MEETING OF THE BOARD OF DIRECTORS (PUBLIC)
TUESDAY, 25th JUNE 2019 AT 9:30AM – 11:30AM

TRAINING ROOM 3&4, EDUCATION & TRAINING CENTRE

A G E N D A

Apologies: Mr A Higgins, Dr D Kilroy

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 21st May 2019 and matters arising **(Attached)**	Chair
4.	To receive a CEO update **(Attached - page 11)**	Chief Executive Officer
SAFE		
5.	To receive a patient story	Director of Nursing and Quality
6.	To approve Maternity Incentive Standards 2019/20 Submission **(Attached - page 17)**	Director of Nursing and Quality
7.	To receive the Annual Nursing & Midwifery Staffing Report **(Attached - page 31)**	Director of Nursing and Quality
8.	To receive a report from the Chair of the Quality, Safety and Patient Experience Committee – 22nd May 2019 **(Attached - page 105)**	Non-Executive Director Ms R Fallon
EFFECTIVE		
9.	To review the Integrated Performance Report as at Month 1 **(Attached - page 108)**	Executive Team
10.	To review the Finance Report Month 2 2019/20 and note the Financial Plan Update **(Attached X 2 - page 139)**	Director of Finance

11.	To agree the National Cost Collection 2019 pre-submission report **(Attached - page 175)**	Director of Finance
12.	Pathology Collaboration Paper **(Attached - page 187)**	Chief Operating Officer
WELL LED		
13.	To receive a report from the Chair of the Audit Committee – 20th May Extra-ordinary Committee 2019 **(Attached - page 216)**	Audit Committee Chair
14.	To approve the Governance Improvement Plan and Terms of Reference for Finance & Performance Committee and Quality & Safety Committee **(Attached - page 218)**	Chief Executive Officer
15.	**Items for noting and receipt (Attached – sent under separate email)**: - Minutes of the Audit Committee – 16th April, 2019 - Minutes of the People & OD Committee – 7th May 2019 - Minutes of the Quality Safety & Patient Experience Committee- 16th April 2019	
16.	Date and Time of Next Meeting: **Board of Directors Meeting** **24th Sept 2019 – 9:30am, Training rooms 3 & 4, Education and Training Centre.**	

MINUTES OF THE BOARD OF DIRECTORS (PUBLIC),
HELD ON TUESDAY, 21ST MAY, 2019, AT 9:30AM-12:00,
BOARDROOM

		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	☑	
Chief Executive Officer	Dr S Gilby	☑	
Executive 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	☒	
Chief Operating Officer	Ms L Burnett	☑	
ICP Managing Director	Ms A Lee	☒	

In attendance:

Mrs D Bryce – Interim Trust Secretary

FORMAL BUSINESS

B35/19 **WELCOME AND APOLOGIES**

The Chair welcomed members to the Board of Directors meeting.

The Chair extended congratulations to Dr Darren Kilroy in his appointment as Executive Medical Director.

B36/19 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

B37/19 **TO RECEIVE AND APPROVE THE BOARD OF DIRECTORS MINUTES OF MEETING HELD ON 26TH MARCH, 2019, AND MATTERS ARISING**

The minutes of the Board of Directors' meeting held on 26th March, 2019, were received as a true and accurate record.

There were no matters arising.

B38/19 **TO RECEIVE A CEO UPDATE**

The Chief Executive Officer referred to the written CEO update paper. In response to Non-Executive Director, Mr Higgins, seeking clarification on the Welsh contract resolution, the Chief Executive Officer informed that the national issue on funding is resolved and that all providers will now receive 2019/20 tariff, although there will be a circa 1.25% residual differential, as Wales do not pay for CQUIN. The Director of Finance informed that the Countess of Chester have now signed the contract with Wales.

SAFE

B39/19 **TO RECEIVE A RESPONSE TO THE CQC REPORT**

The Director of Nursing & Quality referred to the CQC report published on 17th May, 2019, and the Trust's response. It was noted that, disappointingly, the Trust received a *Requires Improvement* overall rating from the CQC, with Caring being rated as *Good*. The response sets out the approach to how the Trust will make improvements, including leadership improvements and a detailed plan to address the "must do" actions.

In response to a question from Non-Executive Director, Mrs Hannah, the Chief Executive Officer informed that the Quality Committee will oversee the action plan.

Non-Executive Director, Mr Higgins, raised that he would welcome a follow-up on the prioritisation of the actions and identification of those delegated down within the organisation. The Chair informed that the Board should take formal time out to review this and the Director of Nursing suggested that this should be quarterly.

The Director of Nursing commented that the key priorities in the Quality Account for 2019/20 reflect the CQC priorities too and the Medical Director informed that this adds extra pace and grip to take this forward positively. The Chief Executive Officer indicated that the Well Led Review is a governance review but also picks up on organisational strategy and that the first stage of this is a clinical strategy, which is near completion.

The Board received the response to the CQC report and the detailed action plan in place to address the "must do" actions.

B40/19 **TO RECEIVE AND AGREE THE QUARTER 4 BOARD ASSURANCE FRAMEWORK**

The Director of Nursing & Quality informed that the Board Assurance Framework will be updated for

Quarter 1 and link to the CQC requirements. The Medical Director commented that the new clinical services strategy will link to the sustainable workforce risk.

Non-Executive Director, Mr Higgins, raised that the risk for CR1 has remained the same despite the CQC report and the findings regarding the safety culture. The Director of Nursing responded that based on what we now know the score would be different and the content and score will be reviewed for Quarter 1. Non-Executive Director, Mrs Hopwood raised the importance of being able to forward project risk within the BAF in the future. Non-Executive Director, Mrs Hannah, raised that the risk likelihood for risk CR7 has increased which is the point in reverse. The Chief Executive Officer informed that there is still work to be done regarding governance from ward to Board. The Chair acknowledged the importance of recognising risk and a change to the risk score once achieved, and suggested that the Audit Committee consider this further.

The Board received and agreed the 2018/19 Quarter 4 Board Assurance Framework and noted the work planned to review the Board Assurance Framework for 2019/20.

B41/19 **TO RECEIVE AND APPROVE THE QUALITY ACCOUNTS 2018/19 AND MANAGEMENT REPRESENTATION LETTER, AND TO RECEIVE THE INDEPENDENT AUDITOR'S REPORT.**

The Director of Nursing highlighted the following in relation to the Quality Accounts 2018/19:

- There are a number of positive messages but not all of the priorities from last year were achieved and they will be cross referenced with the CQC report;
- Key findings include a need to drive improvements in Sepsis performance, the deteriorating patient, infection prevention and control, and reducing process variation;
- Feedback has been received from stakeholders, including the NHS West Cheshire Clinical Commissioning Group (CCG) feedback which has been circulated to Board today and was positive; and
- A few changes within the report were articulated to the Audit Committee yesterday and included a change to the RTT figure to an average for the year, along with a change to the SHMI rate to 1.07 which is the NHS Digital rate.

Non-Executive Director, Ms Fallon, referred to the CQC report reference to the work on falls and the required outcome has not been demonstrated. The Director of Nursing responded that time has been taken to embed the falls work in practice and that an improvement should now start to be seen.

Non-Executive Director, Mrs Hopwood, as chair of the Audit Committee thanked the staff and teams who had contributed to the development of the Quality Accounts, asked the Board to note the limited assurance from the external auditor which is the highest level of assurance, and recommended the Quality Accounts and Management Representation letter to the Board.

The Board approved the 2018/19 Quality Accounts and Management Representation Letter and received the Independent Auditor's Report.

B42/19 **TO RECEIVE A REPORT FROM THE CHAIR OF THE QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE (QSPEC)**

The QSPEC Chair, Non-Executive Director, Mr Higgins, referred to his report and the items for escalation to Board which included equipment failure and the fragility around the external constraints in place. The QSPEC Chair informed that he felt that the Executive and colleagues understand the equipment position even though it was escalated for Board attention, that there had been a good discussion around Sepsis at QSPEC but that a clearer view of the improvement trajectory was needed and will come back to the Committee.

In response to a question from the Chair, the Director of Nursing informed that Sepsis standards will be achieved and improvements in this will be driven for our patients, and that she and the Medical Director are driving this, along with the clinical lead for Sepsis. Non-Executive Director, Mrs Hannah, raised that the work going on should be reflected better within the exception reports and the Director of Nursing agreed to review this.

The Board received the report form the Chair of QSPEC.

EFFECTIVE

B43/19 **TO REVIEW THE INTEGRATED PERFORMANCE REPORT AS AT MONTH 12**

The Chief Operating Officer highlighted the following from the integrated performance report:

- Improvements to the presentation and layout of the performance report should be seen by Quarter 2;
- A&E performance has dropped to 84.9%. The A&E Department is not physically big enough for the patient numbers attending; there is a workforce plan is in place within the Urgent Care Division to support improving performance in the evening.
- RTT performance has dropped to 83.7% and is linked to the prioritisation of cancer work, and an improvement plan is in place with each specialty;
- That the representation of the six weeks diagnostic performance will be flipped around in future to reflect national reporting, but currently is unfortunately at 96.2% (3.8% against the 1% target); and
- The Trust is aiming to achieve 85% for the cancer 62 day standard, but is currently at 82.9%. We did not anticipate an 11% increase in cancer referrals in 2018/19; the previous swings in performance seen in 2017/18 have been levelled out due to improved oversight and tracking of pathways giving a good foundation from which to build our performance against the national standard..

Non-Executive Director, Ms Fallon, suggested that it would be helpful in future to see trajectories for improvement and asked if this year's performance was expected to show these. The Chief Operating Officer responded that the trajectories are included within the annual operational plan and will be included in the reformat of the report by Quarter 2. The Medical Director informed the board of the link between Sepsis and A&E performance and the pathway improvement work that is underway.

The Director of Nursing reported that an external review of infection prevention and control has been commissioned and it is likely that a number of changes will be required, with one issue being

how to maintain patient flow whilst keeping patients safe, which will need to be considered prior to Winter pressures.

In response to Non-Executive Director, Ms Fallon's, query regarding mixed sex accommodation patients, the Director of Nursing responded that main areas of concern were within high acuity patient area step down such as stroke and coronary care and that this is being monitored.

The timescale for clinical correspondence improvements within the exception report was raised by Non-Executive Director, Mrs Hopwood, and the Chief Operating Officer informed that the Trust has agreed with the CCG to focus on three key specialities and that the solution in the future may be linked to a digital, rather than manual, solution.

The Board reviewed and received the integrated performance report for month 12 of 2018/19.

B44/19 **TO REVIEW THE FINANCE REPORT MONTH 12 2018/19 AND MONTH 1 2019/20**

The Director of Finance raised the following:

Month 12 Report:

- The anticipated deficit in Table 1.1 of £12.7m;
- The £13.1m figure in the Annual Accounts, and that the Table reconciles the two numbers;
- £1.7m of Provider Sustainability Funding money was received during the year, and at the end of the year an additional £2.7m of Provider Sustainability Funding received, recognising the national year end distribution of monies (this was calculated after the submission of the Draft Year Accounts, which supports capital as it comes in the form of cash); and
- There is also a £5m technical impairment, which whilst not counted in the Trust's performance against its Control Total, is reflected within the Annual Accounts.

Month 1 Report:

- The Trust have entered into a Payment by Results (PbR) contract, and the position includes estimates of activity as some activity remains un-coded;
- Success this year will be in achieving an £8m deficit position, being the agreed Control Total, and the Trust is £160k away from this target at Month 1, although income remains broadly on-plan; and
- There are pressures on nursing expenditure, combined heat and power generator costs (due to repair taking place off site), medical staffing model costs, and a high number of material human resources cases (which often require backfill, and also impact upon activity)

In response to Non-Executive Director, Mrs Hannah, the Director of Finance responded that cost reduction strategy schemes in black were a "gap" rather than "black" schemes.

The Director of Finance also responded that an emerging cash flow risk was being managed and mitigated around the LED lighting project funding.

The Board reviewed and received the finance report for Month 12 and Month 1.

CARING **TO RECEIVE A REPORT FROM THE CHAIR OF THE PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE**

B45/19 The Chair of the People & OD Committee, Non-Executive Director, Mr Oliver, referred to the report and the meeting of 7th May, 2019. Concern had been raised regarding Trust levels of sickness and a recovery plan is being developed to address this, along with monitoring of the activity being undertaken related to the findings of the NHS Staff Survey 2018. The impact of new proposed Board Committees on the People & OD Committee was also raised.

The Board received the report from the Chair of the People & OD Committee.

RESPONSIVE

B46/19 **TO RECEIVE A PRESENTATION ON TRANSFORMATION PROGRAMMES**

The Director of Planning & Partnerships presented the improvement plans undertaken during 2018/19 and the work that is planned in 2019/20, which included the following:

- A number of initiatives to reduce length of stay and improve patient flow including the benefits seen in the introduction of new services such as the Elective Short Stay Unit and the Emergency Medical Unit;
- The introduction of the Co-ordination Centre and the identification and reduction of idle bed time and other associated efficiencies;
- The introduction of a text reminder service and a steady reduction in DNA's in outpatients and the work planned to improve outpatient efficiencies including improving clinical pathways and service provision;
- Work in theatres to reduce cancellations and increase day case rates and plans further to improve services;
- A number of metrics showing improvement in patient experience.

It was outlined that the transformation programmes would be monitored via the Transformation Group and will continue to link to cash releasing efficiencies.

Non-Executive Director, Mr Higgins, queried if there were connections between increasing the efficiency of the assets and a deterioration in infection prevention and control performance. The Medical Director responded that vigilance is required at every step and there are ideas regarding how quality improvement links to this area to bring the two together.

Non-Executive Director, Mrs Hannah, welcomed the content of the presentation and sought clarification of how the board is more regularly updated on the improvements. The Chief Operating Officer responded that a lot of the work has become business as usual and has not been reported to Board. The Chief Executive Officer raised that the Committee to oversee transformation programmes will be chaired by herself and challenge will be provided to operational teams due to the traditional models in place currently and congratulated the team for the progress made so far.

The Chair thanked the Director of Planning & Partnerships for his presentation.

The Board noted and received the presentation on transformation programmes.

WELL LED

B47/19 **TO APPROVE A PROPOSAL ON GOVERNANCE IMPROVEMENT AND COMMITTEEES OF THE BOARD**

The new proposed Board committee structure was outlined by the Chief Executive Officer with the aim to split assurance from operational management. It was raised that phase one of governance improvement is underway to ensure compliance with the Trust's statutory requirements and the first step is to establish a Quality & Safety, Finance & Performance and Audit Committee and disestablish the People & OD Committee. The Chair suggested further scrutiny on all terms of reference but proposed agreement on the new structure.

Non-Executive Director, Mr Higgins, commented that the real drive of assurance is the manner in which it is fed and it will depend on the restructuring below the committees of the Board. The Chief Executive Officer outlined that the phasing within the plan makes reference to this, including education of members of committees, responsiveness of data and managing governance from ward to Board for the benefit of patients.

There was a discussion, prompted by the Chair, regarding organisational development and if it should sit within the Quality & Safety Committee or Finance & Performance Committee and the Chief Executive Officer stated that it may be better to sit within Quality & Safety but it will depend on the view of the chairs of the committees and the organisational development strategy which is due to be refreshed. The paper proposes to try the new structure for four months, which are two business cycles. Non-Executive Director, Mrs Hopwood, suggested that the chairs of the committees work through the terms of reference and the inclusions.

The Board received the detail within the governance improvement proposal, agreed the new proposed structure for committees of the Board and agreed that further work was required on the terms of reference for the committees of the Board.

B48/19 **TO RECEIVE A REPORT FROM THE CHAIR OF THE AUDIT COMMITTEE – APRIL 2019**

The chair of the Audit Committee, Non-Executive Director, Mrs Hopwood, referred to her report and the items for escalation to the Board, and drew attention to the fraud self-assessment and amber rating, and that the Board Assurance Framework had only been to the Board of Directors twice last year at the time of publication of the internal audit review.

The Board received the report from the chair of the Audit Committee.

B49/19 **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.**

The Director of Finance presented figures in relation to the 2018/19 Accounts and referenced:

- The deficit in the published annual Accounts for the year of £13.1m, after accounting for the impairments;
- That the external auditor has completed an extensive audit and identified three unadjusted items, although these are not considered to be material. The Director of Finance therefore recommended that no adjustment was made, which would have adjusted the accounts by circa £300k figure; and
- That the Director of Finance is comfortable to sign the Management Representation Letter.

The Chair of the Audit Committee, Non-Executive Director, Mrs Hopwood, extended thanks on behalf of the Audit Committee to the Finance Team, Deputy Director - Planning & Partnerships and the Interim Trust Secretary, regarding the 2018/19 Annual Report and associated documents, and informed that an unqualified audit opinion had been received for the Annual Report. The Chair of the Audit Committee raised further that there were two consolidation unadjusted differences within the Accounts and that the Committee were content with these; the Committee had considered Going Concern and depreciation; that the Management Representation Letter includes valuation of land and buildings; that there was an unqualified group assurance certification on the Accounts; and that the documents were recommended to the Board from the Audit Committee.

The Board received and approved the 2018/19 Annual Report, including Annual Governance Statement, the 2018/19 Accounts and the Management Representation Letter.

The Board received the ISA260 Audit Highlights Memorandum and the External Audit Opinion.

B50/19 **TO APPROVE THE NHS PROVIDER LICENCE SELF-ASSESSMENT**

The self-assessment against the NHS Provider Licence was introduced by the Interim Trust Secretary, outlining the reference within the confirmed statements to reflect on the findings of the CQC report and the external governance review, along with the intention to bring the self-assessment to the Board each year.

The chair of the Audit Committee recommended the 2018/19 NHS Provider Licence self-assessment on behalf of the Audit Committee.

The Board approved the NHS Provider Licence Self-Assessment.

B51/19 **TO RECEIVE A REPORT FROM THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE – APRIL 2019**

The Chair of the Charitable Funds Committee, Non-Executive Director, Mr Oliver, reported a healthy state in the charitable funds bank balance and that there had been recent consideration of the Kisizzi project in Uganda, along with equipment requests. In response to a question from the Chair, the Chair of the Charitable Funds Committee confirmed that the Committee were still considering integration of general funds.

The Board received the report from the Chair of the Charitable Funds Committee.

B52/19 **ITEMS FOR NOTING AND RECEIPT**

The Board received and noted the following:

- Minutes of the Audit Committee – 19th February, 2019;
- Minutes of the Quality, Safety & Patient Experience Committee – 19th March, 2019; and
- Minutes of the Charitable Funds Committee – 18th December, 2018.

B53/19 **DATE AND TIME OF NEXT BOARD OF DIRECTORS' MEETING**

Tuesday 25th June, 2019 – 9:30am, Training rooms 3&4, Education and Training Centre.

Item Reference and Title	**Agenda item 4** - Chief Executive's Update
Date of Meeting	Board of Directors Tuesday 25th June, 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 June 2019

1. **Regional/national issues**

1.1 We welcome the announcement of the NHS Improvement interim NHS people plan https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan which sets the national strategic framework for the workforce over the next five years and was published on 3rd June, 2019.

1.2 Amanda Pritchard has been appointed as the NHS' Chief Operating Officer (COO). She is currently Chief Executive of Guy's and St Thomas' NHS Foundation Trust in London and will take up her new post full time on 31 July. The new NHS chief operating officer post is directly accountable to the NHS chief executive Simon Stevens, and serves as a member of the combined NHS England /NHS Improvement national leadership team. The COO oversees NHS operational performance and delivery, as well as implementation of the service transformation and patient care improvements set out in the NHS Long Term Plan.

1.3 The latest monthly NHS operational statistics have been published with overall A&E performance improving last month, as did emergency ambulance response times and the number of 52 week waits for routine surgery. At the same time NHS staff successfully looked after more patients than ever before. As a result of a 15% increase in urgent cancer referrals over the past year, a member of the public's likelihood of being urgently checked for cancer and treated promptly within 62 days is now the highest since records began.

1.4 The NHS has announced an additional £5 million will fund reviews to improve care for people with a learning disability and committed to renewed national action to tackle serious conditions. The world's first program to review the deaths of everyone with a learning disability is being expanded to speed up the spread of best practice. Thousands more reviews will be carried out over the next 12 months, driving local improvements to help save and improve lives.

2. **Local Issues**

2.1 The election process for a number of Public and Staff Governor positions will begin with the opening of nominations planned for early July. Further information on this will be communicated to Trust members and staff.

2.2 The Haygarth Medal for Nursing is set to be awarded later this month. The award is our golden accolade for nursing at The Countess, acknowledging outstanding contributions to the profession from across the organisation. It's an award with historical links to healthcare and nursing in Chester since long before the NHS began and will go to a truly deserving nurse colleague.

2.3 The Trust is set to replace all of the defibrillators across all departments at our Countess and Ellesmere Port hospital this month and for the first time, the person giving CPR will now receive real-time feedback to help improve the rate, depth and overall quality of the compressions given to each patient. The new models are produced by Zoll with feedback technology built into the defibrillator pads which does not require an expensive, standalone device. We will be the first trust in the region to introduce this style of technology for both our Adult and Paediatric patients. To support the roll out, the Zoll deployment team will be on site to deliver familiarisation sessions for all clinical staff from Monday 17 to Friday 28 June. The simplicity of the Zoll defibrillators means that training will take minutes rather than hours.

2.4 The Countess Charity has launched its latest fundraising appeal for new Vital Signs machines as part of the Trust's Electronic Patient Record (EPR) programme. Hospital fundraisers will be undertaking a host of activities to raise money for 85 of the new machines, which will work automatically with the new system, giving clinical staff across the hospital more time back to care. The charity launched the appeal in May with a stand at the hospital entrance, where EPR Clinical Lead Ieuan Giffin gave demonstrations of how they will work and what they will mean for patients and staff.

2.5 Patients, staff and visitors flocked to the garden next to the elderly care wards to enjoy a special visit during Dementia Action Week at the end of May. Chester-based Doolittles, which provides animal therapy sessions and parties, brought along two sheep called Kobi and Bear and two goats called Oscar and Finn to put smiles on patients' faces. Wards 50 and 51 made full use of the additional space created by the Memory Lane Appeal and donations to the Countess Charity also provided a concert during the week as well as an Afternoon Tea which was donated and delivered by The Chester Grosvenor.

3. **Cheshire West Integrated Care Partnership (CWICP) Board – May 23rd 2019**

The following is an update from the recent Cheshire West Integrated Care Partnership Board for which Alison Lee is the Managing Director and Chris Hannah is the Chair:

3.1 Outcomes for our Integrated Care Partnership

Key messages included:

- We need to quickly reach consensus about the five or six outcomes which are key to the work of CWICP in 2019/20 to show how we're making a difference. Only then can we instruct Business Intelligence colleagues to track our performance against the agreed outcomes.
- Colleagues at Cheshire and Wirral Partnership proposed outcomes around:
  1) Ensuring people receive care in the right place at the right time.
  2) A focus on prevention and early intervention.
  3) Reducing health inequalities.
  4) Increasing the number of healthy years people experience.
  5) Assembling the right workforce – looking beyond traditional health and social care roles and utilising community assets.
  6) Reducing care variation.
- Colleagues at Cheshire West and Chester Council proposed outcomes around:
  1) Reducing the proportion of adults who are classified as overweight or obese.

2) Reducing admission episodes for alcohol-related conditions per 100,000 population.
3) Reducing the number of adults who are self-reported smokers.
4) Reducing the life expectancy gap between the most deprived and most affluent areas of the borough.
5) Reducing the number of injuries due to falls in people aged 65 and over.
6) Reducing admissions to residential and nursing homes per 100,000 population.
7) Increasing the proportion of people over 65 who are still at home 91 days after discharge into rehabilitation or re-ablement.
8) Delayed Transfers of Care.

- We need to consider the things that are going to make the most difference in-year, but also look to the medium and long-term goals and the steps we need to take now in order to achieve them.

Partners agreed:

- Alison Lee to work with the CWICP team of directors to develop five or six high-level outcomes, with an acknowledgement that this is an iterative process.
- Ali Wheeler, Louise Barry and Andrea Campbell to review wording of our transformation goals to ensure use of plain English and eliminate any negative terminology.
- Agreed outcomes to be included in the CWICP Business Plan, which will come back to CWICP Board in June 2019.

3.2 Transformation

Key messages included:

- Programme leads across the four priority and six enabling programmes were asked to prepare high-level programme mandates which outline key priorities and objectives. Programmes will only be able to deliver against all the priorities with agreement about how to appropriately resource them.
- Healthy Lives mandate – Query around whether smoking cessation should be classed as transformative when a service was decommissioned in October 2018. Suggestion that the behaviour change aspect makes it transformational.
- Care Communities mandate – Query around which objectives identified will be measurable.
- Long Term Care mandate – The focus on care homes is the right one, however this should be tackled at Care Community level, not borough-wide level. There's also no reference to understanding the goals of individuals. The current wording is very 'medical'.
- Intermediate Care – The starting point for the development of this mandate was the Venn capacity modelling in West Cheshire.
- CWICP pulled together bids totalling £1.4m in response to the availability of Place funding. Within that was a bid of £325,000 to support the infrastructure of the ICP. Following a previous ask to partners around identifying programme and project managers to work with us this bid was developed to enable some posts to be backfilled, if required.
- Conversations are ongoing across the system about how to identify people whose existing job roles support the work of the ICP and are dedicated to achieving the same goals.

- The transformation projects to discover what people want, need and currently get are continuing. A Community Conversations feedback session is set to take place on June 19th with a report from the first phase of the diagnostic review of Care Community teams due in July.

Partners agreed:

- To ask Programme Managers to condense programme mandates to no more than two pages.
- To ask the Care Communities programme to re-word their mandate to clarify how their objectives will be measured.
- To ask the Long Term Care programme to re-develop their mandate to blend the principles of the Care Homes GP Practice with the Care Community model.
- To provide comments on the Intermediate Care mandate to the core CWICP team by no later than Friday, May 31st 2019.

3.3 Resource plan for ICP Programme

Key messages included:

- Partners are currently incurring costs of about £500k pa to fund the CWICP core team and non-pay costs such as events, training etc. This is apportioned via a fair share split calculated some time ago, which needs to be revisited.
- In Cheshire East, the budget is smaller but there are also less people involved in the core team. Separate funding is in place from NHS England / Improvement in terms of finance support. The Development Director is funded directly by the CCG and all partners pay equally.
- To replicate that model in Cheshire West, partners would have to pay £125k assuming abatement for organisations which operate across multiple ICP areas.

Partners agreed:

- Alison Lee to quickly facilitate a meeting of chief executives of contributing organisations to agree the way forward.

3.4 Managing Director Report

Key messages included:

- At the Governance Workshop in April it was noted that there should be parity of representation on the ICP board. Work is ongoing to finalise the Governance Handbook.
- The CWICP team met with new CWaC councillors at a New Members Induction event and had conversations about the integration agenda and what we're doing in our Care Communities. Representatives also presented at Cheshire West and Chester Council's Adult Social Care and Health Stakeholder Network. Agreement has been reached with the CCGs to support the appointment of a Primary Care Medical Director, clinical leads in all nine Care Communities and clinical leadership for the transformation programme.

- A considerable savings target (£1.4m) has been set for services which fall into the scope of CWICP.
- It would be helpful to understand the funding per capita for community services across West Cheshire and Vale Royal.
- A report has been prepared to outline CWICP's readiness to take on CCG functions and staff. This will be discussed at the Joint Commissioning Committee of the Cheshire CCGs on May 24th.

3.5 Working together as a board

Key messages included:

- It would be useful to get an action note out to partners quickly after the board meets to ensure actions don't slip.

Partners agreed:

- Chris Hannah to email CWICP board members to invite suggestions around systems, processes and behaviours which could ensure the effectiveness of the Board.
- To set aside time after six months to review how effectively the board is working together.

Item Reference and Title	**Agenda item 6** - Maternity Incentive Standards 19/20 Submission
Date of Meeting	25th June 2019
Accountable Executive	Alison Kelly, Director of Nursing & Quality/Deputy Chief Executive
Author(s)	Liz Hall, Directorate Manager for Women and Children's and Natasha King, Head of Midwifery and Paediatric Nursing
Alignment to Board Assurance Framework risk	
Alignment to CQC Domains	Safe/Effective/Caring/Responsive/Well Led (all the above apply)
Document Previously Considered by:	
Summary	NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care by incentivising ten maternity safety actions. The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund (approximately £220k for COCH) and will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund. The detailed working document is included:  Maternity incentive 1920.xlsx

Recommendation(s)	**The Board is asked to:** Submission of achievement of the Incentive Standards requires self-certification from the Board. The Board is asked to review the supporting evidence and approve that we have sufficiently achieved all ten standards so that we can submit to NHS Resolution in time for the deadline of 15th August 2019.
Corporate Impact Assessment:	**Legal and regulatory impact: √** **Financial impact:√** **Patient Experience/Engagement: √** **Risk & Performance Management:√** **NHS Constitution/Equality & Diversity/Communication:**

Section A : Maternity safety actions - Countess of Chester Hospital NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Yes
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes

Section B : Action plan details for Countess of Chester Hospital NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**		**When?**	
Monitoring					

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the*		
Lead executive director	*Does the action plan have executive*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Maternity incentive scheme - Board declaration Form

Trust name	**Countess of Chester Hospital NHS Foundation Trust**
Trust code	**T422**

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Medical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process:

Electronic signature	
For and on behalf of the board of	Countess of Chester Hospital NHS Foundation Trust

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name:	
Position:	
Date:	

Item Reference and Title	**Agenda item 7** - Annual Nursing & Midwifery Safe Staffing Report (1st January 2018 – 31st December 2018)
Date of Meeting	25th June 2019
Accountable Executive	Mrs Alison Kelly, Director of Nursing & Quality
Author(s)	Ms Melanie Kynaston, Associate Director of Nursing (Corporate)
Alignment to Board Assurance Framework risk	
Alignment to CQC Domains	Safe/Effective/Caring/Responsive/Well Led *(delete as appropriate)* (all the above apply)
Document Previously Considered by:	N&M Workforce Group, N&M Board
Summary	There is a national requirement for compliance with 'Safe Staffing' to be formally reported to the Board. This is the last time this report will be in this format. A less detailed paper will be produced twice a year. The purpose of this report is to provide details on the Nursing and Midwifery workforce numbers and skill mix at the Countess of Chester Hospital NHS Foundation Trust during 2018. It will evaluate if the current establishment provides the right number of staff, with the right skills in the right place at the right time. Using intelligence gathered from a range of evidenced based tools and triangulates the findings with meaningful safety, quality & patient experience measures to provide a detailed analysis, appraising the information provided and where necessary making recommendations for improvement. This report concludes that the current safe staffing levels in maternity and paediatric services are maintaining safety, quality and patient/service user experience. However, there is further work to be undertaken during 2019 to understand the establishment and skill mix required in paediatrics. Midwifery staffing levels will be monitored using the recognised Birthrate+ methodology[20] periodically to ensure the levels and skills available are appropriate to care for the mothers and babies using maternity services at the hospital.

	However, the report clearly demonstrates during 2018 there were significant gaps in the adult registered nursing numbers across general inpatient wards and departments, as outlined in the Trust's latest CQC Inspection report (2019). This has contributed to a reduction in the quality of care delivered to our patients. Where possible this risk has been mitigated by deploying staff internally, utilising temporary staff (bank and agency) and backfilling shifts unfilled with unregistered nurses. A large programme of work continues to be progressed in order to improve the current situation.
Recommendation(s)	**The Board is asked to:** Note the contents of this report.
Corporate Impact Assessment:	**Legal and regulatory impact:** ✓ **Financial impact:** ✓ **Patient Experience/Engagement:** ✓ **Risk & Performance Management:** **NHS Constitution/Equality & Diversity/Communication:**

Annual Nursing & Midwifery Safe Staffing Report

(1st January 2018 – 31st December 2018)

The purpose of this report is to provide details on the Nursing & Midwifery workforce numbers and skill mix at the Countess of Chester Hospital NHS Foundation Trust during 2018. It will evaluate if the current establishment provides the right number of staff, with the right skills in the right place at the right time. In addition it will outline the current compliance to the National Quality Board (NQB) standards in relation to adult and children's inpatient areas (including Maternity Services).

Contents

1.0 Executive Summary

1.1 The purpose of this report is to provide details on the Nursing and Midwifery workforce numbers and skill mix at the Countess of Chester Hospital NHS Foundation Trust during 2018. It will evaluate if the current establishment provides the right number of staff, with the right skills in the right place at the right time[1,3,4]. Using intelligence gathered from a range of evidenced based tools[3,4,12] and triangulates the findings with meaningful safety, quality & patient experience measures to provide a detailed analysis, appraising the information provided and where necessary making recommendations for improvement. It will outline current compliance to the National Quality Board (NQB), National Institute for Clinical Excellence (NICE) and NHS Improvement (NHSi) standards[1,3,4,10,15,16,17] in relation to adult and children's inpatient areas (including Maternity Services).

1.2 The current position for nursing and midwifery staffing at the Countess of Chester Hospital NHS Foundation Trust is creating a growing challenge, with 75 FTE registered nursing and midwifery posts currently unfilled and a worse position in staff turnover when compared to peer and national comparatives. However, this is an improving position, with a 1.8% reduction in nursing and midwifery turnover seen during the 2018 reporting period. When tracking the starters and leavers figures over a period of time, it is clear that the overall position has been declining since August 2016. These figures collated gave an overall annual vacancy rate of 7.53% and an annual turnover rate of 10.3%.

In addition to the vacancy gaps and turnover rates seen other compounding issues add to the pressure within the ward and department environments, these include (but are not limited to):

- Staff sickness and absence rates; and
- Ward establishments not reflective and/or line with patient acuity and dependency.

These gaps in nursing numbers have resulted in an increased reliance on temporary staffing, which significantly impacted on expenditure in overall nursing costs during 2018.

1.3 As a consequence the combination of these factors has led to the Countess of Chester Hospital not being able to deliver a comparative number of CHPPD when benchmarked against our peer and national acute provider trusts and our cost of care delivery is lower than expected as a result. During 2018 it is clear there was a consistent deficit in the number of adult registered staff available, with fill rates between 87 – 93%. To mitigate the risk associated with this there was an over filling of unregistered staff, with fill rates ranging between 101 – 107%. When triangulated

with safety, quality and experience data, it suggests that this has impacted on patient quality and staff well-being. In order to optimise use of the substantive nursing and midwifery workforce available, we have implemented innovative systems and processes to support the achievement of an acuity based workforce. However, the availability of staff has meant that the acuity and dependency needs of adult patients have not always been met at the level we would expect.

1.4 Details on the compliance against regulatory and National Quality Board standards in relation to safe staffing levels can be found in section 5, page 39. Measurement is made against the following standards:

- National Quality Board (2018) An improved resource for adult inpatient wards in acute hospitals;
- National Quality Board (2017) Safe, sustainable and productive staffing: An improvement resource for maternity services;
- National Quality Board (2018) Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals; and
- NHS Improvement (2018) Care Hours per Patient Day (CHPPD): Guidance for acute and acute specialist trusts.

1.5 This report concludes that the current safe staffing levels in maternity and paediatric services are maintaining safety, quality and patient/service user experience. However, it clearly demonstrates during 2018 there were significant gaps in the adult registered nursing numbers across inpatient wards and departments and that this has contributed to a reduction in the safety of patients in our care. Where possible this risk has been mitigated by deploying staff internally, utilising temporary staff (bank and agency) and backfilling shifts unfilled with unregistered nurses. Nonetheless; this position is not sustainable and requires national, regional and local resolve, particularly in light of the NHS Long-term plan, the ambitions it set outs and the growing financial constraints.

1.6 In response to this report, during 2019 we will be focusing on collaboration with the Cheshire & Merseyside Nursing and Midwifery Workforce Programme to stabilise the vacancy gaps, make evidence base predictions in relation to growth, reduce turnover (retaining skilled staff), improve supply (through undergraduate programmes, apprenticeships, return to practice initiates and overseas recruitment) and prepare for the NMC 'future nurse' standards and consider implementation of the Nursing Associate role. In addition, we will be continuing to work with NHSi on our nursing and midwifery retention programme, which focuses on preceptorship, retire and return, flexible working models and career development.

2.0 Introduction

2.1 The purpose of this report is to provide details on the Nursing and Midwifery workforce numbers and skill mix at the Countess of Chester Hospital NHS Foundation Trust during 2018. It will evaluate if the current establishment provides the right number of staff, with the right skills in the right place at the right time[1,3,4]. Using intelligence gathered from a range of evidenced based tools[3,4,12] and triangulates the findings with meaningful safety, quality & patient experience measures to provide a detailed analysis, appraising the information provided and where necessary making recommendations for improvement. It will outline current compliance to the National Quality Board (NQB), National Institute for Clinical Excellence (NICE) and NHS Improvement (NHSi) standards[1,3,4,10,15,16,17] in relation to adult and children's inpatient areas (including Maternity Services).

2.2 The right nursing and midwifery staffing levels are required to deliver safe, effective, quality care and treatment to patients and families accessing healthcare services[2]. In order to deliver services that are efficient and sustainable the right numbers of appropriately skilled people need to be provided[1,3,15,17].

In nursing, the number of people needed and skills required depends on a number of factors, including but not limited to[4]:

- Patients level of dependency & the complexity of their condition;
- Acuity & severity of illness;
- Ward or department activity;
- Geographical layout of the ward or department;
- Medical staffing model in place; and
- AHP support available.

As a consequence setting nationally agreed 'staff to bed ratios' for nurse staffing levels is problematic and each area needs to be assessed within the context of the patient case-mix seen and the expected level of activity[4]. As acuity and activity can vary and at times behave unpredictably, a flexible and transferable nursing workforce model is required to respond to fluctuating demand and operational pressures. Monitoring key safety, quality and experience metrics is essential to evaluating if the nurse staffing levels in a particular area are appropriate[4]. The triangulation of these metrics, alongside the use of a validated evidenced based tool[11,12] and professional judgement are central to making informed decisions about staffing requirements in real-time, or over a period of time to ensure the nursing establishment meet patients' expectations and provides safe, quality care[1]. At the Countess of Chester Hospital NHS Foundation Trust two nationally validated and endorsed methodologies are used:[11,12]

- Safer Nursing Care tool (also known as the Shelford tool); and

- Care Hours per Patient Day (CHPPD).

In midwifery, the number of people needed and skill required[17]depends on:

- Stage in maternity pathway (pre-conception, antenatal, intrapartum, postnatal);
- Service being provided (clinics, home visits, maternity units);
- Setting in which the service is provided (home, community, free-standing and along-side midwifery led unit, obstetric unit, day assessment unit, fetal and maternal medicine service);
- Complexity of each women and baby;
- Acuity and dependency of patients;
- Activity, capacity and occupancy;
- Adoption of Continuity of Carer model; and
- Woman's preferred choice of care and delivery setting.

As with nursing, this makes it difficult to set nationally agreed midwife to mother ratios and establishments need to be set to safely care for women and their babies in a range of different scenarios, across the span of services provided by the hospital[17,19]. As acuity and activity within maternity services can vary it is important to have a transferable midwifery workforce, with an extensive range of skills to support every stage in the maternity pathway[17]. Again, triangulating staffing levels with key safety, quality and experience metrics, alongside a validated acuity tool to monitor trends in activity that can be used to inform the establishment required[17,19]. At the Countess of Chester Hospital NHS Foundation Trust the Birth Rate+ tool[20] is used for this purpose.

3.0 Current position

3.1 *National Context*

3.1.1 It is recognised that there is a shortfall in in healthcare workforce numbers across the United Kingdom (UK) and this problem has a direct impact on peoples care and experience. NHS hospitals, mental health and community providers are reporting shortages of more than 100,000 FTE staff (representing one in eleven posts), with greater affect seen in some key workforce groups. One of the greatest challenges is seen in nursing, with 41,000 FTE vacancies reported (one in eight posts)[18]. This position has worsened from the reported 10% gap in adult nursing (shortfall of 22,000 FTE) in 2017 and has exceeded the more pessimistic prediction of 38,000 FTE by 2020 [5]. Furthermore, statistics released in 2018 outlined that 33,000 nurses a year are leaving the NHS in England (over 1 in 10 employed); this is 20% more than left in the same period four years ago. Evidence is growing in this area and demonstrates the number leaving outweighs the number joining. The retirement age for nurses is also reducing and younger staff are choosing not to stay in the profession (24% of leavers are under 30, 27% are 30 to 39, 16% are 40 to 49, 23% are 50 to 59)[9].

In addition to the growing shortfall reported, a number of other national challenges compound this issue; these include (but are not limited to):

- Aging workforce profile[6];
- Increase in number of nurses and midwives leaving the profession[7];
- Changes in nurse training & loss of bursary payments[8];
- Reduction of CPD funding impacting on training & development opportunities;
- No backfill provided for nurse apprenticeship programmes; and
- Growing number of advanced nurse practitioner roles to support medical rotas.

Despite the government's efforts to increase the number of nurses and allied health professionals (AHPs) in training by up to 10,000, success is yet to be seen, in fact the number of nurses in undergraduate training has fallen by 4% since 2016[14,18]. The Long-term plan published in January 2019, sets out commitments to improve health outcomes and quality of care, however it recognised that to achieve this healthcare providers need the right number of staff, with the right skills and that adequate support should be provided to staff in order that they can work effectively[18]. An 'Interim NHS People Plan' has just been published and sets out areas of focus in Nursing and Midwifery to increase supply, improve retention and build a pipeline route into registered nursing through the Nursing Associate role[22].

Given the scale of the problem in nursing emphasis has been placed on training numbers, course availability and understanding the predicted pipeline data to

manage expected turnover and close the vacancy gap. Initiatives to date include (but are not limited to):

- Development of new roles (Nursing Associate);
- Future Nurse Programme[21];
- Funding & availability of clinical placements[18];
- Range of training experience[18];
- Attrition rates[18];
- Quality, success and balance of training (reducing variation)[18]; and
- Funding level and flexibility in how it is used[18].

The introduction of the Apprenticeship Levy and the development of Higher Apprenticeship programmes for Registered Nursing and Midwifery, supported by the new Nursing Associate role were welcomed, with the promise that they would offer a sustainable solution to the future pipeline. However, the benefits vary across providers as a result of the challenges to implementing such programmes and how the Levy can be used, issues include (but are not limited to):

- Releasing students for supernumerary placements;
- Mentorship capacity within the clinical environment;
- No backfill monies available to support clinical areas releasing staff which is compounded further by growing vacancy, sickness, maternity & turnover rates; and
- Funding for backfill is the responsibility of the Local Provider.

3.1.2 In addition there has been a significant change in the case-mix of patients; in particular the acuity and dependency of people presenting to the hospital for care and treatment[13]. This coupled with the changing landscape of the healthcare system and the redesign of services to support patients across a local economy; it has led to an increase in complexity, dependency, acuity and patient throughput. Alongside these changing demographics there have been developments in validating methodologies to support understanding around the number of nursing and midwifery hours needed to care for patients within the acute provider.

Lord Carters review of operational productivity and performance in English acute hospitals in 2015[11] explored and tested ways in which to provide a single, consistent and nationally comparable way of recording and reporting nursing staffing in inpatient wards and departments. As a result CHPPD was developed as the single metric to:

- Give a single comparable figure that can simultaneously represent both staffing levels and patient requirements, unlike actual hours or patient requirements alone which has been used traditionally; and

- Facilitate comparisons between wards within a trust and also nationally with wards of the same specialty. As CHPPD has been divided by the number of patients in an area, the value does not increase due to the size of the ward and this facilitates comparisons between wards of different sizes.

CHPPD measures how many hours of care are provided collectively by registered nurses, healthcare assistants and therapists (if included in the ward establishment model) per patient in a 24 hour period. CHPPD is calculated by dividing the total number of nursing hours on a ward or department by the number of patients in beds at the midnight census, representing the number of nursing hours that are available to each patient[16].

$$\text{Care Hours per Patient Day (CHPPD)} = \frac{\text{Hours of RN + Hours of NA over 24 hour period}}{\text{Total Number of In Patients (Midnight Census)}}$$

Taking this a step further the Safe Nursing Care tool (also known as Shelford tool) which has been endorsed by NICE and regulators can be used to enhance the accuracy of the data collected and provide a more representative picture of the CHPPD needed over a period of time to inform establishments[12] (please refer to appendix 1 and 2).

In midwifery, the Birth Rate+ intrapartum acuity tool has been further developed to capture real-time workload within the delivery suite. The tool has been enhanced to offer a prediction of the needs of the woman, based on assessment against key clinical indicators, which provide an indication of their needs during labour. On admission the assessment classifies which Category (I – V) the woman fits within and alerts the midwife to the level of care required; this supported by professional judgement allows the midwifery team to make decisions relating to the staffing ratio needed to deliver safe and responsive care[20].

3. 2 *Local Position (nursing & midwifery)*

3.2.1 The current position for nursing and midwifery staffing at the Countess of Chester Hospital NHS Foundation Trust is creating a growing challenge, with 75 FTE registered nursing and midwifery posts currently unfilled (found in table 1) and a worse position in staff turnover when compared to peer and national comparatives (found in chart 1). However, this is an improving position (found in graph 1), with a 1.8% reduction in nursing and midwifery turnover seen during the 2018 reporting period. When tracking the starters and leavers figures over a period of time, it is clear that the overall position has been declining since August 2016 (found in graph

2). These figures collated gave an overall annual vacancy rate of 7.53% and an annual turnover rate of 10.3% in the 2018 reporting period.

Table 1: Registered nurse & midwifery vacancies (FTE)

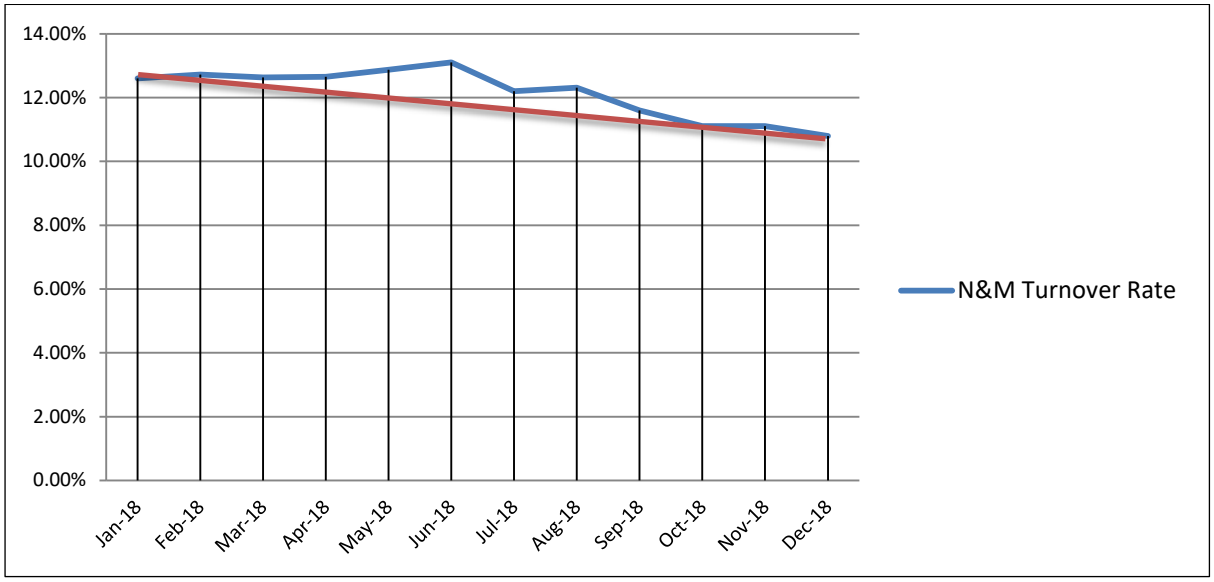
	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
In Month Overall Staff Vacancies WTE	126	86.0	109	179	170	155	171	161	198	217	190	219
Registered Nursing, Midwifery and Health Visiting Staff Vacancy WTE	72.0	40.0	61.0	62.0	54.0	55.0	57.0	57.0	78.0	67.0	57.0	75.0
Registered Midwife Vacancy WTE	0.0	0.0	0.0	0.0	4.0	2.0	2.0	2.0	0.0	0.0	0.0	0.0

Chart 1: Staff retention rates

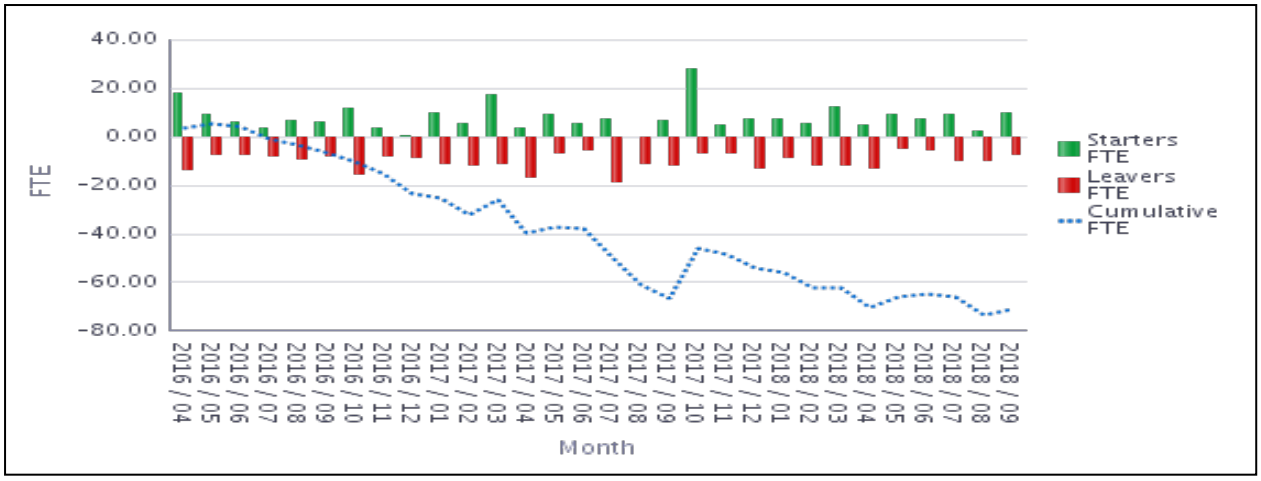
People, Management & Culture: Well-led	Data period	Trust value	Peer median	National median	Chart
Staff Retention Rate - Nursing & Health Visitors	Dec 2018	87.0%	87.4%	87.4%	
Staff Retention Rate - Midwifery	Dec 2018	87.0%	90.2%	88.7%	
Staff Retention Rate - Healthcare Support Workers	Dec 2018	82.2%	83.9%	83.3%	

(Extract from Model Hospital Portal https://model.nhs.uk)

Graph 1: Registered nurse & midwifery turnover rate (%)

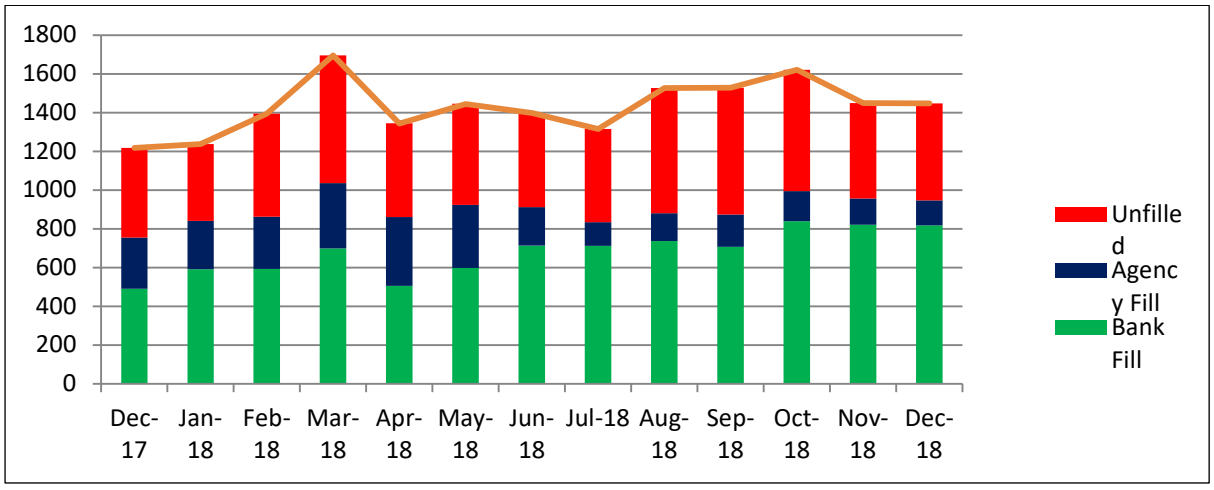


Graph 2: Starters & leavers (FTE) April 2016-September 2018



3.2.2 This growing gap in nursing numbers has resulted in an increased reliance on temporary staffing (found in graphs 3 & 4), which significantly impacts on expenditure in overall nursing costs but particularly on high cost variable pay (found in graph 5). Shift demand has increased by 19% for registered nurses and 12% for unregistered nurses when compared to the same period in 2017. However there has been a significant improvement in the use of agency staff with fill rates down from 21.67% in December 2017 to 8.85% in December 2018, this has been a direct result of the successful implementation of the 'Bank Winter Bonus Scheme' designed to increase fill rates using substantive staff by offering a reward (or bonus) payment per shift worked. On evaluation of the reasons for booking temporary nursing staff (found in chart 2) it is clear than more than half the shifts requested are a result of the vacancy gap.

Graph 3: Registered nursing & midwifery temporary staffing fill rates



Graph 4: Unregistered nursing & midwifery temporary staffing fill rates

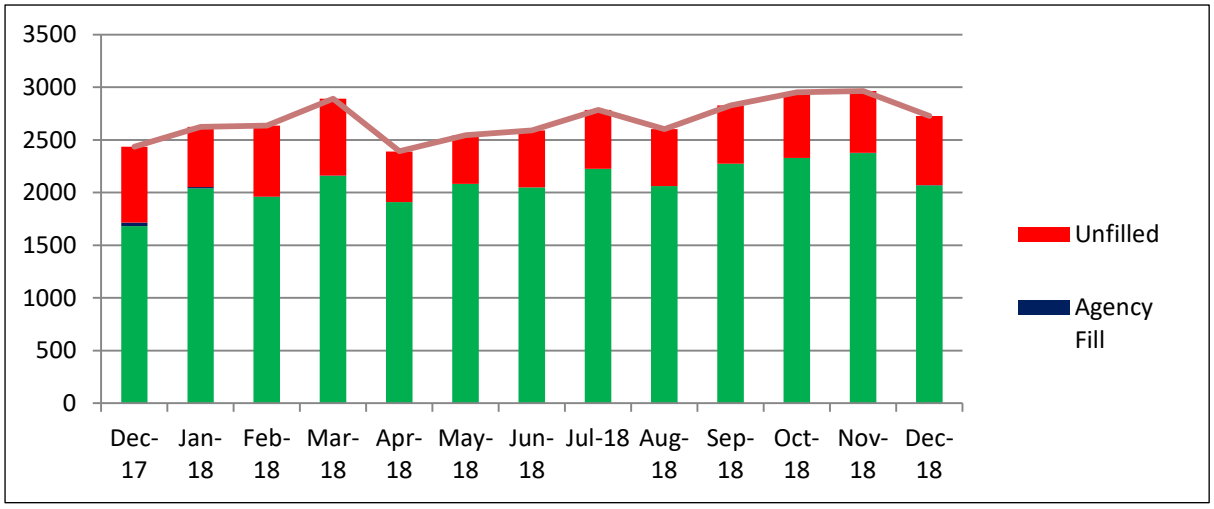
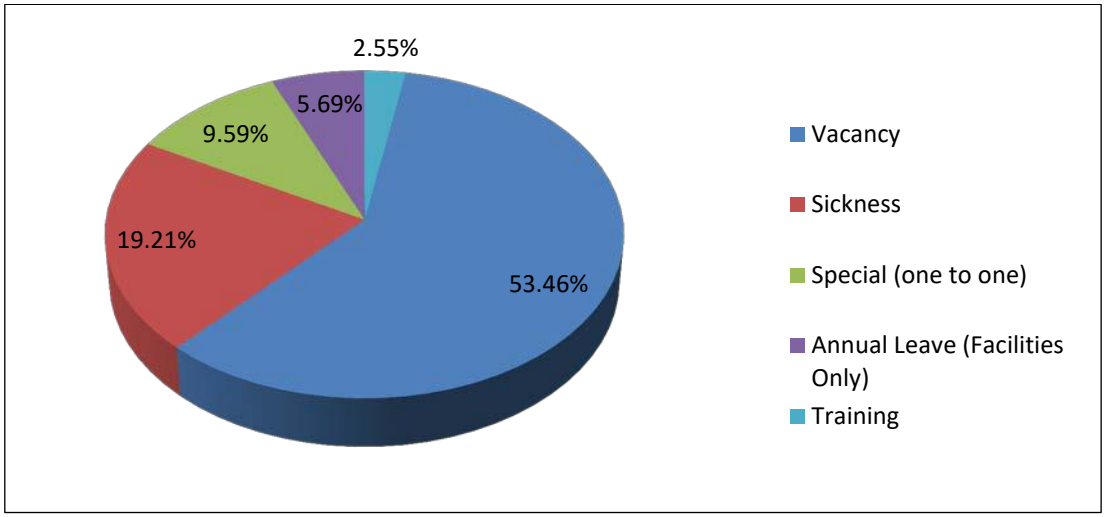


Chart 2: Top 5 reasons for booking temporary nursing staff in 2018



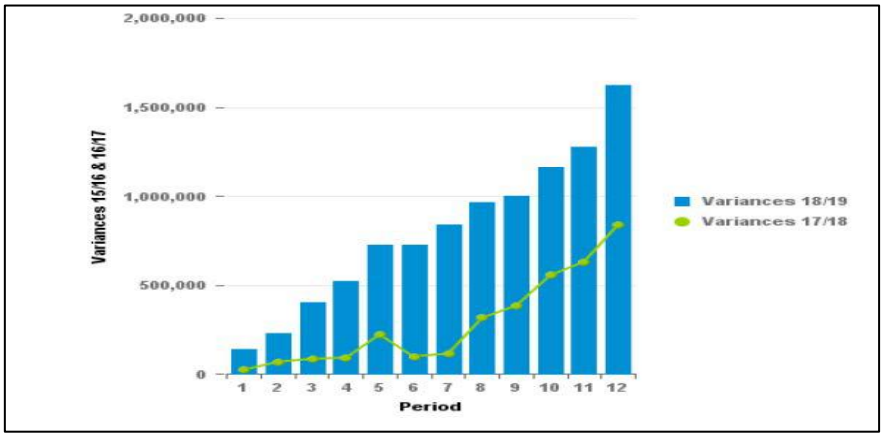
In addition to the vacancy gaps seen other compounding issues add to the pressure within the ward and department environments, these include (but are not limited to):

- Higher than expected turnover;
- Increased reliance on temporary staffing (shifts under filled);
- Staff sickness and absence rates; and
- Ward establishments not reflective and/or line with patient acuity and dependency.

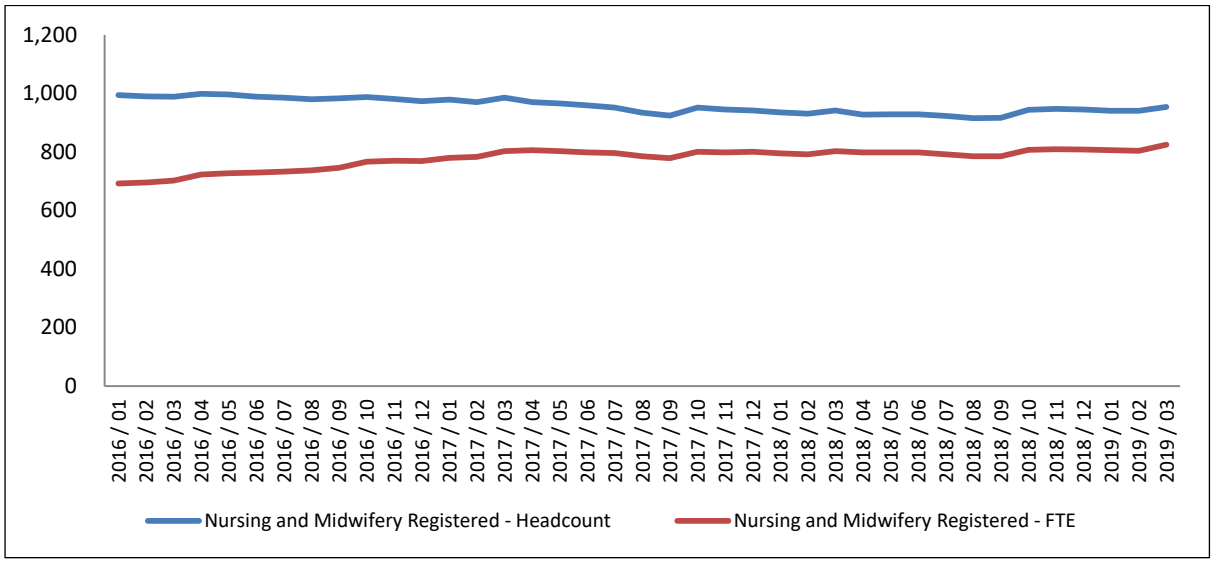
As a result during 2018/19 there was an over spend of £1,621,371 across nursing and midwifery (found in graph 5). This has exceeded the previous year and is likely due to the vacancy, turnover and growth seen in registered nurses needed to support service and pathway development (found in graph 6). This data demonstrates an

increase of 132 FTE registered nurses employed at the Countess of Chester Hospital NHS Foundation Trust since January 2016, with 30 FTE growth seen during the 2018 reporting period.

Graph 5: 2018/19 nursing and midwifery pay variance



Graph 6: Growth in registered nursing workforce (headcount and FTE between January 29016 – March 2019



Sickness and absence rates for registered and unregistered nursing and midwifery staff has also impacted on the staffing levels achieved and the over spend needed. In registered staff groups the overall rate was 4.3%, with higher than expected rates seen in the following areas:

- Inpatient therapies (21.37%)
- Cardiac Catheter Lab (14.07%)
- Rapid response team (7.3%)
- Intermediate Care Unit (5.92%)

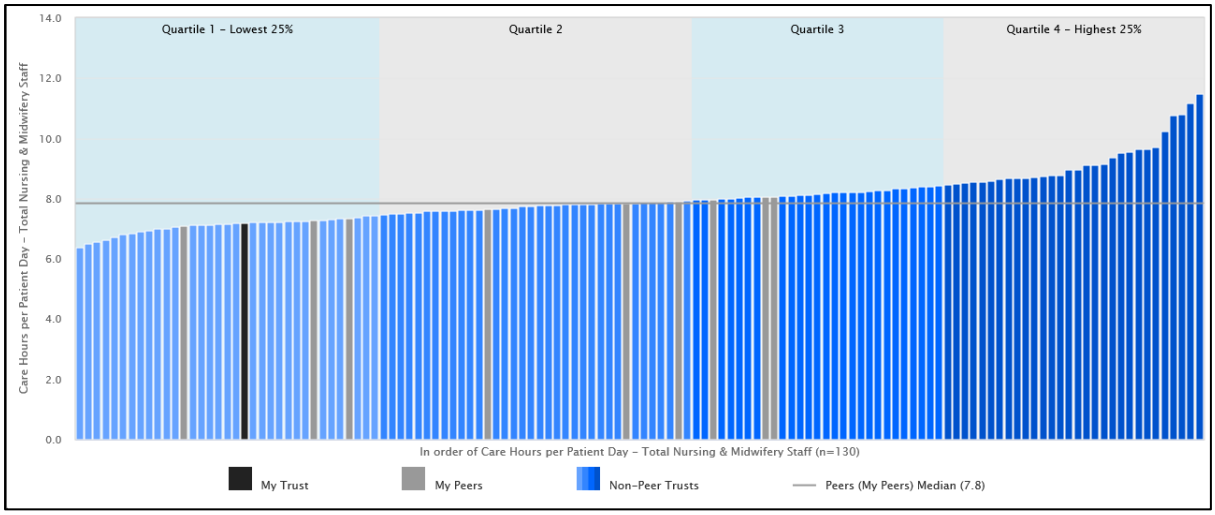
This resulted in an overall loss of 13,743 hours with an assumed cost of £1,379,844 if all hours were covered at the same pay rate. In unregistered staff groups the overall rate of sickness and absence was 6.58%, with higher than expected absence rates seen in the following areas:

- Jubilee Day Care (24.36%)
- Theatres 7 & 8 (19.11%)
- Acute Oncology (18.89%)
- Ambulatory Care (17.85%)
- Coordination Centre (12.31%)
- Rapid Response (11.84%)
- Gynae Outpatients (11.52%)
- Outpatients (11.34%)
- Neuro Early Supported Discharge (11.10%)
- Bluebell (10.58%)
- Theatres 1 & 2 (9.89%)
- Theatres 3 & 4 (9.48%)
- Acute Medical Unit (8.77%)
- Intermediate Care (8.57%)
- Ward 49 (8.53%)
- Ward 54 (8.41%)
- Emergency Department (8.14%)
- Inpatient Therapies (8.12%)
- Ward 33 (8.11%)
- Intensive Care (6.9%)

This resulted in an overall loss of 15,981 hours with an assumed cost of £934,219 if all hours were covered at the same pay rate.

The combination of these factors demonstrates at the Countess of Chester Hospital we are unable to deliver a comparative number of CHPPD when benchmarked against our peer and national acute provider trusts (found in graph 7) and our cost of care delivery is lower than expected as a result (found in chart 3). When viewing this data alongside the nursing expenditure and variable pay bill it evidences that establishments are lower than required to meet the acuity and dependency of patients.

Graph 7: CHPPD (peer and national comparisons)



(Extract from Model Hospital Portal https://model.nhs.uk)

Chart 3: Cost per care hour (peer and national comparisons)

Money & Resources	Data period	Trust value	Peer median	National median	Chart
Cost per Care Hour - Total Nursing & Midwifery Staff	Jan 2019	£18.90	£25.91	£25.80	

(Extract from Model Hospital Portal https://model.nhs.uk)

3.2.3 During 2018 a systematic review of adult nurse staffing levels was undertaken. This evaluated if the current nurse establishment provided the right number of staff, with the right skills in the right place at the right time[1]. It used intelligence gathered from a range of evidenced based tools[3,4,12] and triangulated the findings with meaningful safety, quality & patient experience measures to provide a detailed analysis. The review was undertaken using the Safe Nursing Care Tool (also known as the Shelford tool)[12]. This tool has been validated and is endorsed by NICE[4] and the National Quality Board[3] and is recognised by regulators as the most accurate way to assess nursing requirement within adult inpatient wards and departments. Data collection span a 10 month period for those wards or departments included, with acuity assessments completed up to 3 times daily per patient (including nights and weekends). This standard exceeds the national requirement for establishment reviews and the data collection was quality assured through spot check audits. Quantitative analysis was undertaken using descriptive statistics and each ward and department findings were presented as care hours needed vs the establishment currently available, identifying any variance. Further quantitative measures were then correlated to the findings using safety, quality and patient experience metrics and additional qualitative analysis was undertaken by the Associate Directors of

Nursing to apply professional judgement to the number and skill mix of nursing staff needed by ward or department as indicated by the SafeCare data collected[3,4,12].

The findings identify 2 main issues:

- Current registered nurse vacancy gap (across both bed holding Divisions); and
- Under establishment of non-registered nursing support (across both bed holding Divisions).

The variance in care hours needed to support the patient acuity and dependency most frequently seen within the included adult inpatient wards fell short of those required. When reviewing the skill mix required the largest proportion of additional care hours needed sit within the 1b (amber) category (found in appendix 1), indicating the shortfall is within the unregistered (band 2) nursing assistant level. Following the review investment was made in the nurse establishment for the wards showing the largest variance (wards 50 and 51, Elderly Care). Key performance indicators (found in table 2) have been designed and are being monitored to evaluate the impact of the additional staff.

In addition to the nurse establishment review during 2018 a review of the midwifery workforce was also conducted using the nationally endorsed Birthrate+ tool[20]. In addition to measuring women's needs based on their initial assessment and allocation of the relevant category to determine level of care and staffing support needed, there was also an assessment made against compliance with national best practice standards[17,18]. The review concluded that there was a shortfall in registered midwives within the department, based on the retrospect activity data used in the analysis. However, there has been an overall reduction of activity within maternity services and as such there is no plan to invest in addition staff at the time of writing this report. Nonetheless; this will be monitored using the recognised methodology[20] periodically to ensure the levels of staff and the skills available are appropriate to care for the mothers and babies using maternity services at the hospital. Furthermore; the following measures have been put into place to support peaks in activity and/or acuity:

- Escalation guideline which is enacted at times of high activity including deployment of senior midwifery managers and specialist midwives to support the service as required;
- Rotation of staff to support service needs, ensuring a competent and skilled workforce;
- Established e-roster principles continue to be monitored and refined;

- Development of the workforce through the appraisal process to develop a staffing establishment that is competent for the activity/services to be delivered and identify aspiring leaders;
- On-going review of midwifery indicators in line with national guidance[17,19], including red flags and adverse incidents with an established governance framework; and
- Introduction of Birthrate+ acuity tool (continuously).

Table 2: Key performance indicators for evaluation of additional staff

People Metrics
To demonstrate improvement in Staff well-being by;
Reduction in sickness rates
Improved appraisal rates
Improvement on staff survey results
Workforce Metrics
To demonstrate improvement in Trust benchmarks;
Reduction in turnover rate
Reduction in vacancy rate
Flexibility to train RN & NA via apprentice route
Quality & Safety Metrics
To demonstrate improvement to safety & quality measures;
Reduction in pressure ulcers & falls with harm
Reduction in the number of red flags
Improved mandatory training rates and competency compliance
Improved pathway management for patients with complex care needs (dementia, safeguarding and learning difficulties)
Finance Metrics
To demonstrate cost savings by;
No band 2 variable pay spend *(unless in exception circumstances e.g. excessive specialing requirements with in ability to cohort)*
Reduction in 'bad' variable pay spend *(e.g. not covered within the establishment)*
Reduction in sickness spend
Operational Metrics
To demonstrate increased productivity by;
Improved teletracking compliance
Earlier confirmation of discharges
Reduction in hospital cancellations
Reduction in length of stay
Patient Experience Metrics
To demonstrate improved reputation by;
Improved Friends & Family ratings
Reduction in complaints relating to communication & nursing care

4.0 Organisational overview of staffing levels & triangulation data

4.1 *Staffing levels achieved during 2018*

Reviewing staffing numbers at organisational level is a useful indication of whether the planned hours expected were matched with the actual hours provided. During 2018 the overall staff compliance for the traditional measurement of staff (actual vs planned) varied, with consistent under achievement the Intensive Care, Neonatal and Renal units (found in table 3). However, the actual nurses needed based on acuity and level of care required in these areas, indicated that the staffing levels in these areas was optimal and met the relevant national standards (for example, ICS, BAPM) and as such at times staff were moved from these areas (as patient acuity and dependency allowed) to support other areas in greater need. It is important when analysis overall staffing figures to also consider the skill mix available, this means breaking down the data by staff groups (registered and unregistered) and comparing that to the expected ratio. During 2018 it is clear there was a consistent deficit in the number of registered staff available, with fill rates between 87 – 93%. To mitigate the risk associated with this there was an over filling of unregistered staff, with fill rates ranging between 101 – 107% (found in graphs 8 and 9).

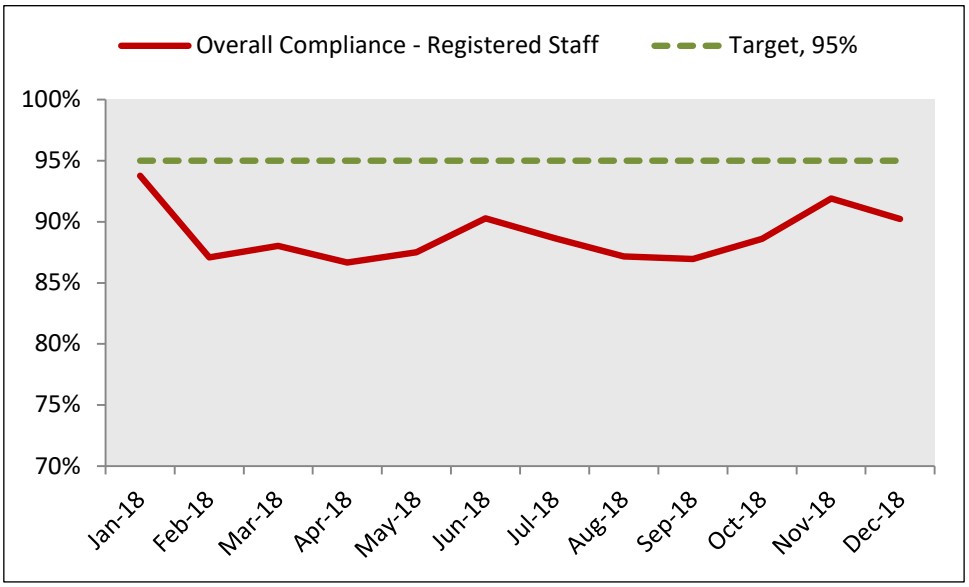
In addition, this data needs to be viewed in the context of the patients acuity and the number of care hours needed to meet their needs. This may vary between shifts and as such at the Countess of Chester Hospital we operate an acuity based transferable workforce model using SafeCare (details found in section 4.2.1).

Table 3: Actual vs planned hours (registered and unregistered staff)

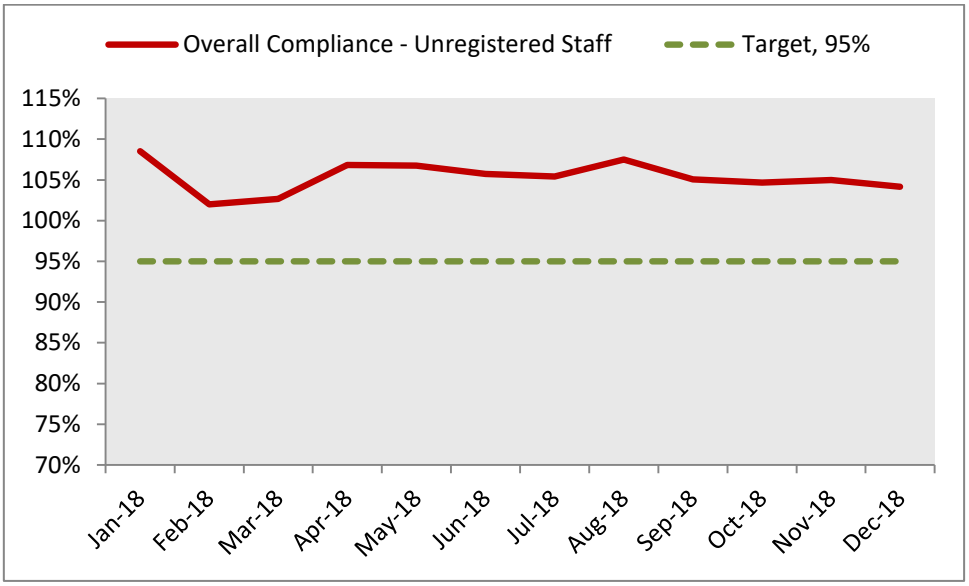
Below 90% of planned staff hours were worked	Between 90% and 94% of planned staff hours worked	Between 95% and 100% of planned staff hours worked	Over 100% of planned staff hours were worked

Ward Name	Specialty	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Months <95%	Months >100%
Bluebell	EPH Rehabilitation	104%	108%	104%	106%	98%	91%	96%	92%	93%	94%	94%	96%	101%	5	4
Children's	Paediatrics	94%	97%	102%	95%	100%	109%	105%	96%	92%	101%	94%	101%	103%	3	6
ICU	Adult Intensive Care	85%	95%	92%	85%	88%	86%	85%	78%	75%	84%	94%	90%	86%	12	0
Maternity	Maternity	138%	104%	104%	106%	83%	95%	94%	100%	100%	97%	96%	98%	97%	3	5
NNU	Neonatal Unit	81%	89%	86%	83%	67%	89%	97%	97%	91%	100%	92%	94%	98%	9	0
Poppy	Intermediate Care Unit	115%	118%	119%	120%	124%	119%	114%	117%	107%	108%	110%	111%	118%	0	12
Renal	Renal	92%	101%	99%	81%	84%	85%	87%	87%	81%	65%	70%	88%	89%	10	1
Ward 33	Stroke	97%	97%	92%	94%	96%	99%	95%	95%	95%	97%	95%	96%	99%	3	0
Ward 34	Intermediate Care Unit	91%	92%	96%	94%	91%	92%	89%	90%	91%	89%	91%	91%	92%	11	0
Ward 41	Surgery	90%	100%	97%	92%	96%	93%	93%	78%	88%	68%	73%	91%	84%	9	0
Ward 42	Cardiology	102%	110%	102%	102%	110%	98%	100%	104%	109%	105%	99%	103%	100%	0	9
Ward 43	Haematology/Oncology	97%	105%	102%	102%	103%	102%	110%	119%	109%	102%	103%	107%	107%	0	11
Ward 44	Surgery	97%	98%	94%	92%	95%	98%	95%	91%	94%	100%	100%	97%	94%	6	0
Ward 45	Surgery	94%	108%	97%	84%	92%	125%	125%	101%	100%	98%	95%	97%	89%	3	5
Ward 47	Acute Medical Unit	91%	93%	87%	83%	89%	95%	90%	91%	87%	88%	90%	91%	89%	11	0
Ward 48	Respiratory	92%	104%	105%	98%	106%	95%	96%	96%	107%	107%	106%	112%	103%	1	7
Ward 49	Gastroenterology	98%	95%	103%	100%	95%	103%	98%	101%	105%	96%	94%	98%	99%	1	4
Ward 50	Care of the Elderly	95%	105%	109%	98%	108%	108%	102%	110%	112%	106%	110%	117%	117%	0	10
Ward 51	Care of the Elderly	102%	107%	105%	101%	103%	108%	103%	107%	107%	106%	112%	109%	110%	0	12
Ward 52	Trauma & Orthopaedics	93%	95%	96%	98%	102%	103%	110%	115%	109%	108%	109%	108%	103%	1	8
Ward 53	Vascular	90%	99%	97%	85%	89%	83%	86%	90%	93%	90%	94%	95%	94%	10	0
Ward 54	General Medicine	101%	107%	98%	94%	97%	77%	102%	95%	97%	94%	91%	83%	81%	6	3
Ward 60	Haem / Oncology Day Case	84%	87%	87%	88%	95%	96%	92%	84%	92%	93%	87%	86%	81%	10	0

Graph 8: Actual vs planned registers (nursing and midwifery) hours



Graph 9: Actual vs planned unregisters (nursing and midwifery) hours



4.1.2 In order to optimise use of the substantive nursing and midwifery workforce available, we have implemented innovative systems and processes to support the achievement of an acuity based workforce. The purpose of this programme was to move away from traditional staffing models and flex the workforce (both number & skill mix) to support the actual acuity and dependency of patients, resulting in the right staff, with the right skills, in the right place at the right time to meet patient's needs.

Electronic rosters have been implemented, with all nursing and midwifery staff being able to instantly access and view their rosters from a phone or tablet. Rosters are published 6 weeks in advance which supports a healthy work-life balance and allows for early planning to cover unfilled shifts. The electronic roster links with BankStaff which supports 24 hour direct booking of nurse bank shifts when these cannot be filled by substantive staff.

Staff record live acuity data in SafeCare[3,4,12], 3 times in each 24 hour period within adult and paediatric inpatient areas. SafeCare links to the roster and provides visibility and transparency of nurse staffing and patient acuity across the organisation. Senior nursing teams are able to identify a shortage or excess of nursing hours based on live patient acuity and can use this information alongside professional judgement to redeploy staff accordingly. The combination of efficient rostering, utilising all contracted hours, improving annual leave management, recruiting to establishment levels, challenge of rosters by senior nurses, peer review through the ward or department key performance indicators and redeployment of staff in accordance with patient acuity, has resulted in optimum use of nursing hours. This has supported the ward and department areas in managing the identified vacancy gap, sickness and absence and the under establishment known in the unregistered workforce.

4.2 *Safety, quality & experience metrics*

4.2.1 *Red flag;* reporting can be used to identify areas with potential risks. Nursing and Midwifery red flags are defined nationally[4,10,19] and are collected within the SafeCare tool in general ward areas and through continuous audit in Maternity. All red flags are reviewed in real-time by ward managers, team leaders and matrons, actions are taken as required to reduce or mitigate any actual or potential issues. Red flags can act an early warning signal that staffing levels have the potential to impact on the safety, quality and experience of patients and service users and also provide information on staff well-being with the ward or department.

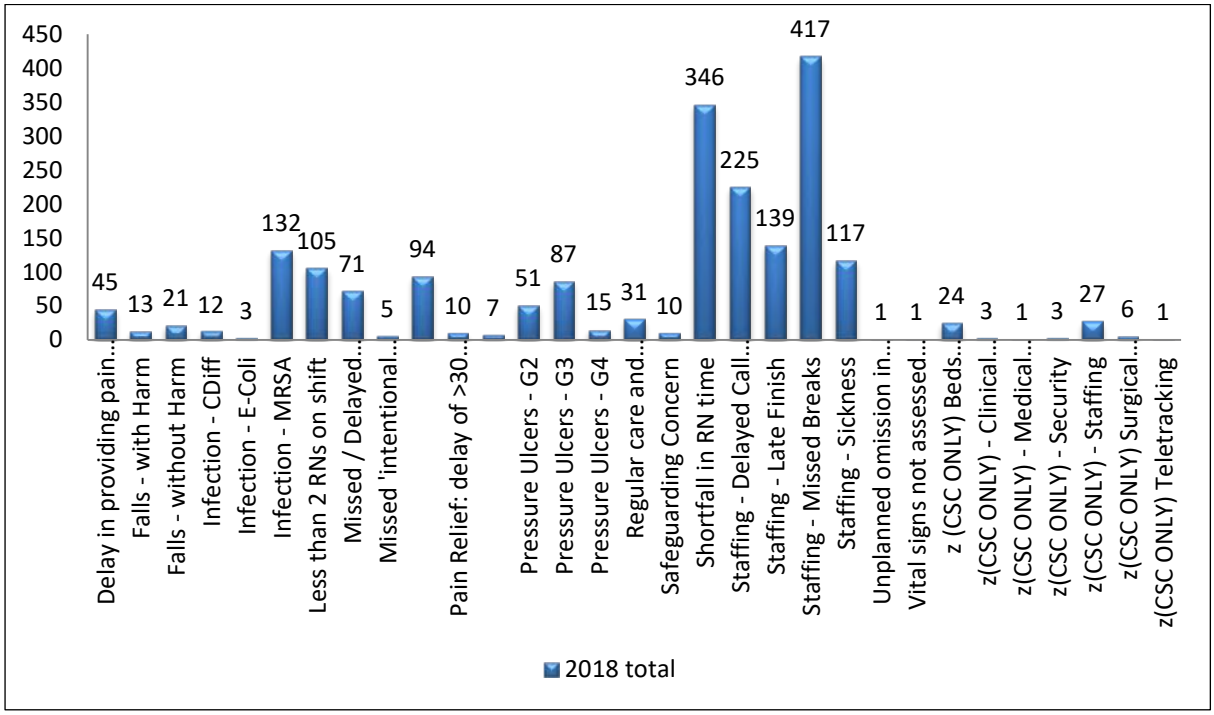
In nursing, during 2018 there were a total of 2,023 red flags reported, compared to 1,995 in 2017 (found in graph 10). The top 5 themes include:

- Staff missing breaks (N) 417
- Shortage of registered nurse time (N) 346
- Delays in responding to call bells (N) 225
- Staff finishing late (N) 139
- MRSA infection (N) 132

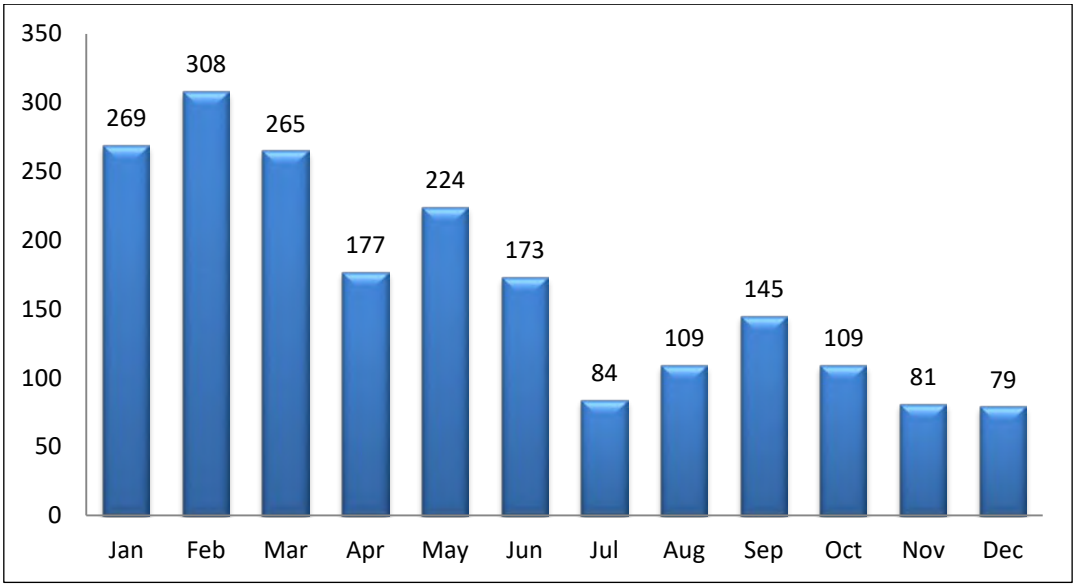
This would suggest that staff are missing breaks and finishing late on shift, as the establishments are not reflective of the requirements of the patients in those areas.

It also indicates that there is not enough staff to be responsive to patients needs and when correlated with the Infection Prevention & Control rates (found on page 4.2.5) and the learning from the route cause analysis investigations it confirms inadequate staffing has been a contributory factor in those cases investigated. When considering the time of reporting it demonstrates that the months with the highest reporting of red flags are January, February and March, which correlates with the busiest period operationally within the hospital (found in graph 11).

Graph 10: 2018 'red flags' by theme



Graph 11: 2018 'red flags' by month



In midwifery during 2018, there were 138 red flags reported however, only 28 of these were in relation to the nationally recognise red flags found in table 4. Now that the Birthrate+ tool has been adopted, when fully implemented during 2019 the system will allow for consistent recording and reporting of red flags in line with the national requirements. In addition, it will allow for red flags to be mapped against the acuity of the women who are in labour within the department at any given time. This will allow for actions to taken to mitigate the risks in real-time and will provided an audit trail for assurance.

Table 4: Midwifery 'red flags'

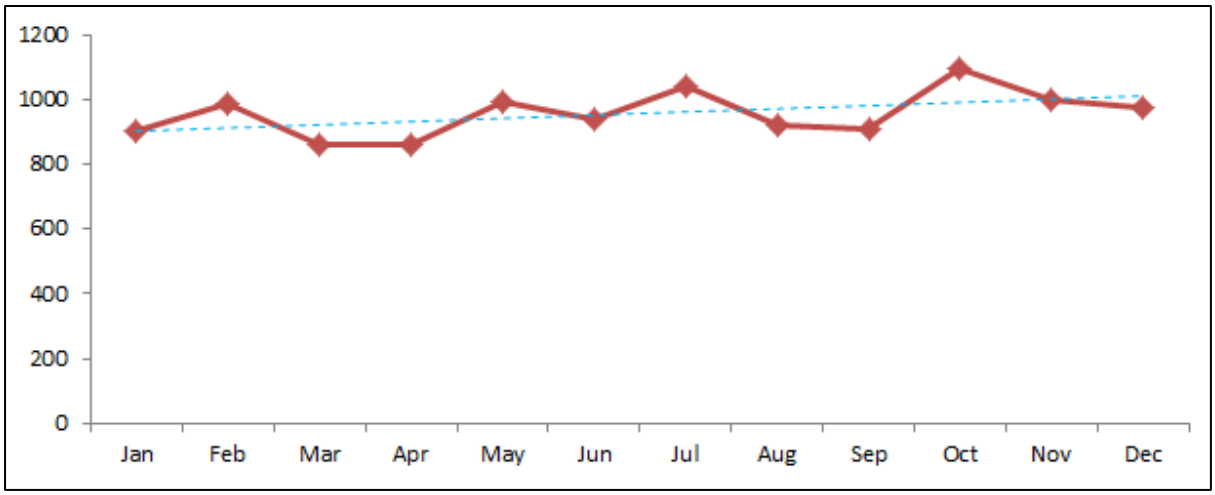
Delayed or cancelled time-critical activity
Missed or delayed care (eg delay of 60 minutes or more in washing and suturing)
Missed medication during an admission to hospital or midwifery-led unit (eg diabetes medication)
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more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

Across adults, paediatrics and maternity it is recognised that red flags are under reported and there are inconsistencies between wards and departments. This means the data presented in this report may under represent the issues reported. As such, it is important to view this information alongside the clinical incident data (found in section 4.2.2).

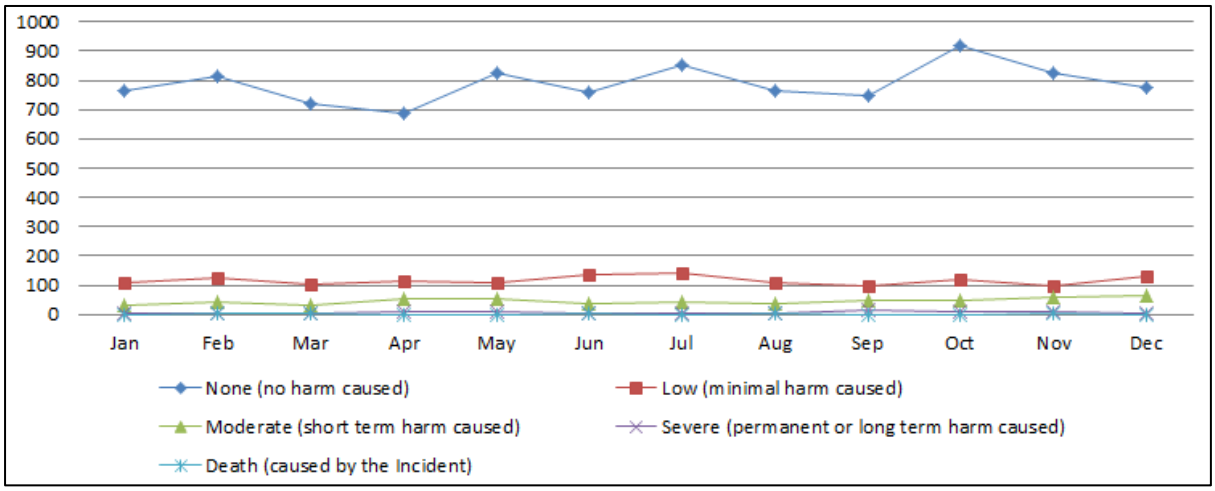
4.2.2 *Incident analysis;* in addition to reviewing potential risks it is essential to consider the number of actual incidents reported and assess these in relation to the level of harm caused and establish if they are linked to staffing and/or skill mix levels. During 2018 the number of incident report ranged between 860 – 1097 per month (found in graph 12), of those reported the majority caused no harm, 561 caused moderate harm, 84 caused severe harm and 19 were found to have contributed to and/or caused the patients death (found in graph 13). When reviewing the 'top 10' categories a large proportion of incident (regardless of harm) are a result of 4 main themes, falls, staffing, medication and skin integrity (found in chart 4). On cross reference with the 'top 10' sub-categories (found in chart 5) the findings collate; with lack of staff, unwitnessed falls and disruptive behaviour contributing to over half of the incidents analysed.

This indicates that staffing levels are impacting on the safety of patients which is likely a result of the changing demographics of patients (challenging and unpredictable behaviour), the registered nurse vacancy gap (delays in care and treatment) and the under establishment of ward and department areas (increased risk of falls and pressure ulcer development).

Graph 12: Number of incident reported during 2018



Graph 13: Incidents by level of harm



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
None (no harm caused)	763	812	720	685	823	758	852	767	747	917	827	774
Low (minimal harm caused)	107	126	103	112	107	135	142	111	100	119	100	130
Moderate (short term harm caused)	32	42	30	53	56	38	44	37	51	51	60	67
Severe (permanent or long term harm caused)	4	6	5	7	9	4	5	5	14	9	12	4
Death (caused by the Incident)	1	3	2	1	0	3	1	2	0	1	4	1

Chart 4: Top 10 incident categories during 2018

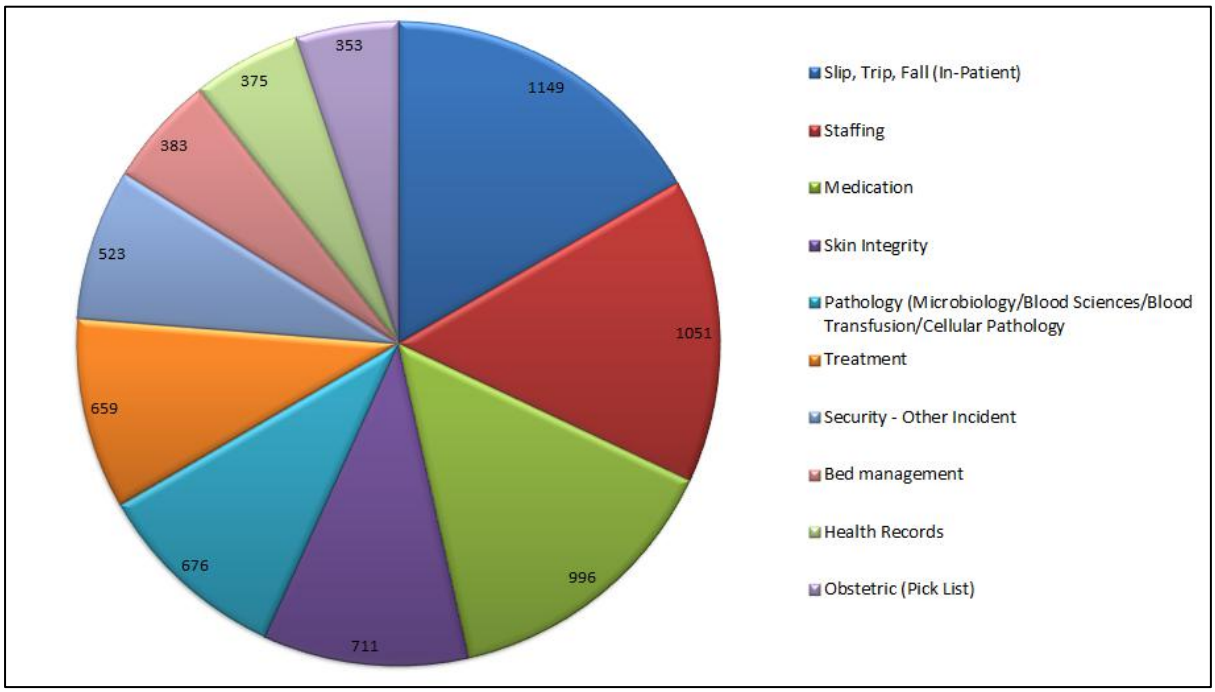
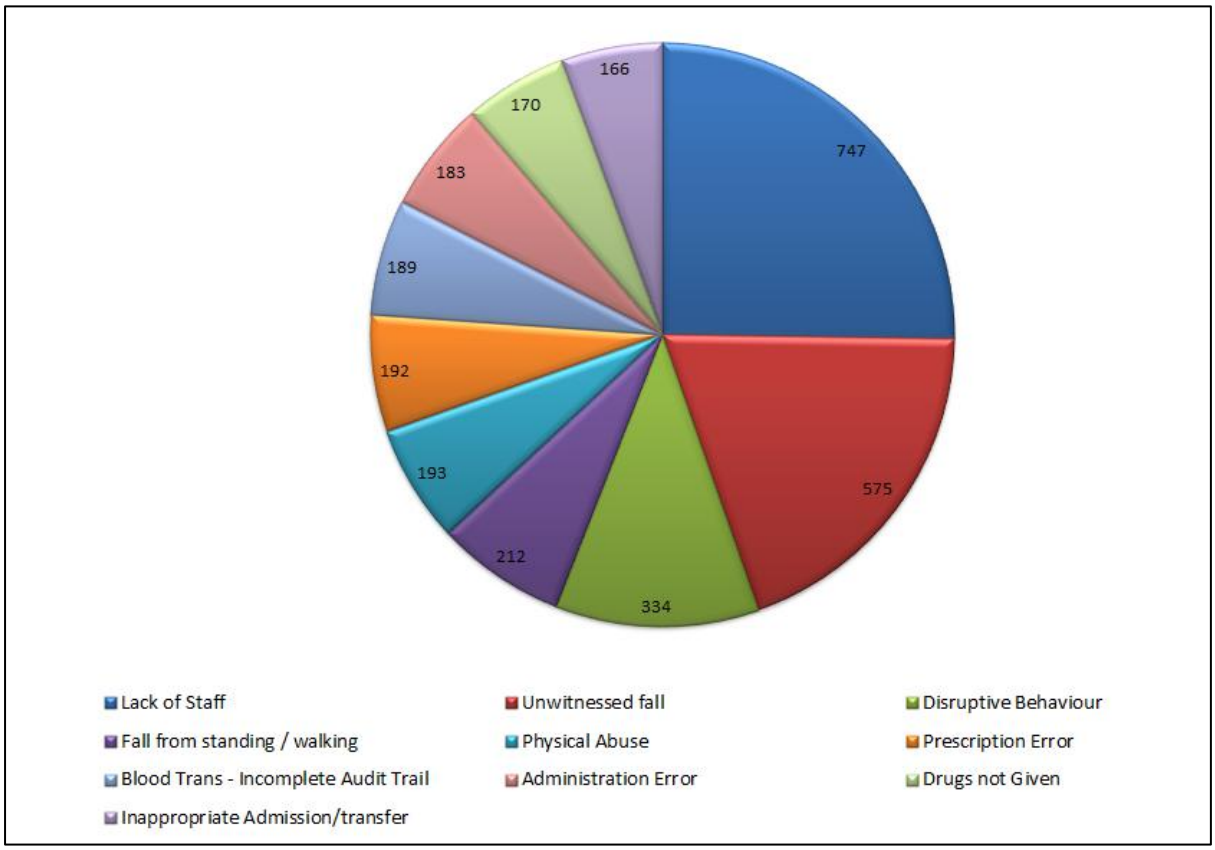
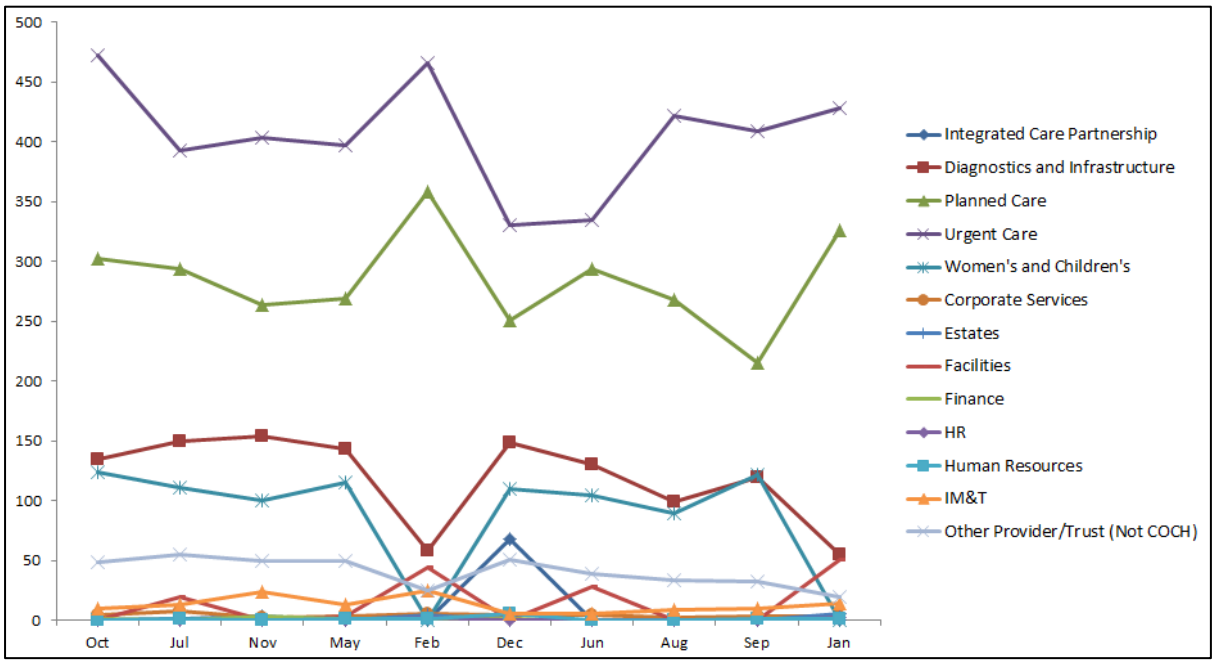


Chart 5: Top 10 sub-categories during 2018



Graph 14: Incident during 2018 by Division



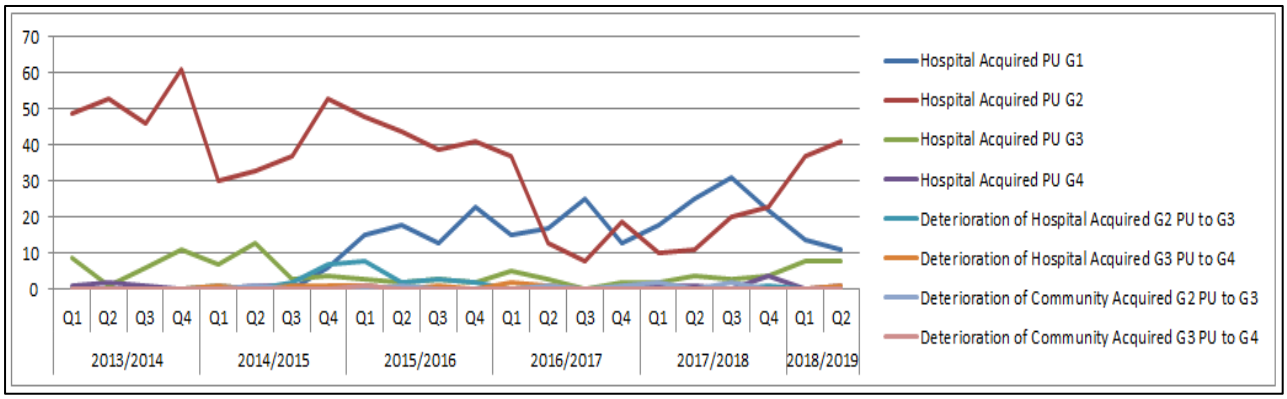
4.2.3 *Falls incidents;* an 800 bed hospital will have an average of 1,500 inpatient falls per year. For the Countess of Chester Hospital this equates to approximately 1,300 falls per year. In the last two years the Countess has delivered below average inpatient falls rates with 1,170 recorded in 2017/18 and 1,150 recorded in 2018/19. This is approximately 13% below the national average for the last two years. The falls rate per 1000 bed days has also reduced by 33.5% since 2015/16 when the 'Falls Prevention Programme' was introduced. This is a reduction from 7.72 falls per 1000 bed days in 2015/16 to 5.5 falls per 1000 bed days in 2018/19. However, despite the overall reduction in falls, as yet we have not seen any impact on reducing the number of falls with moderate or above harm. The rate per 1000 beds days for falls with moderate or severe harm was 0.19 in 2018/19 which is in line with the national average. Each fall with harm is reviewed by the Serious Incident Panel and a Level 1 or 2 investigation is commissioned in accordance with the NHS Serious Incident Framework. A Root Cause Analysis (RCA) is undertaken by a Lead Investigating Officer (LIO) and a table-top review meeting is held to confirm and challenge the details surrounding the fall. Although the Falls Prevention Programme has not seen a reduction to date in the number of falls with harm, it has provided assurance that when such a fall occurs, the hospital have taken all steps possible (in line with national best practice) to reduce or mitigate this risk. Each investigation is subject to an external review by the Clinical Commissioning Group (CCG), where a further confirm and challenge takes place, the incident is only closed when all parties agree with the conclusions made. Further work will take place during Q1 2019/20 to understand if there are any themes or trends in the Level 1 and 2 investigations that could support future improvements.

4.2.4 *Skin Integrity;* the data presented in table 5 shows that there was an overall reduction in the total number of pressure ulcers reported in 2016/17 and 2017/18 compared to the 3 years prior to that. This is despite the additional reporting sub-categories that were implemented late 2014, which had not previously been reported. However, on analysis graph 15 clearly demonstrates a changing trend, highlighting a reduction in the number of grade 1 ulcers report and a correlating increase in grade 2 ulcers since quarter 4 2017/18. This trend has continued to worsen during quarter 1 and 2 of 2018/19 and implies that prevention measures and early management of the deteriorating skin is not as effective. Contributory factors include the increasing acuity and dependency of patients and the inability to achieve the required CHPPD to meet their needs. Work continues through the NHS Improvement collaborative to lead on the development and implementation of any changes to current practice needed in the prevention and management of pressure ulcers. A 'pressure ulcer project plan' is currently in place and work is underway to action the tasks identified.

Table 5: Pressure ulcer incident trends (2013-2018)

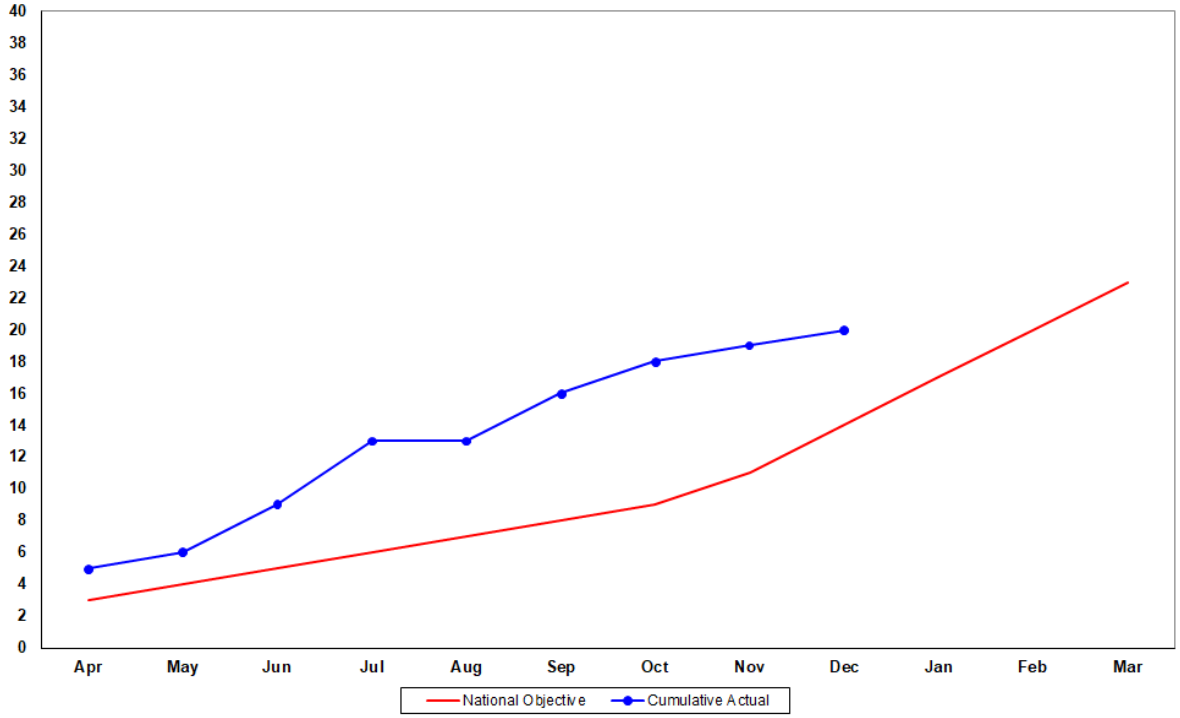
	2013/2014					2014/2015					2015/2016					2016/2017					2017/2018				
Sub-category	**Q1**	**Q2**	**Q3**	**Q4**	**AT**	**Q1**	**Q2**	**Q3**	**Q4**	**AT**	**Q1**	**Q2**	**Q3**	**Q4**	**AT**	**Q1**	**Q2**	**Q3**	**Q4**	**AT**	**Q1**	**Q2**	**Q3**	**Q4**	**AT**
Hospital Acquired PU G1	*	*	*	*	*	*	*	*	6	**6**	15	18	13	23	**69**	15	17	25	13	**70**	18	25	31	22	**96**
Hospital Acquired PU G2	49	53	46	61	**209**	30	33	37	53	**153**	48	44	39	41	**172**	37	13	8	19	**77**	10	11	20	23	**64**
Hospital Acquired PU G3	9	1	6	11	**27**	7	13	3	4	**27**	3	2	3	2	**10**	5	3	0	2	**10**	2	4	3	4	**13**
Hospital Acquired PU G4	1	2	1	0	**4**	0	1	1	0	**2**	1	0	0	0	**1**	0	0	0	0	**0**	1	1	0	4	**6**
Deterioration of Hospital Acquired G2 PU to G3	*	*	*	*	*	1	0	2	7	**8**	8	2	3	2	**15**	0	1	0	0	**1**	0	0	0	1	**1**
Deterioration of Hospital Acquired G3 PU to G4	*	*	*	*	*	1	0	1	1	**3**	1	0	1	0	**2**	2	1	0	0	**3**	0	0	0	0	**0**
Deterioration of Community Acquired G2 PU to G3	*	*	*	*	*	0	1	0	0	**1**	0	1	0	0	**1**	0	1	0	1	**2**	2	0	2	0	**4**
Deterioration of Community Acquired G3 PU to G4	*	*	*	*	*	0	0	0	0	**0**	1	0	0	0	**1**	0	0	0	0	**0**	0	0	0	0	**0**
Quarterly Total	**59**	**56**	**53**	**72**		**39**	**48**	**44**	**71**		**77**	**67**	**59**	**68**		**59**	**36**	**33**	**35**		**33**	**41**	**56**	**54**	
Annual Total (AT)	**240**					**202**					**271**					**163**					**184**				

Graph 15: Number of pressure ulcer incidents by quarter (year on year)



4.2.5 *Infection Prevention & Control rates;* during 2018/19 there has been a deteriorating trend in the number of Clostridium Difficile (C-Diff) and MRSA Bacteraemia cases reported. This has resulted in C-Diff rates remaining above trajectory for 8 months successively (found in graph 16) and a total of 3 MRSA Bacteraemia cases (YTD) being confirmed (compared to 1 cases during 2017/18). Despite the infection reduction strategy there remains issues with screening compliance in some areas and learning has identified that staffing has been a contributory factor.

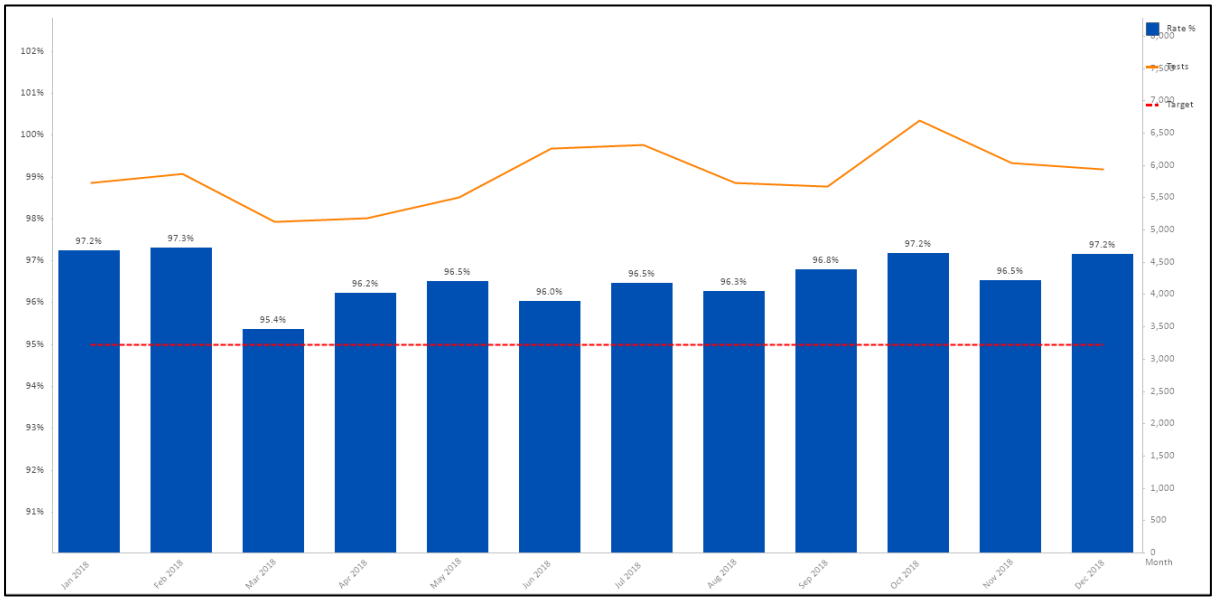
Graph 16: Cumulative Clostridium Difficile rates 2018/19



4.2.6 *Care Metrics;* are designed to provide a snap shot in to the quality of care received by patients and service users and are monitored alongside staffing levels (and other metrics) to provide assurance that levels are adequately meeting patients' needs and to identify any ward or department areas that may require additional support. At the Countess of Chester Hospital during 2018 we were using a locally agreed tool that is considered to now be outdated. Work has already started on adopting the NHSi recommended care assurance framework and ward accreditation system, which we plan to implement during 2019. The new framework will give a more consistent approach to measuring the quality of care provided, will be based on national best practice and will allow for greater confidence in the data collected. Therefore, the information in this section of the report should not be considered in isolation and should be correlated to the safety and patient experience measures.

In nursing; care metric compliance overall for both adult and paediatric areas has remained consistently above the 95% target (found in graph 17 and 18). However, when analysing the finding by quality measure (found in chart 6); compliance in safeguarding, discharge and nutrition are below the expected target across the reporting period. Each of these areas have a work stream established, focused on improving compliance during 2019.

Graph 17: Overall care metric compliance in adult general wards (January – December 2018)



Graph 18: Overall care metric compliance in paediatric department (January – December 2018)

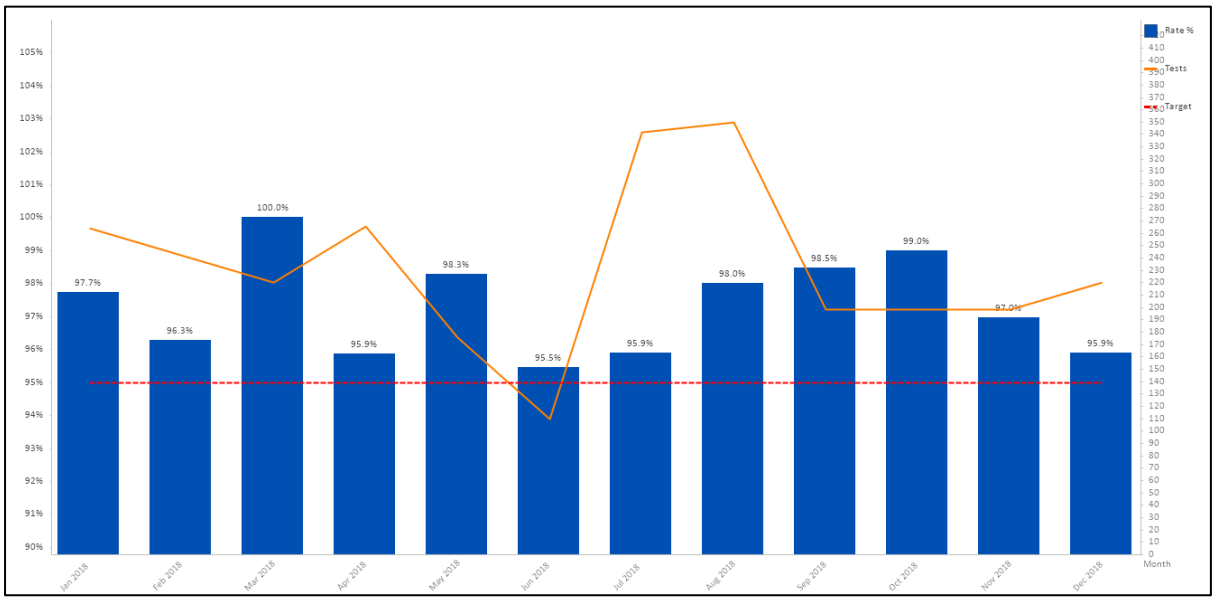
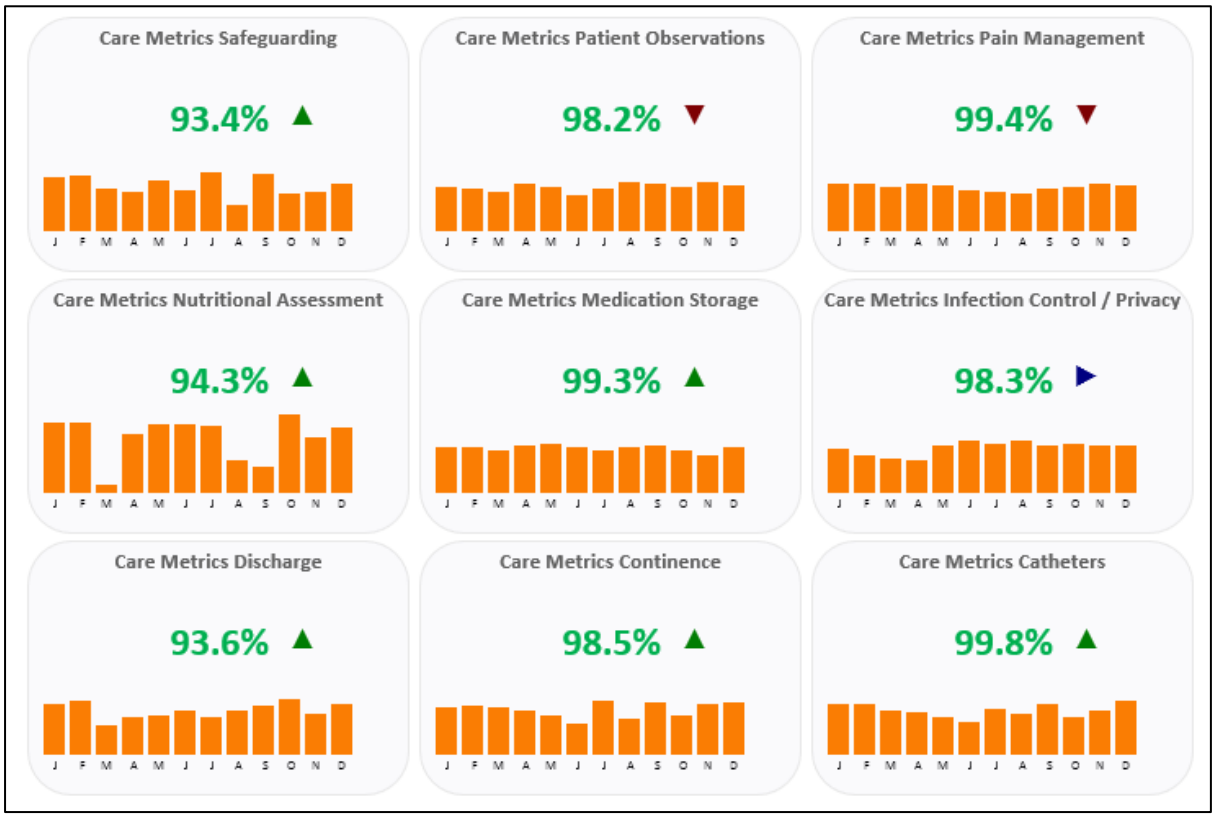


Chart 6: Care metric compliance by measure (January – December 2018)



In midwifery; the quality of care is measured against different standards relevant and in line with maternity best practice. The audit findings found in table 6 demonstrates overall there remains very good compliance with guidelines as per

trust requirement, and in all guidelines there were many elements that achieved 100%. As a result of the audit midwives have been asked to review their record keeping and refer to a particular guideline and reflect. Midwives are also being encouraged to use any feedback following the care they provided and their records being audited as part of their Nursing & Midwifery Council (NMC) revalidation evidence.

Table 6: Care metric compliance for maternity services (April 2018 – September 2018)

Area of practice reviewed	Monthly Audit Results (2018)						Overall Average %	Overall Status
	APR	MAY	JUN	JUL	AUG	SEP		
Maternity Health Records	96	100	98	100	100	100	99 %	
Care of Women in Labour	93	100	98	95	97	99	97%	
Intermittent Auscultation	100	100	75	100		100	95%	
CEFM	93	100	97	85	98	96	95%	
Induction of Labour	92	100	100	100	100	100	99%	
Meows	99	96	96	100	100	100	98.5%	
Bladder Care	90	100	86	100	90	96	94%	
ANS	94	100	100	100	100	98	99%	
VTE Assessment 28 weeks	63	100	54	30	67	86	67%	
Smoking	66	60	90	67	82	50	69%	
RFM				100	100	100	100%	
Medicines management	100	100	100	100	98	100	99%	
Pertussis	90	100	100	100	100	100	98%	
Swab checks	100	100	100	100	88	100	98%	

4.2.7 *Learning from patient feedback & sharing lessons learnt;* there are several mechanisms available for patients and the public to share their feedback with us, these include:

- CQC survey programme;
- Friends & Family test & comments;
- NHS Choices;
- Health Watch (visits, go-sees and engagement events);
- GovRounds;
- Patient Led Assessment of the Care Environment (PLACE);
- Patient Reported Outcome Measures (PROMs);
- Concerns or Complaints; and
- Facebook & Twitter feedback.

Each Division receives a report on patient experience feedback monthly, which identifies themes and trends to support improvement. Learning from complaints and concerns raised are triangulated with incidents, claims and coroners at the Serious Incident Review panel and cascaded out to staff and teams through weekly communication. This email is then used to facilitate safety briefings at a ward, department or speciality level in addition to being fed back through various team meetings, mandatory training and other learning opportunities. In addition; we have continued to share key messages with staff through 'Screen savers' and this information is accessible on the Risk & Safety team intranet pages which all our staff have access to. To complement the various methods of ensuring staff are well informed we have also introduced a monthly Quality & Safety newsletter.

4.2.8 *The Friends and Family Test (FFT)* is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how. One of the key benefits of the FFT is that patients can give their feedback in near real time and the results are available to staff more quickly than traditional feedback methods. This enables staff to take swift and appropriate action should any areas of poor experience be identified.

The FFT asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is important in transforming NHS services and supporting patient choice. Patient comments also identify areas where improvements can be made so that the trust can make care and treatment better for everyone. The FFT question is:

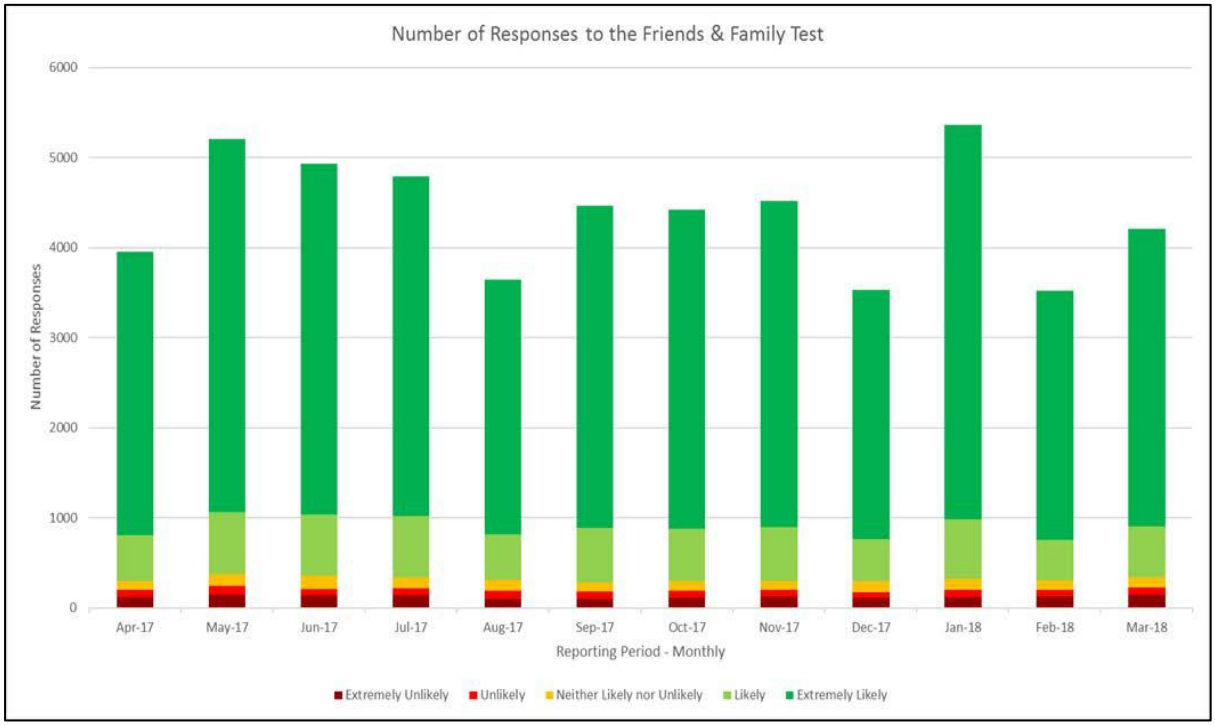
"We would like you to think about your recent experience of our service. How likely are you to recommend <our service> to friends and family if they needed similar care or treatment?

The response options are as follows: extremely likely; likely; neither likely nor unlikely; unlikely; extremely unlikely; and don't know.

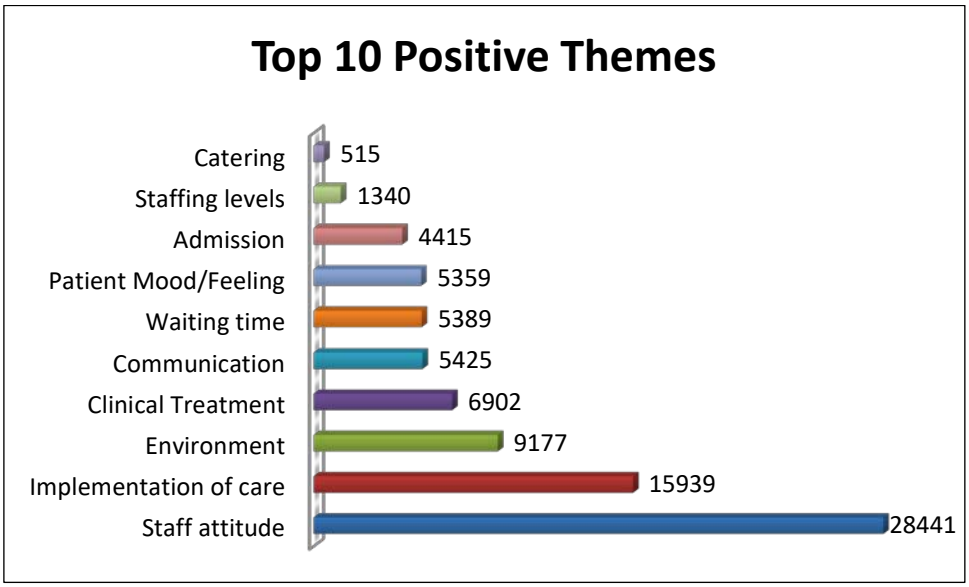
During 2017/18 (covering part of this annual reporting period) we received 52,941 responses, representing a 15.5% response rate, which gave the trust 92% positive feedback (found in graph 19). When reviewing the themes relating to both positive and negative feedback staff attitude and the environment feature in both lists (found in graph 20 and 21). This would

suggest that they are important to patients and service users as they freely provide feedback from each perspective.

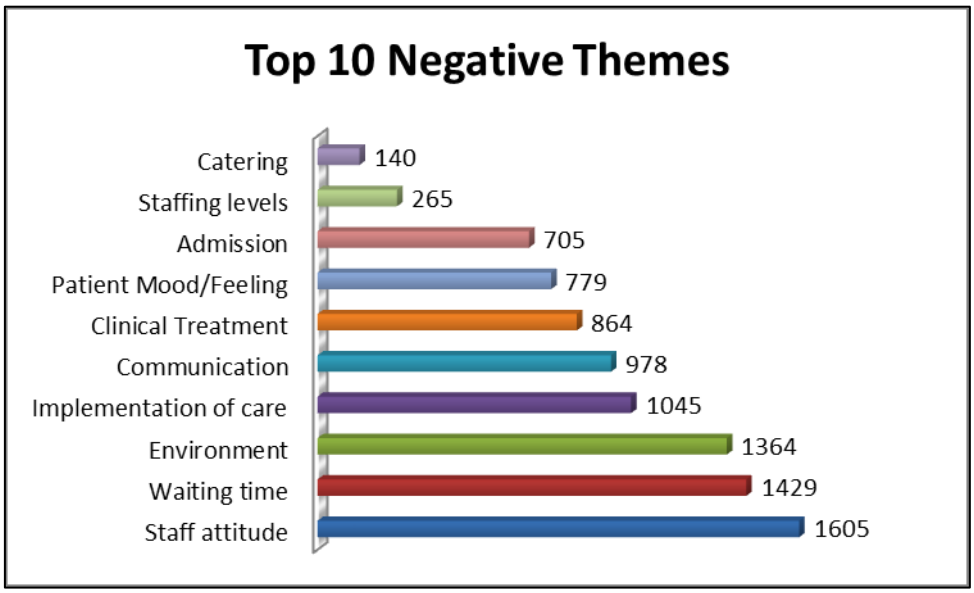
Graph 19: FFT feedback



Graph 20: Top 10 positive themes reported in FFT



Graph 21: Top 10 negative themes reported in FFT



4.2.9 *2017 Adult Inpatient (published by the CQC June 2018)*

This survey looked at the experiences of 72,778 people who were discharged from an NHS acute hospital in July 2017. Data was collected on 1,250 recent inpatients at the Countess of Chester Hospital NHS Foundation Trust and the questionnaire was sent out to 1,230 patients who were eligible for inclusion. Responses were received from 460 patients (reduction from 470 in 2016) in total giving a 37.4% response rate and accounts for 0.63% of the overall CQC responses reviewed.

About our respondents; key facts about the 460 inpatients who responded to the survey:

- 26% of patients were on a waiting list/planned in advance
- 71% came as an emergency or urgent case
- 54% had an operation or procedure during their stay
- 50% were male and 50% were female
- 4% were aged 16-39; 14% were aged 40-59; 19% were aged 60-69 and 64% were aged 70+

These facts are important when the CQC undertake their analysis, as trusts may have differing profiles of people who use their services. As this can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics, the CQC apply a standardised analysis tool which enables a more accurate comparison of results from trusts with different population profiles, making comparisons between trusts as fair as possible.

Our results: When reviewing the findings it is important to consider our position against the national CQC benchmark but also to track trends in performance over time. This allows for recognition of the areas that have improved since the previous survey and identifies those that are lower than the aspirations and/or expectations of the clinical teams despite being within the expected national comparison. The findings largely reflect the national position, showing that overall patient experience has remained consistent, with improvement noted in some areas, whilst others have shown some decline. Graph 22 below demonstrates consistency in the rating of positive patient experience since 2014 at our hospital. Patients' overall views about 'care and services' scored 4.3 which is within the expected national range, however this is a decline locally from 5.6 in 2016 and has highlighted 2 areas in particular that require attention. A rating of 1.7 was given to the question "were you ever asked to give your views on the quality of care" and 2.2 to the question "did you see, or were you given, any information explaining how to complain to the hospital about the care you received" (found in table 7).

Graph 22: Overall experience

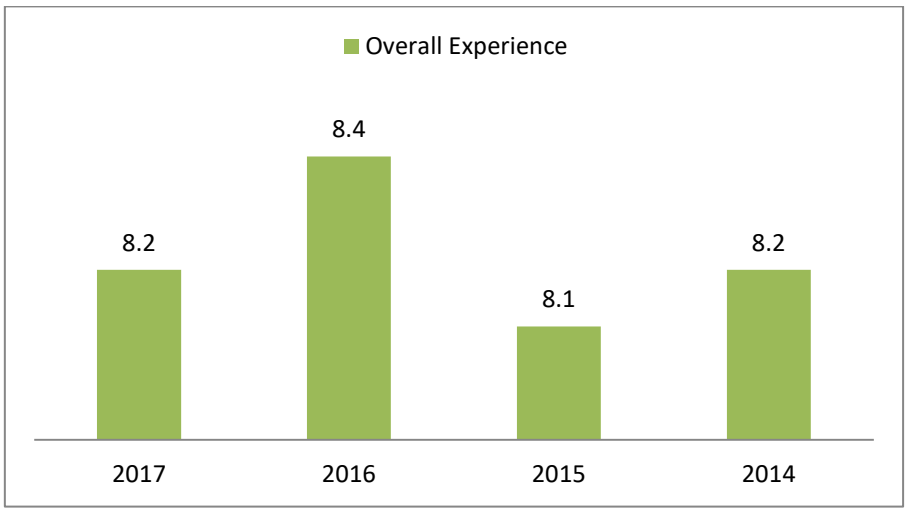


Table 7: Overall views about care and services

Question	2017	2016	2015	2014	Comment
Overall, did you feel you were **treated with respect and dignity**	9.1	9.2	9.0	8.9	Consistently high
During your hospital stay, **were you ever asked to give your views on the quality of care**	1.7	1.8	1.6	1.9	Consistently low; requires improvement
Did you see, or were you given, any **information explaining how to complain to the hospital** about the care you received	2.2	2.4	2.3	3.0	Consistently low; requires improvement
Overall rating for section	**4.3**	**About the same**			

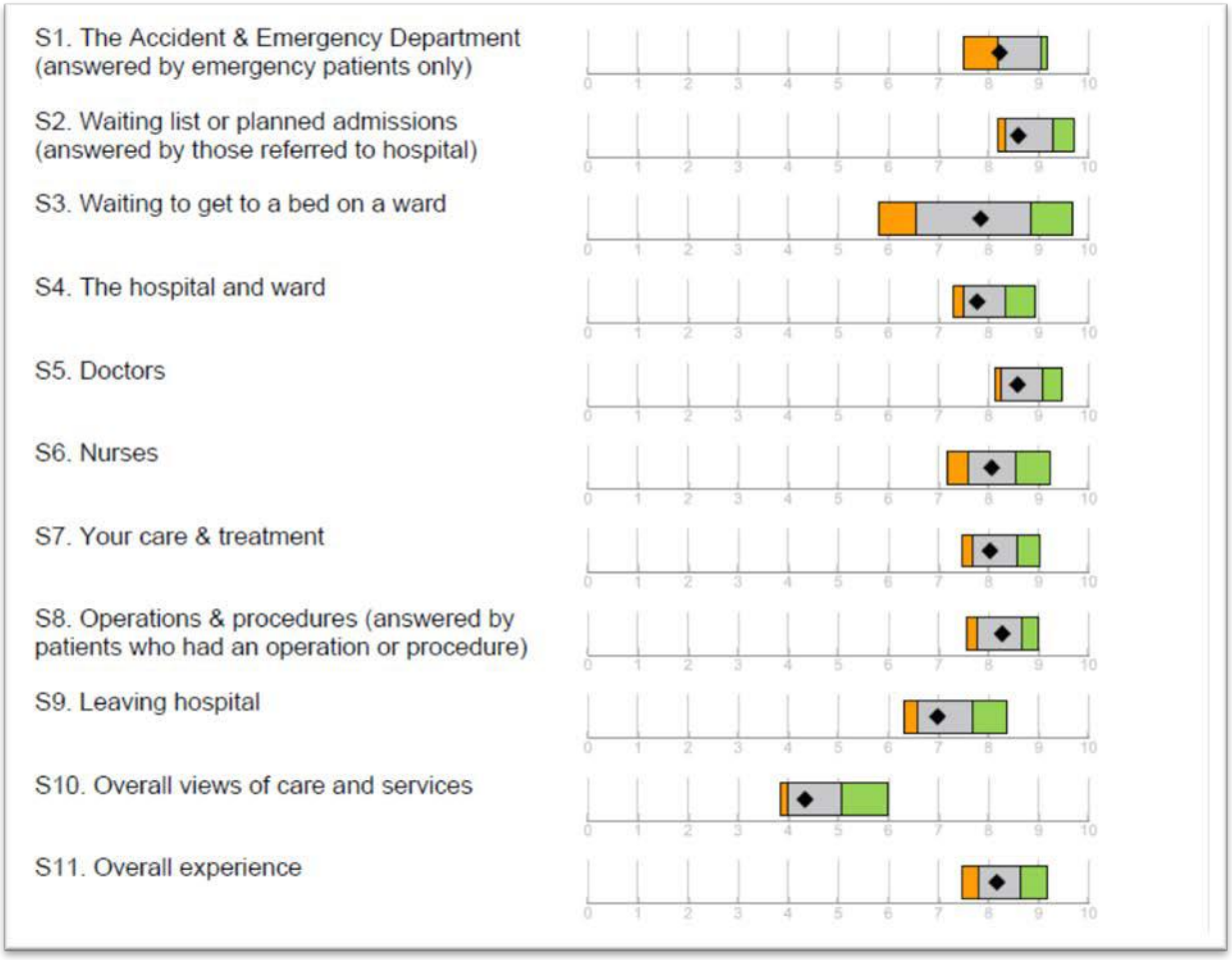
Have we improved? Analysis from the CQC shows that the findings demonstrate gradual improvement in a number of areas. This includes patients' perceptions of:

- the quality of communication between themselves and medical professionals (doctors and nurses);
- the quality of information about operations or procedures;
- privacy when discussing their condition;
- quality of food; and
- cleanliness of their room or ward.

However, the results also indicate that responses to some questions are less positive or have not improved over time. This includes patients' perceptions of:

- noise at night from other patients;
- emotional support from staff during their hospital stay;
- information on new medications prescribed while in hospital; and
- the quality of preparation and information for leaving hospital.

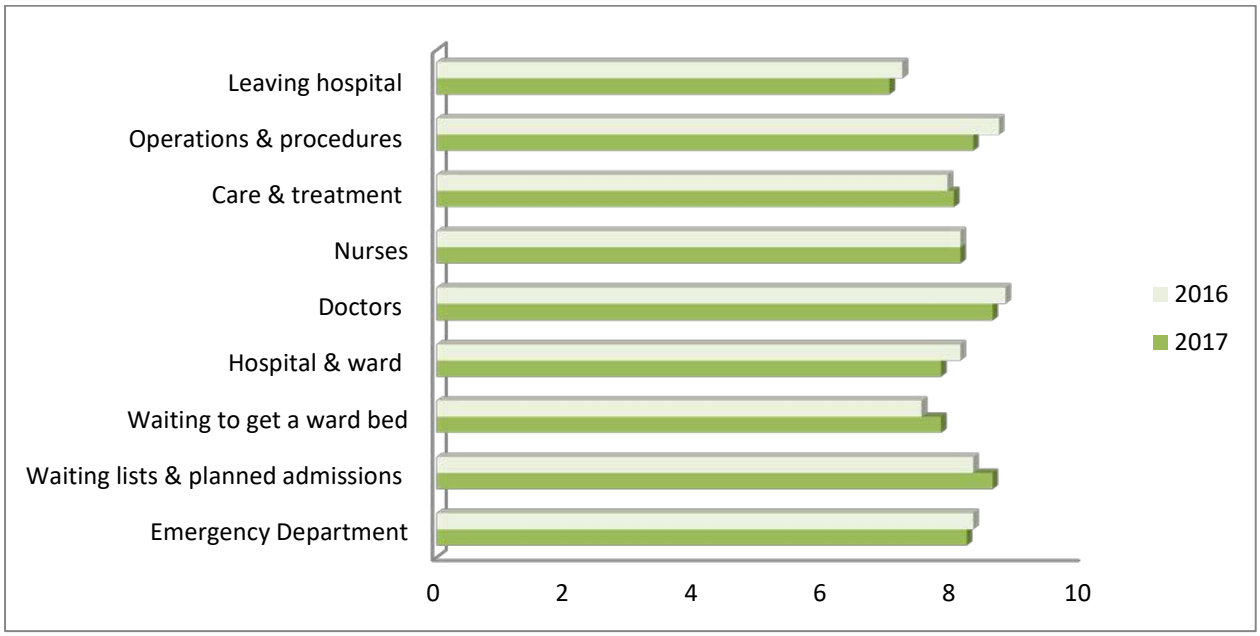
Chart 7: CQC comparison by survey category



The black diamond represents the trusts position and the grey area reflects that performance is within the expected range.

The findings reflect the national statistics and show that improvements have been made in the 'waiting lists & planned admissions' category across all questions (an area identified from the 2016 findings as requiring improvement), as well as the 'care and treatment' and 'waiting to get a ward bed' categories. Improvements have also been noted in other responses but these have not impacted the overall category rating as it is accompanied by a decline in experience in some associated questions. Only one area has scored 'worse' than the national comparison, this relates to being given 'enough privacy' when being examined or treated in the Emergency Department, which is likely to be a direct result of the facilities and space available for the growing demand and complexity of patients seen within this area.

Graph 23: Overall rating by category



4.2.10 *2017 Maternity (published by the CQC in November 2018)*

Chart 8: Sample and response rates

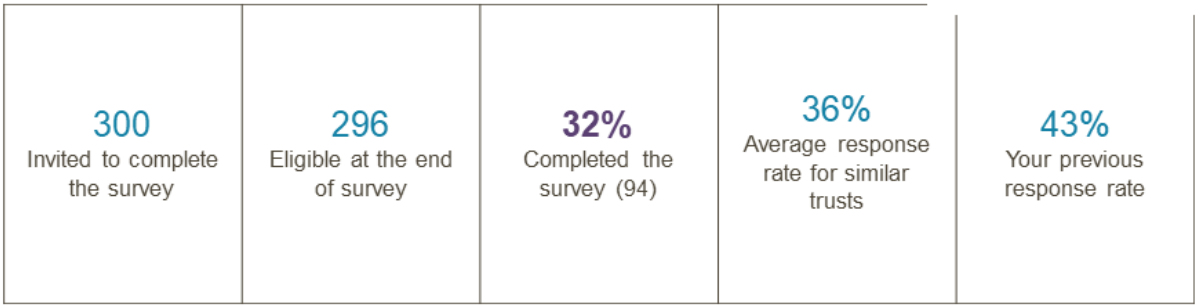


Chart 9: Comparisons

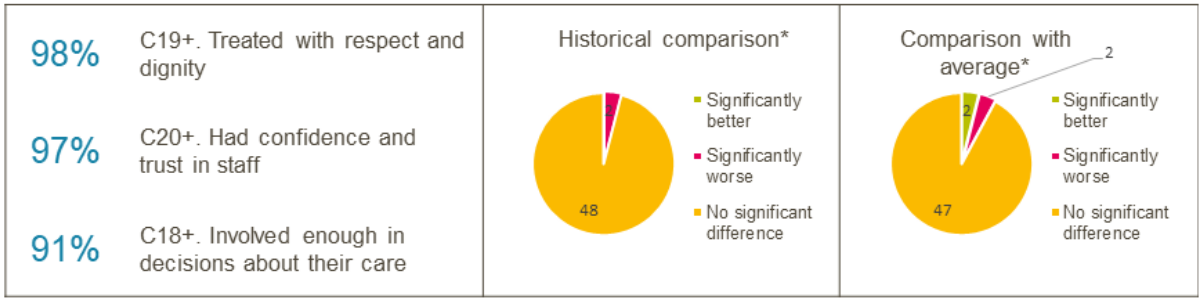
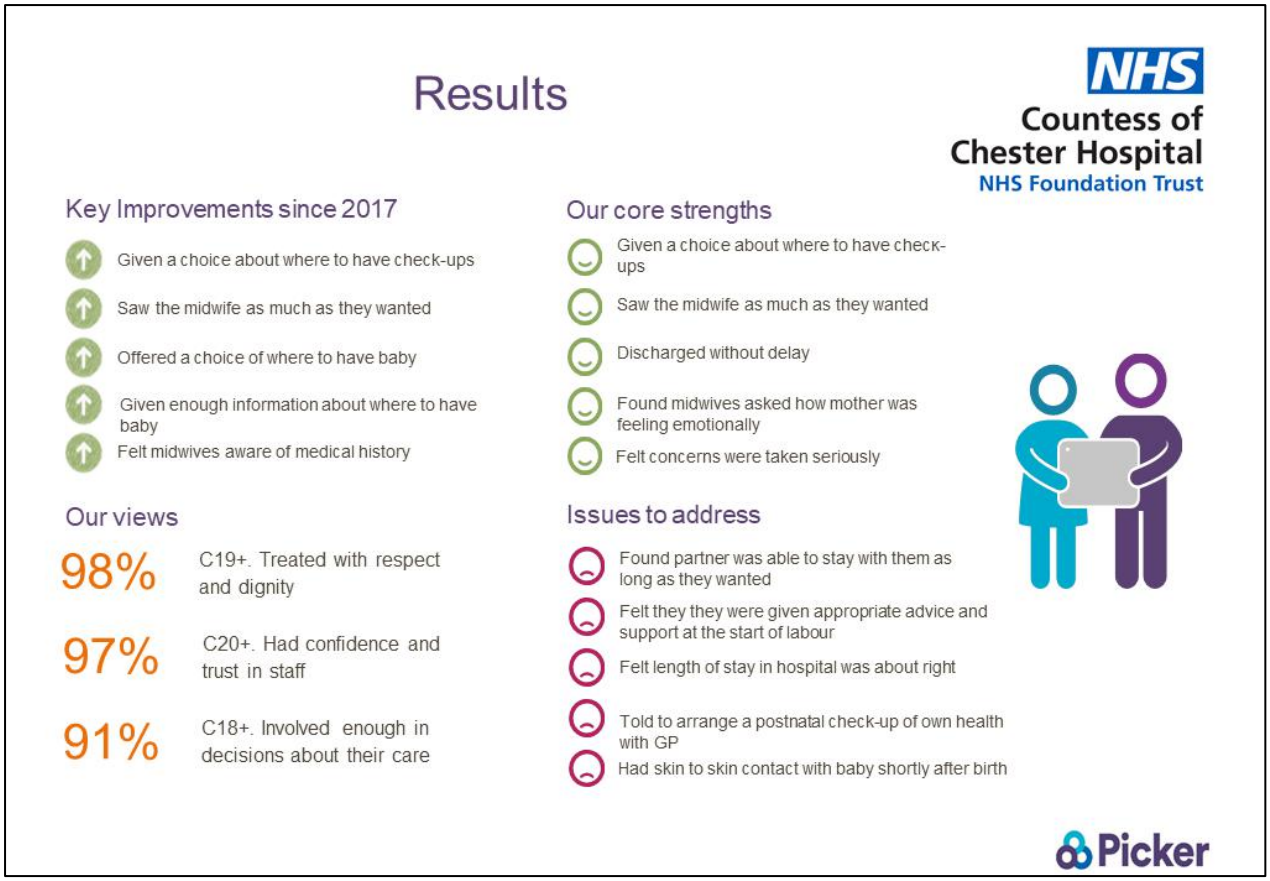


*Chart shows the number of questions that are better, worse, or show no significant difference



Achievements to celebrate:

- 98% of women felt they were treated with dignity and respect
- 97% had confidence in staff
- Women felt they saw the midwife as much as they wanted

Nest steps:

- Review availability for partners staying overnight
- Ensure women are asked about emotional well being
- Improve skin to skin at birth

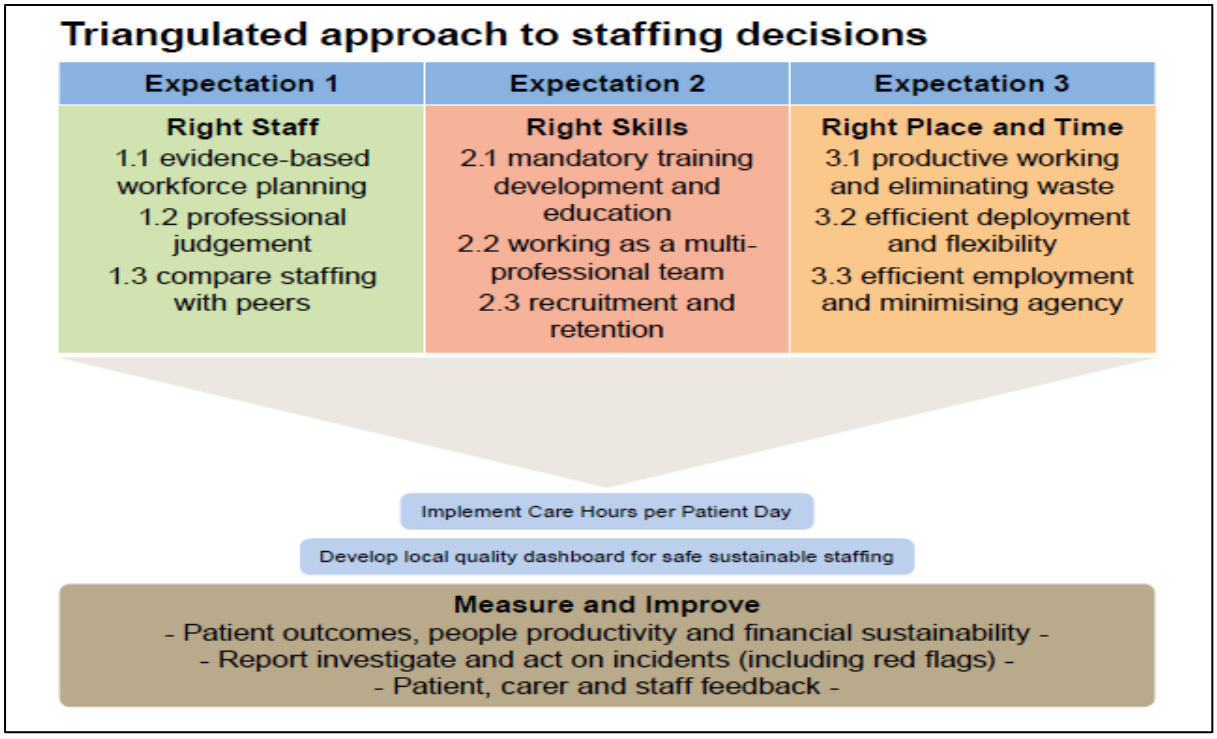
5.0 Compliance against national standards

5.1 This section will provide details on the compliance against regulatory and National Quality Board standards in relation to safe staffing levels. It will provide measurement against:

- National Quality Board (2018) An improved resource for adult inpatient wards in acute hospitals;
- National Quality Board (2017) Safe, sustainable and productive staffing: An improvement resource for maternity services;
- National Quality Board (2018) Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals; and
- NHS Improvement (2018) Care Hours per Patient Day (CHPPD): Guidance for acute and acute specialist trusts.

The National Quality Board (NQB) has published frameworks for provider organisations to use when assessing and reviewing nursing and midwifery safe staffing level. They are designed to ensure transparency in reporting from 'ward to board' and detail the information that should be used to provide assurance[1,3,15,16,17]. The recommendations ensure that staffing reviews focus on 3 expectations (found in chart 10) and provide a structured approach to how staffing levels should be triangulated with safety, quality and experience measures to make an evidenced based assessment to whether staffing levels are safe and meet the expectations of patients and service users.

Chart 10: National Quality Board (NQB) expectations



5. 2 *National Quality Board (2018) An improved resource for adult inpatient wards in acute hospitals*

Recommendation	Compliance	Evidence and/or actions
A systematic approach should be adopted using an evidence-informed decision making tool triangulated with professional judgement and comparison with relevant peers.	Achieved	SafeCare uses NICE recommended 'Shelford Safer nursing care' tool. Acuity census is taken twice daily to measure number of care hours needed. Data collected is used to inform staffing decisions in real-time alongside professional judgement. The data collected over a period of time has been used for the 2018 Nurse Staffing Establishment review. Comparative data on model hospital portal is available.
A strategic staff review must be undertaken annually or sooner if changes to services are planned.	Achieved	Annual staffing paper and 6 monthly progress/update report presented to Board of Directors. Nurse Establishment review undertaken during 2018 and presented to the Board of Directors, investment made to establishment in high risk areas (wards 50 and 51, Elderly Care). If changes to services are made, individual workforce reviews form part of the overarching operational plan, with any additional requirements and/or staffing model changes outlined.
Staffing decisions should be taken in the context of the wider registered multi-professional team.	Partially achieved	This is in place in the intermediate care areas (ward 34, Bluebell and Poppy), however further work is needed to assess the acute ward staffing models needed to meet patients' needs, this assessment forms part of the 'Model Ward' work programme, during 2018 the matron role has been redesigned and implemented, focus in 2019 will include the ward department manager role and the configuration of nursing models. This piece of work will be informed by the 'Interim People Plan'[22], the 'Future Nurse Programme'[21] and the Cheshire & Merseyside Nursing and Midwifery Workforce Programme.
Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning.	Partially achieved	Operational planning includes the workforce requirements; however for nursing the acuity evidence based tool is not always used to quantify nurses and skill mix needed. Operational decisions to move experienced nurses into advanced practice roles and/or offer training programmes to develop the enhanced skill set required for service delivery are becoming more frequent to meet the needs of patients. When this happens there are inconsistencies in the approach taken, challenges include no backfill monies available to support the release of the nurse and/or funding for the substantive post (once qualified) not identified from the relevant

		medical budget (if appropriate), leading to cost pressures and increased use of temporary staffing.
Action plans to address local recruitment and retention prioritises should be in place and subject to regular review.	Achieved	Recruitment & Retention Strategy in place, supported by comprehensive work programme (overview can be found in section 6.2). Task & finish group meet monthly to progress actions and report to the Nursing & Midwifery Workforce Group.
Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit the use of temporary staff.	Not achieved	Systems and processes in place support achievement of this standard but there are currently insufficient numbers to achieve compliance. Flexible employment options available, acuity based workforce model in place to redeploy staff to meet acuity, and work being progressed to attract substantive and bank staff. However due to vacancies, sickness and absence, turnover and ward and department establishments being lower than required for the patient acuity and dependency, there is an over reliance on temporary staffing, with growth in the number of temporary staffing shifts request and although fill rates are increasing alongside they are not at the pace of the growth leaving a significant gap.
A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision making.	Achieved	Safe staffing dashboard developed & in use, reported to QSPEC monthly.
Organisations should ensure they have an appropriate escalation process in cases where staffing is not delivering the outcomes identified.	Achieved	*Real time reporting:* Red flags are loaded into SafeCare system; ward managers and matrons have oversight and manage and/or escalate the risks identified. Any incidents relating to staffing are recorded in the Datix system and investigated in line with governance procedure. The staffing incident report is received at the Serious Incident Panel and the Nursing & Midwifery Workforce Group. If staff redeployment is required the matrons will use the SafeCare tool alongside professional judgement to make staffing decisions (site coordinators out of hours take on this role). *Weekly reporting:* Nursing and Midwifery staffing meeting is held weekly, chaired

		by one of the Associate Directors of Nursing , this is to look forward at the staffing and skill mix numbers, making decisions regarding redeployment, need for temporary staffing and monitoring peak annual leave periods. This allows for decisions to be made early (if required) concerns and issues may also be raised and actioned. *Monthly report:* Ward manager key performance indicators include key safety, quality and patient experience measures, these are reported on and discussed monthly with relevant matron, oversight is provided by the Divisional Associate Director of Nursing who reports monthly the Divisional position to the Director of Nursing & Quality and the relevant Divisional Governance Board.
All organisations should include a process to determine additional staff uplift requirements based on the needs of patients & staff.	Not achieved	Current uplift is not reflective of patient and staff requirements and is not in line with national standard.
All organisations should investigate staffing-related incidents and their outcomes on patients and ensure action & feedback.	Achieved	Risk Management system in use is Datix; this system incorporates all aspects of incident management. The online incident reporting form is simple to use and suitable for both clinical and non-clinical incident reporting. Staffing is a category and in addition every submission (regardless of category) has the section 'is this incident related to staffing'? The system allows the reporter to add detail that is specific to the incident. The Risk & Safety team send all low/no harm staffing incidents to the specific ward or departmental manager to review and action, this allows ownership, prompt action and feedback to staff. The Risk & Safety Leads monitor incidents that have caused moderate and above categories of harm, they then produce an SBAR's for the Serious Incident panel who then decide upon the level of action required. Any action plans that form part of a Level 1 or 2 Investigation are monitored by the Divisional Governance Board until completed and are signed off by the CCG.

5.2.1 *National Quality Board (2017) Safe, sustainable and productive staffing: An improvement resource for maternity services*

Recommendation	Compliance	Evidence and/or actions
Boards are accountable for assuring themselves that appropriate tools (such as the NICE-recommended Birthrate Plus (BR+) tool for midwifery staffing) are used to assess multi-professional staffing requirements.	Achieved	Birthrate+ establishment review completed during 2018, acuity based tool will be used moving forward continuously.
Boards are accountable for assuring themselves that results from using workforce planning tools are cross-checked with professional judgement and benchmarking peers.	Achieved	Annual staffing paper and 6 monthly progress/update report presented to Board of Directors. Midwifery Establishment review using Birthrate+ tool undertaken during 2018. Professional judgement using national frameworks to inform the triangulation of evidence provided. Workforce planning is undertaken in conjunction with the trusts workforce team and local universities (supported by wider HEE work streams). Current projections imply that there will be limited growth in numbers needed over the next 12 months, however changes in skill mix may be required to support new models of care. Benchmarking with peer groups and national providers can be accessed through the NHSi Model Hospital portal.
Boards must review midwifery staffing annually, aligned to their operational and strategic planning processes and review of workforce productivity, as well as a midpoint review every six months in line with NICE guideline NG4.	Achieved	Staffing reviewed conducted 6 monthly, this now uses an evidenced based nationally recognised tool (Birthrate+). Reviewed in line with activity, capacity and occupancy both current and potential future service developments.
Boards are accountable for assuring themselves that staffing reviews use the RCOG, RCoA and OAA guidelines on effective maternity staffing resources.	Achieved	
Boards are accountable for assuring themselves that sufficient staff have attended required training and	Achieved	Midwifery staff undertake an annual appraisal where a detailed discussion takes place in relation to training required to maintain or

development, and are competent to deliver safe maternity care.		advance development to support professional and service objectives, this includes all relevant mandatory training. Rotation of staff to support service needs, ensuring a competent and skilled workforce.
Organisations should have action plans to address local recruitment and retention priorities, which are subject to regular review.	Achieved	Recruitment & Retention Strategy in place, supported by comprehensive work programme (overview can be found in section 6.2). Task & finish group meet monthly to progress actions and report to the Nursing & Midwifery Workforce Group.
Flexible employment options and efficient deployment of trained staff should be maximised across the hospital to limit numbers of temporary staff.	Achieved	Flexible model has been adopted across maternity services, with midwives working across the full range of the maternity pathway, spanning hospital and community, allowing for a flexible and transferable workforce. Flexible working arrangements are available and maternity currently operates an open rostering system allowing for greater staff choice in shift preferences. Only minimum (very occasional) temporary staffing required.
Organisations should have a local dashboard to assure stakeholders about safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.	Achieved	Safe staffing dashboard developed & in use, reported to QSPEC monthly.
Organisations should have clear escalation processes to enable them to respond to unpredicted service needs and concerns about staffing.	Achieved	Escalation process found in staffing policy this is enacted at times of high activity including deployment of senior midwifery managers and specialist midwives to support the service as required.
Establishments should include an uplift to allow for the management of planned and unplanned leave to ensure that absences can be managed effectively.	Achieved	Annual leave rostered evenly throughout the year (in line with key performance indicators). Established e-roster principles continue to be monitored and refined.
Organisations must have mandatory training, development and education programmes for the multidisciplinary team, and establishments must allow for staff to be released for training and	Achieved	Robust training programme available, staff rostered to attend.

development.		
Organisations must take an evidence-based approach to supporting efficient and effective team working.	Achieved	All training and guidelines are evidence based. Rotation of staff to support service needs, ensures a competent and skilled workforce, this also allows for integrated team working across the maternity pathway.
Services should regularly review red flag events and feedback from women, regarding them as an early warning system	Achieved	Red flags are reported in line with national requirements, all safety, quality and experience metrics are monitored and actioned (as required) through the Women's and Children's Governance Board.
Organisations should investigate staffing-related incidents, outcomes on staff and patients, and ensure action, learning and feedback	Achieved	Risk Management system in use is Datix; this system incorporates all aspects of incident management. The online incident reporting form is simple to use and suitable for both clinical and non-clinical incident reporting. Staffing is a category and in addition every submission (regardless of category) has the section 'is this incident related to staffing'? The system allows the reporter to add detail that is specific to the incident. The Risk & Safety team send all low/no harm staffing incidents to the specific ward or departmental manager to review and action, this allows ownership, prompt action and feedback to staff. The Risk & Safety Leads monitor incidents that have caused moderate and above categories of harm, they then produce an SBAR's for the Serious Incident panel who then decide upon the level of action required. Any action plans that form part of a Level 1 or 2 Investigation are monitored by the Divisional Governance Board until completed and are signed off by the CCG.

5.2.2 National Quality Board (2018) Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals

Recommendation	Compliance	Evidence and/or actions
Adopt a systematic approach using an evidence-based decision tool, triangulated with professional judgement and comparison with peers.	Partially achieved	Annual staffing paper and 6 monthly progress/update report presented to Board of Directors. Nurse Establishment review currently taking place with the expectations and recommendations listed in the NQB standards. This will provide benchmarking comparisons and will be concluded in 2019. SafeCare in use utilising the paediatric version of the 'Shelfold' tool.
Undertake a strategic staffing review annually or more often if changes to service are planned.	Partially achieved	Annual staffing paper and 6 monthly progress/update report presented to Board of Directors. Nurse Establishment review currently taking place with the expectations and recommendations listed in the NQB standards. This review will be concluded in 2019.
Staffing decisions should consider the impact of the role and carers.	Achieved	A limitation of the paediatric SafeCrae tool is that it does not account for the role of carers with regards to the child's requirements. Professional judgement is applied to staffing allocation on each shift to take this into consideration.
Factor into the establishment the requirement that all children and young people should have access to a registered children's Nurse 24 hours a day – particularly important in the NHS acute Trusts and DGH's where the children's services are often a small department.	Achieved	Always a minimum of 2 Registered Children's Nurses on any shift.
Take staffing decisions in the context of the wider registered multi-professional team.	Partially achieved	Advanced practitioners are used to support the nursing numbers in the Children's Assessment Unit (currently under established), this leads to limitations in them delivering their usual duties (at an advanced level). A new model with supporting assistant practitioners is currently being explored.
Safe Staffing requirements and workforce	Partially	A work stream reviewing current service delivery for paediatric is

productivity should be integral to operational planning.	achieved	established across Cheshire & Merseyside. Workforce is part of this programme and focuses on new and emerging roles to support across a range of reconfigured services. The Countess of Chester Hospital is an active member of the work stream and is working collaboratively with partner organisations.
Organisations should have plans to address local recruitment and retention priorities, and review them regularly.	Achieved	Recruitment & Retention Strategy in place, supported by comprehensive work programme (overview can be found in section 6.2). Task & finish group meet monthly to progress actions and report to the Nursing & Midwifery Workforce Group.
Hospitals should offer flexible employment and deploy staff efficiently to limit use of temporary staff, paying particular attention to the younger age profile of registered children's nurses.	Achieved	Flexible working arrangements are available, with some agreements in place, these are reviewed annually. Staff deployment within our speciality area reducing the need for temporary staff (which is minimal).
Organisations should have a local dashboard to assure stakeholders about safe and sustainable staffing. It should include quality indicators to support decision-making.	Achieved	Safe staffing dashboard developed & in use, reported to QSPEC monthly.
All organisations should have a process to determine additional staffing uplift requirements based on the needs of patients and staff.	Achieved	Currently 20% uplift, this will be reviewed as part of the Nurse Establishment review.
All organisations should investigate staffing-related incidents and their effect on staff and patients, taking action and giving feedback.	Achieved	Risk Management system in use is Datix; this system incorporates all aspects of incident management. The online incident reporting form is simple to use and suitable for both clinical and non-clinical incident reporting. Staffing is a category and in addition every submission (regardless of category) has the section 'is this incident related to staffing'? The system allows the reporter to add detail that is specific to the incident. The Risk & Safety team send all low/no harm staffing incidents to the specific ward or departmental manager to review and action, this allows ownership, prompt action and feedback to staff. The Risk & Safety Leads monitor incidents

		that have caused moderate and above categories of harm, they then produce an SBAR's for the Serious Incident panel who then decide upon the level of action required. Any action plans that form part of a Level 1 or 2 Investigation are monitored by the Divisional Governance Board until completed and are signed off by the CCG.
Feedback from children, and young people, families and carers, including complaints, should be an early warning to identify service quality concerns and variation.	Achieved	Friends and Family, thank you cards, PALS, Social Media (for example twitter and Facebook), comments are reviewed and actioned appropriately.

5.2.3 *NHS Improvement (2018) Care Hours per Patient Day (CHPPD): Guidance for acute and acute specialist trusts*

Recommendation	Compliance	Evidence and/or actions
Do trusts have a clear process for Safe Staffing monthly returns to be quality assured as well as clinically validated within their organisation prior to submission? This will help ensure accuracy, completeness and robustness of reported CHPPD data.	Achieved	Staff staffing data is pulled from the HealthRoster monthly. This is retrospective so all moves/shift changes are reflected in the information pulled. The data pulled is reflective of actual hours worked (day/night & registered/unregistered) by each ward/department. This information is validated by the Divisional Associate Directors of Nursing and submitted through the Business Intelligence team to NHS Digital before the reporting window closes.
Are the ward and speciality names routinely checked for alignment across other national data returns?	Partially achieved	A review has been completed and it has been identified that the unify submission is not reflective of the actual names, specialities of wards. This needs to be updated to ensure alignment.
Is there an active process for Model Hospital speciality and ward names alignment to be validated and updated with all changes alerted to NHSi?	Partially achieved	A review has been completed and it has been identified that the unify submission is not reflective of the actual names, specialities of wards. As this document then feeds the Model Hospital portal the presentation is also inaccurate on this site. Work to be undertaken to ensure alignment.
Do trusts have an understanding as well as assurance to determine if the level of variation in their nationally reported CHPPD on Model Hospital is warranted or unwarranted?	Achieved	Mechanism to monitor variation is in place. Quarterly portal reports are shared at the Nursing & Midwifery Workforce Group. The portal is also used in this forum to review in real-time. Challenges present at the Countess of Chester Hospital as Welsh activity in not included in the WAU making analysis and comparison difficult across some metrics.
Do trusts have an understanding of their reported CHPPD by ward compared to national averages and also with appropriate comparable wards at peer trusts as part of their establishment setting and review process?	Achieved	National comparisons are monitored at the Nursing & Midwifery Workforce Group monthly. They are included in Safe Staffing papers and Nurse Establishment reviews.

Are ward establishments set using NICE endorsed evidenced based tools such as The Safer Nursing Care Tool (SNCT) and Birthrate Plus and are these in line with NQB and underpinned by auditable clinical judgement?	Partially achieved	Nurse Establishment review was completed using SafeCare evidenced based tool in 2018. Investment has been made in the two wards identified as having the highest risk (wards 50 and 51, Elderly Care), these establishments are now set in line with acuity and dependency of the patient case mix most frequently seen over a 10 month period, a risk based approach will be taken to the remaining ward and department areas. A Midwifery Establishment was also undertaken during 2018 using the Birthrate+ validated tool. Each review met the requirements of the NQB recommendations. Paediatrics Nurse Establishment review is in progress and will be concluded in 2019.
Are such tools used consistently and exactly as instructed in the implementation guidance in an auditable manner?	Achieved	Nationally validated tool used in SafeCare & fully embedded in line with guidance.
Is the set establishment as signed off at budget setting by finance, workforce, operational and clinical leads being expressed in terms of care hours (and could therefore be convertible to CHPPD) to enable comparisons and triangulation with nationally reported CHPPD?	Not achieved	
Do trusts have systems and processes in place to capture the CHPPD that is planned on their daily roster?	Achieved	SafeCare fully embedded and visibility available at ward, divisional and organisation level.
Can this be reviewed on a shift to shift basis?	Achieved	SafeCare fully embedded and visibility available at ward, divisional and organisation level.
Do trusts have systems and processes in place to capture the CHPPD that is actually delivered on their	Achieved	SafeCare fully embedded and visibility available at ward, divisional and organisation level.

daily roster?		
Can this be reviewed on a shift to shift basis?	Achieved	SafeCare fully embedded and visibility available at ward, divisional and organisation level.
Can this then be compared and tracked against establishment CHPPD?	Achieved	Reported monthly to QSPEC and the N&M Workforce Group, Associate Directors of Nursing share information with Divisions through usual governance routes. Comparative data reviewed in Model Hospital portal.
Implementing CHPPD can be enhanced by daily and shift to shift considerations as a transparent basis for levelling redeployment between wards where systems are locally available.	Achieved	This process takes place on a daily basis at the ward managers huddle and in real-time in response to changes in staffing level and/or demand.
To enable helpful comparisons on a daily and shift-to-shift basis, auditable, evidence-based methods that are clinically assured and clearly aligned with guidance are required to capture patient acuity and dependency.	Achieved	SafeCare uses the validated Shelford tool, this has been roll out to all adult and paediatric inpatient wards, using the nationally agreed multipliers to calculate required staffing. In critical care a regional dependency tool has been adopted until a national one is available and the ICS Standards for staffing are applied. In Maternity the Birthrate+ tool is used and in Neonates the BAPM standards are applied in relation to levels of care.

6.0 Conclusions & Next Steps

6.1 *Conclusion*

This report concludes that the current safe staffing levels in maternity and paediatric services are maintaining safety, quality and patient/service user experience. However, there is further work to be undertaken during 2019 to understand the establishment and skill mix required in paediatrics. Midwifery staffing levels will be monitored using the recognised Birthrate+ methodology[20] periodically to ensure the levels and skills available are appropriate to care for the mothers and babies using maternity services at the hospital.

However, the report clearly demonstrates during 2018 there were significant gaps in the adult registered nursing numbers across general inpatient wards and departments, as outlined in the Trust's latest CQC Inspection report (2019). This has contributed to a reduction in the quality of care provided to our patients (as demonstrated in sections 4.2.1, 4.2.2, 4.2.3, 4.2.4 and 4.2.5). Where possible this risk has been mitigated by deploying staff internally, utilising temporary staff (bank and agency) and backfilling shifts unfilled with unregistered nurses. The acuity, dependency and number of available registered and unregistered nurses is monitored daily and staffing decisions are made using professional judgement, supported by an evidenced based tool (SafeCare). A weekly staffing meeting to plan ahead are embedded and confirm and challenge sessions ahead of roster publication provide assurance that they are optimised and as efficient as the numbers of staff allow. However, this position is not sustainable and requires resolution and investment, particularly in light of the NHS Long-term plan, the ambitions it set outs and the growing financial constraints.

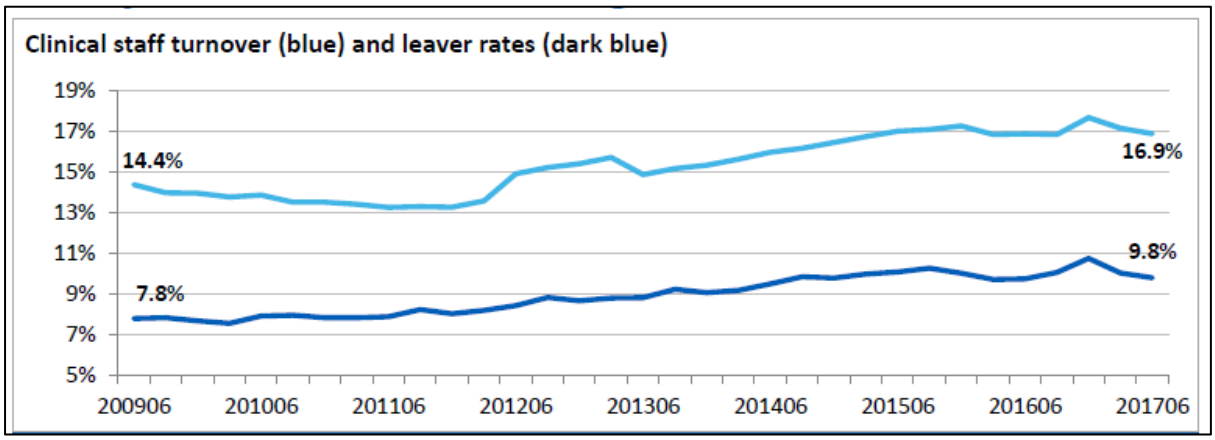
6.2 *Next Steps*

In response to this report, during 2019 we will be focusing on collaboration with the Cheshire & Merseyside Nursing and Midwifery Workforce Programme to stabilise the vacancy gaps, make evidence base predictions in relation to growth, reduce turnover (retaining skilled staff), improve supply (through undergraduate programmes, apprenticeships, return to practice initiates and overseas recruitment) and prepare for the NMC 'future nurse' standards and consider implementation of the Nursing Associate role.

In addition, work will continue to ensure that registered and unregistered nursing and midwifery establishments are fit for purpose and provide adequate resource to deliver safe, kind and effective care to our patients and service users. This will also impact positively on our staffs well-being as it is clear in section 4.2.1, that nursing staff are consistently missing breaks, reporting a shortage of registered nurse time and leaving work late, to maintain as positive an experience for patients as possible under the current pressures.

6.2.1 *Nurse Retention;* will continue to be a priority in Nursing and Midwifery during 2019. The need to focus on staff retention in the NHS has been clearly set out by NHS England[18,22] and is supported by local providers, regulators and NHS Employers. Workforce planning has traditionally been focused on supply and creating a recruitment pipeline to fill the predicted workforce requirements. Given the current situation; it is evident that workforce demand far outweighs the current and expected supply, and as such emphasis has been placed on the retention of skilled healthcare workers within provider organisation to reduce the number of staff leavers, reduce turnover rates and stabilise the vacancies gap. The responsibility for taking this forward sits across the NHS healthcare system from the Department of Health right through to each provider organisation, with support from central office, regulators and NHS Employers. There is no single action that will resolve the current retention issues (demonstrated in graph 24), the approach needed has to be focused on collaboration, shared learning and a combination of actions to make a difference and sustain results that offer benefit across the system.

Graph 24: *Retention Issue*



Data source: NHSi Cohort 4 Retention Event (22nd November 2018)

With the increasing trend in clinical staff turnover and leaver rates (increased across all professional groups in the last 7 years) and the correlating supply gaps which are further complicated by the cost to organisations to recruit, it is more important than ever to focus on retention, particularly as a high proportion of leavers are not staying within the NHS.

However, it is important to note that staff turnover can be healthy for an organisation and when setting targeted rates for improvement it is important to consider what level of turnover is needed to ensure:

- Staff are able to move on to new opportunities to develop themselves and services;

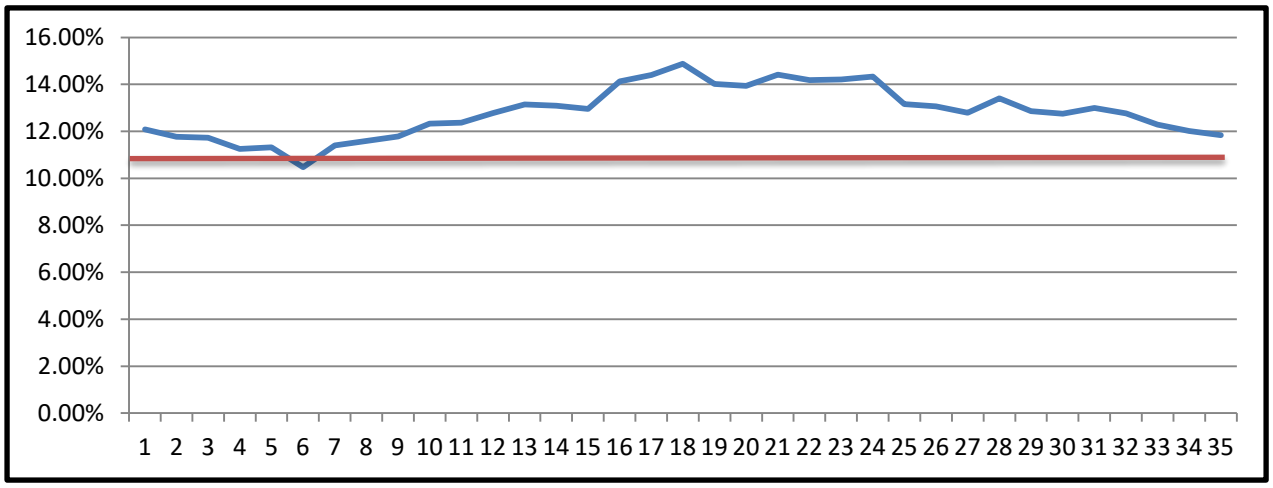
- New starters joining the organisation benefit from new ideas, skills and shared learning through experience; and
- Existing staff can share their experience with new starters.

The challenge is to find the balance; as evidence demonstrates that retaining skilled and competent staff improves patient experience, the overall quality of patient care as well as improving staff satisfaction.

6.2.2 *Looking in depth at our data*

Graph 25 below tracks the percentage turnover in Registered Nursing & Midwifery from April 2016 to March 2019. It shows that our turnover rates have been higher than expected for a sustained period of time. Work completed to date has demonstrated a reduction, however, a more evidenced based approach, using the intelligence available is required to reduce the turnover further (and to achieve the NHSi target of 10.3%) and sustain any improvements made.

Graph 25: Registered Nursing & Midwifery turnover rates (April 2016 – March 2019)



When reviewing Registered Nursing and Midwifery length of service, it evidences the key areas for focus. Analysis between January 2016 and December 2018 shows the highest proportion of leavers go within the first 3 years of employment (54.29%), with a further quarter (26.9%) leaving after 10 years of service. On further analysis of this data and by correlating it with the age of leavers and ESR reasons for leaving it focuses attention on the following key areas:

- Retire & Return;
- Flexible working;
- Career Development; and
- Preceptorship & Beyond.

Table 8: Length of Service (analysis from January 2016 to December 2018)

N&M Leavers January 2016 to December 2018			
Length of Service (Years)	**Headcount**	**% Leavers**	**Grouped %**
0 Years	68	16.19%	**54.29%**
1 year	69	16.43%	
2 Years	52	12.38%	
3 Years	39	9.29%	
4 Years	23	5.48%	**18.81%**
5 Years	8	1.90%	
6 Years	17	4.05%	
7 Years	10	2.38%	
8 Years	11	2.62%	
9 Years	10	2.38%	
10 to 15 Years	34	8.10%	**26.90%**
16 to 20 Years	33	7.86%	
21 to 30 years	23	5.48%	
31 to 44+ years	23	5.48%	

Graph 26: Age of leavers

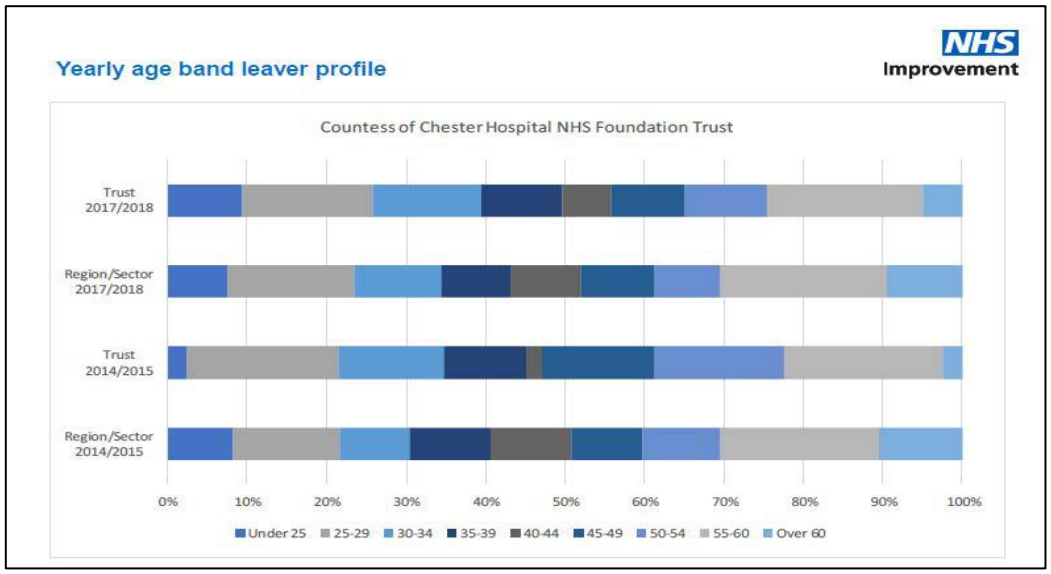
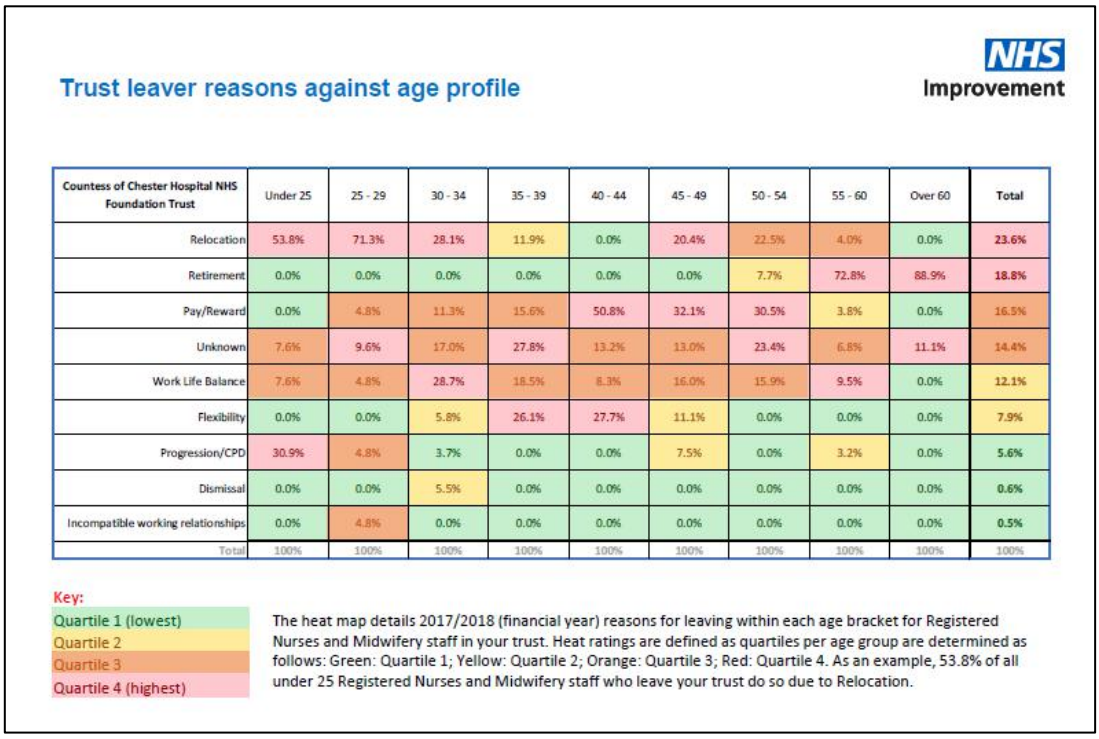


Table 9: Reasons for leaving



Trust leaver reasons against age profile

NHS Improvement

Countess of Chester Hospital NHS Foundation Trust	Under 25	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 60	Over 60	Total
Relocation	53.8%	71.3%	28.1%	11.9%	0.0%	20.4%	22.5%	4.0%	0.0%	23.6%
Retirement	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.7%	72.8%	88.9%	18.8%
Pay/Reward	0.0%	4.8%	11.3%	15.6%	50.8%	32.1%	30.5%	3.8%	0.0%	16.5%
Unknown	7.6%	9.6%	17.0%	27.8%	13.2%	13.0%	23.4%	6.8%	11.1%	14.4%
Work Life Balance	7.6%	4.8%	28.7%	18.5%	8.3%	16.0%	15.9%	9.5%	0.0%	12.1%
Flexibility	0.0%	0.0%	5.8%	26.1%	27.7%	11.1%	0.0%	0.0%	0.0%	7.9%
Progression/CPD	30.9%	4.8%	3.7%	0.0%	0.0%	7.5%	0.0%	3.2%	0.0%	5.6%
Dismissal	0.0%	0.0%	5.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%
Incompatible working relationships	0.0%	4.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Key:

Quartile 1 (lowest)
Quartile 2
Quartile 3
Quartile 4 (highest)

The heat map details 2017/2018 (financial year) reasons for leaving within each age bracket for Registered Nurses and Midwifery staff in your trust. Heat ratings are defined as quartiles per age group are determined as follows: Green: Quartile 1; Yellow: Quartile 2; Orange: Quartile 3; Red: Quartile 4. As an example, 53.8% of all under 25 Registered Nurses and Midwifery staff who leave your trust do so due to Relocation.

6.2.3 *Data supporting focus area 'Retire & Return'; w*hen considering the age profile of the registered Nursing and Midwifery workforce, data analysis between 1st March 2017 and 28th February 2019 has demonstrated that a large proportion (25.59% in nursing and 29.09% in midwifery) of the registered workforce are aged over 51 years, meaning over the next 5 years they may consider retirement. This is irrespective of the changes made to NHS Pension Schemes, as although the retirement age has increased registered staff locally are still choosing to retire at 55 years despite the reduction in pension payments.

Table 10: Registered Nurse age profile

Age Band	Headcount	%
21-25	73	7.66%
26-30	138	14.48%
31-35	124	13.01%
36-40	132	13.85%
41-45	119	12.49%
46-50	123	12.91%
51-55	126	13.22%
56-60	80	8.39%
61-65	36	3.78%
66-70	1	0.10%
>=71 Years	1	0.10%
Grand Total	**953**	

Table 11: Registered Midwives age profile

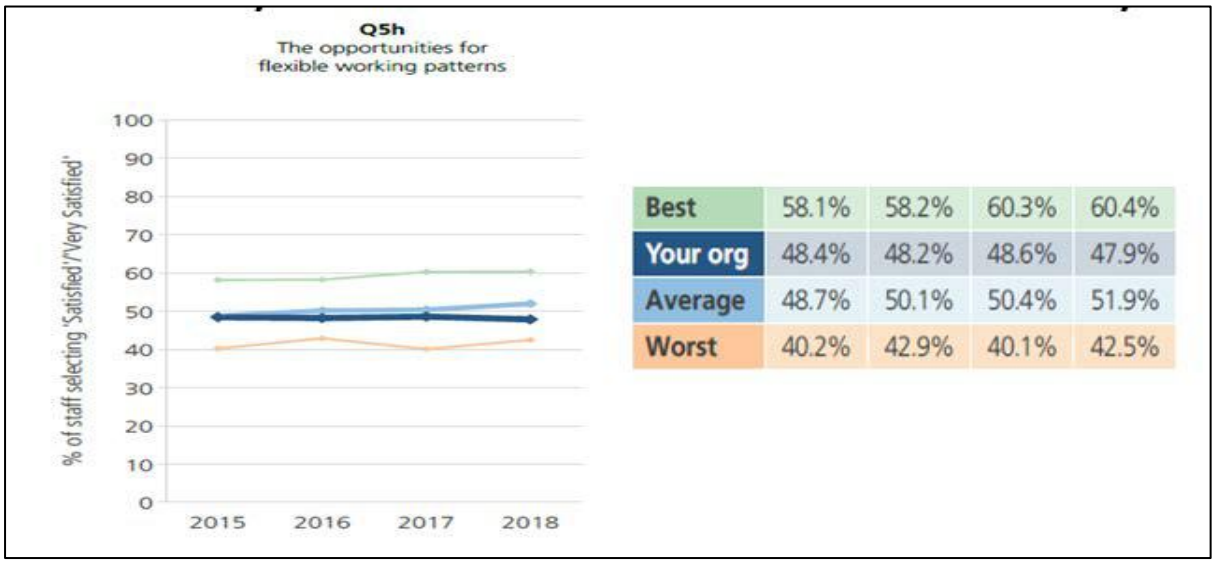
Age Band	Headcount	%
21-25	4	3.64%
26-30	15	13.64%
31-35	18	16.36%
36-40	13	11.82%
41-45	17	15.45%
46-50	11	10.00%
51-55	18	16.36%
56-60	12	10.91%
61-65	2	1.82%
Grand Total	**110**	

6.2.4 *Data supporting focus area 'Flexible Working'; w*hen considering the reasons leavers report for not staying at the Countess of Chester Hospital and feedback from the staff survey in relation to the flexibility offered to staff it is clear there is an opportunity to make improvements to support a healthy work-home life balance. 23.9 FTE staff decided to leave the organisation between January 2018 – December 2018 sighting reasons that may have offered an opportunity to retain them through a more flexible appropriate.

Table 12: ESR Reasons for leaving (linked to flexible working)

ESR Leaving Reason	Headcount	FTE
Voluntary Resignation - Adult Dependants	1	0.25
Voluntary Resignation - Child Dependants	3	2.36
Voluntary Resignation - Health	7	5.04
Voluntary Resignation - Work Life Balance	20	16.25
Grand Total		**23.9 FTE**

Graph 27: Response to staff survey question; opportunities for flexible working



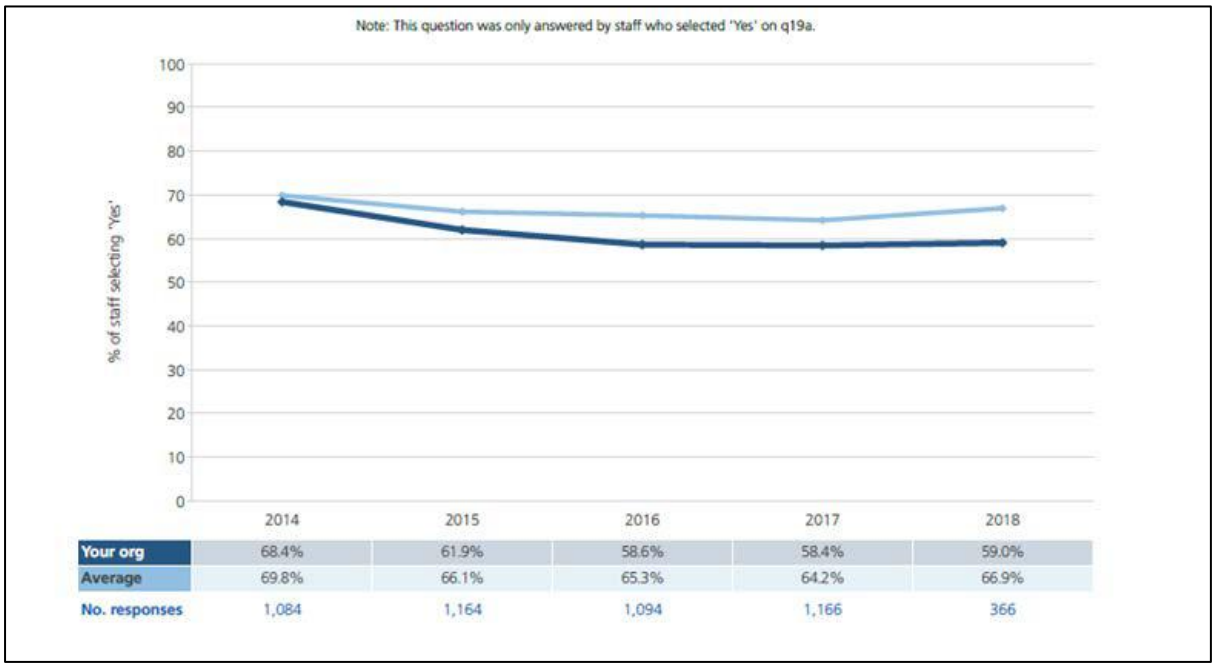
In addition, staff reported less favourably when compared to our national peers in relation to the flexibility offered in working patterns in the 2018 staff survey; this was 4% lower than the average and 12.5% lower than the best performer.

6.2.5 *Data supporting focus area 'Career Development';* when considering the reasons leavers report for not staying at the Countess of Chester Hospital NHS Foundation Trust and feedback from the staff survey in relation to career development it is clear there is an opportunity to make improvements. 24.63 FTE staff decided to leave the organisation between January 2018 – December 2018 sighting reasons that may have been a result of a lack of opportunity for career development.

Table 13: ESR Reasons for leaving (linked to career development)

ESR Leaving Reason	Headcount	FTE
Voluntary Resignation - Better Reward Package	5	4.88
Voluntary Resignation - Lack of Opportunities	3	2.88
Voluntary Resignation - Promotion	14	12.55
Voluntary Resignation - To undertake further education or training	5	4.32
Grand Total		**24.63**

Graph 28: Response to staff survey question; your personal development - Were any training, learning or development needs identified?



In addition, we are below our national peers and have a downward trajectory in the staff survey for identifying and supporting staff with training, learning and development.

6.2.6 *Data supporting focus area 'Preceptorship & Beyond';* when reviewing the highest proportion of leavers it is clear they go within the first 3 years of employment, indicating that improvement to staff support and development needs to be considered for this group.

Table 14: Percentage of leavers by Length of Service

0 to 3 Years (Service Leavers)			
Year	**Headcount of Leavers**	**Total Leavers**	**%**
2016	77	131	58.78%
2017	82	152	53.95%
2018	60	118	50.85%

6.2.7 *2019 Nursing & Midwifery project plan and key performance indicators*

Objective	Actions	Lead	KPI	Status	Deadline
Retire and Return					
Increase the number of Registered Nurses and Midwives returning following retirement	Review of current process and format of exit interviews	**E&D Lead**	Increase the number of retirees returning from 11 to 25 (or 50% to 70%)		**Sept 2019**
	Development of retirement / opportunities meetings	**PDNs and Pensions Team**			**Sept 2019**
	Identify specific opportunities that could be available for retirees whilst enabling easy access to the bank	**Matrons and Recruitment Team**			**Sept 2019**
Flexible Working					
Provision of fair and equal access to formal flexible working arrangements	Review and re-launch flexible working policy	**HR Business Partner**	Reduce the numbers of overall voluntary resignations by 1%		**Oct 2019**
	Review and update restrictions on e-rostering	**E-rostering Team**			**Dec 2019**
	Undertake a second pilot of open rostering following review of restrictions in 2 areas	**E-rostering Team and Matrons**			**Mar 2020**
Career Development					
Enable staff to access career pathways that also support succession	Develop and implement an internal transfer scheme	**PDNs**	Reduce the number of overall voluntary resignations by 1%		**Oct 2019**

planning	Create an accessible training directory on the intranet that includes career pathways	**Clinical Education Team**			**Sept 2019**
	Scope opportunities for external rotations with neighbouring Trusts	**Project Leads**			**Apr 2020**
Preceptorship and Beyond					
Reduce attrition rates of staff leaving the organisation with under 3 years' service in the organisation	Review and re-launch preceptorship policy	**PDNs**	Numbers of leavers with less than 3 years' service reduced by 2%		**Dec 2019**
	Development of department/ward specific induction/training packs that are aligned with local competencies	**PDNs and Matrons**			**Mar 2020**
	Develop and pilot an electronic preceptorship portfolio	**PDNs**			**Oct 2019**

6.3 *Supply*

During 2019 an analysis of the expected supply and growth across adult, paediatric and midwifery will be undertaken in collaboration with the Cheshire & Merseyside Nursing and Midwifery Workforce Programme. This will provide detailed information (sourced through Health Education England (HEE) and local Higher Educational Institutes (HEIs)) on the increased number of training places available to reduce the vacancy gap and meet the anticipated growth. However, it is recognised that the 'traditional' supply pipeline from undergraduate programmes alone is not enough and is not without challenge due to the increase number of clinical placements needed to support additional trainees. Other initiatives designed to support the pipeline include, developing new nursing models (including the Nursing Associate role), return to practice, offering rotational opportunities across the healthcare system and between organisations for speciality development and local, national and international recruitment. This will be supported across Cheshire & Merseyside by the development of a model similar to the 'Capital Nurse Programme'. Our hospital will be an integral part of this regional work stream and will be implementing the outputs during 2019/20.

6.3.1 *Undergraduate training:* it is recognised that locally will need to increase our clinical placement capacity to take the additional student places being offered by our HEIs. This will need to be supported by a mentorship and preceptorship model that can provide a quality training experience to all students and new starters. Models are currently being explored that can support the increase in placements needed but also meet the requirements of the new NMC training standards[21]. Working in collaboration with our local HEIs we will also be implementing the REPAIR[2] recommendations and other regional initiative designed to improve undergraduate programme attrition rates and improve retention in the first 1 – 3 years of qualifying. Work will also continue locally to maintain visibility in the universities, offer workshops to support the application and interview process and make conditional employment offers in year 2 of training.

6.3.2 *Apprenticeships (including Nursing Associate role):* are recognised as part of the overall solution to addressing the nursing and midwifery workforce gaps. At our hospital it was identified during the adult nurse establishment review that apprenticeship training posts for the registered nurse and nursing associates were needed. This work will be further refined and developed during 2019/20.

6.3.4 *Local recruitment:* work will continue during 2019 to ensure we are optimising the use of social media, have up to date recruitment materials and are showcasing the Countess of Chester as a desirable place to work. Recruitment drives will continue in line with the locally agreed plan.

6.3.5 Countess of Chester Recruitment Events Calendar

P	EVENT	DATE
April	Event	Date
May	RCN Congress (Belfast)	12th May 2018
June	Step Into Health	5th June 2018
	Nursing Open Day	9th June 2018
	CCSW Traineeship Open Day	20th June 2018
	Helsby High School Going Further Day	29th June 2018
P	**EVENT**	**DATE**
July	Whitby High School Careers Talk	10th July 2018
	Chester Zoo - CWAC Learners Event	11th July 2018
August	Ward 54 Recruitment Evening	15th August 2018
	Corporate Induction	25th August 2018
	Urgent Care Recruitment Evening	29th August 2018
September	Corporate Induction	3rd September 2018
	Careers Night - EDTC	11th September 2018
P	**EVENT**	**DATE**
October	Health Sector Jobs Recruitment Fair (Multi-Professional)	13th October 2018
November	Welcome Event/ NA Induction	5th November 2018
	Career's Fest (Chester University)	28th November 2018
	NHS Insight Day	1st November 2018
	CCSW Open Day (Work Experience and Apprenticeships)	19th November 2018
	Telford CTP Employment Fair	29th November 2018
December	Welcome Event/NA Induction	3rd December2018
	Planned Care Recruitment Evening	6th December 2018
	Empower Careers Fair, Liverpool	12th December 2018
P	**EVENT**	**DATE**
January	Welcome Event/NA Induction	7th January 2019
	Liverpool John Moores Nursing Careers Event	25th January 2019
	Upton High School Careers Talk	31st January 2019

February	Welcome Event/NA Induction	4th February 2019
March	Welcome Event/NA Induction	4th March
	Bishops Heber High School Careers Talk	13th March 2019
	Helsby High School Careers Talk	20th March 2019

References

1. National Quality Board (2018) *An improved resource for adult inpatient wards in acute hospitals.* Edition 1. Available at: www.nhsimprovement.com

2. Frances, R (2013) *Mid Staffordshire NHS Foundation Trust Public Enquiry*. Available at: http://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report

3. National Quality Board (2016) *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time.* Available at: https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

4. NICE (2014) *Safe staffing for nursing in adult inpatient wards in acute hospitals.* Available at: https://www.nice.org.uk/guidance/sg1

5. Health Foundation (2017) *In short supply: pay policy and nurse number.* Available at: http://www.health.org.uk/publication/short-supply-pay-policy-and-nurse-numbers

6. Health Foundation (2016) *Staffing matters; funding counts-Supplement: Workforce profile and trends*. Available at: http://www.health.org.uk/sites/health/files/SMFCProfileTrends.pdf

7. NMC (2017) *New figures show an increase in numbers of nurses and midwives leaving the profession.* Available at: https://www.nmc.org.uk/news/news-and-updates/new-figures-show-an-increase-in-numbers-of-nurses-and-midwives-leaving-the-professions/

8. Health Foundation (2017) *Rising pressure: the NHS workforce challenge.* Available at: http://www.health.org.uk/sites/health/files/RisingPressureNHSWorkforceChallenge.pdf

9. BBC (2018) *Nurses Day*. January 2018.

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

11. Lord Carter (2015) *Operational productivity and performance in English NHS acute hospitals: unwarranted variation*. Available at: https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

12. Shelford Group (2013) *Safer Nursing Care Tool: implementation resource pack.* Available at: http://shelfordgroup.org/library/documents/130719_Shelford_Safer_Nursing_FINAL.pdf

13. Qidwai (2017), Clinical Practice and Increasing Complexity: Current Status, Challenges and Opportunities. Available at: https://www.jcpsp.pk/archive/2017/Jan2017/02.pdf

14. UCAS End of Cycle Report (2017). Available at: https://www.ucas.com/data-and-analysis/undergraduate-statistics-and-reports/ucas-undergraduate-end-cycle-reports/2018-end-cycle-report

15. National Quality Board (2018) *Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals.* Available at: https://improvement.nhs.uk/documents/2980/Safe_Staffing_CYP_FINAL_PROOF_27_June_2018.pdf

16. NHS Improvement (2018) *Care Hours per Patient Day (CHPPD): Guidance for acute and acute specialist trusts.* Available at: https://improvement.nhs.uk/documents/3177/CHPPD_guidance_-_acute.pdf

17. National Quality Board (2017) *Safe, sustainable and productive staffing: An improvement resource for maternity services.* Available at: https://improvement.nhs.uk/documents/1353/Safe_Staffing_Maternity_final_2.pdf

18. Beech et al (2019) Closing the gap: Key areas for action on the health and care workforce. Available at: https://www.kingsfund.org.uk/sites/default/files/2019-03/closing-the-gap-health-care-workforce-overview_0.pdf

19. NICE (2015) *Safe midwifery staffing for maternity settings.* Available at: https://www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637

20. Birth Rate+ (2017) *Intrapartum acuity tool.* Available at: https://www.birthrateplus.co.uk/new-version-intrapartum-acuity-tool/

21. NMC (2018) Future nurse: Standards of proficiency for registered nurses. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf

22. NHS England (2019) *Interim NHS People Plan*. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

Appendix 1: Safer Nursing Care tool: Levels of Care

Levels of Care	Descriptor
Level 0 (Multiplier =0.99*) Patient requires hospitalisation Needs met by provision of normal ward cares.	**Care requirements may include the following** Elective medical or surgical admission May have underlying medical condition requiring on-going treatment Patients awaiting discharge Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly Regular observations 2 - 4 hourly **Early Warning Score** is within normal threshold ECG monitoring Fluid management Oxygen therapy less than 35% Patient controlled analgesia Nerve block Single chest drain Confused patients not at risk Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence
Level 1a (Multiplier =1.39*) Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	**Care requirements may include the following** Increased level of observations and therapeutic interventions **Early Warning Score** - trigger point reached and requiring escalation. Post-operative care following complex surgery Emergency admissions requiring immediate therapeutic intervention. Instability requiring continual observation / invasive monitoring Oxygen therapy greater than 35% + / - chest

	physiotherapy 2 - 6 hourly Arterial blood gas analysis - intermittent Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains Severe infection or sepsis
Level 1b (Multiplier = 1.72*) Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living.	**Care requirements may include the following** Complex wound management requiring more than one nurse or takes more than one hour to complete. VAC therapy where ward-based nurses undertake the treatment Patients with Spinal Instability / Spinal Cord Injury Mobility or repositioning difficulties requiring the assistance of two people Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care) Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome Patients on End of Life Care Pathway Confused patients who are at risk or requiring constant supervision Requires assistance with most or all activities of daily living Potential for self-harm and requires constant observation Facilitating a complex discharge where this is the responsibility of the ward-based nurse
Level 2 (Multiplier = 1.97*) May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit	Deteriorating / compromised single organ system Post operative optimisation (pre-op invasive monitoring) / extended post-op care. Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute

	respiratory failure First 24 hours following tracheostomy insertion Requires a range of therapeutic interventions including: Greater than 50% oxygen continuously Continuous cardiac monitoring and invasive pressure monitoring Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium Pain management - intrathecal analgesia CNS depression of airway **and** protective reflexes Invasive neurological monitoring
Level 3 (Multiplier = 5.96*) Patients needing advanced respiratory support and / or therapeutic support of multiple organs.	Monitoring and supportive therapy for compromised / collapse of two or more organ / systems Respiratory or CNS depression / compromise requires mechanical / invasive ventilation Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection

Appendix 2: Safe Nursing Care Multipliers

Multipliers can be used to set nursing establishments allied to acuity and dependency measurement. The multipliers agreed for each level of patients on in-patient wards are:

Level 0 0.99* WTE nurse per bed;

Level 1a 1.39* WTE nurse per bed;

Level 1b 1.72* WTE nurse per bed;

Level 2 1.97* WTE nurse per bed; and

Level 3 5.96* WTE nurse per bed.

* this includes a 22% uplift for annual leave, study leave etc.

For example, if a 28-bedded ward has 12 patients at Level 0, 7 patients at Level 1a, 8 patients at Level 1b, and 1 patient at Level 2, a total of 37.34 WTE nursing staff would be required.

Sum

12 patients at Level 0 = 0.99 x 12 = 11.88

7 patients at Level 1a = 1.39 x 7 = 9.73

8 patients at Level 1b = 1.72 x 8 = 13.76

1 patient at Level 2 = 1.97 x 1 = 1.97

Total = 37.34 WTE

This figure is a baseline against which to set nurse staffing levels. Two 28-bedded wards may have different activity. One may have few admissions, discharges or ward attenders whereas another may have many. Professional judgement is required to ensure that establishments are adjusted appropriately under these circumstances.

For Acute Medical Units the following multipliers are used:

Level 0 1.27* WTE nurse per bed;

Level 1a 1.66* WTE nurse per bed;

Level 1b 2.08* WTE nurse per bed;

Level 2 2.26* WTE nurse per bed; and

Level 3 5.96* WTE nurse per bed.

Item Reference and Title	**Agenda item 8** - QSPEC Chair's Report to Board of Directors
Date of Meeting	Board of Directors 25th June 2019
Author	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. 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.

1.0 Key items of business discussed

The QSPEC Committee met on 22nd May and the following key business items were discussed:

- Any new risks escalated from Divisions and ICP update
- Quality & Safety Dashboard – exceptions
- C. difficile infection objective for 2019/20
- Falls Prevention Programme 2018/19
- Risk & Safety Annual Report 2018/19
- Organisational risks, never events and serious incidents
- Complaints, Litigation, Incidents & Coronial cases (CLIC) October 18 to March 19
- MIAA 2018/19 Annual Report
- Quality Account 2018/19
- Quality Schedule 2019/20
- CQC Inspection Report – verbal update
- Receipt & noting of NRLS Report March to September 2018, and sub-committee and divisional governance minutes

2.0 Key agreements or decisions made

A significant proportion of the agenda items and reports submitted relate to summaries of the year to 31st March 2019 and accordingly a number of important updates and assurances were received and discussed by the Committee.

- No new significant risks were escalated by Divisions although the heightened risks reported last month by D&P on the failure of key equipment were reinforced in discussions, together with difficulties in recruiting to under-pressure staff categories.
- The update on the Falls Prevention Programme included some positive data. The Trust has delivered below average inpatient falls rates in both 2017/18 and 2018/19, with the rate per 1000 bed days reducing by 33.5% since 2015/16. While the 2018/19 rate per 1000 bed days with moderate or severe harm is in line with the national average at 0.19, it was acknowledged that the prevention programme has not yet produced a reduction in this key measure. This was attributed in part to continued pressure on staffing and divisional and ward managers intend to continue to exercise close scrutiny to improve measures of falls with harm. It was also noted that some of the measures reported implied a different situation on falls from that portrayed in the CQC report. Rather than dwelling on comparisons, all committee members were focussed on the substantive measures required to produce improvement in the Trust's rate and management of falls.
- The Risk & Safety Annual Report provided a useful update on risk management matters in 2018/19. While many risk objectives had been met in 2018/19, the report highlighted continuing issues with the management of NICE guidelines. Incident data revealed that falls remain the highest cause of reported incident, with staffing and medication not far behind. The report also referenced clinical audit activity and it was agreed that more visibility is required on the level of assurance provided by certain clinical audits.

- No new Never Events were reported, although discussion took place on the high number of level 1 (7) and level 2 (3) incidents arising in April
- The CLIC report triangulates evidence received from different sources to gain an informed view of the Trust's performance on key safety and quality matters. A reduction in complaints was reported in the second half of the year, but an increase in serious incidents and Datix reports. Increases in Infection Control and Obstetric incidents were noted but no clear themes emerged from incidents reported. Overall measures appear relatively consistent with the prior period, although a high increase (55%) arose in potential negligence claims.
- The MIAA Annual Report showed that all recommendations attributed to QSPEC had been actioned within the agreed timeframes. Since the report deals with all internal audit reports issued in the year, it was agreed that it should be communicated to the Audit Committee.
- The verbal update on the recently published CQC report noted that need to set out a prioritised action plan. It was stressed that this plan would be merged with others in the Trust to enable clear priorities to be set and rigorous monitoring to be put in place.
- The Quality Schedule for 2019/20 was reviewed. This sets out the quality and operational expectations and is embedded within the contract. Whilst may indicators roll over from last year there are some new requirements relating to Cancer, Emergency Department Ambulance Wait Times and Duty of Candour. A 2018/19 CQUIN relating to Sepsis is also included in the contract.
- A verbal update on edischarge highlighted that this will be a focus of improvement over the coming months. This will be overseen by the Divisional Governance Boards with a plan to see improvement in Q2 followed by month on month improvement. A further report will be received in October 2019.

3.0 Items for escalation to Board

The Board is asked to note:

- The progress made on falls and the need for continued action and scrutiny to reduce the rate of falls with harm.
- The additional quality indicators included in the contract for 2019/20.
- The assurances received from Risk & Safety, CLIC and MIAA reports.

4.0 Recommendation

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

Item Reference and Title	**Agenda item 9** - Integrate Performance Report, Month 1
Date of Meeting	Board of Directors [25th June 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:	Corporate leaders group, 30th May 2019
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, APRIL 2019

Safe

Indicator	Target	Act.	Alert
All Falls Rate	7	6.07	○
Falls with Harm Rate	0.3	0.06	○
Never Events	0	0	○
Safety Thermometer – Free of new harms %	95	97.8%	○
Q4 Sepsis screening % (Inpatients)	90	44%	○
Q4 Sepsis treatment % (Inpatients)	90	80%	○
Q4 Sepsis screening % (ED)	90	80%	○
Q4 Sepsis treatment % (ED)	90	76%	○
Infection Control: C Difficile	36	3	○
Infection Control: MRSA	0	0	○
Nurse Staffing	95%	94.5%	○

Kind

Indicator	Target	Act.	Alert
Friends and Family: A&E	80	79.0%	○
Friends and Family: Inpatient Wards	90	91.7%	○
Friends and Family: Maternity Services	90	99.0%	○
Open Complaints	40	31	○
Open Complaints > 40 days response time	5	0	○
Open PHSO Complaints	5	1	○
MSA Breaches	0	12	○
Sickness Absence %	3.65	4.08	○
Mandatory Training %	95	94.2	○
Annual Appraisal %	95	85.0	○
Staff Turnover %	10	9.5	○

Effective

Indicator	Target	Act.	Alert
* ED 4 Hour Wait %	95	82.2%	○
* 18 Week RTT %	92	82.6%	○
* 6 week Diagnostic Wait %	99	92.9%	○
* Cancer Treatment 62 Day %	85	82.4%	○
Bed Occupancy %	85	93.4%	○
I&E Variance (including PSF)	Plan	£160K OVERSPEND	○
Forecast Position/ Run Rate	Plan	£0m	○
CRS In Year	Plan	-£362k	○
Contract Income	Plan	-£1,736k	○
Variable Pay	Less YOY	-£235k	○
Total agency spend £m	£4.8 EOY	£2.59m EOY	○
Total agency shifts over cap rate	Less YOY	-228	○

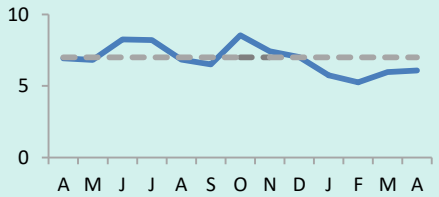
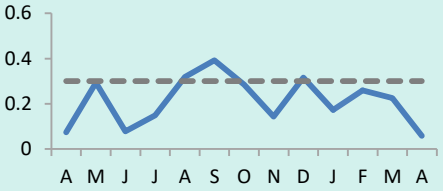
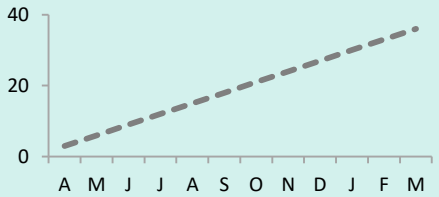
*** Key NHS constitutional target**

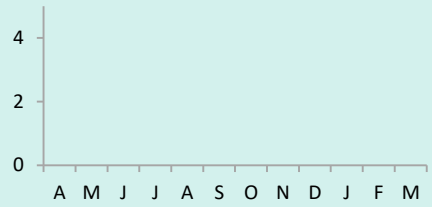
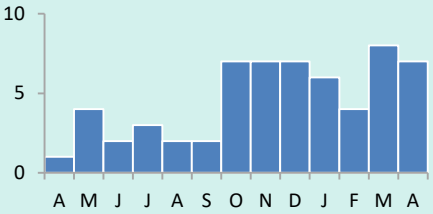
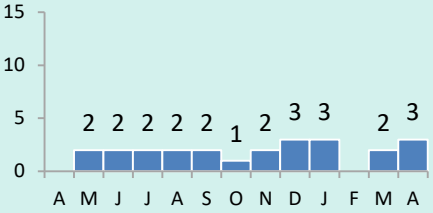
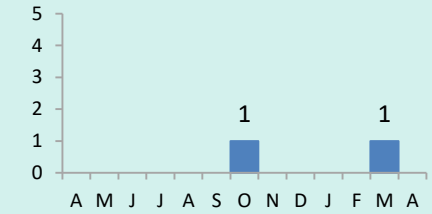
Key ○ Target achieved ○ Target not achieved

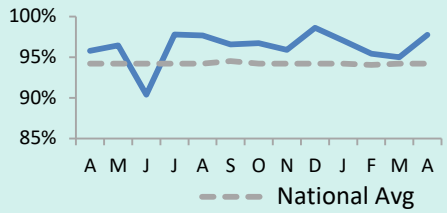
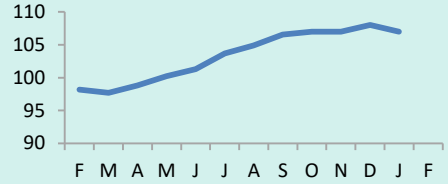
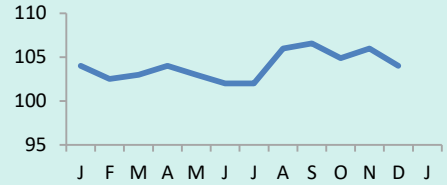
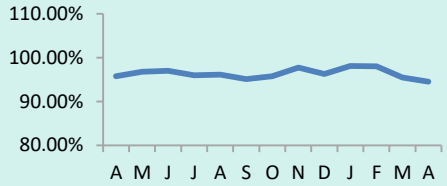
SAFE

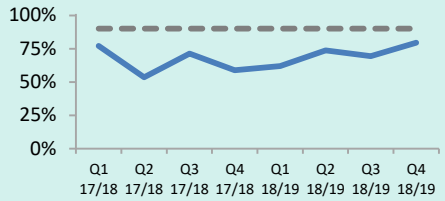
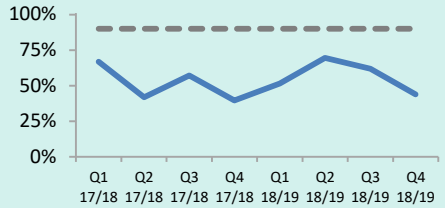
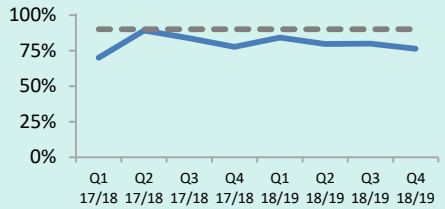
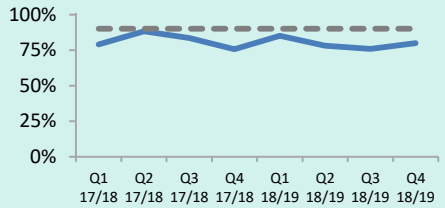
Reducing patient harms

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	6.07	The trust has achieved this target	
Harms: Falls with Harm Rate	Rate of falls with harm per 1000 bed days	0.3	0.06	The trust has achieved this target	
Harms: Infection Control – Rate of C. Difficile	Cases of hospital acquired C. Difficile bacteraemia.	36 cases (2019/20)	3 cases (YTD)	This is within trajectory for the year	

Measure	Definition	Threshold	Actual	Comment	Graph
Harms: Infection Control – Rate of MRSA	Cases of hospital acquired MRSA bacteraemia.	0 cases (2019/20)	0 cases (YTD)	No avoidable cases reported for April.	
Harms: Serious Incidents - Level 1	Number of Serious Incidents at Level 1	No specific target but monitoring of trends	7	SI Panel commissioned seven 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	3	SI Panel commissioned three level 2 serious incident reviews in April.	
Harms: Serious Incidents - Never Events	Number of Never Events reported	0	0	There have been no reported never events during April	

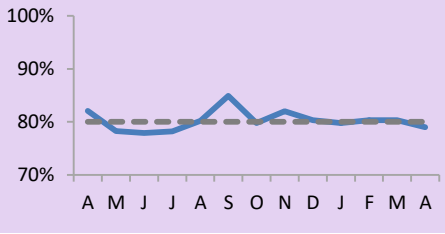
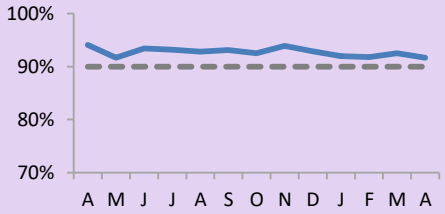
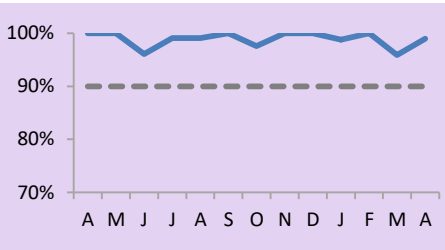
Measure	Definition	Threshold	Actual	Comment	Graph
Harms: Safety Thermometer	Based on monthly Safety Thermometer census. Rate free of new harms should be higher than national average	94.2%	97.8%	Performance remains above the national average.	
Learning from Deaths: Hospital Standard Mortality Rate (HSMR)	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. Updated to Jan 2019	
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.	
Nurse Staffing Compliance	Actual versus Planned Staffing Hours	95%	94.5%	This figure is an overall percentage and should be reviewed alongside the individual ward/department data.	

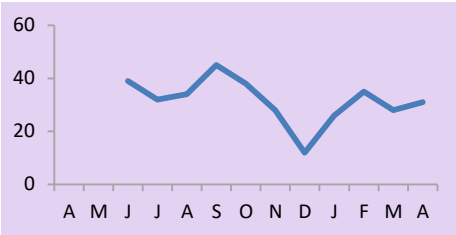
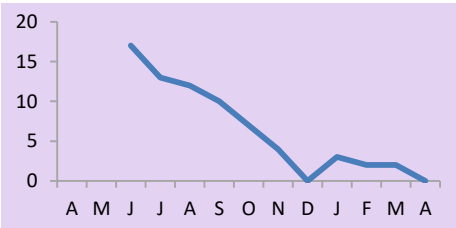
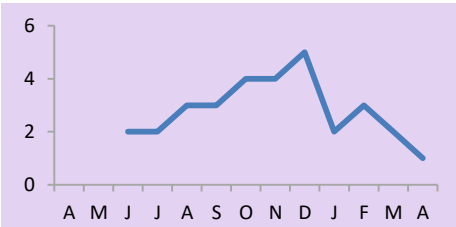
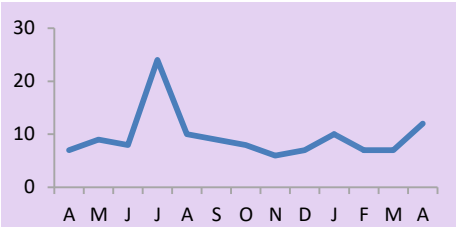
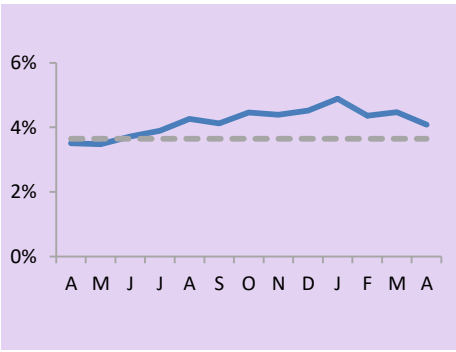
Measure	Definition	Threshold	Actual	Comment	Graph
CQUIN: Sepsis Screening in ED / Inpatient Settings	Timely identification of sepsis in ED	90%	79.6%	QUARTERLY INDICATOR. A 10% increase in screening was achieved during Q4.	
CQUIN: Sepsis Screening in ED / Inpatient Settings	Timely identification of sepsis for inpatients	90%	43.9%	QUARTERLY INDICATOR. The deteriorating position in Q4 relates to a further change in the sampling process in line with national guidance.	
CQUIN: Sepsis Treatment in ED / Inpatient Settings	Timely treatment of sepsis in ED	90%	76.4%	QUARTERLY INDICATOR. Q4 performance for sepsis treatment remains unchanged	
CQUIN: Sepsis Treatment in ED / Inpatient Settings	Timely treatment of sepsis in inpatient settings	90%	80.0%	QUARTERLY INDICATOR. Q4 performance for sepsis treatment remains unchanged	

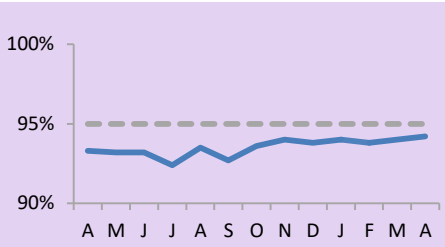
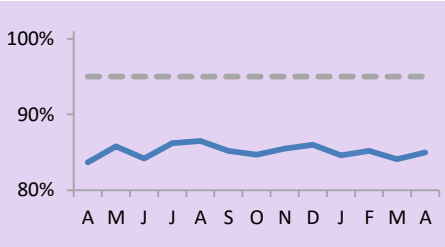
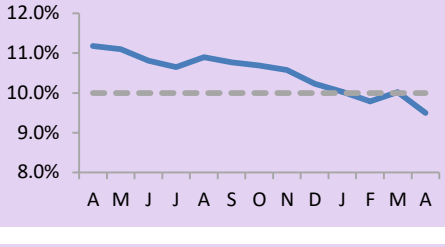
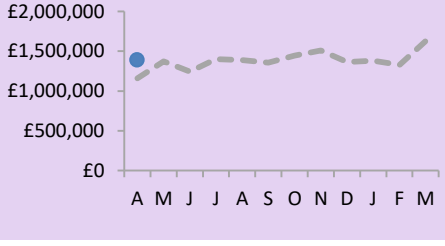
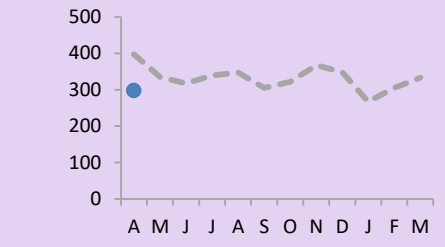
KIND

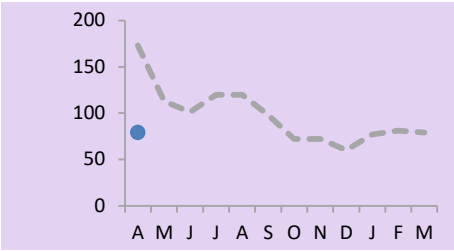
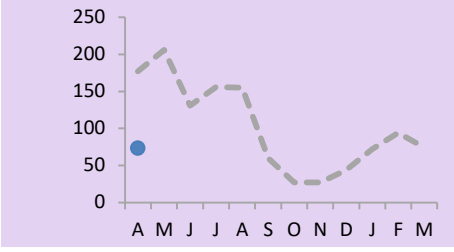
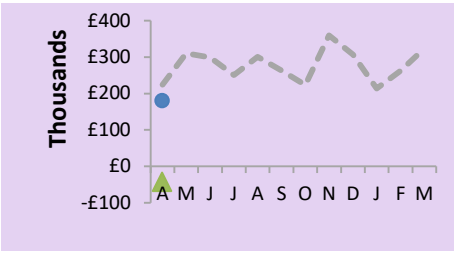
Providing high quality patient care

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%	79.0%	Performance is just below target in April.	
Friends and Family: % Likely to Recommend Inpatient Wards	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	90%	91.7%	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%	99.0%	Performance remains above target for maternity services.	

Patient Feedback: Number of Open Complaints	Number of open patient complaints at month end	40	31	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	0	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	1	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	12	12 breaches in April were not clinically justified. Exception report provided.	
Sickness Absence	% monthly sickness absence, excluding comfort zone and Bank staff	3.65%	4.08%	The April absence rate is 4.08%. Exception report provided.	

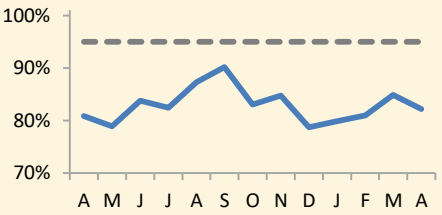
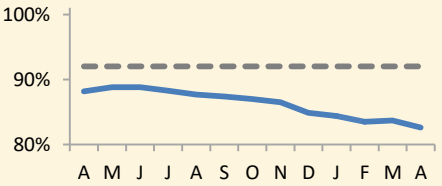
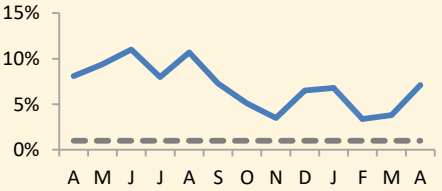
Mandatory Training Compliance	% mandatory training compliance, excluding comfort zone and Bank staff and staff on maternity/long term sick leave	95%	94.2%	Compliance with the Mandatory Training target has increased slightly.	
Annual Appraisal Compliance	Exclusions as above and also exclude staff with less than 1 year's service.	95%	85.0%	Compliance with the Appraisal target has slightly increased. Exception report provided.	
Staff Turnover	Based on headcount in the previous 12 months and on permanent staff only.	10%	9.50%	Performance is at target	
Variable Pay	Reducing and controlling variable pay spend (including overtime, agency, additional clinical activity)	Year on year reduction	+£235k	Variable pay spend decreased in month to £1,389k.	
M&D Reduction in Agency Shifts over Cap Rates	Reducing agency shifts over cap rates.	Year on year reduction	-100	Month 1 shows an decrease against March in shifts above the cap, with 297 Medical shifts above cap rates.	

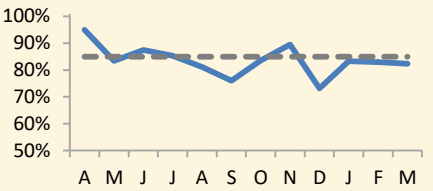
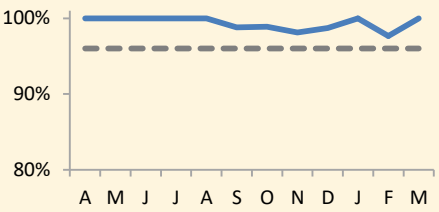
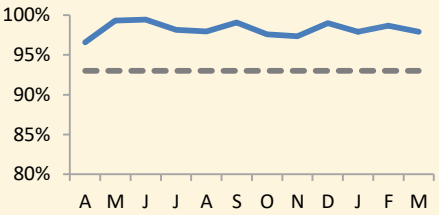
N&M Reduction in Agency Shifts over Cap Rates	Reducing agency shifts over cap rates.	Year on year reduction	-94	In relation to Nursing shifts, 79 shifts were approved above cap rates. A reduction of 94 from same month last year	
'Other' Reduction in Agency Shifts over Cap Rates	'Other' consists of Care Packages, Sonographers, Theatres and CRV Dept.	Year on year reduction	-104	Operating Department Practitioner shifts dropped to 73 approved over the cap. A difference of -104 from same month last year	
People: Medical Agency Spend	Planning improvements in productivity and efficiency	Year on year reduction	-£44k	Medical Pay is overspent by £27k. Agency medical expenditure is £180k (4% of the total medical spends).	
People: Nursing Agency Spend	Planning improvements in productivity and efficiency	Year on year reduction	+£6k	Nursing Pay is £49k overspent. Agency nursing expenditure is £33k which is 1% of total trained nursing spend. Agency decreased £173k to £259k	
People: Total Agency Spend within Budget	Planning improvements in productivity and efficiency	Total agency spend capped at 4.459 for 18/19	-£126k YOY	Total Agency spend for M1 is £213k. (£339k was spent during the same period last year). A straight line forecast is just below the agency ceiling.	

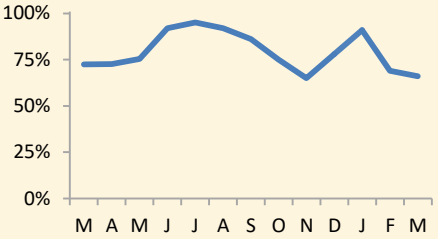
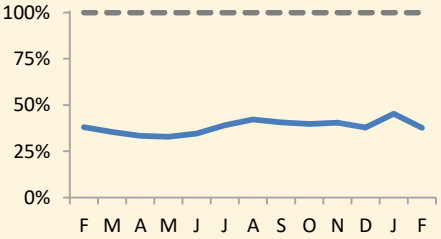
EFFECTIVE

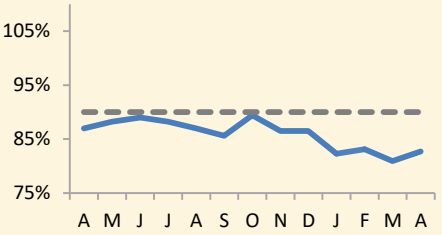
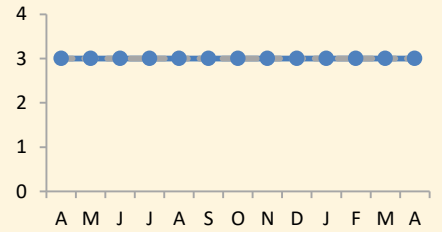
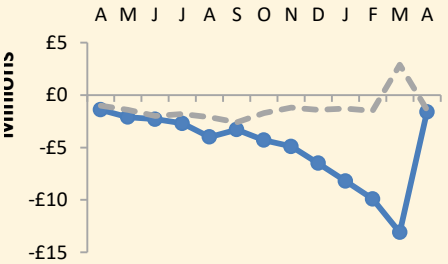
Minimising delay and improving processes

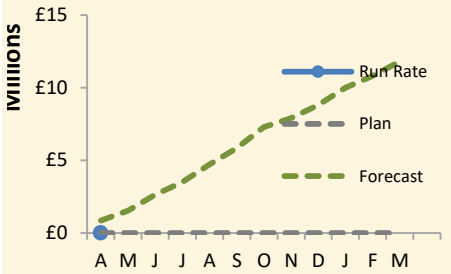
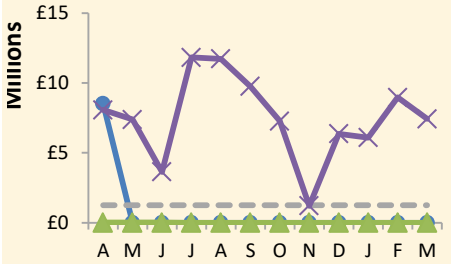
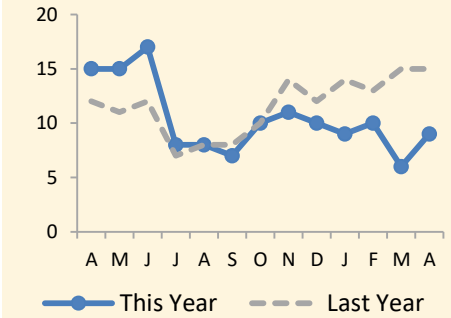
Supporting the Board Assurance Framework:
CR3, CR5, CR6, CR7, CR8, CR9, CR10

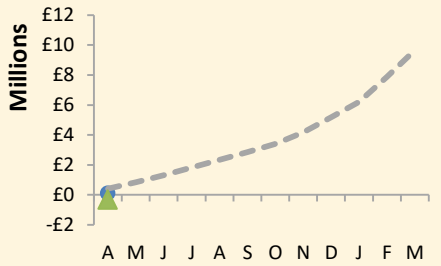
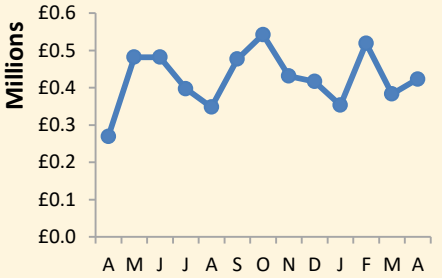
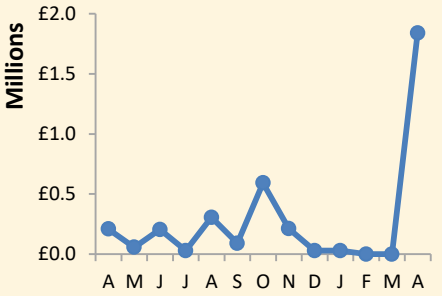
Measure	Definition	Threshold	Actual	Comment	Graph
ED 4 Hour Wait Standard	% A&E attenders seen within 4 hours of arrival	95%	82.2%	Nationally, 85.1% of the total attendances were seen within 4 hours. National type 1 performance was 77.1% An exception report is provided.	
18 Weeks RTT incomplete pathways	Percentage of incomplete pathways for English patients within 18 weeks.	92%	82.6%	Performance has deteriorated during the last month. The RTT incomplete percentage was 82.6% in April. The latest national figure for this indicator is 86.7% (March 2019). An exception report is provided.	
Diagnostic Tests within 6 Weeks (DM01)	Diagnostic tests carried out within 6 weeks of request being received.	1%	7.1%	Performance was 7.1% during the last month. The latest national figure for this indicator is 2.5% (March 2019). An exception report is provided.	

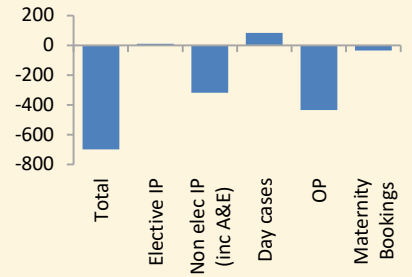
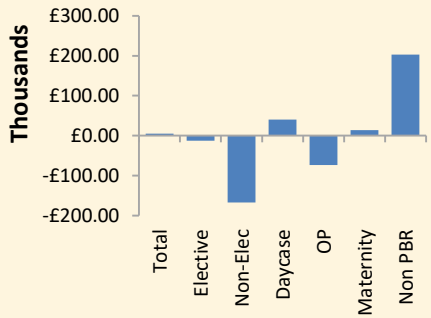
Measure	Definition	Threshold	Actual	Comment	Graph
Cancer Treatments: 62 Day Standard	First treatment for cancer within 62 days of urgent referral through GP 2 week referral route.	85%	82.41%	This indicator is reported one month in arrears. The latest national provisional figure for this indicator is 79.7% (Mar 2019).	
Cancer Treatments: 31 Day Standard	Patients receiving first definitive treatment within 1 month of cancer diagnosis.	96%	100.0%	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%	97.90%	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%	66%	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%	37.65%	Performance has deteriorated from the previous month. 57% of urgent appointments and 34% of routine appointments had OP letters sent within 7 days. This indicator is reported two months in arrears and the latest figure relates to February.	

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%	82.7%	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. The Trust is currently allocated to a 'segment' of 2, of the single oversight framework.	
I&E Plan Variance	Variance to plan	No deviation from plan	£160k overspend	As at the end of April 19, we are reporting a £160k overspend against plan. Notable pressures include a CRS under achievement against plan of £362k. PSF funding has been assumed to be received for the month of April.	

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	£0m	The Trust is currently forecasting to be on plan at the year end.	
Cash	Cash on deposit <3 month deposit	No deviation from plan	+£7.3m	The closing cash balance at the end of April is just under £8.5m, £7.3m ahead of plan. We received £1.6m revenue draw down during April, and have applied for a drawdown of £1.9m in May. 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	9	Unusually debtor days dropped in April to 9 days from 10 in March. The PSF monies are not expected until July at the earliest.	

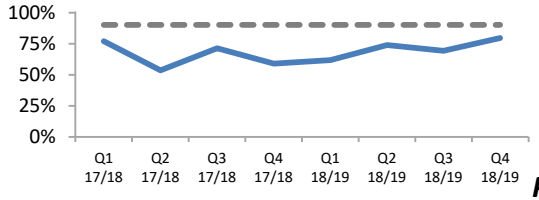
Measure	Definition	Threshold	Actual	Comment	Graph
Capital Expenditure	Capital expenditure performance against plan / forecast out-turn	Performance vs Plan	-£318k	Expenditure for April was £99k. The Trust's 2019/20 loan has been submitted, but a capital expenditure resubmission has been requested by NHSI.	
CRS in year	Planning improvements in productivity and efficiency	No deviation from plan	-£362k	The CRS plan for 2019/20 is £11.1m. The CRS programme is £362k behind plan.	
CRS recurrently	Planning improvements in productivity and efficiency	No deviation from plan	16% identified	Recurrently 16% of the £11.1 target has been identified with 30% in Green or Amber Schemes and 54% in Red or Black schemes.	

Measure	Definition	Threshold	Actual	Comment	Graph
Contract Performance (Activity)	YTD Contract performance against Trust Planned activity (English & Welsh)	No deviation from plan	-700	Daycase (83) and Elective activity (10) are showing a combined over-performance of 93 procedures for April 19. Non-elective activities including A&E attendances are below plan by 321. This is made up -215 A&E attendances, -30 obstetric deliveries and -75 non-obstetric emergency discharges. Outpatient activity is below plan in April by 436 attendances and this is predominately New attendances (-510).	
Contract Income	YTD Contract performance against Trust Planned activity (English & Welsh)	No deviation from plan	£5,010k	The income position for April is £5k above plan. Over-performance on DC and EL activity and maternity bookings (£42k) has been offset by the underperformance on non-elective & outpatient activity (-£240k). There is an over-performance on non-PBR activity of £203k and this is predominately due to critical activity and AMD activity.	

Exception Report

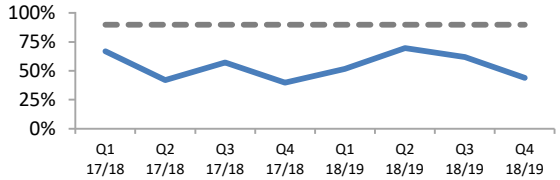
Performance Trend

Sepsis screening (ED

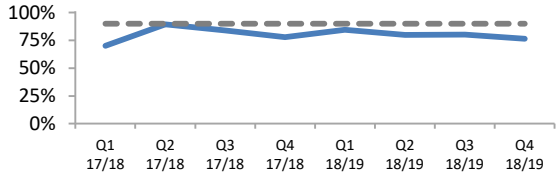


Patients)

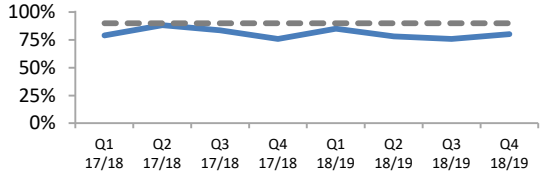
Sepsis screening (Inpatients)



Sepsis treatment (ED)



Sepsis treatment (Inpatients)



Ownership:

Lead: Dr Santokh Singh

Executive Lead: Darren Kilroy, Medical Director

Improvement Objective: Achieve target

Improvement Timescale: By March 2020

Sepsis screening and treatment CQUIN

Performance Issue:

The Sepsis CQUIN screening remains below the year-end target at Quarter 4 for both Inpatients and ED. Treatment of Sepsis continues to perform well but also remains slightly below the year-end target.

Planned Remedial Actions:

A large programme of work has been undertaken during 2018/19 to improve compliance against the national 'screening' and 'timely treatment' measures for sepsis. These measures are important to track and maintain as they provide an indication of how well we recognise and respond to sepsis. Work has progressed during 2018/19 but it is disappointing to report that there has been little overall improvement made to the compliance figures. This has been largely a result of the majority of improvement actions being dependent on the implementation of the standard pathways which was delayed until quarter 4 due to the implementation of the NEWS2 track and trigger tool in quarter 3. During quarter 4 the improvement programme has progressed at pace with the following actions achieved:

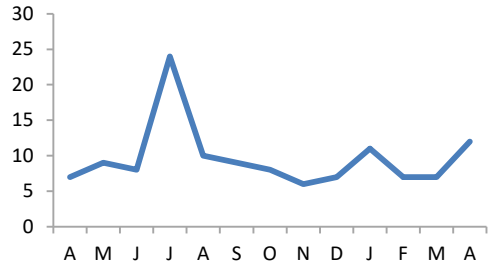
- Standardised Sepsis pathways has been launched in all adult inpatient areas
- Nurse training resource/competency pack designed and rolled out
- Education Strategy implemented (Level 1 and 2 training underway, Level 3 training to be launched using the UK Sepsis Trust train the trainer package in 2019/20)
- Sepsis response kits to be available to all areas (unique design allows for the response kit to act as a teaching aid and is focal point for sepsis awareness training)
- Sepsis awareness provided on induction for registered nurses and nursing assistants
- Sepsis champions identified in adult inpatient areas to support compliance, training and to identify staff who wish to undertake extended roles such as cannulation and venepuncture to aid process of sepsis

It is important when considering these measures to also review the outcomes and survival rates for patients with sepsis as these also give details on the quality of sepsis care and treatment provided at our hospital. Data analysed by the National NHSi Suspicion of Sepsis Dashboard demonstrates that the Countess of Chester Hospital NHS Foundation Trust has a 17.16% 30 day re-admission rate (better than national comparator of 19.52%) and a 91.55% survival rate (in line with national comparator 92.1%).

However, despite this we recognise there is much work to do and that by improving our screening and implementation of early interventions we will improve outcomes and survival further. The Medical Director and Director of Nursing & Quality will be providing close oversight of these measures in order to achieve improvements during 2019/20

Exception Report

Performance Trend



Mixed Sex Breaches

Mixed Sex Accommodation Breaches

Performance Issue:

In April there were 12 Mixed Sex breaches that were not clinically justified.

Planned Remedial Actions:

During April, we have experienced a number of delays in stepping patients down from the Coronary Care Unit (CCU) once the decision has been made that they no longer require continuous monitoring, this has been a result of bed availability within the Coronary Care Ward. In these circumstances is it safer for the CCU patient to remain in the monitored mix sex area to ensure acutely un-well cardiac patients can access a speciality bed immediately.

Ownership:

Lead: Melanie Kynaston, Associate Director of Nursing

Executive Lead: Alison Kelly, Director of Nursing and Quality

Improvement Objective: Reduce the number of MSA breaches

Improvement Timescale: By Sept 2019

Sickness Absence

Historic Data

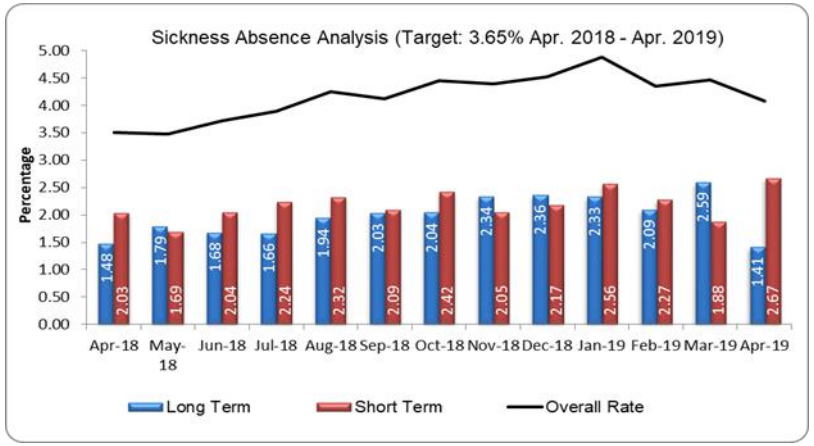


Figure: % Sickness Absence Analysis

Ownership

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

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By Sept 2019

Performance Issue:

The Trust wide sickness absence increased to 4.08% in April.

12 month sickness absence within Staff groups highlights that Nursing & Midwifery is reporting at 4.29% and Support Workers (which include Nursing Assistants) reporting at 6.48%. When analysing divisional sickness absence, 4 Divisions are above 4%, Planned Care (4.67%), Urgent Care (4.32%), Human Resources (4.30%) and Estates & Facilities (5.56%). Despite all being over 4% they have all seen a reduction for the month for April. 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 Iveiw (Dec. 18 Data)	
Trust	**12 Mth Rate**
Liverpool Heart & Chest F	4.02%
North Middlesex Uni	4.54%
Countess Chester F	**4.61%**
South Tyneside F	4.75%
Mid Cheshire F	4.89%
East Cheshire	5.28%
Warrington & Halton F	5.29%
Northamptonshire Health F	5.29%
Wirral Uni Teach F	5.70%
Tameside & Glossop F	5.76%
Southport & Ormskirk	5.90%

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

Mandatory Training Table April 2019

Position	Division	Compliance
1	Human Resources	97.1%
2	Nurse Management	96.4%
3	Finance & Performance	95.1%
4	Planned Care	94.9%
5	Diagnostics and Pharmacy	94.6%
6	Urgent Care	93.3%
7	Estates & Facilities	93.3%
8	HRWBS	91.7%
9	Corporate Non - Clinical	90.3%
	Total	94.2%

Local Induction Table April 2019

Position	Division	Compliance
1	Human Resources	100.0%
2	Nurse Management	100.0%
3	Estates & Facilities	85.7%
4	HRWBS	83.3%
5	Urgent Care	80.1%
6	Diagnostics and Pharmacy	75.5%
7	Planned Care	71.7%
8	Finance & Performance	53.3%
9	Corporate Non - Clinical	50.0%
	Total	75.4%

Figure: % mandatory training compliance

Performance Issue:

Trust compliance remains below target at 94.2%.

Overall compliance for mandatory training in April has marginally increased to 94.2%, which falls short of the Trust target of 95%. Local induction compliance for April decreased again to 75.4% 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.

Ownership

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

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By September 2019

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

Appraisal Table April 2019

Position	Division	Compliance
1	Estates & Facilities	**93.3%**
2	Planned Care	**90.5%**
3	Diagnostics and Pharmacy	**88.4%**
4	Human Resources	**82.1%**
5	Urgent Care	**78.9%**
6	Finance & Performance	**78.6%**
7	HRWBS	**73.7%**
8	Corporate Non - Clinical	**67.6%**
9	Nurse Management	**64.2%**
	Total	**85.0%**

Performance Issue:

Appraisal compliance has seen an decrease in April from 84.1% to 85.0%, this remains below our corporate target of 95%.

Ownership

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

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2020

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. From this month we will be analysing appraisals overdue after 14 months to ensure that we are not over reporting but, this has seen no statistically significant change. 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	**78.66**
Of which Registered Midwife Vacancy WTE	5.78
Of whichRegistered Health Visitor Vacancy WTE	0.00
Of which Advanced Care Practitioner Vacancy WTE	0.00
Total Qualified AHP Vacancy WTE	**14.89**
Of which Qualified Physiotherapist Vacancy WTE	1.39
Of which Qualified Occupational Therapist Vacancy WTE	5.09
Of which Qualified Paramedic Vacancy WTE	0.00
Total Medical/Dental Vacancy WTE	**48.75**
Of which Medical/Dental Consultant Vacancy WTE	23.41
Support to Clinical Staff Vacancy WTE	7.34
Support to Nursing Vacancy WTE	67.00
NHS Infrastructure Vacancy WTE	69.54
Total Vacancies	**286.18**
Budgeted FTE Total	3886.85
Trust Vacancy Rate	**7.36%**

Ownership

Lead: Steve Bridge, Planning & Partnerships

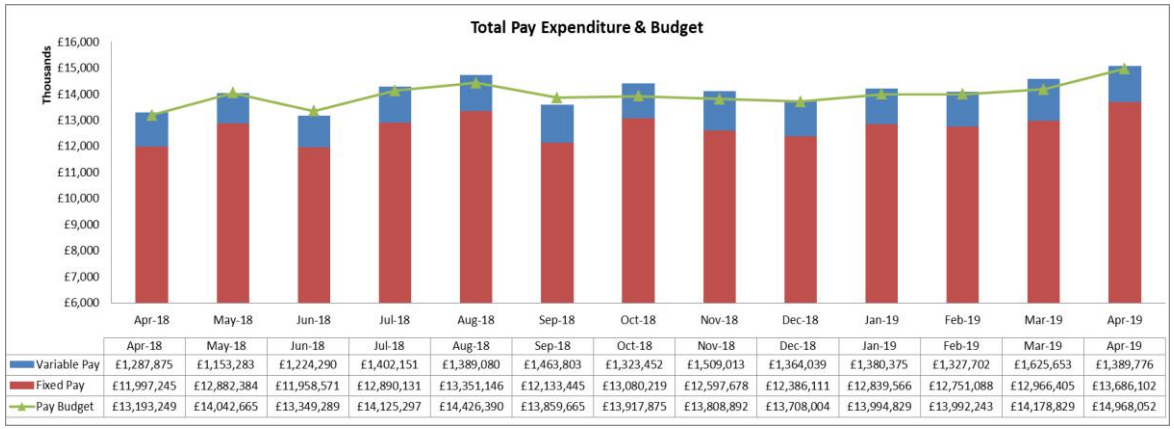
Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2020

Performance Issue:

Medical Bank (185k) rose by 3k in month.
Variable pay spend decreased in month by £235k to £1,389k.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Variable Pay	£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	£1,389,776
Fixed Pay	£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	£13,686,102
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	£14,968,052

Notes:

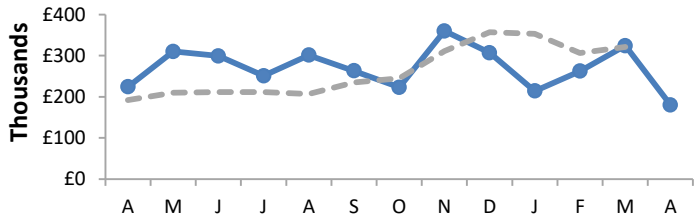
Vacancies are the difference between the budgeted establishment and actual staff in post. The Workforce and Finance teams are still working towards improving data quality in relation to vacancies.

Exception Report

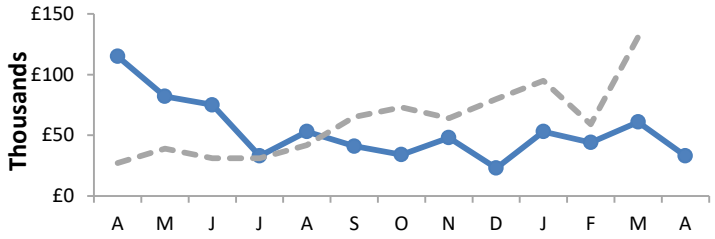
Agency Spend

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 2020

Performance Issue:

To not exceed £4.576m agency expenditure ceiling.
Medical Pay is overspent by £27k. Agency medical expenditure is £180k (4% of the total medical spends). Nursing Pay is £49k overspent. Agency nursing expenditure is £33k which is 1% of total trained nursing spend. Agency decreased £173k to £259k.

Contributing Factors:

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 2018/19					**£ 4,459,000**	**£ 4,576,000**	

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

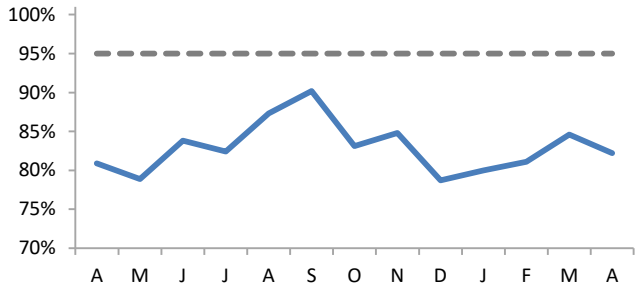


Figure: % ED attenders seen within 4 hours of arrival

Performance Issue:

The 4 hour A&E target was under the national target in April achieving 82.6%. Nationally 85.1% of patients were seen within 4 hours of arrival in March.

Type 1 performance was 83.42% against a national performance of 77.1%.

Planned Remedial Actions:

April saw a decrease in performance due to continued high bed occupancy both pre and post the Easter bank holiday period. The Trust undertook a Perfect Week leading up to Easter and were able to demonstrate benefits in patient flow and increased discharges however levels of demand did not allow for the bed occupancy to significantly reduce at this time.

The Patient Flow Improvement Programme is now underway with recruitment within ED, focus on increasing type 3 to UTC and how we further improve all aspects of patient pathway for non-elective admissions throughout the Trust.

Ownership:

Executive Lead: Lorraine Burnett, Chief Operating Officer

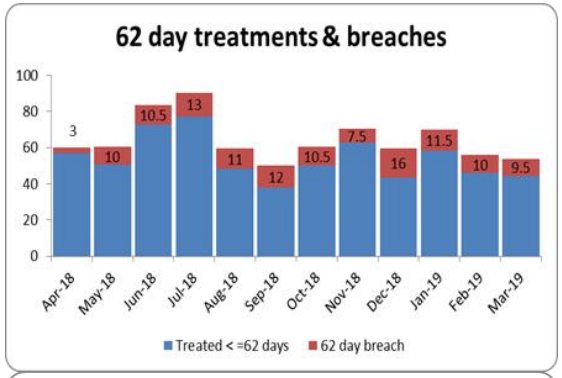
Improvement Objective: Return to national standard

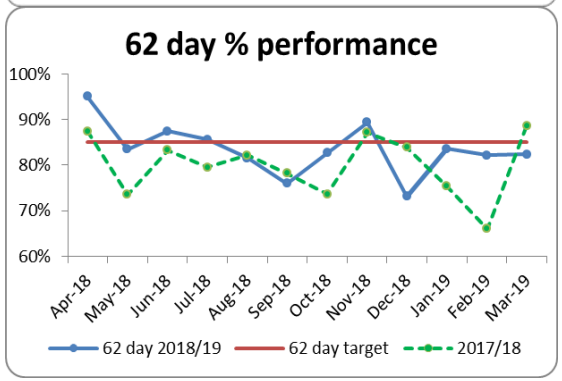
(internal trajectory is to return to 90% compliance)

Improvement Timescale: Sept 2019

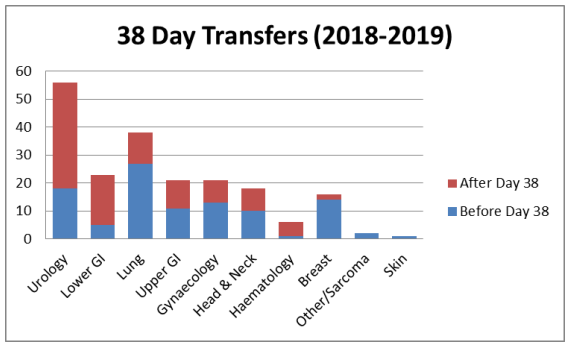
Exception Report

Performance Issue





Late Transfers (after day 38) to Tertiary Centre:-



Cancer Treatment - 62 Day Target

Performance Issue:

The 62 day performance for March was an underachievement of the standard at 82.4%.

Breach Overview:

There were 9.5 breaches in March attributable to COCH:

- Colorectal – 3 breaches. Summary of reasons for breaches include diagnostic delays – (radiology/endoscopy), comorbidities requiring anaesthetic review/fitness tests. Patient cancellations and thinking time through pathway, outpatient review capacity issues, TCI cancellations due to patient being unwell.
- Gynae – 1 breach. Unable to perform diagnostic test, capacity issues for further diagnostic test. Late referral to tertiary centre.
- Haem – 1 breach. Radiology reporting delay. Delay for 2nd opinion at HODS. Transfer from H&N (ENT) to Haem on day 66.
- Head & Neck – 0.5 breach. Radiology reporting delay and PET CT capacity issue. Late referral to tertiary centre.
- Skin – 2 breaches. 1 patient who had 2 lesions (recorded separately). Patient had cardiac surgery and was unable to stop medication for three months.
- Urology – 2 breaches. 1 patient delayed diagnostics due to holidays (45 days). 2nd patient required cardiology opinion prior to diagnostics, results clinic capacity and delay for Bone Scan due to national shortage of isotope.

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 will be monitored through the bi-monthly Cancer Committee.

PTL – work is ongoing on a weekly basis to address the longest waits and an improvement in the overall PTL has been seen.

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

Breaches by Tumour Site Year to Date:

	Total Breaches	% of Trust Breaches
Urology	55	37%
Colorectal	27	18%
Haematology	13	9%
Skin	12	8%
Upper GI	12	8%
Head & Neck	11	7%
Lung	9	6%
Gynae	6	4%
Breast	2	1%
TOTAL	**147**	**100%**

Table: % Breaches by Speciality (April-March)

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. Cancer action plan is in progress and is discussed at the monthly Urology Efficiencies Group.

PTL Position

The following table provides a summary of the PTL position week ending 03/05/2019 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
Colorectal	8	1	9
CUP		1	1
Gynaecology	16		16
Haematology	5		5
Head and Neck	5	2	7
Lung	3	1	4
Skin	11	2	13
Upper GI	12	4	16
Urology	13	5	18
Grand Total	**73**	**16**	**89**

Ownership:

Executive Lead: Lorraine Burnett, Executive Director of Operations

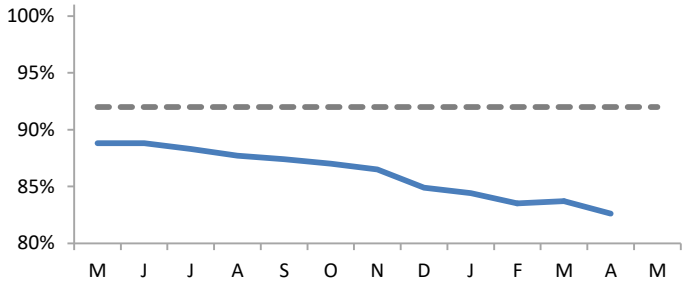
Improvement Objective: Achieve target

Improvement Timescale: By Oct 2019

Referral to treatment (18 weeks)

Performance Trend

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



Performance Issue: RTT performance remains under the 92% target at 82.6%. There continues to be significant RTT pressures across all specialties and there has been deterioration in performance from March to April. April demand continues to be at an increased rate, comparable with 18/19 demand. Cancer referrals and activity continue to take priority and remain high across a number of tumour sites including Skin, Colorectal, Breast and Gynaecology. 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.

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, Endoscopy and Orthopaedics ongoing through May, June & July
- Continued review and scrutiny of over 40 week patients to prevent any 52 week breaches – reviewed on a weekly basis. Continue to have no over 52 week breaches as an organisation
- Urology – action plan and improvement group ongoing. Follow Up improvement plan in place with virtual clinics established to clinically review and discharge patients no longer requiring outpatient review. New Consultant for Urology to start June 2019. From June 2019, CNS Fast Track streams will be established to increase FT and new appointment capacity
- 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 – 0 cancellations in April due to no bed
- 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 already held and action plan developed. Positive impact already being seen. ENT position improving with additional activity established in May, June and July to reduce numbers waiting. Further improvement anticipated in May for ENT
- Revised RTT specialty improvement plans now in place and actions being progressed with key focus in a number of specialties to achieve 92% by July 2019 – Pain, Nephrology, Plastics and Ophthalmology
- New Plastics and ENT consultants start in May which will improve capacity – Locum Plastic Consultant contract extended temporarily to increase capacity over the next 3 months
- Job planning and clinical templates reviews taking place in a number of specialties e.g. Pain and Orthopaedics, to increase clinical capacity. Pain new appointment capacity to increase by additional 10-12 slots from June/July.

Ownership
Lead: Divisional Directors
Executive Lead: Lorraine Burnett, Chief Operating Officer
Improvement Objective: Achieve target
Improvement Timescale: By Mar 2020

Exception Report

Performance Trend

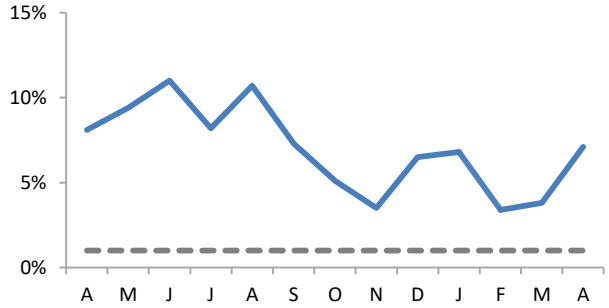


Figure: DM01 - Diagnostic tests carried out within 6 weeks of request being received.

Ownership

Lead: Divisional Directors

Executive Lead: Lorraine Burnett, Chief Operating Officer

Improvement Objective: Achieve target

Improvement Timescale: October 2019

Diagnostic Tests within Timescale

Performance Issue:

DM01 performance was 7.1% in April but remains above the 1% target. This target remains volatile due to increasing demand, national workforce pressures and a low threshold to meet the 1%.

Planned Remedial Actions:

Endoscopy – DM01 performance for April has improved in flexi sigs, cystoscopies and gastroscopies. April JAG validation is undergoing. Continued weekend lists are running to help improve the colonoscopy position. 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 continue to be issues with the delivery of the vascular imaging and the Urgent Care Management Team are looking at a range of issues and processes to increase capacity, optimise utilisation and improve performance. There are limitations for space, equipment and staff, all of which are impacting on ability to seek an improvement in the position however the team are looking at some short, medium and long term solutions to address this and seek a trajectory for improvement

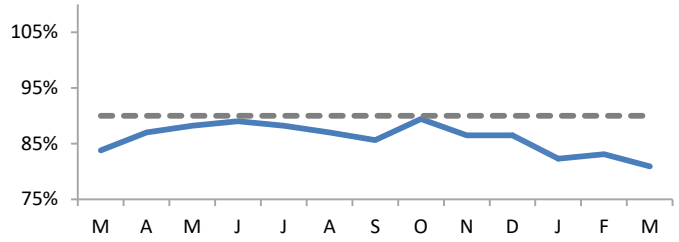
Ultrasound - Significant increases in ultrasound demand, both general and obstetric, coupled with a resignation in month contributed to the number of breaches within this discipline. A long term strategy in relation to training additional sonographers is being developed. The issue has been recognised by Health Education England and a bid for additional training resources regionally is being supported by the Trust.

English - Number of exams >6 weeks

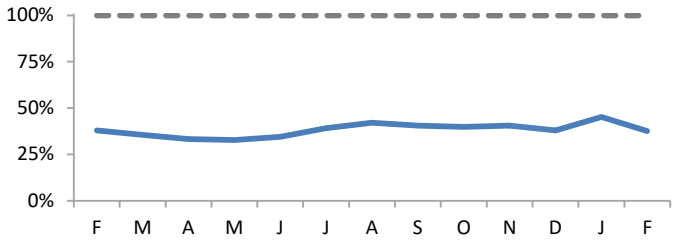
Month End Snapshot	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-18	Mar-18	Apr-18
Magnetic Resonance Imaging	12	5	9					1	2	4	4	4	8
Computed Tomography				1				1	5				14
Non-obstetric ultrasound	177	207	247	165	120	124	80		17				102
CRV - Vascular	2	14	5	12	70	30	8	64	67	128	100	129	177
Audiology - Audiology Assessments													
Cardiology - echocardiography	2			7	72	1	1	6	128	93	2	2	3
Respiratory physiology - sleep studies	3	3	2	3	1			1		2			1
Colonoscopy	77	141	192	87	79	64	39	22	25	45	33	43	40
Flexi sigmoidoscopy	3	5	2	1	12	15	34	27	21	8	2	1	3
Cystoscopy	22	49	59	67	120	69	60	23	30	22	21	17	26
Gastroscopy	74	114	100	72	41	43	34	16	24	19	8	12	28
Total patients waiting	4578	5738	5382	5073	4822	4758	5001	4657	4872	4713	4953	5431	5646
% > Threshold	8.1%	9.4%	11.4%	8.2%	10.7%	7.3%	5.1%	3.5%	6.5%	6.8%	3.4%	3.8%	7.1%

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 April.

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 – Outpatient letter performance is reviewed at specialty level and by the proportion of letters sent out for routine and urgent patients, with Paediatrics, Cardiology and Rheumatology identified for improvement within this Financial year.

Ownership:

Executive Lead: Darren Kilroy, Medical Director
Improvement Objective: Achieve target for 3 identified specialties
Improvement Timescale: Sept 2019

Appendix 1 Nurse Staffing Compliance

Nurse Staffing Heat Map

Ward Name	Specialty	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	Months <95%	Months >100%
Bluebell	EPH Rehabilitation	98%	91%	96%	92%	93%	94%	94%	96%	101%	103%	103%	102%	103%	5	5
Children's	Paediatrics	100%	109%	105%	96%	92%	101%	94%	101%	103%	106%	103%	98%	96%	2	8
ICU	Adult Intensive Care	88%	86%	85%	78%	75%	84%	94%	90%	86%	90%	87%	84%	78%	13	0
Maternity	Maternity	83%	95%	94%	100%	100%	97%	96%	98%	97%	97%	97%	98%	98%	3	1
NNU	Neonatal Unit	67%	89%	97%	97%	91%	100%	92%	94%	98%	98%	95%	94%	97%	6	0
Poppy	Intermediate Care Unit	124%	119%	114%	117%	107%	108%	110%	111%	118%	115%	117%	118%	117%	0	13
Renal	Renal	84%	85%	87%	87%	81%	65%	70%	88%	89%	92%	90%	89%	86%	13	0
Ward 33	Stroke	96%	99%	95%	95%	95%	97%	95%	96%	99%	102%	101%	104%	105%	1	4
Ward 34	Intermediate Care Unit	91%	92%	89%	90%	91%	89%	91%	91%	92%	92%	94%	92%	95%	13	0
Ward 41	Surgery	96%	93%	93%	78%	88%	68%	73%	91%	84%	90%	87%	70%	67%	12	0
Ward 42	Cardiology	110%	98%	100%	104%	109%	105%	99%	103%	100%	101%	115%	100%	97%	0	7
Ward 43	Haematology/Oncology	103%	102%	110%	119%	109%	102%	103%	107%	107%	119%	111%	114%	108%	0	13
Ward 44	Surgery	95%	98%	95%	91%	94%	100%	100%	97%	94%	89%	86%	91%	93%	9	0
Ward 45	Surgery	92%	125%	125%	101%	100%	98%	95%	97%	89%	97%	101%	101%	112%	2	7
Ward 47	Acute Medical Unit	89%	95%	90%	91%	87%	88%	90%	91%	89%	94%	93%	93%	97%	11	0
Ward 48	Respiratory	106%	95%	96%	96%	107%	107%	106%	112%	103%	95%	100%	92%	99%	2	6
Ward 49	Gastroenterology	95%	103%	98%	101%	105%	96%	94%	98%	99%	95%	97%	99%	93%	2	3
Ward 50	Care of the Elderly	108%	108%	102%	110%	112%	106%	110%	117%	117%	110%	112%	110%	86%	1	12
Ward 51	Care of the Elderly	103%	108%	103%	107%	107%	106%	112%	109%	110%	113%	113%	107%	92%	1	12
Ward 52	Trauma & Orthopaedics	102%	103%	110%	115%	109%	108%	109%	108%	103%	99%	95%	97%	101%	0	10
Ward 53	Vascular	89%	83%	86%	90%	93%	90%	94%	95%	94%	97%	93%	93%	93%	12	0
Ward 54	General Medicine	97%	77%	102%	95%	97%	94%	91%	83%	81%	89%	90%	89%	98%	9	1
Ward 60	Haem / Oncology Day Case	95%	96%	92%	84%	92%	93%	87%	86%	81%	85%	83%	85%	99%	10	0
Wards with less than 95% compliance		9	9	10	10	11	9	12	9	10	9	9	11	9		
Wards with more than 100% compliance		9	9	9	9	11	9	7	9	8	8	9	7	6		

Item Reference and Title	**Agenda item 10 (a)** - Financial Position – Month 2, May 2019
Date of Meeting	Board of Directors - Tuesday 25th June 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 31st May 2019 (Month 2)
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 two financial position reported as a £220k overspend before central funding (previously £160k overspend at Month 01); • The Commissioner Income position which is £292k below plan at the end of May 2019 with: o £140k attributable to an adverse movement from month one, following the coding of previously reported high proportion of estimated activity; o underperformance on Neonatal Unit income of £114k year to date (with 5 days in May with no patients within the unit); and a o £40k underperformance on Critical Care; • The continued pressure on pay, with o Medical pay £88k overspend in month, £115k YTD, (including £464k of agency expenditure); and o Nursing pay (£35k YTD, including £59k 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 resulting in circa £60k cost pressure year to date, due to refurbishment and expected to continue until mid-July 2019; o The successful implementation of the of a VAT efficient model, with regards the temporary staffing model for Medical Pay from 27th May 2019 (although resulting in a year to date pressure of circa £120k); and o The significant financial impact of over 10 material Human Resources cases, currently being managed (resulting in a year to date pressure of circa £40k). • The Cost Reduction Savings (CRS) target set at 5% equating to £11.2m, and is behind plan by £20k at the end of month two. However, it should be noted that £3.65m of this target is profiled to be delivered in March 2020, if this was profiled evenly as is the rest of the target the CRS position would move adversely by £608k, to £628k behind plan; • The financial position includes circa £150k drawdown from the Contingency Reserve set at £700k representing 21% ($^{2}/_{12}$ equating to 17%); • 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 issue, together with further capital requirements for 2019/20; • The risk surrounding the current Light Emitting Diode (LED) project; • The potential for financial risk associated with the implementation of the new Cerner Electronic Patient Record; • The financial risks identified to deliver the financial position; and • The steps taken to date, and the proposed actions.
Corporate Impact Assessment:	**Legal and regulatory impact:** **Financial impact:** **Patient Experience/Engagement:**

	Risk & Performance Management: **NHS Constitution/Equality & Diversity/Communication:**

Financial Position
Month 2 May 2019/20

1.0 Overview

The "monitored" financial position i.e. pre Provider Sustainability Fund (PSF) shows an **adverse variance of £220k** at the end of May.

	Annual Budget 2019/20 £000s	May YTD Budget 2019/20 £000s	May YTD Actual 2019/20 £000s	May YTD Variance 2019/20 £000s
Pre PSF (Deficit)	8,040	3,024	3,244	220
PSF	(8,040)	(852)	(852)	0
Post PSF Control Total	**0**	**2,172**	**2,392**	**220**
Donated Asset Transactions	14	(2)	(2)	0
I&E Deficit	**(14)**	**2,174**	**2,394**	**220**

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

- **Income**
  Commissioner income is £292k below plan for April and May. There is an over performance on English activity (£430k) which is offset by an underperformance on Welsh activity (£716k) resulting in an overall under performance.
  Non commissioner income is £195k above plan. This is predominately due to several large Road Traffic Accident (RTA) claims that have been settled in April and May. The value of this is £118k.

- **Expenditure**
  - **Pay**

    The most significant pressures on the expenditure position continue to be medical pay (£88k in month, £115k YTD, including £464k of agency expenditure) and nursing pay £35k YTD, including £59k of agency expenditure) despite investment through the 2019/20 budget setting process.

    The main overspending medical specialities are detailed below, combined with the current activity performance as at end of May: -

Division	Cost Centre Name	WTE Budg	WTE Actua	WTE varianc	YTD Variance	Activity Variance	Activity Value Variance £000s	Reasons For Overspend
Urgent Care Division	Acute Medicine Staff	16.96	19.04	2.08	£ 81,557	(77)	£126,619	Agency Spend for 2 Consultants
Planned Care Division	Urology	9.00	7.27	(1.73)	£ 48,318	(131)	£ 26,306	2x Wte ST1/2 agency covering 2x newly funded posts to be recruited into. Pressure of £36k YTD
Planned Care Division	Ear Nose And Throat	12.14	11.02	(1.12)	£ 42,485	136	-£ 50,636	5x trainee vacancies covered by various agency and extra duties £24k YTD. Consultant agency £19k YTD (vacant post recruited into May '19, no longer a pressure)
Urgent Care Division	Emergency Department -M	38.78	36.44	(2.34)	£ 41,819	(525)	£ 3,917	To cover shifts booked as extra work pressures
Planned Care Division	Ophthalmology	15.60	16.76	1.16	£ 37,096	310	-£ 30,614	1x wte overestablishment on agency to cover trainee extended induction (supernumerary) £32k YTD.
Urgent Care Division	Diabetes/ Endocrinology	10.12	10.97	0.85	£ 28,448	(342)	£ 44,410	Consultant agency £18K YTD pressure. And 1.80 Wte pressure on training grades YTD £10K

The main two overspending wards are shown below with the reasons for the overspend: -

Division	Cost Centre Nar	WTE Budge	WTE Actua	WTE varian	YTD Varian	Reasons For Overspend
Urgent Care Division	Ward 54	32.87	45.15	12.28	£ 87,252	Ward has 6 additional beds. Bank Band 2 & 5 are overspent £57k & £16k respectively to cover vacancies, patient acuity (patients not medically optimised) & escalation
Planned Care Division	Bridge Ward (44)	32.24	34.80	2.56	£ 32,420	9 band 5 vacancies over covered by bank band 5, bank band 2 and nurse recharges

The current challenge with regards the temporary staffing model for Medical Pay (c.£120k); and the significant financial impact of over 10 material Human Resources cases, currently being managed (c.£40k) are currently being offset by underspends in other staff groups and non-pay.

- **Non Pay**

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 completion anticipated mid-July 2019.

A further non pay pressure this month is £74k in relation to Year 6 costs of the VOIP Telecoms system for maintenance, support and licenses. This was previously a capital purchase and procurement / IM&T are reviewing this contract going forward to try and mitigate the increased costs.

- **<u>Cost Reduction Scheme (CRS)</u>**

The CRS target is set at 5% equating to £11.2m, and is behind plan by £20k at the end of month two. However, it should be noted that £3.65m of this target is profiled to be delivered in March

2020, if this was profiled evenly as is the rest of the target the CRS position would move adversely by £608k to £628k behind plan;

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 May, both pre and post PSF:

KEY VARIANCES	Annual Budget £000s	May YTD Budget £000s	May YTD Actual £000s	May YTD Variance £000s	May YTD Variance % of budget
INCOME					
Income - England	(194,869)	(31,754)	(32,184)	(430)	1.4%
Income - Wales	(26,511)	(4,318)	(3,602)	716	-16.6%
Other Clinical Income	(10,082)	(1,876)	(2,024)	(148)	7.9%
Non Patient Income	(13,605)	(2,365)	(2,405)	(40)	1.7%
INCOME	**(245,066)**	**(40,313)**	**(40,216)**	**97**	-0.2%
PAY					
Nursing	63,764	10,901	10,935	34	0.3%
Medical	49,908	8,198	8,313	115	1.4%
Admin & Clerical	22,354	3,790	3,730	(60)	-1.6%
AHP, Therapies, Diagnostics & Pharmacy	25,619	4,351	4,258	(93)	-2.1%
Other	15,500	2,734	2,690	(45)	-1.6%
Vanacies taken to CRS	(194)	(194)	0	194	-100.0%
TOTAL PAY	**176,952**	**29,781**	**29,926**	**145**	0.5%
NON PAY					
Drugs	20,166	3,296	3,274	(22)	-0.7%
Medical & Surgical Equipment	10,940	2,142	2,090	(52)	-2.4%
Depreciation	4,444	355	355	0	0.0%
CNST	7,803	1,301	1,301	0	0.0%
Furniture & Office Equipment, Equip Hire & Computers	4,110	685	771	86	12.6%
Other	35,292	5,802	5,747	(55)	-1.0%
TOTAL NON PAY	**82,755**	**13,581**	**13,538**	**(43)**	-0.3%
CRS	**(6,601)**	**(20)**	**0**	**20**	
TOTAL - PRE PSF & DONATED ASSET TRANSACTIONS	**8,040**	**3,028**	**3,248**	**220**	
PSF (Provider Sustainability Fund)	**(8,040)**	**(852)**	**(852)**	**0**	
POST PSF CONTROL TOTAL	**0**	**2,176**	**2,396**	**220**	
DONATED ASSET TRANSACTIONS	**(14)**	**(2)**	**(2)**	**0**	
I&E (SURPLUS) / DEFICIT	**(14)**	**2,174**	**2,394**	**220**	

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 has agreed with West Cheshire CCG to a phased cap and collar approach:

Performance	Marginal Rate
0% to 1%	20%
1% to 2%	50%
Over 2%	100%

Therefore, if the financial value of activity is above or below the planned baseline by up to 1% then the Trust will be paid or retracted 20% of the full tariff. For activity between 1% and 2% then the payment will be 50% of the full tariff. For activity above or below 2% then 100% of the tariff will be paid or retracted.

The table below shows the month two cumulative activity and value variance by point of delivery. 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 / overperformance)	Value Variance YTD (financial value variance of activity units delivered compared to funded baseline where (x)/x is underperformance / overperformance)	RAG	Movement from Previous Period
Daycases	(46)	(£21,610)	↓	(£62,273)
Elective Inpatients	(14)	(£107,357)	↓	(£95,073)
Non-Elective Inpatients (exc Maternity)	235	£155,246	↑	£179,551
Non-Elective Inpatients - Maternity	(42)	(£142,740)	↓	(£61,598)
First Outpatients	(232)	(£75,115)	↑	£15,413
Follow Up Outpatients	684	£41,954	↑	£50,153
Outpatient Unbundled & Procedures	2	£20,423	↓	(£5,049)
Maternity	(56)	£28,043	↑	£13,976
A&E Attendances	(556)	(£104,447)	↓	(£49,887)
Best Practice Adj'ts	0	(£39,519)	↓	(£32,472)
AMD	274	£259,867	↑	£94,814
Adult Crit Care & Neonatal	(105)	(£74,090)	↓	(£158,232)
Other Non PBR & CQUIN	0	(£232,165)	↓	(£185,841)
PBR & Non PBR Variance	**144**	**(£291,508)**		**(£296,518)**

At the end of May 2019 (month two) the total contract income (for all commissioners) is below plan with a reported £292k adverse 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 2, currently 22% of total activity compared to 3% at month 12 2019;

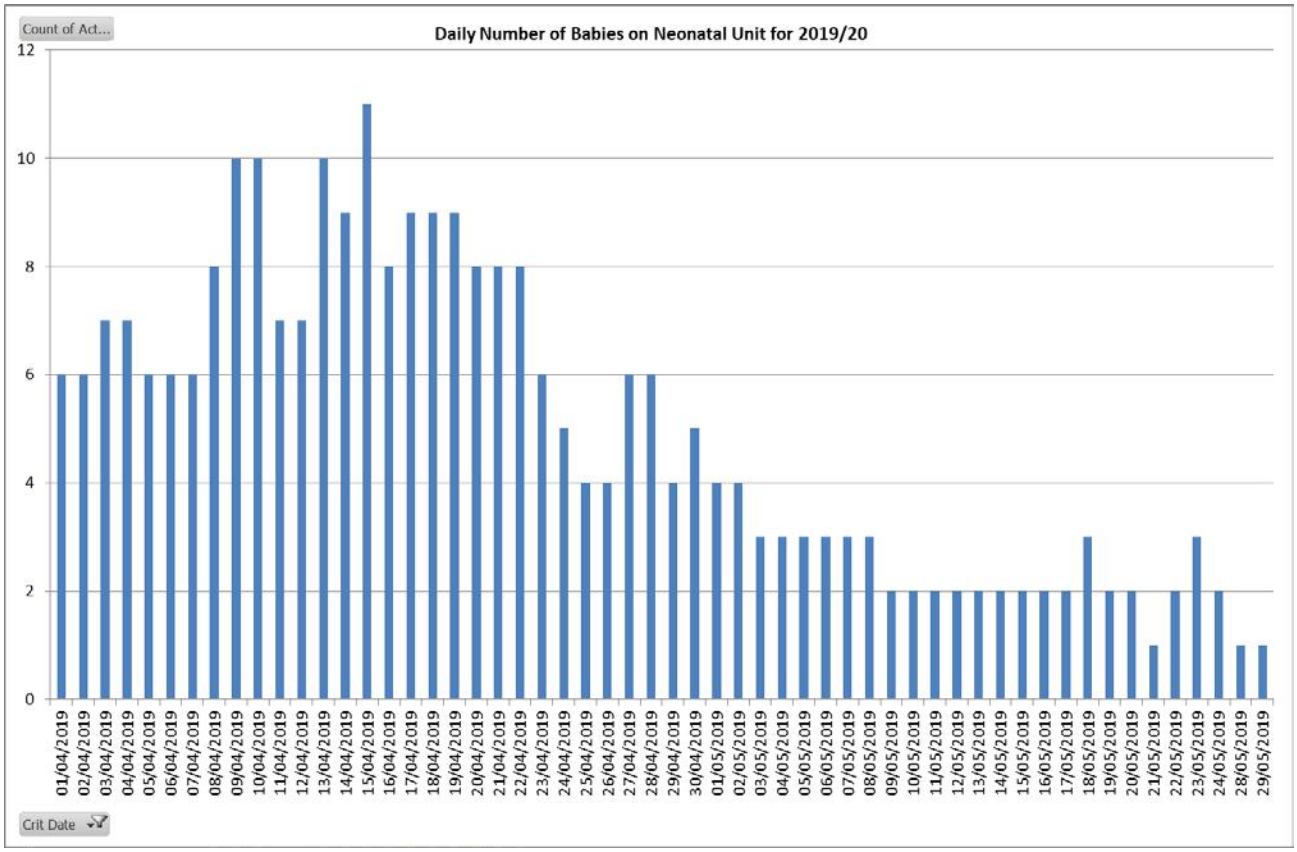
- The Betsi Cadwaladr University Health Board contract has been agreed and signed on 21st May 2019 now the 2019/20 tariff issue has been resolved nationally.

- At the end of May, there has been an over performance on English activity of £425k but this has been more than offset by the underperformance on Welsh activity of circa £716k. This under performance is across all points of delivery but in particular non-elective activity (£302k of which £46k is obstetric deliveries), daycase and elective activity (£157k), outpatient activity (£100k) and adult and neonatal critical care (£110k).

- The declining trend in Obstetric deliveries experienced in the last financial year continues with an £143k under performance across both England and Wales at the end of month two;

- The Acute Macular Degeneration (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; and

- There has been a significant reduction in the level Neonatal activity during May 2019, thus generating an underperformance of £114k in the May positon (and £108k year to date). As with all activity, the income is only recognised when babies are discharged from the Neonatal Unit. During April 2019, there were on average 7 babies on the unit on a daily basis compared to just to 2 babies each day in May. There were 5 days whereby there were no babies on the unit (25th, 26th, 27th, 30th and 31st May). For the same period in the 18/19 financial year there were on average 9 babies each day in April and May 2018. Warrington & Halton Hospitals are also experiencing a similar reduction in activity, but Wirral and Southport & Ormskirk Hospital are reporting a similar, if not increased, level of activity compared to the previous year.



The chart above does not include activity for babies that are still on the Neonatal unit.

Please see appendix 1 for tables detailing the activity and value variance by specialty and point of delivery.

2.1 Non-Commissioner Income

At the end of May 2019, non-commissioner income is showing a favourable variance of £195k. This is due to the following:-

- £118k due to a favourable recovery of RTA income. This relates to several large claims that have been settled in April and May this year. It is not known whether this will continue; and
- Private patient income is £17k below plan for April and May. This is due to the suspension of face to face private patient activity in February 2019 whilst a quality, safety and governance review was undertaken. This will continue to be a financial pressure until this suspension has been lifted.

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	May YTD Var	CRS YTD Var	Pressure exc CRS
	£000s	£000s	£000s
Planned Care	278	324	(46)
Urgent Care	543	276	267
ICP	(48)	56	(104)
D&I	40	201	(161)
Nurse Management	0	3	(3)
Corporate Services	105	12	93
Central (CRS)	(852)	(852)	0
Central Services	154	0	154
Total (before PSF & Donated Assets)	**220**	**20**	**200**

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 May 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	£ 6,547	£ 39,284
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433	£ 3,339,110	£ 463,587	£ 2,781,523
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847	£ 662,413	£ 59,453	£ 356,718
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820	£ 222,289	£ 44,246	£ 265,474
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009	£ 110,124	£ 11,984	£ 71,902
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 4,372,869**	**£ 4,422,108**	**£ 585,817**	**£ 3,514,900**
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 May 2019 CRS Performance

CRS performance as at the end of May 2019 is reported as £20k behind plan, as detailed below.

CRS DIVISIONAL PERFORMANCE AS AT MAY 2019			
Division / Department	Target to MAY	Achieved to MAY	Var
Planned Care	£ 674,472	£ 350,750	£ 323,721
Urgent Care	£ 374,448	£ 98,016	£ 276,432
ICP	£ 107,195	£ 50,959	£ 56,236
D&I	£ 342,596	£ 141,476	£ 201,120
Nurse Mgmt	£ 17,571	£ 14,667	£ 2,904
Corporate Clinical	£ 826	£ 1,000	-£ 174
IM&T	£ 46,401	£ 71,160	-£ 24,759
HR	£ 28,895	£ 12,041	£ 16,854
Trust Administration	£ 14,972	£ 2,740	£ 12,232
Finance	£ 12,898	£ 14,896	-£ 1,998
PPD	£ 15,452	£ 10,201	£ 5,252
Procurement	£ 4,684	£ -	£ 4,684
Central	£ 224,856	£ 174,667	£ 50,189
Central - Risk Reserve 2/12ths	-£ 294,159		-£ 294,159
Central - Profile Adjustment	-£ 608,333		-£ 608,333
TOTAL	**£ 962,772**	**£ 942,571**	**£ 20,201**

If the full target was profiled evenly there would be a further adverse movement of £608k in the month two position.

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 MAY 2019

		IN YEAR						
Division / Department	2019/20 In Year CRS Target	Achieved		Outstanding	Green	Amber	Red	Gap
Planned Care	£ 4,046,829	£ 1,015,039	25%	£ 3,031,790	£ 486,461	£1,073,189	£ 1,065,066	£ 407,074
Urgent Care	£ 2,246,688	£ 458,618	20%	£ 1,788,070	£ 329,253	£ 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	£ 490,642	24%	£ 1,564,932	£ 339,563	£ 235,000	£ 50,000	£ 940,369
Nurse Mgmt	£ 105,423	£ 25,500	24%	£ 79,923	£ -	£ 7,500	£ -	£ 72,423
Corporate Clinical	£ 4,956	£ 1,000	20%	£ 3,956	£ -	£ -	£ -	£ 3,956
IM&T	£ 278,405	£ 131,581	47%	£ 146,824	£ 16,589	£ 21,100	£ 76,535	£ 32,600
HR	£ 173,369	£ 37,733	22%	£ 135,636	£ 7,500	£ 37,775	£ 2,500	£ 87,861
Trust Administration	£ 89,832	£ 16,438	18%	£ 73,394	£ 5,500	£ 5,100	£ -	£ 62,794
Finance	£ 77,386	£ 49,375	64%	£ 28,011	£ 7,000	£ -	£ 3,000	£ 18,011
PPD	£ 92,714	£ 21,034	23%	£ 71,680	£ 13,500	£ -	£ 54,585	£ 3,595
Procurement	£ 28,106	£ -	0%	£ 28,106	£ -	£ 28,106	£ -	£ -
Central	£ 1,349,133	£ 273,000	20%	£ 1,076,133	£ -	£ 609,407	£ 466,726	£ -
TOTAL	**£11,191,584**	£ 2,825,715	25%	£ 8,365,869	£ 1,217,367	£2,499,929	£ 2,039,412	£ 2,609,161
Central - Risk Reserve	**-£ 1,764,951**			-£ 1,764,951				-£ 1,764,951
REVISED TOTAL	**£ 9,426,633**	£ 2,825,715	30%	£ 6,600,918	£ 1,217,367	£2,499,929	£ 2,039,412	£ 844,210
		30%			13%	27%	22%	9%
		30%				39%		31%

2019/20 EFFICIENCY PROGRAMME PERFORMANCE AS AT MAY 2019

RECURRENT

Division / Department	2019/20 Recurrent CRS Target	Achieved		Outstanding	Green	Amber	Red	Gap
Planned Care	£ 4,046,829	£ 668,151	17%	3,378,678	£ 465,500	£ 848,668	£2,055,916	£ 8,594
Urgent Care	£ 2,246,688	£ 432,871	19%	1,813,817	£ 45,000	£ 204,300	£ 20,000	£1,544,517
ICP	£ 643,169	£ 152,575	24%	490,594	£ -	£ 10,000	£ 5,000	£ 475,594
D&I	£ 2,055,574	£ 438,000	21%	1,617,574	£ 471,497	£ 275,000	£ 175,000	£ 696,077
Nurse Mgmt	£ 105,423	£ 13,000	12%	92,423	£ -	£ -	£ -	£ 92,423
Corporate Clinical	£ 4,956	£ -	0%	4,956	£ -	£ -	£ -	£ 4,956
IM&T	£ 278,405	£ 61,817	22%	216,588	£ 16,589	£ 5,000	£ 101,827	£ 93,172
HR	£ 173,369	£ 28,282	16%	145,087	£ -	£ 25,718	£ 3,000	£ 116,369
Trust Administration	£ 89,832	£ 15,604	17%	74,228	£ 500	£ 3,128	£ -	£ 70,600
Finance	£ 77,386	£ 41,257	53%	36,129	£ -	£ -	£ 3,000	£ 33,129
PPD	£ 92,714	£ 13,000	14%	79,714	£ -	£ -	£ 41,500	£ 38,214
Procurement	£ 28,106	£ -	0%	28,106	£ -	£ 28,106	£ -	£ -
Central	£ 1,349,133	£ 118,000	9%	1,231,133	£ -	£ 764,407	£ 466,726	£ -
TOTAL	**£11,191,584**	£ 1,982,557	18%	9,209,027	£ 999,086	£2,164,327	£2,871,969	£3,173,645
Central - Risk Reserve	**-£ 1,764,951**			-£ 1,764,951				-£1,764,951
REVISED TOTAL	**£ 9,426,633**	£ 1,982,557	21%	£ 7,444,076	£ 999,086	£2,164,327	£2,871,969	£1,408,694
		21%			11%	23%	30%	15%
		21%				34%		45%

	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?
Gap	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 now in place;
- Review of the growth income target and corresponding expenditure budgets;
- Review of reserves;
- Further drill down of overspending areas including medical and nursing pay;
- Continued weekly vacancy control panel;
- 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 May was £1.4m against a plan of £834k. 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 will be presented separately for Board approval 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. 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.

The two key building projects are now underway, with the Neonatal build starting on 1 April 2019, and the two phases of the A&E build currently being combined into a single project under a P22 contract.

6.0 Working Balances and Cash

Contract Receivables (Trade Debtors) increased at the end of May 2019, predominantly due to non-receipt of training levy monies from Health Education England, and also the impact of PBR and quarterly service level agreement (SLA) billing. 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 May is £6.4m, which was £5.2m 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).

The Trust received £1.6m revenue distress funding in April 2019 and a further £1.9m in May 2019. No additional cash is required in June or July 19.

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 two:

- **The CRS target for 2019/20** is a significant risk with a considerable proportion unidentified (9%) or red rated (22%) 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. The joint efficiency programme with the CCG continues;
- 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 with £3.5m received to date this financial year;
- 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 Public Dividend Capital (PDC) previously allocated to implement the LED project appears to have been retracted in the short term; and
    - The financial plan currently makes no allowance for changes anticipated with regards to changes to asset lives, although further work is ongoing.
- 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;

- The potential risk associated with the implementation of the new **Electronic Patient Record (EPR)** (see separate Board paper); 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 1A: Activity Variances by Specialty & Point of Delivery

Specialty	Description	Total Activity									
		Point of Delivery									
		DC	EL	NEL	OPFA	OPFUP	OPPROC	Maternity	A&E	Non-PBR	Total
100	General Surgery	9	(2)	(38)	(70)	(26)	1	0	0	0	(126)
101	Urology	3	7	28	(120)	(27)	(23)	0	0	0	(131)
103	Breast Surgery	3	2	3	2	4	36	0	0	0	51
104	Colorectal Surgery	(1)	(1)	14	(23)	94	5	0	0	0	88
106	Upper GI Surgery	(1)	1	6	32	126	0	0	0	0	164
107	Vascular Surgery	(21)	(10)	16	19	(78)	52	0	0	0	(21)
110	Trauma & Orthopaedics	(2)	(5)	38	(146)	65	(69)	0	0	0	(119)
120	ENT	(6)	13	22	(45)	(9)	161	0	0	0	136
130	Ophthalmology	13	(5)	11	57	(38)	272	0	0	0	310
140	Oral Surgery	(90)	(4)	10	(8)	4	0	0	0	0	(88)
143	Orthodontics	0	0	0	(17)	(83)	(306)	0	0	0	(406)
144	Maxillo-Facial Surgery	46	(0)	8	(61)	(32)	6	0	0	0	(34)
160	Plastic Surgery	11	(14)	28	(0)	35	(2)	0	0	0	58
170	Cardiothoracic Surgery	0	0	0	1	(1)	0	0	0	0	(0)
180	A&E	0	0	31	0	0	0	0	(556)	0	(525)
191	Pain Management	75	(1)	12	57	(27)	3	0	0	0	120
223	Paediatric Epilepsy	0	0	0	4	10	0	0	0	0	14
300	General Medicine	4	2	52	(107)	(25)	(2)	0	0	0	(77)
301	Gastroenterology	38	1	21	15	204	1	0	0	0	280
302	Endocrinology	4	2	1	3	(82)	(0)	0	0	0	(73)
303	Clinical Haematology	(10)	16	(6)	(2)	(42)	(1)	0	0	0	(45)
306	Hepatology	0	0	0	3	213	0	0	0	0	216
307	Diabetic Medicine	(0)	(0)	1	(0)	(267)	(2)	0	0	0	(269)
315	Palliative Medicine	0	0	0	3	6	0	0	0	0	9
320	Cardiology	2	(4)	(8)	(44)	97	8	0	0	0	51
324	Anti Coag	0	0	0	(5)	84	0	0	0	0	80
329	TIA	0	0	0	0	0	0	0	0	0	0
330	Dermatology	8	1	0	(38)	12	(153)	0	0	0	(170)
340	Respiratory Medicine	1	(0)	(8)	(61)	(123)	66	0	0	0	(124)
361	Nephrology	0	(1)	(0)	50	22	0	0	0	0	71
410	Rheumatology	5	0	(0)	(19)	52	(24)	0	0	0	14
420	Paediatrics	(1)	0	(69)	(66)	(115)	(9)	0	0	0	(260)
430	Geriatric Medicine	1	(0)	78	(27)	(12)	0	0	0	0	41
501	Obstetrics	0	0	(42)	0	0	0	(56)	0	0	(98)
502	Gynaecology	56	(10)	(15)	36	35	47	0	0	0	148
503	Gynaecological Oncology	0	0	0	0	0	0	0	0	0	0
650	Physiotherapy	0	0	0	219	430	0	0	0	0	650
651	Occupational Therapy	0	0	0	95	229	0	0	0	0	325
653	Podiatry	0	0	0	(3)	34	0	0	0	0	31
654	Dietetics	0	0	0	34	(1)	0	0	0	0	33
655	Orthoptics	0	0	0	(2)	(65)	0	0	0	0	(67)
812	Diagnostic Imaging	0	0	0	0	0	(66)	0	0	0	(66)
822	Chemical Pathology	0	0	0	5	3	0	0	0	0	8
831	Medical Microbiology	0	0	0	0	(18)	0	0	0	0	(18)
987	HIV	0	0	0	0	(7)	0	0	0	0	(7)
ENDO	Endoscopy	(193)	0	0	0	0	0	0	0	0	(193)
SMART	SMART	0	(3)	(1)	0	0	0	0	0	0	(3)
Other	Other	0	0	0	0	0	0	0	0	(105)	(105)
Total		**(46)**	**(14)**	**193**	**(232)**	**684**	**2**	**(56)**	**(556)**	**(105)**	**(130)**

Appendix 1B: Value Variances by Specialty & Point of Delivery

Specialty	Description	Total Value									
		Point of Delivery									
		DC	EL	NEL	OPFA	OPFUP	OPPROC	Maternity	A&E	Non-PBR	Total
100	General Surgery	£15,605	£5,118	(£72,728)	(£12,535)	(£1,651)	£60	£0	£0	£0	(£66,131)
101	Urology	(£3,843)	£1,378	£545	(£18,843)	(£2,161)	(£3,382)	£0	£0	£0	(£26,306)
103	Breast Surgery	£14,808	£10,734	£753	£360	£236	£14,542	£0	£0	£0	£41,432
104	Colorectal Surgery	£2,127	£5,123	(£28,109)	(£6,822)	£3,836	£1,069	£0	£0	£0	(£22,776)
106	Upper GI Surgery	(£630)	£4,656	£17,271	£5,689	£10,008	£0	£0	£0	£0	£36,994
107	Vascular Surgery	(£31,851)	(£29,632)	£28,834	£4,162	(£5,671)	£1,024	£0	£0	£0	(£33,135)
110	Trauma & Orthopaedics	(£19,003)	(£27,029)	(£16,772)	(£15,971)	£3,581	(£10,396)	£0	£0	£0	(£85,590)
120	ENT	(£2,038)	£26,716	£13,074	(£5,650)	(£796)	£19,331	£0	£0	£0	£50,636
130	Ophthalmology	£12,228	(£10,214)	(£2,291)	£5,519	(£1,196)	£26,567	£0	£0	£0	£30,614
140	Oral Surgery	(£51,845)	(£3,057)	£2,487	(£1,083)	£237	£0	£0	£0	£0	(£53,261)
143	Orthodontics	£0	£0	£0	(£3,238)	(£6,267)	(£36,453)	£0	£0	£0	(£45,958)
144	Maxillo-Facial Surgery	£31,439	(£313)	£3,134	(£9,342)	(£2,173)	£739	£0	£0	£0	£23,484
160	Plastic Surgery	(£27,935)	(£33,308)	£6,210	(£116)	£1,869	(£226)	£0	£0	£0	(£53,505)
170	Cardiothoracic Surgery	£0	£0	£0	£219	(£123)	£0	£0	£0	£0	£96
180	A&E	£0	£0	£100,530	£0	£0	£0	£0	(£104,447)	£0	(£3,917)
191	Pain Management	£43,510	(£593)	£759	£11,754	(£363)	£342	£0	£0	£0	£55,410
223	Paediatric Epilepsy	£0	£0	£0	£944	£2,120	£0	£0	£0	£0	£3,063
300	General Medicine	£2,832	£1,035	(£107,699)	(£20,077)	(£2,443)	(£268)	£0	£0	£0	(£126,619)
301	Gastroenterology	£8,860	(£10,206)	(£18,700)	£3,609	£10,830	£75	£0	£0	£0	(£5,532)
302	Endocrinology	£1,926	£670	(£11,502)	£636	(£5,757)	(£28)	£0	£0	£0	(£14,055)
303	Clinical Haematology	(£11,654)	£6,825	(£18,502)	(£522)	£2,945	(£100)	£0	£0	£0	(£21,006)
306	Hepatology	£0	£0	£0	(£259)	£15,826	£0	£0	£0	£0	£15,567
307	Diabetic Medicine	(£396)	(£1,848)	(£3,316)	(£139)	(£24,365)	(£291)	£0	£0	£0	(£30,355)
315	Palliative Medicine	£0	£0	£0	£942	£1,558	£0	£0	£0	£0	£2,501
320	Cardiology	£18,210	(£21,769)	(£2,779)	(£6,491)	£7,691	£1,545	£0	£0	£0	(£3,593)
324	Anti Coag	£0	£0	£0	(£383)	£3,256	£0	£0	£0	£0	£2,873
329	TIA	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
330	Dermatology	£2,679	£332	£0	(£4,934)	£197	(£16,779)	£0	£0	£0	(£18,505)
340	Respiratory Medicine	£2,249	(£3,513)	(£24,076)	(£14,494)	(£11,095)	£17,366	£0	£0	£0	(£33,562)
361	Nephrology	£0	(£867)	(£576)	£8,695	£2,672	(£5)	£0	£0	£0	£9,919
410	Rheumatology	£1,144	(£2,488)	(£105)	(£4,840)	£4,847	(£4,870)	£0	£0	£0	(£6,313)
420	Paediatrics	(£1,224)	£7,791	(£39,580)	(£18,731)	(£8,623)	(£1,656)	£0	£0	£0	(£62,023)
430	Geriatric Medicine	£2,153	(£2,360)	£279,502	(£11,484)	(£2,906)	£0	£0	£0	£0	£264,905
501	Obstetrics	£0	£0	(£144,089)	£0	£0	£22	£28,043	£0	£0	(£116,025)
502	Gynaecology	£56,355	(£21,564)	(£7,629)	£5,651	£2,648	£11,062	£0	£0	£0	£46,523
503	Gynaecological Oncology	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
650	Physiotherapy	£0	£0	£0	£15,991	£24,180	£0	£0	£0	£0	£40,170
651	Occupational Therapy	£0	£0	£0	£11,794	£24,283	£0	£0	£0	£0	£36,077
653	Podiatry	£0	£0	£0	(£202)	£2,148	£0	£0	£0	£0	£1,946
654	Dietetics	£0	£0	£0	£4,639	(£304)	£0	£0	£0	£0	£4,334
655	Orthoptics	£0	£0	£0	(£208)	(£5,274)	£0	£0	£0	£0	(£5,482)
812	Diagnostic Imaging	£0	£0	£0	£0	£0	£1,134	£0	£0	£0	£1,134
822	Chemical Pathology	£0	£0	£0	£647	£558	£0	£0	£0	£0	£1,205
831	Medical Microbiology	£0	£0	£0	£0	(£455)	£0	£0	£0	£0	(£455)
987	HIV	£0	£0	£0	£0	(£1,949)	£0	£0	£0	£0	(£1,949)
ENDO	Endoscopy	(£87,317)	£0	£0	£0	£0	£0	£0	£0	£0	(£87,317)
SMART	SMART	£0	(£8,973)	£18,339	£0	£0	£0	£0	£0	£0	£9,366
Other	Other	£0	£0	£0	£0	£0	£0	£0	£0	(£46,387)	(£46,387)
Total		**(£21,610)**	**(£107,357)**	**(£27,013)**	**(£75,115)**	**£41,954**	**£20,423**	**£28,043**	**(£104,447)**	**(£46,387)**	**(£291,508)**

Appendix 2: Statement of Financial Position and Cash Flow Statement

May 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	1,444	834	7,350
Depreciation	(771)	(771)	(4,293)
Disposals	-	(16)	(63)
Revaluation	-	-	(5,642)
Closing	95,905	100,766	95,232
Current Assets			
Opening Cash Balance	7,434	1,252	9,112
Increase/(Decrease)	(1,016)	-	(1,678)
Closing Cash Balance	6,418	1,252	7,434
Inventories	1,696	1,488	1,687
Contract and Other Receivables	10,075	9,252	9,575
Prepayments	1,868	2,986	1,634
Neonatal Designated Account	2,591	2,200	2,591
Total current assets	23,431	17,178	22,921
Liabilities < 1 Year			
Trade and Other Payables	(7,931)	(7,156)	(8,316)
Capital Payables	(4,245)	(2,617)	(4,400)
Accruals	(3,877)	(3,750)	(3,750)
Provisions	(513)	(519)	(530)
Deferred Income	(2,782)	(1,613)	(2,552)
Other Payables (including Tax and Pension)	(7,555)	(7,200)	(7,204)
Loans (ITFF)	(4,808)	(4,686)	(4,747)
PPP Loan	(51)	(51)	(41)
Total Net Current Assets	(9,114)	(9,932)	(8,619)
Liabilities > 1 Year			
Provisions	(1,272)	(1,350)	(1,272)
Loans (ITFF)	(36,564)	(36,971)	(32,964)
PPP Deferred Income	(1,581)	(1,581)	(1,592)
PPP Loan	(2,020)	(2,020)	(2,037)
Total Assets Employed	**45,354**	**48,430**	**47,748**
Capital & Reserves			
PDC	66,612	66,612	66,612
Revaluation Reserve	5,039	5,625	5,039
Income & Expenditure Reserve	(26,297)	(23,807)	(23,903)
Total Capital & Reserves	**45,354**	**48,430**	**47,748**

May 2019 Cash Flow Statement	2019/20 Actual £000	2019/20 Plan £000	2018/19 Out-Turn £000
Surplus	(1,297)	(1,064)	(2,474)
Working Balance Movements	(674)	(165)	3.757
Donated / Grant Funded Asset Additions	33	34	223
Disposal Proceeds	-	-	96
PPP Income/Interest - non cash movements	(11)	(11)	(65)
	(1,960)	(1,206)	1,537
Other non cash movement	46	291	-
Capital Expenditure	(1,599)	(1,991)	(6,824)
New PDC	-	-	3,012
Purchase of investments	-	-	-
New Loans	3,446	3,860	6,722
Loan re-payments Principle	(846)	(846)	(4,686)
PPP Loan Repayments Principle	(8)	(8)	(37)
Interest Payable	(126)	(104)	(674)
Interest Received	20	4	102
PDC Dividend Paid	-	-	(830)
Cash Inflow / (Outflow)	(1,016)	-	(1,678)
Opening Cash Balance	7,434	1,252	9,112
Closing Cash Balance	**6,418**	**1,252**	**7,434**

NHS
Countess of Chester Hospital
NHS Foundation Trust

Item Reference and Title	**Agenda item 10 (b)** - Financial Plan 2019/20 Update
Date of Meeting	Board of Directors - Tuesday 25th June 2019
Accountable Executive	Executive Director of Finance - Simon Holden
Author(s)	Mr. Simon Holden, Director of Finance Mrs. Sue Phillipson, Head of Financial Management
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 paper is an update to the Financial Plan paper submitted to the Trust Board on 26th March 2019. The first paper depicted the financial plan rejecting the control total. Subsequent negotiations have made it possible to accept the Control Total and this paper outlines the updated budgetary position for 2019/20, in line with the formal submission of the Final Plan on 4th April 2019.
Recommendation(s)	**The Board is asked to note:** o The underlying projected Trust deficit of £15.3m has been in part mitigated by additional WCCCG funding of £3.65m and a further £3.65m internal CRS requirement. Both adjustments combined has facilitated the ability to now accept the PSF/FRF/MRET funding of £8m and deliver the NHSI agreed control of a balanced outturn; o The setting of a 5% internal stretch Cost Reduction Scheme (CRS) target equating to £11.2m this being above the NHSI plan target of £9.4m reflecting the need for headroom for unknowns and slippage; o Details of both current, and new, cost pressures addressed within the 2019/20 plan; o The underlying assumptions in relation to the production of the 2019/20 plan; and o A number of potential risks and mitigations in relation to 2019/20 plan. **The Board is, therefore, asked to formally approve the Trust's Updated 2019/20 Financial Plan.**

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 PLAN 2019/20

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Appendices

1) Introduction

This paper outlines the updated planned budget for 2019/20 in line with the final NHS Improvement (NHSI) Annual Plan submission on 4th April 2019, and includes details on:-

- The developments that have happened to enable acceptance of the Balanced I&E control total;
- The pressures that have been recognised and funded, within the budget plans;
- The setting of a 5% CRS equating to £11.2m;
- How the efficiency target of £11.2m has been allocated to divisions/departments; and
- The risks that may impact on the Trusts ability to achieve the required CRS of £11.2m and the planned balanced I&E position.

2) Summary of the Trust's Balanced I&E Position

The Trust is facing significant financial pressures in 2019/20 which initially resulted in a budget delivering a deficit position of £15.3m and the inability to accept the breakeven control total after the receipt of £8m PSF / FRF/ MRET funding of £8m, as there was still a gap of £7.3m.

Further discussions with Western Cheshire CCG have secured additional income to the Trust of £3.65m and it was agreed at the Trust Board that internally the Trust would plan to deliver a further £3.65m of cost savings. Both adjustments mitigating the gap of £7.3m and meaning that the Trust could now accept the balanced I&E control total position and therefore receive the £8m PSF / FRF / MRET funding.

Please find below a high level summary of the overall Trust budget for 2019/20;

	Budget 2019/20 £000s
Income	
Commissioner Income	£218,680
Training & Education Income	£ 6,793
Other Income	£ 17,179
Total Income	**£242,652**
Expenditure	
Pay	£175,100
Non Pay	£ 78,033
Capital Charges	£ 6,972
Total Expenditure	**£260,105**
Net Deficit	**£ 17,453**
CRS for 2019/20	**£ 9,427**
Planned Net Deficit	**£ 8,026**
Adjust for Donated Asset Income	£ 200
Adjust for Donated Asset Depreciation	£ 186
Adjusted Planned Net Deficit	**£ 8,040**
PSF/FRF/MRET Funding	**£ 8,040**
NHSI Agreed Control Total (Deficit)	**£ -**

The table below analyses how the underlying deficit has been built up and shows how the Trust moved from the underlying brought forward deficit from 2018/19 of £19.8m, to the 2019/20 planned deficit of £15.3m (Not Accepting Control Total column) and the subsequent movement to a balanced I&E (Accepting Control Total column). The movement column depicts the main changes and these are also summarised below further.

Description	Not Accepting Control Total £m	Accepting Control Total £m	Movement £m
B/fwd Underlying Deficit from 18/19	4.3	4.3	0.0
2018/19 CRS Recurrent Non Delivery	8.9	8.9	0.0
Current Cost Pressures 18/19 to Deliver Forecast Outturn	4.5	4.5	0.0
Current Income Pressures 18/19 in relation to Forecast Outturn (Drugs & In Year Performance)	2.1	2.1	0.0
Total Underlying deficit 2018/19	**19.8**	**19.8**	**0.0**
Pay Award & Incremental Drift	8.1	8.1	0.0
Non Pay Inflation for 19/20	0.9	0.9	0.0
Income (Tariff)	(7.4)	(7.4)	0.0
CNST (reduced cost)	(0.4)	(0.4)	0.0
Central Procurement savings	(1.3)		1.3
Efficiencies @ 1.6%	(3.6)		3.6
Total National Pressures & Efficiencies	**(3.7)**	**1.2**	**4.9**
Additional costs - NHS property services - assumed Commissioner funded	0.0	0.0	0.0
Vascular risk share - year 2 increase	0.1	0.1	0.0
EPR (Cerner)	0.0	0.0	0.0
Growth - Expenditure to deliver activity increase	3.0	3.0	0.0
Growth - income	(3.0)	(3.0)	0.0
Clinical Excellence Awards 2019/20	0.2	0.2	0.0
New Pressures 19/20	2.4	2.4	0.0
Contract Negotiations	(0.5)	(0.5)	0.0
Remove Medical Pay Reserve	(2.1)	(2.1)	0.0
Additional Efficiencies @ 0.4%	(0.9)		0.9
Efficiencies		(9.5)	(9.5)
Additional WCCCG support		(3.7)	(3.7)
Total Local Pressures & Efficiencies	**(0.8)**	**(13.0)**	**(12.2)**
Total Deficit	**15.3**	**8**	**-7.3**
Less Control Total	**8**	**8**	**0**
Gap to Accepting Control Total	**7.3**	**0**	**-7.3**

Key Movements: -

- Previous Efficiencies of £4.5m (2%) and Central Procurement savings of £1.3m, replaced with a £9.5m Efficiency Plan, incorporating the additional savings requirement of £3.7m to enable acceptance of the control total, summarised as follows: -

Previous Efficiency Plan	£4.5m	2%
Additional Target to facilitate accepting control total	£3.65m	
SUB TOTAL	**£8.15m**	**3.6%**
Add Central Procurement Target	£1.3m	
REVISED TOTAL	**£9.45m**	
INTERNAL STRETCH TARGET	**£11.2m**	**5%**

- Additional West Cheshire CCG support of £3.7m

3) Pressures Funded & Reserves Ring Fenced

The proposed budget includes provision for the following, full details are included as Appendix 1;

- Fully funded mandated cost pressures for 2019/20 of £6.4m;
- Provides a £500k Care Quality Reserve, £700k Contingency Reserve and £75k contingency for the Combined Heat & Power (CHP) downtime;
- Provides Ring Fenced Funds that can be drawn against to address pressures in relation to maternity leave, minor equipment, apprenticeship levy, and other minor quality initiatives;
- Allows for the funding of cost pressures in relation to delivering forecast outturn for 2018/19 of £4.5m, and new pressures identified for 2019/20 of £2.4m;
- Further cost pressures of £1m and £0.2m are funded from Growth Income and other incomes sources respectively;
- There is no additional Medical Pay Reserve for 2019/20, as this has now been utilised to fund cost pressures identified by divisions at budget setting; and
- There is no additional Winter Reserve as this has now been utilised to fund an additional ward, and its associated support costs.

4) Target Savings by Division/Department of £11.2m (5%) – Summary

The internal CRS target for 2019/20 is set at 5%, equating to £11.2m, made up as follows: -

DIVISION	CRS @ 5%
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
Corporate Non Clinical	£ 739,812
Trust Central Services	£ 1,349,133
TOTAL	**£ 11,191,584**
Risk Reserve	**-£ 1,764,951**
REVISED TOTAL	**£ 9,426,633**

Corporate Non Clinical	CRS @ 5%
Finance	£ 77,386
HR	£ 173,369
IMT	£ 278,405
PPD	£ 92,714
Procurement	£ 28,106
Trust Admin	£ 89,832
TOTAL	**£ 739,812**

The 5% Internal CRS Target is a stretch target reflecting the need for headroom for unknowns and potential slippage on some schemes. The Trust holds a risk reserve to partially offset these potential pressures of £1.8m as shown in the above table.

5) Risks

There are a number of risks which could still impact on the Trust's ability to meet its balanced control total including:-

- Ability to deliver recurrently the 5% Cost Reduction Scheme (CRS) of £11.2m;
- New national procurement model expected to deliver £1.3m savings (as per guidance) in Trust's plan for 19/20;

- No provision is included for the impact of the recent change in asset lives guidance in the Trust's plan, resulting in the potential for a further £0.6m pressure;
- No reserves have been ring-fenced for Medical Agency premiums, Winter, Developments or Nursing specifically, other than the Care Quality and Contingency reserves;
- Very limited Contingency at £0.7m (circa 0.3% of turnover)
- Capital availability (including securing the completion of the Urgent Care development);
- Compliance with Constitutional Target standards;
- Maintenance of current improved West Cheshire economy Delayed Transfers of Care (DTOC) standards;
- Lack of any real future Balance Sheet flexibility;
- Medical Pay award assumed to be awarded from October 19 (similarly to 18/19 pay award);
- Impact of HMRC change in policy regarding the direct engagement model;
- Impact of the final agreement regarding the UK's withdrawal from the EU on the supply of staff and clinical supplies; and
- Winter costs continue above the costs identified in the plan, in order to deliver non elective growth.

6) Assumptions

There are a number of assumptions which could also impact on the Trust's ability to meet its balanced control total, including:-

- Commissioner income has been based on month 9 activity. The impact of the new tariff and Market Forces Factor (MFF) changes have been modelled. Assumes Wales will pay at published English National Tariff rates;
- Pay uplift – Agenda for Change (A4C) has been calculated based on published rates, and 2% uplift for Medical staff from October 2019. Actual incremental drift rates have been calculated;
- General Non Pay reserve has been established at £1.3m (1.8% of non pay), but effectively offset against Central Procurement changes;
- Central Procurement savings – non pay budgets have been reduced to reflect the savings identified for the trust of the impact of the updated funding model;
- For Growth, the additional costs have been assumed to be equal to the additional income;
- The efficiency plan has been calculated at 5% of budgets;
- Assumes 2018/19 capital loan will be fully approved, and brought forward;
- Assumes 2019/20 capital loan will be approved;
- Electronic Patient Record (EPR) implementation – assumes no excess costs of implementation above the £5m Global Digital Exemplar (GDE) funding (with any excess being either Charitable Monies, or Capital);
- The impact of changes to NHS pensions for 2019/20 are not included in the current plan; and
- Activity Growth uplift assumptions: -
  - A&E 2.4%
  - Non Electives (exc Paediatrics & Obstetrics) 2.0%
  - Daycases & Electives 2.0%

- Outpatients 2.0%
- Referrals 2.0%

7) Mitigations

Potential mitigations are as follows:

- Care Quality and Contingency reserves are available to support;
- Investment in clinical coding has been made to bring coding depth, and quality, only up to average levels;
- Review of accounting policies;
- Review of Balance Sheet provisions, though limited further opportunity; and
- Identification of system wide schemes.

8) Cash

In 2018/19 the Trust required £6.7m of interim revenue funding to support the deficit position.

Based on the final budget, the Trust will require additional revenue funding to support the position, particularly in the early part of the year due to late phasing of CRS. Based on the process for previous years, interim funding will be available up to the value of the phased deficit. Any adverse variance will result in an adverse movement in working balances (i.e. a requirement to delay payments to creditors). DHSC do not fund these movements without a significant amount of scrutiny which includes the Trust demonstrating that there is a detrimental operational impact, for example, that suppliers are stopping deliveries or threatening legal action.

Additional interim revenue funding could be made available if the Trust were to submit a revised plan during the year, showing a worsening revenue position (as happened in 2018/19), although this would be a significant step.

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

NHSI have informed the Trust that DHSC are currently not approving any capital loans for 2018/19 or 2019/20 and that the Trust may have to use working balances for emergency capital requirements. This would lead to a working balance requirement as detailed above.

9) Next Steps

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

- Driving the development of new CRS schemes, effectively reducing the "Gap" element
- Ensuring that as schemes are identified, and worked up, that there is an impetus to ensure that they are refined and delivered recurrently (i.e. a "shift" left, from black to red, red to amber etc.);
- Review of CRS schemes to ensure that staffing costs, and productivity, are critically challenged;
- Engaging with NHS Improvement, and others (both internally & externally), in seeking assistance to reduce the underlying deficit;
- Actively reflecting on the remaining reserves held centrally to establish whether these could be better managed ; and
- Challenging the Capital Program hard, to establish the absolute priorities (i.e. effectively the 2018/19 commitments brought forward, and also safety concerns), and relating this to the affordability.

Countess of Chester Hospital NHS Foundation Trust

Appendix 1

Mandated Cost Pressures		
Pay Award & Incremental Drift	£	4,973,947
General Non Pay Inflation	£	1,300,000
CEA	£	150,000
Total Mandated Cost Pressures	**£**	**6,423,947**

Ring Fenced Funds / Contingency		
Contingency Reserve	£	700,000
Care Quality Reserve	£	500,000
Maternity Leave	£	350,000
Minor Equipment	£	100,000
Contingency - CHP Downtime	£	75,000
Quality Monies	£	10,000
Total Ring Fenced Funds / Contingency	**£**	**1,735,000**

Appendix 1 (cont'd)

Total Current Cost Pressures Funding Requested by Divisions / Departments				
Division / Department	**Description**	**Where Agreed**	**WTE**	**Amount**
Central	Pay Protection costs from restructures	Divisional Director		£ 57,996
Central	Strategic Healthcare Partnership Contribution	Chief Executive		£ 47,000
Central Total			**-**	**£ 104,996**
Corporate Non Clinical	HR - Additional costs of implementing weekly bank payroll	HR Director		£ 16,914
Corporate Non Clinical	HR - TRAC - License Fee	HR Director		£ 14,400
Corporate Non Clinical	Procurement - Income pressure from cessation of Squadron rebate	Finance Director		£ 111,189
Corporate Non Clinical Total			**-**	**£ 142,503**
D&P	Breast Biopsy Needles	Divisional Director		£ 20,000
D&P	Cleaning Consumables Pharmacy Asceptic Unit	Divisional Director		£ 22,000
D&P	Drugs Stores Issues	Divisional Director		£ 30,938
D&P	IR Consumables	Divisional Director		£ 32,000
D&P	Lab Equip - Immunology MSC	Divisional Director		£ 15,863
D&P	Pharmacist Technician - ED - Band 5 (prev funded via winter monies)	Divisional Director	0.50	£ 16,230
D&P	Pharmacist Technician - MAU - Band 5	Historic Pressure	1.00	£ 32,460
D&P	Phlebotomy Support Workers - Band 2	Divisional Director	3.00	£ 35,000
D&P	ST3 Radiology ST3	Medical Director	1.00	£ 44,000
D&P Total			**5.50**	**£ 248,491**
Nurse Management	Divisional funding Band 8a	Nursing Director	0.33	£ 18,000
Nurse Management Total			**0.33**	**£ 18,000**
Planned Care	3 way rota - Plastics & ENT ST1/2	CLG	2.00	£ 130,000
Planned Care	3 way rota - T&O ST1/2	CLG	3.00	£ 195,000
Planned Care	Community Paediatric Medical - ADHD diagnosis forms	Divisional Director		£ 1,575
Planned Care	Diabetic Retinopathy -incorrect income accrual	Historic Pressure		£ 70,878
Planned Care	Drugs Stores Issues	Divisional Director		£ 190,335
Planned Care	GP Rotation - F2 posts over funded establishment	Medical Director	2.00	£ 78,000
Planned Care	HSDU income pressure from cessation of Spire Yale contract	Divisional Director		£ 50,000
Planned Care	Income pressure from reduced private patient income	Divisional Director		£ 34,000
Planned Care	Income pressure from UK Birthing Centre	Historic Pressure		£ 29,653
Planned Care	ODP - University training course fee costs	Historic Pressure		£ 9,250
Planned Care	Ophthalmology O.P.D. - Low Vision Aids	Divisional Director		£ 14,000
Planned Care	Orthodontics - Dental Surgery Sundries	Divisional Director		£ 16,000
Planned Care	Orthodontics - ST3 post	Historic Pressure	0.60	£ 46,200
Planned Care	Paediatric Diabetes Specialist Nurses Network subscription BPT	Divisional Director		£ 7,829
Planned Care	Premium Rates for Theatre Nursing Staff	Divisional Director		£ 300,000
Planned Care	Separation of Critical Care & Vascular rotas - Critical care F2s	Smart Board	2.00	£ 112,000
Planned Care	Separation of Critical Care & Vascular rotas - Vascular F2s	Smart Board	4.00	£ 180,000
Planned Care	Theatres Anaesthetics - M&S Sundries	Divisional Director		£ 21,000
Planned Care	Theatres Gynaecology Electrosurgical Equipment	Divisional Director		£ 79,000
Planned Care	Theatres Ophthalmology - Optical items	Divisional Director		£ 152,000
Planned Care	Theatres Plastics - Breast Tissue Expanders	Divisional Director		£ 35,000
Planned Care	Tower Ward (53) - hire of equip	Divisional Director		£ 14,000
Planned Care	Trauma And Orthopaedics - purchase of EMG / EEG tests	Divisional Director		£ 17,000
Planned Care	Urology - Urolift new procedure	Historic Pressure		£ 36,000
Planned Care	Urology ST1/2 training posts, previously HEE funded	Historic Pressure	2.00	£ 130,000
Planned Care	Urology Unit - needles	Divisional Director		£ 24,000
Planned Care Total			**15.60**	**£ 1,972,720**

Division / Department	Description	Where Agreed	WTE	Amount
Urgent Care	A&E Medical Agency pressure	Medical Director		£ 600,000
Urgent Care	Acute Capacity Pot	Divisional Director		£ 63,000
Urgent Care	AMU Consultant, impact of restructure	Chief Executive	0.07	£ 6,525
Urgent Care	Bluebell - ward consumables for increased bed numbers	Divisional Director		£ 10,220
Urgent Care	Care of the Elderly - Consultant	Chief Executive	0.60	£ 66,000
Urgent Care	Care of the Elderly - Ward 54 cover - ST1/2 posts, (prev winter monies)	Divisional Director	2.00	£ 115,663
Urgent Care	Cath Lab Pacing Consumables	Divisional Director		£ 167,779
Urgent Care	Clatterbridge Oncology reduced SLA pressure	Divisional Director		£ 66,916
Urgent Care	COTE Capacity Pot	Divisional Director		£ 63,000
Urgent Care	Diabetic Liaison - Band 6 (prev mat leave cover)	Divisional Director	0.53	£ 19,410
Urgent Care	Discharge Lounge - Patient Flow Assistant - Band 2 (prev funded via winter monies)	Divisional Director	1.00	£ 22,212
Urgent Care	Divisional funding Band 8a	Divisional Director		£ 15,950
Urgent Care	Drugs Stores Issues	Divisional Director		£ 311,439
Urgent Care	ESD Rapid Response - Band 5 nurse (prev CCG funded)	Divisional Director	0.64	£ 24,394
Urgent Care	ESD Rapid Response - Band 6 nurse (prev CCG funded)	Divisional Director	1.24	£ 50,181
Urgent Care	General Medicine (A&E) - F1 post	Medical Director	1.00	£ 40,433
Urgent Care	GPU - Band 4 re Ambulatory Care & GPU merger	Historic Pressure	0.64	£ 17,164
Urgent Care	GPU - Band 5 re Ambulatory Care & GPU merger	Historic Pressure	0.96	£ 33,249
Urgent Care	Medical Secretary Paediatrics Band 2	Divisional Director	0.60	£ 13,049
Urgent Care	Nurse Specials	Nursing Director		£ 100,000
Urgent Care	Pharmacist Ward 51 - Band 7 1.00 wte	Divisional Director		£ 34,347
Urgent Care	Respiratory Medicine GP Rotation Post ST1/2	Medical Director	1.00	£ 60,653
Urgent Care	Ward 34 - ward consumables for increased bed numbers	Divisional Director		£ 8,796
Urgent Care	Ward 46 / 47 - Amalgamation of 2 wards - Band 2 nurses	Nursing Director	4.80	£ 102,019
Urgent Care	Ward 46 / 47 - Amalgamation of 2 wards - Band 6 nurse	Nursing Director	1.00	£ 41,266
Urgent Care Total			**16.08**	**£ 2,053,666**
Grand Total			**37.51**	**£ 4,540,376**

Total New Cost Pressures Funding Requested by Divisions / Departments				
Division / Department	**Description**	**Notes**	**WTE**	**Amount**
Central	Apprenticeship Levy increased top slice			£ 40,000
Central	Discontinuation of Prompt Settlement Discount			£ 30,000
Central	Integrated Care Programme Contribution			£ 131,290
Central	Lead Employers Costs (St H&K Junior doctors)			£ 53,216
Central	Salary Sacrifice - reduced income re tax changes			£ 40,000
Central	VAT on revaluation , not allowed as no Subsidiary Co.			£ 600,000
Central Total			**-**	**£ 894,506**
Corporate Non Clinical	HR - Practice Development Nurses Band 6 - Staff Retention		1.80	£ 64,218
Corporate Non Clinical	IMT - IT Cyber Security	Business Case Required		£ 35,000
Corporate Non Clinical	IMT - License Fee	Business Case Required		£ 10,000
Corporate Non Clinical	IMT - Office 360 migration	Business Case Required		£ 90,000
Corporate Non Clinical	IMT - Penetration Testing (risk management)	Business Case Required		£ 10,000
Corporate Non Clinical	IMT - SOPHOS upgrade & license compliance			£ 10,000
Corporate Non Clinical	PPD - Clinical Coding Team Service Review		2.68	£ 98,104
Corporate Non Clinical	PROCUREMENT - Commercial Procurement - Additional Income			-£ 155,661
Corporate Non Clinical	PROCUREMENT - Commercial Procurement - Band 7		1.00	£ 46,441
Corporate Non Clinical Total			**5.48**	**£ 208,102**
Planned Care	Breast Surgery Consultant appointment - Resilience		1.00	£ 72,500
Planned Care	Bulkamid - change in clinical practice (NICE)			£ 24,005
Planned Care	ICM (Intensive Care Medicine) Trainee - change of 3 F2 posts to 3 CMT2/ST1/2 posts			£ 43,000
Planned Care	ICM (Intensive Care Medicine) Trainee - change of ST1/2 post to ST3/5			£ 28,000
Planned Care	ICU - Continuing Professional Development			£ 12,500
Planned Care	Paediatric EEG tests referred to Alderhey, increased demand			£ 35,000
Planned Care Total			**1.00**	**£ 215,005**
Urgent Care	1 PA increase for Palliative Care Consultant		-	£ 13,406
Urgent Care	Band 6 OT Ward 54 - Bed Reconfiguration		1.00	£ 40,398
Urgent Care	Care of the Elderly Consultant - Bed Reconfiguration		1.00	£ 120,534
Urgent Care	Diabetes Consultant - Bed Reconfiguration		0.60	£ 67,693
Urgent Care	Nursing Investment Paper Ward 50 & 51		27.80	£ 775,000
Urgent Care	Pharmacist Band 8a - Bed Reconfiguration		1.00	£ 57,542
Urgent Care Total			**31.40**	**£ 1,074,573**
Grand Total			**37.88**	**£ 2,392,186**

Total New Cost Pressures Funding Requested by Divisions / Departments Funded from Growth Income			
Division / Department	**Description**	**WTE**	**Amount**
Planned Care	Paediatrics - ST1/2	2.00	£ 130,000
Planned Care	Paediatrics - Consultant	0.20	£ 47,899
Planned Care	Paediatrics ST3	2.00	£ 154,000
Planned Care	Endoscopy - Band 2	1.92	£ 41,242
Planned Care	Endoscopy - Band 5	2.00	£ 74,908
Planned Care	Consultant appointment for 12 months in Urology	1.00	£ 133,000
Planned Care	Jubilee - Ward Staff Band 5	5.20	£ 240,495
Planned Care Total		**14.32**	**£ 821,544**
Urgent Care	Dermatology Specialist Nurse Band 7	1.00	£ 43,567
Urgent Care	Band 7 Diabetes Nurse	1.00	£ 54,890
Urgent Care	Band 6 Diabetes Nurse	2.00	£ 92,000
Urgent Care Total		**4.00**	**£ 190,457**
Grand Total		**18.32**	**£ 1,012,001**

Total New Cost Pressures Funding Requested by Divisions / Departments Funded from other Income Sources			
Division / Department	**Description**	**WTE**	**Amount**
Planned Care	Orthodontic BC - Dental Nurse Band 4	0.80	£ 21,227
Planned Care	Orthodontic BC - extra equipment / consumables		£ 24,663
Planned Care	Orthodontic BC - Orthodontic Therapist post Band 6	1.00	£ 38,754
Planned Care	Paediatric - ASD Co-ordinator / Admin Post - Band 4	1.00	£ 31,974
Planned Care	Paediatric - ASD (Autism Spectrum Disorder) Psychologist - Band 8a	1.00	£ 62,898
Planned Care Total		**3.80**	**£ 179,516**
Urgent Care	Stroke ESD budget to come from CCG Band 4	1.00	£ 32,198
Urgent Care Total		**1.00**	**£ 32,198**
Grand Total		**4.80**	**£ 211,714**

Countess of Chester Hospital NHS Foundation Trust

Item Reference and Title	**Agenda item 11** - National Cost Collection (NCC) 2019 pre-submission report
Date of Meeting	Board of Directors - Tuesday 25th June 2019
Accountable Executive	Simon Holden, Director of Finance
Author(s)	Gavin Rush, Costing Accountant
Alignment to Board Assurance Framework risk	CR7 - Failure to maintain robust corporate governance and overall assurance Risk Score 9
Alignment to CQC Domains	Effective/ Well Led
Document Previously Considered by:	n/a
Summary	This report is intended to: Seek agreement of the costing process in place for the National Cost Collection (NCC) 2019, previously reference costs. As part of 2018/19 National Cost Collection a requirement of NHS improvement & DoH is for the Board to approve the costing process that supports these submissions. This Paper will summarise the trusts costing procedures, changes in the guidance and new requirements. In the Summer of 2019 the trust intends to submit: o Patient Level Information Costing (PLICs) for inpatients, outpatients & Accident and Emergency o Traditional Reference costs for all other areas.
Recommendation(s)	**The Board is asked to** review the costing plan and supporting information provided to ensure that it meets the expected requirements noted in the Approved Costing Guidance
Corporate Impact Assessment:	**Legal and regulatory impact:** This costing submission is mandated as part of the NHS provider Licence **Financial impact:** **Patient Experience/Engagement:** **Risk & Performance Management:** **NHS Constitution/Equality & Diversity/Communication:**

The Scope of Cost Returns

These mandatory costs collections have been used to set prices since Payment by Results (PBR) were introduced in 2003/04 & the scope extended from Inpatient specialty averages to most services now being covered (Inpatient, Outpatient, A&E, Critical Care, Direct Access, Community, Mental Health and Education & Training). The Costing Transformation Program (CTP) is a new initiative from NHS improvement (NHSi) with the objective of improving costing systems across the NHS. The CTP is mandatory for 2019, and has replaced the inpatient, outpatient and A&E elements of reference costs and education and training submissions.

The data collected, either reference costs or at a patient level, is the source data for work by NHS Improvements Model Hospital Team and work on Use of Resources by both NHS Improvement and the Care Quality Commission. Therefore, the Board assurance process has been updated to reflect the importance of these cost submissions and raise the profile of costing across the organisation, especially at a senior level

Limitations of the National Cost Collection (NCC)

- Welsh activity is currently excluded from NCC. The Countess of Chester is unique in the amount of welsh activity we see for an English Hospital, with around £26m of income relating to Wales.
- Matching income to expenditure, as a result they are some areas excluded (such as private patients). This is in line with the reference cost guidance.
- Timeliness. NCC provides a retrospective view on costs and activity, and although useful in making comparisons with other trusts the submission does not other any inside to the current performance of the trust.

Key Changes to the National Cost Collection (NCC)

In 2019 all acute trusts are required to submit a PLICs submission for inpatients, outpatients and A&E, as a result minimal changes have been made to the NCC to try and reduce the burden on the sector. The trust will not be required to provide submission of Spells activity and costs for 2018/19 or calculate excess bed days. There is no requirement for trusts to submit Education and Training costs for 2018/19; however trusts are still expected to complete this exercise.

For the 2018/19 cost submission trusts are required to submit costs for incomplete spells. Any spells starting before 01/04/2018 will only have costs submitted from 1st April, and any spells ending after 31/03/2019 will have costs submitted up to 31st March. This is a change to previous years where costs have been submitted for all spells ending in the relevant financial year. The table in **Appendix A Changes to the National Cost Collection in 2019** summarise the changes.

National Costing Standards & Guidance

Costing Principles

The seven costing principles support the costing process described in the Healthcare costing standards for England and describe what good costing looks like. The Countess has a dedicated costing accountant within the income and contracts team to ensure that these principles are upheld, more detail around this can be found in Appendix C.

Good costing should…		1	…be based on **high quality data** that supports confidences in the results
2	… **include all costs** for an organisation and produce reliable and comparable results	3	… show the **relationship between activities and resources** consumed

4	… involve **transparent processes** that allow detailed analysis	5	… focus on **materiality**
6	… be **consistent across services,** enabling cost comparison within and across organisations	7	… **engage clinical and non-clinical stakeholders** and encourage use of costing information

Plan for Submission

The trust is required to produce the required costing submission by the end of the week commencing 29th July; we are able to submit anytime that week. The costing submission will be reviewed by the Director of Finance on Monday 29th July allowing the rest of that week for any changes or to review the costing data.

Prior to the National Costing Collection being undertook we will produce internal cost reports by specialty and point of delivery for review by the board, divisional manager, clinical leads, business partners and other key personnel. This will provide an opportunity for any feedback around the costing process. Going forward these reports will be produced quarterly and will be subject to regular review

As part of the National Cost Collection transition program NHS Improvement have set out information requirements over the next 3 years. A copy of the trusts gap analysis can be found in Appendix D along with details around the missing data items required for reporting in 2019. The main areas to note are:

- Ward Stays This data is based on when a patient moves wards; however this does not represent a new episode. As a result there may be some matching issues in reporting ward stay/costs by episode. This is still under development and may change prior to submission.
- Theatres Theatres data only contains time stamps so there are some data quality issues when patients are in theatres over midnight. There are also data quality issues around how accurately the data is being entered and missing entries.
- Cerner The introduction of Cerner may impact on our complacence with future costing submission.

In order to meet the NCC requirements the costing team are in the process of installing a new costing system, although the system itself came with no upfront costs there is an annual licence fee and investment was required in IT infrastructure to support the PCG costing system. There has also been investment in the information team to meet the information requirements outlined above. There has been no additional investment in the costing or finance team to deliver the NCC.

Audit Outcomes

The Trust was subject to a light touch audit in January 2018 which reviewed the overall accuracy of the 2016/17 reference cost submission. This audit specifically looked at:

Board engagement

- Costing process approval
- Reference costs submission brief
- Published Reference costs brief

Most recent audit and action plans

- Last three audit reports
- An update on all actions identified in these audits and the final outcome

The trust was deemed to be compliant and no additional action or audit is required at this time.

Board approval and Finance Director sign-off

In accordance with the costs collection guidance the Director of Finance is responsible for the accurate completion of the reference cost return. The reference costs submission should be subjected to the same scrutiny and diligence as any other financial returns submitted by the Trust.

The Board of the Countess of Chester are asked to confirm the following in relation to the reference cost return:

a) the board or its appropriate sub-committee has approved the costing process ahead of the collection
b) the finance director has, on behalf of the board, approved the final national costs collection return before the final submission
c) the return has been prepared in accordance with the Approved Costing Guidance, which includes the national costs collection guidance
d) information, data and systems underpinning the national costs collection return are reliable and accurate
e) there are proper internal controls over the collection and reporting of the information included in the national costs collection, and these controls are subject to review to confirm that they are working effectively in practice
f) costing teams are appropriately resourced to complete the national costs collection return, including the self-assessment quality checklist and validations, accurately within the timescales set out in the guidance.

Appendix

Appendix A - Changes to the National Cost Collection in 2019

Guidance document Change Support the development of price-setting Acute services	Reference costs	PLICS
Antenatal visits: NHS England has been working with the maternity data but was unable to clearly identify all elements of the maternity pathway. Antenatal and postnatal visits will now be submitted as outpatients or in the CHS tab in the NCC workbook, depending on the appointment's setting. We would like to collect a memorandum collection of all antenatal and postnatal visits by setting. This will help trusts locally with commissioning if the non-mandatory tariff is not used.	✔	✔
Excluded prostheses costs: NHS England is working towards a tariff for prosthetic limb fitting services and prosthetic limbs. To help this process, a simple breakdown of the excluded cost is required in the memorandum tab in 2019.	✔	
High cost drugs and homecare drugs: The national cost collection requires some drugs to be categorised as 'high cost'. For PLICS they are identifiable within the patient activity and for reference costs they must not form part of the HRG cost and must be submitted separately. The list in Annex A of the 2019/2020 national tariff document will be used to identify which drugs should be categorised as 'high cost' for both collections. This list has been reviewed by the High Cost Steering Committee and significantly changed. In the high cost drugs (HCD) tab in the NCC workbook there will be a new department called 'HC' to enable trusts to submit high cost drugs that are dispensed as homecare. The remaining 'homecare' drugs should be excluded from the collection. This guidance document has a new section (15: Pharmacy and medicines prescribed) to help with the process of submitting these costs; see Table 25. There is a new collection resource to enable clearer identification of high cost drugs in the submitted data.	✔	✔
HeartFlow analysis: HeartFlow6 is a new diagnostic innovation where a scan produces a 3D visualisation of the heart and blood flow, reducing the need for a patient to undergo invasive investigations. To help the NHS Improvement tariff and pricing team we ask three questions in the NCC workbook survey to identify trusts that provide this new procedure and whether they are willing to work with us on future cost collections.	✔	
IVF drugs: NHS England is working on in vitro fertilisation (IVF) tariffs and needs to understand more about IVF drugs. A memorandum breakdown of the excluded costs will be required in 2019. The costs should still be excluded.	✔	
Improve data quality, validation and assurance	**Reference costs**	**PLICS**
Board assurance: To strengthen the compliance with costing principle 77 NHS Improvement has strengthened the 'board assurance and sign off' in Section 3: Regulatory requirements and standards.	✔	✔

Merging trusts: NHS Improvement has worked with NHS Digital to understand the technicalities for merging trusts and the submission of their national cost collection. Guidance is now included on their submission of PLICS files to NHS Digital.		✔
Provider-to-provider agreements: The standards do not distinguish between services contracted in or out between the private sector and the NHS. The cost collection guidance has always 'assumed' that costs of, and income from, providing services to other NHS trusts will net off without affecting the total cost quantum. Queries were received during the 2018 collection period on how to deal with surplus and deficits made from supplying goods or services to other NHS trusts. We have clarified that the quantum should not be adjusted for any surplus or deficit made from these activities in line with the guidance for 'other income from non-patient care activities'. Where known, profits and deficits from provider-to-provider agreements should be given in the memorandum sheet in the NCC workbook.	✔	✔
Reconciliation statement: We are continuing to improve the guidance on how to complete the reconciliation statement. The section on reconciliation is now much earlier in the guidance (Section 4: Reconciliation) and has been simplified.	✔	✔
Reference cost grouper: A new grouper will be produced and released by the NHS Digital casemix team in the spring for use in the 2019 collection.	✔	✔
Ensuring the collection remains fit for purpose	**Reference costs**	**PLICS**
Minor amendments will be made to the guidance following analysis of the queries received during the 2018 submission, and the feedback on the draft guidance engagement in 2019.	✔	
Where the standards give specific guidance for a service, we will bring the cost collection guidance together for that service and refer to the standards for the costing process to be followed.	✔	
There are no significant changes for the mental health, community or ambulance sectors. The guidance will be updated and enhanced where appropriate for 2019.	✔	
Support the transition to patient level costing	**Reference costs**	**PLICS**
Collection of complete and incomplete episodes in PLICS: Following the engagement on the draft guidance, NHS Improvement has agreed to support the request to bring forward the collection of complete and incomplete episodes in the PLICS collection of APC data. Please follow the guidance in 'PLICS admitted patient care' in Section 2: Scope of activity and cost data to be collected in 2019. Other sectors submitting inpatient episode data should follow the guidance in ': scope of activity for reference cost submissions' in Section 2.		✔

Appendix B – The NHS Provider Licence

The License contains obligations for providers that will allow NHSi to fulfil its duties. Including capturing information (including cost information) in line with guidance, requirements to submit this information to NHSi and providing assurance on accuracy.

Pricing Condition 1: Recording of information	Under this licence condition, Monitor may oblige licensees to record information, particularly information about their costs, in line with guidance to be published by Monitor.
Pricing Condition 2: Provision of information	Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to Monitor.
Pricing Condition 3: Assurance report on submissions to Monitor	When collecting information for price setting, it will be important that the information submitted is accurate. This condition allows Monitor to oblige licensees to submit an assurance report confirming that the information they have provided is accurate.
Pricing Condition 4: Compliance with the National Tariff	The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for NHS health care services. This licence condition imposes a similar obligation on licensees, i.e. the obligation to charge for NHS health care services in line with the National Tariff.
Pricing Condition 5: Constructive engagement concerning local tariff modifications	The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to Monitor for a modification.

Appendix C – COCH's application of costing principles

Principle	Principle Description	Application
…be based on **high quality data** that supports confidences in the results	Accurate costing relies on the quality of the underlying input data	The main patient activity used for PLICs and reference costs are from the same source used in our PBR process that has undergone Internal and Audit Commission audits in recent years. The reference cost submission also underwent an Audit Commission Audit of the 2009/10 submission. Where there are known issues with data quality steps have been taken to reduce the impact this can have on costing information (for e.g. where theatre time is not accurate an average procedure time is used in its place)
… include all costs for an organisation and produce reliable and comparable results	This is the total cost an organisation's cost model should reconcile to its audited accounts.	All expenditure purposes should be traceable to the activities it has been allocated to and then traceable to the patient episode, contact or attendance the cost activity has been matched to. Any costs that cannot be allocated to an activity should be reported under 'cost and activity reconciliation items'. This totality ensures a consistent baseline for each organisation.
… show the **relationship between activities and resources** consumed	Costing should be based on an understanding of causality to minimise its subjectivity	Allocation methods meet the highest level achievable based on best practise within the constraints of the information & resources available
… involve **transparent processes** that allow detailed analysis	Costing should be transparent & auditable	The flow of activity is documented through the costing system of data transfer process. Any changes for Reference costs outside the system are also documented by the system administrator
… focus on **materiality**	Costing effort should be focused on material costs and activities	Agreement with divisions & allocation development is focused on areas with largest financial value
… be **consistent across services,** enabling cost comparison within and across organisations	For some costing purposes, a consistent approach is required across or within organisations	For Reference Costs all costs will be mapped to standard groupings. Where national guidance is unclear clarification is sought from local reference groups or DH directly. Team members attend periodic national costing events allowing best practise to be shared & networks to be established.
… **engage clinical and non-clinical stakeholders** and encourage use of costing information	Effective costing requires input from a wide range of stakeholders, including non-finance staff	The implementation of PLICs involved extensive consultation with service leads. The system is reviewed on a continuous basis. Meetings with Finance leads of each division are scheduled each month which identifies changes or improvements needed. Further 'deep dives' take place during each year where activity, coding, allocations & income distribution are reviewed and presented to service teams. SLR information is included in trust reporting and has been formally championed by the current medical director

Appendix D – Information Gap Analysis

High Level information Gap Analysis

Feed No	Feed Name	Yr1 Compliance	Notes
1	Admitted patient care	89%	Missing fields have no impact on costing
2	Accident and emergency attendances	68%	Some time and Date fields are missing which could impact how activity is costed
3	Non-admitted patient care	79%	Missing fields have no impact on costing
4	Ward stay	83%	Matching rules will need to be applied, this could impact the cost of an episode
5	Non-admitted patient care – did not attend	100%	Not Applicable
6	Critical care – neonatal	79%	Missing fields have no impact on costing, matching rules will need to be applied to report at episode level
6	Critical care – paediatrics	100%	Not Applicable
6	Critical care – adults	67%	Critical care activity code is required and weighting will need to be developed for future submissions, matching rules will need to be applied to report at episode level
6	Critical care transport	100%	Not Applicable
7	Supporting contacts	100%	Required for Year 3 (Summer 2021)
8	Pathology	100%	Required for Year 2 (Summer 2020)
9	Blood products	100%	Required for Year 2 (Summer 2020)
10	Medicines dispensed	46%	Matching rules will need to be applied to report at episode level
11	Clinical photography	100%	Required for Year 3 (Summer 2021)
12	Diagnostic imaging	100%	Required for Year 2 (Summer 2020)
13	Theatres	27%	Data quality issues could impact the quality of costing
14	Cancer multidisciplinary team (MDT) meetings	67%	Based on numbers supplied by the Cancer team - there is no robust method for identifying or recording this activity
15	Prostheses and high-cost devices	100%	Required for Year 3 (Summer 2021)
	Total	**71%**	

Missing fields for year one requirements

Feed name	Field name	Comments	Count
Admitted patient care	Contracted-in indicator	Not Applicable	1
	Organisation identifier (patient pathway identifier issuer)		1
	Patient pathway identifier		1
	Consultant episode completed indicator code	Derived Field	1
Sub-total			**4**
Accident and emergency attendances	Consultant code		1
	Contracted-in indicator	Not Applicable	1
	Contracted-out indicator	Not Applicable	1
	Healthcare professional code		1
	Patient discharged flag		1
	Time decision taken to admit		1
	Time in department		1
	Time to admission		1
Sub-total			**8**
Non-admitted patient care	Contracted-in indicator	Not Applicable	1
	Direct access flag		1
	Multidisciplinary flag	By HRG Code	1
	Multiprofessional flag	By HRG Code	1
	Organisation code (patient pathway identifier issuer)	Not collected - 18 weeks	1
	Patient pathway identifier		1
Sub-total			**6**
Ward stay	Contracted-in indicator	Not Applicable	1
	HDU bed on a general ward		1
Sub-total			**2**
Critical care – adults	Contracted-in indicator	Not Applicable	1
	Core episode number		1
	Critical care activity code		1
	Critical care episode number	Not Applicable	1
	Non-intensive care unit patient flag		1
Critical care – neonatal	Contracted-in indicator	Not Applicable	1
	Contracted-out indicator	Not Applicable	1
	Non-intensive care unit patient flag		1
Sub-total			**8**

Medicines dispensed	Date of prescription		1
	Dispensing healthcare professional code		1
	Episode/attendance/contact ID	Manual/Matching	1
	High cost drugs (OPCS)		1
	Requesting healthcare professional code	Manual/Matching	1
	Requesting location code		1
	Requesting Treatment function code (TFC)	Manual/Matching	1
Sub-total			**7**
Theatres	Anaesthesia duration	Derived Field - Data Quality Issues	1
	Contracted-in indicator	Not Applicable	1
	Contracted-out indicator	Not Applicable	1
	Healthcare professional code	Data Quality Issues	1
	Number of staff in theatre		1
	Operation start date and time		1
	Recovery duration	Derived Field - Data Quality Issues	1
	Theatre duration	Derived Field - Data Quality Issues	1
Sub-total			**8**
Cancer multidisciplinary team (MDT) meetings	Month and year meetings held	As Per Manual Spreadsheet - Annual Totals not monthly	1
Sub-total			**1**
Grand Total			**44**

Appendix E – 2018/19 Nation Cost Collection Timetable

Date	Milestone
27th February	National cost collection guidance for 2019 published
27th February	Draft NCC workbook and PLICS specification documents released
March	Testing – NCC workbook
March	Release of HRG4+ 2018/19 reference costs grouper and documentation
April	Release of NCC workbook
31st May	Data validation tool release for acute and ambulance sector17
17th June	National cost collection window opens
29th July	Countess of Chester Submission Week
23rd August	National cost collection window closes
October	Resubmission period

The Countess of Chester's named submission week for the NCC is currently the week commencing 29th July 2019.

Appendix F - Links

- The new NHS provider licence
  https://www.gov.uk/government/publications/the-nhs-provider-licence
- National cost collection guidance 2019
  https://improvement.nhs.uk/resources/approved-costing-guidance-2019
- HRG4+ 2018/19 National Cost Collection Grouper
  https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/costing---hrg4-2018-19-reference-costs-grouper

Item Reference and Title	**Agenda item 12** - Strategic Pathology Collaboration Wirral and West Cheshire: Current Positon and Next Steps
Date of Meeting	Board of Directors - 25th June 2019
Accountable Executive	Lorraine Burnett, Chief Operating Officer, CoCH Anthony Middleton, Chief Operating Officer, WUTH
Author(s)	Denise Wood, Head of Information and Performance
Alignment to Board Assurance Framework risk	CR2 - Unable to meet the demand for services within available resources
Alignment to CQC Domains	Well Led
Document Previously Considered by:	Wirral and West Cheshire Pathology Collaboration group
Summary	This report is intended to: • Inform the board of the proposals for a pathology collaboration • Provide further detail on the benefits and risks of the project • Enable an informed discussion
Recommendation(s)	• **The Board is asked to** agree a joint pathology service will be delivered through a NHS Partnership Agreement • The governance and finance model set out in this document • The Countess of Chester will host the aforementioned Partnership
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**

1. Executive Summary

Agreement has already been reached by the Boards of COCH and WUTH to establish a joint pathology service between both Trusts. This collaboration between the two Trusts will deliver against indicative NHSI savings targets, provide operational benefits, address current operational risks by providing a long term sustainable model for future Pathology services and position both Trusts for future broader regional collaboration as part of a wider Cheshire & Merseyside Pathology Network. COCH and WUTH have already successfully delivered significant collaboration and service change in Pathology, releasing costs and improving service delivery and sustainability.

In order to progress the collaboration, the two Trust Boards need to agree the governance structure, the hosting model and financial arrangements for the new joint service. An NHS Partnership model is recommended due to offers the ability to deliver a hosting vehicle with shared responsibility for the combined service. It also avoids the costs associated with other models and is aligned with national direction on joint services.

LTS Healthcare, NHSI's primary advisors on pathology reconfiguration, have assessed the local Target Operating Model and the associated delivery of benefits. The proposed service redesign will result in a shared service hosted by a single Trust, delivered through a joint board, with shared responsibility for service and agreement on financial gain/risk share. Alongside positioning the Trusts for future regional collaboration, benefits will be delivered ahead of those that could be achieved regionally. Potential savings from a joint COCH / WUTH Pathology service will come from pay (salaries and shift payments) and non-pay (reagents and equipment rental). LTS Healthcare, have indicated that OPEX savings of:

- Blood Sciences will save between £618K - £761K depending on the final operating model.
- A joint Histology service could yield a return of £221K per annum but the clinical model has yet to be agreed.
- There is potential to save 20-30% on non-pay spend, principally via a new managed service contract, yielding £1.02-£1.53M.
- This provides an overall saving total of between £1.86M and £2.51M which would require an investment of between £297- 304K. The freeing up of estate on either or both sites is another potential benefit. Importantly, services would be more sustainable.

Hosting has no bearing on where and how the service is delivered. This paper proposes a robust governance structure with transparent financial principles agreed by the two Finance Directors. Split hosting (i.e. different disciplines of the Pathology service hosted by different Trusts) would throw up unnecessary challenges and reduce the potential for efficiency and productivity improvement. The rationale behind this is set out in this report. As such, Trust's have been assessed objectively to determine which is better placed to host the service. In light

of this assessment, and the LTS Healthcare report, it is recommended that CoCH would is better placed to host the service.

The Divisional Triumvirates from both Trusts recommend that the Trust Boards agree;

- That a joint pathology service will be delivered through a NHS Partnership Agreement
- The governance and finance model set out in this document
- The Countess of Chester will host the aforementioned Partnership

2. Background

2.1 Drivers for reconfiguration of pathology services:

A Cheshire & Merseyside Health & Care Partnership (HCP) Diagnostics Executive Oversight Group has been established. Trusts within Cheshire and Merseyside are committed to the Cheshire & Merseyside HCP Pathology Network and a memorandum of understanding has been signed off by the CEOs. WUTH and COCH favor the option of three hub laboratories within the network footprint: Liverpool Clinical Laboratories (LCL [Royal Liverpool, Liverpool Heart & Chest, Liverpool Womens Hospital & Aintree]), St Helens & Knowsley (including Southport, Formby and Ormskirk) and Wirral & West Cheshire Pathology Service (WWCPS). This is option would be delivered as part of the wider regional collaboration plan.

A previous Board paper made the case for a joint service. Wirral & West Cheshire can support regional reconfiguration as well as, deliver local benefits earlier and reduce sustainability pressure on current service.

2.2 Wirral & West Cheshire Pathology Service: Wirral & West Cheshire Pathology Service Transitional Management Team

The respective Executive Teams of Wirral University Teaching Hospital (WUTH), and Countess of Chester Hospital have established a Wirral & West Cheshire Pathology Service (WWCPS) Transitional Management Team (TMT). The overall strategic direction of the WCPS is overseen by the Wirral and Chester Joint Collaborative Board (JCB).

In accordance with the overall strategy for WWCPS, and its ToR, the TMT defines any proposed business plans, business cases, governance model and other relevant details. The TMT also define proposed changes to service delivery models to ensure high quality services, clinical & financial sustainability, delivery against required turnaround times and other parameters defined by the JCB, as well as defining a proposed risk and benefit profile, ownership, form and fee structure policies to be applied to founding Trusts for consideration by the JCB. The proposed governance structure is set out in section 4.1 below

2.3 Current provision of services across WUTH and COCH: WUTH and COCH have successfully collaborated on a number of pathology services, delivering savings and high quality services. Current service provision is detailed in Appendix 1.

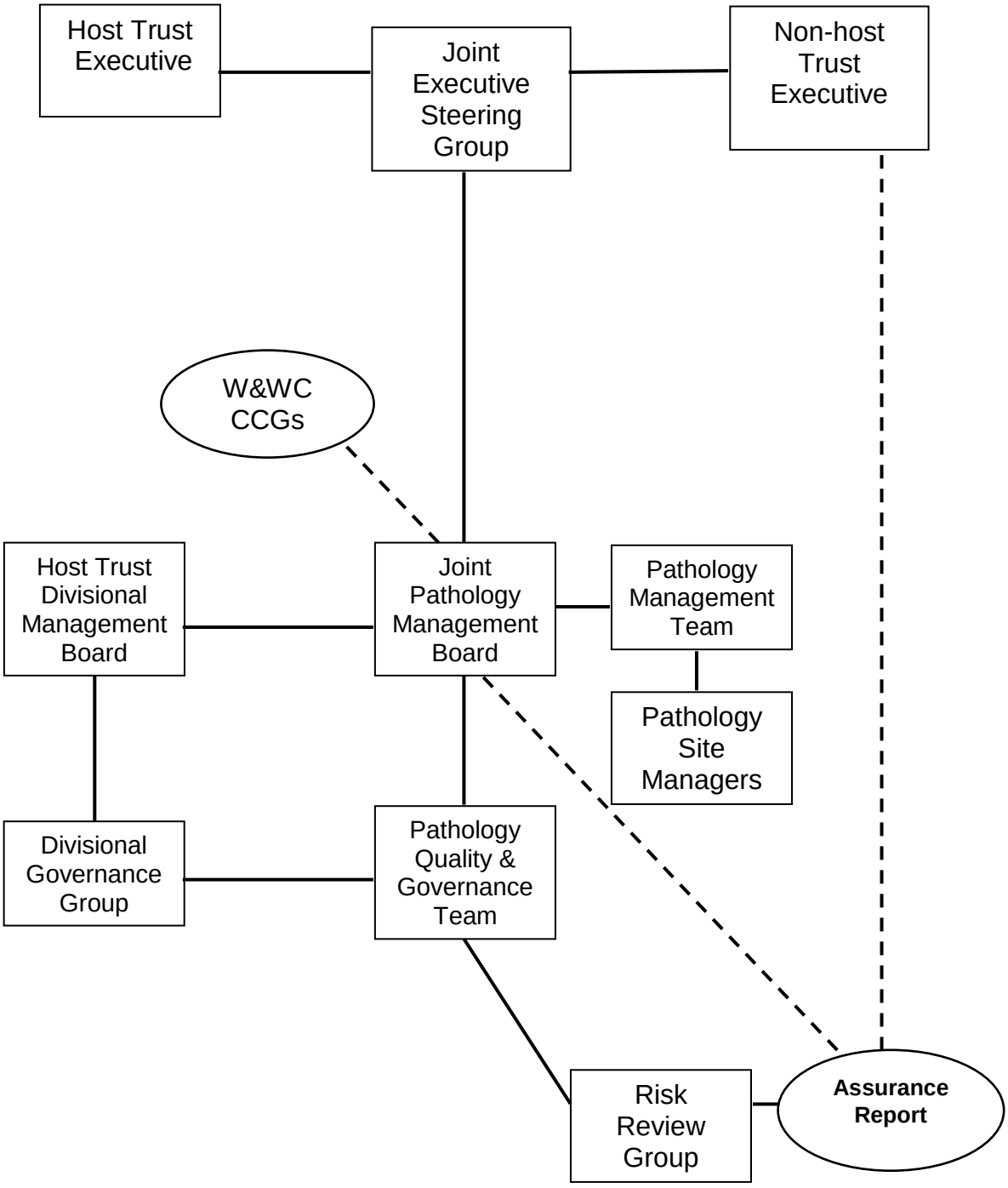
The respective Executive Teams of WUTH and COCH established the Wirral and West Cheshire Pathology Service Transitional Management Team (TMT) to develop a model and case for further collaboration and integration of pathology services between the two Trusts. This has seen Clinical Focus Groups made up of clinical and managerial leads from both Trusts come together to define a model for joint services.

There is further potential to merge the remaining services as outlined in Appendix 2.

3.0 Proposed Governance

The proposed governance structure has been developed on the strengths of the current collaborative work between COCH and WUTH. It was been developed to provide equitable input from both Trust in the management and decision making of the joint service, whilst acknowledging the need for a single host. As such the joint Pathology Service will have a robust governance structure as proposed below. Membership of a Joint Pathology Management Board will include accountable executives from both Trusts. The board will report into the Joint Executive Steering Group.

3.1 Proposed Governance structure



3.2 A proposed Joint Pathology Management Board Membership

The Joint Pathology Management Board Membership would be as follows;

Chair Person	Non-Executive Director
Executive Lead x2	Operational Lead for WUTH and CoCH
Service Director	Pathology Operational Director: Vice Chair
Clinical Director	Jointly appointed Clinical Director
Divisional Directors	WUTH and COCH
Operational Service Leads	Blood Sciences Manager
	Cellular Pathology Manager
	Microbiology Manager
Clinical Service Leads for COCH & WUTH	Blood Sciences Cellular Pathology Microbiology
Commissioners	Wirral & West Cheshire CCG representatives
Principal Finance Partner	Oversight from host and non-host Trust
Procurement Lead	From Host Trust
HR Lead	From Host Trust

The following is noted to give assurance to medical body of each Trust:

- **The service will be jointly run through a joint management board with representatives from both Trusts:**
    - Executives from both Trusts as well as Divisional Medical Director and Divisional Director involvement in the Management Board.
    - Clinical leads for each part of the service will be recruited from each Trust rather than taken from host Trust.

- **No change in service provided to clinicians:**
    - From WUTH perspective there will be no change to ordering or result process, COCH move to Cerner occurring irrespective of plans to bring pathology services together.

- **Service model will support delivery at both sites:**
    - On-site consultant Pathologist, Microbiologist presence.
    - On-site essential and urgent service testing at both sites - moves will be made where it is appropriate to consolidate high volume or specialist testing, increasing local capabilities.
    - Same turnaround times as currently delivered.
    - Clinicians will receive the same clinical advice from the same consultants as now.

The joint service will continue to work with NHSI on the development of further pathology networks across the Cheshire & Merseyside footprint.

4.0 Wirral and West Cheshire Pathology Service Financial Principles

The Executive teams within WUTH and COCH have agreed that there will be a single Pathology service for Wirral and West Cheshire. This will involve the Pathology departments currently serving the two respective Trusts and GP practices merging to form a single service. The single service will be hosted by one Trust. The hosting arrangement is to ensure that the operational and financial benefits of the joint service are maximised, the service will be jointly owned and managed by the two Trusts. It is essential that there is financial transparency and a robust governance structure between the two Trust as set out above.

The following are a set of principles are recommended to ensure this;

- A single virtual budget for the joint Pathology service will be effective from 1st April 2020. The pathology budgets for each Trust will remain on the respective financial ledgers until 31st March 2020.
- Staffing establishments and non-pay budgets will be agreed with a baseline established for 1st April 2020.
- All income related to Pathology services will remain with the respective Trusts. This includes all income associated with GP direct access contracts and SLA. This principle will be subject to annual review.
- The single virtual budget established on the 1st April 2020 will form the financial baseline for the joint service.
- All savings that accrue following the establishment of the financial baseline will be shared on a partnership basis reflective of the drivers for change. The value of the savings will be agreed with the Pathology management team and the Finance teams of both Trusts.
- There is an acknowledgement that to optimise financial and operational efficiencies there may be a requirement to reinvest into the joint service. This will be fully considered when agreeing financial savings.
- All Pathology related pay and non-pay will be hosted on the COCH financial ledger from 1st April 2020 and recharged based on input costs.
- All laboratory related staff (excluding medical staff) will transfer to COCH following the appropriate consultation period. Dates to be confirmed.
- Medical staff will initially remain employed by their current host Trust. This may be subject to change depending on the clinical needs of the service and the most appropriate structure for the medical teams.
- All legacy contracts will novate from 1st April 2020.
- COCH will lead the tender process regional for the procurement of all managed service contracts with effect from 1st November 2019.
- Wirral and West Cheshire Pathology Service will become a virtual separate entity

within the corporate structure of one Trust. WWCP will have a management board and clear reporting and governance arrangements as set out in 4.1. WWCP will have a separate SLA to provide pathology services to both Trusts. These SLAs will be effective from 1st April 2020.

- The contractual value of these SLAs will be agreed with the Chief Finance Officer of both Trusts and will be subject to annual review.
- The financial format of the SLAs and the basis for the sharing of financial risk will be agreed by the CFOs.
- Financial and operational performance will be the responsibility of the WWCP Management Board.
- All business cases relating to Pathology services are subject to approval via the Management Board and individual Trust Boards.
- Each Trust is responsible for ensuring that where changes in clinical practice or known workload changes impact on Pathology, that WWCP are resourced accordingly.
- All investment requirements from 1st April 2020 will be subject to agreement via the WWCP Management Board. The funding and accounting methodology for any investments will be agreed by the CFOs.
- However it is mandated that further work on financial principals and processes will be undertaken through the establishment of a Joint Pathology Finance Working Group (meeting at least monthly). It should also be accepted that these financial principals will need to be refined as the collaborative matures (reflecting an incremental approach).

4.1 Income

Both Trust generate a surplus from Direct Access. It is recommended that both Trusts keep their associated Direct Access and other pathology Income. The joint service would charge back for the cost of testing to both Trusts on a cost times volume basis

4.2 Potential Savings from a single service

An important consideration is the sustainability of the service. There are national retention and recruitment challenges for both scientists and clinical staff. A single hosted service will contain one larger staff group, trained to work on the same equipment across sites, thus providing a more robust service for less

LTS Healthcare has indicated that OPEX savings in Blood Sciences will between £618K and £761K depending on final operating model. A joint histology service would yield a return of £221K per anum but there are concerns about the clinical model and further discussion with the Clinical Focus Group is required. There is potential to save 20-30% on non-pay spend,

principally via a new managed service contract. This would yield £1.02-£1.53M giving an overall saving total of between. The exact amount of saving will depend on which of the different target operating models are chosen. Capital investment for a consolidated histology service would equate to £181,000. Blood Sciences would require an investment of between £116K and £120K.

Whilst managed service contract remain in place until 2022 and both Trusts are now committed to a Cheshire & Merseyside Tender, there will be potential for some small scale savings from 2019.

High level analysis of the proposed model suggests potential savings of between £1.86M and £2.51M across managed service contracts and staffing. Savings will be delivered via joint procurement, moving to a single quality management system, a shared management team, and over time, a significant reduction in general staffing costs as automated and specialist services are consolidated.

The table below sets out these potential savings:

Source	**Spend**	**Potential Savings # range**	**Comment**
Managed Service Contract Tender (Pan pathology in 4/5 lots) including new opportunities	£5.1M	£1.02 - £1.53M	Potential new framework/NHSI Tower or OJEU tender offers up to 30% saving on MES. This will include a reduction in equipment through. Includes new opportunities such as plastics, blood and sample tubes
Staff Savings (Excluding medical, mortuary, phlebotomy and OPAT)	£10.06M	(£0.846m - £1.8	LTS Healthcare has indicated that OPEX savings in Blood Sciences will between £618K and £761K depending on final operating model. A joint histology service would yield a return of ~£221 per anum[#]. Capital investment for a consolidated histology service would equate to £181,000. Blood Sciences would require an investment of between £116K and £120K. Standardisation of order sets, 5% + by Removal of operational management duplication, Quality manager and staff duplication for automated and specialist areas and the standardisation of terms and conditions

Total		**£1.86M - £2.51M**	Split between trusts as per business model. In line with or higher than NHSI target

[#] The clinical model is yet to be agreed and evaluated

The two major constraints to achieving delivery of major savings are the procurement timescale for large managed equipment services within Pathology (large proportion of saving reliant on this and will allow consolidation of work across sites) and COCH moving to Cerner as their Hospital Information System (to allow results and orders to flow between Trusts). Plans are in place for regional procurement, and given work is underway for COCH to migrate to Cerner whereas a regional level IT interoperability has not been addressed – it is thought that a WUTH COCH will be able to deliver savings ahead of a broader regional option for collaboration.

5.0 Key Issues

5.1 Hosting

The WWCPS TMT supports a single Pathology service between both Trusts in which we optimise financial & operational benefits whilst minimising the risk to service. Hosting has no bearing on location of services. Services will be deployed to meet the clinical requirements of both Trusts.

For a single Pathology service to be established, one of the Trusts must take the lead as employer. Consideration must be given to which Trust takes this on. To this end it is important to consider where the key resources and deliverables lie;

- Procurement: The host should have a proven track record in delivering sustainable managed equipment and service contracts that are eligible to recover VAT as per HMRC directives.

- Finance: There needs to be clear delivery models and accounting resource to support pathology as a sustainable business. The team should be able to mitigate any risk with respect to VAT recovery and have capacity to provide proactive support in establishing and managing contracts with suppliers and customers.

- HR: There needs to be resource and expertise to manage staffing in such a way as to support efficient delivery of service models, reducing unproductive staff resource, non-core spend and out of hours costs.

- IT: The host should have a proven track record in delivering IT projects to meet the operational needs of services and facilitate operational work.

The model must facilitate timely delivery and ensure clarity in terms of management, staffing, procurement and performance. Trust Boards need to agree how the service is hosted. The

proposed Joint Pathology Management Board membership set out in 3.2 would give assurance for the non-host Trust that their interests would be protected, in terms of still having sufficient expertise to effectively manage / advise from their end to ensure the service needs of their clinical services were met.

5.1 Evaluation:

The evaluation matrix in Appendix 5 was completed jointly by the Divisional Director at COCH and the Pathology Integration Director, with input from the Divisional Director for Clinical Support at WUTH. This is supported by a SWOT analysis (Appendix 6).

Under evaluation, the Chester hosting model came out marginally better. This is due to their experience with procurement and managed service contracts and VAT reclamation under HMRC guidance as well as the HR track record in delivering change within Pathology services. Furthermore, whilst WUTHs cost per test is lower, COCH's pathology service costs less per head of population and is a much lower percentage of the Trusts operating budget. Both services are accredited by UKAS to ISO15189.

Regardless of which Trust hosts WWCPS, the most important consideration is that neither Trust

is 'giving up' anything.

- The proposed service redesign will result in a shared service delivered across 4 sites and hosted by one Trust.
- The model is one of shared responsibility for the service through a joint board, with agreement on gain share of any financial benefits of the service.

The design of the model does not represent a threat to either Trust, Appendix 1 sets out assurances that can be given to the medical body of each Trust about a proposed joint service. A potential threat of loss of control over service delivery to both Trusts is however seen through failure of COCH and WUTH to reach agreement, with a move to a broader North 4 regionally centralised laboratory service as described in Section 3.3.

The Boards may want to consider a split hosting arrangement, i.e. some services are hosted by COCH, and others by WUTH. This is not recommended for a number of reasons;

- Microbiology is currently jointly hosted: Staff contracts are held by WUTH and WUTH's policies and procedures are followed. Chester holds the financial ledger and manages procurement. Neither management nor staff are entirely happy with this arrangement. There is sometimes a lack of clarity over certain obligations, duplication is terms of risk management governance and finance arrangements. If Blood Sciences, Histology and Microbiology had different host Trusts, some of the aforementioned duplication might take place.

- Staff in different services could be on different terms and conditions with different policies being applied.

- As technologies change (e.g. shifts towards molecular technology) and we rationalise workflow across disciplines with charged reception and processing areas, if the hosting model was based on separate Trusts, it would hamper ability to rationalize workflow.

- Also, single management structure would also be more difficult if disciplines are hosted across Trusts.

- Furthermore, UKAS requires a single legal entity. Therefore, a single quality management system across all disciplines and sites would not be possible, leading to duplication and failure to remove some of the costs that have been identified.

- Split hosting might also confuse the relationship with the wider Cheshire & Merseyside network.

5.2 Vehicle for delivery of a combined Pathology Service across WUTH and COCH:

TMT has explored options for the vehicle for delivery of a combined pathology service across WUTH and COCH. The TMT advised by the Clinical Focus Groups, concerned about a drop in quality and loss of governance ruled out outsourcing models, leaving 2 potential models with 3 configurations. These options were considered in detail; NHS partnership, Wholly Owned Subsidiary or Capital Investment Joint Venture. Details and the evaluation of each model is included in the paper Appendix 4.

Following review of options, the Pathology ***TMT recommends an 'NHS Partnership' between WUTH and COCH***. The main rationale behind a single Trust hosting is to allow the establishment of single working practices across all sites, take advantage of savings on accreditation and allow advantage to be taken of future shifts in workload across disciplines. A special purpose vehicle, jointly owned by both trusts, would equally be able to deliver this. With quotes for set-up costs ranging upwards of £400,000, and given that the financial advantages are not significant, and that the set-up time required creating such a vehicle is considerable (years), the conclusion is that benefits are outweighed by the costs of development. However, upon completion of the service development, there is no reason why the development of a special purpose vehicle to take over the hosting of the service could not be considered if strategic and financial reasons supported such a transition.

As well as avoiding the cost and protracted process of establishing a joint venture as a legal entity, the proposed model acknowledges Department of Health and Social Care guidance that Trusts should pause any current plans to create new subsidiaries and offers a model where both Trusts can agree joint control of the venture and configure services to best meet the requirements of each Trust.

5.3 Target Operating Model

It is proposed, based on evaluation by the clinically led CFGs, that there will be a combined Wirral & West Cheshire Pathology Service delivered over 4 sites (Countess of Chester Hospital, Arrowe Park Hospital, Clatterbridge Cancer Centre and Bromborough St. Helens and Knowsley Hospital). TMT are currently exploring options for a 24/7 Microbiology service with St. Helens and Knowsley Hospital but again there are clinical concerns regarding quality and turn-around times, with work progressing on delivering 24/7 working via the existing WWCPS service. Given the understanding that we may now agree a mutually beneficial working arrangement with staff there is potential to retain the joint microbiology service on the Bromborough site.

There will be a different solution for each discipline that will be designed around the clinical needs of the service and user requirement:

- For the UK Accreditation Service (UKAS) to accredit a joint service, this must be hosted by a single legal entity. This will remove duplication of effort and management cost. Efficiency of operation will also be improved. In order to deliver benefits in line with planned timescales, a decision is required as to which Trust leads on this model as the single employer.

- The target operating model (TOM) encompasses Blood Science laboratories at 3 locations. CCC will have an essential service laboratory, COCH and APH will both provide essential services as well as either specialist services or high volume automated testing.

- The Cellular Pathology service model will begin with joint procurement, included as a ‘lot’ in the upcoming tender, with the option of transitioning to a single combined service. The final model will depend on availability of estate and the clinical and financial benefits.

- The model for Microbiology is subject to further discussion. There is a strong clinical requirement for a 24/7 service model. Various options are being considered to ensure the delivery of a 24/7 clinical service including wider collaboration with other NHS pathology providers. There are clear clinical drivers (e.g. sepsis targets) for a 24/7 Microbiology service and we have entered into discussion with St. Helens and Knowsley about a joint service that could potentially replace the WWCPS service provided from the Bromborough site. It is noted that our clinicians would rather retain the service. Microbiology essential service laboratories at APH and COCH would not only maintain service KPIs but potentially improve TATs for urgent tests and enable us to meet sepsis targets for the first time.

- Consideration must also be given to consolidation by pathology specialty with requirements for logistics, estates, equipment and IT.

- Excellent clinical and team leadership is essential.

- Delivery is reliant on the timely roll out of Cerner PathNet at COCH (Planned for 2020)

5.4 Timescale:

Based on the implementation of a combined service, in line with proposed timescales in Section 8, the staffing savings (£0.846m - £1.8) could be begin to be delivered from May 2020, depending on the CoCH Cerner go-live date. The remaining savings delivered from 2022 once the MES tender is complete, allowing services to fully align. Delay in procurements savings is on the basis of tie-ins on current contracts with significant costs for buy-out. There will be opportunities to move specialist testing between sites now that will yield small-scale immediate savings whilst providing more robust service provision. A delayed hosting decision will push back benefits realization.

An adjusted timeline is described in Section 8.

6.0 Recommendations

Split hosting would throw up unnecessary challenges and reduce the potential for efficiency and productivity improvement. The rationale behind this is set out in this report.

The Wirral & West Cheshire Pathology Transitional Management Team have objectively assessed which Trust is better placed to host the service.

It is recommended that the Trust Boards agree;

- That joint pathology service will be delivered through an NHS Partnership Agreement
- The governance and finance model set out in this document
- CoCH host the aforementioned partnership

7.0 Next Steps/Considerations & Timeframe

Action	Responsible Person/Team	Target date
Decision as to progress with single service	Trust Boards of CoCH and WUTH	31/12/18 Completed
Agreed financial savings principles: Directors of Finance agree business model, commercial contract, business model, profit and risk sharing. Executive decision on “no redundancy” policy	WUTH/CoCH DoF AB/RB will facilitate and provide a proposal document	30/12/18 Completed
The TMT requires Executive membership. A senior operations executive could link the needs of the Trust with service delivery. Pathology collaborations that work well have executive participation on both sides. Also, new chair is required	Executive Steering Group	30/11/18 Completed
Agreement of formal governance arrangements on the management of the single service. Propose: both Trusts are equal stakeholders	Executive Steering Group & trust Boards	30/06/19
Decision on hosting arrangements	Trust Boards	31/07/19
Decision taken on blood sciences configuration. Propose: COCH autolab, WUTH specialist lab. Essential service laboratory on both sites	WWC TMT	30/06/19

Commencement of tender for single MSC for Blood Sciences (pan-pathology N4 tender)	CoCH Procurement Manager	30/09/19
Elect a Clinical Lead for each Service (already in place for Microbiology)	Clinical Focus Groups and TMT	30/09/19
Agree TUPE process for staff, conduct consultation and transfer of staff	WUTH & COCH HR teams and service managers	Dates to be confirmed
Phased implementation of Blood Sciences MSC	Operational Director	COCH 2020, WUTH 2022
Single LIMs – Cerner	Informatics	31/09/20
Single quality management system & governance structure	WCCTMT	31/09/20
Single accreditation	WWC Quality Manager	31/05/21
24/7 microbiology service to meet clinical needs of patients	WWC Microbiology Focus Group	01/09/19
All staff to work to same Ts&Cs	Host Trust HR Team	01/04/21

Appendix 1: Summary of current service provision

Blood Sciences

- Different managed service providers. COCH = Beckman Coulter. WUTH = Roche
- MSC end dates. Beckman = 2020. Roche =2022
- Staffing issues at WUTH
- Different OOH payment and shift arrangements
- Immunology moved to Chester on 2013
- Both Trusts provide the following core blood sciences services
- Chemistry, haematology, transfusion, point of care testing
- Other services include; Genetics, immunology, GP warfarin dosing
- Both Trusts provide these services to the following users
- Inpatients, outpatient, ED, GP direct access

Cellular Pathology

- Genmed managed service contracts on both sites
- Processing and cut-up at both sites with on-site reporting by consultant histopathologists who support local MDTs
- Mortuary on both sites
- Non-gynae cytology at both sites
- Cervical screening at WUTH
- Her2 testing at WUTH
- Different practices across the 2 Trusts with regard to reporting with WUTH working in subspecialty teams and COCH doing general reporting*
    - *Reporting of breast restricted in numbers at both set due to screening requirements with joint screening MDT to support joint screening service

Microbiology

- Joint lab opened April 2012
- Delivered significant savings circa £800K
- Keele benchmarking indicates lower than average costs per test
- Continued staffside issues in relation to pay and hours of lab opening
- Lab is an asset jointly owned by both Trusts

Referred Tests

- A significant volume of tests are referred.
- Blood Sciences including HODS to LCL and LWH
- Microbiology to Central Manchester Hospitals
- Potential opportunity to consolidate some of these volumes into new WWCPS shared service
- There will always be a need for referral to specialist centres

Appendix 2 : Potential options to merge the remaining services

Blood Sciences

- Status Quo: Stay as 2 separate labs and minimise costs by maximising technology
- Joint Outsourcing: Establish 2 spoke sites around the LCL hub as per NHSI recommendations or tender services
- Network Model (a) Establish a joint laboratory across 2 sites: COCH to be automated hub for cold work plus hot acute lab. WUTH to be specialist hub with hot acute lab
- Network Model (b) Establish a joint laboratory across 2 sites: WUTH to be automated hub for cold work plus hot acute lab. COCH to be specialist hub with hot acute lab
- New Hub 3 ESLs Build a new central hub lab with 3 essential service labs (COCH, CC,WUTH)
- "As Is" Structure with Joint management, procurement etc ie Merge team and QMS procurement but keep 2 sites as is

Cellular Pathology

- Stay as 2 separate labs from a processing and consultant perspective ie status quo
- Create single processing lab with consultants remaining with each Trust
- Move all processing to LCL as per NHSI recommendation
- Establish a single cellular pathology department to serve both Trusts at CoCH
- Establish a single cellular pathology department to serve both Trusts at WUTH
- Contract AQP to provide outsourced service
- New Hub: Potential single cellular pathology department off-site option
- Establish a single service with joint SOPs, procurement etc working as is on 2 sites

For a Joint Service:

Single workforce. Employer arrangements tbc

4-5 year plan with full implementation in 2022

Joint testing protocols

Maximise pre-analytical and post-analytical automation: potential to include urine screening

Consider what other acute pathology work is needed in an essential service lab to support flow/clinical excellence eg molecular Infection control screens, blood culture and CSF

Microbiology is already a shared service: what are the Potential Options?

- **As is but develop lab as South of Mersey microbiology service**.
    - Would require 24/7 working, flexible workforce.
- **Potential for to join with Whiston/Warrington or another service**

  - note: we would need to ensure there is sufficient capacity andthat this options is cost effective. Managed service options available for sample automation. Potential for 2 hub model in North 4 combining Warrington Wirral and Chester with Liverpool/Whiston operating other hub or CWMS as one and Whiston as the other with CWMS taking LCLs bacteriology and Whiston processing the other work from North Mersey ie Warrington (+Southport)

- **Close lab and move work to central hub in line with NHSI recommendations.**
    - Capacity could be an issue for LCL. Need to consider rapid testing requirements at acute sites.

Appendix 3: LTS Evaluation Reports

LTS_APH and CoC Pathology Evaluation

LTS_APH and CoC Pathology Evaluation

Appendix 4 Consideration of options for single employer model

The TMT advised by the CFGs has ruled out outsourcing models leaving 2 potential models with 3 configurations;

1. NHS partnership

An NHS partnership is a pathology reconfiguration initiative between NHS parties, generally with the aim of creating joint laboratory model across several of trusts. This is enabled by one of the trust parties 'hosting' the venture. The model transfers all 'cold' activity from the sites to a central laboratory, along with all GP activity. Within the business model Direct Access income will remain with the two Trusts. Each trust retains a small emergency services laboratory (ESL) for 'hot' testing. Specialist testing may be consolidated on one site.

This is an internal NHS model – NHS parties retain full operational control of the joint venture and service delivery is kept within the NHS. Savings and improvements are made through the consolidation of services.

WUTH or COCH can become the lead employer.

2. Wholly Owned Subsidiaries or Capital Investment Joint Venture

A capital investment joint venture is a form of NHS partnership in which pathology services are reconfigured between NHS parties to create a joint model across a number of trusts. The JV becomes the legal entity. This is enabled by a new legal entity being created. The hub and spoke model transfers all 'cold' activity from the sites to a central laboratory, along with all GP activity. Each trust retains a small ESL for 'hot' testing.

This joint venture is responsible for delivering the pathology services. This is an internal NHS model as the NHS parties retain full operational control of the joint venture and service delivery remains within the NHS. Savings and improvements are made through the consolidation of services in the hub and spoke arrangement. However, there is a cost of establishing a JV as a new legal entity which could exceed £400,000.

In these NHS partnerships a joint venture can be set up with the private sector to manage facilities and the business, tapping into expertise and capital from the private sector.

However, the regulatory approach to wholly owned subsidiaries in the provider sector has changed. From October 2018-19, the proposed creation of subsidiary companies will now become a reportable transaction to NHS Improvement under the Transactions Guidance*. A formal requirement under Managing Public Money is for Accounting Officers (including the Principal Accounting Officer, individual trust Accounting Officers and NHS Improvement as the regulator) to ensure the establishment of these companies is not for the sole purpose tax avoidance (although they could be proposed as a way of providing a more resilient service. The

Department of Health and Social Care have indicated in “Managing Public Money” that Trusts should pause any current plans to create new subsidiaries or change existing subsidiaries.

*Department of Health and Social Care: Accounting Officer System Statement. July 2018

Appendix 5: Hosting Evaluation Matrix – an explanation of the key differences is given over the page

Trust name: W&WC Micro

				Option Scoring				Weighted Score			
Area	**Description**	**Sub-weighting**	**Overall weighting**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
				Status quo: Stay as we are, split or share services	CoCH Hosts	WUTH Hosts	JV: separate legal entity	Status quo: Stay as we are, split or share services	CoCH Hosts	WUTH Hosts	JV: separate legal entity
Patients and Clinical Quality		**60%**									
Standardisation	The model facilitates the introduction of common procedures, common ranges, KPIs and clinical reporting across sites	15%	9%	2	5	5	5	0.18	0.45	0.45	0.45
Patient Safety and Experience	The option minimises any potential risk to patient safety, e.g. The need to have some services within a certain proximity to the patient, any necessary linked between staff, consultants (MDTs) and the patient are preserved.	30%	18%	2	5	5	5	0.36	0.9	0.9	0.9
Clinical Quality	The option provides the right level of clinical oversight to create a consultant led service with a common clinical governance structure across all sites	40%	24%	2	5	5	3	0.48	1.2	1.2	0.72
Achievability	The service addresses the emerging needs of the pathology market and would face the lowest level of resistance by stakeholders. Evidence that other organisations have successfully implemented the model without affecting quality	15%	9%	5	4	3	4	0.45	0.36	0.27	0.36
General, Financial, and Governance Requirement		**40%**									
Strategic fit, innovation, and clinical sustainat	The option would provide the greatest chance for WWCPS to become a sustainable organisation supporting it on the retention of current revenues and supporting the development of the service to meet the future needs of the market and service.	15%	6%	2	5	3	4	0.12	0.3	0.18	0.24
Potential affordability	The option would provide the best opportunity to access funding and is likely to provide a high return on investment. Capital requirements are low and therefore achievable.	25%	10%	5	4	4	3	0.5	0.4	0.4	0.3
Potential value for money	The option would provide the greatest level of savings over the long term through economies of scale	30%	12%	3	5	3	5	0.36	0.6	0.36	0.6
Facilities, IT and Eqmt Systems	The options allows the introduction of a common IT LIMS that would link all sites and common equipment platforms across all sites. Availability of estates for development of pathology	15%	6%	3	4	5	4	0.18	0.24	0.3	0.24
Control and governance	The option would allow WWCPS to operate with an autonomous governance structure allowing to operate in the market and effectively respond to market forces	15%	6%	2	4	3	5	0.12	0.24	0.18	0.3
							Total Weighted	**2.75**	**4.69**	**4.24**	**4.11**

Explaining the Differences

Criteria	COCH score	WUTH score	Commentary
Achievability The service addresses the emerging needs of the pathology market and would face the lowest level of resistance from stakeholders. Evidence that other organisations have successfully implemented the model without affecting quality.	4/5	3/5	Scoring relates to COCH having more successfully implemented change within Pathology than WUTH. WUTH has seen greater challenge to proposed change within Pathology. Recent examples include COCH implementing flu testing via 24/7 blood science dept, whereas proposed implementation in WUTH met with resistance and progress not made.
Strategic fit, innovation and clinical sustainability The option would provide the greatest chance or WWCPS to become a sustainable organisational supporting it on the retention of current revenues and supporting the development of the service to meet the future needs of the market and service.	5/5	3/5	Scoring relates to previous ability to deliver cost reduction and to support contract management. WUTH has taken significant time to deliver VAT savings on managed services, missing out of 3 years opportunities. Spend on joint services transfer to COCH in order that WUTH to take advantage of benefits of VAT savings. Delay in agreeing SLAs with suppliers and customers at WUTH. Currently a number of key SLAs are outstanding. COCH nominated to lead procurement for Regional Pathology collaboration. COCH have successfully progressed innovation in relation to cost and demand management via initiatives such as care sets. As such they have lowest cost / demand per capita and the lowest Pathology costs in the region. They are used as an exemplar by Keele benchmarking.
Potential value for money The option would provide the greatest level of savings over the longer term through economies of scale	5/5	3/5	As decision on hosting not determined by the eventual service configuration or target operating model, evaluation here (as above) relates to ability to deliver cost reduction. COCH currently have a lower cost per capita for Pathology that WUTH.
Control and governance The option would all WWCPS to operate with an autonomous governance structure allowing to operate in the market and effectively respond to market forces.	4/5	3/5	COCH have overall CQC rating of 'good'.

Appendix 6: Hosting SWOT analysis

		Strengths	Weaknesses	Opportunities	Threats	Comments
1	Status quo: Stay as we are, split or share services	Little set-up resource Shared risk	Duplication of effort e.g. 2 finance teams making calculations. Potential for misunderstanding Unlikely to get True merged Service Procurement difficulties Staff/Unions playing one Trust off against the other Ambiguity of which policy to follow	It would be a missed opportunity!	N4 Veto N4 Overtakes Collaboration between Trusts fragments Da income is lost or reduced	
2	CoCH Hosts	Organisational Culture Track record re progress Capacity in HR Successful VAT reclaim on 2 MSCs Track record in procurement. ?more capacity in procurement Less partnership working?	Less partnership working? Unions would favour less. Perception of takeover. Unequal risk sharing	Joint Histology at APH CoCH will lead N4 Procurement Take on other N4 work as blood sciences has room to expand.	N4 Veto N4 Overtakes this DA income to WUTH if not apportioned correctly Industrial action more likely	Preferred option
3	WUTH Hosts	Service hosted at larger Trust. More staff happier?	Organisational Culture Process to progress Lack of capacity in HR Failure to reclaim VAT on MSC/avoidance of risk Less of a track record in procurement (higher cost MSC) Capacity in procurement More likely to be perceived as a takeover. Lack of Room at APH to expand Blood Sciences	Joint Histology At APH Take on other N4 work	Unequal risk sharing N4 Veto N4 Overtakes this DA income> Wirral CCG wants COCH prices	Car park on one side of Blood Sciences and 'courtyard' make blood science expansion difficult but with cytology moving, both histology services could go into APH
4	JV: separate legal entity	Shared/reduced risk for both organisations. No perception of takeover: "fresh start"	Cost and resource to set up JV Risk of running clinical service as business entity, esp. in light of NHSI treats to DA tariff Contacting HR finance etc.	Take on other N4 work and/or brand into N4	NHSI Veto N4 Overtakes this JV DA contracting/reduction in tariff	

Countess of Chester Hospital NHS Foundation Trust

Item Reference and Title	**Agenda item 13 - Audit Committee Chair's Report to Board of Directors (BoD)**
Date of Meeting	Board of Directors' – 25th June 2019 (from Audit Committee Meeting – 20th May 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: • Outline the work of the Committee. • Highlight items for escalation or recommendation to Board.
Recommendation(s)	**The Board is asked to**: • Receive all items for escalation from Audit Committee. • The Audit Committee reviewed the NHS Provider Licence self-assessment and recommend this to Board for approval.

Countess of Chester Hospital NHS Foundation Trust

1.0 Key items of business discussed

The Audit Committee met on 20th May, 2019.

The meeting covered the review of the Annual Accounts, Quality Report and Management Letter of Representations for 2018/19 which were recommended to, discussed and approved at Board on 21st May 2019.

In addition, the following key business items were discussed:

- Update on GDPR compliance: Procurement.
- NHS Provider License Self-Assessment.
- MIAA's Cyber Security Assurance 2018/19 (Moderate).
- Conflicts of Interest Review 2018-19.
- Current Internal Audit Progress.

2.0 Key agreements or decisions made

- 2019 / 20 Internal Audit Plan change: Cancer 62 day review was shelved and replaced with neonatal action plan advisory review at the request of the COO and Director of Nursing / Medical Director.
- The Audit Committee will not be aligning its agenda going forward under the CQC domains.
- The Audit Committee reviewed the NHS Provider Licence self-assessment and recommend this to Board for approval.

3.0 Items for escalation to Board

- Cyber Security Assurance: no formally documented risk management policy exists currently; lack of staff active training.
- Conflicts of Interest Review: Declaration of interest register is not available on the Trust's website.
- Request to approve moving the timing of internal audit of Cerner Implementation progress to Q3 was deferred to next meeting, with the requirement that this is also subject to Board discussion. Audit Committee have requested ToR in July for review.

4.0 Recommendation(s)

4.1 Receive all items for escalation from Audit Committee.

Item Reference and Title	**Agenda item 14 –** Governance Improvement Plan and Terms of Reference for Finance & Performance Committee and Quality & Safety Committee
Date of Meeting	Board of Directors - 25th June 2019
Accountable Executive	Susan Gilby, Chief Executive
Author(s)	Debbie Bryce, Interim Trust Secretary, Darren Thorne, External 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: Seek approval of Terms of Reference for the new Finance & Performance and Quality & Safety Committees, following approval at the May Board to disestablish the Financial & Integrated Governance Committee, People & Organisational Development Committee and the Quality, Safety and Patient Experience Committee. Outline the high level recommendations from the external governance review and propose the high level improvement plan to address these recommendations.
Recommendation(s)	The Board is asked to approve the terms of reference for the new Finance & Performance and Quality & Safety Committees. The Board is asked to approve the high level governance improvement plan in response to the high level recommendations from the external governance review.

Corporate Impact Assessment:	**Legal and regulatory impact:** Improved compliance with The NHS Foundation Trust Code of Governance **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

1.0 Background

On 21st May, 2019, the Board of Directors approved the disestablishment of the Financial & Integrated Governance Committee, People & Organisational Development Committee and the Quality, Safety and Patient Experience Committee and agreed to establish a Finance & Performance Committee and a Quality and Safety Committee, with further work undertaken on the terms of reference for these committees (and also the Audit Committee).

2.0 Terms of Reference

The terms of reference for the new Finance & Performance Committee and Quality & Safety Committee can be found within ***Appendix One*** and ***Appendix Two***.

The Governance Improvement paper received at the 21st May, 2019, Board of Directors, proposed a review period of four months to test the new approach over two business cycles, and this remains the case.

3.0 External Governance Review High Level Recommendations and High Level Governance Improvement Plan

The Trust recently commissioned an independent review of its governance, this reported in early April, 2019, making 20 recommendations for improvement, as follows:

Trust Board and corporate support

1. Consider a redesign of the corporate support, capability and capacity available to the trust board so that there is a strengthened and coordinated approach to governance that will enable the board and its directors to discharge their responsibilities effectively.

2. Review the non-executive directors' portfolios and development needs so that there is good understanding of their roles and responsibilities as a non-executive director.

3. Disestablish and re-commission the board committees ensuring their roles and responsibilities are clear and that they perform as assurance committees.

4. Give consideration to the governance of issues that fall outwith trust core business; for example, we recommend you review the governance and oversight arrangements for; the Integrated Care Partnership, the implementation of Cerner, provision of medicines management service to the CCG and Commercial activity.

Assurance and use of data

5. Implement a development programme for board members and senior operational leaders to improve individual and organisational understanding and knowledge around seeking and providing assurance. This should include areas such as: a. reassurance v assurance;

b. three lines of defence;

c. effective challenge and scrutiny of evidence;
d. how to present and interpret information and data into intelligence and

e. evidence to support effective decision making.

Board Assurance Framework and Risk Management
6. The BAF needs to become a dynamic and live document that informs the board of risks to progress in meeting its strategic objectives.

7. Review all data and information sets so that there is a cycle of high-quality data which can then be triangulated to support decision making, enables a consistent and coordinated approach to reporting and provides “one version of the truth”

Strategy, purpose and vision
8. Develop a long-term strategy that outlines the trust’s purpose and vision and is supported by appropriate enabling strategies, such as clinical, workforce, IM&T, financial, so that there is a clear and shared understanding of the trust’s direction of travel.

Organisational structure
9. Review of the executive directors’ portfolios so that there is alignment with functions and a focus on integrated structures, maximising strengths and closing capability gaps.

10. Review and refresh the organisational structures so that: a. clinical leadership is at the forefront including a review of all clinical support services to ensure integration in the delivery agenda;

b. a ‘corporate management’ function supports the divisional structures.

11. Review the safety, risk and quality functions so that: a. there is a more integrated approach to the process of gathering and interpreting intelligence;

b. there is a coordinated approach to improvement, and

c. functions are more cohesively aligned and purposeful.

Systems and processes

12. Improve meeting management discipline by the implementation of best practice approach to business governance including: a. taxonomy for example reserving the use of 'board' to appropriate circumstances;

b. preparation of agendas and board papers, including cover sheets and templates to reports;

c. scheduling of meetings to inform cycle of business;

d. timeline for distribution of papers;

e. attendance and resilience;

f. behaviours and etiquette;

g. training for best practice in minute recording so that a more formal, accurate and complete record is achieved;

h. report writing training.

13. Develop a meeting map – so that there is a collective understanding throughout the organisation on the purpose, reporting and accountability of the board committees, operational groups and management meetings; this should include: the management meeting required to provide assurance to the board committees membership, 'attendees', terms of reference, roles and responsibilities.

14. Develop a governance handbook and accountability framework so that individual roles and committee responsibilities and accountabilities are clearly documented.

15. Develop a ward-to-board framework so that the board receives assurance of its clinical quality and safety. This should ensure that there are clear and effective flows of information from ward to board.

16. Review and rationalise the divisional governance arrangement so that: a. there a single operational approach to divisional governance to provide consistency and uniformity in the meeting and reporting arrangements;

b. there is reliance when the organisation is at high levels of pressure.

Organisational policies and guidelines
17. Improve the corporate oversight of the control, development, updating, ratification and distribution of clinical and corporate policies, procedures and guidelines through a rigorous vetting and checking process.

Leadership, culture and behaviour
18. Continue to embed the quarterly divisional performance meetings so that management grip and clear accountability becomes a recognised and appropriate way of working at the Countess of Chester Hospital NHS Foundation Trust.

19. Consider a review of people and organisational development strategy, and delivery plan [2016-2018] to make it fit for purpose to address workforce challenges.

20. Consider undertaking a cultural and behaviour organisational review to ensure the organisation and its people align with the aspirations of the board.

The high level governance improvement plan can be found in ***Appendix Three***. A detailed improvement plan to address all recommendations is currently under development and will be delivered in phases, at outlined to the Board on 21st May 2019:

Phase one: Achieving compliance and building the basics (3 months);
Phase two and three: Implementing better basics and embedding practice (6 months);
Phase four: Creating sustainable change (3 months).

4.0 Recommendations

4.1 The Board is asked to approve the terms of reference for the Finance & Performance Committee and the Quality & Safety Committee.

4.2 The Board is asked to approve the high level governance improvement plan in response to the high level recommendations from the external governance review.

Appendix One

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

QUALITY AND SAFETY COMMITTEE TERMS OF REFERENCE

1.00 PURPOSE

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

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

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

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated Non-executive Director
- Two further nominated Non-executive Directors
- Medical Director (the joint Lead Officer for the Committee)
- Director of Nursing and Quality (the joint Lead Officer for the Committee)
- 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 Executive Medical Director or Director of Nursing & Quality). A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

4.03 The Committee shall meet 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

Approved by Trust Board: [Date]

Reviewed by the Quality & Safety Committee [Date]

Next Review:

Appendix Two

COUNTESS OF CHESTER HOSPITAL 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 plans and performance.

1.02 The Committee shall also provide information to the Audit Committee and Quality and Safety 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]

Reviewed by the Finance & Performance Committee [Date]

Next Review:

Countess of Chester Hospital NHS Foundation Trust

Appendix Three – High Level Governance Improvement Plan