this in turn, will empower them to understand how the criteria governs whether a RIDDOR report is required or not.

There is a process in place, as a part of this training, where the Health & Safety Compliance Manager is informed or consulted for any assistance the Managers may require.

An example of one particular incident which was reportable under the RIDDOR legislation in the past 2 years was the electric shock from a bed incident resulting in harm to a member of staff on Ward 51 in July 2018.

Following meticulous investigation, it was established the incident occurred due to damaged cables either by one and/ or several of the following;

a) Running over of the power cable
b) Trapping cable in the bed during use of remote control i.e. back rest movement
c) Plug being ejected from socket if not removed prior to movement of bed.

**Actions taken**

1. Beds are now serviced to have the long fixed cable replaced by new coil style cable which is bright orange and less likely to be run over. Estimated cost approx. £2K per year for next 2 years
2. Mandatory training presentations has been updated to include this incident
3. Risk & Safety Leads are now briefed regarding updated training contents
4. Alert briefing has been produced for all relevant staff groups i.e. nursing/porters, this was signed off prior to circulation
5. There is a long term plan for RCD's to be used for each bed plug. A paper regarding the costs will be presented to CLG
6. Beds are serviced as per manufacturers' recommendations. The Trust will assess how many beds are over this deadline
7. Estates raised an issue that upgrade work/basic maintenance was behind schedule due to lack of a decant ward. This work would facilitate the installation of RCD protection in fuse boards. However, due to nature of wiring in the Trust wards need to be fully empty to facilitate this as a bay by bay approach not an option

**Current practice**

All RIDDOR reportable incidents are thoroughly investigated and captured in the Datix case notes.

These investigations and subsequent action plans are then closed off when complete and made available to the Legal Department should any personal injury claims arise.

They would also be evidence for any external investigation which may be carried out as a result.

## 7 Health and Safety Policy

It is recommended that the Health and Safety Policy be reviewed, signed and dated by the Chief Executive, and added to the Trust Intranet. This should be an annual procedure. The Health and Safety Compliance Manager has reviewed the policy in August 2020. This policy will now be presented to the Health & Safety Group meeting in September and then approved at the next QGG meeting. A communication plan is being developed to raise awareness of the Health and Safety Policy.

## 8 Conclusion

The latter part of the reporting year has been a challenge to the Trust in view of the COVID 19 pandemic. However, further work is required to ensure the full compliance for Health and Safety across the Trust and this is underway.

With more support and awareness training, the Health and Safety Compliance Manager will be able to improve the culture for Health and Safety across the Trust.

The next steps identified below will ensure that the Trust will be fully compliant in all risk assessments, policies and procedures, providing robust assurance and ensuring that we are prepared for the Care Quality Commission / Health and Safety Executive Audit at all times.

## 9 Next Steps

### 9.1 Health and Safety Group

- Strengthen visibility of the group
- Strengthen membership engaging with staff side and Partnership forum colleagues
- Development of a work plan to inform Management business
- Development of a Training Programme (with focus on identified areas of risk)
- Develop a Health and Safety Audit plan
- The main objective for the Health and Safety Committee will be to meet quarterly and to have a more pro-active agenda with the creation of a new task and finish sub-group to be more interactive in the Health and Safety culture within the Trust.

### 9.2 Risk Assessment

The development of a Risk Assessment Sub-Group who will be a team all trained in producing high quality risk assessments of a consistent standard at a local level. In turn they will be able to provide local support in addition to the ward managers.

The Trust has staff that have been trained in carrying out risk assessments but not all are actively involved in creating and reviewing the risk assessments we have in place. By involving staff in the creation and review of risk assessments this will also help to improve the Health and Safety culture within the organisation.

### 9.3 Focus on Sharps Injuries

The number of sharps injuries has reduced since the introduction of the New, Safer Sharps Initiative in 2017. However, it would be pertinent to raise awareness of sharps injuries and the need for greater care further through local promotions i.e. screen savers; local flyers; Multidisciplinary Team (Clinical Leaders, Occupational Health Department; suppliers etc) hosting an awareness day for the Trust.

As detailed in this report, the Inoculation / sharps injuries are not just needlestick injuries but this category is the highest (63.06%).

We will improve safety culture around needlestick injuries by learning from incidents and education through better communication.

By working with the Practice Development team we can promote safer working by using screen savers, by enhancing the content of mandatory training content for all Clinical and medical groups to raise awareness and look at best practice.

We could create an online E-learning session for staff to undertake following any sharps incident by way of re-educating them.

### 9.4 RIDDOR

It is recommended that a training awareness session is developed for all Department and Ward Managers on the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR).

Incidents are put into DATIX, they are investigated and if they meet the criteria they are reported to the HSE and reported under the RIDDOR legislation.

They are then usually submitted by the Health and Safety Compliance Manager but some Department Leads are able to do this. All RIDDOR Reports are then added to the Datix Case notes.

The introduction of a Management training session on the back of the recent DATIX training for Ward and Department managers will raise awareness about the process required to report any incidents, which fall under the RIDDOR legislation, to the Health and Safety legislation. These incidents are usually where an employee has been off work for more than 7 days as a result of an injury or illness in the workplace. Other criteria for reporting are certain types of fractures, diseases or dangerous occurrences.

Regular auditing of the DATIX system will be carried out to monitor the number of incidents reported under the RIDDOR legislation. We can then communicate any relevant findings to the Trust.

## 10. Recommendations

The Quality & Safety Committee is asked to receive this assurance report and note the Health & Safety activity during the year April 2019 – March 2020 and support proposed next steps for 2020/2021.

**Appendix 1**

Countess of Chester Hospital NHS
NHS Foundation Trust

**Terms of Reference**
**Health and Safety Group**

## 1. Main Authority

The Risk, Health and Risk Committee exists to allow appropriate scrutiny and review of health and safety related functions to ensure the delivery of national standards and targets. The committee will review risk, health and safety in all areas of the Trust

## 2. Main Duties and Responsibilities

The Risk and Performance Committee will;

- To be at all times conversant with the key Risk and Health and Safety regulations, standards and guidance and the expectations of the Trust's Board of Directors, Quality Governance Group and Corporate Leadership Group
- To monitor the performance and effectiveness of the Trust's Health and Safety systems, policies and procedures.
- To keep up to date with relevant changes in legislation and to ensure new policies and procedures are developed if necessary.
- To develop and monitor the implementation of the Trust's Risk, Health and Safety priorities in respect of all operational aspects and key performance indicators
- To manage the Trust's Health and Safety Risk Register
- To identify areas of hospital policy that requires change in order to effect improvements.
- To agree action plans developed from risk assessment, which may have financial investment implication and prepare these for escalation to the Risk and Performance Committee
- To receive information regarding all relevant incidents and to ensure all risk reductions systems have been used
- To receive, monitor and action reports following visits by enforcement officers i.e. Inspectors of the Health and Safety Executive, Environmental Health Officers and the Fire Service.
- To monitor relevant indicators (e.g. trends revealed in incident report forms, violent incident reports and statistics on fire).

- To formulate and oversee systems of audit in relation to all aspects of Health and Safety, including risk assessment and training.
- To prepare a Chairs report following each meeting
- To resolve issues of risk and health and safety which cannot be dealt with at departmental level and to refer matters which the Group cannot resolve to the Quality Governance Group and Senior Leaders Group

**3. Constitution**

**Frequency of Meetings:**

- The Risk, Health and Safety Committee will meet bi monthly

**Chair:**

The Chair of the Risk, Health and Safety Committee is currently the Health and Safety Compliance Manager

**Membership: 2020**

| Division | Name |
|---|---|
| Health and Safety Manager (Chair) | Michael Sturgess |
| Fire Safety Manager | Nigel Bruty |
| Occupational Health Manager | Catherine De Beger |
| Catering Representative | Sue Miller / Sarah Pemberton |
| Facilities | Sam Tompkins |
| HSDU | David Cryle |
| Manual Handling Representative | TBC |
| Estates Representative | Ian Miller / Andy Tilston / Barry Ollerhead |
| Security Representative | Tim Lister / Mark Nightingale |
| Urgent Care Representative | Caterina Witkiss |
| Planned Care Representative | Lucy Parry / Jo Keogh |
| Diagnostic and Infrastructure Representative | Alan Shaw |
| Union Representation | Chris Clarke |

**Quorum:**

A quorum shall be 6 members, to include at least 3 Department Leads

**Reporting:**

The minutes of the Risk and Performance Committee will be prepared by the PA to the Chief Executive and received by the Finance and Integrated Governance Committee as a means of assurance.

**Approved:**

**By:** The Risk, Health and Safety Committee **Date:** TBC

Countess of Chester Hospital NHS Foundation Trust

**Appendix 2**

# Legal Claims Apr 19 – Mar 20

| Claim ref | Datix incident ref | Type of claim | Date claim received | Incident date | Description of incident and alleged injury | Position of claim | Damages paid | Costs paid | Damages Reserve | Costs Reserve |
|---|---|---|---|---|---|---|---|---|---|---|
| 3591 | 177848 | Employer Liability – Sharps injury | 26/06/19 | 18/05/19 | Claimant cleaning side room in ED and picked up a pile of tissues from the floor which contained sharps, causing injury | Liability admitted – claim settled and closed | £2,600 | £2,070 – claimant costs | n/a | n/a |
| 3595 | 179072 | Employer Liability – Sharps injury | 10/07/19 | 24/06/19 | Claimant cleaning in theatres and was removing orange waste bag. Sustained sharp injury from sharp incorrectly disposed of in orange bag | Liability admitted – claim settled and closed 07/10/19 | £2,000 | £1,080 – claimant costs | n/a | n/a |
| 3603 | n/a | Public Liability – Slip/trip/fall | 25/07/19 | 15/04/19 | Claimant allegedly slipped on uneven ground near Stores while delivering parcel | Liability denied – claim closed 10/12/19 | Nil | Nil | Nil | Nil |
| 3639 | 182896 | Public Liability – Assault by staff | 11/10/19 | 16/09/19 | Claimant allegedly hit by Security Officer after being told about parking in non-designated parking place outside ED | Liability denied 31/01/20 – case still open | Nil | Nil | Nil | Nil |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 3648 | 180570 | Employer Liability – Sharp injury | 12/11/19 | 05/08/19 | Claimant sustained sharps injury while taking blood from vulnerable patient with assistance from patient's mother | Liability denied – claim closed 11/03/20 | Nil | Nil | Nil | Nil |
| 3685 | 173582 | Employer Liability – Slip/trip/fall | 16/01/20 | 23/01/19 | Claimant allegedly sustained injury after slipping on ice on path going towards Haygarth Building | Liability denied – Challenged – claim open | n/a | n/a | £25,000 | £3,500 – claimant costs |
| 3696 | 178216 | Employer Liability – Slip/trip/fall | 14/02/20 | 31/05/19 | Claimant allegedly sustained injury when their shoe got caught on leg of desk while moving to use phone on another desk | Liability admitted – settlement being negotiated | n/a | n/a | £10,000 | £2,000 |
| 3705 | 186733 | Employer Liability – Slip/trip/fall | 28/02/20 | 31/01/20 | Claim for injuries when claimant tripped over kerb which was obstructed by temporary barriers on path that was poorly lit | Liability admitted – settlement being negotiated | n/a | n/a | £10,000 | £12,000 |
| 3706 | n/a | Employer Liability – Manual Handling | 28/02/20 | 09/08/18 | Claimant allegedly sustained back injury while assisting intoxicated patient from trolley in ED and patient fell onto claimant. | Claimant advised to prove claim happened as alleged as incident not reported – claim open | n/a | n/a | £10,000 | £4,000 – claimant costs |

Countess of Chester Hospital NHS Foundation Trust

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|---|---|---|---|---|---|---|---|
| **Meeting** | **19th January 2021** | | **Board of Directors** | | | | |
| **Report** | **Agenda item 14.e** | | **Council of Governors Chair's Report** | | | | |
| **Purpose of the Report** | Decision | | Ratification | | Assurance | Information | **x** |
| **Accountable Executive** | Chris Hannah | | | | Chair | | |
| **Author(s)** | Keith Haynes<br><br>Debbie Bryce | | | | Interim Governance Consultant,<br><br>Lead for Governance Improvement | | |
| **Board Assurance Framework** | G1 | Governance Improvement | | | | | |
| **Strategic Aims** | To develop and improve corporate governance | | | | | | |
| **CQC Domains** | Well Led | | | | | | |
| **Previous Considerations** | The previous Council of Governors Chair's report was to December 2020 Board of Directors, outlining the 1 October 2020 Council of Governors meeting content. | | | | | | |
| **Summary** | This report is intended to provide a summary update of business from the Council of Governors meeting held on 11 December 2020. | | | | | | |
| **Recommendation(s)** | The Board of Directors is asked to note the report. | | | | | | |
| **Corporate Impact Assessment** | | | | | | | |
| **Statutory Requirements** | The Council of Governors holds the non-executive directors individually and collectively to account for the performance of the Board of Directors, and represent the interests of the members of the Trust as a whole and the interests of the public. | | | | | | |
| **Quality & Safety** | | | | | | | |
| **NHS Constitution** | | | | | | | |
| **Patient Involvement** | | | | | | | |
| **Risk** | | | | | | | |
| **Financial impact** | | | | | | | |
| **Equality & Diversity** | | | | | | | |
| **Communication** | | | | | | | |

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## 1.0 Key items of business considered

**1.1** The meeting of the Council of Governors was held via videoconference on 11 December, 2020. There was both a public and private session held. The items of business included:-

In public session:

- The written Chief Executive Officer's (CEO) update report;
- Questions on the Board of Directors meetings, 8th September and 1st December, along with the October 2020 integrated performance report and the October finance report;
- Questions in relation to the Quality & Safety Committee and Finance & Performance Committee Chair's reports;
- The request to approve amendments to the Trust's Constitution, including Standing Orders;
- Results of Governor elections 2020;
- Update on Governor training held in November 2020; and
- Governors' feedback on intelligence received from members and the public on services provided by the Trust.

In private session:

- Short-term extension of external auditor contract;
- To consider and approve recommendations from the Chair of the Governor Nominations Committee in relation to the appointment of a Non-Executive Director and chair of Audit Committee; and
- Update on appointment of the Trust Chair.

**1.2** It was noted that due to operational pressures associated with the pandemic, the number of executive directors in attendance at the meeting was lower than usual.

**1.3** In relation to the October finance report, governors made enquiries in relation to the differences between the latest report and the previous report, the high nursing agency expenditure and capital expenditure. In the responses from executives, it was noted that the overspend at the end of October was less than expected; there was COVID-related staff absence on top of normal absence rates; and there were efforts in place to support the capital programme expenditure by 31st March 2021.

**1.4** In response to the Quality & Safety Committee chair's report, there was a discussion, prompted by governor questions, in relation to the CQC temperature monitoring solution and mitigations in place, along with the falls and pressure ulcers deep dives and the impact of long lengths of stay on pressure ulcers. Governors were also informed that hospital acquired infections would be explored further at the 15 December meeting of the Quality & Safety Committee.

**1.5** The proposed refreshed Trust Constitution, including Standing Orders, was presented to governors for approval. It was noted that work had been undertaken to update the Constitution

and provide a greater alignment with the model constitution adopted by many trusts. The opportunity had also been taken to include a number of provisions which the Governors and the Trust Board wished to make – e.g. residency requirements for Non-Executive Directors, provision for Associate Non-Executive Directors, clarification of terms of office for Non-Executive Directors which better aligns with good governance practice, and that a small governor task and finish group had been involved.

**1.6** The final governor election results were noted, following the process operated by an independent election services provider. The published voting Report and Uncontested Report were shared with the Council of Governors.

**1.7** The governors noted the paper which outlined details of attendance and content of the governor two half-day *Govern Well: Core-Skills* training sessions held on 10 and 12 November 2020, operated by NHS Providers.

**1.8** In private session, the Director of Finance explained the background and rationale to a proposal to extend the existing external auditor contract for an additional one year with an option to extend for a further one year and not to go out to the marketplace currently. Private examples of other trust's recent experience and challenges with the marketplace were shared. There was a thorough discussion and consideration of the issue by governors.

**1.9** In private session, the Chair of the Governor Nominations Committee, Deputy Lead Governor, Mr Russell Jackson, updated the governors on the recent work of the Appointments Panel, making a recommendation as to appointment. Furthermore, he updated governors on the progress with the Trust Chair's appointment and informed that the advertisement had been circulated extensively and is hoping will be able to attract a wide range of people to the appointment for the Appointments Panel to consider in February 2021.

## 2.0 Key agreements or decisions made

The Council of Governors:

**2.1** Unanimously approved the refreshed Trust Constitution, including Standing Orders.

**2.2** Approved the extension of the existing external audit contract with KPMG for an additional one year with an option to extend for a further one year if required.

**2.3** Approved the appointment of a Non-Executive Director and Audit Chair and noted the intention to undertake a skills audit prior to consideration of the appointment process for a seventh Non-Executive Director.

## 3.0 Recommendation

**3.1** The Board of Directors is asked to note the report.

NHS
Countess of Chester Hospital
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|---|---|---|---|---|---|---|---|---|
| **Meeting** | **19 January 2021** | | **Board of Directors** | | | | | |
| **Report** | **Agenda item 14.f** | | **Board Business Cycle** | | | | | |
| **Purpose of the Report** | Decision | | Ratification | | Assurance | | Information | x |
| **Accountable Lead** | Keith Haynes | | Interim Governance Consultant | | | | | |
| **Author(s)** | Debbie Bryce | | Lead for Governance Improvement | | | | | |
| **Board Assurance Framework** | G1 | Governance Improvement | | | | | | |
| **Strategic Aims** | To develop and improve corporate governance | | | | | | | |
| **CQC Domains** | Well Led | | | | | | | |
| **Previous Considerations** | - | | | | | | | |
| **Summary/ Highlights** | The report provides the updated cycle of business of the Board for 2020-21.<br><br>The following key items of business have been deferred on the Board business cycle in January 2021:<br><br>i. Gender pay gap report (*submission due in March*).<br>ii. Integrated Care Partnership Board Report - within CEO report (*as ICP Board postponed due to Covid-19 pressures*).<br><br>The following item has been added to the business cycle in January:<br>(a) Update on capital budget.<br><br>Work has begun on refreshing the business cycle for 2021-22 and there will be engagement with Executives and the Chair on this prior to 9th March Board meeting. | | | | | | | |
| **Recommendation(s)** | The Board is asked to note the updated business cycle. | | | | | | | |
| **Corporate Impact Assessment** | | | | | | | | |
| **Statutory Requirements** | - | | | | | | | |
| **Quality & Safety** | | | | | | | | |
| **NHS Constitution** | | | | | | | | |
| **Patient Involvement** | | | | | | | | |
| **Risk** | | | | | | | | |
| **Financial impact** | | | | | | | | |
| **Equality & Diversity** | | | | | | | | |
| **Communication** | | | | | | | | |

**Countess of Chester Hospital NHS Foundation Trust - Board Business Cycle (Version 13 - for January 2021 Board)**

| | | | | Qtr | | | Qtr | | Qtr | | Qtr | | Qtr | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Item** | **Frequency** | **Lead** | **Nov'19** | **Jan'20** | **Mar'20** | | **Apr'20** | **June** | **July** | **Sep'20** | **Oct'20 *** | **Dec'20** | **Jan'21** | **Mar'21** |
| **General Business** | | | | | | | | | | | | | | |
| Welcome and apologies for absence | Monthly | N/A | x | x | x | | x | x | x | x | x | x | x | x |
| Declarations of Interest | Monthly | N/A | x | x | x | | x | x | x | x | x | x | x | x |
| Minutes of last meeting | Monthly | N/A | x | x | x | | x | x | x | x | x | x | x | x |
| Action tracker and Matters Arising | Monthly | N/A | x | x | x | | x | x | x | x | x | x | x | x |
| CEO report | Monthly | Chief Executive Officer | x | x | x | | x verbal | x verbal | x | x | x | x | x | x |
| Infection Control BAF | Each meeting | Dir of Nursing & Quality | | | | | | x | x | x | x | x | x | x |
| BAF and CRR mapped onto BAF | Quarterly | Dir of Corporate Affairs | x | x | | | x | | x | | x | x | x | |
| **Quality of Care** | | | | | | | | | | | | | | |
| Patient Story | Monthly | Dir of Nursing&Quality | | x | x | | → | → | → | → | x | x | x | x |
| Clinical Presentation - Clinical Service Deep Dive (covered within Q&S Committee Chair's report from Dec 2020) | Quarterly | Dir of Nursing&Quality and Exec Medical Director | | | | | | → | | x | | x | | x |
| GMC National Trainee Survey Results | Annual | Exec Medical Director | | | | | | | → | | → | | | x |
| Quality & Safety Committee Chair Update | Monthly | Non-Exec Director | x | | x | | | x | x | x | x | x | x | x |
| Safeguarding Annual Report | Annual | Dir of Nursing&Quality | | | x 18-19 | | | | → | x | | | | |
| Quality Impact Assessment Report | Annual | Dir of Nursing&Quality and Exec Medical Director | | | | | | x | ← | | | | | |
| Quality Accounts | Annual | Dir of Nursing&Quality | | | | | | → | | → | → | x | | |
| Patient Experience Annual Report | Annual | Dir of Nursing&Quality | | | x 18-19 | | | | x | ← | | | | |
| Learning Disability Mortality Report (within Safeguarding report) | Annual | Exec Medical Director | | | | | | | → | x | | | | |
| Guardian for Safer Working Report | Annual | Exec Medical Director | | | | | | x | | | | | | |
| Freedom to Speak Up Guardian Report | 6 monthly | Dir of Nursing&Quality | | | x | | | | | | → | x | | |
| Learning from Incidents Qtr Report (covered within Q&S Committee Chair's report from Dec 2020) | Quarterly | Dir of Nursing&Quality | | | x | | | | x | | x | | x | |
| Learning from Deaths Report | Bi-Annually | Exec Medical Director | | | | | | → | | | x | | | |
| Mortality Indicators Report | Quarterly | Exec Medical Director | x | x | x | | x | | x | | x | | x | |
| CQC Inspection Report | Adhoc | Dir of Nursing&Quality | | Adhoc | | | | | | | | | | Adhoc |
| Healthcare Acquired Infections Report | Annual | Dir of Nursing&Quality | x | | | | | | | | | x | | |
| Director of Nursing Bi-annual Nurse Staffing Report | 6 Monthly | Dir of Nursing&Quality | | | x | | | | | → | → | x | | |
| Maternity Incentive Standards Submission | Annual | Dir of Nursing&Quality | | | | | | | x | | | | | |
| Updates on Clinical Services Strategy (covered within F&P Chair's report from Dec 2020) | Quarterly | Exec Medical Director | | | | | | → | | x | | x | | → |
| PLACE Report | Annual | Dir of Nursing&Quality | | | | | | → | x | | | | | |
| **Operational Performance** | | | | | | | | | | | | | | |
| Integrated Performance Report | Monthly | Executives | x | x | x | | x | x short version | x short version | x | x | x | x | x |
| Winter Planning | Annual | Chief Operating Officer | | | | | | | | | x | x | | |
| **Finance, Use of Resource and Performance** | | | | | | | | | | | | | | |

| Item | Frequency | Lead | Nov'19 | Jan'20 | Mar'20 | Apr'20 | June | July | Sep'20 | Oct'20 * | Dec'20 | Jan'21 | Mar'21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance & UoR Indicators | Monthly | Director of Finance | x | x | x | x | x | x | x | x | x | x | x |
| Consultant and Honorary Consultant Appointments | Adhoc | Dir of HR & OD and Exec Medical Director | | | | | | | | | | | |
| National Cost Collection Pre-Submission Report | Annual | Director of Finance | | | | → defer 12 mths | | | | | | | |
| Update on Capital Budget | As required | Director of Finance | | | | | | x | | | | x | x |
| Finance & Performance Committee Chair Update | Monthly | Non-Exec Director | x | x | x | x | → | x | → | x | x | x | x |
| Finance & Performance Committee Annual Report | Annual | Director of Finance and Chief Operating Officer | | | | | | | | → | | | → |
| Audit Committee Chair Update | Monthly | Non-Exec Director | x | | | x | x | x | x | | | x | x |
| Charitable Funds Committee Chair Report (covered within Corporate Trustee meeting from Jan 2021) | Quarterly | Non-Exec Director | | | | → | | x | ← | | x | x | x |
| Procurement & Commercial Report | Annual | Director of Finance | | | | | | x | | | | | |
| Remuneration Committee Annual Report | Annual | Dir of HR & OD and Chair | | | | | | x | | | | | |
| Accounts and Annual Report | Annual | Director of Finance and Dir of Corporate Affairs | | | | | x | | | | | | |
| Charitable Funds Accounts (covered within Corporate Trustee meeting from Jan 2021) | Annual | Director of Finance | | x | | | | | | | → | x | |
| Estates & Facilities Report | Annual | Chief Operating Officer | | | | | | | | | → | | x |
| **Strategic Change** | | | | | | | | | | | | | |
| Revenue Budget | Annual | Director of Finance | | | x | | | | | | | | x |
| Capital Budget | Annual | Director of Finance | | | x | | | | | | | | x |
| Trust Board Oversight Report - Radiology Services | Annual | Chief Operating Officer | | | | | | → | | → | | → | x |
| Emergency Planning & Resilience | Annual | Chief Operating Officer | x | | | | | | | x | | | |
| Brexit Impact Assessment | As required | Chief Operating Officer | | | x In F&P report | | | | | | | | |
| Health & Safety Annual Report | Annual | Chief Operating Officer | | | | | | → | | → | | x | |
| Transformation and Quality Improvement Report (to be covered within Chair's report from Dec 2020) | Quarterly | Chief Executive Officer | | | | → | | → | | → | x | → | x |
| Inclusion [Strategy or Report] | Annual | Director of HR & OD | | | | | | | | → | x | | |
| Well-led Framework Review and Action Plan | Annual | Director of Nursing & Quality | | | | | → | | | → | | | |
| Information Governance Annual Report | Annual | Dir of Corporate Affairs | | | | | | x | ← | | | | |
| Operating Plan | Annual | Chief Operating Officer and Director of Finance | | | x | | | | | | | | x |
| Annual Plan (update against strategic objectives) | Quarterly | Chief Executive Officer | | | | | | → | | x | | x | |
| Strategic Objectives | Adhoc | Chief Executive Officer | | | | → | | | | | → | x | |
| IT Strategy and annual update on progress with strategy | Annual | Chief Digital Information Officer | | | | | | | | | → | | x |
| Update on cyber security progress | Bi-annual | Chief Digital Information Officer | | | | | | | → | | x | | x |
| Estates Strategy and annual update on progress with strategy | Annual | Chief Operating Officer | | | | | | | | | → | | x |
| Communications & Engagement Strategy and annual update on progress with strategy | Annual | Dir of Corporate Affairs | | | | | | | | → | | | |
| People & OD Strategy and annual update on progress with strategy | Annual | Dir of HR & OD | | | | | | | | x | | | |

| Item | Frequency | Lead | Nov'19 | Jan'20 | Mar'20 | Apr'20 | June | July | Sep'20 | Oct'20 * | Dec'20 | Jan'21 | Mar'21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Electronic Patient Record update report | bi-monthly | Chief Digital Information Officer | | | | x | | → | → | x | x | | x |
| Integrated Care Partnership Board Reports (within CEO report) | Six times per year | Chief Executive Officer | | | x | X ICPB post-poned | | x | x | | x | → | x |
| **Leadership & Improvement Capability** | | | | | | | | | | | | | |
| Staff related CQUINs | Annual | Director of HR & OD | | | | → | | | | x | | | |
| Annual Review of Rules of Procedure/SFI's | Annual | Director of Finance & Dir of Corporate Affairs | | | | → | | x | | | | | |
| Annual Organisational Audit for Revalidation | Annual | Exec Medical Director | | | | | | | x | | | | |
| Senior Independent Director Annual Report | Annual | Non-Exec Director/SID | | | | | | | | | | | x |
| Education & Development Annual Report (referenced within F&P Chair's report) | Annual | Exec Medical Director | | | | | → | | → | | x | | → |
| Gender Pay Gap | Annual | Director of HR & OD | | x | | | | | | | → | → | x |
| Council of Governors Report/Update | Three times per year | Dir of Corporate Affairs | | x | | x (Mar COG post-poned) | | → meet 24th July | x | | x | x | |
| Annual Provider License Self Certification | Annual | Dir of Corporate Affairs | | | | | x | | | | | | |
| Annual Staff Survey | Annual | Director of HR & OD | | | | → | | | x | | | | |
| Fit and Proper Person Report | Annual | Dir of Corporate Affairs and Dir of HR & OD | | | | | | x | ← | | | | |
| Variation to Standing Orders for Covid-19 and subsequent review | Ad-hoc | Dir of Corporate Affairs | | | | x | x | | | | | | |
| Proposed terms of reference Remuneration & Nominations Committee | Ad-hoc | Dir of Corporate Affairs | | | | | | x | | | | | |
| Public Sector Equality Duty and Equality Delivery System (Workforce Equality Analysis Report - WEAR, WRES and WDES) | Annual | Director of HR & OD | | x (WEAR) | | | | x | x (WRES & WDES) | | | x | |
| **Other Items** | | | | | | | | | | | | | |
| Minutes from Quality & Safety Committee | Monthly | N/A | x | x | x | x | x | x | x | x | x | x | x |
| Minutes from Finance & Performance Committee | Monthly | N/A | x | x | x | x | x | x | x | x | x | x | x |
| Minutes from Audit Committee | Monthly | N/A | | x | x | | x | x | x | | x | x | x |
| Minutes from Charitable Funds Committee | Quarterly | N/A | | x | | → | | x | | x | | x | |
| Any Other Business | Monthly | N/A | x | x | x | x | x | x | x | x | x | x | x |
| Questions from the Public | Monthly | N/A | | | | → | → | x | x | x | x | x | x |
| Review of the Meeting | Monthly | N/A | x | x | x | x | x | x | x | x | x | x | x |

Note:

*Updates since previous version shown in blue text.*

→ indicates original position of item on business cycle and intention to move forward and reschedule or pick up at an original date scheduled

April and June 2020 Board were focused on essential business only due to the Covid-19 response and an agreed variation to Standing Orders

* October 2020 Board was amended to an informal Board, in private, due to the proximity to the previous meeting,

Continuous Improvement Strategy bi-annual update scheduling to be considered for 2021/22