NHS
Countess of Chester Hospital
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS (PUBLIC)
TUESDAY, 21st MAY 2019 AT 9:30AM – 12:00

BOARDROOM

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 26th March 2019 and matters arising **(Attached)**	Chair
4.	To receive a CEO update **(Attached)**	Chief Executive Officer
SAFE		
5.	To receive a response to the CQC report **(to follow)**	Director of Nursing and Quality
6.	To receive and agree the Quarter 4 Board Assurance Framework **(Attached)**	Chief Executive and Executive Team
7.	To receive and approve the Quality Accounts 2018/19 and Management Representation Letter, and to receive the Independent Auditor's Report **(Attached – sent under separate email)**	Director of Nursing and Quality & Chair of Audit Committee
8.	To receive a report from the Chair of the Quality, Safety and Patient Experience Committee – 19th March 2019 **(Attached)**	Chair of QSPEC
EFFECTIVE		
9.	To review the Integrated Performance Report as at Month 12 **(Attached)**	Executive Team
10.	To review the Finance Report Month 12 2018/19 and Month 1 2019/20 **(Attached)**	Director of Finance

NHS
Countess of Chester Hospital
NHS Foundation Trust

CARING		
11.	To receive a report from the Chair of the People & Organisational Development Committee **(Attached)**	Chair of POD Committee
RESPONSIVE		
12.	To receive a presentation on Transformation Programmes	Chief Operating Officer & Director of Planning & Partnerships
WELL LED		
13.	To approve a proposal on Governance Improvement and Committees of the Board **(to follow)**	Chief Executive Officer
14.	To receive a report from the Chair of the Audit Committee – April 2019 **(Attached)**	Audit Committee Chair
15.	To receive and approve the Annual Report, including Annual Governance Statement, Accounts 2018/19 and Management Representation Letter, to include receipt of the ISA260 Audit Highlights Memorandum and External Audit Opinion on the Annual Report & Accounts **(to follow)** **(Attached – sent under separate email)**	Director of Finance, Chief Executive, & Chair of Audit Committee
16.	To approve the NHS Provider Licence self-assessment **(Attached)**	Chief Executive Officer
17.	To receive a report from the Chair of the Charitable Funds Committee – April 2019 **(Attached)**	Chair of Charitable Funds Committee
18.	Items for noting and receipt **(Attached – sent under separate email)**: - Minutes of the Audit Committee – 19th February, 2019 - Minutes of the Quality, Safety & Patient Experience Committee – 19th March 2019. - Minutes of the Charitable Funds Committee – 18th December, 2018	Chair
19.	Date and Time of Next Meeting: **Board of Directors Meeting** **25th June 2019 – 9:30am, Training rooms 3 & 4, Education and Training Centre.**	

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BOARD OF DIRECTORS (PUBLIC)

MINUTES OF THE MEETING HELD ON TUESDAY, 26TH MARCH 2019 AT 13.15PM – 15.15PM
TRAINING ROOM 1

		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	☑	
Non-Executive Director	Mrs C Hannah	☑	
Acting Chief Executive	Dr S Gilby	☑	
Acting Medical Director	Dr D Kilroy	☑	
Director of Finance	Mr S Holden	☑	
Director of Nursing & Quality/Acting Deputy Chief Executive	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	☑	
ICP Managing Director	Ms A Lee	☑	

In attendance:

Mrs D Bryce – Lead for Governance Improvement (minute taker)

FORMAL BUSINESS

B15/19 **WELCOME AND APOLOGIES**

The Chair welcomed members and attendees to the Board meeting.

The Chair extended congratulations to Ms Ros Fallon in the 12 months extension of her term of office as Non-Executive Director and also to Dr Susan Gilby on her permanent appointment as Chief Executive, from 1st April 2019.

B16/19 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

B17/19 **TO RECEIVE AND APPROVE THE BOARD OF DIRECTORS MINUTES OF MEETING HELD ON 29TH JANUARY 2019 AND MATTERS ARISING**

The Board of Directors minutes of the meeting held on 29th January, 2019, were received as a true and accurate record.

There were no matters arising.

QUALITY & ASSURANCE

B18/19 **TO RECEIVE DETAILS OF THE STAFF SURVEY 2018 RESULTS**

The Director of People and Organisational Development referred to the key staff survey results and noted the following:

- Disappointment in the response rate of 36% which was below the acute hospital average of 44%;
- The survey was conducted on a sample basis this year and a full survey is recommended for next year's survey;
- That the Board needs to focus on those areas where the Trust is below the average which include morale, quality of appraisals, staff engagement and safety culture;
- That an action plan has been produced and it is recommended that the People & OD Committee monitor progress of this;
- That a progress update is provided to the Board in September, 2019, before the next survey is issued in October;

Non-Executive Director, Mrs Fallon, enquired about the operational managers and teams roles to deliver the actions. The Director of People and Organisational Development responded that the action plan template had been issued to Divisions to populate and will also be discussed at Corporate Leadership Group.

Non-Executive Director, Mrs Hannah, queried why the response rate is low and how this can be improved. The Director of People and Organisational Development responded a trend in lower response rates and a plan to review the format in future.

Non-Executive Director, Mr Higgins, acknowledged that the safety culture findings were disappointing and asked what can be done better as it had been reported that the Trust would improve this previously, along with communication issues. The Acting Chief Executive raised that a prioritised, refreshed, strategic response to the actions would need to be taken and would want to take this to Executive Group and Safety Group to agree the outcomes wanted, especially regarding the safety culture work required within the organisation. The recently appointed Freedom To

Speak Up Guardian was also raised as bringing a fresh approach to safety communication.

The Board received the results of the staff survey 2018.

B19/19 **TO REVIEW THE INTEGRATED PERFORMANCE REPORT AS AT MONTH 11 TO INCLUDE A FINANCE REPORT**

In relation to the constitutional metrics, the Chief Operating Officer raised the following points from the performance report for month 11:

- The A&E clinical lead work and the A&E improvement plan that is in place;
- That cancer 62 day performance is just below the national level this month and an additional Urology Consultant has been recruited in the short-term;
- 18 week performance has dropped;
- 91% of patients cancelled are being re-booked within 28 days which is an improvement; and
- Diagnostics performance is starting to improve and there is a plan to change how this is shown from April.

The Interim Medical Director referred to the challenging infection control agenda and informed that he and the Director of Nursing & Quality have commissioned an infection control review which has started. The work to implement the Sepsis Screening tool and Sepsis management was also raised.

Non-Executive Director, Mrs Fallon, asked how the Trust benchmarked against other organisations. The Interim Medical Director responded that the Trust is not where it should be on Sepsis and is in the middle of the pack on C-Difficile performance, but that the trend is not going the right way.

Non-Executive Director, Mrs Hannah, raised that Sepsis is not reflected in exception reports and there are no visible trajectories for improvement. The Director of Nursing & Quality informed that the clinical lead for Sepsis now has dedicated time to lead on this and the support needed is being discussed. The Acting Chief Executive informed that the Trust are now engaged in evidence based work across the region and that Sepsis is one of the highest areas for improvement.

The Director of People and Organisational Development, in relation to the workforce indicators, raised that a recovery plan has been commissioned regarding sickness absence and annual appraisal compliance; turnover rates have improved; and the Trust is expected to achieve below its agency expenditure cap.

Non-Executive Director, Mrs Hopwood, enquired as to what is being done to address the shortage of Occupational Health access for referrals. The Director of People and Organisational Development responded that a review of the Occupational Health service has been commissioned and an alternative option with better access has been secured and will start soon.

The Director of Nursing and Quality reported, in relation to nurse staffing, that the reporting would change in the future and that there has been recruitment of additional Health Care Assistants for wards 50 & 51, which is part of a bigger piece of work regarding reviewing the nursing workforce.

Non-Executive Director, Mrs Hannah, enquired about how the Trust benchmarks on turnover, as 10% looks high. The Director of People and Organisational Development informed that 10% appears to be a consistent number. The Director of Nursing & Quality informed that nursing and midwifery turnover was previously 15% and a reduction has been seen, but that there is still more work to do. In response to Non-Executive Director, Mrs Hopwood's enquiry, the Director of People and Organisational Development agreed to look further into the turnover of 'regretted leavers'. The ICP Managing Director acknowledged the high turnover rates too for Allied Health Professionals.

FINANCE REPORT FOR MONTH 11 (FEBRUARY 2019)

The Director of Finance gave an overview of the Trust's financial position to the end of February 2019 and raised the following points:

- The forecast position for the year is a £12.7m deficit and nothing has changed in the forecast;
- The level of over performance with the host commissioner is greater than £2m;
- There is a risk regarding increased costs for the combined heat and power electricity generator whilst it is being fixed;
- There is a risk regarding a challenge to the Brooksons' system;
- The Trust is borrowing cash from the Department of Health; and
- The Trust has been successful in a £1.5m bid to put LED lighting throughout the hospital.

Non-Executive Director, Mr Higgins, raised concern that the Trust's capital loan may not be approved. The Director of Finance responded that recommendations from NHS England may address this, that urgent and necessary capital requests procurement processes have begun and that the capital requirements for 2020 are currently under consideration.

In response to a question from Non-Executive Director, Mrs Hopwood, regarding the current position of cost reduction strategy (CRS) delivery, the Director of Finance informed that the Trust are going to deliver approximately half of their CRS figure this year, with a 2% forecast CRS figure next year, and informed that a large proportion of the Trust's overall expenditure, circa 80%, is on pay. The Chair requested a split of recurring and non-recurring CRS. The Director of Finance confirmed later that 2.4% of CRS has been delivered non-recurrently (£5m) and that only half (circa 1%) had been delivered recurrently.

The Board reviewed and received the February 2019, month 11, Performance Report and the Finance Report at Month 11.

B20/19 **TO RECEIVE AND APPROVE THE OPERATIONAL PLAN 2019/20 AND BUDGET SETTING 2019/20**

The Director of Finance referred to the 2019/20 proposed Operational Plan and that Commissioners have agreed that this year the best way forward is a Payment by Results system, as the Trust have undertaken £2.7m of activity this year that has not been paid for on the previous block contract.

The Chief Operating Officer informed that the operational plan needs to be submitted by 4th April 2019, that Cheshire West Integrated Care Partnership (ICP) and Cheshire & Mersey Health & Care Partnership (HCP) will be an important part of the plan, and that the plan covers seven day services aspirations, along with a continuous improvement culture.

The Director of Finance informed that the Trust has a control total financial target of an £8m deficit and as it stands today the Trust will be unable to agree the control total, which will result in a £15m deficit budget in 2019/20. The Director of Finance referred to the paper which covers the budget setting detail, including the pressure from the pay award, and requested delegated authority to take forward the decision on the agreement, or not, of the financial control total for 2019/20 following and outside of the Board meeting.

Non-Executive Director, Mr Higgins, referred to a large element of CRS being vacancy savings and enquired if there were mechanisms in place to do this from 1st April, 2019, and asked if there was agreement of the control total within the local health system. Non-Executive Director, Mrs Hopwood, also asked how likely risks will come into play to accept the plan, for example, the Welsh contract risk. The Director of Finance responded that the Trust need to improve at delivering recurrent savings, i.e. transformational changes of doing more for less, and also monitor incentive schemes of sharing savings across the health system. He also informed that a meeting had taken place yesterday regarding the Welsh contract and there was some optimism of reaching a solution. In response to a question from Non-Executive Director, Mrs Hopwood, the Director of Finance responded that the Trust had used £5m of reserves this year.

Non-Executive Director, Mrs Hannah, raised that the £8m deficit control total should not be accepted if it is not realistic. The Acting Chief Executive raised that there should be a system solution to achieve the £8m deficit control total, that discussions continue with one week to go, that she has concerns regarding accepting a £15m deficit and the associated risk and would like a recovery plan over 2-3 years, and would like the Board to approve a realistic view on out-turn for 2019-20. The Acting Chief Executive also stated that engagement with clinicians could help achieve the system control total and that it was planned to bring some external support to provide challenge to clinicians. Non-Executive Director, Mrs Hopwood, supported a review of risk regarding a realistic out-turn position.

The Chair suggested that himself, Non-Executive Directors Mrs Hopwood and Mr Higgins, the Director of Finance, Acting Chief Executive and the Director of Nursing & Quality be given delegated authority to sign-off the final 2019/20 Operational Plan and budget on behalf of the Board, which included doing this electronically.

The Board agreed the delegated authority, as suggested by the Chair, to agree and sign-off the final 2019/20 Operational Plan and budget.

B21/19 **TO RECEIVE AN UPDATE ON NEVER EVENTS AND SERIOUS UNTOWARD INCIDENTS**

The Director of Nursing & Quality reported that there had been one never event in March 2019 which related to a patient going out of a ground floor window. A review of window restrictors has taken place and an investigation is being undertaken.

The Board received the verbal update including the detail of one never event reported in March 2019.

B22/19 **TO RECEIVE AND APPROVE THE BOARD ASSURANCE FRAMEWORK AS AT QUARTER 3**

The Director of Nursing and Quality referred to the Quarter 3 Board Assurance Framework and informed that it may look different in the future. The Interim Medical Director raised that the clinical strategy referenced within risk CR3 should be completed soon. The Director of People & OD raised, with reference to risk CR10, that a clearer clinical education strategy is due, along with a revised People & OD Strategy. The Director of Finance requested that the Board accept an increased total risk score in Quarter 3 for risk CR5.

The Acting Chief Executive informed that a large part of the external governance review has included how the Board use the Board Assurance Framework and it may look different over the next six months.

The Board received and approved the Board Assurance Framework as at Quarter 3.

B23/19 **TO RECEIVE AN UPDATE ON FREEDOM TO SPEAK UP (FTSU) AT THE TRUST**

The Director of People & Organisational Development referred to the update paper and outlined that a key focus is ensuring FTSU is a key part of the organisation and that recruitment has been completed for a FTSU Guardian who will start in late May 2019, for two days per week. The FTSU policy is being revised, and the self-review tool has been completed.

Non-Executive Director, Mrs Fallon, asked about confidence levels that the system in place is working and how assurance is obtained. The Director of People & Organisational Development responded that there is room for improvement currently and that a wider network for champions, as well as guardians, is needed. The Director of Nursing & Quality informed that one of the recommendations from the National Guardians office is that Executive and Non-Executive Directors can be conflicted, so an independent guardian is better, hence the new appointment, plus there is a need for a network of guardians at ground floor level.

The Managing Director of the ICP suggested that the Board should recognise that a future increase in FTSU incidents/numbers will not be a bad thing.

The Board received the update on Freedom to Speak Up.

B24/19 **TO RECEIVE AN UPDATE ON KISIIZI**

The Director of Finance referred to his paper of the current Kisiizi programme that is in place and informed that he would like to raise the profile of the programme with the Board and requested support for the recommendations within the paper.

The Board received the update paper on the Kisiizi programme and the recommendations within it.

STRATEGIC DEVELOPMENT

B25/19 **TO RECEIVE DETAILS ON THE PROGRESS OF THE INTEGRATED CARE PARTNERSHIP, INCLUDING THE PROGRESS REPORT AND APPROVAL OF THE INTEGRATION AGREEMENT**

The Managing Director of the Cheshire West Integrated Care Partnership (ICP) outlined details of the ICP progress and noted the following points:

- That the Trust are one of six ICP partners;
- That in-depth engagement work that has been jointly commissioned across health and social care is due to report back around May 2019;
- In relation to Public Health, the needs of patients are being considered;
- Other work is ongoing to review Care Community Teams;
- Work is ongoing to develop an intelligent-led ICP via use of data; and
- The report highlights the first services in scope of the ICP

The Managing Director of the ICP also referred to the Integration Agreement which outlines collaborative governance across six organisations which does not supersede existing governance arrangements. The integration agreement is not legally binding and the Countess of Chester Hospital is the Host, which is currently a role of "co-ordinator".

Non-Executive Director, Mrs Hopwood, asked, with reference to Appendix 1 in the Integration Agreement, how the People, Overview & Scrutiny Committee was scrutinising. The Managing Director of the ICP responded that the Committee was a Local Authority Committee and can call any decisions to answer to the members.

Non-Executive Director, Mr Higgins, raised the challenges of collaborative governance and the risk the Trust may assume, and enquired as to what mechanisms were in place to manage this. The Managing Director of the ICP confirmed that there was no additional risk currently as the ICP/Trust had taken no additional responsibility for services that outlie the current Trust remit and that governance arrangements for existing services will continue.

In relation to a question from the Chair, the Acting Chief Executive responded that if a service is registered with an organisation, then they are responsible.

There was a discussion regarding the practicalities of the boarders of the ICP, Wales and also children's services and the Managing Director of the ICP confirmed that children's services will

remain the responsibility of the Local Authority.

Non-Executive Director, Mrs Hannah, stated that the complexities and challenges need to be recognised, along with the learning from others.

The Lead for Governance Improvement referred to the integration agreement and informed that the requirement for the Trust to create an ICP sub-committee of the Board was not yet needed. Two minor changes were also raised with regard to a change to the address for South Cheshire & Vale Royal GP Alliance and the reference to this organisation in Appendix One requiring correction to its full name.

The Board noted and received the Integrated Care Partnership progress report.

The Board agreed and approved the Cheshire West ICP Integration Agreement.

B26/19 **TO RECEIVE A CEO UPDATE**

The Acting Chief Executive provided a verbal update on the following:

- There has been a business issue with the builder of the Emergency Department development; this will not impact dramatically and has been addressed;
- That the Neonatal build enabling work has started, following planning permission being granted;
- There was a CQC inspection in November 2018, plus a Well Led review in December. The draft report was received on Friday and is currently being reviewed for factual accuracy. There is nothing within the content that is a surprise and a number of areas that require improvement. An external governance review was commissioned by the Trust in December 2018 and a workshop was held with the Board today which will allow the Board to improve and build on its strengths;
- NHS Improvement and NHS England have come together under a single regional team and engagement has started with the regional director;
- The Acting Chief Executive attended a national provider CEO meeting last week which included a presentation from the National Director of Patient Safety. A national strategy is being developed which will help locally to keep patients safe in a proactive way.
- Assurance has been provided by the NHS Director for Brexit regarding the robust plans in place to support the NHS, and the work on this regionally and nationally.
- That the Trust is not alone in its financial position and the challenge it has being off-plan, but there is an aim nationally for all providers to be in financial balance by 2023.

The Board received the verbal update from the Acting Chief Executive.

B27/19 **TO RECEIVE AN UPDATE ON GOVERNOR MATTERS**

The Director of Corporate & Legal Services informed that the Trust values the input of the Governors and that the Council of Governors met on 22nd March to consider the proposed Trust operational

plan. The Director of Corporate & Legal Services thanked the Governors for all the work that they do.

The Board received the verbal update on Governor matters.

FOR NOTING & RECEIPT

B28/19 **TO RECEIVE THE MONTH 10 AND MONTH 11 LETTERS TO NHS IMPROVEMENT**

The Board received and noted the month 10 and month 11 letters to NHS Improvement.

B29/19 **TO RECEIVE THE EQUALITY AND DIVERSITY ANNUAL UPDATES TO INCLUDE THE GENDER PAY GAP REPORT (Appendix 4)**

The Board received and noted the Equality and Diversity Annual Updates, including the Gender Pay Gap Report.

B30/19 **TO RECEIVE THE MINUTES OF THE QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE**

The Board received and noted the minutes of the Quality, Safety and Patient Experience Committee – January 2019

B31/19 **TO RECEIVE THE MINUTES OF THE AUDIT COMMITTEE – 20TH NOVEMBER, 2018**

The Board received and noted the minutes of the Audit Committee of 20th November, 2018.

B32/19 **TO REVEIVE THE CORPORATE INFECTION PREVENTION AND CONTROL ASSURANCE QUARTERLY REPORT**

The Board received and noted the Corporate Infection Prevention and Control Assurance Quarterly Report, which was a retrospective report based upon November 2018 quarterly data update.

B33/19 **OTHER BUSINESS RAISED**

The Chair noted that it was the last attendance at Board of Directors for the Director of Corporate & Legal Services, Mr Cross, after twelve years with the Trust. The Chair thanked Mr Cross for his service to the Trust and working relationships with the Governors and wished him well in his retirement.

B34/19 **DATE AND TIME OF NEXT BOARD OF DIRECTORS MEETING**

Tuesday 21st May 2019 – 9:30am

NHS
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NHS Foundation Trust

Item Reference and Title	Agenda item 4 - Chief Executive's Update
Date of Meeting	Board of Directors Tuesday 21 May 2019
Accountable Executive	Susan Gilby
Author(s)	Susan Gilby
Alignment to Board Assurance Framework risk	CR7 Failure to maintain robust corporate governance and overall assurance. Overall risk score 12
Alignment to CQC Domains	Well Led
Document Previously Considered by:	N/A
Summary	This report is intended to: • Provide an update on local, regional and national issues within the NHS / Countess of Chester Hospital
Recommendation(s)	The Board is asked to note the update.
Corporate Impact Assessment:	**Legal and regulatory impact:** **Financial impact:** **Patient Experience/Engagement:** **Risk & Performance Management:** **NHS Constitution/Equality & Diversity/Communication:**

Countess of Chester Hospital NHS Foundation Trust

CEO report May 2019

1. **Regional/national issues**

1.1 We welcome the announcement that specialist mental health support for new Mothers is to be available in every part of England The rollout of specialist perinatal community services across the whole of England, means that mums and mums-to-be who are experiencing anxiety, depression or other forms of mental ill health should be able to access high quality care much closer to home. Five years ago two in five parts of the country had no access to specialist community perinatal mental health treatment, but there is now full geographical coverage for the first time, with services in every one of the 44 local NHS areas, and plans to develop them further. The expansion comes alongside the opening of four new mother and baby units, which mean that the most seriously ill women can receive residential care without being separated from their babies in every region. Further information is available at: https://www.england.nhs.uk/2019/04/specialist-mental-health-support-for-new-mums-available-in-every-part-of-england/

1.2 We are delighted to report that Max and Keira's Bill passed into law. A new system for organ donation that will save hundreds of lives has come into law, with the Organ Donation (Deemed Consent) Bill receiving Royal Assent on 15 March. Royal Assent means the bill is now an act of parliament. The Organ Donation Act will mean adults in England will be considered potential donors unless they chose to opt out or are excluded. The act is known as Max and Keira's law in honour of a boy who received a heart transplant and the girl who donated it. Max lives in Winsford in the Vale Royal area of Cheshire and has been recognised nationally for his campaign to improve the lives of others.
Currently there are more than 6,000 people currently waiting for an organ in the UK. Three people die each day while on the waiting list. The new law will help to reduce the number of people waiting for a life-saving transplant. Changes to the way consent is granted will take effect in 2020. Before this happens, the government will launch a public awareness campaign to make sure people understand the new system and the choices they have. Those excluded from the plans include: children under 18 people who lack the mental capacity to understand the changes for a significant period before their death people who have not lived in England for at least 12 months before their death There will also be strict safeguards in place and specialist nurses will always discuss donation with families so an individual's wishes are respected. Those who do not wish to donate their organs will still be able to record their decision on the NHS Organ Donation Register. They will be able to do this through NHS Blood and Transplant's website or helpline.

2. **Local Issues**

2.1 Our staff now has access to a new Employee Assistance Programme, which provides improved counselling services as well as online information on a wide variety of topics that can be viewed at any time both in and out of work. This confidential service is designed to help anyone dealing with personal and professional problems. I hope everyone who works at The Countess will take advantage of this service if and when they need it. We recognise that working on the front line in the NHS can be difficult and stressful. We are committed to doing whatever we can to support our staff and this is a fine example of that.

2.2 Last week was Dying Matters Week, which is a national campaign to raise awareness of death and bereavement. As part of the push to 'get people talking', our palliative care team held a Support to Care

Café in our Spiritual Care Centre. As an acute hospital ensuring the privacy and dignity of any patients recognised to be in the last days of life is vitally important to us.

2.3 We are working with NHS Improvement as part of a healthcare associated infection review. This will give us an opportunity to identify what we are doing well and where improvements in infection prevention and control need to be made. We have been set targets for 2019/20 of having zero avoidable MRSA bacteraemia and less than 36 cases of C. difficile infection. We need to do all we can to make sure we meet those targets.

2.4 Work has begun to install a state-of-the-art CT scanner in Radiology. While this is ongoing a temporary mobile scanner will be on site to ensure it does not affect patient care or waiting times. This is an exciting time for Radiology because the new scanner features advanced imaging technology and has the ability to help improve workflow.

2.5 We have made a £440,000 investment to purchase 80 new defibrillator machines for the entire Trust. These machines will be among the most advanced in the region and this underlines our commitment to improving patient safety in the hospital.

2.6 Thanks to the generosity of Tesla Owners UK our paediatric patients can now drive themselves over the bridge for investigations and procedures in a brand new Radio Flyer mini Tesla Model S. The motorised toy car has been donated to us as part of a campaign by Tesla Owners UK to reduce anxiety in children attending theatre in hospitals. A local Tesla driver and his family selected The Countess to receive one and we are absolutely delighted. Going to theatre can be a scary time for anyone, especially children, but this gives them something to look forward to while they are here.

2.7 Our Commercial Procurement Services team have been recognised for their work by winning and being among the finalists of numerous awards in 2019. They were finalists for 14 different awards in 2018/19 including the prestigious CIPFA Public Finance Awards 2019, HSJ Value Awards 2019, The NHS in the North West Excellence in Supply Awards 2018.

2.8 We hosted the Inclusive Top 50 ‘Closing the Diversity Gap in the Public Sector’ event on 17 April, demonstrating our continued excellent commitment to equality and diversity.

3. **Resolution of contracting dispute with Welsh Assembly.**
I am grateful to NHS England, the Welsh health ministry and in particular to Matt Hancock, for working hard together to resolve this issue over recent weeks. The involvement of the Secretary of State has been key to resolving this issue. On point of fact, we were clearly informed that there were no ongoing negotiations to address the issue of contracting for cross border secondary (as opposed to tertiary) care prior to our decision. Nor are there any existing protocols which would mandate that we continue to accept underfunded elective referrals at the expense of investments in patient safety. Our focus remains the delivery of high quality services to the population we serve. We now look forward to agreeing a contract with Betsi Cadwaladr University Health Board in the knowledge that all patients will benefit from the planned safety investments enabled by appropriate resources.

4. **Appointment of Executive medical director**: Verbal update

5. **Care Quality Commission**:
Welcome the report, staff will inevitably be disappointed with the ratings. Given that the inspection was 6 months ago and improvements were already underway, we are confident that we have the leadership in place to be able to consistently demonstrate safe, effective, caring and responsive care.

Item Reference and Title	Agenda Item 5: Response to the CQC Report
Date of Meeting	Board of Directors 21st May 2019
Accountable Executive	Mrs Alison Kelly, Director of Nursing & Quality
Author(s)	Mrs Alison Kelly, Director of Nursing & Quality
Alignment to Board Assurance Framework risk	CR1 : Failure to maintain and enhance the quality and safety of the patient experience and ensure regulatory compliance 4x3 = 12
Alignment to CQC Domains	Safe/Effective/Caring/Responsive/Well Led
Document Previously Considered by:	N/A
Summary	This report is intended to provide an overview of the recently received final CQC Inspection Report and associated action plan which addresses the 'Must Do' actions.
Recommendation(s)	**The Board is asked to** • Note the progress of MUST DO actions and agree the monitoring processes • Agree the proposed approach to continuous improvement and cultural change. • Agree that recommendations from the Governance review will underpin the changes outlined in this paper.
Corporate Impact Assessment:	**Legal and regulatory impact: √** **Financial impact:** **Patient Experience/Engagement: √** **Risk & Performance Management: √** **NHS Constitution/Equality & Diversity/Communication:**

Countess of Chester Hospital NHS Foundation Trust

Response to the CQC Inspection Report (May 2019)

1. Introduction

This paper is written in response to the findings of the Care Quality Commission (CQC) 'Well Led' inspection which was undertaken in December 2018. As part of this process, an unannounced inspection was undertaken in November 2018 as well as a 'Use of Resources' assessment which is taken into account in the overall rating.

The formal outcome of the most recent inspection was 'Requires Improvement'. The Trust accepts this rating and recognises the need to improve in a number of areas. Set out in this paper are the findings with an associated action plan of the immediate actions from the report, providing assurance that the Trust has either completed or is progressing these actions.

2. Findings

The Trust was rated Requires Improvement overall for the following reasons:

- Safe, Effective, Responsive and Well led domains were rated as Requires Improvement.
- Caring was rated as Good.
- Three core services were inspected, the medical, surgical and urgent & emergency care. All three were rated as Requires Improvement. Previously these had been rated Good (this was under a different Inspection regime).
- Rating of services not inspected at this time was also taken into account.
- The overall rating for the Trust regarding Well Led was Requires Improvement.
- The Trust's Use of Resources assessment was given a rating of Requires Improvement.

The CQC could not be assured that our current systems and processes were effective. They identified a number of areas for improvement including requirement notices against the following regulations:

- Regulation 10 (HSCA) (RA) Regulations 2014 Dignity & Respect
- Regulation 12 (HSCA) (RA) Regulations 2014 Safe Care & Treatment
- Regulation 18 (HSCA) (RA) Regulations 2014 Staffing
- Regulation 17 (HSCA) (RA) Regulations 2014 Good Governance

Within the findings 18 'MUST DO' actions were identified which the Trust must put right (Appendix 1), with a further 23 'SHOULD DO' actions the Trust should improve on to comply with minor breaches that did not justify regulatory action. The themes identified in the SHOULD DO actions included improving on the culture of the Trust, training compliance, estates and infrastructure issues and visibility of managers.

A key theme identified from the Well Led inspection was that the Trust did not have fully effective systems for managing risk, that the risk management system did not connect to the Board Assurance Framework, that Committee reporting accountabilities were not clear, and that some issues raised in the last inspection had not been addressed in a timely manner, with gaps in governance and safety issues.

Prior to the inspection, it was identified by the then Acting Chief Executive, that a robust external review was required of the Trust's governance processes, with the purpose of deepening the organisation's understanding of its leadership and governance arrangements and identifying key development actions. This was commissioned before the CQC Well Led inspection.

Key recommendations from the external governance review include: -

- Developing a long-term strategy for the organisation;
- Making better use of the Board Assurance Framework (BAF) to drive the Board agenda and aligning the BAF to the Trust's risk management system.
- Implement a development programme for Board members and senior operational leaders to improve knowledge around assurance and use of data.
- Review and refresh organisational structures.
- Improve systems and processes.
- Embed leadership, culture and behaviours.

A new model of integrated governance will be implemented in response to the above recommendations. This will provide oversight and realignment of all governance and risk processes, including quality governance, clinical governance, financial governance, information governance and staffing/people governance.

3. Assurance

The Trust accepts the above findings and is required to ensure all the identified actions are implemented in order to improve the Trust's culture. The regulatory actions will be monitored in a CQC Task & Finish Group which will be jointly chaired by the Director of Nursing & Quality and the Medical Director. This will ensure all MUST DO actions are completed with assurance provided that actions are audited and embedded in practice. 'SHOULD DO's' will also be considered. This assurance will be fed into the newly formed Quality Committee (a Board reporting Committee) and will be reviewed on a regular basis.

4. Approach to Transformation and Continuous Improvement

In respect of Trust-wide cultural transformation, changes will be required to ensure compliance with behavioural standards, supporting leadership development, commencing with the triumvirate Divisional teams, in clearly describe what is expected of them in their leadership roles. There will also be the development of an accountability framework. This will be in the context of implementing the recommendations from the external Governance review.

It has been recognised that having numerous action plans to address issues isn't the most effective way of progressing improvement. The priority is understanding the root cause of issues and ensuring the Trust has robust systems and processes in place in order to deliver safe care. This will only be achieved by Trust-wide cultural change.

Further understanding of the CQC regulations and standards is required for Teams and the use of CQC terminology will be embedded so that all standards are continuously referenced in everything that is done. A step towards this has already taken place in that all key meetings will utilise the CQC domain headings within their agendas (including the Board). It will be an expectation that all corporate documentation, business cases etc. will use these headings. A mapping exercise will ensure that all CQC standards and regulations are embedded into all aspects of quality governance to ensure continuous awareness and thus improvements. The Director of Nursing & Quality will look to develop this.

A Quality Improvement Strategy will be developed building on the Trust's existing Quality Improvement programme. Previously the Trusts approach has been the Model for Improvement (based on IHI) which has been adopted by the wider NHS. There is now an opportunity to review and identify what our quality improvement methodology is and what will best suit the organisation.

This will be supported by:

- Implementing a ward accreditation framework
- Communication and training for all staff in continuous improvement
- Ensuring our improvements are aligned with the Trust strategies
- Gaining clarity on existing Quality Champion roles
- Building on staff capability so staff are empowered and confident to improve services
- Designed Executive lead and engagement with senior leaders across the Trust
- Utilising contacts and resources from other NHS Trusts who have successfully undertaken transformational change utilising a continuous improvement methodology.

5. Recommendations

The Board of Directors is asked to:

- Note the progress of MUST DO actions and agree the monitoring processes
- Agree the proposed approach to continuous improvement and cultural change.
- Agree that recommendations from the Governance review will underpin the changes outlined in this paper.

COCH Response to Regulatory Notices following CQC Well-led Assessment in December 2018

An audit plan will be developed to monitor compliance against all actions which will be received in a monthly CQC Task & Finish Group

Regulation & Action	Lead/s	Progress to Date	Evidence	Deadline/Next Steps
Trust wide				
Regulation 17(1). The trust must take actions to strengthen governance processes and systems in place for the management of risks to ensure there are effective on-going assurance and management oversight processes across the trust.	Associate Director of Risk & Safety Executive Business Planning Manager	Programme of E**x**ecutive meetings with Divisions regarding risk registers Guidance for staff regarding risk register management currently in production Risk register training sessions planned for June External Governance review completed April 2019 Recommendations to underpin trusts quality improvement and culture plans	Summary outcomes of E**x**ecutive meetings with Divisions regarding risk registers in progress External Governance Review undertaken and recommendations being implemented. Dedicated Governance resource in place for 3 months.	September 2019 Review due August 2019
Regulation 10(1) (2) (a). Ensure that all patients' have their privacy and dignity maintained at all times. Patients should not receive treatment, be reviewed, or handed over directly in front of, or next to other patients, or their relatives.	Associate Director of Nursing (Planned Care) Associate Director of Nursing (Urgent Care)	Curtains are now in place in the ambulance off load bay within the ED providing privacy within this area, it has been communicated to all nurse team leaders and time critical nurse that this area must only be used if no available cubicles in majors. Within the ward areas patient handovers take place away from the patient bed spaces, when being reviewed by a Doctor or patient undergoing nursing intervention curtains are drawn, if the 29th bed is used patients who are able to transfer/mobilise to the bathrooms are cared for in this area, privacy screens are also utilised.	29th bed checklist utilised. Checklist audit takes place monthly. Additional spot checks also undertaken by Ward Managers. April result 92.7% 4b ED Safty Checklist.pdf	**Complete** Evidence of spot check audits of to be undertaken monthly by ED Matron May Audit to be presented to Nursing & Midwifery Board (6th June 2019)

Regulation & Action	Lead/s	Progress to Date	Evidence	Deadline/Next Steps
			4b Process for monitoring compliance	
Regulation 17(1) (2) (b). Ensure patients at risk of falls are assessed in a timely manner, and appropriate mitigation of risk is implemented according to the trust policy and guidance	Associate Director of Nursing (Corporate)	Patients are assessed (using RCP & NICE screening questions-deemed national best practice) on admission and within the 6 hours outlined within the policy (provided as evidence). When identified as a concern an alert is placed on the patient EPR. That alert can also be displayed on the Teletracking screen. Standard falls prevent measures are in place as routine practice and evidenced through the completion of the care and comfort charts (example provided in the policy). Lying/standing BP and vision assessment are part of the falls assessment process, this data can be printed ward falls risk list. A 'slipper bank' was implemented during 2018 and slipper socks are now ward stock items. Ward falls risk list has been designed to allow area manager to quickly review compliance with falls prevention measures. 121 supervision is assessed using a standardised tool as outlined in the Enhanced Supervision guidance (provided as evidence). Staff are deployed were appropriate to support zoned (enhanced supervision) or 121 nursing, where this is not possible it is reflected in the SafeCare acuity data and supports staffing establishment reviews, investment has already been made in the 2 highest risk areas (wards	107COCH_1718_801 _ Management of Fall MIA action plan post audit 2018.docx ENHANCED SUPERVISION 1to1 U Teletracking.docx Policy for Assessment and Mana An 800 bed hospital will have an average of 1,500 inpatient falls per year. For Chester this equates to approximately 1300 falls per year. In the last two years the Countess has delivered below average inpatient falls rates with 1170 recorded in 17/18 and 1150 recorded in 2018/19. This is approximately 13% below the national average for the last two years.	Thematic review of Falls RCA's planned July 2019

Regulation & Action	Lead/s	Progress to Date	Evidence	Deadline/Next Steps
		50/51). A request option for temporary staffing has been added to state if it is for enhanced supervision or 121 to allow for audit/cross reference. The falls assessment process promotes staff in educating patients with falls prevention information (RCP leaflet used). Patients aged 65 or older identified as not fully mobile in the manual handling assessment have an automatic EPR referral to physio generated. Any patients aged 50 – 64 with a medical condition which increases their risk of falls have an automatic EPR referral to physio generated. Communication of falls risk is included on all patient handovers. Patient and family are involved and informed of risk identified and risk prevention/reduction measures being implemented.	Falls rates per 1000 bed days has reduced by 33.5% since 2015/16 from 7.72 falls per 1000 bed days in 2015/15 to 5.5 falls per 1000 bed days 2018/19. This satisfies the upper limit of expectation if implementing all best practice guidelines as can be evidenced at the Countess. Further audit information is available in the 2018/19 Quality Account.	
Regulation 12(1) (2) (c). Ensure adequate training and knowledge of the processes around sepsis identification and management are embedded amongst staff across all wards and departments	Trust Sepsis Lead	Trust wide sepsis pathway launched Sepsis management boxes available in all ward areas Sepsis Level 1 and Level 2 training for both levels agreed and delivered locally on individual wards or at SUN and on nurse induction. *NEWS2 competency including staff demonstrating physiological scoring and clinical response Revised Nurse Induction to capture 100% of new starters. Revised Skills Update for Nurse course (SUN) in	 sepsis action plan 3.docx  RecognisingDeteriorationLiABulletinFINAL.p	 NEWS2 Ward results February 2019.docx

Regulation & Action	Lead/s	Progress to Date	Evidence	Deadline/Next Steps
		order for presentation on sepsis and NEWS2 to be delivered with a view to staff signing competencies for NEWS2 and sepsis management at the conclusion of the session Work with safeguarding lead to review pre-existing safeguarding training in relation to Learning difficulties and potential limitations of NEWS2 in assessing the person	NEWS2 AND THE SEPSIS PATHWAY-up	
Regulation 12(1) (2) (g). Ensure the safe storage and management of medicines.	Director of Pharmacy	Repeat Duthie Audit data collection has been completed. Next step to collate and report on the findings. Short Duthie audits to be introduced as spot checks including checks on fridge monitoring. 'Medicines in a Minute' bulletins to be scheduled highlighting key storage issues as a reminder. Director of Nursing has raised concerns regarding compliance with senior nurse leaders. Further awareness articulated at Ward managers meeting on 15th May 2019	Data collection forms have been collected in and are awaiting analysis.	June 2019 July 2019 June 2019
Regulation 18(1) (2) (a). Ensure all wards and departments have enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. Especially with regard to paediatric nurse staffing in the Emergency Department	Associate Director of Nursing (Planned Care) & Associate Director of Nursing (Urgent Care)	Ongoing corporate and bespoke recruitment continues. Staff are trained within speciality areas accordingly. Staffing and skill mix is examined both in advance and on a daily basis and staff moved to support areas where necessary. Specialist areas such as Critical Care are compliant in number of staff holding the critical care qualification. The numbers of staff within ED that are APLS trained has been collected and 4 further nurses attended the APLS training in March 2019 with the aim to ensure all B6 and B7 staff complete this training. In addition 5 nurses within the ED have commenced (April 2019) a level 6/7 module	N&M Recruitment and Retention meetings. Daily staffing huddles with Matron and Ward Managers. Weekly staffing meetings with Matrons across both Planned and Urgent Care. Staffing plans left with Clinical Site Co-ordinators for known out-of-hours challenges. NM RecruitmentRetentior	Continuous review in place and monitored via the Nursing & Midwifery Workforce Board December 2019 for all relevant staff to have undertaken APLS training and additional staff to have secured a place on fundamental skills in

Regulation & Action	Lead/s	Progress to Date	Evidence	Deadline/Next Steps
		with the university "fundamental skills in managing children". We are waiting to hear if there is another course set to commence in September 2019 for further staff to attend	ED staff have attended or in the process of undertaking training/ courses.	managing children course (delay in completion date due to availability of course)
Regulation 12(2) (d). Ensure fire escapes are available for use in an emergency	Fire Safety Advisor	During fire training, all staff are reminded to ensure fire exits are unobstructed at all times. There are some wards used as escalation wards where a patient is located in front of a set of fire doors – in these cases measures to mitigate risk include: 1) full risk assessment, 2) ward staff fire evacuation training provided, 3) signs on opposite side of the fire doors to inform staff of the presence of a patient, 4) presence of an escalation bed/patient to be strictly limited/controlled and only the most ambulant patients allowed, 5) escalation bed to be removed as soon as possible, 5) In the event of a fire, staff are trained to remove the escalation bed first.	Ward staff fire evacuation training carried out "face to face" with Trust Fire Safety Advisor. Ward Fire Evacuation training is recorded on ESR Director of Nursing & Quality & Head of Estates undertake regular estates/patient experience walkabouts (Plan for the year in place)	Fire Evacuation plan to be updated to reflect current compliance June 2019
Urgent and Emergency				
Regulation 18 (1). The service must ensure that there is a staff member qualified in advanced paediatric life support (APLS) on each shift.	ED Matron	Rosters will reflect all staff with APLS and E-Roster rule to be set for 1 nursing staff member with APLS to be on each shift. All medical consulting staff are APLS trained	Awaiting rule to be changed in the e-roster system, however this is considered by senior nurse when completing the off duty	July 2019
Regulation 18 (1). The service must ensure there is clinical oversight of the ambulance hand-over area and main waiting area at all times.	ED Matron	Nurse allocated to this area to ensure oversight if patients are waiting for a cubical in majors. However if a cubicle is available in majors patients are transferred through immediately	Allocation within the E-roster system. Team Leader ensures cover provided for staff breaks	**Complete** ED Audit programme to be developed to assure actions are embedded in practice
Regulation 12 (2)(b). The service must ensure the risks with having no emergency call bell in the ambulance hand-over area are constantly reviewed and all staff are aware of	ED Matron	Emergency bell now in place in the ambulance handover area.	Emergency bell in situ	**Complete**

Regulation & Action	Lead/s	Progress to Date	Evidence	Deadline/Next Steps
processes to follow in an emergency.				
Regulation 17 (1). The service must ensure that there is recorded evidence of cleaning tasks that have been completed.	ED Matron	Daily checks being undertaken to ensure the cleanliness of the department	Team leader / matron daily checklist developed and in use which includes ensuring areas have been cleaned e.g. Kids Zone. Spot check undertaken by ADoN 9.5.19. Feedback from recent clinical round commented that the unit was clean	**Complete** Matron / ADoN spot audits will continue
Regulation 12 (2) (e). The service must ensure that daily checks of resuscitation equipment are completed and recorded in an orderly way in line with trust policy	ED Matron	Key message reminders have been given to all staff	Spot check undertaken by ADoN on 9.5.19 throughout February, March, April and to date in May daily checks of the resus equipment had taken place on all bar one day	**Complete.** Matron / ADoN spot checks will continue
Medical Care				
Regulation 17 (1) Improve local and divisional risk registers to show actions, areas of responsibility for actions, progress and completion dates.	Divisional Director Divisional Medical Director Associate Director of Nursing (Urgent Care)	ADoN, Divisional lead for Risk and Patient Safety, ED Matron and all ward managers have jointly reviewed and updated all ward risk registers in the Division to fully reflect risk action and progress of the actions	Change in risk registers evident within the system	**Complete**
Regulation 12 (2) (d). Rectify problems with emergency call bells in the medical division.	Associate Director of Nursing (Urgent Care)	New system has been ordered and work is due to commence to install on 20th May 2019.	Date confirmed for commencement of work 20.5.19	31st May 2019
Regulation 12 (2) (c). Ensure staff have appropriate training and competencies in the management of deteriorating patient (including use of early warning score tools).	Associate Director of Nursing (Urgent Care) Divisional Medical Director	Management of deteriorating patient and NEWS training has continued throughout the Division. This is also included in the RGN and NA Induction and the Skills Update for Nurses (SUN) course. Level 2 sepsis training is also underway which also includes this training. This is also included on RGN and NA Induction and the SUN course. To date there is in excess of 300 staff entered into ESR having completed this training.	See Sepsis actions	See previous NEWS2 compliance

Regulation & Action	Lead/s	Progress to Date	Evidence	Deadline/Next Steps
Surgery				
Regulation 12 (1) Ensure compliance with World Health Organization safer surgery processes.	Divisional Director Directorate Manager-Theatres	Relaunch of the five steps of safer surgery, starting with the debrief process. Theatres Culture and Safety lead developing a training programme to focus on the standardisation of the five steps process. WHO Working Group to be established to standardise processes throughout the organisation.	Debrief paperwork and white boards have been re-designed, and a trial has taken place in theatre nine. The plan is to roll the new process out to all theatres.	July 2019 Audit plan to be redesigned across all theatre and interventional areas – review Oct 2019 June 2019 June 2019
Regulation 12 (2) (a) (b) Ensure substances hazardous to health are stored safely.	Associate Director of Nursing (Planned Care) Health & Safety Compliance Manager	All clinical areas within the Trust assessed by Health & Safety Compliance Manager in May 2019. Information prompt to be produced for clinical areas. COSH guidance shared with wards and departments. Particular focus on appropriate storage of Chlor Clean fluid for cleaning. Annual risk assessments undertaken with support of the Health & Safety Compliance Manager.	 Copy of COSHH Storage May 2019.xls Areas highlighted in yellow will be review over the coming weeks Spot checks ensuring compliance are undertaken by Ward Managers and Matrons	**Complete** June 2019 **Complete**
Regulation 17b (2) (c) Reduce the risk that patient records may be accessed by unauthorised persons by ensure all patient records are stored securely.	Associate Director of Nursing (Planned Care) Divisional Medical Director Divisional Director	Lockable note trolleys have been ordered for ward and assessment areas. Notes currently stored in areas in sight of nursing staff away from patients.	Await delivery of new note trolleys. Matrons undertake spot checks in ward departments to ensure compliance. Annual clinical ward audits also spot check	June 2019.

Regulation & Action	Lead/s	Progress to Date	Evidence	Deadline/Next Steps
			compliance and allow further scrutiny in management of patient record storage. Monthly IG Audits in place  IG Audit report (Feb 2019).doc	

(If embedded documents cannot be viewed, they are available upon request from: foi.enquiries@nhs.net)

NHS
Countess of Chester Hospital
NHS Foundation Trust

Item Reference and Title	**Agenda item 6 - Board Assurance Framework – Quarter 4 2018/19**
Date of Meeting	Board of Directors – 21st May, 2019
Accountable Executive	Chief Executive Officer and Executive Team
Author(s)	Interim Trust Secretary
Alignment to Board Assurance Framework risk	Risks CR1 to CR10
Alignment to CQC Domains	Well Led
Document Previously Considered by:	Board of Directors – 26th March 2019 (Quarter 3 Board Assurance Framework)
Summary	This report provides the updated proposed Board Assurance Framework for Quarter 4, 2018/19, covering the organisation's ten key strategic risks. Overall risk scores have remained the same since Quarter 3, with the exception of risk CR7 (failure to maintain robust corporate governance and overall assurance) which has increased from an overall score of 9 in Quarter 3 to 12 in Quarter 4. This is in view of the findings from the external governance review and will be addressed in 2019/20 via an agreed improvement plan. It should be noted that: • The Board Assurance Framework will undergo a radical refresh based on an interim set of strategic objectives and will be reviewed again following a refreshed organisational strategy. • **Strategic Risk CR5: Failure to deliver in year financial plan and manage consequences of delivering a deficit budget -** This strategic risk materialised during 2018/19 with the Trust reporting a deficit position of £12.7m pre Provider Sustainability Funding (PSF). This is in line with the revised forecast submitted to NHSI at month 6 (which was done in accordance with the NHSI protocol for changing in year

	financial forecast). The impact on cash flow has been managed via securing interim revenue distress loans. The recurrent 2018/19 financial position has been accounted for through the 2019/20 financial planning process. In addition, this adverse position contributed to the outcome of the Use of Resources inspection. The strategic risk remains for the 2019/20 financial plan.
Recommendation(s)	(i) That the Board agree the Quarter 4 Board Assurance Framework for 2018/19, with an increase to the overall risk score for risk CR7 (failure to maintain robust corporate governance and overall assurance). (ii) The Board note that a refreshed BAF in early 2019/20 will reflect an interim set of strategic objectives. (iii) The Board note the accompanying narrative above for risk CR5 (failure to deliver in year financial plan and manage consequences of delivering a deficit budget).
Corporate Impact Assessment:	**Legal and regulatory impact:** **Financial impact:** **Patient Experience/Engagement:** **Risk & Performance Management:** YES; The BAF covers the strategic risks to the organisation. **NHS Constitution/Equality & Diversity/Communication:**

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

ASSURANCE FRAMEWORK

CONTENTS

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Change in total risk score - Q4
CR1 18/19	Failure to maintain and enhance the quality and safety of the patient experience and ensure regulatory compliance	Director of Nursing & Quality	Quality, Safety & Patient Experience	4x3=12	4x3=12	4x3=12	4x3=12	
CR2 18/19	Unable to meet the demand for services within available resources	Chief Operating Officer	Finance and Integrated Governance	4x3=12	4x4=16	4x4=16	4x4=16	
CR3 18/19	Failure to collaboratively innovate and transform the Trust's clinical services	Medical Director & Deputy Chief Executive	Finance and Integrated Governance	4x3=12	4x3=12	4x3=12	4x3=12	
CR4 18/19	Failure to deliver the Trust's culture, values and staff engagement plan	Director of People & Organisational Development	People & Organisational Development	4x3=12	4x3 =12	4x3 =12	4x3 =12	
CR5 18/19	Failure to deliver in year financial plan and manage consequences of delivering a deficit budget	Chief Finance Officer	Finance and Integrated Governance	4x4=16	4x4=16	4x5=20	4x5=20	
CR6 18/19	Failure to comply with Compliance Framework	Chief Operating Officer	Finance and Integrated Governance	4x3=12	4x4=16	4x4=16	4x4=16	
CR7 18/19	Failure to maintain robust corporate governance and overall assurance	Director of Corporate & Legal Affairs / Chief Executive	Finance and Integrated Governance	3x3=9	3x3=9	3x3=9	3x4=12	Score increased from 9 to 12 (likelihood from 3 to 4)
CR8 18/19	Failure to maintain Information Governance standards	Director of Corporate & Legal Affairs	Finance and Integrated Governance	3x4=12	3x4=12	3x4=12	3x4=12	
CR9 18/19	Failure to provide appropriate Informatics infrastructure, systems and services that effect high quality patient care in-line with the business	Chief Finance Officer	Finance and Integrated Governance	3x4=12	4x3=12	3x4=12	3x4=12	
CR10 18/19	Failure to recruit, train and retain professional staff	Director of People & Organisational Development	People & Organisational Development	3x4=12	4x4=16	4x4=16	4x4=16	

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
ASSURANCE FRAMEWORK - KEY

This Assurance Framework assesses the most important risks that the Trust faces to date, and which have the highest potential for external impact. Such risks differ in magnitude and complexity to operational risks and often require comprehensive risk mitigation plans which span over a longer timescale than most operational risks. The Trust defines strategic risk as a strategic control issue that could:

- *Close down a service / services.*
- *Seriously prejudice or threaten achievement of a principal objective.*
- *Threaten the safety of service users.*
- *Threaten the reputation of the Trust/NHS.*
- *Lead to significant financial imbalance and/or the need to seek additional funding to allow to be resolved and/or result in significant diversion of resources from another aspect of the*

Strategic risks will be reviewed as part of the annual business planning process and can also be identified in-year. They are managed as part of a complex process as opposed to discrete events. The Trust Board needs to be satisfied that strategic risks are being properly identified and managed robustly.

Risk score= consequence/impact x likelihood

The matrix below can be used to calculate a risk score, which will determine what category the risk falls within, that score informing follow up action, its urgency, and the required performance management to ensure the risk is managed effectively.

LIKELIHOOD	CONSEQUENCE / IMPACT				
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
	Almost no impact on achievement of objectives	Small impact on achievement of objectives	Sgnificant impact on the achievement of objectives	Major impact on the achievement of objectives	Objectives could not be achieved
1 Rare	**1**	**2**	**3**	**4**	**5**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
3 Possible	**3**	**6**	**9**	**12**	**15**
4 Likely	**4**	**8**	**12**	**16**	**20**
5 Almost Certain	**5**	**10**	**15**	**20**	**25**

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency(broad descriptors of frequency)	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

A fuller description and explaination of the impact and likelihood categories are contained within the Risk Management Strategy and Policy

Controls

The extent to which the controls in place are satisfactory impacting on the mitigation of the strategic risk.

- Effective control partially in place and thus only impacting in a limited way on the mitigation of the strategic risk.
- Effective control in place but only partially impacting on the mitigation of the strategic risk.
- Effective control in place and positively impacting on the mitigation of the strategic risk.

Reporting

The extent to which the reporting to a committee is providing assurance against each of the controls.

- Reporting to a committee is in place, but is not regular and only provides limited assurance against each of the controls.
- Reporting to a committee is in place, regular but not always providing assurance against each of the controls.
- Reporting to a committee is in place, regular and providing assurance against each of the controls.

Movement

The direction from last reported quarter

- ↓ Indicates improvement from last reported quarter
- → Indicates same level from last reported quarter
- ↑ Indicates slippage or further required work from last reported quarter
- ★ New item added since last quarter
- • Exception Report required if deadline not achieved

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 4 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-19	TARGET RISK SCORE Mar-20		
	4x2=8	4x3=12	4x3=12	4x2=8	4x2=8		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR1 18/19	**Failure to maintain and enhance the quality and safety of the patient experience and ensure regulatory compliance**	Director of Nursing and Quality	Quality, Safety & Patient Experience Committee	Amber	→

LINKED CORPORATE PRIORITIES *(up to top 3)*
Safe, Kind & Effective
Model Hospital

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Non compliance with regulatory standards & commissioner contracts
PC2	Risk to Registration & Licence to operate
PC3	Poor patient experience - impact on Trust reputation
PC4	Breach of NHSI's Terms of Authorisation as a Foundation Trust

INTERDEPENDENCIES: CR2;CR3;CR4;CR5;CR6;CR7

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Kirkup Report
O2	NQB National Guidance on Learning from Deaths
O3	Workforce skills/competencies
O4	CQC Fundamental Standards
O5	Compliance with Trust policies and procedures
O6	Failure to observe Trust values - cultural issues
O7	Demographic/needs of local population
O8	Capacity issues - patient experience
O9	NHS Operating Framework 2017/18
O10	NNU Police Investigation

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
C1	Completion and regular review of Provider Compliance Assurance (PCA) framework	Green	→
C2	Monitoring of performance with Commissioners including visits	Green	→
C3	Regular reviews of CQC Insight data & Assessment framework	Green	→
C4	Scheduled Regulatory Engagement meetings	Green	→
C5	Implementation of Patient Experience Strategy	Amber	→
C6	Model Hospital Behavioural Standards (culture & behaviours)	Green	→
C7	Workforce Committees (Medical and Nursing & Midwifery)	Green	→
C8	Integrated Services agenda	Amber	→
C9	Clinical Rounds/unannounced clinical reviews	Green	→

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY	Strength RAG (Red Amber Green)	Movement
R1	Quarterly, Safety & Patient Experience Committee (NED Chair)	Monthly	Green	→
R2	Patient Experience Operational Group	Monthly	Green	→
R3	CCG assurance meetings	Monthly	Green	→
R4	Governor related Forums	Monthly	Green	→
R5	ICP Clinical Advisory Group	Monthly	Green	→
R6	Board of Directors / FIG	Monthly	Green	→
R7	External Stakeholders visits e.g. Healthwatch	As required	Green	→
R8	Model Hospital Programme Board/Risk & performance Committee	Monthly	Green	→
R9	Corporate Leadership Group	Monthly	Green	→
R10	People & OD Committee	Bi-monthly	Green	→

These are the POSITIVE ASSURANCES received…

What are the key positive assurances received through reporting that a control has remained effective (up to 20)

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R6	Patient & Staff Stories	Each Board
R1	QSPEC Dashboard - metrics & nurse staffing (monthly)	Monthly
R1	Clinical Rounds - six month summary report	16.10.18
R1	Consent Policy - verbal update to QSPEC	16.10.18
R1	Falls Project Update - Quarter 3 18/19	15.01.19
R1	Aggregated Report - Complaints, Litigation, Incidents & Coronial Cases (CLIC) Apr-Sept 2018	20.11.18
R1	CQUIN update Quarter 3 18/19	19.03.19
R6	Learning From Deaths - Board of Directors Report	18.12.18
R1/R6	Adult Safeguarding Annual Report 2017/18	18.12.18
R1	Learning From Deaths - Quarterly report	19.03.19
R1	PLACE Annual Report 2017/18	15.01.19

GAPS IN CONTROL (as reflected in Divisional Risk Registers)

What are the remaining key gaps in the controls (up to 10)

REF	GAP	ACTION PLAN / EXCEPTIONS	RISK REGISTER REF	DEADLINE
G1	NNU risks	Police investigation continues. Staff support in place. Unit Activity, acuity & staffing monitored daily.	Ref 1508	Q4 18/19
G2	Poor Compliance with management of Sepsis	Steering Group in place with training programme integrated into work plan. Developing trajectory for improvement.		Q1 19/20
G3	Capacity issues due to lack of social care provision and flow issues within the Trust	System wide programme of improvement in place. Winter resilience being planned. ICP in development.	Ref 1334	Q4 18/19
G4	Increase in falls with harm	Quality Improvement Falls Project (RCP Falls programme) in place with dedicated Lead and Therapy support. Review of Trust Falls Group, links to ext. falls strategy	Ref 1362	Q4 18/19
G5	Medicines Safety including Prescribing errors	Profile of medicine safety across the Trust increased; Medicines Safety Group reporting into QSPEC; regular incident reviews in place	Ref 1095/474	Q4 18/19
G6	Gap in provision and knowledge re. Adult Safeguarding	Action Plan in place, training plan under review. Governance re reporting undertaken, MIAA report, July 18 = Limited Assurance	Ref 1785	Q4 18/19
G7	Learning from Deaths	Process of reviewing mortality in place, governance now agreed via Learning from Deaths Committee, ongoing data & dashboard refinement	Ref 1979	Q4 18/19
G8	End of Life (CQC Requires Improvement)	Action Plan in place monitored through the End of Life/Palliative Care Group. Further engagement planned	Ref 1817	Q4 18/19
G9	National shortage of a large number of key drugs- potential unknown impact of Brexit	Monitored via Director of Pharmacy and Divisional Governance Assurance Board. Provides updates to QSEPC . National guidance re Brexit & Medication.	Ref 1749	Q4 18/19
G10	Increased incidence of c.Difficile and MRSA	Quality Improvement programme to be implemented with NHSi support		Q1 19/20

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST (GUIDANCE TEMPLATE)

Board Assurance Framework - Quarter 4 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-19	TARGET RISK SCORE Mar-20		
	4x4 = 16	4x4 = 16	4x4=16	4x2=8	4x2=8		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR2 18-19	Unable to meet the demand for services within available resources	Chief Operating Officer	Finance & Integrated Governance	Red	→

LINKED CORPORATE PRIORITIES *(up to top 3)*
safe, kind & Effective
Model Hospital
Accountable Care system across West Cheshire

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	increasing patient waits for access to services
PC2	failure to meet key compliance targets
PC3	failure to deliver safe, kind & effective care
PC4	impact on trust license & reputation

INTERDEPENDENCIES: CR1;CR3;CR4;CR5;CR6

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	lack of resilience of community sector and social care
O2	Cross border issues
O3	Demographic of local population
O4	constraints on budgets across west Cheshire system
O5	failure of commissioners to commission sufficient capacity to meet demand
O6	Insufficient understanding of the organisational capacity/specialist staff shortage
O7	Number of medically optimised patients and delayed transfers of care
O8	High cost of variable pay & national cap on expenditure
O9	Operational pressures and impact on retention/health and wellbeing appraisals, mandatory training etc.
O10	Rising demand for services

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
C1	Agreed capacity and demand analysis	Green	→
C2	Monitoring of demand, performance and approved escalation processes	Green	→
C3	assessment capacity across main emergency care specialities	Green	→
C4	Early supported discharge & step down beds	Green	↓
C5	operational escalation levels & system wide escalation protocol	Green	→
C6	Winter Resilience Planning	Amber	→
C7	Operational dashboards (real-time)	Green	→
C8	Tracking & Validation teams	Green	→
C9	AE Delivery Board chaired by CoCH CEO	Green	→
C10	Tele tracking system	Green	↓

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective?

REF	REPORTING MECHANISM	FREQUENCY	Strength RAG (Red Amber Green)	Movement
R1	Finance and Integrated Governance Committee	Bi -Monthly	Green	→
R3	Board of Directors	Bi -Monthly	Green	→
R4	Daily SITREP reporting	Daily	Green	→
R5	Weekly performance review	Weekly	Green	→
R7	A&E Delivery Board	Monthly	Green	→
R8	Reporting to Commissioners, NHSI & NHSE	As required	Green	→
R9	Contract and performance meetings	Monthly	Green	→

These are the POSITIVE ASSURANCES received…

What are the key positive assurances received through reporting that a control has remained effective (up to 20)

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R3	Integrated Performance Report	Monthly
R5	Weekly Operational Performance meeting	Weekly
R7	West Cheshire A&E Delivery board	Monthly (Mar 19)
R3	Update on winter planning to Board	Sep-18
R3	Quarterly cancer update to board	Mar-19
R4	Real-time Dashboards & OPEL reporting	daily
R1	Capacity meetings	daily
R8	Elective care meeting with CCG	Monthly
R5	Weekly PTL review meetings (including cancer)	Weekly
R1	Cancer board	monthly (Mar 19)
R7	NHSi/NHSE resilience reporting	Mar-19
R4	NHSI Tableau analytics	daily

GAPS IN CONTROL (as reflected in Divisional or Executive Risk Registers)

What are the remaining key gaps in the controls (up to 10)

REF	GAP	ACTION PLAN / EXCEPTIONS	RISK REGISTER REF	DEADLINE
G1	insufficient diagnostic capacity to meet demand	endoscopy recovery plan, including evening and weekends activity, ultrasound recovery plans, including outsourcing of reporting to enable activity sessions. Monitoring of cancer PTL & diagnostic waits to ensure cancer diagnostics are prioritised	Ref 1864	Q4 18/19
G2	lack of sufficient financial resources	Inability to in source/outsource to meet the growth of demand. Short term Business Cases to meet overall capacity being produced via Trust process. Agreed contract with commissioner.	Ref 1735	Q1 19/20
G3	insufficient bed capacity	daily oversight of admissions and discharges, discharge delays and bed occupancy. Fortnightly exec oversight of >21 LoS days. Trust bed realignment.	Ref 1334	Q1 19/20
G4	operational excellence & quality improvement	integration of services across organisations to enable new models of care with best use of available resources.	Ref 1956	Q4 18/19
G5	insufficient demand management control leading to growth	implementation of E-RS to support triage of referrals. Joint plan with WCCCG to control demand for elective care	Ref 1366	Q4 18/19
G6	gaps in medical & nurse staffing	divisional support to develop workforce plans & alternative roles to be presented via medical pay meeting & Nursing & midwifery workforce group	Ref 1202 Ref 1643	Q4 18/19
G7	ED Capacity due to sustained increase in attendances	Refurbishment of ED underway for completion in Q1 19/20. ED improvement plan.	Ref 1594	Q1 19/20
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST (GUIDANCE TEMPLATE)

Board Assurance Framework - Quarter 4 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Mar-19	TARGET RISK SCORE Apr-20		
	4x3=12	4x3=12	4x3=12	4x3=12	4x2=8		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR3 18-19	Failure to collaboratively innovate and transform the Trust's clinical services	Medical Director / Deputy Chief Executive	Finance & Integrated Governance Committee	Amber	→

LINKED CORPORATE PRIORITIES *(up to top 3)*
Concentrating on the right services to meet the needs of our patients
Services focused on improving health
To be safe, kind and effective

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Future organisational sustainability
PC2	Inability to deliver services to regulator/commissioner specification or local need
PC3	Failure to develop integrated plan leading to quality and safety being risked by approach to financial savings
PC4	Re-organisation/de-commissioning of services disadvantaging people of West Cheshire

INTERDEPENDENCIES: CR1;CR2;CR4;CR5;CR6;CR9

Potential or actual origins that have led to the risk… *What are the most significant origins (up to 10) which could or have led to the risk?*

REF	ORIGIN
O1	Effects of service reconfiguration within larger footprints e.g. STP
O2	Long term contractual and commissioning intentions / regional / local
O3	National specialised service specifications / Royal College standards
O4	Maintaining 24/7 acute rotas / EWTD / Limitations of A4C / Doctor contracts / 7 day services
O5	West Cheshire Demographics (Patient and Workforce)
O6	Future tariff/ Pbr framework / Better Care Fund
O7	Cross border protocols
O8	Changes to key WUTH senior management and executive posts
O9	Development of Integrated Care Partnership
O10	

The risks are CONTROLLED by…		Strength	Movement
What are the key controls (up to 10) that are in place to mitigate these risks?		*Red Amber Green*	
REF	CONTROL	RAG	
C1	Business plan process and development	Amber	→
C2	Annually refreshed five year LTFM	Green	→
C3	Financial assumptions based on a shared understanding with commissioners	Amber	→
C4	Integrated Care Partnership (ICP) Transformation programme	Amber	→
C5	ICP Care Pathway Development	Amber	→
C6	Systematic service review process (COCH/Vertical/Horizontally)	Amber	→
C7	Introduction of a new shared Electronic Patient Record system	Amber	→
C8	Clinical engagement	Green	→
C9			
C10			

The REPORTING mechanisms are…			Strength	Movement
What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective?			*Red Amber Green*	
REF	REPORTING MECHANISM	FREQUENCY	RAG	
R2	Board of Directors Meeting	Bi-Monthly	Green	→
R3	ICP Shadow Board	Monthly	Green	→
R4	People and OD Committee	Bi-Monthly	Green	→
R7	CCG contract review meetings	Monthly	Green	→
R8	Corporate Leadership Group	Weekly	Green	→
R9	Annual General Meeting	Annual	Green	→

These are the POSITIVE ASSURANCES received…

What are the key positive assurances received through reporting that a control has remained effective (up to 20)

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R4	Electronic Job Planning and Roster Management software procured. Update at Audit Committee	16-Apr-19
R4	Reprovision of existing junior doctor rosters in trauma care to match increased demand. To start 1st August 2019.	06-Sep-18
R1	EPR Programme Board launch with Specialty Clinical Lead appointment process	01-Aug-18
R8	Corporate Leaders Group timings amended to enable Clinical Leads to attend and engage in the corporate agenda with consistency. Completed.	Ongoing - evidenced by diary
R7	Monthly 1-1 meetings between Trust MD and CCG established Nov 2018	Ongoing - evidenced by diary
R8	Scheduled 1-1 recurring meetings with all Clinical Leads on a monthly basis across the Trust	Ongoing - evidenced by diary
R4	Specialty Doctor Engagement Project : 1-1 meetings with all Trust SAS Grade Doctors	Ongoing - evidenced by diary
R4	NHS England 7 Day Services Programme (North West) - to QSPEC quarterly.	19-Mar-19

GAPS IN CONTROL (as reflected in Divisional or Executive Risk Registers)

What are the remaining key gaps in the controls (up to 10)

REF	GAP	ACTION PLAN / EXCEPTIONS	RISK REGISTER REF	DEADLINE
G1	Gaps in workforce therefore inability to deliver services effectively across Wirral & West Cheshire	Develop clinical services across West Cheshire to ensure streamlined patient pathways	Ref 1202 Ref 1643	Q4 18/19
G2	Implementation of new EPR not until May 2020	Commence clinical pathway design with WUTH ahead of implementation; key clinical leadership posts being recruited to, to support implementation	Ref 1708	Q4 19/20
G3	No ratified current Trust clinical strategy	The Trust Clinical Strategy development plan is now under way, incorporating a comprehensive consultation with clinical stakeholders. Board workshop planned 21st May 2019.	Ref 1982	Q2 19/20
G4				
G5				
G6				
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 4 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Mar-19	TARGET RISK SCORE Apr-20		
	4x3=12	4x3=12	4x3=12	4x3=12	4x3=12		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR4 18/19	**Failure to deliver the Trusts culture, values and staff engagement plan**	Director of People & OD	People and Organisational Development	Amber	➔

LINKED CORPORATE PRIORITIES *(up to top 3)*
The foundations for change to happen
Concentrating on the right services to meet the needs of our patients
Transforming care for patients

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Poor Staff Experience- impact on Trust reputation and ability to recruit and retain
PC2	Poor Patient Experience - impact on Trust reputation/ increase in complaints
PC3	Non-compliance with regulatory/commissioners contracts e.g. Well Led domain CQC
PC4	Possible reduction in Safety/Quality/Performance/Staffing indicators

INTERDEPENDENCIES **CR1;CR2;CR3;CR5;CR6;CR7;**

Potential or actual origins that have led to the risk…	*What are the most significant origins (up to 10) which could or have led to the risk?*
REF	ORIGIN
O1	Levels and incidents of Bullying & Harassment against local & national targets
O2	Associated pressures and the impact on culture / values / behaviours
O3	Operational demands and the impact on appraisals / leadership/mandatory training
O4	Quality, Safety, Financial & Operational metrics: Never Events/SUIs
O5	Incidents reported via Freedom to Speak Up
O6	Delivery of National CQUIN targets linked to Health & Well Being.
O7	CQC Well Led Domain requirements & Key Lines of Enquiry, including FTSU
O8	Findings of NHS Staff Survey 2018
O9	Historical non compliance with DBS checks for substantive staff prior to the Kate Lampard report
O10	

The risks are CONTROLLED by…		Strength	Movement
What are the key controls (up to 10) that are in place to mitigate these risks?		*Red Amber Green*	
REF	CONTROL	RAG	
C1	Board support for Culture, Performance and Behavioural workstreams	Green	➔
C2	Implementation of the appraisal system to capture values & behaviours	Amber	➔
C3	Improving the communications across the organisation including face to face with Exec's (Whats Brewing etc)	Green	➔
C4	Offering out Leadership Development programmes both internal and through the Leadership Academy	Green	➔
C5	Freedom to Speak up: Promoting openness and honesty, duty of candour	Amber	➔
C6	Promotion of Freedom to Speak Up champions across the organisation including union reps.	Amber	➔
C7	Culture workstream included in Model hospital programme and engagement	Green	➔
C8	Developing Coaching programme for individuals and teams.	Amber	➔
C9	Recognising our people both annual with Celebration of Achievement and quickly via Countess Gems	Green	➔
C10	Reporting through to various Boards on progress in each of the CQC domains	Green	➔

The REPORTING mechanisms are…			Strength	Movement
What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective?			*Red Amber Green*	
REF	REPORTING MECHANISM	FREQUENCY	RAG	
R1	Board of Directors reports (integrated performance report)	Bi-monthly	Green	➔
R2	People and OD Committee	Bi-monthly	Green	➔
R3	Council of Governors	Bi monthly	Green	➔
R4	Executive Directors Group / Corporate Leadership Group	Weekly	Green	➔
R5	Freedom to Speak Up Committee	Bi-monthly	Green	➔
R6	Partnership Forum / Local Negotiating Committee	Monthly / Bi-monthly	Green	➔
R7	Corporate Leaders Group	Fortnightly	Green	➔
R8	Multi Disciplinary Education Committee	Bi-monthly	Green	➔
R9	Staff Survey and Staff Friends & Family Tests	Annual/Quarterly	Green	➔
R10	Finance & Integrated Governance Committee	Bi-monthly	Green	➔

These are the POSITIVE ASSURANCES received…

What are the key positive assurances received through reporting that a control has remained effective (up to 20)

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
C1/R2	People & OD Strategy documentation & implementation plan to POD	26-Sep-17
C2/R2	Monitoring through Culture & Engagement Steering Group that reports back to POD	18-Apr-19
C3/R4	Implementation of What's Brewing with Execs	1-Sep-18
C4/R4	Subscription to NW Leadership Academy and internal leadership courses discussed at EDG	21-Feb-18
R2/R8	Leadership Progs in place - High Performance workshop, QI, leadership summit.	25-Sep-18
C5/R2	Staff Survey/SFFT Report to Board of Directors with associated action plan. Monitored by POD.	26-Mar-19
C7/R2	High Performance Culture work stream investment linked to Model Hospital programme	18-Apr-19
C9/R2	Recognition informal and formal systems in place	18-Apr-19
C9/R4	Monthly Countess Gems, monitor by feedback and twitter	Mar-19
R3	Partnership Forum: Staff engagement /staff survey/staff experience/SFFT reviewed monthly	11-Apr-19
R8	Student Experience/Satisfaction Surveys - open all year Multi-Prof Practice Placement meeting	13-Feb-18
C2/R2	Appraisal performance has increased from last year although still not consistent	Mar-19
R2	Health & Well Being Strategy & performance reported to POD	22-Jan-19
R1/R2/R10	Reporting to Board /FIGC/POD on workforce KPIs	22-Jan-19
C1/R6	Exit Interview / How are we doing interviews implemented. Feedback to SPF on periodic basis.	11-Apr-19
R2/R6	Exec discussion re Kate Lampard report showing staff/roles/analysis with/without DBS	22-Jan-19

The GAPS IN CONTROL (as reflected in Divisional or Executive Risk Registers)

What are the remaining key gaps in the controls (up to 10)

REF	GAP	ACTION PLAN / EXCEPTIONS	RISK REGISTER REF	DEADLINE
G1	Delivery of High Performance Workshops to all staff	Two cohorts of the programme in place to cover 300 leaders - non-release of staff is not possible due to high pressure in system. 2 hr prog for all staff in dept..	Ref 1881	Q4 18/19
G2	Limited budget so looking at designing in house, limited resource and other priorities in the New Year	Looking to make a decision quickly, content has been drafted and mocked up. Need to trial a pilot.	Ref 1946	Q4 18/19
G3	Communications still falter at middle manager level	Introducing What's Brewing and all staff briefings to eliminate layers and barriers	Ref 1948	Q4 18/19
G4	Staff Survey results 2018/19	Action plans & dashboards monitored through POD committee worked up for Divisions and staff groups		Q4 18/19
G5	FTSU: Revision of policy, processes, resources & comms required	FTSU: Revision of policy, processes, resources & comms required	Ref 1949	Q4 18/19
G6	Communication of Freedom to Speak Up	Encourage reporting via Union Representatives with added protection. Recruitment process undertaken in Q4.	Ref 1950	Q4 18/19
G7	Capacity to support Health Economy initiatives such as ACO and STP	Fortnightly / monthly meetings in place. LDS action plan in place, ACO workforce plan in development	Ref 1897	Q4 18/19
G8	Complex employment legislation, managers & staff side will require HR support at a high level	Development sessions being scoped for delivery e.g. investigation training, appeals, tribunals	Ref 1898	Q4 18/19
G9	Delivery of national CQUIN targets linked to Health & Wellbeing	Monitored monthly by Health & Wellbeing Steering Group, discussed at Nursing & Midwifery Board for additional nursing support re flu vaccination programme.	Ref 1901	Q4 18/19
G10	Substantive staff without DBS checks	There is further debate required to establish risk and options for consideration		Q4 18/19

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 4 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-19	TARGET RISK SCORE Mar-20		
	4x5=20	4x4=20	4x5=20	4x3=12	4x1=4		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR5 18/19	Failure to deliver in year financial plan and manage consequences of delivering a deficit budget	Chief Finance Officer	Finance & Integrated Governance Committee	Red	→

LINKED CORPORATE PRIORITIES *(up to top 3)*
Concentrating on the right services to meet the needs of our patients
The foundations for change to happen

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Not achieving the required control total and hence Risk Rating and subsequent NHSI escalation process
PC2	Negative financial impact on local economy and lack of capital for investment.
PC3	Inability to maintain safe and effective local services
PC4	Potential liquidity impact and therefore ability to pay staff and suppliers and fund future investments/capital programme

INTERDEPENDENCIES:

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Identification and operational delivery of efficiency schemes
O2	High levels of medically optimised patients and delayed transfers of care and associated costs / risk to income
O3	Financial impact of decreased activity demand and associated loss of income for PbR contracts
O4	Increase in non elective demand delivered at premium cost
O5	Medical & nursing pay pressures - gaps and acuity leading to high agency usage
O6	Need for future investments to maintain safe service delivery
O7	Additional contractual income of £1m for WCCCG (linked to bed occupancy) not yet received
O8	Outcome of capital loan is currently unknown
O9	Potential requirement for revenue distress loan should cash releasing savings not be delivered as planned
O10	Poor budgetary management and control

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
C1	Production of Annual Budget and Monitor Forward Plans and Templates	Green	→
C2	Proactive horizon scanning of risks and opportunities	Green	→
C3	Robust performance monitoring and financial management control. Budget review meetings and regular updates on efficiency schemes through weekly CRS meetings, monthly Model Hospital Board and governance arrangements	Amber	→
C4	Review of capital requirements through ERPE process to prioritise and subsequent reporting to CLG	Amber	→
C5	Review of medical workforce costs by the Medical Pay Board	Amber	→
C6	Workforce planning including international recruitment, development of physician associates roles, joint working with WWL to support recruitment of medical workforce	Amber	→
C7	Robust contractual monitoring information to inform contract negotiations	Green	→
C8	Audit reports/assessments/reviews	Green	→
C9	Acuity tool within e-rostering	Green	→
C10	Daily cashflow	Green	→

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective?

REF	REPORTING MECHANISM	FREQUENCY	Strength RAG (Red Amber Green)	Movement
R1	Board of Directors	Bi-monthly	Green	→
R2	Finance & Integrated Governance Committee/Finance Committee	Bi-Monthly	Green	→
R3	Commissioner contract meetings (WC / BCU / NHSE)	Monthly	Green	→
R4	Model Hospital Board	Monthly	Green	→
R5	NHSI Financial Reporting Returns and CRS returns	Monthly	Green	→
R6	Divisional Board Meetings	Monthly	Green	→
R7	Quality, Safety & Patient Experience Committee	Monthly	Green	→
R8	Council of Governors	Quarterly	Green	→
R9	Corporate Leaders Group	Monthly	Green	→
R10	Audit Committee and Risk Committee	Quarterly	Green	→

These are the POSITIVE ASSURANCES received…

What are the key positive assurances received through reporting that a control has remained effective (up to 20)

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R1	Integrated performance Report including exceptions	Monthly
R3	Performance Report to Commissioner Meetings	Monthly
R5	NHSI Monitoring Templates & Reports	Monthly
R7	CQUIN update to Quality, Safety & Patient Experience Committee	Monthly
R1	Monthly Finance Board Report	Monthly
R5	NHSI Fortnightly CRS returns	Fortnightly
R2	Weekly CRS Group	Weekly
R5	NHSI quarterly review meeting	12-Feb-19
R10	Audit Committee	19-Feb-19
R1	Board Meeting	26-Mar-19
R3	West Cheshire CCG Contractual Performance Meeting	28-Feb-19
R3	Betsi Contractual Performance Meeting	25-Mar-19
R3	NHSE Contractual Performance Meeting	18-Dec-18
R1	Board Session - financial plan	18-Mar-19

The GAPS IN CONTROL (as reflected in Divisional or Executive Risk Registers)

What are the remaining key gaps in the controls (up to 10)

REF	GAP	ACTION PLAN	RISK REGISTER REF	DEADLINE
G1	Gap and high risk of efficiency plans	To.be risk assessed and monthly meetings with departments to continue to identify further plans. Joint working with CCG for system wide savings. Review of NHSI checklist. Identification of non recurrent savings to support 17/18 plan.	Ref 1830	Q4 18/19
G2	Control of volumes of medically optimised patients and delayed transfers of care and further activity growth impacting on financial position	Joint working with CCG to control demand and discussions with local councils regarding recharges. A&E Delivery Board tasked with reducing bed occupancy to 85%	Ref 1686	Q4 18/19
G3	Failure to deliver performance improvement trajectory and consequent impact of STF funding	Weekly performance meeting and increased scrutiny at Divisional level alongside A&E Delivery Board .	Ref 1871	Q4 18/19
G4	Failure to deliver activity plan resulting in loss of income to the Trust	Monthly reporting through Division and up to EDG with recovery plans in progress where necessary	Ref 1872	Q4 18/19
G5	Impact of lack of information on Junior doctor rotational gaps and medical and nursing vacancies and ability to secure visas.	Pro-active management to anticipate potential gaps and escalation process with Deanery. Exploring recruitment options for nursing workforce	Ref 620	Q4 18/19
G6	Continued high demand for non elective care requiring Ward 54 to remain open thus depleting the winter reserve with no known additional winter funding externally to date.	Proactive management to staff ward in most efficient way. Regular monitoring of additional costs incurred.	Ref 1870	Q4 18/19
G7	Funding gap for centralised vascular service.	Financial recovery plan currently being progressed with the division	Ref 625	Q4 18/19
G8	The capital loan has not been approved to date.	Escalation process is in place to enable emergency capital to be approved by the Executive team whilst waiting for loan application outcome.	Ref 1868	Q4 18/19
G9	Outcome of STP Bid to support redesign of A&E Department currently unknown.	Other funding sources and smaller development is currently being explored.	Ref 1873	Q4 18/19
G10	Revenue distress loan required	Daily cashflow forecasting is in place.	Ref 1869	Q4 18/19

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST (GUIDANCE TEMPLATE)

Board Assurance Framework - Quarter 4 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-19	TARGET RISK SCORE Mar-20		
	4x4 = 16	4x4 = 16	4x4=16	4x2=8	4x2=6		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR6 18/19	**Failure to comply with Compliance Framework**	Chief Operating Officer	Finance & Integrated Governance	Red	→

LINKED CORPORATE PRIORITIES *(up to top 3)*
safe, kind & Effective
Model Hospital
Integrated Care system across West Cheshire

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Reduced Single Oversight Framework rating
PC2	Escalation with Commissioners/NHSI/CQC
PC3	Negative publicity & reputational damage
PC4	Negative Impact on staff/patient experience

INTERDEPENDENCIES: CR1;CR2;CR3;CR4;CR5;CR7;CR9

Potential or actual origins that have led to the risk… *What are the most significant origins (up to 10) which could or have led to the risk?*

REF	ORIGIN
O1	Delivery of C Diff target/MRSA
O2	Delivery of Cancer target 62 day
O3	Delivery of A&E target
O4	Delivery of the 18 week RTT
O5	Number of medically optimised patients and delayed transfers of care
O6	Delivery of diagnostic 6 week waiting time
O7	Demand exceeding available capacity
O8	High cost of variable pay & national cap on expenditure
O9	Operational pressures and impact on retention/health and wellbeing appraisals, mandatory training etc.
O10	Delivery of target to reduce >21 day LoS patient numbers

The risks are CONTROLLED by… *What are the key controls (up to 10) that are in place to mitigate these risks?*

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
C1	Daily capacity meeting & escalation processes	Amber	→
C2	NHSI regional improvement programmes	Green	→
C3	Clinical Streaming in A&E with UTC	Amber	→
C4	Ambulatory Care and Early supported discharge to aid patient flow	Green	→
C5	Daily monitoring of cancer patients and improved escalation process	Green	→
C6	Root Cause Analysis for each case of C Difficile	Green	→
C7	Intensive hand hygiene regime and monitoring	Green	→
C8	Waiting list validation	Green	→
C9	Weekly performance report and review	Green	→
C10	Qlikview operational dashboards	Green	→

The REPORTING mechanisms are… *What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective?*

REF	REPORTING MECHANISM	FREQUENCY	Strength RAG (Red Amber Green)	Movement
R2	Finance & Integrated Governance Committee	Bi-monthly	Green	→
R3	Board of Directors	Bi-monthly	Green	→
R4	Commissioner contract meetings (WC) (E)	Monthly	Green	→
R5	NHSI monthly oversight meetings	Quarterly	Green	→
R6	Quality, Safety & Patient Experience Committee	Monthly	Green	→
R7	Infection Control Committee	Quarterly	Green	→
R8	Council of Governors	Quarterly	Green	→
R9	Performance meeting	weekly	Green	→
R10	CLG	monthly	Green	→

These are the POSITIVE ASSURANCES received…

What are the key positive assurances received through reporting that a control has remained effective (up to 20)

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R2	Integrated performance Report & Risk Register to FIGC	Bi monthly
R3	Integrated performance Report to BoD	Bi monthly
R4	Performance Report to WC Quality & Performance meeting	Monthly
R5	NHSI Improvement trajectory & reports	Quarterly
R9	weekly performance dashboard to COO & DD's	Weekly
R3	Cancer update to Board	Quarterly
R5	Weekly tracking of improvement trajectories	Weekly
R3	Winter planning update to Board	annual (Sept '18)
R5	NHSI daily/monthly performance dashboard	daily
R2	intensive support team improvement reports - A&E & Cancer 62 days	Mar-19

GAPS IN CONTROL (as reflected in Divisional or Executive Risk Registers)

What are the remaining key gaps in the controls (up to 10)

REF	GAP	ACTION PLAN / EXCEPTIONS	RISK REGISTER REF	DEADLINE
G1	lack of queue oversight due to current EPR	EPR upgrade and manual tracking of follow up PTL	Ref 1818	Q3 20/21
G2	>21 day length of stay patients	validate bed capacity data and exec oversight for nationally set reduction target	Ref 1686	Q4 18/19
G3	Cancer performance	Implementation of key actions identified in action plan Increased clinical engagement & oversight - 473, 1174, 1177, 1232, 1373	Ref 473	Q4 18/19
G4	18 week failure of incomplete pathway	Development of actions to address 18 weeks and longest waiters	Ref 1224	Q1 19/20
G5	insufficient capacity in ED leading to prolonged waits	Whole system approach to hospital avoidance and effective primary care. Submission of capital plans for new build.	Ref 1594	Q1 19/20
G6	Demands exceeding capacity within budget	Implementation and support to CCG demand management work streams and clinical pathway redesign. Agree PbR contract for 19/20.	Ref 1735	Q1 19/20
G7	Lack of capacity in diagnostic services	Increasing primary care/demand for diagnostics and hospital requires senior oversight, education & training	Ref 1155	Q4 18/19
G8	lack of sufficient financial resources	Inability to in source/outsource to meet the growth of demand. Short term Business Cases to meet overall capacity	Ref 1735	Q4 18/19
G9	gaps in medical & nurse staffing	divisional support to develop workforce plans & alternative roles to be presented via medical pay meeting & Nursing & midwifery workforce group	Ref 1202 Ref 1643	Q4 18/19

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 4 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Mar-19	TARGET RISK SCORE Apr-20		
	3x1=3	3x3=9	3x4=12	3x3=9	3x1=3		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR7 18-19	**Failure to maintain robust corporate governance and overall assurance**	Director of Corporate & Legal Services/ Chief Executive	Board of Directors	Amber	↑

LINKED CORPORATE PRIORITIES *(up to top 3)*
Understanding patient experience
Concentrating on the right services to meet the needs of our patients
The foundations for change to happen

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Impact on CQC Rating
PC2	Failure to maintain Provider Licence (NHSI)
PC3	Impact on Trust's overall performance
PC4	Reputation of Trust

INTERDEPENDENCIES: CR1;CR6;CR8

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN		
O1	CQC Well Led Review	Amber	→
O2	Recruitment of substantive Chief Executive Officer	Amber	→
O3	Outcome of external Governance Review	Amber	→
O4	Board development	Amber	→
O5	Re-appointment of Non Executive Directors	Amber	↑
O6	Appointment of Company Secretary	Amber	→
O7	Interim Director of HR	Green	↓
O8	Acting Medical Director	Amber	→
O9	Board risk appetite review required	Amber	→
O10			

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
C1	Board Assurance Framework review	Green	→
C2	Revising staffing structure clinical and non-clinical teams	Green	→
C3	Control by the Executive Team/Council of Governors/Board of Directors	Green	→
C4	Support MIAA and KPMG regarding the Well Led review	Green	→
C5	Aggregated report to be received at Board of Directors regarding Complaints, Litigation and Claims	Amber	→
C6	External Governance Review (commissioned Dec '18)	Amber	
C7			
C8			
C9			
C10			

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective?

REF	REPORTING MECHANISM	FREQUENCY	Strength RAG (Green)	Movement
R1	Regular updates to Board of Directors and Board committees	Monthly	Green	→
R2	Regular updates to Council of Governors/Governors Quality Forum	As required	Green	→
R3	Updates to Corporate Leadership Group	Bi-weekly	Green	→
R4	NHSI / NHSE / CQC / WC CCG	As required	Green	→
R5	Weekly reporting to Execs	Weekly	Green	→
R6	Freedom to Speak Up Group	Bi-Monthly	Green	→
R7				
R8				
R9				
R10				

These are the POSITIVE ASSURANCES received…

What are the key positive assurances received through reporting that a control has remained effective (up to 20)

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R5	Provided an update at the Weekly Executive meeting	Weekly
R1	Provided an update to the Board of Directors	26.03.19
R2	Provided an update to the Council of Governors/Governors Quality Forum	22.03.19
R1	Regular communication and discussion with the Chairman	Weekly
R6	Appointment of FTSU Guardian	30.04.19
R1	Receipt of the Board Assurance Framework at Board of Directors	26.3.18
R3	Update to Corporate Leadership Group	07.03.19
R1	Board risk appetite review session - 2nd May 2019	26.03.19

The GAPS IN CONTROL (as reflected in Divisional or Executive Risk Registers)

What are the remaining key gaps in the controls (up to 10)

REF	GAP	ACTION PLAN	RISK REGISTER REF	DEADLINE
G2	Trusts Audit Committee are sighted on Integrated Care Partnership developments	Key risks are articulated to the Audit Committee including governance arrangements		Q1 19/20
G3	Final Agreement of ICP Governance arrangements	Monthly ICP Governance meetings established to progress and finalise governance arrangements. ICP Integration agreement agreed at Board of Directors in March 2019. Governance workshop held in April		Q2 19/20
G4	Development of Executive Review Group	Executive Risk Review Group established.		Q1 19/20
G5	Changes in Board structure and Executive Scheme of Delegation	Review of Changes in Board structure and Executive Scheme of Delegation/portfolios being undertake at Executive Directors Group. Appointment of interim Company Secretary from 1st April 2019		Q1 19/20
G6	Outcomes from the CQC Report	CQC report awaited.		Q1 19/20
G7	Outcomes from External Governance Review	Report awaited.		Q1 19/20
G8	Re-review of Board risk-appetite	Review risk appetite at Board Workshop 2nd May 2019		Q1 19/20
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 4 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-19	TARGET RISK SCORE Mar-20		
	4x4=16	3x4=12	3x4=12	3x4=12	3x4=12		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR8 18/19	**Failure to maintain Information Governance standards**	Director of Corporate & Legal Services	Finance & Integrated Governance	amber	→

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
	REF	*What are the key potential consequences (up to 4) of the risk?*
	PC1	Unable to share clinical data effectively with partner organisations to support the delivery of integrated clinical services
	PC2	Patient confidence in the Trust adversely impacted
	PC3	Adverse impact on Trust's reputation resulting from adverse publicity
	PC4	Information Commissioners Office (ICO) impose a fine

INTERDEPENDENCIES:	

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN	Trust Analysis completed ✓	Movement
O1	Unintended loss or inappropriate access or misdirection of confidential or valuable paper data (clinical, corporate & employee)	amber	→
O2	Incorrect disposal of data media or its content that does not protect confidentiality e.g. confidential waste in a non-confidential bin	amber	→
O3	Inadequate security practices that enable inappropriate access to confidential/valuable data e.g. generic usernames and passwords	amber	→
O4	Access to confidential/valuable data is incorrectly provided to individuals e.g. staff granted system access beyond role based needs	green	→
O5	Confidential/valuable data shared to a public domain or an unsecured area inappropriately e.g. provision of payroll details for mailshot	green	→
O6	Confidential or valuable data retained for longer than is mandated by the Department of Health e.g. Meditech records kept indefinitely	amber	→
O7	Security controls/data media used puts at risk access/legibility/accuracy of data e.g. temporary staff without legitimate data access	green	→
O8	Intentional (approved/unapproved) disposal/transfer of confidential/valuable data, inappropriately e.g. child records weeded at 7yrs	amber	→
O9	Pending maternity leave and sickness levels within team could cause impact	amber	→
O10	Forthcoming clinical system merge with WUTH may lead to IG risks if not appropriately managed	amber	→

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
C1	100% of staff undertook Information Governance training within the last 2 years	green	→
C2	Information Governance and IT Security policies and procedures including DPIAs and ISAs	green	→
C3	Use of encryption to secure data on portable devices	amber	→
C4	Secure disposal of sensitive, confidential and person identifiable waste (paper and electronic)	amber	→
C5	Data flow mapping	amber	→
C6	Maintain up-to-date Information Asset Register	amber	→
C7	Members of the Information Governance Committee fully trained including IG Manager	green	→
C8	Identified and trained Caldicott Guardian and Senior Information Risk Owner	green	→
C9	IG Project Management Board work to control new EPR Implementation	amber	→

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective?

REF	REPORTING MECHANISM	FREQUENCY	Strength RAG (Red Amber Green)	Movement
R1	Risks and incident trends reported to the Risk and Performance Committee	monthly	amber	→
R2	Risks and incidents reviewed by the IG Committee, ICO and STEIS	monthly	green	→
R3	Significant incidents reported through STEIS and ICO	As required	green	→
R4	Audits and research data requests reviewed by the IG Committee and Action Plans tracked	As required	green	→
R5	Information Governance plan updates to the Informatics Board	Quarterly	green	→
R6	Exec Team receives updates on significant risks and issues	Weekly	green	→
R7	Finance & Integrated Governance receives IG Committee minutes	Bi-Monthly	green	→
R8	GDPR/IG Progression reported to IG Committee	Quarterly	green	→
R9	EPR Programme Board/IG Committee	Quarterly	green	→

These are the POSITIVE ASSURANCES received…

What are the key positive assurances received through reporting that a control has remained effective (up to 20)

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
A1	Routine email communications relating to IG alerts and threats	As required
A2	MIAA DSP Toolkit Audit - mandatory (Moderate Assurance) (New format)	Jan-19
A3	2018/2019 DSP Toolkit submitted - all standards met 100% submitted (Awaiting outcome of new format)	Mar-19
A4	Bi-Annual SIRO Report received by Informatics Board	Feb-19
A5	IG and Caldicott Panel minutes reported to FIG	Bi-Monthly
A6	MIAA Core IT Infrastructure Review (Significant Assurance)	Jan-15
A7	NHS.Net email secure encryption implemented; reviewed and approved by the IG Panel	Jun-15
A8	Information Security Officer - Qualified HealthCare Information Security and Privacy Practitioner	Nov-15
A9	Information Governance Spot Check Audits Undertaken	Monthly
A10	IT Security Manager is Certified Information Systems Security Professional	Sep-16
A11	Cross Departmental cover for IG Team	As required
A12	Qualified GDPR Practitioner - IG Team trained and certification passed	Nov-17
A13	GDPR Implementation successful and rolled out across the Trust	Mar 19
A14	New reporting mechanism to Audit Committee developed	Nov-17

The GAPS IN CONTROL (as reflected in Divisional or Executive Risk Registers)

What are the remaining key gaps in the controls (up to 10)

REF	GAP	ACTION PLAN	RISK REGISTER REF	DEADLINE
G1	Secure disposal of sensitive, confidential and person identifiable paper waste	Review contract to improve security of confidential waste storage	765	Q1 19/20
G2	Extend data flow mapping	Continue work on Data Flow Mapping, focus on Level 3 assets	973	Q1 19/20
G3	Extend Information Asset Register	Continue work on Asset Register, focus on Level 3 assets	973	Q1 19/20
G4	Colleagues across the Trust are fully trained in Information Governance	Appropriate online training undertaken by staff members	1800	Q1 19/20
G5	Dictation devices not encrypted	On-going rollout of digital dictation and replacement of dictation devices without encryption	767	Q1 19/20
G6	Electronic equipment including medical devices disposed of without removal of unencrypted confidential patient data	Undertake risk assessments for all medical devices containing unencrypted confidential patient data	767	Q1 19/20
G7	General Data Protection Regulation (GDPR) fully implemented - national clarification	Interpret GDPR requirements and develop proposals to achieve compliance within existing resources and brief Board as appropriate	51	Q1 19/20
G8	Unknown associated risks with EPR Project and Collaborative working	Discuss with external organisations what their IG strategy was when merging and implementing new systems, link in with ICO and collaborate with WUTH	1953	Q1 19/20
G9	Limited IG Resources within Organisation	Look at business continuity and risk assess team/resources	1954	Q1 19/20

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 4 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Mar-18	TARGET RISK SCORE Apr-19		
	4x4=16	4x3=12	4x3=12	4x3=12	4x3=12		

What is the strategic risk to be controlled?					
REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE		
CR9 18-19	**Failure to provide appropriate Informatics infrastructure, systems and services that effect high quality patient care in-line with the business objectives of the Trust**	Chief Financial Officer	Finance & Integrated Governance	amber	→

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
	REF	*What are the key potential consequences (up to 4) of the risk?*
	PC1	That patients receive poor quality care or experience avoidable harm
	PC2	That patients experiences poor quality clinical outcomes which are below published national and international standards
	PC3	That the staff user experience is suboptimal and does not facilitate the delivery of high quality care
	PC4	That the organisation is unable to deliver current services efficiently and/or plan to meet future service requirements

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Failure to provide operational continuity (& resilience to faults), cyber security services/systems, initial training & refresher training services
O2	Failure to provide timely, efficient, accurate and value for money Informatics services to agreed levels
O3	Failure to provide development services to identify and exploit available technology
O4	Failure to provide development services to implement technology that enables change with managed risk
O5	Failure to enable the organisation to realise full benefits of the technology assets under management
O6	Failure to provide technology that enables the integration required to support the delivery of healthcare
O7	Failure to provide an information reporting service (operational and corporate governance)
O8	Failure to provide Informatics services in-line with corporate and regulatory standards
O9	Failure to provide a health records service that supports the delivery of healthcare
O10	Failure to provide strategic leadership in the use and exploitation of technology

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL	Strength RAG	Movement
C1	Good programme and project governance (e.g. industry standard methodologies, business change & benefits)	amber	→
C2	Information Governance, IT Security and Informatics Services policies, plans and procedures	green	→
C3	Appropriate membership and governance arrangements for the Informatics Board and its sub-groups	amber	→
C4	Proactive approach to risk mgt, KPI monitoring, incident review, action planning, disaster recovery & continuity	amber	→
C5	Clinical engagement through Chief Clinical Information Officer, Divisional CIO's and Clinical Advisory Group	amber	→
C6	Up-to-date and fit for purpose Informatics Strategy which is owned by the business	amber	→
C7	Audit programme including Pen Testing, Coding, Backup & Resilience, IGT, Asset Management, Data Quality, etc.	green	→
C8	IT infrastructure, desktop and mobile assets supported, maintained and replaced in-line with best practice	amber	→
C9	Comprehensive user training programme (initial and refresher) across all assets under management	red	→
C10	Appropriately resourced, qualified, knowledgeable, motivated, well trained and sustainable workforce	amber	→

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective?

REF	REPORTING MECHANISM	FREQUENCY	Strength RAG	Movement
R1	Informatics Board	quarterly	green	→
R2	Annual Plan reviewed and approved by Informatics Board	quarterly	amber	→
R3	Informatics Board monitoring project progress (value >£50k)	as required	amber	→
R4	Informatics service Key Performance Indicators	monthly	green	→
R5	Audits reviewed by the Informatics Board and Action Plans tracked	as required	amber	→
R6	Finance & Integrated Governance receives Informatics Board minutes	bi-monthly	amber	→
R7	Risks and incidents reported and reviewed at Informatics Board, etc.	monthly	amber	→
R8	Informatics Performance & Governance Group review	monthly	amber	↓
R9	Cheshire Care Record Group	TBC	green	→
R10	Receives minutes & updates from appropriate Informatics sub-groups	monthly	green	→

These are the POSITIVE ASSURANCES received…

What are the key positive assurances received through reporting that a control has remained effective (up to 20)

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E= External Assurance*	DATE LAST REPORTED TO COMMITTEE
R1	North West Informatics Skills Development Network Accreditation (Foundation Level)	Mar-16
R1	MIAA Cyber Security: Baseline Technical Controls Assessment 16/17 (Satisfactory Control)	Jan-17
R1	Global Fast Follower application	Sep-17
R1	Network Access Control Software procured	
R1	Fast Follower funding application approved by NHS Digital	Jan-18
R1	Approval from Risk & Performance Committee to address cyber security resource gap	May-18
R1	Presentation at Audit Committee on cyber security	Sep-18
R1	Implementation of Network Access Control system; currently in monitoring mode	Sep-18
R1	EPR Programme Board minutes to FIG	Sep-18
R1	Informatics board reinstated	Feb-19
R1	Informatics Accreditation by ISD network; informal visit suggests reaccreditation to level 1, possibly level 2	May-19

GAPS IN CONTROL (as reflected in Divisional or Executive Risk Registers)

What are the remaining key gaps in the controls (up to 10)

REF	GAP	ACTION PLAN	RISK REGISTER REF	DEADLINE
G1	Informatics Strategy requires review	Informatics Strategy will be reviewed in the context of Global Fast Follower application and procurement of new Electronic Patient Record (EPR)	Ref 1980	Q2 19/20
G2	Review of IT Leadership	Formalise the senior IT leadership structure	Ref 1981	Q2 19/20
G3	Reducing the threat of a Cyber Security attack	Assess implementation of network Access control systems and physical processes to mitigate risks. Cyber Attack 'table top' exercise planned for Jan 2018	Ref 1753, 1688, 1475	Q4 18/19
G4	No approved governance between COCH and WUTH for shared EPR	Joint executive workshop to be scheduled to address this	Ref 2014, 2013, 2010	Q1 19/20
G5	MIAA report Extended cyber security assurance report	Report provides moderate assurance across a number of Cyber Security domains; actions due for completion by March 2020		Q4 19/20

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 4 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Mar-19	TARGET RISK SCORE Apr-20		
	4x3=12	4x4=16	4x4=16	4x3=16	4x3=12		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR10 18/19	**Failure to recruit, train and retain professional staff.**	Director of People & OD	People and Organisational Development	Red	➔

LINKED CORPORATE PRIORITIES *(up to top 3)*
The foundations for change to happen
Concentrating on the right services to meet the needs of our patients
Transforming care for patients

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Poor Staff Experience- impact on Trust reputation and ability to recruit and retain
PC2	Poor Patient Experience - impact on Trust reputation/ increase in complaints
PC3	Non-compliance with regulatory/commissioners contracts e.g. Well Led domain CQC
PC4	Possible reduction in Safety/Quality/Performance/Staffing indicators

INTERDEPENDENCIES **CR1;CR2;CR3;CR5;CR6;CR7;**

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	National and local staff shortages; including those with specialist clinical skills e.g. Nurses/ED/Sonographers/Anaes/CRV/Theatres
O2	High cost of agency / locum staff (Nursing/Medical/ODPs) as monitored by the Variable Pay work stream
O3	Tighter UK border controls following Brexit & non EU countries / Tier 2
O4	Age profile/demographic in some staff groups e.g. Midwifery / Nursing
O5	National Pay restraint & impact on recruitment and retention into NHS / Trust, impact of Bursary removal
O6	Sustainability and efficiency of services within financial envelope
O7	Impact of no agency cap rates in Wales & staff working cross-border for higher rates
O8	Poor compliance with LQAF framework standards
O9	Impact of pensions; lifetime allowance bringing forward retirement decisions
O10	NHS Staff Survey Findings 2018

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
C1	Development & assessment of new and/or extended roles such as Adv.Practice, PAs and Apprenticeships	Green	➔
C2	Monitoring of Medical staffing agency usage	Green	➔
C3	Rolling programme of recruitment including overseas	Green	➔
C4	Development of Retention strategies and retraining opportunities	Amber	➔
C5	Staff engagement across the Trust including promotion of Freedom to Speak Up and High Performance Culture	Green	➔
C6	High Performance Culture work stream within Model Hospital programme	Green	➔
C7	HCP & ICP, Streamlining and collaboration across the health economy	Amber	➔
C8	Development of libraries strategy	Amber	➔
C9			
C10			

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective?

REF	REPORTING MECHANISM	FREQUENCY	Strength RAG (Red Amber Green)	Movement
R1	Board of Directors reports (integrated performance report)	Bi-monthly	Green	➔
R2	People and OD Committee	Bi-monthly	Green	➔
R3	Partnership Forum / Local Negotiating Committee	Monthly/ Bi monthly	Green	➔
R4	Executive Directors Group / Corporate Leadership Group	Weekly	Green	➔
R5	Council of Governors	Bi-monthly	Green	➔
R6	Finance & Integrated Governance Committee	Bi-monthly	Green	➔
R7	GMC Trainee Survey (E) / Student Experience Survey / HEE visits	Annual/ open all year	Green	➔
R8	Multi Disciplinary Education Committee	Bi-monthly	Green	➔
R9	Staff Survey and Staff Friends & Family Tests	Annual/Quarterly	Green	➔
R10	Freedom to Speak Up Committee	Bi-monthly	Green	➔

These are the POSITIVE ASSURANCES received…

What are the key positive assurances received through reporting that a control has remained effective (up to 20)

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
C2	Monthly Nursing & Midwifery Workforce Group chaired by Director of Nursing & Quality	28-Mar-19
C2	Reviewing skill mix in theatres, discussing local courses with Chester University	28-Mar-19
R1/R2/R9	Compliance Reports (Appraisal/Mandatory Training/Local Induction) BOD, People & OD, MDEC	22-Jan-19
R8/R9	GMC Trainee Survey- reported to Multi-Disciplinary Education Committee	08-May-18
R8/R9	Regular Pulse Checking via SFFT/SOS/GMC trainee surveys/Student Exp surveys	22-Jan-19
R8	Exec attendance at monthly education programmes e.g. CHAPS for FTSU discussion.	Mar-19
C3	Medical agency spend / recruitment and retention strategy reviewed by Medical Workforce Board	21-Jun-18
C4/R4	European & International Nurse Recruitment plan in development	28-Mar-19
C5/R4	E-roster / Safe care implementation in progress & increased notice of rosters	27-Sep-18
C9	Monthly ICP, HRD Meetings, Regional Collaborative Bank led by Dir of People & OD, Streamlining	13-Sep-18
C2/R2	Apprenticeship Strategy & delivery presented to POD, PF and CLG	25-Sep-18
C4	Joined cohort 4 of NHSi retention programme	01-Dec-18
C8	Commence recruitment of a qualified librarian	Mar-19
C4	Name, establishment review required for BOD	Check date
O9	Working on development of actions to support impact of pensions ad lifetime annual allowance	Mar-19
O10	Staff Survey & Findings report to BOD	26-Mar-19

The GAPS IN CONTROL (as reflected in Divisional or Executive Risk Registers)

What are the remaining key gaps in the controls (up to 10)

REF	GAP	ACTION PLAN / EXCEPTIONS	RISK REGISTER REF	DEADLINE
G1	Increases in turnover for nursing staff / staff working agency shifts in Welsh trusts (no cap)	Retention strategy, weekly bank pay from October, corporate plans re pay review, escalation to BCUHB, surveys in dept with nursing staff, e-roster.	Ref 1951	Q4 18/19
G2	Agencies still charging over capped rate, holding Trusts to ransom	Fortnightly reviews & increased management information from Medical Staffing via Brooksons. Review at MWB. Development of Medical Workforce Strategy (MWS).	Ref 1905	Q4 18/19
G3	Pressures of capacity and demand on staff and ability to manage pressures	Divisional risks item added to each POD meeting as standing item to discuss capacity, demand & pressures. Monitored monthly through HRBPs and triangulation with data.	Ref 1884/1886/1910/1911	Q4 18/19
G4	Medical gaps esp ED & ENT/T&O/Plastics rotas & impact on patient safety / variable pay spend	Recruitment into permanent posts, skill mix review, engagement needed with Medical Leads in hot spot areas through MWB. Development of Medical Workforce Strategy.	Ref 1885/1896/1890	Q4 18/19
G5	The reduction in training & conversion courses is causing a shortage in some clinical areas such as Sonographers	Working with Divisions to develop retention strategy, e.g. Theatres recruitment & retention strategy, apprenticeship strategy & delivery with HEIs.	Ref 1899	Q4 18/19
G6	The funding for training & conversion courses is causing a shortage in some clinical areas such as ODP's	Working with Divisions to develop retention strategy, e.g. Theatres recruitment & retention strategy, apprenticeship strategy & delivery with HEIs.	Ref 1952	Q4 18/19
G7	Completion of recruitment process for qualified librarian and complete library strategy	Working with current librarian to develop strategy and support recruitment process.	Ref 1991	Q4 18/19
G8	Lead employer, charges & late comms on delegated juniors / specialities	St Helens & Knowsley is the provider of Junior Doctors. Additional changes include OH. Also, late notifications of juniors assigned to specialities.	Ref 1894 / 1895	Q4 18/19
G9	Shortage of nursing staff	There is an increasing vacancy gap for nurses across the UK. The Trust continues to hold recruitment fairs & events	Ref 1882	Q4 19/20
G10				

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NHS Foundation Trust

Item Reference and Title	Agenda item 8 - QSPEC Chair's Report to Board of Directors
Date of Meeting	Board of Directors 21st May 2019
Author(s)	Andrew Higgins
Alignment to Board Assurance Framework risk	CR1 Failure to maintain and enhance the quality and safety of the patient experience and ensure regulatory compliance. (risk score – 12)
Alignment to CQC Domains	Safe/Caring/Responsive
Summary	This report is intended to: • provide an update on the Committee's work and decisions • highlight certain risks and issues for the attention of the Board
Recommendation(s)	The Board is asked to note the update.

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1.0 Key items of business discussed

The QSPEC Committee met on 16th April 2019 and the following key business items were discussed:

- New risks escalated from Divisions
- ICP update
- Report on the Sepsis QI Programme
- Quality & Safety Dashboard – exceptions
- Organisational risks, never events and serious incidents
- Pressure Ulcer Report and Trend Analysis
- Clinical Rounds Report, October 2018 to March 2019
- Audit feedback on past incidents and progress on MIAA recommendations
- Approval of Corporate and Divisional Policy, Guideline & SOP templates
- Receipt & noting of Adult Safeguarding Action Plan and sub-committee and divisional governance minutes

2.0 Key agreements or decisions made

- Heightened risks were reported from Diagnostics & Pharmacy on the failure of key equipment to make aseptic products. Executive discussions had taken place on balancing clinical and financial risks. An update on this risk and EDG decisions on the capital programme will be brought to the next meeting.
- The presentation on Sepsis QI highlighted actions taken but also the continuing failure to meet compliance targets – 90% ED and in-patient targets were not achieved in Quarters 1, 2 & 3. Risks to progress include training for key decision makers; full implementation of the Paediatric & Obstetric Sepsis Pathway; lack of testing of Cerner and Sepsis response kits; compliance with NCEPOD & NICE recommendations; and 24/7 escalation to the Critical Care Outreach Team. The Committee asked for a clear improvement trajectory on CQUIN compliance and training targets, prioritisation of actions for Q1 2019/20 and establishment of key milestones to enable effective oversight.
- The major exception on the dashboard related to Infection Control measures. A review of practice with the lead from NHSI is commencing, to develop a QI approach.
- No new Never Events were reported. Details were given of a recent incident relating to a patient with dementia that bore some similarity with the Never Event from the previous month. Executives were disseminating lessons learned as speedily as possible.
- The Q3 Pressure Ulcer report evidenced a downward trend in the incidence of Grade 3 & 4 pressure ulcers. There had, however, been a significant rise in the number of Grade 2 ulcers reported. Remedial actions have been initiated. The Committee asked that timescales to complete overdue actions should be more clearly documented on the Action Plan.
- Following the report on Audit Feedback in response to Incidents, the Committee asked for a clearer linkage between the Trust's Clinical Audit Plan, audit coverage of incidents reported and clinical priorities.
- The Committee approved the Corporate & Divisional Policy, Guideline & SOP templates.

3.0 Items for escalation to Board

The Board is asked to note:

- The further example of increasing risk around equipment failure and consequent pressure on the Trust's capital programme.
- The continuing non-compliance with Sepsis targets and risks to achieving further improvement. A clearer improvement trajectory and training targets are required and have been requested, together with prioritisation of actions and milestones for 2019/20.
- The reporting of an incident relating to the care of a patient with dementia and the security of the care environment.

4.0 Recommendation

The Board is asked to note the contents of this update and in particular those issues highlighted in Section 3.0.

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Item Reference and Title	**Agenda item 9 - Integrate Performance Report, Month 12**
Date of Meeting	Board of Directors 21st May 2019
Accountable Executive	Lorraine Burnett, Chief Operating Officer
Author(s)	Denise Wood, Head of Information and Performance
Alignment to Board Assurance Framework risk	CR 1,2,3,4,5,6
Alignment to CQC Domains	Safe/Effective/Caring/Responsive/Well Led
Document Previously Considered by:	
Summary	This report is intended to: • Summarise the key performance Indicators • Assure the BoD of the monthly oversight of trust priorities against agreed targets • Highlight areas of high or low performance for operational, quality, safety, workforce or financial metrics
Recommendation(s)	**The Board is asked to** note the overall performance against all areas and actions being taken to meet targets
Corporate Impact Assessment:	**Legal and regulatory impact: Y** **Financial impact: Y** **Patient Experience/Engagement: Y** **Risk & Performance Management: Y** **NHS Constitution/Equality & Diversity/Communication: Y**

COUNTESS OF CHESTER

PERFORMANCE REPORT, MARCH 2019

Safe

Indicator	Target	Act.	Alert
All Falls Rate	7	5.97	○
Falls with Harm Rate	0.3	0.23	○
Never Events	0	1	○
Safety Thermometer – Free of new harms %	95	94.9%	○
Q3 Sepsis screening % (Inpatients)	90	69%	○
Q3 Sepsis treatment % (Inpatients)	90	62%	○
Q3 Sepsis screening % (ED)	90	80%	○
Q3 Sepsis treatment % (ED)	90	76%	○
Infection Control: C Difficile	23	30	○
Infection Control: MRSA	0	3	○
Nurse Staffing	95%	95.5%	○

Kind

Indicator	Target	Act.	Alert
Friends and Family: A&E	80	80.3%	○
Friends and Family: Inpatient Wards	90	92.5%	○
Friends and Family: Maternity Services	90	95.9%	○
Open Complaints	40	28	○
Open Complaints > 40 days response time	5	2	○
Open PHSO Complaints	5	2	○
MSA Breaches	0	7	○
Sickness Absence %	3.65	4.47	○
Mandatory Training %	95	94.0	○
Annual Appraisal %	95	84.1	○
Staff Turnover %	10	10.02	○

Effective

Indicator	Target	Act.	Alert
*** ED 4 Hour Wait %**	95	84.9%	○
*** 18 Week RTT %**	92	83.7%	○
*** 6 week Diagnostic Wait %**	99	96.2%	○
*** Cancer Treatment 62 Day %**	85	82.9%	○
Bed Occupancy %	85	96.4%	○
I&E Variance (including PSF)	Plan	£16m OVERSPEND	○
Forecast Position/ Run Rate	Plan	+£12m	○
CRS In Year	Plan	-£5,637k	○
Contract Income	Plan	-£1,736k	○
Variable Pay	Less YOY	+£318K	○
Total agency spend £m	£4.8 EOY	£4.4m EOY	○
Total agency shifts over cap rate	Less YOY	-228	○

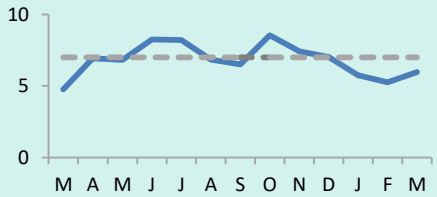
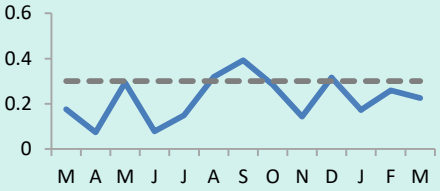
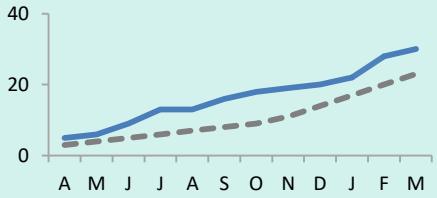
*** Key NHS constitutional target**

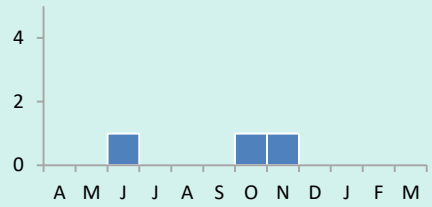
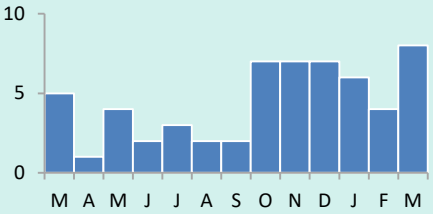
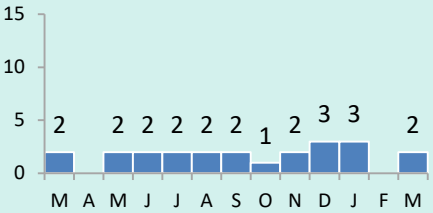
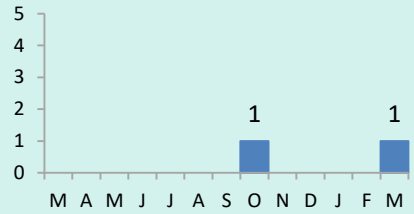
Key ○ Target achieved ○ Target not achieved

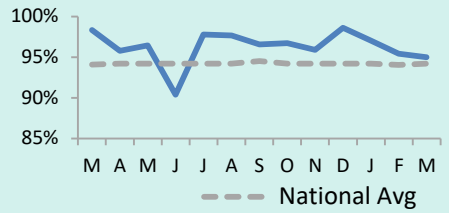
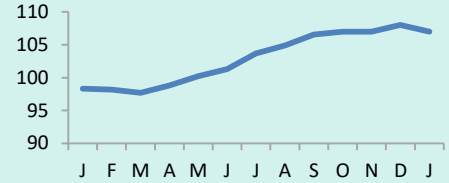
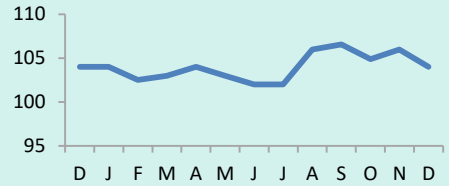
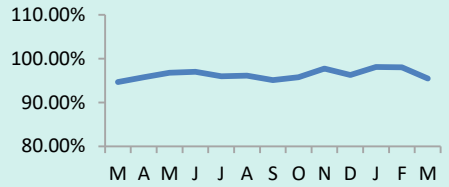
SAFE

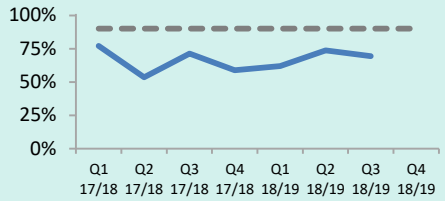
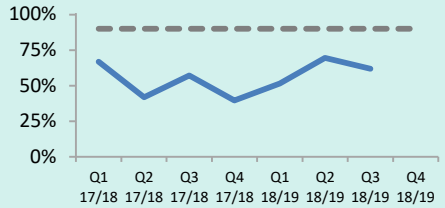
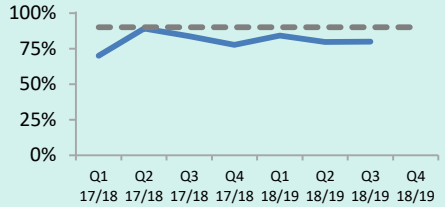
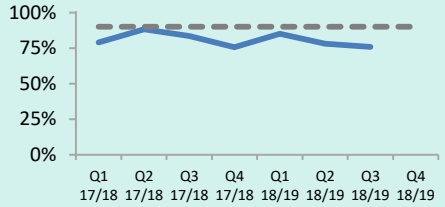
Reducing patient harms

Supporting the Board Assurance Framework: *CR1, CR2, CR3, CR6, CR7, CR10*

Measure	Definition	Threshold	Actual	Comment	Graph
Harms: All Falls Rate	Rate of all falls per 1000 bed days	7	5.97	Performance remains below the threshold.	
Harms: Falls with Harm Rate	Rate of falls with harm per 1000 bed days	0.3	0.23	Performance remains below the threshold.	
Harms: Infection Control – Rate of C. Difficile	Cases of hospital acquired C. Difficile bacteraemia.	23 cases (2018/19)	30 cases (YTD)	2 new cases identified in March. We have exceeded the end of year target for this indicator.	

Measure	Definition	Threshold	Actual	Comment	Graph
Harms: Infection Control – Rate of MRSA	Cases of hospital acquired MRSA bacteraemia.	0 cases (2018/19)	3 cases (YTD)	No new avoidable cases reported for March.	
Harms: Serious Incidents - Level 1	Number of Serious Incidents at Level 1	No specific target but monitoring of trends	8	SI Panel commissioned eight level 1 serious incident reviews in March. No new trends were identified, but all are being investigated as part of the usual Serious Incident process	
Harms: Serious Incidents - Level 2	Number of Serious Incidents at Level 2	No specific target but monitoring of trends	2	SI Panel commissioned two level 2 serious incident reviews in March.	
Harms: Serious Incidents - Never Events	Number of Never Events reported	0	1	One Never Event reported in March which is subject to a serious incident review	

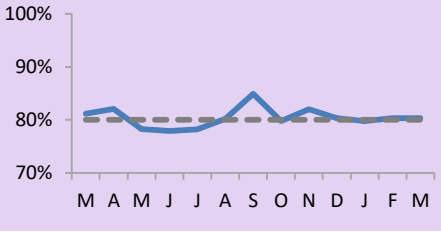
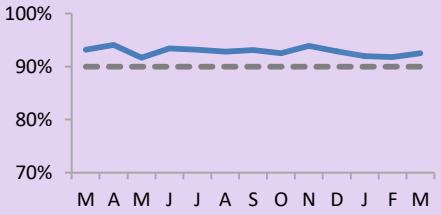
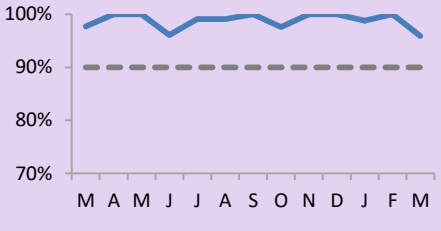
Measure	Definition	Threshold	Actual	Comment	Graph
Harms: Safety Thermometer	Based on monthly Safety Thermometer census. Rate free of new harms should be higher than national average	94.2%	95.0%	Performance remains above the national average.	
Learning from Deaths: Hospital Standard Mortality Rate (HSMR)	Ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death	Alert is red when HSMR is an outlier relative to other Trusts.	107	This measure is based on diagnosis groups that account for approximately 80% of inpatients. The HSMR is above the expected range relative to peers and is currently at an amber status.	
Learning from Deaths: Standardised Hospital Mortality Index (SHMI)	Risk adjusted mortality ratio based on number of expected deaths. National published figure from HSCIC.	Alert is red when SHMI is an outlier relative to other Trusts.	104	This information has been refreshed nationally up to December 2018. The SHMI value is above the expected range relative to peers and is currently at an amber status.	
Nurse Staffing Compliance	Actual versus Planned Staffing Hours	95%	95.5%	This figure is an overall percentage and should be reviewed alongside the individual ward/department data. See appendix below.	

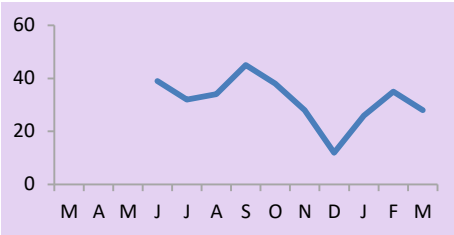
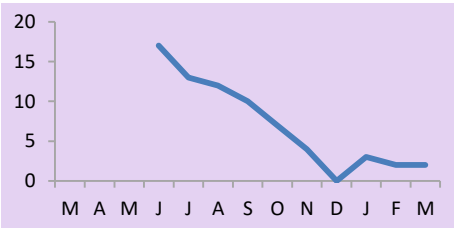
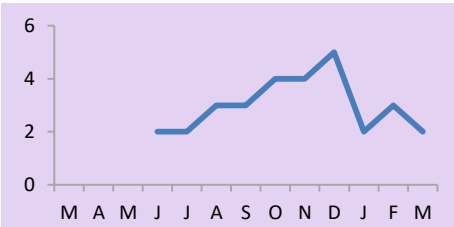
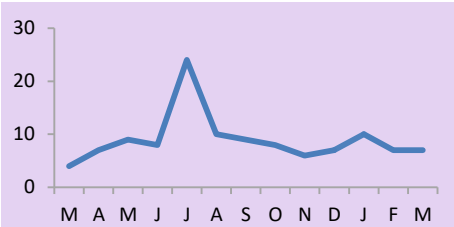
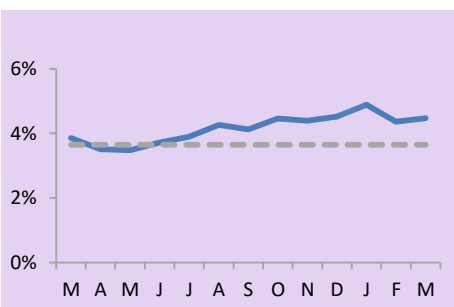
Measure	Definition	Threshold	Actual	Comment	Graph
CQUIN: Sepsis Screening in ED / Inpatient Settings	Timely identification of sepsis in ED	90%	69%	QUARTERLY INDICATOR. Q3 performance for sepsis screening remains below the 90% target.	
CQUIN: Sepsis Screening in ED / Inpatient Settings	Timely identification of sepsis for inpatients	90%	62%	QUARTERLY INDICATOR. Q3 performance for sepsis screening remains below the 90% target.	
CQUIN: Sepsis Treatment in ED / Inpatient Settings	Timely treatment of sepsis in ED	90%	80%	QUARTERLY INDICATOR. Q3 performance for sepsis treatment remains unchanged	
CQUIN: Sepsis Treatment in ED / Inpatient Settings	Timely treatment of sepsis in inpatient settings	90%	76%	QUARTERLY INDICATOR. Although Q3 performance for sepsis treatment remains under the 90% target, steps are being taken to support improvement. Details are provided in the exception report	

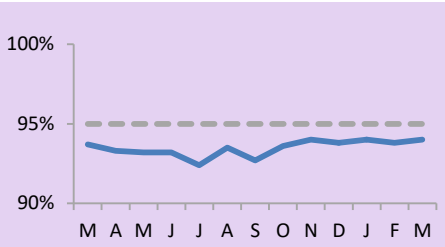
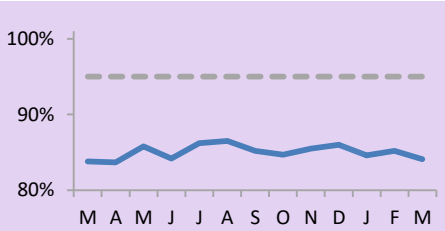
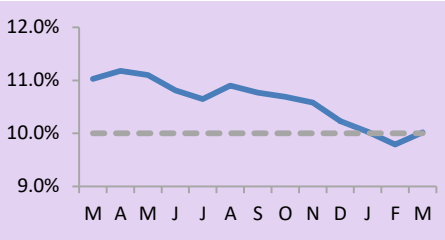
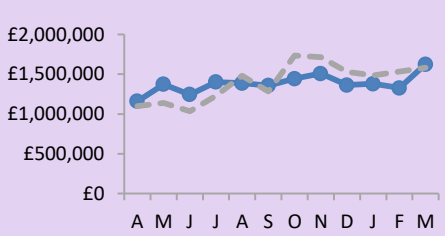
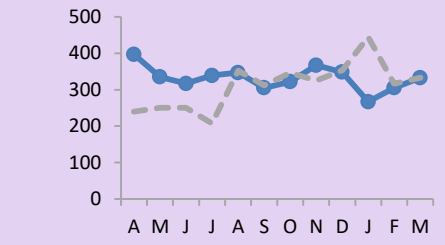
KIND

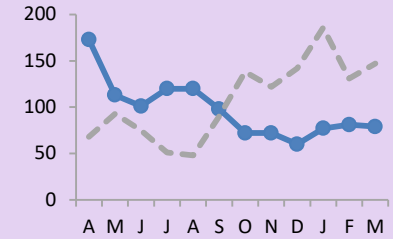
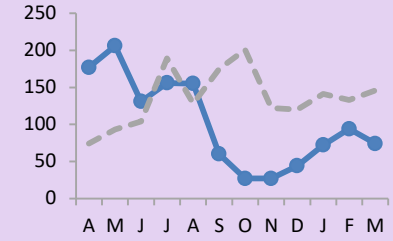
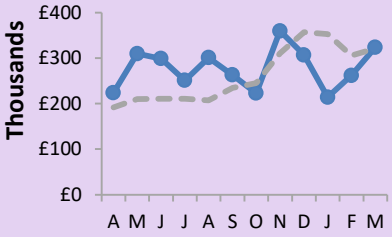
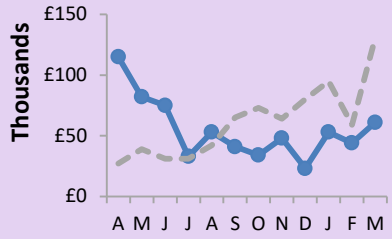
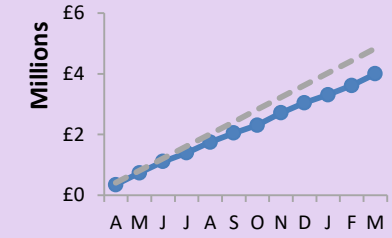
Providing high quality patient care

Supporting the Board Assurance Framework:
CR1, CR4, CR6, CR7, CR10

Measure	Definition	Threshold	Actual	Comment	Graph
Friends and Family: % Likely to Recommend A&E	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	80%	80.3%	Performance is above target in February.	
Friends and Family: % Likely to Recommend Inpatient Wards	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	90%	92.5%	Performance remains above target for inpatient stays.	
Friends and Family: % Likely to Recommend Maternity Services	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	90%	95.9%	Performance remains above target for maternity services.	

Patient Feedback: Number of Open Complaints	Number of open patient complaints at month end	40	28	The number of open complaints has increased but remains within the expected threshold for this measure.	
Patient Feedback: Number of Complaints Past 40 Day Response Time	Number of Complaints Past 40 Day Response Time	5	2	Performance remains within the expected threshold for this measure.	
Patient Feedback: Number of Complaints Open with PHSO	Number of Complaints being investigated by the PHSO	5	2	Performance remains within the expected threshold for this measure.	
Mixed Sex Accommodation Breaches	Number of non-clinically justified breaches of the single sex accommodation standard	0	7	7 breaches in March were not clinically justified. Exception report provided.	
Sickness Absence	% monthly sickness absence, excluding comfort zone and Bank staff	3.65%	4.47%	The March absence rate is 4.47%. Exception report provided.	

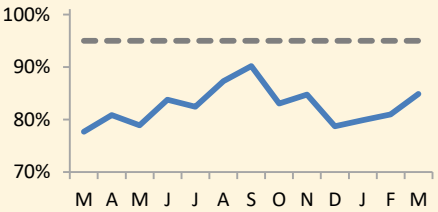
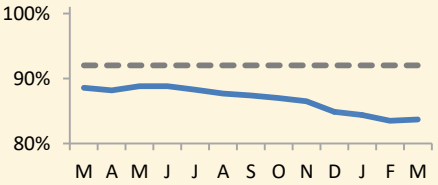
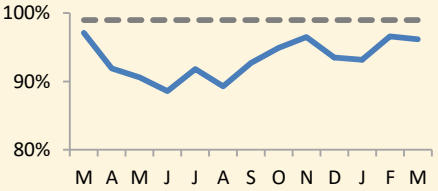
Mandatory Training Compliance	% mandatory training compliance, excluding comfort zone and Bank staff and staff on maternity/long term sick leave	95%	94.0%	Performance has changed slightly since last month. Compliance with the Mandatory Training target has increased in March to 94.0%.	
Annual Appraisal Compliance	Exclusions as above and also excludes staff with less than 1 year's service.	95%	84.1%	Compliance with the Appraisal target has slightly decreased in March to 84.1%. Exception report provided.	
Staff Turnover	Based on headcount in the previous 12 months and on permanent staff only.	10%	10.02%	Performance is just outside target at 10.02%	
Variable Pay	Reducing and controlling variable pay spend (including overtime, agency, additional clinical activity)	Year on year reduction	+£298k	Variable pay spend increased in month by £298k to £1,625k. Agency increased £87k to £433k and Medical Bank (183k) rose by 18k in month too. Total agency expediture for 2018/19 is £4.4 million.	
M&D Reduction in Agency Shifts over Cap Rates	Reducing agency shifts over cap rates.	Year on year reduction	+28	Month 12 shows an increase against February in shifts above the cap, with 333 Medical shifts above cap rates.	

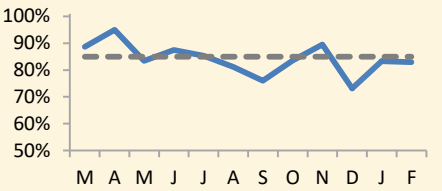
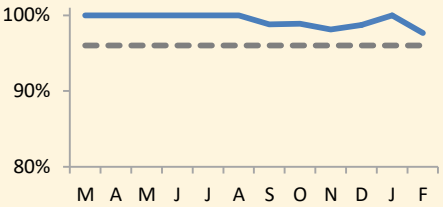
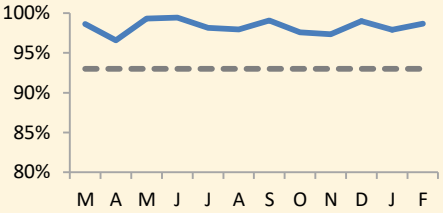
N&M Reduction in Agency Shifts over Cap Rates	Reducing agency shifts over cap rates.	Year on year reduction	-68	In relation to Nursing shifts, 79 shifts were approved above cap rates. A difference of -68 from same month last year	
'Other' Reduction in Agency Shifts over Cap Rates	'Other' consists of Care Packages, Sonographers, Theatres and CRV Dept.	Year on year reduction	-72	Operating Department Practitioner shifts dropped to 74 approved over the cap. A difference of -72 from same month last year	
People: Medical Agency Spend	Planning improvements in productivity and efficiency	Year on year reduction	+£3k	Medical Pay is overspent by £1,313k. Agency medical expenditure is £3,015k (7% of the total medical spend).	
People: Nursing Agency Spend	Planning improvements in productivity and efficiency	Year on year reduction	-£70k	Nursing Pay is £1,275k overspent. Agency nursing expenditure is £662k which is 2% of total trained nursing spend. A difference of -£72k from same month last year	
People: Total Agency Spend within Budget	Planning improvements in productivity and efficiency	Total agency spend capped at 4.459 for 18/19	£4.00m EOY	Total Agency spend for M1-12 is £4,000k. (£4,836k was spent during the same period last year). A straight line forecast is just below the agency ceiling.	

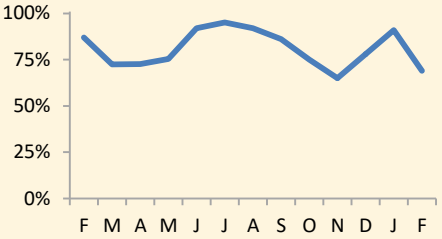
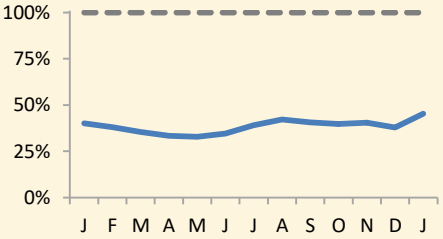
EFFECTIVE

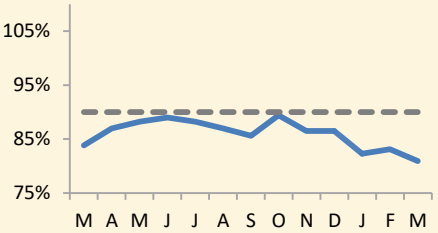
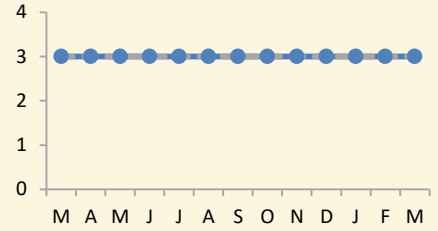
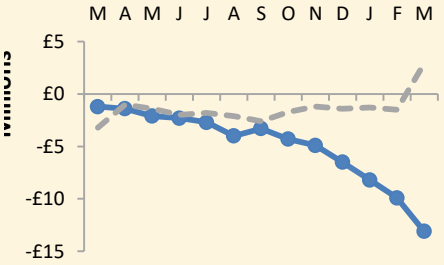
Minimising delay and improving processes

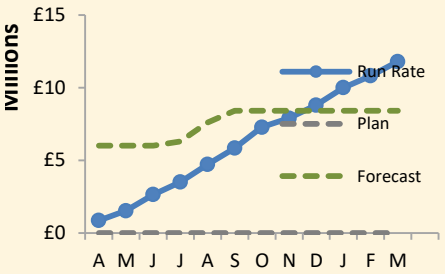
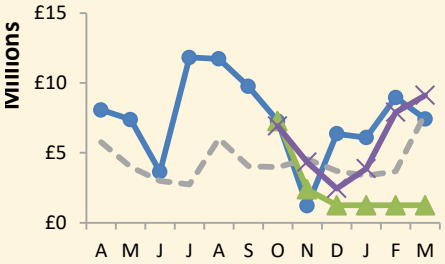
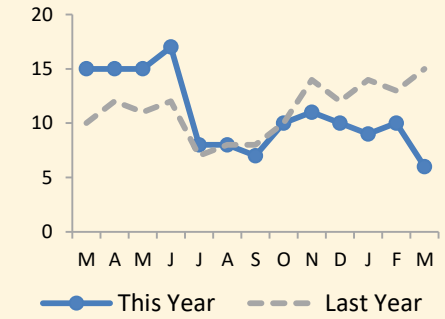
Supporting the Board Assurance Framework:
CR3, CR5, CR6, CR7, CR8, CR9, CR10

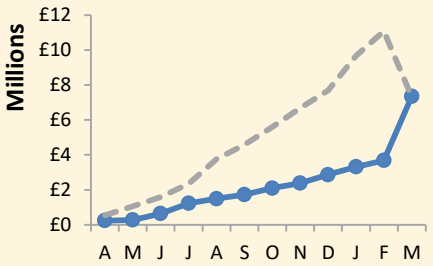
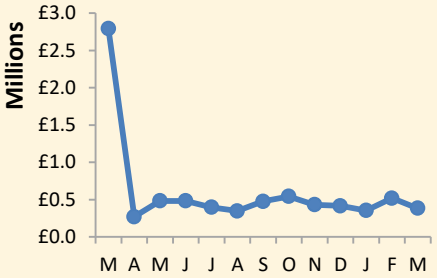
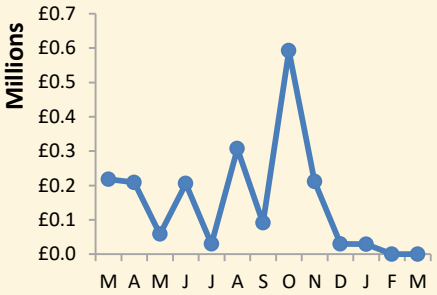
Measure	Definition	Threshold	Actual	Comment	Graph
ED 4 Hour Wait Standard	% A&E attenders seen within 4 hours of arrival	95%	84.9%	Performance has improved to 84.9% in March. Nationally, 86.5% of patients were seen within 4 hours of arrival in March, type 1 nationally 79.5% were seen within 4 hours	
18 Weeks RTT incomplete pathways	Percentage of incomplete pathways for English patients within 18 weeks.	92%	83.7%	Performance has deteriorated during the last month. The RTT incomplete percentage rose slightly to 83.7% in March. The latest national figure for this indicator is 87.0% (February 2019). An exception report is provided.	
Diagnostic Tests within 6 Weeks (DM01)	Diagnostic tests carried out within 6 weeks of request being received.	99%	96.2%	Performance was 96.2% during the last month. The latest national figure for this indicator is 96.4% (January 2019).	

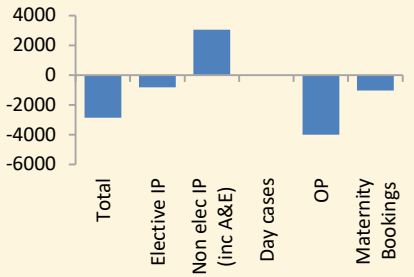
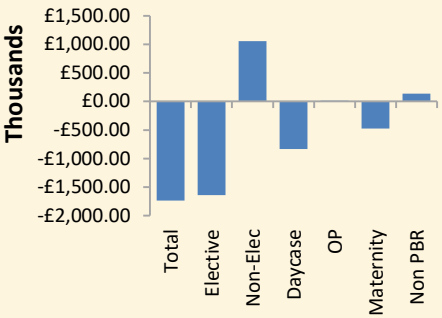
Measure	Definition	Threshold	Actual	Comment	Graph
Cancer Treatments: 62 Day Standard	First treatment for cancer within 62 days of urgent referral through GP 2 week referral route.	85%	82.90%	This indicator is reported one month in arrears. The latest national provisional figure for this indicator is 76.1% (Feb 2019).	
Cancer Treatments: 31 Day Standard	Patients receiving first definitive treatment within 1 month of cancer diagnosis.	96%	97.67%	Performance remains above target. This indicator is reported one month in arrears.	
Cancer Treatments: 14 Day Standard	Patients referred from GP with suspected cancer should have their first appointment within 14 days	93%	98.68%	Performance remains above target. This indicator is reported one month in arrears.	

Measure	Definition	Threshold	Actual	Comment	Graph
Number of Urgent Operations Cancelled on Day	Urgent operations cancelled on the day of the procedure	0	0	Performance is unchanged.	
% Cancelled Operations Rebooked within 28 Days	Patients given a TCI date that is within 28 days of a procedure cancelled on the day.	100%	69%	This indicator is reported a month in arrears to ensure all patients offered rescheduled procedures within 28 days are included.	
Clinical Correspondence: OP Letters within 7 days	100% of outpatient letters to be sent within 7 days.	100%	45.2%	Performance has improved during the previous month. 65% of urgent appointments and 42% of routine appointments had OP letters sent within 7 days. This indicator is reported two months in arrears.	

Measure	Definition	Threshold	Actual	Comment	Graph
Clinical Correspondence: E-Discharge within 24 Hours	Percentage of clinical discharge letters that were sent within 24 hours	90%	80.9%	Performance has deteriorated since last month. An exception report has been created for this indicator.	
Use of Resources	NHS Improvements measure of financial risk	A score of 3 each month (restated)	3	Performance is unchanged. The Trust is currently at a level 4 for Capital Service Capacity, liquidity, I&E Margin ratings, which when combined with 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.	
I&E Plan Variance	Variance to plan	No deviation from plan	£16.0m overspend	As at the end of March19, we are reporting a £16,076k overspend against plan. Notable pressures include £5,508 lost PSF for A&E & Finance , (£127k) in relation donated asset transactions, £5,056 k relating to the impairment adjustment, and (£2,758k) additional Incentive PSF culminating in a reported net adverse position of £8,397. (£4,101k non recurrent support has been required to deliver this position)	

Measure	Definition	Threshold	Actual	Comment	Graph
Run Rate	Run Rate is I&E Variance adjusted for non-recurrent items and CRS profile. Forecast is then derived from run rate and known mitigation.	No deviation from plan	+£12m	Performance has deteriorated. The underlying run rate at the end of March is £11,803k after adjusting for the non-recurrent benefit of £3,406k within the position.	
Cash	Cash on deposit <3 month deposit	No deviation from plan	+£0.3m	The closing cash balance at the end of March is just under £7.5m, £300k behind plan. The £3.5m loan drawdown was received in March, which made the total revenue drawdown for 2018/19 of £6.7m. The capital loan is still not approved by DHSC..	
Debtor Days	Debtor Days: Trade Debtors divides by income x 365	No target has been set for this indicator	6	Debtor days have reduced to 6 days from 10. Wirral debtors remain significant but they made a payment of just over £1m right at the end of March. We then released an equivalent payment of creditors to them. They have since paid another £300k. Local Authority DTOCs invoices remain unpaid.	

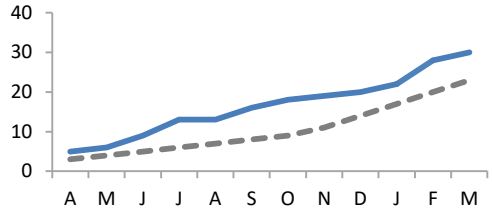
Measure	Definition	Threshold	Actual	Comment	Graph
Capital Expenditure	Capital expenditure performance against plan / forecast out-turn	Performance vs Plan	£0 (-£6.9m) See comment	YTD capital expenditure of £7.3m did undershoot the original capital plan by £6.9m, however it did meet the revised plan of £7.3m The Trust's capital loan has been approved by NHSI and is with DHSC for final approval. The PDC funded A&E scheme has been delayed due but will hopefully recommence soon.	
CRS in year	Planning improvements in productivity and efficiency	No deviation from plan	-£5,637k	The CRS plan for 2018/19 is £10.7m. The CRS programme is £5,637k behind plan as at March 19. In year 48% of the target has been delivered with 52% unachieved in either Red or Black (unidentified) schemes.	
CRS recurrently	Planning improvements in productivity and efficiency	No deviation from plan	16% identified	Recurrently 16% of the £10.7m target has been identified with 2% in Green or Amber Schemes and 82% in Red or Black (unidentified) schemes.	

Measure	Definition	Threshold	Actual	Comment	Graph
Contract Performance (Activity)	YTD Contract performance against Trust Planned activity (English & Welsh)	No deviation from plan	-3,049	All points of delivery are showing an under performance against plan YTD with the exception of non-elective (+3,049). This is made up of 2,009 additional ED attendances and 1,493 additional discharges but is offset by an underperformance on maternity discharges (-453).	
Contract Income	YTD Contract performance against Trust Planned activity (English & Welsh)	No deviation from plan	-£1,736k	Prior to adjustment for the block contract with WCCCG, the March income position is above plan by £1,175k. The block contract adjustment to reflect the over-performance on WCCCG offsets this over-performance by £2,911k resulting in an adverse position on contract income of £1,736k.	

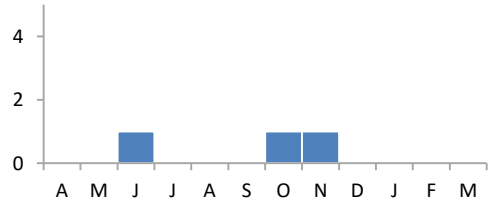
Exception Report

Performance Trend

C Difficile



MRSA



Infection Control

Performance Issue:

C Difficile has been above trajectory throughout the year. Additionally, there have been a total of 3 avoidable incidences of MRSA, these occurred in June, October & November.

Planned Remedial Actions:

March 2019 brings us to the end of the infection prevention and control surveillance year, with the year-end position for healthcare associated infection as follows:

- MRSA bacteraemia – 3 avoidable infections against the national objective of zero avoidable infections within year
- C. difficile infection – 30 cases of infection against an objective of no more than 23 cases within year

There were 2 hospital onset cases of C. difficile infections within in March 2019, which was a sharp decrease on the number of infections reported within the previous month and within the Trust objective of no more than 3 cases within month. The focus for infection prevention and control and antimicrobial stewardship remains on quality improvement activity for all infections, including MRSA and C. difficile. Moving forwards, this work will be supported by the NHS Improvement healthcare associated infection quality improvement review that commenced from 1st April 2019.

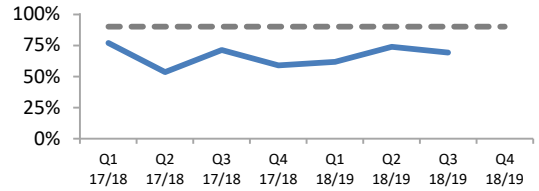
Ownership:

Lead: Samantha Walker, Lead Nurse – Infection Control
Executive Lead: Darren Kilroy, Interim Medical Director
Improvement Timescale: By March 2019

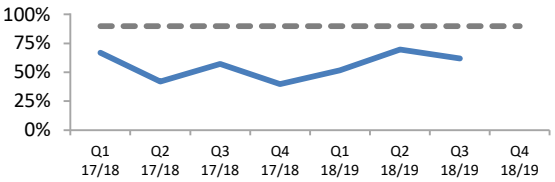
Sepsis screening and treatment CQUIN

Performance Trend

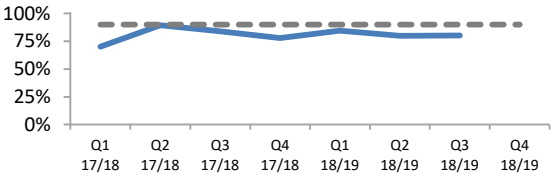
Sepsis screening (ED Patients)



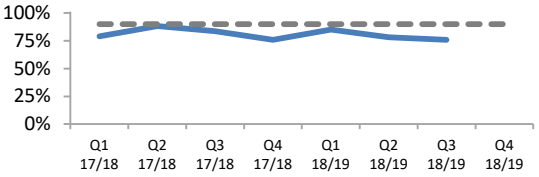
Sepsis screening (Inpatients)



Sepsis treatment (ED)



Sepsis treatment (Inpatients)



Performance Issue:

The Sepsis CQUIN screening remains below the year-end target at Quarter 3 for both Inpatients and ED. Treatment of Sepsis continues to perform well but also remains slightly below the year-end target.

Planned Remedial Actions:

The sepsis steering group has been re-established with wider clinical membership and the work programme continues to be progressed. Key achievements during Q3 include Trust wide roll out of the adult inpatient sepsis pathway, design of sepsis boxes to support front line staff which will be launched during Q4 and the development of an education and training strategy across all staff groups (clinical and non-clinical staff of all grades).

An update on the progress with the Sepsis group was given to the Quality, Safety and Patient Experience committee in April.

Ownership:

Lead: Dr Santokh Singh

Executive Lead: Darren Kilroy, Interim Medical Director

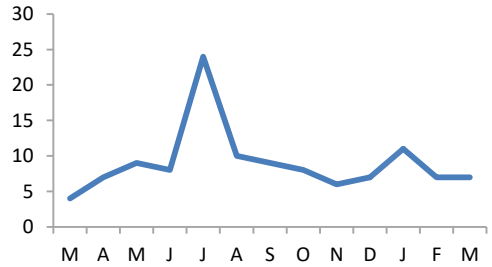
Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Exception Report

Mixed Sex Accommodation Breaches

Performance Trend



Mixed Sex Breaches

Performance Issue:

In March there were 7 Mixed Sex breaches that were not clinically justified.

Planned Remedial Actions:

During March, we continue to have a small percentage of mixed sex breaches due to operational pressure; to maintain quality and safety on occasion patients have been mixed to ensure access to the relevant speciality or level of care. Full explanations have been provided to both patients and families affected, no complaints have been received.

Ownership:

Lead: Melanie Kynaston, Associate Director of Nursing

Executive Lead: Alison Kelly, Director of Nursing and Quality

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Exception Report

Sickness Absence

Historic Data

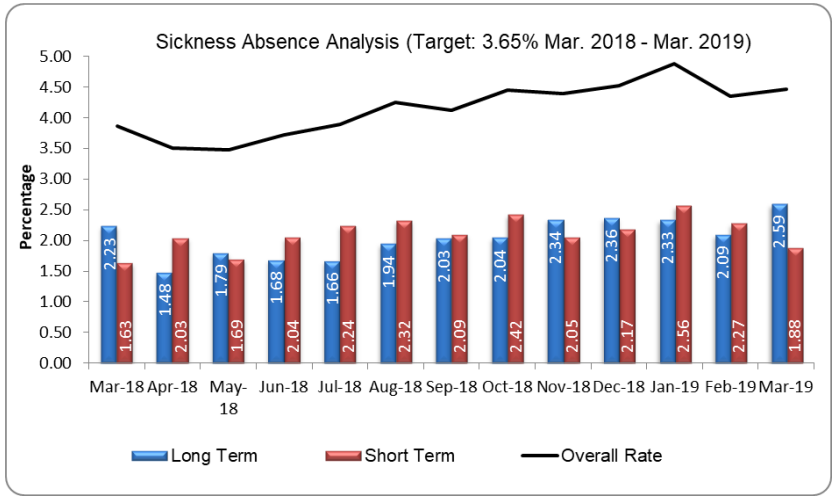


Figure: % Sickness Absence Analysis

Ownership

Lead: Dee Appleton-Cairns, Deputy Director of People and OD

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

The Trust wide sickness absence increased to 4.47% in March. Sickness absence within Staff groups highlights that Nursing & Midwifery is reporting at 4.36% and Support Workers (which include Nursing Assistants) reporting at 5.93% in March. When analysing divisional sickness absence, 3 Divisions are above 4%, Planned Care (4.72%), Urgent Care (4.51%), and the newly merged Estates & Facilities (7.37%).Despite Planned Care being above 4% they have seen a reduction in month. The 5 remaining divisions are under target of 3.65%. Benchmarking information shows that we compare favourably with our Peer Trusts.

Model Hospital Benchmarking Group Source Iview (Nov. 18 Data)	
Trust	**12 Mth Rate**
North Middlesex Uni	4.07%
Liverpool Heart & Chest F	4.29%
Mid Cheshire F	4.39%
Countess Chester F	**4.44%**
South Tyneside F	4.93%
East Cheshire	5.06%
Wirral Uni Teach F	5.14%
Warrington & Halton F	5.17%
Northamptonshire Health F	5.29%
Tameside & Glossop F	5.64%
Southport & Ormskirk	6.09%

Proposed Actions

Absence in all areas of the Trust continues to be monitored with detailed analysis taking place in all areas. A new staff support provider has been identified and launched to staff during April. We continue to provide resilience support sessions for staff which teaches techniques to support stress at home and at work.

Exception Report

Mandatory Training

Performance Trend

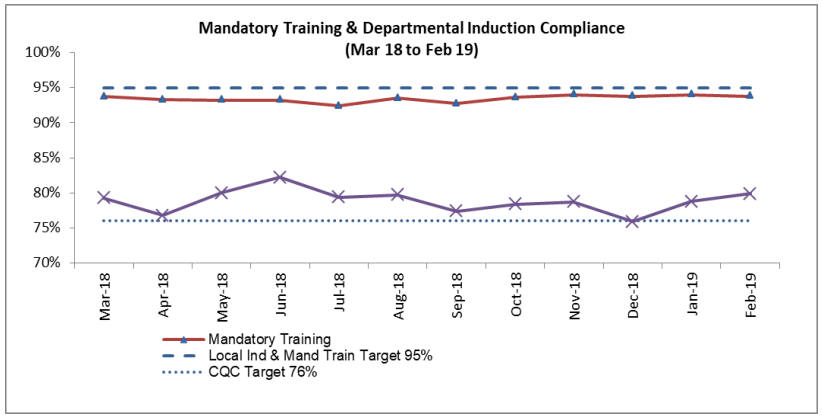


Figure: % mandatory training compliance

Ownership

Lead: Dee Appleton-Cairns, Deputy Director of People and OD

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

Trust compliance remains below target at 94%.

Mandatory Training Table March 2019

Position	Division	Compliance
1	Human Resources	98.6%
2	Finance & Performance	97.5%
3	Nurse Management	96.6%
4	Planned Care	94.7%
5	Diagnostics and Pharmacy	93.5%
6	Urgent Care	93.1%
7	HRWBS	92.9%
8	Estates & Facilities	92.8%
9	Corporate Non - Clinical	92.6%
	Total	94.0%

Local Induction Table March 2019

Position	Division	Compliance
1	HRWBS	100.0%
2	Human Resources	100.0%
3	Nurse Management	100.0%
4	Urgent Care	82.9%
5	Diagnostics and Pharmacy	73.2%
6	Planned Care	72.5%
7	Estates & Facilities	70.0%
8	Corporate Non - Clinical	55.6%
9	Finance & Performance	50.0%
	Total	76.7%

Overall compliance for mandatory training in March has marginally increased to 94%, which falls short of the Trust target of 95%. Local induction compliance for March decreased again to 76.7% which is significantly short of the Trust's 95% target and we are working with line mangers to ensure that completed forms are entered onto ESR timely to improve compliance rates. We continue to perform poorly against our own Corporate target of 95%, which we have failed to achieve in the last 12 months reporting period.

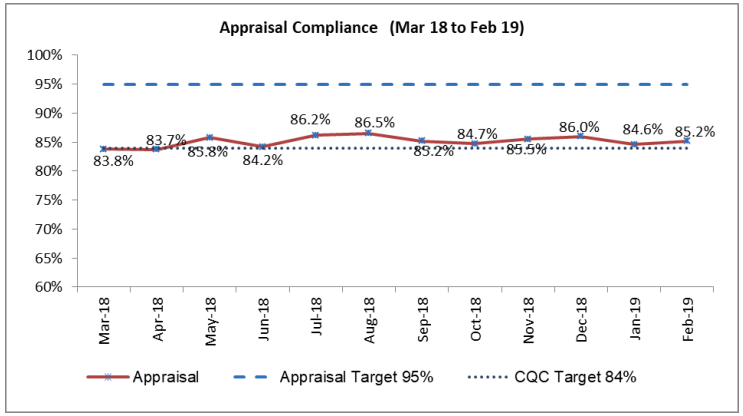
Planned Remedial Actions:

Mandatory training is currently being reviewed in terms of Trust provision and to ensure compliance with the Core skills training Framework. Sallie Kelsey, Head of Clinical Education, is redesigning the delivery of these requirements and it is hoped that by streamlining the provision and encouraging uptake of e-learning, this figure will improve. The new Education Governance board will ratify all developments and the New Policy and agree strategy providing assurance to the People and OD Committee that the Trust strategies for education and training are implemented fully and risks are managed.

Exception Report

Appraisals Completed in last 12 months

Historic Data



Performance Issue:

Appraisal compliance has seen an decrease in March from 85.2% to 84.1%, this remains below our corporate target of 95%. The higher sickness levels in March have contributed to the time available for managers and staff to complete Appraisals.

Appraisal Table March 2019

Position	Division	Compliance
1	HRWBS	97.3%
2	Estates & Facilities	89.2%
3	Planned Care	88.3%
4	Diagnostics and Pharmacy	87.4%
5	Human Resources	83.6%
6	Finance & Performance	80.6%
7	Urgent Care	76.7%
8	Nurse Management	66.0%
9	Corporate Non - Clinical	54.3%
	Total	**84.1%**

Ownership

Lead: Dee Appleton-Cairns, Deputy Director of People and OD

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

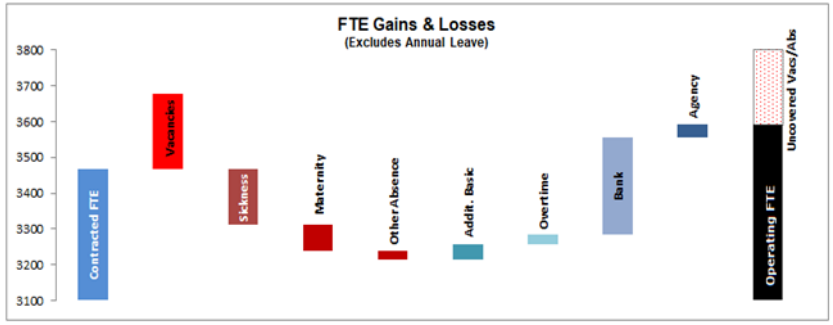
Improvement Timescale: By March 2019

Planned Remedial Actions:

HR Business Partners continue to escalate the compliance rate in the monthly divisional reports & at governance boards, stressing the importance of completing appraisals on a timely basis. Guides to inputting appraisals via ESR have also been sent out monthly to ensure the input is accurate and timely. Development of the new electronic PDR system is continuing with further discussions taking place to support the system to be ready later in the year. For the next reporting period, we will be analysing appraisals over due after 14 months to ensure that we are not over reporting. Following feedback from the Staff Survey and CQC, we will also be reviewing the perceived value and quality of appraisals to support staff to undertake their roles.

Variable Pay

Performance Trend



Total Registered Nursing, Midwifery and Health Visiting Staff Vacancy WTE	**73.83**
Of which Registered Midwife Vacancy WTE	4.86
Of whichRegistered Health Visitor Vacancy WTE	0.00
Of which Advanced Care Practitioner Vacancy WTE	0.00
Total Qualified AHP Vacancy WTE	**16.90**
Of which Qualified Physiotherapist Vacancy WTE	0.30
Of which Qualified Occupational Therapist Vacancy WTE	5.78
Of which Qualified Paramedic Vacancy WTE	0.00
Total Medical/Dental Vacancy WTE	**43.40**
Of which Medical/Dental Consultant Vacancy WTE	18.00
Support to Clinical Staff Vacancy WTE	4.90
Support to Nursing Vacancy WTE	24.73
NHS Infrastructure Vacancy WTE	47.45
Total Vacancies	**211.21**
Budgeted FTE Total	3886.85
Trust Vacancy Rate	**5.43%**

Ownership

Lead: Steve Bridge, Planning & Partnerships

Executive Lead: Sue Hodkinson

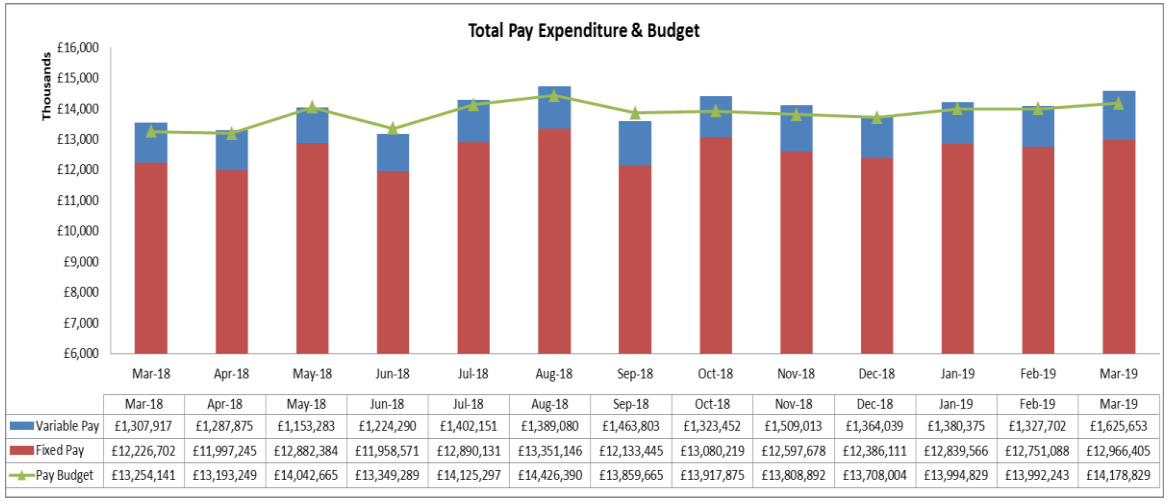
Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

To not exceed £4.459m agency expenditure ceiling. To deliver £1.5m agency spend savings.

Variable pay spend increased in month by £298k to £1,625k. Agency increased £87k to £433k and Medical Bank (183k) rose by 18k in month too. Total agency expediture for 2018/19 is £4.4 million.



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Variable Pay	£1,307,917	£1,287,875	£1,153,283	£1,224,290	£1,402,151	£1,389,080	£1,463,803	£1,323,452	£1,509,013	£1,364,039	£1,380,375	£1,327,702	£1,625,653
Fixed Pay	£12,226,702	£11,997,245	£12,882,384	£11,958,571	£12,890,131	£13,351,146	£12,133,445	£13,080,219	£12,597,678	£12,386,111	£12,839,566	£12,751,088	£12,966,405
Pay Budget	£13,254,141	£13,193,249	£14,042,665	£13,349,289	£14,125,297	£14,426,390	£13,859,665	£13,917,875	£13,808,892	£13,708,004	£13,994,829	£13,992,243	£14,178,829

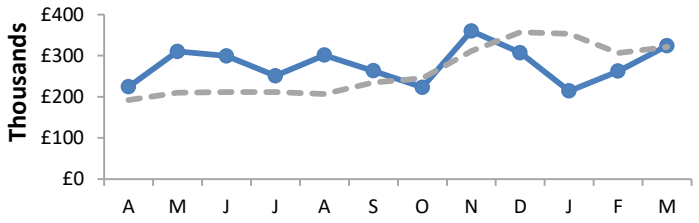
Notes:

Vacancies are the difference between the budgeted establishment and actual staff in post. The Workforce and Finance teams are still working towards improving data quality in relation to vacancies.

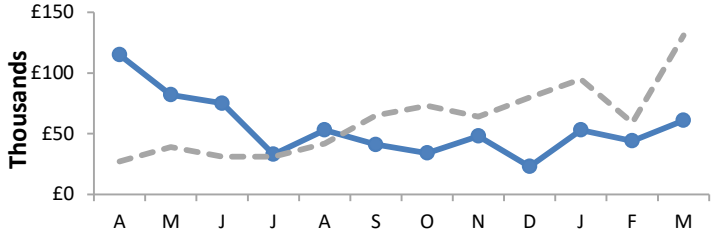
Exception Report

Performance Trend

Medical Agency Spend



Nursing Agency Spend



Ownership

Lead: Steve Bridge, Planning & Partnerships
Executive Lead: Sue Hodkinson
Improvement Objective: Achieve Plan
Improvement Timescale: By March 2019

Agency Spend

Performance Issue:

Medical Pay is overspent by £1,486k. Agency medical expenditure is £3,339k (7% of the total medical spend). Nursing Pay is £1,621k overspent. Agency nursing expenditure is £662k which is 2% of total trained nursing spend. Total Agency spend for M1-12 is £4,422k (£4,374k was spent during the same period last year). The in-year agency spend is just below the agency ceiling of £4,459k.

Contributing Factors:

Agency Spend by Staff Group	14/15	15/16	16/17	17/18	18/19
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 85,760	£ 88,172
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433	£ 3,339,110
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847	£ 662,413
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820	£ 222,289
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009	£ 110,124
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 4,372,869**	**£ 4,422,108**
Agency Ceiling 2018/19					**£ 4,459,000**

Planned Remedial Actions:

The above is being reviewed in terms of presentation in conjunction with the variable Pay group to focus on key metrics to ensure comparison across other organisations. For further actions see actions proposed under Variable Pay.

A&E 4 Hour Standard

Performance Trend

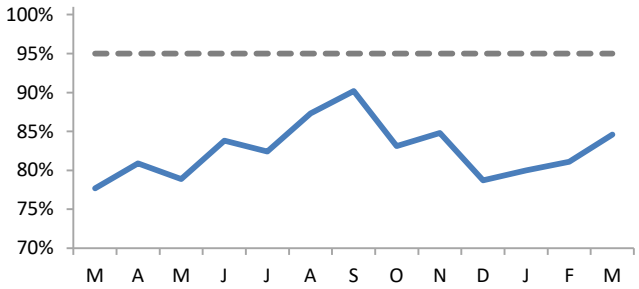


Figure: % ED attenders seen within 4 hours of arrival

Ownership:

Executive Lead: Lorraine Burnett, Chief Operating Officer

Improvement Objective: Return to national standard

(internal trajectory is to return to 90% compliance)

Improvement Timescale: Sept 2019

Performance Issue:

The 4 hour A&E target was under the national target in March achieving 84.6%. Nationally 86.6% of patients were seen within 4 hours of arrival in March.

Type 1 performance was 83.42% against a national performance of 79.5%.

Planned Remedial Actions:

A&E improved in terms of performance in March, with the end of year position maintained, as per 17/18, at 83%. The majority (90%) of attendances are classed as type 1 and require the emergency department. There is a consistent attendance at the Urgent treatment Centre (UTC) (approx. 10%) with no performance issues.

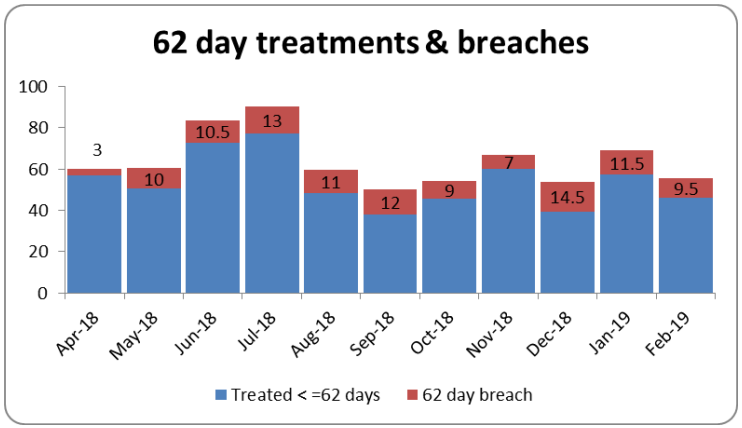
June 2018's Ambulance Handover Compliance data was adversely affected by recording issues on the NWAS dispatch system. The trust continues to perform above target for this measure; March's performance was highest of the year.

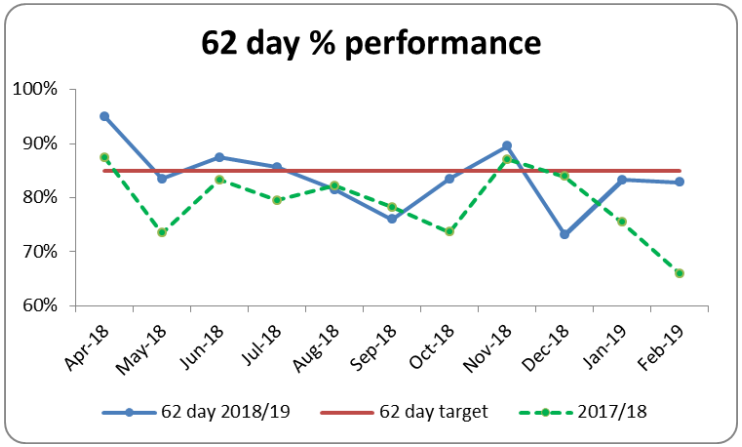
During March we undertook a Rapid Improvement Event to engage all staff with Teletracking and promote the benefits associated with patient flow – this was a successful week and we are building on this to deliver improvements ahead of the Easter bank holiday weekend

The Urgent Care division have launched an ED/Patient Flow Improvement Programme which includes a work stream to optimise the activity through UTC. The work is being undertaken in conjunction with the national emergency care intensive support team.

Exception Report

Performance Trend:





Cancer Treatment - 62 Day Target

Performance Issue:

The 62 day performance for February was an underachievement of the standard at 82.88%.

Breach Overview:

There were 9.5 breaches in February attributable to COCH:

- Urology (3 breaches) – reasons include late referrals to tertiary centres, repeat diagnostic tests, results clinic capacity, clinical decision delay.
- Colorectal (3 breaches) – reasons include patients having to undergo surgery for another condition prior to cancer treatment and relevant investigations, diagnostic delays for endoscopy, and repeat test in 4 weeks but capacity delays caused an increase in waiting time.
- UGI (3.5 breaches) – reasons include late referrals to tertiary centres, 2nd opinions required, repeat diagnostic tests required, multiple discussions as different SMDTS due to complexity, diagnostic delays.

Planned Remedial Actions:

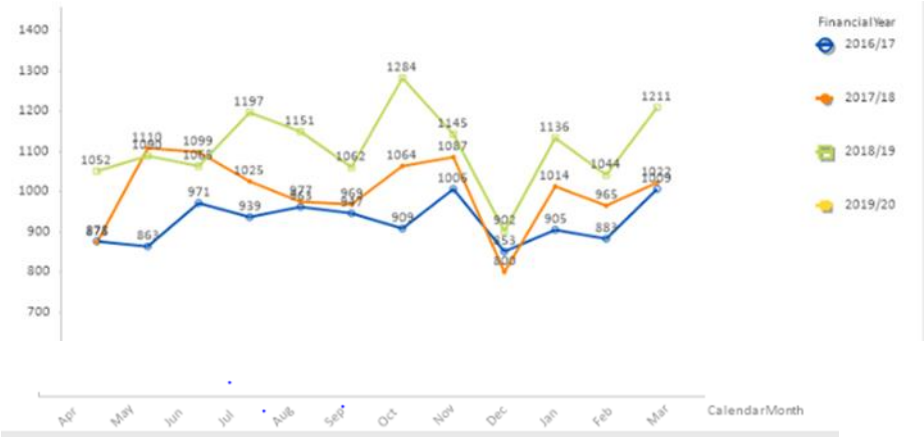
Actions relating to cancer improvement are tracked weekly at the PTL meeting with a focus on pathway changes to support an improvement.

Site specific action plans are monitored through the bi-monthly Cancer Committee.

Urology – Urology now has a CNS in post to support cancer within Urology. CNS new fast track telephone clinic is in process of being set up. Pathways for triage and template for clinic is currently being reviewed with a view to implement telephone clinic as soon as possible. New results clinic process has been set up. Clinics will be reviewed 6 weeks ahead of time so that if there are any cancellations due to leave, these will be either backfilled or replaced to ensure cancer capacity is not lost.

Upper GI – the Trust has implemented part 1 of the newly commissioned pathway working with the Royal Liverpool university hospital Trust to

Referrals



Breaches by Tumour Site Year to Date:

	Total Breaches	% of Trust Breaches
Urology	53	39%
Colorectal	24	18%
Haematology	12	9%
Skin	12	9%
Upper GI	12	9%
Head & Neck	9	7%
Lung	7	5%
Gynae	5	4%
Breast	2	1%
TOTAL	**136**	**100%**

Table: % Breaches by Speciality (April-February)

undertake all specialist Upper GI surgery referred in to COCH. Part 2 still to be signed off. Meeting held with the Cheshire & Merseyside Cancer Alliance on 10th April to discuss implementation of the Oesophago-gastric cancer diagnostic pathway. Cancer Alliance expected sign off in June 2019.

PTL Position

The following table provides a summary of the PTL position week ending 19/04/19, for patients waiting above 62 days and identifies the number of patients over 104 days

	PTL between 63 and 99 Days	PTL above 104+ Days	Grand Total
Breast	1		1
Colorectal	10	2	12
CUP	1		1
Gynaecology	8		8
Haematology	3		3
Head and Neck	8		8
Lung	2	1	3
Other	1		1
Skin	7	1	8
Upper GI	5	6	11
Urology	12	5	17
Grand Total	**58**	**15**	**73**

Ownership:

Executive Lead: Lorraine Burnett, Executive Director of Operations

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Referral to treatment (18 weeks)

Performance Trend

Figure 1: Percentage of incomplete pathways for English patients within 18 weeks.

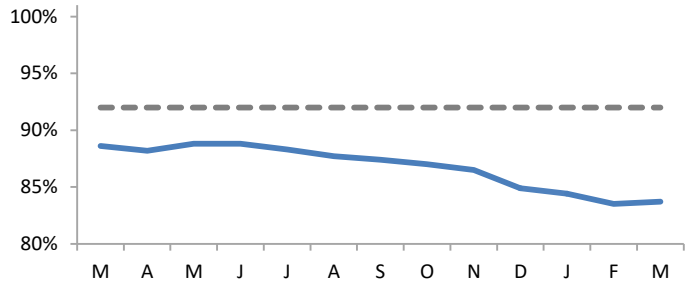


Figure 2: Reduction in the number of cancellations due to no beds

	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
April	35	47	18	0	11	97	16	14	1	5	17
May	19	4	12	0	8	39	18	16	10	11	11
June	7	10	0	0	28	0	22	14	9	10	6
July	0	0	0	1	5	0	56	7	3	3	0
August	0	6	5	14	18	0	4	7	15	3	0
September	1	37	4	23	24	21	12	8	0	11	1
October	0	10	0	28	7	21	53	33	0	32	10
November	6	0	0	12	7	8	33	28	3	41	9
December	46	0	63	26	0	33	28	45	4	4	1
January	44	37	23	11	23	59	35	123	6	19	0
February	46	51	0	90	11	0	10	189	19	63	2
March	14	4	2	35	15	9	13	92	20	83	6
TOTAL	**218**	**206**	**127**	**240**	**157**	**287**	**300**	**576**	**90**	**285**	**63**

Ownership
Lead: Divisional Directors
Executive Lead: Lorraine Burnett, Chief Operating Officer
Improvement Objective: Achieve target
Improvement Timescale: By Oct 2019

Performance Issue: RTT performance remains under the 92% target at 83.7%.

There continues to be significant RTT pressures across all specialties but there has been an improvement in performance in March from February. Demand for March was higher than for February but slightly lower than the same period last year and there continues to be 5% growth year on year. Cancer referrals continue to take priority and remain high particularly for Skin and Colorectal tumour sites. Workforce pressures in both Medical and Nursing roles continue to cause pressure due to a lack of available capacity, specifically in the following areas; Urology, Oral Surgery, Gynaecology, Respiratory and General Surgery. Issues relate to unfilled vacancies, long term sickness and HR exclusions.

Planned Remedial Actions:

Specific actions being taken to improve the position include;

- Additional activity being arranged, where possible, to reduce number of long waiters. Additional activity in Plastic Surgery, ENT, Pain and Endoscopy ongoing through April
- Continued review and scrutiny of over 40 week patients to prevent any 52 week breaches – reviewed on a weekly basis
- Urology – action plan and improvement group ongoing. Follow Up improvement plan being established following agreement to increase clinical workforce for a temporary period – new Consultant for Urology to start June 2019 following recruitment in December 2018.
- Establishment of Elective Short Stay Unit in December and extension of Day Case recovery opening times continue to have a positive effect with a significant reduction seen in elective cancellations. The impact of this will be seen over the coming months as this time last year there was a significant number of cancellations which led to an increase in backlog patients to be treated, causing the position to deteriorate in the early part of 18/19.
- Working with the CCG across a number of specialties to review referral criteria to reduce demand. Planned workshops arranged with particular specialties i.e. ENT
- Revised RTT specialty plans to be in place from April to include improvement trajectories to reach 92% in the next financial year – being established to be replicated across all specialties
- New Plastics and ENT consultants start in May
- Additional clinics and lists done in April for Pain and Nephrology to improve RTT position

Continued work with HR and Medical staffing departments to fill vacancies, reduce numbers of staff on long term sick and progress HR processes to conclusions.

- Paper with Execs regarding Oral Surgery position and referrals options

Exception Report

Diagnostic Tests within Timescale

Performance Trend

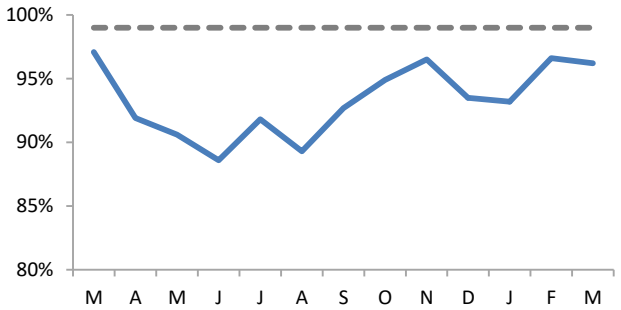


Figure: DM01 - Diagnostic tests carried out within 6 weeks of request being received.

Ownership

Lead: Divisional Directors

Executive Lead: Lorraine Burnett, Chief Operating Officer

Improvement Objective: Achieve target

Improvement Timescale: October 2019

Performance Issue:

DM01 performance was 96.2% in March but remains below the 99% target. This target remains volatile due to increasing demand, national workforce pressures and a low threshold to meet the 1%.

Planned Remedial Actions:

Endoscopy – activity has dropped slightly in March but remains over performing year to date and demand continues to be high. DM01 performance for March has improved in flexi sigs, cystoscopies and gastroscopies. There has been a drop in colonoscopy performance but 6 lists (24 colonoscopies) have now been confirmed for April, with another 2 in progress.
All cancer and long-waiting RTT patients are currently being prioritised and further validation is being completed. Actions to date include changes to dating in advance to reduce FTA and cancellation rates by giving more notice to patients, maximising utilisation and we are starting to see improvements relating to this.

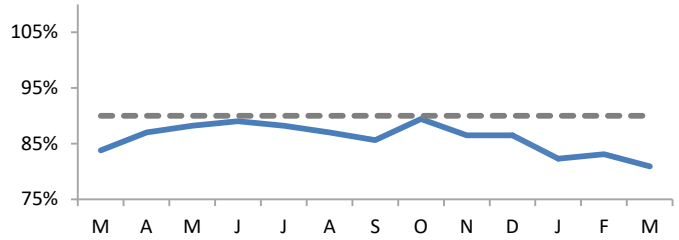
CRV vascular - there is a key piece of work commencing in Urgent Care with CRV undertaking a 'deep dive' into the vascular capacity and demand, reviewing validation process and liaising with Planned Care to make a fundamental change to the provision of service and improve performance. In the interim the team continue ensure all capacity is utilised and additional hours are offered to staff.

English - Number of exams >6 weeks

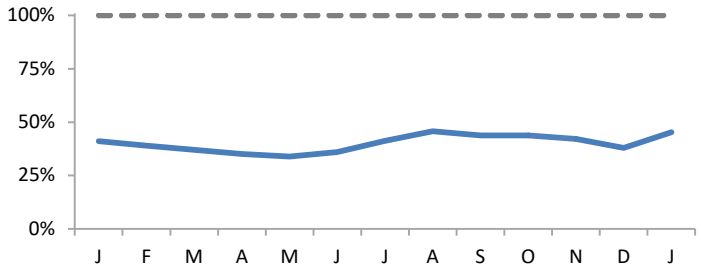
Month End Snapshot	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-18	Mar-18
Magnetic Resonance Imaging	10	12	5	9					1	2	4	4	4
Computed Tomography					1				1	5			
Non-obstetric ultrasound	51	177	207	247	165	120	124	80		17			
CRV - Vascular	14	2	14	5	12	70	30	8	64	67	128	100	129
Audiology - Audiology Assessments													
Cardiology - echocardiography		2			7	72	1	1	6	128	93	2	2
Respiratory physiology - sleep studies	3	3	3	2	3	1			1		2		
Colonoscopy	19	77	141	192	87	79	64	39	22	25	45	33	43
Flexi sigmoidoscopy	8	3	5	2	1	12	15	34	27	21	8	2	1
Cystoscopy	18	22	49	59	67	120	69	60	23	30	22	21	17
Gastroscopy	12	74	114	100	72	41	43	34	16	24	19	8	12
Total patients waiting	4623	4578	5738	5382	5073	4822	4758	5001	4657	4872	4713	4953	5431
%<6 weeks	97.1%	91.9%	90.6%	88.6%	91.8%	89.3%	92.7%	94.9%	96.5%	93.5%	93.2%	96.6%	96.2%

Exception Report

Performance Trend



% e-discharge letters sent within 24 hours



% Outpatient letters sent within 7 days

Clinical Correspondence

Performance Issue:

Neither of the clinical correspondence targets were achieved in March.

Contributing Factors:

The specialties with the highest number of outpatient letters over 10 days were unchanged: Ophthalmology, ENT, Paediatrics and Trauma & Orthopaedics.

These areas of particular challenge reflect increased demand within these services. Specific action plans have been developed to improve performance relating to correspondence.

Planned Remedial Actions:

eDischarge - Discussions are taking place with the CCG to reflect new mandatory elements to eDischarge letters and ensure compliance with these elements across all specialties. In addition, we are working to agree a sub-set of specialties within which we will work to include additional non-mandatory clinical data for patient benefit.

Outpatient letters – Both routine and urgent appointments have seen an improvement in performance since June and approximately 70% of urgent letters are now being sent within timescale. We have seen an improvement in timeliness of 10% in the past 6 months and this will further be critiqued and reviewed at the February CCG Elective Care Group.

Ownership:

Executive Lead: Darren Kilroy, Interim Medical Director
Improvement Objective: Achieve target
Improvement Timescale:

Appendix 1 Nurse Staffing Compliance

Nurse Staffing Heat Map

Ward Name	Specialty	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Months <95%	Months >100%
Bluebell	EPH Rehabilitation	106%	98%	91%	96%	92%	93%	94%	94%	96%	101%	103%	103%	102%	5	2
Children's	Paediatrics	95%	100%	109%	105%	96%	92%	101%	94%	101%	103%	106%	103%	98%	2	6
ICU	Adult Intensive Care	85%	88%	86%	85%	78%	75%	84%	94%	90%	86%	90%	87%	84%	10	0
Maternity	Maternity	106%	83%	95%	94%	100%	100%	97%	96%	98%	97%	97%	97%	98%	3	2
NNU	Neonatal Unit	83%	67%	89%	97%	97%	91%	100%	92%	94%	98%	98%	95%	94%	6	0
Poppy	Intermediate Care Unit	120%	124%	119%	114%	117%	107%	108%	110%	111%	118%	115%	117%	118%	0	10
Renal	Renal	81%	84%	85%	87%	87%	81%	65%	70%	88%	89%	92%	90%	89%	10	0
Ward 33	Stroke	94%	96%	99%	95%	95%	95%	97%	95%	96%	99%	102%	101%	104%	2	0
Ward 34	Intermediate Care Unit	94%	91%	92%	89%	90%	91%	89%	91%	91%	92%	92%	94%	92%	10	0
Ward 41	Surgery	92%	96%	93%	93%	78%	88%	68%	73%	91%	84%	90%	87%	70%	9	0
Ward 42	Cardiology	102%	110%	98%	100%	104%	109%	105%	99%	103%	100%	101%	115%	100%	0	6
Ward 43	Haematology/Oncology	102%	103%	102%	110%	119%	109%	102%	103%	107%	107%	119%	111%	114%	0	10
Ward 44	Surgery	92%	95%	98%	95%	91%	94%	100%	100%	97%	94%	89%	86%	91%	6	0
Ward 45	Surgery	84%	92%	125%	125%	101%	100%	98%	95%	97%	89%	97%	101%	101%	3	4
Ward 47	Acute Medical Unit	83%	89%	95%	90%	91%	87%	88%	90%	91%	89%	94%	93%	93%	9	0
Ward 48	Respiratory	98%	106%	95%	96%	96%	107%	107%	106%	112%	103%	95%	100%	92%	0	6
Ward 49	Gastroenterology	100%	95%	103%	98%	101%	105%	96%	94%	98%	99%	95%	97%	99%	1	3
Ward 50	Care of the Elderly	98%	108%	108%	102%	110%	112%	106%	110%	117%	117%	110%	112%	110%	0	9
Ward 51	Care of the Elderly	101%	103%	108%	103%	107%	107%	106%	112%	109%	110%	113%	113%	107%	0	10
Ward 52	Trauma & Orthopaedics	98%	102%	103%	110%	115%	109%	108%	109%	108%	103%	99%	95%	97%	0	9
Ward 53	Vascular	85%	89%	83%	86%	90%	93%	90%	94%	95%	94%	97%	93%	93%	10	0
Ward 54	General Medicine	94%	97%	77%	102%	95%	97%	94%	91%	83%	81%	89%	90%	89%	7	1
Ward 60	Haem / Oncology Day Case	88%	95%	96%	92%	84%	92%	93%	87%	86%	81%	85%	83%	85%	8	0
Wards with less than 95% compliance		12	9	9	10	10	11	9	12	9	10	9	9	11		
Wards with more than 100% compliance		6	9	9	9	9	11	9	7	9	8	8	9	7		

Countess of Chester Hospital NHS Foundation Trust

Item Reference and Title	**Agenda item 10 - Financial Position – Month 12, March 2019**
Date of Meeting	Board of Directors 21st May 2019
Accountable Executive	Director of Finance
Author(s)	Simon Holden, Director of Finance Jennie Birch, Deputy Director of Finance
Alignment to Board Assurance Framework risk	CR 5 – Failure to deliver in year financial plan and manage consequences of delivering a deficit budget – risk score 20
Alignment to CQC Domains	Effective
Document Previously Considered by:	-
Summary	This paper is intended to provide details of the Trust's financial position, as at 31st March 2019 (Month 12)
Recommendation(s)	**The Board is asked to note:** o the final outturn position, subject to External Audit, being in line with the revised Plan submitted at Month 06, before Provider Sustainability Funding (PSF), of a £12.7m deficit; o the receipt of an additional (indicative) NHSI General Distribution of PSF of £2,758k for inclusion in the draft accounts, over and above the PSF of £1,789k already achieved for the year, resulting in a post PSF deficit for the year of £8.2m, before any technical adjustments (summarised in Appendix 1); o the deficit for the full year in the published accounts of £13.1m, after technical adjustments of £4.9m; o The adverse overall variance of £16,077k against plan, after technical items (being £11,148m before technical items), with £5,056k Impairments of Fixed Assets being a

	significant factor. o The improvement in the delivery of the West Cheshire CCG activity, with the over performance against block moving from £2,720k over to £2,912k over performance year to date (being circa £1,450k over performance if Therapies changes were excluded) and noting a PbR contract has been agreed for 2019/20; o The additional agreed payment from West Cheshire CCG of £242k in recognition of joint financial recovery plan initiatives; o The cash position of the organisation, and the interim revenue distress funding received to date, together with noting the ongoing cash planning and further drawdowns requested); o The level of non-recurrent resource (£3,406k) required to achieve this position; o The underlying financial pressures, being consistent with other NHS providers, namely: o Winter/additional capacity o Growing elective lists o National A4C Pay award shortfall o Slippage on CRS delivery (Avastin/Lucentis) o Embargo on Subsidiary Companies o Increase in Agency Spend The absence of confirmation of the Trust's "urgent and essential" Capital Loan for 2018/19 remains an outstanding risk going forward into 2019/20.
Corporate Impact Assessment:	**Legal and regulatory impact:** **Financial impact:** **Patient Experience/Engagement:** **Risk & Performance Management:** **NHS Constitution/Equality & Diversity/Communication:**

Countess of Chester Hospital
NHS Foundation Trust

Financial Position
Month 12, March 2018/19

1.1 Overview

	Annual Budget 2018/19 £000s	March YTD Budget 2018/19 £000s	March YTD Actual 2018/19 £000s	March YTD Variance 2018/19 £000s
Pre PSF (Deficit)	4,334	4,336	12,735	8,398
PSF	(7,297)	(7,297)	(1,789)	5,508
PSF (Incentive)	0	0	(2,758)	(2,758)
Post PSF Control Total	**(2,963)**	**(2,961)**	**8,188**	**11,148**
Impairment	0	0	5,056	5,056
Donated Asset Transactions	45	45	(82)	(127)
I&E Surplus	**(2,916)**	**(2,916)**	**13,162**	**16,077**

The "monitored" financial position i.e. pre Provider Sustainability Fund (PSF) is a **£8,398k adverse variance** at the end of March. The key points to note include:

Income

There is an adverse position on commissioner income of £1,736k noting:

- Underlying over performance on the West Cheshire CCG contract is £2,912k at the end of the financial year, but this is not recognised within the financial position due to the block arrangements;
- The Welsh contract is underperforming by £833k at the end of month 12;
- There is an adverse variance on other English commissioners of circa £903k and is attributable predominantly to critical care activity within the NHS England contract; and
- The loss of the additional £1m funding from West Cheshire CCG, that was included in the plan profiled between October to March, has been accounted for.

Expenditure

The most significant pressures on the expenditure position continue to be nursing pay and medical pay.

- Nursing pay is £1,621k overspent (including agency spend to date of £662k); and
- Medical pay is £1,486k overspent (including agency spend to date of £3,339k).

The key cost drivers continue to be vacancies, activity pressures, and the number of patients requiring one to one care. Drugs and Medical & Surgical Equipment costs are also overspent by £1,091k and £369k respectively. This is across a number of specialities and seems to be reflective of current case-mix on the wards. The drugs overspend this month includes the impact of the increased high cost drug spend above what was included within the block contract of £623k.

Cost Reduction Scheme (CRS)

The Cost Reduction Scheme (CRS) is £5,637k behind plan as at 31st March 2019.

Reserves

Ward 54 has been open on a permanent basis alongside additional beds on wards 46, 34 and Bluebell all year. This has utilised in full the Winter Reserve, plus another £263k in year and £331k recurrently from contingency.

Further reserves of £695k have been utilised to support the financial position.

Technical Opportunities

Use of non-recurrent resource of £3,406k has been used to support the position to ensure receipt of PSF for the first two quarters of the year.

1.2 Provider Sustainability Funding (PSF)

Provider Sustainability Funding is available to organisations that signed up to deliver the 2018/19 control total, with 70% awarded for financial delivery and 30% awarded for A&E performance. The profile of the funds available is shown in the table below:

Provider Sustainability Funding	Q1	Q2	Q3	Q4	Total
Financial Performance (70%)	766,185	1,021,580	1,532,370	1,787,765	5,107,900
A&E Performance Performance (30%)	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**
Weighted %	15%	20%	30%	35%	100%

The Trust is required to deliver to financial plan at the end of each quarter to be able to access the associated PSF for financial performance for that period. Therefore, significant non recurrent resource of £3.406m, and deployment of recurrent reserves of £695k, has been specifically released into the position to achieve the required financial performance thus enabling the Trust to access PSF of £1,789k for quarter one and quarter two.

The Trust has an adverse variance on PSF of £5,509k at the end of month 12 with £2,189k loss due to the non-achievement of the required A&E target year to date and £3,320k is due to the non-achievement of the financial performance in October to March.

Under achievement of PSF nationally (at year end) is redistributed based on a centrally determined (unknown) funding formula. The Trust was notified on 18th April that the share to be received will be £2,758k Incentive PSF (general distribution).

1.3 Income and Expenditure Summary

The table below summarises the financial position as at March, both pre and post PSF:

KEY VARIANCES	Annual Budget £000s	Mar YTD Budget £000s	Mar YTD Actual £000s	Mar YTD Variance £000s	Mar YTD Variance % of budget	Movement from Feb £000s
INCOME						
Income - England	(180,488)	(180,488)	(178,977)	1,511	-0.8%	47
Income - Wales	(25,807)	(25,807)	(24,831)	976	-3.8%	277
Other Clinical Income	(12,109)	(12,109)	(12,989)	(880)	7.3%	(18)
Non Patient Income	(15,801)	(15,801)	(16,288)	(487)	3.1%	(51)
INCOME	**(234,206)**	**(234,206)**	**(233,086)**	**1,120**	-0.5%	**255**
PAY						
Nursing	59,987	59,987	61,609	1,621	2.7%	347
Medical	48,306	48,306	49,792	1,486	3.1%	173
Admin & Clerical	21,222	21,222	20,823	(399)	-1.9%	(19)
AHP, Therapies, Diagnostics & Pharmacy	23,485	23,485	23,311	(174)	-0.7%	(77)
Other	13,599	13,599	12,684	(914)	-6.7%	(77)
TOTAL PAY	**166,600**	**166,600**	**168,219**	**1,620**	1.0%	**347**
NON PAY						
Drugs	18,992	18,992	20,083	1,091	5.7%	697
Medical & Surgical Equipment	12,265	12,265	12,634	369	3.0%	57
Depreciation	4,237	4,237	4,151	(86)	-2.0%	(86)
CNST	8,206	8,206	8,206	0	0.0%	0
Furniture & Office Equipment, Equip Hire & Computers	4,037	4,037	4,174	137	3.4%	36
Other	29,842	29,842	33,409	3,567	12.0%	4,223
TOTAL NON PAY	**77,579**	**77,579**	**82,657**	**5,078**	6.5%	**4,927**
CRS	**(5,637)**	**(5,637)**	**0**	**5,637**		
TOTAL - PRE PSF & DONATED ASSET TRANSACTIONS	**4,336**	**4,336**	**17,791**	**13,454**		
EXCLUDE IMPAIRMENT OF FIXED ASSETS	**0**	**0**	**5,056**	**5,056**		
REVISED I&E (SURPLUS) / DEFICIT	**4,336**	**4,336**	**12,735**	**8,398**		
PSF (Provider Sustainability Fund)	**(7,297)**	**(7,297)**	**(1,789)**	**5,508**		
PSF Incentive - General Distribution	**0**	**0**	**(2,758)**	**(2,758)**		
POST PSF CONTROL TOTAL	**(2,961)**	**(2,961)**	**13,244**	**16,204**		
DONATED ASSET TRANSACTIONS	**45**	**45**	**(82)**	**(127)**		
I&E (SURPLUS) / DEFICIT	**(2,916)**	**(2,916)**	**13,162**	**16,077**		

Please note: (Favourable) / adverse

2.1 Commissioner Income

A summary of the activity & income variances by Point of Delivery (POD) are shown below:-

Point of Delivery	Activity Variance YTD (actual activity delivered compared to funded baseline where (x)/x is underperformance / overperformance)	Value Variance YTD (financial value variance of activity units delivered compared to funded baseline where (x)/x is underperformance / overperformance)	Block Adjustment relating to West Cheshire CCG where (x)/x represents over performance not paid for / underperformance not penalised for	Value Variance attributable to Welsh and Other English Commissioners (where (x)/x is underperformance / overperformance)	RAG	Movement from Previous Period
Daycases	(40)	(£832,772)	(£618,512)	(£1,451,283)	↓	(£100,790)
Elective Inpatients	(822)	(£1,638,842)	(£526,915)	(£2,165,757)	↓	(£154,591)
Non-Elective Inpatients (exc Maternity)	1,493	£2,264,825	£73,082	£2,337,907	↑	£152,004
Non-Elective Inpatients - Maternity	(453)	(£1,335,961)	£562,537	(£773,424)	↓	(£84,674)
First Outpatients	2,279	£264,290	(£201,037)	£63,252	↓	(£21,491)
Follow Up Outpatients	(7,583)	(£531,483)	£279,153	(£252,330)	↓	(£35,854)
Outpatient Unbundled & Procedures	1,291	£280,426	(£227,961)	£52,465	↑	£18,561
Maternity	(1,049)	(£473,080)	£577,548	£104,468	↓	(£4,329)
A&E Attendances	2,009	£46,018	£127,645	£173,663	↑	£4,443
Best Practice Adj'ts	0	£82,229	(£31,114)	£51,115	↓	(£6,755)
Drugs & Devices	0	£370,920	(£582,821)	(£211,901)	↑	£396,608
AMD	992	£728,103	(£374,865)	£353,238	↑	£40,674
Adult Crit Care & Neonatal	(1,392)	(£1,432,426)	(£220,914)	(£1,653,340)	↓	(£81,128)
Other Non PBR & CQUIN	0	£1,778,213	(£1,747,345)	£30,868	↓	(£406,401)
PBR & Non PBR Variance	**(3,276)**	**(£429,539)**	**(£2,911,519)**	**(£3,341,058)**		**(£283,723)**
Welsh Therapies Settlement		(£87,748)		(£87,748)		(£87,748)
Critical Care Risk		£1,692,785		£1,692,785		£149,114
Total Excluding STF Funding		**£1,175,498**	**(£2,911,519)**	**(£1,736,021)**		**(£222,357)**

At the end of March 2019 (month 12) the total contract income (for all commissioners) is £1,175k above plan prior to the block adjustment, which when applied results in an overall financial underperformance of £1,736k, thus not recognising £2,912k over performance in the position. This is because the over performance is attributed to West Cheshire CCG which is on a block contract and the underperformance has been experienced on Payment by Results (PbR) contracts.

Please note the following key points in relation to income:

- There has been a change in charging for therapies activity, which has previously been counted but not charged for. This change is to ensure consistent treatment in line with neighbouring Trusts, with a value for all commissioners of circa £1,723k for April 2018 to March 2019, and circa £1,462k of this relating to West Cheshire CCG;

- Overall performance on the West Cheshire CCG contract has further improved in month 12 and even excluding the therapies charging change, the West Cheshire CCG contract would be now £1,450k above the agreed contract baseline;

- Welsh and non-West Cheshire English activity which are paid for via the national tariff are underperforming resulting in a net underperformance within the financial position for month 12

despite improved delivery of (West Cheshire) activity. However, the underperformance is lower than in previous months;

- The volume of un-coded activity at month 12 is currently at 3% of total activity. The Trust continues to pursue regular reviews of coding;

- Obstetric deliveries continue to be below plan in March with a cumulative under performance of £1,336k prior to the block adjustment. The pressure within the financial position following the block adjustment is £773k for the financial year and predominantly relates to Welsh activity. Obstetric bookings are also below plan but this is mitigated by the block contract for West Cheshire patients. The previous reduction in the number of Welsh women booking to have their care at the Countess, has started to materialise in the numbers of deliveries;

- The net overall non-PBR position is showing an over performance of £175k following the block adjustment which largely relates to critical care which is explained below; and the loss of the additional £1m funding from West Cheshire CCG that was included in the plan profiled between October to March has been accounted for; and

- Critical Care and Neonatal bed day activity is £1,653k below (for all Commissioners) the internal funded levels of activity within the plan year to date after the application of the block adjustment. This was in part anticipated and a risk reserve established as part of the 2018/19 budget setting. The application of the risk reserve has resulted in an over performance of £39k.

2.2 Non-Commissioner Income

At the end of March 2019, non-commissioner income is below plan by £2,133k mainly attributable to:-

- The loss of the PSF monies in relation to A&E (£2,189k) and financial performance (£3,320k) but offset by the general allocation of £2,758k totalling £2,751k; and

- A technical non recurrent benefit of £750k in relation to the provision held for Road Traffic Accident income following a review of the accounting policy.

3.0 Key Variances

The table below summarises the divisional financial performance and identifies the value of the over spend that is attributable to non-delivery of Cost Reduction Scheme (CRS) targets:

Divisional Variances	Mar YTD Var	CRS YTD Var	Pressure exc CRS
	£000s	£000s	£000s
Planned Care	3,054	1,232	1,822
Urgent Care	3,452	851	2,601
D&P	297	112	185
Facilities	(152)	(12)	(140)
Estates	(253)	(63)	(190)
Nurse Management	(51)	0	(51)
Corporate Services	(481)	(137)	(344)
Central (CRS)	3,654	3,654	0
Central Services	(1,123)	0	(1,123)
Total (before PSF, Donated Assets & Impairment)	**8,397**	**5,637**	**2,760**

3.1 Agency Spend & Variable Pay

The agency expenditure position as at March 2019 is shown below. The Trust expenditure on Agency staff of £4,422k is just under the agency ceiling of £4,459k for the year.

Agency Spend by Staff Group	14/15	15/16	16/17	17/18	18/19
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 85,760	£ 88,172
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433	£ 3,339,110
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847	£ 662,413
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820	£ 222,289
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009	£ 110,124
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 4,372,869**	**£ 4,422,108**

Agency Ceiling 2018/19	**£ 4,459,000**

The variable pay position for month 12 is shown below, as is the comparison with previous month's performance: -

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Additional Clinical Activity (WL)	£ 96,253	£ 72,869	£ 83,557	£ 104,828	£ 140,342	£ 146,800	£ 196,243	£ 157,336	£ 92,498	£ 197,082	£ 161,254	£ 147,078
Medical Bank	£ 170,001	£ 159,831	£ 148,181	£ 174,522	£ 192,785	£ 217,039	£ 187,564	£ 274,953	£ 176,165	£ 225,224	£ 164,371	£ 182,688
Additional Basic Pay	£ 81,765	£ 71,566	£ 77,576	£ 97,283	£ 79,551	£ 78,052	£ 69,408	£ 87,576	£ 91,316	£ 81,016	£ 40,192	£ 96,532
Overtime	£ 172,810	£ 111,476	£ 94,082	£ 85,607	£ 127,253	£ 110,446	£ 104,493	£ 98,706	£ 81,159	£ 82,145	£ 109,017	£ 88,722
Agency Expenditure	£ 375,766	£ 428,800	£ 404,881	£ 306,956	£ 370,401	£ 335,858	£ 310,211	£ 433,894	£ 361,353	£ 304,074	£ 346,482	£ 433,198
Bank Expenditure	£ 391,280	£ 308,742	£ 416,014	£ 632,955	£ 478,748	£ 575,608	£ 455,531	£ 456,548	£ 561,548	£ 490,835	£ 506,386	£ 677,434
Total Variable Pay Expenditure	**£ 1,287,875**	**£ 1,153,283**	**£ 1,224,290**	**£ 1,402,151**	**£ 1,389,080**	**£ 1,463,803**	**£ 1,323,452**	**£ 1,509,013**	**£ 1,364,039**	**£ 1,380,375**	**£ 1,327,702**	**£ 1,625,653**
Pay Budget	**£13,193,249**	**£14,042,665**	**£13,349,289**	**£14,125,297**	**£14,426,390**	**£13,859,665**	**£13,917,875**	**£13,808,892**	**£13,708,004**	**£13,994,829**	**£13,992,243**	**£14,178,829**
Variable Pay as % of Total Budget	**10%**	**8%**	**9%**	**10%**	**10%**	**11%**	**10%**	**11%**	**10%**	**10%**	**9%**	**11%**

	2016/17 Full Year Spend	2017/18 Full Year Spend	2018/19 YTD Spend
Additional Clinical Activity (WL)	£1,136,104	£1,225,459	£1,596,139
Medical Bank	£1,581,579	£2,025,090	£2,273,324
Additional Basic Pay	£1,487,368	£1,200,461	£951,833
Overtime	£1,167,972	£1,530,417	£1,265,916
Agency Expenditure	£3,452,003	£4,372,869	£4,411,874
Bank Expenditure	£2,809,066	£3,665,410	£5,951,630
Total Variable Pay Expenditure	**£ 11,634,092**	**£ 14,019,705**	**£ 16,450,716**
Pay Budget	**£ 155,020,877**	**£ 157,824,980**	**£ 166,599,630**
Variable Pay as % of Total Pay Budget	**8%**	**9%**	**10%**

3.2 Delayed Transfers of Care

Delayed Transfers of Care (DTOC) continue to cause both an operational and financial pressure for the Trust. The table below shows the number of beddays for the first eleven months of the year compared to the same period last year for bed days. There is an overall reduction in Delayed Transfers of Care (DTOC) but note the continued pressure in relation to Welsh patients:

Bed Days

Local Authority	2017/18 Total			2018/19 Total			2018/19 Total Variance		
	Health	Social	Total	Health	Social	Total	Health	Social	Total
Cheshire West & Chester	3,510	3,347	6,857	4,144	1,741	5,885	634	(1,606)	(972)
Wales	1,528	1,067	2,595	750	2,055	2,805	(778)	988	210
Halton	36	56	92	15	22	37	(21)	(34)	(55)
Warrington	67	187	254	84	27	111	17	(160)	(143)
Wirral	94	40	134	30	86	116	(64)	46	(18)
Shropshire	16	4	20	0	0	0	(16)	(4)	(20)
Cheshire East	10	3	13	18	6	24	8	3	11
Wigan	0	3	3	0	0	0	0	(3)	(3)
Stockport	10	0	10	0	23	23	(10)	23	13
Lancashire	2	0	2	0	0	0	(2)	0	(2)
West Sussex	13	0	13	0	0	0	(13)	0	(13)
Warwickshire	0	0	0	6	0	6	6	0	6
Manchester	0	0	0	31	0	31	31	0	31
Total	**5,286**	**4,707**	**9,993**	**5,041**	**3,960**	**9,001**	**(245)**	**(747)**	**(992)**

4.0 Cash Releasing Savings (CRS)

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

Divisional / Central Allocation	£000	%
Operational Challenge (Divisions / Departments)	6,141	3.5%
Central Challenge	4,598	1.3%
Total CRS Requirement	**10,739**	**4.8%**

Divisional and departmental targets and performance can be found in section 4.2.

4.1 March 2019 CRS Performance

CRS performance as at the end of March 2019 is £5,637k behind the plan. Reserves of £695k have been released to support the overall financial position and offset against the CRS target.

The profile of the CRS target can be found in the table below:

	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%**

4.2 In Year & Recurrent CRS Performance

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

NHS
Countess of Chester Hospital
NHS Foundation Trust

2018/19 EFFICIENCY PROGRAMME PERFORMANCE AS AT MARCH 2019

IN YEAR

Division / Department	2017/18 In Year CRS Target	Achieved		Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,515,966	£ 1,284,044	51%	£ 1,231,922	-£ 1	£ -	£ 513,718	£ 718,204
Urgent Care	£ 1,754,308	£ 903,267	51%	£ 851,041	£ 0	£ 0	£ 410,000	£ 441,040
D&P	£ 840,000	£ 727,523	87%	£ 112,477	-£ 1	£ -	£ 112,478	£ -
Estates & Facilities	£ 489,724	£ 564,834	115%	-£ 75,110	-£ 0	£ -	£ -	-£ 75,110
Nurse Mgmt	£ 71,791	£ 71,791	100%	-£ 0	-£ 0	£ -	£ -	£ -
Corporate Clinical	£ 7,756	£ 5,090	66%	£ 2,666	£ -	£ -	£ 2,290	£ 376
IM&T	£ 167,599	£ 174,541	104%	-£ 6,942	£ -	£ -	£ -	-£ 6,942
HR	£ 106,018	£ 108,115	102%	-£ 2,097	£ 0	£ -	£ -	-£ 2,097
Trust Administration	£ 108,457	£ 83,305	77%	£ 25,152	£ -	£ -	£ 1,000	£ 24,152
Finance	£ 52,470	£ 52,470	100%	-£ 0	-£ 0	£ -	£ -	£ -
PPD	£ 11,328	£ 8,858	78%	£ 2,470	£ -	£ -	£ 2,470	£ -
Procurement	£ 15,771	£ 174,314	1105%	-£ 158,543	£ -	£ -	£ -	-£ 158,543
Central	£ 4,597,684	£ 943,666	21%	£ 3,654,018	£ -	£ -	£ 3,650,000	£ 4,018
TOTAL	**£10,738,872**	£ 5,101,819	48%	£ 5,637,053	-£ 2	£ 0	£ 4,691,956	£ 945,098
		48%		52%	0%	0%	44%	9%
						-£ 1		£ 5,637,055
						0%		52%

2018/19 EFFICIENCY PROGRAMME PERFORMANCE AS AT MARCH 2019

RECURRENT

Division / Department	2017/18 Recurrent CRS Target	Achieved		Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,515,966	£ 268,148	11%	2,247,818	£ 2,630	£ -	£ 797,904	£1,447,284
Urgent Care	£ 1,754,308	£ 638,163	36%	1,116,146	£ 29,000	£ 83,333	£ 410,000	£ 593,812
D&P	£ 840,000	£ 242,275	29%	597,725	£ 79,592	£ -	£ 170,000	£ 348,133
Estates & Facilities	£ 489,724	£ 264,184	54%	225,540	£ -	£ -	£ 140,000	£ 85,540
Nurse Mgmt	£ 71,791	£ 5,000	7%	66,791	£ -	£ -	£ 14,964	£ 51,827
Corporate Clinical	£ 7,756	£ 5,090	66%	2,666	£ -	£ -	£ 2,290	£ 376
IM&T	£ 167,599	£ 34,595	21%	133,004	£ -	£ -	£ 61,792	£ 71,212
HR	£ 106,018	£ 36,464	34%	69,554	£ -	£ -	£ 29,392	£ 40,162
Trust Administration	£ 108,457	£ 33,027	30%	75,430	£ -		£ 1,000	£ 74,430
Finance	£ 52,470	£ 30,251	58%	22,219	£ -	£ -	£ -	£ 22,219
PPD	£ 11,328	£ 3,000	26%	8,328	£ -	£ -	£ -	£ 8,328
Procurement	£ 15,771	£ 15,771	100%	-	£ -	£ -	£ -	£ -
Central	£ 4,597,684	£ 185,832	4%	4,411,852	£ -	£ -	£5,100,000	-£ 688,148
TOTAL	**£10,738,872**	£ 1,761,799	16%	8,977,073	£ 111,222	£ 83,333	£6,727,342	£2,055,175
		16%		84%	1%	1%	63%	19%
						£ 194,555		£8,782,517
						2%		82%

	Status	Definition
Blue	Complete	Scheme delivered, budget savings removed for year

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

5.0 Model Hospital Update

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

Model Hospital Programme	Sum of TARGET In Year	Sum of ACHIEVED In Year	Sum of VARIANCE In Year	Green	Amber	Red	Pipeline
Business as usual	£ 4,860,665	£ 3,830,861	£ 1,029,804	-£ 2	£ -	£ 1,027,806	£ 2,000
Collaboration & Integration	£ 520,000	£ -	£ 520,000	£ -	£ -	£ 520,000	£ -
Co-ord Centre & Dashboards	£ 21,000	£ 21,000	£ -	£ -	£ -	£ -	£ -
Drugs	£ 2,231,781	£ 492,686	£ 1,739,095	£ 0	£ -	£ 1,739,094	£ -
Outpatients	£ 67,096	£ 67,096	£ -	£ -	£ -	£ -	£ -
Patient Flow	£ 627,997	£ 77,997	£ 550,000	£ -	£ 0	£ 550,000	£ -
Procurement	£ 708,650	£ 302,494	£ 406,156	-£ 0	£ -	£ 564,699	-£ 158,543
Stranded Patients (DTOCs)	£ 130,511	£ 130,511	£ -	£ -	£ -	£ -	£ -
Theatres	£ 544,618	£ 144,261	£ 400,357	-£ 0	£ -	£ 290,357	£ 110,000
Unidentified	£ 1,026,554	£ 34,913	£ 991,641	£ -	£ -	£ -	£ 991,641
Grand Total	**£ 10,738,873**	£ 5,101,819	**£ 5,637,053**	-£ 2	£ 0	£ 4,691,956	£ 945,098
		48%			0%		52%

6.0 Capital Expenditure

The slow start to the year in respect of capital spend continued but accelerated during March, with actual spend of £7.3m by the end of the financial year, compared to the plan of £14.3m. The revised plan of £7.3m was met.

The 2018/19 capital loan application has been approved by NHSI (local and national) and has been with DHSC awaiting final approval since October. The Capital regime appears to be 'hardening' even further and it may be that DHSC do not approve the loan at all. This would mean (as it currently stands) that there would be no cash available to fund ANY capital expenditure going forward. The advice from NHSI capital

team is that we would need to run out our creditors until we had operational difficulties with non-payment, before we could justify getting 'exceptional' revenue cash to cover the emergency capital spend going forward. This instruction is counter to all public sector guidance around Better Payment Practice Code and being a responsible member of the local business community – and would also potentially put patients at risk if suppliers put our account on stop as a result.

All capital items not purchased during 2018/19 will be brought forward for consideration as part of the 2019/20 capital planning process.

The £1m PDC in respect of the Cerner project has been drawn down and a revised profile has been agreed with NHS Digital.

Galliford Try have now been appointed to deliver both phases of the A&E project, and are currently carrying out a redesign which will aims to deliver an improved operational solution by more effectively combining the available space.

The Neonatal enabling works are underway.

The £1.5m of PDC for LED lighting across the Trust will generate revenue savings due to the anticipated reduction in energy usage and will form part of the 2019/20 CRS programme. We have received the formal Memorandum of Understanding and a detailed plan for the work is being developed. However, the award has recently been put on hold pending a review of the 2019/20 capital program nationally, which may result in a reduced award, or potentially some (or possibly all) of the award being slipped to 2020/21.

7.0 Working Balances and Cash

Contract Receivables (Trade Debtors) fell significantly in March, with a number of NHS bodies managing to clear previously (seemingly) intractable debts, potentially due to the year-end cash targets they are trying to hit. This was offset by the award of the PSF general distribution of £2.8m notified on 18 April as part of the closedown of the accounts. The closing working balance position is broadly in line with plan, with a slight increase in deferred income relating to agreed billing profiles around Hospital at Home and the Cheshire Care Record.

The closing cash balance at the end of March is £7.4m, which was £300k behind plan.

The Trust received £6.7m revenue distress funding to offset the impact of the deficit during 2018/19. The April drawdown of revenue distress funding of £1.5m has been received, and a further application for £1.9m for May has also been submitted.

Following discussions with NHSI, the unfunded capital spend is currently being included in the cash flows that support the interim revenue loan requests. It is unclear how long this will continue. The PSF general distribution notified last week, of £2.8m, will also support the capital cash requirements going forward, until the issues around the interim capital loans have been resolved.

The £2m PDC recently awarded to renovate the emergency department was drawn down prior to the year end, as was the £1m PDC dividend awarded in relation to the Cerner project.

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.

Countess of Chester Hospital NHS Foundation Trust

Appendix 1: Financial Summary 2018/19 (Subject to Audit)

Directors are asked to note the draft outturn position, including the achievement of its Control Total, and in particular the additional (indicative) NHSI General Distribution and 18 April 2019, for inclusion in the draft accounts. Accordingly, and as can be seen below, all these subsequent adjustments enabled the Trust to finish the year with a pre-impairment deficit of £8.2m, in line with the revised forecast.

2018/19 £000 Pre-Audit		**2017/18 £000 Audited**
2,963	**Initial planned Surplus / (Deficit) – Control Total**	**(3,628)**
(5,509)	A&E STF Monies Not Achieved	(1,440)
-	COCH Improvement in Outturn Position re Babygrow revenue donation	1,860
(8,400)	COCH (Undershoot) / Improvement in Outturn Position	34
-	NHSI £ for £ Matched Incentive	1,894
2,758	NHSI General Distribution	1,669
-	NHSI Bonus Fund	1,358
(8,188)	**(Deficit) / Surplus Reported on a Control Total basis**	**1,747**

Note. Technical Adjustments

The following items reflect adjustments made to the Control Total Deficit, to arrive at the published deficit in the Trust's accounts.

2018/19 £000 Pre-Audit		**2017/18 £000 Audited**
(8,188)	**(Deficit) / Surplus Reported on a Control Total basis - See above**	**1,747**
(5,056)	(Impairments) / Reversal of Impairments	12,054
223	Purchase of donated assets (Charitable Funds)	183
(141)	Donated Asset Depreciation	(147)
(13,161)	**(Deficit) / Surplus per published Accounts**	**13,837**

Accordingly, once the NHSI Control Total adjustments are taken into account, and the technical items relating to the Trust's draft deficit per its own accounts is £13.2m.

Appendix 2: Statement of Financial Position and Cash Flow Statement

March 2019 Statement of Financial Position	2018/19 Actual £000	2018/19 Plan £000	2017/18 Out-Turn £000
Property, Plant and Equipment			
Opening	97,880	84,759	81,508
Capital Spend	7,351	14,271	7,648
Depreciation	(4,293)	(4,382)	(4,324)
Disposals	(63)	(100)	(73)
Revaluation	(5,643)	5,199	13,121
Closing	95,232	99,747	97,880
Current Assets			
Opening Cash Balance	9,112	9,112	7,093
Increase/(Decrease)	(1,678)	(1,323)	2,019
Closing Cash Balance	**7,434**	7,789	9,112
Inventories	1,687	1,480	1,437
Contract and Other Receivables	9,521	8,824	12,530
Prepayments	1,634	1,948	1,948
Neonatal Designated Account	2,591	1,091	2,591
Total current assets	22,867	21,132	27,618
Liabilities < 1 Year			
Trade and Other Payables	(8,262)	(8,086)	(9,033)
Capital Payables	(4,400)	(4,321)	(3,874)
Accruals	(3,750)	(2,195)	(1,945)
Provisions	(530)	(1,232)	(1,232)
Deferred Income	(2,552)	(1,789)	(1,803)
Other Payables (including Tax and Pension)	(7,204)	(7,704)	(7,395)
Loans (ITFF)	(4,747)	(5,333)	(4,686)
PPP Loan	(41)	(41)	(37)
Total Net Current Assets	(8,619)	(9,569)	(2,387)
Liabilities > 1 Year			
Provisions	(1,272)	(1,350)	(1,350)
Loans (ITFF)	(33,964)	(29,219)	(31,924)
PPP Deferred Income	(1,592)	(1,592)	(1,658)
PPP Loan	(2,037)	(2,038)	(2,078)
Total Assets Employed	**47,748**	**55,979**	**58,483**
Capital & Reserves			
PDC	66,612	66,100	63,600
Revaluation Reserve	5,039	6,029	5,625
Income & Expenditure Reserve	(23,903)	(16,150)	(10,742)
Total Capital & Reserves	**47,748**	**55,979**	**58,483**

March 2019 Cash Flow Statement	2018/19 Actual £000	2018/19 Plan £000	2017/18 Out-Turn £000
Surplus	(2,475)	9,090	7,332
Working Balance Movements	3,698	2,909	(6,942)
Donated / Grant Funded Asset Additions	223	100	182
Disposal Proceeds	96	-	12
PPP Income/Interest - non cash movements	(66)	(66)	(67)
	1,476	12,033	517
Other non cash movement		1,500	-
Capital Expenditure	(6,825)	(13,824)	(4,349)
New PDC	3,012	2,500	266
Purchase of investments	-	-	(2,591)
New Loans	6,722	9,379	14,839
Loan re-payments Principle	(4,686)	(11,437)	(5,129)
PPP Loan Repayments Principle	(37)	(36)	(55)
Interest Payable	(612)	(658)	(590)
Interest Received	102	25	41
PDC Dividend Paid	(830)	(805)	(930)
Cash Inflow / (Outflow)	(1,678)	(1,323)	2,019
Opening Cash Balance	9,112	9,112	7,093
Closing Cash Balance	**7,434**	**7,789**	**9,112**

Item Reference and Title	**Agenda item 10 - Financial Position – Month 1, April 2019**
Date of Meeting	Board of Directors - Tuesday 21st May 2019
Accountable Executive	Executive Director of Finance - Simon Holden
Author(s)	Simon Holden, Director of Finance Jennie Birch, Deputy Director of Finance
Alignment to Board Assurance Framework risk	CR5, Failure to deliver the in-year financial plan and manage the consequences of a deficit budget, risk score 20
Alignment to CQC Domains	Effective and Well Led
Document Previously Considered by:	N/A
Summary	This report is intended to provide details of the Trust's financial position, as at 30th April 2019 (Month 1)
Recommendation(s)	**The Board is asked to note:** • The Trust has accepted the 2019/20 control total and the opportunity to secure £8m central funds (via Provider Sustainability Funding PSF, Financial Recovery Fund FRF and Marginal Rate Emergency Tariff MRET); • The month one financial position reported as a £160k overspend pre central funding; • The Commissioner Income position which is broadly on plan at the end of April 2019; • The continued overspend on nursing pay (£49k, including £33k of agency expenditure) and medical pay (£27k, including £180k of agency expenditure) despite investment through the 2019/20 budget setting process; • The other significant pressures currently being managed are: o Electricity Combined Heat & Power (CHP) downtime during the month, due to refurbishment (c.£30k); o The current absence of a VAT efficient model, with regards the temporary staffing model for Medical Pay (c.£60k); and o The significant financial impact of over 10 material Human Resources cases, currently being managed (c.£20k).

	• The CRS target set at 5% equating to £11.2m, and is behind plan by £362k at the end of month one; • The cash position of the organisation, and the interim revenue distress funding received to date, together with noting the ongoing cash planning and further drawdowns requested; • The absence of confirmation of the Trust's "urgent and essential" Capital Loan for 2018/19 remains an outstanding with further capital requirements going forward into 2019/20; • The risk surrounding the current Light Emitting Diode (LED) project, and noting the production of a separate Board Paper, with potential for discussions outside of the normal Board cycle, possibly with a dedicated Board Sub Group; and • The financial risks identified to deliver the financial position.
Corporate Impact Assessment:	**Legal and regulatory impact:** **Financial impact:** **Patient Experience/Engagement:** **Risk & Performance Management:** **NHS Constitution/Equality & Diversity/Communication:**

Financial Position
Month 1 April 2019/20

1.0 Overview

The "monitored" financial position i.e. pre Provider Sustainability Fund (PSF) shows an **adverse variance of £160k** at the end of April.

	Annual Budget 2019/20 £000s	April YTD Budget 2019/20 £000s	April YTD Actual 2019/20 £000s	April YTD Variance 2019/20 £000s
Pre PSF (Deficit)	8,040	1,822	1,982	160
PSF	(8,040)	(426)	(426)	0
Post PSF Control Total	**0**	**1,396**	**1,556**	**160**
Donated Asset Transactions	(14)	(1)	(1)	0
I&E Deficit	**14**	**1,397**	**1,557**	**160**

The key points to note (with further detail in the sections below) include:

- **Income**
  Both Commissioner and Non Commissioner income are broadly balanced in month one. This includes delivery of anticipated growth but care should be taken given the high proportion of un-coded activity at this stage in the financial year.

- **Expenditure**
  The most significant pressures on the expenditure position continue to be nursing pay (£49k, including £33k of agency expenditure) and medical pay (£27k, including £180k of agency expenditure). The current absence of a financially efficient model, with regards the temporary staffing model for Medical Pay (c.£60k); and the significant financial impact of over 10 material Human Resources cases, currently being managed (c.£20k). This is offset by underspends in other staff groups and non-pay (£135k). There is a cost pressure of circa £1k per day associated with the broken Combined Heat and Power (CHP) system, although remedial works are currently underway with a completion anticipated in June 2019.

- **Cost Reduction Scheme (CRS)**
  The Cost Reduction Scheme (CRS) is £362k behind plan as at 30th April 2019.

1.1 Non Recurrent Central Funding

The Trust submitted the final Financial Plan for 2019/20 on the 4th April 2019 and accepted the control total deficit of £8.040m. If delivered, additional non recurrent funding will be received as detailed below and enabling the Trust to deliver balanced financial position post central funding:

Non Recurrent Central Funding	£m
Provider Sustainability Fund (PSF)	3.809
Financial Recovery Funding (FRF)	3.515
Marginal Rate Emergency Tariff (MRET)	0.716
Total	**8.040**

The Trust is required to deliver to financial plan at the end of each quarter to be able to access the associated PSF and FRF for that period. The profile of the funds available is shown in the table below and

reflects the same profile as the previous financial year. The MRET funding is payable quarterly in advance and as such the Trust has received £179k to date.

Month	Q1	Q2	Q3	Q4	Total
PSF	15%	20%	30%	35%	100%
Financial Value	571,350	761,800	1,142,700	1,333,150	3,809,000
MRET	25%	25%	25%	25%	100%
Financial £	179,000	179,000	179,000	179,000	716,000
FRF	15%	20%	30%	35%	100%
Financial £	527,250	703,000	1,054,500	1,230,250	3,515,000
Total Plan	**1,277,600**	**1,643,800**	**2,376,200**	**2,742,400**	**8,040,000**

1.2 Income and Expenditure Summary

The table below summarises the financial position as at April, both pre and post PSF:

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	(195,004)	(15,788)	(16,033)	(245)	1.6%
Income - Wales	(26,546)	(2,177)	(1,937)	240	-11.0%
Other Clinical Income	(10,060)	(1,036)	(1,122)	(87)	8.4%
Non Patient Income	(13,401)	(1,095)	(1,096)	(1)	0.1%
INCOME	**(245,011)**	**(20,095)**	**(20,188)**	**(93)**	0.5%
PAY					
Nursing	64,095	5,546	5,595	49	0.9%
Medical	50,156	4,128	4,155	27	0.7%
Admin & Clerical	22,377	1,943	1,907	(36)	-1.8%
AHP, Therapies, Diagnostics & Pharmacy	25,418	2,220	2,191	(30)	-1.3%
Other	14,918	1,472	1,487	15	1.0%
TOTAL PAY	**176,964**	**15,310**	**15,336**	**26**	0.2%
NON PAY					
Drugs	20,363	1,603	1,584	(19)	-1.2%
Medical & Surgical Equipment	10,735	1,030	982	(47)	-4.6%
Depreciation	4,630	386	386	0	0.0%
CNST	7,803	650	650	0	0.0%
Furniture & Office Equipment, Equip Hire & Computers	4,059	330	330	0	0.0%
Other	35,518	2,973	2,904	(69)	-2.3%
TOTAL NON PAY	**83,108**	**6,971**	**6,836**	**(135)**	-1.9%
CRS	**(6,993)**	**(362)**	**0**	**362**	
TOTAL - PRE PSF & DONATED ASSET TRANSACTIONS	**8,068**	**1,824**	**1,983**	**160**	
PSF (Provider Sustainability Fund)	**(8,040)**	**(426)**	**(426)**	**0**	
POST PSF CONTROL TOTAL	**28**	**1,398**	**1,557**	**160**	
DONATED ASSET TRANSACTIONS	**(14)**	**(1)**	**(1)**	**0**	
I&E (SURPLUS) / DEFICIT	**14**	**1,397**	**1,556**	**160**	

Please note: (Favorable) / adverse

2.0 Commissioner Income

For the financial year 2019/20, all contracts are based on Payment by Results (PbR) where national tariffs are available and locally agreed tariff where necessary i.e. the contracts are cost and volume based.

The exception to this is the "blended approach" included within the 19/20 National Tariff Framework. This requires provider organisations to agree a "cap and collar" threshold for marginal rates to share the financial risk above and below agreed activity baselines. This is applicable to A&E and non-elective activity only (excluding obstetrics) and only for contracts where the value of this activity is greater than £10m. Therefore this only applies to the West Cheshire Clinical Commissioning Group (WCCCG) contract. There are different approaches within the region in terms of where the "cap and collar" is set and associated marginal rates. The Trust is in the process of finalising this with WCCCG.

The table below shows the month one activity and value variance by point of delivery. It has been assumed that 2019/20 National Tariff will be received in relation to Welsh activity. Caution needs to be taken when reviewing the income due to the high proportion of un-coded activity experienced at the start of the financial year:

Summary for all Commissioners (Assuming National Tariff):-

Point of Delivery	Activity Variance YTD (actual activity delivered compared to funded baseline where (x)/x is underperformance / over performance)	Value Variance YTD (financial value variance of activity units delivered compared to funded baseline where (x)/x is underperformance / over performance)	RAG
Daycases	83	£40,663	
Elective Inpatients	10	(£12,284)	
Non-Elective Inpatients (exc Maternity)	(75)	(£24,305)	
Non-Elective Inpatients - Maternity	(30)	(£81,142)	
First Outpatients	(510)	(£90,528)	
Follow Up Outpatients	(44)	(£8,199)	
Outpatient Unbundled & Procedures	118	£25,473	
Maternity	(36)	£14,067	
A&E Attendances	(215)	(£54,559)	
Best Practice Adj'ts	0	(£7,048)	
AMD	171	£165,053	
Adult Crit Care & Neonatal	57	£84,143	
Other Non PBR & CQUIN	0	(£46,324)	
PBR & Non PBR Variance	**(473)**	**£5,010**	

At the end of April 2019 (month one) the total contract income (for all commissioners) is broadly on plan with a reported £5k favorable variance.

Please note the following key points in relation to income:

- The activity baselines have been set on forecast outturn with the growth identified through the financial planning process included and thus accounted for in the table above;

- The high volume of un-coded activity at month 1, currently 43% of total activity compared to 3% at month 12 2019;

- The declining trend in Obstetric deliveries experienced in the last financial year continues with an £81k under performance across both England and Wales at the end of month one; and

- The AMD over performance is due to an increase in activity and the associated income will be utilised in part to fund the additional drug costs incurred.

2.1 Non-Commissioner Income

At the end of April 2019, non-commissioner income is showing a balanced position.

3.0 Key Variances

The table below summarises the divisional financial performance and identifies the value of the over spend that is attributable to non-delivery of Cost Reduction Scheme (CRS) targets:-

Divisional Variances	Apr YTD Var	CRS YTD Var	Pressure exc CRS
	£000s	£000s	£000s
Planned Care	212	227	(15)
Urgent Care	232	151	81
ICP	(38)	28	(66)
D&I	16	133	(117)
Nurse Management	(3)	6	(9)
Corporate Services	18	17	1
Central (CRS)	(202)	(200)	(2)
Central Services	(75)	0	(75)
Total (before PSF & Donated Assets)	**160**	**362**	**(202)**

3.1 Agency Spend

Despite significant investment in nursing and medical pay through the 2019/20 financial plan, agency expenditure continues. The position as at April 2019 is shown in the table below and the agency ceiling set at £4,576k for 2019/20:-

Agency Spend by Staff Group	14/15	15/16	16/17	17/18	18/19	19/20	19/20 Annual Straight Line Projection
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 85,760	£ 88,172	£ -	£ -
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433	£ 3,339,110	£ 179,761	£ 2,157,137
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847	£ 662,413	£ 33,227	£ 398,725
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820	£ 222,289	£ 38,819	£ 465,823
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009	£ 110,124	£ 7,851	£ 94,215
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 4,372,869**	**£ 4,422,108**	**£ 259,658**	**£ 3,115,900**

Agency Ceiling					**£ 4,459,000**		**£ 4,576,000**

4.0 Cash Releasing Savings (CRS)

In order to sign up to the control total and thus enable access to the central funding (£8m), the Trust has set an ambitious CRS target for 2019/20. All departments and divisions have been set a 5% target which equates to £11,192k (5%). If delivered in full this will close the financial gap and also provide some mitigation for other risks identified within the plan. The CRS target has been allocated as follows and performance can be found in section 4.1:-

Division / Department	2019/20 In Year CRS Target £
Planned Care	4,046,829
Urgent Care	2,246,688
ICP	643,169
D&I	2,055,574
Nurse Mgmt	105,423
Corporate Clinical	4,956
IM&T	278,405
HR	173,369
Trust Administration	89,832
Finance	77,386
PPD	92,714
Procurement	28,106
Central	1,349,133
TOTAL	**11,191,584**

4.1 April 2019 CRS Performance

CRS performance as at the end of April 2019 is £362k behind plan, as detailed below.

CRS DIVISIONAL PERFORMANCE AS AT APRIL 2019 Division / Department	Target to APRIL	Achieved to APRIL	Variance
Planned Care	337,236	109,997	227,239
Urgent Care	187,224	36,073	151,151
ICP	53,597	25,480	28,118
D&I	171,298	38,500	132,798
Nurse Mgmt	8,785	3,083	5,702
Corporate Clinical	413	0	413
IM&T	23,200	32,581	(9,380)
HR	14,447	2,357	12,091
Trust Administration	7,486	1,300	6,186
Finance	6,449	8,008	(1,559)
PPD	7,726	1,083	6,643
Procurement	2,342	0	2,342
Central	112,428	164,833	(52,406)
Central - Risk Reserve 1/12th	(147,079)		(147,079)
TOTAL	**785,553**	**423,295**	**362,258**

4.2 In Year & Recurrent CRS Performance

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

2019/20 EFFICIENCY PROGRAMME PERFORMANCE AS AT APRIL 2019

IN YEAR

Division / Department	2019/20 In Year CRS Target	Achieved		Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 4,046,829	£ 812,920	20%	£ 3,233,909	£ 572,861	£1,084,769	£ 252,396	£ 1,323,883
Urgent Care	£ 2,246,688	£ 432,871	19%	£ 1,813,817	£ 355,000	£ 412,752	£ 199,000	£ 847,065
ICP	£ 643,169	£ 305,756	48%	£ 337,413	£ 12,000	£ 70,000	£ 122,000	£ 133,413
D&I	£ 2,055,574	£ 399,917	19%	£ 1,655,657	£ 388,583	£ 180,000	£ 63,500	£ 1,023,574
Nurse Mgmt	£ 105,423	£ 15,000	14%	£ 90,423	£ -	£ -	£ -	£ 90,423
Corporate Clinical	£ 4,956	£ -	0%	£ 4,956	£ -	£ -	£ -	£ 4,956
IM&T	£ 278,405	£ 96,192	35%	£ 182,213	£ 43,265	£ 20,000	£ 41,820	£ 77,128
HR	£ 173,369	£ 28,281	16%	£ 145,088	£ 5,122	£ 40,719	£ 5,000	£ 94,247
Trust Administration	£ 89,832	£ 15,604	17%	£ 74,228	£ 5,500	£ 5,100	£ -	£ 63,628
Finance	£ 77,386	£ 41,090	53%	£ 36,296	£ 20,248	£ -	£ 3,000	£ 13,048
PPD	£ 92,714	£ 13,000	14%	£ 79,714	£ 28,085	£ 2,500	£ 6,500	£ 42,629
Procurement	£ 28,106	£ -	0%	£ 28,106	£ -	£ 28,106	£ -	£ -
Central	£ 1,349,133	£ 273,000	20%	£ 1,076,133	£ -	£ 665,407	£ 1,039,653	-£ 628,927
TOTAL	**£11,191,584**	£ 2,433,631	22%	£ 8,757,953	£ 1,430,664	£2,509,353	£ 1,732,869	£ 3,085,067
		22%		78%	13%	22%	15%	28%

2019/20 EFFICIENCY PROGRAMME PERFORMANCE AS AT APRIL 2019

RECURRENT

Division / Department	2019/20 Recurrent CRS Target	Achieved		Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 4,046,829	£ 628,825	16%	3,418,004	£ 376,450	£1,021,915	£ 256,246	£1,763,393
Urgent Care	£ 2,246,688	£ 432,871	19%	1,813,817	£ 45,000	£ 204,300	£ 20,000	£1,544,517
ICP	£ 643,169	£ 78,000	12%	565,169	£ 74,575	£ 10,000	£ 5,000	£ 475,594
D&I	£ 2,055,574	£ 427,000	21%	1,628,574	£ 490,000	£ 255,000	£ 175,000	£ 708,574
Nurse Mgmt	£ 105,423	£ 13,000	12%	92,423	£ -	£ -	£ -	£ 92,423
Corporate Clinical	£ 4,956	£ -	0%	4,956	£ -	£ -	£ -	£ 4,956
IM&T	£ 278,405	£ 51,000	18%	227,405	£ 68,557	£ 20,000	£ 41,820	£ 97,028
HR	£ 173,369	£ 28,282	16%	145,087	£ 3,000	£ 20,718	£ 5,000	£ 116,369
Trust Administration	£ 89,832	£ 13,000	14%	76,832	£ 3,104	£ 3,128	£ -	£ 70,600
Finance	£ 77,386	£ 36,090	47%	41,296	£ 5,168	£ -	£ 3,000	£ 33,128
PPD	£ 92,714	£ 13,000	14%	79,714	£ -	£ -	£ 37,085	£ 42,629
Procurement	£ 28,106	£ -	0%	28,106	£ -	£ 28,106	£ -	£ -
Central	£ 1,349,133	£ 118,000	9%	1,231,133	£ -	£ 764,407	£1,039,653	-£ 572,927
TOTAL	**£11,191,584**	£ 1,839,068	16%	9,352,516	£ 1,065,854	£2,327,574	£1,582,804	£4,376,284
		16%		84%	10%	21%	14%	39%

	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

4.3 CRS Approach for 2019/20 – Actions taken and Next Steps

The following actions / steps have been taken / implemented:

- Any under delivery of the 2018/19 "original" CIP, critically reviewed and rolled forward where appropriate;
- Any under delivery of the 2018/19 "Recovery Plan" CIP, critically reviewed and rolled forward where appropriate;
- Confirm & challenge sessions have been held with all Divisions, and Corporate areas, with particular regards to challenging the identified cost pressures for 2018/19 & 2019/20;
- Review of benchmarking information (i.e. Model Hospital Portal, NHS Improvement Corporate benchmarking etc.);
- Appointment & challenge from, external financial support;
- Program Initiation Documents (PIDs) completed where necessary;
- Identified a lead, and a Division, for all schemes;
- Anticipated financial benefit identified for all schemes;
- Obstetrics has continued the underperforming trend, and hence a critical review is required to look at expenditure, and activity capture (i.e. coding);
- A financially efficient temporary staffing model is required, and hence further dedicated work is required in order to rectify the current impasse;
- Focused work needs to continue, with regards the current material human resources cases, in order to reach a conclusion; and
- Given the CRS shortfall, measures to accelerate the implementation of the CRS transformational schemes need to be taken.

5.0 Capital Expenditure

Capital spend in April was only £99k against a plan of £417k, predominantly due to the fact that the 2018/19 loan remains unapproved by Department of Health and Social Care (DHSC), despite having been approved as 'emergency' by NHS Improvement in October last year. To date, £1.9m has been cash funded through interim revenue support drawn down in March 2019, leaving £4.9m required in 2019/20 to complete the 2018/19 capital program.

The detailed capital program for 2019/20 is currently undergoing a review process, to enable the Trust to finalise its capital funding requirement prior to submitting an interim capital loan application for the current year.

On 7 May 2019, the newly merged NHS England & NHS Improvement wrote to Trusts indicating that the 2019/20 capital expenditure limit set for the NHS would be breached if all the capital included in current plans was delivered. To avoid this, all central capital budgets are now under review, including the £1.5m we had previously been awarded for the LED lighting project which is currently underway. A separate Board Paper will follow, with potential discussions required outside of the normal Board cycle, possibly with a Board Sub Group. The Public Dividend Capital (PDC) Fast Follower funding awarded for the Electronic Patient Record (EPR) is not affected by this review with an opportunity to reclassify as revenue in 2019/20.

Providers are being asked to resubmit 2019/20 plans, with the intention that all non-urgent / non-critical expenditure should be deferred into future years wherever possible. If the gap cannot be closed, then it seems likely that some form of capital rationing will be introduced, through a combination of STP level prioritisation and (potentially) top-down control measures. The Trust does not intend to reduce the capital request since items included within the programme are all deemed to be "urgent and necessary".

We continue to work with the NHSI&E Capital & Cash Team to ensure that they are aware of the urgent need to resolve the current impasse, and to notify them of any capital expenditure that is approved at risk.

The two key building projects are now underway, with the Neonatal build starting on 1 April, and the two phases of the A&E build currently being combined into a single project. The newly appointed construction company, Galliford Try are currently carrying out a redesign which aims to deliver an improved operational solution by more effectively combining the available space.

6.0 Working Balances and Cash

Contract Receivables (Trade Debtors) remained stable at the end of April, with some higher than normal cash collections offsetting the effect of the quarterly Service Level Agreement (SLA) contract billing and PSF / FRF debtor. The closing working balance position is broadly in line with plan, with an increase in deferred income relating to advance payment of invoices from the CCG.

The closing cash balance at the end of April is £8.5m, which was £7.3m ahead of plan, due to cash currently being ring-fenced for capital creditors from 2018/19 and better than expected cash collection, predominantly in respect of Wirral University Teaching Hospital (WUTH) and the timing of the weekly payment run leading to increased trade creditors.

The Trust received £1.6m revenue distress funding in April 2019, and a further application for £1.9m for May 2019 has been approved.

Following discussions with NHSI, the unfunded capital spend is currently being included in the cash flows that support the interim revenue loan requests. It is unclear how long this will continue.

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.

7.0 Key Risks and Mitigation

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

- **The CRS target for 2019/20** is a significant risk with a considerable proportion unidentified (28%) or red rated (15%) and limited management capacity to deliver. Divisions and departments continue to identify and implement schemes, organisation wide schemes are being pursued and support from an external turnaround director has been sought;
- Failure to deliver the CRS programme and failure to balance operational budgets will impact on the Trust's **cash** balances. Daily cash flow forecasting is in place with NHSI aware of the Trust's position. Revenue distress loans will be applied for accordingly;
- There are a number of risks relating to **capital and associated charges** to the Trust specifically:

- The severe restriction of **capital funding** within the NHS resulting in the absence of approval for 2018/19 urgent and necessary capital loan;
- The requirement to borrow further capital to support urgent and necessary capital items in 2019/20;
- There is limited (£500k) capital included within the 2019/20 capital cash loan for the implementation of the new Electronic Patient Record (EPR);
- The PDC previously allocated to implement the LED project appears to have been retracted in the short term; and
- The financial plan makes no allowance for changes anticipated with regards to changes to asset lives (circa £600k).

- The Financial Plan for 2019/20 contains very limited levels of **contingency;**
- The **Procurement** savings top sliced (£1.3m) may not deliver in full and hence widen the financial gap. Monitoring of non-pay budgets is in place to track anticipated savings; and
- **The Control Total** may not be delivered should the risks above all materialise and therefore non central funding may not be received in full.

Appendix 1: Statement of Financial Position and Cash Flow Statement

April 2020 Statement of Financial Position	2019/20 Actual £000	2019/20 Plan £000	2018/19 Out-Turn £000
Property, Plant and Equipment			
Opening	95,232	100,719	97,880
Capital Spend	99	417	7,350
Depreciation	(386)	(386)	(4,293)
Disposals	-	(8)	(63)
Revaluation	-	-	(5,642)
Closing	94,945	100,742	95,232
Current Assets			
Opening Cash Balance	7,434	1,252	9,112
Increase/(Decrease)	1,101	-	(1,678)
Closing Cash Balance	**8,535**	1,252	7,434
Inventories	1,707	1,484	1,687
Contract and Other Receivables	9,376	8,911	9,575
Prepayments	1,669	1,888	1,634
Neonatal Designated Account	2,591	2,352	2,591
Total current assets	23,878	15,885	22,921
Liabilities < 1 Year			
Trade and Other Payables	(7,663)	(5,240)	(8,316)
Capital Payables	(4,056)	(2,767)	(4,400)
Accruals	(3,514)	(3,750)	(3,750)
Provisions	(524)	(519)	(530)
Deferred Income	(3,917)	(1,609)	(2,552)
Other Payables (including Tax and Pension)	(7,686)	(7,200)	(7,204)
Loans (ITFF)	(4,794)	(4,686)	(4,747)
PPP Loan	(41)	(46)	(41)
Total Net Current Assets	(8,317)	(9,932)	(8,619)
Liabilities > 1 Year			
Provisions	(1,272)	(1,350)	(1,272)
Loans (ITFF)	(33,544)	(36,638)	(32,964)
PPP Deferred Income	(1,587)	(1,586)	(1,592)
PPP Loan	(2,034)	(2,029)	(2,037)
Total Assets Employed	**46,191**	**49,207**	**47,748**
Capital & Reserves			
PDC	66,612	66,612	66,612
Revaluation Reserve	5,039	5,625	5,039
Income & Expenditure Reserve	(25,460)	(23,030)	(23,903)
Total Capital & Reserves	**46,191**	**49,207**	**47,748**

April 2019 **Cash Flow Statement**	**2019/20 Actual £000**	**2019/20 Plan £000**	**2018/19 Out-Turn £000**
Surplus	(1,010)	(842)	(2,474)
Working Balance Movements	977	(531)	3.757
Donated / Grant Funded Asset Additions	17	17	223
Disposal Proceeds	-	-	96
PPP Income/Interest - non cash movements	(6)	(6)	(65)
	33	(1,362)	1,537
Other non cash movement	42	141	-
Capital Expenditure	(443)	(1,424)	(6,824)
New PDC	-	-	3,012
Purchase of investments	-	-	-
New Loans	1,580	2,681	6,722
Loan re-payments Principle	-	-	(4,686)
PPP Loan Repayments Principle	(4)	(4)	(37)
Interest Payable	(62)	(34)	(674)
Interest Received	10	2	102
PDC Dividend Paid	-	-	(830)
Cash Inflow / (Outflow)	1,101	-	(1,678)
Opening Cash Balance	7,434	1,252	9,112
Closing Cash Balance	**8,535**	**1,252**	**7,434**

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Item Reference and Title	**Agenda item 11 - People & Organisational Development Committee Chair's Report to Board of Directors**
Date of Meeting	Board of Directors - 21st May 2019
Author(s)	Ed Oliver Non-Executive Director Chair of People & Organisational Development Committee
Alignment to Board Assurance Framework risk	CR4 – Failure to deliver the Trust's Culture, values and engagement plan (risk score 12) CR10 – Failure to recruit, train and retain professional staff (risk score 16).
Alignment to CQC Domains	Caring
Summary	This report is intended to provide an update on the meeting of the People & OD Committee, held on Tuesday, 7th May 2019.
Recommendation(s)	The Board is asked to note the update.

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1.0 Key items of business discussed

The People & Organisational Development (OD) Committee met on Tuesday, 7th May 2019, and the following key business items were discussed, namely:

- To discuss the future format of the Committee
- To receive an update from the Partnership Forum
- To receive an update on the Trust position in relation to Variable Pay Expenditure as at 2018/19 year-end (March 2019) and actions in development for 2019/20
- To understand key workforce actions and risks as identified by divisional representatives
- To receive a report and presentation on the results of the NHS Staff Survey 2018 and the progress against the work plan
- To review the current workforce Board Assurance Risks as at Quarter 3 2018/2019:
    - CR4 – Failure to deliver the Trust's Culture, values and engagement plan
    - CR10 – Failure to recruit, train and retain professional staff
- To receive a report on from the Occupational Health and Wellbeing Manager on the developments and initiatives undertaken and planned by Occupational Health to support the health and wellbeing of our staff
- To review Workforce intelligence data for as at 2018/19 year-end (March 2019).
- To receive an update on the Health Education England (HEE) related to the Workforce Development Funding 2019/20 and plans to monitor by the Education Governance Board.

2.0 Key agreements or decisions made

The key agreements made were:

- The committee structure may change as a result of the Governance review and it was agreed that the Committee members would be advised if and when these changes would take effect;
- An agreement to re-establish the variable pay work stream with specific focus on agency spend and all areas of the trust working within the Standing Financial Instructions when booking agency workers;
- An agreement for the Nursing & Midwifery Workforce Board to consider and review the winter bonus scheme for bank staff;
- An agreement to review the risks and concerns related to the impact of the Annual Allowance and Lifetime Allowance on the Trust and activity undertaken by clinical colleagues and to work with Staff Side colleagues to seek options for review and action;
- A decision to provide wider awareness to staff that they can receive feedback when raising a Datix, following the feedback within the NHS Staff Survey 2018;

- An agreement to include the actions identified by the NHS Staff Survey 2018 within a single thematic work plan linked to recent reviews the Trust has received;
- An agreement to provide further updates on the work being delivered by the Occupational Health & Wellbeing Team to a future committee;
- An agreement to receive a recovery plan to address the delivery of the sickness absence target of 3.65% at a future meeting;
- An agreement to receive a report on the plans to utilise the HEE Workforce Development Funding received for 2019/20 at a future meeting, following the consultation and data capture process that is currently being undertaken;
- An agreement to receive a report on the work-plan for review and renewal of People-related policies at a future meeting;
- An agreement to receive a report on the plan to fully utilise all of the Apprenticeship levy to be received at a future meeting;
- A discussion on the outstanding actions from the Audit Tracker and a review of the audit plan for 2019/2020, with the Director of People & OD attending the next Audit Committee meeting.

3.0 Items for escalation to Board

Items identified for escalation to the Board were:

- The potential changes to the committee structure which will relate to the People & OD Committee;
- Monitoring of the activity being undertaken related to the findings of the NHS Staff Survey 2018; and
- Awareness of the development of a recovery plan to address the non-delivery of the sickness absence target.

4.0 Recommendation(s)

The Board is asked to note the update.

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Item Reference and Title	**Agenda item 13 - Governance Improvement and Committees of the Board**
Date of Meeting	Board of Directors 21st May 2019
Accountable Executive	Susan Gilby, Chief Executive
Author(s)	Darren Thorne, Governance Advisor
Alignment to Board Assurance Framework risk	Corporate Risk 6 – Failure to comply with Compliance Framework
Alignment to CQC Domains	Well Led
Document Previously Considered by:	Executive Directors Group
Summary	This report is intended to: • Provide an update on governance improvement plan • Seek approval to dis-establish Board Committees and establish new Committees and associated Terms of Reference
Recommendation(s)	**The Board is asked to** approve the disestablishment of the Financial & Integrated Governance Committee, People & Organisational Development Committee and the Quality, Safety and Experience Committee. The Board is asked to approve the establishment of a Quality and Safety Committee and a Finance & Performance Committee and associated Terms of Reference. The Board is asked to approve the new proposed Terms of Reference for the Audit Committee.
Corporate Impact Assessment:	**Legal and regulatory impact:** Improved compliance with governance code **Patient Experience/Engagement:** Improved assurance to the board for patient experience **NHS Constitution/Equality & Diversity/Communication:** Improved assurance to the board on the NHS Constitution

Governance Improvement and Committees of the Board

Governance Review

The Trust recently commissioned an independent review of its governance, this reported in early April making 20 recommendations for improvement. An improvement plan to address all recommendations is currently being developed. The plan will set out 12 months of improvement across three phases:

Phase one: Achieving compliance and building the basics (3 months)
This phase is focussed on ensuring compliance with all statutory requirements and putting in place the essential elements of a good governance system. It will include disestablishing the current board committees, developing essential documents and frameworks.

Phase two and three: Implementing better basics and embedding practice (6 months)
Implementation of better basics through training, observation and coaching. In this phase accelerated learning from board to ward and rapid roll out of the skills to implement good governance systems will be the focus. The effectiveness of the new business cycle will be evaluated dynamically whilst making ongoing improvements.

Phase four: Creating sustainable change (3 months)
In this phase the focus is nurturing maturity, this will focus on developing a plan to achieve excellence through an outstanding rating. There will be robust handovers of the co-produce systems and the development of self-assessment tools for the Trust to plot its journey to maturity.

The high level improvement plan is attached at Appendix 2, this is underpinned by a more detailed plan which will be monitored through a proposed management group, Transformation Board.

Board Committees

One recommendation focused on the board re-commissioning its Board Committees, to facilitate this we are proposing a new set of Terms of references. The focus being too clearly separate assurance and operational management discussions. It is therefore proposed to establish two new committees to replace the existing three. In addition, we have taken the opportunity to review the Audit Committee Terms of Reference.

It is proposed that:

- The Quality Safety and Patient Experience Committee is disestablished, and a Quality and Safety Committee is established in its place.

- The Finance and Integrated Governance Committee is disestablished, and a Finance and Performance Committee is established in its place.

- The People and Organisation Development Committee is disestablished, and assurance is sought through the newly established Finance and Performance Committee

Terms of refence for the proposed board committees are attached in Appendix one, a review period of 4 months has been proposed to test the new approach over two business cycles.

Alongside these proposals the Executive Directors will be establishing management groups that focus on providing assurance to the Board Committees.

The board is asked to approve to disestablish the following committees:

- Quality Safety and Patient Experience
- Finance and Integrated Governance
- People and Organisation Development

The board is asked to approve the establishment of the following committees through approving the attached terms of reference:

- Quality and Safety
- Finance and Performance

The board is asked to approve the new terms of reference for the Audit Committee.

Appendix 1

COUNTESS OF CHESTER NHS FOUNDATION TRUST

QUALITY AND SAFETY COMMITTEE TERMS OF REFERENCE

1.00 PURPOSE

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

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

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

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

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

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

- Chief Executive
- Associate Director of Risk and Safety
- Associate Director of Nursing (Corporate)
- Head of Facilitates
- Head of Estates

2.03 The Trust Chair shall propose which Non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair, based on the Chair's recommendations.

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

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

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

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

3.00 ROLE AND RESPONSIBILITIES

AUTHORITY

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

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

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

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

DUTIES

Quality strategy, targets and outcomes

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

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

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

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

Compliance and Regulation

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

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

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

Clinical governance and risk management

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

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

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

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

3.16 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High Level Operational Risks with a significant potential for impact on the Trust's quality risk appetite, and promote continuous quality improvement with regard to the management of clinical and non-clinical risk and the control environment throughout the Trust.

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

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

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

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

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

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

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

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

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

Patient experience

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

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

Complaints and reviews

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

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

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

Development, education and training

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

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

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

Estates strategy

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

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

REPORTING AND RELATIONSHIPS

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

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

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

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

4.00 CONDUCT OF BUSINESS

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

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

4.03 The Committee shall meet at least four times in each financial year. The Chair may request an extraordinary meeting if he/she considers one to be necessary.

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

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

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

5.00 STATUS OF THESE TERMS OF REFERENCE

Reviewed by the [committee] [Date]

Approved by Trust Board: [Date]

Next Review: [Date]

Appendix 2

COUNTESS OF CHESTER NHS FOUNDATION TRUST

FINANCE AND PERFORMANCE COMMITTEE
TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Finance and Performance Committee is to support the Board to ensure that all appropriate action is taken to achieve the financial and operational performance objectives of the Trust through regular review of financial and operational strategies and performance, investments, and capital and estates plans and performance.

1.02 The Committee shall also provide information to the Audit Committee and Quality Assurance Committee as appropriate to assist those Committees in ensuring good structures, processes, and outcomes across all areas of governance.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Two further nominated non-executive Directors
- Chief Executive
- Director of Finance (Lead Officer for the Committee)
- Medical Director
- Director of Nursing & Quality
- Director People and Organisational Development
- Chief Operating Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations. At least one of the Committee members should have recent and relevant financial experience.

2.03 Those normally in attendance at the Committee meetings shall be (as appropriate):

- Director of Procurement
- Director of IM&T

Any member of the Board of Directors shall have the right to be in attendance at any meeting of the Committee by prior agreement with the Chair.

2.04 The executive members of the Committee may exceptionally send a deputy to the meeting but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.05 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible.

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

3.00 ROLE AND RESPONSIBILITIES

AUTHORITY

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

3.02 The Committee shall have delegated authority to award Contracts and approve Business Cases up to the value delegated to it by the Trust Board.

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

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

DUTIES

Financial and Operational policy, management and reporting

3.04 To ensure the Trust develops and maintains an appropriate financial strategy in relation to both revenue and capital.

3.05 To consider the Trust's annual financial plans and annual budgetary policy and proposals before submission to the Trust Board.

3.05 To ensure the Trust develops and maintains an appropriate operational strategy and annual plan in relation to Trust performance.

3.06 To consider the Trust's annual operational plan and supporting proposals before submission to the Trust Board.

3.07 To commission and consider risk-based, in-depth reviews of financial performance (in particular service areas/Divisions or Trust-wide), including the relationship between underlying activity, workforce performance and utilisation, income and expenditure, and budgets.

3.08 To monitor all efficiency programmes, including to obtain assurance that no efficiency programme has an unforeseen detrimental impact on quality of care (linked to the work delivered through the Quality Committee) or on the performance of the Trust especially in respect of constitutional and key operational metrics; and to make recommendations as necessary to the Board about action required in-year.

3.09 To monitor all Workforce Transformation programmes, including to obtain assurance that no programme has an unforeseen detrimental impact on quality of care ((linked to the work delivered through the Quality Committee) or on the performance of the Trust especially in respect of constitutional and key operational metrics; and to make recommendations as necessary to the Board about action required in-year.

3.10 To receive assurances on the robustness of governance processes overseen by the Programme Management Office relating to Efficiency and Transformation programmes.

3.11 To consider proposals for major capital expenditure business cases and estates developments and their funding sources and to make recommendations to the Board as appropriate.

3.12 To commission any necessary reviews of strategic finance and performance issues affecting the Trust, and to review the results before submission to the Board.

3.13 To review, as necessary, the efficacy of the financial and operational control processes that support the Trust's financial statements and the disposition of its funds and assets, and refer any concerns to the Audit Committee.

3.14 To monitor and receive assurances on the robustness of the Trust's main income sources, the contractual safeguards, and efficiency programmes, and to make reports to the Audit Committee and the Board as appropriate.

3.15 To receive and scrutinise, as appropriate, reports on 'commercial' activities of the Trust and to make recommendations to the Board as appropriate.

3.16 To review, as necessary and receive assurance over the data quality systems and processes that support the Trust's operational performance reporting.

3.17 To receive reports on changes in statutory and regulatory requirements that fall under the remit of the duties of the Committee.

Cash management and reporting

3.18 To approve the Trust's cash management policy.

3.19 To receive regular reports on the Trust's cash position.

Procurement strategy and policy

3.20 To review the Trust's procurement strategy and policies on a regular basis and to make recommendations to the Board.

3.21 To consider any significant variations to the Trust's existing procurement methodology as set out in the Trust's Standing Orders and Standing Financial Instructions.

3.22 To monitor and receive assurance for agreed key metrics relating to procurement and make reports to the Audit Committee as appropriate.

Commercial strategy and policy

3.23 To review the Trust's commercial strategy and policies on a regular basis and to make recommendations to the Board.

3.24 To consider any significant variations to the Trust's existing commercial strategy or policy.

3.25 To monitor and receive assurance for agreed key metrics relating to commercial activity and make reports to the Audit Committee as appropriate.

Capital programme

3.26 To review and approve the Trust's capital programme.

3.27 To monitor progress and risks associated with the delivery of this programme and to escalate to the Board any significant risks within its delivery and to the Quality Assurance Committee

Information management and technology

3.25 To review the IM&T strategy and recommend it to the Board, and to monitor progress against and risks associated with the strategy, and monitor other IM&T-related improvement plans

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

Organisational controls

3.27 In support of the Audit Committee, the Committee will report to the Audit Committee any identified risks to the adequacy and effectiveness of the Trust's financial and operational performance reporting frameworks.

3.28 To make arrangements to ensure that all Board members maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust.

3.29 To examine any other matter referred to the Committee by the Trust Board.

3.30 To review draft Trust policies pertaining to the Committee's function prior to their being considered by the Board.

People and Organisational Development

3.31 To approve and deliver the People and Organisational Development Strategy and Workforce Annual Plan.

3.32 To ensure the Trust has the structures, systems and processes it needs to achieve its key objectives, whilst ensuring they are monitored and performance is managed in order to improve the effectiveness of its workforce, building well led effective teams whilst reducing labour costs.

3.33 To ratify new and existing People/OD policies and procedures, ensuring that these are notified to the Board via the appropriate minutes, following development at other committees (e.g. Partnership Forum).

3.34 To receive assurance and monitor the implementation of Equality and Diversity Statutory delegations under the single Equality Duty (2011).

3.35 Monitor internal workforce performance indicators, on behalf of the Board of Directors and report to the Board via the integrated performance report and on exception basis.

3.36 Monitor performance against pay and variable pay and provide updates at each meeting and report into the Board via the integrated performance report and on exception basis.

3.37 Review the annual staff survey report, monitor actions taken and advise the Board on developments arising as a consequence by exception.

3.38 Receive periodic updates from the Guardian of Safe Working, Director of Medical Education and for Medical Staffing.

REPORTING AND RELATIONSHIPS

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

3.40 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

3.41 The Committee shall refer to the Audit Committee any matters requiring review or decision-making in that forum.

3.42 The Committee chair will provide annually a report to the Board detailing how the Committee has discharged its Terms of Reference.

3.43 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

4.00 CONDUCT OF BUSINESS

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

4.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be either the Chief Executive or Director of Finance. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

4.03 The Committee shall meet not less than six times in each financial year.

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

4.05 Agendas and briefing papers should be prepared and circulated in sufficient time for Committee Members to give them due consideration.

4.06 Minutes of Committee meetings should be formally recorded and distributed to Committee Members within 10 working days of the meetings. Subject to the approval of the Chair, the Minutes will be submitted to the Trust Board at its next meeting and may be presented by the Committee Chair. The Committee Chair will draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

5.00 STATUS OF THESE TERMS OF REFERENCE

Approved by Trust Board: [Date]

Next Review: Sept 2019

Appendix 3

COUNTESS OF CHESTER NHS FOUNDATION TRUST

AUDIT COMMITTEE
TERMS OF REFERENCE

1.0 PURPOSE

1.01 The purpose of the Audit Committee is to support the Board of Directors to deliver the Trust's responsibilities for the conduct of public business and the stewardship of funds; to be responsible for providing assurance to the Board that appropriate systems of internal control and risk management are in place covering all corporate and clinical areas of the Trust; and to make recommendations to the Council of Governors on the appointment of external auditors.

1.02 The Committee shall seek to ensure that business is conducted in accordance with the law and proper standards; public money is safeguarded and properly accounted for; Financial Statements are prepared in a timely manner and give a true and fair view of the financial position of the Trust for the period in question; services are managed so as to secure economic, efficient and effective use of resources; and that reasonable steps are taken to prevent and detect fraud and other irregularities.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Two further nominated non-executive Directors

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Board shall approve the appointment of the Committee Chair and non-executive members, based on the Trust Chair's recommendations. (The Foundation Trust Code of Governance requires that the Committee should be composed of at least three independent non-executive Directors, at least one of whom has recent and relevant financial experience.)

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

- Director of Finance (the Lead Officer for the Committee)
- External Auditors
- Internal Auditors
- Local Counter Fraud Specialist (as appropriate)
- Company Secretary

Any member of the Board of Directors shall have the right to be in attendance at any meeting of the Committee by prior agreement with the Chair of the Committee.

2.04 Those who are normally in attendance may exceptionally send a deputy to the meeting.

2.05 Other managers and clinicians may be required to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible.

2.06 The Chief Executive should be invited to attend at least annually to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

2.07 The Trust Chair shall not be a member of the Committee.

2.08 At least once a year the Committee should meet privately with the External Auditors, Internal Auditors and Local Counter Fraud Service

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

3.00 ROLE AND RESPONSIBILITIES

AUTHORITY

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

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

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

DUTIES

Governance, Risk Management and Internal Control

3.04 The Committee shall assure itself that the Trust has established and maintains an effective integrated system of governance, risk management and internal controls, across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives.

3.05 In particular, the Committee shall assure itself (either directly or through the work of the Quality and Risk Committee) of the accuracy, adequacy and effectiveness of:

- All risk and control-related disclosure statements (in particular the Annual Governance Statement and relevant declarations of compliance with the requirements of Monitor and the Care Quality Commission), together with any accompanying statement from the Head of Internal Audit, any external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives and the effectiveness of the management of principal corporate and clinical risks. These will include but will not be limited to: the Board Assurance Framework; the Risk Management Strategy; and the Risk Register along with realistic prioritised action plans and targets to eliminate or minimise risk.
- The policies and controls for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as set out by NHS Protect

3.06 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, Local Counter Fraud Service (LCFS), and other assurance functions, but will not be limited to these audit and assurance functions.

3.07 The Committee will seek assurance from the Quality and Risk Committee, to the extent that this is reasonable and possible, that the quality and clinical risk elements of the Trust's Board Assurance Framework, Risk Register, Risk Management Strategy and underpinning risk management and clinical governance processes are in place, fully effective and in line with best practice. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

Internal Audit and Counter Fraud

3.08 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

3.09 The Committee shall also satisfy itself that the organisation has adequate arrangements in place for countering fraud.

3.10 This will be achieved by:

- Approval of the appointment of the Internal Auditor.
- Consideration of the provision of the Internal Audit service, the cost of the audit service and any questions of resignation and dismissal.
- Reviews and approval of the Internal Audit Strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework and Risk management Strategy.
- Consideration of the major findings of internal audit work and the response of managers, ensuring that recommendations are followed-up and any lessons are learned within the Trust.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of internal audit and of co-ordination between the Internal and External Auditors to optimise audit resources.
- Regular review of resource allocation to the local counter-fraud service (LCFS), progress against the LCFS work plan and ongoing LCFS investigations, and the outcomes, learning and actions resulting from counter fraud work.

External Audit

3.11 The Committee shall support the Council of Governors with their duty to appoint, re-appoint, or remove the external auditor. The Committee shall:

- agree the criteria for appointment or removal with the Council of Governors, and advise on the external audit terms and conditions including fees;
- report to the Council of Governors annually on the performance of the external auditor;
- and agree with the Council of Governors a policy on the engagement of the external auditor to provide non-audit services.

3.12 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the performance of the External Auditor, as far as the rules governing the appointment permit.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local NHS.
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Local Health Economy and associated impact on the audit fee.
- Reviewing all External Audit reports, ensuring appropriate management responses and monitoring the implementation of responses
- agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

3.13 The Audit Committee shall receive assurance from the Quality and Risk Committee on its review of the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc).

3.14 The Committee shall review the work of other Committees within the organisation whose work can provide relevant assurances. This will particularly include the Quality and Risk Committee, the Finance and Investments Committee and any other risk management Committees that may be established. In reviewing the work of the Quality and Risk Committee and issues concerning clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

3.15 The Committee shall review all decisions made by the Board to suspend Standing Orders or Standing Financial Instructions.

3.16 The Committee shall receive reports at least Quarterly on the work relating to Security.

Management

3.17 The Committee shall require and review reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

3.18 The Committee may also require specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

3.19 The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

3.20 The Committee shall ensure that that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.21 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- significant judgements in the preparation of financial statements;
- significant adjustments resulting from the audit;
- letter of representation
- qualitative aspects of financial reporting.

REPORTING AND RELATIONSHIPS

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

3.23 The Committee shall make an annual report to the Board of Directors to demonstrate the Committee's discharge of its duties and to confirm the fitness for purpose of the Trust's assurance framework, risk management, and governance processes.

3.24 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

3.25 The Committee shall make an annual report to the Council of Governors identifying any matters where it recommends that action or improvement is necessary; and reporting on the performance of the external auditor.

3.26 The Committee shall review the minutes and recommendations of the Quality and Risk Committee and other Committees as appropriate.

3.27 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

4.00 CONDUCT OF BUSINESS

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

4.02 The Committee shall be deemed quorate if there are at least two non-executive Directors present. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

4.03 The Committee shall meet not less than four times in each financial year. The Chair of the Committee may request an extraordinary meeting if he/she considers one to be necessary. The External Auditor or Head of Internal Audit may request a meeting of the Committee if either or both consider that one is necessary.

4.04 At the discretion of the Chair of the Committee business may exceptionally be transacted either: through a teleconference where an agenda has been issued in advance; or through the signing by two thirds of members of a written resolution sent in advance to members and recorded in the minutes of the next formal meeting.

4.05 Agendas and papers should be prepared and circulated five clear days before each meeting.

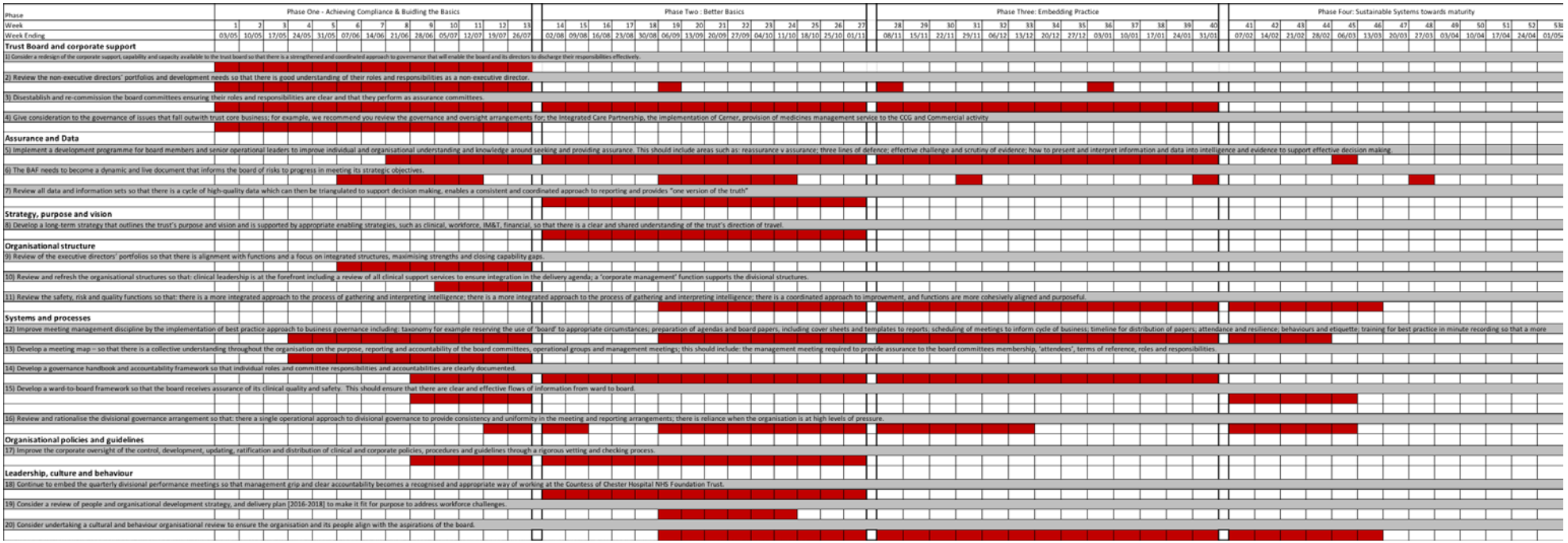
4.06 Minutes of Committee meetings should be formally recorded and distributed to Committee Members, normally within 10 working days of the meetings. Subject to the approval of the Chair of the Committee, the Minutes will be submitted to the Trust Board at its next meeting and may be presented by the Chair. The Chair will draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

5.00 STATUS OF THESE TERMS OF REFERENCE

Approved by Trust Board: [Date]

Next Review: Sept 2019

Appendix Four - High Level Governance Improvement Plan



NHS
Countess of Chester Hospital
NHS Foundation Trust

Item Reference and Title	**Agenda item 14 - Audit Committee Chair's Report to Board of Directors (BoD)**
Date of Meeting	Audit Committee Meeting – 16th April 2019
Author(s)	Rachel Hopwood - Chair
Alignment to Board Assurance Framework risk	CR7 – Failure to maintain robust corporate governance and overall assurance (risk score 12).
Alignment to CQC Domains	Well Led
Summary	This report is intended to: • Provide an update on the work and decisions of the committee. • Notify the BoD of MIAA's Internal Controls Assurance Opinion and Anti-Fraud Annual Report (included in items for escalation to Board). • Highlight other items for escalation to Board: o Frequency of BAF at BoD in 2018/19; o Need for rework on Annual Governance Statement to appropriately reflect the Trust's current position; o Unable to currently approve the proposed going concern and asset valuation treatment in the year end accounts to May's meeting.
Recommendation(s)	**The Board is asked to**: • Receive all items for escalation from Audit Committee. • Ratify inclusion of GDPR compliance oversight within the Terms of Reference (ToR) of the FIG (or successor) Committee.

NHS
Countess of Chester Hospital
NHS Foundation Trust

1.0 Key items of business discussed

The Audit Committee met on 16th April, 2019, and the following key business items were discussed:

- Progress on Outstanding Actions and Audit Tracker.
- Update on GDPR compliance: Information Governance & Procurement.
- Update on MIAA work: Progress Report; Internal Audit Annual Opinion; draft 2019/20 Audit Plan; industry insights; Anti-Fraud Annual Report & Action Plan.
- Review of Draft Annual Governance Statement (AGS).
- Technical update from KPMG.
- Review of proposed changes to 2018/19 accounting policies.
- Review of significant issues, estimates and judgements arising during preparation and audit of 2018/19 Annual Accounts.

2.0 Key agreements or decisions made

- Director of Finance (DoF) to provide an update to Board on 2019/20 CRS plans including full transparency on progress made against items identified in Q4 2018/19 Recovery Plan. (Complete – received 2nd May 2019).
- Director of People & OD to attend next Committee to update on aged outstanding people-related issues on the Audit Tracker.
- DoF to attend next Committee to update on aged outstanding procurement issues on the Audit Tracker.
- Cerner MIAA review Terms of Reference to be circulated to Audit Committee members for review ahead of commencement of internal audit.
- Responsibility for oversight in ensuring all suppliers are GDPR compliant (vendors handling sensitive information to be prioritised) to be included in FIG (or successor committee) terms of reference.
- Gap review to be prioritised by DoF on Carter Programme Efficiency Guidance and Grip and Control Guidance materials, with feedback provided to the BoD.
- Head of Procurement to review contracts for impact of guidance issued by NHSI on IFRS15 (timing of income recognition).
- Committee approved the following accounting policies: single segmental reporting & non-consolidation of charitable funds.
- Outstanding review of relationships with other Board Committees (pending ongoing Governance Review) and NHS Provider Licence assurance submission review deferred to next meeting.

3.0 Items for escalation to Board

- MIAA has issued a Moderate Assurance Opinion that there is an adequate system of internal control for inclusion within the Annual Governance Statement based on audit work performed (opinion unchanged from 2017/18).
- MIAA Anti-Fraud Annual Report was "RAG" rated overall amber (unchanged from 2017/18). As part of the Anti-Fraud Annual Report, the Director of Finance and Chair of Audit completed a self-assessment return post the meeting (30th April 2019).
- MIAA review determined that BAF was presented to BoD twice last year – frequency to be addressed as part of on-going Governance Review.
- Rework has been requested on the draft AGS which was presented to Committee. It was felt to not adequately reflect the Trust's worsening financial position, was over-optimistic in tone, the new model of integrated governance required more explanation and the Trust's shortcomings should have more prominence.
- The Audit Committee were unable to approve the going concern statement and measurement valuation (Cushman and Wakeman assets valuation methodology) based on the documentation provided at the April meeting. Additional support for the treatment currently proposed by the Trust in the accounts on these matters has been requested and will be reviewed in May's meeting.

4.0 Recommendation(s)

4.1 Receive all items for escalation from Audit Committee.

4.2. Ratify inclusion of GDPR compliance oversight within the Terms of Reference (ToR) of the FIG (or successor) Committee.

NHS
Countess of Chester Hospital
NHS Foundation Trust

Item Reference and Title	**Agenda item 16 - NHS Provider Licence Statement – Self Certification**
Date of Meeting	Board of Directors 21st May, 2019
Accountable Executive	Chief Executive Officer
Author(s)	Interim Trust Secretary
Alignment to Board Assurance Framework risk	CR7 – Failure to maintain robust corporate governance and overall assurance; and
Alignment to CQC Domains	Well Led
Document Previously Considered by:	Document also submitted to 20th May, 2019, Audit Committee
Summary	This report provides the Trust Board self-certification detail against the following Licence Conditions: • G6: Systems for Compliance with Licence Conditions • CoS7: Continuity of Service • FT4: Corporate Governance Statement • Training of Governors. The Board are required to respond "confirmed" or "not confirmed" to the statements. In addition, within the Corporate Governance Statement, the Board is required to outline risks and mitigating actions.
Recommendation(s)	The Board is asked to approve the statements within the NHS Provider Licence Self-Certification
Corporate Impact Assessment:	**Legal and regulatory impact:** Yes, Provider Licence Conditions. **Financial impact:** **Patient Experience/Engagement:** **Risk & Performance Management:** **NHS Constitution/Equality & Diversity/Communication:**

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NHS Foundation Trust

(A) Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence (2018/19)

1 & 2 General condition 6 – Systems for compliance with licence conditions			
		Response	**Comments**
1.	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	*Paragraph 2 (a) and (b) from condition G6 are as follows:* *(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and* ***(b)** regular review of whether those processes and systems have been implemented and of their effectiveness.* The Trust has had no conditions imposed upon it preventing it from discharging its statutory responsibilities. The Trust has a risk management system in place. The Head of Internal Audit provides *Moderate* assurance on the effectiveness of the system of internal control, as outlined within the Annual Governance Statement. The Trust is implementing a Governance Improvement Plan following an external governance review with a view to improving the effectiveness of its processes and systems.

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Countess of Chester Hospital
NHS Foundation Trust

3. Continuity of services condition 7 – Availability of Resources (FTs designated commissioner requested service (CRS) designation)

		Response	Statement of main factors taken into account when making this declaration (e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.):
	EITHER		
3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate	Not confirmed	See text below
	OR		
3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services	Confirmed	The Trust is not in financial special measures. See text below.
	OR		
3c	In the opinion of the Director of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate	Not Confirmed	

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Countess of Chester Hospital
NHS Foundation Trust

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6:
The Trust has been set a £8m Deficit Control Total (before Provider Sustainability Funding PSF, Financial Recovery Funding FRF, and Marginal Rate Emergency Tariff MRET), as part of the national financial regime, that if the Trust is successful will lead to a breakeven position in 2019/20.

(B) Corporate Governance Statement (FT4 declaration)

		Response	Position Statement	Risk and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which would reasonably be regarded as appropriate for a supplier of health care services to the NHS	Confirmed	The Trust applies the NHS Foundation Trust Code of Governance on a "comply or explain" basis and Disclosures are included within the 2018/19 Annual Report. The Trust has no CQC warning notices.	To address any 'must do's' within the recent CQC report.
2.	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	NHSI guidance is reviewed following issue. An external governance review was commissioned in December 2018.	Governance will be strengthened in 2019/20 via a Governance Improvement Plan following an external governance review.
3.	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for the staff reporting to the Board and	Confirmed	Board sub-committees report into board with defined terms of reference. A Schemes of Reservation and Delegation is in place. Non-Executive Directors bring challenge to the Unitary Board.	Committee structures, meeting structure, responsibilities and lines of accountability will be strengthened in 2019/20 via a Governance Improvement Plan.

	those committees; and (c) Clear reporting lines and accountabilities throughout its organisation		An external governance review was commissioned in December 2018 that has indicated that committee structures and lines of accountability could be strengthened. This has been outlined within the Annual Governance Statement.	
4.	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate,	Confirmed	(a) The Trust has accepted its deficit financial control total but does have a challenging cost improvement programme. Economy, efficiency and effectiveness are referenced within the Annual Governance Statement. (b) The Integrated performance report is produced monthly and reported to each Board. The CQC are satisfied with the Trust's governance processes. (c) The Trust has challenging performance with a number of key Constitutional targets. A response to the CQC review is being agreed. Key clinical policies are in place and reporting of infection control standards and never events is included within reports to Board. (d) The Going Concern statement is outlined within the Annual Report and subject to external audit. The Trust has a	(b) & (e) Systems and processes will be further strengthened in 2019/20 following recommendations from the external governance review. A risk-based internal audit plan has been agreed for 2019/20. (c) The Trust will address any 'must do' actions from the CQC report. The outcomes for patients will be agreed, along with an overall strategy for the organisation. (d) The Board recognises the challenges of the cost improvement programme and the deficit position in 2018/19 is reported within the Annual Governance Statement and Annual Accounts.

	comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		financial plan, which includes financial recovery plans. (e) Information and reports are provided for Board and committee decision making. Minutes of Board committee meetings are also provided to the Board. (f) The Trust has a Risk Management Strategy in place which outlines the Trust's approach to risk and provides a framework for managing risk across the organisation. The Board Assurance Framework is presented to Board outlining the strategic risks. Lessons Learned are shared within the Trust as part of the development of a learning culture. An unannounced CQC inspection has taken place in 2018, along with a Well Led review. The Trust has had no conditions imposed upon it preventing it from discharging its statutory responsibilities. (g) The Trust has in place an operational plan agreed by the Trust Board. Business plans are considered at Corporate Leadership Group. (h) The Trust applies the NHS Foundation Trust Code of Governance on a "comply or explain" basis which includes some statutory requirements. Changes in	

			legislation are considered as they arise via Executive Directors Group in the first instance and then at the appropriate Committee/Board.	
5.	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including	Confirmed	(a) The Board has had a change in senior leadership in-year. (b) Quality Impact Assessments are part of decision making processes and are signed off by the Medical Director and Director of Nursing and Quality. (c) Data collection/ data quality/ data validation systems are in place, which are subject to internal and external audit. (d) The Board and Quality, Safety & Patient Experience Committee receives regular information on quality of care. (e) This is referenced within the Quality Accounts. There is a process of Quality Spot Checks in place and feedback from Governors at the Governors Quality Forum. (f) The Trust's risk management process is in place which links to the Board Assurance Framework.	(a) & (f) An improvement plan will be put in place following the external governance review. (a) Executive portfolios are under review and a clinical strategy is near completion. The Board is reviewing their appetite for risk as part of a review of the Board Assurance Framework. (e) Recommendations from the MIAA Quality Spot Checks review have been completed.

	escalating them to the Board where appropriate.			
6.	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Systems are in place to confirm staff qualifications upon appointment. Board Members comply with the Fit & Proper Person's Test. A Unitary Board is in place which includes appropriately qualified Directors and Non-Executive Directors.	

Training of Governors

		Response	**Position Statement**
1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	The Trust has a number of Governors who have attended Governor training courses. However, there are new Governors who are yet to attend. The Trust intends to review Governor training needs in early 2019/20 and put in place a refreshed Governor training programme. The Trust holds a monthly Governors Quality Forum to ensure that the Governors have the knowledge of current Trust issues in order to undertake their role.

NHS
Countess of Chester Hospital
NHS Foundation Trust

Item Reference and Title	**Agenda item 17 - Charitable Fund's Committee Chair's Report to Board of Directors**
Date of Meeting	Board of Directors - 21st May 2019
Author(s)	Ed Oliver Non-Executive Director Chair of Charitable Funds Committee
Alignment to Board Assurance Framework risk	CR7 – Failure to maintain robust corporate governance and overall assurance (risk score 12)
Alignment to CQC Domains	Well Led
Summary	This report is intended to provide an update on the meeting of the Charitable Funds Committee, held on Tuesday, 9 April 2019.
Recommendation(s)	The Board is asked to note the update.

1.0 Key items of business discussed

The Charitable Funds Committee met on Tuesday, 9 April 2019, and the following key business items were discussed, namely:

- To review and approve the Charitable Funds Accounts, as at 31 March 2019, including
  - A report on Investments & Bank Balances held;
  - A report on Income and Expenditure activities over the last year; and
  - A report on the Charitable Fund individual fund activity
- To receive a report from the Head of Fundraising
- To discuss the Kisiizi Project, and next steps
- To receive an update on the new Neonatal Development.

2.0 Key agreements or decisions made

The key agreements made were:

- An agreement to look at dormant individual Charitable Funds at the next meeting;
- An agreement to purchase 30 Vital Signs Monitors , from Funds held, in order to support patient care;
- To approve a number of smaller purchases , including:
  - supporting International Nurses Day, on Monday 13 May 2019;
  - Emergency Medical Unit (EMU) improvement of patient toilet facility;
  - Activity Boxes for the Dementia Team ;
  - New Chairs for the Gynaecology Assessment Unit;
  - Purchase of Malling Perching Stools, for Ward 54, with a commitment to potentially purchase more;
  - Purchase of Vein Viewer Flex, for the Phlebotomy Team;
  - Purchase of a Bladder Scanner for Ellesmere Port Hospital; and
  - Wall protection for the Magnetic Resonance Imaging suite.
- A decision to review the staffing mix within the Charitable Funds Team, following a number of recent departures; and
- The need to seek funding requested by the Community Midwives Team from the monies held by the Childbirth Trust.

3.0 Items for escalation to Board

Items identified for escalation to the Board were:

- The potential to do something different with regards to the annual “Tree of Life” celebrations at

both the Countess of Chester Hospital and Ellesmere Port Hospital; and

- To seek to liaise with the staff with regards to ascertaining their preference about supporting either a local Charity, or continuing with the Kisiizi scheme, in the longer term.

4.0 Recommendation(s)

The Board is asked to note the update.