Countess of Chester Hospital
NHS Foundation Trust

BOARD OF DIRECTORS AGENDA AND PAPERS

TUESDAY, 22ND MAY 2018

NHS
Countess of Chester Hospital
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS (PUBLIC)
TUESDAY, 22ND MAY 2018 AT 1.00PM – 3.00PM

LECTURE HALL

A G E N D A

FORMAL BUSINESS

1.	Welcome and Apologies	Chair
2.	Declarations of Interest	Chair
3.	To receive and approve the Board of Directors minutes of meeting held on 13th March 2018 and matters arising **(Attached)**	Chair

QUALITY & ASSURANCE

4.	To receive and approve the Annual Report & Accounts 2017/18 to include: • Annual Accounts 2017/18 • ISA260 Audit Highlights Memorandum • Management Representation Letter (to follow) • Annual Report 2017/18 and Annual Governance Statement • Quality Accounts 2017/18 and Limited Assurance Audit Opinion • External Assurance on the Quality Accounts 2017/18 • Management Representation Letter **(Attached – sent under separate email)**	Chief Executive Chair of Audit Committee Chief Finance Officer
5.	To review the Integrated Performance Report as at Month 12 to include: • Capital Programme **(Attached)**	Executive Team
6.	To receive an update on Freedom to Speak Up **(Attached)**	Director of Nursing & Quality/ Director of Corporate & Legal Services / Director of People & Organisational Development
7.	To receive details on the progress of the Learning from Deaths Policy **(Attached)**	Medical Director/Deputy Chief Executive
8.	To receive an update on Data Security and Protection Requirements (DSPR) **(Attached)**	Chief Finance Officer

9.	To receive an update on the Board Assurance Framework **(Presentation)**	Director of Nursing and Quality
10.	To receive an update on the work undertaken in preparation for the General Data Protection Regulation (GDPR) **(Attached)**	Director of Corporate & Legal Services
11.	To receive an update on Never Events and Serious Untoward Incidents **(Verbal)**	Director of Nursing and Quality

STRATEGIC DEVELOPMENT

12.	To receive a CEO Update **(Verbal)** to include: Sexual Health Tender Update Health Catalyst	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 CNST Maternity Standards	Director of Nursing & Quality
15.	To receive and approve the Costing Process & System Approval	Chief Finance Officer
16.	To receive the Month 11 and Month 12 letter to NHS Improvement	Chief Finance Officer
17.	To receive the Safeguarding Adults Report 2016-2017	Director of Nursing & Quality
18.	To receive the Safeguarding Children Report 2016-2017	Director of Nursing & Quality
19.	To receive the minutes of the Audit Committee – 20th November 2017	Chief Finance Officer
20.	To receive the minutes of the Quality, Safety and Patient Experience Committee – 20th February 2018, 20th March 2018 and 17th April 2018	Director of Nursing & Quality
21.	To receive the minutes of the Finance and Integrated Governance Committee – 20th February 2018	Chief Executive
22.	To receive the minutes of the People and Organisational Development Committee – 28th November 2017 and 27th March 2018	Director of People & Organisational Development

23. To receive the minutes of the Charitable Funds Committee – 24th October 2017 Chief Finance Officer

24. Date and Time of Next Meeting:
Board of Directors Meeting
24th July 2018 – time and venue to be confirmed

BOARD OF DIRECTORS (PUBILC)

MINUTES OF THE MEETING HELD ON TUESDAY, 13TH MARCH 2018 AT 1.00PM
RETRO CAFE

		Attendance	
Chair	Sir D Nichol	☑	
Non Executive Director	Mr A Higgins	☑	
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		☒
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	☑	
Chief Operating Officer	Ms L Burnett	☑	

In attendance:

Mrs C Raggett – Secretary to the Board
Dr D Kilroy - Divisional Medical Director (Planned Care and Clinical Variation)
Ms M Whelan - Widening Participation and Apprenticeship Lead
Ms L McGonigle - Admin Apprentice

FORMAL BUSINESS

B01/18 **WELCOME AND APOLOGIES**

Sir Duncan welcomed all attendees to the Board meeting and in particular Dr Kilroy who was representing Mr Harvey, Medical Director.

Apologies were received from Mr Harvey.

B02/18 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

B03/18 **TO RECEIVE AND APPROVE THE BOARD OF DIRECTORS MINUTES OF MEETING HELD ON 5TH DECEMBER 2017 AND MATTERS ARISING**

The Board of Directors minutes of the meeting held on 5th December 2017 were received as a true and accurate record.

MATTERS ARISING

There were no matters arising.

QUALITY ASSURANCE

B04/18 **TO RECEIVE A STAFF STORY ON APPRENTICESHIPS**

Mrs Hodkinson introduced Ms Whelan, Widening Participation and Apprenticeship Lead and Ms McGonigle who is an admin apprentice at the Trust and had recently won an Apprenticeship Award at the Trust.

Ms McGonigle gave a presentation on her excellent experience of being an apprentice at the Trust. Ms McGonigle now has a permanent role within the Urgent Care division.

Mrs Hodkinson thanked Ms Whelan and Ms McGonigle on the presentation.

B05/18 **TO REVIEW THE INTEGRATED PERFORMANCE AS AT MONTH 10 TO INCLUDE A FINANCIAL UPDATE FOR MONTH 11**

The Board received details on the key issues within the integrated performance and finance report as at Month 10 and the following points were raised:

Performance

- Ms Burnett stated that there had been 25 cases of C. Difficile which was over trajectory. This was partly due to the flu epidemic which means an increase in the use of antibiotics.
- Mrs Kelly reported that there had been 4 falls with harm during month 10. There was a detailed quality improvement plan underway to support the work around falls across the Trust.
- Mrs Kelly referred to the sepsis screening performance. Performance has dropped due to the review of processes being undertaken. This is improving although further work on antibiotic treatment is needed.
- Mrs Kelly reported there had been 80 cases of mixed sex accommodation during January 2018. These were due to the NHSI/NHSE directive around the Trust to support operational pressures and step back from compliance during the very busy winter period. Mrs Kelly was pleased to report that the Trust was reverting back to normal.
- Ms Burnett stated that the new CQUIN offering advice and guidance is a new process and

that a detailed explanation would be given to the Board in July 2018.

- Ms Burnett reported that the operational targets performance reflected the pressure the Trust is under. There is pressure in endoscopy and also radiology from urgent care needing immediate diagnostics.
- Ms Burnett stated that the Trust has not been able to do full elective work since mid-December. The Trust has not been able to create the bed capacity and actions have been taken over and above escalation including using the day case surgical unit as a medical ward. The Trust is not alone as Trusts across the region have also agreed some extra-ordinary measures.
- Ms Burnett stated that the 18 week RTT target performance will decline due to the stepping down of the elective programme. The Trust has been concentrating on urgent and cancer patients. This has had a knock on effect for patients on the routine elective list. There is concern about repeated cancellations and the impact this has on the patient experience.
- Mrs Hodkinson reported that the people indicators are red which is reflective of the pressures on the organisation.
- Mrs Hodkinson stated that the Trust has had a fantastic flu vaccination campaign with over 82% of front line staff being vaccinated. However, there had been an increase in the sickness rate in January 2018. The Trust is performing significantly better in terms of sickness rates compared to the other Trusts in the region.
- Mrs Hodkinson reported that to support additional clinics and ensure the right balance of staff for patient safety, there has been a 22% increase in variable pay. The Trust is still positive that it will achieve the agency pay gap. Mr Oliver has attended a workshop on variable pay and a second workshop is scheduled and the Quality Improvement team will be attending. There are a number of key actions and Dr Kilroy will be key part of this significant piece of work.
- Ms Burnett stated that the Trust been running with 70 additional beds.
- Ms Burnett wanted to recognise the work of the Care of the Elderly Clinicians who are also managing beds at Pinetum and Upton Dene nursing homes.
- Dr Kilroy added that this was very positive and that the clinical collaboration was second to none and the collective effort was phenomenal. Dr Kilroy acknowledged that the patient experience may not be ideal however the Trust remains a high quality medically sound place to be a patient.

Mrs Fallon referred to the falling appraisal rates and asked what plans were in place to address this issue. Mrs Hodkinson replied that there were two parts to the plan, one is refocussing divisions on undertaking appraisals during the operational pressures and the other part is around the high performance workshops. These conversations are taking place through the People and Organisational Development Committee.

Mrs Fallon referred to the 6 week diagnostics and 18 week RTT targets and suggested that it may be helpful to articulate the actions being taken against the trajectory. Ms Burnett replied that the planning guidance has said to maintain the waiting list position. The Trust recognises that certain specialities were affected more than others and the Trust is working with commissioners on this issue. Ms Burnett added that there has been a rise in demand for 6 week diagnostics with staff leaving in Endoscopy and the Trust asking to focus on cancer patients.

Mrs Hopwood referred to the exception report and the risk projection detailed in the performance

report. The A&E 4 hours target is green for Q4 however Mrs Hopwood could not see any actions that would get the target back on track. Ms Burnett replied that there were a lot of actions put in place with the challenge being to get the target green. However, due to the operational pressures this would not happen. This will continue to be the challenge for the February 2018 performance report.

Sir Duncan stated that he could see the actions being taken but that it was difficult to understand the mismatch of the actions and the results. Ms Burnett replied that is was balance for targets and performance. In order to improve the A&E position, the Trust needs lower bed occupancy, community beds and a reduction in delayed transfers of care (DTOCs). However, the Trust has seen a rise in demand and increased pressures due to flu which has impacted the Trust's ability to deliver the A&E 4 hour target.

Mr Chambers added that the performance report would be refreshed for 2018/19 which will include a forecast and a re-adjusted forecast. Mrs Hopwood concurred with Mr Chambers' suggestion and that the forecast should be a reflection of where the performance will land and also include where the risks are. Ms Burnett added that the new performance report would be used from Quarter 1.

FINANCE

Mr Holden outlined the Trust's financial position as at month 11 and highlighted the follow points:

- Mr Holden stated that the Trust has £178k favourable variance at month 11 before any fines and other charges.
- Mr Holden reported that contract income was below target with Wales due to the mix of patients, too many non-elective and not enough planned elective patients.
- The Trust has enough contingency in place to be able to achieve the year end control total. The Trust would then qualify for a bonus from NHSi. However, the Trust cannot continue to use reserves to achieve the year end position.
- The CRS has delivered 80% of £11.5m however only 61% of this recurrent savings.
- With regards to the invoices to Cheshire West and Chester Council (CWAC) for DTOCS. Mr Chambers and Mr Holden have been discussing this matter with CWAC and are hopefull that there is a short term resolution for this year.
- The Trust received £1.7m winter monies during 2017/18 however the Trust has to achieve the A&E 4 hour target to get these funds. NHSi have not enforced any actions as yet to Trusts that did not achieve the A+E target.

Mrs Hopwood asked about the progress of conversations with Wales. Mr Holden replied that Wales have stated that they want similar activity levels to 2017/18 with the option of 1000 orthopaedic procedures over the next 3 years. The Trust is working with divisions as to how capacity for this could be made available during a time when the hospital is under pressures for beds, non-elective work and staffing. These conversations are continuing and are subject to approval by the Welsh Government.

The Integrated Performance Report for Month 10 and the financial update for Month 11 were received and noted by the Board.

B06/18 **TO RECEIVE THE NURSING AND MIDWIFERY ANNUAL STAFFING REVIEW**

Mrs Kelly gave a detailed overview of the Nursing and Midwifery annual staffing review which reflected the extremely challenging year in terms of workforce. Mrs Kelly and her teams discuss safely staffing wards and departments on a daily basis, there is flexibility for staffing and a multi-disciplinary workforce model. However, the trust cannot look at staffing in isolation but alongside quality and safety.

Mrs Kelly gave details of the national staffing issues and the option of how to skill up nurses to support medical roles.

Mrs Kelly highlighted the following points:

- As of February 2018 the Trust has 70 WTE vacancies in Nursing and Midwifery.
- The Trust needs to recruit 15 nurses a month. There were 21 nurses at induction in March 2018 which is great.
- The use of bank staff has increased to support operational delivery. Mrs Kelly is working with Dr Kilroy on how to utilise the escalation areas in a better way.
- There is a rigorous sign off process for agency nurses.
- There has been an increase in the number of patients that require 1-1 nursing. Work is being undertaken around dementia patients and the possibility of volunteers to support the ward areas.
- E-Rostering has really progressed and the Trust can look at the data in a meaningful way.
- There is a gap analysis against the National Quality Board Standards. The Trust is red on 2 areas, one of which will be addressed by utilisation of the e-rostering data and work around increasing staff in one area and reduce in another to deploy staff more effectively.
- Care metrics are being broadly maintained and assurance is monitored monthly at the Nursing and Midwifery Board.
- A Trust wide recruitment and retention group is to be established.

Mrs Kelly stated that the Trust has had challenges but there has not been a significant dip in quality and safety which is a testament to the hard work of the staff.

Mrs Kelly added that there were very similar themes for midwifery staffing. The Trust is now utilising the national birth rate plus system and an exercise is being undertaken around this. There has been a reduction in maternity activity but an increase in complexity; this will be fed into the wider Women and Children's strategic plan.

Mr Higgins asked about the care hours per patient per day on the adult acute wards and if there was further opportunity to get more data from e-rostering and the safe care tool to support the divisions. Mrs Kelly replied that the information already available was proving very useful. The Trust is an outlier for maternity leave with some areas having a third of staff on maternity leave. This has a massive impact on staffing, if the Trust then includes sickness and special leave this does put pressure on the teams. The teams can now access the data for each ward and department and measure the information against the monthly KPis.

In response to a question from Mr Higgins, Mrs Kelly stated that the maternity service had a 6 WTE

shortfall however this would be reviewed now that the Trust has birth rate plus which will give more meaningful information.

Mrs Hodkinson added that the care hours per day were impacted by the escalation areas being open.

Mr Chambers asked about the potential 61 nurses who have expressed an interest in coming to join the Countess. Mrs Kelly replied that there was a mix of newly qualified and qualified nurses from all over the country. The Trust has also made a recruitment video which has been branded by the Communications Team and clearly shows the positive culture at the Countess.

B07/18 **TO RECEIVE AN UPDATE ON CANCER 62 DAY PERFORMANCE**

Ms Burnett presented the paper on cancer 62 day performance, the key areas of concern are urology, upper G.I and colorectal. There has been a 91 increase in the number of patients referred from GPS through the cancer pathway but who do not subsequently have a cancer diagnosis. The Trust have a limit of 22 breaches per quarter.

Ms Burnett added that waiting lists have grown and it has been difficult to get patients through for their diagnostics in a timely way, there have been issues in the endoscopy service, and referrals to tertiary centres need to be made by day 38 and so breaches can occur due to the tertiary centre but this delay is out of the Trust's control.

The Trust has a dedicated performance and management team who are working on reducing the time to the first appointment, eliminating admin days and ensure transfer out before 38 days where appropriate. There has been a recent reduction in the number of patients over 62 days and this will also help performance going forward. The team are expecting performance to drop further in February and March whilst actions are taken to clear those patients over 62 days, with improvement in performance during Q1.

Ms Burnett stated that the Trust is working with the Cancer Alliance live dashboard to monitor patients and identify where delays may occur. The Trust has invested in nursing posts ie. The Head and Neck cancer speciality. The Trust is also producing a patient information leaflet to explain why the patient has received the appointment and that they are on the cancer pathway. This will reduce the 'Did Not Attend' (DNA) rate and increase capacity. The clinical teams are engaged and want to improve performance for the benefits of the patient.

Sir Duncan acknowledged the work around the improved processes, the appointment of a new clinical lead with protected time, admin support and access to information not previously available and added that this portfolio should make demonstable progress.

B08/18 **TO RECEIVE DETAILS OF THE STAFF OPINION SURVEY 2017 RESULTS**

Mrs Hodkinson gave a detailed presentation on the results of the staff survey 2017 and highlighted the following points:

- The survey was undertaken in September 2017 - December 2017 which was a particularly

pressured time at the Trust and this is reflected in the survey results. This is reflected nationally as well.

- The response rate was 40% and the national average response rate for acute Trusts was 42%.

Mrs Hodkinson gave a detailed presentation on the results of the staff survey 2017 and stated that there are some areas where the score had reduced or increased; these included an increase in the number of staff experiencing bullying or harassment whilst the staff experience score has improved.

Mrs Hodkinson stated that staff survey results action plan and results will be monitored at the People and Organisational Development Committee (POD). Sir Duncan suggested that it would be helpful to see the actions alongside the survey findings.

B09/18 **TO RECEIVE THE TRUST'S GENDER PAY GAP REPORT**

Mrs Hodkinson gave an overview of the gender pay gap report which is to be submitted annually and will be accessible on the Trusts website. Gender pay is different to equal pay, the definition is the difference of women's and men's average salary earning expressed as % of men's salary.

Mrs Hodkinson reported that there is a gender pay gap at this moment In time however, the Trust will be broadly in line with its peers. Further analysis will be undertaken via the POD committee and an update provided to Board later in the year. There is a £5.42 per hour difference equating to 27.8%, there are also different elements in terms of bands of staff.

Mrs Hodkinson advised that there were no great concerns around the gaps as the Trust is not an outlier and there are a clear set of actions going forward with an annual update to Board.

Sir Duncan asked if the Trust has any equal pay issues. Mrs Hodkinson replied that she did not believe there was at this moment in time.

In response to a question from Sir Duncan, a discussion took place regarding the gender pay gap and links to the medical workforce strategy.

B10/18 **TO RECEIVE AN UPDATE ON THE BOARD ASSURANCE FRAMEWORK**

Mrs Kelly gave a detailed presentation on the current Board Assurance Framework (BAF) and stated that there were 3 risks which are rated as red.

Mrs Kelly reported that risks are reflective of the challenges around capacity and operating at 97% bed occupancy, the lack of social care and community provision to manage demand and workforce gaps.

Mrs Hodkinson stated that risk for failure to implement the people and Organisational Development Strategy and delivery plan was not just about nursing it is also about increased turnover, recruitment and retention issues.

Mrs Kelly reported that the risk for failure to achieve compliance targets are all interlinked.

Mrs Kelly added that MIAA had undertaken a review of the BAF and had provided positive assurance; the report will be shared with the Audit Committee.

Mrs Kelly stated that BAF will continue to be a focus at Board and at the Finance and Integrated Governance Committee meetings

B11/18 **TO RECEIVE AN UPDATE ON NEVER EVENTS AND SERIOUS UNTOWARD INCIDENTS**

Mrs Kelly reported that there had been no never events.

STRATEGIC DEVELOPMENT

B12/18 **TO RECEIVE A CEO UPDATE**

Mr Chambers gave an update and noted the following points:

- The 'One Show' has filmed at the Countess as part of the celebrations for the 70th anniversary. It was a very high profile event and the Trust was very proud to be chosen. Mr Chambers thanked all those involved.
- This year has been the worst season for flu for a number of years with high attendances breaking all records across the system.
- Mr Chambers also welcomed Dr Kilroy to the Board meeting.
- Mr Chambers advised the Board that Mr Harvey would be retiring in August 2018. Mr Harvey has been a consultant at the Countess for over 28 years.
- The recruitment process for the new medical director will commence in April 2018 and the Trust will take this opportunity to make connections vertically and horizontally to prepare for the future.
- The Trust is hoping to sign the contract for the replacement Electronic Patient Record (EPR) and Dr Sedgwick will be taking the lead on this project.
- Dr Frank Joseph will take on the role of Divisional Medical Director for urgent care and work alongside Dr Kilroy and Dr Fraser.
- Mr Holden has been substantively appointed as Chief Finance Officer.
- Dr Chatterjee and the stroke team have been approved as the first hub and spoke hyper acute stroke research unit with Walton which is a fantastic achievement.
- The Trust has welcomed 4 new physician associates, they will be in black scrubs and working in A&E and gastro services.
- The Trust has launched the Countess Gems along with a 'Thank You Wall' on the Trust's intranet page.
- The Trust held its Apprenticeship Awards, there were 5 categories including Apprentice of the Year.
- The catering team at the Countess take pride in what they do and they have been awarded a 5 star food hygiene rating for the 8th consecutive year.
- Helen Nowakowska, Business Performance Manager Outpatients Services has been awarded an unsung hero award.
- Mary O'Brian, a Countess midwife who was on the 'One Show' has been named the best

midwife in the North West and will go forward to represent the North West as part of the national awards.

B13/18 **TO RECEIVE AN UPDATE ON GOVERNOR MATTERS**

Mr Cross was pleased to see so many Governors attending the public Board and thanked them for their continued support.

Mr Cross stated the GovRounds to wards are being developed with training for the Governors being held in April 2018 with the first GovRound taking place in May 2018. He thanked Ms Kynaston, Associate Director, Corporate Nursing and Mr Folwell, Public governor for their work on this matter.

Mr Cross reported that the Trust is undertaking a procurement exercise for a provider for Governor elections.

Mr Cross added that there are a number of events planned throughout the year to celebrate the NHS 70th anniversary and further details will be shared in due course.

FOR NOTING & RECEIPT

B14/18 **TO RECEIVE AN UPDATE ON REFERENCE COSTS 2016/17**

The Board received and noted the update on reference costs 2016/17.

B15/18 **TO RECEIVE THE MONTH 9 AND MONTH 10 LETTERS TO NHS IMPROVEMENT**

The Board received and noted the month 9 and month 10 letters to NHS Improvement.

B16/18 **TO RECEIVE THE EQUALITY & DIVERSITY REPORT 2017-2018**

The Board received and noted the Equality & Diversity Report 2017-2018.

B17/18 **TO RECEIVE THE MINUTES OF THE QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE – 20TH NOVEMBER 2017**

The Board received and noted the minutes of the Quality, Safety and Patient Experience Committee – 20th November 2017. There were no meetings in December 2017 or January 2018.

B18/18 **TO RECEIVE DETAILS OF THE FREEDOM OF INFORMATION REQUESTS RECEIVED BY THE TRUST SEPTEMBER 2017 – JANUARY 2018**

The Board received and noted the details of the Freedom Of Information requests received by the Trust September 2017 – January 2018.

B19/18 **TO RECEIVE CORPORATE INFECTION PREVENTION AND CONTROL ASSURANCE – QUARTERLY REPORT (RETROSPECTIVE REPORT BASED UPON NOVEMBER 2017 QUARTERLY DATA UPDATE)**

The Board received and noted the Corporate Infection Prevention and Control Assurance – Quarterly Report (retrospective report based upon November 2017 quarterly data update).

B20/18 **DATE AND TIME OF NEXT MEETING**

Tuesday 22ND May 2018, 1.00pm in the Lecture Hall, Countess of Chester Hospital.

Countess of Chester Hospital NHS
NHS Foundation Trust

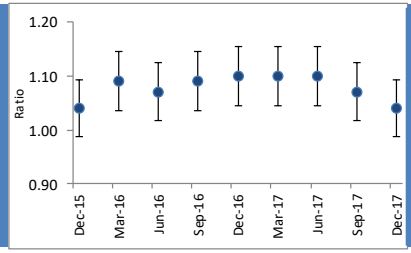
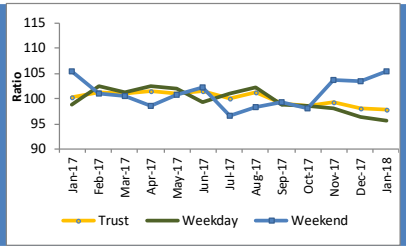
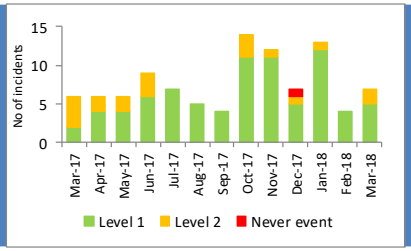
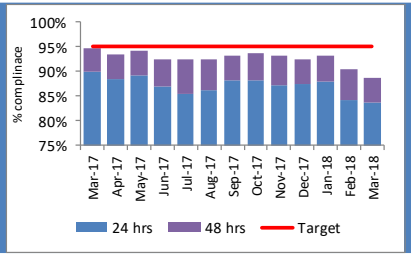
March 2018

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics March 2018

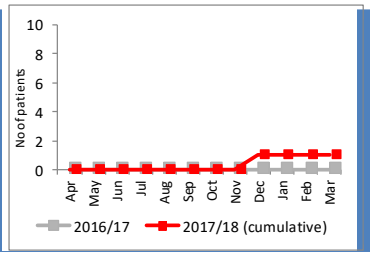
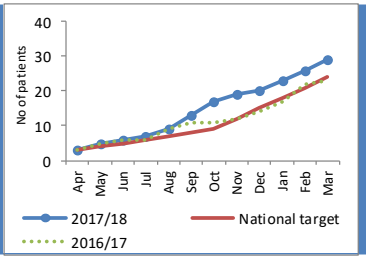
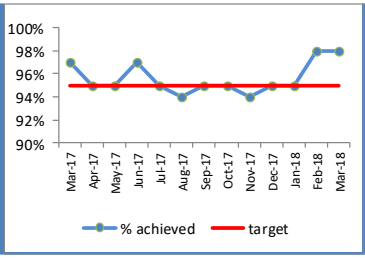
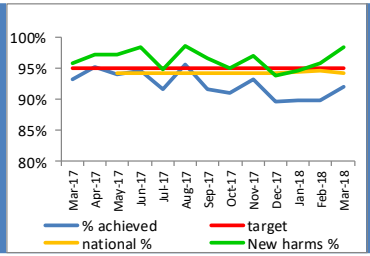
BAF ref: CR1, CR2, CR3, CR6, CR7, CR10

	Description	Current position/comments	Trend	Target
Mortality SHMI	Risk adjusted mortality ratio based on number of expected deaths. National published figure from HSCIC.	A mortality surveillance group is meeting to review cases. The group combines staff from the coding, clinical and Business Intelligence areas.		As expected - Blue Above expected - Red Below expected - Green
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 diagnosis groups that account for approximately 80% of our inpatients. A ratio above 100 suggests that more deaths occured then expected, while a ratio of less than 100 suggests fewer deaths occured than expected. The chart shows a rolling 13 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 5 incidents at level one in March. There were 2 level 2 incidents and no never events reported last month. The Risk and Quality team have launched "Key Safety message of the month" to ensure learning from incidents is shared widely across all multi professional teams.		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 e-discharge performance remained under target in March. An exception report on page 15 has been produced for this indicator.		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 March 2018

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

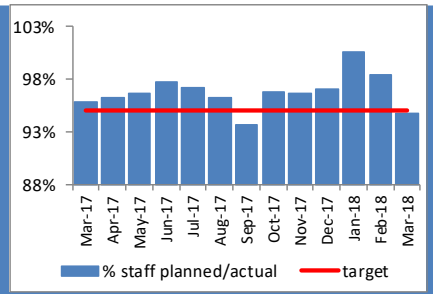
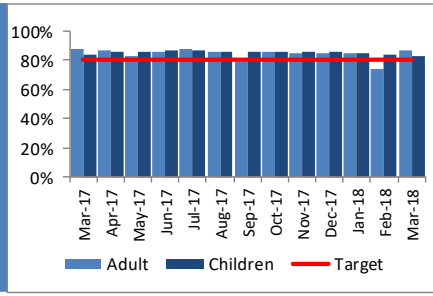
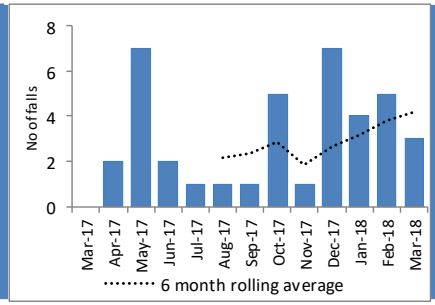
	Description	Current position/comments	Trend	Target
MRSA	Number of cases of hospital acquired MRSA bacteraemia (meticillin-resistant staphylococcus aureusis)	No further cases of post 48 hour MRSA were identified during March. One case for the year 2017/18.		Zero avoidable cases for the year
CDiff	Number of cases of Clostridium Difficile	The target for end of year is a maximum of 24 C Diff cases By the end of March we had confirmed 29 cases for the year to date against the trajectory of 24. An exception report is provided on page 16.		24 maximum annual cases
Hand hygiene	Based on ward based hand hygiene audits. Each ward is required to submit two audits each month	Hand Hygiene maintained a good level of performance in March, achieving 98%. Work continues to maintain and improve hand hygiene compliance in the Trust.		95% each month
Safety Thermometer	Tool to survey a snapshot of harm free patient care. Includes pressure ulcers, falls, catheters, UTIs and VTE	In March, the figure for patients free of new harms was 98.34%		Compare to National average Above average - Green Below average - red

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics March 2018

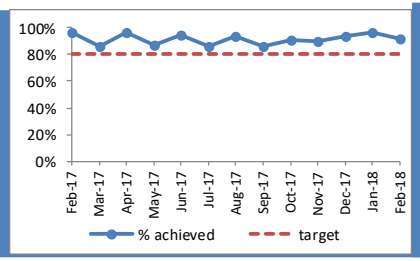
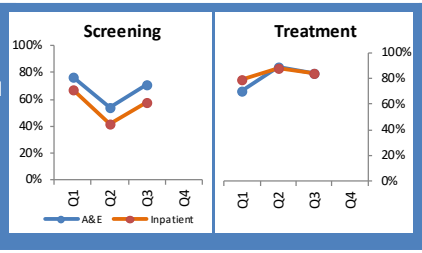
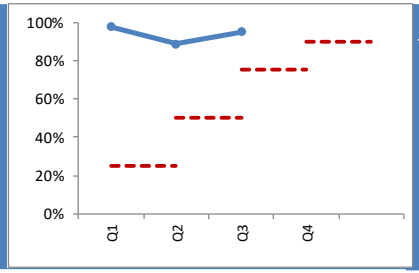
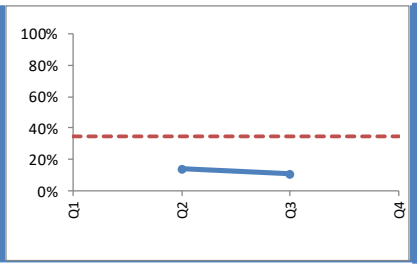
BAF ref: CR1, CR2, CR3, CR6, CR7, CR10

	Description	Current position/comments	Trend	Target
Safe Staffing	Actual staffing compared to planned for registered nurses/ midwives and care staff	The safe staffing rate was under the 95% target in March. See appendix 1 for the staffing and ward analysis report. An exception report is provided on page 17.		>95% per month
Safeguarding training	% of level 2 training undertaken to be split by training for Adults and Children	Adult safeguarding achieved the 80% target in March 2018. Child safeguarding training continues to perform above target.		>80% in month
Inpatient falls	Inpatient falls with moderate or above harm	There were 3 falls with moderate or above harm in March. This is an improvement on previous months. The Falls Prevention Programme continues to be rolled out with a strong focus on staff education and training. The falls target for 2018/19 is currently under review.		Trend line shows rolling 6month average

Are we effective?

Countess of Chester Hospital NHS Foundation Trust — Board Assurance metrics March 2018

BAF ref: CR3, CR7, CR10

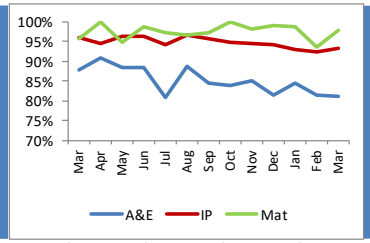
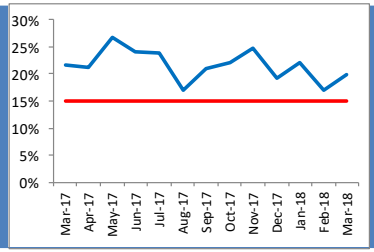
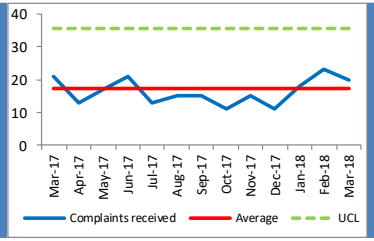
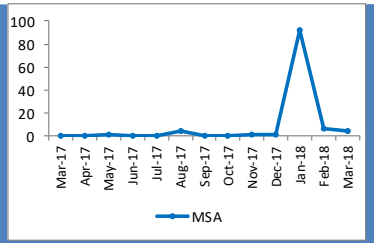
	Description	Current position/comments	13 month rolling trend	Target
Stroke	All Stroke patients who spend at least 90% of their time in hospital on a stroke unit	This indicator is reported one month in arrears. The target was met for the month of February with 91.7% achieved against a target of 80%.		>80% per month
Sepsis screening and treatment	CQUIN 2a/2b Timely identification and treatment of sepsis in ED and acute inpatient settings	Q3 performance data has now been submitted. Performance on screening has improved for A&E and Inpatients in Q3. An exception report has been created and can be seen on page 19		National CQUIN. 90% of pts with sepsis screened and received IVAB within 1 hour of diagnosis
Antibiotics review	CQUIN 2c Antibiotics review between 24-72 hours for patients with sepsis who are still an inpatient at 72 hours	Performance in Q3 was above the 75% target, with 37/39 prescriptions reviewed within the 24 hour target (94.9%).		National CQUIN. Target is 25% (Q1), 50% (Q2)
Offering advice and guidance	CQUIN 6 Percentage of GP referrals to elective outpatient specialties which provide A&G	Data collection process is underway for this CQUIN. Q3 results show that 3 specialties can provide advice and guidance and these specialties accounted for 11% of new, non-urgent GP referred appointments in Q3. An exception report has been created for this indicator and can be seen on page 20.		National CQUIN. Target of 35% of GP referrals providing advice and guidance by end of financial year

Are we caring?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics March 2018

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.	Feedback continues to achieve target. The % likely to recommend scores in March were: - Inpatients 93.2% - A&E 81.2% - Maternity 97.7%		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 March was 19.8%. and remains above the target figure.		>15% per month
Feedback	Monthly Trust complaints and formal thank you letters received by the Trust	In March 2018, the Trust received 20 new formal complaints.		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	There were 4 mixed sex accomodation breaches in March 2018.		Zero cases per month

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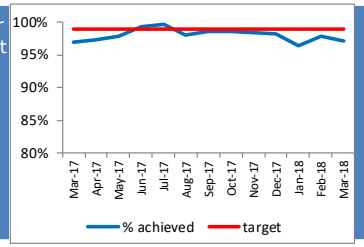
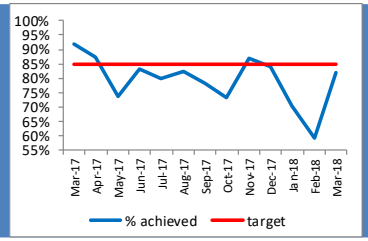
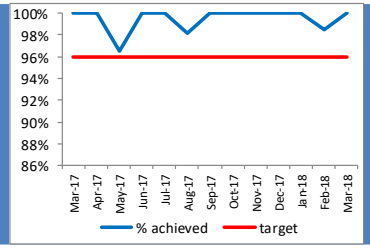
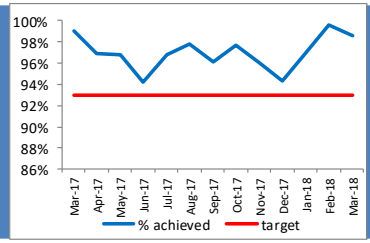
Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics March 2018

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

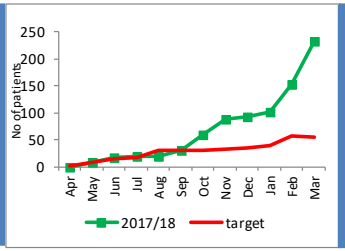
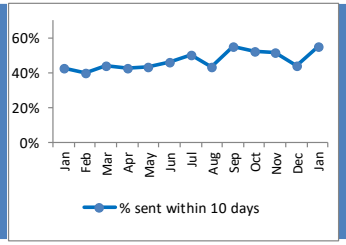
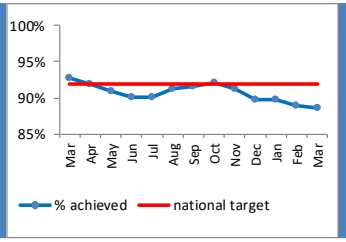
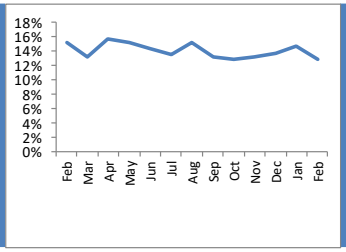
	Description	Current position/comments	13 month rolling trend	Target
Diagnostic 6 week standard	Diagnostic tests to be carried out within 6 weeks of request being received. This is measured on the National DM01 return.	The diagnostics figure remains under target at 97.1%. An exception report is provided on page 21.		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 62 Day provisional performance for March is a predicted underachievement of the standard. An exception report is provided on page 22.		85% per Quarter
Cancer 31 day standard	Patients receiving first definitive treatment within 1 month of cancer diagnosis. The threshold is 96%.	The provisional 31 day figure for March is above the 96% target.		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 the 2 week standard continues to exceed target.		93% per Quarter

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics March 2018

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

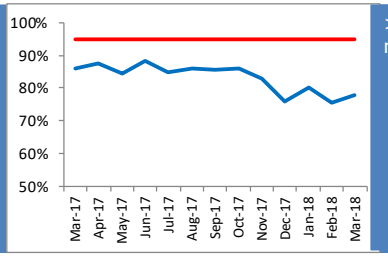
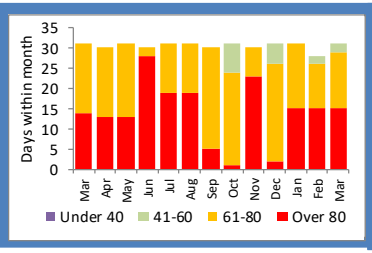
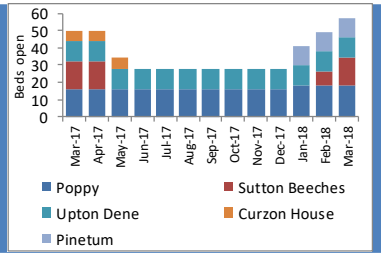
	Description	Current position/comments	Trend	Target
Cancellation due to no beds	Hospital cancellations due to no beds	There were 80 cancellations due to no beds in March. These figures do not include patients cancelled due to critical care beds which are tracked separately.		Internal target based on 2016/17 levels
Outpatient clinic letters	100% of outpatient clinic letters to be sent within 10 days	This data is always two months in arrears. Performance improved in January with 55.2% letters being sent within 10 days. An exception report can be seen on page 15.		Within 10 days from April 2017; Within 7 days from April 2018
RTT incomplete pathways	Percentage of incomplete pathways for English patients within 18 weeks. The threshold is 92%.	RTT incomplete performance has remained at 88.6% compared to the 92% target. The Trust continues to proactively manage all over 35 week waiters. An exception report has been created for this indicator on page 23.		92% per month
Readmission rate	Number of emergency readmissions within 28 days. Excludes patients with diagnosis of cancer, nephrology, obstetrics	This is currently reported one month in arrears to allow for the readmissions and subsequent coding.		No target agreed

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics March 2018

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

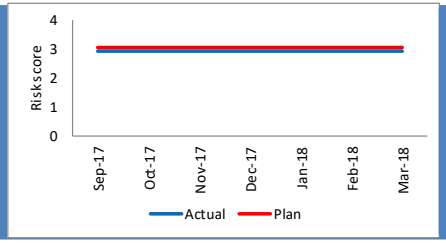
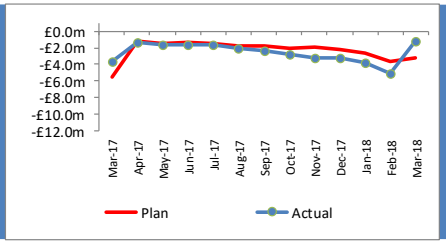
	Description	Current position/comments	13 month rolling trend	Target
A&E 4 hour standard	Maximum wait time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.	Performance was 77.7% in March against the 95% national target. The exception report is shown on page 24.		>95% per month
Medically optimised patients	Number of days within the month where there are medically optimised patients within acute beds	There were 15 days in March when there were over 80 medically optimised patients. The exception report is shown on page 25.		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	In March, Curzon House remained closed with a loss of 6 intermediate care beds. There were 16 beds available in Sutton Beeches. Additional escalation beds were available on Bluebell ward at Ellesmere Port and on the intermediate care unit ward 34 to support operational pressures.		No target agreed

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics March 2018

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

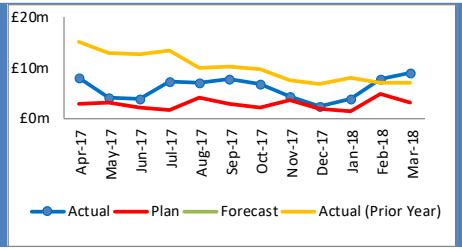
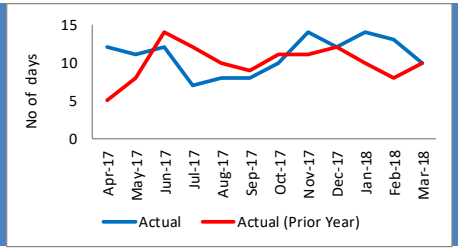
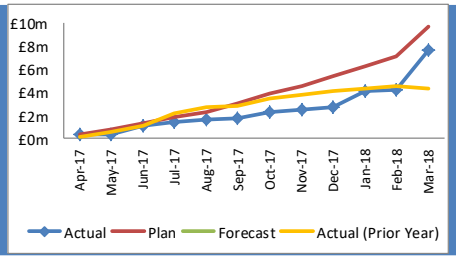
	Description	Current position/comments		
Use of Resources	NHS Improvement's measure of financial risk.	The Trust is currently at a level 4 for Capital Service Capacity , liquidity and I&E Margin rating, which when combined with Plan Variance and Agency expenditure, results in an overall score of 3. Under the Single Oversight Framework 1 is the best score, 4 the lowest. The Trust is currently 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 the end of March 18, we are reporting a £1,803k overspend against plan. Notable pressures include £1,441k in relation to lost STF due to not achieving the A&E target and £397k in relation donated asset transactions. Notable movements this month include the agreed transfer from Charitable Funds of £1,860k in relation to the BabyGro		As Plan

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics March 2018

BAF ref: CR3, CR5, CR6, CR7,

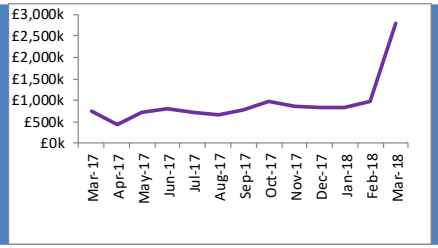
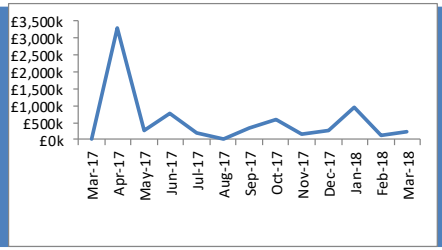
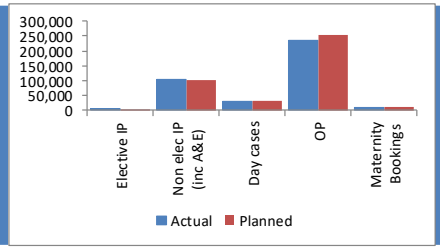
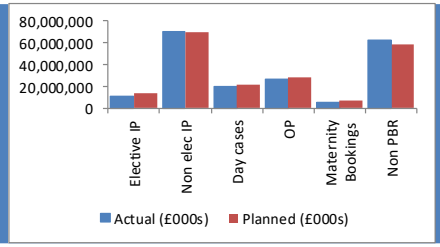
	Description	Current position/comments		
Cash	Cash on deposit <3 month deposit	The closing cash balance at the end of March is £9.1m, £6m ahead of plan. The full capital loan of £8m has been drawn down, as has a total of £6.75 revenue distress funding. We continue to monitor capital and revenue monies separately.		£3.1m
Debtor Days	Debtor Days: Trade Debtors divides by income x 365	Debtor days fell slightly to 10days at the end of March. Q3 STF monies were received in March as was the remaining winter monies of £1.2m. DTOCs invoices due from Local Authorities remain unpaid. Wirral FT have begun to clear their outstanding debt, which built up due to their problematic system upgrade.		No target
Capital Expenditure	Capital expenditure performance against plan / forecast out-turn	YTD capital expenditure of £7.6m is under the original plan by £2.1m but is broadly in line with the revised forecast used to support the subsequent capital loan application..		£9.7m

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics March 2018

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

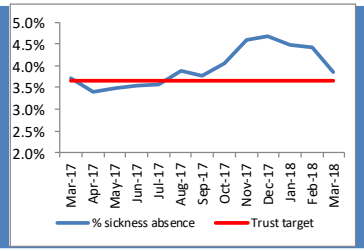
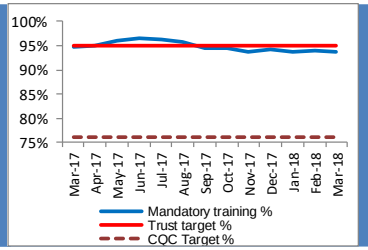
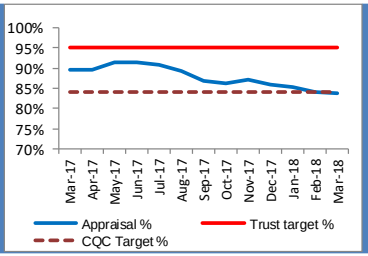
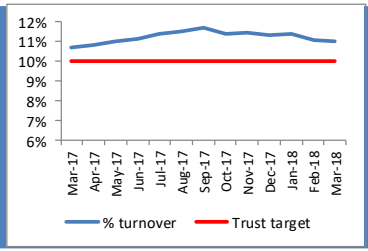
	Description	Current position/comments		
CRS In Year	Planning improvements in productivity and efficiency	Based on the £11.4m revised plan for 2017/18, the CRS programme is delivered in full as at the end of March.		No deviation from plan
CRS Recurrently	Planning improvements in productivity and efficiency	Based on the £11.4m revised plan, £7.3m (64%) of CRS savings has been achieved recurrently. Of the outstanding amount, £0.2m (2%) is rag rated green or amber and £3.9m (34%) is rag rated red or black.		No deviation from plan
Contract performance Activity	YTD Contract performance against Trust Planned activity (English & Welsh)	All points of delivery are showing an under performance against plan YTD with the exception of Non-elective activity (+3,289). This is made up of 4,063 Emergency Department attendances more than planned which is offset by an underperformance on non-elective discharges (-774). However this additional NEL activity does not materialise in additional income.		Actual Activity should be greater than Planned activity
Contract performance Financial Value	YTD Contract performance against Trust Planned Value (English & Welsh)	Prior to adjustment for the block contract with WCCCG, the March year end income position is below plan by -£4,131k. The block contract adjustment to reflect the under performance on WCCCG mitigates £3,117k in year resulting in an adverse position on contract income of -£1,104k.		Actual Value should be greater than Planned Value

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics March 2018

BAF ref: CR3, CR4, CR6, CR7

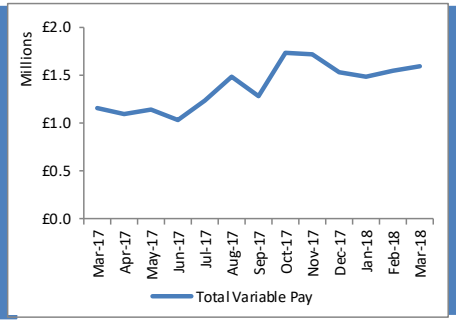
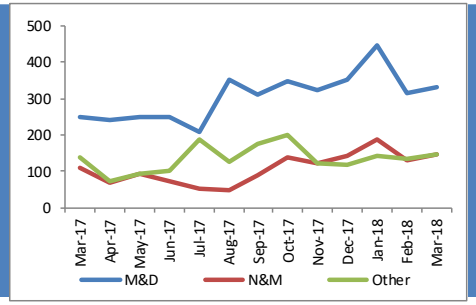
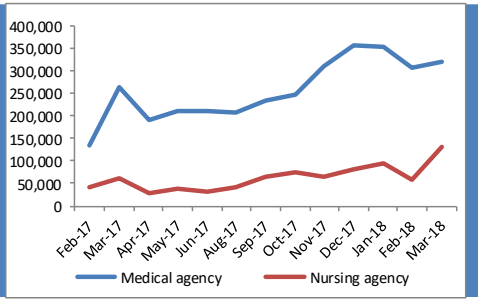
	Description	Current position/comments	13 month rolling trend	Target
Sickness Absence	% sickness absence. Monthly rate excludes Comfort zone and Bank staff	The absence rate reduced to 3.86%, which exceeds the Trust target of 3.65% but when comparing to local trusts, our absence rate is significantly less. The rate for the same period in 2017, was 3.70% & the rolling 12 month average was 4.03%, against 5.3% regionally (eWin extract Jan 2018). Short term absence decreased to 1.49%, while long term absence increased to 2.53%.		Below 3.65% per month Please note these are initial figures for March 18 & subject to variance due to an issue loading the sickness
Mandatory Training	Mandatory Training Monthly Rate Excludes Comfort Zone, Bank Staff, Staff on long term sick & mat. leave.	The Trust compliance target decreased in March with Mandatory Training standing at 93.7%, still exceeding the CQC target (76%) but marginally below Trust target of 95%. When taking into account those already booked to attend, the Trust continues to exceed the Trust target, reporting a slightly higher 96.1% 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 decreased further in March to 83.8%, which continues to exceed the CQC target (84%). This continues to be symptomatic with the increased winter pressures across the Trust and further details are provided within the exception report.		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.	The Trust Turnover rate reduced marginally again in March but remained above target at 11.03%. This rate is based on a headcount, turnover by FTE also remained above target at 10.72%. An exception report has been provided.		Below 10% per month

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics March 2018

BAF ref: CR3, CR4, CR6, CR7

	Description	Current position/comments	Breakdown by type by month	Target
Variable Pay	Reducing and controlling variable pay spend (including overtime, agency, additional clinical activity)	Variable pay spend increased in month and continues to remain higher than at the same period as 16/17 at £1,582k. Agency costs increased with spend in month of £479k, with costs increasing on nursing including Jubilee Theatres, Ward 46 – Short stay unit) and medical staff. Year end spend is £16.2m, which is a 25% or £3m increase on 16/17. However, it is important to note that we have delivered under the NHSI agency cap at £4.37m.		To achieve levels of spend in line with 14/15 (£12.876m) delivering £1.6m saving
Agency Shifts Over Cap Rates	M&D Agency shifts over cap rates. 'Other' consists of Care Packages, Sonographers, Theatres and CRV Dept.	Month 12 shows an overall increase in shifts above the cap, with 445 medical shifts above cap rates. Operating Department Practitioner shifts decreased to 131 approved over the cap. In relation to Nursing shifts, 147 shifts were approved above cap rates. In total, 626 shifts were paid across all staff groups above the cap rates.		A reduction in the total number of agency shifts paid above the cap rate compared to the previous year & month.
Agency spend	Planning improvements in productivity and efficiency	Medical Pay is overspent by £1,232k. Agency medical expenditure is £3,268k (7% of the total medical spend). Nursing Pay is £840k overspent. Agency nursing expenditure is £748k which is 2% of total trained nursing spend. Total Agency spend for April to March is £4,373k. (£3,451k was spent during the same period last year).		Total Agency ceiling set at £4,843m for 17/18

EXCEPTION REPORT

Indicator: Clinical correspondence

Issue:

The eDischarge target was not achieved in in March and performance declined slightly compared with February.

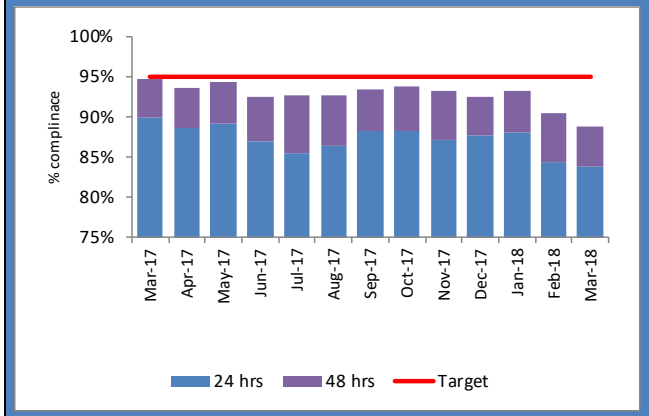
Outpatient letters sent within 10 days performance improved to 55.2% in January

Proposed actions:

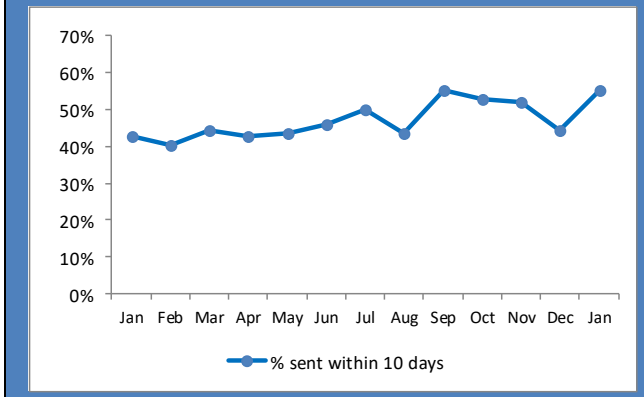
eDischarge - actions are being being led by Medical Director and Associate Medical Directors. Clinical teams to plan and start to complete the eDischarge before discharge. Daily reports are sent out and reviewed by ward clerks and consultants.

Outpatient letters - a number of projects are underway to help improve the sign off process for clinicians, including the continued roll out of Medisec Digital Dictation and a pilot of speech recognition. An action plan is being developed but needs to include introduction of partial booking and eRS. Due to operational pressures Divisional managers have had to re-prioritise this piece of work, but work continues to identify the resource which will be required to meet 7 day compliance from April.

Historic data:



e-discharge



OP Letters sent within 10 days

Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:

Executive Lead: Ian Harvey, Medical Director

EXCEPTION REPORT

Indicator: Number of MRSA and C. Difficile Cases

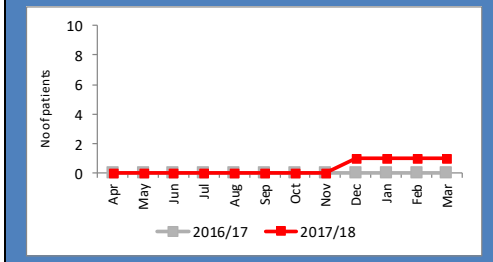
Issue:

During 2017/18 there were 29 cases of C. Difficile, exceeding the annual target of 24.
In December, there was one case of avoidable MRSA when the target for 2017/18 was zero cases.

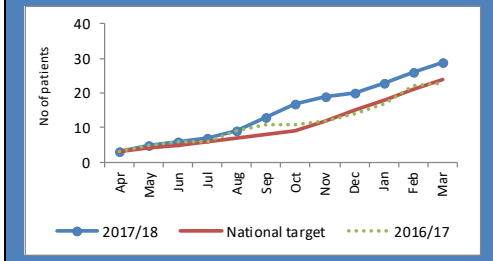
Proposed actions:

Cdiff - Recent surveillance has demonstrated that the number of cases of C. difficile infection remain within objective for five consecutive months, November 2017 – March 2018 inclusive. Case by case surveillance for this infection continues, including a focus on compliance with prevention and control measures.

Historic data:



MRSA



C Difficile vs target

Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:

Executive Lead: Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

Indicator: Safe Staffing

Issue:

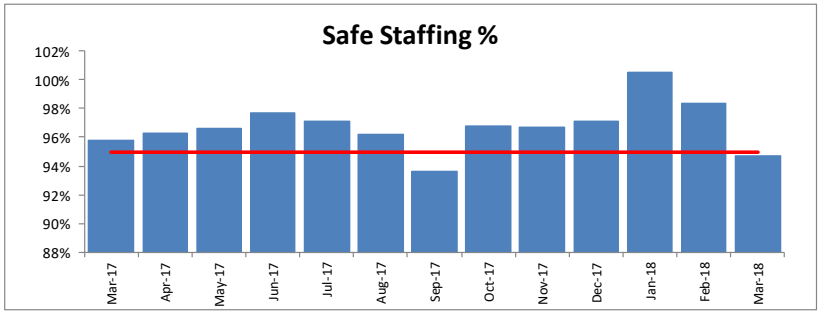
In March 2018, the rate of hours worked against hours planned was below the 95% target. The safe staffing rate was 94.7%

Proposed actions:

Registered and Unregistered nurse staffing levels are reviewed in real time using the SafeCare tool in line with patient acuity. Staff are mobilised to support areas of greatest need to minimise the impact of lower than expected staffing levels. Work continues on the recruitment and retention work programme to close the vacancy gap and retain our skilled workforce. Although the areas identified in grey present with less than expected levels of staff, this is reflective of the patient acuity and activity within those areas during March.

Current Month

WARD	FUNCTION	STAFFING RATE	
Renal	Renal	81%	
NNU	Neonatal Unit	83%	
ICU	Adult Intensive Care	85%	
Ward 60	Haem / Oncology	88%	
Ward 47	Acute Medical Unit	83%	Wards below 90%
Ward 45	Surgery	84%	
Ward 53	Vascular	85%	
Ward 40	Women's Surgical	89%	
Ward 41	Surgery	92%	Wards below 95%
Ward 44	Surgery	92%	
Ward 54	General Medicine	94%	
Ward 34	Intermediate Care Unit	94%	
Ward 33	Stroke	94%	
Children's	Paediatrics	95%	Wards 95-100%
Ward 52	Trauma & Orthopaedics	98%	
Ward 48	Respiratory	98%	
Ward 50	Care of the Elderly	98%	
Ward 49	Gastroenterology	100%	
Ward 51	Care of the Elderly	101%	Wards above 100%
Ward 42	Cardiology	102%	
Ward 43	Haematology/Oncology	102%	
Ward 32	Maternity	104%	
Bluebell	EPH Rehabilitation	106%	
Labour	Maternity	106%	
Poppy	Intermediate Care Unit	120%	



Forecast for improvement:

Q1	Q2	Q3	Q4

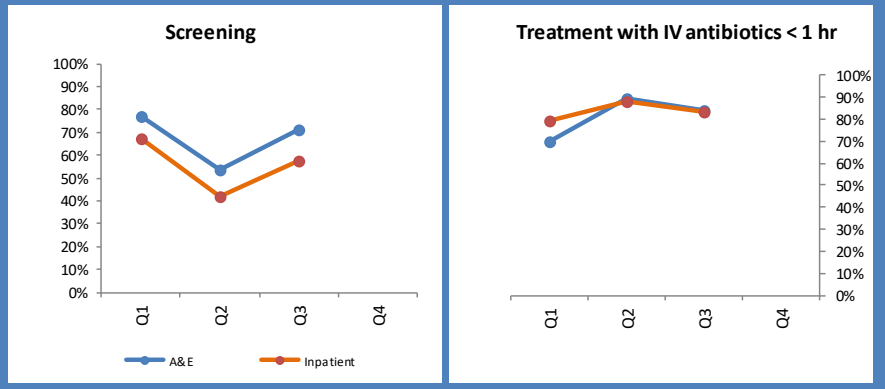
Lead:	Mel Kynaston, Associate Director of Nursing
Executive Lead:	Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

Indicator: Sepsis

Issue:
The Sepsis CQUIN compliance is below 90% for screening and IV antibiotics administration within one hour

Proposed actions:
There has been an improvement in screening compliance for A&E and admitted patients during Q3. Work continues on implementing our quality improvement plan and we expect that the higher level of performance seen during Quarter 3 will be sustained, with further improvement seen during 2018/19.



Forecast for improvement:			
Q1	Q2	Q3	Q4

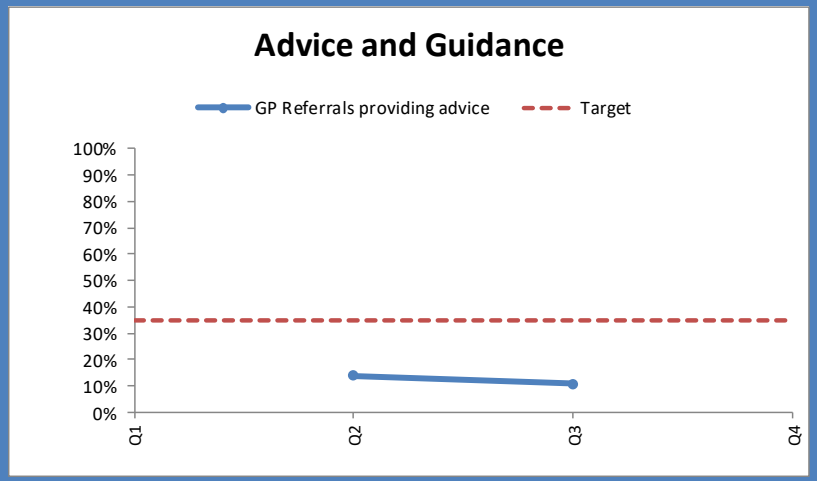
Lead:	
Executive Lead:	Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

Indicator: Advice & Guidance CQUIN

Issue:
By the end of Q1 a scoping exercise should be complete specialties with the highest volume of GP referrals (for Advice & Guidance implementation), with a defined trajectory for when specialties are able to provide this service. Q3 compliance is lower than the 35% trajectory.

Proposed actions:
Progress against this CQUIN has been delayed due to the functionality within the ACENDA system. The decision has now been made to move to e-RS, which will allow for all specialties to offer advice and guidance. A project plan has been designed and implementation is planned for 2018/19 to achieve the year end target.



Forecast for improvement:			
Q1	Q2	Q3	Q4

Lead:	
Executive Lead:	Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

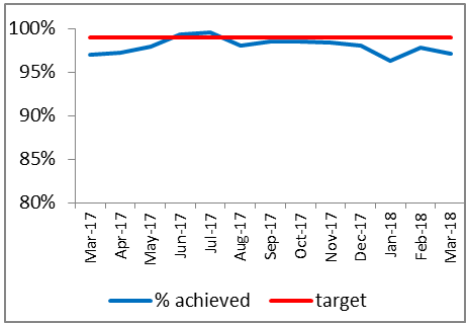
Indicator: Diagnostic 6 week wait

Issue:
Diagnostic performance is below the 99% target at 97.01%. NB: get update on vascular scans and progress since Janaury. More info on endoscopy, cysto.

Proposed actions:
Endoscopy - work continues with the action plan and an improvement has been seen within the last month in the numbers waiting **Radiology** – there has been an increase in demand due to non-elective patients. Direct Access demand is also putting extra pressure on the system.

Historic data:

Diagnostic tests within 6 weeks



Month End Snapshot	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Magnetic Resonance Imaging	1	2	24	22	2	1	1			5	5	2	10
Computed Tomography		1				3		1		1	4		
Non-obstetric ultrasound	1	3	6		1	1	8	3	5	7	13	6	51
CRV - Vascular							2	19	10	13	56	29	14
Audiology - Audiology Assessments													
Cardiology - echocardiography	124	112	58	3	4	9	3	3	7	5	10		
Respiratory physiology - sleep studies	2			2	3	8			1	2	2	5	3
Colonoscopy						23	7	6	8	8	20	14	19
Flexi sigmoidoscopy							2		2	9	3	1	8
Cystoscopy	9	2			5	15	10	14	14	16	12	17	18
Gastroscopy			1	1	1	15	6	12	20	18	54	19	12
Total patients waiting	4542	4231	4166	3917	3908	3721	3775	3872	4215	4399	4799	4228	4623
%<6 weeks	97.0%	97.2%	97.9%	99.3%	99.6%	98.0%	98.7%	98.5%	98.4%	98.1%	96.3%	97.8%	97.1%

Forecast for improvement:

Q1	Q2	Q3	Q4

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

EXCEPTION REPORT - February 2018

Indicator: 62 day cancer

Issue:

The 62 day performance for March is a provisional underachievement of the standard. There are currently 13 breaches in March, which will now be validated. Initial findings show breaches are broken down under the following specialties:

- Colorectal - 1 breach
- Gynae - 1 breach
- Haem - 2 breach
- Lung - 1 breach
- Upper GI - 3 breaches
- Urology - 6 breaches

The Quarter will be a fail for this target.

Proposed actions:

Improvement Plan

The action plan has been developed and bi-weekly meetings are due to commence mid-March. Individual speciality action plans are currently being developed.

The Cancer Alliance continues to work on developing optimal pathway ways for Colorectal, Prostate and Lung.

The Cancer Services team now have a more functional PTL to allow a clearer oversight of the patient pathway. This continues to be rolled out to the operational divisions to support these patients through the cancer pathway.

Forecast for improvement:

Q1	Q2	Q3	Q4

Supporting PTL data:

	PTL between 63-99 Days	PTL 100+ Days	Grand Total
Breast	1		134
Colorectal	17	3	205
Gynaecology	6		83
Haematology	1	1	10
Head and Neck	7		163
Lung	4		36
Other			1
Paediatric			3
Sarcoma			1
Skin	5		173
Upper GI	6	3	88
Urology	25	9	174
Grand Total	**72**	**15**	**1071**

Lead:

Executive Lead: Lorraine Burnett, Director of Operations

EXCEPTION REPORT

Indicator: Referral to treatment (18 weeks)

Issue:

RTT incomplete performance for March 2018 remains under the 92% target at 88.6%

Proposed actions:

There have been continued operational pressures in March with significant numbers of cancellations for patients due to no bed being available. During this period, cancer and clinically urgent patients were prioritised in line with NHSE guidance. To ensure patient safety, long waiting patients were also prioritised so that there are minimal numbers of patients waiting beyond 30 weeks for an elective procedure.

It is likely the RTT position will continue to fail the 92% target for a number of months.

March 2018 performance by specialty

Incomplete Pathways		92.0%		
	<18Weeks	>18Weeks	Total	%
General Surgery	1944	531	2475	78.5%
Urology	1143	305	1448	78.9%
Trauma & Orthopaedics	1066	207	1273	83.7%
Ear, Nose & Throat (ENT)	2130	168	2298	92.7%
Ophthalmology	1572	155	1727	91.0%
Oral Surgery	963	106	1069	90.1%
Neurosurgery	0	0	0	
Plastic Surgery	374	51	425	88.0%
Cardiothoracic Surgery	0	0	0	
General Medicine	306	9	315	97.1%
Gastroenterology	796	39	835	95.3%
Cardiology	561	43	604	92.9%
Dermatology	656	37	693	94.7%
Thoracic Medicine	410	17	427	96.0%
Neurology	0	0	0	
Rheumatology	201	4	205	98.0%
Geriatric Medicine	166	5	171	97.1%
Gynaecology	812	93	905	89.7%
Other	1278	74	1352	94.5%
Total	14378	1844	16222	88.6%

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:

The 4 hour A&E target was under target in March, achieving 77.7%.

Proposed actions:

The Trust continues with >95% bed occupancy which is significantly above regional average – high attendances and consistent use of escalation areas throughout February.

We have introduced an ambulance handover bay to support handover times and also Ambulatory Majors which we are currently embedding within the department.

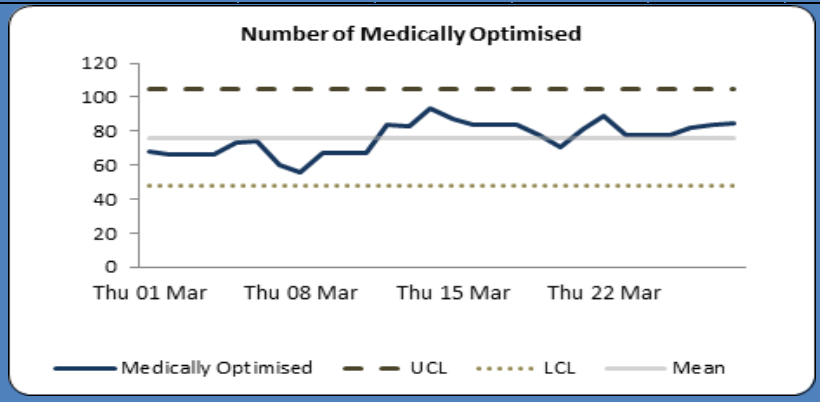
All out of hospital capacity is being utilised - now 23 beds.

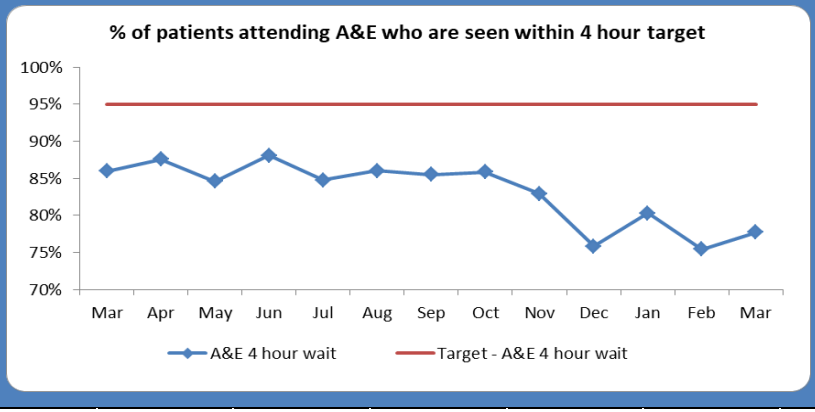
Continue to work with Co-ordination Centre, ECIP/NHSi to improve process and systems to improve flow.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:





EXCEPTION REPORT

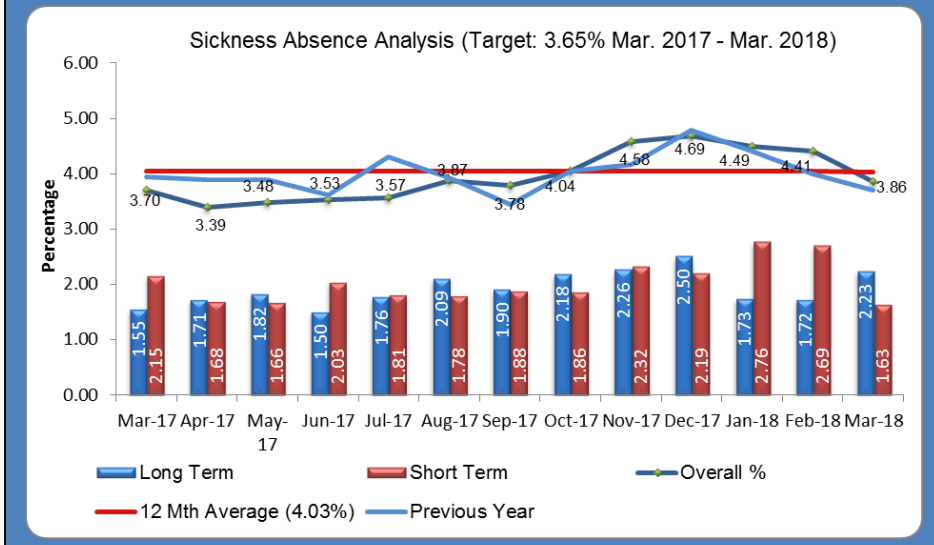
Indicator: Monthly Sickness Absence rate

Issue:
The Trust wide absence decreased in March to 3.86% which exceeds the Trust target of 3.65%. There has been a decrease in long term sickness to 2.23%, and short term cases have decreased to at 1.63%. Sickness absence within Staff groups highlights that Nursing & Midwifery is reporting a increase at 4.42% and Support Workers (which include Nursing Assistants) is at 5%. When analysing divisional absence, Planned Care has decreased to 4.29% with a number of long term cases returning to work this month. Absence in Urgent Care has decreased with careful management to 4.05%. The Corporate non clinical areas are at 2.09% and is mainly due to a small number of long term cases. Facilities has decreased to 5.39% with a small number of long term sick cases which due to their nature are being sensitively managed. There is still a backlog of OH referrals albeit this is now decreasing due to careful management.

Proposed actions:
Absence in all areas of the Trust continues to be monitored with detailed analysis taking place in all areas. Additional support has been put in place within the Occupational Health & Wellbeing Team to ensure there is a timely process for referral management but this continues to cause a cost pressure. Managers are monitoring and managing absence in line with the policy, making every effort to support staff back into work as appropriate.

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:

Despite a period of significant pressure upon our organisation, Mandatory Training compliance has remained relatively unchanged at 93.7%.
Staff "booked on" remains over the trust target of 95%.
Both continue to far exceed the CQC target of 76%.
At 79.3% Local Induction compliance sits well below our trust target of 95%.

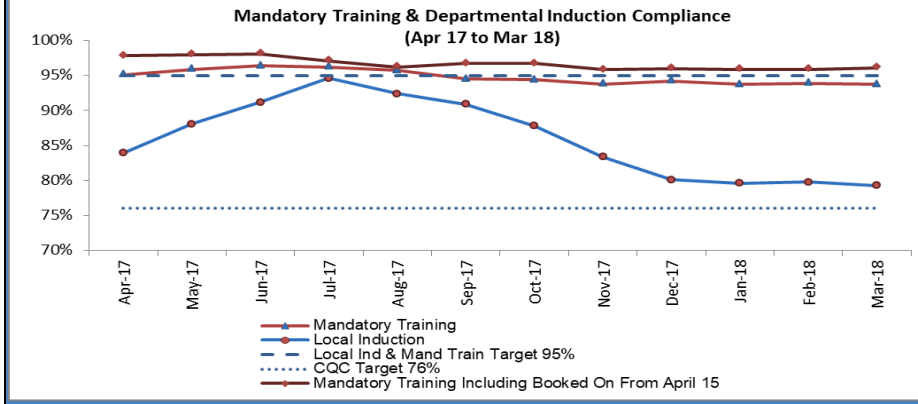
Proposed actions:

The Trust Training Needs Analysis (TNA) is in the process of being completely redesigned to offer staff a very clear breakdown of their mandated learning.
Through the expanded use of "blended learning" of face to face and e-learning we will offer our staff increased flexibility in completing their mandatory training, whilst ensuring we remain compliant with the standards of the Core Standards Training Framework.
It should be noted that a single person missing local induction can cause a significant swing to small departments figures. In 2018, we are revising the local induction pathway to reflect regional changes agreed by the streamlining group. This offers an opportunity to highlight the importance of the process to all staff groups.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Mandatory Training Table March 2018

Position	Division	Compliance
1	Corporate Clinical	100.0%
2	Estates	97.3%
3	Finance & Performance	96.9%
4	Human Resources	95.2%
5	COCH & WUTH Collaboration	95.1%
6	Urgent Care	94.2%
7	Diagnostics and Pharmacy	93.3%
8	Facilities	93.3%
9	Planned Care	93.0%
10	Corporate Non - Clinical	89.5%
11	Nurse Management	84.8%
	Total	93.7%

Local Induction Table March 2018

Position	Division	Compliance
1	Facilities	100.0%
2	COCH & WUTH Collaboration	100.0%
3	Planned Care	84.7%
4	Human Resources	80.0%
5	Diagnostics and Pharmacy	78.4%
6	Urgent Care	75.0%
7	Corporate Non - Clinical	70.0%
8	Nurse Management	60.0%
9	Finance & Performance	56.3%
10	Estates	-
11	Corporate Clinical	-
	Total	79.3%

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

EXCEPTION REPORT

Indicator: Appraisals Completed In The Last 12 Months

Issue:

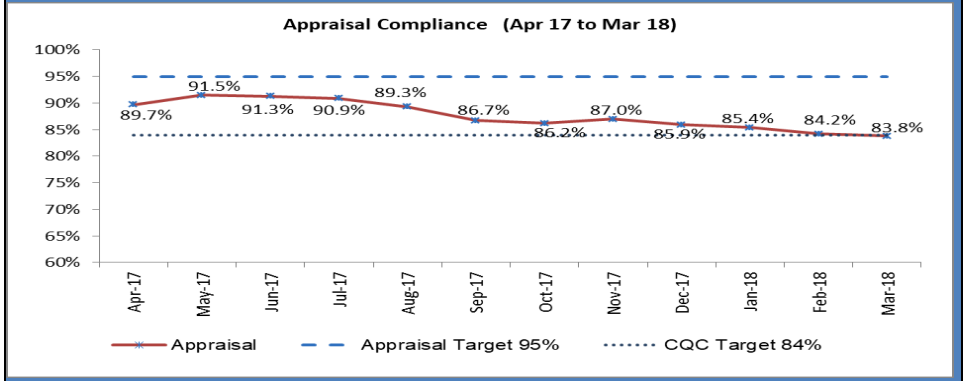
A further decrease to 83.8% Appraisal compliance, reflects a further fall against the trust target of 95% and for the first time in the last 12 months compliance has dropped below the CQC standard of 84%.

Appraisal's are showing as a particular challenge in Urgent Care areas, reflecting the increased pressures being felt over a prolonged winter period. If pressures ease we would anticipate similar improvements in 2018 to that which we saw in 2017.

Proposed actions:

Whilst we continue to report monthly on Appraisal rates, the compliance figures continue to drop. We must focus on the upcoming launch of our "Trust Behavioural Standards" workshops available to all staff, where we can provide an opportunity to engage with our staff and managers. HRBP's will be highlighting the decrease in compliance rate in the monthly divisional reports, stressing the importance of completely appraisals timely.

Historic data:



Appraisal Table March 2018

Position	Division	Compliance
1	Corporate Clinical	100.0%
2	Estates	100.0%
3	COCH & WUTH Collaboration	96.9%
4	Facilities	93.9%
5	Planned Care	87.3%
6	Finance & Performance	86.5%
7	Diagnostics and Pharmacy	83.8%
8	Human Resources	78.6%
9	Corporate Non - Clinical	78.3%
10	Urgent Care	77.8%
11	Nurse Management	67.9%
	Total	83.8%

Forecast for improvement:

Q1	Q2	Q3	Q4

Lead: Dee Appleton-Cairns, Deputy Director of HR

Executive Lead: Sue Hodkinson

EXCEPTION REPORT

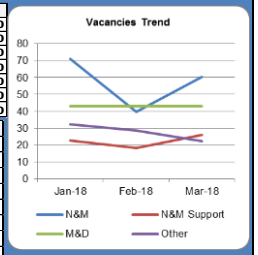
Indicator: Variable Pay

Issue:

To not exceed £4.843m agency expenditure ceiling. To deliver variable savings target in line with 14/15.

M&D Vacancies	Urgent	Planned	Diag/Radiol	Total
Consultant	5.00	1.00	1.00	**7.00**
ST3+	5.00	10.00	0.00	**15.00**
ST1/2	5.00	11.00	0.00	**16.00**
Specialty Doctor	3.00	1.00	0.00	**4.00**
F1/F2	0.00	0.00	0.00	**0.00**
GP Trainee	0.00	1.00	0.00	**1.00**
Total	**18.00**	**24.00**	**1.00**	**43.00**

Vacancies (FTE)	Urgent Care	Planned Care	Diag/Radiol/Pharm	Total
N&M Registered	21.97	38.52	0.00	**60.49**
Support Staff	11.82	12.05	2.00	**25.87**
Radiographer/Sonographer	0.00	0.00	8.25	**8.25**
Allied Health Professionals	2.00	0.00	0.00	**2.00**
Healthcare Scientist	0.00	0.00	0.00	**0.00**
Pharmacy Support	0.00	0.00	7.60	**7.60**
Pharmacist	0.00	0.00	4.38	**4.38**
Total	**35.79**	**50.57**	**22.23**	**108.59**



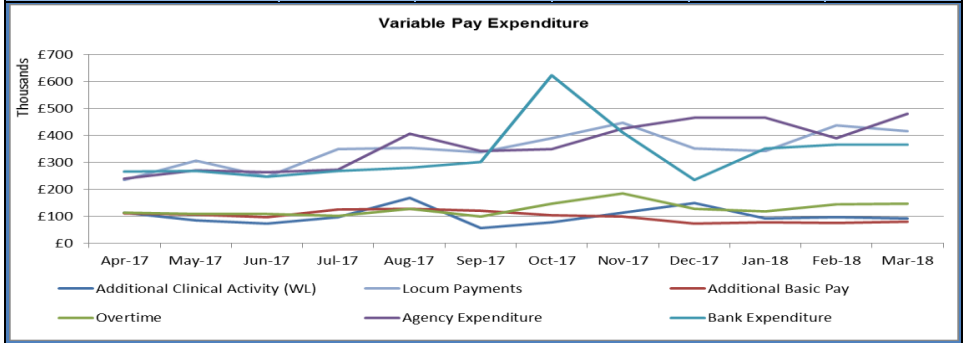
Proposed actions:

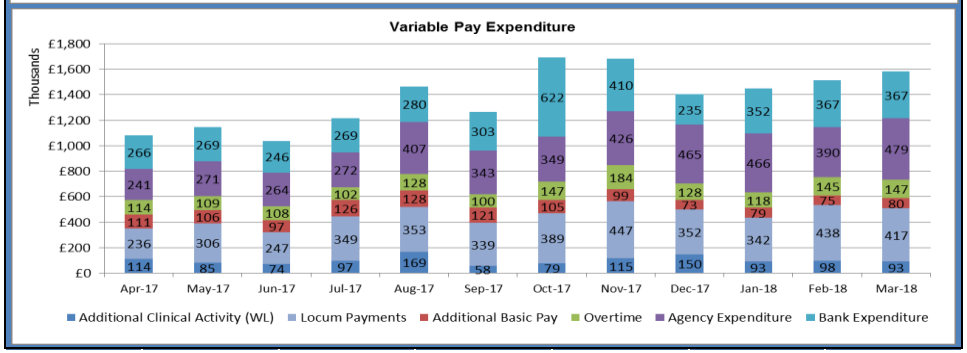
Recruitment: the Trust is continuing to attend regional nursing job fairs. We are continuing to experience no approvals in the certificate of sponsorship for non-EU medical posts, which the Trust has escalated nationally. Retention: retention meetings continue with significant actions in place. Alongside the move to weekly bank pay, the nursing pay rates were revised during February and we continue to see a positive increase in the number of Band 6 nurses available to work on the bank. A Variable Pay Steering group has been established and met late March with key areas of focus in 18/19 including focus on technology and rollout of rostering across other staff groups, increasing recruitment to the medical bank, variable pay data review to support intelligence and focus on "bad variable pay", focus on targets for divisions and variable pay ambassadors. Meetings will be taking place monthly.

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 is at 11.03% marginally reducing in month. The continuing reduction is an encouraging sign after enduring the winter pressures. The rate based on FTE is also above target at 10.72%. Staff groups over target are: Addit. Prof. & Tech. at 10.70% due to 19 leavers, the figure by FTE is 9.14%. Additional Clinical Services at 10.80%, represents 104 leavers in the last year, 65 of which were Healthcare Assistants. Allied Health Professionals at 12.34%, represents 31 leavers in the last year. Admin. and Clerical again decreased to 11.39% representing 105 leavers in the last 12 months (8 of which were MARs plus 10 age retirements). Nursing & Midwifery Registered Staff decreased to 12.63% with 11 Midwives, 126 Staff Nurses & 8 Nurse Managers leaving the Trust in the last year. Trends will be continually monitored.

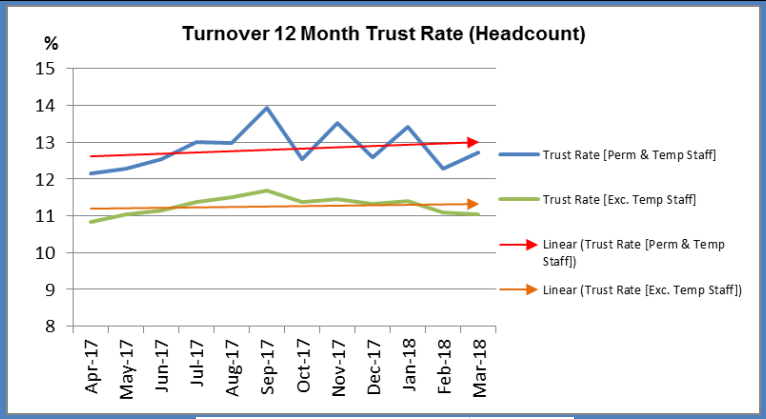
Proposed actions:

Significant focus is being placed on retention of staff particularly within the nursing, midwifery and medical staff groups, working on indetifying area and ways in which we can encoruage staff to remain witht the trust. Exit interviews are also looking to be updated to include questions around, if a member of staff would return if a suitable post becomes available. Leaving information entered onto ESR has been inconsistent, making reporting on why staff are leaving the Trust less accurate but the introduction of a Resignation Form & process is aimed at improving this input and reporting in 2018. It is important to note that the North West average based on headcount is 14.67% (15.28% for Acute Trusts) according to EWin at January 2018.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Staff Group - Apr 17 - Mar 18 Excludes Temporary Staff	Turnover %
Add Prof Scientific and Technic	10.70%
Additional Clinical Services	10.80%
Administrative and Clerical	11.39%
Allied Health Professionals	12.34%
Estates and Ancillary	8.35%
Healthcare Scientists	9.32%
Medical and Dental	9.51%
Nursing and Midwifery Registered	12.63%
Trust Totals & Rate	

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

EXCEPTION REPORT

Indicator: Agency Spend

Issue:

Medical Pay is overspent by £1,232k. Agency medical expenditure is £3,268k (7% of the total medical spend). Nursing Pay is £840k overspent. Agency nursing expenditure is £748k which is 2% of total trained nursing spend. Total Agency spend for April to March is £4,373k. (£3,451k was spent during the same period last year)

Agency Spend by Staff Group	14/15	15/16	16/17	17/18
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 85,760
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 4,372,869**

Proposed actions:

See actions proposed under Variable Pay.

Forecast for improvement:

Q1	Q2	Q3	Q4

Appendix 1

Nurse Staffing March 2018

Below 90% of planned staff hours were worked

Between 90% and 94% of planned staff hours worked

Between 95% and 100% of planned staff hours worked

Over 100% of planned staff hours were worked

Ward Name	Specialty	Staffing Rate	Wards below RN budgeted staffing (WTE)	Sickness Absence	CHPPPD (Avg long term)	CHPPPD (This month)	CHPPPD variance (This month)	Pressure Ulcers at Grade 2+	Falls with moderate and above harm	Red Flags (Patient Risks)	Red Flags (Staffing Risks)	Care Metrics	VTE Assessment (provisional)
Bluebell	EPH Rehabilitation	105.7%	-1.7	3%	6.10	5.86	-0.2	3	0	0	0	-	NA
Children's	Paediatrics	95.5%	-0.2	3%	NA	11.52	NA	0	0	0	0	100%	NA
ICU	Adult Intensive Care	85.4%		3%	26.56	28.89	2.3	4	0	0	2	98%	98%
Labour	Maternity	106.0%		NA	NA	18.49	NA	0	0	0	0	-	99%
NNU	Neonatal Unit	83.3%		NA	NA	19.92	NA	0	0	0	0	-	NA
Poppy	Intermediate Care Unit	120.2%	-3.7	6%	6.70	5.98	-0.7	0	0	6	2	96%	91%
Renal	Renal	81.1%	-0.4	3%	NA	NA	NA	0	0	0	0	95%	100%
Ward 32	Maternity	104.1%		NA	NA	NA	NA	0	0	0	9	-	97%
Ward 33	Stroke	93.8%		3%	6.41	7.17	0.8	0	0	1	0	98%	99%
Ward 34	Intermediate Care Unit	93.8%	-1.2	3%	4.04	4.24	0.2	1	0	5	12	-	NA
Ward 40	Women's Surgical	89.4%	-3.1	3%	7.45	7.28	-0.2	0	0	1	24	93%	92%
Ward 41	Surgery	92.2%	-4.1	6%	5.47	5.27	-0.2	1	0	8	44	96%	95%
Ward 42	Cardiology	101.8%	-1.7	2%	8.29	8.84	0.5	1	0	5	17	98%	100%
Ward 43	Haematology/Oncology	102.2%	-0.7	1%	6.85	7.13	0.3	0	0	10	23	99%	0%
Ward 44	Surgery	92.3%	-4.1	8%	5.09	5.44	0.3	1	2	8	6	89%	95%
Ward 45	Surgery	83.6%	-1.3	4%	5.27	7.83	2.6	0	0	6	25	98%	97%
Ward 47	Acute Medical Unit	82.8%		3%	6.39	9.40	3.0	1	0	5	19	91%	98%
Ward 48	Respiratory	98.1%		4%	6.48	5.95	-0.5	3	0	7	4	94%	98%
Ward 49	Gastroenterology	99.6%		11%	5.09	5.23	0.1	0	0	3	25	97%	100%
Ward 50	Care of the Elderly	98.4%	-2.5	6%	5.30	5.78	0.5	1	1	1	5	-	NA
Ward 51	Care of the Elderly	100.5%	-0.7	6%	5.66	5.67	0.0	0	0	0	0	95%	NA
Ward 52	Trauma & Orthopaedics	97.7%	-1.9	4%	5.62	5.80	0.2	1	0	4	5	92%	99%
Ward 53	Vascular	85.5%	-3.4	5%	6.17	7.07	0.9	1	0	7	24	-	98%
Ward 54	General Medicine	93.7%		2%	5.61	5.44	-0.2	0	0	2	3	98%	92%
Ward 60	Haem / Oncology	88.4%		1%	NA	NA	NA	0	0	8	3	95%	100%

NB: An issue with the ESR HR database means that sickness figures for maternity wards are not yet available. This information will be updated week commencing 16th March.

Subject	Financial Position – Month 1, April 2018
Date of Meeting	Board 22nd May 2018
Author(s)	Mr. Simon Holden, Director of Finance Ms. Jennie Birch, Deputy Director of Finance
Annual Plan Objective No.	
Summary	This paper is intended to provide details of the Trust's financial position, as at 30th April 2018 (Month 1).
Recommendation(s)	**The Board is asked to note:** o The adverse variance (Month 1) of £367k against plan, being made up as follows, namely: o Underlying position before PSF (Provider Sustainability Fund), previously known as STF funding, £250k adverse, being the "monitored" position; o The PSF & Donated Asset position is £117k adverse, principally due to low levels of A&E performance (resulting in penalties of £109k), and a technical accounting issues relating to donated assets (£8k adverse). o The forecast "true" Month 01 position of a £480,000 overspend, when all potential non recurrent items and the profiling of cost reduction savings, taken into account, resulting in a "realistic" £2m overspend (i.e. £5m off plan); o The forecast position also effectively utilising all reserves & contingency, meaning no flexibility for 2019/20, & beyond; o The plan to reflect achievement in the earlier periods of the year (i.e. quarters 1 and 2) in order to effectively maximise Provider Sustainability Fund income; o The total Contract Income headline being £69k shortfall below plan with over performance on non-elective activity, and the underperformance on elective work; o The pressures on nursing pay, with regards to patients on special intensive packages with agency costs at £115k for April 2018 compared to £27k For the same period last year (April 2017); o The overall reduction in Delayed Transfers of Care (DTOC), but potentially concealing a continued pressure in relation to Welsh patients;

	o Cost Reduction Scheme (CRS) target of £10.739m and month one position of £117k behind profiled plan. If the target had been profiled evenly we would be £626k behind plan before any potential non recurrent offset(i.e. profile impact to date £509k); o The work on-going with regards to Divisions refining their cost reduction programs, and also with regards to centrally orientated schemes, which may help mitigate this position further; o The underlying risks, most notably the expectation, included within this position, of a further £1m, over and above the £149.4m agreed at the start of the year, reflecting current occupancy levels; o The unknown impact of winter, with regards to both activity pressures, and any potential, as yet unknown, additional winter funding; o Further details on capital are available in separate paper; o The inclusion of both monthly balance sheet and cash flow, following audit recommendation; and o The continued proactive management of the Trust's cash balances (noting a closing cash balance of circa £8m).
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.

NHS
Countess of Chester Hospital
NHS Foundation Trust

Board of Directors

Financial Position
Month 1 2018/19

1.0 Overview

	Annual Budget 2018/19 £000s	Apr YTD Budget 2018/19 £000s	Apr YTD Actual 2018/19 £000s	Apr YTD Variance 2018/19 £000s
Pre PSF (Provider Sustainability Fund, previously STF)	4,334	1,346	1,596	250
PSF	(7,297)	(364)	(255)	109
Post PSF Control Total	**(2,963)**	**982**	**1,341**	**359**
Donated Asset Transactions	45	4	12	8
I&E Surplus	**(2,918)**	**986**	**1,353**	**367**

The financial position Pre PSF is a £250k adverse variance, with the following key points to note: -

- Contractual Income is potentially £69k off plan, noting that the volume of un-coded activity at month one is high as a proportion of total activity;
- The Winter Escalation Ward remains open and has utilised one twelve of the £1.2m Winter Reserve identified at budget setting;
- Nursing pressures are significant for the month of April with a reported £141k overspend on nursing pay. Urgent Care accounts for £90k and Planned Care £42k of this overspend. This predominantly relates to nurse agency spend (£115k in April) and nurse special pressures;
- The Cost Reduction Scheme (CRS) is £117k behind profiled plan. If the target had been profiled evenly we would be £626k behind plan (i.e. profile impact to date £509k); and
- Use of non-recurrent resource and reserve utilisation to support this month's financial position is £108k.

NHS
Countess of Chester Hospital
NHS Foundation Trust

KEY VARIANCES	Annual Budget £000s	Apr YTD Budget £000s	Apr YTD Actual £000s	Apr YTD Variance £000s	Apr YTD Variance % of budget
INCOME					
Income - England	(177,155)	(14,038)	(13,931)	107	-0.8%
Income - Wales	(24,808)	(2,047)	(2,039)	8	-0.4%
Other Clinical Income	(11,316)	(978)	(957)	21	-2.2%
Non Patient Income	(13,151)	(1,117)	(1,144)	(27)	2.4%
INCOME	**(226,430)**	**(18,180)**	**(18,071)**	**109**	-0.6%
PAY					
Nursing	56,416	4,803	4,944	141	2.9%
Medical	46,047	3,849	3,861	12	0.3%
Admin & Clerical	20,707	1,661	1,623	(39)	-2.3%
AHP, Therapies, Diagnostics & Pharmacy	22,861	1,842	1,821	(21)	-1.1%
Other	16,207	1,218	1,216	(2)	-0.2%
TOTAL PAY	**162,239**	**13,373**	**13,465**	**92**	0.7%
NON PAY					
Drugs	19,047	1,667	1,665	(2)	-0.1%
Medical & Surgical Equipment	10,907	900	858	(42)	-4.6%
Depreciation	4,382	365	365	0	0.0%
CNST	8,206	684	684	0	0.0%
Furniture & Office Equipment, Equip Hire & Computers	3,826	221	227	6	2.7%
Other	32,443	2,433	2,402	(31)	-1.3%
TOTAL NON PAY	**78,811**	**6,270**	**6,202**	**(68)**	-1.1%
CRS	**(10,286)**	**(117)**	**0**	**117**	
TOTAL - PRE PSF & DONATED ASSET TRANSACTIONS	**4,334**	**1,347**	**1,596**	**250**	18.5%

PSF (Provider Sustainability Fund, previously STF)	**(7,297)**	**(364)**	**(255)**	**109**	-29.9%
POST PSF CONTROL TOTAL	**(2,963)**	**983**	**1,341**	**359**	36.5%
DONATED ASSET TRANSACTIONS	**45**	**4**	**12**	**8**	200.0%
I&E SURPLUS	**(2,918)**	**987**	**1,353**	**367**	37.2%

Please note: (Favorable) / adverse

SUMMARY OF DIVISIONAL VARIANCES AS AT 30TH APRIL 2018

Division	Annual Budget	Budget to Date	Pay Variance	Non Pay Variance	Income Variance	Divisional CRS Variance	Grand Total	Variance as a % of Budget to Date
	£000	£000	£000	£000	£000	£000	£000	
Planned Care Division	72,517	6,207	52	(121)	58	139	128	2%
Urgent Care Division	52,267	5,508	84	15	(4)	145	239	4%
Diagnostics & Pharmacy Division	23,523	1,888	(18)	30	1	44	56	3%
Facilities	7,093	577	(5)	7	(3)	(11)	(11)	-2%
Estates	6,728	539	(3)	0	(2)	2	(3)	-1%
Nurse Management	2,077	168	1	(4)	(2)	(8)	(13)	-8%
Corporate Services - Non Clinical	13,692	1,094	(25)	(2)	(13)	10	(29)	-3%
Corporate Services - Clinical	125	47	0	0	0	0	1	2%
Other (Inc. Contract Income)	(182,818)	(15,198)	5	10	182	(204)	(7)	0%
	(4,796)	**830**	**92**	**(65)**	**218**	**117**	**362**	**44%**
Interest Receivable	(37)	(3)	0	0	(4)	0	(4)	125%
Interest Payable	653	54	0	0	0	0	0	1%
Impairements & Gains/Loss on Disposals	0	0	0	0	0	0	0	0%
Govt Interest & Dividends	1,162	97	0	0	0	0	0	0%
Operating (Surplus) / Deficit	**(3,018)**	**978**	**92**	**(64)**	**215**	**117**	**358**	**37%**
Donated Assess Depreciation	100	8	0	0	8	0	8	100%
I&E SURPLUS	**(2,918)**	**987**	**92**	**(64)**	**223**	**117**	**367**	**37%**

Please note: (Favourable) / adverse

2.0 Income

3.1 Commissioner Income

At the end of April 2018 (month 1) the total contract income is £40k above plan prior to the block adjustment, which when applied results in an overall financial underperformance of £69k. This is because the over performance is on the West Cheshire block contract (£108k), and there is an underperformance on Welsh and other English PbR Contracts (£69k).

The volume of un-coded activity at month one is high as a proportion of total activity. The Trust continues to pursue regular reviews of coding.

After adjusting performance for the block contract there are a number of points of delivery that are underperforming In April: Day case activity (£136k), elective activity (£200k), and maternity bookings activity (£21k). This activity is partially offset by an over performance of £13k on outpatient activity following the block adjustment.

There is an over performance on Emergency Department attendances of £13k and an over performance on non-elective discharges excluding obstetric deliveries (£38k). This predominately relates to non-West Cheshire English Emergency Department attendances non-West Cheshire non-elective discharges.

Obstetric deliveries are continuing to reduce and activity is below plan in April to the value of £134k prior to the block adjustment. The pressure within the financial position following the block adjustment is £25k for April. Obstetric bookings are also contributing an underperformance of £21k year to date. There has been a significant reduction in the number of Welsh women booking to have their care at the Countess, so the Trust is working with the commissioner to understand the reasons for this.

The net overall non-PBR position is showing an over performance of £261k following the block adjustment.

Critical Care and Neonatal bed day activity is £61k above plan year to date after the application of the block adjustment. The application of the risk reserve has increased this over performance by £143k.

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	34	(£28,523)	(£107,324)	(£135,846)	(£135,846)
Elective Inpatients	-68	(£152,647)	(£47,039)	(£199,685)	(£199,685)
Non-Elective Inpatients (exc Maternity)	91	£75,620	(£37,212)	£38,408	£38,408
Non-Elective Inpatients - Maternity	-46	(£134,491)	£109,853	(£24,638)	£39,232
First Outpatients	208	£30,967	£8,265	£39,232	£39,232
Follow Up Outpatients	-886	(£61,364)	£47,787	(£13,577)	(£13,577)
Outpatient Unbundled & Procedures	-1,142	(£11,247)	(£1,207)	(£12,454)	(£12,454)
Maternity	-165	(£37,944)	£17,101	(£20,843)	(£20,843)
A&E Attendances	150	£12,483	£572	£13,055	£13,055
Best Practice Adj'ts	0	£2,070	(£1,726)	£344	£344
Drugs & Devices	0	£26,608	(£24,008)	£2,600	£2,600
AMD	-61	(£62,392)	£60,296	(£2,096)	(£2,096)
Adult Crit Care & Neonatal	136	£211,703	(£150,725)	£60,978	£60,978
Other Non PBR & CQUIN	0	£25,645	£17,141	£42,786	£42,786
PBR & Non PBR Variance	**-1,749**	**(£103,512)**	**(£108,225)**	**(£211,736)**	**(£211,736)**
Critical Care Risk		£143,086		£143,086	£143,086
Total Excluding STF Funding		**£39,574**	**(£108,225)**	**(£68,650)**	**(£68,650)**
Sustainability & Transformation funding				**£0**	£0
Total Including STF Funding		**£39,574**	**(£108,225)**	**(£68,650)**	**(£68,650)**

Please note favourable / (adverse) income

3.2 Non-Commissioner Income

At the end of April 2018, non-commissioner income is below plan by £149k for the following reasons:-

- The loss of the STF monies in relation to A&E performance of £109k.
- RTA income is below plan by £20k

4.0 Key Expenditure Variances

4.1 Pay

<u>Nursing Pay</u> – £141k over spent in total.

Nursing pressures are significant for the month of April with a reported £141k overspend on nursing pay. Urgent Care accounts for £90k and Planned Care £42k of this overspend. This predominantly relates to nurse agency spend (£115k in April 2018 compared to £27k in April 2017) and nursing 1:1 pressures.

Main Urgent Care Nursing Pressures: -

Ward	Sum of WTE Budget	Sum of WTE Actual	Sum of WTE Var	Sum of Pay Var in month
Emergency Department	81.71	84.90	3.19	£ 10,921
Gp Assessment Unit	6.38	7.80	1.42	£ 9,618
Rapid Response Team	31.61	38.84	7.23	£ 20,948
Ward 46 - Short Stay Unit	23.72	25.56	1.84	£ 5,150
Ward 47 - Acute Medical Unit	51.73	56.52	4.79	£ 20,666
Ward 49 - Foregate Ward	33.85	38.18	4.33	£ 12,693
Ward 51 - Acute Frailty Unit	39.43	44.48	5.05	£ 10,382
Grand Total	**268.43**	**296.28**	**27.85**	**£ 90,379**

Main Planned Care Nursing Pressures: -

Ward	Sum of WTE Budget	Sum of WTE Actual	Sum of WTE Var	Sum of Pay Var In Month
Bridge Ward (44)	33.34	36.30	2.96	£ 11,760
Care Packages	35.11	40.65	5.54	£ 10,383
Castle Ward (52)	37.98	39.40	1.42	£ 8,321
Intensive Care Unit	78.99	79.09	0.10	£ 16,317
Jubilee D.C. Theatres	15.36	15.42	0.06	£ 9,884
Palace Ward (45)	30.52	36.50	5.98	£ 18,292
Tower Ward (53)	38.59	39.73	1.14	£ 8,064
Ward 40 Womens Surg Unit	17.20	17.62	0.42	£ 5,320
Grand Total	**287.09**	**304.71**	**17.62**	**£ 88,343**

4.2 Agency Spend & Variable Pay

The agency expenditure position for April 2018 is shown below with a simple straight line projection. The previous year's full year expenditure figures are also shown for comparison:-

Agency Spend by Staff Group	14/15	15/16	16/17	17/18	18/19 YTD to Apr	18/19 Annual Straight Line Projection
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 85,760	£ 7,646	£ 91,757
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433	£ 224,530	£ 2,694,360
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847	£ 115,324	£ 1,383,885
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820	£ 12,519	£ 150,226
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009	£ 15,846	£ 190,153
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 4,372,869**	**£ 375,865**	**£ 4,510,381**

The variable pay position for April is shown below as is the comparison with previous months / year's performance: -

	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Additional Clinical Activity (WL)	£ 149,847	£ 93,189	£ 97,769	£ 92,896	£ 96,253
Locum Payments	£ 351,805	£ 342,263	£ 438,003	£ 416,580	£ 227,108
Additional Basic Pay	£ 73,113	£ 78,788	£ 75,483	£ 80,013	£ 81,765
Overtime	£ 128,066	£ 118,032	£ 144,792	£ 146,771	£ 172,810
Agency Expenditure	£ 464,728	£ 466,077	£ 389,860	£ 478,983	£ 260,969
Bank Expenditure	£ 234,985	£ 352,468	£ 366,705	£ 367,010	£ 320,470
Total Variable Pay Expenditure	**£ 1,402,544**	**£ 1,450,817**	**£ 1,512,612**	**£ 1,582,252**	**£ 1,159,375**
Pay Budget	**£ 13,209,743**	**£ 13,410,595**	**£13,438,463**	**£13,254,141**	**£13,373,246**
Variable Pay as % of Total Budget	**11%**	**11%**	**11%**	**12%**	**9%**

	2014/15 Full Year Spend	2015/16 Full Year Spend	2016/17 Full Year Spend	2017/18 Full Year Spend	2018/19 YTD Spend
Additional Clinical Activity (WL)	£ 1,693,801	£ 1,514,408	£ 1,136,104	£1,225,459	£96,253
Locum Payments	£ 1,996,586	£ 2,833,197	£ 2,905,458	£4,215,573	£227,108
Additional Basic Pay	£ 1,128,161	£ 1,454,549	£ 1,487,368	£1,200,461	£81,765
Overtime	£ 993,742	£ 1,143,224	£ 1,167,972	£1,530,417	£172,810
Agency Expenditure	£ 3,774,873	£ 5,097,591	£ 3,452,003	£4,372,869	£260,969
Bank Expenditure	£ 2,805,054	£ 2,840,072	£ 2,809,066	£3,665,410	£320,470
Total Variable Pay Expenditure	**£ 12,392,217**	**£ 14,883,041**	**£ 12,957,971**	**£ 16,210,188**	**£ 1,159,375**
Pay Budget	**£ 145,850,540**	**£ 148,236,202**	**£ 155,020,877**	**£ 157,824,980**	**£ 13,373,246**
Variable Pay as % of Total Pay Budget	**8%**	**10%**	**8%**	**10%**	**9%**

4.3 Delayed Transfers of Care

Delayed Transfers of Care (DTOC) continue to cause both an operational and financial pressure for the Trust. Invoices have not been raised in respect of this nor income accrued at this point.

The table below shows the numbers for April 2018 compared to the same period last month for both bed days and associated income:

Local Authority	Apr-17			Apr-18		
	Health	Social	Total	Health	Social	Total
Cheshire West & Chester	150	437	587	223	39	262
Wales	161	79	240	79	266	345
Halton	10	0	10	0	7	7
Warrington	32	35	67	31	0	31
Wirral	26	0	26	0	17	17
Cheshire East	0	0	0	0	6	6
Total	**379**	**551**	**930**	**333**	**335**	**668**

Chargeable Income

Local Authority	Apr-17			Apr-18		
	Health	Social	Total	Health	Social	Total
Cheshire West & Chester	£19,500	£56,810	£76,310	£28,990	£5,070	£34,060
Wales	£20,930	£10,270	£31,200	£10,270	£34,580	£44,850
Halton	£1,300	£0	£1,300	£0	£910	£910
Warrington	£4,160	£4,550	£8,710	£4,030	£0	£4,030
Wirral	£3,380	£0	£3,380	£0	£2,210	£2,210
Cheshire East	£0	£0	£0	£0	£780	£780
Total	**£49,270**	**£71,630**	**£120,900**	**£43,290**	**£43,550**	**£86,840**

Please note the income for 2018/19 has not been accounted for within the position to date.

5.0 Cash Releasing Savings (CRS)

The CRS target for 2018/19 is set at £10,739k, made up as follows: -

Operational Challenge (Divisions / Departments)	£6,141k	3.5%
Central Challenge	£4,598	1.3%
Total CRS Requirement	**£10,739**	**4.8%**

Row Labels	Sum of TARGET In Year	
Central	£	4,597,684
Corporate Clinical	£	7,756
D&P	£	840,000
Estates & Facilities	£	489,724
Finance	£	52,470
HR	£	106,018
IMT	£	167,599
Nurse Mangement	£	71,791
Planned Care	£	2,515,966
PPD	£	11,328
Procurement	£	15,771
Trust Admin	£	108,458
Urgent Care	£	1,754,308
Grand Total	**£**	**10,738,873**

Review of the following are to be pursued to support delivery of the central target: -

- Drug prescribing
- Wholly Owned Subsidiary
- ICP / Collaborations
- Reserves
- Balance Sheet Provisions

5.1 April 2018 CRS Performance

CRS performance as at the end of April 2018 is £117k behind the profiled plan.

CRS DIVISIONAL PERFORMANCE AS AT APRIL 2018			
Division / Department	Target to Apr	Achieved to Apr	Var
Planned Care	£ 209,664	£ 70,952	£ 138,712
Urgent Care	£ 146,192	£ 1,616	£ 144,576
D&P	£ 70,000	£ 26,186	£ 43,814
Estates & Facilities	£ 40,810	£ 49,826	-£ 9,015
Nurse Mgmt	£ 5,983	£ 14,137	-£ 8,154
Corporate Clinical	£ 646	£ 424	£ 222
IM&T	£ 13,967	£ 18,397	-£ 4,430
HR	£ 8,835	£ 2,115	£ 6,720
Trust Administration	£ 9,038	£ 7,066	£ 1,972
Finance	£ 4,373	£ 417	£ 3,956
PPD	£ 944	£ 250	£ 694
Procurement	£ 1,314	£ -	£ 1,314
Central	£ 383,140	£ 78,000	£ 305,140
Profile Adjustment (from evens)	-£ 509,011		-£ 509,011
TOTAL	**£ 385,895**	**£ 269,385**	**£ 116,510**

The profile of the CRS target can be found in the table below. In summary the unidentified proportion of divisional / department / central targets, as at the 30th April plan submission date, have been profiled into March 2019. The balance of the targets were profiled to deliver evenly throughout the year apart from Wholly Owned Subsidiary was planned to start delivering from October 2018 and Drug savings from July 2018.

Therefore the CRS performance would be worse by £509k if the target had been profiled evenly. i.e. If this profile adjustment had not been assumed the CRS programme would have been £626k off plan.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Total Target	**386**	**386**	**386**	**536**	**536**	**536**	**703**	**703**	**703**	**703**	**703**	**4,461**	**£10,739**
Monthly Profile	4%	4%	4%	5%	5%	5%	7%	7%	7%	7%	7%	42%	**100%**
Quarterly Profile			11%			15%			20%			55%	**100%**

5.2 In Year & Recurrent CRS Performance

Total CRS schemes delivered in year and recurrently are shown below: -

2018/19 EFFICIENCY PROGRAMME PERFORMANCE AS AT APRIL 2018

IN YEAR

Division / Department	2017/18 In Year CRS Target	Achieved		Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,515,966	£ 86,242	3%	£ 2,429,724	£ 249,948	£ 310,000	£ 521,500	£ 1,348,276
Urgent Care	£ 1,754,308	£ 8,016	0%	£ 1,746,292	£ 374,584	£ 284,000	£ 410,000	£ 677,708
D&P	£ 840,000	£ 26,186	3%	£ 813,814	£ 100,000	£ 100,000	£ 220,000	£ 393,814
Estates & Facilities	£ 489,724	£ 196,936	40%	£ 292,788	£ 97,000	£ 135,000	£ -	£ 60,788
Nurse Mgmt	£ 71,791	£ 18,720	26%	£ 53,071	£ 20,000	£ 10,000	£ -	£ 23,071
Corporate Clinical	£ 7,756	£ 5,090	66%	£ 2,666	£ -	£ -	£ 2,290	£ 376
IM&T	£ 167,599	£ 33,453	20%	£ 134,146	£ 26,838	£ 87,624	£ 13,295	£ 6,389
HR	£ 106,018	£ 9,227	9%	£ 96,791	£ 25,217	£ 24,500	£ 22,707	£ 24,367
Trust Administration	£ 108,457	£ 13,468	12%	£ 94,989	£ 9,579	£ -	£ 1,000	£ 84,410
Finance	£ 52,470	£ 5,000	10%	£ 47,470	£ 17,504	£ -	£ -	£ 29,966
PPD	£ 11,328	£ 3,000		£ 8,328	£ -	£ -	£ 2,000	£ 6,328
Procurement	£ 15,771	£ -	0%	£ 15,771	£ -	£ 15,771	£ -	£ -
Central	£ 4,597,684	£ 78,000	2%	£ 4,519,684	£ -	£ -	£ 3,650,000	£ 869,686
TOTAL	**£10,738,872**	£ 483,338	5%	**£ 10,255,534**	£ 920,670	£ 966,895	£ 4,842,792	£ 3,525,178
		5%		95%	9%	9%	45%	33%
						£1,887,565		£ 8,367,970
						18%		78%

2018/19 EFFICIENCY PROGRAMME PERFORMANCE AS AT APRIL 2018

RECURRENT

Division / Department	2017/18 Recurrent CRS Target	Achieved		Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,515,966	£ 16,680	1%	£ 2,499,286	£ 145,216	£ 80,000	£ 569,500	£1,704,570
Urgent Care	£ 1,754,308	£ -	0%	£ 1,754,308	£ 590,559	£ 168,333	£ 400,000	£ 595,416
D&P	£ 840,000	£ -	0%	£ 840,000	£ 100,000	£ 100,000	£ 220,000	£ 420,000
Estates & Facilities	£ 489,724	£ 160,484	33%	£ 329,240	£ 97,000	£ 210,000	£ -	£ 22,240
Nurse Mgmt	£ 71,791	£ 5,000	7%	£ 66,791	£ 5,169	£ 10,000	£ 9,795	£ 41,827
Corporate Clinical	£ 7,756	£ 5,090	66%	£ 2,666	£ -	£ -	£ 2,290	£ 376
IM&T	£ 167,599	£ 6,705	4%	£ 160,894	£ 3,771	£ 96,831	£ 3,295	£ 56,997
HR	£ 106,018	£ 6,635	6%	£ 99,383	£ 6,000	£ 3,750	£ 31,563	£ 58,070
Trust Administration	£ 108,457	£ -	0%	£ 108,457	£ -	£ -	£ 1,000	£ 107,457
Finance	£ 52,470	£ 5,000	10%	£ 47,470	£ 20,005	£ -	£ -	£ 27,465
PPD	£ 11,328	£ 3,000		£ 8,328	£ -	£ -	£ -	£ 8,328
Procurement	£ 15,771	£ -	0%	£ 15,771	£ -	£ 15,771	£ -	£ -
Central	£ 4,597,684	£ -	0%	£ 4,597,684	£ -	£ -	£5,100,000	-£ 502,315
TOTAL	**£10,738,872**	£ 208,594	2%	**£ 10,530,278**	£ 967,720	£ 684,685	£6,337,443	£2,540,431
		2%		98%	9%	6%	59%	24%
						£1,652,405		£8,877,874
						15%		83%

	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

6.0 Model Hospital Update

The following table provides a summary of the work streams for 2018/19 and progress against the associated savings.

Division / Department	Annual Target	Target to Apr	Achieved to Apr	Var
Business as usual	£ 2,778,528	£ 231,544	£ 263,760	£ 32,216
Collaboration & Integration	£ 540,771	£ 45,064		-£ 45,064
Co-ord Centre & Dashboards	£ 100,000	£ 8,333		-£ 8,333
Drugs	£ 1,901,000	£ 158,417	£ 816	-£ 157,600
Outpatients	£ 50,000	£ 4,167	£ 4,000	-£ 167
Patient Flow	£ 701,000	£ 58,417		-£ 58,417
Procurement	£ 664,396	£ 55,366	£ 559	-£ 54,808
Stranded Patients (DTOCs)	£ 65,000	£ 5,417		-£ 5,417
Theatres	£ 410,000	£ 34,167		-£ 34,167
Unidentified	£ 3,528,178	£ 294,015	£ 250	-£ 293,765
Profile Adjustment (from evens)		-£ 509,011		£ 509,011
Grand Total	**£ 10,738,873**	**£ 385,895**	**£ 269,385**	**-£ 116,510**

Key updates on the workstreams are as follows -

6.1 Process Variation

Patient Flow

An Older Persons Assessment Unit (EMU) is to open in June 2018 which will run a 'hot clinic' with the emphasis around admission avoidance. If patients do need admitting for 1-2 days they will then go to AMU. If they are likely to require admission over 2 days the aim is that they will go directly to Ward 50/51.

A leadership workshop for consultants and lead nurses in the Emergency Department is to be held on the 11th May 2018. Data collection regarding medical variability in how many patients for each A&E doctor is being reviewed. This may help identify patterns of individual learning and developmental needs. Patient safety meetings have been taking place with specialty colleagues with the aim to try and improve cross-specialty working.

Stranded Patients (patients delayed in hospital over 7 days)

An initial meeting regarding this new focus of work was held on the 19th April 2018. It was agreed a point-prevalence of capacity and demand was needed across the system. There was an agreement that a 40% reduction in delayed transfers of care would free up 11 beds per month in the Trust. Further agreement the need to aim for no more than 50 delayed discharges at CoCH and 15 delayed discharges at EPH.

Coordination Centre Programme

A number of small technical issues have been resolved, and the transfer of ownership for core activities to business as usual has taken place, including patient badge management and service desk support. Focus now for the organisation is to maximise the use of the system across the trust to maximise patient flow. This is being monitored through compliance metrics in real time.

Theatres

Plans for a 'perfect week' for theatres are ongoing with it due to take place the first week of July. The text reminder system for inpatient, day case and endoscopy patients are now with IM&T for completion and due to come in to place in June. A competency matrix for combined pre-assessment has also been completed. Theatres improvement boards (communication cells) have been planned and will soon be installed.

Outpatients

The Paper Switch Off project for e-RS (Electronic Referral Service) has completed two months ahead of schedule. The following specialties are now using e-RS for Consultant online triage: Cardiology, Rheumatology, Diabetes & Endocrine, Respiratory, Breast, Urology, and Vascular. Training roll out continues with the remaining specialties. NHS England acknowledgement of this achievement has been received.

There has also been the launch of the electronic Clinic Room Booking Calendar with positive feedback received.

6.2 Clinical Variation

Model Ward

A workforce planning session has been held and a driver diagram completed to form the development of the project plan. A meeting with Associate Directors of Nursing took place on the 1st May with further detail added which reflects ongoing work until February 2019.

A visit to WUTH with senior nurses from Wd 52/53/34 on the 25th April took place to observe their red to green and SAFER processes. The Ward Managers flow meeting has now been renamed to SAFER Patient Flow meeting with key focus on red to green and the SAFER care bundle.

Procurement

Agreed work plan and schemes identified for 2018/19 with the Divisions. This includes 138 projects, 174 maintenance renewals, 27 capital schemes and 19 adhoc pieces of work.

6.3 Performance and Culture

High Performing Culture

A visit with St Helens & Knowsley took place to review their appraisal system, and identify possible partnerships for this project. A conference call has been held with Leeds Trust to gather details about their custom appraisal system, which has led to refinement in the scope and content of our plan. A stakeholder meeting was held on the 26th April with additional detailed responsibilities and targets identified. The number of Management (2 day) sessions is to be increased by 20 by March 2019, and 1/2 day staff sessions increased by 100% each month.

A Staff Barometer group meeting is scheduled for 8th May to confirm Safe, Kind Effective definitions, and review final language for our standards.

Acuity Workforce

The program continues to roll out e-rostering with a planned pilot on Ward 43 for implementation of student nurses. Training for therapy team leaders is taking place as we enter the three-month implementation in therapies.

Alongside these a review and enhanced support is being given to outpatients and theatres.

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Variable Pay

Total variable pay spend reduced in April by £423k compared to the previous month (-27%). The areas incurring the highest spend of agency costs are in Jubilee day case Theatres, ward 46, the escalation ward, and in medical staff.

The variable pay target this year is a £1.5m reduction in expenditure against last year's total of £16.2m.

Planned and Urgent Care divisions are being supported by the Quality Improvement agenda and have produced driver diagrams to identify key issues for action.

6.4 Quality Improvement

A new Quality Improvement Committee has started with the aims to create a strategy to create a culture where by all staff have the tools to be able to improve the areas of which they work. This committee will report to QSPEC and involves a number of multi professions, consultants, lead nurses and AHPs. This Committee is focusing on the following areas:

- Increased engagement, publication and awareness regarding QI
- Improved training programmes and appropriate tools to support staff
- Support the junior doctors and their foundation programme
- Improved monitoring sharing and learning from each other on various projects
- Building relationships and learning with other organisations e.g. Airbus, Toyota etc

7.0 Capital Expenditure

There has been a slow start to the year in terms of capital spend, which represents the brought forward items from 2017/18, with actual spend of £0.2m, compared to the plan of £0.5m.

The new capital program for 2018/19 is set out in a separate paper, and will form the basis of an application for interim revenue loan funding to be submitted to NHSI following approval by the Board.

Based on the experience of the previous year, the approval process could prove to be a protracted one, and it is anticipated that any critical expenditure may need to be approved 'at risk' prior to the loan being approved, in a similar manner to last year.

In addition, the Trust expects receipt of Public Dividend Capital (PDC) in relation to Fast Follower status and the implementation of a new Patient Administration System (PAS).

Furthermore, the Trust, in collaboration with system partners will be submitting a "place" based bid in an attempt to secure funds to improve the facilities used to deliver Acute Care.

8.0 Working Balances and Cash

The closing cash balance at the end of April is £8.1m, which is £2.3m ahead of plan, due primarily to slower than expected brought forward capital payments and a better than anticipated debt recovery from NHS organisations.

The Trust has not requested interim revenue distress funding so far this year, but has agreed to 'roll-over' the amount of the interim revenue loan drawn (currently £6.7m), and review the position once the 2017/18 STF cash (£6.2m) has been received, expected to be in August.

As noted above, a capital loan application will be submitted in due course, to fund the 2018/19 capital program – with the 2017/18 slippage being financed by brought forward cash resulting from the loan for that year being drawn down fully in March.

Cash balances continue to be monitored on a daily basis, feeding into a rolling 13 week cash-flow and the Trust remains in close communication with NHSI to ensure that all future cash funding requirements are clearly identified.

Capital and revenue cash funding and expenditure are clearly segregated as per monitoring and reporting requirements. This includes £2.6m currently held in a separate designated account for the delivery of the Neonatal Unit, which is excluded from the cash figures above.

9.0 Key Risks and Mitigation

The following key risks and mitigation have been identified as at the end of month one:

- **The CRS target for 2018/19** is a significant risk with a significant proportion unidentified 33% or red rated 45%. Divisions and departments continue to identify and implement schemes, organisation wide schemes are being pursued and a review of reserves and balance sheet opportunities is underway;
- **Non Elective Activity and Winter Costs** - escalation capacity has remained and consequently a twelfth of the winter reserve has been applied. There is no confirmation of additional winter funding at this stage in the financial year. It is anticipated that escalation capacity will close imminently;
- **Delayed Transfers of Care (DTOCs)** - remain high and contribute to the requirement to keep escalation capacity open. The associated costs are partially rechargeable in line with the Community Care Act 2014 (where the regulations state a recharge of £130 per bed day for DTOCs), however, unfortunately discussions remain ongoing with partners. As such invoices have not yet been raised for 2018/19 and no income has been accrued at this stage;

- **Elective activity** – there is an under performance on the elective baseline which has been partly mitigated by the West Cheshire block. This represents a risk going forward. Work is underway to explore options to ring fence elective capacity to recover this position;
- **Ellesmere Port Hospital (EPH) Rental Recharges –** NHS Property Services have invoiced the organisation for rental charges for EPH. This is currently in dispute as funding for this did not transfer on the disbursement of the PCT. Discussions continue to try and resolve this matter with support from colleagues at NHSI;
- **The Control Total** may not be delivered should the risks above all materialise;
- **The proposed capital programme** looks to replace urgent and necessary items to enable business to continue as usual, however, a loan application will be required to proceed with purchases approved. The proposed application is not guaranteed;
- **A STP Capital Bid** will be submitted in an attempt to secure funds to support the Acute Care System. If the bid is unsuccessful, a further loan application maybe required;

Appendix 1: Statement of Financial Position and Cash Flow Statement

April 2018 Statement of Financial Position	2018/19 Actual £000	2018/19 Plan £000	2017/18 Out-Turn £000
Property, Plant and Equipment			
Opening	84,759	84,759	81,508
Capital Spend	234	539	7,648
Depreciation	(365)	(365)	(4,324)
Disposals	(8)	(8)	(73)
Revaluation			
Closing	84,620	84,925	84,759
Current Assets			
Opening Cash Balance	9,112	9,112	7,093
Increase/(Decrease)	(1,035)	(3,357)	2,019
Closing Cash Balance	8,077	5,755	9,112
Inventories	1,356	1,441	1,437
Trade and Other Receivables	15,121	16,641	14,478
Neonatal Designated Account	2,591	2,591	2,591
Total current assets	27,145	26,428	27,618
Liabilities < 1 Year			
Trade and Other Payables and Provisions	(26,037)	(25,132)	(25,282)
Loans (ITFF)	(4,686)	(4,688)	(4,686)
PPP Loan	(37)	(37)	(37)
Total Net Current Assets	(3,615)	(3,429)	(2,387)
Liabilities > 1 Year			
Trade and Other Payables and Provisions	(1,350)	(1,350)	(1,350)
Loans (ITFF)	(31,924)	(31,922)	(31,924)
PPP Deferred Income	(1,653)	(1,652)	(1,658)
PPP Loan	(2,069)	(2,075)	(2,078)
Total Assets Employed	**44,009**	**44,497**	**45,362**
Capital & Reserves			
PDC	63,600	63,721	63,600
Revaluation Reserve	4,558	4,558	4,558
Income & Expenditure Reserve	(24,149)	(23,782)	(22,796)
Total Capital & Reserves	**44,009**	**44,497**	**45,362**

April 2018 Cash Flow Statement	2018/19 Actual £000	2018/19 Plan £000	2017/18 Out-Turn £000
Surplus	(843)	(469)	7,332
Working Balance Movements	468	(2,367)	(6,942)
Donated / Grant Funded Asset Additions	8	8	182
Disposal Proceeds	-	-	12
PPP Income/Interest - non cash movements	(6)	(6)	(67)
	(373)	(2,834)	517
Capital Receipts	-	-	-
Capital Expenditure	(643)	(620)	(4,349)
New PDC	-	121	266
Purchase of investments	-	-	(2,591)
New Loans	-	-	14,839
Loan re-payments Principle	-	-	(5,129)
PPP Loan Repayments Principle	(3)	(3)	(55)
Interest Payable	(23)	(23)	(590)
Interest Received	7	2	41
PDC Dividend Paid	-	-	(930)
Cash Inflow / (Outflow)	(1,035)	(3,357)	2,019
Opening Cash Balance	9,112	9,112	7,093
Closing Cash Balance	**8,077**	**5,755**	**9,112**

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Financial Plan 2018/19
Date of Meeting	Board 22nd May 2018
Author(s)	Mr. Simon Holden, Director of Finance Ms. Sue Phillipson, Head of Financial Management
Annual Plan Objective No.	
Summary	This paper outlines the planned budgetary position for 2018/19, in line with the formal submission made to NHS Improvement (on 30th April 2018).
Recommendation(s)	**The Board is asked to note:** o The requirements for a £10.7m Cost Reduction Scheme (CRS), equating to circa 4.8%; o The target surplus for 2018/19 of £2.9m, being the "Control Total", and the underlying Trust deficit of £7.8m (i.e. £2.9m + £7.8m = £10.7m); o The underlying assumptions relating to cost pressures; o The allocation of 3.5% to operational Divisions / Departments, with the remaining 1.3% being a central challenge; o The initiatives underway underpinning the required Cost Reduction Scheme, including Model Hospital & Procurement led schemes; and o A number of the underlying risks, most notably the assumed receipt of an additional £1m from West Cheshire CCG in relation to the "stocktake point", with regards to bed occupancy levels. o
Risk Score	**N/A**

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Countess of Chester Hospital NHS
NHS Foundation Trust

FINANCIAL PLAN 2018/19

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Appendices

1) Introduction

This paper outlines the planned budget for 2018/19 in line with the final NHS Improvement (NHSI) Annual Plan submission on 30th April 2018, and includes details on:-

- The calculation of the forecast underlying Trust Deficit of £7.8m;
- The subsequent requirement for a £10.7m CRS to deliver the agreed planned net surplus control total of £2.9m;
- The pressures that have been recognised, and funded, within the budget plans;
- How the efficiency target of £10.7m has been allocated to divisions/departments; and
- The risks that may impact on the Trusts ability to achieve the required CRS of £10.7m and the planned net surplus of £2.9m.

NB: Technical Note:
Our notified Control Total surplus is £3m, however this excludes the impact of reporting donated asset-related transactions. When added into the position, this planned net surplus reduces to £2.9m. Therefore, for the purposes of this report the target planned net surplus referred to is, the £2.9m.

2) Summary of the Initial Gap (£7.8m)

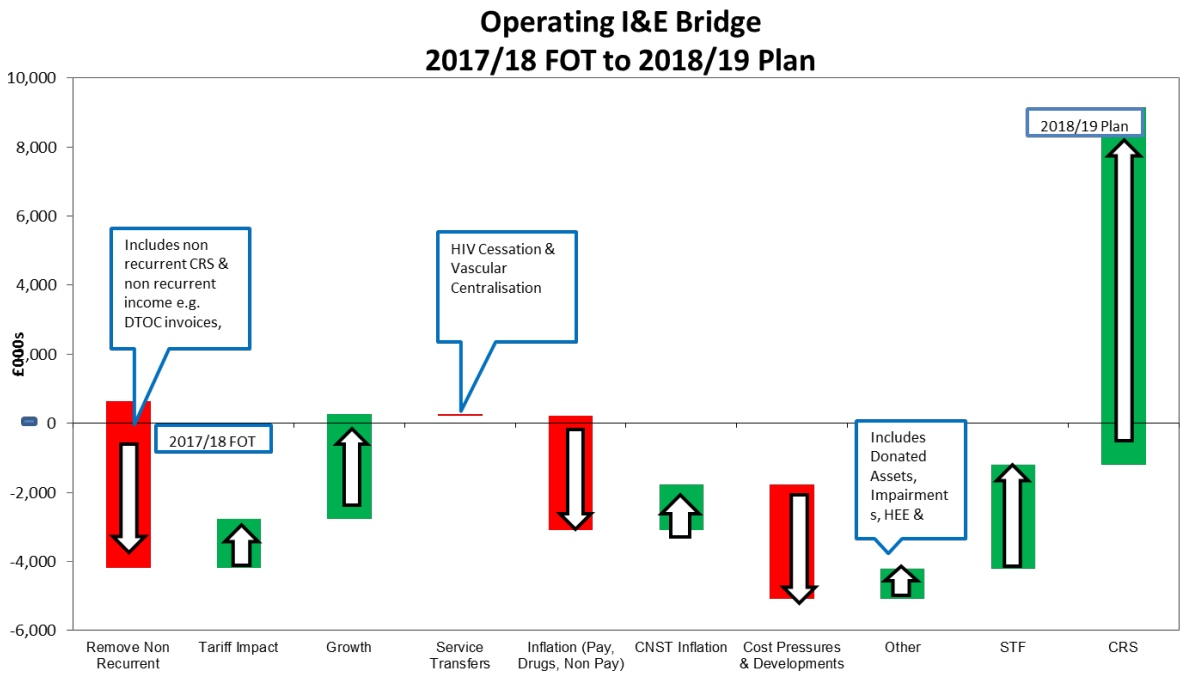
The Trust is facing significant financial pressures in 2018/19 which has resulted in a budget delivering a deficit position of £7.8m, which therefore requires a CRS programme of £10.7m in order to deliver the planned net surplus of £2.9m.

Please find below a high level summary of the overall Trust budget for 2018/19: -

		Proposed Budget 2018/19 £000s
Income		
Commissioner Income	£	201,800
PSF	£	7,297
Training & Education Income	£	7,260
Other Income	£	16,655
Total Income	**£**	**233,012**
Expenditure		
Pay	£	161,897
Non Pay	£	73,392
Capital Charges	£	5,544
Total Expenditure	**£**	**240,833**
Net Deficit	**£**	**7,821**
CRS for 2018/19	**£**	**10,739**
Planned Net Surplus	**-£**	**2,918**
Adjust for Donated Asset Income	£	100
Adjust for Donated Asset Depreciation	-£	145
NHSI Agreed Control Total (Surplus)	**-£**	**2,963**

The table below details how the Trust ended the 2017/18 financial year with a reported £1.8m surplus, largely through the receipt of additional STF Incentive monies and also the £ for £ matched incentive monies from the Babygrow revenue donation.
The subsequent bridge then depicts how the Trust moved from this outturn position to the 2018/19 planned surplus of £2.9m.

2017/18 £'000 Pre Audit		2016/17 £'000
-3,628	**Initial planned Deficit – Control Total**	-3,950
n/a	NHSI Movement Agreed	-1,500
-3,628	**Target Surplus/(Deficit) – Control Total**	**-5,450**
-1,440	A&E STF Monies Not Achieved	-184
1,860	COCH Improvement in Outturn Position re Babygrow revenue donation	n/a
34	COCH Improvement in Outturn Position	300
1,894	NHSI £ for £ Matched Incentive	300
n/a	NHSI Additional Incentive for managing national pressures Change in Discount Rate	745
1,669	NHSI General Distribution	-
1,358	NHSI Bonus Fund	789
1,747	**Reported Surplus/(Deficit) on a Control Total basis**	**-3,500**
n/a	(Impairments) / Reversal of Impairments	3,874
n/a	Loss on Disposals	-8
183	Purchase of donated assets (Charitable Funds)	98
-147	Donated Asset Depreciation	-146
1,783	**Surplus/(Deficit) per the published Accounts**	**318**



3) Underlying Initial Assumptions (in arriving at the gap of £10.7m)

The initial budget included provision for the following: full details are included as Appendix 1:-

- Fully funded mandated cost pressures for 2018/19 of £3,479k;
- Provided a £500k contingency reserve, and £75k contingency for the Combined Heat & Power (CHP) downtime;
- Provided Ring Fenced Funds that can be drawn against to address pressures in relation to medical agency, maternity leave, minor equipment, winter escalation, apprenticeship levy, cerner and other quality initiatives;
- Allows for previously agreed investments and notified cost pressures of £3,619k;

4) Target Savings by Division/Department (£10.7m) – Summary

The CRS target for 2018/19 is set at £10,739k, made up as follows: -

Operational Challenge (Divisions / Departments)	£6,141k	3.5%
Central Challenge	£4,598	1.3%
Total CRS Requirement	**£10,739**	**4.8%**

Row Labels	Sum of TARGET In Year
Central	£ 4,597,684
Corporate Clinical	£ 7,756
D&P	£ 840,000
Estates & Facilities	£ 489,724
Finance	£ 52,470
HR	£ 106,018
IMT	£ 167,599
Nurse Mangement	£ 71,791
Planned Care	£ 2,515,966
PPD	£ 11,328
Procurement	£ 15,771
Trust Admin	£ 108,458
Urgent Care	£ 1,754,308
Grand Total	**£ 10,738,873**

Areas for the central challenge to be pursued are: -

- Drug prescribing
- Wholly Owned Subsidiary
- ICP / Collaborations
- Reserves
- Balance Sheet Provisions

Please see the table below for the profile of the CRS target:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Total Target	**386**	**386**	**386**	**536**	**536**	**536**	**703**	**703**	**703**	**703**	**703**	**4,461**	**£ 10,739**
Monthly Profile	4%	4%	4%	5%	5%	5%	7%	7%	7%	7%	7%	42%	**100%**
Quarterly Profile			11%			15%			20%			55%	**100%**

5) Target Savings by Division/Department (RAG) – Summary

As at April 2018, the current position by divisions / departments against the above targets is shown below, for comparison, the overall percentage position as at April 2017 is also shown.

Sum of TARGET In Year	Column Labels				
Row Labels	Green	Amber	Red	Black	Grand Total
Central	£ 78,000		£ 3,650,000	£ 869,686	£ 4,597,686
Corporate Clinical	£ 5,090		£ 2,290	£ 376	£ 7,756
D&P	£ 126,186	£ 100,000	£ 220,000	£ 393,814	£ 840,000
Estates & Facilities	£ 293,936	£ 135,000		£ 60,788	£ 489,724
Finance	£ 22,504			£ 29,966	£ 52,470
HR	£ 33,088	£ 24,500	£ 24,063	£ 24,367	£ 106,018
IMT	£ 44,379	£ 96,831	£ 20,000	£ 6,389	£ 167,599
Nurse Mangement	£ 38,720	£ 10,000	£ -	£ 23,071	£ 71,791
Planned Care	£ 336,190	£ 310,000	£ 521,500	£ 1,348,276	£ 2,515,966
PPD	£ 3,000		£ 2,000	£ 6,328	£ 11,328
Procurement		£ 15,771			£ 15,771
Trust Admin	£ 23,047		£ 1,000	£ 84,410	£ 108,457
Urgent Care	£ 382,600	£ 284,000	£ 410,000	£ 677,708	£ 1,754,308
Grand Total	**£ 1,386,740**	**£ 976,102**	**£ 4,850,853**	**£ 3,525,178**	**£ 10,738,873**
	13%	9%	45%	33%	100%
Apr-17	37%	16%	13%	34%	100%

6) Target Savings by Division/Department (Model Hospital) - Summary

In order to deliver savings, the overall program has been developed as a combination of Model Hospital work streams, and more traditional initiates. The table below seeks to show those Model Hospital cross cutting initiatives, and to also indicate their status:-

Sum of TARGET In Year	Column Label				
Row Labels	Green	Amber	Red	Black	Grand Total
Business as usual	£ 1,243,844	£ 375,331	£1,159,353	£ -	£ 2,778,528
Collaboration & Integration	£ 5,000	£ 15,771	£ 520,000		£ 540,771
Co-ord Centre & Dashboards		£ 100,000			£ 100,000
Drugs	£ 45,000	£ 100,000	£1,756,000		£ 1,901,000
Outpatients	£ 50,000				£ 50,000
Patient Flow	£ 6,000	£ 145,000	£ 550,000		£ 701,000
Procurement	£ 3,896	£ 95,000	£ 565,500	£ -	£ 664,396
Stranded Patients (DTOCs)		£ 65,000			£ 65,000
Theatres	£ 30,000	£ 80,000	£ 300,000		£ 410,000
Unidentified	£ 3,000			£3,525,178	£ 3,528,178
Grand Total	**£ 1,386,740**	**£ 976,102**	**£4,850,853**	**£3,525,178**	**£10,738,873**
	13%	9%	45%	33%	100%

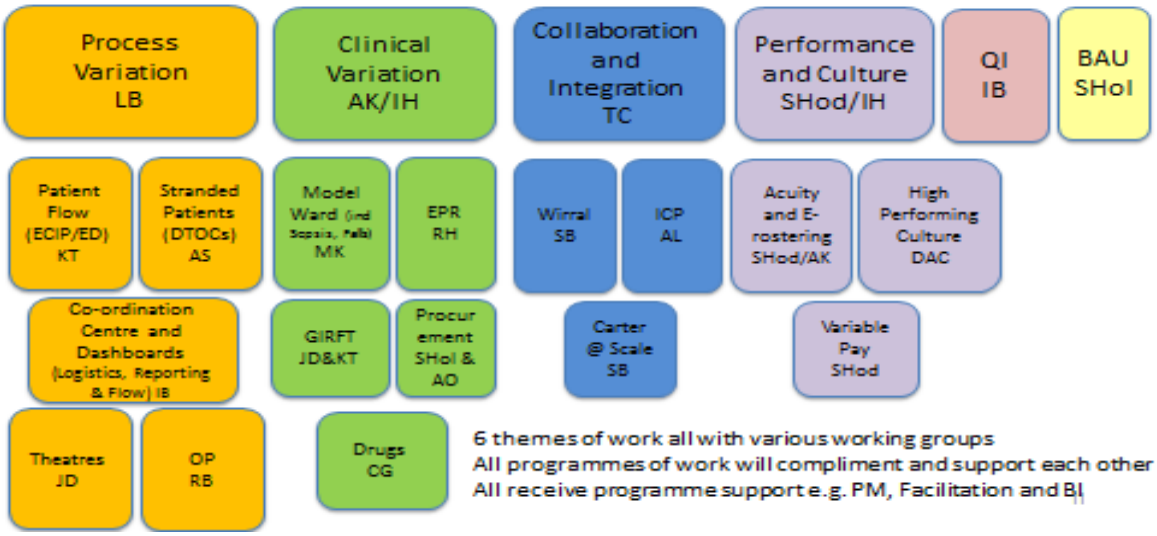
Attached at Appendix 2 are the current details for the saving plans put forward from all the divisions / departments as at April 2018. These are regularly monitored at the weekly CRS meetings to ensure adherence to milestones and targets and progress against unidentified amounts. The Model Hospital Board will also hold the executive leads to account for each of their work-streams, this board reports to FIG.

7) Model Hospital Programme

The Trust has consistently delivered recurrent savings of between £4m - £6m (2% - 3%), however it is becoming more and more difficult to continue to achieve the savings required without a different approach, inside and outside of the hospital. Externally the Trust will be working with its local health and social care partners across West Cheshire, as part of the developing Integrated Care Partnership. A key objective is to help reduce demand on the Trust to bring our bed occupancy levels down to c85% from the current 97%. The benefits of this are significant for our patients and ourselves, from a clinical, operational, safety, wellbeing, and financial perspective. This will give us the headroom and opportunity to explore where further internal savings opportunities can be generated through our Model Hospital workstreams.

Internally, the Model Hospital work shows how good clinical practice, workforce management and careful spending will lead to measurable efficiency improvements while retaining and improving quality. Our work with 'The Carter Review' into NHS productivity, as commissioned by The Department of Health has raised our profile as a pioneer in this field. *The Model Hospital* through a programme based approach will drive progress and accelerate delivery, focusing on four main elements of –

- Process Variation
- Clinical Variation
- Collaboration & Integration
- Performance & Culture



These will be supported by new Quality Improvement processes, and consolidated business as usual activities.

Process Variation

This workstream comprises 5 projects and is sponsored by the Chief Operating Officer –

- **Patient Flow** – building on the work we have done to date to reduce non-elective and elective length of stay in line with national benchmarking, decreasing the number of medically optimised patients and reducing elective cancellations.
- **Stranded Patients (DTOCs)** – working with our local health and care partners to actively reduce the number of stranded patients within our hospital, through active and coordinated discharge management and coordination.
- **Coordination Centre & Dashboards** – building on the Care Coordination project to improve patient flow, and develop and lever operational reporting and intelligence to drive further efficiencies, and support the other Process Variation projects.
- **Theatres** – to continue to drive theatre efficiency projects, focussing on start and end times, access and utilisation, and daycase rates, using the care coordination system analytics.
- **Outpatients** - Improving booking processes to reduce DNA rates and maximise clinic capacity. Review different ways of working to reduce the need for face to face follow up appointments in line with patient need and based on national benchmarking.

Clinical Variation

This workstream comprises four projects and is sponsored by the Medical Director and the Director of Nursing –

- **Model Ward** – focussing on leadership & culture, operational processes, patient safety and escalation processes using best practice quality improvement techniques. Includes a focus on Sepsis and falls, and will start on two medical and two surgical wards initially.
- **Electronic Patient Record –** replacement of our Meditech system and leveraging the benefits as part of the Global Digital Exemplar Fast Follower Programme.
- **GIRFT (Getting it Right First Time) –** building on the reports and recommendations of best practice for clinical services, in conjunction with our Wirral and West Cheshire Alliance work.
- **Procurement –** standardising product procurement and pricing to drive best practice and efficiencies, reducing variation in conjunction with our Alliance and Carter partners. The procurement workplan can be found in appendix 3.

Collaboration and Integration

This workstream comprises 3 projects and is sponsored by the Chief Executive –

- **Wirral & West Cheshire Alliance** – developing our collaborative activities with the Wirral Hospital, with a focus on the shared management and leadership of both clinical and back office services. We will undertake a joint clinical services review to help shape future sustainable models of care across our populations.
- **Integrated Care Partnership** – in West Cheshire, working with our local health and care partners with a focus on the frail elderly, respiratory conditions, risk stratification, enhanced care through integrated working, and community and digital front doors.
- **Carter at Scale** – working across Cheshire & Merseyside to develop new sustainable models of back office and clinical support services, as part of the wider Health and Care Programme work (ex STP).

Performance and Culture

This work stream comprises 3 projects and is sponsored by the HR Director and Medical Director:

- **Patient Acuity & E-Rostering –** building on the work done already with our nursing staff to expand e-rostering into other staffing groups across the Trust.
- **High Performing Culture –** continuing with this project and focussing on leadership and performance management, appraisal and rewards.

- **Variable Pay –** further developing our project to reduce our reliance on variable pay, with a focus on waiting list payments, locum costs, overtime, agency and bank pay.

Each of the workstreams and projects will be supported by our Planning & Partnerships Team, with a new Quality Improvement Committee that will oversee the development and delivery of QI projects and ensure that we meet our Countess vision of being Safe, Kind & Effective.

8) Risks

There are a number of assumptions and risks which could still impact on the Trust's ability to meet its planned surplus including:-

- Ability to deliver recurrently the Cost Reduction Scheme (CRS) at 4.8%;
- The planned net surplus of £2.9m assumes full delivery in year of the £10.7m CRS programme. The delivery of the 2017/18 in year CRS target was achieved with non-recurrent slippage from reserves etc;
- The unidentified element of CRS plans is profiled into March 2019, which is a high risk strategy;
- Limited level of reserves held;
- No reserves have been ring-fenced for future developments or pump priming of initiatives;
- No backlog activity to be undertaken (waiting lists remain);
- Social Care / DTOC issue not resolved;
- Interpretation of "stocktake" point with WCCCG in terms of receipt of the additional £1m that is assumed in our plans;
- Current financial position is supported by non-recurrent items;
- Additional premium costs to deliver non elective activity continue into 2018/19;
- Unknown whether access to winter monies is dependent upon A&E performance;
- Ellesmere Port Hospital Rental charges with NHSPS;
- Approval of required capital loan is assumed; and
- Reduction in elective activity and associated income.

PSF (Provider Sustainability Fund) Risks

If the Trust fails to deliver cost reduction plan and / or performance targets. It is important to note that the PSF monies are more heavily weighted into the second half of the year, meaning that financial or performance failure in quarters 3 and 4 carry a greater penalty – see profile below:

PSF Funding 2018/19	Q1	Q2	Q3	Q4	Total
Financial Elelement	£ 766,185	£ 1,021,580	£ 1,532,370	£ 1,787,765	£ 5,107,900
Performance	£ 328,365	£ 437,820	£ 656,730	£ 766,185	£ 2,189,100
Total	**£ 1,094,550**	**£ 1,459,400**	**£ 2,189,100**	**£ 2,553,950**	**£ 7,297,000**

9) Mitigations

Potential mitigations are as follows:

- Contingency reserve is available to support;
- Modern Equivalent Asset (MEA) review is in progress;
- Clinical Coding Review is in progress (Maxwell Stanley);
- Ellesmere Port Hospital Rental Charges with NHSPS;
- Review of accounting policies; and
- Review of Balance Sheet provisions.

10) Cash

The Trust finished 2017/18 with £9.1m cash, which includes around £3.9m in respect of committed capital spend, including capital creditors. In addition, the Trust is due to receive £6.2m around August 2018 (pending final approval by NHSI) which represents the outstanding Sustainability and Transformation Funding (STF) in respect of the year.

The Trust is not planning to require interim revenue funding in 2018/19, although this is dependent on the successful delivery of the plan, including the challenging CRS target, and the receipt of Provider Sustainability Funding (PSF) during the year. In addition to this, on receipt of the 2017/18 STF, the Trust could potentially repay the £6.7m interim revenue loans drawn down in the previous year.

Capital financing is planned to be provided through an interim capital loan, which will be submitted early in the current year. The Trust is currently finalising the capital requirements, to establish the value of the loan that will be required.

11) Next Steps

There remain a number of next steps that need to be followed, namely:

- Driving the development of new CRS schemes, effectively reducing the "unidentified" element, which as at April 2018 stands at c£3.5m and continuing with the focus;
- Ensuring that as schemes are identified, and worked up, that there is an impetus to ensure that they are refined and delivered (i.e. a "shift" left, from black to red, red to amber etc.);

- Engaging with NHS Improvement, and others (both internally & externally), in seeking assistance to bridge this gap;
- Reviewing the Workforce Options, and evaluating the appetite for implementing a number of the options identified (i.e. conducting a risk/reward evaluation);
- Developing a "contingent" scheme list, of possible initiatives that could be considered, should delivery of the plan be off trajectory;
- Actively seeking to use, and work with, the new Medical Management Structure, as this should be a key enabler of success;
- Actively reflecting on the remaining reserves held centrally to establish whether these could be better managed locally (i.e. through the new Medical Management Structure), and the timing of implementing any potential change; and
- Challenging the Capital Program hard, to establish the absolute priorities (i.e. effectively the 2017/18 commitments brought forward, and also safety concerns), and relating this to the affordability.

Appendix 1

Mandated Cost Pressures		
Pay Award	£	1,574,059
Incremental Drift	£	1,108,119
CEA	£	178,220
General Non Pay Inflation	£	619,000
Total Mandated Cost Pressures	**£**	**3,479,398**

Ring Fenced Funds / Contingency		
Medical pay reserve (agency)	£	2,452,349
Maternity Leave	£	350,000
Contingency	£	500,000
Contingency - CHP Downtime	£	75,000
General Reserve	£	819,778
Minor Equipment	£	100,000
Winter Escalation	£	1,200,000
Quality Monies	£	9,688
Apprenticeship Levy	£	600,000
Cerner	£	328,159
Total Ring Fenced Funds / Contingency	**£**	**6,434,974**

Appendix 1 (cont'd)

Total Funding Disbursed to Divisions / Departments: -			
Cost Pressure / Development Funding			
Planned Care	6th vascular reg	£	24,134
Planned Care	Drugs	£	169,671
Planned Care	Washer testing HSDU	£	9,604
Planned Care	Plastics OP rental at WUTH	£	12,505
Planned Care	Upper GI SLA Betsi	£	15,484
Planned Care	SAU band 7 - 1.00 wte	£	26,000
Planned Care	GP rotation (F2s)	£	135,347
Planned Care	AMD increase from part time to full time at COCH wef 1/4/18	£	119,768
Planned Care Total		**£**	**512,513**
Urgent Care	A&E Nursing - non pay pressures	£	25,016
Urgent Care	Acute Oncology - Clatterbridge SLA reduction	£	66,918
Urgent Care	Cath Lab - pacing consumables	£	27,891
Urgent Care	Drugs	£	202,163
Urgent Care	Drugs FP10s	£	45,374
Urgent Care	Drugs Medical Gases	£	5,607
Urgent Care	Integrated Discharge Team - Delayed Discharge Grant SLA with CWAC	£	52,800
Urgent Care	Intermediate Care Unit - band 2 bank budget	£	14,652
Urgent Care	Intermediate Care Unit - band 5 bank budget	£	6,646
Urgent Care	SSU original budget M-F, now weekends also, cost pressure in relation to enhancements	£	21,282
Urgent Care	Acute Medicine - 1.00 wte ST1/2	£	158,424
Urgent Care	A&E Medical - 4 speciality doctors	£	294,088
Urgent Care	Bluebell band 2 fire safety post required to cover 7 nights 52 weeks per year	£	48,352
Urgent Care	Bluebell - OT band 5	£	54,369
Urgent Care	Bluebell - OT band 6	£	30,404
Urgent Care	Bluebell - Physio band 6	£	38,164
Urgent Care	Nurse Specials (band 2)	£	184,776
Urgent Care	UTC - Staff Grade (Emergency Med)	£	84,000
Urgent Care	A&E Nursing - bank band 2	£	3,354
Urgent Care	Acute Medicine - 1.00 wte Consultant (Acute Internal Medicine)	£	109,526
Urgent Care	Intermediate Care Unit - 1.00 wte band 6 (Elderly)	£	47,779
Urgent Care	Bluebell band 6 15 hours mental health nurse (Elderly)	£	16,879
Urgent Care	Bluebell - PAM band 3 (support)	£	42,066
Urgent Care	Bluebell - PAM band 4 (support)	£	26,126
Urgent Care	Bluebell - housekeeper (support)	£	14,673
Urgent Care	Frailty (Old Persons) Assessment Unit Ward 46 (band 5s)	£	235,848
Urgent Care Total		**£**	**1,857,177**

D&P	Micropath - CWMS budget	£	132,813
D&P	UTC - reception	£	28,000
D&P	Health Records scanning BC band 2 - 2 wte	£	30,000
D&P Total		**£**	**190,813**
Estates & Facilities	Estates - EBME maintenance contract	£	80,000
Estates & Facilities	Estates - Rates 18/19 revaluation	£	27,000
Estates & Facilities	Estates - water testing	£	22,000
Estates & Facilities	Estates - Climate Change Levy	£	7,000
Estates & Facilities	Estates - authorise engineers	£	27,500
Estates & Facilities	Facilities - Security staff	£	13,000
Estates & Facilities	Facilities - UTC Domestics	£	15,000
Estates & Facilities Total		**£**	**191,500**
Nurse Management	UTC & Radiology to be added to friends & family test	£	5,000
Nurse Management	Falls post 1.00 wte band 7 (Acute, Eld, General)	£	52,490
Nurse Management Total		**£**	**57,490**
Corporate Non Clinical	Finance - additional CFO costs	£	13,457
Corporate Non Clinical	HR - Annual staff survey	£	5,869
Corporate Non Clinical	Information - additional resp allow re: restructure	£	6,799
Corporate Non Clinical	OH - Hep B vaccine	£	6,155
Corporate Non Clinical	IMT - back up tapes mtce contract previously charged to capital	£	4,000
Corporate Non Clinical	IMT - Microsoft licenses due to expansion of PCs, laptops & mobiles	£	20,000
Corporate Non Clinical	Teletracking - annual charge	£	500,000
Corporate Non Clinical	Model Hospital -staff costs until 30th Apr 18	£	1,773
Corporate Non Clinical	HR - union rep 2 days band 1	£	7,584
Corporate Non Clinical	Trust Admin - Information to Solicitors income target	£	61,200
Corporate Non Clinical	W&C Management	£	70,242
Corporate Non Clinical	IMT- Network Access Control	£	28,800
Corporate Non Clinical	HR - Allocate Health Medics Proposal	£	54,122
Corporate Non Clinical	Finance - new costing system (server cost)	£	29,245
Corporate Non Clinical Total		**£**	**809,246**
Grand Total		**£**	**3,618,739**

Appendix 2 – Divisional / Department CRS Scheme Progress as at April 2018

Higher Division	Planned Care				
Sum of TARGET In Year	**Column Labels**				
Row Labels	**Green**	**Amber**	**Red**	**Black**	**Grand Total**
Alder Hey Endoscopy/HSDU			£ 2,000		£ 2,000
Birth Rate Plus 17/18	£ 5,772				£ 5,772
Capacity Pots	£ 100,000				£ 100,000
Closure of 6 EL beds			£150,000		£ 150,000
CNST rebate		£150,000			£ 150,000
Community dental SLA			£ 6,000		£ 6,000
Dental Nurse Consultation	£ 15,000				£ 15,000
Divisional / Department Unidentified				£1,348,276	£ 1,348,276
Drugs savings			£ 46,000		£ 46,000
ENT review of outpatients (linked with CCG and Audiology)					
ENT SLA 17/18	£ 1,518				£ 1,518
Great Sutton Vasectomy Rental	£ 2,313				£ 2,313
Hearing aids		£ 30,000			£ 30,000
HSDU Getinge contract savings	£ 3,896				£ 3,896
Incremental point savings	£ 5,000				£ 5,000
IVI rental for additional space	£ 15,000				£ 15,000
IVI Year End Benefit	£ 4,887				£ 4,887
Managed endoscopy					
Moviprep					
Non Recurrent Vacancies	£ 120,000				£ 120,000
Obstetrics structure pension savings	£ 7,000				£ 7,000
Orthotics contract					
Outpatients nursing	£ 20,000				£ 20,000
PPAT training endoscopy	£ 804				£ 804
Private patient development					
Procurement savings		£ 50,000	£ 7,500		£ 57,500
THEATRES efficiencies			£300,000		£ 300,000
THEATRES Ophthalmology additional work for Wales	£ 30,000				£ 30,000
THEATRES Ophthalmology pre-loaded lenses			£ 8,000		£ 8,000
THEATRES Welsh activity		£ 80,000			£ 80,000
Urology collaboration					
Vestibular income			£ 2,000		£ 2,000
W&C alliance project support	£ 5,000				£ 5,000
Grand Total	**£ 336,190**	**£310,000**	**£521,500**	**£1,348,276**	**£ 2,515,966**

Higher Division	Urgent Care				
Sum of TARGET In Year	**Column Labels**				
Row Labels	**Green**	**Amber**	**Red**	**Black**	**Grand Total**
Best Practice Tariffs				£ -	£ -
Chester Uni - Therapies Tutoring		£ 6,000			£ 6,000
Clinical MD Program			£ 10,000		£ 10,000
Divisional / Department Unidentified				£677,708	£ 677,708
Drugs savings	£ 45,000				£ 45,000
Extend Therapy Led Ward Concept to EPH		£ 65,000			£ 65,000
Freeze on incremental uplifts	£ 15,000				£ 15,000
Insulin Pump Supplier Discount - 50% Gainshare				£ -	£ -
MAFS	£ 2,000				£ 2,000
MARS		£ 10,000			£ 10,000
Milk Bank Surplus		£ 10,000			£ 10,000
Non Recurrent Vacancies	£ 150,000				£ 150,000
Patient Transport Review - Private Taxis		£ 10,000			£ 10,000
Procurement savings		£ 20,000			£ 20,000
Reduction in non-pay	£ 120,000				£ 120,000
Reduction in tests referred budget	£ 35,000				£ 35,000
Review model of care across UC Wards		£100,000			£ 100,000
Review of bed capacity Cardiology	£ 6,000				£ 6,000
Review of SJA Contract		£ 10,000			£ 10,000
Staffing Reviews		£ 3,000			£ 3,000
Stoke Bariatric Service SLA	£ 9,600				£ 9,600
Therapies - Bariatric Pathway		£ 5,000			£ 5,000
Urgent Care Reduction in 0.5 day LOS			£400,000		£ 400,000
Ward 46 & Ward 47 Merge		£ 45,000			£ 45,000
Grand Total	**£ 382,600**	**£284,000**	**£410,000**	**£677,708**	**£ 1,754,308**

Higher Division	D&P				
Sum of TARGET In Year	**Column Labels**				
Row Labels	**Green**	**Amber**	**Red**	**Black**	**Grand Total**
Consultant productivity			£ 50,000		£ 50,000
Consultant retire & Return	£ 30,000				£ 30,000
Divisional / Department Unidentified				£393,814	£ 393,814
Drugs savings		£100,000			£ 100,000
IR consumables			£ 40,000		£ 40,000
Joint microbiology			£ 20,000		£ 20,000
MSK MRI direct access			£ 50,000		£ 50,000
Non Recurrent Vacancies	£ 26,186				£ 26,186
Partial booking					£ -
Pathology collaboration					£ -
Staffing Reviews	£ 70,000		£ -		£ 70,000
Ward technicians			£ 60,000		£ 60,000
Grand Total	**£ 126,186**	**£100,000**	**£220,000**	**£393,814**	**£ 840,000**

Higher Division	Estates & Facilities			
Sum of TARGET In Year	**Column Labels**			
Row Labels	**Green**	**Amber**	**Black**	**Grand Total**
Car parking income	£ 20,000			£ 20,000
Catering income	£ 30,000			£ 30,000
Divisional / Department Unidentified			£60,788	£ 60,788
ELDU		£ 10,000		£ 10,000
EPH electricity	£ 5,000			£ 5,000
Estates subscriptions	£ 7,000			£ 7,000
Fire Safety training	£ 2,000			£ 2,000
Joint on-call	£ 12,000			£ 12,000
LED replacement lighting		£ 10,000		£ 10,000
Linen income	£ 10,000			£ 10,000
Linen tender		£ 15,000		£ 15,000
Maintenance	£ 60,000			£ 60,000
Non Recurrent Vacancies	£ 12,452			£ 12,452
Patient transport	£ 5,000			£ 5,000
Porter staffing review		£100,000		£ 100,000
Recurrent income	£ 2,484			£ 2,484
Retail income	£ 48,000			£ 48,000
Sale of scrap	£ 5,000			£ 5,000
Staffing Reviews	£ 65,000	£ -		£ 65,000
Transport	£ 5,000			£ 5,000
Waste review (cardboard)	£ 5,000			£ 5,000
Grand Total	**£ 293,936**	**£135,000**	**£60,788**	**£ 489,724**

Higher Division	Nurse Mangement

Sum of TARGET In Year	Column Labels				
Row Labels	Green	Amber	Red	Black	Grand Total
Comms recurrent non pay savings			£ -		£ -
Comms recurrent pay savings	£ -				£ -
Divisional / Department Unidentified				£ 23,071	£ 23,071
ICP			£ -		£ -
Income generation			£ -		£ -
Non recurrent income	£ 9,200				£ 9,200
Non recurrent non pay savings	£ 20,000				£ 20,000
Non recurrent pay savings	£ 4,520				£ 4,520
Recurrent non pay savings		£ 10,000			£ 10,000
Recurrent pay savings	£ 5,000				£ 5,000
Talley Ventiuri pumps and dressing			£ -		£ -
Grand Total	**£ 38,720**	**£ 10,000**	**£ -**	**£ 23,071**	**£ 71,791**

Higher Division	Corporate Clinical

Sum of TARGET In Year	Column Labels			
Row Labels	Green	Red	Black	Grand Total
Divisional / Department Unidentified			£ 376	£ 376
Recurrent non pay savings		£ 2,290		£ 2,290
Staffing Reviews	£ 5,090			£ 5,090
Grand Total	**£ 5,090**	**£ 2,290**	**£ 376**	**£ 7,756**

Higher Division	Trust Admin

Sum of TARGET In Year	Column Labels			
Row Labels	Green	Red	Black	Grand Total
Divisional / Department Unidentified			£ 84,410	£ 84,410
Income generation	£ 3,357			£ 3,357
Non Pay Reduction		£ 1,000		£ 1,000
Non Recurrent Vacancies	£ 9,240			£ 9,240
Staffing Reviews	£ 10,450			£ 10,450
Grand Total	**£ 23,047**	**£ 1,000**	**£ 84,410**	**£ 108,457**

Higher Division	Finance

Sum of TARGET In Year	Column Labels		
Row Labels	Green	Black	Grand Total
Divisional / Department Unidentified		£29,966	£ 29,966
Finance Non Pay	£ 5,000		£ 5,000
Staffing Reviews	£ 17,504		£ 17,504
Grand Total	**£ 22,504**	**£29,966**	**£ 52,470**

Higher Division	HR

Sum of TARGET In Year	Column Labels				
Row Labels	Green	Amber	Red	Black	Grand Total
Clinical Education Income Outturn 17/18	£ 3,000				£ 3,000
Clinical Education Income Growth 18/19			£ 1,000		£ 1,000
Divisional / Department Unidentified				£24,367	£ 24,367
HR services for Chester Child Birth Charity					
HRWBS electronic expenses and Paperless Pay Slips and other efficiency savings			£15,563		£ 15,563
Increments Withheld Mandatory Training Non Compliant		£15,000			£ 15,000
Manual Handling Travel	£ 3,635				£ 3,635
Medical Staff Post Grad Course Fees		£ 9,500			£ 9,500
Non Recurrent Vacancies	£ 19,217				£ 19,217
Practice Development Nurses Non Pay	£ 1,000				£ 1,000
Salary Sacrifice Schemes					
Sign Language Interpreter fees	£ 5,000				£ 5,000
Staff Counselling joint tender with Mid Cheshire			£ 2,500		£ 2,500
Staffing Reviews			£ 5,000		£ 5,000
Wirral Community Equality & Diversity SLA 6 months	£ 1,236				£ 1,236
Grand Total	**£ 33,088**	**£24,500**	**£24,063**	**£24,367**	**£ 106,018**

Higher Division	IMT

Sum of TARGET In Year	Column Labels				
Row Labels	Green	Amber	Red	Black	Grand Total
Divisional / Department Unidentified				£6,389	£ 6,389
Maint Contracts			£10,000		£ 10,000
Mobiles		£ 4,000			£ 4,000
Non Recurrent Vacancies	£ 20,000				£ 20,000
San Maint Contracts			£10,000		£ 10,000
Senior Management Restructure		£88,831			£ 88,831
Staffing Reviews	£ 22,991				£ 22,991
Text Messaging		£ 4,000			£ 4,000
Year End Creditors	£ 1,388				£ 1,388
Grand Total	**£ 44,379**	**£96,831**	**£20,000**	**£6,389**	**£ 167,599**

Higher Division	Procurement

Sum of TARGET In Year	Column Labels	
Row Labels	Amber	Grand Total
Collaboration with WUTH	£ 15,771	£ 15,771
Grand Total	**£ 15,771**	**£ 15,771**

Higher Division	PPD

Sum of TARGET In Year	Column Labels			
Row Labels	Green	Red	Black	Grand Total
Divisional / Department Unidentified			£6,328	£ 6,328
Income generation		£2,000		£ 2,000
Non Pay Reduction	£ 3,000			£ 3,000
Grand Total	**£ 3,000**	**£2,000**	**£6,328**	**£ 11,328**

Higher Division	Central

Sum of TARGET In Year	Column Labels			
Row Labels	Green	Red	Black	Grand Total
Central Unidentified			£869,686	£ 869,686
Drugs savings		£1,650,000		£ 1,650,000
ICP / Collaboration		£ 500,000		£ 500,000
Procurement savings		£ 500,000		£ 500,000
Reserve Utilisation	£ 78,000			£ 78,000
Wholly Owned Subsidiary		£1,000,000		£ 1,000,000
Grand Total	**£ 78,000**	**£3,650,000**	**£869,686**	**£ 4,597,686**

Appendix 3 – Procurement Work Plan
CRS target 2018/2019 - £400k

Number of Projects

- 138 Core/General Projects
- 176 Maintenance Renewals
- 24 Adhoc Projects
- 8 Capital Projects

Total Projects for 2018/2019 - 346

Background to Formulation of Workplan

The workplan is formulated by renewals of contracts that are due to expire in 2018/2019, projects carried over from the workplan 2017/2018, PPIB data and Non Contracted spend opportunities. Projects were carried over from the 2017/2018 workplan, due to Adhoc Projects that came up during the course of the year and took precedence over the Core/General Projects

We are now operating a rolling workplan to better support delivery of Projects and in turn CRS, in addition to resource management and prioritisation.

Key Schemes

The below table provides a snapshot of some of the Key and Critical Schemes Procurement will be working on in respect of spend and potential savings. The below in itself represents a spend of approximately £5,958,496 and potential savings opportunities of £238,339

Project Title
Interventional Radiology & Catheter Lab Consumables
Endosurgery Consumables (Trocars - Phase 2)
Shoulders & Related Consumables
Sterile Hospital Procedure Packs
Hearing Aids
Primary Knees
Covidien Ligasures Consumables
Framework Surgical Services Outsourcing
Framework Surgical Services Insourcing
Haemodialysis Consumables - Fresenius
Ophthalmic Theatre Consumables
Managed Service for Blood Grouping Analyser
Unified Communications (VoIP)
Shared Health Records

Medical Surgical and General Consumables
External Audit
eRostering and Acuity Based Workforce System
Surgical Instruments & Surgical Instrument Repair
Hand towels
Catering Food Purchases
Spend under a/c 67319 (Additional To Maintenance Contract)
Infusion Devices
Intraocular Lenses Phaco Consumables and Associated Equipment
Miscellaneous Print combined with Printed Stationery, Medical Case Notes and X Ray Envelopes
Water and sewerage services

Other Key Schemes that the Contracts Team will be working on in 2018/2019, but will not deliver in year and contribute to savings are Cerner and Ritmocore

Additional areas for review

As part of the workplan we will be looking into some new areas identified as part of the Non Contracted Spend analysis. It has been identified that further work can be done around Agency Spend, in order to fully understand where we are spending, to ensure compliance with EU Legislation and identify potential savings opportunities. A piece of work will be done to have a closer look into our spending under the overarching category of food. There are complexities in this area due to fluctuations in pricing, however it has been highlighted as a potential opportunity.

Collaborative working with other Trusts

Projects that are currently being progressed in collaboration with other Trusts are as follows:

- Radiation Protection Services
- Clean Room Clothing
- CPAP
- Clinical Benchmarking

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Proposed Capital Program 2018/19
Date of Meeting	Board - Tuesday 22nd May 2018
Author(s)	Mr. Simon Holden, Director of Finance Ms. Jennie Birch, Deputy Director of Finance
Annual Plan Objective No.	
Summary	This paper sets out the process used to determine the proposed capital program for 2018/19.
Recommendation(s)	**The Board is asked to approve:** o The proposed Capital Programme for 2018/19 and subsequent loan application; and note o The revenue implications of the capital programme; and o The proposed "place" based bid for STP capital.
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.

Proposed Capital Program 2018/19

1.0 Financial Summary

The table below shows the value of the priority one schemes and recommended phasing resulting in a proposed capital program of £7m for 2018/19.

Row Labels	2018/19	2019/20	2020/21	Grand Total
Central	£ 779,000			£ 779,000
D&P	£ 1,423,649	£ 1,730,000		£ 3,153,649
EDTC HR	£ 140,000			£ 140,000
Estates and Facilities	£ 1,880,339	£ 252,575	£ 13,200	£ 2,146,114
IM&T	£ 472,028	£ 235,000		£ 707,028
Nurse Management				
Planned Care	£ 1,854,403	£ 1,157,990	£ 304,732	£ 3,317,125
Urgent Care	£ 409,859	£ 800,000		£ 1,209,859
Grand Total	**£ 6,959,278**	**£ 4,175,565**	**£ 317,932**	**£ 11,452,775**

Please see appendix 1 for full detail of schemes.

2.0 Process

The process adopted to determine the proposed capital program is as follows:

- The Equipment Replacement Priority Tool (ERPE) was utilised to determine high priority items which met the criteria of urgent and necessary and are termed “Priority One Items”;
- Divisional Directors were responsible for prioritising their own areas;
- Significant Schemes (by value or volume) were discussed at the Capital Steering Group;
- Consideration was given to the need to replace certain items of medical equipment simultaneously to minimise clinical risk e.g. defibrillators and anaesthetic machines;
- Links to STP cross cutting schemes were noted and reinforced;
- Cognisance taken of “deliverability” in year; and
- Multi-year approach adopted although this paper only includes “Priority One Items” and consequently does not reflect the full requirement for subsequent financial years.

3.0 Financial Implications

As the Trust is currently in revenue distress, a capital distress loan will be required to support the proposed capital program; it is proposed that the loan is taken out over a 15 year period subject to DH approval.

The associated capital charges including depreciation and interest have been approximated and subsequently factored into the 18/19 financial plan.

4.0 STP Capital

In addition to the loan application to support the requirements detailed above, there is also an opportunity to bid for capital resource via the STP. As NHS capital remains constrained, funds will be targeted at the schemes which demonstrate deliverability of the greatest clinical and financial sustainability. Each "Place" has the opportunity to bid for capital and it has been agreed within our local partners that our "Place" based bid will focus on acute care within the system.
It is therefore proposed that this route is pursued in the first instance to secure additional funds to support the required development of the estate. Should this prove to be unsuccessful, a further loan application may be required e.g. to support development of the A&E facility.

5.0 Recommendation

The Board is asked to:

- Approve the proposed Capital Programme and subsequent loan application;
- Note the financial implications of approving the capital program; and
- Note the approach regarding STP capital.

Sum of AMOUNT	Column Labels			
Row Labels	2018/19	2019/20	2020/21	Grand Total
Central	**£ 779,000**			**£ 779,000**
Capital Staffing	£ 250,000			£ 250,000
Loan repayment above depreciation	£ 529,000			£ 529,000
D&P	**£ 1,423,649**	**£1,730,000**		**£ 3,153,649**
BF - 1 Ultrasound scanner Breast	£ 51,871			£ 51,871
BF - 2 Cytotoxic isolators	£ 60,876			£ 60,876
BF - Outpatients Refurbishment - All areas		£ 20,000		£ 20,000
CT scanner (advanced)	£ 564,000			£ 564,000
Laboratory refurbishment to accommodate equipment for GP sample processing for COCH /WUTH. Re-location of transfusion to the first floor. This would involve removing walls between the current Immunology laboratory ,making the floor/ ceiling good and replacing one office.		£ 120,000		£ 120,000
Microscope with teaching arm(s)	£ 14,902			£ 14,902
Replacement of 5 blood gas analysers		£ 60,000		£ 60,000
Replacement of A&E Minors Mediwell unit		£ 30,000		£ 30,000
Replacement of Aseptic Unit		£1,440,000		£ 1,440,000
Replacement of Pharmacy Robot.	£ 480,000			£ 480,000
TEMPERATURE MONITORING SYSTEM	£ 60,000			£ 60,000
upgrade / replacement of Airtube system		£ 60,000		£ 60,000
US Breast unit	£ 192,000			£ 192,000
EDTC HR	**£ 140,000**			**£ 140,000**
Defibrillators	£ 140,000			£ 140,000

Estates and Facilities	£	1,880,339	£	252,575	£	13,200	£	2,146,114
150 litre steam heated cooking kettles	£	24,000					£	24,000
BF - Cancer Tracker conversion	£	50,000					£	50,000
BF - Chilled water plant JDSC	£	31,029					£	31,029
BF - Distribution Boards 52, 53, 42, 46, 47 and A&E	£	59,693					£	59,693
BF - Equipment and Controls Heating and Ventilation Plant Room 2 (further use of CHP waste heat may be possible as part of this project)	£	529,200					£	529,200
BF - Exec Relocation	£	56,138					£	56,138
BF - Fire Alarm upgrades, Fire Compartmentation works (that includes works arising from risk assessments and audits	£	60,000					£	60,000
BF - Medical Gases, Electrical upgrade Neonatal Unit	£	75,000					£	75,000
BF - Theatre 9	£	589,650					£	589,650
BF - Theatre Chillers	£	38,029					£	38,029
BF - Washing machine replacement	£	6,000					£	6,000
Blast chiller from Foster code RBC20					£	13,200	£	13,200
Bradshaw tug for patient meals			£	11,375			£	11,375
CCTV upgrade			£	12,000			£	12,000
Ciller Haygarth	£	17,000					£	17,000
Community Dental Ventilation	£	30,000					£	30,000
Cooker	£	11,000					£	11,000
JDSC Lift	£	19,000					£	19,000
LED lighting	£	24,000					£	24,000
Net2 upgrade			£	12,000			£	12,000
Nurse Call Ward 46/54/Antenatal	£	54,000					£	54,000
Plant Room 11 supplying heating and hot water to Wards 48,49,50,51 and ward 60	£	60,000					£	60,000
Ride on scrubber/drier	£	21,600					£	21,600
Self - cleaning oven from Rational ovens SCC201			£	25,200			£	25,200
Staff Restaurant heating system upgrade	£	18,000					£	18,000
Steamer	£	11,000					£	11,000
Theatre 5 Essential critical engineering works			£	96,000			£	96,000
Theatre 6 Essential critical engineering works			£	96,000			£	96,000
Vacuum Plant in Women and Children's Building is non compliant, AGSS individual systems required	£	96,000					£	96,000

IM&T	£	472,028	£	235,000		£	707,028
Air Handling Units Data Centre 1	£	27,000				£	27,000
BF - EPR - Tech Fund - outstanding balance from NHS Digital monies not spent (I Giffins) to be used to purchase computer hardware required to provide Cerner access to wards	£	43,808				£	43,808
BF - General Infrastructure			£	50,000		£	50,000
BF - Network Access Control	£	144,000				£	144,000
BF - Shared Infrastructure Services			£	80,000		£	80,000
Cyber Security (inc annual health check)			£	10,000		£	10,000
Ensure evolve servers are on Microsoft SQL Platform - one off	£	15,000				£	15,000
KACE supports the trusts virtualised infrastructure maximisation of server resources. Revenue cost to support Server Patching Tool Set above	£	5,000				£	5,000
NAGOIS early warning to prevent outages	£	10,000				£	10,000
North West Shared Infrastructure, revenue implication of Shared Infrastructure Services above			£	20,000		£	20,000
Pager Replacement	£	77,220				£	77,220
Rolling Switch replacement			£	75,000		£	75,000
Server and License Refresh (Cyber Security)	£	75,000				£	75,000
Server Patching Tool Set (Security Patches)	£	25,000				£	25,000
Virtual Server Rolling Refresh	£	50,000				£	50,000

Planned Care	£ 1,854,403	£1,157,990	£304,732	£ 3,317,125
Alphamaxx		£ 50,400		£ 50,400
Anaesthetic machine / Vent	£ 58,145	£ 106,653		£ 164,798
Auto Refractometer		£ 11,117		£ 11,117
Autoclave		£ 72,000		£ 72,000
Automatic Tourniquet	£ 5,254			£ 5,254
BARIATRIC DIRECT PLACEMENT LEG HOLDERS	£ -		£ 7,200	£ 7,200
BF - 2 Europrobe Sentinel Node Machines (Breast Surgery)	£ 40,000			£ 40,000
BF - 3 Anaesthetic machines	£ 54,000			£ 54,000
BF - 3 Ultrasound scanners CLS / ANC	£ 120,077			£ 120,077
BF - 8 CPAP / Bipap devices	£ 69,000			£ 69,000
BF - Duoscope 25	£ 49,975			£ 49,975
BF - ENT Power control Units	£ 90,000			£ 90,000
BF - Fetal Monitor	£ 9,909			£ 9,909
BF - Fetal Monitoring	£ 27,198			£ 27,198
BF - Patient trolley	£ 9,137			£ 9,137
BF - Slitlamp	£ 28,320			£ 28,320
BF 1T240 Bronchoscope	£ 116,640			£ 116,640
Biometric Ultrasound		£ 6,413		£ 6,413
Bipolar Electrosurgical Unit		£ 9,915		£ 9,915
Bladder Scanner	£ 9,504			£ 9,504
Blood Scavenging System	£ 28,800			£ 28,800
Camera system		£ 7,314		£ 7,314
CF 240L Colonoscope		£ 230,400		£ 230,400
CF Q260DL Colonoscope			£ 57,600	£ 57,600
CHOLEDOCOSCOPE	£ -			£ -
Colposcope	£ 15,161	£ 10,567		£ 25,728
CYF 240 Cystoscope		£ 36,000		£ 36,000
Defibrillator monitor & rec & AED	£ 94,479			£ 94,479
Defibrillator monitor & rec & pacer	£ 21,281			£ 21,281
DH14258		£ 64,800		£ 64,800
DIRECT PLACEMENT LEG HOLDERS	£ -			£ -
ENT workstation	£ -	£ 23,709	£123,840	£ 147,549
Fetal Monitor	£ 21,279			£ 21,279
Fundus Camera	£ 83,585			£ 83,585
GIF 1T240 Gastroscope		£ 302,400	£ 50,400	£ 352,800
Humphrey Field Analyser	£ 77,371			£ 77,371
Light Source	£ -			£ -
Microkeratome DSAEK System	£ -			£ -
Microscope	£ 12,263			£ 12,263
MODEL "J"		£ 50,400		£ 50,400
OPERATING TABLE, MODEL MR	£ 50,400			£ 50,400
ORTHOSTAR OPERATING TABLE	£ 244,800			£ 244,800
Otoscope - Halogen Set	£ -			£ -
Perimeter	£ -			£ -
Radioguided Surgical Probe	£ -			£ -
RINI OPERATING TABLE		£ 21,600		£ 21,600
Slit lamp	£ 86,400			£ 86,400

STILLE IMAGIQ TABLE	£ 79,200			£ 79,200
Surgical Diathermy	£ 28,645	£ 62,098	£ 60,514	£ 151,257
Synoptophore	£ 21,600			£ 21,600
Syringe Driver			£ 5,178	£ 5,178
THEATRE INSTRUMENTS	£ 100,381			£ 100,381
TJF 240 Duodenoscope	£ 201,600			£ 201,600
TJF 260v Duodenoscope		£ 50,400		£ 50,400
Tonometer	£ -			£ -
Ultrasound Scanner		£ 10,080		£ 10,080
VNG/ENG System		£ 31,725		£ 31,725

Urgent Care	**£ 409,859**	**£ 800,000**		**£ 1,209,859**
9 BIPAPS	£ 77,625			£ 77,625
BF - Cath lab suite		£ 800,000		£ 800,000
BF - Central System Support - AMU & Stroke	£ 38,877			£ 38,877
BF - Measure Dose Dosimeter - CRV (KOKO)	£ 5,872			£ 5,872
Defibrillators	£ 173,700			£ 173,700
Development of Older Persons Assessment Unit	£ 45,000			£ 45,000
Echocardiography & vascular ultrasound machine	£ 68,785			£ 68,785
Grand Total	**£ 6,959,278**	**£4,175,565**	**£317,932**	**£ 11,452,775**

For Information Capital Schemes over £400k (included above)

EQUIPMENT	DIVISION	2018/19	2019/20	AMOUNT
BF - Cath lab suite	Urgent Care		£ 800,000	£ 800,000
BF - Equipment and Controls Heating and Ventilation Plant Room 2 (further use of CHP waste heat may be possible as part of this project)	Estates and Facilities	£ 529,200		£ 529,200
BF - Theatre 9	Estates and Facilities	£ 589,650		£ 589,650
CT scanner (advanced)	D&P	£ 564,000		£ 564,000
Loan repayment above depreciation	Central	£ 529,000		£ 529,000
Replacement of Aseptic Unit	D&P		£ 1,440,000	£ 1,440,000
Replacement of Pharmacy Robot	D&P	£ 480,000		£ 480,000
Grand Total		**£ 2,691,850**	**£ 2,240,000**	**£ 4,931,850**

Board of Directors

Subject	**Speak Out Safely / Freedom to Speak Up Update**
Date of Meeting	**22nd May 2018**
Author(s)	**Alison Kelly, Director of Nursing & Quality**
Presented by	**Alison Kelly, Director of Nursing & Quality**
Annual Plan Objective No.	N/A
Summary	The purpose of this paper is to provide a further update to the Board from the Freedom to Speak Up (FTSU) Committee. This includes a quarter 4 position on the Trusts cases in addition to internal actions being progressed to reflect the National Guardians Office guidance and expectation.
Recommendation(s)	The Board is asked to receive and note the information contained within this report.
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.**

Speak Out Safely & Freedom to Speak Up Update (FTS)
to the Board of Directors
(May 2018)

1.0 Executive Summary

The purpose of this paper is to provide an update to the Board from the Freedom to Speak Up (FTSU) Committee. It will articulate updates on policy, training and awareness, communication and engagement, resources, national agenda, local data and learning from cases. A significant amount of work, facilitated via the FTSU Committee, has progressed since the last update to the Board (in November 2017). This paper is to provide assurance that progress is being made.

The FTSU Committee, which is constituted from the FTSU Guardians across the Trust, held a planning workshop in January 2018. The Trust was lucky enough to have this facilitated by a senior officer from the National Guardians Office which was invaluable. This was a detailed session covering a revision to the current Speak out Safely (Raising Concerns About Patient Care) and Whistle Blowing Policy, processes, communication and engagement plan, training and education, infrastructure and resourcing in addition to a review of the latest National Guardian Offices documents. In light of the breadth of this important agenda, and as well as regular committee meetings, a further three hour planning session was held on the 1st May 2018 to progress actions.

Further to the detail provided in the previous report to the Board, the FTSU Committee has continued to go from strength to strength in addressing the key topic areas mentioned above, in ensuring FTSU becomes 'business as usual'. The sections below will provide an update on each area of the agenda articulating progress to date.

2.0 Progress To Date

2.1 Revision of Speak Out Safety Policy

It is important to note that whilst a review of the Trusts policy is being undertaken in the context of the national agenda, the current Speak Out Safety policy still stands. A national FTSU Policy template is now available including key sections to include which the Trust is utilising. Significant discussion has been undertaken ensuring the Trusts FTSU policy is clear and understandable for teams. The draft policy clearly states the roles and responsibilities of key stakeholders in the FTSU process. Discussion and action has taken place to explore utilisation of the Trusts incident reporting system (Datix) for FTSU, so that there is a consistent approach to raising issues or concerns. This option is being explored but it is recognised that the importance of this aspect is that this will be anonymous and will complement the current mechanisms of how to raise concerns under Freedom To Speak Up (ie via A FTSU Guardian, confidential telephone line and email address). The draft policy will be completed by the end of Quarter 1 2018/19.

2.2 Training & Awareness

In respect of training and awareness, a training needs analysis is required to fully understand the awareness that the Trusts staff require. This has been discussed by the Committee in respect of the following elements, formal Guardian training, training for Ambassadors and awareness sessions for

the rest of the Trust. A training log is being developed to track the compliance of t
members as formal external training is required of Guardians. This will be monitored via the FTSU committee meetings. NHSi have recently provided guidance for Boards on FTSU including training (Appendix 2). A number of members of the FTSU Committee have recently attended regional and national meetings/conferences on the topic and have fed back any points of learning to the committee.

2.3 Communication & Engagement

It is essential that the revised policy is meaningful and understandable to staff. Once the draft Trust Policy has been finalised, it will be shared with the Staff Barometer Group to test the practicalities of the Policy and its application in practice. Once feedback has been obtained and amendments made, a communication and engagement plan will be devised with the Communications Team and key stakeholders regarding approval of the Policy and the sharing of the policy more widely across the Trust. FTSU continues to be a key topic for discussion and awareness with staff at every opportunity, for example on executive walkabouts, clinical area reviews, student forums, Trust induction and High Performance Culture workshops.

2.4 Resources to Support the FTSU Agenda

It has been referenced in the previous Board update that the resource for managing the current FTSU agenda is via the current FTSU Guardians in addition to their daily workload. It is evident that this is not sustainable going forward. In light of this, options are being explored to ensure the appropriate resources are made available for a dedicated named Guardian who will lead this agenda with the support from existing Guardians and Ambassador roles throughout the Trust. It is recognised that this action is required to be addressed before the end of Quarter 1.

2.5 National Reports/Guidance

The National Guardians Office had previously published a case review from Southport & Ormskirk Hospital NHS Trust and more recently a further report has been published regarding North Lincolnshire & Goole NHS Foundation Trust. It is important that lessons are learnt from these case reviews and in order to provide an assessment of the Countess' current position, a gap analysis has been undertaken against the Southport & Ormskirk Hospital NHS Trust (Appendix 1). The areas for improvement are being addressed within the workplan of the FTSU Committee.

As previously articulated NHSi have recently published guidance for Boards (attached), this has already been shared with the FTSU committee. NHSi have recently requested that the Trust undertake a self-assessment of its FTSU activity (as all other NHS organisations have), this is to be undertaken within Quarter 1 2018/19

2.6 Q4 Data Submission to National Database

As previously articulated in the last Board update, the Trust is required to submit speaking up data to the National Guardians Office (NGO) on a quarterly basis for national publication. The Trusts most recent submission for quarter 4 2017/18 is as follows:

- Number of cases raised (this equates to the number of members of staff involved) – 8
  The above 'cases' are from 2 separate areas of the Trust.
- Number of cases raised anonymously – 2
- Number of cases with element of patient safety / quality – 1
- Number of cases with element of bullying / harassment – 1

- Number of cases where the person speaking up may have suffered some form of detriment – 0

2.7 Learning From Cases

The work being undertaken to revise the current policy will also include the important process for feedback (to the individuals/s and also in respect of themes to the wider Trust) with associated learning. Once this has been finalised, the above data and learning taken from dealing with cases will be shared with the Board but also the wider organisation. It is evident from cases which have yet to be closed, that there is potential transferrable learning and actions to further improve our culture.

3.0 Conclusion and recommendations to the Board of Directors

The Board is asked to receive and note the information contained within this report, including the appendices. It is clear that this agenda is significant and supports and compliments the work already underway within the Trust in ensuring we have a culture that is open and transparent to reflect our values of being Safe, Kind and Effective.

Prepared by:

Alison Kelly, Director of Nursing & Quality
May 2018

National Guardian
Freedom to Speak Up

NHS
Improvement

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

May 2018

Contents

Introduction

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

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

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

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

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

About this guide

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

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

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

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

Key terms used in this guide

- **The board**: we use this term when we mean the board as a formal body.
- **Senior leaders**: we use this term when we mean executive and non-executive directors.
- **Workers**: we use this term to mean everyone in the organisation including agency workers, temporary workers, students, volunteers and governors.

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

Our expectations

Leaders are knowledgeable about FTSU

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

Leaders have a structured approach to FTSU

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

Leaders actively shape the speaking up culture

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

Leaders are clear about their role and responsibilities

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

Leaders are confident that wider concerns are identified and managed

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

Leaders receive assurance in a variety of forms

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

- workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process
- steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers
- speak up issues that raise immediate patient safety concerns are quickly escalated
- action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority
- lessons learnt are shared widely both within relevant service areas and across the trust
- the handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented
- FTSU policies and procedures are reviewed and improved using feedback from workers.

In addition the board receives a report, at least every six months, from the FTSU Guardian. For more information see page 11 below. Boards should consider inviting workers who speak up to present their experience in person.

Leaders engage with all relevant stakeholders

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

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

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

Leaders are focused on learning and continual improvement

Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience. Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.

The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.

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

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

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

Individual responsibilities

Chief executive and chair

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

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

Executive lead for FTSU

The executive lead is responsible for:

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

Non-executive lead for FTSU

The non-executive lead is responsible for:

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

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

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

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

The non-executive director should inform NHS Improvement and CQC that they are overseeing an investigation into a board member. NHS Improvement and CQC can then provide them with support and advice. The trust would need to think about how to enable a non-executive director to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the

confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Human resource and organisational development directors

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

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

Medical director and director of nursing

The medical director and director of nursing are responsible for:

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

FTSU Guardian reports

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

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

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

Board reports on FTSU could include:

Assessment of issues

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

Potential patient safety or workers experience issues

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

Action taken to improve FTSU culture

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

Learning and improvement

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

Recommendations

- suggestions of any priority action needed.

Resources

Care Quality Commission (2017): Driving Improvement Accessed at: www.cqc.org.uk/sites/default/files/20170614_drivingimprovement.pdf

National Guardian Office (2017): Example job description Accessed at: http://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

National Guardian Office (2017): Annual report Accessed at www.cqc.org.uk/sites/default/files/20171115_ngo_annualreport201617.pdf

NHS Improvement (2014) Strategy development toolkit Accessed at https://improvement.nhs.uk/resources/strategy-development-toolkit/

NHS Improvement (2016) Freedom to speak up: whistleblowing policy for the NHS Accessed at https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/

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

NHS Improvement (2016/17): Creating a culture of compassionate and inclusive leadership Accessed at https://improvement.nhs.uk/resources/culture-leadership/

NHS Improvement (2017): Well Led Framework Accessed at: https://improvement.nhs.uk/resources/well-led-framework/

National Framework (2017): Developing People - Improving Care Accessed at: https://improvement.nhs.uk/resources/developing-people-improving-care/

National Guardian Office (2018): Guardian education and training guide

Accessed at: http://www.cqc.org.uk/sites/default/files/20180419_ngo_education_training_guide.pdf

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SOUTHPORT & ORMSKIRK FTSU REPORT

Appendix 1. **Gap Analysis Vs Countess of Chester Hospital NHS Foundation Trust Actions**
V2 (updated May 2018)

Recommendation	Actions Required	Lead	Target Date	Evidence	RAG
The Trust should publish its new speaking up policy.	Further work required in finalising the policy with union colleagues before wider consultation.	HR Policy Manager/Partnership Forum vice chair	Q1 18/19	Minutes of FTSU Committee Action Log	
Within three months the Trust should ensure that, in accordance with its own policies and procedures and in accordance with good practice, all those managers and leaders responsible for handling concerns provide feedback to every individual who speaks up, including any actions they intend to take in response.	Actions required as part of policy compliance above. Communication & Engagement plan development when policy finalised and approved	FTSU Committee	Q! 18/19	Minutes of FTSU Committee Action Log	
Trust leaders should take appropriate steps to ensure that they are visible and accessible to all workers to promote a culture of visible leadership.	Annual plan developed re clinical rounds, walkabouts etc (to include NED's and governors) Further staff engagement meeting planned for 25th May 2018 to further develop above plan linking to Staff Survey workstream	Director of Nursing & Quality & Director of People & OD (With Comms support)	Completed	Regular walkabouts Shadowing Clinical Reviews/Rounds Countess Briefing sessions	
The Trust should ensure that it responds to the concerns raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice and report to the Board evidence of this.	Board report being presented in May 2018 re update on practices, policies, procedures and comms. Process for feedback to be incorporated into policy review	FTSU Committee	Q1 18/19	Governance processes in place to raise concerns through existing policy.	

SOUTHPORT & ORMSKIRK FTSU REPORT

Recommendation	Actions Required	Lead	Target Date	Evidence	RAG
				Reporting to Board to be included in the annual reporting plan	
The Trust should ensure that it responds to all concerns raised by its workers in relation to the recruitment of staff strictly in accordance with its policies and procedures and in accordance with good practice.	Processes in place in respect of this	Director of People & OD	In place	FTSU processes HR dashboard	
The Trust should ensure that appropriate steps are taken to publicise the role of Guardian and any staff supporting that role, using methods that reach all workers.	Comms plan to be further developed once policy finalised	FTSU Committee	Q1 18/19	Visible badges worn by Guardians. Methods in place of raising concerns, ie email, confidential phone line. All existing guardians access a number of forums to raise the profile of FTSU across all staff groups. Visibility at a number of forums	
The Trust should ensure that it provides appropriate resources for the role of Freedom to Speak Up Guardian, in line with guidance provided by the National Guardian's Office,	No dedicated resource in place for FTSU Guardians at present. Current Guardians undertake this role on top of their regular role	FTSU Committee	Q1 18/19	FTSU Committee minutes Executive meeting minutes	

SOUTHPORT & ORMSKIRK FTSU REPORT

Recommendation	Actions Required	Lead	Target Date	Evidence	RAG
including sufficient cover to support their work in their absence, and alternative routes to handle speaking up matters to overcome any possible conflicts.	Executive sign off to be formalised re resources required to support a dedicated role in the Trust. Conflicts of interest discussed at May FTSU Committee meeting Independent NED utilised already to support one case				
The Trust should take appropriate steps to ensure that minority and vulnerable workers, including black and minority ethnic workers are free to speak up.		E&D Manager	Completed	Active E&D agenda within the Trust. Key stakeholder groups established	
The Trust should seek to share learning of its cultural review with its workers, taking all necessary steps to protect the confidentiality of individuals.	N/A Cultural review not undertaken/identified at CoCH	N/A	N/A		
Within three months the Trust should consider requesting support from the NHS England WRES Implementation Team to help meet the needs of its black and minority ethnic workers.	N/A (see evidence column)	E&D Manager	Completed	Excellent WRES compliance. No support required	
The Trust should take steps to ensure all existing and new workers are aware of the contents of the new freedom to speak up policy.	Once Policy has been finalised and approved at POD. Develop comms plan to raise awareness and share key messages re Policy	FTSU Committee & Comms team		FTSU raised at Trust Induction and across a number of staff forums. Current policy still stands until revised document is approved and shared	

SOUTHPORT & ORMSKIRK FTSU REPORT

Recommendation	Actions Required	Lead	Target Date	Evidence	RAG
The Trust should put in place effective systems to monitor the development of a positive speaking up culture.	Build on existing forums and processes	FTSU Committee		Staff Barometer group in place, focus groups undertaken as required. Staff engagement sessions. High Performance Culture workshop series in place	
Within six months the Trust should look again at its appointment process for the role of Freedom to Speak Up Guardian and ensure a Guardian is appointed using a process that is open and fair.	Resources being identified for a dedicated FTSU Guardian. Transparent process will be implemented re their appointment	FTSU Committee	Q1 18/19	See previous action	
Within six months the Care Quality Commission should, where regulating matters relating to a fit and proper persons test under section 5 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014, take appropriate steps to assure itself that those tests are conducted in accordance with that regulation.	N/A re CQC review		In Place	Robust governance in place and regular review undertaken through sub Board committees	
The Trust should take all appropriate steps to address the concerns raised by black and minority ethnic workers in the Trust 2016 Survey.	N/A	N/A	N/A		
The Trust should appoint a senior member of staff as Equality & Diversity Lead and ensure that position is appropriately resourced.			In Place	Award winning manager in place, acknowledged at regional and	

SOUTHPORT & ORMSKIRK FTSU REPORT

Recommendation	Actions Required	Lead	Target Date	Evidence	RAG
				national level for his contribution to E&D	
The Trust should implement all aspects of its draft Freedom to Speak Up action plan, by the plan's stated completion dates.	Number of actions underway, directed as an outcome of a FTSU guardian workshop (facilitated by NGO)	FTSU Group	Q2 18/19 review	FTSU Committee minutes and action log	
The Trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	Will form part of National Staff Survey results action plan in associate with the High Performance Culture programme	Board of Directors with Dir of HR/OD leading	Work ongoing	Culture & transformational programme in place, developing and embedding Trusts V&B.	
Within 12 months the Trust should provide all workers, including all managers, with regular, updated and mandatory training on speaking up and supporting and responding to people who speak up. The Trust should monitor the effectiveness of this training.	Training Needs analysis to be developed to support policy implementation	FTSU Committee	Q1/2 18/19	FTSU features in a number of training sessions, CHAPs (Human Factors), Nurse Induction, Junior Doctor induction,	
The Trust should take appropriate steps to ensure that all aspects of its work are consistent with the Francis Freedom to Speak Up principles, including where it undertakes a Fit and Proper Person review.		Board of Directors		Good awareness of FTSU and F&PP tests. Actively undertaken as part of business as usual.	
The Trust should take steps to ensure that its policies and procedures are supportive of all workers affected by the speaking up process, including those who are the subject of concerns	Cross referencing being undertaken to other HR/OD policies when reviewing the FTSU Policy to ensure consistency.	HR Policy Manager	Q1 18/19	FTSU Committee minutes. People & OD Committee minutes	

SOUTHPORT & ORMSKIRK FTSU REPORT

Recommendation	Actions Required	Lead	Target Date	Evidence	RAG
raised.					
The Trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up.		Deputy Director of HR		Mediation is always identified as an option to resolving issues where appropriate	
The Trust should implement all the recommendations of its cultural review.	N/A	N/A			

Full compliance – significant evidence in place
Partial Compliance – some evidence in place
Non Compliance – no evidence in place
Not Applicable

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Learning from Deaths Board Report
Date of Meeting	Board 22nd May 2018
Author(s)	Mr. Ian Harvey, Medical Director Mr David Semple, Associate Medical Director
Annual Plan Objective No.	
Summary	This report is intended to provide on the progress by the Trust in relation to the "The National Guidance on Learning from Deaths (National Quality Board, March 2017)".
Recommendation(s)	**The Board is asked to note:** • The Board approved a policy "Mortality review – responding to, and learning from, the death of patients under the management and care of the Trust" in May 2017 • A Mortality Surveillance Group (MSG), chaired by a Non-Executive Director and including a Governor, was set up to oversee learning from deaths • The Medical Director, Associate Medical Director for Quality and Safety and the Associate Director of Risk and Safety attended the Royal College of Physicians training on the Structured Judgement Review (SJR) process • Two "in-house" training sessions on the SJR have been held for permanent medical staff • Review of in-hospital deaths using the SJR has commenced and is the basis of this report • Training on and the introduction of the Datix platform for mortality review and analysis • Using HED data the MSG has directed which clinical diagnostic groups are reviewed

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.

LEARNING FROM DEATHS

BOARD REPORT

Mr Ian Harvey

Medical Director May 2018

BOARD REPORT - LEARNING FROM DEATHS

INTRODUCTION

Following the publication of "The National Guidance on Learning from Deaths (National Quality Board, March 2017)" a number of steps have been taken:

- The Board approved a policy "Mortality review – responding to, and learning from, the death of patients under the management and care of the Trust" in May 2017.
- A Mortality Surveillance Group (MSG), chaired by a Non-Executive Director and including a Governor, was set up to oversee learning from deaths.
- The Medical Director, Associate Medical Director for Quality and Safety and the Associate Director of Risk and Safety attended the Royal College of Physicians training on the Structured Judgement Review (SJR) process.
- Two "in-house" training sessions on the SJR have been held for permanent medical staff.
- Review of in-hospital deaths using the SJR has commenced and is the basis of this report.
- Training on and the introduction of the Datix platform for mortality review and analysis.
- Using HED data the MSG has directed which clinical diagnostic groups are reviewed.

<u>Structured Judgement Review</u>

The SJR blends traditional, clinical-judgement based review methods with a standard format. The objective of the review method is to look for strengths and weaknesses in the care process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. The quality of care is assessed against a scale of excellent, good, adequate, poor and very poor. Each case is reviewed by a single reviewer.

The SJR breaks down the care into phases

- Admission and initial care – first 24 hours (approximate)
- Ongoing care
- Care during a procedure / peri-operative care
- End of life care
- Assessment of care overall

This provides a structured framework for the review. Not all phases of care will be appropriate for every case. Explicit judgement comments are made about each phase of care. This allows the reviewer to concisely describe how and why they assess the quality of care provided and it also provides a commentary in a way that other health professionals can understand.

Examples of explicit statements could include

- Referral to ICU was too late
- Lack of leadership
- Poor planning and delay in treatment
- Although the patient was discussed with the consultant and registrar, for 4 days the patient was only seen by a junior doctor
- Very good care – rapid triage and escalation to senior team and appropriate use of Sepsis 6 bundle
- Good ceiling of care treatment discussion and end-of-life good

Commentary on holistic care is just as important as that on the technical care provided, particularly where complex end-of-life care discussions might or should have been held. Overall phase of care comments are intended to bring the reviewer to a judgement on the whole care episode.

Examples of explicit statements for the overall care could include

- Overall a fundamental failure to recognise the severity of this patients respiratory failure

- On the whole good documentation of clinical findings, investigation results, management plan and discussion with other teams
- Good multidisciplinary team involvement

Each phase of care is given an overall score

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

These scores are recorded after the judgement comments have been written. Only one score is given for each phase of care. Research suggests that an overall score of 1 or 2 might happen in fewer than 10% of cases. An overall score of 2 or under will trigger a second-review process.

The SJR also looks at whether problems in care have caused harm as well as the quality and legibility of the records.

<u>Training in the use of SJR</u>

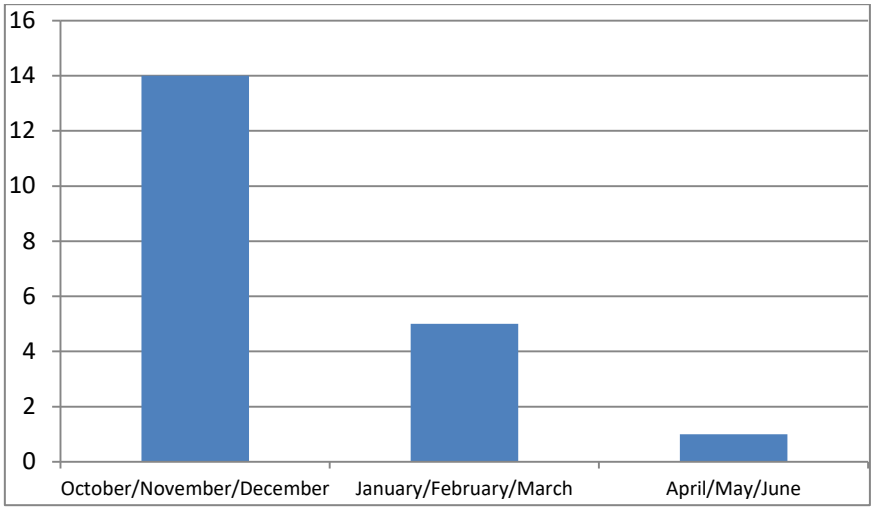
Two "in-house" training sessions on the SJR have been held for permanent medical staff. The two training sessions were held during hospital rolling half days to reduce impact on clinical activity. The first session was held in January 2018 at which 6 doctors underwent training. The second training session was undertaken on 17th May 2018 at which a further 10 doctors underwent training. Each SJR is completed within the new Datix platform for mortality review and analysis.

Case note review using the SJR takes up expensive clinical resource and it is expected that each review may take between 1-2 hours. The plan is that each reviewer will start reviewing one case per month and after 2-3 months move onto reviewing a maximum of two cases per month. This would equate to one PA of clinical time per month which needs to be bulilt into job plans.

As the most recent training meeting was undertaken in May 2018 only a small number of cases have been reviewed using the SJR method (see table below)

Results

To date 20 deaths have been reviewed using the SJR with distribution over the quarters since inception as below:



The number of deaths in each month (April may be amended subject to validation) was:

Dec	Jan	Feb	Mar	Apr
114	123	93	89	73

The age/ sex distribution was:

	26	68	70	72	73	74	75	79	80	81	85	88	Over 90	Total
Female	1	1	0	1	0	0	1	0	1	0	1	1	4	11
Male	0	0	1	0	1	1	1	1	0	2	2	0	0	9
Total	1	1	1	1	1	1	2	1	1	2	3	1	4	20

The distribution of day of admission (row) and day of death (column) was:

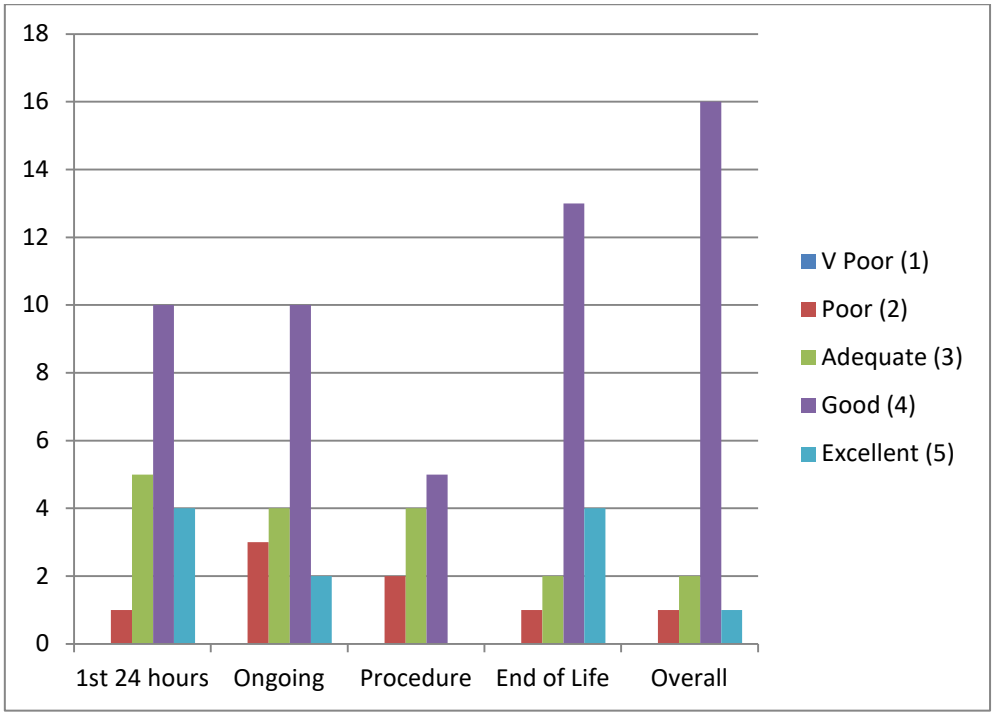
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
Monday	0	0	0	2	0	0	0	2
Tuesday	0	0	1	1	0	1	0	3
Wednesday	1	0	1	1	1	0	1	5
Thursday	2	0	0	1	0	0	0	3
Friday	0	1	0	0	0	0	0	1

Saturday	1	0	0	2	0	0	0	3
Sunday	0	0	0	1	0	0	2	3
Total	4	1	2	8	1	1	3	20

Eighteen of the deaths were reviewed because they were related to sepsis, 2 were due to stroke.

Quality of Care

The quality of care for the different phases of care using the SJR methodology showed:



There was no care adjudged to be very poor and in the majority of cases the care was good which is also well demonstrated by a word cloud derived from the frequency of use of words in the overall care review.

Word Cloud

Secondary Review

Secondary review takes place within the learning from deaths framework when the first stage reviewer judges care overall to be very poor (score 1) or poor (score 2), or when harms have been identified, or if concerns have been raised about a case. One possibility is to work alongside colleagues, trained in SJR judgement review, at WUHT (and vice-versa) for secondary review cases which would allow for impartial objective judgement reviews to be undertaken (Next Steps on Page 11).

In this report there was one review that went for secondary review. The second reviewer agreed with the concerns of the first stating that there was “no apparent appreciation of possible sepsis despite red flag signs and deterioration” and that there was “delay in management of sepsis”. It was judged that death was probably avoidable i.e. more than 50:50 chance. The results of the review have been fed back to the clinical team and their response, particularly with regard to learning from the case, will be monitored by the MSG.

Learning Disability

There were two patients in the reviews who were recorded as having a learning disability. There was no evidence in the reviews of any failure of care related to their having a learning disability. The overall quality of care was assessed as good in one and adequate in the other. In the second, adequate care, case the assessment was linked to a lack of senior review although it wasn't felt that this compromised the care.

Mortality and Morbidity Meetings

All acute specialities undertake M&M meetings where deaths and major morbidity cases are discussed. Learning from M&M meetings tends to be within specialities. Various templates / proformas are used (two examples below) -

Current COCH Surgical M&M discussion template

Date discussed	
Consultant	
Patient	CC00XXXXXX
Procedure	
Mortality	Yes / No
Avoidable ?	
Discussion	

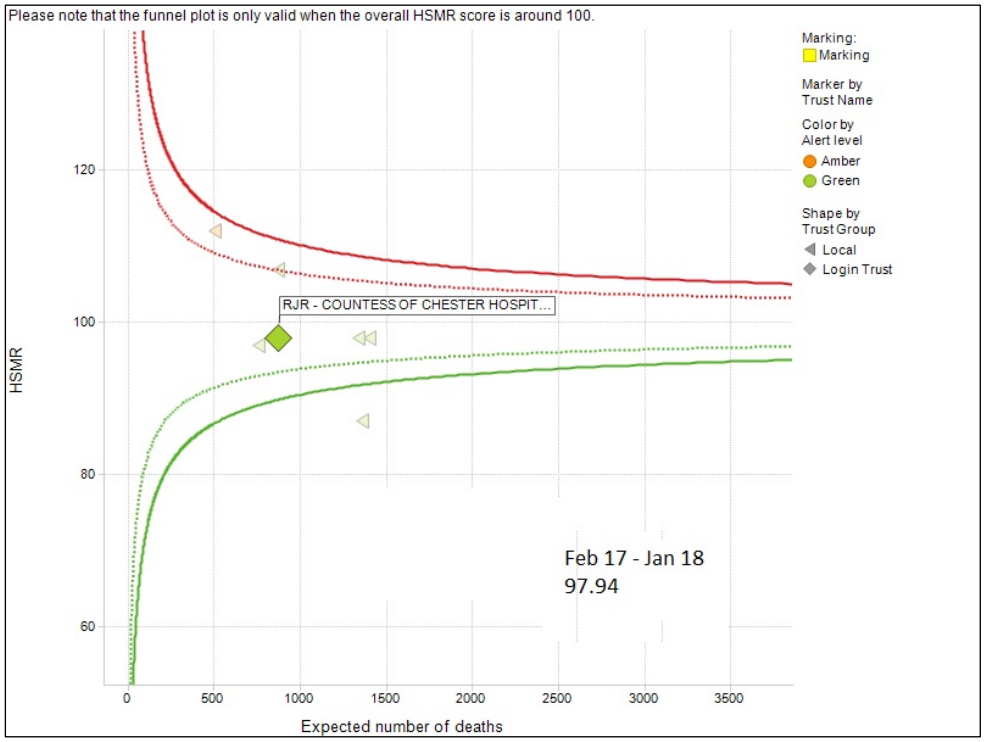
Current COCH Obstetric / Neonatal Perinatal M&M discussion template

Case number / DOB	**Event / factor identified**	**Comments / Action Taken**	**Learning Points**	**PNM Risk Factors**
CC00XXXXXX				
CC00XXXXXX				

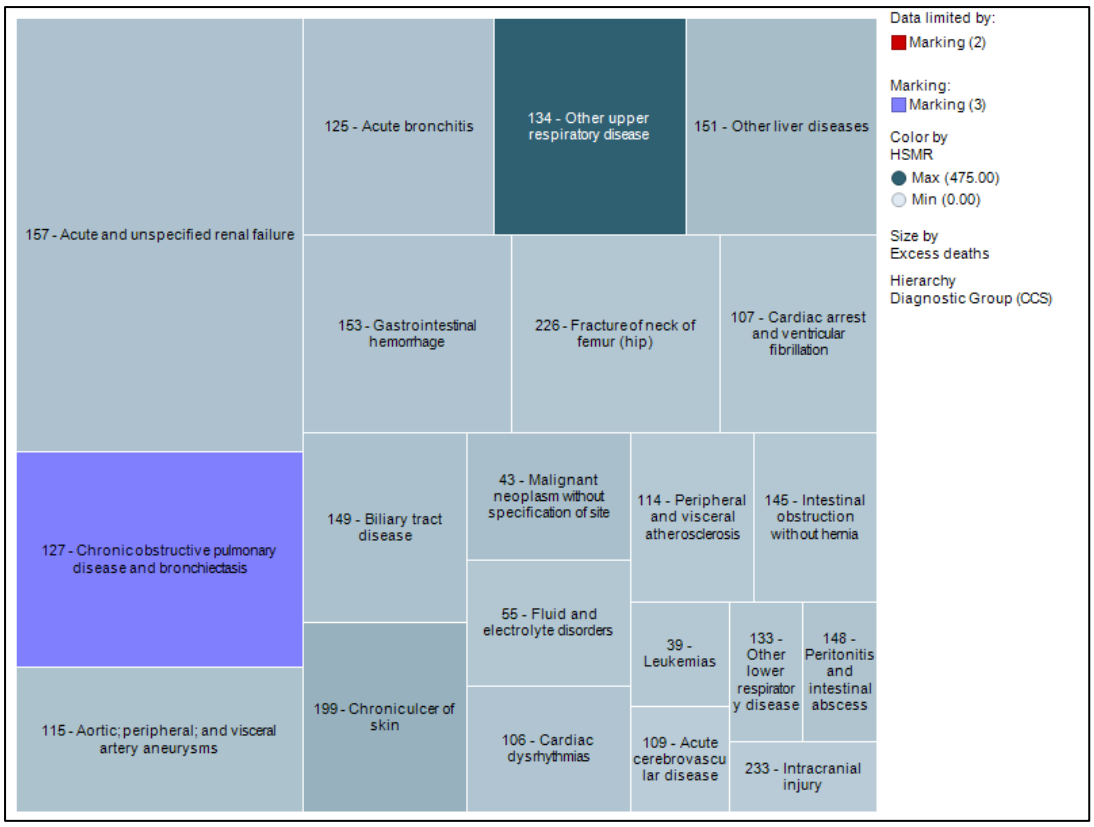
M&M templates need to be standardised (allowing for some speciality variation) and the reporting / escalation of the M&M minutes and learning points needs to be embedded within the current clinical governance structures and also feed into the SJR process.

<u>HED data</u>

The most recent HED data for HSMR shows:

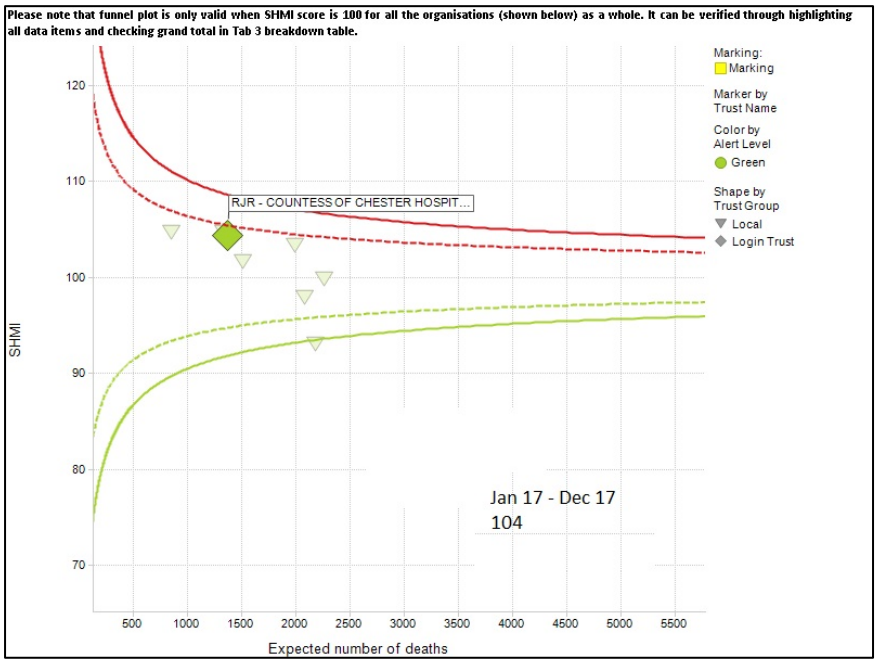


The treemap for HSMR for clinical conditions shows:

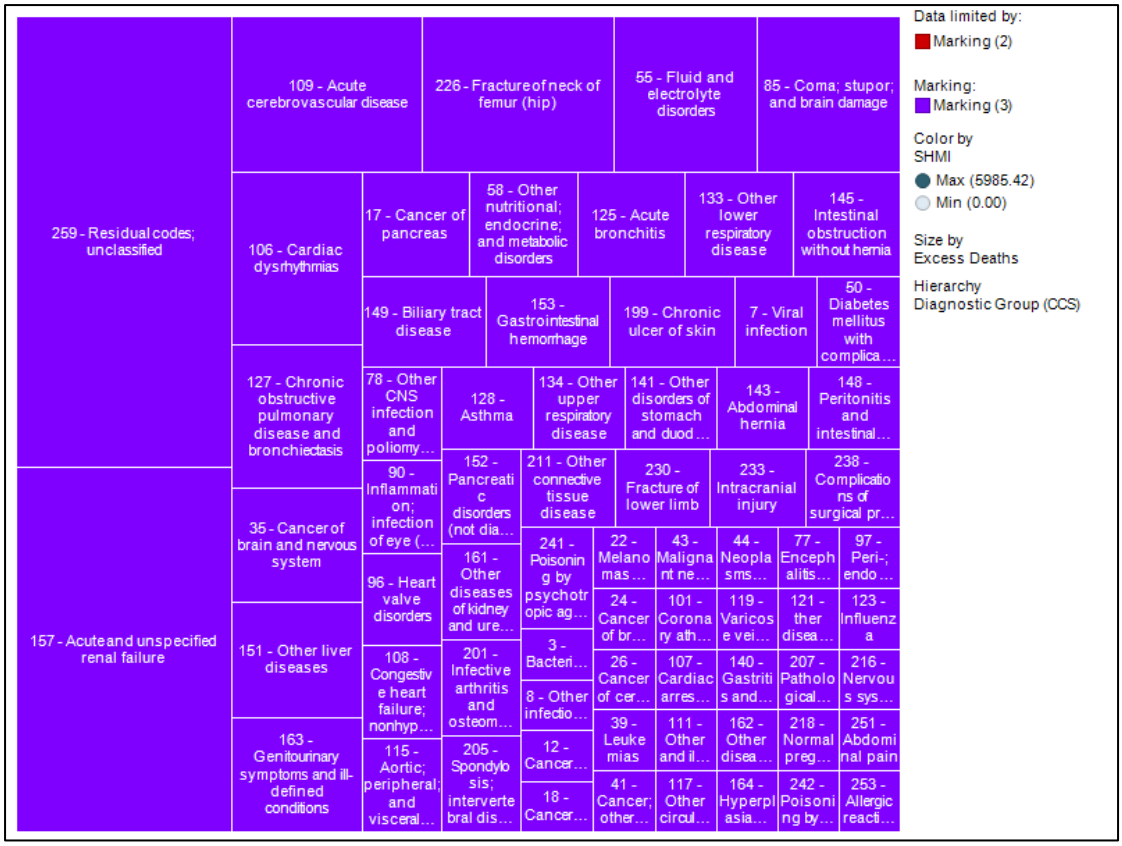


SHIMI

The monthly SHMI has again improved:



Whilst the SHMI treemap shows:



This data is reviewed monthly by the MSG to direct areas for particular review under the learning from deaths framework.

<u>Next Steps</u>

Now that the process of learning from deaths has been instituted there are a number of actions that have been identified and will be completed ahead of the next Board report.

- The policy for learning from deaths and terms of reference for the MSG need to be reviewed to ensure that they remain relevant
- M&M meetings reports need standardised and embedded within the current governance structures
- A graphic representation of the pathway needs to be developed to allow easy demonstration of the process
- The process of case selection needs to be described and embedded
- Staff trained in SJR need to commence case note review on the Datix mortality review platform

- The pathway for passing the results of reviews to clinical teams and ensuring that any learning is derived and shared needs embedding with the MSG
- A dashboard which contains the data needed for national reporting needs to be developed to allow timely and efficient reporting to Board and nationally (Appendix 1)
- A rolling program of review and reporting the results quarterly follows this report
- Consider working alongside colleagues in WUHT to standardise mortality processes across the two Trusts allowing the benchmarking of mortality data, the sharing of secondary review's and ultimately encourage the sharing of good practice

Appendix 1 – Sample Dashboard

Learning from Deaths Dashboard.xls

Learning from Deaths Dashboard

Organisation	COCH
Financial Year	2017-18
Month	MAY

Learning from Deaths Dashboard

Purpose of the dashboard

This suggested dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by NHS Trusts. Trusts may use this to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Guidance on what should be recorded in individual fields is provided below, alongside instructions for completing and updating the dashboard. This guidance on individual fields complements the wider guidance provided in the National Framework on Learning From Deaths and separate methodology guidance on the Structured Judgement Review (SJR) as developed by the Royal College of Physicians (RCP). The dashboard is not prescriptive and Trusts may set their own definitions according to local goals and data availability, although minimum requirements are set out in the framework.

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

Guidance on individual fields

Field No.	Field	Description of Field
Recording data on structured judgement reviews:		
1	**Total Number of Deaths in scope**	This must as a minimum include all adult inpatient deaths excluding maternity services. Where additional deaths are included (for example maternal deaths, deaths post-discharge or deaths of outpatients etc) the inclusion criteria should be made clear in this field, which can vary by trust. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields in this work book. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge. Note that where it has been identified that a patient has a learning disability the death should be recorded separately (see Data item 6, below).
2	**Total Number of Deaths Reviewed under the SJR methodology**	This is the total number of deaths for which the care provided to the patient has been reviewed by your Trust. This may be a combination of deaths reviewed under national and local minimum requirements and random sampling of all other deaths in scope.
3	**Total number of deaths considered to have more than a 50% chance of having been avoidable**	The Structured Judgement Review methodology, for use in relation to adult acute inpatient deaths, allows for reviewers to score a death as having a more than 50% chance of having been avoidable when this judgement is made in relation to the care provided by the trust conducting the review. This is the equivalent of a score of 3 or less. If using the RCP SJR then the number of such deaths scored in this way is equivalent to this field If not using RCP SJR, then the method used to judge whether a death was more likely than not to have been avoidable in relation to the care provided by the trust conducting the review (or another provider if appropriate) should be stated here including any definitions used. Note that if you are applying other methodologies to specific groups, such as learning disabilities patients, those methodologies may require a degree of judgement to determine whether the death was more likely than not to be avoidable. It may be appropriate to cross-reference those outputs with the processes for assessing structured judgement reviews, and if appropriate to include those outputs here. If the RCP SJR methodology is being used for structured judgement reviews Trusts are able to include monthly totals of reviewed deaths that were in each category 1 to 6. If the Trust is not using this methodology these fields can be either left blank or edited as appropriate.
Recording data on LeDeR reviews:		
4	**Total Number of Deaths in scope**	This must include all adult inpatient deaths for patients with identified learning disabilities. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge.
5	**Total Deaths Reviewed Through the LeDeR Methodology**	Formally, the LeDeR review methodology should be applied to all of the deaths shown as 'in scope'. You should record the total number of deaths reviewed here.
6	**Total Number of deaths considered to have been potentially avoidable**	Record the total number of deaths for which review evidence leads to a conclusion that it is more likely than not that the death was potentially avoidable. This will require that a degree of judgement is applied to the outputs of the LeDeR review, and it may be appropriate to cross-reference these outputs with the processes for assessing structured judgement reviews

How to update the dashboard

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

To update the dashboard with new data:
1. Enter data for appropriate month(s) in the Data tab. Note that the RCP1 to RCP6 and Trust comparison fields are optional and the dashboard will still function correctly if these fields are left blank.
- In the first 3 columns enter the data for your structured judgement reviews (number of deaths in scope, numbers reviewed, and numbers deemed potentially avoidable)
- You have the option of recording how many of the SJR reviews placed cases in each of the RCP1 to RCP 6 categories.
- For learning disabilities patients, enter the number of deaths in scope, numbers reviewed under the LeDeR methodology, and numbers deemed potentially avoidable

2. Change the month and year on the Front Sheet tab to the most recent month of data.
3. Change the data range on the time series charts as required by using the interactive dropdowns on the Dashboard tab (eg cell V4). Note that the time series charts are not linked to the front sheet selection and are driven entirely by the dropdowns.

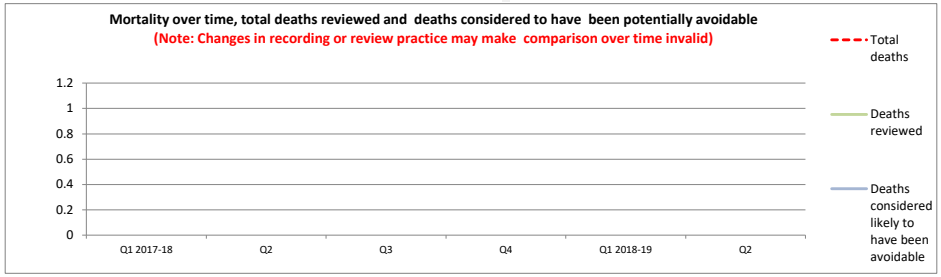
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
X	X	X	X	X	X
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
X	X	X	X	X	X
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
X		X		X	

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

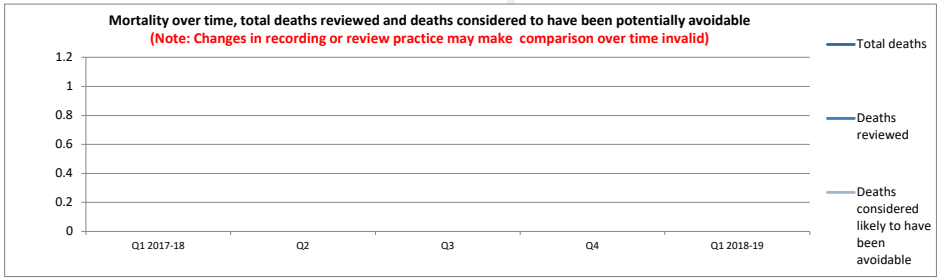
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	X	-	This Month	X	-	This Month	X	-	This Month	X	-	This Month	X	-	This Month	X	-
This Quarter (QTD)	X	-	This Quarter (QTD)	X	-	This Quarter (QTD)	X	-	This Quarter (QTD)	X	-	This Quarter (QTD)	X	-	This Quarter (QTD)	X	-
This Year (YTD)	1	100.0%	This Year (YTD)	X	-	This Year (YTD)	X	-	This Year (YTD)	X	-	This Year (YTD)	X	-	This Year (YTD)	X	-

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

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
X	X	X	X	X	X
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
X	X	X	X	X	X
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
X	X	X	X	X	X

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



Trust	COCH
Org Code	
Month	MAY
Year	2017-18

Financial Year	Month	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Deaths Avoidable > 50% (not LD)	RCP1	RCP2	RCP3	RCP4	RCP5	RCP6	LD Deaths	LD Deaths Reviewed	LD Deaths Avoidable > 50%
2017-18	April												
2017-18	May												
2017-18	June												
2017-18	July												
2017-18	August												
2017-18	September												
2017-18	October												
2017-18	November												
2017-18	December												
2017-18	January												
2017-18	February												
2017-18	March												
2018-19	April												
2018-19	May												
2018-19	June												
2018-19	July												
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2022-23	August												

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2022-23	December
2022-23	January
2022-23	February
2022-23	March
2023-24	April
2023-24	May
2023-24	June
2023-24	July
2023-24	August
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2025-26	July
2025-26	August
2025-26	September
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2025-26	January
2025-26	February
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2026-27	April
2026-27	May
2026-27	June
2026-27	July
2026-27	August
2026-27	September
2026-27	October
2026-27	November
2026-27	December
2026-27	January
2026-27	February
2026-27	March

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Data Security and Protection Requirements (DSPR)
Date of Meeting	Board 22nd May 2018
Author(s)	Mr. Simon Holden, Director of Finance Mr. Rob Howorth, Informatics Director
Annual Plan Objective No.	
Summary	This report is intended to provide an update on the self-assessment, undertaken by the Trust, against the ten standards, contained within the Data Security and Protections Requirements.
Recommendation(s)	**The Board is asked to note:** o That from April 2018, the new Data Security & Protection Toolkit (DSP Toolkit) will replace the Information Governance Toolkit (IG Toolkit); o That these 10 standards will form part of the Care Quality Commission's (CQC) mandate under the "well led" element; o The assessment criteria requires Trust to self-assess for each of these ten standards, as to full, partial, or unmet; o That the Trust shows a good level of compliance, with the majority of standards being fully compliant, although there is still an underlying risk in a number of areas; and o That the overarching recommendation is that the Trust's Risk Committee receives a separate report highlighting how this area can be strengthened further, recognising the financially constrained situation (per the attached SBAR document).
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

Informatics Department
Data Security and Protection Requirements
Board update May 2018

Introduction

From April 2018 the new Data Security and Protection Toolkit (DSP Toolkit) will replace the Information Governance Toolkit (IG Toolkit). The focus of the new toolkit will, as the name suggests be heavily focused on information security and data protection, as well as covering existing elements of the IG toolkit such as legislation and organisation processes and procedures. The new DSP toolkit will form part of a new framework for assuring that organisations are implementing the 10 data security standards and meeting their statutory obligations around data security and protection. These 10 standards apply to all health and care organisations and will form part of the CQC inspection mandate when focussing on the "well led" element.

The Trust was required to submit a brief assessment of its compliance with regard to meeting the 10 standards by 11/05/18; part of this assessment required a board level approval of the position.

The 10 standards and Trust compliance

The standards are logically grouped into 3 subject groups; these are People, Processes and Technology. The assessment criteria required the Trust to self-assess for each standard on the basis of full, partial or unmet.

People

Leadership obligation 1 – ***Senior Level Responsibility:*** *There must be a named senior executive to be responsible for data and cyber security in your organisation. Ideally this person will also be your Senior Information Risk Owner (SIRO), and where applicable a member of your organisation's board.* – The Trust considers it has fully met this obligation; Alison Kelly, Director of Nursing and Quality is the Trust's Senior Information Risk Owner (SIRO).

Leadership obligation 2 - ***Completing the Information Governance Toolkit v14.1:*** *In 2017/18, organisations are still required to achieve at least level two on the current IG Toolkit before it is replaced with a new approach (the new DSP Toolkit), from 2018/19 onwards, to measuring progress against the ten data security standards.* – The Trust considers it has fully met this obligation, achieving a level 3 – 82%

Leadership obligation 3 - ***Prepare for the introduction of the General Data Protection Regulation (GDPR) in May 2018:*** *The Beta version of the Data Security and Protection Toolkit, to go live in February 2018, will help organisations understand what actions they will need to take to implement GDPR, which comes into effect in May 2018.* The Trust considers it has fully met this obligation; a self-assessment of the ICO toolkit relating to GDPR readiness has been scored green.

Leadership obligation 4-. ***Training Staff:*** *All staff must complete appropriate annual data security and protection training. This training replaces the previous IG training whilst retaining key elements of it:* The Trust is fully compliant with this standard, with IG training across the Trust at 88% complete.

Processes

Process obligation 5 – ***Acting on CareCert advisory notices****; The Trust is required to act on CareCert advisories where relevant, confirm within 48hours that plans are in place to act on High Severity CareCert notices and have a primary contact point for CareCert advisories.* The Trust is fully compliant with all these elements

Process obligation 6 – ***Continuity Planning****: A fully comprehensive business continuity plan (BCP) must be in place to respond to data and cyber security incidents.* The Trust is partially compliant with this standard; full BCPs are in place but they have not been fully tested. A table top exercise is planned for this year to test the BCPs.

Process obligation 7 – ***Reporting incidents:*** *Staff across the organisation must report data security incidents and near misses, and incidents should be reported to CareCERT in line with reporting guidelines.* The Trust is fully compliant with this obligation, having a high level of incident reporting and escalation where appropriate

Technology

Technology obligation 8 - ***Unsupported systems*** *the organisation must identify unsupported systems (including software, hardware and applications) and have a plan in place by April 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems.* The Trust is only partially compliant with this requirement; some systems are known and identified and have been appropriately risk assessed and in some instances the removal of these systems is not appropriate e.g. the Remisol system (a clinical system that supports renal dialysis). In addition there are a number of other systems that sit outside the jurisdiction of Informatics which are relatively 'unknown'.

Technology obligation 9 – ***On site assessments*** *The Trust must have undertaken or have signed up to an on-site cyber and data security assessment by NHS Digital act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with your commissioner.* The Trust is fully compliant with this obligation; the most recent assessment by NHS Digital was conducted on 10/05/18; the report following this assessment has not yet been received and therefore the recommendations have not been assessed or acted upon as yet. The report from the previous year was fully actioned, however the report was not shared with the Trust commissioner; this will be rectified in 2018.

Technology obligation 10: ***Checking supplier certification*** *The Trust should ensure that any supplier of critical IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification (suppliers may include other health and care organisations).* The Trust has partial compliance with this regulation as not all existing suppliers have been approached to understand their compliance with this requirement.

Summary and recommendations

The Trust shows a good level of compliance with the majority of these recommendations; however in a number of areas there is a limited level of exposure which is a reflection of the position reported in the SBAR on Information Security to the Quality and Performance committee earlier this year. The Trust board is asked to note the level of compliance in this paper and support the

recommendations in the above mentioned SBAR relating to the restructure of Informatics resource to fully support the Information Security agenda

Appendix 1


Information Security Resource SBAR.docx


20180510_GDPR_BoardPaper_V0.1.docx

NHS
Countess of Chester Hospital
NHS Foundation Trust

Board of Directors – GDPR

Subject	General Data Protection Regulation (GDPR) and the Countess of Chester
Date of Meeting	22nd May 2018
Author(s)	Leanne Whalley, Head of Information Governance
Presented by	Stephen Cross, Director of Legal and Corporate Services
Annual Plan Objective No.	
Summary	The General Data Protection Regulation is a refreshed view of the current Data Protection Act; provides tighter controls on how we process both staff and patient information. The Information Governance Team have been working to an extensive Plan to ensure organisational compliance ahead of the implementation date of 25th May 2018.
Recommendation(s)	**The Board is asked to:** acknowledge the current organisational situation with GDPR compliance, and review the improvements in place and plans going forward.
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.

GDPR and the Countess of Chester

1) Background

The General Data Protection Regulations (GDPR) come into force on 25 May 2018 and applies to all data controllers and processors across the EU. In addition there is a Bill being taken through Parliament. This Bill contains additional parts of the GDPR which are specific to the UK (known as derogations). The GDPR represents a step change in the way that data is protected and managed and the principles are consistent with, and extend the Data Protection Act 1998.

This paper provides an overview of the General Data Protection Regulations (GDPR) required to be implemented by the Trust by 25 May 2018. The Government has confirmed that the United Kingdom's decision to leave the EU will not affect the commencement of the GDPR in the UK. National guidance is being developed by NHS England but is not yet available. Some guidance has been issued by the Information Commissioner's office (ICO) which provides an interpretation from a regulatory perspective. The Countess of Chester's activities will focus on what can be delivered now; further guidance will be awaited about other areas.

2) GDPR Issues

Key requirements of the GDPR include:

- **Fine enforcement** - the GDPR allows the ICO to impose significant fines for data breaches. The maximum fine available is currently £500,000 but this will rise to €20 million, or 4% of annual turnover per breach.

- **Incident & breach notification** - where individuals are likely to suffer some form of damage or risk to their rights and freedoms as a result of a breach, there will be a requirement to notify the ICO within 72 hours. It will also be mandatory to report high risk breaches directly to the data subject(s). Failure to report may result in a fine, as well as a fine for the breach itself**.**

- **Changes to obtaining consent (particularly children's consent)** - where consent is used as the legal basis to process personal information (normally for secondary, non-care purposes), this will need to be freely given, specific, informed, unambiguous, and only processed for the direct purpose it was obtained. Consent cannot be assumed, inferred from silence, or by pre-populated tick boxes. For children, additional consent requirements relate to providing online services.

- **Data Protection Officer** – a dedicated senior level role monitoring organisational compliance for data protection (this has been incorporated within the existing role of the Director of Legal and Corporate Services).

- **Individual rights** - there will be enhanced Data Protection rights for individuals, affecting the way COCH manages information and potentially requiring changes to operational systems relating to:

    - the right to object to certain types of processing being undertaken (to stop data being used for certain purposes such as marketing);
    - the right to restrict processing (to stop their data being used);
    - the right to data rectification (to have data changed if inaccurate);

- changes to the way data subjects can request their information under less time to respond to requests and understanding what processing is carried out on it);
- the right to data portability (allows individuals to obtain and reuse their personal data for their own purpose and for it to be moved, copied or transferred easily from one IT environment to another in a safe and secure way, without hindrance to usability).

- **Privacy notices** - more information will need to be routinely provided to patients (via patient leaflets and privacy notices available online), detailing the legal basis for processing their data, how we will use information, retention periods and who we share this information with.

- **Privacy by design** – data protection impact assessments will be routinely required for all new projects where the processing of patient/staff data is affected.

- **Data Flow Mapping** - COCH will need to fully document the personal data it holds, where it came from, who it is shared with and the legal basis under which it is used/shared.

- **Use of Data Processors** - where COCH uses third parties to process data on our behalf, additional criteria will need to be built into contracts and/or Confidentiality Agreements to ensure the right legal protections are in place and that.

  (ICO Guidance – Appendix 1)

3) Improvements in place

The Information Governance Team (IGT) conducted an initial gap analysis to determine the trust's current compliance with the requirements of the GDPR across the organisation. Although there is a well-developed IG framework and programme, a wide range of changes are still required to become fully compliant.

An action plan has been developed to facilitate GDPR compliance by May 2018 which has been well supported by colleagues across the Trust (Appendix 2). An ICO Self Assessment Checklist (Appendix 3) was carried out in April 2018 to determine our current compliance level. We were provided with a GREEN level of compliance which resulted in areas of immediate concern being highlighted.

Full implementation of the action plan rests on further guidance being published by the Information Commissioner/EU for a number of areas (such as consent, children' consent, and the individual rights).

Activities will be staggered between those which can be taken now and those awaiting further guidance. The ICO does not expect organisations to be fully compliant on 25th May 2018. They have suggested there will be an evolution phase after this date and will support organisations to continue to build compliance.

a) Activities already completed or in progress:

- IGT have been providing regular training sessions (both mandatory and ad-hoc) with colleagues to inform and update;
- 'GDPR risks have been identified on both the Risk Register and the BAF;

- IGT has linked with relevant departments to ensure that national advice and gu implications / risks are identified;
- GDPR communications have been provided to staff through meetings, email updates, training, the Intranet page and payslip notifications. There is a further comms plan in place which includes the use of screensavers;
- IGT is conducting a wide ranging data flow mapping exercise across all teams. This will establish the personal confidential data we receive;
    - What we do with it
    - Who we share it with
    - Why we share it and the legal basis to do so
- As part of this process, IGT is collating and building a central repository of Information Sharing (ISAs) and Data Processing Agreements (DPAs) held by all COCH teams;
- IGT is reviewing guidance for staff in the use of DPIAs and DPAs/ISAs. Revised guidance and templates will be made available via our intranet site. Where required more detailed training will be provided;
- A new Patients Privacy Notice has been developed and will be signed off by the Patient Experience Group on 21st May 2018. This is already active online. A Staff Privacy Notice has also been developed and is also available on our Intranet page.

b) As and when further guidance becomes available the work of the groups will be modified

c) Assurance is obtained via the following routes:

- Oversight of the project by the information governance committee.
- Regular updates to the Director of Legal and Corporate Services;
- Briefings for Board Meetings;
- Attendance at various meetings such as Partnership Forum etc.

4) Recommendations

The Board is asked to acknowledge the current organisational situation with GDPR compliance, and review the improvements in place and plans going forward.

Appendix 1 – ICO guidance

Preparing for the General Data Protection Regulation (GDPR) 12 steps to take now

1 Awareness
You should make sure that decision makers and key people in your organisation are aware that the law is changing to the GDPR. They need to appreciate the impact this is likely to have.

2 Information you hold
You should document what personal data you hold, where it came from and who you share it with. You may need to organise an information audit.

3 Communicating privacy information
You should review your current privacy notices and put a plan in place for making any necessary changes in time for GDPR implementation.

4 Individuals' rights
You should check your procedures to ensure they cover all the rights individuals have, including how you would delete personal data or provide data electronically and in a commonly used format.

5 Subject access requests
You should update your procedures and plan how you will handle requests within the new timescales and provide any additional information.

6 Lawful basis for processing personal data
You should identify the lawful basis for your processing activity in the GDPR, document it and update your privacy notice to explain it.

7 Consent
You should review how you seek, record and manage consent and whether you need to make any changes. Refresh existing consents now if they don't meet the GDPR standard.

8 Children
You should start thinking now about whether you need to put systems in place to verify individuals' ages and to obtain parental or guardian consent for any data processing activity.

9 Data breaches
You should make sure you have the right procedures in place to detect, report and investigate a personal data breach.

10 Data Protection by Design and Data Protection Impact Assessments
You should familiarise yourself now with the ICO's code of practice on Privacy Impact Assessments as well as the latest guidance from the Article 29 Working Party, and work out how and when to implement them in your organisation.

11 Data Protection Officers
You should designate someone to take responsibility for data protection compliance and assess where this role will sit within your organisation's structure and governance arrangements. You should consider whether you are required to formally designate a Data Protection Officer.

12 International
If your organisation operates in more than one EU member state (ie you carry out cross-border processing), you should determine your lead data protection supervisory authority. Article 29 Working Party guidelines will help you do this.

ico. Information Commissioner's Office

ico.org.uk

Appendix 2 – IG Work Plan

1	Awareness	You should make sure that decision makers and key people in your organisation are aware that the law is changing to the GDPR. They need to appreciate the impact this is likely to have.	1.1	Brief IG & Caldicott Panel of GDPR and implications – update at all IG Panel events
			1.2	Provide Briefing to Exec Team
			1.3	Provide briefing to Board
			1.4	Develop Communication roll out to all senior departmental managers
			1.5	Information Governance Manager to complete relevant GDPR training
			1.6	Develop guidance for staff to raise awareness of GDPR – monthly mailshots to all staff via newsletter/email
			1.7	Identify wider team training requirements in relation to GDPR
			1.8	Develop and hold GDPR workshop with identified management team

			1.9	Provide training to relevant managers/individuals on specific elements of GDPR
			1.10	Develop GDPR training documents for staff
2	Information you Hold	You should document what personal data you hold, where it came from and who you share it with. You may need to organise an information audit.	2.1	Develop and communicate new data flow mapping exercise to all departments
			2.2	Work with departments to complete data flow mapping exercise
			2.3	IG Team to audit and review mapping exercises to highlight any risks and look to reduce
			2.4	Ensure data quality audits are carried out across all shared information
			2.5	Identify Trusts mechanism for recording and managing assets, information flows associated risks
			2.6	Review questions included in standard procurement templates and contract clauses to ensure that informatio about supplier's proposed transfer of personal data for which the trust is responsible is understood and conducted in a compliant way.
			2.7	Review current data transfer mechanisms that are in plac and develop plans for secure data transfer methods to be reviewed and considered by Panel.
3	Communicating privacy information	You should review your current privacy notices and put a plan in place for making any necessary changes in time for GDPR implementation.	3.1	Identify all pre-existing privacy notices including ad-hoc sharing intiatives
			3.2	Ensure links to all privacy notices are available through COCH publication scheme
			3.3	Communicate changes and need for privacy notices to all front line staff
			3.4	Review all information sharing agreements/data processing to identify where Privacy Notices apply
4	Individuals' rights	You should check your procedures to ensure they cover all the rights individuals have, including how you would delete personal data or provide data electronically and in a commonly used format.	4.1	Review of all SOPs/SLAs, Pols and Pro to ensure the 8 rights for individuals are included
			4.2	Ensure privacy notices identify the individuals' rights
			4.3	Develop training programme and procedural document to support rights specifically
			4.4	Review accessibility of records and ease of transfer to individuals – ensuring we can provide electronically with ease

			4.5	Consider how the Trust will capture and record this objection and how this can be checked against elements like audits, commissioner information provisions
5	Subject Access Requests	**You should update your procedures and plan how you will handle requests within the new timescales and provide any additional information.**	5.1	Carry out audit on SAR process currently reviewing response times and accessibility of records
			5.2	Review and update Access to Records Policy to reflect legislative changes – possibly create standalone SAR procedural document
			5.3	Consider developing data subject access portals, to allow direct exercise of subject access rights.
			5.4	Review customer facing team's processes, procedures and training – are they sufficient to deal with the GDPR's access and portability rules?
			5.5	Develop template response letters, to ensure that all elements of supporting information are provided.
6	Lawful basis for processing personal data	**You should identify the lawful basis for your processing activity in the GDPR, document it and update your privacy notice to explain it.**	6.1	Review current process for recording lawful basis for processing data for direct care purposes
			6.2	Identify how consent is recorded within the clinical system and if this is explicit/written
			6.3	Review ISAs and Data Processing Agreements to ensure the lawful basis is included
			6.4	Review internal Governance processes to ensure the Trust can demonstrate how decisions to use data for further processing purposes have been reached and that relevant factors have been considered.
			6.5	Ensure the grounds relied on by your organisation to Process sensitive data, and check these grounds will still be applicable under the GDPR
7	Consent	**You should review how you seek, record and manage consent and whether you need to make any changes. Refresh existing consents now if they don't meet the GDPR standard.**	7.1	Review trust processes and procedures to ensure we are compliant and review what changes are required
			7.2	Develop consent process procedural document to support legislative changes
			7.3	Identify relevant staffing and roll out training on the new consent process

8	Children	**You should start thinking now about whether you need to put systems in place to verify individuals' ages and to obtain parental or guardian consent for any data processing activity.**	8.1	Consider whether legislative changes relating to children are applicable to organisation
			8.2	Detailed audit to review services, provisions and information provided to children and implications of obtaining parent or legal Panel consent and establishing legal Panel/parental responsibility
			8.3	Discuss potential implications with teams dealing with children providing appropriate training and guidance
			8.4	Where services are offered directly to a child, ensure notices are drafted clearly with a child's understanding in mind.
			8.5	Ensure any reliance on "legitimate interests" to justify processing children's data is backed up with a careful and documented consideration of whether a child's interests override those of your organisation.
9	Data Breaches	**You should make sure you have the right procedures in place to detect, report and investigate a personal data breach.**	9.1	Insurance policies should be revisited to assess the extent of their coverage in case of breaches.
			9.2	Ensure contracts and suppliers are informed of changes and requirement to notify the organisation wtihin specified timeframes
			9.3	Template MSA/data protection clauses and tender documentation should be updated by customers, including: (i) to require suppliers to proactively notify breaches to them; and (ii) put a great emphasis on the duty to cooperate between the parties
			9.4	Work with your IT/IS teams to make sure they implement appropriate technical and organisational protections to render the data unintelligible in case of unauthorised access.
			9.5	Review and update their internal breach notification procedures, including incident identification systems and incident response plans to take account of 72 hour reporting timeframe
10	Data Protection by Design and Data Protection Impact Assessment	**You should familiarise yourself now with the ICO's code of practice on Privacy Impact Assessments as well as the latest guidance from the Article 29 Working Party, and work out how and when to implement them in your organisation.**	10.1	Review Privacy Impact Procedures and requirements to ensure that these are routinely completed for all Trust items involving data
			10.2	Stengthen requirements of departmental managers to complete DPIAs as a mandated requirement
			10.3	Ensure that a full compliance program is designed for your organisation incorporating features such as: PIAs, regular audits, HR policy reviews and updates and training and awareness raising programs.
11	Data Protection Officers	**You should designate someone to take responsibility for data protection compliance and assess where this role will sit within your organisation's structure and governance arrangements. You should consider whether you are required to formally designate a Data Protection Officer.**	11.1	Assign responsibility and budget for data protection compliance within your organisation. Decide who is appropriate to be DPO bearing in mind responsibilities and reporting requirements of the role.
			11.2	Board and Executive Directors to be clear as the special status afforded to DPOs by the GDPR
			11.3	Consider what training is required to enable the DPO to fulfil the role
			11.4	Consider reporting lines –supervisory authorities will expect a line direct to the board – and the job specification for those designated with data protection
			11.5	Draw up illustration to demonstrate partnership working between IG Team, Caldicott Guardian, SIRO and DPO
12	International	**more than one EU member state (ie you carry out cross-border processing), you should determine your lead data protection supervisory authority. Article 29 Working**	12.1	Ensure no data is shared outside of the EEA and apply restricted where applicable
			12.2	Ensure checks are carried out when implementing new systems/servers/storage to identify location of storage

Appendix 3 – ICO Self-Assessment

Your overall rating was green.

- 2: Not yet implemented or planned
- 3: Partially implemented or planned
- 18: Successfully implemented
- 8: Not applicable

RED: not implemented or planned

Your business has documented what personal data you hold, where it came from, who you share it with and what you do with it.

Suggested actions

You should:

- maintain records of processing activities detailing what personal data you hold, where it came from, who you share it with and what you do with it. This will vary depending on the size of your business;
- consider using an information asset register to do this; and
- ensure you have procedures to guide staff on how to manage information you hold.

Your business has an appropriate data protection policy.

Suggested actions

You should have a standalone policy statement or general staff policy that:

- sets out your approach to data protection together with responsibilities for implementing the policy and monitoring compliance;
- aligns with and covers the measures within this checklist as a minimum;
- management approve and you publish and communicate to all staff; and
- you review and update at planned intervals or when required to ensure it remains relevant.

AMBER: partially implemented or planned

Your business has conducted an information audit to map data flows.

Where you have only partially implemented measures, please select the appropriate actions from the detail below:

Suggested actions

You should:

- organise an information audit across your business or within particular business areas to identify the data that you process and how it flows into, through and out of your business;
- ensure this is conducted by someone with in-depth knowledge of your working practices; and
- identify and document any risks you have found, for example in a risk register.

Your business has processes in place to ensure that the personal data you hold remains accurate and up to date.

Where you have only partially implemented measures, please select the appropriate actions from the detail below:

Suggested actions

You should:

- implement procedures to allow individuals to challenge the accuracy of the information you hold about them and have it corrected if necessary;
- establish a policy about how to record any requests you receive verbally;
- introduce appropriate systems to rectify or complete information, or allow individuals to provide a supplementary statement;
- have procedures to inform other organisations you have disclosed the information to of the rectification where possible;
- create records management policies, with rules for creating and keeping records (including emails);
- conduct regular data quality reviews of systems and manual records you hold to ensure the information continues to be adequate for the purposes of processing (for which it was collected);
- regularly review information to identify when you need to correct inaccurate records, remove irrelevant ones and update out-of-date ones; and
- promote and feedback any data quality trends to staff through ongoing awareness campaigns and internal training.

Your business has a written contract with any processors you use.

Where you have only partially implemented measures, please select the appropriate actions from the detail below:

Suggested actions

You should:

- ensure that you have a written contract in place whenever you use a processor (a natural or legal person or organisation which processes personal data on your behalf);
- check both new and existing contracts in force oinclude certain specific terms, as a minimum, to ensure that data processing meets the requirements of the GDPR;.
- outline in the contract the technical and organisational arrangements the processor must have in place;
- include arrangements for security of processing, keeping records of processing activities, and notification of data breaches;
- refer to the ICO guidance (link below) to clarify responsibilities and liabilities, and to help you draft new contracts and amend existing ones. Please note that this guidance may be subject to change as our formal GDPR guidance evolves, so look out for publication of new ICO guidance.

GREEN: successfully implemented

Your business has identified your lawful bases for processing and documented them.

Your business has reviewed how you ask for and record consent.

Your business has systems to record and manage ongoing consent.

Your business has paid the data protection fee to the Information Commissioner's Office.

Your business has made privacy information readily available to individuals.

Your business has established a process to recognise and respond to individuals' requests to access their personal data.

Your business has a process to securely dispose of personal data that is no longer required or where an individual has asked for it to be erased.

Your business monitors its own compliance with data protection policies and regularly reviews the effectiveness of data handling and security controls.

Your business provides data protection awareness training for all staff.

Your business manages information risks in a structured way so that management understands the business impact of personal data related risks and manages them effectively.

Your business has implemented appropriate technical and organisational measures to integrate data protection into your processing activities.

Your business understands when you must conduct a DPIA and has processes in place to action this.

Your business has a DPIA framework which links to your existing risk management and project management processes.

Where required, your business has appointed a DPO. In other cases, you have nominated a data protection lead.

Decision makers and key people in your business demonstrate support for data protection legislation and promote a positive culture of data protection compliance across the business.

Your business has an information security policy supported by appropriate security measures.

Your business ensures an adequate level of protection for any personal data processed by others on your behalf that is transferred outside the European Economic Area.

Your business has effective processes to identify, report, manage and resolve any personal data breaches.

Not applicable

If your business relies on consent to offer online services directly to children, you have systems in place to manage it.

Your business communicates privacy information in a way that a child w

If you may be required to process data to protect the vital interests of an individual, your business has clearly documented the circumstances where it will be relevant. Your business documents your justification for relying on this basis and informs individuals where necessary.

If you are relying on legitimate interests as the lawful basis for processing, your business has applied the three part test and can demonstrate you have fully considered and protected individual's rights and interests.

Your business has procedures to respond to an individual's request to restrict the processing of their personal data.

Your business has processes to allow individuals to move, copy or transfer their personal data from one IT environment to another in a safe and secure way, without hindrance to usability.

Your business has procedures to handle an individual's objection to the processing of their personal data.

Your business has identified whether any of your processing operations constitute automated decision making under Article 22 of the GDPR and has procedures in place to deal with the requirements.