Countess of Chester Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA AND PAPERS

TUESDAY, 4TH APRIL 2017

Countess of Chester Hospital NHS
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

TUESDAY, 4TH APRIL 2017 AT 1PM
TRAINING ROOM 3 & 4

A G E N D A

FORMAL BUSINESS

1.	Welcome and Apologies	Chairman
2.	Declarations of Interest	Chairman
3.	To receive and approve the Board of Directors minutes of meeting held on 7th February 2017, BoD action tracker (March 2017) and matters arising **(attached)**	Chairman

QUALITY & ASSURANCE

4.	To receive a Patient Story (Frailty Unit)	Director of Nursing and Quality
5.	To review the Integrated Performance and Finance Report as at Month 11 to include: Financial Position – Month 11, Forecast Outturn 2016/17 Capital Paper Budget 2017/18 (Key operational objectives) **(Attached)**	Executive Team
6.	To receive the results of the Staff Survey 2016 **(Attached)**	Director of People and Organisational Development
7.	To receive the Patient Experience Strategy **(Attached)**	Director of Nursing and Quality
8.	To receive details of the Nursing and Midwifery Safe Staffing Position papers – July 2016 – December 2016 **(Attached)**	Director of Nursing and Quality
9.	To receive a update on Never Events and Serious Untoward Incidents	Director of Nursing and Quality

STRATEGIC DEVELOPMENT

10.	To receive details of the West Cheshire Accountable Care Organisation (ACO) to include:	Chief Executive

	Approval for Memorandum of Understanding for ACO Leadership Group **(Attached)** *(MOU Sent under separate cover)*	
11.	To receive a an Update on the Strategic Estates Partnership – respective roles and obligations **(Attached)**	Interim Chief Finance Officer
12.	To receive a CEO Update to include an update on Back Office Collaboration **(Verbal)**	Chief Executive
13.	To receive an update on Board and Governor Matters **(verbal)**	Director of Corporate & Legal Services

FOR NOTING & RECEIPT

14.	To receive the Month 8, Month 9, Month 10 and Month 11 letters to NHS Improvement	Interim Chief Finance Officer
15.	To receive the minutes of the Quality, Safety and Patient Experience Committee – 16th January 2017 and 20th February 2017	Director of Nursing and Quality
16.	To receive the minutes of the Audit Committee – 10th January 2017	Interim Chief Finance Officer
17.	To receive the minutes of the Finance and Integrated Governance Committee – 10th January 2017	Chief Executive
18.	To receive the minutes of the People and Organisational Development Committee - 24th January 2017	Director of People and Organisational Development
19.	To receive Corporate Infection Prevention and Control Assurance – Quarterly Report (retrospective report based upon November 2016 quarterly data update)	Medical Director
20.	To receive details of the Freedom of Information Requests received by the Trust – September 2016 to January 2017	Director of Corporate and Legal Services
21.	Date and Time of Next Meeting: **Board of Directors Workshop** **Tuesday 2nd May 2017 at 9.30am – 11.30am, Training Room 3 & 4** **Board of Directors Meeting** **Tuesday 23rd May 2017 @ Time TBC - Training Room 3 & 4**	

BOARD OF DIRECTORS

MINUTES OF THE MEETING HELD ON MONDAY, 7th FEBRUARY 2017 AT 1PM TRAINING ROOM 3 & 4

		Attendance	
Chairman	Sir D Nichol	☑	
Non Executive Director	Mr A Higgins		☒
Non Executive Director	Mr J Wilkie	☑	
Non Executive Director	Mr E Oliver	☑	
Non Executive Director	Mrs R Hopwood	☑	
Non Executive Director	Ms R Fallon		☒
Chief Executive	Mr T Chambers	☑	
Medical Director	Mr I Harvey	☑	
Interim Chief Finance Officer	Mr S Holden	☑	
Director of Nursing & Quality	Mrs A Kelly	☑	
Director of People and Organisational Development	Mrs S Hodkinson	☑	
Director of Corporate & Legal Services	Mr S P Cross	☑	
Director of Operations	Ms L Burnett	☑	
Programme Director, Model Hospital	Mr I Bett	☑	

In attendance:

Mrs C Raggett – Secretary to the Board

FORMAL BUSINESS

B01/17 **WELCOME AND APOLOGIES**

Sir Duncan welcomed all attendees to the Board meeting.

Mr Chambers advised the Board that Mrs O'Neill, Chief Finance Officer has formally stepped down as Chief Finance Officer from 1st February 2017 and will leave the Trust on a date to fixed and in the meantime will undertake a role within the STP programme. Mr Holden will be Interim Chief Finance Officer for the coming months to allow the Trust to explore what kind of Chief Finance Officer will service the Trust best in the future.

Mr Chambers on behalf of the Board thanked Mrs O'Neill for her commitment and leadership. The Trust has been truly fortunate to have Mrs O'Neill's professionalism and dedication and

wished Mrs O'Neill the very best for the future.

Sir Duncan on behalf of the Board thanked Mrs Williams, deputy Director of Nursing for her hard work and support of the Trust and in particular her support to the Council of Governors and wished her the very best for retirement. Mrs Kelly also thanked Mrs Williams for her tremendous commitment and support.

Apologies were received from Mr Higgins and Mrs Fallon.

B02/17 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

B03/17 **TO RECEIVE AND APPROVE THE MINUTES OF BOARD OF DIRECTORS' MEETING HELD ON 6TH DECEMBER 2016 AND BOARD ACTION TRACKER AS AT END OF JANUARY 2017**

The Board of Directors minutes of the meeting held on 6th December 2016 were received as a true and accurate record.

The Board noted the Board Action Tracker as at end of January 2017.

MATTERS ARISING

There were no matters arising.

STRATEGIC DEVELOPMENT

B04/17 **TO APPROVE AND GRANT DELEGATED AUTHORITY FOR THE TRUST'S CASH REQUIREMENTS FROM APRIL 2017**

Mr Holden, Interim Chief Finance Officer presented the Trust's Cash Requirements from April 2017 paper to the Board.

Mr Thomas, Assistant Chief Finance Officer outlined the details of the process for the Trust to apply for distress financing from NHS Improvement (NHSi) and the Department of Health (DOH). The Trust will need to sign up to certain conditions in order to access the financing.

Mr Thomas stated that the Trust will need to access a rolling capital facility for part of the financing and an interim revenue option. The Trust will need to achieve the control total and the financing will be limited to 30 days operating costs.

Mr Thomas detailed how the process maybe superseded by the Sustainability and Transformation Fund (STF) plan which could in effect mean that the Trust would not require the distress financing.

Mr Thomas referred to Section 5 of the Cash Requirements paper which details the actual resolution to approve the loan, the authorised signatory for the loans and the signatory for the accompying loan schedules.

Mr Holden advised the Board that he supported the resolution as outlined the in the Cash Requirement Paper.

Mr Wilkie asked if Mr Holden and Mr Thomas were confident that the Trust can satisfy all the requirements set out in schedule 8. Mr Thomas replied that the Trust was following a well-established process and would be able to satisfy the requirements set out in Schedule 8. Mr Holden added that the NHS runs a united approach to funding organisations and they mandate the process for accessing funding when a Trust is reporting a deficit.

In response to a question from Sir Duncan regarding the repayment terms of the loans, Mr Thomas stated that it was expected that the loans would be replaced by refinancing eventually.

The Board of Directors approved the resolution as follows:

(A) approving the terms of, and the transactions contemplated by, the finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;
(B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf;
(C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party; and
(D) confirming the Borrower's undertaking to comply with the Additional Terms and Conditions (Schedule 8)

The Board of Directors approved that either:

- **Tony Chambers** **Chief Executive Officer; and**
- **Simon Holden** **Interim Chief Finance Officer**

can approve the loan agreements and other documents referred to above, including any subsequent utilisation request.

B05/17 **TO CONSIDER AND APPROVE THE STRATEGIC ESTATES PARTNERSHIP – BRIEFING PAPER FEBRUARY 2017**

Mr Holden outlined the details of the Strategic Estates Partnership (SEP) briefing paper and noted the following points:

- The paper details the progress of establishing a SEP partner with Wirral University Teaching Hospital (WUTH).
- The Trust owns and runs its current estate efficiently from a clinical perspective.
- The Trust is looking for a joint venture partner to run other parts of the estates such as any surplus land, retail opportunities and car parking.
- Once a partner is appointed both parties must agree to the scheme being taken forward.
- The Urgent Care Unit is the number one priority for the Trust. A private partner will consider the most economical way to achieve this.

Sir Duncan stated that he could see the benefits for the Trust and asked what the benefits were for the private partner. Mr Holden stated that the partner would receive a fee if the Trust decides to go ahead with a project. The income and fee would be signed off at each stage of the project. The partner would also anticipate that they would be able to undertake the building work however, this was not guaranteed.

Mr Wilkie asked how the number of potential partners had been reduced from 8 down to 2. Mr Holden replied that there had been a range of criteria which had reduced the number of bidders from 8 to 5 and then 5 down to 2. Mr Oliver, Non Executive Director was on the panel and the criteria included the financial details, their track record, their ability to deliver, innovation and added value.

Mr Oliver added that due to the strict criteria; it had been straight forward to reduce the number down to 5 bidders and then challenging to reduce to 2 based on the variations and quality of the bidders. The major scheme for the bidders is to consider the new Urgent Care Unit.

Sir Duncan stated that as the normal capital approaches were no longer available due to the current financial position, the SEP would provide an alternative funding option for the very important Urgent Care Unit,

The Board approved the next steps for the SEP as detailed within the paper:

- **Work with the two final shortlisted bidders to generate realistic, innovative and deliverable solutions, so they can be quickly adopted by the Board (subject to usual governance process, staff and patient engagement) following formal appointment of a partner**
- **Formal Board Appointment of successful Private Sector Partner, including rationale for selection (April 2017)**
- **Formal establishment of Joint Venture, with nominated director posts (April 2017)**
- **Formal Board approval of the Strategic Estates Partnership Annual Business Plan, scheduling, and risk appetite (May 2017)**

QUALITY ASSURANCE

B06/17 **TO RECEIVE A PATIENT STORY**

Mrs Kelly introduced a montage of patient stories with positive comments from patients and staff. Mrs Kelly added that even in the light of the pressures across departments, the stories showed how the staff supports each other.

Sir Duncan noted that there were some very positive tributes to the staff in A&E which showed their great team spirit and asked how the Trust benchmarks this against previous winters. Mrs Kelly replied that a lot of work had been undertaken during the year to implement extra processes and services to support patients attending A&E. The ward managers and matrons also feel it is different this year which is also a testament to how the staff are supporting each other.

Ms Burnett reported that she had recently spent 6 hours in A&E, it was a very busy shift and there is a good team with good support from managers. The does not have the same delays for ambulances as other Trusts in the region and the Countess has received thanks from North West Ambulance (NWAS) for this. The Trust currently has only 17 delayed transfers of care patients which demonstrates the hard work across the system.

Sir Duncan on behalf of the Board thanked the A&E staff for their continued hard work.

B07/17 **TO REVIEW THE INTEGRATED PERFORMANCE AND FINANCE REPORT AS AT MONTH 9**

The Board received details on the key issues within the integrated performance and finance report as at Month 9 and the following points were raised:

- Ms Burnett stated that the A&E performance against the 4 hour target was at 88% for the year to date. The Trust is ranked 22 out of 127 Trusts for the weekly performance of the A&E target.
- Ms Burnett reported that the 18 week RTT target is currently at 90.7%, this is off trajectory due to the reduction of elective work over the Christmas period following national guidance. The list is managed more effectively and has been validated for accuracy. The Trust is continuing to work with the CCG to support demand management from primary care.
- Ms Burnett stated that in May 2016 the Trust had 13 patients who were over 52 weeks for treatment and she asked the Board to note that there were now no patients waiting over 52 weeks.
- Ms Burnett reported that the 62 day cancer target remains an issue which had been impacted further due to the 18 week RTT target and lack of capacity. Further focus on the target will be undertaken over the coming months.
- The 6 week diagnostic target is below 95% at 90.45% this is due to reduced capacity over the Christmas period and an increase in demand.
- Mrs Kelly reported that the Trust has undertaken a big piece of work regarding falls and has established a falls group which is led by a clinician. This work also links to patients who lack capacity and safeguarding such patients whilst they are in our care.
- Mrs Hodkinson reported that there had been an increase in the staff sickness level due to norovirus out in the community. Trusts across the region have also experienced similar increases.
- Mrs Hodkinson stated that the Trust has achieved over 90% for mandatory training and 8 divisions are now over 90% for appraisals which is great news.
- Mrs Hodkinson stated that the Trust had the lowest level of variable pay in December 2016 and a lower level of agency spend compared to the same time last time last year.
- Mr Holden reported that the Trust was on plan financially at month 9 and that there were controls in place regarding spending and where savings can be made.
- Mr Harvey was pleased to report that despite the high bed occupancy rates and the associated risks, the Trust has not had a case of MRSA for over 12 months. The Trust was also 1 under trajectory for C.Difficle cases as at the end of January 2017. Mr Harvey added that the effect of C.Difficile on the patient is awful and it was a testament to the hard work of the medical and nursing staff that the number of cases remains low.

In response to a question from Sir Duncan, a discussion took place regarding the potential impact of not achieving targets and the new finance regime in terms of the Sustainability and Transformation Funds (STF).

The Integrated Performance Report for Month 9 was received by the Board.

B08/17 **TO RECEIVE AND APPROVE THE BOARD ASSURANCE FRAMEWORK AS AT Q3**

Mr Chambers presented the Board Assurance Framework (BAF) as at the end of Q3 which had been reviewed and updated by the Executive Team.

In response to a question from Mr Wilkie, a discussion took place regarding the process and

risks detailed in the BAF and it was agreed that a full review of the BAF and risk would be undertaken at the next Audit Committee workshop and Board workshop.

B09/17 **TO RECEIVE AN UPDATE ON NEVER EVENTS AND SERIOUS UNTOWARD INCIDENTS**

Mrs Kelly reported that the Trust had a never event in December 2016 which was a wrong site block and then a never event in January 2017 which was a retained swab. This was extremely disappointing as a lot of work has been undertaken in mitigating never events.

Mrs Kelly emphasised that there had been no harm to the patients and they had been advised under the duty of candour.

In response to a question from Sir Duncan, Mr Harvey and Mrs Kelly acknowledged that it was important that staff know that poor practice is not acceptable and that it was essential that staff were able to challenge at all levels. Team work and support are as important as clinical practice. Mrs Kelly and Mrs Hodkinson are working to support the culture in theatres so that staff feel they can speak up going forward.

B10/17 **TO RECEIVE A CEO UPDATE**

Mr Chambers gave a verbal update on the following points:

- Mr Chambers acknowledged and thanked the Executive Team for their hard work and the work they do supports the Trust through tough times whether that be operational or financial. Mr Chambers stated that the Trust was in a better position this winter which is in part a consequence of improved relationships with the local authority and Ms Burnett's role working with them.
- The average savings for NHS providers for the last year was 3 – 5% of operating costs. The Trust's savings target was 4.5% and the Trust was on target to deliver this, which was the best performance on CRS to date. The next financial year will be tough. The 2017/18 average savings will be between 5-8% and the Trust will continue to focus on continuing the good performance from this year.
- Mr Chambers stated that the Board will be aware that in July 2016, clinicians raised concerns regarding an increase of deaths in the neonatal unit. The unit changed the admission criteria and the Trust invited the Royal College of Paediatric and Child Health (RCPCH) to undertake a review. The RCPCH suggested a more in-depth independent review be undertaken which had been completed. The independent case review highlighted some areas for improvement but did not identify a single causal factor or raise concerns regarding unnatural causes.
- There is a lot of activity on how the Trust can work with partners to bring services together for the benefit of patients. The STPs are being taken forward across the health economy to develop an integrated provider organisation over the next 12 months.
- The Trust is working with WUTH and other Trusts to avoid duplication in areas such as financial services and procurement.
- The Teletracking project will be going live at the end of February 2017 with the transport module for porters.
- Dr Huw Charles-Jones has stepped down as Chair of the CCG and the new Chair is Dr Chris Richardson. Mr Chambers will invite Dr Richardson to a future Board meeting.

B11/17 **TO RECEIVE AN UPDATE ON GOVERNOR MATTERS**

Mr Cross was delighted to see so many Governors at the Board meeting and stated that the Board appreciates their support.

The Governors Quality Forum (GQF)was held on 24th January 2017 and was an excellent meeting. The Governors Quality Forum will now meet monthly to align with the Trust's reporting schedule.

FOR NOTING& RECEIPT

B12/17 **TO RECEIVE AND NOTE THE SEP COCH SITE STRATEGY REPORT**

The Board received and noted the SEP CoCH Site Strategy Report.

B13/17 **TO RECEIVE THE MONTH 6 AND MONTH 7 LETTERS TO NHS IMPROVEMENT**

The Board received and noted the month 6 and month 7 letters to NHS Improvement.

B14/17 **TO RECEIVE THE MINUTES OF THE QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE – 21ST NOVEMBER 2016**

The Board received and noted the minutes of the Quality, Safety and Patient Experience Committee – 21st November 2016.

B15/17 **TO RECEIVE THE MINUTES OF THE AUDIT COMMITTEE – 4TH OCTOBER 2016**

The Board received and noted the minutes of the Audit Committee – 4th October 2016.

B16/17 **TO RECEIVE THE MINUTES OF THE FINANCE AND INTEGRATED GOVERNANCE COMMITTEE 2016 – 4TH OCTOBER 2016**

The Board received and noted the minutes of the Finance And Integrated Governance Committee 2016 – 4th October 2016.

B17/17 **TO RECEIVE THE MINUTES OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – 29TH SEPTEMBER 2016 AND 1ST DECEMBER 2016**

The Board received and noted the minutes of the People and Organisational Development Committee – 29th September 2016 and 1st December 2016.

B18/17 **TO RECEIVE THE MINUTES OF THE CHARITABLE FUNDS COMMITTEE – 25TH OCTOBER 2016**

The Board received and noted the minutes of the Charitable Funds Committee – 25th October 2016.

B19/17 **TO RECEIVE AND APPROVE THE CHAPLAINCY REPORT 2016**

The Board received and approved the Chaplaincy Report 2016.

B20/17 **DATE AND TIME OF NEXT MEETING**
Tuesday 4th April 2017 – 1pm, Training Room 3 & 4, Countess of Chester Hospital.

Countess of Chester Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG 2016/17

Meeting Date	Minute Ref:	Issue	Action	Update	Responsibility	Target Date
05.07.16		Update on CQC inspection report actions		Following discussion at QSPEC a further detailed report will be presented to FIGC in March 2017	Alison Kelly	March 2017
05.07.16		Update on CQC inspection report actions		Following discussion at QSPEC a further detailed report will be presented to Board in May 2017	Alison Kelly	May 2017
07.02.17	B08/17	To undertake a full review of the Board Assurance Framework	Workshop with the Board to be held in May 2017		Stephen Cross	May 2017
07.02.17	B09/17	Mr Chambers to invite Dr Richardson, Chair of CCG to a future Board			Tony Chambers	July 2017

	Action has slipped
	Action is not yet complete but on track
	Action complete
*	Moved with agreement

Countess of Chester Hospital NHS
NHS Foundation Trust

Integrated Board Report - February 2017

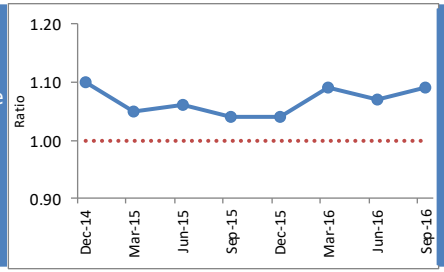
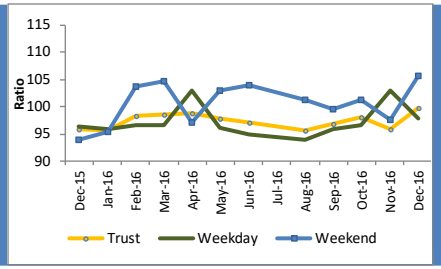
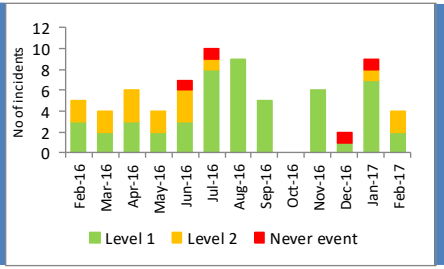
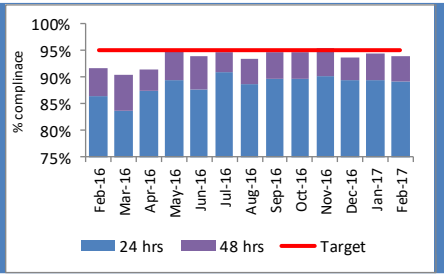
Contents

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

BAF ref: CR1, CR2, CR3, CR6, CR7, CR10

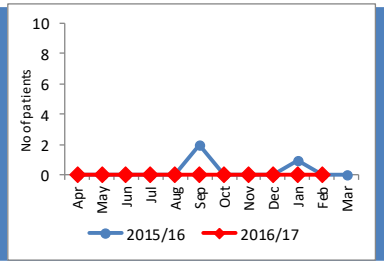
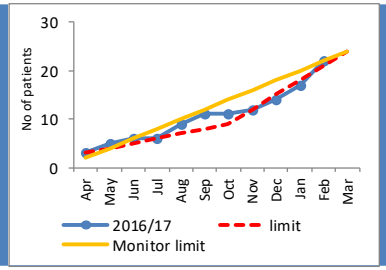
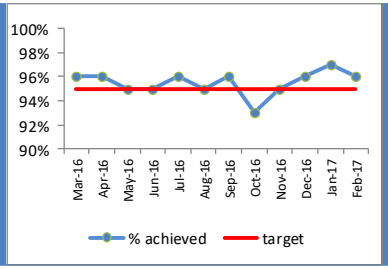
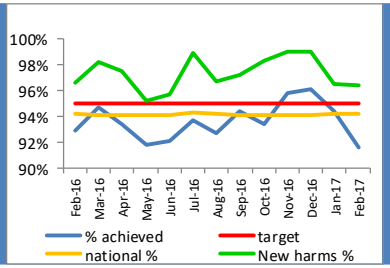
	Description	Current position/comments	Trend	Target
Mortality SHMI	Risk adjusted mortality ratio based on number of expected deaths. National published figure from HSCIC.	This measure does not take into account palliative care codes. It provides a complete picture of hospital deaths and includes deaths within 30 days of discharge showing whether the Trust is within the expected range when compared to the quarterly rebased national baseline. SHMI should not be trended nor directly compared to previous months due to the national data being rebased everytime.		The expected rate is 1.00
Mortality HSMR	Ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death	This measure is based on specific diagnosis groups that account for approx 80% of our inpatients. A ratio of greater than 100 means more deaths occured then expected, while a ratio of less than 100 suggests fewer deaths occured than expected. The chart is a rolling 12 months.		The predicted rate is 100
Serious Incidents	Level 2 severe harm or death to patient. Never events are serious largely preventable patient safety incidents	There were two level one and two level two incidents in February.		No current target but any never event highlighted as red in month
Electronic Discharge for admitted patients	90% of electronic discharges for admitted pts should be sent within 24 hrs, 95% within 48 hrs and all within 2 weeks	The 24 hour and 48 hour were slightly under target. Work continues on reviewing the process for recording eDischarge, to increase compliance in line with NHS mandated guidance.		90% within 24 hrs per month 95% within 48 hrs per month

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

BAF ref: CR1, CR2, CR3, CR6, CR7, CR10

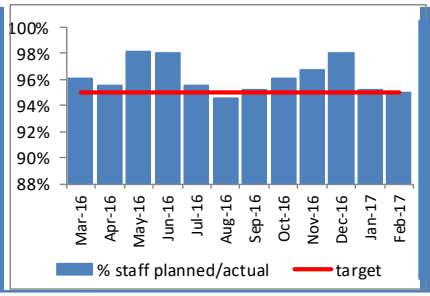
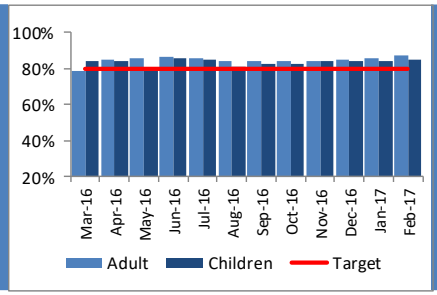
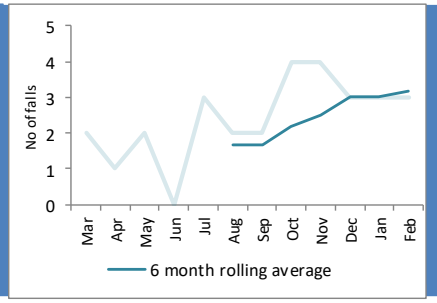
	Description	Current position/comments	Trend	Target
MRSA	Number of cases of hospital acquired MRSA bacteraemia (meticillin-resistant staphylococcus aureusis)	The target for MRSA is zero cases within the year and there were no new cases within the month. Although there was one case assigned to COCH in June following local investigation, this is an unavoidable case so will not count towards the Trust objective of zero avoidable MRSA bacteraemia.		Zero avoidable cases for the year
CDiff	Number of cases of Clostridium Difficile	A maximum of 24 cases has been set for 2016/17 at the same level as 2015/16. There were five cases reported in February, resulting in YTD 22 cases against the trajectory of 21.		24 maximum annual cases
Hand hygiene	Based on ward based hand hygiene audits. Each ward is required to submit two audits each month	96% compliance was achieved in February.		95% each month
Safety Thermometer	Tool to survey a snapshot of harm free patient care. Includes pressure ulcers, falls, catheters, UTIs and VTE	In February, the figure for new harms was 96.42% and our all harms performance was 91.64%. This demonstrates a number of patients have been admitted with existing harm.		Compare to National average Above average - Green Below average - red

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

BAF ref: CR1, CR2, CR3, CR6, CR7, CR10

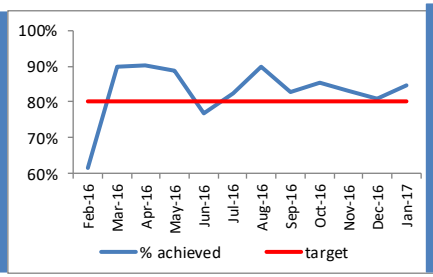
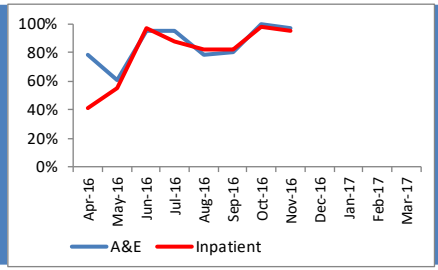
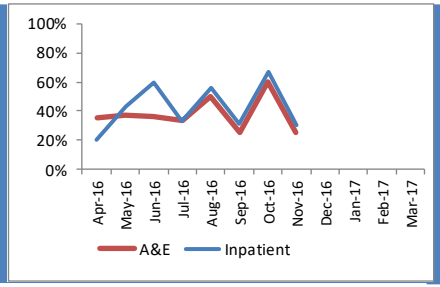
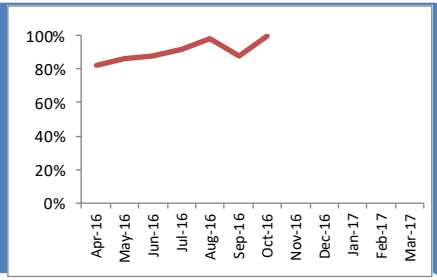
	Description	Current position/comments	Trend	Target
Safe Staffing	Actual staffing compared to planned for registered nurses/ midwives and care staff	See appendix 1 for detailed safe staffing report.		>95% per month
Safeguarding training	% of level 2 training undertaken to be split by training for Adults and Children	The training compliance for both adult and childrens safeguarding training remained above the 80% target in February 2017.		>80% in month
Inpatient falls	Inpatient falls with moderate or above harm	There were three falls within February with moderate or above harm. See exception report on page 15.		Trend line shows rolling 6month average

Are we effective?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

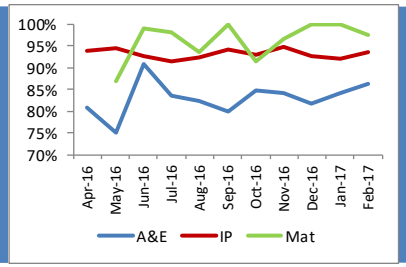
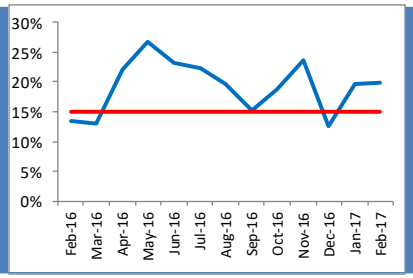
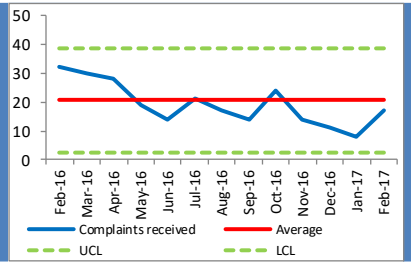
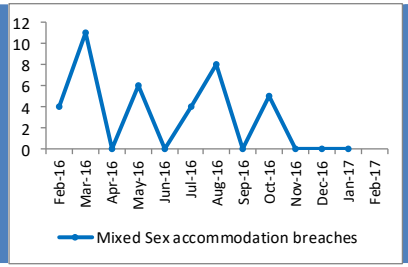
BAF ref: CR3, CR7, CR10

	Description	Current position/comments	13 month rolling trend	Target
Stroke	All Stroke patients who spend at least 90% of their time in hospital on a stroke unit	The target was met for the month of January.		>80% per month
Sepsis 1	National CQUIN	Percentage of people appropriate for sepsis screening who were screened Part 1 - A&E Setting Part 2 - Inpatient Setting The trajectory for this measure is 90% at year end. We are currently on target to meet this.		Improvement on baseline
Sepsis 2	National CQUIN.	Percentage of people appropriate for sepsis screening who were administered antibiotics within an hour of diagnosis Part 1 - A&E Setting Part 2 - Inpatient Setting The trajectory is 80% at year end. There is a risk attached to this as we are currently below our agreed trajectory. There is ongoing education to raise the profile of the process for Sepsis patients		Improvement on baseline
Antibiotics	National CQUIN.	Percentage of antibiotic prescriptions that were reviewed within 72 hours. We are currently over trajectory on this measure and it expected that this will be achieved at year end		Improvement on baseline

Are we caring?

Countess of Chester Hospital NHS Foundation Trust — Board Assurance metrics February 2017

BAF ref: CR1, CR4, CR6, CR7, CR10

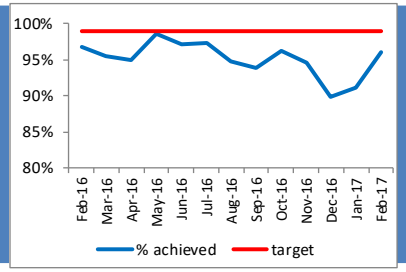
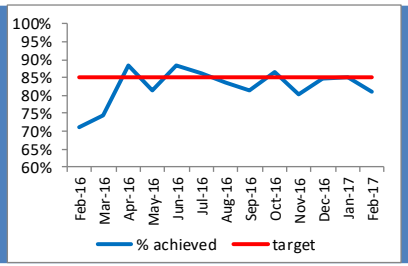
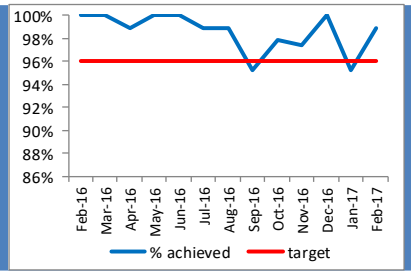
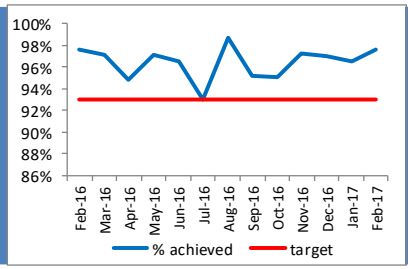
	Description	Current position/comments	Trend	Target
Friends & Family - % likely to recommend	Would patients recommend service to friends & family. Introduced in 2013 for Inpatients, A&E and maternity.	Satisfaction has increased in A&E and Inpatients with really complimentary comments despite the hospital being busy. The % likely to recommend scores were: - Inpatients 93.4% - A&E 88% - Maternity 97.6%		90% for maternity and Inpatients. 80% for A&E
Friends & Family response rate	Number of responses received for IP, A&E and maternity compared to eligible patients	The response rate for February is similar to that seen last month and remains above the 15% target.		>15% per month
Feedback	Monthly Trust complaints and formal thank you letters received by the Trust	In February 2017 the Trust received 17 new formal complaints. This is an increase on last month but remains below average. Compared to last year this reduction in complaints could relate to the significantly lower number of cancelled operations.		Complaints to be within expected control limits
Mixed Sex accommodation breaches	Number of breaches to the mixed sex accommodati -on standard for non clinical reasons	A nil return was submitted for February as further validation is required on the process for reporting mixed sex accommodation breaches.		Zero cases per month

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

BAF ref: CR3, CR5, CR6, CR7, CR8, CR9, CR10

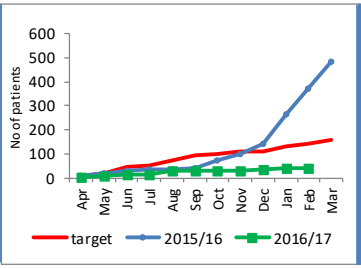
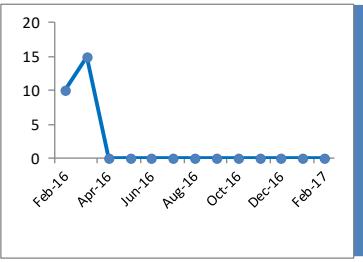
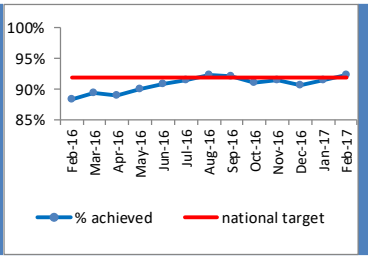
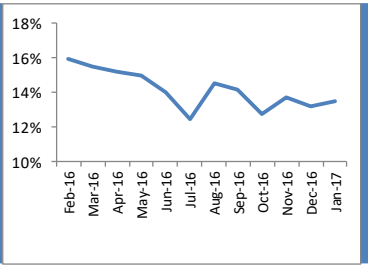
	Description	Current position/comments	13 month rolling trend	Target
Diagnostic 6 week standard	Diagnostic tests to be carried out within 6 weeks of request being received. This is measured on the National DM01 return.	The diagnostics figure improved in February to 96%, but remains below the national 99% target . See page 17 for exception report.		99% per month
Cancer 62 day standard	First treatment for cancer within 62 days of urgent referral through GP 2 week referral route. 85% threshold	The unvalidated figure for February is under the 85% target at 81.05%. See page 18 for exception report.		85% per Quarter
Cancer 31 day standard	Patients receiving first definitive treatment within 1 month of cancer diagnosis. The threshold is 96%.	The provisional figure for February is above the 96% target at 98.89%. See page 19 for exception report.		96% per Quarter
Cancer 2 week standard	Patients referred from GP with suspected cancer should have their first appointment within 14 calendar days	Performance against this standard continues to achieve .		93% per Quarter

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

BAF ref: CR3, CR5, CR6, CR7, CR8, CR9, CR10

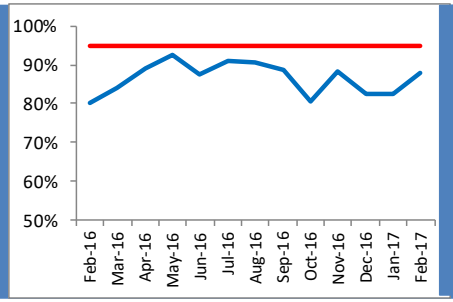
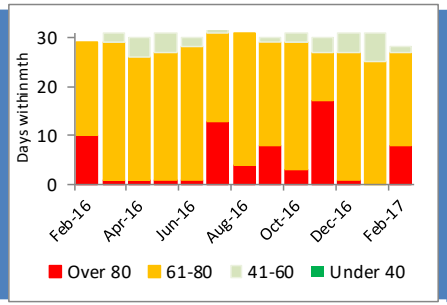
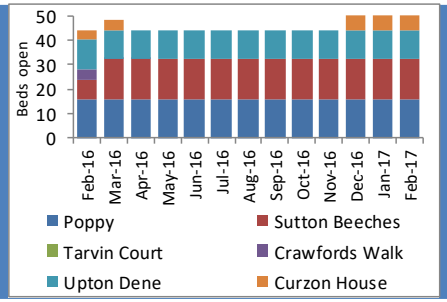
	Description	Current position/comments	Trend	Target
Cancellation due to no beds	Hospital cancellations due to no beds	There was one cancellation due to no beds in February. Please note these figures do not include patients cancelled due to critical care beds which are tracked separately.		Internal target based on 2012/13 levels
Urgent cancellations	Urgent cancellations for second or subsequent time for non clinical reasons	There were no urgent cancellation for the second or subsequent time in the month of February. Following a review of the guidance we have found that we had been over reporting on this measure in previous months, and resubmissions of data for the year to date have been made to reflect this.		Zero cases per month
RTT incomplete pathways	Percentage of incomplete pathways for English patients within 18 weeks. The threshold is 92%.	RTT incomplete performance is above the 92% target for the month of February at 92.3%. The Trust continues to proactively manage all over 35 week waiters.		92% per month
Readmission rate	Number of emergency readmissions within 28 days. Excludes patients with diagnosis of cancer, nephrology, obstetrics	This is currently reported two months behind to allow for the readmissions and subsequent coding		No target agreed

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

BAF ref: CR3, CR5, CR6, CR7, CR8, CR9, CR10

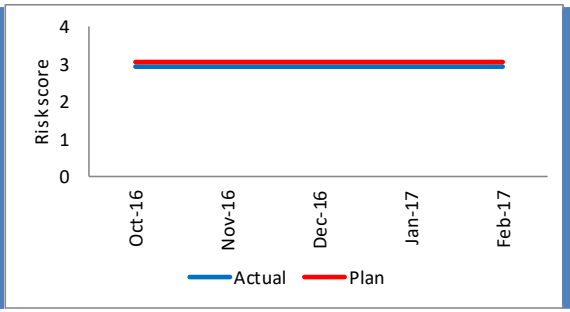
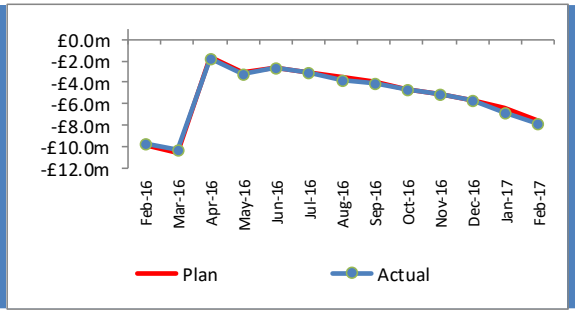
	Description	Current position/comments	13 month rolling trend	Target
A&E 4 hour standard	Maximum wait time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.	Performance improved in February to 87.73%, but this remains under the 95% performance target. Exception report on page 21.		>95% per month
Medically optimised patients	Number of days within the month where there are medically optimised patients within acute beds	There were eight days within the month of February where there were over 80 medically optimised patients. See A&E exception report on page 21.		Less than 40 medically optimised patients within acute beds each day (target agreed with CCG)
Number of Intermediate care beds	Number of intermediate care beds open in use in the Community	There were 50 available intermediate care beds for the month of February. Additional beds were available in Curzon House from December.		No target agreed

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

BAF ref: CR3, CR5, CR6, CR7, CR8, CR9,

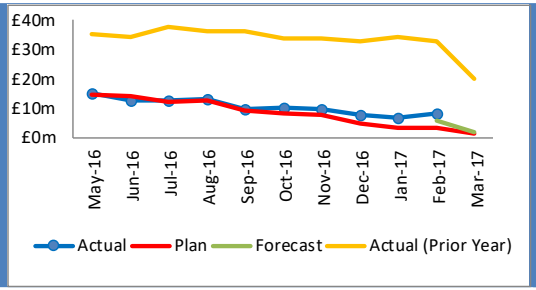
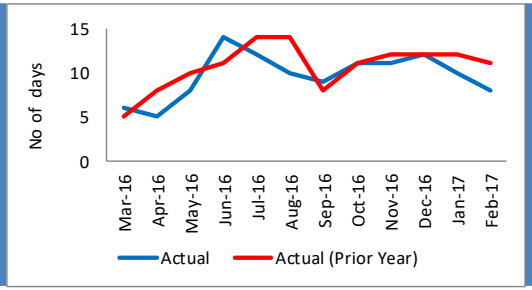
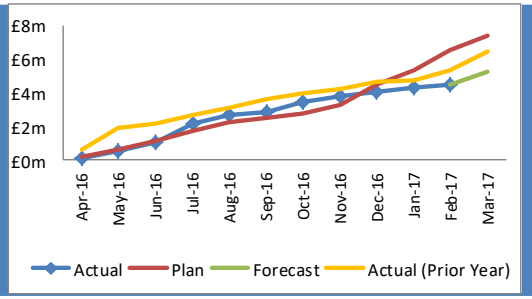
	Description	Current position/comments		
Use of Resources	NHS Improvement's measure of financial risk.	The Trust is currently at a level 4 for Capital Service Capacity Capacity, liquidity and I&E Margin rating resulting in an overall score of 3. The new Single Oversight Framework is now live, and as a result the scoring has flipped, with 1 now being the best score. The Trust has been provisionally allocated to a 'segment' of 2, despite the Use of Resources score.		A score of 3 each month (restated)
Normalised net surplus/ deficit	Net income and expenditure after adjusting for hosted services and impairments	As at February17, we are reporting a £390k overspend. £492k relates to the loss of the STF funding for the 4hr A&E target for Q2, Q3, Jan 17 & Feb 17. Partly offset by overachievement of the CRS target by £102k as at the end of Feb 17. More detail on the position will be provided in a separate Finance report to the Board.		As Plan

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

BAF ref: CR3, CR5, CR6, CR7, CR8, CR9,

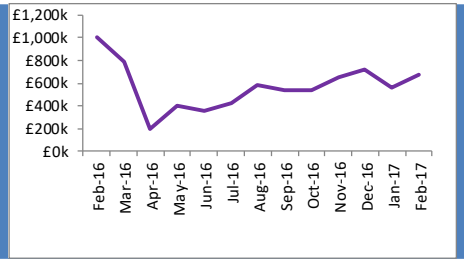
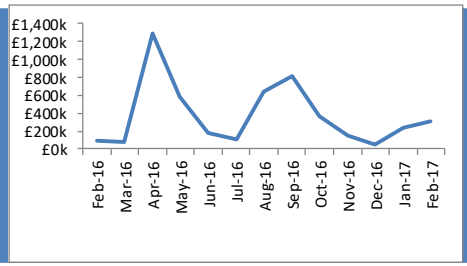
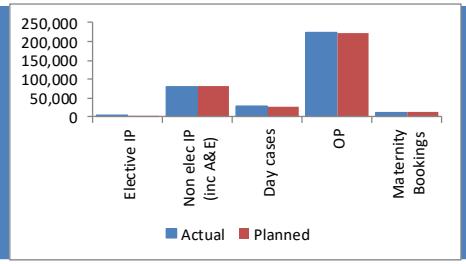
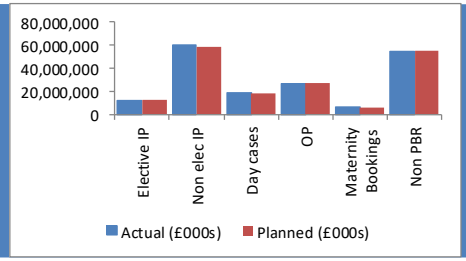
	Description	Current position/comments		
Cash	Cash on deposit <3 month deposit	The closing cash balance at the end of February is £4.7m ahead of plan, due in part to capital slippage, and the timing of weekly payment runs. The Board has recently approved (in principle) the 'distress' loans that the Trust will need to enter into to support both the revenue and capital requirements from the end of this financial year.		£3.3m
Debtor Days	Debtor Days: Trade Debtors divides by income x 365	Debtor days have fallen to 8 days at the end of February. The largest element relates to the timing of STF funding. Most of the remaining amounts are spread accross a number of organisations, the largest being Wirral FT with whom we are in weekly contact.		No target
Capital Expenditure	Capital expenditure performance against plan / forecast out-turn	As at February 2017 the capital programme is £2m behind the original Monitor plan. This is due in the main to slippage on works schemes and IM&T spend for the year behind profile . The forecast out-turn has been revised down by £2.2m.		£6.5m

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

BAF ref: CR3, CR5, CR6, CR7, CR8, CR9,

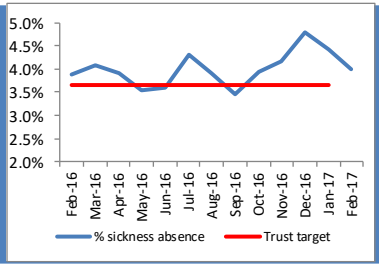
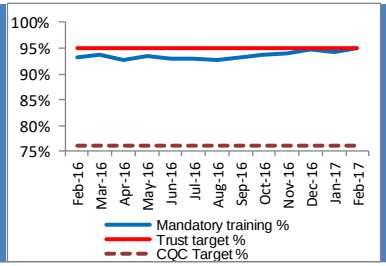
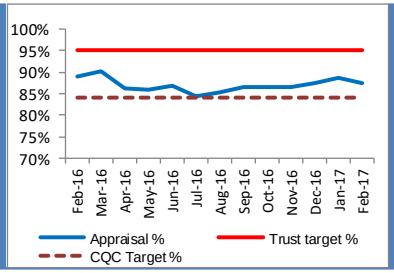
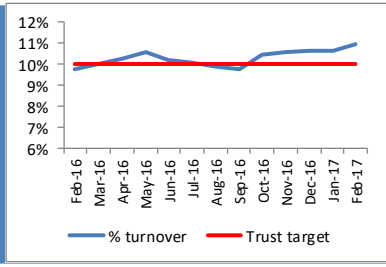
	Description	Current position/comments		
CRS In Year	Planning improvements in productivity and efficiency	Based on the £6.141m original plan, at the end of February the CRS programme is £102k ahead of the profiled plan		No deviation from plan
CRS Recurrently	Planning improvements in productivity and efficiency	Based on the £6.141m original plan, recurrently £4,717k (77%) in CRS savings have been achieved. Of the outstanding £199k (3%) is in Green and Amber schemes and £1,225k (20%) is in Red and Black schemes.		No deviation from plan
Contract performance Activity	YTD Contract performance against Trust Planned activity (English & Welsh)	Elective Inpatient activity is lower than planned but offset by Daycase activity that is over plan. Non Elective activity is higher than planned, but the main driver of the overperformance financially is casemix in this area.		Actual Activity should be greater than Planned activity
Contract performance Financial Value	YTD Contract performance against Trust Planned Value (English & Welsh)	Year to date the income is above plan - Elective IP -£291k Non-Elective IP £1507k Daycase £680k Outpatients -£377k Maternity -£168k Non PBR* -£1169k *-£1,400k relates to adjustment to Western Cheshire CCG block , an reduction of £57k in month		Actual Value should be greater than Planned Value

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

BAF ref: CR3, CR4, CR6, CR7, CR11

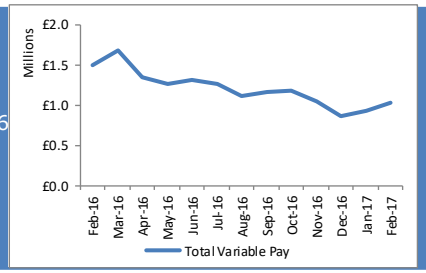
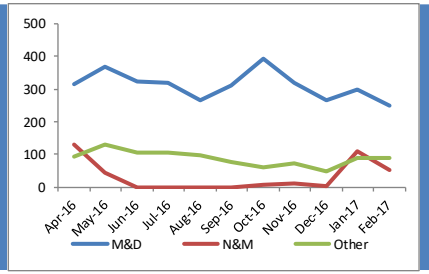
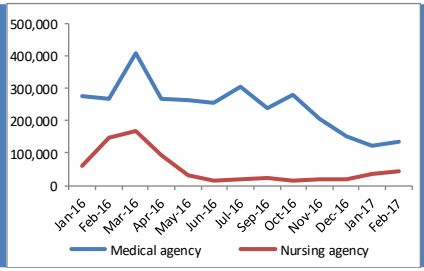
	Description	Current position/comments	13 month rolling trend	Target
Sickness absence	% sickness absence. Monthly rate excludes Comfort zone and Bank staff	Trust wide attendance management levels have decreased to 3.99%, which is above the Trust target of 3.65%. In comparison to February 2016, the rate was 3.88%. The rolling 12 month average is 4.04%, against 5.3% regionally (eWin data extract Dec 2016), with short term absence increasing to 2.54% & long term absence decreasing to 1.45%.		Below 3.65% per month
Mandatory Training	Mandatory Training Monthly Rate Excludes Comfort Zone, Bank Staff, Staff on long term sick & mat. leave.	For the first time since reporting commenced, compliance with Mandatory Training has been achieved this month. The current compliance rate of 95.1% exceeds the CQC target (76%) and the Trust target of (95%). When taking into account those already booked to attend, the Trust continues to exceed the Trust target, reporting 97.3% compliance.		95% per month *The CQC target is 76% (the CQC take the results from the Staff Survey)*
Staff with completed Appraisal	Appraisal Monthly Rate Exclusions as above and also excludes staff with less than 1 years service.	Compliance with the Appraisal target has disappointingly reduced marginally to 87.4%, which continues to exceed the CQC target (84%). Further details are provided within the exception report. 7 divisions continue to achieve over 90%. However, there are 3 hotspot areas in particular which require improvement, with less than 85% compliance.		Above 95% per month *The CQC target is 84% (the CQC take the results from the Staff Survey)*
Staff turnover	Turnover Rate Based on headcount in the previous 12 months and on permanent staff only.	Turnover has remained above target this month to 10.93%. This rate is based on a headcount, turnover by FTE also remained above target at 10.60%. An exception report has been provided.		Below 10% per month

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics February 2017

BAF ref: CR3, CR4, CR6, CR7, CR11

	Description	Current position/comments	Breakdown by type by month	Target
Variable pay	Reducing and controlling variable pay spend (including overtime, agency, additional clinical activity)	As anticipated, M11 illustrates a month-on-month increase of £123k, due to operational pressures and escalation. However, performance remains positive with a £381k saving from the M11 15/16. The increase in costs particularly relates to bank expenditure (£47k), locum expenditure (£45k) in General medicine ED, & Trauma & Orthopaedics, and Overtime Expenditure (£24k).		To not exceed £4.843m agency expenditure ceiling (circa £500k saving). To deliver variable savings target at 2014/15 level
Agency Shifts Over Cap Rates	M&D Agency shifts over cap rates. 'Other' consists of Care Packages, Theatres and the CRV Dept.	Month 11 demonstrates a decrease in medical shifts above the cap, with 250 shifts above cap rates. Operating Department Practioner shifts, remain the same with 90 shifts approved over the cap. In relation to Nursing shifts, 54 shifts were approved above cap rates. In total, 394 shifts were paid across all staff groups above the cap rates.		To reduce the number of agency shifts paid above the cap in all staff groups
Agency spend	Planning improvements in productivity and efficiency	Medical Pay is currently overspent by £110k. Agency medical expenditure is £2,479k YTD (6% of the total medical spend). Nursing Pay is £68k overspent. Agency nursing expenditure YTD is £320k which is 0.8% of total trained nursing spend. Total Agency spend for months 1 to 11 is £3,117k, compared to £4,461k for the same period last year.		Total Agency ceiling set at £4,843m for 16/17

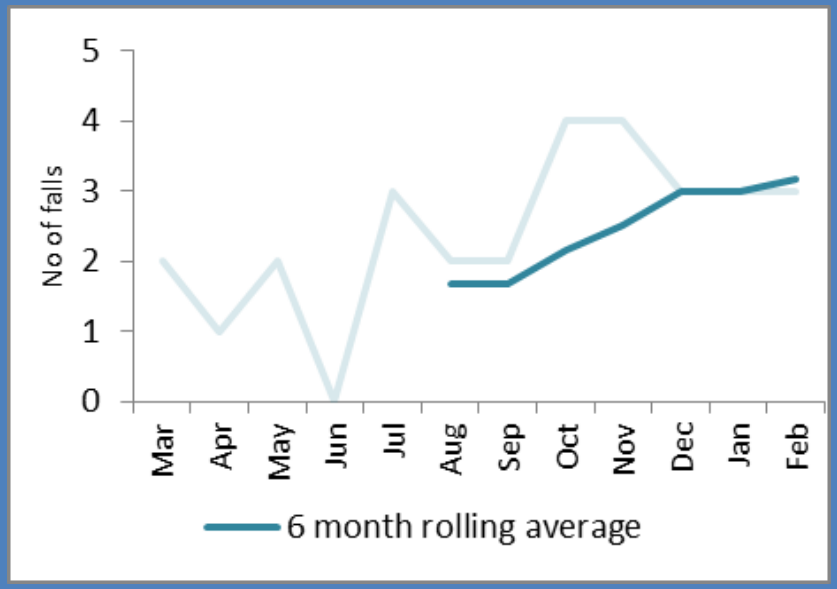
EXCEPTION REPORT

Indicator: Falls with harm

Issue:
There were 3 Inpatient falls with moderate or above harm within the month of February

Proposed actions:
It is recognised that the implementation of more robust actions is required in order to demonstrate learning. In light of this the following actions are being taken: - a Trust wide review of TABS alarms has been undertaken. The preference going forward will be for chair or bed sensors, trials of these devices is being undertaken during March - review of the Trusts falls and delirium policy is underway in addition to changes to Meditech screens to reflect policy changes - falls safe care bundle is being trialled on ward 34. When this has been formally evaluated, a plan will be developed for Trust roll out - development of a falls root cause analysis template, this will support managers articulating areas of improvement and learning to the Director of Nursing & Quality - The Urgent care Division have the highest prevalence of falls due to their patient group. Options are currently being considered in respect of having a therapy lead for falls who will support training and quality improvement

Historic data:



Forecast for improvement:			
Q1	Q2	Q3	Q4

Lead:	Sian Williams, Deputy Director of Nursing
Executive Lead:	Alison Kelly, Director of Nursing & Quality

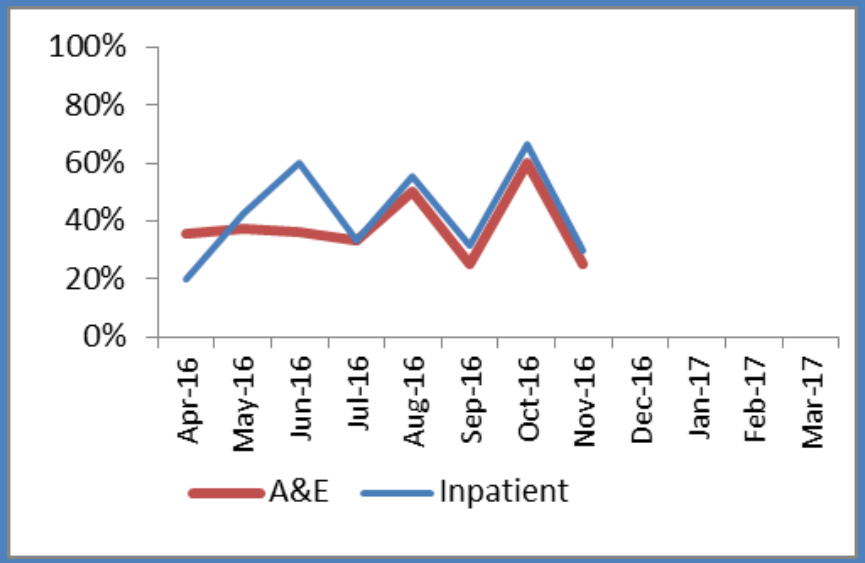
EXCEPTION REPORT

Indicator: Sepsis - adminstering antibiotics within an hour

Issue:
Percentage of people appropriate for sepsis screening who were administered antibiotics within an hour of diagnosis Part 1 - A&E Setting/Part 2 - Inpatient Setting The trajectory is 80% at year end. There is a risk attached to this as we are currently below our agreed trajectory.

Proposed actions:
The Sepsis group meets monthly. The issue remains that there is a delay administering antibiotics in the time period. Divisions have been reminded of their responsibility via this group. Delays may only be for 5-10 minutes. Education is on-going using outreach and the PDN team. The Director of Nursing & Quality will be reviewing how CQUINs are monitored from April 1st 2017 to ensure clinical engagement and ongoing monitoring of performance.

Historic data:



Forecast for improvement:			
Q1	Q2	Q3	Q4

Lead:	Sian Williams, Deputy Director of Nursing
Executive Lead:	Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT - February 2017

Indicator: 62 day cancer

Issue:

The 62 day performance for February is a provisional underachievement of the standard. There were 9 breaches in February, which will now be validated. Initial findings show breaches are broken down under the following specialties:

- Colorectal - 1 breach
- Head & Neck - 1 breach
- Lung - 1 breach
- Skin - 1 breach
- Upper GI - 2 breaches
- Urology - 3 breaches

The Quarter is at risk for this target.

N.B. - still awaiting histology for 3 patients (will be breaches if confirmed cancer).

Proposed actions:

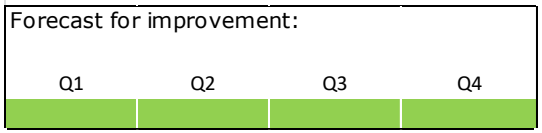
Urology continues to be a pressure on the performance of the Cancer 62 day target with late referrals to tertiary centres. IT continue to work on the interface between Meditech and GP software, to allow commencement of a pilot in March for the Prostate pathway with one GP practice before roll out to all GP's in the area. Testing is on-going to resolve the glitches identified.

Head and Neck continues to be a pressure on the Trust's performance. Network Task and Finish group now commenced to review the pathway across the Network. H&N are contributing to 8 of the Haematology breaches.

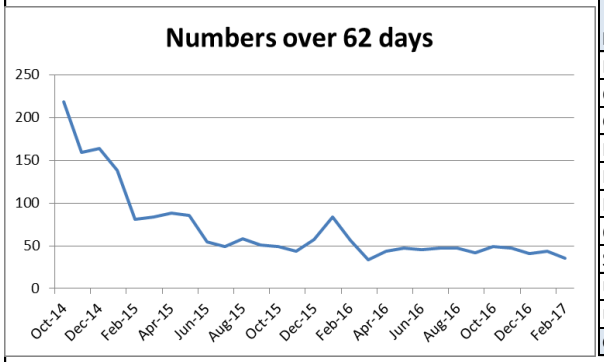
UGI concerns still remain for number of patients waiting over 62 days, and therefore this continues to be monitored closely.

Skin - work has commended with the clinical teams to look at structure of the MDT, performance and pathways.

Forecast for improvement:



Supporting PTL data:



Row Labels	63+ Days	100+ Days	Grand Total
Breast	4		4
Colorectal	4	2	6
Gynaecology		1	1
Haematology			0
Head and Neck	5		5
Lung	1		1
Other		1	1
Skin			0
Upper GI	6	3	9
Urology	6	2	8
Grand Total	**26**	**9**	**35**

Supporting Breach Data by Speciality - April to February (Provisional) Performance:

Speciality	No. of Breaches	% of Trust Breaches
Urology	19	20%
H&N	16	17%
Haematology	15	16%
Upper GI	13	14%
Lung	12	13%
Skin	9	9%
Breast	6	6%
Colorectal	3	3%
Gynae	3	3%
TOTAL	**96**	

Lead:

Executive Lead: Lorraine Burnett, Director of Operations

EXCEPTION REPORT

Indicator: Diagnostic 6 week wait

Issue:

The diagnostic 6 week standard failed the standard in February mainly due to breaches for echo

Proposed actions:

Echo

A full review of the echo service, including the application of the diagnostic definitions and process for managing waiting list and validation was completed during February with a number of key changes to be applied. In addition, additional lists continue and new starters in post since end of January to make sufficient improvement in compliance

Cystoscopy

The Division continues to arrange additional sessions

Historic data:

English - Number of exams > 6 weeks

Month End Snapshot	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Magnetic Resonance Imaging	22	82	110	25	0	5	4	25	13	8	12	2	0
Computed Tomography								1	1				
Non-obstetric ultrasound		21	82	14	75	47	24	10	6	1	47	8	1
Audiology - Audiology Assessments	10	12											
Cardiology - echocardiography	89	82	4	19	19	30	149	168	72	137	300	373	144
Respiratory physiology - sleep studies	3	1	1		4	5	1		3	1	5		
Colonoscopy													
Flexi sigmoidoscopy	1												
Cystoscopy	10	6		6	14	28	48	71	72	98	75	15	15
Gastroscopy						1			1	0			
Total patients waiting	4266	4428	3916	4321	3889	4066	4332	4528	4439	4493	4350	4467	4027
% < 6 weeks	96.8%	95.4%	95.0%	98.5%	97.1%	97.2%	94.8%	93.9%	96.2%	94.5%	89.9%	91.1%	96.0%

Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:	Divisional Directors
Executive Lead:	Lorraine Burnett, Director of Operations.

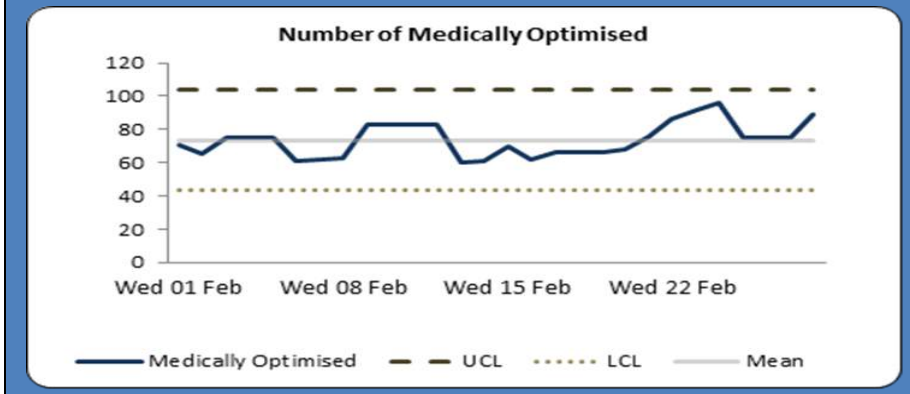
EXCEPTION REPORT

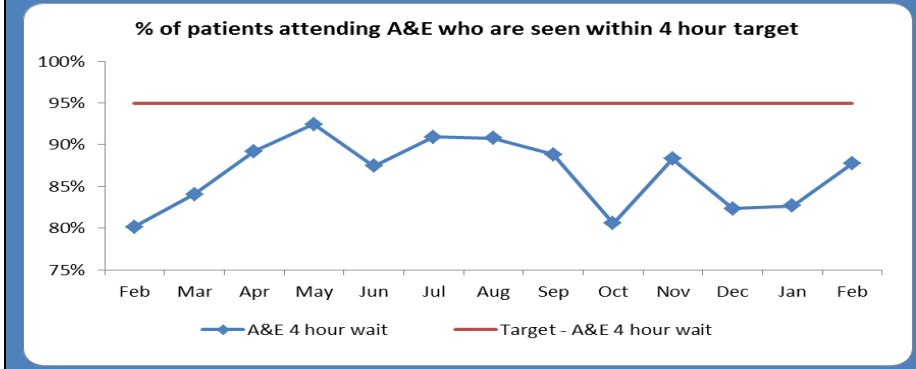
Indicator: A&E 4 hour standard

Issue:
Failure of ED 4 hour target in February and below the 95% Monitor trajectory.

Proposed actions:
During February we have continued to utilise winter escalation and saw a rise in medical outliers and number of medically optimised patients i.e. 8 days during February we had over 80 patients which was an increase from previous month. The team continue to work together to meet the operational needs of the Division

Historic data:





Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:	Karen Townsend, Divisional Director, Urgent Care
Executive Lead:	Lorraine Burnett, Director of Operations

EXCEPTION REPORT

Indicator: Monthly Sickness Absence rate

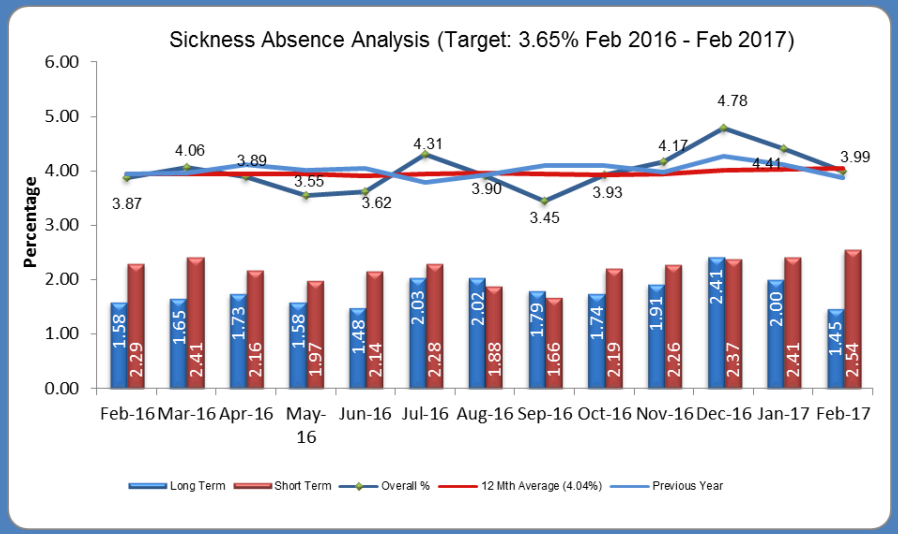
Issue:
The Trust wide absence remained above target at 3.99% in Month 11. Short Term sickness increased from 2.41% to 2.54% and long term sickness decreased from 2.00% to 1.45%. Long term decrease was due to Stress & Anxiety decreasing by 95.88% (9.43 WTE) and Other musculoskeletal problems decreasing by 77.09% (6.87WTE). Short Term absences increased with Other Musculoskeletal Problems increasing by 51.61% (5.55 WTE), Stress & Anxiety also increased 29.81% (5.07WTE). However there was a decrease in Cold, Cough, Flu - Influenza by 35.84% (4.71 WTE). The Trust rolling 12 month average is running at 4.04%, lower than our peers, with absence rates across the region currently averaging 5.3% (EWIN regional benchmarking data Dec 2016).

.

Proposed actions:
Absence continues to be monitored with detailed analysis taking place in all areas. Urgent Care is now below the Trust target at 3.4% but are still targeting hot spot areas. Planned Care has dropped below 5% from an increase over the winter. We continue to support managers with individual cases, many requiring sensitivity due to the nature of the absence. The Facilities department has experienced a challenging period with a high number of terminal illness cases and, sadly, the passing away of 5 serving staff members in the last 18 months. There have also been significant long term absences related to hip and knee replacements, with the manual nature of the roles requiring extensive recovery time and preventing temporary redeployment in most cases. A fine balance is required due to the Staff Survey results showing some staff returning to work when still unwell. Occupational Health & Wellbeing Team are continuing to support staff with actions related to the strategy.

Forecast for improvement:			
Q1	Q2	Q3	Q4

Historic data:



Lead:	Dee Appleton-Cairns, Deputy Director of HR
Executive Lead:	Sue Hodkinson

EXCEPTION REPORT

Indicator: Mandatory Training Completed In The Last 12 Months

Issue:

The level of Mandatory Training completed has for the first time exceeded our 95%, Trust target and exceeds the CQC target (76%) An additional measurement is partial compliance where staff who are non-compliant but are booked onto future programmes is now standing at 97.3%. Local Induction continues to be a concern, reducing to 85.3%, however there are 4 areas where there needs to be improvement with less than 70% compliance. Their is no doubt that the incremental pay policy and the link to compliance, has supported in improvements across the Trust and our forecast for improvement in Q3 & Q4 was reliant on the influence this would have. Despite improvements we do have to be mindful of the demands being placed on teams across the Trust, but our aim is to continually work towards compliance for Q4.

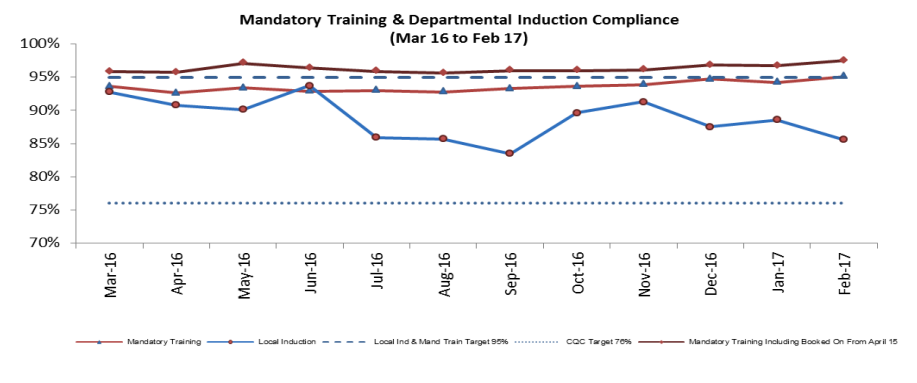
Proposed actions:

Out of the 11 divisions, 8 divisions have achieved over 95% for Mandatory Training and 3 divisions achieved the target for local induction. Follow up will be undertaken with those divisions with less than 70% local induction compliance, with the Head of Learning & Development to agree actions with the Director of People & OD. The HR Specialist Team are continuing to issue letters to those whose incremental dates are coming up and who are not complaint, to remind them that they will not receive their increment.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Mandatory Training Table February 2017

Position	Division	Compliance
1	Corporate Clinical	100.0%
2	Estates	97.5%
3	Human Resources	97.0%
4	Planned Care	95.6%
5	Finance & Performance	95.4%
6	Corporate Non - Clinical	95.3%
7	Urgent Care	95.2%
8	COCH & WUTH Collaboration	95.2%
9	Diagnostics and Pharmacy	**94.8%**
10	Nurse Management	**94.7%**
11	Facilities	**91.1%**
	Total	**95.1%**

Local Induction Table February 2017

Position	Division	Compliance
1	COCH & WUTH Collaboration	100.0%
2	Nurse Management	100.0%
3	Human Resources	100.0%
4	Facilities	100.0%
5	Planned Care	**91.5%**
6	Diagnostics and Pharmacy	**87.2%**
7	Corporate Non - Clinical	**86.7%**
8	Urgent Care	**85.0%**
9	Finance & Performance	**56.5%**
10	Corporate Clinical	**0.0%**
11	Estates	**0.0%**
	Total	**85.6%**

Lead: Linda Walker, Head of Learning & Development

Executive Lead: Sue Hodkinson

EXCEPTION REPORT

Indicator: Appraisals Completed In The Last 12 Months

Issue:

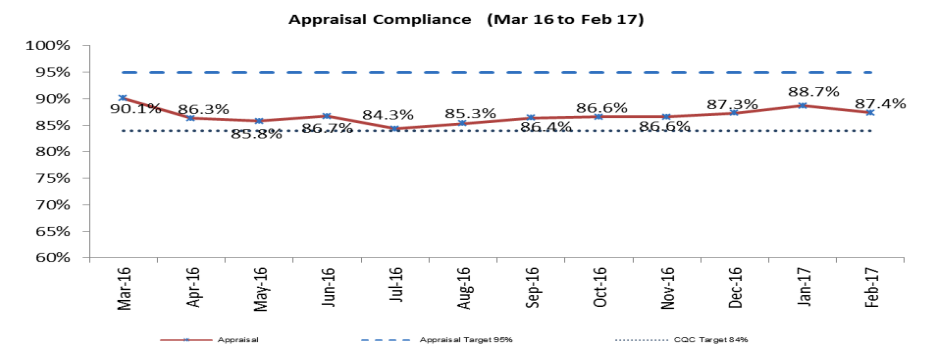
Disappointingly performance against the appraisal target of 95% has reduced this month to 87.4% . This remains above the CQC target of 84% but remains below the Trust target of 95%.

Where there are any issues of reduced compliance, Senior Managers are alerted and urgent action plans are requested in order to bring compliance back into line. Action for non-compliance affecting individuals incremental progression and therefore actions to address non-compliance are essential, this is being managed by the HR Business Partner Team.

Proposed actions:

Currently, line managers and all members of staff should be ensuring that appraisals are planned so incremental pay will not be affected . The HR Business Partner Team continue to issue letters to those whose incremental dates are coming up and who are not complaint, to remind them that they will not receive their increment. All Divisional Managers will receive the details of areas of non-compliance supported by the reminder regarding responsibilities related to the new policy. Out of the 11 divisions, there are 3 areas which have achieved over 95%, 4 areas over 90%, with 4 requiring improvement with less than 85% and follow up to understand actions to progress.

Historic data:



Appraisal Table February 2017

Position	Division	Compliance
1	COCH & WUTH Collaboration	100.0%
2	Facilities	97.6%
3	Human Resources	96.4%
4	Planned Care	92.3%
5	Corporate Clinical	92.3%
6	Nurse Management	91.4%
7	Corporate Non - Clinical	90.9%
8	Finance & Performance	87.2%
9	Diagnostics and Pharmacy	83.2%
10	Urgent Care	81.9%
11	Estates	39.5%
	Total	87.4%

Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:	Linda Walker, Head of Learning & Development
Executive Lead:	Sue Hodkinson

EXCEPTION REPORT

Indicator: Variable Pay

Issue:

To not exceed £4.843m agency expenditure ceiling. To deliver variable savings target (to be determined).

M&D Vacancies	Urgent	Planned	Diag/Radiol	Total
Consultant	8	0	0	**8**
Speciality Doctor	4	1	0	**5**
Middle Grade	0.8	3	0	**3.8**
Junior Grade	2.4	6	0	**8.4**
Total	**15.2**	**10**	**0**	**25.2**

Vacancies (FTE)	Urgent Care	Planned Care	Diag/Radiol/Pharm	Total
N&M Registered	21.30	17.62	0.00	**38.92**
Support Staff	9.98	5.60	1.00	**16.58**
Radiographer/Sonographer	0.00	0.00	4.80	**4.80**
Allied Health Professionals	3.13	0.00	0.00	**3.13**
Healthcare Scientist	0.00	0.00	0.00	**0.00**
Pharmacy Support	0.00	0.00	13.63	**13.63**
Pharmacist	0.00	0.00	0.00	**0.00**
Total	**34.41**	**23.22**	**19.43**	**77.06**

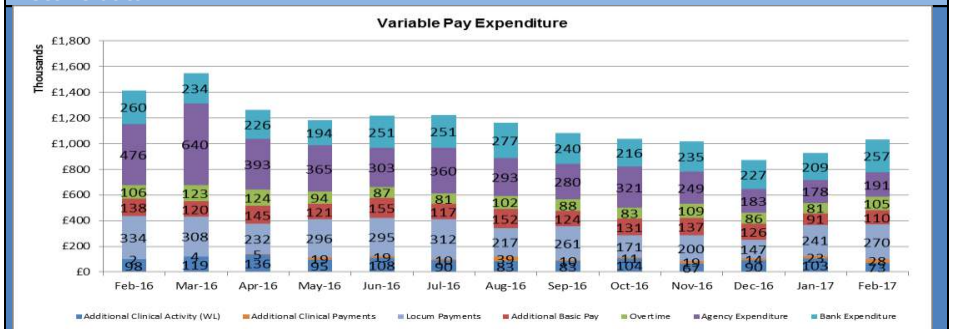
Proposed actions:

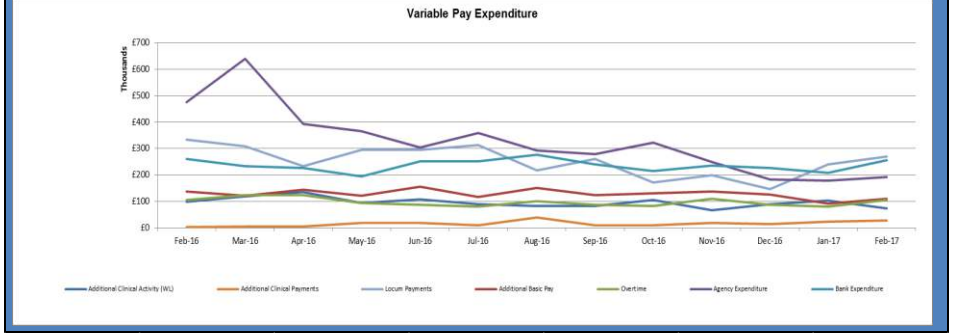
Due to operational pressures, variable pay spend has increased month-on-month, as anticipated. However, discussions have taken place with Divisional Directors and the wider project group to focus on the following actions. A workshop to support the new medical management structure on the actions around variable pay is being planned for Q1, when in post; a physicians associate workshop was undertaken 09/03 and well received, with support from a number of specialities looking to take forward and build on availability of roles from Health Education England; detailed analysis being undertaken of overtime, locum payments and further drive around medical agency spend; nurse staffing working group to plan around future nurse staffing requirements and planning for Winter 2017; series of actions to implement changes re IR35 and workforce supply guidance from NHS Improvement.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:





Lead:	Jane Hayes Green, Project Manager
Executive Lead:	Sue Hodkinson

EXCEPTION REPORT

Indicator: Turnover

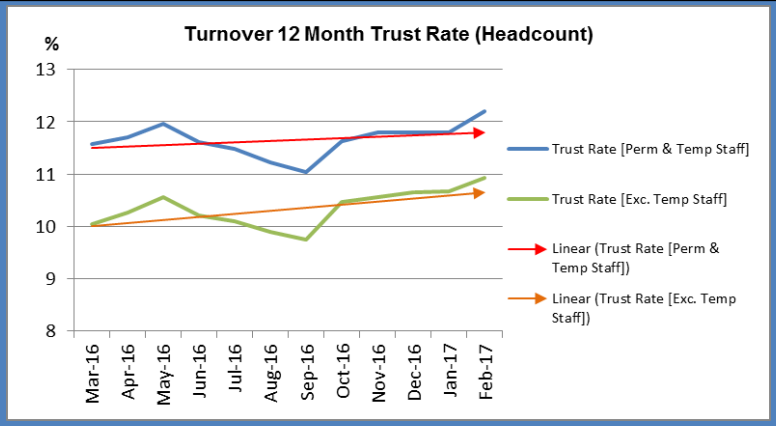
Issue:

Turnover in January remained above target at 10.93%. The rate based on FTE is also above target at 10.60%. The staff groups over target are:
Additional Professional Scientific and Technical Staff at 11.97%, which represents 19 leavers in the last year, 9 of which were ODPs, with no trends regarding the reason for leaving recorded on ESR.
Healthcare Scientist at 11.63%, representing 10 leavers in the last year.
Nursing & Midwifery Registered Staff at 12.46% with 18 Midwives and 104 Staff Nurses leaving the Trust in the last year.

Proposed actions:

We will be continuing to monitor the rates over the next few months and providing further breakdowns, alongside analysis of exit interview responses to understand any trends.

Historic data:



Staff Group - Mar 16 - Feb 17 Excludes Temporary Staff	Turnover %
Add Prof Scientific and Technic	11.97
Additional Clinical Services	9.84
Administrative and Clerical	12.00
Allied Health Professionals	8.81
Estates and Ancillary	10.53
Healthcare Scientists	11.63
Medical and Dental	5.56
Nursing and Midwifery Registered	12.46
Trust Totals & Rate	**10.93**

Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:	Dee Appleton-Cairns, Deputy Director of HR
Executive Lead:	Sue Hodkinson

EXCEPTION REPORT

Indicator: Agency Spend

Staff Group	14/15	15/16	16/17 to M11	16/17 Proj (straight line)	16/17 Adjusted Projection	Method used for Adjusted Projection
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	-£ 787	£ 0	
Medical	£ 2,531,112	£ 3,911,032	£ 2,478,921	£ 2,704,278	£ 2,766,148	uses trajectory from 15/16
Nursing	£ 830,776	£ 642,734	£ 319,817	£ 348,891	£ 523,000	Director of Nursing Projection
Allied Health Professional	£ 177,384	£ 218,871	£ 83,980	£ 91,615	£ 95,235	uses trajectory from 15/16
Health Care Scientists	£ 115,743	£ 161,736	£ 234,316	£ 255,618	£ 255,618	uses straight line
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,116,854**	**£ 3,399,613**	**£ 3,640,001**	

Issue:

Medical Pay is currently overspent by £110k. Agency medical expenditure is £2,479k YTD (6% of the total medical spend). Nursing Pay is £68k overspent. Agency nursing expenditure YTD is £320k which is 0.8% of total trained nursing spend. Total Agency spend for months 1 to 11 is £3,117k, compared to £4,461k for the same period last year.

Proposed actions:

The adjusted projection for agency spend now falls below the level of spend in 14/15, which is a positive position for the Trust. However, focus is currently on the actions related to the IR35 national legislative changes, with communication being issued w/e 17/03 to agencies, engaged agency workers and other service providers who come under the remit of IR35. In addition, actions are being worked through to address the workforce supply risks on the back of NHSI guidance re agency workers who are also in substantive posts. This includes communication to the agencies to amend framework requirements and communication to the wider organisation. Planning for Easter to minimise impact is also underway.

Forecast for improvement:

Appendix 1

Countess of Chester Hospital NHS Foundation Trust		Feb-17						
		Registered Nurses/Midwives			Care Staff			All staff
Specialty	Ward	Planned monthly hours	Actual monthly hours	%	Planned monthly hours	Actual monthly hours	%	% planned hours staffed
Paediatrics	30	2,408.00	2,377.00	**98.7%**	644.00	646.00	**102.1%**	99.0%
Obstetrics	32	2,083.50	1,956.75	**93.9%**	2,156.00	2,266.25	**104.8%**	99.6%
Stroke Unit	33	2,369.00	1,938.25	**81.8%**	2,242.50	2,373.33	**96.0%**	93.5%
Therapy Services	34	2,220.00	1,991.75	**89.7%**	2,013.50	1,980.83	**100.1%**	93.8%
General Surgery	40	1,356.00	1,116.00	**82.3%**	735.00	632.75	**76.4%**	83.6%
General Surgery	41	1,885.50	1,645.50	**87.3%**	1,671.75	1,623.00	**99.9%**	91.9%
Cardiology	42	3,506.75	3,377.25	**96.3%**	2,346.50	2,162.58	**92.1%**	94.6%
Geriatric Medicine	43	1,693.00	1,601.50	**94.6%**	1,326.25	1,250.50	**95.1%**	94.5%
General Surgery	44	1,847.50	1,738.50	**94.1%**	2,074.00	1,919.50	**92.0%**	93.3%
Urology	45	1,876.75	1,584.75	**84.4%**	2,351.50	2,389.58	**100.2%**	94.0%
Respiratory	48	2,316.50	2,000.50	**86.4%**	1,864.50	2,091.17	**102.5%**	97.9%
Gastroenterology	49	1,713.50	1,585.00	**92.5%**	1,880.50	2,148.58	**99.7%**	103.9%
Haemotology	50	1,790.33	1,644.08	**91.8%**	2,517.17	2,513.75	**96.9%**	96.5%
General Medicine	51	1,793.50	1,748.00	**97.5%**	2,514.00	2,491.42	**97.9%**	98.4%
General Surgery	52	1,832.25	1,668.50	**91.1%**	2,376.00	2,331.50	**97.2%**	95.1%
General Surgery	54	2,400.50	2,080.30	**86.7%**	2,358.00	2,255.00	**95.6%**	91.1%
Acute Medicine	AMU	4,143.17	3,368.62	**81.3%**	2,016.00	1,932.50	**95.9%**	86.1%
Rehabilitation - EPH	Bluebell	1,866.50	1,658.00	**88.8%**	4,669.50	5,286.00	**113.2%**	106.2%
Cardiology	CCU	1,822.00	1,789.25	**98.2%**	644.00	631.50	**98.1%**	98.2%
Critical care medicine	ICU	9,145.75	7,700.50	**84.2%**	676.50	605.75	**89.5%**	84.6%
Labour Ward	Labour Ward	3,864.00	3,831.50	**99.2%**	794.00	936.00	**117.9%**	102.4%
Neonatal	NNU	2,756.00	2,485.00	**90.2%**	644.00	908.50	**141.1%**	99.8%
Rehabilitation - EPH	Poppy	1,089.00	1,053.50	**96.7%**	1,743.50	1,865.22	**107.0%**	103.0%
Renal	Renal	290.00	260.00	**89.7%**	618.50	507.50	**82.1%**	84.5%
Total		58,069.00	52,200.00	89.9%	42,877.17	43,748.72	102.0%	95.0%

BOD Item No

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Financial Position – Month 11, February 2017 Forecast Outturn 2016/17
Date of Meeting	4th April 2017
Author(s)	Mr Simon Holden, Interim Chief Finance Officer
Presented by	Mr Simon Holden, Interim Chief Finance Officer
Annual Plan Objective No.	
Summary	This paper is intended to provide details of the Trust's financial position, as at 28th February 2017 (Month 11) and an overview of the indicative year end outturn.
Recommendation(s)	**The Board is asked to:** Directors are asked to note :- • The position at the end of February 2017 (Month 11) being on plan, before STF monies and slightly off plan after anticipated A&E STF penalty loss (£61,000 per month x 8 months) • The indicative year end outturn of a deficit of £5.45m, being in line with the agreed revised deficit Control Total; and • The slippage on the Capital Program, which it is planned to manage into 2017/18 (in collaboration with NHS Improvement).
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [X] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Countess of Chester Hospital NHS
NHS Foundation Trust

Board 4th April 2017
Financial Position: Month 11 2016/17

1.0 Executive Summary

- For the period April 2016 to February 2017 (i.e. Month 11) the Trust is reporting a headline overall overspend of £390k.
    - The trust is actually in a balanced position before STF is taken into account, with a slight overachievement of CRS of circa £102k.
    - It is worth noting that the position which is being monitored by NHS Improvement is the position before STF monies.
    - The £390,000 adverse overspend, reflects the position after additional STF monies is taken into account. This is reflective of the fact that the Trust has lost its Q2 A&E appeal, equating to £184k reduction. In addition, until the outcome of the Q3 appeal is known we have made the prudent assumption that this funding, plus Month 10 & 11, will not be forthcoming. This totals £492k and produces the reported overspend of £390k.
    - For Cancer and RTT we are assuming the STF income

- The over performance for Western Cheshire CCG has decreased by £0.057m in month, and is now above plan at £1.40m.

- Variable pay is 11% less than the same period in 2015/16. Forecasts indicate that the Trust will be below the £4.8m agency cap by the end of the year at £3.7m.

- CRS is ahead of the NHSI-profiled plan by £102k.

- Remaining risks, such as winter pressures and reduction in neonatal income, will be mitigated though the contingency reserve.

- The remaining £3m will be delivered through £1.5m of non-recurrent savings, with the remainder coming from NHSI either through a reduced control total, or additional STF monies.

- Cash at the end of February was £4.4m ahead of plan due predominantly contributions received for the hosting of a regional IT project, the slippage on the capital program, and the timing of payment runs.

- As at February the capital programme is £2.0m behind of the original plan. This is due in the main to IM&T spend and backlog maintenance for the year being behind the profile. Distress capital funding will be required from April 2017 and managers are being asked to review their requests (including this year's slippage) to ensure that they meet the "urgent and necessary" criteria.

In summary, pre-STF funding the financial position is balanced. However, £492k of STF monies have been lost due to the failure to meet the A&E trajectory in Q2, Q3 and Month 10-11. We are still awaiting the outcome of the Q3 appeal and therefore

this position could still change. Variable pay is reducing year on year, the CRS is £102k ahead of plan. The remaining £1.5m pressure will be met through non-recurrent opportunities. Capital funding for 2017/18 plans, plus 2016/17 slippage is of concern and requires in depth management review to ensure NHSI criteria is met.

2.0 Overview

2.1 Month 11 (2016/17)

The financial position for February 2017 (month 11) is showing an over-spend against plan of £390k. This position assumes the loss of the STF for missing the A&E 4 hour target for Q2, Q3, January and February (£492k). This is partly offset by over-performance of the CRS plan by £102k as at the end of February.

KEY VARIANCES	Annual Budget £000s	Feb YTD Budget £000s	Feb YTD Actual £000s	Feb YTD Variance £000s	Feb YTD Variance % of budget
INCOME					
Income - England	(173,831)	(159,103)	(158,265)	838	-0.5%
Income - Wales	(25,876)	(23,274)	(23,847)	(573)	2.5%
Other Clinical Income	(10,946)	(10,129)	(9,727)	402	-4.0%
Non Patient Income	(14,722)	(13,706)	(13,845)	(139)	1.0%
Release of Provisions			(163)	(163)	
INCOME	**(225,375)**	**(206,212)**	**(205,847)**	**365**	
PAY					
Nursing	57,303	52,639	52,707	68	0.1%
Medical	44,077	40,504	40,614	110	0.3%
Admin & Clerical	20,454	18,787	18,367	(420)	-2.2%
AHP, Therapies, Diagnostics & Pharmacy	21,209	19,394	19,223	(171)	-0.9%
Other	11,998	10,430	10,361	(69)	-0.7%
TOTAL PAY	**155,041**	**141,754**	**141,272**	**(482)**	
NON PAY					
Outsourcing	602	596	846	250	41.9%
Furniture & Office Equipment, Equip Hire & Computers	3,018	2,748	2,797	49	1.8%
Drugs	20,168	17,981	18,043	62	0.3%
Medical & Surgical Equipment	12,460	11,561	11,601	40	0.3%
Laboratory Equipment	5,013	4,588	4,689	101	2.2%
Building / Engineering / EBME	1,082	1,002	1,118	116	11.6%
Depreciation	4,200	3,884	3,884	0	0.0%
CNST	8,669	7,947	7,947	0	0.0%
Other	21,722	21,255	21,724	469	2.2%
Release of Provisions			(187)	(187)	
Use of Contingency Reserve	291	291		(291)	
TOTAL NON PAY	**77,225**	**71,853**	**72,462**	**609**	
CRS	**(2,941)**	**102**		**(102)**	
TOTAL DEFICIT	**3,950**	**7,497**	**7,887**	**390**	

2.2 Month 12 (2016/17) – Addendum

The Trust had originally forecast a deficit, before Sustainability & Transformation Fund (STF) monies, of £9.9m for 2016/17 (with STF monies being allocated of £5.95m).

It was also forecast that this planned deficit subsequently reduced to £3.95m (i.e. the "Control Total"), if the Trust was successful in achieving 100% of its Sustainability & Transformation Fund metrics.

This position being very much based upon the Trust delivering £12.0m of Cost Reduction Savings (CRS).

However, as the year progressed the Trust's Control Total was amended, by a further £1.5m, to a £5.45m deficit (after STF monies).

Accordingly, the Trust now has a robust forecast to deliver a reported, a deficit for the year of £5.45m, after receipt of STF monies (i.e. effectively achieving its stated Control Total).

Therefore, in summary the Trust has delivered Cost Reduction Savings of £10.5m (against an original Plan of £12.0m), which has resulted in a deficit after STF monies of £5.45m.

This is a positive outcome for the year, especially given the uncertainties surrounding the delivery of an ambitious Cost Reduction Scheme program, the block with Western Cheshire CCG, and the management of the hospital over the Winter period.

3.0 Income

INCOME SUMMARY AS AT 28th FEBRUARY 2017

	ANNUAL BUDGET £000's	YEAR TO DATE POSITION BUDGET £000's	ACTUAL £000's	VAR £000's	MOVEMENT FROM PREV PERIOD £000's
PATIENT INCOME					
Income Wales	**25,876**	**23,274**	**23,847**	**(573)**	**111**
Income England (Excluding STF)	**167,931**	**153,695**	**153,349**	**346**	**0**
Private Patients	309	285	279	6	2
RTA's	1,000	917	654	263	(3)
Other Clinical Income	9,636	8,927	8,794	133	(7)
TOTAL OTHER CLINICAL	**10,945**	**10,129**	**9,727**	**402**	**(8)**
TOTAL CLINICAL INCOME	**204,752**	**187,098**	**186,923**	**175**	**103**
Training	8,443	7,846	7,846	0	0
Car Parking Income (Staff & Public)	1,391	1,275	1,270	5	(2)
Staff Restaurant Income	475	436	487	(51)	(1)
Shop Income	629	577	631	(54)	0
Other Non Clinical	3,784	3,572	3,775	(203)	(12)
TOTAL NON PATIENT INCOME	**14,722**	**13,706**	**14,008**	**(302)**	**(15)**
TOTAL INCOME (Excluding STF)	**219,474**	**200,804**	**200,930**	**(127)**	**88**
STF Funding	**5,900**	**5,408**	**4,916**	**492**	**62**
TOTAL INCOME (Including STF)	**225,374**	**206,212**	**205,847**	**365**	**150**

Variances not driven by commissioner contracts include a reduction of RTA income £262k, and Other clinical income £133k. This relates to the Wirral Renal dialysis SLA £123k.

3.1 Contract Income

As at 28th February 2017 Income is £84k over plan, a reduction of £330k in month driven by a decrease in elective & non-elective over performance & continuation of the effects of the Neonatal reduction in beds and level of care provided. Of the over performance £701k relates to Welsh activity, primarily non-elective & critical care and additional Gynaecology elective activity planned care agreed to undertake (£129k). English Commissioners excluding Western Cheshire CCG are below plan for the year (£521k), this is mainly the specialised commissioning contract where Adult critical care is under YTD by £388k and Neonatal continues to be lower than planned due to the step down and reduction of cots whilst the clinical review is undertaken at £732k.

The impact of the block contract with Western Cheshire CCG reduced by £57k in month to £1,400k YTD, the main pressures are Non-Elective Inpatients £1493k, (case mix driven £1,033k, activity driven £440k), Day case £465k, High Cost Drugs and Devices £364k and AMD activity higher than plan £812k

A Summary of the activity & income variances by Point of Delivery are shown below:-

Point of Delivery	Activity Variance YTD	Value Variance YTD	Block Contract Impact YTD	Value Variance after block adjustment YTD	Movement from Previous Period
Daycases	1,370	£680,002	(£465,473)	£214,529	£19,207
Elective Inpatients	-291	(£291,298)	£206,013	(£85,285)	(£60,472)
Non-Elective Inpatients	4	£1,456,307	(£1,493,067)	(£36,760)	(£197,078)
First Outpatients	-2,555	(£479,530)	£265,052	(£214,478)	(£24,704)
Follow Up Outpatients	-984	(£61,123)	£131,224	£70,101	£7,643
Outpatient Unbundled & Procedures	5,075	£168,106	£4,858	£172,964	£14,182
Maternity	-73	(£168,228)	£170,168	£1,940	£4,095
A&E Attendances	316	£34,702	(£101,790)	(£67,088)	(£11,416)
Best Practice Adj'ts & Growth		£11,003	£650,521	£661,524	£54,735
Drugs & Devices		£1,593,584	(£363,713)	£1,229,871	£53,248
AMD	585	£839,584	(£812,298)	£27,286	£22,961
Adult Crit Care & Neonatal	-1,574	(£1,683,170)	£1,100,845	(£582,325)	(£127,529)
Other Non PBR & CQUIN		(£518,834)	(£692,150)	(£1,210,984)	(£85,853)
PBR & Non PBR Variance		**£1,581,105**	**(£1,399,810)**	**£181,295**	**(£330,981)**
CQUIN & Contract Penalties		**(£97,065)**		**(£97,065)**	£1,179
Total Excluding STF Funding		**£1,484,040**	**(£1,399,810)**	**£84,230**	**(£329,802)**
Sustainability & Transformation funding		**(£491,667)**		**(£491,667)**	(£61,638)
Total Excluding STF Funding		**£992,373**	**(£1,399,810)**	**(£407,437)**	**(£391,440)**

Action: System wide schemes to address Elective Care pressures include the introduction of a referral facilitation system including a virtual basket of referral, the focus now must be on the referrals being reviewed by specialties in a timely manner and extending roll out to more specialties. System wide schemes to address Urgent Care pressures include Primary care A&E streaming, GP out of hours have moved to COCH to enable diversion away from A&E to primary care, step up beds and care home support. All these schemes are dependent on support & ownership from COCH Clinicians.

A review of processes and practices regarding the follow-up of outpatients is being undertaken in conjunction with the model hospital team with a view to a significant change and reduction in the number of patients being brought back into clinic.

A Business case has been approved to reduce the use of Rheumatology Biologics and the switch to Biosimilars in Gastroenterology has taken place. These schemes have, and should, reduce the High Cost drug cost into 2017/18.

4.0 Key Expenditure Variances

4.1 Pay

Nursing Pay – has moved favourably in month by £92k to give a £68k overspend YTD. The main reason being funding from the winter reserve of £121k was allocated for the escalation ward within Urgent Care. Nursing agency spend was £43k giving a YTD spend of £320k.
The main overspending nursing areas are shown below: -

Nursing Pay February Cost Centre	Total Budget YTD	Actual Non Agency Spend YTD	Agency Spend YTD	Total Spend YTD	Variance YTD	Variance January YTD	Movement
Ward 47 - Acute Medical Unit	£1,664,806	£1,754,794	£2,072	£1,756,866	£92,060	£71,508	£20,552
Ward 41	£693,846	£764,160	£3,765	£767,926	£74,080	£68,771	£5,309
Gp Assessment Unit	£55,013	£136,289	(£7,993)	£128,295	£73,283	£73,335	(£52)
Rapid Response Team	£836,511	£898,809	£0	£898,809	£62,298	£64,110	(£1,812)
Theatre Recovery	£816,901	£796,204	£80,574	£876,778	£59,877	£60,761	(£884)
Ward 33 - Stroke Unit	£1,200,232	£1,247,913	£1,804	£1,249,717	£49,485	£44,634	£4,851
Radiology	£251,519	£289,855	£0	£289,855	£38,335	£35,545	£2,790
Pals And Complaints	£0	£37,805	£0	£37,805	£37,805	£32,961	£4,844
Diabetic Liaison	£216,463	£253,267	£0	£253,267	£36,804	£33,394	£3,410
Palace Ward (45)	£959,866	£987,525	£7,412	£994,938	£35,072	£34,892	£180
Other	£45,943,872	£45,220,263	£232,183	£45,452,446	(£491,426)	(£359,712)	(£131,714)
Grand Total	£52,639,028	£52,386,884	£319,817	£52,706,701	£67,673	£160,199	(£92,526)

Further details on key movements in month are provided below:-

Area	Feb In Month Var £000s	Jan In Month Var £000s	Dec In Month Var £000s	Nov In Month Var £000s	YTD Var £000s	Reason	Action
Nursing							
GPAU	0	9	10	22	73	Staffing pressures and escalation beds in January.	Budget to be realigned and merged with ACU to mitigate pressures. Escalation beds have now closed.
Ward 47 (AMU)	21	3	13	13	92	In month pressure relates to unsocial enhancements significantly above run rate, unfunded maternity leave and a small pressure on HCAs.	YTD pressure also relate to previous months unfunded escalation beds and bank usage. Posts now recruited too so bank usage should reduce.
Ward 41	5	0	1	2	74	£2.5k add basic pay and high enhancements compared to the budget	Shift patterns and budget being reviewed in finance and with ward manager.

Medical Pay – has moved adversely in month by £19k to give a £110k YTD overspend. The main overspending medical areas are shown below: -

Medical Pay February Cost Centre	Total Budget YTD	Actual Non Agency Spend YTD	Agency Spend YTD	Total Spend YTD	Variance YTD	Variance January YTD	Movement
Acute Medicine Staff	£1,329,642	£1,095,003	£381,474	£1,476,477	£146,834	£110,400	£36,434
Anaesthetics	£5,456,364	£5,374,946	£171,353	£5,546,299	£89,935	£89,809	£126
Emergency Department -M	£2,805,780	£2,622,003	£265,338	£2,887,340	£81,560	£75,995	£5,565
Endoscopy Suite	£74,390	£136,484	£0	£136,484	£62,094	£39,155	£22,939
General Surgery	£2,574,715	£2,504,136	£131,775	£2,635,911	£61,197	£54,910	£6,287
Trauma And Orthopaedics	£2,135,395	£1,966,930	£209,820	£2,176,750	£41,354	£35,657	£5,697
Gp Rotation	£117,851	£153,989	£0	£153,989	£36,138	£28,047	£8,091
Plastic Surgery	£990,124	£704,343	£314,134	£1,018,476	£28,352	£24,519	£3,833
Urology	£669,178	£694,428	£1,349	£695,778	£26,600	£27,663	(£1,063)
Primary Care Unit	£18,131	£39,647	£2,454	£42,102	£23,971	£14,168	£9,803
Other	£24,332,058	£22,842,584	£1,001,224	£23,843,808	-£488,251	(£409,559)	(£78,692)
Grand Total	**£40,503,630**	**£38,134,492**	**£2,478,921**	**£40,613,413**	**£109,784**	**£90,764**	**£19,020**

Further details on key movements in month are provided below:-

Area	Feb In Month Var £000s	Jan In Month Var £000s	Dec In Month Var £000s	Nov In Month Var £000s	YTD Var £000s	Reason	Action
Medical							
Emergency Department	6	30			82	Movement in month due to additional locum shifts to support performance and overlap of new substantive specialty doctors, who were previously covered by agency.	Review of staffing currently being undertaken by Acute Directorate Manager and CFBM.
AMU	36	9	28	21	147	Currently using 2 agency consultants, 1 to cover mat leave, 1 to cover bed pressures. There is also a pressure on junior medical staff.	Alternative options to cover the additional consultant post within current resource are under review. The pressure on junior medical staff is under investigation.
Endoscopy	23	-7	-4	20	62	Use of ACAs to cover capacity gap due to less sessions being provided by Gastro Consultants due to implications of GI bleed rota and nurse scopists than were previously provided	Recent advert for nurse scopists has proved unsuccessful. Alternative options need to be progressed

Admin & Clerical – has seen a favourable movement in month of £36k to give a £420k underspend YTD. Where possible, to assist the financial position, departments (mainly back office) are delaying recruitment for as long as possible, resulting in the underspends described below. This is recognised as a short-term, non-recurrent measure. Details of the main under spending departments are provided below.

Admin Pay February Cost Centre	Total Budget YTD	Total Spend YTD	Total Variance YTD	Variance January YTD	Movement
Procurement Services	£733,013	£678,919	(£54,094)	(£42,272)	(£11,822)
Service Support	£409,434	£355,932	(£53,502)	(£47,847)	(£5,655)
Radiology Admin	£432,940	£381,634	(£51,306)	(£48,073)	(£3,233)
Payroll And Pensions	£655,719	£615,919	(£39,800)	(£35,145)	(£4,655)
Imt Projects	£388,716	£351,429	(£37,287)	(£30,101)	(£7,186)
Pals And Complaints	£131,766	£94,751	(£37,015)	(£32,135)	(£4,880)
Ppd	£328,432	£296,711	(£31,721)	(£28,908)	(£2,813)
Divisional Support	£160,418	£139,122	(£21,296)	(£19,414)	(£1,882)
Imt Coders	£508,929	£491,593	(£17,336)	(£14,171)	(£3,165)
Commercial Procurement Service	£92,571	£76,737	(£15,834)	(£17,759)	£1,925
Other	£14,945,046	£14,884,549	(£60,496)	(£68,226)	£7,729
Grand Total	**£18,786,982**	**£18,367,295**	**(£419,687)**	**(£384,051)**	**(£35,636)**

4.2 Agency spend & Variable Pay

We have spent £3.1m on agency pay for months 1 to 11, using a straight line forecast this would take us to £3.4m by the end of the year. An adjusted projection based on a combination of 15/16 spend trajectories and professional judgement would be £3.6m. Both forecasts are below the £4.8m agency cap.

Staff Group	14/15	15/16	16/17 to M11	16/17 Proj (straight line)	16/17 Adjusted Projection	Method used for Adjusted Projection
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	-£ 787	£ 0	
Medical	£ 2,531,112	£ 3,911,032	£ 2,478,921	£ 2,704,278	£ 2,766,148	uses trajectory from 15/16
Nursing	£ 830,776	£ 642,734	£ 319,817	£ 348,891	£ 523,000	Director of Nursing Projection
Allied Health Professional	£ 177,384	£ 218,871	£ 83,980	£ 91,615	£ 95,235	uses trajectory from 15/16
Health Care Scientists	£ 115,743	£ 161,736	£ 234,316	£ 255,618	£ 255,618	uses straight line
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,116,854**	**£ 3,399,613**	**£ 3,640,001**	

When reviewing spend in relation to Variable Pay further, we can see a 11% reduction overall when comparing the position year on year. Key areas of variable pay that have seen a reduction in the year on year position are Additional Clinical Activity Payments and Agency Expenditure.

	2015/16 Full Year Spend	2015/16 Month 11 YTD Spend	2016/17 Month 11 YTD Spend	Spend Variance	% age change
Additional Clinical Activity (WL)	£ 1,514,408	£ 1,395,782	£ 1,031,400	-£ 364,382	(26.1%)
Additional Clinical Payments	£ 165,110	£ 161,130	£ 196,846	£ 35,716	22.2 %
Locum Payments	£ 2,833,197	£ 2,525,251	£ 2,624,156	£ 98,905	3.9 %
Additional Basic Pay	£ 1,454,549	£ 1,334,146	£ 1,408,416	£ 74,270	5.6 %
Overtime	£ 1,143,225	£ 1,019,869	£ 1,038,661	£ 18,792	1.8 %
Agency Expenditure	£ 5,098,650	£ 4,459,021	£ 3,116,655	-£ 1,342,366	(30.1%)
Bank Expenditure	£ 2,840,073	£ 2,605,930	£ 2,582,228	-£ 23,702	(0.9%)
Total Variable Pay Expenditure	**£ 15,049,212**	**£ 13,501,129**	**£ 11,998,362**	**-£ 1,502,767**	(11.1%)
Pay Budget	**£ 149,141,142**	**£137,062,076**	**£141,753,627**		
Variable Pay as % of Total Budget	**10%**	**10%**	**8%**		

4.3 Non Pay

Key issues are in the following areas:

- **Outsourcing £250k YTD variance**
  Overspend relates to the following specialties being in excess of planned expenditure: -

Ophthalmology	£110k (actual spend to date £225k)
O&G	£19k (actual spend to date £19k)
T&O	£103k (actual spend to date £173k)
Anaesthetics	£12k (actual spend to date £12k)
General Surgery	£0k (actual spend to date £410k)
ENT	£6k (actual spend to date £7k)

  The Ophthalmology Department have now recruited to three consultant posts, which will result in the reduction of outsourcing spend in this area and is a more cost-effective approach to meet these levels of demand.

- **Building / Engineering / EBME £116k YTD variance, £17k in month variance**
  Overspend being driven predominantly by vacancies and the subsequent use of contractors to cover service.

- **Other £469k YTD variance, £99k in month variance**
  Key areas contributing this overspend are as follows: -

	In Month	YTD
Details	**£000s**	**£000s**
Nursing Home Placements	(2)	143
Chargeable overseas deceased patients - bad debt provision	121	121
Services Received	14	103
Printing & Stationery	1	77
Telephones	11	45
TOTAL OTHER NON PAY VARIANCE	**145**	**489**

Action: - A number of non-pay pressures are directly linked to over performance within the Western Cheshire CCG contract with no additional funding due to the block contract. There are however a number of non-patient related overspends which may see restrictions put in place to avoid further spend in these areas such as furniture / office equipment, conferences, expenses, subscriptions etc. Also a change in the approval process for requisitions has been piloted within Urgent Care and if this proves successful will be rolled out to other areas.

5.0 CRS

The CRS target for 2016/17 has been set at £6.1m (3.74% of departmental budgets) for delivery by operational departments, with an additional £2.7m fully identified and delivered through technical and capital charge changes. The further £3m requested from NHSI Targeted S&T Funds (profiled in month 12) has been declined. However, a compromise has been brokered, whereby if we find additional in year non-recurrent savings of £1.5m NHSI will either provide additional monies or revise our control total by the same amount of £1.5m, avoiding the STF Q4 fine.

The information below relates only to the £6.1m to be delivered across the Trust.

5.1 February 2017 CRS Performance

CRS Performance for the month of February is shown below. We are currently 102k ahead of plan. The adjustment to the monthly profile is shown on the Central line (£92k for months 1-11), as is any slippage from investments, release of non-pay inflation reserve etc, which totals £804k to date. If the profile adjustment had not been actioned, the position for CRS would have been £10k ahead of plan.

CRS DIVISIONAL PERFORMANCE AS AT FEBRUARY 17					
Division / Department	Target to February	Achieved to February	Var to February	Var to January	Var in month
Planned Care	£ 2,272,524	£ 2,130,551	£ 141,973	£ 256,447	-£ 114,474
Urgent Care	£ 1,941,174	£ 1,094,975	£ 846,199	£ 799,772	£ 46,427
D&P	£ 406,641	£ 405,239	£ 1,402	£ 2,375	-£ 973
Estates & Facilities	£ 465,403	£ 449,655	£ 15,748	£ 15,748	-£ 0
Nurse Mgmt	£ 54,236	£ 54,236	-£ 1	-£ 2	£ 1
Corporate Clinical	£ 12,260	£ 8,959	£ 3,301	£ 3,301	-£ 0
IM&T	£ 214,761	£ 214,761	£ 0	£ 0	£ 0
HR	£ 94,239	£ 95,626	-£ 1,387	-£ 5,366	£ 3,979
Trust Administration	£ 70,355	£ 66,780	£ 3,576	£ 4,001	-£ 426
PPD	£ 14,735	£ 62,403	-£ 47,667	-£ 41,709	-£ 5,959
Finance	£ 49,952	£ 53,024	-£ 3,072	-£ 2,792	-£ 279
Procurement	£ 22,005	£ 193,540	-£ 171,535	-£ 155,941	-£ 15,594
Appointments Hotline	£ 11,193	£ 5,088	£ 6,105	£ 5,088	£ 1,018
Central	-£ 92,121	£ 804,112	-£ 896,233	-£ 925,553	£ 29,319
TOTAL	**£ 5,537,356**	**£ 5,638,947**	**-£ 101,591**	**-£ 44,630**	**-£ 56,961**

5.2 In Year & Recurrent CRS Performance

Total CRS schemes already delivered in year and recurrently are shown below for both in year and recurrently.

2016/17 EFFICIENCY PROGRAMME PERFORMANCE AS AT FEBRUARY 2017

IN YEAR

Division / Department	2016/17 In Year CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,479,117	£ 2,324,620	£ 154,497	£ -	£ 67,497	£ 24,000	£ 63,000
Urgent Care	£ 2,117,644	£ 1,230,378	£ 887,266	£ 26,728	£ 1,000	£ 187,979	£ 671,560
D&P	£ 443,608	£ 429,341	£ 14,267	£ 14,267	£ -	£ -	£ -
Estates & Facilities	£ 507,712	£ 469,447	£ 38,265	£ -	£ -	£ -	£ 38,265
Nurse Mgmt	£ 59,166	£ 57,069	£ 2,097	£ -	£ 1,931	£ 166	£ -
Corporate Clinical	£ 13,375	£ 9,141	£ 4,234	£ -	£ -	£ 4,234	£ -
IM&T	£ 234,285	£ 234,285	£ 0	£ 0	£ -	£ -	£ -
HR	£ 102,806	£ 100,214	£ 2,593	£ 2,593	£ -	£ -	£ -
Trust Administration	£ 76,751	£ 73,581	£ 3,170	£ 3,170	£ -	£ -	£ -
PPD	£ 16,075	£ 69,701	-£ 53,626	£ -	£ -	£ -	-£ 53,626
Finance	£ 54,493	£ 57,845	-£ 3,352	-£ 3,352	£ -	£ -	£ -
Procurement	£ 24,005	£ 211,134	-£ 187,129	£ -	£ -	£ -	-£ 187,129
Appointments Hotline	£ 12,211	£ 5,088	£ 7,123	£ -	£ -	£ -	£ 7,123
Central		£ 912,466	-£ 912,466	£ -	£ -	£ -	-£ 912,466
TOTAL	**£ 6,141,248**	**£ 6,184,309**	**-£ 43,061**	**£ 43,406**	**£ 70,428**	**£ 216,379**	**-£ 373,273**
		101%	**-1%**	**1%**	**1%**	**4%**	**-6%**

2016/17 EFFICIENCY PROGRAMME PERFORMANCE AS AT FEBRUARY 2017

RECURRENT

Division / Department	2016/17 Recurrent CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,479,117	£2,111,142	£ 367,975	£ -	£ -	£ 73,275	£ 294,700
Urgent Care	£ 2,117,644	£1,155,040	£ 962,604	£ 0	£ -	£ 778,314	£ 184,289
D&P	£ 443,608	£ 356,101	£ 87,507	£ 62,553	£ -	£ -	£ 24,954
Estates & Facilities	£ 507,712	£ 242,712	£ 265,000	£ -	£ 140,000	£ 100,000	£ 25,000
Nurse Mgmt	£ 59,166	£ 59,166	£ -	£ -	£ -	£ -	£ -
Corporate Clinical	£ 13,375	£ 2,000	£ 11,375	£ -	£ -	£ 11,375	£ -
IM&T	£ 234,285	£ 168,876	£ 65,409	£ -	£ -	£ 65,409	£ -
HR	£ 102,806	£ 72,332	£ 30,474	£ -	£ -	£ 8,000	£ 22,474
Trust Administration	£ 76,751	£ 74,298	£ 2,453	£ -	£ -	£ 2,453	£ -
PPD	£ 16,075	£ 80,927	-£ 64,852	£ -	£ -	£ -	-£ 64,852
Finance	£ 54,493	£ 57,845	-£ 3,352	-£ 3,352	£ -	£ -	£ -
Procurement	£ 24,005	£ 211,134	-£ 187,129	£ -	£ -	£ -	-£ 187,129
Appointments Hotline	£ 12,211	£ -	£ 12,211	£ -	£ -	£ -	£ 12,211
Central	£ -	£ 125,392	-£ 125,392	£ -	£ -	£ -	-£ 125,392
TOTAL	**£ 6,141,248**	**£4,716,965**	**£ 1,424,283**	**£ 59,201**	**£ 140,000**	**£1,038,826**	**£ 186,255**
		77%	**23%**	**1%**	**2%**	**17%**	**3%**

Recurrently, the £1.2m red and black outstanding amounts for the divisions will largely be mitigated through the contract negotiations for 2017/18.

5.3 CRS Movement by Month

The table below shows the overall Trust movement in CRS performance by month and the progress made in scheme identification and delivery:-

IN YEAR	2016/17 In Year CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
April	£ 6,141,248	£ 1,434,341	£ 4,706,907	£ 783,267	£ 1,361,232	£ 1,023,025	£ 1,539,383
May	£ 6,141,248	£ 2,149,189	£ 3,992,059	£ 655,957	£ 871,253	£ 3,452,083	-£ 987,233
June	£ 6,141,248	£ 2,484,243	£ 3,657,005	£ 598,814	£ 786,599	£ 1,707,080	£ 564,512
July	£ 6,141,248	£ 2,817,420	£ 3,323,828	£ 577,470	£ 907,376	£ 1,373,830	£ 465,152
August	£ 6,141,248	£ 3,492,207	£ 2,649,041	£ 507,296	£ 738,455	£ 923,657	£ 479,634
September	£ 6,141,248	£ 4,351,680	£ 1,789,568	£ 451,333	£ 402,996	£ 398,050	£ 537,189
October	£ 6,141,248	£ 4,753,167	£ 1,388,081	£ 439,743	£ 195,264	£ 376,564	£ 376,511
November	£ 6,141,248	£ 5,135,245	£ 1,006,003	£ 287,137	£ 223,858	£ 349,284	£ 145,725
December	£ 6,141,248	£ 5,677,896	£ 463,352	£ 177,942	£ 145,406	£ 234,177	-£ 94,173
January	£ 6,141,248	£ 5,954,800	£ 186,448	£ 110,636	£ 98,411	£ 251,708	-£ 274,306
February	£ 6,141,248	£ 6,184,309	-£ 43,061	£ 43,406	£ 70,428	£ 216,379	-£ 373,273
Movement		£ 229,509	-£ 229,509	-£ 67,230	-£ 27,983	-£ 35,329	-£ 98,967

RECURRENT	2016/17 Recurrent CRS Target	Achieved to date	Outstanding	Green	Amber	Red	Pipeline
April	£ 6,141,248	£ 1,289,723	£ 4,851,525	£ 555,688	£ 1,812,167	£ 1,265,525	£ 1,218,145
May	£ 6,141,248	£ 1,866,320	£ 4,274,928	£ 460,394	£ 1,154,804	£ 3,766,834	-£ 1,107,104
June	£ 6,141,248	£ 2,044,231	£ 4,097,017	£ 410,722	£ 1,086,870	£ 2,219,046	£ 380,379
July	£ 6,141,248	£ 2,146,718	£ 3,994,530	£ 486,537	£ 1,092,281	£ 2,063,289	£ 352,423
August	£ 6,141,248	£ 2,793,248	£ 3,348,000	£ 459,892	£ 1,033,121	£ 1,601,054	£ 253,933
September	£ 6,141,248	£ 3,605,071	£ 2,536,177	£ 401,561	£ 697,475	£ 1,106,701	£ 330,441
October	£ 6,141,248	£ 3,966,159	£ 2,175,089	£ 412,220	£ 495,282	£ 1,094,299	£ 173,288
November	£ 6,141,248	£ 4,111,952	£ 2,029,296	£ 383,512	£ 409,862	£ 1,008,514	£ 227,408
December	£ 6,141,248	£ 4,167,791	£ 1,973,457	£ 316,680	£ 376,166	£ 911,709	£ 368,901
January	£ 6,141,248	£ 4,410,510	£ 1,730,738	£ 265,603	£ 218,887	£ 1,031,939	£ 214,308
February	£ 6,141,248	£ 4,716,965	£ 1,424,283	£ 59,201	£ 140,000	£ 1,038,826	£ 186,255
Movement		£ 306,455	-£ 306,455	-£ 206,402	-£ 78,887	£ 6,887	-£ 28,053

Colour	Status	Definition
Blue	Complete	Scheme delivered, budget savings removed for year
Green	Active	Low Risk, Confident of delivery, milestones on track but not removed from budget due to future start date
Amber	Active	Minor risk, Fairly confident of delivery but actions/minor issues to be resolved to ensure delivery within the timeframe
Red	Active	High Risk, Significant issues to be resolved before savings can be realised e.g. - Opportunity savings identified but plans not yet worked up accurately - Cross divisional issues to address - Potential negative impact on quality/safety - Requires investment?
Black	Yet to be activated	High Risk - Pipeline schemes with no value/milestones etc identified - Unidentified balance

5.4 £1.5m Non-recurring savings

There are a number of non-recurrent opportunities to achieve the £1.5m. The items where a non-recurrent favourable outturn is now currently forecast include the outcome of an appeal regarding personal injury benefit claims, payment of Condé Nast VAT reclaim and the outcome of overtime payment challenge from one staff group. Hence, it is currently envisaged that as these issues are each resolved, this should generate sufficient additional flexibility to be able to achieve the agreed plan.

5.5 Model Hospital Update

Key updates on the remaining work streams are as follows:

Patient and Asset Tracking

The Transport Tracking module (Portering) has been successfully implemented with over 10,000 jobs completed over the first 3 weeks. The system has been embedded into business as usual.

The Discovery and Design weeks have now been completed, where key members of staff from across the organisation worked with the TeleTracking team to map out our current working processes. This will inform the next phase which is the installation of the Real Time Locating System hardware in all wards, clinical and operational areas. The team will be working with Ward Managers and departmental leads to discuss installation requirements and agree individual plans to minimise the impact on clinical and operational activities across the first phase areas including seven wards and AMU.

The programme plan will see the capacity management suite, clinical workflow suite, transfer centre and community access portal go live over the month of September 2017, in line with the Trust ambition to have the system live before winter.

Medical Management

Good progress over the last period with the posts Divisional Medical Directors for both Planned Care and Urgent Care and the Associate Director for Diagnostics and Integrated Care now being successfully recruited to, with candidates expected to take up post by the end April, subject to recruitment processes being finalised. Work is underway to invite expressions of interest for Clinical Leads and progress induction arrangements, including objective setting, as the next phase.

Acuity Based Workforce

Implementation of E Rosters has taken place across 22 areas in total, including the latest implementation in Critical Care. The team is currently working with Theatres staff on a five week programme of implementation.

SafeCare and the Countess Acuity Tool have now been piloted on six wards. Matrons and Hospital Co-ordinators have been trained in the use of this system and are starting

to use it at daily bed meetings to support safe staffing across wards. SafeCare & the introduction of Red Flags will be rolled out across all wards from 3rd April 2017.

High Performance Culture

The first four modules of the High Performance Culture Workshops have been delivered. Excellent feedback has been received following module 4. The last module will be delivered by mid-May. Completion of Cohort 2 is scheduled for the end of July with Cohort 3 starting in August.

· Progress continues on the design of the High Performance Culture framework, which will result in a system specification which will need to be costed and appraised. During April, we will be engaging with all of our staff in designing a set of positive and negative consequences that will sit within the framework.

Pay & Variable Pay

The focus of this workstream will now be shifting to also include 'pay' initiatives, in addition to the focus on variable pay, following on from the achievements in 16/17.

Pay - The next period will see a number of workforce options being developed and quantified in terms of potential risks and benefits. Work will be in progress to develop a full communications plan to support this programme.

Variable Pay - Work is underway to agree new targets for the coming year with early consultation with both Finance the clinical Divisions. Likely focus areas will be locum payments / hotspots and overtime.

The new Medical Management structure post holders will play a key role in variable play targets and also the delivery of the wider CRS targets for clinical areas. The weekly Medical Pay Board will also be reviewed and utilised to help build rigour into the process. Operational excellence projects (see below) will also align and compliment through specialty performance reviews etc.

Preparations are also underway for an NHSI visit taking place on the 21st April with the intention being to aim to influence a greater national focus on agency spend and encouraging stronger controls on costs and rates.

Operational Excellence Plans for 17/18

Continued progress has been made in developing plans on the efficiency in theatres, outpatients, bed capacity and TeleTracking. Strong leadership and engagement from across the Divisions has continued aiding to the further development of these plans.

Outpatients efficiency

A new outpatient dashboard is in final stages of development and being tested in two specialty areas. The introduction of a touch screen booking in system is being assessed to improve patient flow, and partial booking process for review patients only is being progressed. A review of outpatient reception areas across the Trust is also being undertaken.

Theatres

A controlled trial for ENT pre-assessment under one roof, aiming to be a 'one stop shop' commences on 18th April for approximately three months, if successful this will be rolled out across multiple specialities. Theatre efficiencies are currently focussed on ENT, Plastics & OMFU. Work has progressed well with multiple stakeholders to look at reducing avoidable cancellations, with a view to having a reminder service in place before the end of quarter one.

Length of stay

The main areas of work underway are; specialties reviewing their length of stay (with a focus on 'right patient, right ward') at monthly speciality meetings and weekly review of 'Amber' patients on Ward 42 identifying the top three reasons for delays.

Throughout April/May we will be piloting a number of additional initiatives on Ward 42 such as Safer Patient Flow Bundle and Criteria Led Discharge as well as implementing a Bed Declaring SOP and options booklets for patients, careers and relatives. Red/Green days continue to be a success on the Intermediate Care Unit with an updated action log to help eliminate red days, all underpinned with a strong focus on measurement of baseline data.

Stock

The challenges to recruit to the Pharmacy Technician posts remain. The posts are being re-advertised but for a few of the posts, the option to recruit at a band 4 and train up to a band 5 level are under active consideration.

6.0 Reserves, Risk and 2016/17 Forecast

The following table sets out how ring-fenced reserves have been distributed so far this financial year and an estimate of what will be required for the rest of the year.

Ringfenced Monies / Reserves	Budget £000s	Allocated £000s	Balance £000s	Ringfenced £000s	Balance Available £000s
Discretionary Awards	189	(64)	125	(125)	0
Medical Agency	3,238	(2,835)	403	(253)	150
Maternity - Nursing	350	(310)	40	(40)	0
CHP Downtime Contingency	150	(110)	40	(40)	0
Non Pay Inflation	870	(760)	110	(5)	105
Minor Equipment	150	(127)	23	(23)	0
15/16 Agreed Investments c/fwd	947	(931)	16	(16)	0
Quality	62	(46)	16	(16)	0
CQUIN / Drugs contract risk	750	0	750	(750)	0
Winter Pressure Monies	999	(799)	200	(200)	0
TOTAL RINGFENCED MONIES FOR DISTRIBUTION	7,705	(5,982)	1,723	(1,468)	255
Contingency Reserve	500	(291)	209	0	209
TOTAL CONTINGENCY RESERVE	500	(291)	209	0	209
GRAND TOTAL	8,205	(6,273)	1,932	(1,468)	464

Any available balances at the end of the year will be used to mitigate potential CRS risks as set out in the following table:

Financial Risk	Risk	Mitigation	Residual Risk	RAG Rating	Action
Gap between CRS and Control Total	£1,500,000	(£1,500,000)	£0	AMBER	To be achieved non-recurrently, awaiting outcome of Personal Injury Benefit claim, Conde Nast VAT reclaim, review of annual leave accrual, outcome of potential overtime claim.
Q4 A&E	£184,000	£0	£184,000	RED	Notification received that Q2 appeal had been rejected, while we are awaiting the outcome of the Q3 appeal (due on the 24th February). Taking a prudent approach, we have assumed the loss of both Q3 and Q4 A&E STF monies in the YTD and forecast position.
Q3 A&E	£184,000	£0	£184,000	RED	
Q2 A&E	£184,000	£0	£184,000	RED	
Non Delivery of Cost Releasing Scheme - Red and Black schemes	£0	£0	£0	GREEN	**To be mitigated through use of reserves:**
					Minor Equipment Reserve
					Contingency Reserve
					Further Mitigation to come from:
					Workforce options (if implemented)
					Partial delivery of Model Hospital Schemes - Acuity Based Care and Stock
					Accelarated CRS Delivery for High Cost Drug price changes
Budgetary Overspends	£0	£0	£0	GREEN	Month 1-9 overspend currently met through release of contingency and non-recurrent provision
Winter pressures (over and above ringfenced reserve)	£250,000	(£150,000)	£100,000	AMBER	Reduce Elective programme in Q4 (submit appeal to NHSI to secure STF monies)
Commissioning for Quality & Innovation (CQUIN) 0.5% national	£750,000	(£750,000)	£0	GREEN	CQUIN reserve created at the beginning of the year, to either offset CQUIN non-delivery or Drug overperformance
Activity Growth (pass through payments) - WC CCG M9 onwards	£847,333	(£847,333)	£0	GREEN	See above
Activity Growth - WC CCG M9 onwards	£200,667	(£200,667)	£0	GREEN	Current growth mitigated, with run rate slowing in months 5-9. Dependent on demand management schemes implemented across the system
Reduction in Neonatal Intensive Care income (Mth 9 onwards)	£200,000	(£100,000)	£100,000	AMBER	M10 pressure absorbed in current position of financial balance - need to review costs in line with service provision
Total	**£4,300,000**	**(£3,548,000)**	**£752,000**		

Incorporating the red risks into the realistic forecast and the amber risks into the worst case forecast sets out the following projected outturn.

2016/17 Forecast Outturn	Best	Realistic	Worst
	£000s	£000s	£000s
Planned Deficit 2016/17 (After STF)	**- 3,950**	**- 3,950**	**- 3,950**
Change to Control Total or additional STF monies	- 1,500	- 1,500	- 1,500
Expected Deficit 2016/17 (After STF)	**- 5,450**	**- 5,450**	**- 5,450**

7.0 Cash and Debtors

Cash at the end of February was £4.4m ahead of plan due predominantly contributions received for the hosting of a regional IT project, the slippage on the capital program, and the timing of payment runs.

Deferred Income is higher than plan due primarily to some billing in advance for a regional IT project that the Trust hosts, and the phasing of the main CCG block contract against the income plan.

Following receipt of the formal guidance on the application for a rolling working capital facility, a formal paper was taken to the February Board for approval ready for the planned draw-down in the next financial year.

We still await full details of the 2017/18 capital distress funding regime, which will be required to ensure that the Trust can commit to its planned capital program from the end of this financial year, although we are currently working on the application templates required for 2016/17 on the basis that NHSI believe that the process will be similar.

The capital slippage noted below, combined with the additional STF funding now expected in Q4 following agreement of our revised control total, means that the cash low point expected in April will now not occur. Also, on the basis that the slippage is added to next year's capital program, then it will (if the application is successful) be funded from distress capital, and so will no longer impact on the revenue cash requirement. This means that it is likely, depending on performance against budget / CRS that the revenue cash requirement won't occur until the next cash low point in September / October following the mid-year payment of loans PDC dividend.

Cash balances are being monitored on a daily basis, feeding into a rolling 13 week cash-flow to ensure that any required loan application can be made in good time. Despite NHSI's reluctance to allow loan applications until the month before they are required, it appears sensible to continue with the application for both capital and revenue funding as planned.

8.0 Capital

As at February the capital programme is £2.0m behind of the original plan. This is due in the main to IM&T spend and backlog maintenance for the year being behind the profile.

As requested by NHS Improvement, we have reviewed our committed capital spend, and allowed as much as possible to move into 2017/18, which has resulted in a revised forecast out-turn of £5.2m, against a plan of £7.4m.

Distress capital funding will be required from April 2017 for the whole capital programme, plus any slippage from this year. This application is in progress. Managers are being asked to review their 2017/18 capital requests as well as this year's slippage to ensure that all expenditure qualifies as "necessary and urgent" and that the schemes are deliverable within the anticipated timescale.

9.0 Summary

In summary, pre-STF funding the financial position is balanced. However, £492k of STF monies have been lost due to the failure to meet the A&E trajectory in Q2, Q3 and Months 10&11. We are still awaiting the outcome of the Q3 appeal and therefore this position could still change. Variable pay is reducing year on year, the CRS is £102k ahead of plan. The remaining £1.5m pressure will be met through non-recurrent opportunities. Capital funding for 2017/18 plans, plus 2016/17 slippage is of concern and requires in depth management review to ensure NHSI criteria is met.

BOD Item No

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Capital Programme & Funding Proposals (2017/18)
Date of Meeting	4th April 2017
Author(s)	Mr Simon Holden, Interim Chief Finance Officer
Presented by	Mr Simon Holden, Interim Chief Finance Officer
Annual Plan Objective No.	
Summary	This paper is intended to outline the approach taken in constructing the 2017/18 Capital Programme and to provide a commentary on the processes behind the recently submitted Capital Loan Application.
Recommendation(s)	Directors are asked to note:: • The rationale for the recently submitted Capital Funding Request; • The internal prioritisation process followed, as in previous years, to establish the precise sum requested; • The fact that this sum was part of a two year Capital Program previously agreed by the Board; • The new "urgent & essential" criteria for accessing Capital Loans, introduced by NHS England; • The proactive management of the 2016/17 Capital Program, slipping a number of schemes from 2016/17 into 2017/18 (also helping the national picture); • The risks relating to the non-delivery of the planned 2017/18 Program; • The alternative approach being adopted with regards to the Urgent Care Hub (of utilising the Strategic Estates Partner); and • The next steps with regards to enhancing prioritisation and adopting a longer term planning horizon
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [X] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Countess of Chester Hospital NHS
NHS Foundation Trust

Trust Board – 4th April 2017

2017/18 Capital Programme & Funding Proposals

Recommendation Paper

1. Background

The Trust has invested significantly in its capital programme over the last five years, concentrating mainly on the most urgent and essential infrastructure and medical equipment replacement. It has also invested in a small number of larger capital projects such as the Haygarth Building and the extension of the Jubilee Daycase Unit.

To do this we have borrowed from the Foundation Trust Financing Facility, and taken advantage of the current historically low interest rates. This has also benefitted our NHS I (ex Monitor) Financial Risk Rating with, until recently, a high level of liquidity. The consequence of this borrowing, however is that our debt repayments come from our depreciation figure (£4.5m), which combined with the current cost pressures, and lack of capital resources after April 2017, means that to fund any new capital in 2017/18 we need to submit a distress funding Capital Loan Application to NHS England.

The detailed proposed capital programme is described in the next section, however to get to this we have worked internally with every division and department to review and assess their urgent and essential requirements for the next financial year. The expectation from NHS England is that only 'urgent and essential' capital schemes will get funded in 2017/18, however they have as yet to describe the exact process and timescale to do this.

2. Proposed 2017/18 Capital Programme

The table below illustrates the proposed capital programme and financing requirement for 2017/18.

The Trust Board approved the proposed capital programme of £11.2m for 2017/18 in December 2016, as part of the 2-year Operational Plan submission assurance process. This plan has been reviewed and prioritised further by the Trust's divisional and operational teams, and to incorporate 2016/17 deferred items, resulting in the new requirement of £7.7m for 2017/18.

	2016/17 Deferred	2017/18	Total 2017/18 Funding Request	Q1 Requirement
Urgent Care - Replacement Medical Equipment	0.112	0.110	**0.222**	0.112
Planned Care - Replacement Medical Equipment	0.115	1.618	**1.733**	0.715
Diagnostics & Pharmacy - Replacement Medical Equipment	1.180	0.268	**1.448**	1.180
IM&T Plan	0.185	0.704	**0.889**	0.185
Corporate - Replacement Equipment	0.041	0.237	**0.278**	0.131
Backlog Maintenance	0.279	0.905	**1.184**	0.279
Theatre Refurbishments		0.550	**0.550**	
Urgent Care - Cardiac Catheter Suite / IR Replacement		1.300	**1.300**	
Contingency		0.100	**0.100**	
Total	**1.912**	**5.792**	**7.704**	**2.602**

A number of capital schemes commenced planning in 2016/17, but did not fully complete installation before the end of the year. The most significant of these is the replacement of an MRI Scanner, where a cheaper option of refurbishment has been taken, but this has delayed implementation. This option will cost £1.024m and will be carried out in May 2017.

Other items that have commenced either implementation or procurement processes are the Image Intensifier, Wireless Network upgrade, Chillers, Foetal Monitoring Unit, e-rostering, WITT Haemodynamics system, and other smaller items totalling £0.888m.

The Trust requires additional capital funding to invest in urgent and essential replacement of key medical equipment as part of its on-going programme to update and renew operationally. All the items of equipment on our renewal programme are at least 10 years old, have a high risk rating (12 or over) on our risk registers, have reached the end of their operational lives, or are no longer supported by the original manufacturer or incurring significant revenue maintenance costs. This group includes the replacement of our Cardiac Cath Lab in year 1 and one of our CT scanners in year 2.

We will also invest in our backlog maintenance programme, informed by yearly site condition surveys and the ERIC returns. Our objective is to ensure that the 'High' and 'Significant' risks are covered to ensure the key operational infrastructure of the hospital is secured. We invest c£0.900m per year in backlog maintenance across the Trust, mainly in key gas, water and electrical systems, control and security systems.

IM&T systems and our PAS replacement also play a significant role in our forward capital programme over the next three years. The Trust's Informatics Strategy describes the strategic direction of travel, however the specific investments in IT software and hardware are described below –

- Network Access Control
- Switch Rolling Replacement
- Virtual Server Hardware Refresh
- UPS replacement
- North West Shared Infrastructure Services
- Air Management System replacement in DC1
- Evolve Scanner Refresh
- Tape Archive replacement

- General Infrastructure Replacement
- Pager replacement

All the above have been prioritised using the 'MOSCOW' risk rating system, and only those 'Must Do's' have been included here. These have been approved through the Trust's Informatics Board.

All of the items included in this section the Trust has classed as urgent and essential to ensure continuity of services and its future sustainability.

In summary, the programme comprises £1.9m of capital spend carried forward from 2016/17 (the majority being the replacement of one of our MRI scanners), and £5.8m of new capital. It is likely that any new emergency loan capital will be issued quarterly, therefore we have prioritised the likely spend profile accordingly, with £2.6m being required in quarter 1 (as a result of existing commitments). We feel that the above capital requirements are the minimum the Trust needs to safeguard services to patients, the quality of care we provide, ensure business continuity, and meet our future sustainability and transformation objectives.

3. Risks

The risks of non-delivery of these capital priorities, and schemes, are potentially significant and described below –

- Significant clinical risk due to high risk of breakdown and non-availability of critical equipment
- Loss of accreditation in certain departments and services
- Disruption to or loss of service/ Inability to provide services
- Closure of units/ wards and associated loss of income
- Risk of prosecution/ litigation
- Failure to meet statutory requirements/ compliance with targets and guidelines
- Degradation of risk rating
- Increased maintenance costs
- Patient safety compromised

It is therefore essential that our proposed capital programme is supported, so that the above risks can be mitigated.

4. Financing

The reason that additional capital financing is required is as a result of the previous capital financing strategy, leading to the current cumulative loan repayments exceeding the internally generated resource (retained depreciation).

In practice, the Trust will need access to capital loan funding from April 2017. Whilst it is appreciated that any capital investment the Trust requires will be the subject of significant scrutiny and challenge, it is vital that the review process is completed expeditiously to ensure that £2.6m of

the required funding is available to draw from the start of the new financial year. There is a danger that vital equipment and backlog maintenance will not be commenced in line with the required timetable, putting the quality and safety of the care we provide to patients at risk.

Capital Financing	**2017/18 £000**
Retained Depreciation	4,579
Other non-cash adjustments	(100)
New PDC	-
PDC Repayment	-
New Capital Loans	8,410
Capital Loans repaid	(5,185)
Donated Assets	590
Cash Reserves (required to support deficit)	-
Total	**8,294**

The table above sets out the capital financing requirement for 2017/18. The main reason that capital financing is required is as a result of the cumulative loan repayments exceeding the internally generated resource.

5. Planned Approach & Prioritisation

The Trust's planned approach is to submit a capital finance application before the end of March 20174 to NHS England, requesting funding for the full £7.7m as described above. As yet, the precise details regarding this submission such as format, timescales and decision making processes are unknown, therefore we have utilised the format used by other trusts during 2016/17. In addition, the following additional prioritisation activities will take place internally.

- **Three Year Approach** – by department to understand where specific projects or capital purchases can be phased over a three year plan;
- **Cath Lab** – equipment is 10 years old currently. Discuss prioritisation at QSPEC. Note 12 month planning and implementation period for this project, therefore material spend will not be incurred during 2017/18; and
- **EBME Review** – of all replacement medical equipment in plan using new risk rating methodology. This will help us prioritise both short-term (Q1 & Q2) requirements, and long term (+12m) requirements.

We feel therefore that we have submitted a robust and justifiable capital loan application for 2017/18 that has reviewed the priorities and risks in the organisation, and demonstrated that our requirements are both urgent and essential. We will continue to further review and prioritise as demonstrated above.

6. Omissions

The main capital omission is the Urgent Care Centre (circa £13m), which has previously been identified as an organisational priority. It is currently envisaged that this whole scheme will be the priority area for the Trust's Strategic Estates Partner (SEP) upon their appointment.

The view being that a pragmatic solution needs to be found quickly, to relieve the pressures on the physical department, enhance patient experience, and also aid patient flow.

7. Recommendation

The Trust Board reviews the approach described above, to support our initial capital loan application and the further prioritisation activities, to both balance risk and help mitigate the immediate need for additional capital financing.

Simon Holden

March 2017

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	**Headlines from the results & recommendations from the National NHS Staff Survey 2016**
Date of Meeting	4th April 2017
Author(s)	Linda Walker, Head of Learning and Development
Presented by	**Sue Hodkinson, Director of People and Organisational Development**
Annual Plan Objective No.	N/A
Summary	The purpose of this paper is to provide details to the Board on the results of the 2016 National NHS Staff Survey and to identify a series of recommendations and actions to be implemented to address priority areas of concern. The People and Organisational Development committee will oversee the progress of the action plan.
Recommendation(s)	The Board is asked to receive and note the results within this report and to support the on-going and future recommendations and actions that have been identified. Progress will be reported to the Board in September 2017, with updates provided to the People & Organisational Development Committee on a bi-monthly basis.
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [X] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Report to the Board of Directors
on the results of the National NHS Staff Survey 2016
(March 2017)

1.0 Executive Summary

With a key aspect of the Trust People Strategy focused on improving our staff experience to enable improvements in our patient experience, the results of the NHS Staff Survey are a key indicator in observing the culture of our organisation; the views of our staff and their experiences whilst working within the Trust. Since the first NHS Staff Survey was run in 2003, researchers have examined the data carefully to discover what it tells us about how to improve patient care and staff well-being.

It is recommended that the Board make best use of the NHS Staff Survey results to assess staff engagement and experience. Although it is an annual survey and not real-time, it allows us to monitor and check progress over the years, which, in addition to the quarterly Staff Friends and Family Test provides good intelligence of the culture and mood of our staff on an on-going basis.

The purpose, therefore, of this paper is to provide the Board with a review of the results of the 2016 NHS Staff Survey and to provide assurance regarding the associated recommendations and actions which have been identified to address the priority areas of concern.

Improving the experience of our staff has never been more important, especially with the on-going demands and pressures teams throughout the Trust are facing. However, it is imperative that throughout the Trust, there is a collective & shared responsibility to act on the key themes that have been identified, including working in partnership with our Staff Side colleagues, rather than this being seen as an initiative driven through the Human Resources teams. Therefore, the Board is asked to receive and note the results and provide continued support and monitoring of progress against the action plan, to ensure the experience and engagement of our staff remains a high profile point of discussion.

2.0 Background

The survey is produced as a resource to NHS trusts and commissioners to help them improve staff experience, and taking part in the survey is mandatory for all NHS Trusts. The Care Quality Commission will use the results to help make sure essential safety and quality standards are met and NHS Improvement also looks at the findings to identify variation between organisations focus and help them focus on areas needing attention. NHS England runs a number of programmes to address any issues at national level. Obtaining feedback from staff, and taking account of their views and priorities, is vital for driving real service improvements in the NHS, and other stakeholders (e.g. our local CCG, our patients and local community, the HSJ Top 100 Employers within the NHS) also utilise the results to assess our performance (including using data to verify and determine CQUINs) and to understand how our staff evaluate their experience of working within the Trust.

According to NHS Employers, the NHS Staff Opinion Survey is the largest example of listening to those on the front line anywhere in the world. The survey was carried out between September and December 2016 across 316 NHS organisations garnering 423,000 staff responses, an increase of 124,000 more people participating than last year. This takes in views from about a third of the NHS workforce and is the biggest response achieved in the survey's 14-year history. The Trust uses these results as a measure of staff engagement and in partnership with our Staff Partnership Forum, Local Negotiating Committee, Medical Staff Committee, Staff Governors and the Divisions; devise action plans to address areas of concern, publishing results and informing staff of progress.

Since 2011, the Trust has conducted a full survey of staff (excluding bank staff). Our Top Five ranking scores and Bottom Five ranking scores are detailed in Appendix 1. The national brief summary document outlining our results is provided as supplementary information in Appendix 4.

3.0 National Context

The 2016 NHS Staff Survey involved 316 NHS organisations in England. Over 982,000 NHS staff were invited to participate using an online or postal self-completion questionnaire. Responses were received from over 423,000 NHS staff, a response rate of 44% (41% in 2015). The results of the Staff Survey were published nationally on the 7th March 2017.

4.0 Headline Results for the Trust

- Of the 32 key findings:-
  - 0 (compared against 4 in 2015) have shown improvement
  - 32 (compared against 17 in 2015) have remained the same i.e. no statistically significant change
  - 0 (compared against 1 in 2015) has deteriorated
  - 0 (compared against 10 in 2015) cannot be compared due to changes in the questions.

- ↓ The overall 36% response rate for the Trust was in the worst 20% of trusts (40%) in comparison to acute trusts in England and had dropped 4% from 2015. We received 1377 responses, from a sample size this year of 3871 staff.

- 〓 Pleasingly although we reduced slightly, we are still above average in Key Finding 1 'Staff Recommendation of the organisation as a place to work or receive treatment.

- 〓 The overall picture is that there is little change from the 2015 results, with no real areas of concern. However, it is important to note that there are still 6 key findings (2 more than 2015) where we sit in the worst 20% of acute trusts, which have all been acknowledged within the action plan. Conversely there are 5 key findings (1 more than 2015) where we are amongst the best 20% of acute Trusts.

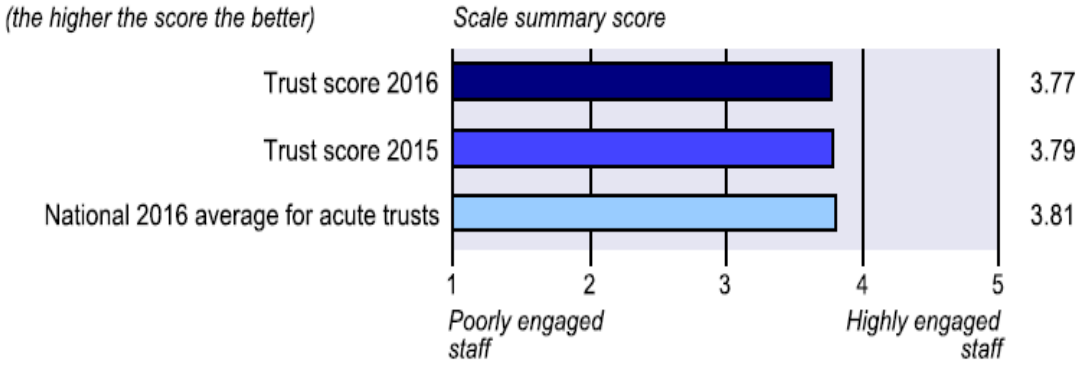
- The ' Scatter Map' (appendix 2) comparing NHS Acute Trusts, produced by the Listening into Action company, captures an analysis of NHS staff responses to 20 of the Picker Institute's Key Findings from the 2015 National Staff Survey. We are just sitting in the top right quadrant of best performing Trusts. We will be utilising this intelligence to seek to adopt best practice wherever possible. The position of each Trust is clear:
  - The best-performing Trusts based on how staff feel in 2016 are in the top-right quadrant - above average performance and trending positively too. The Countess sits in this quadrant.
  - The second best quadrant is the top-left - above average against the peer group, but trending negatively compared to 2015.
  - The third best quadrant is the bottom-right - below average against the peer group, but trending positively compared with 2015.
  - The bottom-left quadrant is the worst quadrant to be in - below average against the peer group, and trending negatively compared with 2015.

4.1 Staff Engagement Responses

The overall picture of staff engagement indicates a retrograde step taking us back to our 2012 level which situates us as below (worse than) average. There is a statistically significant change in our members of staff ability to contribute towards improvements at work, where we now sit in the worst 20% of Trusts. Internally, our score for this key finding was not statistically significant from 2015 and in

the other two key findings; changes are not statistically significant either. However key findings 1 places us as average and 4, below average compared to all acute trusts. Overall in the context of the relentless level of demand and pressures in the service and on staff, it once again is a testament to the resilience of leaders and their teams that our situation has not moved significantly. However, as a Trust we would appear to be moving into a position where we are in below (worse than) average positions which we clearly need to focus our attention on. As part of the action plan, we will be liaising with a small number of Trusts whose Staff Survey results in relation to how staff feel about the leadership and culture of their Trust, have made significant improvements this year. Our aim is to understand what they have done to achieve this and to pick up any best practice that we could usefully adopt in our Trust where possible.

OVERALL STAFF ENGAGEMENT

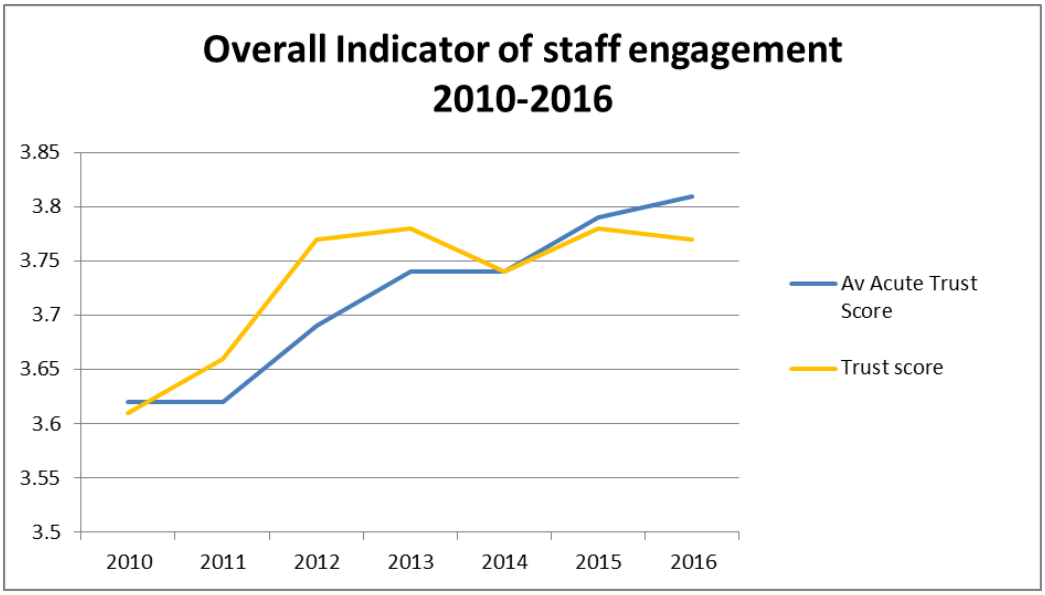


Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who "Agree" and "Strongly Agree" compared to the total number of staff that responded to the question.

Q21a, Q21c and Q21d feed into Key Finding 1 "Staff recommendation of the organisation as a place to work or receive treatment".

		Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	74%	76%	75%
Q21b	"My organisation acts on concerns raised by patients / service users"	72%	74%	71%
Q21c	"I would recommend my organisation as a place to work"	63%	62%	65%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	73%	70%	74%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.79	3.77	3.80



4.2 Key Areas of Concern

In the 2016 survey, of the 32 Key Findings (KFs), the Trust has 6 areas where our ranking is in the worst 20% of acute trusts i.e. an increase of 2 from 2015. The areas are:-

- ! KF 7: Percentage of staff able to contribute towards improvements at work
- ! KF13: Quality of non- mandatory training, learning or development
- ! KF18: % feeling pressure in the last 3 months to attend work when feeling unwell
- ! KF23: Percentage of staff experiencing physical violence from staff in the last 12 months
- ! KF28: % witnessing potentially harmful errors, near misses or incidents in the last month
- ! KF32: Effective use of patient/service user feedback

Finally, of equal importance are Key Findings 26 and 27; % of staff experiencing harassment, bullying or abuse from staff in the last 12 months and the % of staff/colleagues reporting most recent experience of harassment, bullying or abuse are areas, where further analysis is required and actions taken.

5.0 Recommendations

- An initial summary draft action plan with clear responsibilities, suggested leads and timescales is attached (**Appendix 3).** Divisional managers will be contacted by these leads and will be asked to support improvement plans and sharing of best practice in order to maintain progress on addressing improving Trust practices. The areas for action can broadly be categorised into the following areas; with particular emphasis on where our results fall into the worst 20% of acute Trusts and/or our bottom five ranking:-
  - Safe
  - Kind
  - Effective

- The action plan also shows progress in relation to the2015 Action Plan.
- The People and Organisational Development Committee will oversee the progress of the action plan with the nominated leads personally reporting into the Committee on a regular basis. The Committee has already been briefed about the Survey results (28/03/17).
- Additionally, whilst recognising the pressure and demands that the service is under, the only way we feel that true ownership of the results will happen, is for each individual area to have access to their results. In order to protect anonymity, the results can be broken down to their lowest level where a minimum of 11 staff have responded to the survey. There are 35 specific areas across the

Trust where we are able to share these results. We recommend that managers seek an advocate for staff engagement from within their team; preferably a more junior work colleague to work with the wider team and identify a minimum of one finding from the survey that they could work together to improve over the next four months. Feedback from each area will be sought during the summer so that we can share the stories of what actions have been taken to improve the working lives of the team. This will include linking to staff stories that are presented to the Board.

- Where there are areas with minimal or nil response rates, we need to understand from teams why that is and what support they would need in the future to participate, whilst taking some best practice from high responding teams.
- The HR Business Partners, with support from our Information Team, will also help identify any other areas of particular concern in relation to particular divisions or staff groups and share these with Divisional Managers/Professional Leads in order to identify an action plan for improvement where appropriate.
- Communication to our staff – the following actions will be undertaken as part of communicating the results and actions from the survey:
    - A communication plan will be delivered which will include an intranet posting to all staff with links to survey results,
    - Continued publication of the Team Countess newsletter in both electronic and paper format,
    - Communication of the action plan and regular updates on progress.
    - It is recommended that every opportunity is taken to communicate and discuss the findings of the survey and subsequent progress on actions; at events such as the Staff Open Forums, Senior Management Team meetings, CDG meetings, Ward Manager forums and attendance at existing meetings across the Trust.
    - Significant effort will be placed into continuing to further improve communicating and engaging with front line staff and this will be embodied into the High Performance Culture work stream within the Model Hospital programme.
- Communication to Partnership Forum, our Local Negotiating Committee (LNC) and Medical Staff Committee (MSC)– an update on the results and associated themes / actions will be provided in April.
- Communication to our Governors – a presentation on the results and associated themes / actions will be provided to the Council of Governors in April.
- The full results and key findings report from the NHS Staff Survey Centre allows data to be compared across all NHS England Trusts. The information has been released into the public domain and a short report will be prepared and published on our website and intranet, in the same way as the Staff Friends and Family Test is published. This will be via our Open and Honest pages and our "Working with Us" section on the Trust website.
- Data has now been loaded by Quality Health (our Survey Provider) which will enable us to commence the interrogation and drill down into the survey responses. We will undertake triangulation of the data to support analysis of the patient experience along with the Staff Friends and Family Test (SFFT).
- Results and actions will need to be owned at **all** levels of the Trust, including Staff Partnership Forum, LNC and MSC and Staff Governors; with whom we will work closely and seek their views & support on any particular areas of concern.

5.0 Conclusion

The Board is asked to receive and note the results within this report and to support the recommendations that have been identified. An update on progress will be reported to the Board in September 2017 and will be received by the People and OD Committee on a bi-monthly basis.

Prepared by:
Linda Walker
Head of Learning & Development
28.3.17

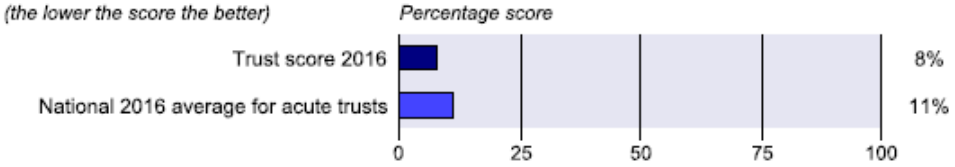
3. Summary of 2016 Key Findings for Countess of Chester Hospital NHS Foundation Trust

3.1 Top and Bottom Ranking Scores

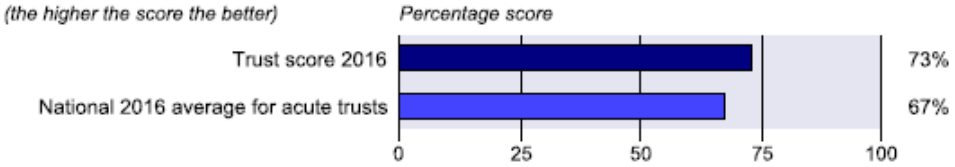
This page highlights the five Key Findings for which Countess of Chester Hospital NHS Foundation Trust compares most favourably with other acute trusts in England.

TOP FIVE RANKING SCORES

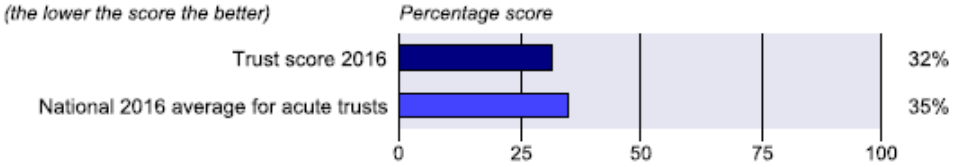
✓ KF20. Percentage of staff experiencing discrimination at work in the last 12 months



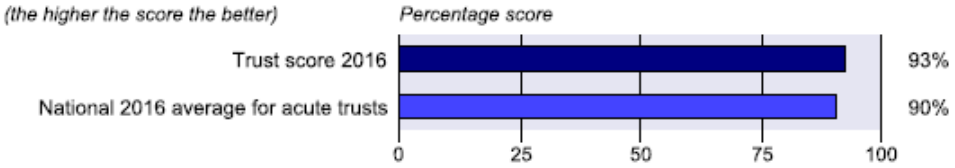
✓ KF24. Percentage of staff / colleagues reporting most recent experience of violence



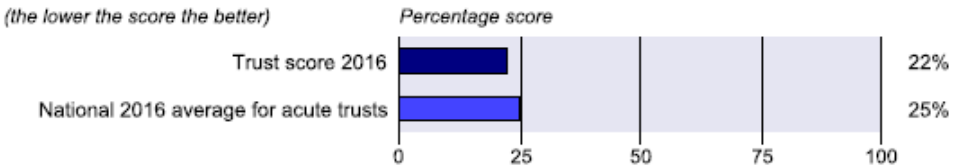
✓ KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months



✓ KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month



✓ KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



This page highlights the five Key Findings for which Countess of Chester Hospital NHS Foundation Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

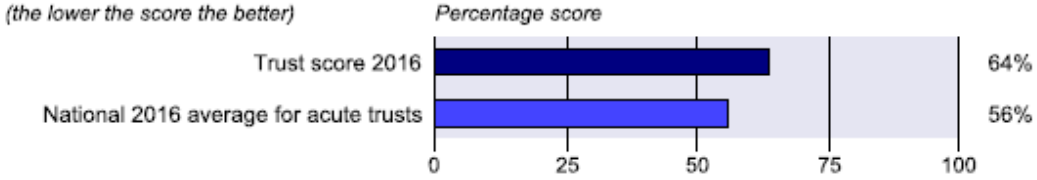
BOTTOM FIVE RANKING SCORES

! KF13. Quality of non-mandatory training, learning or development

(the higher the score the better)

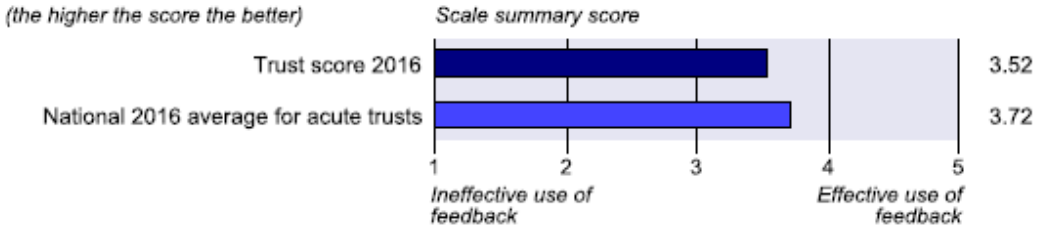
! KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



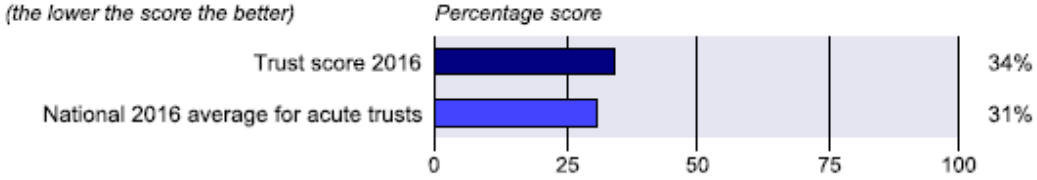
! KF32. Effective use of patient / service user feedback

(the higher the score the better)



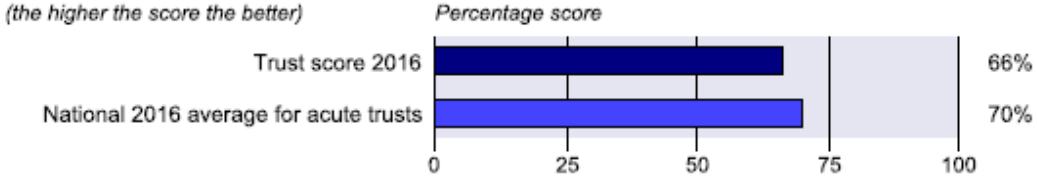
! KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

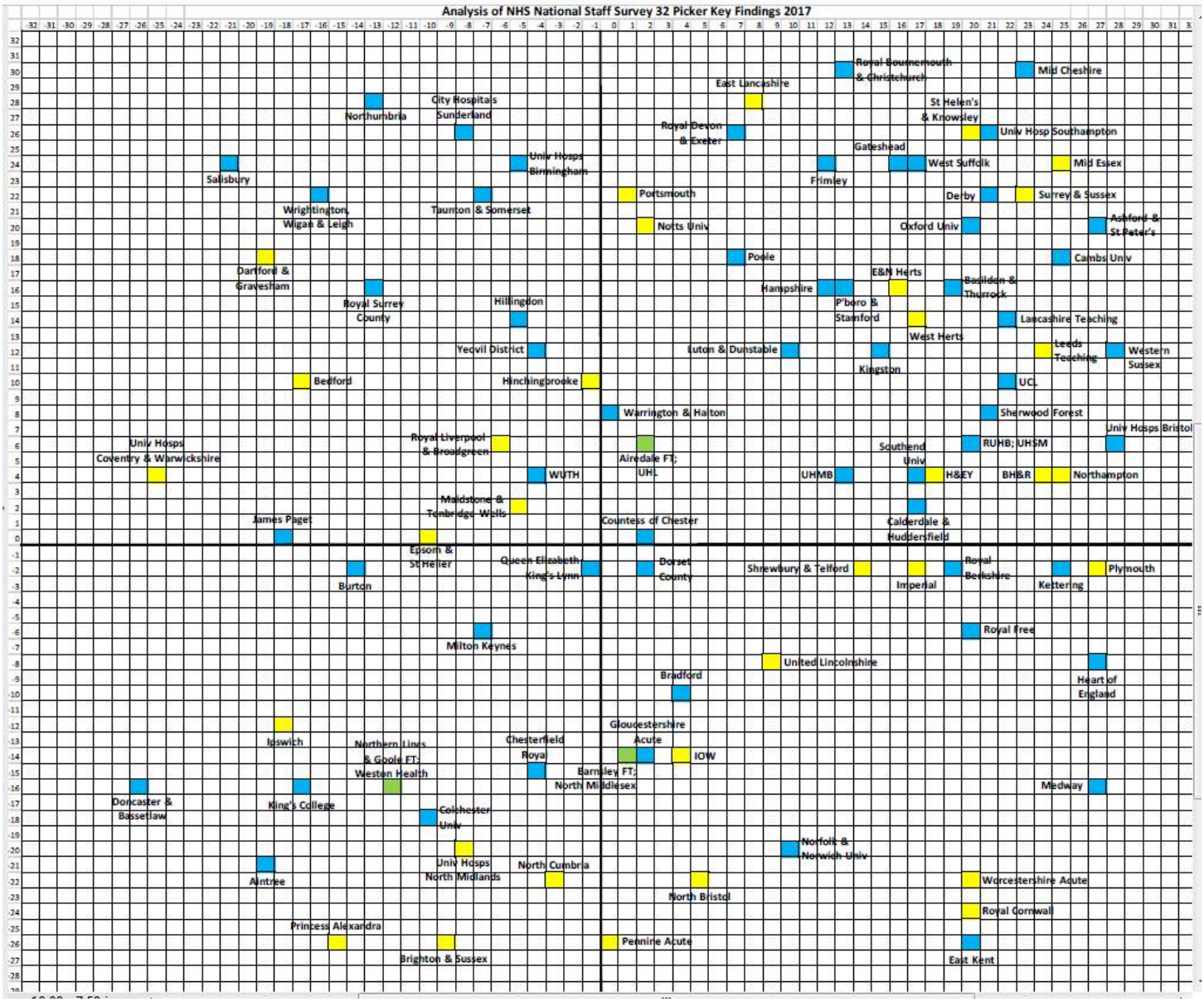
(the lower the score the better)



! KF7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)





All Trusts' results are reflected at a grid reference on a 32 by 32 ‘Scatter Map’ that shows how staff have rated the Trust’s leadership and culture over the past year.
It's simple to understand:

- The higher up you are, the better your Trust is performing against your peers in the eyes of your staff
- The further to the right you are, the more positive your trend, year-on-year.

So, the best quadrant to find your Trust in is 'top right': an above average performance and a positive trend. Second best is 'top left': a positive relative performance according to staff, but they are less positive than the same time last year. The second worst quadrant is 'bottom right': below median performance with some encouraging positivity from staff to soften the blow. The worst quadrant is 'bottom left', with staff views on leadership and culture resoundingly negative.

Countess of Chester Hospital NHS
NHS Foundation Trust

2016 NHS STAFF SURVEY ACTION PLAN **APPENDIX 3**

AREA	ACTION	SUGGESTED EXEC LEAD & SERVICE LEAD	NEXT POD REPORTING DATE
SAFE			
KF 28: % of staff witnessing potentially harmful errors, near misses or incidents in the last month (34% of respondents)	Slight improvement of 2% from 2015, but still in worst 20% of acute Trusts. Analysis of data to highlight hotspots and good practice areas by Division, staff groups, areas/departments.	AK	May 2017
KF26: % of staff experiencing harassment, bullying or abuse from staff in the last 12 months (22% response rate)	No change from 2015 survey data and we are in the top (best) 20% of acute Trusts. However we are not complacent on this issue and will identify hotspot areas	SH & DAC	May 2017
KF27: % of staff/colleagues reporting most recent experience of harassment, bullying or abuse (48% response rate)	Increase in reporting from 2015, up 2% and better than average for acute Trusts. Analysis of data to highlight hotspots and good practice areas by Division, staff groups, areas/departments	SH & DAC	May 2017
KIND			
KF18: % of staff feeling pressure in the last 3 months to attend work when feeling unwell (64% response rate)	Improvement from 2015 levels of 3%. However we are in the worst 20% of acute Trusts. Further analysis of data to highlight hotspots and good practice areas by Division, staff groups, areas/departments.	SH & DAC	May 2017
Effective			
KF13 Quality of non - mandatory training, learning and development (3.94 scoring)	Improvement from 2015 levels of 0.02 but in the worst 20% of acute Trusts. Analysis of data to highlight hotspots and good practice areas by Division, staff groups, areas/departments. Analysis of headroom budgetary allowance for such activity, impact of introduction of career pathways, apprenticeship levy implications and improved personal development plans will be incorporated as part of the Model Hospital culture work stream.	SH & LW	May 2017

AREA	ACTION	SUGGESTED EXEC LEAD & SERVICE LEAD	NEXT POD REPORTING DATE
KF32: Effective use of patient/service user feedback (3.52 score)	Further reduction in score from 3.57 to 3.52 since 2015 and in worst 20% of acute Trusts. Analysis of data to highlight hotspots and good practice areas by Division, staff groups, areas/departments. Continue improved wider communication of how we use this feedback, as introduced during 2016.	AK	May 2017
KF7: percentage of staff able to contribute to improvements at work (66% response rate)	Reduction in 2% from 2015 levels and our score is in worst 20% of acute Trusts. Analysis of data to highlight hotspots and good practice areas by Division, staff groups, areas/departments. Continue and improved wider communication of how we use this feedback, as introduced during 2016.	IB/J O'N	May 2017
Sharing of results with teams who have more than minimum number of respondents	Managers to receive individual team reports and asked to nominate a front line member of staff to assess responses and chose an area where the team feels they could make a difference and feel empowered to make at least one change. Feedback to be requested from all areas to share the stories across the Trust.	SH/LW	May 2017
Working with those who had minimal or no responses	Managers to be notified and ideas sought and shared as to how they can engage with staff better in 2017. Teams asked what would make them feel it's worth completing. Bench marking with areas with positive indicators for response rates. Information will be collated by LW and feed back to those attending	SH/LW	May 2017
Seek out best practice from other Trusts to improve staff engagement	This will be embodied into the Model Hospital Culture work stream. Utilising the Scatter graph and league table we will approach a small number of Trusts including the top 5 positive movers this year in relation to leadership and culture and our local colleagues at Mid Cheshire Hospitals NHS Trust (top of the league table) for best practice and look to implement ideas/suggestions where appropriate.	SH/LW	May 2017

BOD Item No

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Patient Experience Strategy
Date of Meeting	4th April 2017
Author(s)	Sian Williams, Deputy Director of Nursing & Gill Galt, Head of Communications
Presented by	Alison Kelly, Director of Nursing and Quality
Annual Plan Objective No.	
Summary	This strategy articulates the plans going forward for the Patient Experience agenda, this will be further strengthened to support the delivery of the Model Hospital transformation programme. The focus will be on how we utilise patient feedback from a number of sources in order to further improve our services to patients.
Recommendation(s)	**The Board is asked to:** **Approve the strategy.**
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [X] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Countess of Chester Hospital NHS
NHS Foundation Trust

The Model Hospital

Patient experience and Involvement Strategy 2017-19

Our plans for how we seek feedback from patients and use this information to make improvements and changes to the way we work

Foreword

The Patient Experience and Involvement Strategy 2017-19 sets out intentions for how The Countess will proactively seek feedback from its patients and use this information to make improvements and changes to the way we work and inform plans for the future.

The Countess of Chester Hospital NHS Foundation Trust's vision is to deliver NHS care locally that makes both our staff and the local community proud. This means we regularly need to be listening to and responding to the experiences of our patients and our staff as advocates of our patients.

As part of our plans to be The Model Hospital, we have learnt a great deal from patients like 93-year old Win who was admitted to The Countess for 106 days following a fall in sheltered housing. We must keep the people we care for at the forefront of our minds when we reimagine and redesign services. We must be more pre-emptive about what patients may need, and support navigating them through their NHS pathway or journey to maximise the quality of their experience.

A key part of this strategy is to ensure that channels are in place for patients and our local community to feel empowered to broadcast perspectives, ideas, good news and frustrations about hospital care without fuss or complication. At the same time our staff must be supported to have the time and space to realise the value of this feedback.

This strategy recognises that a 'one size fits all' approach to patient experience and involvement does not work. If we think about how we provide feedback outside of work in our interactions with key service industries, we want the opportunity to do this in in different ways, at different times and on different devices. Some people will choose to interact with our hospital from behind a computer screen or smartphone, they may need support from another person to advocate on their behalf, others will request a printed feedback form and there will always be those who want to see us face to face to challenge us about the quality of care we provide in our hospital. We have a responsibility to cover all bases.

This is not a standalone document. It needs to be considered alongside the context of our future direction (in particular The Model Hospital and our recently published People Strategy), as well as building on our work to date in delivering an ambitious equality and diversity agenda and improved communications and engagement infrastructure.

The pages that follow explain the changes in approach that we will start to develop and refine. The intentions are good. When we get it right, we will do more of the same. When we get it wrong, we will try something different. In keeping with any patient experience strategy there will be opportunities for input and feedback along the way.

With best wishes,

Alison Kelly,
Executive Director of Nursing and Quality

How this fits with the bigger picture...

Strategic direction

Our vision is to deliver NHS care locally that makes our staff and community proud by being safe kind and effective. The Countess has set out to achieve this vision through three key strategic programmes:

The West Cheshire Way
sees us working with local healthcare partners to redesign services so they are more joined up and easier for patients to access.

Integrated Specialist Services
sees our hospital developing services as either a specialist centre in its own right, or through clinical networks in partnership with neighbouring hospitals to reduce clinical variation.

The Model Hospital
is how we review core services to make sure they deliver the quality and outcomes our patients deserve.

For each of these programmes, we are clear that patient experience should be at the heart of any discussions that impact on the future of this hospital.

Existing patient experience channels

Currently there are a wide range of channels available for gathering, monitoring and understanding patient feedback. Some approaches are more effective than others. To date most of our activity has been on high volume gathering of data, using Friends and Family Test recommendation systems and annual programmes of patient surveys. Feedback is also gathered from other routes such as Patient Advice and Liaison Services (PALs and complaints), social media, governor roadshows as well as equality and diversity involvement groups.

An opportunity to join-up systems and direction

The approaches and systems predominantly work independently of one another. This strategy presents an opportunity to join up systems, take a broader view about what patient experience feedback is telling us, and whether it should be explored in more detail to complement and support strategic programmes that will see changes being made to services.

The model below (Diagram 1) highlights how high volume patient experience feedback systems might be monitored and used to determine areas for further patient and staff involvement, including filmed stories and opportunities for redesigning services.

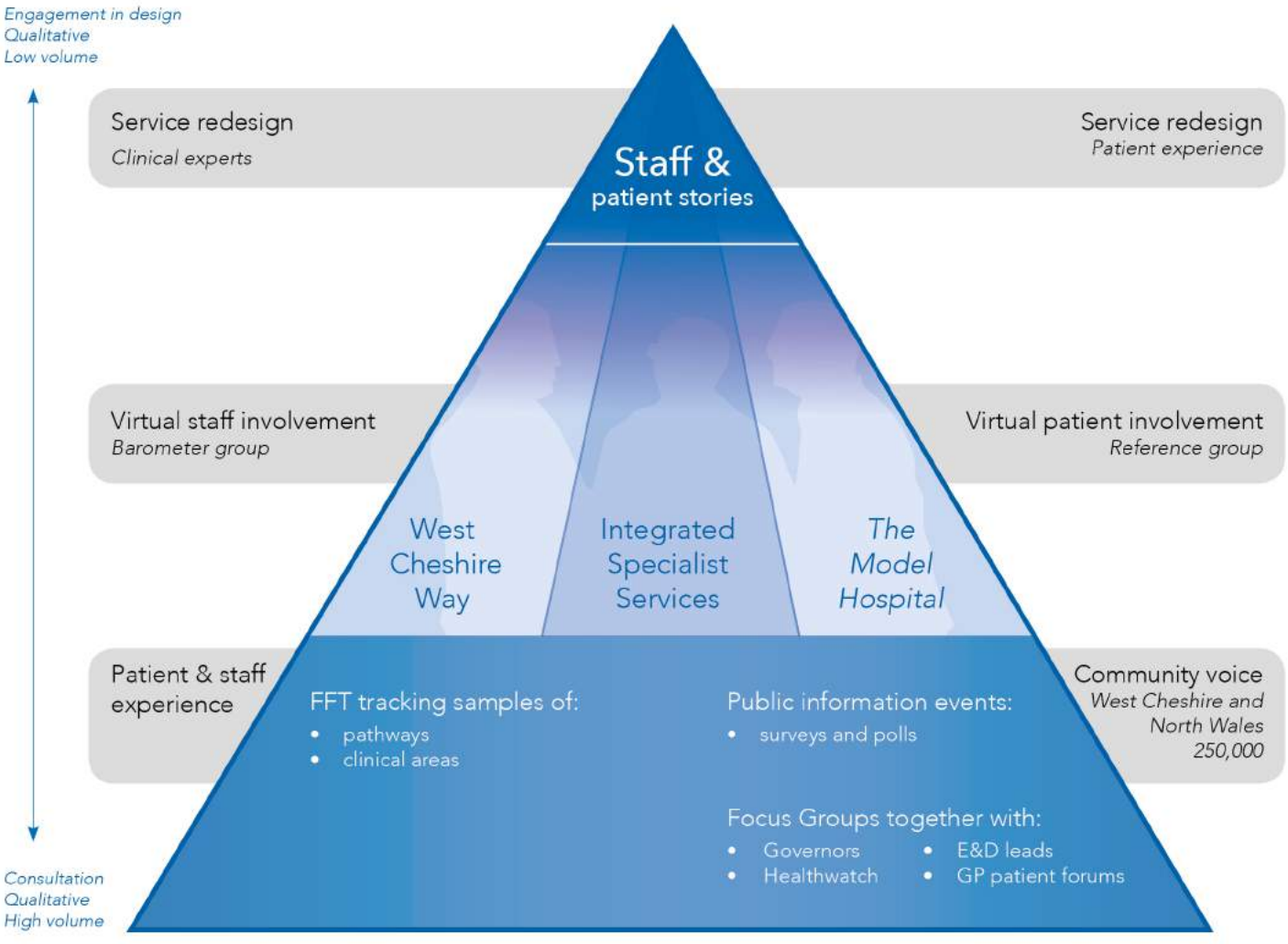


Diagram 1: Using high volume patient feedback as a starting point for involvement

Closing the feedback loop

At the same time as joining-up systems, the Trust needs to improve how it demonstrates patient experience is listened to and acted on. This is about 'closing the feedback loop'. It is an area highlighted for improvement in the annual NHS staff survey. The principles are simple as set out in the cycle below (Diagram 2).

Diagram 2: The five stages to using patient experience feedback

The Model Hospital

Roles and responsibilities for patient experience

Responsibilities for ensuring a positive patient experience are relevant to all staff. However, for the effective delivery of this strategy, there are some key internal groups that have a significant contribution to make, particularly in light of no one individual or service area being accountable for patient experience.

Clinical leaders (eg nurses, midwives, AHPs, doctors)
to set the standard for the value of how patient experience feedback drives improvement and actively seek out and use patient experience feedback from operational dashboards.

PALs and Patient Experience leads
for managing effective systems and processes to provide oversight of topical feedback themes and risk.

Risk and Patient Safety leads
for ensuring oversight of how patient experience feedback aligns with risk and incident intelligence to protect patient safety.

Communications leads
for promoting channels for providing patient experience feedback, monitoring any matters of reputational risk and showcasing best practice on corporate communication channels.

Staff recognition leads
for embedding patient feedback opportunities into existing and new reward and recognition schemes.

Equality and diversity leads
for embedding best practice in seeking and responding to feedback from groups with protected characteristics.

Project managers
as advocates of using patient experience stories and involvement as a driver for shared purpose and change (service and quality improvement methodology).

Service clinical leads
(eg clinical nurse specialists) as advocates of using patient experiences stories and involvement to inform service redesign opportunities.

Governors
to contribute to the governance of patient experience feedback as representatives of their constituencies.

Volunteers
for support in gathering and listening to feedback about the patient experience.

Patient Experience Operational Group
as owners of the patient experience and involvement strategy in monitoring implementation and progress.

Quality Safety and Patient Experience Committee
for governance and oversight of the strategy and implications at board level to receive assurance it is being implemented effectively.

What this strategy will deliver...

We will focus on three areas:

1. Organisational culture

- To align how we use feedback (be it good or bad) in a way that enhances the culture of the organisation
- To clearly demonstrate examples of how patient feedback is listened to and acted on at all levels
- Further strengthen the involvement of our Governors in implementing changes to support this strategy

2. Operational excellence

To ensure effective and inclusive systems are in place for patients and the public to provide feedback

3. Organisational renewal

- To use patient experience information to intelligently guide wider patient involvement opportunities
- embed patient experience more effectively as part of planned service improvement and service redesign activities

Our plan on a page outlines the changes we will make in these areas.

Learning from Win

Last year a very frail 93-year-old, called Win, was admitted to The Countess following a fall in her sheltered housing. During her 106-day stay with us she developed pneumonia on four occasions, received care under five different consultant teams, moved wards 15 times and needed treatment for two pressure ulcers. We gave Win five units of blood and took 1.5 units of Win's blood. She was sent for 11 x-rays, had a total of 174 pathology tests (49 being blood tests) and issued 78 drug prescriptions.

When we met Win, she believed she'd had a good patient experience and had no complaints... but this cannot be the norm. It was three months before Win left our Ellesmere Port Hospital for a nursing home. We came across the full picture of her story by chance. When our doctors looked into Win's history we realised the opportunity was missed to refer her to a falls clinic for assessment on three previous occasions. This could have prevented the admission in the first place.

How many other Wins are out there? How is this good enough? We need to keep Win at the forefront of our minds when we reimagine what The Model Hospital could be in ensuring a greater level of satisfaction for our patients.

The Model Hospital

Patient

Our Vision

"Delivering NHS care locally that makes our staff and community proud"

Our Values and Behaviours

Safe Kind Effective

Organisational Culture

Align how we use feedback to enhance the culture of the organisation by:

1. Increasing profile of 'thank you' interactions between patients and staff (aligned to values and behaviours).
2. Increasing profile of 'areas for improvement' based on feedback
3. Maintaining links between patient feedback and staff award processes.
4. Review role of use of patient feedback as part of individual performance discussions.
5. Develop improved reporting systems to report themed feedback activity categorised by compliance / breach of behavioural standards.

Demonstrate examples of how patient feedback is listened to and acted on at all levels by:

1. Ensuring filmed patient stories demonstrate learning from feedback and are communicated beyond board level.
2. Publish and cascade national survey programme results.
3. Support clinical areas with development of effective and up to date 'feedback' displays.
4. Re-launch publishing of 'You Said, We Did' PALs notice board displays (with recognition of increased routes for feedback).

Operational Excellence

Ensure effective and inclusive systems are in place by:

1. Maintaining Friends and Family Test response rates (using text and paper based systems).
2. Increase child friendly, dementia friendly and other alternative format FFT options for potential respondents.
3. Improve profile of PALs and complaints processes.
4. Improve profile of social media feedback options (Facebook and Twitter).
5. Develop improved system for capturing 'thank you card' feedback direct to wards.
6. Re-launch patient nominated staff award option.
7. Develop improved reporting systems that captures activity across all areas outlined above.

Organisational Renewal

Use feedback to guide wider patient involvement opportunities by:

1. Developing process for identifying and agreeing 'themes' for further exploration and action.
2. Develop a centralised log of all existing patient experience groups.
3. Increase organisational capability for patient focus group discussions to review themes for either assurances or learning.
4. Expand reporting and involvement in reviewing feedback to existing equality networks.

Embed patient experience more effectively as part of planned service improvement and service redesign activities by:

1. Ensuring use of Friends and Family Test dashboards within team meetings.
2. Increase organisational capability in use of patient feedback / stories as a tool for improvement (eg Experience Based Design).
3. Increase organisational capability for patient focus group discussions to test and review service improvement plans (eg patient barometer group).
4. Increase testing and reviewing of service improvement plans (strategic direction) with existing equality networks.

How we will monitor getting this right...

Through our implementation plan, we will focus on the following:

Aim	How we will measure improvement
To ensure effective and inclusive systems are in place for patients and the public to provide feedback.	• Response rates across all areas tracked. • Frequency of reports generated to schedule / reported at board. • Feedback from focus groups and equality network.
To align how we use feedback (be it good or bad) in a way that enhances the culture of the organisation.	• Opportunities to see profiling of feedback. • Monitoring feedback based on compliance or breaches against behaviours.
To use patient experience information to intelligently guide wider patient involvement opportunities.	• Number of themes identified for further action. • Number of focus groups held and attendance. • Number of actions generated for improvement.
To embed patient experience more effectively as part of planned service improvement and service redesign activities.	• Audit how feedback is being used at a team level. • Uptake on requests for service improvement input using patient experience feedback.
To clearly demonstrate examples of how patient feedback is listened to and acted on at all levels.	• Opportunities to see profiling of feedback • Number of filmed patient stories that demonstrate learning. • Number of up to date feedback displays.

Countess of Chester Hospital NHS Foundation Trust

Liverpool Road, Chester, Cheshire CH2 1UL
www.coch.nhs.uk

BOD Item No 2017

Countess of Chester Hospital NHS
NHS Foundation Trust

People & Organisational Delivery Committee

Subject	Biannual Safe Nurse Staffing Establishment Review – July-December 2016
Date of Meeting	4th April 2017
Author(s)	Sian Williams, Carmel Healey, Sandra Flynn, Karen Rees
Presented by	Alison Kelly, Director of Nursing & Quality
Summary	To ensure the Board receives its biannual assurance that patient safety is being maintained in regard to staffing numbers and skills. The report also provides assurance both internally and externally, that ward establishments are safe, and that staff are able to provide appropriate levels of care to patients.
Recommendation(s)	**The Committee is asked to:** Note the contents and support future actions.
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document nonsensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: X **A. This document is for full publication** **B. This document includes FOIA exempt information** **C. This whole document is exempt under the FOIA** IMPORTANT: • If you have chosen A. or B. above, confirm to the Chair which applicable exemption(s) apply to the whole document or highlighted sections. • If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal.

Countess of Chester Hospital NHS
NHS Foundation Trust

Biannual Safe Nurse Staffing Establishment Review
July-December 2016

Authors:

Sian Williams - Deputy Director of Nursing & Quality

Carmel Healey - Head of Nursing, Planned Care

Sandra Flynn – Acting head of Nursing Planned care

Karen Rees - Head of Nursing, Urgent Care

On behalf of Alison Kelly – Director of Nursing & Quality

Date of Paper: January 2017

Date Presented to Public Trust Board: April 2017

1.0 Introduction

The purpose of this paper is to ensure the Board receives its biannual assurance that patient safety is being maintained in regard to staffing numbers and skills.

The report also provides assurance both internally and externally, that ward establishments are safe, and that staff are able to provide appropriate levels of care to patients.

This is the sixth nursing establishment review following the publication of the Francis Report and its recommendations. The last was presented in September 2016 covering the previous 6 months up to and including June 2016

The Trust has a duty to ensure that ward staffing levels are adequate and that patients are cared for safely by appropriately qualified and experienced staff.

Reviews must be carried out twice a year in line with the national recommendations on inpatient ward areas. However this may change following early information for the latest draft guidance to yearly and or when wards and/or services change

2.0 Summary of Key recommendations and actions taken from the June 2016 nurse staffing establishment review.

The Board supported the recommendation of the Model Hospital programme of work now being undertaken, supporting;

- E-rostering

The e-roster Team was set up in July 2016 to introduce Electronic Rosters for nurses and midwives across the Trust. The team has now introduced e-rostering in all inpatient wards at the Trust which has resulted in benefits for staff and patients. The E Roster team has worked in partnership with Ward Managers and Matrons to create and publish their rosters 6 weeks in advance of the date they are worked.

Rosters are created in an automated way, reducing dependency on paper based systems which has freed up time for patient care. In addition to time saved creating rosters, the system further reduces the burden of administration for Ward Managers as it eliminates the need for SVL's and the Unify Department of Health mandated staffing returns (which are currently done manually) after 1 April 2017.

Publishing rosters 6 weeks in advance supports staff to manage their work/life balance and enables senior staff to plan and action the requirement for temporary staff where required, this also meets the NHS Improvement recommendations. Staff can use their mobile phones or tablets anywhere, to log in to Employee Online to view their rosters and make requests for duty leave or annual leave. The system supports Ward Managers to keep track of staff hours and annual leave which ensures that substantive staff work their contracted hours and take the correct annual leave entitlement.

Senior nurses across the organisation hold a monthly 'Confirm & Challenge Session' where ward rosters are checked before approval to ensure each roster is maximising the use of the substantive workforce and wards are safely staffed.

Early indications are that e-rostering is having a positive impact within the Trust. Since implementation there has been a reduction in spend on bank and agency nurses, and on nurse overtime payments through more efficient ways of working. In addition, clinical outcomes have improved with a reduction in the incidence of pressure ulcers and falls.

The next areas scheduled for e-rostering implementation are at Critical Care, Theatres, Outpatients, A&E and Maternity. These areas will complete the phase 1 implementation by the end of July 2017.

- Acuity

Alongside the implementation of electronic rosters, wards are piloting the use of the Countess Acuity Tool. Nursing Staff use the tool to measure real time patient acuity 3 times in each 24 hour period and enter this information into a system called 'Safe Care Live'. This links to the electronic roster and supports the allocation of staffing based on patient acuity & dependency on a ward at any given time. The tool is being used to inform decision making around whether staff are distributed appropriately across wards and whether current ward establishments need adjustment. This work on acuity will be enhanced by the implementation of electronic tracking which will provide information on the actual number of Nursing Hours per Patient per day that patients are receiving.

3.0 Methodology

As in previous reviews, it must be remembered that the most important factor in any review is the professional judgment of the senior nurses. Their views have supported the use of the following objective information:

- Establishments were compared to June 2016
- National standards for specialty wards e.g. Intensive Care
- Review of Registered to unregistered staff ratios
- Review of staff to bed ratios in line with current national guidance
- Use of nursing quality indicators and key safety and outcome measures
- The review covered the general wards on sites as well as the Emergency Department, Intensive Care Unit and Midwifery services

4.0 Establishments were compared to June 2016

Overall the Trust reports an acceptable level of hours planned against actual, overall on average it was 97.4% **(Appendix 1).**

Month	July	August	September	October	November	December	Year Average
Trust	101.3%	94.7%	95.2%	96.1%	96.8%	98.1%	97.4%

There are well embedded processes to support areas that fall below to ensure patient safety

5.0 Review of the bank nurse pay costs versus agency pay rates

The Heads of Nursing (HoN) review all bank and agency expenditure monthly. They take account of staffing expenditure and cost pressures across both Planned and Urgent Care Divisions.

The process of bank request will by mid-year be on e-roster for all areas. The introduction of the challenge and confirm sessions has made the process of bank request very transparent.

To the Divisions credit the process they have put in place has seen the real improvement to variable pay and this continues to be monitored regularly at both Divisional and Corporate levels.

Divisions have now embedded process for the approval of over the cap agency rates. This means the use of agencies that the Trust has to pay more per shift/hour to maintain patient safety is now signed off by the Director of Nursing & Quality.

There has been a notable reduction in the overall use of agency nurses and continued reduction of over cap payments. In the main the areas that use agency now are Theaters and occasionally ITU these are also the areas of over cap.

Actions are in place to address recruitment challenges in these areas.

6.0 Measuring Patient Acuity

As previously articulated in other reviews there are no national mandated minimum standards for the general adult wards in England. However NICE guidance in 2015 made reference to, but stopped short of mandating a 1:8 Registered Nurses to patient ratio on day shifts. Recent draft guidance from the National Quality Board (NQB) also reiterates this recommendation but also now references the use of Care Hours per Patient per day (CHPPD). The next few months the Divisions will work through the guidance once ratified.

The Trust Ward Managers are well engaged with e-rostering and many of the inpatient wards are now live. There has been a 2 month trial of the Trust version of Safe Care Nurse Tool (SCNT). This has resulted in some alterations to the tool this now will be utilised on 4 wards this will then be rolled out

7.0 Divisional Reviews

- **Adult General wards (Planned and Urgent Care)**

The Heads of Nursing have reviewed the staffing establishment with each individual Ward Manager and determined the patient ratio numbers. This demonstrates staff to patient ratio meets the recommended NICE guidance of 1:8 for day shifts. This ratio is then supported by the supernumerary Ward Manager. However, this has been challenging to achieve at times due to the number of vacancies in some areas.

The Heads of Nursing acknowledge the need to revisit the 5 day supervisory Ward Manager role once there is full implementation of the e-roster and with the support of Teletracking and the full effects of e-rostering are in place

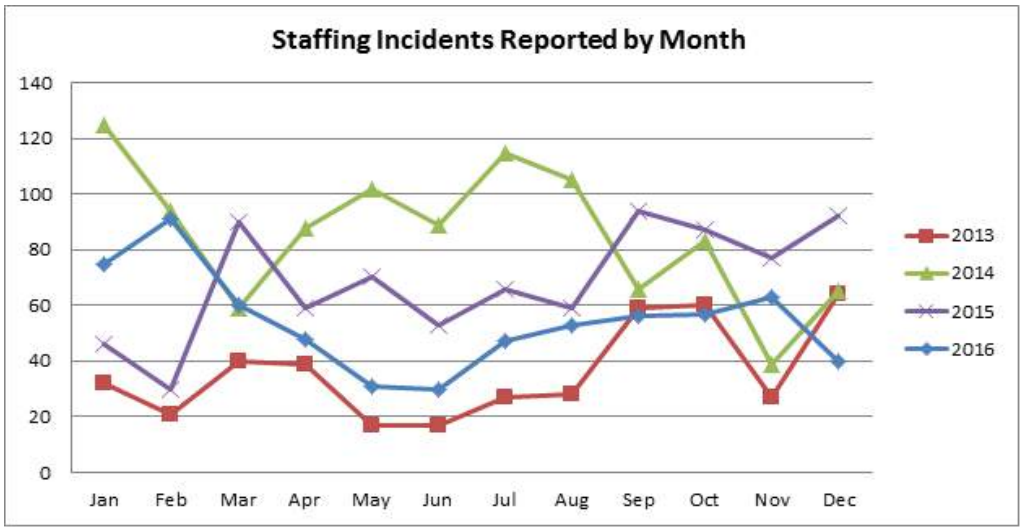
The Trust continues to be supportive of Ward Managers who use their professional judgment to use a lower skill mix than the 60/40 that most wards have. As long as the areas are reviewing balancing measures such as the Safety Thermometer measures to ensure that it does not compromise patient safety.

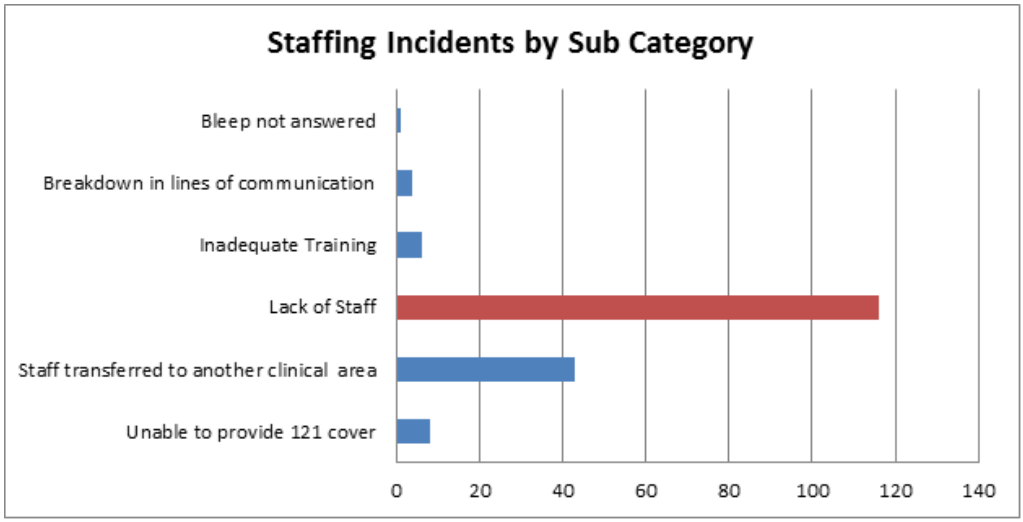
All specialist nurse well as the Advanced Nurse Practitioners (ANP) roles have been reviewed. The Heads of Nursing are near completing the full review of the educational requirements of the roles as they stand.

Once again both Divisions have reconfigured their bed capacity to ensure the service model is improved with the right patient in the right place. Although some staffing establishments have changed as the new bed model is implemented, there maybe the need for further review. The ward managers have been fully involved in assessing the staffing and developing the service models.

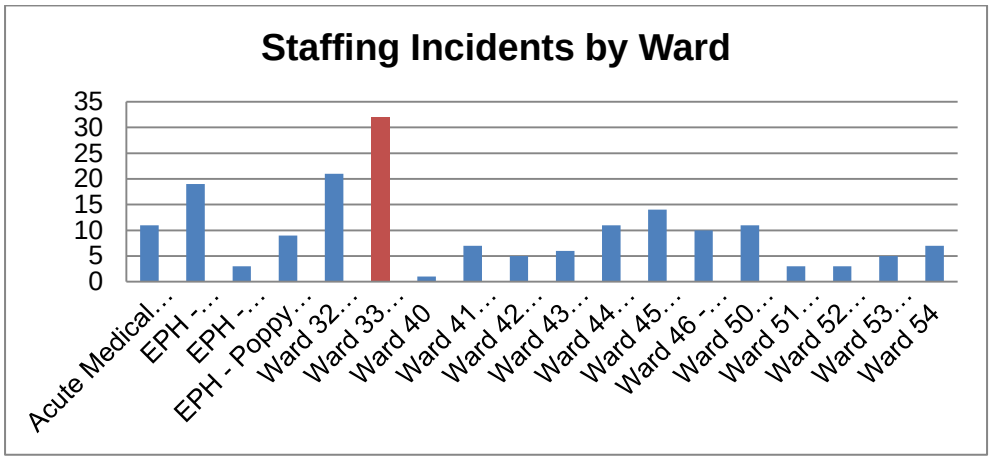
- **Staffing Incidents**

The Trust remains a high reporter of staffing incidents but the relative harm associated for the incidents is low (Appendix 2). However the absolute numbers have decreased particularly in the last 6 months. The Director of Nursing has sent out a number of reminders to ensure staff continue to report any staffing shortages especially if these can be linked to patient harm.





AMU, ward 54 and ward 33 are the highest reporters. Ward 33 regularly reports the loss of the third RN on nights although there is no impact. The manager is now looking at a skill mix on the ward.



8.0 Current Staffing Challenges and Opportunities

- There continues to be a recruitment problem in regard to registered nursing and specialist posts such as Theatres in particular for ODPs/theatre practitioners. Theatres have an ongoing action plan and further work supported by e-roster and the implementation of tracking may help maximise resources
- The agreement to uses apprenticeship funding to support additional posts and the new Nursing Associate post may help support further training.
- Agreed minimum staffing levels are a challenge at times. This is risk assessed on a shift by shift basis to mitigate harm.
- Areas that do not meet current national guidance are on Divisional risk registers. These are monitoring any negative impact via red flags and datix.

- EU - the leaving of the EU has already been felt by the agency which supports our recruitment in Spain. The uncertainty surrounding time frames etc. may cause further problems. This is likely to be more acute this year going forward.

9.0 Urgent Care Adult Inpatient Wards

.

- **AMU** - The Division has now agreed to reduce the number of beds on the assessment area, giving the eight beds to the newly developed short stay ward. This area has the capacity to admit 13 patients who remain under the care of the Acute Physicians with Care of the Elderly support at the weekends. The intention is that patients will experience a seamless multi-disciplinary approach during their first 72 hours of care.

- **GPAU/ACU** – have also been merged into a single unit GPU and relocated to the front of the Emergency Department, next to the EAU. This was recommended by ECIST following evidence that patient flow would be much improved, if all of the assessment areas were located in the same place. This will help in achieving the 4 hour standard within the Emergency Department.

- **Ward 43** - – The Haematology, Oncology, Diabetes & Endocrine specialties have now been relocated to this ward and currently has 19 beds, which include the new development of side rooms, of which there are 10. This is to assist with the care of patients who are neutropenic and may have infection risks, therefore improving their patient experience. The ward establishment has been reviewed and amended to reflect the acuity, number of patients admitted and to reflect the change in the ward layout.

- **Ward 50** — Frailty Ward. Care of the Elderly ward has transferred from Ward 43 to Ward 50. The reason for this is to ensure that there is cohesion with both Ward 50 and 51, making a combined unit, for the elderly patient. The intention is that this ward will become the female ward. The patients are looked after by a multi - disciplinary team, who meet twice daily, in order to progress treatment and care. This has the benefit of improving patient flow and timely discharges.

- **Ward 51** - **Frailty Ward**. The Division has agreed a set budget and has funded the staffing establishment, now that it has become a permanent bed base. The management of this ward is a reflection of what is provided on Ward 50. Together, Ward 50 and 51 are the Frailty Unit.

- **Ward 34 –** In July 2016, this ward became the new Intermediate Care Unit (IMCU) which comprises 28 beds; the staffing establishment has changed to reflect the ward requirements. The case mix of the patients cared for on ward 34 will no longer require support by medical teams. The staffing compliment will be from both nursing and therapy and this has make up the agreed establishment. This intermediate care unit is managed by an Occupational Therapist and is also supported by Pharmacy Technicians. An Advanced Nurse Practitioner also helps support the care of this group of patients. The expected length of stay for this group of patients is two weeks.

- **Bluebell Ward – EPH** – Diamond and Ruby Ward were combined in July 2016. The reason for this was to continue the roll out of the Discharge to Assess process, rehabilitating patients within 21 days and ensuring the patient's discharge met their individual needs. This is a 40 bedded ward and the staffing establishment was reviewed and agreed, to match the client group. Two Community Geriatricians support this ward, together with therapists.

- **Poppy Ward –** This ward is currently an 18 bedded ward and has the Discharge to Assess process firmly embedded. This ward is medially supported by an external provider Partners4Health

10.0 Urgent care - Other areas

- **NNU**

Neonatal Unit staffing is currently established to safely staff a Level 1 NNU, however, this will need to be addressed further prior to returning to a Level 2 Unit if the decision is made to re-instate this level of care following Implementation of the external Neonatal Review.

- **Paediatrics**

Children's Unit will be fully established by February and for general working of the Children's Unit this is adequate. If the acuity on the Paediatric Ward increases due to ITU/HDU patient's or a high level of infants under 2 years of age the Ward Manager escalates this to the Head of Nursing to book extra staff to support the demand. However, this is not a regular occurrence which would then question the nursing establishment.

11.0 Planned Care - Inpatient Wards

Action in the last 6 months

- Ward 52 (acute surgical) and ward 45 (Orthopaedic trauma) swapped over on the 5th January. Plans continue to facilitate the swapping of wards 53 and 54 so that 53 comes the vascular unit. This will increase the current number of side rooms from 5 to 8 and will improve the overall footprint of the unit and support patient flow.

- The Surgical Admission Unit has been transferred to Planned Care and is currently located on ward 46. Following its relocation in January 2017. This will be reviewed again with the progression of the Surgical Hub.

Vacancies and staffing

- Whilst there has been no breach of planned care staffing resulting in patient care needs going unmet the wards are currently carrying vacancies and a number of wards continue to be reliant upon temporary staffing requests. In addition 4 nurses remain without NMC PIN numbers (wards 54, 44, 40 and 41).

E-rostering has been rolled out across all planned care wards and is being used to consistently monitor staffing levels and establishments. The system has identified staffing issues particularly on ward 45 which have now been addressed.

- **ICU**

Currently open to 15 beds, consisting of 8 level 2 beds that require 2-1 ratio of qualified nursing and 7 level 3 beds that require 1-1 ratio of qualified nursing.

Vacancies in the department have seen a dramatic reduction and the current establishment is 73.09 WTE qualified nurses including matron and the practice development nurses, this meets the national guidance.

An important consideration is to ensure we have staff trained with ITU course which has been made more difficult with reduction in post graduate funding & the large turnover of staff we had last year. There is an on-going drive within the department to meet the training requirements of staff.

- **Theatres**

One of the biggest challenges facing theatres is the difficulty in recruiting Operating Department Practioners (ODP) following national changes to ODP training. This means that the department has been reliant on agency staffing. Staff unfortunately choose to work for agencies as they offer higher rates of pay which serves to compound the problem.

The action plan is focusing on:

- A review of the current establishment
- Physician Assistant options
- Qualified Nurse to ODP "top up" approach
- Review current Bank rate and any options to change
- Review and action options regarding incentivising students
- Review and action apprenticeship options

12.0 Midwifery

The past six months booking numbers have reduced slightly and are more in line with 2014. It is recognised that staffing does not currently meet current guidelines, however monitoring of all incidents and 'red flags' ensures that the risk is managed. The recent CCQ Inspection identified no significant risks in relation to midwifery staffing levels and acknowledged the current ratio.

13.0 Quality & Safety

- **Mitigating risk**

There is a well-established process whereupon the Director of Nursing (DoN) monitors the staffing incidents at the weekly Serious Incident panel (SI). The approval of the DH staffing data that is uploaded monthly onto the Department of Health UNIFY portal also enables the Director of Nursing not only to review the staffing percentage compliance but also the ward 'red flag' indicators. These indicators are in year going forward likely to be recorded on e-roster

It is a well embedded process that staffing is discussed at the daily ‘Patient Flow Meetings’. This meeting takes place 3 times a day, and ward dependency, ‘one to ones’ and general staffing gaps are discussed. The following actions are agreed to support a reduction of risk:

- Moving staff from one ward to another to cover gaps
- Moving from outpatient areas
- Cohorting patients who require additional support in ‘zoned areas’
- Heads of Nursing sanctioning additional staff if required due to a patient safety risk
- The use of bank, and only if absolutely necessary to maintain patient safety, will agency be considered. This is authorised by the Heads of Nursing.
- Divisions each have a safety huddle to discuss and escalate risk

The Divisions now jointly host the whole hospital ward managers there is no division specific meeting. This is really fostering an exceptionally good working relationship from both bed owning areas and ensures staffing risks are managed.

14.0 Nurse sensitive Indicators

Using Nurse sensitive indicators is a recognised set of balancing measures. These are also recommended by NICE

- **Safety Thermometer**

The NHS Safety Thermometer "Classic" allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism.

This is a point of care survey that is intended to be carried out on 100% of patients on one day each month and is possibly the largest patient safety data collection of its kind in the world.

One of the most unique aspects is the concept of a 'harm free care' measure, the proportion of patients who are free from any of the harm measured. However, some of the harms are old and patients are admitted with them.

The new harms in our care is in the main above the 95% and in fact have averaged at 1.7%

- **All harms**

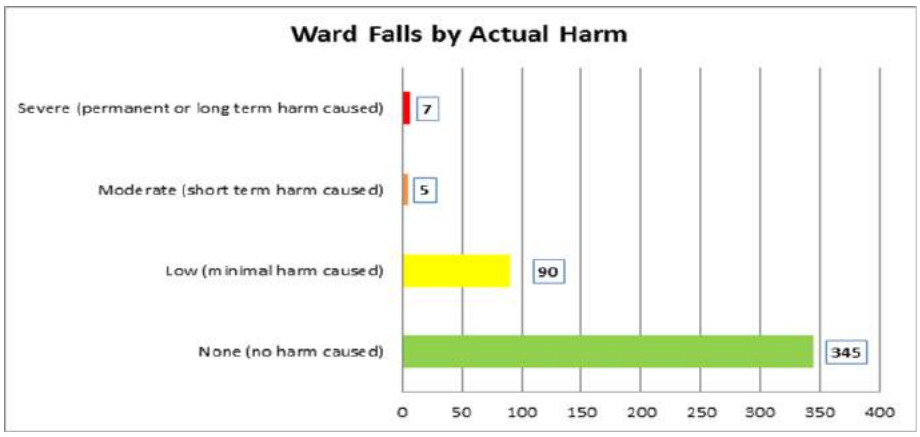
The trust has seen a significant reduction in all hospital acquired Pressure Ulcers. Falls have remained a challenge for some wards. These are being monitored by the Matrons using the Ward Manager KPIs.

- **Falls**

A recent thematic review of falls continues to demonstrate that there were missed opportunities to provide adequate falls prevention measures

The Director of Nursing (DoN) will has reviewed the current process following a patient fall with harm. A meeting will now take place between the Ward/Unit managers and the DoN to go through the investigation and the actions required.

The absolute number of falls has decreased in the last 6 months form 632 reported on datix to 447. However the harm level has increased.

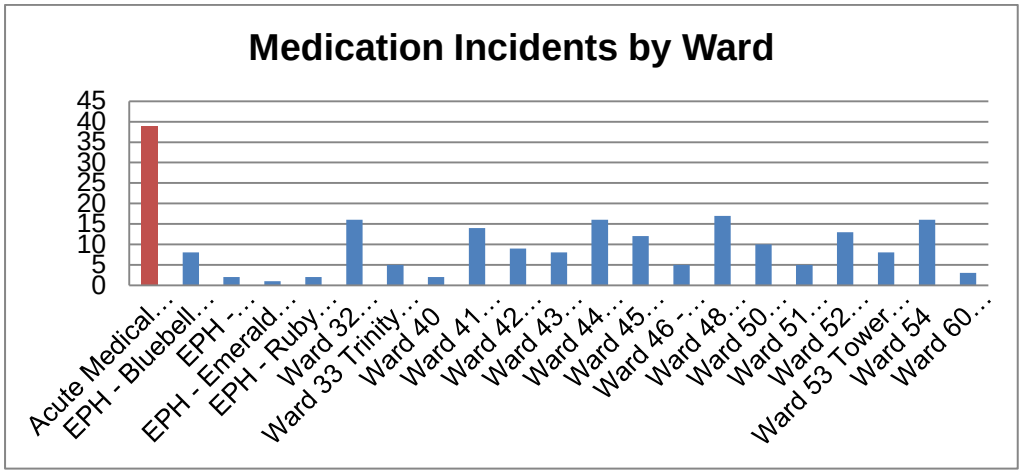


Appendix 3 continues to demonstrate that ward 34 remains has a high number of falls compared to other designated older persons wards. This recently changed to Intermediate Care Unit. A number of Ward Managers and a Matron have recently agreed to lead a working group to improve practice in this area

- **Medication incidents**

The graph below displays the medication errors in totality. However most of the errors relate to prescribing of medicines and are reported by the pharmacy staff. This is confirmed by the high reporters by AMU. A number of Medicine administration rounds are now performed by pharmacy technicians following a successful pilot. This has raised the safety culture of prescribing. Due to the successful pilot this prole is now being adopted by 34 this will also support the aspiration of patients administering their own medication in preparation for discharge.

Any nurse errors are supported by the well embedded workshop of learning



- **Care metrics**

The care metrics work has been revised in year and the current compliance is 95-96%. The end of year 16/17 will see a change of some of the metrics going forward.

15.0 Red Flags

The monitoring of 'red flag' indicators such as staffing and missing breaks is recorded on the 'S' drive. It remains variable as to the compliance. Some wards are showing areas that need to be reviewed and the Heads of Nursing are aware of these wards. Work is now being undertaken use Allocate e-rostering to collect the data. In the meantime Ward managers have been reminded to us the Red Flag file.

The Department of Health is also proposing the use of a national nursing dashboard. Confirmation of the metrics are awaited

- **Overtime**

Overall has decreased over the last 6 months – as a red flag indicator there are a number of wards that are using this – what is not clear however, is it in respect of short term absences, vacancies and/or patient acuity. Variable pay which includes overtime has continued to be a real focus for the nursing teams. This is now very transparent with the use of e-roster and is latterly starting to see an impact.

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand To-tal
£18,621	£18,272	£13,472	£10,376	£16,778	£18,009	£22,610	£16,644	£15,150	£149,933

16.0 Patient Feedback

We survey our patients in a number of ways. The information obtained from the surveys is a helpful barometer of the patients' perception to any delays in the care they receive

- **Annual Survey**

The annual survey from 2016 has yet to be published this will appear in the next paper as measure of feedback.

- **Friends and Family**

Friends and Family Test (FFT) at the Countess has evolved significantly in 2016.
In mid-January this year we started working with a new supplier.

The table below shows results in the first last months this year 2016.

	Inpatients		Outpatients		AED	
	Responses Received	Ratings	Responses Received	Ratings	Responses Received	Ratings
July	1662	91%	3487	92%	625	79%
August	1567	92%	2875	91%	536	84%
September	1203	92%	2858	92%	552	82%
October	1483	93%	2971	92%	565	82%
November	1853	95%	3336	92%	540	83%
December	879	92%	1812	93%	480	86%

Our overall ratings for OP and IP have stayed above 90% i.e. the number of people who have given the Trust a 1 or 2 (Extremely Likely or Likely to recommend) ED has also remained much the same as the previous 6 months which is a testament to the staff given the increasing use of the service.

An additional question was added to the IP F and F in the last month of the year.

- ***did you get the care that mattered to you during your recent admission?***

The question was asked 272 times (i.e. those in-patients who answered the first two questions).

- 217 people answered YES or a variation of yes
- 47 people didn't respond
- 1 person hinted at a NO but the answer was long and rambling
- 7 said NO

We will continue to ask this question for the next few months as this can give ward level data for assurance.

- **Complaints**

Once again the numbers of complaints remain comparatively low. Reassuringly the number of complaints in relation to poor nursing care has also seen a decrease. The numbers of complaints below the expected standards of care are low. The practice development team are ensuring that themes are covered in training and induction

17.0 Staffing Challenges

There has been a slight increase in turnover of the RN workforce and a 2% increase of turnover in the Nursing Assistants. Nationally we remain low compared to peers

July 2016 - Dec. 2016	6 Month Total			
	Sickness Absence %	Turnover %	Starters	Leavers
All Trust Registered Nursing & Midwifery	4.63%	6.00	36	66
All Trust Healthcare Support Staff	4.88%	5.32	55	36

There are 'hot spots' (**appendix 4)** and on-going work supported by the Practice Development Nursing (PDN) Team and staff side is underway to ensure all nursing staff are given the opportunity to have an exit interview. The results are either dealt with as trends and themes. There are occasions whereupon an individual response is required

- **Attendance**

Overall the Trust's sickness absence is slightly higher than the previous six months in RNs but lower in NAs. However the Trust recognises that there are potential other reasons for absence and is participating in the national CQUIN for Health and Wellbeing of staff. A number of actions are underway – healthy eating, Occupational Health (OH) drop-ins, as well the OH team walkabouts. There has been really positive feedback from staff following the implementation if the schemes.

- **Recruitment**

The Senior Nursing team are continuing the active recruitment process. This still remains a challenge despite the intensive work to improve. Reviewing all nursing roles at ward level has allowed the appointment of Band 5 Pharmacy Technicians to administer medications. This pilot has been successful on AMU and is now due to be commenced on ward 34 the Therapy/Intermediate care area ward

The Divisions are considering the need for further recruitment overseas. The final decision will be following a scoping of the RN availability from the local Universities as well as the turnover.

- **Retention**

Acorn *'Growing Our Own and Keeping Them Rooted'* programme is now on its second co-hort. The Acorn programme echoes this goal in its our nursing recruitment strategy.

- **Temporary staffing**

Review of the Temporary Staffing Bank with regards to Registered Nurses was completed last year. A number of actions were agreed however ithis has made little difference to the RN availability.

In the last two months the Temporary Staffing Bank has now gone live on e-roster so nursing staff now book direct. Early feedback has been encouraging from staff. It is still too early to measure the impact on availability and use.

18.0 Conclusion

The information collected and reviewed within the paper demonstrates no areas of concerns, however close monitoring of staffing levels, acuity as well as safety and quality metrics continue.

19.0 Recommendation

Going forward the nursing and midwifery workforce will require re-modelling in respect of fully embedding and integrating electronic rostering, acuity measurement and tracking. In addition to this, creativity will continue in respect of reviewing establishments to create multi-professional teams who meet the needs of our patients. The use of Teletracking will allow the Trust to collect the number of nursing hours actually spent with patients and then cross reference it with available hours of nursing. This can then be used to inform staffing reviews in the future alongside the Safe care acuity information. This will support the NHS Improvement Model Hospital Dashboard to ensure efficiency and cost reduction is considered in the context of keeping staffing levels sufficient to provide safe care.

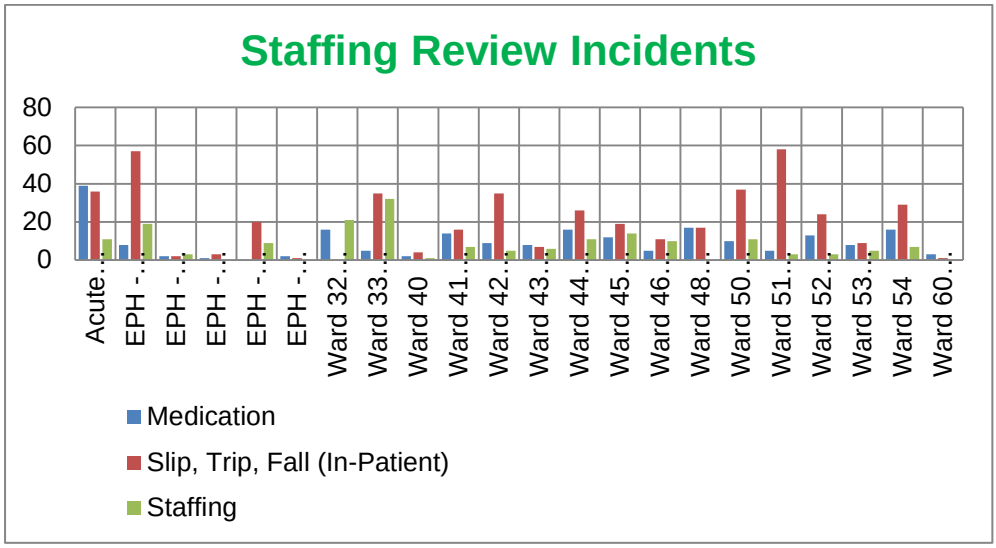
The Board of Directors are asked to continue to support the proposal above and actions going forward.

Alison Kelly -Director of Nursing and Quality
January 2017

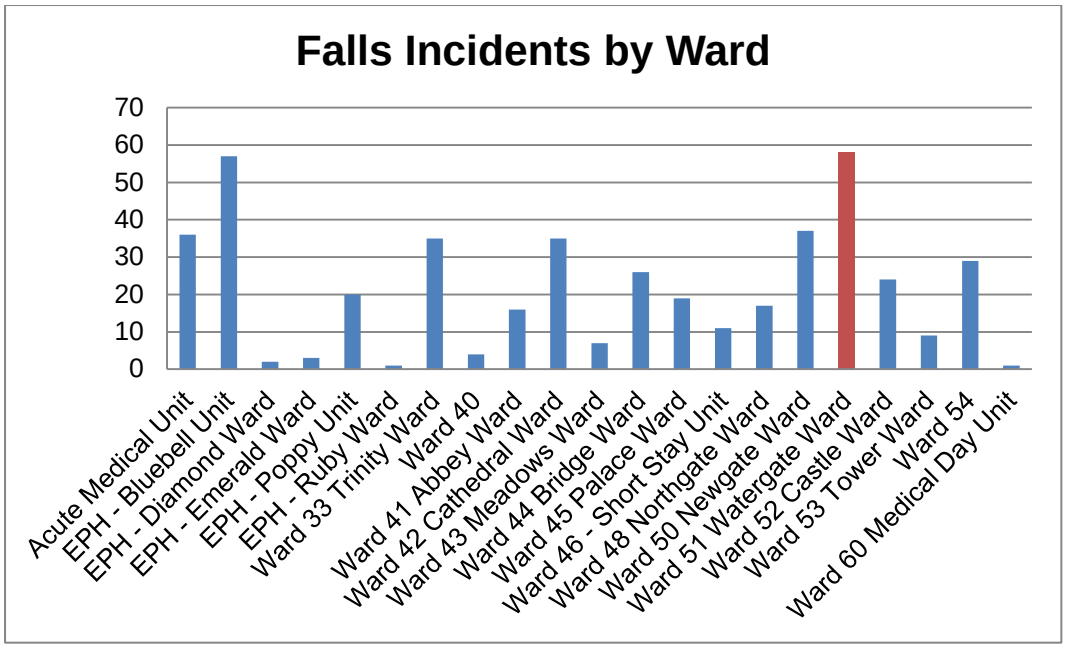
Appendix 1-Safe Staffing: % Compliance, July – December 2016

Ward Name	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Compliance over 6 month period
30	100.0%	102.5%	111.0%	95.7%	113.4%	104.3%	104.0%
32	68.5%	83.5%	81.5%	98.5%	106.9%	109.2%	89.0%
33	169.2%	100.5%	99.7%	93.8%	99.6%	97.4%	110.0%
34	97.8%	95.1%	74.3%	73.5%	74.1%	99.8%	87.0%
40	106.0%	97.4%	105.4%	102.8%	92.5%	95.1%	100.0%
41	92.0%	93.4%	97.3%	94.3%	102.4%	95.7%	96.0%
42	101.9%	100.4%	95.9%	100.2%	105.0%	105.5%	101.0%
43	79.0%	84.5%	94.9%	91.7%	98.8%	97.9%	90.0%
44	98.5%	92.6%	92.6%	92.7%	91.8%	85.6%	92.0%
45	107.3%	105.7%	97.5%	94.0%	99.7%	97.5%	100.0%
50	102.5%	102.3%	93.3%	100.6%	103.6%	105.3%	102.0%
51	94.3%	91.6%	97.8%	96.1%	97.3%	95.0%	95.0%
52	105.3%	93.5%	94.5%	100.1%	112.2%	104.5%	102.0%
54	90.9%	91.0%	88.7%	90.0%	92.0%	92.0%	91.0%
Bluebell	161.1%	107.9%	104.4%	103.6%	114.7%	118.7%	116.0%
ICU	91.9%	88.1%	90.2%	91.5%	93.1%	90.1%	91.0%
NNU	94.4%	91.1%	94.0%	91.9%	89.2%	93.2%	92.0%
Poppy	97.8%	82.2%	100.2%	90.7%	92.3%	107.3%	95.0%
Labour Ward	100.3%	105.1%	104.3%	106.2%	100.0%	106.9%	104.0%
Renal	93.9%	99.3%	96.3%	101.4%	102.1%	102.3%	99.0%
Trust	101.3%	94.7%	95.2%	96.1%	96.8%	98.1%	97.4%

Appendix 2



Appendix 3


Falls Incidents by Ward
70
60
50
40
30
20
10
0
Acute Medical Unit
EPH - Bluebell Unit
EPH - Diamond Ward
EPH - Emerald Ward
EPH - Poppy Unit
EPH - Ruby Ward
Ward 33 Trinity Ward
Ward 40
Ward 41 Abbey Ward
Ward 42 Cathedral Ward
Ward 43 Meadows Ward
Ward 44 Bridge Ward
Ward 45 Palace Ward
Ward 46 - Short Stay Unit
Ward 48 Northgate Ward
Ward 50 Newgate Ward
Ward 51 Watergate Ward
Ward 52 Castle Ward
Ward 53 Tower Ward
Ward 54
Ward 60 Medical Day Unit

Appendix 4 : In patient Ward Sickness and Staff turnover (July 16 – December 216)

Safe Staffing Report In Line With National Quality Board Expectations

	July 2016 - Dec. 2016	6 Month Total			
		Sickness Absence %	Turnover %	Starters	Leavers
	All Trust Registered Nursing & Midwifery	4.63%	6.00	36	66
	All Trust Healthcare Support Staff	4.88%	5.32	55	36

Division	Area Of Work	6 Month % Sickness Absence Rate (FTE)	6 Month Turnover %	Starters	Leavers
210 PLANNED DIVISION		4.44%	4.99%	11	13
210 PLANNED DIVISION	210 Bridge Ward 44	3.38%	5.97	0	2
210 PLANNED DIVISION	210 Castle Ward (52)	4.50%	8.82	4	3
210 PLANNED DIVISION	210 Crit Care Staff & Hdu Non Pay	5.24%	5.03	1	5
210 PLANNED DIVISION	210 Palace (45)	6.04%	2.53	3	1
210 PLANNED DIVISION	210 Tower Ward (53)	4.93%	0.00	0	0
210 PLANNED DIVISION	210 Ward 54	1.95%	4.65	3	2
210 URGENT CARE DIVISION		5.02%	6.76%	37	37
210 URGENT CARE DIVISION	210 Accident & Emergency	7.17%	3.02	1	3
210 URGENT CARE DIVISION	210 Acute Medical Unit (Ward 47)	4.24%	9.52	10	7
210 URGENT CARE DIVISION	210 Cathedral Ward (42)	7.40%	9.38	4	3
210 URGENT CARE DIVISION	210 Coronary Care Unit	3.96%	4.55	0	1
210 URGENT CARE DIVISION	210 EPH BLUEBELL WARD (Was Ruby V	5.71%	17.58	3	8
210 URGENT CARE DIVISION	210 EPH POPPY WARD	3.99%	6.67	0	2
210 URGENT CARE DIVISION	210 Foregate Ward (49) - Gastro	5.44%	6.15	8	2
210 URGENT CARE DIVISION	210 Newgate Ward [50]	5.96%	2.30	2	1
210 URGENT CARE DIVISION	210 Nnu	4.78%	8.11	0	3
210 URGENT CARE DIVISION	210 Priory Ward (34)	4.97%	8.70	3	3
210 URGENT CARE DIVISION	210 The Childrens' Unit (29 & 30)	1.57%	5.83	1	3
210 URGENT CARE DIVISION	210 Trinity Ward (33)	2.98%	2.17	5	1

BOD Item No 2017/

Countess of Chester Hospital NHS
NHS Foundation Trust

People & Organisational Delivery Committee

Subject	Midwifery Establishment Review (Safer Staffing) – July-December 2016
Date of Meeting	4th April 2017
Author(s)	Julie Fogarty
Presented by	Alison Kelly, Director of Nursing & Quality
Summary	The review ensures that the Trust Board receives assurance that patient safety is being maintained with regards to midwifery staffing numbers and skills. The report also provides assurance both internally and externally, that midwifery staffing and safety metrics are monitored and actioned accordingly.
Recommendation(s)	**The Board is asked to:** Note the contents and support future actions.
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document nonsensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [X] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: • If you have chosen A. or B. above, confirm to the Chair which applicable exemption(s) apply to the whole document or highlighted sections. • If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal.

Countess of Chester Hospital NHS
NHS Foundation Trust

Midwifery Establishment Review (Safer Staffing)

For the Period July – December 2016

Author: Julie Fogarty
Head of Midwifery
January 2017

1.0 National Picture

1.1 The purpose of the review is to ensure the Trust Board receives assurance that patient safety is being maintained with regards to midwifery staffing numbers and skills.

In July 2016, the NQB published "*Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing".* This safe staffing improvement resource provides an updated set of expectations for nursing and midwifery care staffing, to help NHS provider boards make local decisions that will support the delivery of high quality care for patients within the available staffing resource. This resource:-

- sets out the key principles and tools that provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable and productive service, including introducing the care hours per patient day (CHPPD) metric;
- offers guidance for local providers on using other measures of quality, alongside CHPPD, to understand how staff capacity may affect the quality of care;
- identifies three updated NQB expectations that form a 'triangulated' approach to staffing decisions:-

Expectation 1 **Right Staff**	**Expectation 2** **Right Skills**	**Expectation 3** **Right Place and Time**
1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	2.1 mandatory training development & education 2.2 working as a multi-professional team 2.3 recruitment & retention	3.1 productive working & eliminating waste 3.2 efficient deployment & flexibility 3.3 efficient employment & minimising agency

Midwifery as part of the Model Hospital work stream acuity based workforce will incorporate the triangulated approach to its E-rostering when launched within Midwifery in June 2017. The CHPPD will also be explored in the future.

1.2 The report is also to provide an assurance both internally and externally, that midwifery establishments are safe and that staff are able to provide appropriate levels of care to women & babies with a level of care that reflects the Trust values, the ethos of Leading Change, Adding Value, A framework for nursing, midwifery and care staff (2016) and the Trust's Nursing & Midwifery Strategy. This is particularly important in light of key recommendations made in the Francis Report (2013) and the Berwick Report (2013) and the publication of NICE, Safe Midwife Staffing in Maternity Settings (2015).

1.3 The report also supports the Care Quality Commission (CQC) requirements under the Essential Standards of Quality & Safety, including outcomes 13 (staffing) and 14 (supporting staff). The CQC inspection of Maternity Services in February 2016

awarded a good in all 5 key lines of enquiry; safe, effective, caring, responsive & well led however stated in its report that "*the number of midwives employed did not meet best practice Birthrate Plus recommendations*". This calculation will be applied in the acuity based workforce e-rostering set-up.

1.4 NICE published Safe Midwife Staffing in Maternity Settings in February 2015, this report acknowledges that guidance, however the staffing tool to accompany the guidance has not been produced therefore the staffing formula via Birthrate Plus a nationally recognised midwifery staffing tool has been applied using same format as for the previous reviews but with recent data. In the NICE Guidance a minimum staffing ratio for women in established labour has been recommended, based on the evidence available and the Safe Staffing Advisory Committee's knowledge and experience. The Committee did not recommend staffing ratios for other areas of midwifery care. This was because of the local variation in how maternity services are configured and therefore variation in midwifery staffing requirements, and because of the lack of evidence to support setting midwife staffing ratios for other areas of care. High Quality Midwifery Care (RCM 2014) recognises the need that staffing levels are appropriate across the entire maternity pathway otherwise labour ward care is always prioritised at the expense of antenatal and postnatal care. The Midwifery & Support Staffing policy was updated in 2015; the Director of Nursing & Quality signed it off as per NICE guidance (February, 2015 p13) prior to formal ratification.

1.5 MBBRACE-UK 2016

The third of the Confidential Enquiry into Maternal Deaths annual reports produced by the MBRRACE-UK in December 2016 included data on surveillance of maternal deaths between 2012 and 2014. Through rigorous investigations the enquiry recognises the importance of learning from every woman's death, during and after pregnancy, not only for staff and health services, but also for the family and friends she leaves behind.

Over a quarter of women who died during pregnancy or up to six weeks after pregnancy died from a cardiovascular cause. There was evidence of a focus on excluding, rather than making, a diagnosis in women who presented repeatedly for care. Repeated presentation should be considered a 'red flag' by staff caring for pregnant and postpartum women in any setting.

Once again, a number of women received fragmented care, and important messages concerning planned care were not passed between teams, highlighting the urgent need for joint, multidisciplinary, maternity and cardiac care.

1.6 In February 2016 the national review of Maternity Services was published. The review has 28 recommendations with varying timescales from immediate implementation to a deadline of 2020. Several of the recommendations require early adopters to be pilots of which COCH as part of the Cheshire & Merseyside Vanguard has been selected. There are definite staffing implications if the recommendation that "Every woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the women and family, and can

provide continuity throughout the pregnancy, birth and postnatally" is to be adopted, however it is prudent to await further national feedback from pilot sites.

1.7 The Trust publishes its midwifery staffing hours both Registered and Unregistered - planned versus actual, in line with the National Quality Board (NQB) guidance. This is published externally on NHS Choices with a link to the Trust's own website.

1.8 In January 2009 the Royal College of Midwives issued a position Statement on staffing standards in Midwifery; this was followed in February 2009 by a guidance paper. The implications of this paper for midwifery staffing requirements are that the Royal College of Midwives (RCM) recommends a national ratio of midwives to women of 1:29.

2.0 Background

2.1 The Trust has a duty to ensure that Midwifery staffing levels are adequate and that women are cared for safely by appropriately qualified and experienced staff. This is incorporated within the NHS Constitution (2013) and the Health and Social Care Act (2012). NICE (2015) states of the Trust board that it '*should ensure that the budget for maternity services covers the required midwifery staffing establishment for all settings'*

2.2 This Maternity Staffing Review paper has been produced to inform the Women and Children's Care Governance Board of Midwifery staffing levels which via a cascading process is received by the Trust Executives

2.3 The evidence suggests that appropriate staffing levels and skill mix influences patient outcomes, for example:

- Reducing mortality & morbidity
- Reducing 30 day readmissions for both mothers and babies
- Reducing adverse incidents, particularly related to medication errors
- Improves the patient experience

2.4 Nice Guidance, Safe midwifery staffing for maternity settings, February, 2015 has recommended the use of red flags. *A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.* The following are the recommended red flags, this data is collected and forms part of this staffing review report. There have been several months were there has been high numbers of delayed critical activity due to midwifery staffing

- Delayed or cancelled time critical activity.

- Missed or delayed care (delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (e.g., diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

2.5 Staffing levels and skill mix within maternity services have been the focus of much debate in recent years. Maternity services nationally are constantly under pressure to utilise their manpower resources effectively and efficiently. A number of other factors have emerged, which include population demographics, national reports and guidelines along with an increase in public awareness and expectation especially in light of Morecambe Bay. In addition, diversity and complexity of patient needs continue to increase, and range from promoting health and well-being through the wider public health agenda to the high dependency care of sick women and babies. National data published in July 2016 by the ONS stated that the rate of women having babies in their 40's is higher than that of under 20's for the first time since 1947, this increase in age profile comes with a recognised increase in complexities. The additional work associated with increased antenatal screening and the national Saving Babies Lives Care Bundle which includes the GAP/GROW programme of assessing fetal growth has been an additional pressure to the service.

2.6 It is acknowledged that a workforce designed around the needs of its users, can rapidly respond to the expectations of the public. The composition and skills of the workforce will determine how effectively services are able to respond to demands. However this in itself is difficult due to Any Qualified Provider 121 Midwifery as women who book with their service do not choose place of delivery until in established labour making it more difficult to workforce plan effectively.

2.7 Increased annual leave provisions under Agenda for Change; core and specific mandatory training requirements; the increase in the complexity of care required by women across Western Cheshire & surrounding areas who select COCH as their unit of delivery has reduced the time available for midwives to provide direct care to

women. Lean & productive ward tools has supported some service changes to further improve the efficiency of the workforce.

2.8 One of the Francis Report (2013) recommendations was that Trusts should make all ward managers supervisory. This has not been achieved in the past 6 months midwifery due to the shortfall in WTE against national recommendation and sickness requiring management time being converted to clinical shifts.

2.9 NICE, Safe midwifery staffing for maternity settings also recommends that when calculating the midwifery staffing levels that you base the number of whole-time equivalents on registered midwives, and do not include the following in the calculations:

- registered midwives undertaking a Local Supervising Authority Programme
- registered midwives with supernumerary status (this may include newly qualified midwives, or midwives returning to practice)
- student midwives
- the proportion of time specialist and consultant midwives who are part of the establishment spend delivering contracted specialist work (for example, specialist midwives in bereavement roles)
- The proportion of time midwives who are part of the establishment spend coordinating a service, for example the labour ward.

3.0 Methodology for January 2017 Establishment Review

3.1 A review of recent national publications was undertaken prior to commencement of the establishment review in order to incorporate the latest evidence to inform the methodology and the recommendations.

3.2 It is an important factor to incorporate the professional judgment of the midwifery managers. Their views are then supported objectively by the use of the following information:

- Establishments were compared to January & July 2016
- Review of registered to unregistered midwives ratios
- The application of Birthrate Plus® a nationally recognized tool which is the classification of case mix by categories I–V
- Booking & delivery statistics

3.3 It is essential to undertake robust workforce planning to ensure there are appropriate staffing levels and skill mix with in the maternity service to ensure best outcomes are achieved for mothers and their babies therefore the Head of Midwifery has utilised the staffing data via Finance, Local Supervising Authority and the women's & babies acuity data via Meditech from the Divisions I.T. Analyst.

3.4 The review process involved auditing the current staffing establishment against the Safer Childbirth (2007) RCOG standards for staffing levels in the maternity service to establish whether COCH were comparable via the nationally recognised tool for Midwifery Services known as Birthrate Plus.

4.0 Birth rate Plus Methodology

The Birthrate Plus Midwifery workforce planning system is based upon the principle of providing one to one care during labour and delivery to all women, with additional midwife hours for women in the higher clinical need categories.
The Full study assesses the midwifery workforce of a service based on the needs of women and records for a minimum period of 4 Months on intrapartum care, hospital activity, and all other aspects of care provided by midwives from pregnancy till the mother and baby are discharged from postnatal care.

The application of Birthrate Plus® which is the classification of case mix by categories I–V. (Appendix A).This classification for labour and delivery care has been used as a measurement of COCH current case mix and staffing levels. The data to undertake this report was derived from the Meditech Maternity System.

5.0 Findings

5.1 Staffing

National and local statistics indicate that the profession continues to be predominantly female and that the age profile is rising. This contributes to increased competition for a workforce beset by similar issues and constraints. Along with these factors, the retirement of senior skilled midwifery staff is also expected to contribute to increasing staff pressures and potential shortfall of staff in the future. The maternity services currently employ 159 staff (headcount) in a variety of roles including management. The Trust employs midwives who work both within the hospital and community; **37.3 %** of midwives are eligible to take retirement over the next 5 years based on a retirement age of 55, with **11.7%** eligible to take retirement now. This data itself demonstrates the fact that Chester has the potential to lose a large number of experienced staff from all fields in the near future including all its management roles and most specialist roles in the next 5 years. However it must be noted that the service has experienced no difficulties in recruiting to its vacancies this year to date and has robust succession plans in place with staff already in training to ensure current services are maintained in the future when required.

Desktop exercise

On the basis of this analysis the following staffing needs are required 59.5 % of COCH women in BR+ Category i---iii, which means the ratio for assessing the requirement of midwives in hospital is 1:45.
The Requirement for homebirth including all ante and postnatal care is 1:35 and the community ante and postnatal care only ratio is 1:96.

For a DGH the management and specialist component is an additional 8%.
Stats are for the period 1st January 2016– 31st December 2016

Hospital births
2973 1:45 2973/45 = 66.06 WTE MW
Homebirths
30 1:35 30/35 = 0.85 WTE MW
Community
2230 1:96 2230/96 =23.22 WTE MW

(2973+ 30+ 35 Imports = 3038 – 808 exports = 2230)
Total Clinical midwifery requirement = **90. 13 WTE midwives**
Management and specialist requirement at 8% = 90.13 x 8% = **8.87WTE Midwives**

Total Clinical, Specialist & Management Requirement = 99.00WTE Midwives

The current midwifery workforce is made up of 96.50 WTE Midwives.

Shortfall = 2.5 WTE

6.0 Quality & Safety

Staffing is discussed as part of the CLS shift leader hand over as they have the overview of Midwifery. This meeting takes place twice a day, and ward dependency, women on protocol (high risk needing midwifery High dependency 121 care) and overall staffing ratios/ gaps are discussed. The following actions are agreed to support a reduction of risk:

- Moving from outpatient areas
- Moving staff from one ward to another
- Moving from or to Community midwifery
- Sanctioning additional staff if required due to a patient safety risk
- Closing the Maternity Unit

To support the management of any identifiable risks, the midwives in charge of wards/departments are engaged with staff at a safety brief. A Trust Midwifery Staffing Policy is in place to support the decision making process. The risks discussed for example are high acuity women and babies requiring additional monitoring to that of a low risk newborn. Staff also receives feedback regarding complaints or leaning from incidents that have taken place in or that affect the Trust.

6.1 Midwifery Unit Closure

Part of the Trust Patient Flow Policy which was updated in 2015 contains a section regarding management of Midwifery capacity. Within the Midwifery section is a comprehensive section upon the reasons why the Maternity Unit would temporarily

close to admissions (one of which is staffing levels) and the processes surrounding the closure to ensure safety of women & babies and to support collaborative working with neighboring Trusts.

During the period 1st July -31st December 2016 the Maternity unit closed 2 times due to peak in activity resulting in 10 women delivering at another provider.

The Neonatal Unit experienced a temporary change to its gestation entry criteria at the time of the production of this report; this however had no major impact upon the overall running of Maternity Services due to low numbers involved in relation to the additional work associated with intra- uterine transfers.

Cheshire & Merseyside Model of Care Midwifery arm of the Vanguard has reviewed each Trust's Policies for divert/closure and produced a single policy across all maternity services. This draft policy is currently out for comment.

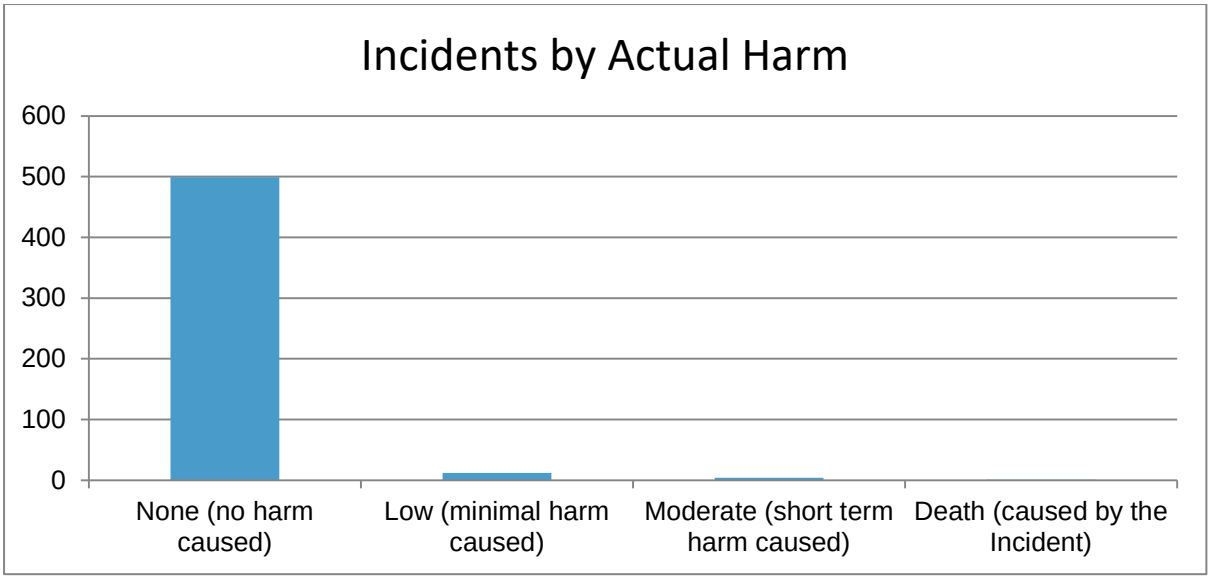
6.2 Staffing Incidents 1st July -31st December 2016

During the period of 1st July to 31st December 2016 there were 101 logged incidents in relation to staffing. This is a significantly marked increase from 37 in the previous six months. Each Datix is reviewed in the context of the status of the maternity unit capacity, women's acuity and overall staffing levels.
The table below shows the incidents by location and sub category:

	Lack of Staff	No staff availabl e	Nursing and Medical Staffing issues	Staff transferred to another clinical area	Staffing levels (Nursing, Midwifery and Medical)	Tota l
Antenatal Clinic	0	0	0	0	1	1
Central Labour Suite	2	1	2	0	53	58
Ward 32 Cestrian Ward	15	0	0	6	21	42
Total	17	1	2	6	75	101

6.3 Datix incidents overall

There were a total of 516 incidents reported in obstetrics during the period of 1st July – 31st December 2016 – of these incidents, 82 occurred as a direct result of staffing levels.
The table below shows all incidents by actual harm:



- There was 1 maternal death during this time period
  - Occurred when the lady was 26 days post-partum and has been subject to a NPSA level 2 joint review.
- 4 moderate harms were reported
  - 1 term admission to the Neonatal unit following misinterpretation of a CTG
  - 2 staff personal injury, 1 involving a patient bed and one following a faint
  - 1 laceration to a baby at elective c/s

The table below shows all obstetric incidents during this period by week and actual harm:

	None (no harm caused)	Low (minimal harm caused)	Moderate (short term harm caused)	Death (caused by the Incident)	Total
01/05/2016	3	0	0	0	3
22/05/2016	1	0	0	0	1
29/05/2016	7	0	0	0	7
05/06/2016	13	0	0	0	13
12/06/2016	11	0	0	0	11
19/06/2016	16	1	0	0	17
26/06/2016	17	0	0	0	17
03/07/2016	8	0	0	0	8
10/07/2016	18	0	0	0	18
17/07/2016	24	0	1	0	25
24/07/2016	13	0	0	0	13
31/07/2016	14	0	0	0	14
07/08/2016	14	0	1	0	15
14/08/2016	28	1	0	0	29

21/08/2016	15	1	0	0	16
28/08/2016	17	1	0	0	18
04/09/2016	21	0	0	0	21
11/09/2016	16	0	0	0	16
18/09/2016	27	1	0	0	28
25/09/2016	12	1	0	0	13
02/10/2016	21	0	0	0	21
09/10/2016	13	0	0	0	13
16/10/2016	32	0	1	0	33
23/10/2016	20	0	0	0	20
30/10/2016	15	4	0	0	19
06/11/2016	13	1	0	0	14
13/11/2016	17	0	0	0	17
20/11/2016	13	0	0	1	14
27/11/2016	24	0	0	0	24
04/12/2016	13	1	0	0	14
11/12/2016	12	0	0	0	12
18/12/2016	8	0	0	0	8
25/12/2016	3	0	1	0	4
Total	499	12	4	1	516

Data Source Annemarie Lawrence –Risk Midwife

6.4 Midwifery Indicators (Red Flags)

Midwifery red flag data is collected daily at the end of each shift and recorded within an sdrive folder so that results can be easily reviewed and trends identified. Managers are also able to react to the results in a timely manner, address any issues or investigate when required. The red flag data demonstrated an issue relating to Induction of Labour processes, whilst time of admission was adjusted the Unit has continued to see a delay due to Labour Ward staffing associated with activity and the subsequent knock on effect on commencing IOL on ward 32 due to collaborative working to increase safety outcomes. Use of the national & Midwifery Safety Thermometer tool is also a helpful measure that supports risk reduction of harm, the midwives ask additional questions linked to the outcome of the national maternity survey in 2015 to the basic maternity safety thermometer to try and improve women's satisfaction of maternity services.

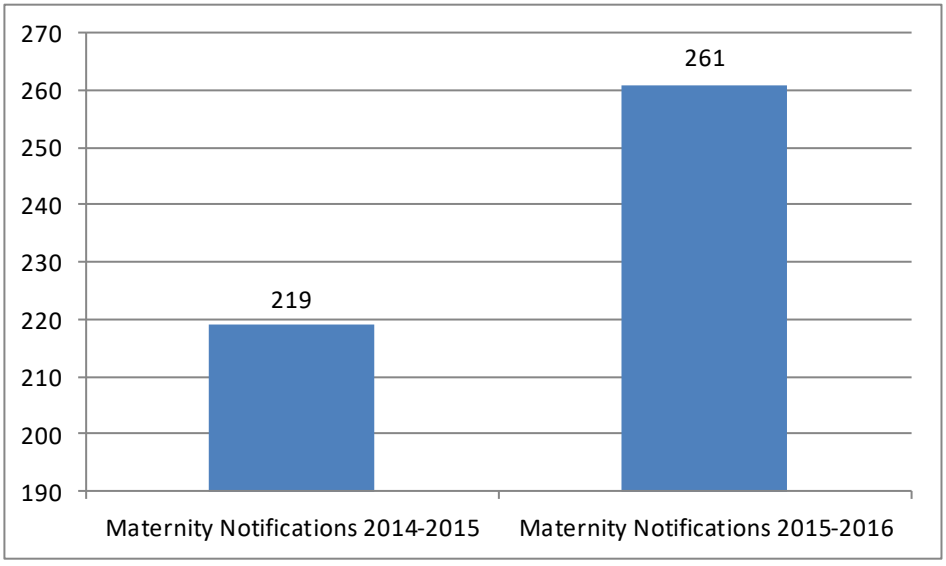
	Number of times red flag triggered					
Midwifery Red flag	July	Aug	Sept	Oct	Nov	Dec
Delayed or cancelled time critical activity CLS	10	9	21	29	25	6
Missed or delayed care (delay of 60 minutes or more in washing and suturing).	0	0	0	0	0	0
Delay in transfer from Ward 32 to CLS for IOL	19	24	8	36	24	21
Missed medication during an admission to hospital or midwifery-led	0	0	0	0	0	0

unit (e.g., diabetes medication).						
Delay of more than 30 minutes in providing pain relief or medication	0	14	2	3	8	4
Delay of 30 minutes or more between presentation and triage.	0	0	0	0	0	0
Full clinical examination not carried out when presenting in labour.	0	0	0	0	0	0
Delay of 2 hours or more between admission for induction and beginning of process.	25	14	22	28	25	9
Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output).	0	4	0	1	0	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.	0	0	0	2	3	0

6.5 Supervisory Ward Managers

The Ward Managers work in a semi supervisory capacity. However, there are times due to staffing challenges or peak in activity, when it is not always achieved as patient care will always take president over management activities. Midwifery services has experienced a peak in sickness over the past 12 months' all of which has been managed as per the trusts attendance management policy but this has impacted on the ability of the management team due to their requirement to work clinically.

7.0 Safeguarding work



The above table demonstrates the notifications to the Safeguarding Children team by Midwives in 2015-2016 and the comparisons between the data from 2014-2015 and 2015-2016 which clearly depicts a significant increase in the number of maternity safeguarding children cases dealt with by Midwifery staff. This in itself adds pressure to the midwifery workforce especially in relation to the increasing

number of case conference and birth planning meetings attended all of which require report production prior to attendance.

8.0 Challenges & Risks

The age profile of the Midwifery staff and no staff recruited to the midwifery bank resulting in below minimum staffing on occasions remain a potential risk to the organisation. However we have not experienced a problem with recruitment into any Midwifery vacancies to date and continue to explore recruitment to the Midwifery bank, staff work additional hours to cover gaps in off duty where possible.

9.0 Conclusion

This six month review demonstrates that the Midwifery staffing currently has a staffing shortfall of 2.5 WTE identified from this review and a ratio of 1:31 (7.05 WTE shortfall to meet this) which is outside of the national recommend ratio of 1:29. This was also recognised within the 2016 CQC inspection report and will be an objective within the Trusts bespoke Maternity Services Safety Improvement Plan which forms part of the Department Of Health *Safer Maternity Care* requirements.

The past six months booking numbers have reduced slightly and are more in line with 2014 however a number of the women who initially opt to book at COCH then transfer care during pregnancy to AQP 121 Midwifery but predominantly deliver at COCH, some also transfer back to COCH either in the antenatal period or in labour and some are booked with AQP 121 but have antenatal care via COCH Services, ultimately all these combinations contribute to making workforce planning more difficult and add to the workload of the Countess employees. The sustained increase in the complexity of women has also had an effect on staffing pressures in conjunction with the additional requirements of the GROW programme.

In light of the staffing shortfall against national recommendations the Head of Midwifery recommends:-

1) Full Birthrate plus assessment of the workforce

2) A business case to address the 2.5 WTE shortfall which equates to 93.5 midwifery hours of care or 7.05 WTE to meet the nationally recommended 1:29 ratio. The additional staff would be placed to address the issues with delayed critical care activity and transfer of Induction of Labour as demonstrated by the red flag data.

The Head of Midwifery is also mindful that the national maternity review recommendation in relation to 'Every *woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the women and family, and can provide continuity throughout the pregnancy, birth and postnatally*' will not be achievable within the current midwifery staffing framework.

The Head of Midwifery presents this report to the Director of Nursing & Quality for approval. It will also be received at Women & Children's' Governance Board and ultimate cascading to Nursing & Midwifery Board & People & Organisational Delivery Committee.

Appendix A

Birthrate Plus Classification

Integral to Birthrate Plus® is the classification of case mix by categories I–V:
Data L N=Mohan IM&T

Setting	Case mix category	Definition	Midwife to woman standard	MCA to midwife
Home	**I and II**	**Low-risk midwifery care**: normal birth, no intervention, good birth weight and Apgar, no epidural. 0.79%	1 WTE Midwife to 1 woman	1 MCA for team of 6 m/w
COCH	**I and II**	**Low-risk midwifery care**: normal birth, no intervention, good birth weight and Apgar, no epidural. 29.2%	1 WTE Midwife to 1 woman	1 MCA for team of 6 m/w
COCH	**III**	**Moderate degree of intervention**: Induction, fetal monitoring Instrumental delivery, third-degree tear, preterm birth. 29.6%	1.2 WTE Midwives to I woman	1 MCA for 4 m/w s each shift
COCH	**IV**	**Higher-risk/higher choice or need**: normal birth with epidural for pain relief, elective caesarean sections, post-delivery complications, 22.8%	1.3 WTE Midwives to I woman	1 MCA for 4 m/w s each shift
COCH	**V**	**Highest risk, including emergencies**: emergency caesarean sections, medical or obstetric complications, multiple births, stillbirths, severe pregnancy-induced hypertension. 17.4%	1.4 WTE Midwives to I woman	1 MCA for 4 m/w s each shift

Data Source
Laura Mohan IM&T

Appendix B

Age Profile of Midwives in My Trust(s) Age Number of Midwives Percentage of Total

Age	Number of Midwives	Percentage of Total
Under 21	0	0.0%
21 to 25	3	2.3%
26 to 30	11	8.5%
31 to 35	18	14.0%
36 to 40	18	14.0%
41 to 45	10	7.8%
46 to 50	21	16.3%
51 to 55	33	25.6%
56 to 60	13	10.1%
61 to 65	2	1.6%
Over 65	0	0.0%
Total	**129**	**100%**

Please note not all 129 midwives are employed by COCH as midwives 12 are bank or work using their midwifery registration so submit an ITP via their SoM at Chester
Data Source
LSA Database

Appendix C

Midwifery WTE stats
In Hospital Midwifery - 3120 you have:
Midwives = (69.88 WTE) (Band 5 to 8a)
Midwifery Support Workers = (8.11 WTE)
Midwifery Assistants = (19.08 WTE)

In Community Midwifery - 3140 you have:
Midwives = (25.62 WTE)
Midwifery Support Workers = (3.90 WTE)
Midwifery Assistants = 0.00 WTE

Head of Midwifery = (1.0 WTE)

Across the whole of Midwifery then you have:
Midwives = (96.50 WTE)
Midwifery Support Workers = (12.01 WTE)
Midwifery Assistants = (19.08 WTE)

Data source
Sammir Radha Finance

Appendix D

Midwifery booking stats

Count of Mother Unit Number	Column Labels		
Row Labels	**2014**	**2015**	**2016**
Jan	321	290	292
Feb	284	313	285
Mar	294	335	308
Apr	275	332	284
May	278	265	282
Jun	255	296	270
Jul	300	301	284
Aug	273	251	290
Sep	288	304	282
Oct	306	299	272
Nov	274	297	310
Dec	267	319	252
Grand Total	**3415**	**3602**	**3413**

Data Source
Laura Mohan IM&T

Appendix E

Delivery stats

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	July-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Number of mothers delivered	225	231	250	215	230	230	265	239	270	257	246	224
Deliveries in COCH CONS unit	204	197	224	192	208	208	235	216	234	221	216	204
Deliveries in MLU unit	21	34	26	23	22	22	30	23	36	36	30	20
Number of babies born	231	233	255	220	231	231	270	244	270	263	249	226
Deliveries <34 Weeks	5	3	11	1	3	3	3	1	3	3	4	3
Deliveries <34 Weeks: Spontaneous	2	2	3	0	2	2	1	1	2	2	3	1
Stillbirths	0	0	1	0	0	0	1	0	1	0	0	0
Planned Home Deliveries	4	1	2	4	5	5	2	1	1	1	1	4
Number of BBA's	1	1	2	4	4	4	0	2	2	3	0	0
Intrauterine Transfers Out	0	4	1	0	0	0	0	0	0	1	3	4

Data Source: - Laura Mohan IM&T

REFERENCES

Ball J.A. & Washbrook M; (1996). *Birthrate Plus; A Framework for Workforce Planning and Decision Making for Midwifery Services.* Books for Midwives Press/ Elsevier Press.

Care Quality Commission. (2016) The Countess of Chester Hospital NHS Foundation Trust Quality report. London: CQC

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London: The Stationery office.
http://www.midstaffspublicinquiry.com/

Home Office. (2016). Office for National Statistic. Births in England & Wales 2015
https://www.**ons**.gov.uk

King's Fund (2011). *Staffing Maternity Units: Getting the right people in the right place at the right time.* London: King's Fund
www.kingsfund.org.uk/publications/staffing-maternity-units

MBBRACE-UK (2016). Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14. Oxford
https://www.npeu.ox.ac.uk/mbrrace-uk/reports

NHS England. National Quality Board (2016) "*Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing*".
https://www.england.nhs.uk/ourwork/part-rel/nqb/

NHS England. (2014). Safer Staffing: A Guide to Care Contact Time. London
www.england.nhs.uk/wp.../safer-staffing-guide-care-contact-time.

NHS England. (2014). NHS Five Year Forward View
https://www.england.**nhs**.uk/wp-content/uploads/2014/10/**5**yfv-web.pdf

NHS England. (2016).BETTER BIRTHS. Improving outcomes of maternity services in England. A Five Year Forward. View for maternity care.
https://www.england.nhs.uk/wp.../national-maternity-review-report

NICE (2015) Safe midwifery staffing for maternity settings.
https://www.nice.org.uk/guidance/ng4

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007*). Safer Childbirth: Minimum Standards For The Organisation And Delivery Of Care In Labour*. London: RCOG Press. www.rcog.org.uk

Royal College of Midwives. (2009) *Position Statement 15: Staffing Standards in Midwifery Services.* London: RCM.
www.rcm.org.uk/EasySiteWeb/GatewayLink.aspx?alId=57039

Royal College of Midwives. (2009). *Guidance Paper No 7: Staffing Standards in Midwifery Services.* London: RCM

BOD Item No / /

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Memorandum of Understanding for West Cheshire Accountable Care Organisation (ACO) Governance
Date of Meeting	4th April 2017
Author(s)	Ben Wright, West Cheshire ACO Programme Director
Presented by	Tony Chambers
Board Assurance No.	CR6 - Failure to develop and deliver a robust long-term whole health economy service, workforce and financial savings and recovery plan
Summary	Recently the West Cheshire Accountable Care Leadership Group approved a roadmap detailing what needs to happen next in order to deliver an Accountable Care Organisation in West Cheshire by 1st April 2018. As the statutory bodies the Governing Bodies and/or Boards are now asked to approve an ACO Memorandum of Understanding between The Parties that form the West Cheshire ACO Leadership Group (ALG)
Recommendation(s)	**The Board is asked to:** a. Approve the Memorandum of Understanding for West Cheshire Accountable Care Organisation (ACO) Governance. b. Note the positive progress made so far in developing an Accountable Care Organisation in West Cheshire. c. Note the Next Steps and the implications of doing so.
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [x] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Context

Between October and December 2016, the Accountable Care Organisation Leadership Group (ALG) appointed a Senior Responsible Officer and a Programme Director to lead the management and development of an Accountable Care Organisation in West Cheshire. It also approved the appointment of a consultancy (PriceWaterhouseCoopers) to undertake an initial 'due diligence' phase of work in order to assess the system's readiness for taking on such a programme.

This phase of work completed as of early March 2017, at which point the ALG approved a Roadmap detailing what needs to happen next in order to deliver an Accountable Care Organisation in West Cheshire by 1st April 2018. It was also agreed to seek the approval of respective Boards, as the statutory bodies, for an ACO Memorandum of Understanding, appended to which are the ALG Terms of Reference.

Memorandum of Understanding

The ACO Memorandum of Understanding functions as the initial formal agreement to support the Parties' ongoing work towards the establishment of an accountable care organisation for West Cheshire. It does not seek to diminish or shift existing statutory powers from any signatory party. Its purpose is to capture the will of the parties coming together to develop the ACO.

Agreement of the ACO Memorandum of Understanding shows support of the programme that aims to deliver the joint vision of improved health and care for the population of West Cheshire.

It is also the route through to playing a material and influential role in the construction of the future ACO and ultimately to its leadership. A party that does not sign up to the Memorandum of Understanding would by definition be 'outside' the ACO.

Accountable Care Organisation Leadership Group (ALG) – Terms of reference

The ALG is the senior leadership forum tasked with leading the development of an ACO in West Cheshire. The terms of reference confirm its membership and how it operates. This leadership group has been central to driving the significant progress made to date on the ACO programme. It has established an Independent Chair and Senior Responsible Officer for the ACO programme.

Next Steps

The next 10-12 weeks will be a period in which working assumptions will be 'stress tested' to ensure the proposed Accountable Care Organisation model defined by the ALG in recent months is right for West Cheshire.

Other actions include:

- ALG to confirm the resource for the next Phase of the programme (running April –June 2017);
- Running of the Workstreams to deliver the following outputs required to complete Phase Two: i) System (high level) Business Case ii) Commissioning Memorandum of Information and iii) Provider Memorandum of Understanding.

This work will require the support and input of a broad range of experts, clinicians, leaders and staff during what is likely to continue to be a very challenging period for the organisations involved. Senior leadership will need to find a way to parallel run the 'day to day' and the transformational work necessary within their organisations.

RECOMMENDATIONS

The Board is asked to:

d. Approve the Memorandum of Understanding for West Cheshire Accountable Care Organisation (ACO) Governance.
e. Note the positive progress made so far in developing an Accountable Care Organisation in West Cheshire.
f. Note the Next Steps and the implications of doing so.

BOD Item No

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Strategic Estates Partnership (SEP) – Briefing Paper April 2017
Date of Meeting	4th April 2017
Author(s)	Mr Simon Holden, Interim Chief Finance Officer
Presented by	Mr Simon Holden, Interim Chief Finance Officer Mrs Rosemary Jago, Partner, Bevan Brittan LLP
Annual Plan Objective No.	
Summary	This paper is intended to provide an overview of the joint SEP procurement process followed: • To provide an overview of the respective roles, responsibilities and obligations; and • To provide an overview of the decision making process
Recommendation(s)	Directors are asked to note: • The process followed to date; • The aim to verbally recommend the appointment of a Preferred Bidder; • The respective responsibilities and obligations; and • The intention to have a dedicated Private Board in May 2017, with legal and financial representation present, to formally conclude this process Directors are therefore asked to formally indicate the appointment of a Preferred Bidder that the Trust is minded to appoint, following the evaluation process.
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [X] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

COUNTESS OF CHESTER NHS FOUNDATION TRUST (the "Trust")

STRATEGIC ESTATE PARTNERSHIP ("SEP")

BOARD PAPER – PROCESS AND RESPONSIBILITIES OVERVIEW

1 INTRODUCTION

1.1 As the Board is aware the Trust has been working towards establishing a SEP jointly with Wirral University Teaching Hospital NHS Foundation Trust (WUTH). The Trusts have undertaken the procurement of a private sector SEP partner and through a competitive process have narrowed this down to a shortlist of two bidders.

1.2 Further to a request from the Board, this paper provides an outline of the process which has been undertaken by the Trusts in procuring a SEP partner (and thus establishing the SEP) and the respective obligations and responsibilities on each of the parties involved in the SEP when the preferred bidder is selected and the parties formally enter into the contractual and corporate SEP arrangements.

2 OVERVIEW OF THE PROCUREMENT AND KEY STAGES

2.1 The Trusts' procurement for a SEP partner was triggered by the issue of an **OJEU Notice** in the Official Journal of the European Union on 14 October 2016 (with reference number 2016/S 202-365928).

2.2 A **Project Information Memorandum** (or Memorandum of Information) set out further detail of the Trusts requirements and plans accompanied such OJEU Notice. This set out the detail regarding the Trusts' expectations and procurement strategy for the market to consider.

2.3 A **Selection Questionnaire (SQ)** was published to which bidders responded. The SQ was designed to assess a bidder's financial standing, technical capability and experience in delivering similar contracts. The questions in the selection questionnaire were designed to identify those bidders who have the financial strength and capability and track-record to be able to provide/manage the complete range of services specified in the OJEU (either themselves or through an identified supply chain as part of their bidding consortium) specific to the procurement and SEP.

2.4 Following the return and evaluation of the SQs by the Trusts and its advisors, a "long list" of bidders was identified, with whom the Trust commenced dialogue to develop their solutions, in response to the Trusts' requirements for the SEP. The start of dialogue was triggered by the issue of an **Invitation to Participate in Competitive Dialogue (ITPD).** The ITPD was issued to the "long list" of bidders and comprised four volumes: (i) information and background to the bidders regarding the procurement and strategy, (ii) suite of draft legal documentation; (iii) Trusts' requirements for the SEP and (iv) the evaluation criteria and methodology that was to be applied to assess the bidders' solutions and bids.

2.5 The table below highlights the key stages of dialogue and the activities that have been undertaken to refine, develop and shape the bidders' proposals to the requirements of the Trusts for a SEP partner.

Process	Summary of Key Activities
Competitive Dialogue (Stage 1)	• Opening of competitive dialogue and issue of ITPD to **four (4)** Bidders following successful completion of SQ. • Initial dialogue and clarification period. • Presentation of outline solutions to the Trusts and feedback. • Formal submission of outline solutions (ITPD Submission) and evaluation/selection of solutions to continue to participate in

Process	Summary of Key Activities
	detailed dialogue.
Competitive Dialogue (Stage 2)	• Update of procurement documentation and issue of an **Invitation to Continue Dialogue (ITCD)** with **two (2)** Bidders. • Detailed dialogue and clarification period. • Formal conclusion of dialogue and issue **Invitation to Submit Final Tenders (ISFT).** • Submission of Final Tenders. • Clarification, specification and optimising only (which does not distort competition or have a discriminatory effect) of the Final Tenders, as required. • Evaluation and selection of a Preferred Bidder the Trusts are minded to appoint.
Preferred Bidder Stage	• Confirming commitments of the Preferred Bidder's Final Tender. • Preferred Bidder secures any funding required for the Project • Approval and award of the contracts for the SEP. • Expiry of standstill period and establishment of the SEP.

2.6 During the dialogue phase the Trusts have had discussions with bidders with the aim of identifying and defining the best solution to meet the Trusts' requirements.

2.7 The first stage of the competitive dialogue process was an invitation to bidders to **submit outline proposals**. The questions that Bidders were required to answer in preparing their outline solutions were set out in the ITPD and included questions on Partnering, Estate Solutions, (Non- Clinical) Service Transformation Proposals, Financial and Legal.

2.8 The evaluation criteria against which the outline solutions were assessed and the evaluation methodology applied was set out in the ITPD. The outcome of the evaluation was the selection of solutions from two (2) remaining bidders with whom the Trusts continued detailed dialogue, **Interserve Prime and Ryhurst.** At this point, the Trusts issued an **Invitation to Continue Dialogue** (ITCD) that set out clearly the defined set of Final Bid deliverables. During this stage of dialogue (CD Stage 2), following further dialogue meetings with the Trusts, bidders were asked to present their solution(s) allowing the Trusts to feedback comments on the proposal(s). This phase of dialogue continued until the Trusts were satisfied that both of the final solutions proposed by bidders were capable of meeting all of the Trust's requirements. At this point, the Trusts declared the dialogue to be concluded and issued an **Invitation to Submit Final Tenders (ISFT)** to Bidders on 10 March 2017.

2.9 The evaluation criteria against which the final tender responses are assessed and the evaluation methodology applied are provided in the ISFT.

2.10 Final tenders are expected to be based on the solution(s) identified at the conclusion of the dialogue and should meet the Trusts' requirements. Final tenders are expected to be final as there is limited opportunity to vary tenders after submission. However, the Trusts may request bidders to clarify, specify or optimise their tender. Following the submission of final tenders, the Trusts are undertaking an evaluation and selection process to identify a **Preferred Bidder** which the Trusts are minded to appoint.

2.11 It is proposed that a member of the Project Team will present an evaluation report to the Trust Board in April (verbally), based on an evaluation of the **two final tenders** and make a recommendation to

the Trust Board **for approval of the Preferred Bidder the Trust is minded to appoint**. The same process will be undertaken in parallel at WUTH on the basis of the same evaluation report and recommendation.

2.12 Following appointment of a Preferred Bidder there is a further opportunity to 'confirm commitments' provided, there are no substantial changes to the bid and that this does not risk distorting competition or cause discrimination. Once the "confirm commitments" stage has been completed to the Trusts' satisfaction, the Trusts may then **formally award the contract to the Preferred Bidder** and enter into the necessary contractual documentation to establish the SEP. The decision to formally award the contract to the Preferred Bidder and to enter into the SEP legal documentation will be for the Trust Boards to consider and approve in May. At this Board meeting, a summary of the legal documentation will be presented and delegated authority sought for named authorised signatories to sign and execute the documentation and affix the Trusts seal in accordance with the Trusts Standing Orders/Scheme of Delegation. It is proposed that BDO (financial advisers) and Bevan Brittan will present to the Board in private session the detail of the proposed arrangements and address any specific questions the Board may have.

2.13 In the ITPD the Trust reserves the right to vary the selection procedure and cancel the procurement at any point. The ITPD also makes it clear that the entering into the SEP contractual arrangements will be subject to Trust Board approval.

2.14 Please refer to Appendix 1 for a flow diagram setting out the process outlined above.

3 OVERVIEW OF ROLES, RESPONSIBILITIES AND OBLIGATIONS

3.1 The role of the SEP will be to work alongside the Trust to: support the development and delivery of each of its estate strategy in line with the Trusts' current and future clinical strategy; optimise estate costs; maximise the value of the estate and drive efficiency in the Trusts' operations including potentially through (but not limited to): implementation of the Trusts' estate strategy; estates rationalisation; capital programme planning; master-planning; raising finance and investment; strategic service transformation planning; and also the procurement and project/contract management of a range of services in relation to New Projects and Secondary Services (as defined below).

3.2 Please refer to Appendix 2 for a diagram setting out the proposed structure for the SEP and the roles of the respective parties within that structure.

3.3 The structure proposed is that the Trust (and separately WUTH) will enter into a Partnering Agreement with the Partner (the same Partner, jointly procured) to establish the SEP. The Partner and each Trust will also each incorporate a limited liability partnership, which will be owned 50% by each Trust and 50% by the Partner ("**JV LLP"**). The SEP will be governed by an LLP Agreement entered into between the JVLLP, Trust and Partner. The key provisions (including the obligations and rights of each party) of the Partnering Agreement and LLP Agreement are summarised in Volume 2 of the Invitation to Continue Dialogue procurement documentation. Any new capital projects to be delivered by each of the Trusts separately will be delivered through each respective Trust SEP. In respect of any joint capital projects, it is proposed that a separate Project Co/LLP will be created at the relevant point in time, owned 50% by the Partner and 25% each by CoCH and WUTH (**Joint SEP**).

3.4 Each Trust SEP will be for a term of 10 years with an option for each Trust to extend it by a further 5 years. However, the partnering activities may give rise to New Projects or other estate solutions that last beyond the term of the 10 - 15 year partnership. The parties' respective obligations in relation to any such activities would be set out in the arrangements for those particular New Projects.

3.5 Each Trust SEP and the parties' specific responsibilities will be governed by a Partnership Plan. As part of the procurement bidders will be required to submit Initial Partnership Plans for each Trust SEP, exploring also potentially any joint opportunities. The Initial Partnership Plans shall become the overarching plans adopted by the Trust SEPs setting out the proposals for transforming the Trusts' estates over the short medium and long term.

3.6 Proposed **New Projects** (relating to the Trust SEP or the joint activities for both Trusts) as defined in each draft Trust SEP Partnering Agreement (which could include new build or refurbishment schemes, land development/disposal and income generation schemes) will be required to be approved through a New Projects Approval Procedure (**NPAP**) which is set out in the Partnering Agreement before such New Project can be delivered. The NPAP is summarised by the flowchart contained in the note at Appendix 3 below.

3.7 It will be part of the SEP's role (individually or jointly) to develop New Projects. The resource, risk and responsibility taken on by each party in respect of any New Project will be agreed by the Trust and Partner as part of the initial stages of the NPAP. It will not be part of the role of either the Partner or the SEP to actually deliver the construction works or FM Services that may be required to deliver a particular New Project. However, their role will instead be to 'integrate' a design, construction and FM services supply chain to deliver these elements of the New Project. Such supply chain will be required to be procured via a 'secondary' EU compliant tendering procedure by the Trust with adaptable assistance and support provided by the Partner through the SEP.

3.8 The Partner/SEP may also propose solutions in relation to service transformation. As with the construction and FM elements of New Projects, the Partner/SEP will not actually provide the Secondary Services itself but may put forward proposals to the Trusts to change the way Secondary Services are delivered and to provide strategic management and supply chain management, and may be required to support the Trusts in relation to procurement services (at the Trusts' request). Where a new supply chain is required to actually deliver the Secondary Services as part of a Partner/SEP's proposal on Secondary Services, such supply chain will be required to be procured by the Trusts via a 'secondary' EU compliant tendering procedure and the Partner, through the SEP, may be required to provide adaptable assistance and support to the Trusts in relation to any such procurements.

3.9 Proposals relating to non-clinical service transformation ("Secondary Services") will be required to be approved through a separate procedure that mirrors the NPAP process as set out in the note at Appendix 3.

3.10 The Partner/SEP role will therefore include the provision of operational project management services in providing procurement support to the Trust, co-ordinating and managing external contractors engaged to deliver any proposed and approved New Projects to deliver capital requirements and/or Secondary Services during the term of the partnership.

3.11 It should also be noted that:

3.11.1 the **Trusts do not grant any exclusive right** for the Partner or SEP to deliver any particular New Project or Secondary Service; and

3.11.2 the **Partner's role also includes an obligation to provide working capital** in order to resource the SEPs Although the SEP itself will be relatively lightly resourced the Partner will still need to ensure it has enough working capital and/ or provide such personnel as necessary to establish and run it. If further funding is required by the SEP or its subsidiaries, this will also be provided by either the Partner or (with the approval of the SEP Management Board) a third party Financial Institution. It is likely that any debt financing would be given directly to a project company where required. The funding requirements (and any working capital requirements) for each New Project (individual or joint projects) will be considered (at project level) on a case by case basis agreed by the Trust(s) through the NPAP.

In summary, the Trusts' key obligations are to:	In summary, the Partner's key obligations are to:
• ensure proper attendance at SEP Management Board meetings; • set priorities, agree outcomes • approve the initial (and updated) Partnership Business Plan for the SEP; • review and consider New Project proposals/non clinical service transformation proposals through the NPAP and NSSAP processes mentioned above and as set out in detail in the paper at Appendix 3.	• ensure proper attendance at SEP Management Board meetings; • set priorities, agree outcomes; • provide working capital; • deliver strategic and other services (as set out above) to identify solutions to drive value from the estate/maximise value (commercial and income generating); • identify the best source of finance and secure funding for the delivery of new projects/service transformation proposals; • manage the supply chain for delivery of projects.

4 DECISION MAKING

4.1 We have appended at Appendix 3, how the Trust will be able to influence the priorities for the SEP and make decisions once the SEP is established and also with a view to the final stage of dialogue and confirmation of the preferred bidder.

4.2 During operation of the partnership, the role of the Trust in decision making primarily focusses around the Management Board and the New Project Approval Procedure the arrangements for which are all set out in the Partnering Agreements which govern each of the SEPs.

4.3 Also included in the note in Appendix 3 is an explanation as to how the Trusts are able to influence decisions prior to establishment of their respective SEPs. For example: the approval of the Initial Partnership Plan, working capital requirements, resourcing the SEP and the "priorities". This is what much of the later stages of dialogue have focussed in readiness to establish the SEP and submission of Final Tenders – and in particular what the proposals will be for the first year.

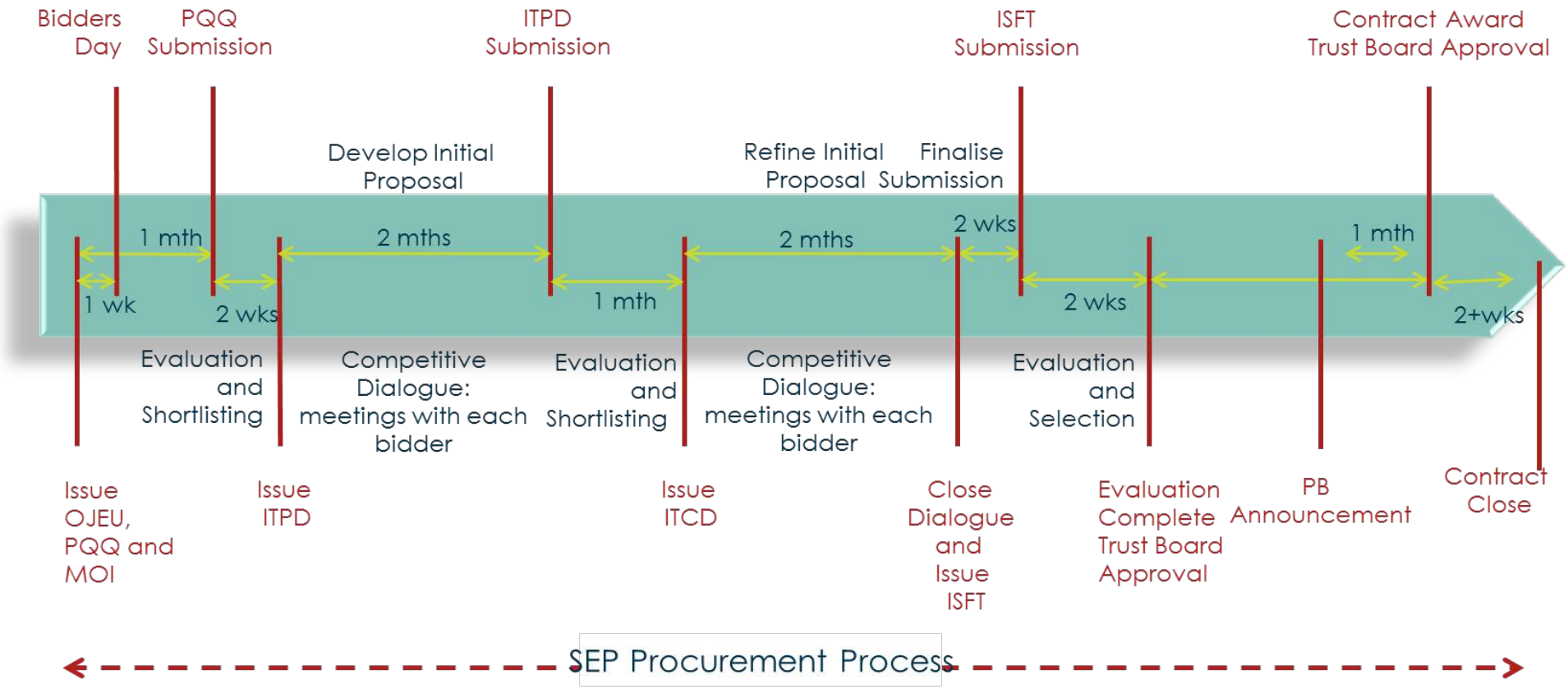
4.4 In addition to the formal Management Board arrangements both bidders envisage a "client informed group", which is more of the day to day group for the SEP/JV or Partner to "test" thinking and ideas. Whilst the Trusts will lead discussion and strategy through the Management Board meetings at the outset and delivery of the Initial Partnership Plan (agreed at close), the client informed group (which could be an individual leading or more of a group – as you would individually see most appropriate) would be helpful to consider on a day to day basis and for operation.

March 2017

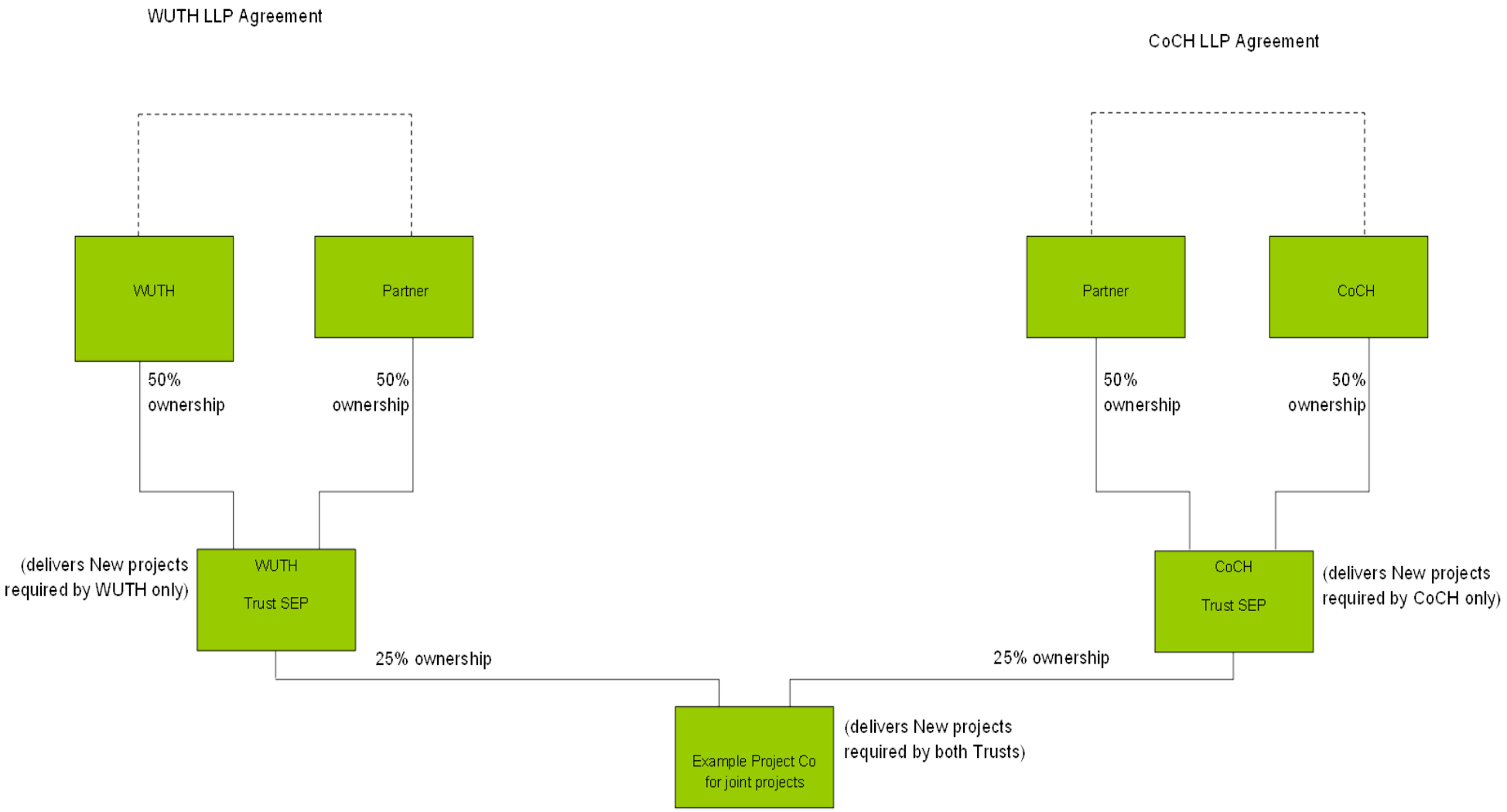
Bevan Brittan LLP

APPENDIX 1 – KEY STAGES FLOW DIAGRAM

Strategic Estates Partnership Tender Process



APPENDIX 2 – ROLES OF THE PARTIES



APPENDIX 3 - DECISION MAKING SUMMARY

DECISION MAKING DURING PROCUREMENT

During the procurement process, the Trust has met with bidders in a number of dialogue sessions. The following matters have been considered during dialogue, which will shape the way in which the SEP is run and the relationship between the Partner (i.e. the preferred bidder) and Trust as joint venture partners of the SEP.

1 PARTNERSHIP PLAN

The SEP will be governed, not only by the 'LLP Agreement' and 'Partnering Agreement', but also by a 'Partnership Plan'. The business of the SEP must always be run in accordance with the Partnership Plan. Each plan will cover the next three accounting years of the SEP and will be updated annually. It will be drafted by the management board of the SEP and approved by the Trust and Partner either directly or by delegation through the Management Board. The first Partnership Plan (the 'Initial Partnership Plan', which will be appended to each of the Partnering Agreement and the LLP Agreement) will either be adopted at completion of the SEP or within 60 days of completion. The Partnership Plan will be drafted by the bidders and tested by the bidders and Trust during procurement. This will enable the Trust to understand the bidder's proposals as to how the business of the SEP will be run (i.e. how it will be managed and what it will achieve by way of new projects and secondary services) and what resources and profits the SEP is likely to make in the first three accounting years. It should be split into short, medium and long term priorities and as a minimum include the following matters:

(a) **phasing plan** - the Partnership Plan should set out a Phasing Plan, broken down into the short term (0-3 years), medium term (3-5 years) and long term (5-15 years). This sets out the proposed activities of the SEP and will identify the estate solutions proposed taking into account the Trust's requirements and priorities. For the Initial Partnership Plan, this will also reflect the tasks that the Partner proposes to complete in the first year, an evaluation question set for bidders during the procurement. This will give the Trust insight into how quickly the bidder is likely to move during the first year and whether they have the capacity and capability to set up a strong management structure and deliver new projects at pace;

(b) **working capital** – the Partnership Plan should detail how the Partner and Trust propose to fund the SEP and how working capital is to be repaid. Please see the working capital section below for more details. The Partnership Plan should outline exactly what working capital is required and the reasons why. This will enable the Trust to see whether the Partner is envisaging providing most of the funding itself or whether it is more likely to want to obtain third party funding. It will also set out the likely rates of funding available. The LLP Agreement envisages funding to either be provided by the Partner or by third party funders, subject to obtaining the prior written consent of the Trust and partner at all times (as set out in clause 8 of the LLP Agreement);

(c) **priority projects** – the bidders will be expected to consider the Trust's priority projects and the best ways of structuring these both from a financial and estates strategy perspective. The Partnership Plan should then outline when these priority projects are to be completed (short, medium or long term), how they are to be funded and resourced and the projected profits resulting from each project. This will give the Trust a clear indication as to the capacity and capability of each bidder and the direction of the SEP going forward; and

(d) **resourcing** – see resources section below. The Partnership Plan will need to outline the resources to be provided to the SEP from the Trust/partner in order to enable the SEP to be run. It will also need to outline the cost of the resources and how those costs are met. Each bidder will have differing opinions on how much resource the SEP requires, for example some bidders may want to run the SEP as a thin JV with only few resources being transferred into the SEP and all other resources being licensed in e.g. seconding employees, resources provided through management services agreements. Other bidders may want to run the SEP as a thick JV and as

such may want the SEP to recruit employees and purchase resources directly. We would expect most SEPs initial to be a thin JV, to keep the running costs of the SEP low.

2 PHASING PLAN

The Partner will be expected to draft a Phasing Plan which will outline what the Partner proposes to do in the first year, for approval by the Trust. This is likely to include work on items such as priority projects as well as initial general management matters. This will be considered and drafted for the Trust's review during procurement. The Trust then has an opportunity to provide feedback to the bidder during procurement on any changes it would like to see to the plan. Although the Partnership Agreement (clause 5A) requires agreement from the Trust and the Partner as to the content of the Partnership Plans (including the Initial Partnership Plan) such plans are adopted through the LLP Agreement.

3 FEE METHODOLOGIES

The Fee Methodology (Schedule 5 of the Partnering Agreement) will be negotiated during procurement by the Trust and bidders and on completion will contain a range of ways in which the Partner can be paid by the SEP for its services. This acts as a menu of options for the Trust. When the SEP then requests services from the Partner, the SEP and the Trust will negotiate with the Partner as to how it will be paid based on the menu of choices. This will provide the Trust with a clear idea as to the profits the SEP is likely to make and therefore the returns the Partner and Trust will take. The expectation is that the Schedule 5 (Fee Methodologies) will form the basis for all future New Projects and Secondary Services, proposals for which will be developed through the New Project Approval Procedure ("**NPAP**") and New Secondary Services Approval Procedure ("**NSSAP**") respectively and approved by the Trust. Such fee methodologies should apply to all future New Projects and Secondary Services whether undertaken for one of the Trusts or as a joint project. It is expected that the bidder will submit the same fee methodologies for each of the two SEPs so there should not be any conflict in flowing this down into joint projects.

4 WORKING CAPITAL

The working capital requirements to be provided to the SEP during the SEP's lifetime to enable the SEP to be run according to the Partnering Agreement, LLP Agreement and Partnership Plan is tested during procurement. During the procurement process, the bidder and Trust will also consider and test the ways in which working capital will be repaid. The LLP Agreement (specifically clause 8.6) is drafted on the basis that either the Partner will provide funding to the SEP (by way of debt funding so as not to change the 50/50 relationship of the Partner and Trust) or a third party financial institution will provide debt funding to the SEP. The Partner is likely to propose that it is repaid from successful projects, i.e. that any debt outstanding (payable by the SEP) is set off from any profits of the SEP accrued from successful projects. During the procurement, bidders will be asked to submit any working capital loan agreements proposed for the SEP. Dialogue meetings with bidders to date indicate that there may be a range of proposals for the Trust to consider in relation to the Partner's repayment. The Initial Partnership Plan will also incorporate further details of the initial working capital for the SEP. Schedule 5 (Fee Methodology) will (as highlighted above) set out how the Partner will be paid for delivering services and this will include reference to any margins to be applied to the delivery of successful New Projects to repay working capital.

5 RESOURCES

The resources to be provided by the Partner and Trust (if the Trust wishes to provide any) to the SEP are tested during procurement. Once agreed, these are documented in management services agreements entered into between the Partner/Trust and SEP in the relevant form of agreement which will be set out at schedule 6 of the Partnering Agreement. The resources to be provided will also be detailed in the Partnership Plan, which will outline the way in which the SEP's business will be managed and resourced and the anticipated profits to be recovered from the SEP. The Trust may wish to provide resources to the SEP for example procurement, HR, administrative services. Alternatively it can choose not to provide any resources to the SEP.

Once the above matters are considered and a preferred bidder is chosen, the Partnering Agreement, LLP Agreement, management services agreements and Initial Partnership Plan can be agreed and completion can occur. Once the SEP is up and running the next stage is to approve new projects and secondary services (please see next section).

DECISION MAKING FOLLOWING ESTABLISHMENT OF THE SEP

1 MANAGEMENT BOARD

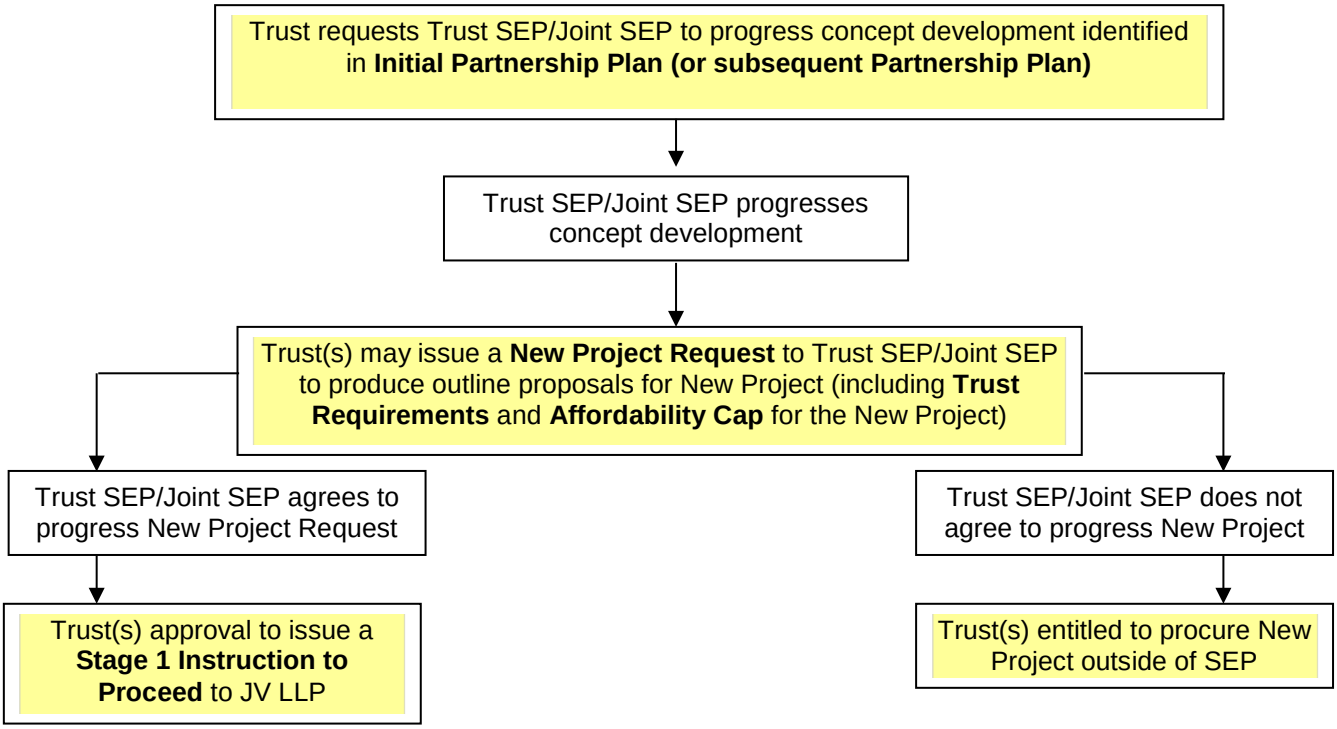
It is proposed that the Trust and Partner will enter into the SEP through the establishment of the LLP with 50:50 ownership (and governed by the LLP Agreement) and also entry into a 'Partnering Agreement'. The Partnering Agreement will be the main document governing the SEP and the relationship between the Trust and Partner and will set out how the SEP will be carried on and managed. Note that the LLP itself is bound by these terms of the Partnering Agreement as a party to it.

The actions of the LLP will be subject to the consent of both the Trust and Partner through their membership of and equal voting rights on the Management Board (see clauses 10 – 15 of the LLP Agreement). . Any direction and consent required from the Trust and Partner in relation to the carrying on of the LLP, decision making and all activities will be obtained from the Management Board.

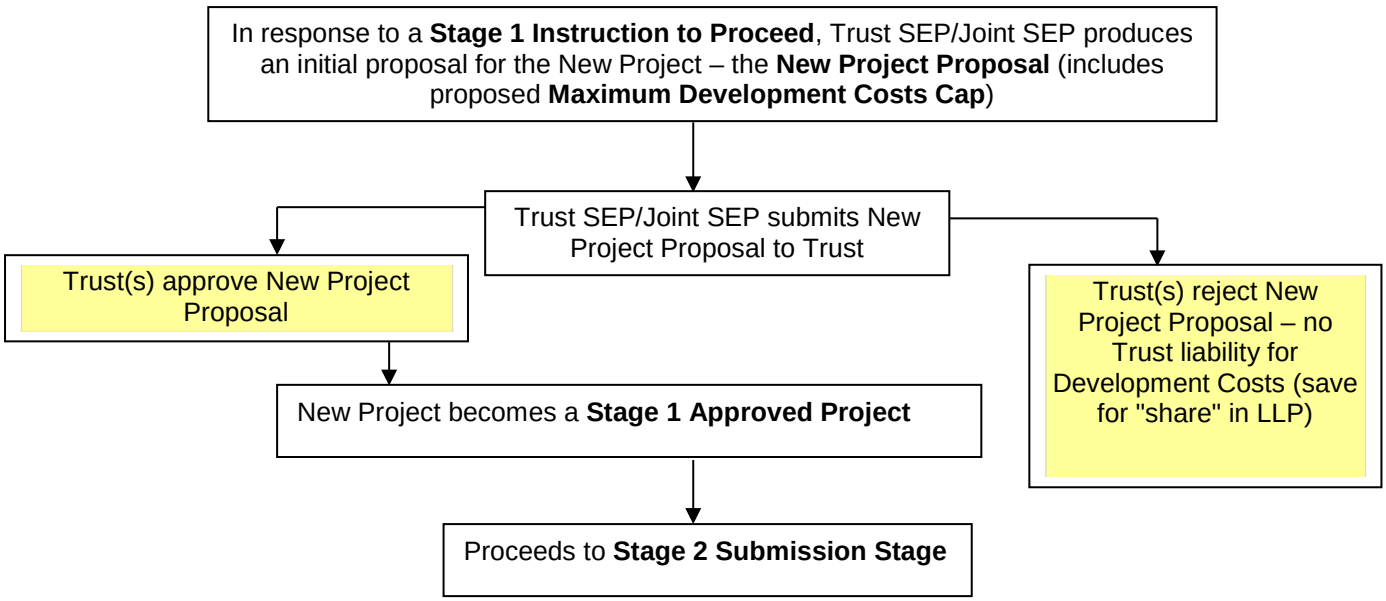
2 NEW PROJECTS

Once the SEP has been established, new projects and secondary services will be approved for development or commencement (as the case may be) through the respective New Projects Approval Procedure ("NPAP") and New Secondary Services Approvals Procedure ("NSSAP") processes found in Parts 1 and 2 respectively of schedule 2 to the Partnering Agreement. Both processes are largely the same and are detailed in the flowchart below. The processes are split into three stages; the concept stage, stage one and second stage. Please see a summary of the decision making required at each stage, below.

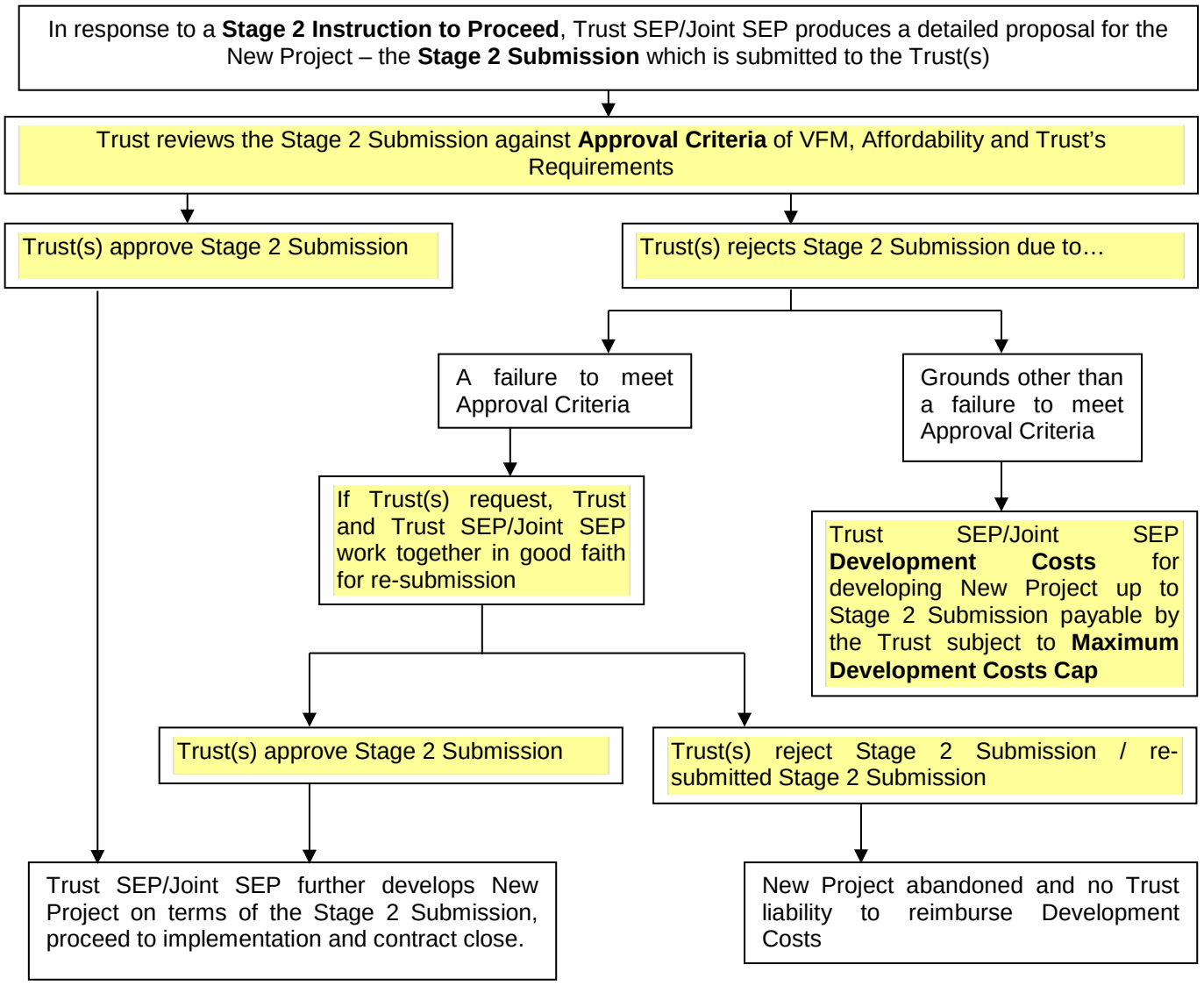
Concept Stage



Stage 1 Approval



Stage 2 Approval



Concept stage

The Trust must identify what new projects or secondary services it wants to process and these are then included in the Partnership Plan (see paragraph 2 in each of Parts 1 and 2 of schedule 2 to the Partnering Agreement and also see above on Page 1 of this note regarding details of the Partnership Plan). Once these are decided, the Trust invites the SEP (being its Trust SEP or the joint SEP) to begin the concept stage of each new project or secondary service. It may be that the Trust(s) knows exactly what it wants to do by way of new projects. However the Partner is there to also suggest secondary services that could produce efficiencies and new projects that could better the Trusts' estate strategy. It is important that the Trust board(s) support the proposed new projects and secondary services and this should be achieved through the involvement of the Trust(s) in the process of approval and development of the Partnership Plan.

Once the new projects and secondary services are identified, the concept stage commences. The concept stage involves the Trust SEP/ Joint SEP outlining the structure and details of the new project/secondary service, including confirming the outputs and benefits to the Trust(s), an estimate of costs and details of implications for potential estate and facilities management issues following practical completion of the development works. The concept stage is at the risk of the Partner and so if the new project or secondary service does not reach second stage, the Partner picks up the costs of processing the concept stage.

During this stage, the Trust and the Trust SEP/ Joint SEP will agree a set of Trust(s) requirements which the SEP must meet in developing the concept stage, including indicative development costs of developing the new project proposal to stage 1 approval, the source of funding and proposed resourcing for the development of the new project and an indicative timetable for the whole NPAP (or NSSAP). If the Trust agrees the Trust requirements with the SEP, the new project proceeds to stage one approval. If the Trust and SEP cannot agree on these Trust requirements, the Trust(s) is entitled to procure someone else to provide the new project and does not owe any money to the Partner or SEP for costs incurred during the concept stage. Therefore the Trust has the benefit that it can request the Partner to develop a new project or secondary service up to concept stage or allow the Partner to do so on request of the Partner, without incurring any liability.

Stage one

Once the new project or secondary service has stage one approval, the SEP submits a new project proposal which includes a full description of the new project, including evidence of meeting the Trust's requirements as detailed in paragraph 5.3 of schedule 2 of the Partnering Agreement. The Trust(s) must then consider this proposal. If the Trust(s) accepts the proposal, it will progress to stage two. If the proposal is rejected, it can either be submitted again with amendments or it can be rejected entirely. Any costs incurred during stage one are the liability of the SEP and not the Trust or partner. Therefore these costs will sit on the books of the LLP and will either be set off from profits incurred by the SEP at a later date or if the SEP is wound up will be processed as part of the winding up of the SEP.

Stage two

Once the new project or secondary service has stage two approval, the SEP must develop the proposal into a stage two submission. This submission should again be in full form and outline the matters detailed in paragraph 6.4 of schedule 2 of the Partnering Agreement. The Trust(s) must then consider this further proposal. The Trust can then either approval the proposal, reject it because it does not meet the Approval Criteria (as detailed in paragraph 6 of schedule 2 of the Partnering Agreement) or reject it for other reasons. If the Trust rejects the proposal because it does not meet the Approval Criteria, it can either decide not to proceed with the proposal (in which case the Trust has no obligation to reimburse the SEP for any development costs) or work with the SEP to address the reasons for failure. If the Trust rejects the proposal for any other reason, it must reimburse the SEP for all development costs up to the maximum development costs agreed with the Partner.

The Trust therefore has the opportunity to consider a new project or secondary service and to develop that through concept stage without incurring any liability in terms of development costs. This will evidence to the Trust the merit of the new project or secondary service. If the Trust rejects a stage one approval for any reason or a stage two approval because the Approval Criteria were not met, the development costs are the liability of the SEP and therefore the SEP will pay the Partner for any development costs it incurs. If the Partner has provided any lending, although it may not request a parent company guarantee, on a winding up

of the SEP, if the Partner funding has been used to pay for the development costs, any assets transferred into the SEP will be used to set-off the debt owed to the Partner. Alternatively if the development costs are merely sitting as a debt in the SEP's accounts, they will be off-set from any profits the SEP makes before profits can be distributed to the Trust and Partner.