Countess of Chester Hospital
NHS Foundation Trust

BOARD OF DIRECTORS AGENDA AND PAPERS

TUESDAY, 13TH MARCH 2018

NHS
Countess of Chester Hospital
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS (PUBLIC)
TUESDAY, 13TH MARCH 2018 AT 1.00PM – 3.00PM

RETRO CAFÉ

A G E N D A

FORMAL BUSINESS

1.	Welcome and Apologies	Chairman
2.	Declarations of Interest	Chairman
3.	To receive and approve the Board of Directors minutes of meeting held on 5th December 2017 and matters arising **(Attached)**	Chairman

QUALITY & ASSURANCE

4.	To receive a Staff Story on Apprenticeships (**presentation**)	Director of People and Organisational Development
5.	To review the Integrated Performance Report as at Month 10 to include Finance Update for Month 11 **(Attached)**	Executive Team
6.	To receive the 'Nursing & Midwifery Annual Staffing Review' **(Attached)**	Director of Nursing and Quality
7.	To receive an update on Cancer 62 Day Performance **(Attached)**	Chief Operating Officer
8.	To receive details of the Staff Opinion Survey 2017 Results	Director of People and Organisational Development
9.	To receive the Trust's Gender Pay Gap Report **(Attached)**	Director of People and Organisational Development
10.	To receive an update on the Board Assurance Framework	Director of Nursing and Quality
11.	To receive an update on Never Events and Serious Untoward Incidents **(Verbal)**	Director of Nursing and Quality

STRATEGIC DEVELOPMENT

12.	To receive a CEO Update **(Verbal)**	Chief Executive
13.	To receive an update on Board and Governor Matters **(Verbal)**	Director of Corporate & Legal Services

FOR NOTING & RECEIPT

14.	To receive an update on Reference Costs 2016/17	Chief Finance Officer
15.	To receive the Month 9 and Month 10 letter to NHS Improvement	Chief Finance Officer
16.	To receive the Annual Equality & Diversity Report 2017-2018	Director of People and Organisational Development
17.	To receive the minutes of the Quality, Safety and Patient Experience Committee – 20th November 17 (no meetings held in December 2017 or January 2018)	Director of Nursing and Quality
18.	To receive details of the Freedom of Information requests received by the Trust September 2017 – January 2018	Director of Corporate and Legal Services
19.	To receive Corporate Infection Prevention and Control Assurance – Quarterly Report (retrospective report based upon November 2017 quarterly data update)	Medical Director
20.	Date and Time of Next Meeting: **Board of Directors Meeting** **22nd May 2018 – time and venue to be confirmed**	

BOARD OF DIRECTORS

MINUTES OF THE MEETING HELD ON TUESDAY, 5TH DECEMBER 2017 AT 1.30PM BOARDROOM

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

In attendance:

Mrs C Raggett – Secretary to the Board

FORMAL BUSINESS

B86/17 **WELCOME AND APOLOGIES**

Sir Duncan welcomed all attendees to the Board meeting.

Apologies were received from Mr Higgins.

B87/17 **DECLARATIONS OF INTEREST**

Mr Cross reported that Mr Wilkie had retired from the Board as of the 30th November 2017.

Mr Cross reported the Mr Higgins had been re-appointed for a further 2 year of office and Mrs Hopwood had been re-appointed for a further 3 year term in office by the Council of Governors.

B88/17 **TO RECEIVE AND APPROVE THE BOARD OF DIRECTORS MINUTES OF MEETING HELD ON 18TH OCTOBER 2017 2017, BOD ACTION TRACKER (NOVEMBER 2017)**

The Board of Directors minutes of the meeting held on 18th October 2017 were received as a true and accurate record.

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

MATTERS ARISING

There were no matters arising.

QUALITY ASSURANCE

B89/17 **PATIENT STORY**

Mrs Kelly reported that the Patient Experience Operational Group (PEOG) has been tasked with sourcing patient story material for the Board. The PEOG has good engagement with patients and is going from strength to strength.

Mrs Kelly presented and played audio feedback from the friends and family test. There are both positive and negative comments with this month's focus being around staff attitude. The Trust does need to learn from negative feedback.

Mrs Kelly stated that there were negative comments around conflicting messages from doctors and nurses, this is also reflected in the national survey. Mrs Kelly added that there were also negative comments regarding the nurses attitudes which is disappointing and will be dealt with appropriately. Mrs Kelly also stated that there were negative comments around patients being moved to several wards during their admissions. Mrs Kelly assured the Board that PEOG feed these types of messages through to clinical teams.

In response to a question from Sir Duncan, Mrs Kelly outlined how poor behaviours of staff are being reported by staff supported through freedom to speak up as such behaviour is no longer accepted by colleagues. Mrs Hodkinson added that there are good relationships with union colleagues who also support freedom to speak up and the raising of issues, as issues raised are not always in relation to patients. There is a is a lot of good work and a range of mechanisms including the feedback from the high performance culture workshops, however these workshops do not hear the patients voice which could be included going forward.

Mr Cross stated that governors also provide feedback at the Governors Quality Forum and Council Of Governors meeting and this would be fed into PEOG going forward.

Mr Chambers stated that when Teletracking went live, one thing that happened was the variation in culture across wards and departments, some reacted positively and some less so to the new technology and this even changed by shift. There are opportunities for more transparency on culture and the Trust is exploring how to do this.

B90/17 **TO REVIEW THE INTEGRATED PERFORMANCE AS AT MONTH 7 TO INCLUDE:**
FINANCIAL UPDATE
WINTER PLANNING

The Board received details on the key issues within the integrated performance and finance report as at Month 7 and the following points were raised:

Performance

- Mr Harvey stated that performance for e-discharge had dipped in a year, however there is an upward trend partly due to close day to day management. This trend needs to continue and there are some areas that are supported by technology.
- Mr Harvey reported that it had been over a year since there had been a case of MRSA.
- Mr Harvey reported that the C.Difficile target was at the worst position for 4 years which is a reflection of how busy the Trust is and comorbidity and illnesses of patients. There have also been shortages of antibiotics nationally. My Harvey noted that the initial root cause analysis demonstrates that the majority of cases are deemed as unavoidable as they are consequence of antibiotic treatment for life threatening illnesses.
- Mrs Kelly reported that safe staffing levels were green, however this does not reflect the challenges in October which continuing into November 2017. The teams work hard on an hour by hour basis for staffing with any gaps. The teams are flexing and using temporary workforce. This continues to be a challenge despite being on green.
- Mrs Kelly reported that there had been 5 falls in October 2017 that had resulted in harm. There have been detailed discussions at the Quality Safety and Patient Experience Committee (QSPEC) and Steve Worrall is leading a huge piece of work across the Trust around patients admitted with a history of falls.
- Mrs Kelly reported that sepsis was a key priority which governors had been involved in. There is a work plan rebasing of data, review of processes and noted that performance would get worse before it gets better as the data will have a time lag.

In response to a question from Sir Duncan, Mrs Kelly and Mrs Hodkinson gave details of the current staffing position for nursing and the actions being taken regarding recruitment:

- There are currently 60 nursing vacancies at the Trust.
- There has been good recruitment of newly qualified nurses; however they aren't available until 2018.
- There are a number of senior nurses retiring.
- The recruitment and retention work stream reports into the nursing and midwifery Board.
- Feedback from staff is that CPD is a key element of why staff like to stay at an organisation.
- There is a lot of discussion nationally on CPD for nurses as the funding has been cut dramatically. The Trust is working closely with Chester University as how to develop and provide career progression for nursing staff within financial restraints.
- There has been some success in international recruitment.

- Mrs Hodkinson and Mrs Kelly are involved in a piece of work across the region in terms of recruitment.
- In addition to 60 nurse vacancies, there are also 60 nurses on maternity leave and sickness.
- The Trust is utilising e-rostering and Teletracking and being as flexible as possible, with matching staffing to acuity being a challenge.
- Mrs Hodkinson stated that there are issues nationally in recruiting sonographers.
- Mrs Hodkinson added that conversations are being held with colleagues across the patch, with a significant number of actions being taken across the Trust. There are also challenges with Wales as they do not have the same agency cap and therefore Wales pay their bank staff more money.
- Mrs Kelly stated that there are healthy conversations taking place across organisations and the Trust is working together with Wales who are receptive to have further conversations around rates of pay.

Ms Burnett referred to the CQUIN around offering advice and guidance electronically for all referrals and stated that the CCG are going to use the E-referral system from February 2018.

Ms Burnett reported that the 6 week diagnostic target was at 98.5%. This was partly due to endoscopy staffing issues that have now been addressed and the second was in relation to vascular scans which are now included in the return. The Trust is working with MIAA around this new element and performance will become clearer in the coming months.

Ms Burnett reported that the 62 day cancer target was extremely difficult as there have been some delays for onward referrals earlier in the year. There has been a change in the management structure in the cancer team and there have been successful bids for different pathways which include another nurse for lung cancer. There will be a time lag before improvement will be seen in performance.

Ms Burnett reported that there had been a rise in elective cancellations due to the pressures in A&E. The A&E 4 hour target is at 88.35%. There has been a rise in the number of A&E attendances needing admission. There are also 50 escalated beds in the hospital and teams are working hard to discharge those patients that no longer require care in a hospital setting.

Mrs Hodkinson reported that variable pay was a challenge during October linked to the staffing challenges. In response to feedback from nurses, bank staff are now paid weekly. There are staffing challenges due to half term, maternity and sickness levels which the Trust had to make staff available at an increased rate of pay. The People And Organisational Development Committee (POD) have had detailed discussions about the increase in variable pay which is higher than last year. Mrs Hodkinson noted that if the projections continue agency spend levels will be lower than last year. Agency spend was also discussed at the Medical Workforce Board.

Mrs Hopwood referred to increased rate of pay during half term holidays and asked what the strategy was going forward as different areas have different school holidays and what actions being taken mean that the Trust has a grip on variable pay from January 2018. Mrs Hodkinson replied that the decision to pay more during school half terms had not been taken lightly. A paper is being prepared on types of payments and a longer term strategy for the holiday periods. Mrs Kelly has weekly conference calls regarding staffing looking forward rather than on a daily basis. There is a 6 week rota so the Trust can see what is coming. Mrs Hodkinson added that the forecast for Q4 will be revised as

the variable pay target was not achieved in Q3.

In response to a question from Mrs Hopwood, Ms Burnett advised that the Trust will look at the planning for the integrated performance report to reflect the level of risk in a more timely manner.

Mrs Fallon noted the huge amount of work undertaken in relation to the diagnostics and cancer targets and asked if the report could show at speciality level the activity and timescale to get back to the required performance. Ms Burnett stated that she would look into this.

Mrs Fallon referred to the levels of C.Difficile and asked if the levels were reflected in other Trusts regionally and nationally and were there anything system wide to address the issue. Mr Harvey replied that yes it was reflected nationally across the NHS and some surrounding Trusts were worse than the Countess. The Countess is providing infection control support to neighbouring Trusts, as the Trust is viewed as high performing in our infection control process. It is important to continue to drive forward the messages for basic measure such as hand hygiene of patient spaces.

Mr Harvey added that the Trust is hampered due to the CQUIN mandating reduction in antibiotic usage but there is a shortage of some antibiotics and therefore, the Trust has to use multiple antibiotics which increase the risk of C.Difficile.

FINANCE

Mr Holden outlined the Trust's financial position as at month 7 and highlighted the follow points:

- The Trust is £50k off plan at month 7, which is good when the STF monies are taken out for A&E. The Trust must meet the financial targets to achieve the additional £4M STF monies.
- Mr Holden is commented on the block contract with the CCG as the Trust is not doing activity at premium costs, some work has cancelled due to capacity constraints, staffing challenges and the NHS have changed coding with Trusts being advised they have under received however CCG's have been told differently
- The financial position is tight with significant pressures in urgent care for medical and nursing costs.
- The CRS target is doing well however, there is a need for more recurrent savings.
- Cash continues to be an issue and the cash balances are closely monitored.
- The Trust's capital loan application has been approved.
- Mr Holden assured the Board that everything that could be done was being done to achieve the yearend financial target.

Sir Duncan asked if it was possible for the Trust to get ahead and have some room for manoeuvre for the year end position. Mr Holden replied that the Trust should achieve the financial position at the yearend however, there will be no contingency funds.

Mr Oliver stated that the POD were reviewing the variable pay in a very detailed manner and that there should not be an impact from variable pay in terms of the Trusts ability to achieve the financial target at year end.

The Integrated Performance Report for Month 7 was received by the Board.

B91/17 **TO RECEIVE AN UPDATE ON THE BOARD ASSURANCE FGRAMEWORK – NOVEMBER 2017**

Mr Chambers presented the updated 'Board Assurance Framework' (BAF) to the Board and outlined the process for updating the BAF. Mrs Kelly has met with executive colleagues on reviewing each of the risks. There is further work needed on the elements in the gaps section as these are fed from the organisational risk registers.

Mr Chambers' referred to CR2 which reflects the issues raised in the performance report.

Mr Chambers added that there had been a number of conversations regarding the re-scoring of risks. Ms Burnett noted that CR2 was scored RED as further pressures were expected due to cancelled operations over the winter period.

Mrs Kelly stated that CR6, CR2 and CR1 interlink in terms of risks and that it is important to make the connections and manage the risks. Mrs Kelly added that there would be a further Board workshop regarding risk appetite at the Trust and the impact financially and operationally.

Sir Duncan asked if the clinicians whose operations had been cancelled could support in A&E? Mr Harvey replied that he was discussing this with clinicians around arrangements when there was cancelled activity. There are beneficial interventions that clinicians can undertake such as early senior reviews and consideration given the redeployment of other staff during periods of cancelled activity.

B92/17 **TO RECEIVE AN UPDATE ON THE GENERAL DATA PROTECTION REGULATIONS (GDPR)**

Mr Cross presented the paper on the General Data Protection Regulation (GDPR) primary legislation which comes into effect from 25th May 2018. GDPR means that the Trust will have greater accountability for the data it holds. It is complex, in particular there is now a need for explicit consent with regards to any data the Trust holds. Ms Leanne Cheers, Head Of Information Governance is now reporting to Mr Cross. There is a lot of work to do and an operational group will be established to continue to take this forward. The BBoard also has responsibility for GDPR and Mr Cross will keep the Board updated on developments.

B93/17 **TO RECEIVE AN UPDATE ON FREEDOM TO SPEAK UP**

Mrs Hodkinson gave a detailed overview on freedom to speak up (FTSU) and noted the following points:

- The FTSU committee comprises of Mr Higgins, Mrs Kelly, Mr cross, Mr Harvey, Mrs Hodkinson and Ms Hayley Cooper, chair of staff side all of whom are FTSU guardians.
- A new case review process has been published.
- The National Guardians Office now publish an annual report which is a helpful document and the FTSU committee will work through the actions in the report.
- The Trust will submit data for Q2 which demonstrates the number of issues raised to the committee.
- The FTSU committee are also holding a full day session to review the increasing amount of actions

from the National Guardians' Office.

Mrs Hopwood asked about the actions being taken to reach the hard to reach staff groups who do not have computer access. Mrs Hodkinson replied that the principle focus was through line management. Mrs Allan, Head Of Facilities and her team have been very focused on this. The FTSU committee is looking at how FTSU champions may help to reach such staff groups.

Sir Duncan advised the Board, that following Mr Wilkie's retirement, Mrs Fallon would now chair the Partnership Forum.

Mrs Kelly added that the FTSU is a key part of the CQC well led domain and that she and Mr Cross are discussing how these link together.

B94/17 **TO RECEIVE AN UPDATE ON NEVER EVENTS AND SERIOUS UNTOWARD INCIDENTS**

Mrs Kelly reported that it had been 335 days since the last never event. There is a good learning from previous never events with Mr Harvey and Ms Whitelaw, Theatre Manager giving a good presentation to QSPEC about the learning. The serious untoward incidents (SUI) panel are reviewing more incidents on a weekly basis.

Mrs Kelly reported that that there had been 3, level 2 investigations in October 2017, one around an airway obstruction and 2 around sepsis which are being fed into the sepsis work.

STRATEGIC DEVELOPMENT

B95/17 **TO RECEIVE A CEO UPDATE**

Mr Chambers gave a CEO update and noted the following points:

- The Trusts have decided not to proceed with the SEP implementation having regard, amongst other things, to certain uncertainties facing the market. The Trusts are grateful to all bidders for the time and effort associated with the procurement and for the excellence of their input.
- The Trust has vaccinated 81% of staff against flu which is a fantastic achievement.
- The staff survey closed on 1st December and the results of the survey will be brought to a future Board meeting once they are received.
- A&E activity is increasing with nearly 300 attendances each day. The Trust has invited the Emergency Care Intensive Improvement Team (ECIST) to come and talk to staff and look at our processes and see if there is anything else we can do. It is really important that the system has a shared understanding of DTOCs and stranded patients to drive actions and budgets. The ECIST team will test this and give a single version which will be helpful. Mr Chambers will provide an update on ECIST to a future Board meeting.
- The Trust has to make sure that patients are transferred from ambulances as soon as possible as there are other patients in the community that need the ambulances.
- There are lots of patients coming from nursing and care homes and they do come with a lot of personal belongings. These patients now have a red bag and this simple change can speed up discharge and improve the hospital experience for the patient.

- The Care Co-Ordination Centre has gone live and the Trust is holding a launch event with over 100 people coming from all over the NHS to see the work we are doing as it is not being done anywhere else.
- The Trust held its Celebration Of Achievement Awards in November 2017 which had been well supported by sponsors such as RCN, Allocate, Brooksons and Teletracking. There were over 10 awards and it was a fantastic evening, so thank you to Mrs Hodkinson and her team.
- Mr Joe O'Grady has been awarded Diversity Manager Of The Year For The Public Sector which is a significant award. This is a huge national diversity awards event and the Trust had 2 other representatives at the event, no other Trust had that many staff involved which is fantastic.
- There were other areas who have received recognition including the paediatrics team being awarded the best training in the North West, e-rostering was highly commended for Care Needs First category, the finance team have been short listed for an award and the Trust received the national silver award for work experience. There are many things for us to be proud of as a Trust.
- Mr Chambers on behalf of the Board thanked all the staff for their hard work and commitment through what has been a difficult year.

B96/17 **TO RECEIVE AN UPDATE ON GOVERNOR MATTERS**

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

Mr Cross reported that there will be a joint planning session with the Board Of Directors and Council Of Governors in January 2018

Mr Cross reported that several governors had attended national training sessions with the NHS providers.

Mr Cross stated that there is a lot of work being undertaken in terms of governor ward visits and these will be launched in March 2018.

Mr Cross stated the induction process for the newly elected governors was underway.

FOR NOTING & RECEIPT

B97/17 **TO RECEIVE THE GUARDIAN OF SAFE WORKING REPORT – Q2**

The Board received and noted the Guardian Of Safe Working Report – Q2.

B98/17 **TO RECEIVE THE MONTH 7 LETTER TO NHS IMPROVEMENT**

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

B99/17 **TO RECEIVE THE MINUTES OF THE QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE – 18TH SEPTEMBER 2017 AND 6TH OCTOBER 2017**

The Board received and noted the minutes of the Quality, Safety and Patient Experience Committee – 18th September 2017 and 6th October 2017.

B100/17 **TO RECEIVE THE MINUTES OF THE AUDIT COMMITTEE – 24TH APRIL 2017 AND 23RD MAY 2017**

The Board received and noted the minutes of the Audit Committee – 24th April 2017 and 23rd May 2017.

B101/17 **TO RECEIVE THE MINUTES OF THE CHARITABLE FUNDS COMMITTEE – 25TH JULY 2017**

The Board received and noted the minutes of the Charitable Funds Committee – 25th July 2017.

B102/17 **TO RECEIVE THE MINUTES OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – 26TH SEPTEMBER 2017**

The Board received and noted the minutes of the People And Organisational Development Committee – 26th September 2017.

B103/17 **DATE AND TIME OF NEXT MEETING**

Tuesday 13th March 2018, 1.00pm in Training Room 3 & 4, Countess of Chester Hospital.

Countess of Chester Hospital NHS
NHS Foundation Trust

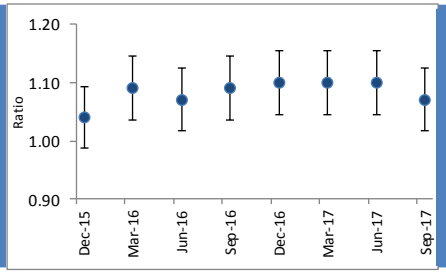
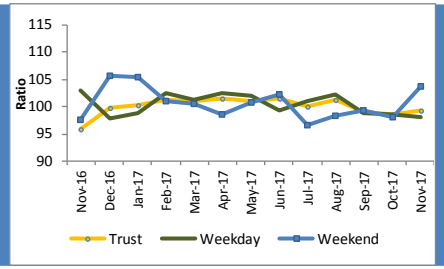
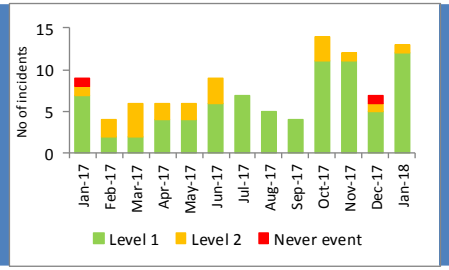
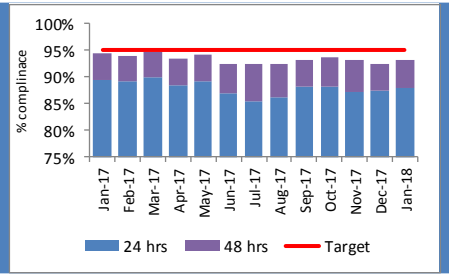
January 2018

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

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

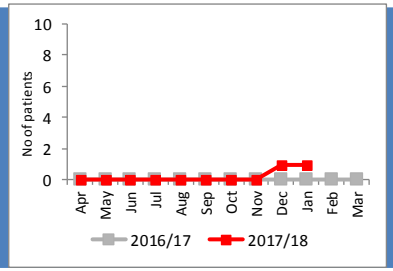
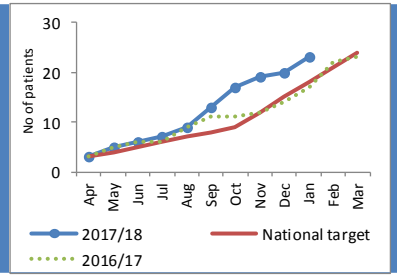
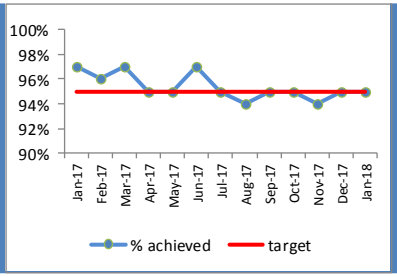
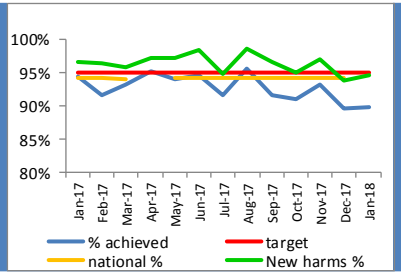
	Description	Current position/comments	Trend	Target
Mortality SHMI	Risk adjusted mortality ratio based on number of expected deaths. National published figure from HSCIC.	A mortality surveillance group is meeting regularly to investigate further including staff from the clinical, coding and Business Intelligence areas.		As expected - Blue Above expected - Red Below expected - Green
Mortality HSMR	Ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death	This measure is based on diagnosis groups that account for approximately 80% of our inpatients. A ratio greater than 100 suggests that more deaths occured then expected, while a ratio of less than 100 suggests fewer deaths occured than expected.The chart is a rolling 12 months.		The predicted rate is 100
Serious Incidents	Level 2 severe harm or death to patient. Never events are serious largely preventable patient safety incidents	There were twelve incidents at level one in January. There was 1 level 2 incidents and no never events reported last month. The Risk and Qualilty team have launched "Key Safety message of the month" to ensure learning from incidents is shared widely across all multi professional teams.		No current target but any never event highlighted as red in month
Electronic Discharge for admitted patients	90% of electronic discharges for admitted pts should be sent within 24 hrs, 95% within 48 hrs and all within 2 weeks	The 24 hour and 48 hour e-discharge performance remained under target in January. An exception report on page 15 has been produced for this indicator.		90% within 24 hrs per month 95% within 48 hrs per month

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

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

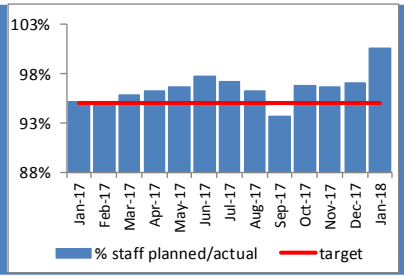
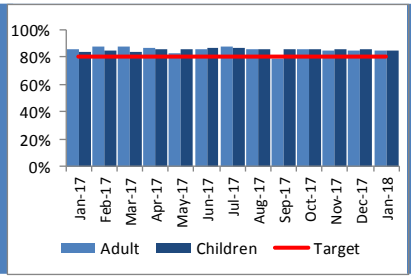
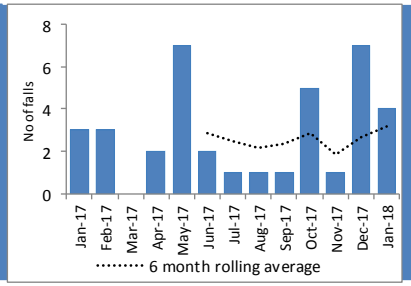
	Description	Current position/comments	Trend	Target
MRSA	Number of cases of hospital acquired MRSA bacteraemia (meticillin-resistant staphylococcus aureusis)	No further cases post 48 hour MRSA identified during January.		Zero avoidable cases for the year
CDiff	Number of cases of Clostridium Difficile	The target for end of year is a maximum of 24 C Diff cases By the end of January we had confirmed 23 cases for the year to date against the trajectory of 18. An exception report is provided on page 16.		24 maximum annual cases
Hand hygiene	Based on ward based hand hygiene audits. Each ward is required to submit two audits each month	Hand Hygiene met the 95% target in December. Work continues to maintain and improve hand hygiene compliance in the Trust.		95% each month
Safety Thermometer	Tool to survey a snapshot of harm free patient care. Includes pressure ulcers, falls, catheters, UTIs and VTE	In January, the figure for patients free of new harms was 94.55%. We are currently awaiting the National average for comparison.		Compare to National average Above average - Green Below average - red

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

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

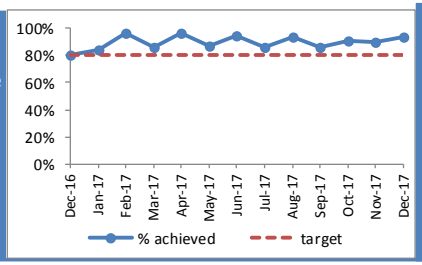
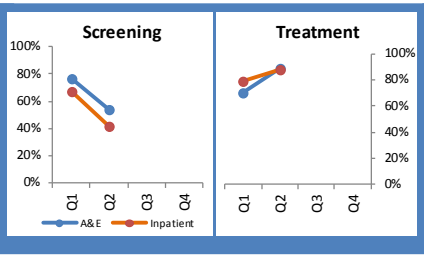
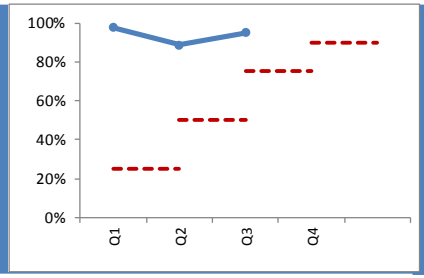
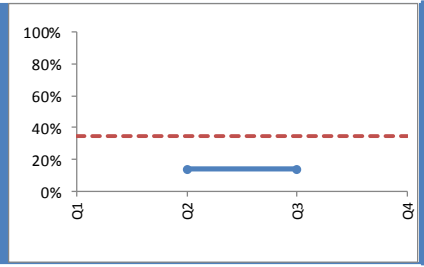
	Description	Current position/comments	Trend	Target
Safe Staffing	Actual staffing compared to planned for registered nurses/ midwives and care staff	See appendix 1 for the nurse staffing ward analysis report.		>95% per month
Safeguarding training	% of level 2 training undertaken to be split by training for Adults and Children	Rates of adult and children safeguarding training at level 2 both remain above the 80% target for January.		>80% in month
Inpatient falls	Inpatient falls with moderate or above harm	There were 4 falls with moderate or above harm recorded in January. See exception report on page 17.		Trend line shows rolling 6month average

Are we effective?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

BAF ref: CR3, CR7, CR10

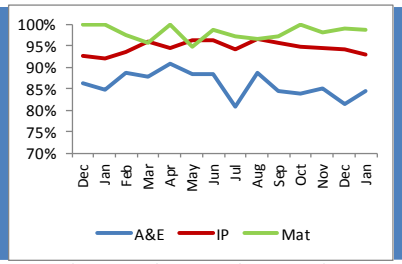
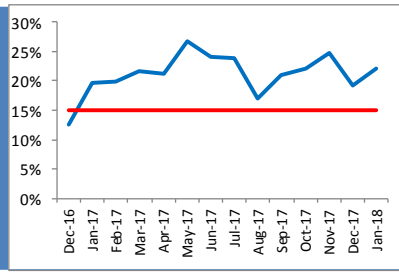
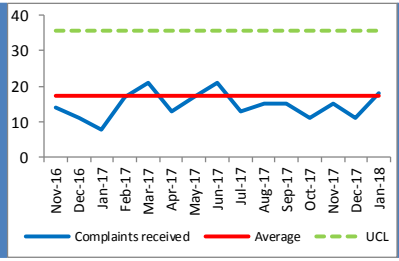
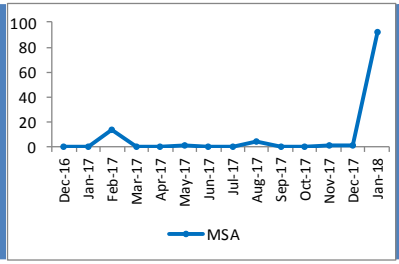
	Description	Current position/comments	13 month rolling trend	Target
Stroke	All Stroke patients who spend at least 90% of their time in hospital on a stroke unit	The target was met for the month of December with 93.5% achieved against a target of 80%. This metric is reported one month behind to allow for coding.		>80% per month
Sepsis screening and treatment	CQUIN 2a/2b Timely identification and treatment of sepsis in ED and acute inpatient settings	Work is ongoing to improve screening and treatment rates towards the 90% target level. An exception report has been created and can be seen on page 18		National CQUIN. 90% of pts with sepsis screened and received IVAB within 1 hour of diagnosis
Antibiotics review	CQUIN 2c Antibiotics review between 24-72 hours for patients with sepsis who are still an inpatient at 72 hours	Performance in Quarter 3 was above the 75% target, with 37/39 prescriptions reviewed within the 24 hour target time (94.9%).		National CQUIN. Target is 25% (Q1), 50% (Q2)
Offering advice and guidance	CQUIN 6 Percentage of GP referrals to elective outpatient specialties which provide A&G	Data collection process is now underway for this CQUIN. Q3 results suggest that we are still in a position where 3 specialties can provide advice and guidance and these specialties accounted for 14% of new, non-urgent GP referred appointments in Q3. An exception report has been created for this indicator and can be seen on page 19.		National CQUIN. Target of 35% of GP referrals providing advice and guidance by end of financial year

Are we caring?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

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

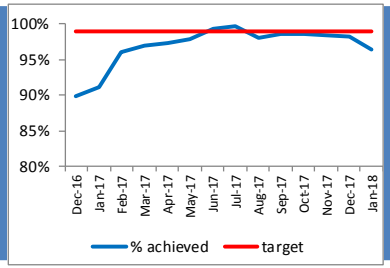
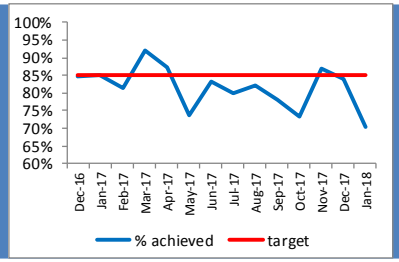
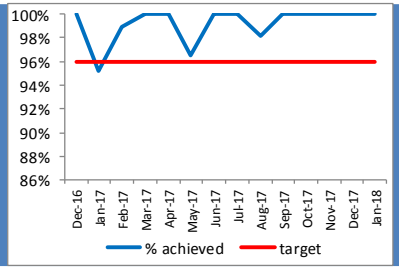
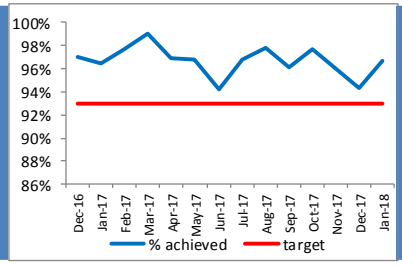
	Description	Current position/comments	Trend	Target
Friends & Family - % likely to recommend	Would patients recommend service to friends & family. Introduced in 2013 for Inpatients, A&E and maternity.	Feedback continues to achieve target. The % likely to recommend scores in January were: - Inpatients 92.9% - A&E 84.3% - Maternity 98.8%		90% for maternity and Inpatients. 80% for A&E
Friends & Family response rate	Number of responses received for IP, A&E and maternity compared to eligible patients	The response rate for January was 22.10%. and remains above the target figure.		>15% per month
Feedback	Monthly Trust complaints and formal thank you letters received by the Trust	In January 2018, the Trust received 18 new formal complaints.		Complaints to be within expected control limits
Mixed Sex accommodation breaches	Number of breaches to the mixed sex accommodati -on standard for non clinical reasons	There were 92 MSA patients in January. As per NHSI guidance this standard has been suspended nationally due to Winter pressures		Zero cases per month

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

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

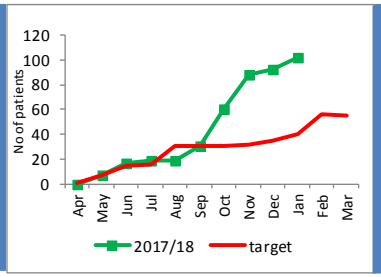
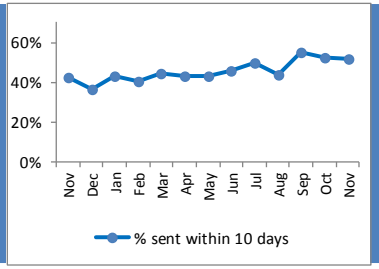
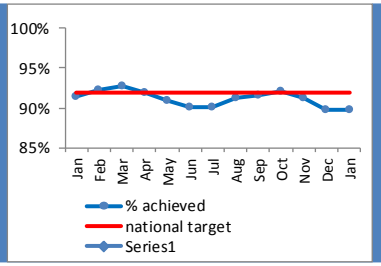
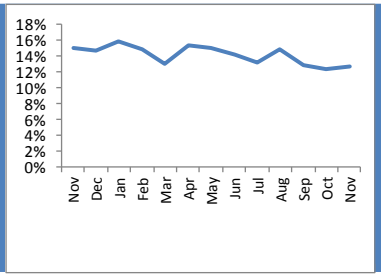
	Description	Current position/comments	13 month rolling trend	Target
Diagnostic 6 week standard	Diagnostic tests to be carried out within 6 weeks of request being received. This is measured on the National DM01 return.	The diagnostics figure continued to underperform in January with a score of 96.3%. An exception report is provided on page 20.		99% per month
Cancer 62 day standard	First treatment for cancer within 62 days of urgent referral through GP 2 week referral route. 85% threshold	The 62 Day performance for January is a provisional underachievement of the standard. An exception report is provided on page 21.		85% per Quarter
Cancer 31 day standard	Patients receiving first definitive treatment within 1 month of cancer diagnosis. The threshold is 96%.	The provisional 31 day figure for January is above the 96% target.		96% per Quarter
Cancer 2 week standard	Patients referred from GP with suspected cancer should have their first appointment within 14 calendar days	Performance against the 2 week standard continues to exceed target.		93% per Quarter

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

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

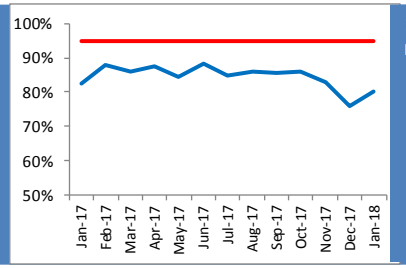
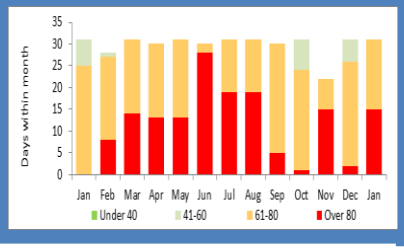
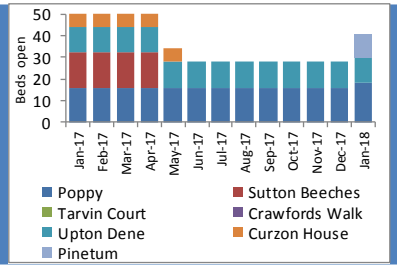
	Description	Current position/comments	Trend	Target
Cancellation due to no beds	Hospital cancellations due to no beds	There were 10 cancellations due to no beds in January. These figures do not include patients cancelled due to critical care beds which are tracked separately.		Internal target based on 2016/17 levels
Outpatient clinic letters	100% of outpatient clinic letters to be sent within 10 days	This data is always two months in arrears. Performance for November shows 52.0% of letters were sent within 10 days. An exception report can be seen on page 15.		Within 10 days from April 2017
RTT incomplete pathways	Percentage of incomplete pathways for English patients within 18 weeks. The threshold is 92%.	RTT incomplete performance has remained at 89.8% compared to the 92% target. The Trust continues to proactively manage all over 35 week waiters. An exception report has been created for this indicator on page 22.		92% per month
Readmission rate	Number of emergency readmissions within 28 days. Excludes patients with diagnosis of cancer, nephrology, obstetrics	This is currently reported two months behind to allow for the readmissions and subsequent coding.		No target agreed

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

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

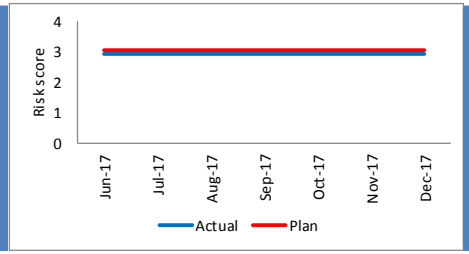
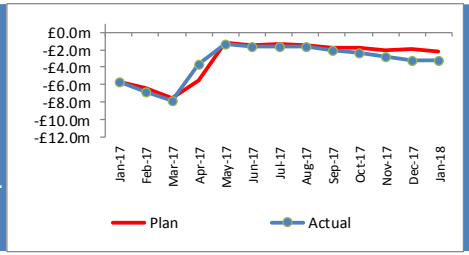
	Description	Current position/comments	13 month rolling trend	Target
A&E 4 hour standard	Maximum wait time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.	Performance was 80.32% in January against the 95% national target. The exception report is shown on page 24.		>95% per month
Medically optimised patients	Number of days within the month where there are medically optimised patients within acute beds	There were 15 days in January when there were over 80 medically optimised patients. The exception report is shown on page 26.		Less than 40 medically optimised patients within acute beds each day (target agreed with CCG)
Number of Intermediate care beds	Number of intermediate care beds open in use in the Community	There were 41 available intermediate care beds at the end of January, with the additional beds at Pinetum.		No target agreed

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

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

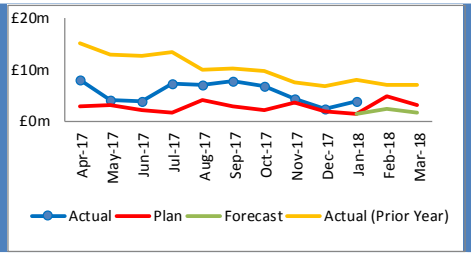
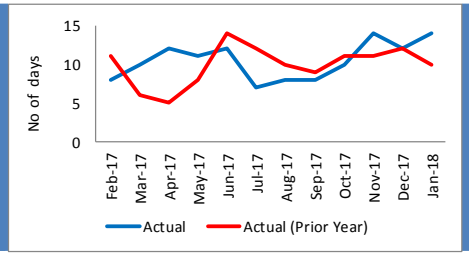
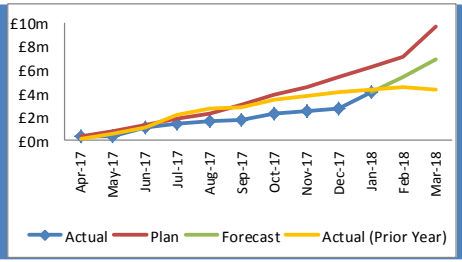
	Description	Current position/comments		
Use of Resources	NHS Improvement's measure of financial risk.	The Trust is currently at a level 4 for Capital Service Capacity , liquidity and I&E Margin rating, which when combined with Plan Variance and Agency expenditure, results in an overall score of 3. Under the Single Oversight Framework 1 is the best score, 4 the lowest. The Trust is currently allocated to a 'segment' of 2, despite the Use of Resources score.		A score of 3 each month (restated)
Normalised net surplus/ deficit	Net income and expenditure after adjusting for hosted services and impairments	As at the end of January 18, we are reporting a £1,147 overspend against plan. Notable pressures include £1,077k in relation to lost STF due to not achieving the A&E target, £310k in relation to Donated Asset transactions., £459k CRS behind plan and Medical & Nursing pay pressures within Urgent Care. Further details provided in the Board		As Plan

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

BAF ref: CR3, CR5, CR6, CR7,

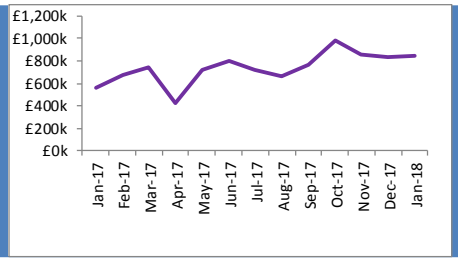
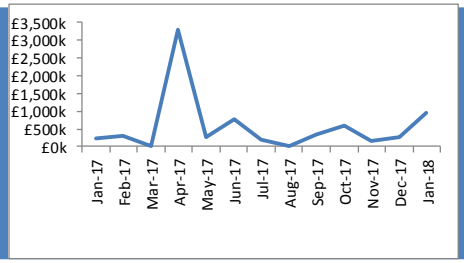
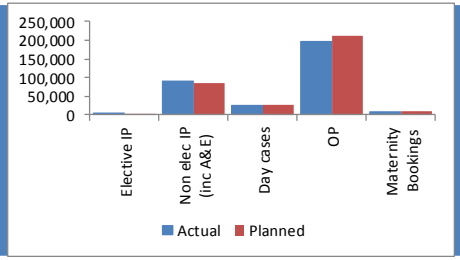
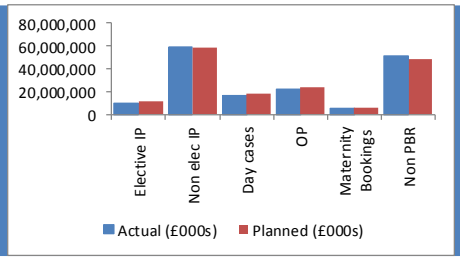
	Description	Current position/comments		
Cash	Cash on deposit <3 month deposit	The closing cash balance at the end of January is £3.9m, £2.4m ahead of plan. £6.1m of the capital loan has been drawn down to date. Going forward, it is now critical to monitor capital and revenue cash seperately, as DH funding is segregated. Distress funding of £1.7m was paid to us on 15/01/17. £1.3m revenue distress funding is due to be paid on 12th February.		£1.5m
Debtor Days	Debtor Days: Trade Debtors divides by income x 365	Debtor days has increased slightly to 14 days at the end of January. Q1 STF monies of £661k and Q2 £726.6 has been received. A first instalment of £267k winter monies has also been received. DTOCs invoices due from Local Authorities remain unpaid. We are currently not receiving payments from Wirral since their system upgrade .We are therefore currently not paying them		No target
Capital Expenditure	Capital expenditure performance against plan / forecast out-turn	YTD capital expenditure of £4.1m has consisted mainly of committed brought forward spend from 2016/17 including the MRI scanner. This is under plan by £2m. The capital programme has now been revisited to be reprioritised and re profiled.		£6.1m

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

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

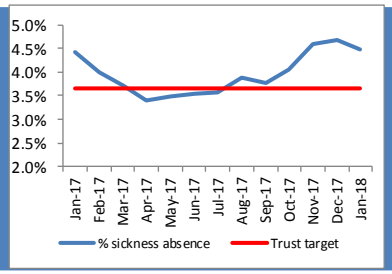
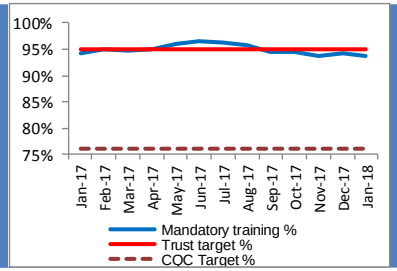
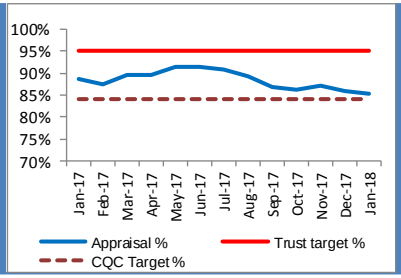
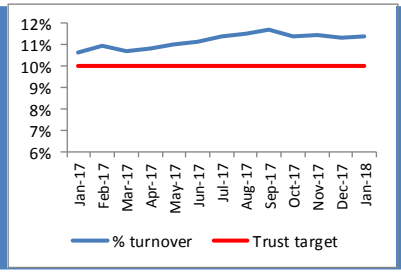
	Description	Current position/comments		
CRS In Year	Planning improvements in productivity and efficiency	Based on the £11.4m revised plan for 2017/18, the CRS programme is £459k behind the profiled plan as at the end of January. In year £9.1m (80%) has been delivered, with £0.4m (3%) of the outstanding amount rag rated green or amber and £1.9m (17%) outstanding rag rated red or black.		No deviation from plan
CRS Recurrently	Planning improvements in productivity and efficiency	Based on the £11.4m revised plan, £6.9m (61%) of CRS savings has been achieved recurrently. Of the outstanding amount, £0.7m (6%) is rag rated green or amber and £3.8m (33%) is rag rated red or black.		No deviation from plan
Contract performance Activity	YTD Contract performance against Trust Planned activity (English & Welsh)	All points of delivery are showing an under performance against plan YTD with the exception of Non-elective activity (+2,939). This is made up of 3,635 Emergency Department attendances more than planned which is offset by an underperformance on non-elective discharges (-695). However this additional NEL activity does not materialise in additional income.		Actual Activity should be greater than Planned activity
Contract performance Financial Value	YTD Contract performance against Trust Planned Value (English & Welsh)	Prior to adjustment for the block contract with WCCCG, the January year to date income position is below plan by -£3,632k. The block contract adjustment to reflect the under performance on WCCCG mitigates £2,923k in year resulting in an adverse position on contract income of -£709k.		Actual Value should be greater than Planned Value

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

BAF ref: CR3, CR4, CR6, CR7

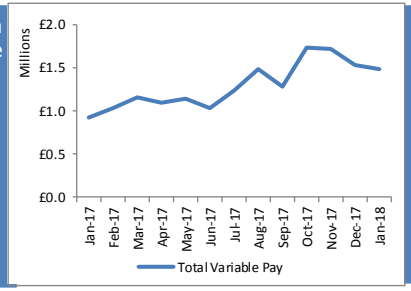
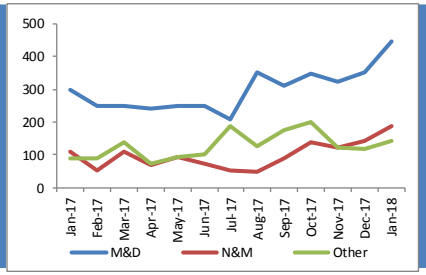
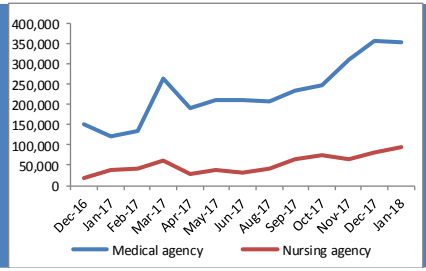
	Description	Current position/comments	13 month rolling trend	Target
Sickness Absence	% sickness absence. Monthly rate excludes Comfort zone and Bank staff	The absence rate reduced to 4.49%, which exceeds the Trust target of 3.65% but when comparing to local trusts, our absence rate is significantly less. The rate for the same period in 2017, was 4.41% & the rolling 12 month average was 4.01%, against 4.7% regionally (eWin extract Nov 2017). Short term absence decreased to 1.73%, while long term absence increased to 2.76%.		Below 3.65% per month
Mandatory Training	Mandatory Training Monthly Rate Excludes Comfort Zone, Bank Staff, Staff on long term sick & mat. leave.	The Trust compliance target has decreased marginally in January with Mandatory Training standing at 93.7%, still exceeding the CQC target (76%) but marginally below Trust target of 95%. When taking into account those already booked to attend, the Trust continues to exceed the Trust target, reporting a slightly higher 95.9% compliance.		95% per month *The CQC target is 76% (the CQC take the results from the Staff Survey)*
Staff with completed Appraisal	Appraisal Monthly Rate Exclusions as above and also excludes staff with less than 1 years service.	Compliance with the Appraisal target has decreased marginally in January to 85.4%, which continues to exceed the CQC target (84%). This is symptomatic with the pressures across the Trust and further details are provided within the exception report.		Above 95% per month *The CQC target is 84% (the CQC take the results from the Staff Survey)*
Staff turnover	Turnover Rate Based on headcount in the previous 12 months and on permanent staff only.	Turnover reduced marginally but remained above target for January at 11.40%. This rate is based on a headcount, turnover by FTE also remained above target at 11.10%. An exception report has been provided.		Below 10% per month

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics January 2018

BAF ref: CR3, CR4, CR6, CR7

	Description	Current position/comments	Breakdown by type by month	Target
Variable Pay	Reducing and controlling variable pay spend (including overtime, agency, additional clinical activity)	Variable pay spend reduced £45k in month and continued to remain higher than at the same period as 16/17 at £1,484k. Increased spend incurred on the Bank, locum payments & ACAs, due to continuing Nursing & Medical vacancies. The year end forecast based on trajectory indicates variable pay spend of £16m, which indicates a 22% or £3m increase on 16/17. Agency spend is forecast to be below the agency cap at £4.1m		To achieve levels of spend in line with 14/15 (£12.876m) delivering £1.6m saving
Agency Shifts Over Cap Rates	M&D Agency shifts over cap rates. 'Other' consists of Care Packages, Sonographers, Theatres and CRV Dept.	Month 10 again demonstrates an increase in shifts above the cap, with 445 medical shifts above cap rates. Operating Department Practioner shifts decreased to 141 shifts approved over the cap. In relation to Nursing shifts, 186 shifts were approved above cap rates. In total, 615 shifts were paid across all staff groups above the cap rates.		A reduction in the total number of agency shifts paid above the cap rate compared to the previous year & month.
Agency spend	Planning improvements in productivity and efficiency	Medical Pay is overspent by £1,329k. Agency medical expenditure is £2,641k (7% of the total medical spend). Nursing Pay is £556k overspent. Agency nursing expenditure is £558k which is 2% of total trained nursing spend. Total Agency spend for April to January is £3,504k. (£2,925k was spent during the same period last year).		Total Agency ceiling set at £4,843m for 17/18

EXCEPTION REPORT

Indicator: Clinical correspondence

Issue:

Performance remains below target for eDischarge in December

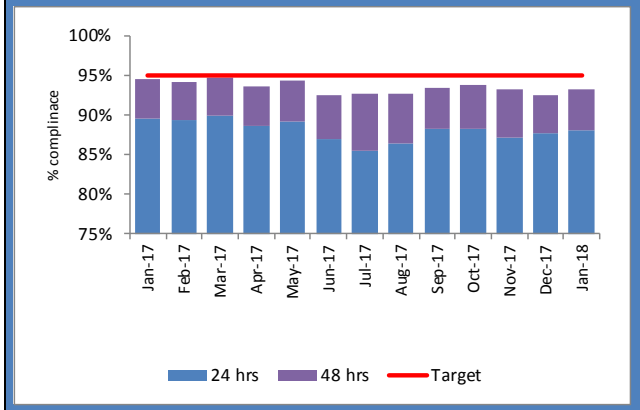
Outpatient letters sent within 10 days performance was slight lower with 52.6% of letters sent within 10 days during October

Proposed actions:

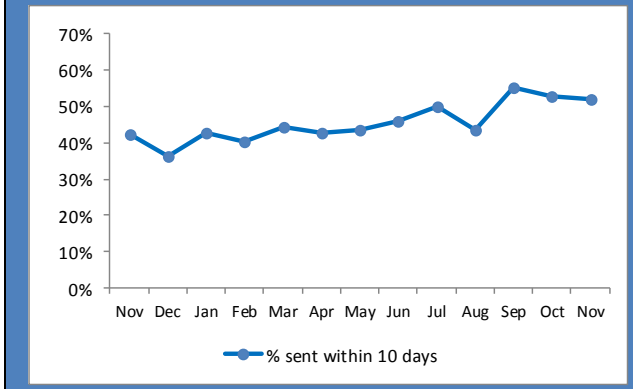
eDischarge - actions are being being led by Medical Director and Associate Medical Directors. Clinical teams to plan and start to complete the eDischarge before discharge. Daily reports are sent out and reviewed by ward clerks and consultants.

Outpatient letters - a number of projects are underway to help improve the sign off process for clinicians, including the continued roll out of Medisec Digital Dictation and a pilot of speech recognition. A review of processes will be required to meet the full compliance.

Historic data:



e-discharge



OP Letters sent within 10 days

Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:

Executive Lead: Ian Harvey, Medical Director

EXCEPTION REPORT

Indicator: Number of MRSA and C. Difficile Cases

Issue:

To date there have been 23 C Diff cases against a target of 18 for the year to date. The end of year target is to record fewer than 24 cases.

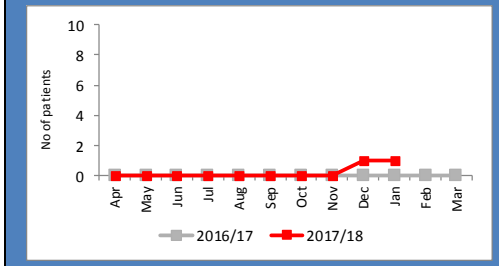
Proposed actions:

C. difficile infection

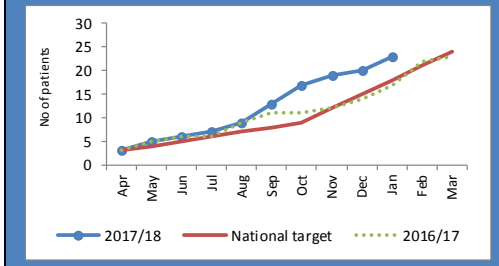
Recent surveillance has demonstrated that the number of cases of C. difficile infection remain within objective for three consecutive months, November 2017 – January 2018 inclusive; although it must be noted that the total number of cases remains above trajectory for this point within the surveillance year – at 23/24 total number of cases for 2017/18.

Case by case surveillance for this infection continues, including a focus on compliance with prevention and control measures.

Historic data:



MRSA



C Difficile vs target

Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:

Executive Lead: Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

Indicator: Falls with harm

Issue:

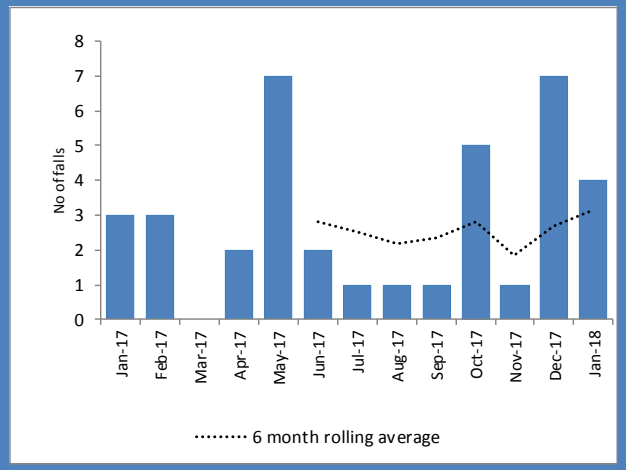
There were 4 inpatient falls causing moderate or severe harm in January.

Proposed actions:

Following review of all recent cases with harm, the following themes are emerging:
- many of the inpatient falls with harm are in patients who are medically optimised and awaiting placement elsewhere
- others are unsupervised falls in patient bathroom areas - non-compliance to 1-1 supervision or zoned bay supervision (the reasons for this varies and is often a result of the staff member attending to another patient)

In response the falls prevention programme lead is also undertaking a review of the enhanced supervision policy

Historic data:



Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:

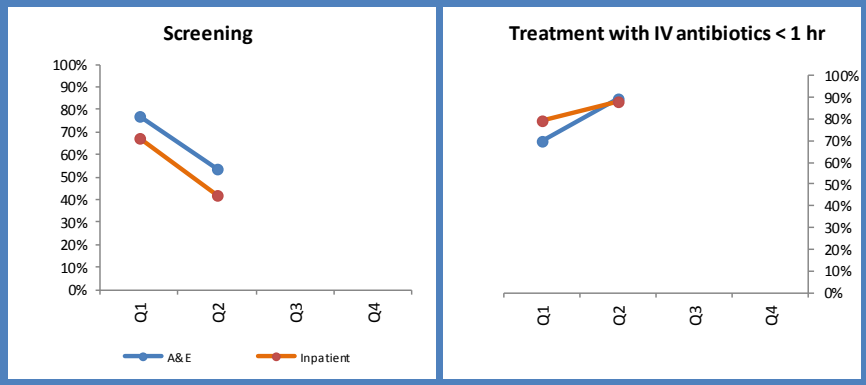
Executive Lead: Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

Indicator: Sepsis

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

Proposed actions:
Following the changes made to improve our data sampling and collection we have seen an expected reduction in compliance to screening. However this provides confidence that a larger proportion of our patients receive the appropriate treatment within the recommended timeframe (shown in the treatment percentages). Work continues on implementing our quality improvement plan and we expect to see an improvement in the percentage for screening during Q4.



Forecast for improvement:			
Q1	Q2	Q3	Q4

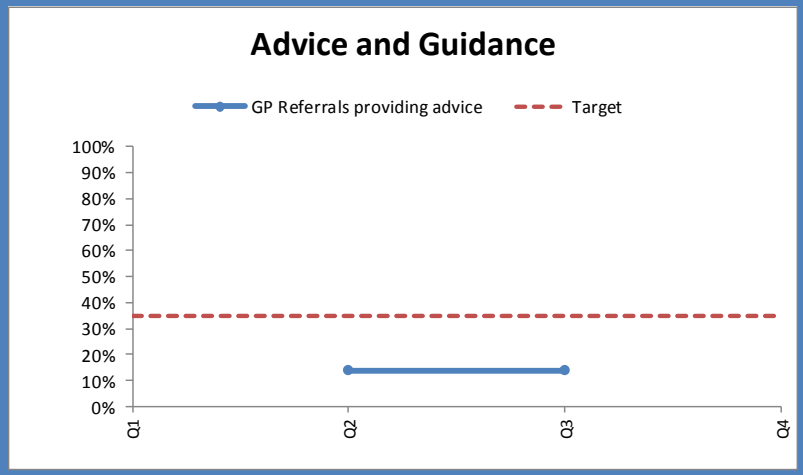
Lead:	
Executive Lead:	Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

Indicator: Advice & Guidance CQUIN

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

Proposed actions:
Agreement to implement eRS system which will provide the mechanisms required to deliver on the CQUIN targets.



Forecast for improvement:			
Q1	Q2	Q3	Q4

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

EXCEPTION REPORT

Indicator: Diagnostic 6 week wait

Issue:

Diagnostic performance is below the 99% target.

Proposed actions:

Endoscopy - The nurse vacancies are now in post, except for 1 RGN who declined before they were just about to commence in post, and are completing their GIN training which is a JAG requirement before they can act as a band 5 in a room with a band 2 nurse. In the meantime we are facilitating the running of rooms with our experienced band 4 nurses to ensure maximum capacity.

A member of staff has had flexi-sig training and will be proving capacity for these types of patients each week starting in February:

- they will progress from 6 patients per list to 10 per list over an 8 week period
- undertake a Colonoscopy course which will see them qualified and scoping around October 2018 providing future capacity
- agreed to a flexible job plan meaning only picking up sessions that would have been stood down which is highly cost effective and there are enough for a complete full time job plan

Sessions have also been offered via a PA to all Consultants. There has been some interest and this is currently being worked through. This offer has also been extended to GP's and we have had one expression of interest so far which is being worked through

Unfortunately we are still experiencing a high number of FTA or cancellations on the day so a separate working group has been set up to tackle this issue which will commence at the end of January. We are also hopeful that Endoscopy can be part of the automated reminder service to help with this.

A large amount of breaches have occurred due to the Trust prioritising FT patients throughout the Christmas period, this has meant a significant number of routine patients have been moved to accommodate and therefore their time waiting has increased

Historic data:

English - Number of exams > 6 weeks

Month End Snapshot	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Magnetic Resonance Imaging	2	0	1	2	24	22	2	1	1			5	5
Computed Tomography				1				3		1		1	4
Non-obstetric ultrasound	8	1	1	3	6		1	1	8	3	5	7	13
Audiology - Audiology Assessments													
Cardiology - echocardiography	373	144	124	112	58	3	4	9	3	3	7	5	10
CRV - Vascular									2	19	10	13	56
Respiratory physiology - sleep studies	0	0	2			2	3	8			1	2	2
Colonoscopy								23	7	5	8	8	20
Flexi sigmoidoscopy									2			9	3
Cystoscopy	15	15	9	2			5	15	10	8	14	16	12
Gastroscopy					1	1	1	15	6	6	20	18	54
Total patients waiting	4467	4027	4542	4231	4166	3917	3908	3721	3775	3872	4215	4399	4799
% < 6 weeks	91.1%	96.0%	97.0%	97.2%	97.9%	99.3%	99.6%	98.0%	98.7%	98.5%	98.4%	98.1%	96.3%

Forecast for improvement:

Q1	Q2	Q3	Q4

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

EXCEPTION REPORT - January 2018
Indicator: 62 day cancer

Issue:

The 62 day performance for January is a provisional underachievement of the standard. There are currently 19 breaches in January, which will now be validated. Initial findings show breaches are broken down under the following specialties:

- Colorectal - 5 breaches
- Gynae - 1 breach
- Head & Neck - 8 breaches
- Lung - 1 breach
- Skin - 1 breach
- Upper GI - 1 breach
- Urology - 2 breaches

The Quarter will be a fail for this target.
N.B. - still awaiting histology for 2x patients (these will be a breach if confirmed cancer).

Proposed actions:

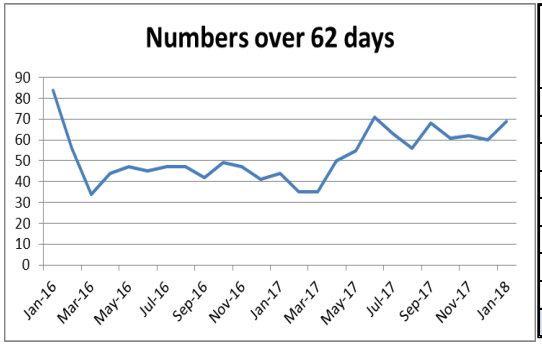
Improvement Plan
The action plan is in the final stages of development and is due to be shared with the Board in March. Individual speciality action plans are currently being developed. Actions continue to reduce the number of patients over 38 days and 62 days in quarter 4 to meximise the chance of achieving from April.
The Cancer Alliance continues to work on developing optimal pathway ways for Colorectal, Prostate and Lung.

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

Forecast for improvement:

Q1	Q2	Q3	Q4

Supporting PTL data:



	PTL between 63 and 99 Days	PTL above 104+ Days	Grand Total
Breast	1		1
Colorectal	20	4	24
Gynaecology	5		5
Haematology	2	2	4
Head and Neck	9		9
Skin	6	2	8
Upper GI	7	1	8
Urology	6	4	10
Grand Total	**56**	**11**	**67**

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

	Total Breaches	% of Trust Breaches
Urology	27	19%
Colorectal	25	17%
Upper GI	24	17%
Head & Neck	19	13%
Lung	13	9%
Haematology	12	8%
Gynae	10	7%
Skin	8	6%
Breast	5	3%
TOTAL	**143**	

Lead:
Executive Lead: Lorraine Burnett, Director of Operations

EXCEPTION REPORT

Indicator: Referral to treatment (18 weeks)

Issue:
RTT incomplete performance for January 2018 under the 92% target at 89.8%

Proposed actions:
The Trust recommenced Inpatient operating on Monday 22nd January, this was following a 2 week period whereby Jubilee Day Surgery Centre (JDSC) was converted into an inpatient environment to accommodate medical escalation. However, there have been continued operational pressures into February with significant numbers of cancellations for patients due to no bed being available. During this period, Cancer and clinically urgent patients were prioritised in line with NHSE guidance. To ensure patient safety, long waiting patients were also prioritised so that there are minimal numbers of patients waiting beyond 30 weeks for an elective procedure Considering the step down in activity and high volume of cancellations both on the day and prior to day of surgery, the Trust has been able to maintain the same RTT position as December. It is likely the RTT position will continue to fail the 92% target for a number of months

January 2018 performance by specialty

	<18Weeks	>18Weeks	Total	%
General Surgery	2078	451	2529	82.2%
Urology	1154	232	1386	83.3%
Trauma & Orthopaedics	1039	134	1173	88.6%
Ear, Nose & Throat (ENT)	2049	75	2124	96.5%
Ophthalmology	1544	227	1771	87.2%
Oral Surgery	993	195	1188	83.6%
Neurosurgery	0	0	0	
Plastic Surgery	402	47	449	89.5%
Cardiothoracic Surgery	0	0	0	
General Medicine	358	3	361	99.2%
Gastroenterology	810	45	855	94.7%
Cardiology	624	22	646	96.6%
Dermatology	701	91	792	88.5%
Thoracic Medicine	409	11	420	97.4%
Neurology	0	0	0	
Rheumatology	259	2	261	99.2%
Geriatric Medicine	192	7	199	96.5%
Gynaecology	907	67	974	93.1%
Other	1181	52	1233	95.8%
Total	14700	1661	16361	89.8%

Forecast for improvement:			
Q1	Q2	Q3	Q4

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

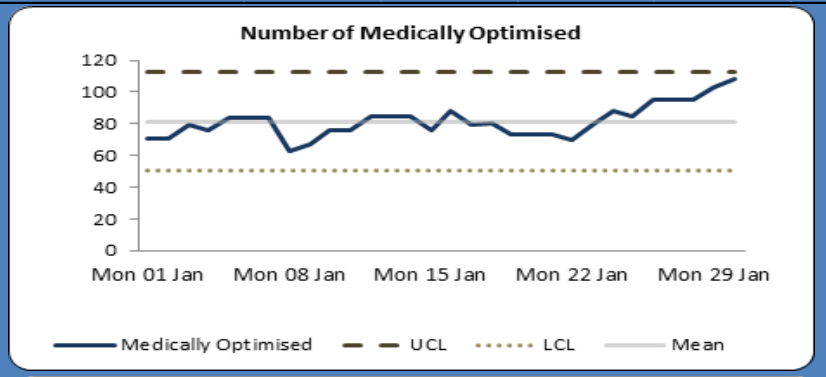
EXCEPTION REPORT

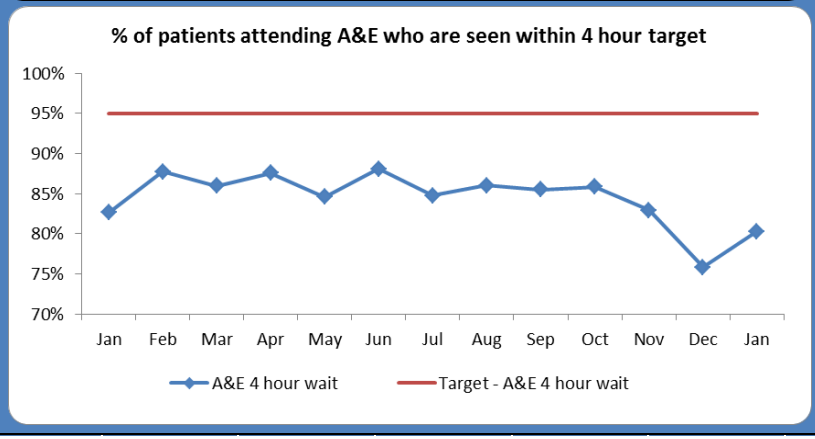
Indicator: A&E 4 hour standard

Issue:
The increased levels of attendances and surges in December has impacted on the Trusts ability to improve its performance against four hours.

Proposed actions:
The Trust has been particularly challenged with high ED attendances and admissions utilising all assessment areas across Planned & Urgent Care for escalation which reduced ability in flow following and subsequent days. Worked with Planned Care to utilise JDSC for 16 medical patients during a two week period to release the assessment capacity and try to improve flow – this has some success for January. An additional 11 beds 'Out of hospital capacity' were available from beginning of January which helped with moving patients outside of acute for on-going assessment needs and Upton Dene was extended to end of financial year. The Trust continue to work closely with NHE/I and ECIP in developing systems to transform and improve patient flow on a more sustainable basis

Historic data:





Forecast for improvement:

Q1	Q2	Q3	Q4

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

EXCEPTION REPORT

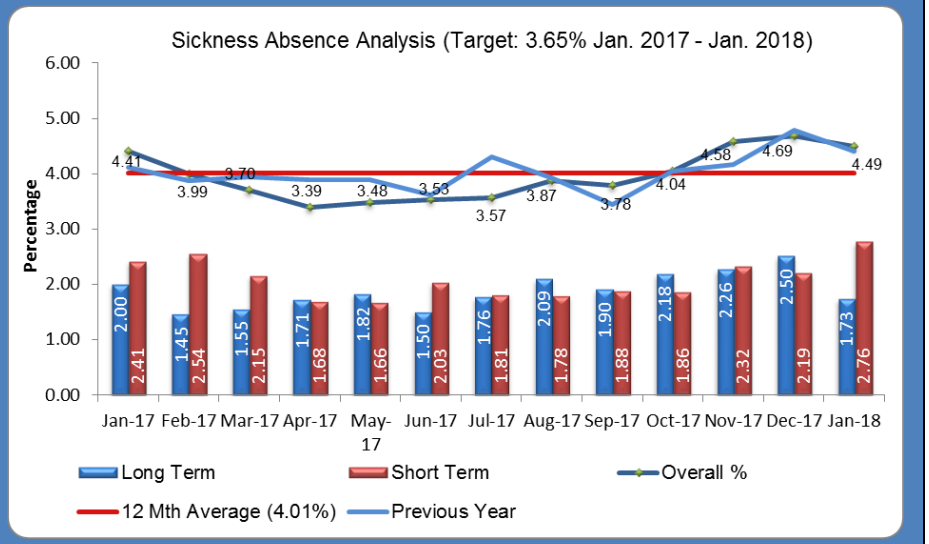
Indicator: Monthly Sickness Absence rate

Issue:
The Trust wide absence marginally decreased in January to 4.49% which still exceeds the Trust target of 3.65%. There has been an increase in long term sickness which has increased to 2.76%, but short term cases have decreased significantly to 1.73%. Sickness absence within Staff groups highlights that Nursing & Midwifery is reporting 4.53% and Support Workers (which include Nursing Assistants) is at 5.89%. When analysing divisional absence, Planned Care is at 5.16% with a number of long term cases returning to work this month. Absence in Urgent Care has come down significantly with careful management to 3.95%. The areas with the most sickness in Corporate areas are HR with 6.01% this is due to one or two long term cases. Facilities has increased to 7.61% with a small number of long term sick cases which due to their nature are being sensitively managed. A plan is also in place to manage the current backlog of OH referrals.

Proposed actions:
Absence in all areas of the Trust continues to be monitored with detailed analysis taking place in all areas. Additional support has been put in place within the Occupational Health & Wellbeing Team to ensure there is a timely process for referral management but this continues to cause a cost pressure. Joe O'Grady is extending the provision of stress clinics and we now have in post a dedicated resource for the health & wellbeing agenda shared with the Manual Handling Team.

Forecast for improvement:			
Q1	Q2	Q3	Q4

Historic data:



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

EXCEPTION REPORT

Indicator: Mandatory Training Completed In The Last 12 Months

Issue:

Despite a period of significant pressures upon our organisation, mandatory training compliance has not significantly reduced since August 2017. With completion figures of 93.7%, and "booked on" remaining over the trust target of 95%. Both continue to far exceed the CQC target of 76%. We anticipate the figures to increase if the ongoing pressures reduce in the coming months, and the link to incremental pay policy may be a significant factor.

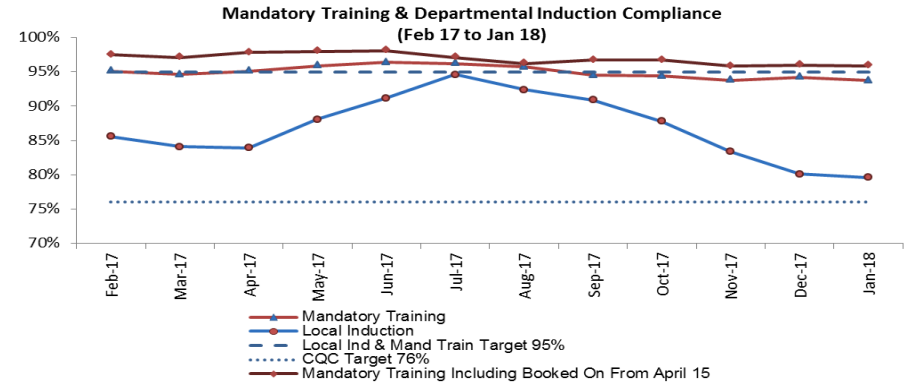
Local Induction compliance has fallen to an overall rate of 79.6% . There has been a sharp fall from July 17 of 95% but it should be noted this reflects a similar trend as the previous 12 months.

Proposed actions:

Whilst we will continue to monitor and feedback compliance, we must identify why specific divisions are unable to achieve targets and put measures in place to support them. We continue to review our mandatory training provision to allow staff easier access through multiple modalities, including provision of bespoke days for porters, annual skills update days for Nurses and nursing assistants (SUN Courses), and improvements to ESR (Elearning)

In 2018, we are revising the local induction pathway to reflect regional changes agreed by the streamlining group. This offers an opportunity to highlight the importance of the process to all staff groups.

Historic data:



Mandatory Training Table January 2018

Position	Division	Compliance
1	COCH & WUTH Collaboration	100.0%
2	Corporate Clinical	100.0%
3	Estates	97.4%
4	Finance & Performance	94.7%
5	Diagnostics and Pharmacy	94.6%
6	Urgent Care	94.3%
7	Human Resources	93.8%
8	Planned Care	93.4%
9	Facilities	91.7%
10	Corporate Non - Clinical	88.0%
11	Nurse Management	77.4%
	Total	93.7%

Local Induction Table January 2018

Position	Division	Compliance
1	Nurse Management	100.0%
2	COCH & WUTH Collaboration	100.0%
3	Human Resources	100.0%
4	Facilities	88.2%
5	Planned Care	86.8%
6	Finance & Performance	84.2%
7	Diagnostics and Pharmacy	82.8%
8	Urgent Care	70.4%
9	Corporate Non - Clinical	70.0%
10	Estates	-
11	Corporate Clinical	-
	Total	79.6%

Forecast for improvement:

Q1	Q2	Q3	Q4

Lead: Dee Appleton-Cairns, Deputy Director of HR

Executive Lead: Sue Hodkinson

EXCEPTION REPORT

Indicator: Appraisals Completed In The Last 12 Months

Issue:

An overall rate of 85.4% compliance reflects a further fall from the trust target of 95%, and risks dropping below the CQC standard of 84%. In 2017, these figures increased after the winter pressures and we would anticipate similar improvements in 2018.

Proposed actions:

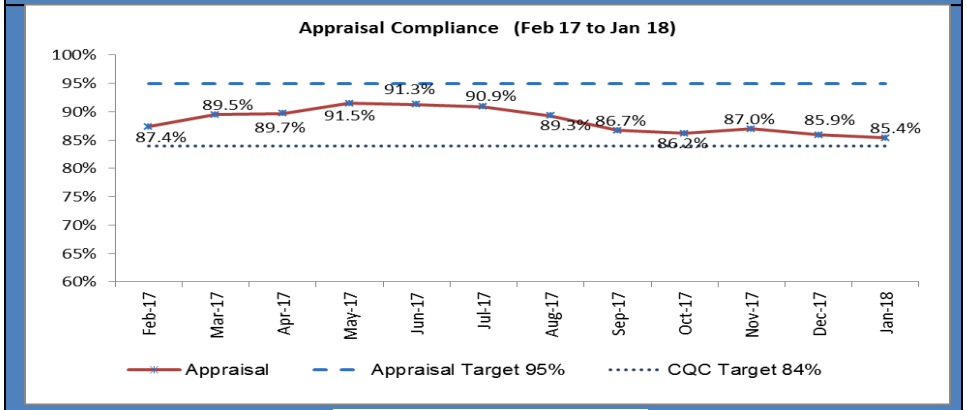
Whilst we continue to report monthly on appraisal rates, the compliance figures remain largely unchanged. 2018 sees the launch of our "Trust Behavioural Standards" workshops available to all staff, providing an opportunity to engage with our staff and managers and gain buy in to the process.

Individual departments with particularly low compliance rates will be contacted to ascertain any specific problems that we can assist with.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Appraisal Table January 2018

Position	Division	Compliance
1	Facilities	96.2%
2	Corporate Clinical	92.3%
3	Human Resources	91.5%
4	Planned Care	90.2%
5	Estates	88.9%
6	Finance & Performance	84.6%
7	Diagnostics and Pharmacy	84.6%
8	Urgent Care	79.5%
9	Nurse Management	76.9%
10	Corporate Non - Clinical	74.6%
11	COCH & WUTH Collaboration	68.8%
	Total	85.4%

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

EXCEPTION REPORT

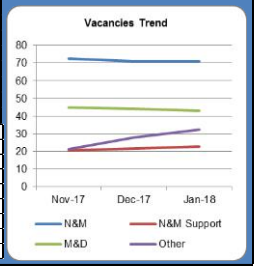
Indicator: Variable Pay

Issue:

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

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

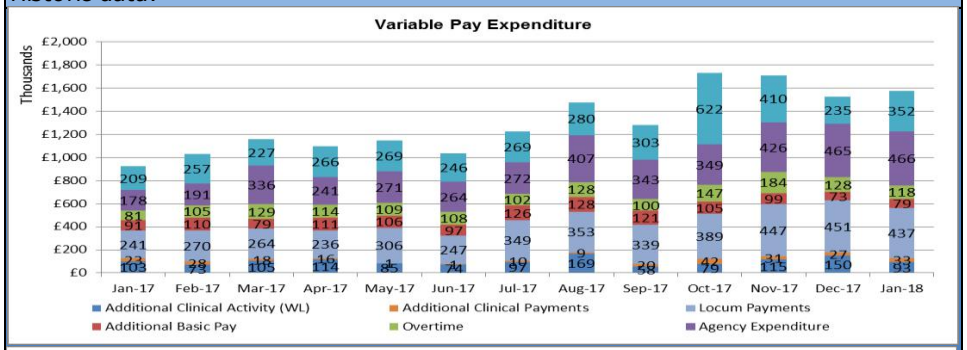
Vacancies (FTE)	Urgent Care	Planned Care	Diag/Radiol/Pharm	Total
N&M Registered	24.79	46.35	0.00	**71.14**
Support Staff	12.76	7.80	2.00	**22.56**
Radiographer/Sonographer	0.00	0.00	9.80	**9.80**
Allied Health Professionals	3.00	0.00	0.00	**3.00**
Healthcare Scientist	0.00	0.70	1.60	**2.30**
Pharmacy Support	0.00	0.00	10.76	**10.76**
Pharmacist	0.00	0.00	6.38	**6.38**
Total	**40.55**	**54.85**	**30.54**	**125.94**

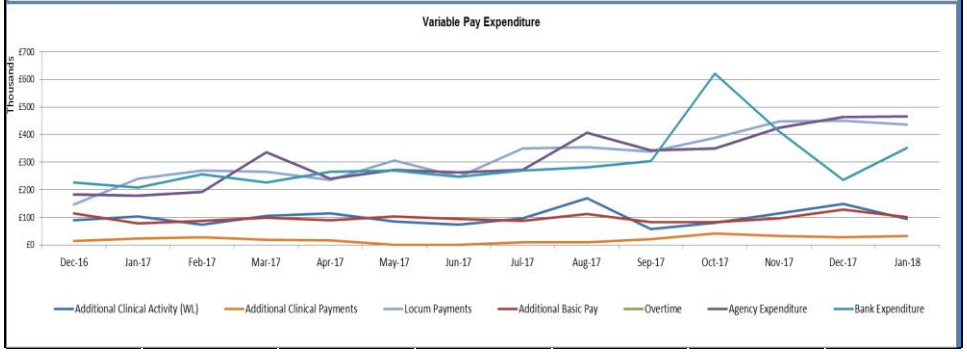


Proposed actions:

Recruitment: the Trust has attended a regional nursing job fairs, with its new Nurse recruitment video achieving very positive results with 61 nurses interested in joining the Trust. As a result, a nursing open day is in the process of being agreed. To support medical recruitment, we are exploring a further video alongside social media campaign. We have also secured a small cohort of non-EU nurses. However, we are continuing to experience a reduction in the certificate of sponsorship approvals for non-EU medical posts, which the Trust has escalated nationally. Retention: retention meetings continue with significant actions in place. Alongside the move to weekly bank pay, the nursing pay rates have been revised. A Variable Pay QI Workshop is planned for 1st March with key stakeholders, with a further workshop planned for 29th March, to ensure plans are fully developed for 18/19.

Historic data:





Forecast for improvement:			
Q1	Q2	Q3	Q4

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

EXCEPTION REPORT

Indicator: Turnover

Issue:

Turnover remained above target at 11.40% but reduced marginally in month. The rate based on FTE is also above target at 11.10%. The staff groups over target are: Add Prof Scientific and Technical at 10.66% which represents 18 leavers, Additional Clinical Services at 10.21%, which represents 92 leavers in the last year, 64 of which were Nursing Assistants. Allied Health Professionals at 13.24%, representing 31 leavers in the last year. Administration and Clerical has increased to 12.96% representing 120 leavers in the last 12 months (8 of which were MARs & a further 15 age retirements). Nursing & Midwifery Registered Staff decreased to 12.60% with 13 Midwives and 110 Staff Nurses leaving the Trust in the last year. There are no current trends for leavers recorded on ESR or in exit interview analysis.

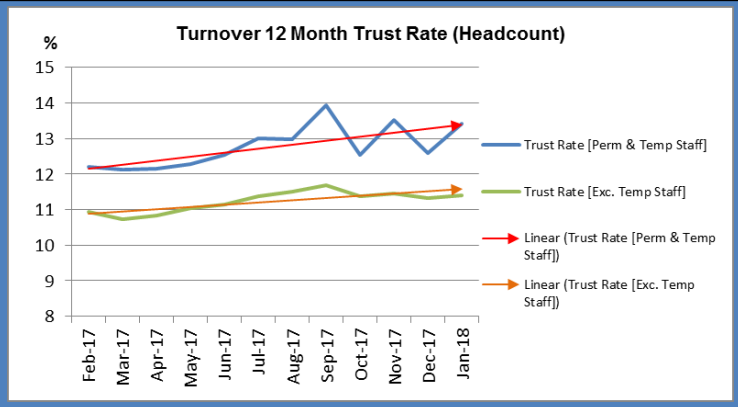
Proposed actions:

Significant focus is being placed on retention of staff particularly within the nursing, midwifery and medical staff groups. Exit interviews are also looking to be updated to include questions around if a member of staff would return if a suitable post becomes available. Leaving information entered onto ESR has been inconsistent, making reporting on why staff are leaving the Trust less accurate but the introduction of a Resignation Form & process is aimed at improving this input and reporting in 2018. It is important to note that the North West average based on headcount is 14.65% (15.47% for Acute Trusts) according to EWin at November 2017.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Staff Group - Feb 17 - Jan 18 Excludes Temporary Staff	Turnover %
Add Prof Scientific and Technic	10.66
Additional Clinical Services	10.21
Administrative and Clerical	12.96
Allied Health Professionals	13.24
Estates and Ancillary	8.67
Healthcare Scientists	9.34
Medical and Dental	8.51
Nursing and Midwifery Registered	12.60
Trust Totals & Rate	**11.40**

Lead: Dee Appleton-Cairns, Deputy Director of HR

Executive Lead: Sue Hodkinson

EXCEPTION REPORT

Indicator: Agency Spend

Issue:
Medical Pay is overspent by £1,329k. Agency medical expenditure is £2,641k (7% of the total medical spend). Nursing Pay is £556k overspent. Agency nursing expenditure is £558k which is 2% of total trained nursing spend. Total Agency spend for April to January is £3,504k. (£2,925k was spent during the same period last year)

Agency Spend by Staff Group	14/15	15/16	16/17	17/18 YTD to Jan 18
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 75,670
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 2,641,101
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 557,541
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 142,960
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 86,753
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 3,504,024**

Proposed actions:
See actions proposed under Variable Pay.

Nurse Staffing January 2018

Below 90% of planned staff hours were worked

Between 90% and 94% of planned staff hours worked

Between 95% and 100% of planned staff hours worked

Over 100% of planned staff hours were worked

Ward Name	Specialty	Staffing Rate	Vacancies	Sickness Absence	CHPPPD (Avg long term)	CHPPPD (This month)	CHPPPD variance (This month)	Pressure Ulcers at Grade 2+	Falls with moderate and above harm	Red Flags (Patient Risks)	Red Flags (Staffing Risks)	Care Metrics	VTE Assessment (provisional)
Bluebell	EPH Rehabilitation	107.6%	TBC	7%	6.10	5.68	-0.4	0	0	0	2	-	NA
Children's	Paediatrics	97.1%	TBC	4%	NA	12.93	NA	0	0	0	5	98%	NA
ICU	Adult Intensive Care	94.9%	TBC	4%	26.56	26.41	-0.2	2	0	0	1	99%	100%
Labour	Maternity	103.6%	TBC	-	NA	19.19	NA	0	0	11	1	NA	99%
NNU	Neonatal Unit	89.0%	TBC	4%	NA	15.57	NA	0	0	0	0	91%	NA
Poppy	Intermediate Care Unit	117.8%	TBC	4%	6.70	5.94	-0.8	1	1	1	6	99%	50%
Renal	Renal	101.3%	TBC	3%	NA	NA	NA	0	0	0	0	90%	100%
Ward 32	Maternity	97.4%	TBC	8%	NA	NA	NA	0	0	4	1	NA	95%
Ward 33	Stroke	97.3%	TBC	2%	6.41	6.72	0.3	0	0	2	1	97%	100%
Ward 34	Intermediate Care Unit	92.0%	TBC	7%	4.04	4.15	0.1	0	0	0	6	NA	NA
Ward 40	Women's Surgical	95.1%	TBC	10%	7.45	7.31	-0.1	0	0	1	10	96%	91%
Ward 41	Surgery	99.6%	TBC	4%	5.47	5.15	-0.3	1	0	0	18	95%	93%
Ward 42	Cardiology	110.2%	TBC	3%	8.29	8.62	0.3	0	0	3	6	99%	100%
Ward 43	Haematology/Oncology	104.9%	TBC	4%	6.85	6.69	-0.2	0	0	8	10	96%	0%
Ward 44	Surgery	97.6%	TBC	7%	5.09	5.12	0.0	0	2	11	12	97%	97%
Ward 45	Surgery	108.0%	TBC	2%	5.27	6.71	1.4	0	0	6	20	98%	100%
Ward 47	Acute Medical Unit	93.5%	TBC	6%	6.39	6.92	0.5	0	0	1	20	99%	97%
Ward 48	Respiratory	104.4%	TBC	3%	6.48	5.97	-0.5	1	0	0	3	95%	100%
Ward 49	Gastroenterology	95.5%	TBC	9%	5.09	5.29	0.2	0	0	0	12	95%	100%
Ward 50	Care of the Elderly	105.3%	TBC	7%	5.30	5.52	0.2	0	0	1	7	-	NA
Ward 51	Care of the Elderly	107.4%	TBC	4%	5.66	5.54	-0.1	0	0	4	0	99%	NA
Ward 52	Trauma & Orthopaedics	95.5%	TBC	8%	5.62	5.53	-0.1	0	0	3	2	96%	97%
Ward 53	Vascular	99.4%	TBC	9%	6.17	5.99	-0.2	0	1	3	14	97%	92%
Ward 54	General Medicine	107.4%	TBC	8%	5.61	4.57	-1.0	0	0	0	5	93%	NA
Ward 60	Haem / Oncology	86.6%	TBC	5%	NA	NA	NA	0	0	14	5	96%	100%

Appendix 2: Cancer Board Report, Quarter 3 2017/18

Overview of finalised performance for all cancer targets

The following table provides the final confirmed performance for all cancer standards.

	Oct	Nov	Dec	Quarter 3
14 Day (93%)	97.61%	95.98%	94.36%	96.08%
14 Day - Breast Symptomatic (93%)	98.31%	84.48%	88.89%	90.85%
31 Day - Diagnosis to Treatment (96%)	100.00%	100.00%	100.00%	100.00%
31 Day - Surgery (94%)	100.00%	96.15%	91.30%	95.45%
31 Day - Drugs (98%)	100.00%	100.00%	100.00%	100.00%
62 Day - Referral to Treatment (85%)	73.58%	87.07%	83.90%	81.76%
62 Day - Screening (90%)	76.00%	100.00%	100.00%	89.66%
62 Day - Upgrade (85%)	95.89%	100.00%	93.75%	96.57%

14 Day Breast Symptomatic Target

The 14 Day Breast Symptomatic was a quarter fail for the speciality, due to unplanned consultant absence and increase in referrals during October and November. In December there were a low number of referrals which affected the denominator.

62 Day Screening Target

There were three breaches for this target in October and due to the small number of treatments this has affected the denominator causing the quarter to fail.
Two of three referrals were received late from the Bowel Screening programme, and subsequent delays were due to complexity, diagnostic and admin delays.

62 Day Referral to Treatment Performance

Performance details by speciality:-

	Oct	Nov	Dec	Quarter 3
TRUST POSITION	73.58%	87.07%	83.90%	81.76%
Breast	100.00%	100.00%	100.00%	100.00%
Gynaecology	40.00%	33.33%	85.71%	60.00%
Haematology	0.00%	66.67%	40.00%	35.29%
Head & Neck	33.33%	50.00%	100.00%	50.00%
Lower GI	46.15%	75.00%	100.00%	68.42%
Lung	44.44%	100.00%	100.00%	66.67%
Sarcoma	100.00%	100.00%	100.00%	100.00%
Skin	92.00%	95.74%	100.00%	96.04%
Upper GI	66.67%	100.00%	50.00%	60.87%
Urology	88.24%	85.71%	77.78%	83.08%

Quarter 1 – Breach Overview for 62 days by Speciality – 2017/2018 Performance

	Total Breaches	% of Trust Breaches
Urology	25	20%
Upper GI	23	19%
Colorectal	20	16%
Haematology	12	10%
Lung	12	10%
Head & Neck	11	9%
Gynae	9	7%
Skin	7	6%
Breast	5	4%
TOTAL	**124**	

	Colorectal	Gynaecology	Haematology	Head & Neck	Lung	Skin	Upper GI	Urology	Grand Total
October	**4**	**2**	**2**	**1**	**3**	**1**	**2**	**1**	**16**
Admin Delay	1					1			2
Complex Pathway		1	1		2				4
Diagnosis delayed for medical reasons (Patient unfit for diagnostic episode)					1				1
Healthcare Provider Initiated Delay	1								1
Outpatient capacity inadequate	1		1	1			2	1	6
Patient did not attend an appointment for a diagnostic test or treatment planning event		1							1
Treatment Delayed for Medical Reasons	1								1
November	**3**	**1**	**1**	**1**		**1**		**2**	**9**
Complex Pathway	2		1						3
Elective Capacity Inadequate						1		1	2
Healthcare Provider Initiated Delay		1		1					2
Outpatient capacity inadequate	1							1	2
December		**1**	**3**				**3**	**4**	**11**
Complex Pathway			1						1
Healthcare Provider Initiated Delay		1	2				3	4	10
Grand Total	**7**	**4**	**6**	**2**	**3**	**2**	**5**	**7**	**36**

This quarter has shown a poor performance for transfers out of the Trust to a tertiary centre for treatment by Day 38 (all diagnostics have to be completed and reported).

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

	Before Day 38	After Day 38	% of Total Transfers – After Day 38
Upper GI	4	22	24%
Urology	8	19	21%
Lung	41	12	13%
Head & Neck	18	11	13%
Colorectal	3	11	13%
Gynaecology	12	10	11%
Haematology	0	2	2%
Skin	0	2	2%
Breast	13	1	1%
Other/Sarcoma	2	1	1%
TOTAL	**101**	**91**	**47%**

The main reasons for late transfers continue to be the first outpatient appointment are around day 14, lack of diagnostic capacity (endoscopy, radiology and theatre biopsy's) for both appointments (approx. 10-12 day wait) and delays reporting of results. Patients still require discussion at MDT and also a clinic appointment to discuss results and if further investigations are required etc., prior to transfer.

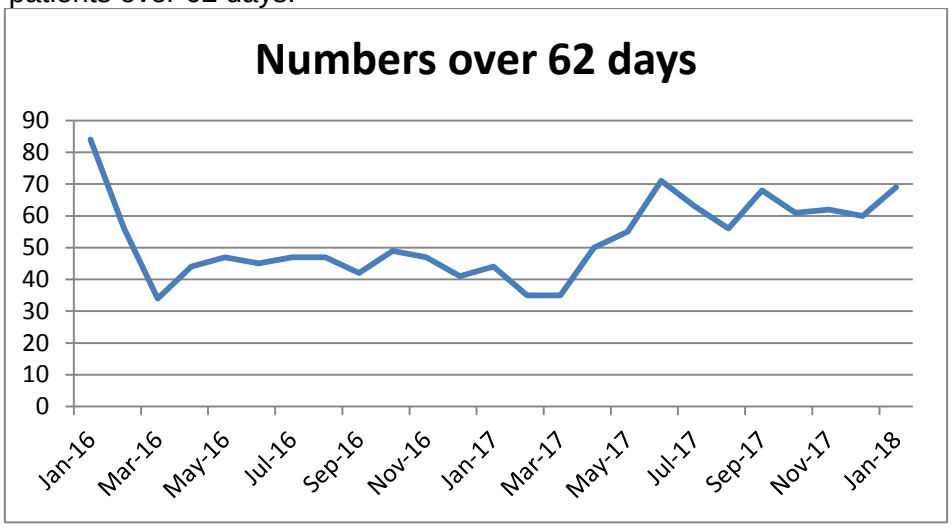
Improvement Plan

An improvement event took place in January and an action plan is being developed. Individual speciality action plans are also being developed with both clinical and operational leads.

The Cancer Services team are now using a new PTL that allows more functionality and oversite on a daily basis, and also improving the escalation process. This is now being rolled out to the operational divisions and also a plan for the clinical teams to use.

PTL Position

The following chart provides an updated summary of the current progress in relation to the number of suspected patients over 62 days.



The following table provides a summary of the PTL position week ending 26/01/18 for patients waiting above 62 days and identifies the number of patients over 104 days.

	PTL between 63 and 99 Days	PTL above 104+ Days	Grand Total
Breast	1		1
Colorectal	20	4	24
Gynaecology	5		5
Haematology	2	2	4
Head & Neck	9		9
Skin	6	2	8
Upper GI	7	1	8
Urology	6	4	10
Grand Total	**56**	**11**	**67**

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Financial Position – Month 11, February 2018
Date of Meeting	Board – Tuesday 13th March 2018
Author(s)	Mr Simon Holden, Interim Chief Finance Officer
Annual Plan Objective No.	
Summary	This paper is intended to provide details of the Trust's financial position, as at 28th February 2018 (Month 11)
Recommendation(s)	**The Board is asked to:** Directors are asked to note: • The overspend in February (Month 11) of £1,471k against plan, being made up as follows, namely: o Underlying position before STF funding, (£178k) favourable being the "monitored" position; o The STF & Donated Asset position is £1,649k adverse, principally due to low levels of A&E performance (resulting in penalties of £1,258k) and a technical accounting issues relating to donated assets (£391k adverse); culminating in o The reported net position of £1,471k adverse (overspend) against plan • The total Contract Income headline being £3.8m shortfall below plan, with £0.9m being attributable to Welsh and "other" English contract underperformance although subject to further investigation; • The relatively tight operational financial performance, being offset by a number of non-recurrent initiatives, although noting a plan is in place to deliver the amended Control Total by 31st March 2017; • Cost Reduction Scheme (CRS) delivery is off plan by £466k, also the program is back loaded. Hence, mitigations are being developed to ensure delivery of red and black items. • An indication of the potential best, probable, and worst case forecast outturns; • The underlying risks to achievement of the Trust's Control Total, which are currently being managed; • The continued proactive management of the Trust's cash balances; and • The work on going currently with regards to the 2018/19 financial position, with a view to further board discussion and sign off before final submission.

Risk Score	N/A
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [X] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

NHS
Countess of Chester Hospital
NHS Foundation Trust

Board of Directors

Financial Position
Month 11 2017/18

1.0 Executive Summary

- As at 28th February 2018, the Trust is reporting an overspent position of £1,471k against the plan.
    - Pre STF –the position shows a favourable variance of (£178k).
        - ❖ *NB. It should be noted that it is this "Pre STF position" that is the number against which NHS Improvement use to monitor the Trust's performance.*
    - Post STF & Donated Asset Transactions - the position shows an adverse variance of £1,471k (i.e. it deteriorates by £1,649k), due to the Trust failing the A&E 4 hour target (for April through to February) and the subsequent loss of £1,258k STF and, in addition, an adverse movement of £391k relating to donated assets.
- The strongly caveated forecast position for the year, before Donated Assets, being
    - Best case scenario delivers £3.1m more than required control total, assuming the Trust is able to take advantage of a financial opportunity in relation to the Neonatal build.
    - Most probable case forecast outturn on plan, with exception of loss of STF for A&E performance; and
    - Worst case forecast outturn of £4.1m off plan (prior to loss of STF) with key risks identified as CRS and increasing costs to deliver winter.
- As previously reported, the CRS target had been reduced by £1m to reflect the change in the control total (by NHS Improvement). This has reduced the unidentified target profiled in month 12, so consequently has not impacted on the year to date position on CRS which is currently behind the planned profile by £466k.
- Capital expenditure is £4.2m year to date.
- The underlying significant risks to achievement of the Trust's required Control Total, which are being managed, of circa £4.1m (worst case scenario) pre any mitigation.

2.0 Overview

	Original Annual Budget 2017/18 £000s	Restated Annual Budget 2017/18 £000s	Feb YTD Budget 2017/18 £000s	Feb YTD Actual 2017/18 £000s	Feb YTD Variance 2017/18 £000s
Pre STF	7,817	8,817	8,566	8,388	(178)
STF	(5,189)	(5,189)	(4,583)	(3,325)	1,258
Post STF Control Total	**2,628**	**3,628**	**3,983**	**5,063**	**1,080**
Donated Asset Transactions	(433)	(433)	(366)	25	391
I&E Deficit (pre impairments)	**2,195**	**3,195**	**3,617**	**5,088**	**1,471**

The financial position Pre STF is a (£178k) favourable variance, with the following key points to note: -

- Contractual Income is potentially £0.9m off plan (after a block adjustment of £2.9m in relation to WCCCG activity, therefore the underlying recurrent income position is off plan by £3.8m to date);
- The Winter Escalation Ward has now been open all year, utilising the full Winter Reserve set aside at the start of the year. The financial position assumes receipt of additional winter monies;
- Income of £577k has been assumed in the position for Delayed Transfers of Care (DTOCs) for April to February. It is anticipated that this invoice may be challenged, and potentially legal action maybe required, and it is therefore high risk;
- Urgent Care continues to experience both Medical & Nursing Pay pressures above the funded budget, of circa £1,518k and £766k respectively after 11 months;
- At the end of February the value of the Red & Black CRS schemes totals £1.6m. Of which, £1.4m is within divisions and departments and £0.2m is the centrally held unidentified target; and
- Significant non recurrent resource has been utilised to support the financial position circa £3m.

For information: -

- The STF variance of £1,258k is due to the loss of STF funding for missing the A&E target for April to February.
- The Donated Asset Transactions variance of £391k is due the delay in spending against the Baby-grow Appeal against previously submitted plans.

Please note the agreed change to the control total is represented in the table below:

KEY VARIANCES	Annual Budget £000s	Feb YTD Budget £000s	Feb YTD Actual £000s	Feb YTD Variance £000s	Feb YTD Variance % of budget
INCOME					
Income - England	(172,081)	(157,119)	(157,199)	(80)	0.1%
Income - Wales	(26,050)	(23,799)	(22,839)	960	-4.0%
Other Clinical Income	(12,435)	(11,453)	(11,288)	166	-1.4%
Non Patient Income	(14,053)	(13,052)	(14,477)	(1,425)	10.9%
INCOME	**(224,618)**	**(205,423)**	**(205,803)**	**(380)**	0.2%
PAY					
Nursing	57,353	52,687	53,319	632	1.2%
Medical	45,077	41,342	42,399	1,058	2.6%
Admin & Clerical	20,035	18,283	17,956	(327)	-1.8%
AHP, Therapies, Diagnostics & Pharmacy	22,717	20,753	20,446	(307)	-1.5%
Other	12,944	11,506	11,245	(261)	-2.3%
TOTAL PAY	**158,126**	**144,571**	**145,365**	**795**	0.5%
NON PAY					
Drugs	20,012	18,364	18,806	442	2.4%
Medical & Surgical Equipment	12,092	11,133	11,049	(84)	-0.8%
Depreciation	4,579	382	382	(0)	-0.0%
CNST	9,536	8,741	8,741	0	0.0%
Furniture & Office Equipment, Equip Hire & Computers	3,098	2,852	3,004	152	5.3%
Other	27,761	28,412	26,845	(1,568)	-5.5%
TOTAL NON PAY	**77,078**	**69,884**	**68,826**	**(1,058)**	-1.5%
CRS	**(1,769)**	**(466)**	**0**	**466**	
TOTAL - PRE STF & DONATED ASSET TRANSACTIONS	**8,817**	**8,566**	**8,389**	**(178)**	-2.1%
STF	**(5,189)**	**(4,583)**	**(3,325)**	**1,258**	-27.4%
POST STF CONTROL TOTAL	**3,628**	**3,983**	**5,064**	**1,080**	27.1%
DONATED ASSET TRANSACTIONS	**(433)**	**(366)**	**25**	**391**	-106.8%
I&E DEFICIT	**3,195**	**3,617**	**5,089**	**1,471**	40.7%

Please note: (Favourable) / adverse

SUMMARY OF DIVISIONAL VARIANCES AS AT 28TH FEBRUARY 2018

Division	Annual Budget	Budget to Date	Pay Variance	Non Pay Variance	Income Variance	Divisional CRS Variance	Grand Total	Variance as a % of Budget to Date
	£000	£000	£000	£000	£000	£000	£000	
Planned Care Division	67,657	62,409	(37)	(224)	(85)	122	(225)	-0%
Urgent Care Division	71,531	66,727	2,160	340	(556)	881	2,825	4%
Diagnostics & Pharmacy Division	23,909	21,836	(217)	337	(54)	141	206	1%
Facilities	7,556	6,925	(43)	53	16	63	88	1%
Estates	6,304	5,685	(49)	74	(16)	7	16	0%
Nurse Management	2,064	1,892	(64)	(15)	(6)	(1)	(86)	-5%
Corporate Services - Non Clinical	13,262	12,103	(372)	132	50	(0)	(190)	-2%
Corporate Services - Clinical	223	203	(4)	6	(7)	(0)	(5)	-2%
Other (Inc. Contract Income)	(191,747)	(176,358)	(579)	(1,759)	1,536	(746)	(1,547)	1%
	759	**1,421**	**795**	**(1,056)**	**878**	**466**	**1,082**	**76%**
Interest Receivable	(37)	(34)	0	0	(2)	0	(2)	6%
Interest Payable	771	701	0	0	0	0	0	0%
Impairements & Gains/Loss on Disposals	0	0	0	0	0	0	0	0%
Govt Interest & Dividends	1,112	1,019	0	0	0	0	0	0%
Operating (Surplus) / Deficit	**2,605**	**3,107**	**795**	**(1,056)**	**876**	**466**	**1,080**	**35%**
Donated Assess Depreciation	590	510	0	0	391	0	391	77%
I&E DEFICIT	**3,195**	**3,617**	**795**	**(1,056)**	**1,267**	**466**	**1,471**	**41%**

Please note: (Favourable) / adverse

3.0 Income

3.1 Commissioner Income

At the end of February 2018 (month 11) the total contract income is £3.8m below plan. This reflects a shortfall attributable to the block, of circa £2.9m, and an underperformance on Welsh and other English patients of £0.9m.

Whilst there are a number of explanations for an element of this underperformance (as outlined below), there is an assertion nationally that changes between the HRG4 and HRG4+ may have consequently resulted in this headline drop in income. Hence, further work is now underway in order to establish whether the Trust's underperformance has been magnified by errors emanating from national coding changes.

However, taking the above into account, all elective points of delivery are below plan (before and) after adjusting performance for the block contract as follows: Day case activity (£520k), elective activity (£401k), outpatient activity (£109k) and maternity bookings activity (£500k).

As outlined previously there are a number of other known contributing factors described below:

- General Surgery activity has continued to be below plan in February, but two new locum upper GI consultants have now started. A Colorectal Consultant was appointed in September, and will start in post in April 2018, following completion of their fellowship.

- Prioritisation of cancer work within Urology, coupled with annual leave within the team, has resulted in the service being unable to backfill all sessions to deliver the baseline. This is compounded by activity lost in prior months earlier in the year. A consultant has now retired, and the locum cover arrangements are in place.

- Underperformance on day case and elective activity within Orthopaedics continued in the month of February. The department have agreed to take additional work from Betsi Cadwaladr University Health Board with discussions already underway for the transfer of patients. The day case waiting list is down due to the Procedures of Limited Clinical Priority (PLCP) Commissioner Policy, although this may change once the Community Triage Team has exhausted all options other than to refer.

- Ophthalmology is showing a significant under performance across all points of delivery year to date. There were 2 additional locum specialty doctors during the same period last year providing additional capacity to clear the backlog of activity. Two new consultants have now started, and job plans are fully in operation, and this is evident in the over performance in the in February position.

- Oral Surgery underperformance year to date has been predominately due to medical gaps, however these have now been resolved. There is a significant pressure in dental nursing sickness, which resulted in a reduction in the number of lists and clinics but capacity has been restored in January and activity is above plan in the month of February.

- Since December 2016 the Gastroenterology service have been down by 2 consultants. This has meant that the other consultants have had to increase on call frequency which has compounded the loss of clinic capacity.

- As part of the deep-dive into activity performance, it has been highlighted that there has been a change in the Respiratory Medicine cancer pathway. General Practitioners can now order the tests, and investigations required, prior to the patient's first attendance and therefore has reduced the number of follow up appointments a patient requires, which is reflected within the activity position.

There is an over performance on Emergency Department attendances of £199k but this is partially offset by an under performance on non-elective discharges (£23k). This predominately relates to non-West Cheshire English Emergency Department attendances and an element of Welsh non-elective discharges.

Within the emergency activity category, obstetric deliveries are continuing to show a significant underperformance against planned activity levels at the end of February to the value of £1,031k prior to the block adjustment. Obstetric bookings are also contributing a significant underperformance of £893k year to date. There has been a significant reduction in the number of Welsh women booking to have their care here, so the Trust is working with the commissioner to understand the reasons for this.

There have also been significant recruitment and retention issues for the Primary Care Unit which has compounded pressures within the Emergency Department. Higher than planned A&E attendances are generating £199k additional income to offset underperformance in other areas. This is non-West Cheshire English activity.

The net overall non-PBR position is showing an over performance of £501k following the block adjustment. Within this position there continues to be an underperformance of £25k relating to Fertility. Due to the new arrangements, the lab has not been up and running, which has meant there has been a delay in the number of IVF cycles the Trust has initiated. This loss of income is within the Planned Care divisional finance position, however it is anticipated that this will recover by the end of the financial year.

Critical Care and Neonatal bed day activity is £2,006k below plan year to date after the application of the block adjustment. The application of the risk reserve has largely offset this in prior months, but there is a net pressure of £608k.

Eleven twelfths (11/12's) of the CQUIN risk reserve has been utilised within the February financial position, so £368k is offsetting underperformance within other areas.

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

Point of Delivery	Activity Variance YTD	Value Variance YTD	Block Contract Impact YTD	Value Variance after block adjustment YTD	Movement from Previous Period
Daycases	-1,250	(£1,080,404)	£560,879	(£519,525)	(£45,144)
Elective Inpatients	-739	(£2,195,882)	£1,795,277	(£400,605)	(£144,802)
Non-Elective Inpatients	-838	£653,344	(£675,919)	(£22,575)	£12,091
First Outpatients	-854	(£79,290)	£35,926	(£43,364)	£4,231
Follow Up Outpatients	-9,427	(£794,518)	£652,461	(£142,057)	(£8,451)
Outpatient Unbundled & Procedures	-4,614	(£478,224)	£554,545	£76,321	£30,640
Maternity	-1,368	(£892,985)	£392,560	(£500,425)	(£16,593)
A&E Attendances	3,747	£140,545	£58,300	£198,844	£15,162
Best Practice Adj'ts & Growth	0	(£99,121)	£59,601	(£39,520)	(£2,210)
Drugs & Devices	0	(£545,198)	£486,484	(£58,714)	(£89,350)
AMD	331	£244,840	(£224,399)	£20,441	(£619)
Adult Crit Care & Neonatal	-1,616	(£1,488,452)	(£517,969)	(£2,006,421)	(£222,647)
Other Non PBR & CQUIN	0	£1,049,530	(£230,688)	£818,843	£163,595
PBR & Non PBR Variance	**-16,627**	**(£5,565,814)**	**£2,947,059**	**(£2,618,755)**	**(£304,097)**
CQUIN & Contract Penalties		£367,534		£367,534	£33,412
Critical Care & SCBU Risk		£1,398,891		£1,398,891	£127,172
Total Excluding STF Funding		**(£3,799,389)**	**£2,947,059**	**(£852,330)**	**(£143,513)**
Sustainability & Transformation funding		**(£1,258,333)**		**(£1,258,333)**	(£181,615)
Total Including STF Funding		**(£5,057,722)**	**£2,947,059**	**(£2,110,663)**	**(£325,128)**

Please note favourable / (adverse) income

3.2 Non-Commissioner Income

At the end of February 2018, non-commissioner income is below plan by £26k for the following reasons:-

- Non-recurrent VAT rebate in May 2017 of £282k, with £78k in August 2017 and a further £47k in October, totalling £407k year to date;
- Invoices have been raised to Cheshire West and Chester Council and other local health authorities for delayed transfers of care (DTOC's) for £577k; and
- The above are offset by the loss of the STF monies in relation to A&E performance of £1,258k.

4.0 Key Expenditure Variances

4.1 Pay

Medical Pay – £1,058k over spent in total.

This relates predominantly to Urgent Care with an overall medical pay overspend of £1,518k. The main pressures are as follows:-

Explanation / Action	In Month £000s	YTD £000s
Acute Medicine - There is currently an over establishment of one consultant post and also a cumulative pressure relating to a consultant maternity leave which was covered by agency.	15	337
Acute Medicine - There are two CT1/2 posts above funded establishment. In addition there is an agency doctor (also CT1/2) to cover short stay ward (ward 46).	22	178
The Emergency Department are incurring costs for additional Staff Grade locum shifts to support work pressures. Furthermore there are agency staff covering middle grade gaps. The Division are: reviewing the capacity with ED, trialling progress chasers and early assessment nurse, are out to advert for middle grade rota gaps and are also working with other Trusts to recruit from overseas.	205	1,042
Paediatrics - are currently covering a consultant gap with agency and have incurred costs to cover maternity leave in previous months.	14	117
Paediatrics - are covering one ST1/2 gap with agency.	41	183
Cardiology - additonal Agency consultant	44	64
Clinical Haematology - previously 1.23 wte consultant vacancies covered by agency, substantive appointment made Dec 17	(5)	157
Remainder spread across number of areas - COTE £104K, Diab £91K, UTC £86K gen med £33K, Respiratory (£13K), Rheumatology £15K, Psychiatry F1 £12K, Derm is £9K , cardio thoracic £8K, Community Paeds is (£3K) , HIV is (£8K), Gastro is (£14K)	0	322
Funding allocated from medical pay reserve.	(81)	(882)
Total	**255**	**1,518**

Please note: (Favourable) / adverse expenditure

Nursing Pay – £632k over spent in total.

Urgent Care currently has a nursing overspend of £766k, which is offset by underspends in Planned Care nursing.

The main reasons for the overspent nursing position within Urgent Care Nursing are as follows:-

Explanation / Action	In Month £000s	YTD £000s
Financial pressure as a result of maternity leave over and above the funding available.	17	163
Financial Pressure as a result of patients requiring additional nursing care above the funding available.	41	201
Short Stay Unit (Ward 46) is incurring additional costs as a result of over establishment of Band 5 / Band 2 nurses, partly incurred due to the opening of 7 additional escalation beds from 9th Oct 17.	14	171
Ward 49 is incurring additional costs due to over establishment on ward - predominantly band 2s.	10	71
The Intermediate Care Unit is over established by 1 wte Band 6 (with the approval of the Director of Nursing) and is also incurring bank costs to cover for sickness. The CFBM and Head of Therapies are reviewing the current funding and resources.	10	92
Emergency Department - nurse bank usage and nurse recharges due to long term sick and maternity leave and operational pressures have resulted in this overspend within the Emergency Department.	3	118
Nurse Management - all nurse training posts now cohorted on one central cost centre (previously on individual wards)	1	21
Across other areas	(16)	(71)
Total	**80**	**766**

Please note: (Favourable) / adverse expenditure

4.2 Agency spend

The agency expenditure position, year to date to February 2018 is shown below; previous years full year expenditure figures are also shown.

Agency Spend by Staff Group	14/15	15/16	16/17	17/18 YTD to Feb 18
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 80,530
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 2,947,322
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 617,066
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 156,259
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 92,709
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 3,893,885**

5.0 Cash Releasing Savings (CRS)

The CRS target for 2017/18 was originally set at £12.4m. However, this has been reduced by £1m as a result of the agreed change to the control total so the restated CRS target for 2017/18 and recurrently is now £11.4m.

£2.4m has been achieved by reducing reserves held by the Trust at the beginning of the year, leaving £9m to be delivered by Divisions and Departments. It was agreed that Clinical budgets would deliver 3.5% of their budgets, and Back Office areas would deliver 6% of their budget.

This originally left £2.5m unidentified centrally, but is now £0.2m (see table below):

	£m
Original Month 12 Target	2.5
NHSI Control Total Adjustment	(1.0)
Reduction in medical pay reserve	(0.5)
Removal of Junior Dr contract reserve	(0.5)
Reduction in apprenticeship levy reserve	(0.1)
Other	(0.2)
Total Central CRS Target Outstanding	**0.2**

Further plans to address the balance are being formulated, but are now more likely to focus on a combination of mitigations which are currently being pursued (outlined in section 10).

5.1 February 2018 CRS Performance

The profile of the CRS target can be found in the table below and broadly reflects historic delivery, with CRS savings picking up pace as the year progresses and as schemes are developed. The centrally held unidentified target which currently stands at £0.2m (see table above) is profiled in month 12 with the expectation that schemes will be developed to offset this target during the remaining months of this financial year.

CRS Profile	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
	637	644	630	710	730	764	978	971	1,002	1,001	985	2,328	11,380
Monthly Profile	6%	6%	6%	6%	6%	7%	9%	9%	9%	9%	9%	20%	100%
Quarterly Profile			17%			19%			26%			38%	100%

CRS Performance as at the end of February is £466k behind plan, as shown in the table below:

CRS DIVISIONAL PERFORMANCE AS AT FEBRUARY 2018			
Division / Department	Target to Feb	Achieved to Feb	Var
Planned Care	£ 2,221,764	£ 2,100,230	£ 121,534
Urgent Care	£ 2,077,763	£ 1,196,134	£ 881,629
D&P	£ 728,923	£ 587,809	£ 141,114
Estates & Facilities	£ 792,028	£ 722,648	£ 69,381
Nurse Mgmt	£ 66,037	£ 66,762	-£ 725
Corporate Clinical	£ 11,142	£ 11,211	-£ 69
IM&T	£ 368,157	£ 383,860	-£ 15,703
HR	£ 159,808	£ 165,190	-£ 5,382
Trust Administration	£ 134,840	£ 112,407	£ 22,433
Finance	£ 83,272	£ 84,631	-£ 1,359
Procurement	£ 26,129	£ 26,129	-£ 0
Central	£ 3,761,804	£ 3,128,254	£ 633,550
Profile Adjustment	-£ 1,379,585		-£ 1,379,585
TOTAL	**£ 9,052,082**	**£ 8,585,264**	**£ 466,818**

5.2 In Year & Recurrent CRS Performance

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

2017/18 EFFICIENCY PROGRAMME PERFORMANCE AS AT FEBRUARY 2018

IN YEAR

Division / Department	2017/18 In Year CRS Target	Achieved		Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,423,743	£ 2,179,325	90%	£ 244,418	£ 15,000	£ 5,600	£ 223,819	-£ 1
Urgent Care	£ 2,266,650	£ 1,219,304	54%	£ 1,047,346	£ 80,388	£ 51,667	£ 470,678	£ 444,613
D&P	£ 795,189	£ 645,258	81%	£ 149,931	£ -	£ -	£ 150,000	-£ 69
Estates & Facilities	£ 864,031	£ 761,226	88%	£ 102,806	£ 0	£ -	£ 95,000	£ 7,805
Nurse Mgmt	£ 72,040	£ 70,322	98%	£ 1,718	£ 0	£ -	£ -	£ 1,718
Corporate Clinical	£ 12,155	£ 12,044	99%	£ 111	£ 0	£ -	£ -	£ 111
IM&T	£ 401,626	£ 401,626	100%	£ -	£ -	£ -	£ -	£ -
HR	£ 174,336	£ 174,336	100%	-£ 0	-£ 0	£ -	£ -	£ -
Trust Administration	£ 147,098	£ 118,825	81%	£ 28,273	£ 1,000	£ -	£ 17,700	£ 9,573
Finance	£ 90,842	£ 90,842	100%	£ 0	£ 0	£ -	£ -	£ -
Procurement	£ 28,504	£ 28,504	100%	£ -	£ -	£ -	£ -	£ -
Central	£ 4,103,786	£ 3,907,899	95%	£ 195,887	£ 12,737	£ -	£ -	£ 183,150
TOTAL	**£11,380,000**	£ 9,609,511	84%	**£ 1,770,489**	£ 109,125	£ 57,267	£ 957,198	£ 646,900
		84%		16%	1%	1%	8%	6%

2017/18 EFFICIENCY PROGRAMME PERFORMANCE AS AT FEBRUARY 2018

RECURRENT

Division / Department	2017/18 Recurrent CRS Target	Achieved		Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,423,743	£1,108,819	46%	£ 1,314,924	£ 207,742	£ 110,000	£ 757,536	£ 239,646
Urgent Care	£ 2,266,650	£ 993,541	44%	£ 1,273,109	£ 0	£ -	£ 590,000	£ 683,109
D&P	£ 795,189	£ 411,899	52%	£ 383,290	£ -	£ -	£ 300,000	£ 83,290
Estates & Facilities	£ 864,031	£ 502,626	58%	£ 361,405	£ -	£ -	£ 320,000	£ 41,405
Nurse Mgmt	£ 72,040	£ 46,311	64%	£ 25,729	£ -	£ -	£ -	£ 25,729
Corporate Clinical	£ 12,155	£ 10,000	82%	£ 2,155	£ -	£ -	£ -	£ 2,155
IM&T	£ 401,626	£ 144,588	36%	£ 257,038	£ -	£ -	£ 257,038	£ -
HR	£ 174,336	£ 76,590	44%	£ 97,746	£ 37,354	£ -	£ 16,940	£ 43,452
Trust Administration	£ 147,098	£ 74,473	51%	£ 72,625	£ -	£ -	£ 18,200	£ 54,425
Finance	£ 90,842	£ 57,016	63%	£ 33,827	£ 23,826	£ -	£ 5,000	£ 5,001
Procurement	£ 28,504	£ 28,504	100%	£ -	£ -	£ -	£ -	£ -
Central	£ 4,103,786	£3,605,899	88%	£ 497,887	£ 12,737	£ -	£ -	£ 485,150
TOTAL	**£11,380,000**	£7,060,266	62%	**£ 4,319,734**	£ 281,660	£ 110,000	£2,264,714	£1,663,361
		62%		38%	2%	1%	20%	15%

As can be seen, the challenge currently needs to be to effectively "convert" the non-recurrent CRS delivery, into recurrent schemes.

	Status	Definition
Blue	Complete	Scheme delivered, budget savings removed for year
Green	Active	Low Risk, Confident of delivery, milestones on track but not removed from budget due to future start date
Amber	Active	Minor risk, Fairly confident of delivery but actions/minor issues to be

		resolved to ensure delivery within the timeframe
Red	Active	High Risk, Significant issues to be resolved before savings can be realised e.g. - Opportunity savings identified but plans not yet worked up accurately - Cross divisional issues to address - Potential negative impact on quality/safety - Requires investment?
Black	Yet to be activated	High Risk - Pipeline schemes with no value/milestones etc identified - Unidentified balance

6.0 Model Hospital Update

6.1 Acuity Based Workforce

The implementation of e-rostering is continuing with a Security roster, and the implementation schedule will extend to Therapy staff in the next few weeks. The current pressure of patient demand in the system, and within the hospital on beds however may put this at risk, as staff are diverted from their normal duties.

6.2 Culture & Performance

A new High Performance Project Board has been held, with 2-day workshop dates agreed for 2018. It is planned that all staff will access a three hour High Performance Culture session in future. We are revisiting options for electronic appraisal and performance systems. A stakeholder barometer group will be established.

6.3 Variable Pay (position at January 2018)

Total variable pay spend increased slightly in January compared to the previous month, however there is continued pressure in locum payments and agency expenditure. This is due to the need to fill gaps in vacancies and rotas during the month.

The area incurring the highest spend of medical agency use to date includes the Emergency Department, Paediatrics and Acute Medicine.

The full year forecast spend on variable pay is currently £16.2m, an increase of £3m on the previous year.

A Variable Pay Workshop was held on the 1st March, which reviewed the issues and started to agree a project plan moving forward. This will be followed by another workshop on the 29th March and the establishment of a Delivery Group with representatives of the key stakeholders within the Trust.

The feasibility study continues with the development of a collaborative medical bank to support issues in the recruitment of medical staff particularly in filling gaps in rotas.

6.4 Length of Stay

The continuing patient demand pressure on beds in the hospital has limited activities in this area, however a number of activities on Ward 54 have progressed, including the introduction of standardised daily discharge planning documentations, and the renaming of the ward bays as a precursor to the future model Ward activities.

A Model Ward planning day was held on the 27th February 2018, where it was agreed to trial new activities on two medical and two surgical wards. The Model Ward programme will include a focus on leadership, workforce, culture, operational processes and care delivery processes.

6.5 Theatres Efficiency

A number of activities are being held and developed, including a theatres asset management stocktake, electronic pre-assessment action plan, a theatre staff open day/evening, and an audit of cancellations on the day.

6.6 Outpatients Efficiency

In the Partial Booking project the queue report issues have been resolved and validation proceeding. The rollout within Rheumatology is continuing, and training for other specialties is progressing.

The new text reminder system has a new live date following further testing.

The Clinic Room Utilisation project continues with the new SharePoint calendars scheduled live from mid-April 2018. Administration controls are in place and being tested in tandem with existing SOPs. A communication plan for the Trust is to be completed.

The Paper Switch Off project (ERS) continues with a 2WW pilot underway with Northgate Medical Practice. A rollout plan is in progress, with communication to clinicians regarding electronic triage using e-RS. Smartcards are being issued to clinicians. A Train the Trainer event occurred and a training plan developed. The Accenda decommissioning plan is in place, and process maps and instructional training guides have been developed.

6.7 Coordination Centre Programme (Teletracking)

The Coordination Centre Programme continues to progress well, with long-standing issues starting to be resolved and the technology becoming incorporated into our business as usual activities.

The delivery of the staff badges continues with more than over half of our staff having received their badges. The continued roll out of the staff badges will be targeted into areas of low uptake over the coming weeks, with the expectation that by the end of March all of our staff to have received their badge.

The implementation team are now working to move the Coordination Centre Programme to a more business as usual approach, with a formal handover into Urgent Care once the winter pressures have eased.

6.8 Staff Showcase Event

An internal Model Hospital Showcase event for our staff is planned to be held on the 23rd March which will include work stream displays, exec presentations and visits to the new Coordination Centre. The aims of the day are to show the progress that has been made as part of the Model Hospital Programme over the last 18 months.

7.0 Capital Expenditure

As at the end of February, the capital expenditure stands at £4.2m which represents £2.9m behind plan. The delay in the loan approval has resulted in a number of key projects working to the deadline of March 2018 for completion and consequently a spike in capital expenditure is anticipated next month. There is some risk to the Trust's ability to actually procure this capital programme in full, given the delay experienced in securing the capital loan, however, the Trust continues to forecast the planned expenditure by year end dependent on progress with the Neonatal new build.

8.0 Working Balances and Cash

The closing cash balance at the end of February is £7.907m, which is £2.958m ahead of plan.
The Trust received interim revenue "distress" loans in January (£1.7m) and February (£1.3m) and is expecting receipt of £3.72m on the 12th March 2018.

A number of factors have resulted in this requirement, most notably:

- Impact of overspends and slippage on CRS;
- Non-cash Income &Expenditure (I&E) "benefits" released;
- Non-achievement of STF A&E target;

- Impact of contract under-performance on non-block contracts;
- Non-payment of Local Authority DTOCs invoices; and
- Q3 STF (Finance) receipt.

The Trust does not anticipate requiring further interim revenue distress in April as receipt of quarter 3 STF and winter funding is assumed.

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.

9.0 Forecast

Best case, probable, and worst case outcomes have been estimated in the table below, with a number of the key risks accounted for in the worst case scenario. The main upside difference being attributed to a possible financial planning opportunity in relation to the Neonatal development, in order to maximise resource available.

The risks and mitigation is described in section 10 below.

2017/18 Forecast Outturn	Best £000s	Realistic £000s	Worst £000s
Pre-STF 2017/18	(8,817)	(8,817)	(8,817)
CRS Forecast (Red & Black Schemes)			(1,604)
DTOC invoices not paid			(629)
Winter funding not secured but costs still incurred			(1,200)
Ellesmere Port Rental Dispute Unresolved			(405)
Underlying I&E position net of non recurrent benefit			(301)
Charitable fund revenue gift	2,000		
Sub Total	2,000	0	(4,140)
Revised Pre-STF Total	**(6,817)**	**(8,817)**	**(12,957)**
Total STF available	5,189	5,189	5,189
Loss of Q1 A&E (Performance Element Only) STF	(117)	(117)	(117)
Loss of Q2 A&E (Performance Element Only) STF	(311)	(311)	(311)
Loss of Q3 A&E (Performance Element Only) STF	(467)	(467)	(467)
Loss of Q4 A&E (Performance Element Only) STF		(545)	(545)
STF bonus (£1 for£1)	2,000		
Anticipated STF	**6,294**	**3,749**	**3,749**
Post STF Total	**(523)**	**(5,068)**	**(9,208)**
Adjusted control total	**(3,628)**	**(3,628)**	**(3,628)**
Over / (under) control total by:	**3,105**	**(1,440)**	**(5,580)**
Achievement of NHSI target (excluding STF)	**√**	**√**	**X**

10.0 Key Risks and Mitigation

10.1 Key Risks

The key risks remain unchanged and are outlined below:

- **CRS** – the £1.6m risk identified on CRS above is made up of the unidentified £0.2m profiled in month 12 and the CRS schemes which have been risk rated as red or black within divisions and departments;

- **Non Elective Activity and Winter Costs** - escalation capacity has remained open for the eleven months of 17/18 resulting in additional costs. This has been funded from the Winter Reserve which is now fully utilised. Additional national winter funding of £1.7m has been made available, however a condition of the allocation is that the Trust is required to improve forecast outturn position by circa £534k (i.e. this element is effectively not available to be spent), thus leaving £1.2m for additional costs incurred. Receipt of this funding is dependent on delivery of an improvement to the 4 hour A&E target, which is in itself a risk;
- **Delayed Transfers of Care (DTOCs)** - remain high and contribute to the requirement to keep escalation capacity open. Within the February position, a recharge to our partners within the local health system of £577k has been raised predominantly to the local authorities. This is in line with the Community Care Act 2014 where the regulations state a recharge of £130 per bed day for DTOCs can be charged. The invoices have not yet been paid and there is a risk that this may become a bad debt;
- **Ellesmere Port Hospital (EPH) Rental Recharges –** NHS Property Services have invoiced the organisation for rental charges for EPH. This is currently in dispute as funding for this did not transfer on the disbursement of the PCT. Discussions are on-going to try and resolve this matter with support from colleagues at NHSI;
- **Elective activity** - performance remains low with an adjustment of £2.9m at the end of 11 months reflecting the value of the under performance against the baseline with West Cheshire CCG. The block with the West Cheshire CCG contract mitigates the majority of the risk to income for the current financial year but may pose a risk for the 18/19 baseline and consequent contract value. Contract negotiations for 2018/19 are underway but not yet concluded; and
- **Capital** – the delay in the approval of the capital loan has resulted in significant delays in progressing the capital programme. This may result in capital slippage in 2017/18.

10.2 Key Mitigations

The following key mitigations have been identified:

- **CRS** – continual review of CRS delivery is in place and the CRS working group continues to meet weekly;
- **Reserves –** an assessment of reserves has taken place to identify slippage and contingency available to mitigate financial risks identified, this is refreshed on a monthly basis;
- **Modern Equivalent Asset Review –** the Trust is currently undergoing a review of the asset values with the expectation that it could generate a revenue saving;

- **Balance Sheet –** as part of the current financial planning, in addition to reviewing all the Trust's contingency and reserves, a similar exercise is underway to review a number of provisions, and accruals. The current assumption, although subject to audit scrutiny, is that perhaps there is potential to prudently release circa £1m non recurrently, whilst still maintaining sufficient financial rigour.
- **Capital –** it is anticipated that it will be possible to ring fence the capital cash loan that has been drawdown for the 17/18 capital programme beyond this financial year if necessary.
- **Accounting policies –** a further review of accounting policies is underway to identify any further opportunities, although also subject to audit scrutiny.

10.3 Review of Financial Risks and Assumptions

Review of Financial Risks and Assumptions
Month 11 2017/18

Summary

	£m
Revised I&E Deficit (including STF & donated asset transactions)	**(3.195)**
Current underspend	0.178
Potential Risk	(4.140)
Absolute maximum potential mitigation dependent on assumptions below	4.368
Potential Outturn	(2.789)
On plan by	**0.406**

Please note the following significant assumptions and mitigations:	**Mitigation £m**
Further CRS schemes identified (£1.5 req'd v £1.0m offered by NHSI	
Red and Black CRS schemes deliver an additional £0.5m	0.500
DTOCs invoices are paid in full	
Required A&E performance is achieved to secure additional funding for winter	1.200
NHS Property services raise a credit note for Ellesmere Port rental	0.405
CHP overhaul is delayed until 2018/19	
Estimated disbursement of reserves is accurate resulting in reserves uncommitted	0.563
Further review of reserves held to delay expenditure	0.200
CRS schemes currently categorised as green or amber are assumed to deliver in full	
Operational budgetary performace does not extrapolate exponentially	
CRS profile is back loaded	
Modern Equivalent Asset Review	0.200
Balance Sheet review	0.800
Further review of accounting policies	0.500
No further risks materilise	
The CCG does not retract funding for under performance, penalties or CQUIN	
Total Mitigation	**4.368**

Nursing & Midwifery Annual Staffing Review

The purpose of this paper is to provide details on the Nursing & Midwifery workforce numbers and skill mix at the Countess of Chester NHS Foundation Trust. 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.

Reporting period 1st January 2017-31st December 2017

Contents

Introduction

The purpose of this paper is to provide details on the Nursing & Midwifery workforce numbers and skill mix at the Countess of Chester NHS Foundation Trust. 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]. Using intelligence from evidenced based tools and the triangulation of meaningful safety, quality & patient experience measures to appraise the information provide and where necessary make recommendations for improvement during 2018.

Safe registered nurse & 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[3]. In nursing and midwifery, the number of people needed and skills required depend 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
- AHP support available

As a consequence setting nationally agreed standards for safe 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 and midwifery 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 and midwifery staffing levels in a particular area are appropriate[4]**. The triangulation of these metrics, alongside the use of a validated evidenced based tool and professional judgement are central to making informed decisions about staffing requirements in real-time, or over a period of time to ensure nursing & midwifery establishments meet patients' expectations and provide high quality care[1].

Traditional methodologies for assessing the number of staff needed are recognised to be out dated. Care Hours Per Patient Day (CHPPD) was introduced as part of Lord Carters review of operational productivity and performance in English acute hospitals in 2015[11], as a way of representing staffing data that can better summarise the complexity of the constant change in staff and patient numbers. It measures how many hours of care are provided collectively by registered nurses/midwives, 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 unit by the number of patients in beds at the midnight census, representing the number of nursing hours that are available to each patient.

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

CHPPD is a way of representing staffing data that puts the care hours in the context of the patient activity, in an easy to understand figure. Using CHPPD has a number of advantages over other methods as it;

- gives a single figure that represents both staffing levels and patient requirements, unlike actual hours alone
- allows for comparisons between wards/units, as CHPPD has been divided by the number of patients, the value doesn't increase due to the size of the unit – allowing comparisons between different units of different sizes

Section 1: National Context

It is recognised that there is a shortfall in nurse numbers across the United Kingdom (UK). In adult nursing this represents 10% of the overall nursing workforce needed, which equates to a shortfall of 22,000 nurses[5]. Depending on the number of nurses trained and/or recruited this figure may increase, with the most pessimistic national scenario reporting a shortfall of 38,000 nurses[4] by 2020. 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
- Growing number of advanced nurse practitioner roles to support medical rotas

Further statistics released in the national press in January 2018 outlines 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 is demonstrating the number leaving outweighs the number joining. The retirement age for nurses and midwives 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]. Applications to Higher Education Institutes (HEIs) for Nursing, Midwifery & Allied Healthcare Professional (AHP) training have fallen by 23% across the United Kingdom (UK) since the loss of the bursary, with reports of 1200 less students enrolled on Registered Nursing programmes in England in the autumn of 2017[8].

Health Education England (HEE) is responsible for ensuring that there is sufficient future supply of staff to meet the workforce requirements for Healthcare in England. The introduction of the Apprenticeship Levey and the development of Higher Apprenticeship programme for Registered Nursing (soon to include Midwives), supported by the new Nursing Associate role have been welcomed by NHS Employers. Together they offer a solution to ensure a sustainable model that is underpinned by clear career progression and allows for Local Providers to determine the number of training places needed & offered to meet demand. However, challenges to implementing such programmes include;

- 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
- Funding for backfill is the responsibility of the Local Provider

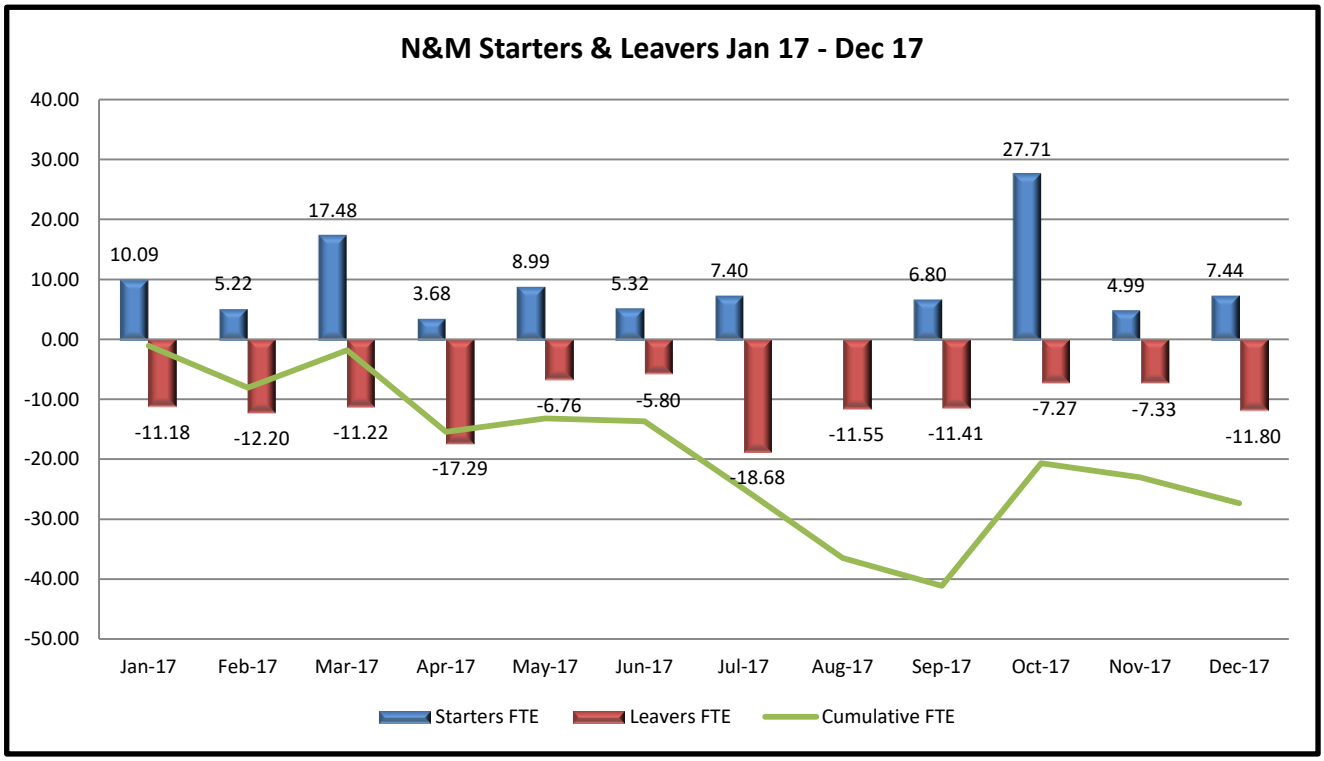
Section 2: Local Context

The current position for nursing & midwifery staffing at the Countess of Chester NHS Foundation Trust is creating a growing challenge, with **70.14 FTE registered nursing & midwifery posts currently unfilled** (found in table 1) and **an increasing trend in staff turnover currently reaching 14.31%** (found in graph 1). Compounding this situation is the additional staff required to cover sickness/absence and unfunded parent leave creating a growing reliance on temporary staffing solutions (including bank & agency). In addition, the growing complexity & increasing acuity has been coupled with an increase in the number of additional staff required to maintain safety in the clinical area, with a significate increase noted for 1:1 supervision shifts during 2017.

Table 1: Current registered nurse & midwifery vacancies (FTE)-update-Julie Weeks

	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Band 6	7.34	5.06	6.00	6.00
Band 5	60.65	67.58	64.14	64.14
Total	**67.99**	**72.64**	**70.14**	**70.14**

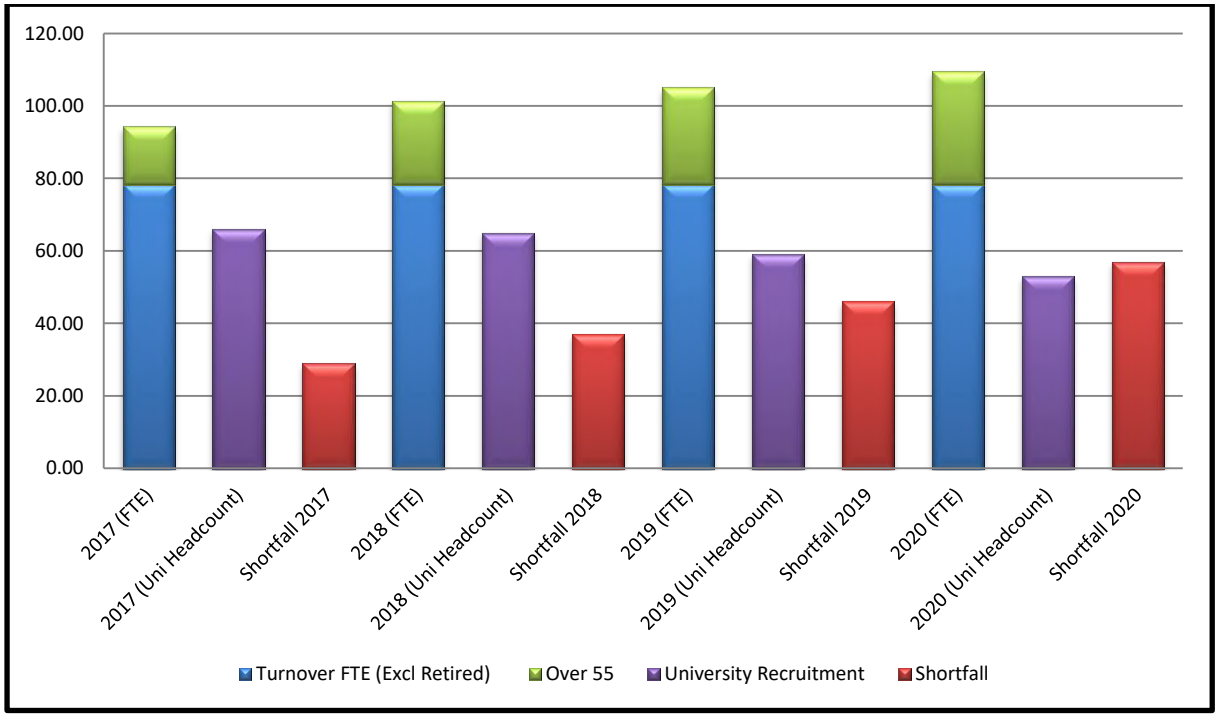
Graph 1: Current turnover (Starters & leavers figures, January- December 2017)



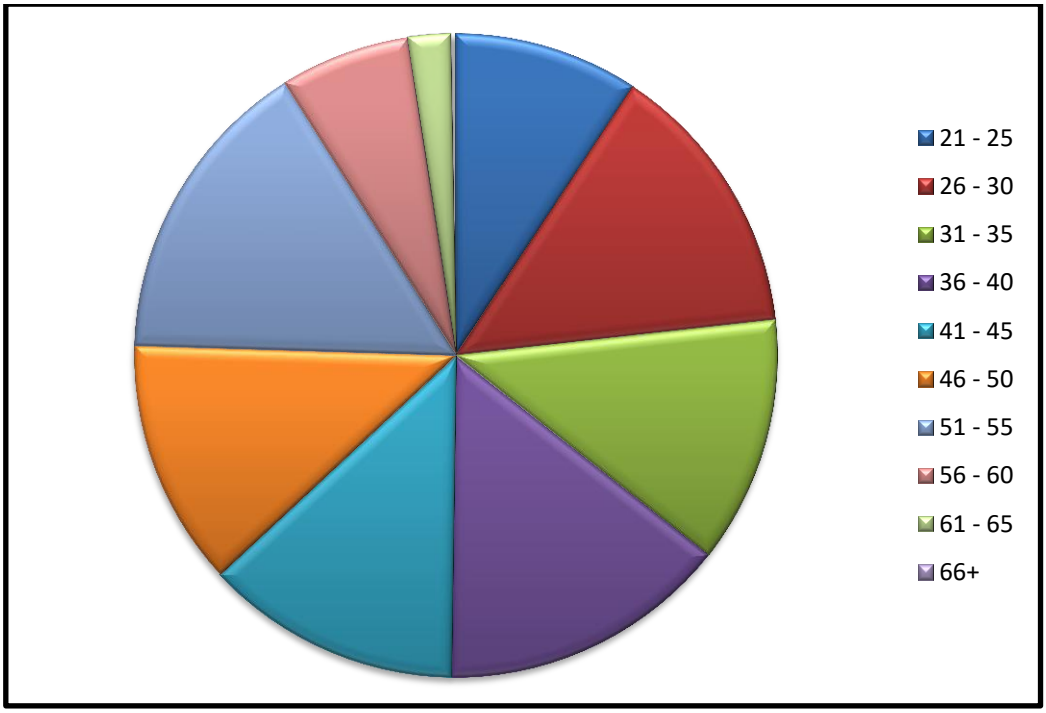
Recruitment of newly qualified nurses from the University of Chester remains a priority in the trusts recruitment strategy. However, **the number of new recruits fall short of the expected numbers of registered nurses needed** (found in graph 2). In June 2017 a snap shot of the current nursing age profile was taken which demonstrates that **24.5% of the nursing workforce is aged 50 years or over** (found in graph 3), with **8.9% of these aged 55 years or over.** When these components are reviewed together (found in graph 4) it demonstrates that there is a significant risk if university recruitment alone is relied upon to fill nurse vacancies *(NB. These projections were made prior to the loss of*

bursary). The overarching nursing and midwifery workforce risks are articulated in the relevant people & workforce section within the Board Assurance Framework.

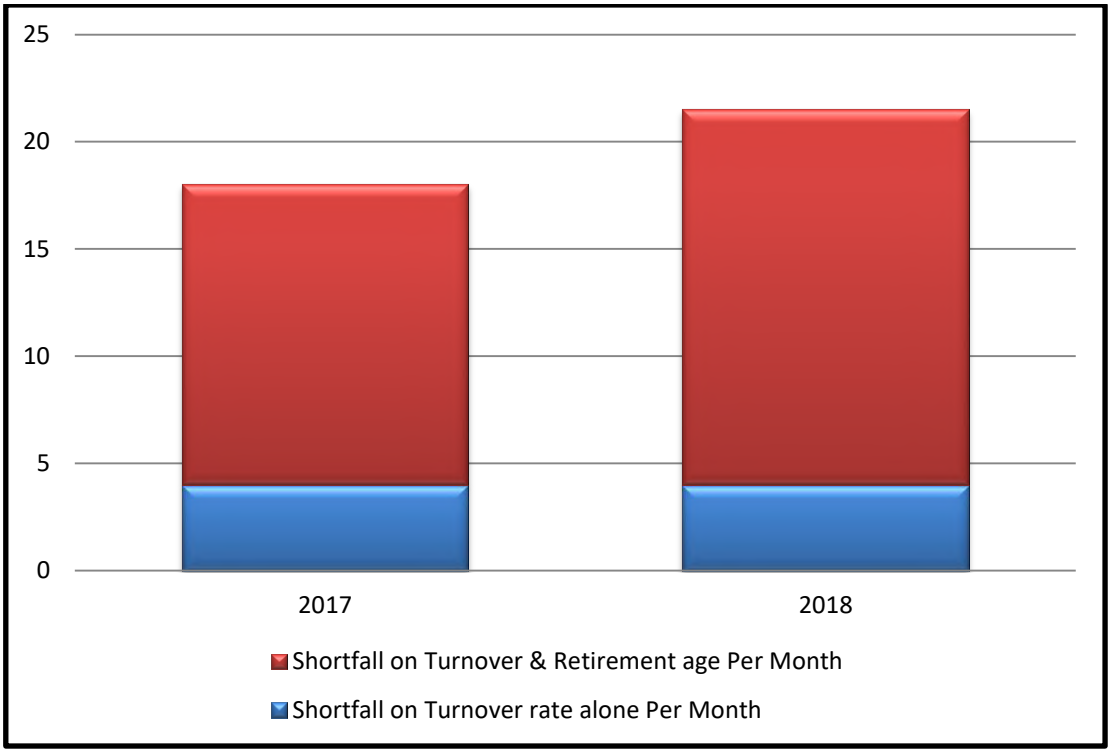
Graph 2: COCH projected shortfall figures for RNs



Graph 3: Age profile of nursing & midwifery staff in post (June 2017)



Graph 4: Shortfall in nurse fill rates when reviewing University recruitment only



Staffing Solutions demand & supply has grown significantly during 2017 and **reached an unsustainable position in December**. The data presented below (found in table 2 & 3) shows a comparison between December 2016 & December 2017 for both RNs & NAs in relation to;

- Number of staff employed by Staffing Solutions
- Number of shifts requested
- Fill rates

Table 2: Registered Nurse (RN) demand & supply

	December 2016	**December 2017**	**Difference**	**% increase/ decrease**
Number of RNs registered on our bank	298	318	20	**7%**
RN Shifts requested (demand)	596	1210	614	**103%**
RN hours requested	4591	10137	5546	**121%**
WTE requested	122.43	270.32	147.89	**121%**
RN shifts filled (supply)	254	490	236	**93%**
RN hours filled	1962	4025	2063	**105%**
WTE filled	52.32	107.33	55.01	**105%**
Fill rates (shifts)	42.62%	40.50%	-0.02	**-5%**
RN agency shift fill	50	255	205.00	**410%**

This information demonstrates that there has been an increase of 103% on RN requests & a 121% increase in hours needed when compared to December 2016. Despite there being a growth of 7% in the number of RNs working on the bank it is clear there is a shortfall on the supply of RNs needed and as a result fill rates have reduced by 5% in comparison. This increases reliance on agency staff

and adds additional pressure to roster management, as temporary staff (bank or agency) tend to work desirable shifts and often in a chosen area. There are also many substantive staff members who work on the bank which increases the risk of 'burnout' and can affect team & individual resilience.

Table 3: Nursing Assistants (NA) demand & supply

	December 2016	December 2017	Difference	% increase/ decrease
Number of NAs registered on our bank	563	608	45	**8%**
NA Shifts requested (demand)	1190	2433	1243	**104%**
NA hours requested	10345	18592	8247	**80%**
WTE requested	275.87	495.79	219.92	**80%**
NA shifts filled (supply)	894	1681	787	**88%**
NA hours filled	7879	12709	4830	**61%**
WTE filled	210.11	338.91	128.8	**61%**
Fill rates (shifts)	75.13%	69.09%	-0.06	**-8%**
NA agency shift fill	0	31	31.00	**310%**

This information demonstrates an 8% increase in NAs working on the bank; however there has been a 104% increase in the number of shifts requested which equates to an additional 1243 shifts when compared to December 2016. This has resulted in an overall reduction in fill rates by 8% and a 310% increase in agency shifts at NA band 2 to support.

This increased reliance on temporary staffing solutions correlates with the increase in;

- **Number of vacancies**
- **% turnover**
- **% maternity/adoption leave**
- **Acuity & dependency**

An analysis taken from HealthRoster comparing **maternity/adoption leave** in April 2017 with December 2017 demonstrates a 43% increase in Planned Care and a further 3% increase in Urgent Care. **This is not currently reflected in the uplift provided in establishments for 'unavailability'.**

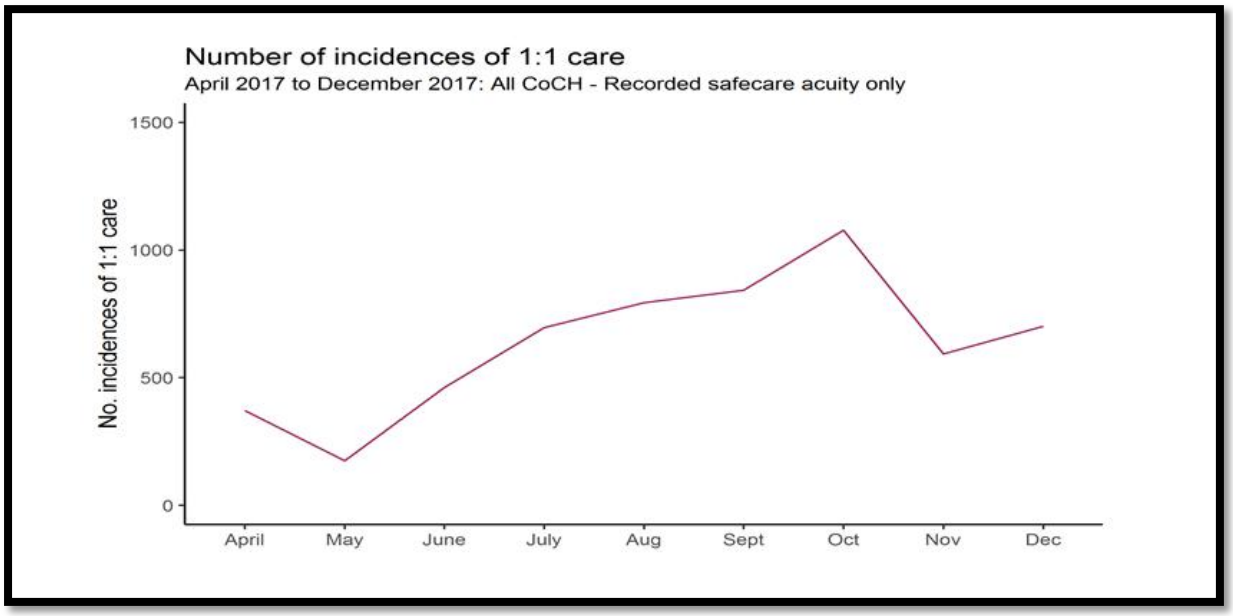
During 2017 between 500-1000 shifts were requests for **1:1 supervision** (NA band 2) per month. Table 4 shows those wards who requested more than 300 shifts consistently each month, with the highest requesters in blue. Graph 5 demonstrates the increase in demand for 1:1 shifts between April 2017 & December 2017.

Table 4: 1:1 care incidences (over 300) by ward, with the 5 highest wards highlighted in blue (data range April 2017 & December 2017)

Ward Name	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Ward 48	32	15	168	166	234	312	283	7	13
Ward 33	82	0	0	146	187	138	1	3	2

Ward 50	15	4	1	61	167	22	104	90	55
Bluebell Unit	20	58	47	66	42	136	61	10	0
Ward 44	13	1	20	1	19	51	106	63	150
Ward 45	2	10	23	83	41	62	98	45	14
Ward 49	2	3	21	26	20	12	110	27	110
Ward 47	41	24	22	33	27	29	77	38	23
Ward 42	49	3	51	51	7	0	27	58	60

Graph 5: Demonstrates the increase seen in 1:1 incidents

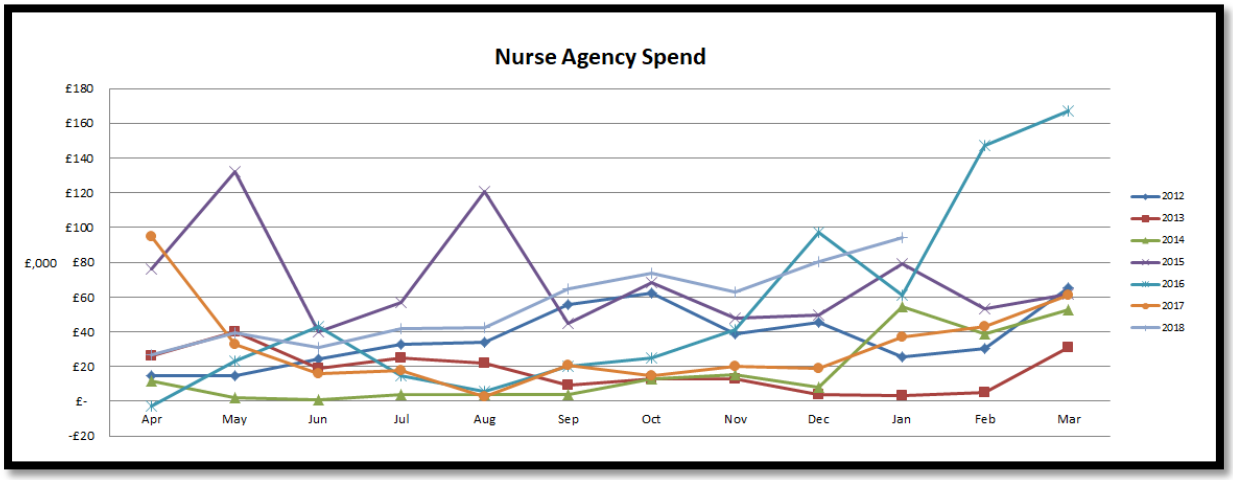


In order to optimise use of the substantive nursing & midwifery workforce, the Trust has implemented innovative systems and processes to support the achievement of an acuity based workforce. The purpose of this programme is to move away from traditional staffing models and flex the workforce (both number & 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 (HealthRoster) have been implemented in 40 wards/departments across the Trust with 2999 nurses and midwives now 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 shifts cannot be filled by substantive staff.

Staff record live acuity data in SafeCare, 3 times in each 24 hour period within adult & paediatric inpatient areas. SafeCare links to HealthRoster and provides visibility and transparency of nurse staffing and patient acuity across the Trust. 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, staffing to establishment levels and not

above them, challenge of rosters by senior nurses, peer review through the ward managers key performance indicators (KPIs) and redeployment of staff in accordance with patient acuity, has resulted in optimum use of nursing hours and care that is tailored to the needs of patients. The acuity based workforce programme has also supported efficiency savings during 2017 including a 41% reduction in nurse agency spend and a 9% reduction in nurse overtime.

Graph 6: Provides details of agency spend in Nursing & Midwifery over time

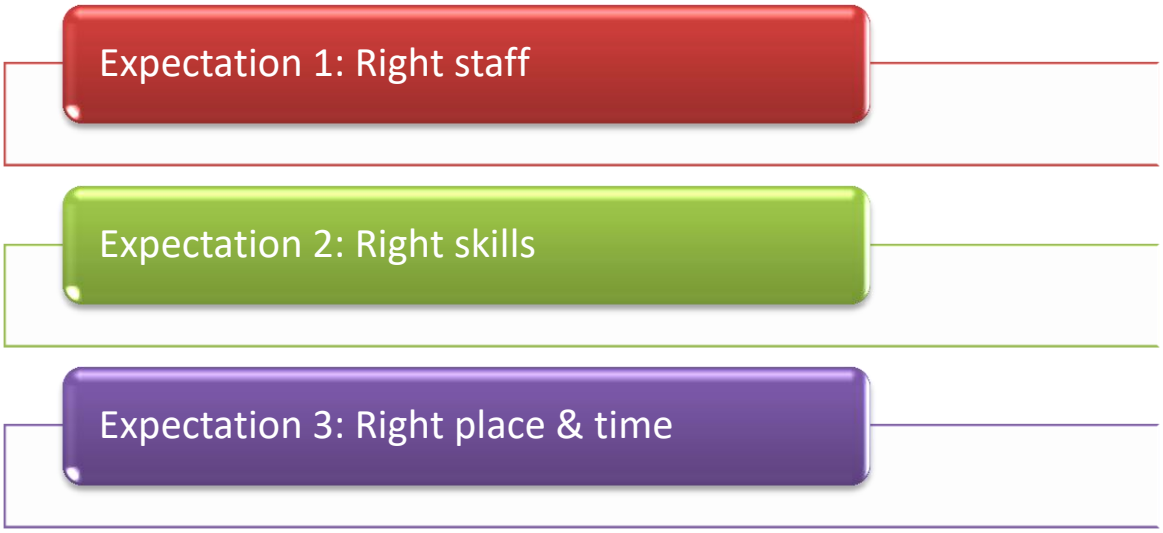


Section 3: Staffing review & evaluation of compliance against national standards

Assessing the nursing & midwifery needs of individual patients is central to making informed decisions about staffing levels and the skills needed by staff.[4, 10] There is no single nurse to patient ratio that can be applied across all acute provider settings, largely due to the diversity of inpatient areas, the complexity of patent needs and the geographical layout of wards & departments. As such, it is paramount that a combination of factors are taken into consideration when reviewing if the nursing & midwifery staffing numbers & skill mix are sufficient to maintain the safety of patients and provided a high quality experience[1].

Methodology

The National Quality Board (NQB) has published a framework for provider organisations to use when assessing and reviewing nursing & midwifery establishments. It is designed to ensure transparency in reporting from ward level to board level and details the information that should be used to provide assurance[1]. The recommendations ensure that staffing reviews focus on 3 expectations;



This framework provides a structured approach, using the best available evidence to ensure triangulation of key safety, quality & patient experience measures that can then be used to interpret if staffing levels meet the expectations of patients. This review includes the overall organsiational position and then a breakdown by ward/department (appendix 1—26) by evaluating;

- Number of nurses & midwives planned for
- Number of nurses & midwives available
- Number of nurses needed based on acuity assessment (using a validated tool & CHPPD)
- Any shortfall in nursing & midwifery hours
- Current vacancy & sickness rates by ward/department
- Triangulation of information from;
    - Red flags analysis[4]
    - Analysis of staffing incidents with harm[1]
    - Evaluation of concerns or complaints raised by patients[1]

In addition for Midwifery a further analysis against relevant national standards can be found in appendix 4.

Position against 2018 National Quality Board (NQB) recommendations

Table 5 & 6 demonstrate the Countess of Chester NHS Foundation Trusts compliance against the newly published 2018 NQB recommendations and provides details of how these are achieve. Where gaps do exist the plan for achieving compliance during 2018 is outlined.

Table 5: Compliance to NQB (2018) 'adult inpatient wards in acute hospitals' recommendations

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 3 times daily to measure number of care hours needed. Data collected is used to inform staffing decisions alongside professional judgement. 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 presented to Trust Board in March 2018. 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), however further work is needed to assess the acute ward staffing models to meet patients' needs in the next 5-10 years. An action plan has been designed to support this work stream, details of which can be found in section 5.
Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning.	Achieved	Operational planning includes the workforce requirements needed to underpin new models of care or changes in operational process. This will continue during 2018 and is a key feature in the Trust's Buisness Plan and the Model Ward programme.
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 5). Task & finish group meet monthly to progress actions and report to the Nursing & Midwifery Workforce Committee. Membership recently extended to include AHP colleagues.
Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit the use of temporary staff.	Partially achieved	Flexible employment options available, acuity based deployment model in place, however due to vacancies, increase in parenting leave & increase in patient acuity (in particular 1:1 requests) there

		has been an increase in the reliance on temporary staffing solutions towards the end of 2017.
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.	Partially achieved	Safe staffing dashboard developed & in use, reported to QSPEC monthly. Care assurance framework under development and Qlikview 'Safety & Quality' dashboard to be launched by April 2018.
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 & matrons have oversight & 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. 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:** Virtual nursing & midwifery staffing call held weekly, chaired by one of the Associate Directors of Nursing , looking forward at the staffing & skill mix numbers, making decisions regarding redeployment, need for temporary staffing & peak annual leave periods. Concerns & issues may also be raised and actioned. **Monthly report:** Ward manager KPI's include key safety, quality & 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.
All organisations should include a process to determine additional staff uplift requirements based on the needs of patients & staff.	Not met	Current uplift is not reflective of patient & staff requirements.
All organisations should investigate staffing-related incidents and their outcomes on patients and ensure action & feedback.	Achieved	COCH Risk Management system 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 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/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, produce SBAR's for the Trust 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. The Datix system promotes a culture of learning by recording, investigating and analysing COCH's incidents and stores evidence to support compliance/action plans/emails to colleagues/contacts with service users. The compliance manager has built a staffing incidents dashboard which facilitates ease of review for current status/trends/themes.

Table 6: Compliance to NQB (2018) improvement resource for maternity services' recommendations

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.	In process	Planned for May 2018.
Boards are accountable for assuring themselves that results from using workforce planning tools are cross-checked with professional judgement and benchmarking peers.	Not met	No workforce planning tool in use currently (please refer to section 6; recommendations for 2018).
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.	Partially achieved	Staffing reviewed conducted 6 monthly, however accurate staffing requirements not available as yet to implement evidence based workforce planning tool.
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	Achieved	All staff attend mandatory training

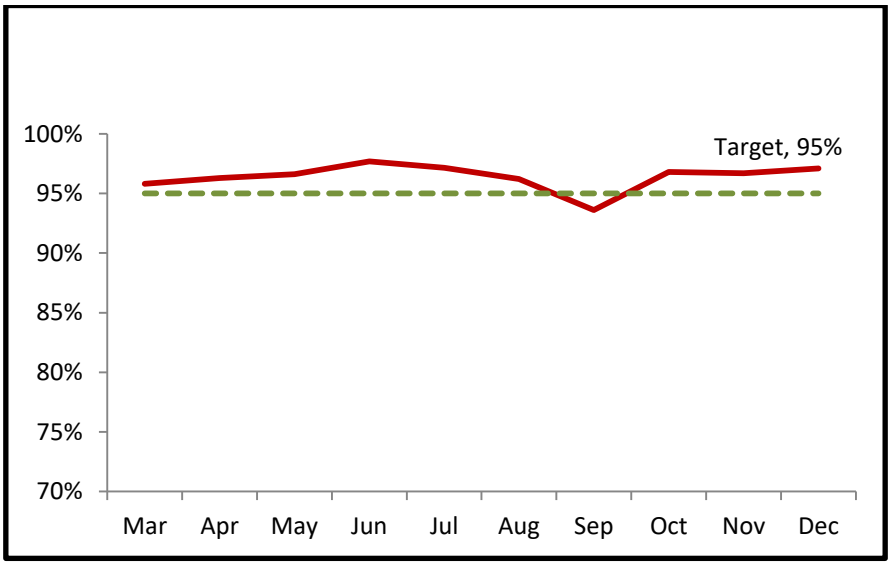
themselves that sufficient staff have attended required training and development, and are competent to deliver safe maternity care.		annually.
Organisations should have action plans to address local recruitment and retention priorities, which are subject to regular review.	Achieved	Recruitment & Retention Strategy in place, support by comprehensive work programme (details of which can be found in section 5). Task & finish group meet monthly to progress actions and report to the Nursing & Midwifery Workforce Committee. Membership recently extended to include AHP colleagues.
Flexible employment options and efficient deployment of trained staff should be maximised across the hospital to limit numbers of temporary staff.	Achieved	Only 1 midwife utilised through temporary staffing, fix term/temporary midwives employed to cover maternity/adoption leave.
Organisations should have a local dashboard to assure stakeholders about safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.	Partially achieved	Safe staffing dashboard developed & in use, reported to QSPEC monthly. Care assurance framework under development and Qlikview 'Safety & Quality' dashboard to be launched by April 2018.
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 guideline.
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 KPI's). Introduction of e-rostering supports this.
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 development.	Achieved	Robust training programme staff rostered to attend.
Organisations must take an evidence-based approach to supporting efficient and effective team working.	Achieved	All training and guidelines are evidence based.
Services should regularly review red flag events and feedback from women, regarding them as an early warning system	Achieved	Red flags as per report (found in appendix 4). Safety thermometer and F&F completed monthly.
Organisations should investigate staffing-related incidents, outcomes on staff and patients, and ensure action, learning and feedback	Achieved	COCH Risk Management system 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 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/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, produce SBAR's for the Trust 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. The Datix system promotes a culture of learning by recording, investigating and analysing COCH's incidents and stores evidence to support compliance/action plans/emails to colleagues/contacts with service users. The compliance manager has built a staffing incidents dashboard which facilitates ease of review for current status/trends/themes.

Organisational overview: Staffing numbers, triangulated with key safety, quality & patient experience outcomes

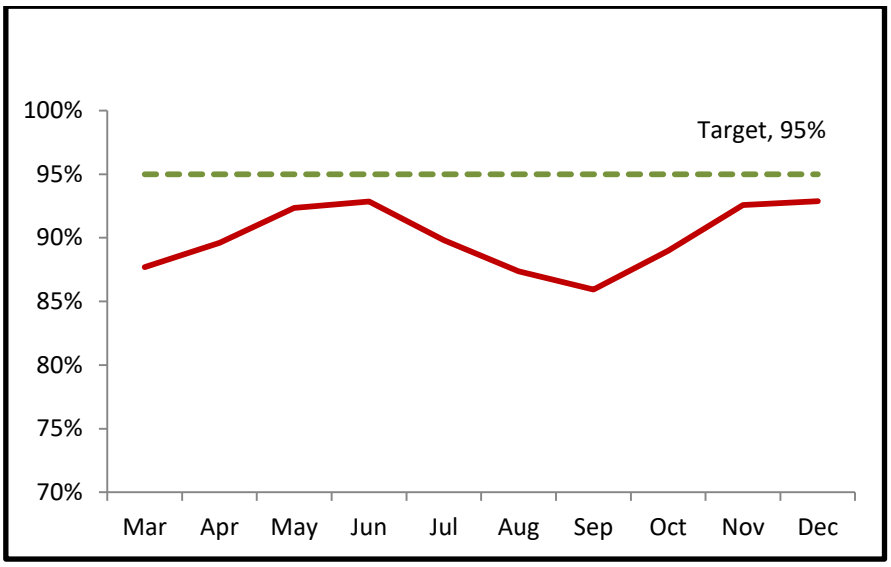
Reviewing staffing numbers at organisational level is a useful indication of whether the planned hours expected were matched with the actual hours provided. However, it is important to also consider the skill mix available by breaking down the staff groups by registered and unregistered staff and comparing that to the expected ratio. Graphs 7, 8 & 9 provide information on the Trusts overall compliance to the planned staffing needed.

Graph 7: Overall compliance, all staff

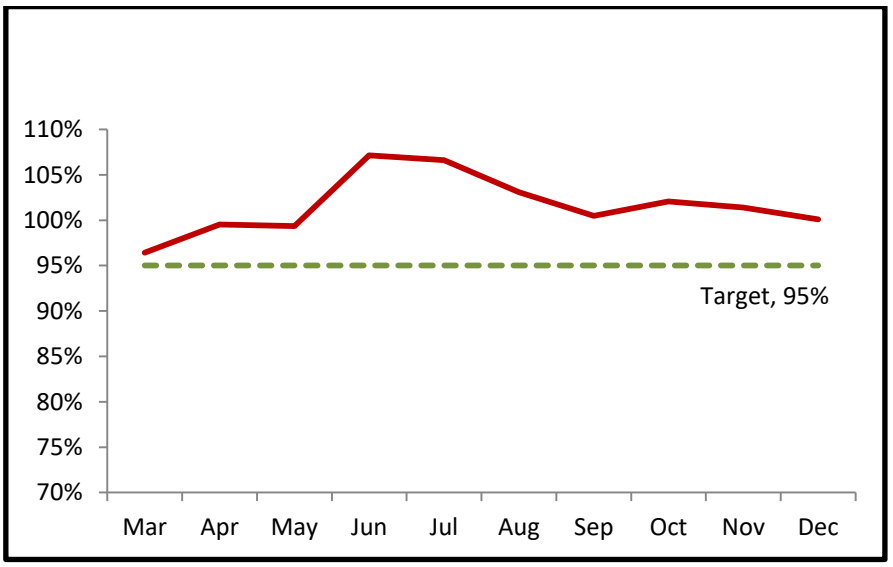


During 2017 the target of 95% compliance was achieved consistently throughout the year, however when broken down by staff group it shows the registered staff numbers were under the required amount (ranging between 85-94% compliance), with an over performance in the unregistered staff group (ranging between 95-107% compliance). This suggests that the shortfall in registered hours was covered with unregistered hours to maintain adequate numbers in ward & department areas. However, the skill mix needed overall fell below the expected level. The following triangulation of safety and quality measures will provide context as to whether this reduction in registered hours has had an impact on patient experience.

Graph 8: Overall compliance, registered staff

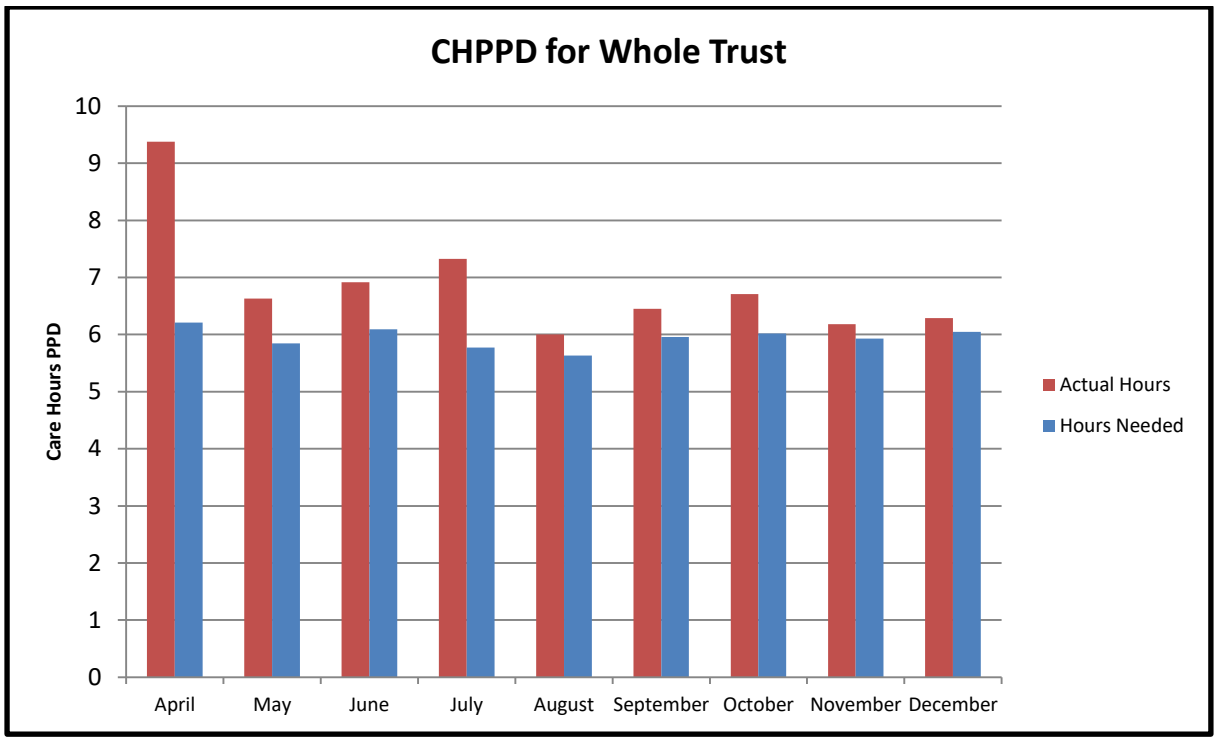


Graph 9: Overall compliance, unregistered staff



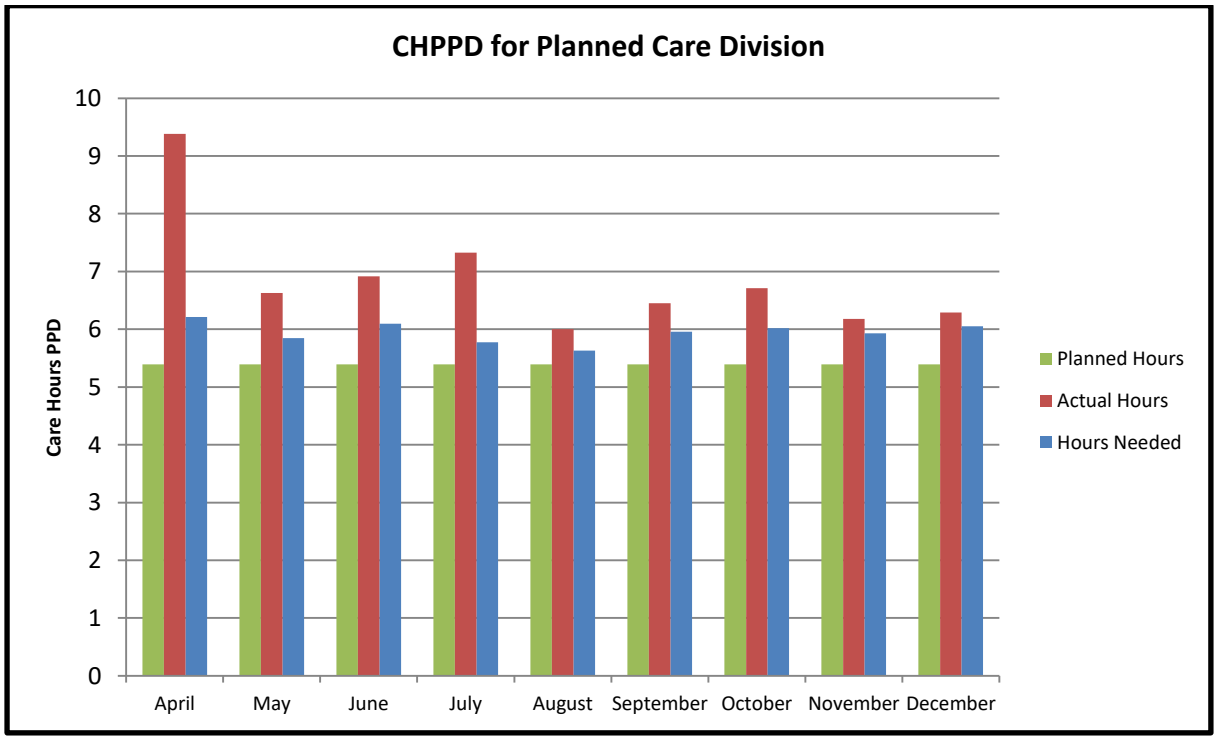
To provide more meaning analysis the overall staffing numbers have been converted into CHPPD to better understand the complexity of the constant change in staff and patient numbers. Graph 10 provides an overall position across the Trust by month (starting in April 2017 when SafeCare was implemented).

Graph 10: Whole Trust; CHPPD delivered by month

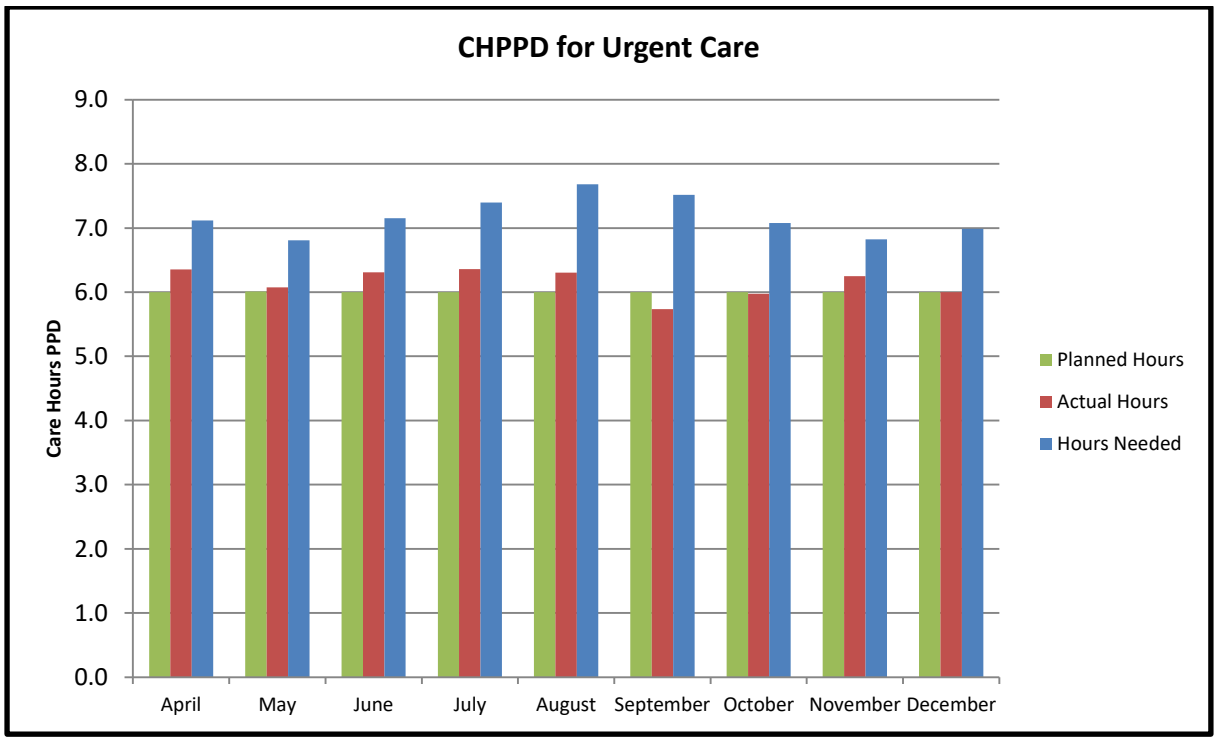


When taking the activity and acuity into consideration (hours needed in blue) using an evidence based tool (SafeCare) it demonstrates that the overall staffing levels consistently meet or exceed the required amount. This can be broken down further to review staffing levels across a Division as seen in graphs 11 & 12.

Graph 11: Planned Care; Care Hours Per Patient Day delivered by month



Graph 12: Urgent Care; CHPPD delivered by month

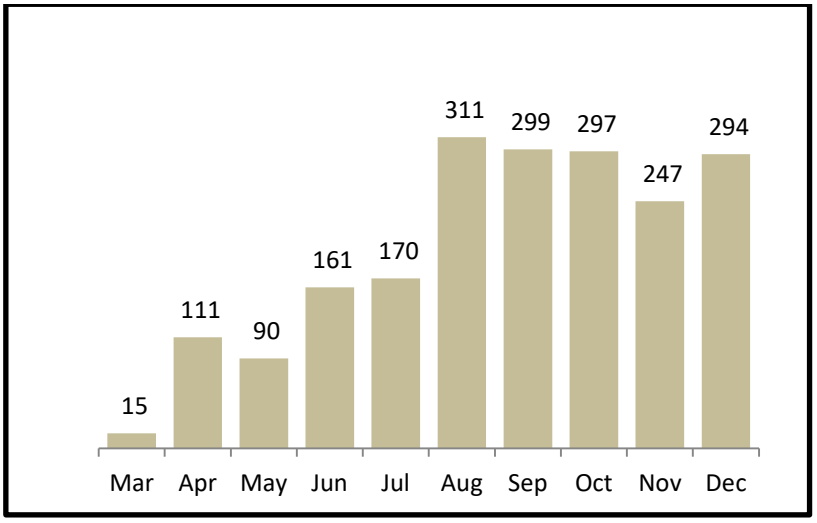


When evaluating levels across a Division it becomes clear that some areas have more challenges in relation to staffing levels than others. Therefore it is important each ward & department is reviewed to provide detail on areas with potential risks, which may require additional support. **Appendix 1—26 provide details of each ward & department across the organisation.**

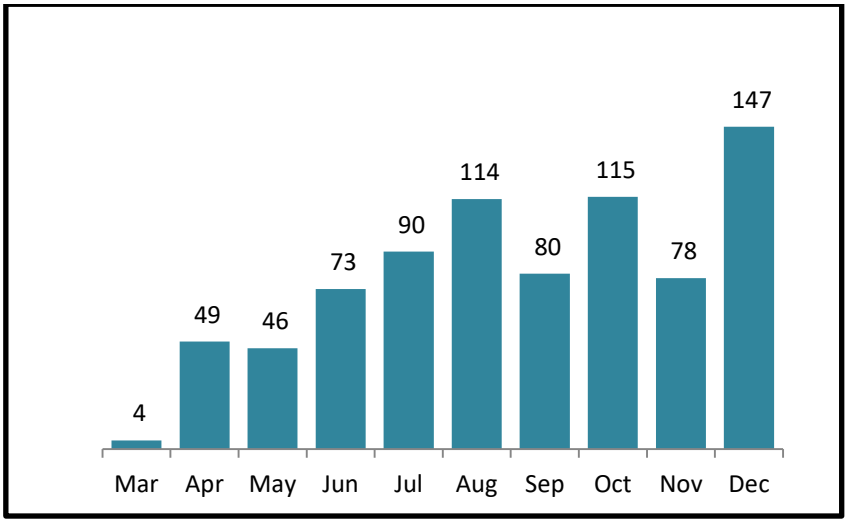
'Red flag' reporting can be used to identify areas with potential risks. Nursing & Midwifery red flags are defined nationally[4, 10] and are collected within the SafeCare tool in general ward areas and through continuous audit in Maternity. All red flags are reviewed in real-time by ward managers, team leaders and matrons, actions are taken as required to reduce or mitigate any actual or potential issues. Graphs 13, 14 & 15 provide an analysis overtime of the number of red flags reported since March 2017. **When reviewing the data it is important to note that not all these incidents relate to actual harm or risk.** The data shows that there has been a significant increase in the reporting of red flags since August 2017 and this does correlate with the reduction in registered nursing levels, the increases in vacancies & the increase in staff turnover. This would suggest that the increase in registered nurse workload has created an improved reporting culture to identify & escalate potential issues within clinical areas.

Red flags have been split in graphs 14 & 15 to show the spread across patient and staff risks. This helps to interpret if the staffing levels in the area have the potential to impact on patient safety, quality or experience or whether it has the potential to impact on staff health & wellbeing.

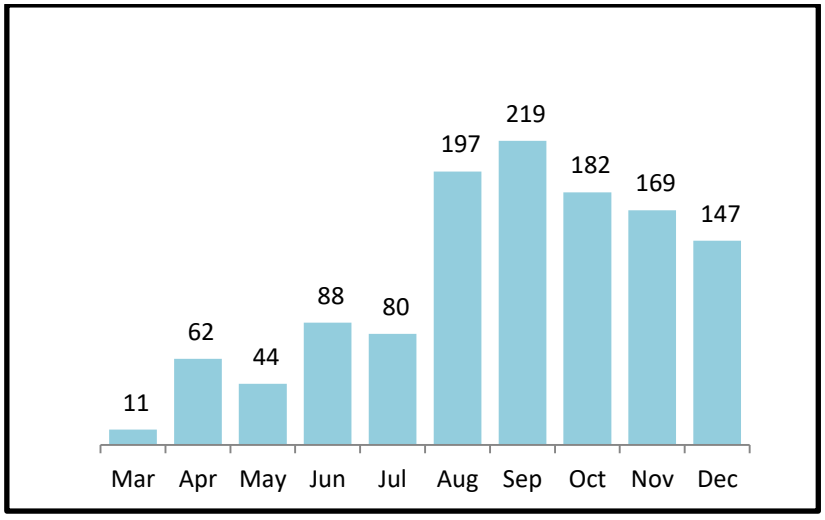
Graph 13: Trust wide red flags reported



Graph 14: Patient risk red flags reported

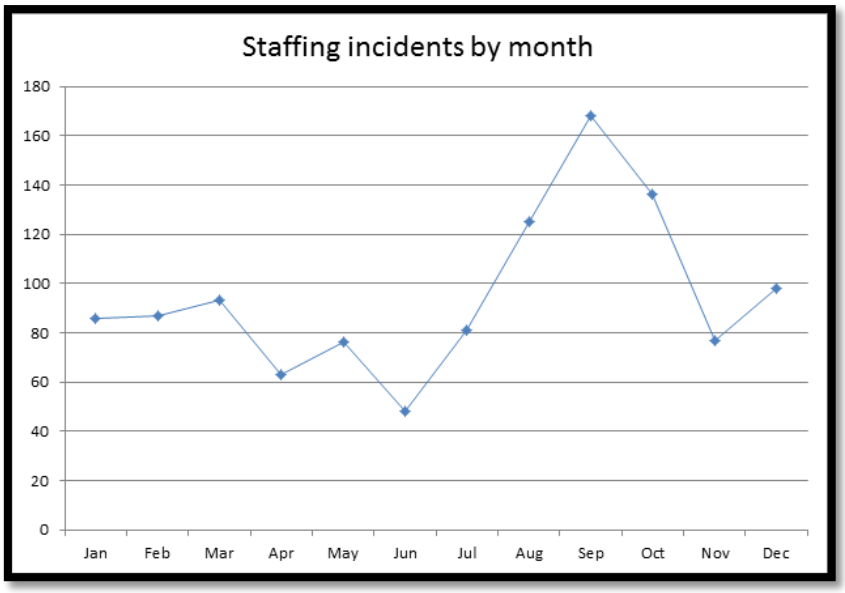


Graph 15: Staff risk red flags reported

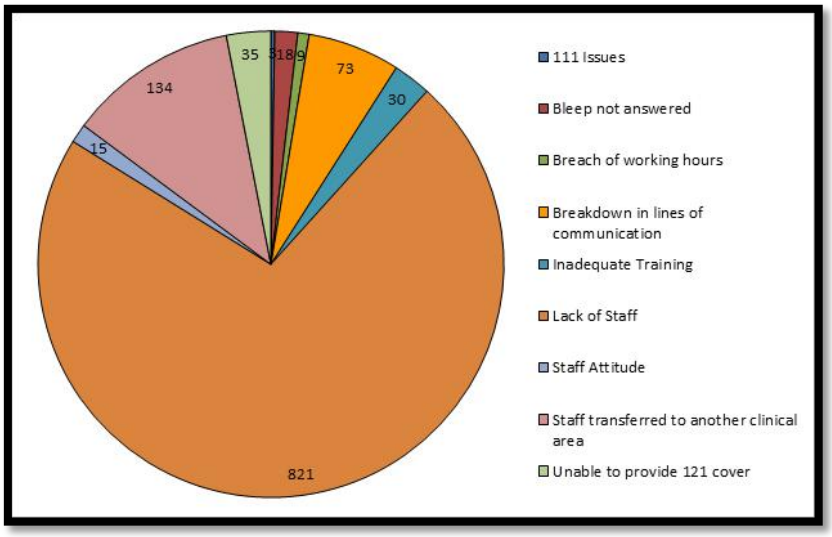


In addition to reviewing potential risks it is essential to consider the number of actual incidents reported in relation to staffing levels and/or skill mix. During 2017 the trend mirrors that of the red flag analysis (graph 16), demonstrating an increase in the number of staffing incidents reported since August 2017, however unlike the red flag data it also shows that these incidents have reduced back to the expected range during November & December. When reviewing the incidents by theme it identifies (graph 17) that the largest reporting category is lack of staff. **Please note, not all of these incidents resulted in harm to patients & whilst the data extract from Datix is robust it is unable to account for instances when the Datix is submitted for multiple staffing incidents.** Information on the number of staffing incidents resulting in harm can be found by ward or department in appendix 1—26.

Graph 16: Number of staffing incidents reported by month during 2017



Graph 17: Staffing incidents by theme during 2017



Key quality metrics are monitored throughout the year and can when reviewed against staffing levels provide a strong indication if the numbers & skill mix within the area are adequate to meet patients expectations and care needs[1]. Figure 1 provides a Trust overview of the main measurements used and associated patient outcomes, including;

- Incidents with harm (including infections, pressure ulcers, falls & serious incident reviews)
- Safety thermometer
- Care metrics
- Friends & family

Figure 1: Overview of safety, quality & experience measures (March 2017 to present)

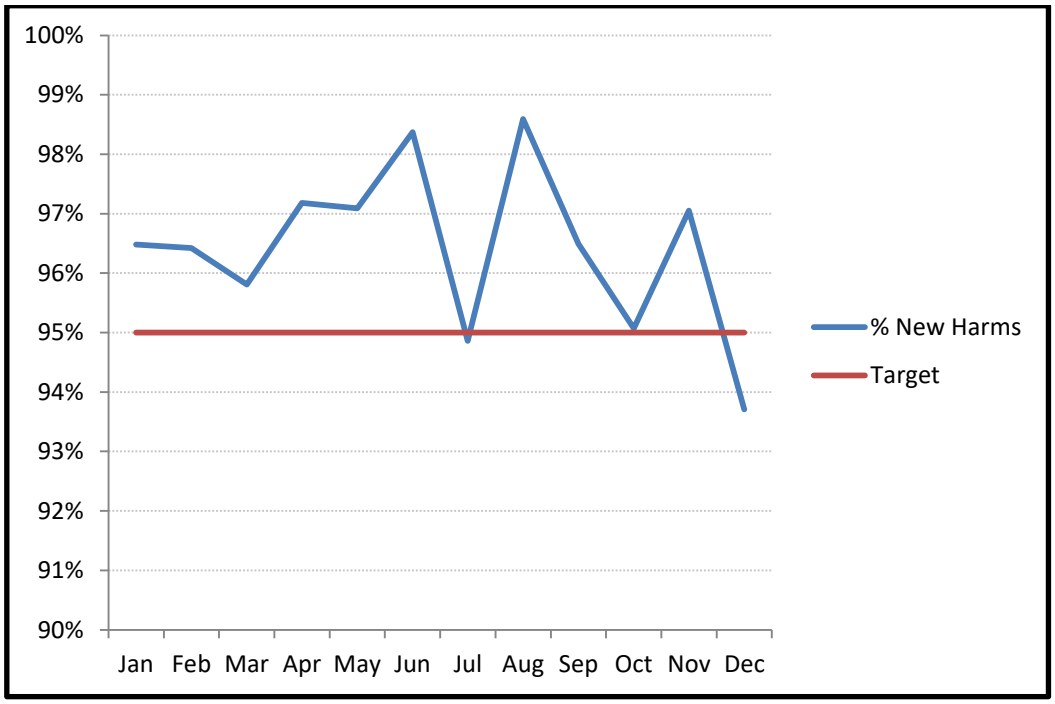
MetricDesc	Latest Mo	Trend	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Care Metrics Safeguarding			89.7%	95.5%	94.2%	94.3%	94.7%	97.3%	96.3%	94.2%	94.2%	96.5%	95.7%	94.9%
Falls No Harm			98	100	77	68	83	62	71	100	79	91	85	26
Care Metrics Discharge			90.1%	92.1%	92.9%	91.6%	92.0%	93.0%	91.0%	94.8%	89.8%	93.3%	94.1%	94.8%
Friends and Family A&E Score			84.2%	86.5%	85.0%	84.5%	80.8%	84.9%	84.4%	83.9%		81.4%	84.3%	
Friends and Family Antenatal			100.0%	100.0%	90.5%	92.3%	92.3%	87.5%	100.0%	83.3%		94.2%	100.0%	
Friends and Family Birth			95.7%	95.2%	93.5%	97.5%	97.3%	93.3%	97.3%	100.0%		99.1%	98.8%	
Friends and Family Inpatients Score			94.2%	92.1%	94.7%	94.2%	94.0%	93.8%	95.5%	94.6%		94.0%	92.9%	
Friends and Family Postnatal Community			97.7%	96.6%	98.1%	100.0%	97.9%		100.0%	100.0%		100.0%	90.0%	
Friends and Family Postnatal Ward			100.0%	93.5%	94.2%	100.0%	98.2%	78.9%	92.4%	100.0%		93.7%	93.3%	
Care Metrics Catheters			98.5%	97.7%	99.3%	99.3%	99.6%	99.2%	98.6%	98.6%	97.3%	98.8%	99.4%	100.0%
Care Metrics Continence			94.3%	95.9%	97.6%	96.8%	98.1%	97.1%	98.1%	97.0%	96.7%	97.5%	97.7%	99.5%
Care Metrics Falls Assessment			98.5%	98.0%	99.5%	98.0%	99.2%	99.0%	99.2%	99.7%	99.0%	99.0%	99.2%	99.0%
Care Metrics Infection Control / Privacy			97.8%	98.0%	98.7%	97.8%	99.0%	98.4%	98.6%	98.5%	97.4%	98.4%	97.0%	97.0%
Care Metrics Medication Storage			98.1%	98.6%	98.3%	98.9%	99.2%	98.7%	98.4%	99.3%	99.0%	99.5%	99.4%	99.0%

Presenting the data in this way can articulate easily those areas were improvements across the Trust are required. In this case the 2 priority areas are adult safeguarding and reduction of falls. Both of these measures have quality improvement programmes agreed and are at various stages of implementation. Falls in particular has already shown a reduction in the latter reporting period as changes in practice are taking shape (also refer to figure 2).

Figure 2 & graph 18 demonstrates the overall position in relation to incidents with harm. Pressure ulcers are a key indicator for the quality of fundamental nursing & midwifery care delivered. It is reassuring to see that the numbers of grade 3 & 4 pressure ulcers remain consistently low, accompanied by a reduction in grade 2 and an increasing trend in grade 1 ulcers. This would suggest that there are good prevention measures in place across the Trust and that when an ulcer is identified it is managed in a timely & effective way to prevent further deterioration to a grade 2 or above.

Figure 2: Overview of incidents dashboard: March 2017 to present

Graph 18: Overview of safety thermometer trends: January – December 2017



Graph 19 & figure 3 provide further detail on the quality of care delivered to patients during 2017 using the Care Metrics data set which has been designed to incorporate nationally agreed standards of care. The analysis in graph 19 provides confidence that the care metrics measures across the Trust hold consistently high compliance, above the target expected. Figure 5 demonstrates compliance by category and can be used to monitor trends in patient outcomes and identify areas for further improvement.

Graph 19: Overview of care metrics trends: March 2017 to present

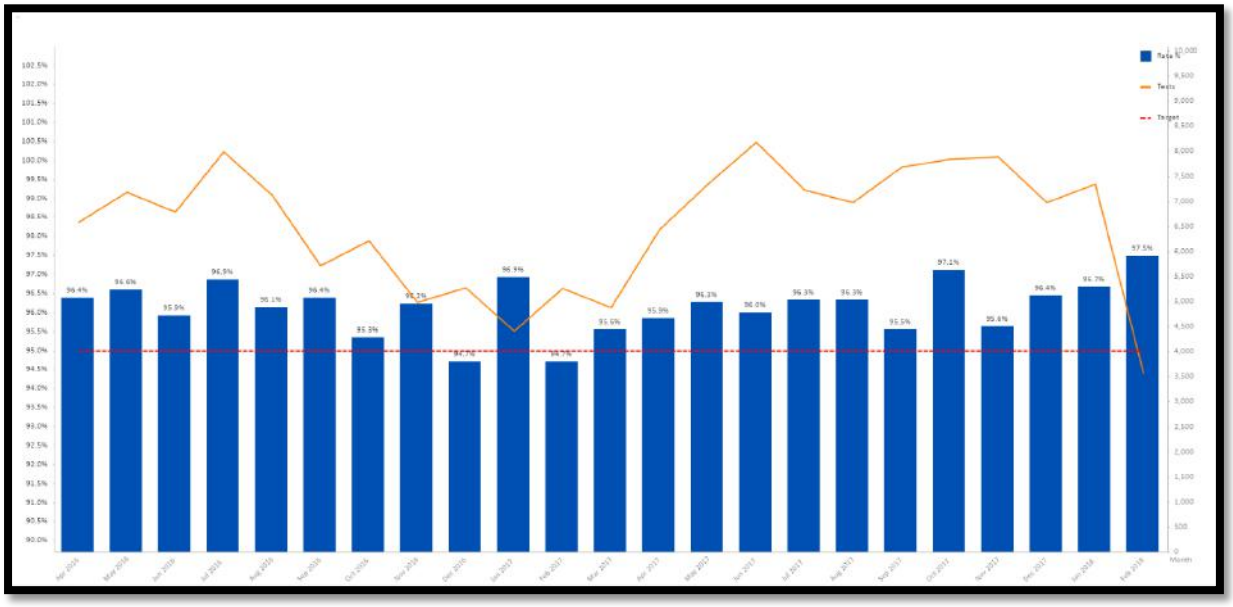
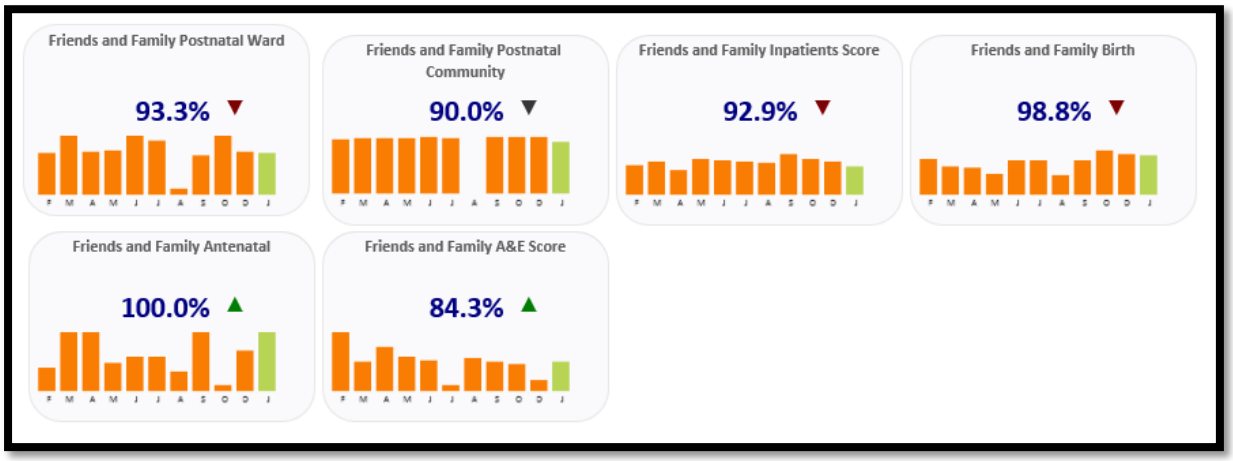


Figure 3: Overview of care metrics dashboard: March 2017 to present

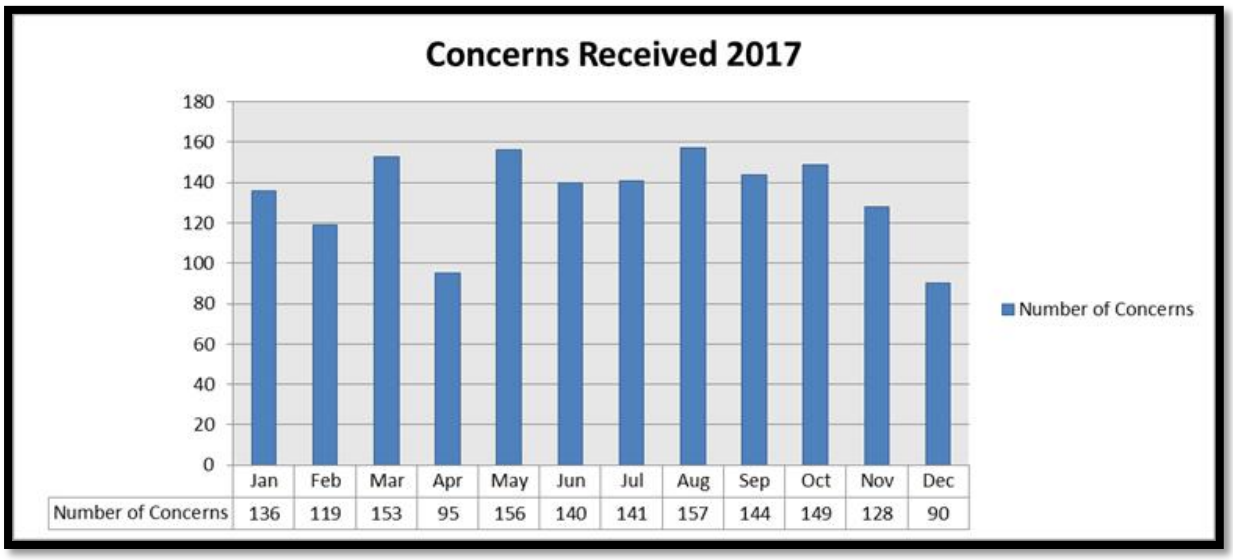
Please note, the Care Metrics data set is due to be reviewed & updated during 2018.

Seeking the views of patients is a key component when reviewing staffing levels & skill mix[1]. Patient experience is a reflection of the care that has been received but also the lived experience of those receiving it. It is personal to the individuals involved and goes beyond the traditional measures of safety, quality & outcome. There are various approaches to capturing patient experience from high level quantitate methods such as the Friends & Family test, through to rich qualitative methods that capture the whole patient journey. Figure 4 provides information on Friend & Family recommendation rates during 2017 which demonstrates consistently high scores across all areas and graphs 20—24 show the number & types of concerns and formal complaints raised by patients.

Figure 4: Overview of Friend & Family: March 2017 to present

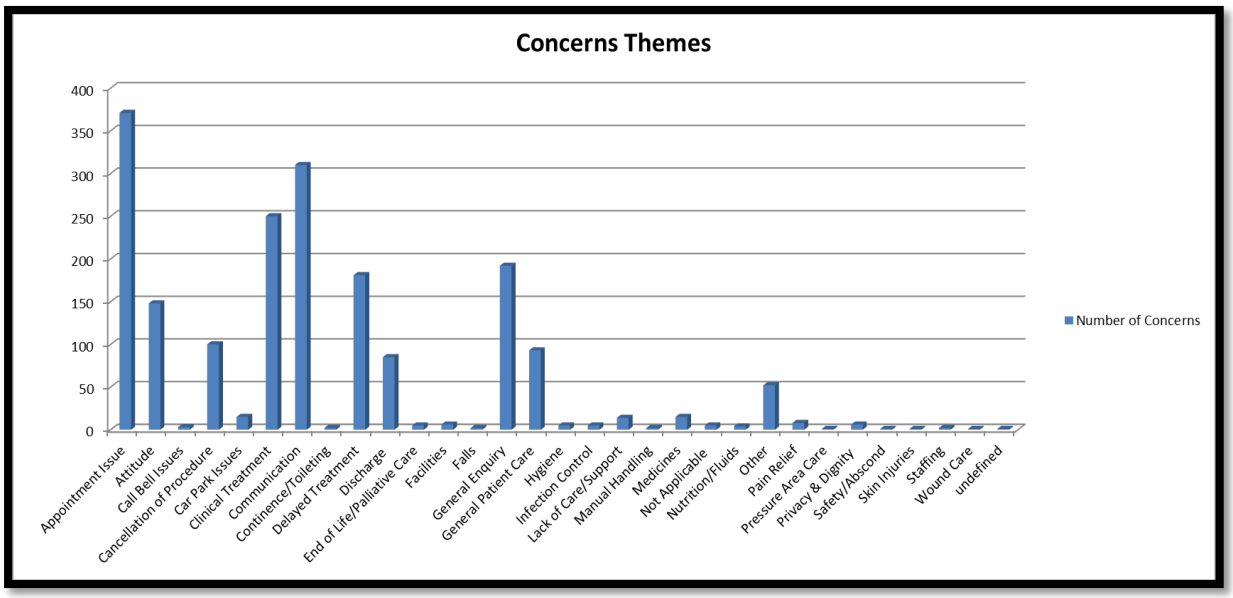


Graph 20: Number of concerns received during 2017

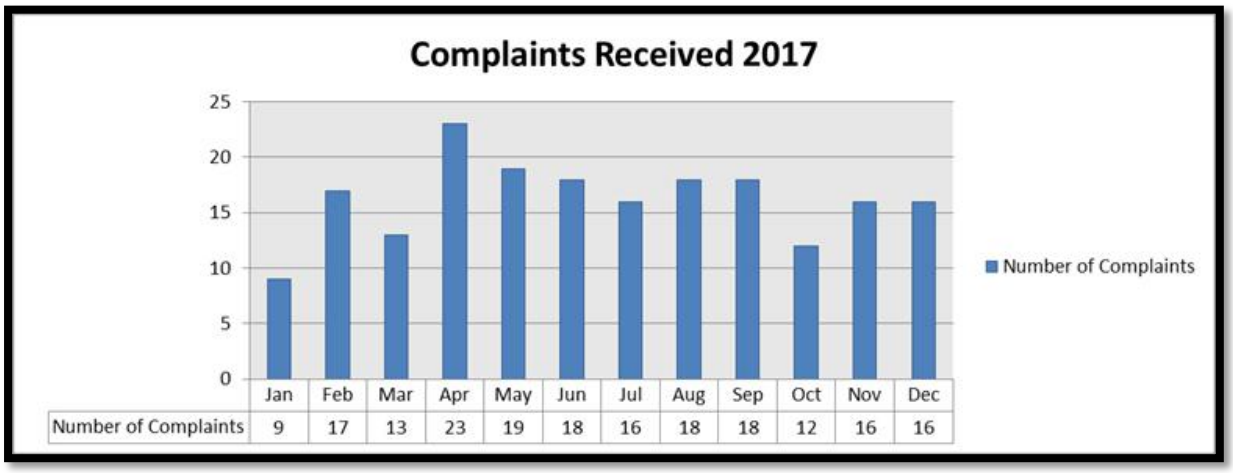


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Concerns	136	119	153	95	156	140	141	157	144	149	128	90

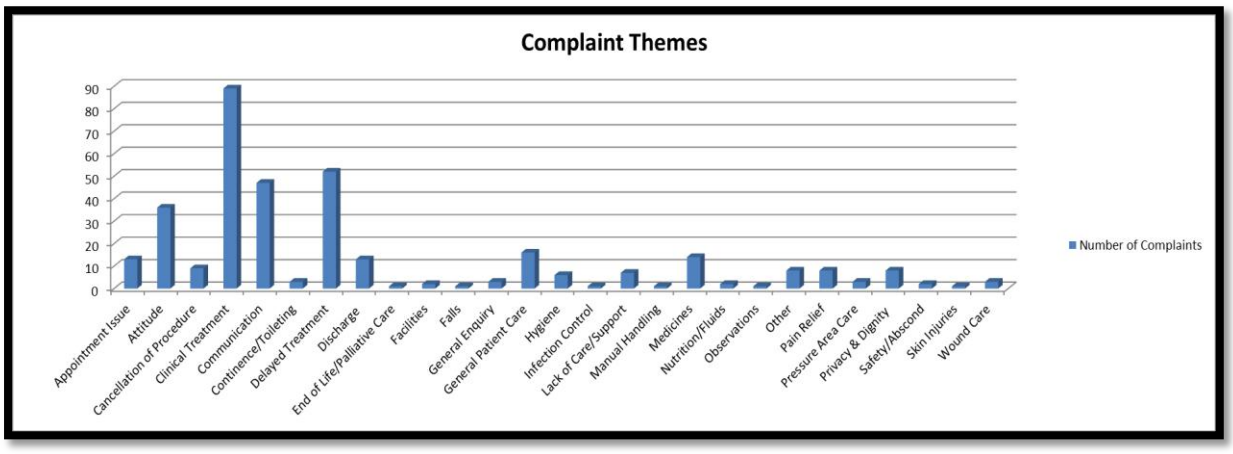
Graph 21: Concerns by theme



Graph 22: Number of complaints received during 2017



Graph 21: Complaints by theme



Section 5: Actions taken during 2017 to support the Nursing & Midwifery workforce

Weekly staffing teleconference

During 2017 the senior nursing team has introduced a weekly teleconference for nursing & midwifery staffing. This is held on a Monday and looks forward to the week ahead. An unfilled shift report is produced by day to evaluate gaps across the Trust and identify where additional support or temporary staffing solutions may need to be adopted. The Divisions work together to respond to patient's needs. Actions are taken forward to reduce gaps & mitigate risks and agreement for bank, overtime and agency staff is sort. This prospective review allows for plans to be put into place ahead of time and the workforce is flexed and mobilised to the areas of greatest need and to ensure there is adequate cover for expected operational needs. This forum also provides the opportunity to challenge leave allocation (particularly during school holidays) and question the need for 'unavailable shift' which result from education, management and administration days.

Recruitment & Retention work programme

The Nursing & Midwifery (N&M) 'Recruitment & Retention' task & finish group (a sub-group of the N&M Workforce Committee) undertook a review of the current nursing & midwifery workforce numbers, vacancies & turnover during 2017. As a result a number of work streams are being progressed to support the successful recruitment & retention of registered staff. The group has recently extended its membership to include AHP colleagues and incorporate the theatre working group which also focuses on the Operating Department Practitioner (ODP) shortfall and plans during 2018 include joining with medical colleagues to work collaboratively across all clinical professional groups.

Recruitment work streams include (but are not limited to):

- Review & update of Comms Strategy to support recruitment (including utilising LinkedIn, FB & Twitter)
- Update of recruitment materials
- Update of website to include a 'one stop shop' to living in Chester & working at the Countess
- Redesign of job advert & review of benefits offered to new starters
- Introduction of 'book on tours' for interested applicants to visit the hospital & meet teams
- Rotational posts offering structured development opportunities
- Maximising National recruitment fairs
- Engagement with local University
- Increasing return to practice numbers
- Theatre open days & career events
- Evaluation of recruitment process using feedback from end-users
- Collaboration with 'Temporary Staffing' to support pay incentives (moving to weekly payroll) & improve technology to support recruitment process
- International recruitment

Retention work streams that include (but are not limited to):

- Review of ward staffing models, utilising acuity & teletracking data to support model development and design teams that reflect the needs of patients

- Scope the nursing & midwifery workforce requirements over the next 5—10 years and develop a training strategy using apprenticeship models to support career development towards professional registration
- ODP training programmes using apprenticeship models
- Theatre practitioner programmes using apprenticeship models
- Review of additional hours payments & incentives to join the Countess Bank
- Building a 'pool' of flexible staff on contracts to support short notice/unplanned gaps
- Collaboration with Education & Training to offer competency based/higher apprenticeship development opportunities

Registered Nursing & Midwifery staff survey

A snapshot survey of registered nurses & midwives has also been undertaken during 2017, this comprised of 26 questions, covering the topics of working patterns, incentives and professional development. A total of 70 nursing & midwifery staff completed this. The feedback from this survey was listened and responded to by the Executive team and as a result the following has been implemented;

- Offer to increase contracted hours from 36 to 37.5
- Offer of 37.5 hour contracts to new registered nursing & midwifery employees
- Offer to work regularly over 37.5 hours (for individuals who requested this as an option)
- Increase bank pay in line with substantive pay for registered nurses & midwives

Staffing Solutions

Work has started to attract more bank staff to support the filling of unplanned registered nursing gaps, this includes;

- Weekly pay
- Regularly advertising bank posts across multiple staff groups
- Offering shorter shift patterns for peak hours in the day/early evening
- Reviewing nursery options and childcare for bank workers
- Working collaboratively across Cheshire & Merseyside on the 'Collaborative Bank' project

Winter staffing action planning

The Director of Nursing held meetings during September/October of 2017 with Ward Managers and senior nursing & midwifery leaders, to obtain their ideas on how further support can be provided to the nursing & midwifery workforce to mitigate risks. Some examples of additional ideas and options are as follows;

- Advance book 10 agency staff eight weeks in advance & allocate on arrival by Clinical Site Coordinator
- Train all pre-booked agency staff in Meditech & EMAR
- Increase the number of pharmacy technicians, converting band 5 nursing posts to cover cost
- Review Band 3 role, identify skills required and the specific areas where these could be utilised
- Consider incentives for new staff to encourage recruitment i.e. Supermarket vouchers
- Develop a shorter shifts e.g. 4 hour shifts or 'Twilight' shifts (increasing flexibility)
- Increase the number of band 2 pool staff for all shifts

- Introduce a revised induction process for staff who have left & returned to a substantive post within 18 months of leaving
- Each Specialist Nursing role with no direct clinical activity mandated to allocate one shift per month from November 2017 to March 2018
- Train non-clinical volunteers to support with patient experience

Clinical Nurse Specialist (CNS) & Advanced Nurse Practitioner (ANP) Review

During 2017 a review of the CNS & ANP roles has been undertaken. This has provided the opportunity to map the current service models and operational requirement to the knowledge & skills provided through the CNS & ANP teams. This is essential to ensuring the right staff, with the right skills are available to provide care and treatment at the point of need. In addition, it has allowed for the standardisation of job descriptions and the completion of a training needs analysis to reduce variation and improve efficiency. The revised job descriptions & new job plans now mirror the national standards for advanced practice.

Section 6: Conclusions & Recommendations for 2018

In conclusion; it is clear that 2017 has been challenging for ensuring the right staffing numbers & skill mix are provided consistently across wards and departments to maintain safety, quality & patient experience. There has been an increase in vacancies (particularly in registered groups) and an increase in turnover seen, making the overall numbers and skill mix available difficult to manage particularly in the later part of the year (September through to December 2017). This has been compounded by the increase in activity and demand seen, with escalation areas remaining open throughout the year. However, there is evidence to demonstrate that the safety of patients has been maintained alongside patient outcomes, quality measures and experience metrics.

There has been a reduction in the number of registered staff available and wards & departments have needed additional unregistered staff to support these gaps, this has allowed for the provision of the right numbers in each clinical area. However, this has resulted in a reduction in skill mix available which has impacted on the workload of the registered staff and has caused addition pressure as seen in the increase reporting of red flags & staffing incidents.

Planned Care overall staffing analysis demonstrates that the planned nursing hours were less than the actual hours provided, suggesting that additional staffing has been needed to support activity and acuity. However, when considering the hours needed (based on the available acuity data), it shows there is an excess of hours provided overall. When this high level data is broken down by ward/department it shows there are some areas with more challenges than others, with Ward 41, 44 & 53 experiencing lower levels of staffing & skill mix in comparison to others.

Urgent Care overall staffing analysis demonstrates that the planned hours were less than the actual hours provided in 10 out of the 12 months included. However, when considering the hours needed (based on the available acuity data) it shows that more hours were needed than provided. This is likely a result of the growing demand on services, the increase patient turnover, and the escalation ward remaining open throughout the year without a funded establishment.

The acuity based workforce model has been key to supporting decision making across the Trust, to mobilise staff as and when required to the areas of greatest need. This has provided transparency (at a glance) and has been used alongside professional judgement to make real-time decisions to maintain the safety of patients and provide the best possible staffing & skill mix within each clinical area.

Despite the challenges seen, it is testament to the nursing & midwifery teams that they have continued to provide high quality care and a positive experience to our patients, as ssen in the safety, quality & patient experience measures outlined within this review.

Recommendations for 2018

Ward team model reviews

As part of the 'Model Ward' programme of work there will be a focus on testing different workforce models to support the changing nature of the acute care environment. This will include;

- Undertaking a literature review
- Analysis of demographic data locally
- Reviewing ward profile (across all professional groups)
- Developing toolkits and defining job plans for ward mangers & deputies (to include training on staff engagement & empowerment)
- Growing the link nurse/champion roles (to include all bands), developing an outline for each link nurse role/responsibilities
- Implementing a Care Assurance Framework (CAF), with ward managers leading improvement plans in response to findings
- Using lessons learning from patient feedback and clinical incidents (includes trends over time)
- Designing ward accreditation & implementing individual recognition
- Further developing & embedding a high performance culture
- Outlining expectations, roles & responsibilities (designing a cascade for learning, support/clinical supervision & appraisals)

Recruitment & Retention work programme

Building on work started in 2017 & further progressing at pace the retention elements of the programme which include;

- Protected status for newly qualified (2-3 year programme)
- University engagement to progress local recruitment & improve attrition rates at the Countess on qualifying
- Building a programme for rotational posts
- Working with university colleagues to establish a PG Cert (18-24 month programme post registration)
- Developing clear career pathways from Nursing Assistant through to Director of nursing
- Options appraisal for registered nursing training (university & apprenticeship models)

Effective use of intelligence

A key focus during 2018 will be to ensure the data collected from HealthRoster & SafeCare is used to make informed real-time decisions and analysed overtime to structure team models and establishments and improve reporting from ward to Board. This work stream will be strengthen through the 'Trust's Business Plan', within the context of the Model Hospital programme and Tele-tracking efficiency work.

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Countess of Chester Hospital NHS
NHS Foundation Trust

Midwifery Establishment Review (Safer Staffing)

Updated February 2018

Author: Julie Fogarty
Head of Midwifery
Up Dated July 2017
Updated February 2018

CONTENTS **PAGES**

1.0 National Picture

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

A draft resource based on the July 2016, the NQB *document "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing", was published in July 2017 final version Jan 2018. This* safe staffing improvement resource provides an updated set of expectations for nursing and midwifery care staffing, to help NHS provider boards make local decisions that will support the delivery of high quality care for patients within the available staffing resource. This resource:-

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

Expectation 1 **Right Staff**	**Expectation 2** **Right Skills**	**Expectation 3** **Right Place and Time**
1.0 Evidence-based workforce planning 1.1 Appropriate skill mix 1.2 Review staffing using the Birthrate plus workforce planning tool annually and with a midpoint reveiw	2.1 Multiprofessional mandatory training, development & education 2.2 Working as a multi-professional team 2.3 Recruitment & retention	3.1 Productive working & eliminating waste 3.2 Efficient deployment & flexibility including robust escalation 3.3 Changes in working around Better births, including increased continuity and caseloading and improvements in postnatal and mental health issues

Recommendations From: NQB Edition 1 January 2018 Safe,sustainable and productive staffing .An improvement resource for maternity services.

In determining staffing requirements for maternity services:

No		R	A	G	Comments
1	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 multiprofessional staffing requirements				Discussion with finance re requirement for BR+
2	Boards are accountable for assuring themselves that results from using workforce planning tools are cross-checked with professional judgement and benchmarking peers.				No work force planning tool in use
3	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.				Staffing reviewed 6 monthly , however accurate staffing requirements not available due to lack of use of work force planning tool
4	Boards are accountable for assuring themselves that staffing reviews use the RCOG, RCoA and OAA guidelines on effective maternity staffing resources				
5	Boards are accountable for assuring themselves that sufficient staff have attended required training and development, and are competent to deliver safe maternity care.				All staff attend mandatory training annually
6	Organisations should have action plans to address local recruitment and retention priorities, which are subject to regular review.				
7	Flexible employment options and efficient deployment of trained staff should be maximised across the hospital to limit numbers of temporary staff				Only 1 midwife on bank and 2temporary midwives employed to cover mat leave
8	Organisations should have a local dashboard to assure stakeholders about safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.				
9	Organisations should have clear escalation processes to enable them to respond to unpredicted service needs and concerns about staffing.				Escalation process found in staffing guideline
10	Establishments should include an uplift to allow for the management of planned and unplanned leave to ensure that absences can be managed effectively.				Annual leave rostered evenly throughout the year . introduction of e rostering supports this
11	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 development				Robust training programme staff rostered to attend
12	Organisations must take an evidence-based approach to supporting efficient and effective team working.				All training and guidelines are evidence based
13	Services should regularly review red flag events and feedback from women, regarding them as an early warning system				Red flags as per report . Safety thermometer and F&F completed monthly
14	Organisations should investigate staffing-related incidents, outcomes on staff and patients, and ensure action, learning and feedback				

A further document from Clinical Negligence Scheme for Trusts (CNST) has introduced an incentive scheme for trusts. "Maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified to us in 2016/17, obstetric claims represented 10% of the volume and 50% of the value. It is important to remember that trusts that improve their maternity safety will be saving the NHS money, allowing more money to be made available for frontline care". *Maternity Safety Strategy actions and Clinical Negligence Scheme for Trusts (CNST) incentive scheme 2018.*

One of the ten required standards for the trust is:

"*Can you demonstrate an effective system of midwifery workforce planning"*

Required standard and evidential requirement for this standard is:

- *Evidence of a systematic, evidence-based process to calculate midwifery staffing establishment;*
- *Trust policy demonstrating that, as standard, midwifery labour ward shifts are rostered in a way that allows the labour ward coordinator to have supernumerary status (defined as having no case load of their own during that shift); and*
- *Good practice includes neonatal workforce within work force plans.*

Trusts should be evidencing the position as at end April 2018. Evidence for item 1 could include Board minutes or evidence of a full audit or table-top exercise using a tool such as **Birthrate+2"**
Maternity Safety Strategy actions and Clinical Negligence Scheme for Trusts (CNST) incentive scheme 2018.
Midwifery as part of the Model Hospital work stream acuity based workforce will incorporate the triangulated approach to its E-rostering . The CHPPD will also be explored in the future.

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

1.3 The report also supports the Care Quality Commission (CQC) requirements under the Essential Standards of Quality & Safety, including outcomes 13 (staffing) and 14 (supporting staff). The CQC inspection of Maternity Services in February 2016 awarded a good in all 5 key lines of enquiry; safe, effective, caring, responsive & well led however stated in its report that "*the number of midwives employed did not meet best practice Birthrate Plus recommendations*". This calculation will be applied in the acuity based workforce e-rostering set-up.

1.4 NICE published Safe Midwife Staffing in Maternity Settings in February 2015, this report acknowledges that guidance, however the staffing tool to accompany the guidance has not been produced therefore the staffing formula via Birthrate Plus a nationally recognised midwifery staffing tool has been applied using same format as for the previous reviews but with recent data. In the NICE Guidance a minimum staffing ratio for women in established labour has been recommended, based on the evidence available and the Safe Staffing Advisory Committee's knowledge and experience. The Committee did not recommend staffing ratios for other areas of midwifery care. This was because of the local variation in how maternity services are configured and therefore variation in midwifery staffing requirements, and because of the lack of evidence to support setting

midwife staffing ratios for other areas of care. High Quality Midwifery Care (RCM 2014) recognises the need that staffing levels are appropriate across the entire maternity pathway otherwise labour ward care is always prioritised at the expense of antenatal and postnatal care. The Midwifery & Support Staffing policy was updated in 2015; the Director of Nursing & Quality signed it off as per NICE guidance (February, 2015 p13) prior to formal ratification.

1.5 MBBRACE-UK 2016

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

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

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

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

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

1.8 In January 2009 the Royal College of Midwives issued a position Statement on staffing standards in Midwifery; this was followed in February 2009 by a guidance paper. The implications of this paper for midwifery staffing requirements are that the Royal College of Midwives (RCM) recommends a national ratio of midwives to women of 1:29 current staffing based on 1:45.

1.9 MBRACE- UK Perinatal Confidential Enquiry 2017

This report focused upon Term, singleton, intrapartum stillbirths and intrapartum related neonatal deaths. One of the report findings identified staffing issues a possible related issue in 7 cases. The report also outlines how heavy workload and staff capacity issues can affect the care provided, leading to delays/ postponement in induction of labour. There are many reasons why there is an increased demand on maternity services and all factors are associated with an increase in perinatal death.

2.0 Background

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

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

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

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

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

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

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

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

2.7 Increased annual leave provisions under Agenda for Change; core and specific mandatory training requirements; the increase in the complexity of care required by women across Western Cheshire & surrounding areas who select COCH as their unit of delivery has reduced the time available for midwives to provide direct care to women. Lean & productive ward tools has supported some service changes to further improve the efficiency of the workforce.

2.8 One of the Francis Report (2013) recommendations was that Trusts should make all ward managers supervisory. This has been partially achieved in the past 6 months midwifery due to the shortfall in WTE against national recommendation and sickness requiring management time being converted to clinical shifts.

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

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

3.0 Methodology for February 2018 Establishment Review

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

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

- Establishments were compared to July 16 & January 2017
- Review of registered to unregistered midwives ratios
- The application of Birthrate Plus® a nationally recognized tool which is the classification of case mix by categories I–V
- Booking & delivery statistics

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

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

4.0 Birth rate Plus Methodology

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

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

5.0 Findings

5.1 Staffing

National and local statistics indicate that the profession continues to be predominantly female and that the age profile remains static. The maternity services currently employ **136 midwifery** staff (headcount) plus 2 on bank, in a variety of roles including management. The Trust employs midwives who work both within the hospital and community; **22%** of midwives are eligible to take retirement over the next 5 years based on a retirement age of 55, with **17%** eligible to take retirement now. This data itself demonstrates the fact that Chester has the potential to lose a large number of experienced staff from all fields in the near future including all its management roles and most specialist roles in the next 5 years. However it must be noted that the service has experienced no difficulties in recruiting to its vacancies this year to date and has robust succession plans in place with staff already in training to ensure current services are maintained in the future when required.

5.2 Desktop exercise

Birth rate plus quote several ratios of midwives to women, without full assessment it is difficult to determine what requirements are needed at COCH. In: **2010** the mean national ratio based on 87 DGHs and 9 tertiary units in England was defined as **29.5 births per wte midwife** with a range of 27.3 - 31.5 births per wte midwife (Ball and Washbrook 2010).
However this exercise is based on
For hospital birth activity only:

- Tertiary services: 38 births per wte midwife.
- DGH with > 50% in category IV and V: 42 births per wte midwife.
- DGH with < 50% in category IV and V*: 45 births per wte midwife.
- Homebirths and MLUs: 35 births per wte midwife.
- For community services activity only: 96 births (cases) per wte midwife.
- The home birth ratio of 35 births per wte midwife was unchanged.

For a DGH the management and specialist component is an additional 8%.
Stats are for the period 1st January 2017– 31st December 2017
Staffing requirements based on average 1:42
Shift leader supernumerary
Plus 8% management specialist component

PLACE OF BIRTH	NOS OF BIRTHS	WTE MIDWIFE REQUIRED
HOMEBIRTHS	21	21/35 = .6 WTE
HOSPITAL BIRTHS	2811	2811/32 = 66.9 WTE
COMMUNITY PN	2230	2230/96 = 23.22 WTE
		90.75

Basic Requirement	90.75 wte
Plus 8%	7.25 wte
Plus supernumerary shift leader	5.14 wte
Plus 20% annual leave etc	20.6 wte
Total	**123.74 wte**
Shortfall of :	**30.47 wte**

This shortfall seems high however without an accurate review using a recognized assessment tool there will continue to be inaccuracies in calculation of requirements due to ratios need to be assed based on activity / acuity within the maternity unit.
Staffing review of requirements for community under review with implementation of 'Continuity of Carer' for antenatal, intrapartum and postnatal care.

6.0 Quality & Safety

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

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

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

6.1 Midwifery Unit Closure

Part of the Trust Patient Flow Policy which was updated in 2015 contains a section regarding management of Midwifery capacity. Within the Midwifery section is a comprehensive section upon the reasons why the Maternity Unit would temporarily close to admissions (one of which is staffing levels) and the processes surrounding the closure to ensure safety of women & babies and to support collaborative working with neighboring Trusts.

During the period 1st January -31ST December 2017 the Maternity unit closed seven times resulting in 13 women delivering at another provider. See attached summary.

Unit Closure Summary 2017.docx

The Neonatal Unit continues at level 1 status at the time of the production of this report; this however had no major impact upon the overall running of Maternity Services due to low numbers involved in relation to the additional work associated with intra- uterine transfers.
Cheshire & Merseyside Model of Care Midwifery arm of the Vanguard has reviewed each Trust's Policies for divert/closure and produced a single policy across all maternity services. This has been ratified at W&C Governance Board in July 2017 and is embedded of the Trust Patient Flow Policy and under Obstetric guidelines on Sharepoint.

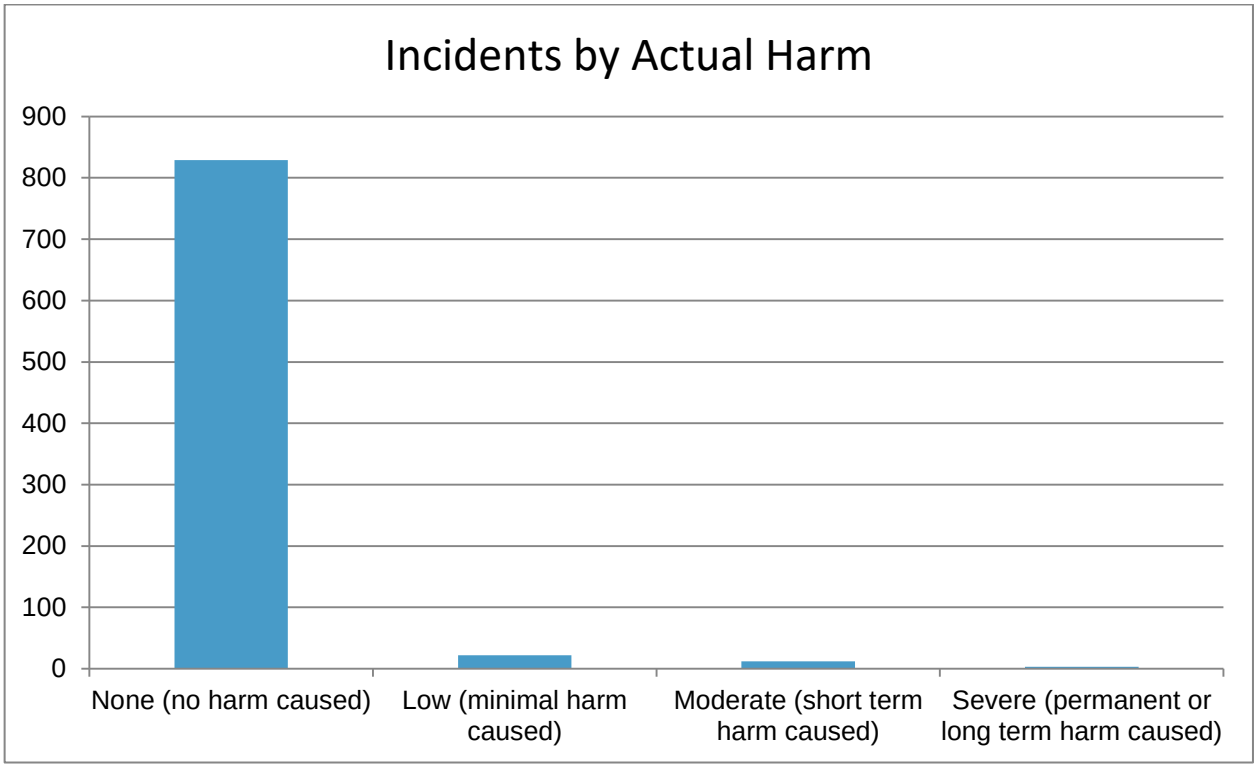
6.2 Staffing Incidents 1st January – 31st December 2017

During the period of 1st January to 31st December 2017 there were 155 logged incidents in relation to staffing. This is a similar number to the previous year. Each Datix is reviewed in the context of the status of the maternity unit capacity, women's acuity and overall staffing levels.
The table below shows the incidents by location and sub category:

	Inadequate Training	Lack of Staff	Staff transferred to another clinical area	Total
Antenatal Clinic	0	1	0	1
Central Labour Suite	0	109	6	115
OFF SITE	0	1	0	1
Ward 32 Cestrian Ward	1	34	3	38
Total	1	145	9	155

6.3 Datix incidents overall

There were a total of 399 incidents reported in obstetrics during the period of 1st January – 31st December 2017 – of these incidents, 56 occurred as a direct result of staffing levels.
The table below shows all incidents by actual harm:



There were 3 severe harms reported during that timescale:

- There was one severe harm incident reported during this time period which occurred when a patient who had consented for tubal ligation at elective caesarean section attended in preterm labour and underwent an emergency caesarean section. As per COCH guidelines the patient did not undergo sterilization at the time of emergency C/S but this was not communicated to the patient at the time of the event; the patient later became pregnant and underwent a termination of pregnancy procedure.
- Severe harm reported when a patient with placenta accreta (who delivered at WUTH) was admitted to COCH following c/s and hysterectomy with bi-lateral pulseless legs due to sheaths not being removed at the end of her surgery.
- Severe harm when known placenta praevia patient required hysterectomy at emergency c/s resulting in an blood loss of 13750mls and required admittance to ITU.

There were 12 moderate harms reported during that timescale:

- 1 personal injury when a staff member slipped on water leaking from the floor cleaning machine
- 2 Iatrogenic injury's to a patients bladder which occurred at the time of elective caesarean section
- 1 complaint received when a patient felt she did not receive adequate pain relief at emergency caesarean section
- 1 complaint when incomplete miscarriage diagnosed incorrectly
- Postnatal readmission with postpartum cardiomyopathy and pulmonary oedama which following administration of diuretic drained 3L
- Delay in delivery for Cat 2 c/s
- Baby requiring admission to NNU following delay in delivery of cat 2 c/s (>4 hours)
- Staff member injured herself whilst trying to empty the pool in room 5 on CLS
- Term stillbirth
- Unexpected collapse of term baby on NNU requiring commencement of therapeutic cooling
- Postnatal readmission following forceps delivery with infected perineum and MRI showed significant damage to anterior external sphincter

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

	None (no harm caused)	Low (minimal harm caused)	Moderate (short term harm caused)	Severe (permanent or long term harm caused)	Total
01/01/2017	10	0	0	0	10
08/01/2017	26	0	0	0	26
15/01/2017	15	0	0	1	16
22/01/2017	11	0	0	0	11
29/01/2017	19	1	0	0	20
05/02/2017	13	1	0	0	14
12/02/2017	16	0	0	0	16
19/02/2017	11	0	0	0	11
26/02/2017	17	0	0	0	17
05/03/2017	22	2	1	0	25
12/03/2017	16	0	1	0	17
19/03/2017	13	0	0	0	13
26/03/2017	17	0	0	0	17
02/04/2017	21	0	0	0	21
09/04/2017	7	0	0	0	7
16/04/2017	25	0	0	0	25
23/04/2017	17	0	0	0	17
30/04/2017	9	0	0	0	9
07/05/2017	12	0	0	0	12
14/05/2017	10	0	1	0	11
21/05/2017	5	0	0	0	5
28/05/2017	15	3	0	0	18
04/06/2017	17	1	0	0	18
11/06/2017	9	0	0	0	9
18/06/2017	21	0	0	0	21
25/06/2017	12	0	0	0	12
02/07/2017	23	0	0	0	23
09/07/2017	11	2	1	1	15
16/07/2017	19	0	3	0	22
23/07/2017	20	0	1	0	21
30/07/2017	17	1	0	0	18
06/08/2017	30	0	0	0	30
13/08/2017	17	0	0	0	17
20/08/2017	25	1	0	0	26
27/08/2017	15	1	0	1	17
03/09/2017	21	0	0	0	21
10/09/2017	25	0	1	0	26
17/09/2017	17	1	0	0	18
24/09/2017	19	0	0	0	19
01/10/2017	18	0	0	0	18
08/10/2017	23	1	1	0	25
15/10/2017	10	0	0	0	10
22/10/2017	9	0	0	0	9
29/10/2017	13	0	0	0	13
05/11/2017	15	0	0	0	15
12/11/2017	18	2	0	0	20
19/11/2017	8	2	0	0	10
26/11/2017	22	0	0	0	22
03/12/2017	10	1	0	0	11
10/12/2017	11	0	0	0	11
17/12/2017	16	1	0	0	17
24/12/2017	7	0	1	0	8
31/12/2017	4	1	1	0	6
Total	829	22	12	3	866

Data Source Annemarie Lawrence –Risk Midwife

6.4 Midwifery Indicators (Red Flags)

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

6.5 Supervisory Ward Managers

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

7.0 Safeguarding work

The CoCH annual safeguarding Children Trust Board Report 2016-2017 once again reflects the high number of safeguarding children cases dealt with in maternity services and this also serves to evidence the willingness of maternity services staff, and in particular the community midwives to challenge situations and information that may lead to a safeguarding children issue. In addition the senior management support in relation to these processes is commendable, especially given the pressures this work can place on the midwifery capacity. All in all the CoCH can strongly evidence a high knowledge base and a high level of commitment from all staff to the safety and welfare of our maternity service users.

8.0 Challenges & Risks

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

Unsupported/ verified required staffing numbers presents as a risk for future workforce planning. Changes in acuity in workload due to an increase of complexities women present with is not reflected at present in current staffing levels. Birth rate plus will provide a robust tool/ system to accurately assess staffing requirements with the maternity service.

9.0 Conclusion

This twelve month review demonstrates that the Midwifery staffing currently has a staffing shortfall. This was also recognised within the 2016 CQC inspection report and will be an objective within the Trusts bespoke Maternity Services Safety Improvement Plan which forms part of the Department Of Health *Safer Maternity Care* requirements.

The past twelve months booking numbers have reduced and are more in line with 2014 however a number of the women who initially opt to book at COCH then transfer care during pregnancy to AQP 121 Midwifery but predominantly deliver at COCH, some also transfer back to COCH either in the antenatal period or in labour and some are booked with AQP 121 but have antenatal care via COCH Services, ultimately all these combinations contribute to making workforce planning more difficult and add to the workload of the Countess employees.
From February 2018 women booked with 1-1 with complex issues their bookings will be computed by ANC midwives, therefore, impacting on workload.
Out of area bookings predominantly from Wales have reduced in the last 3 months of 2017. This is mainly due to women not allowed to book at COCH talks with BCUH ongoing.
The sustained increase in the complexity of women has also had an effect on staffing pressures in conjunction with the additional requirements of the GROW programme.

In light of the staffing shortfall against national recommendations the Head of Midwifery recommends:-
1) Full Birthrate plus assessment of the workforce
2The Head of Midwifery is also mindful that the national maternity review recommendation in relation to 'Every *woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the women and family, and can provide continuity throughout the pregnancy, birth and postnatally*' will not be achievable within the current midwifery staffing framework.

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

10.0 Appendices

Appendix A

Birthrate Plus Classification

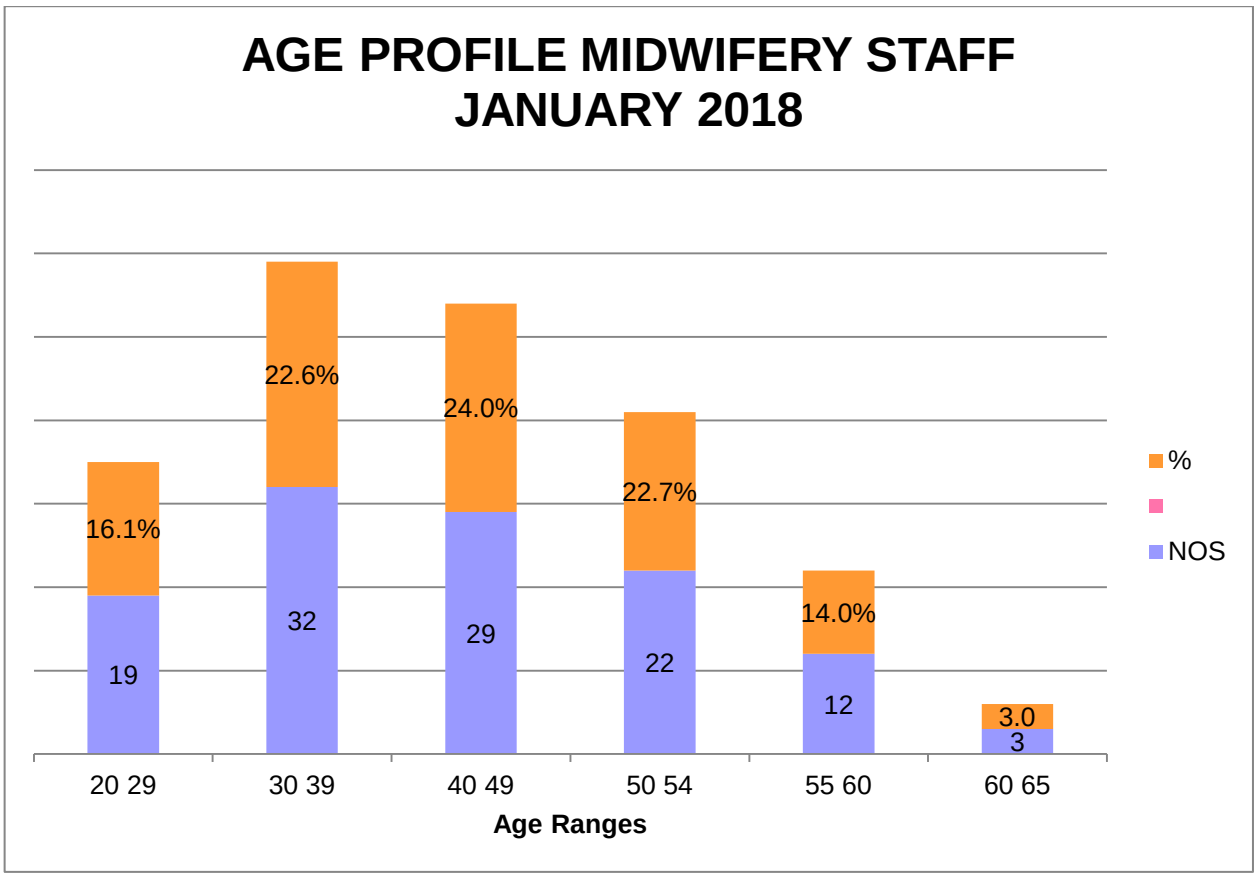
Integral to Birthrate Plus® is the classification of case mix by categories I–V: The nos is categories ivand v has increased due to changes in the classifications of risk factors.

Data L N=Mohan IM&T

BR+CRITERIA 2018.docx

Data Source
Laura Mohan IM&T Feb 2018

Appendix B



Appendix C

Midwifery WTE stats – January DATA

HOSP	BAND	WTE
	8b	1
	8a	1.8
	7	10.17
	6	48.52
	5	8.68
COM	7	.8
	6	22.3
TOTAL		**93.27**

Appendix D

All Bookings						
(excluding booked at One to One)						
Count of Mother Unit Number	**Column Labels**					
Row Labels	**2014**	**2015**	**2016**	**2017**	**2018**	**Grand Total**
Jan	312	298	293	276	205	1384
Feb	287	308	285	269		1149
Mar	295	330	307	301		1233
Apr	274	333	285	242		1134
May	279	262	282	285		1108
Jun	255	297	273	225		1050
Jul	300	301	285	223		1109
Aug	273	252	296	247		1068
Sep	287	304	286	223		1100
Oct	307	299	274	233		1113
Nov	276	297	318	232		1123
Dec	268	317	258	176		1019
Grand Total	**3413**	**3598**	**3442**	**2932**	**205**	**13590**
		5.4%	4.3%	14.8%		

Data Source
Laura Mohan IM&T

Appendix E

Delivery Statistics 2017

CLS Stats proforma 2017_18 with KPIs_G

Data Source: - Laura Mohan IM&T

Appendix F

PN Home Visits Statistics 2017

PN_visits_2017.xlsx

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Countess of Chester Hospital NHS
NHS Foundation Trust

SUMMARY REPORT
JANUARY – DECEMBER 2017 INCLUSIVE
MIDWIFERY CARE METRICS

Lead
Jean Fisher
Head of Midwifery (Interim)

Date February 2018

Introduction

The Maternity Service is expected to demonstrate through monitoring that their processes to manage risk have been implemented.
The Obstetric Lead and Head of Midwifery following consultation with relevant colleagues developed a plan in 2015 as to the baseline for future audit and reporting to ensure a high quality service that is able to recognize trends in incidents; triangulate complaints, incidents & legal cases and demonstrate ongoing evaluation of areas that are consider to be high risk midwifery. This plan was received at the Trust's Quality, Safety & Patient Experience Committee
The plan also can accommodate a responsive audit to a suspected trend, incident, national reports or area that gives rise to concern in addition to the ongoing surveillance.
The Midwifery care metrics results detailed with this summary report contributes to the overall Maternity Services governance plan.

In monitoring this process the Maternity Service has specifically utilized health records for audit in accordance with the minimum requirements in each Trust guideline

The maternity service will demonstrate through audit of the health records that the minimum requirements for each guideline are met in 75% of cases in each month.

Audit and monitoring is across all care settings [including homebirth] and all staff and patient groups.

The audit tool is supported by a staff database to enable identification of potential poor practice, a record of communication to staff is also kept as part of robust evidence sources. Whilst overall, all the guidelines met the 75% minimum target where deficiencies have been identified actions have been taken and changes made to reduce the risk and increase compliance for the specific sections of guidelines that failed to meet the minimum 75% target.

The maternity service is striving to achieve 100% compliance.

Summary

This twelve month care metrics report is based upon a requirement to monitor clinical practice.

The report monitors the compliance of the specific approved Maternity Services guidelines in relation to:-

- Medical Records
- Care of Women in Labour
- Intermittent Auscultation
- Continuous electronic fetal monitoring
- Induction of Labour
- Meows
- Bladder Care
- Neonatal Obs (Discontinued Aug 17)
- VTE Assessment at 28 weeks (Commenced Aug 17)
- Antenatal Screening Compliance (Commenced Aug 17)
- Medicines Management
- Pertussis vaccination offer
- Swab checking

Following the cessation of the NHSLA CNST Standards for Maternity Services in 2014, the Obstetric & Midwifery team has reviewed the audit, monitoring, evaluation and reporting structure previously required for the CNST assessment process and devised a system that focuses on high risk areas, that is able to be responsive to practice at COCH.

Between the months of January 2017 – December 2017 inclusive ten maternity health records have been audited throughout each month using a modification of the successful audit tool devised for CNST assessment.

The monthly audit also includes medicines management, the offer of the pertussis vaccine and adherence to swab checking process.

The records are benchmarked against adherence to the Trust guidelines, the audit tool tests and allows for monitoring and evaluation of the compliance to these guidelines.

Aim and Objectives

Aim

To provide a continuous audit process of:

- ❖ Medical Records
- ❖ Care of Women in Labour
- ❖ Intermittent Auscultation
- ❖ Continuous electronic fetal monitoring
- ❖ Induction of Labour
- ❖ Meows
- ❖ Bladder Care
- ❖ Neonatal Obs (Discontinued Aug 17)
- ❖ VTE Assessment at 28 weeks (Commenced Aug 17)
- ❖ Antenatal Screening Compliance (Commenced Aug 17)
- ❖ Medicines management

- Any omissions of medication not administered have recorded code and reason entered on EMAR
- All Patients have printed ID band
- All medications administered in line with Trust policy e.g. identification and recording
- IV fluids documented on infusion chart and fluid chart
- All patients with medication allergy are identified and alert recorded on EMAR and Meditech

- ❖ Pertussis vaccination offer

- To ensure the audit of health records meets the requirements specified in the Trust guideline

- ❖ Swab checking

- To ensure that the all counts relating to swab checks has been documented.

Objectives

1. To ensure that 10 of maternity case notes are audited each month.
2. To aim for 100% compliance of our trust guidelines
3. To ensure that the audit confirms a minimum 75% compliance for each guideline
4. To ensure that any risks are identified and actioned (Striving to achieve 100% compliance met).

Methodology

Through audit the maternity service will demonstrate that it is monitoring compliance with the implemented guidelines outlined above.

Audit Sample

Between the months of January 2017 – December 2017 inclusive 10 maternity health records for the subjects listed earlier in this report have been audited throughout each month.

Data Collection Tool

Each month Maternity health records are selected to audit against the guidelines included in this audit. The method of selection is random to ensure a cross case mix of care.

The Modified CNST Care metrics Audit tool has been used to record the compliance level within the Health records.

The tool was specifically developed using the approved clinical guidelines and the minimum requirements at Level 3 in the CNST Risk management standards and then adapted to meet COCH current requirements.

The Tool uses formulas to calculate the total number of applicable health records and compliance using Microsoft Excel.

Data Collection

The health records have been identified from deliveries between the months of January 2017 – December 2017 and audited by a group of senior midwives continuously throughout the six months.

Data Analysis

The data has been analyzed using quantitative data analysis:

- To confirm 75% compliance to each minimum requirement against Trust guidelines

Results

- ⇨ Objective 1- The aggregated audit tool demonstrates 120 maternity health records have been audited which meets the 10 sets a month
- ⇨ Objective 2 -There were some elements that failed to meet the 100% compliance of all sections of our guidelines to the minimum requirements specified the guideline.
- ⇨ Objective 3- The audit tool has demonstrated that all guidelines meet the required standard of 75%:
- ⇨ Objective 4- As a result of the audit an action plan was not required as no element failed to meet the overall 75% minimum requirement. The audit results have already been reviewed monthly and actions taken to address precise none compliance with specific individuals and these monthly reports are displayed on the ward quality boards.

Area of practice reviewed	Monthly Audit Results												Overall Average %	Overall Status
2017	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		
Maternity Health Records	52	100	96	89	100	89	96	77	98	96	100	100	91%	
Care of Women in Labour	86	100	100	100	87	85	97	93	78	95	100	100	93%	
Intermittent Auscultation	100		100		100		100		88		100	100	98%	
CEFM	93	100	93	99	96	97	96	97	91	100	100	100	97%	
Induction of Labour	100	100	100	100	33	83	100	100	100	92	100	100	92%	
Meows	79	93	98	93	95	91	80	73	92	94	100	100	91%	
Bladder Care	80	100	80	70	90	80	70	90	50	90	100	100	83%	
Neonatal Obs		100	100	100	100	100	100						100%	
Medicines management	100	100	100	100	100	80	100	100	100	100	100	100	98%	
Pertussis	100	100	100	100	100	100	100	90	100	100	100	100	99%	
Swab checks	100	100	100	90	100	100	80	100	90	90	100	100	96%	
VTE Assessment at 28 weeks								0	0	76	0	90	33%	
ANS Compliance								100	96	98	100	100	99%	

Discussion

- The audit demonstrated overall there remains very good compliance with guidelines as per Trust requirements. In all guidelines there were many elements that achieved 100%.
- VTE Assessment at 28 weeks
    - New guideline has been relaunched
    - Discussion with staff re completion of 28 week assessment
    - Review of data capture – awaiting meditech screens to be updated

As per attached monthly reports

As a result of the audit several midwives have been asked to review their record keeping/refer to a particular guideline and reflect. A new tool has been implemented for peer audit for staff who fail to comply with accurate and complete documentation. The identified midwife must have 10 sets of notes audited by their peers as an ongoing live process during care provided during labour. On completion the management team will randomly select notes audited to ensure compliance.

Midwives are being encouraged to use any feedback following the care they provided and their records being audited as per of their Nursing & Midwifery Council revalidation evidence.

Key actions

- ❖ Ward managers and shift leader will utilise safety briefs to cascade information/ actions required by them to staff.
- ❖ Doctors will utilise lunchtime teaching session and hand over to cascade information/ actions required by them to staff.
- ❖ Email to shift leaders regarding outcome from the audit regarding noncompliance so they are all fully aware of their role in the pursuit to increase compliance.
- ❖ Peer auditing introduced

As we strive to achieve 100% compliance against the guideline we continue to monitor and provide feedback to staff groups as required. Report to be shared with all staff via Practice Development Midwife

Limitations

There were no limitations to the audit process

Recommendations

The audit has been analyzed by the Head of Midwifery.
The results will be reviewed by the Women & Children Safety & Quality Group and presented to the Women & Children's Care Governance Board.
Any risks identified are escalated as appropriate.
This report will be shared with all midwifery staff

Action Plan

Nil required in relation to the Overall Audit results however managers need to ensure the results are cascaded to all staff via PDM.

Peer Audit Tool

Notes Reviewed.docx

References

National Health Service Litigation Authority (2013-14).

Jean Fisher
Head of Midwifery (Interim)
Produced 21/2/18

Key actions

- Ward managers and shift leader will utilise safety briefs to cascade information/ actions required by them to staff.
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Peer Audit Tool

Notes Reviewed.docx

References

National Health Service Litigation Authority (2013-14).

Jean Fisher
Head of Midwifery (Interim)
Produced 30/10/17

NHS
Countess of Chester Hospital
NHS Foundation Trust

Board of Directors – Cancer 62 day performance

Subject	Cancer 62 day performance
Date of Meeting	13th March 2018
Author(s)	Denise Wood, Head of Information & Performance, on behalf of Lorraine Burnett
Presented by	Ms Lorraine Burnett, Chief Operating Officer
Annual Plan Objective No.	
Summary	The 62 day cancer performance is under the 85% target due to a number of specific reasons which are described in the paper, along with the improvements already in place and planned. Action plans from the cancer improvement event and site specific plans are shown in the appendices.
Recommendation(s)	**The Board is asked to:** acknowledge the current under performance of this standard, and review the improvements in place and planned, to reduce the number of days waiting from referral to first definitive treatment
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [X] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Cancer 62 day performance

1. Background

- **Performance data**

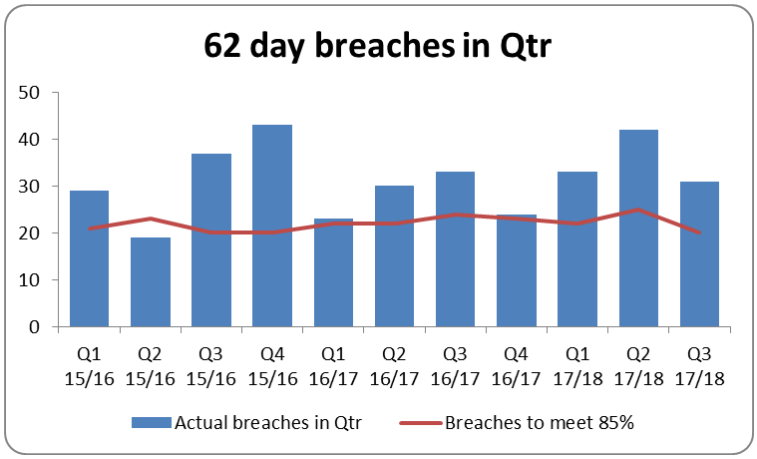
The 2 week wait 62 day target relating to referrals from a GP is the area of most concern.
Although the breast symptomatic target has underachieved, this has been due to specific problems during these quarters relating to staffing and capacity, and not expected to be an ongoing issue. The 62 day screening target failure is due to low numbers and 1 patient can affect the overall percentage. The 31 day Surgery failure in Q1 was due to capacity in Plastic Surgery and this has now been resolved.

	Target	2015/16				2016/17				2017/18			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
14 Day	93%	96.35%	96.19%	97.21%	96.99%	96.34%	95.81%	96.45%	97.92%	95.90%	96.91%	96.08%	
14 Day - Breast Symptomatic	93%	96.09%	94.86%	93.87%	96.73%	95.92%	96.45%	94.92%	96.39%	84.35%	92.90%	90.85%	
31 Day - Diagnosis to Treatment	96%	98.46%	99.35%	99.32%	100.00%	99.64%	97.37%	99.04%	97.88%	98.97%	99.32%	100.00%	
31 Day - Surgery	94%	97.67%	97.83%	100.00%	94.34%	100.00%	94.34%	92.59%	96.67%	90.38%	98.36%	95.45%	
31 Day - Drugs	98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
62 Day - Referral to Treatment	85%	82.94%	89.05%	78.43%	76.37%	86.74%	83.19%	82.90%	86.67%	82.02%	80.09%	81.76%	
62 Day - Screening	90%	94.59%	100.00%	100.00%	100.00%	100.00%	100.00%	95.35%	87.23%	97.30%	87.76%	89.66%	
62 Day - Upgrade	85%	95.04%	89.10%	90.40%	92.86%	96.45%	87.65%	94.19%	91.33%	92.62%	88.98%	96.57%	

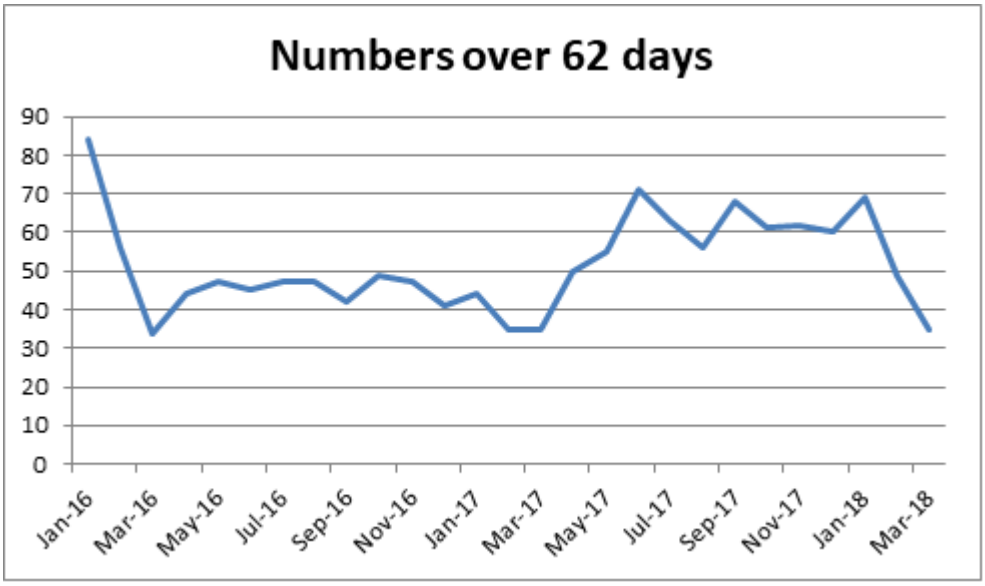
During 2017/18 to the end of Q3 the breaches were for the following tumour sites:

	Total Breaches	% of Trust Breaches
Urology	25	20%
Upper GI	23	19%
Colorectal	20	16%
Haematology	12	10%
Lung	12	10%
Head & Neck	11	9%
Gynaecology	9	7%
Skin	7	6%
Breast	5	4%
TOTAL	**124**	

As a Trust we can only have approximately 22 breaches per quarter to achieve the 62 day target, but this is also dependent on the number of treatments seen within the quarter.



- Number of over 62 days – this is the number of patients on a two week wait pathway so excludes screening and upgrades. The increase from summer 2017 coincides with the issues within both Radiology and Endoscopy listed below.



- **Specific issues which have impacted on performance:**

(i) Issues with Radiology

During the summer period of 2017 Radiology had a significant reporting backlog of reporting due to greatly increased demand for all imaging including emergency medicine, inpatients, cancer fast track, stroke and urgent referrals. In addition the reporting capacity was greatly reduced due to Radiologist vacancies and summer annual leave. Extra reporting sessions were being undertaken

by Radiologists to try and keep up the urgent workload, and some were outsourced to a reporting company, however even they reported issues with keeping up with demand as all Trusts were, and continue to be in the same position. This backlog is listed on the Trust Risk Register and Radiology is continuing to try and recruit to the outstanding vacancies.

(ii) Issues with Endoscopy

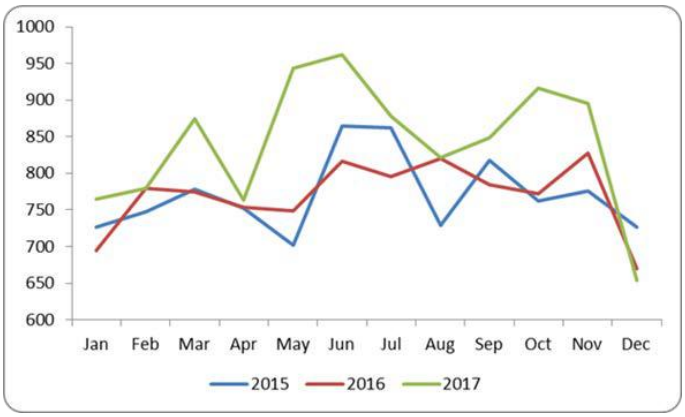
This was due to five registered Nurse vacancies. This issue started in August and initial recruitment wasn't successful. On the third round of recruitment three posts were filled and on the fourth round of recruitment two posts were filled, but this was followed by one further RGN resignation

(iii) Referrals to tertiary centres

We need to send out patients to tertiary centres by day 38. If there is any delay and the patient then waits over 62 days the breach is allocated to COCH. Diagnostic delays have contributed to late referrals, but there have been issues with our dependency on tertiary capacity for diagnostic, treatment and acceptance of referrals in a timely manner.

(iv) Increase in demand

The referrals for 2015 and 2016 were similar, but there was a 9% increase in GP referrals in 2017 and this is expected to continue in to 2018. This is partly due to NICE cancer guidelines. Although these patients may not be confirmed cancers and wouldn't necessary be included in the treatment numbers, they do need to be tracked and have the relevant diagnostic tests.



	No of GP referrals
2015	9243
2016	9237
2017	10099

2. Improvements in place

(i) Focus on bringing in long waiters. Micro-management of all patients waiting over 62 days and in particular those waiting over 100 days. There has been an improvement in the number of patients waiting over 62 days:

PTL date	Total on PTL	All pts >62 days	2 wk wait pts >62 days
01/12/2017	1134	73	56
08/12/2017	1018	60	48
15/12/2017	1042	79	59
22/12/2017	992	80	60
05/01/2018	914	91	66
12/01/2018	872	84	63
19/01/2018	986	89	68
26/01/2018	965	93	69
02/02/2018	940	86	62
09/02/2018	937	86	62
16/02/2018	954	78	56
23/02/2018	961	70	49
02/03/2018	957	51	35

(ii) Cancer improvement event was held in January 2018 with approximately 50 staff in attendance. A number of work streams are now in place covering:

3. Diagnostics (focus on Radiology and Endoscopy)
4. Internal processes (tracking process and use of Qlikview for visibility of data and management of the PTL)
5. MDT (standardise process, rollout best practice and use of technology)
6. Technology and data (Qlikview, breach reporting, improved Radiology requesting from GPs)
7. Optimum clinical pathways (using local and Regional best practice)
8. Workforce, education & engagement (recruitment and retention of staff and communications strategy)

This programme is being led by the Chief Executive Officer Tony Chambers. Each group will hold a bi-weekly meeting and the action plans will be monitored through highlight reports submitted to the Model Hospital Programme Board. Each work stream has an executive lead. The full action plan is shown in appendix 1.

(iii) Endoscopy

- Four out of the five posts have been recruited to and three are not in place, however when they arrive they need GIN training which takes 2/3 months. We are seeing an improvement in Endoscopy waiting times and continue to prioritise cancer patients

- The Endoscopy team leader post which has been vacant since May due to long term sickness, is now in place and will prioritise capacity and demand work
- Teletracking has been very successful in Endoscopy in terms of flow of patients
- Foot pumps have been purchased which will reduce the amount of patients who cancel on the day due to visibility within the bowel
- A band 5 nurse has been trained in to an extended role so that flexi sigmoidoscopy can be undertaken, with further training planned to include bowel scoping and colonoscopies by the end of the year. If this proves to be successful a further training post will be provided within budget which will perform OGDs
- A six week forecasting tool has been created to understand capacity and demand requirements six weeks ahead

(iv) Radiology

- Recruitment to vacant posts
- Increase number of CT fast track appointments through the use of evening lists
- Use of partial booking for fast track patients
- Reduce delays in receiving requests following MDT
- Improve communication to clinicians for referrals for imaging, and reduce inappropriate referrals
- Use of PTL to track outstanding appointments using Qlikview
- Improve referral pathway for specialties

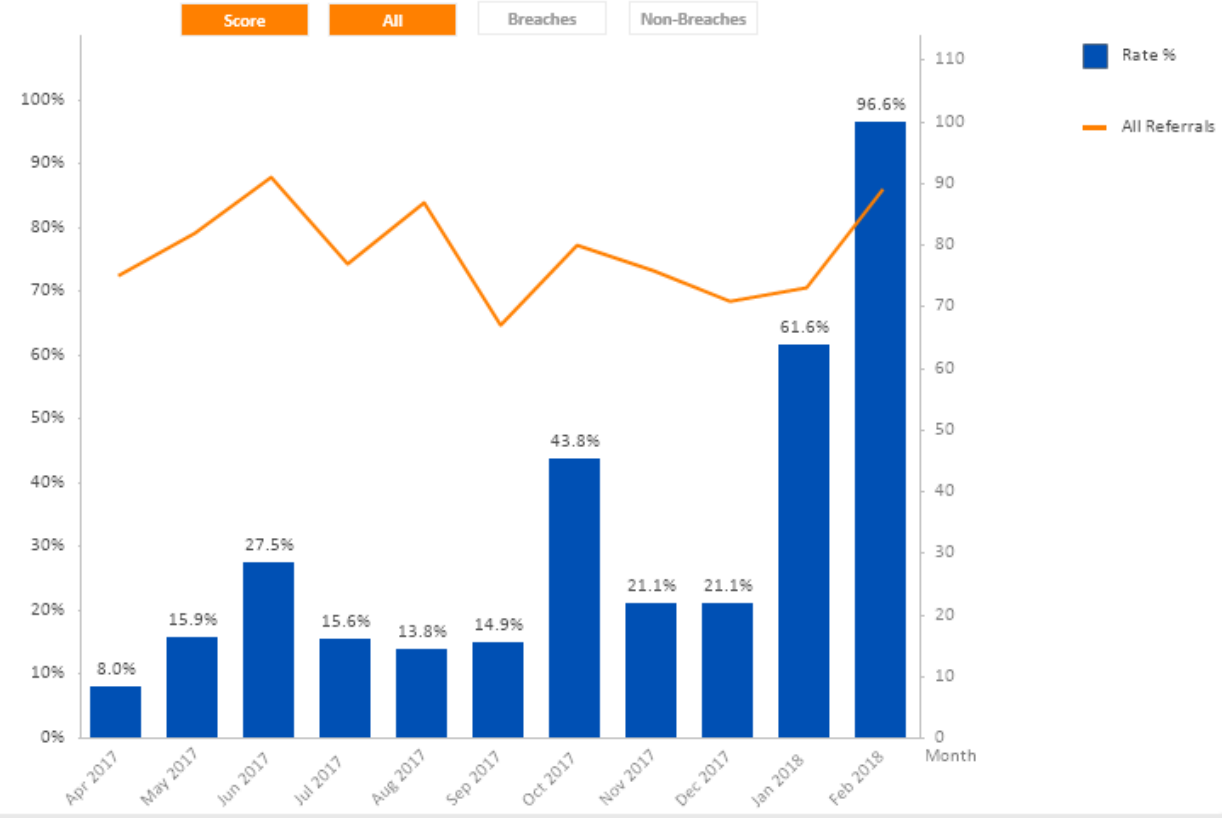
(v) Cancer Alliance funds have been secured for the following initiatives:

- to support the provision of the service improvement post for 6 months with the provision of a 6 month temporary tracker
- development of Qlikview dashboard
- five fixed term (2 years) band 4 support worker posts to support remote surveillance for Breast and Prostate pathways, early diagnosis for Lung and Colorectal and Vague symptoms
- additional video conferencing facilities for the Pathology seminar room

(vi) Clinical lead in post since October after a gap of several months from previous post holder. The initial focus has been liaising with the leads from each tumour site, understanding the tumour site issues which has included attending MDT meetings.

(vii) Clinical pathways. Full action plan detail shown in appendix 2 based on Regional and Local pathway gap analysis, with actions in place to mitigate or reduce gaps. Some work already undertaken includes:

- Head & Neck – first appointment within 7 days has shown an improvement within the months of January and February, which is sustainable due to the changes made to clinic templates. Performance is shown below.



Approval has been received to recruit to a permanent CNS to provide full time working across ENT and OMFU. This post will be advertised during March.

- Colorectal – changes to the first outpatient appointment process have been made with a staged plan to deliver from day 10 to day 7
- Gynaecology – plan to deliver first outpatient appointment in April
- Review of follow up capacity for all sites to ensure cancer patient outpatient delays are reduced
- Use of CNS staff for all sites to have early contact with query cancer patients, triage, review telephone clinics and maintain regular communication to reduce patient initiated delays
- Collaboration with other Trusts including Wirral University Hospitals Trust for Urology, and Royal Liverpool for Upper GI pathways

(viii) New style escalation meetings started for Colorectal and Upper GI on a Wednesday afternoon using live data available through Qlikview. This will be rolled out to Urology mid-March, with a continued roll out to other sites.

(ix) Qlikview live data for improved visibility of data and escalation process

(viii) Working closely with the Cancer Alliance to deliver best practice and regional initiatives

(ix) Patient education leaflet in place to reduce patient initiated delays

3. Trajectory:

It is difficult to predict future performance due to a number of patients being seen at other Trusts, and treatments are reliant on a cancer diagnosis being made.

As a Trust we can only have approximately 22 breaches per quarter to achieve the 62 day target. As we have had a backlog of patients waiting over 62 days, the plan has to treat as many long waiters during Q4 so that the PTL is more manageable from Q1. This is along with other changes at other parts of the pathway and improved performance in Radiology and Endoscopy.

- Current over 62 day waiters

Of 35 patients who had waited over 62 days (2 week wait patients as at 02/03/18):

3 have been removed

14 are COCH patients;

4 are confirmed cancers and all have treatment dates in February and March

Of the remaining 10 patients where cancer has not been confirmed, the estimated treatment dates are March/April – these are not known and may go into April as many patients have cancelled diagnostics etc.

18 are with tertiary sites;

11 are confirmed cancers and have treatment dates in February and March

3 of these were sent before day 38 so we will not be allocated the breach

Of the 7 remaining patients where cancer has not been confirmed, the estimated treatment dates are all within February and March, 3 of these patients are awaiting Histology

- Q4 performance

62 day (2 week wait)	Jan-18	Feb-18 *	Mar-18**
Number of patients	59.5	44	50
Number treated	44.5	26	30
Number of breaches	15	18	20
%	74.79%	59.09%	60.0%

* February performance is provisional and Tertiary centre data may affect the final figure reported once they have uploaded
** March data is an estimate based on the number of breaches anticipated based on a high level review of the PTL

Appendix 1 – Cancer improvement work streams

1. Diagnostics

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
RAD 1.1	Referrals for imaging not specific for Cancer	Improve communications to all clinicians	Claire Gale / Ruth Buckley	Oct-17	GREEN	Closed	E mail sent, to be followed up in September.
RAD 1.2	Delays in receiving requests following MDT	MDT co-ordinators to have access to requesting under clinician guidance	Claire Gale / Ruth Buckley	Nov-17	GREEN	Closed	MDT is part of Cancer improvement work stream
RAD 2.1	Delay in sending appointments	Use of partial booking for fast track patients	Jenny Turner	Oct-17	GREEN	Closed	Darren and Jenny to evaluate implementation and increase awareness
RAD 2.2	Delay in sending appointments	Use of PTL to track outstanding appointments	Darren Rowlands	Jan-18	GREEN	Open	
RAD 3.1	Delay in protocolling requests	Improved tracking	Darren Rowlands	Jan-18	GREEN	Open	
RAD 4.1	Lack of capacity (CT)	Increase number of CT fast track appointment	Ruth Buckley / Emma Fondacaro	Sep-17	GREEN	Open	Requires increase in staffing hours - increased evening lists, appointments within 7 days
RAD 4.2	Lack of capacity (MRI)	Investigate increasing outsourcing	Ruth Buckley	Jan-18	AMBER	Open	No further scope at present but increased number of contrast slots now available with evening cover
RAD 4.3	Lack of capacity (US)	Partial booking will reduce DNA's and wasted slots from rebooks/Reduce number of inappropriate referrals	Catalina Macdonald / Jenny Turner	Oct-17/Mar-18	AMBER	Open	Appointments up to date and fewer DNAs
RAD 4.4	Lack of capacity (IR)	Improve referral pathway	Collette Markey	Oct-17	GREEN	Open	SOP written and being circulated with lung team and then rolled out to all specialties
RAD 5.1	Delay in receiving CTC	Booking process to be streamlined; possible improvement in delivery of bowel prep.	Catalina Macdonald	Apr-18	GREEN	Closed	
RAD 6.1	Delay in reporting (CTCs)	Process improvement of allocations	Catalina Macdonald	Feb-18	GREEN	Open	

RAD 6.2	Delay in reporting	Recruit to vacant posts	Mark Fraser / Gerard Doyle	Dec-17	GREEN	Open	2 radiologists starting - August and September. 1 further radiologist accepted post, awaiting visa clearance
RAD 6.3	Delay in reporting	Tracking of reports and allocation to radiologists	Darren Rowlands	Jan-18	GREEN	Open	Cancer folder to be used following PACS upgrade
RAD 6.4	Delay in reporting	Review cancer reporting streams – investigate dedicated PACS folder for cancer	Gerard Doyle / Ruth Buckley	Oct-17	GREEN	Open	
RAD 7.1	Increasing demand	Reduce inappropriate referrals	Gerard Doyle/ Mark Fraser / Ruth Buckley	Mar-18	GREEN	Closed	
ENDO 1.1	Workforce (scopists)	Extra lists to be offered out wherever possible for all procedures to ensure there is robust capacity in place to meet demand	Kirsty Roberts / Lucy Parry	Sep-17	RED	Open	Cystoscopy can run at weekends but is dependent upon availability of nursing staff. OGD and Colons are currently proving difficult to back-fill, there is an option for band 8 nurses to run these lists (double time/ACA rate not agreed for Nurse Scopists). Funding available for 8a Scopist and Vacancy Control Form submitted for Vacancy Panel 22/09/17 No interest in vacancy, progressing with the training for current staff and increase PA activity through consultant activity. Training completed for flexi sig, on-going for colonoscopy, once completed the department will have another 8a scopist. Training programme to recommence to support a fouth scopist.
ENDO 1.2	Workforce (nursing)	Nursing vacancies (x5 posts)	Kirsty Roberts / Lucy Parry	Sep-17	AMBER	Open	x4 posts recruited to (one vacancy recruited to, however another resignation was received) rolling advert until post filled - GIN nurse training has commenced
ENDO 1.3	Workforce (admissions)	Team leader sickness / vacancy	Kirsty Roberts	May-18	GREEN	Closed	Successfully recruited to - completed
ENDO 2.1	Reminder Service	Refresh the rules, script and ensure call back to patient is completed	Kirsty Roberts	Sep-17	GREEN	Closed	Completed
ENDO 2.2	Reminder Service	Link in with Helen Nowakowska about the new reminder service and see how it could work for Endoscopy	Kirsty Roberts / Craig Brothwood	Jun-18	GREEN	Open	
ENDO 3.1	DNA Rate	Review / analyst of baseline data; impact of DNA rate	Kirsty Roberts	Apr-18	GREEN	Open	Laura Mohan to extract data for review
ENDO 3.2	DNA Rate	Develop a DNA poster which shows percentage of DNA's and cost of this to Endoscopy. Discuss at next team meeting to gain approval to display	Craig Brothwood	Mar-18	GREEN	Open	Poster completed, awaiting rollout
ENDO 3.3	DNA Rate	Develop a postcards to be used across Endoscopy and Admissions (shared funding arrangment)	Kirsty Roberts / Loretta Lloyd	Aug-17	GREEN	Closed	Completed and funding approved
ENDO 4.1	Forecasting Demand & Capacity Modelling	A 6-week forward planning tool is being developed with the information team to improve ability of team to forecast Capacity to meet Demand	Kirsty Roberts / Liz Cliff / Laura Mohan	Apr-18	GREEN	Open	This will enable forecasting against capacity and demand and highlight possible issues early. Currently working with the Information Team to progress to incorporate into Qlikview, awaiting further update. Testing for 3 week projection completed, update to 6 weeks and repeat testing phase.
ENDO 5.1	Management of Annual Leave	Annual leave is not always getting through to Endoscopy and lists are not cancelled timely - Endoscopy / Planned Care Management left to resolve issues	Kirsty Roberts / Laura Bennett	Nov-18	RED	Open	Review of annual leave process - a weekly meeting is being instigated which involves Endoscopy, Gastro and General Surgery to cross check all lists and maximise impact commenced in Nov 2017. Earlier identification of issues, however solutions are not being agreed.

2. Internal processes

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
IP 1.1	Priority based tracking	Cancer Services PTL data validation	Claire Gale	Jan-18	GREEN	Closed	Completed
IP 1.2	Priority based tracking	Radiology PTL data validation	Ruth Buckley	Jan-18	GREEN	Closed	TBC by DW
IP 1.3	Priority based tracking	Cancer Services go-live with PTL (agreed access level)	Claire Gale	Jan-18	GREEN	Closed	Completed
IP 1.4	Priority based tracking	Urgent and Planned Care go-live with PTL (agreed access level)	Denise Wood	Feb-18	GREEN	Open	Rollout to Urology & Endoscopy (Kirsty Roberts) and Upper & Lower GI (Debbie Gilligan)
IP 1.5	Priority based tracking	Radiology go-live with PTL (agreed access level)	Ruth Buckley	Feb-18	GREEN	Open	X3 licences (Ruth Buckley, Catalina MacDonald, Darren Rowlands)
IP 1.6	Priority based tracking	Consultant go-live with PTL (agreed access level)	Liz Redmond	Mar-18	GREEN	Open	Rollout to commence Cancer Services Clinical Group (end of February)
IP 1.7	Priority based tracking	Nurse go-live with PTL (agreed access level)	Helen Thomas	Mar-18	GREEN	Open	Rollout to commence Cancer Nurse Specialist Forum (March)
IP 1.8	Priority based tracking	Summary PTL available for distribution via Nprinting	Liz Cliff	Mar-18	GREEN	Open	
IP 2.1	Weekly tracking	Confirmation of weekly tracking dates via the PTL	Claire Gale	Feb-18	GREEN	Open	
IP 2.2	Weekly tracking	Access to DD+ to remove requirement to wait for typed letters	TBC	TBC	GREEN	Open	
IP 3.1	F2F escalation	Assess requirements for escalation process using the live PTL	Claire Gale	Feb-18	GREEN	Open	
IP 3.2	F2F escalation	Escalation as per site specific policy inline with Optimal Clinical Pathways	TBC	TBC	GREEN	Open	
IP 3.3	F2F escalation	Monitor agreed 7 day plans via Cancer Committee	Claire Gale	Jan-18	GREEN	Closed	
IP 3.4	F2F escalation	Monitor 24 hours typing turnaround / OP letters	Denise Wood	TBC	GREEN	Open	To be reviewed
IP 4.1	Breach reporting review	SOP for breach reporting process	Claire Gale	TBC	GREEN	Open	
IP 4.2	Breach reporting review	Specialty review of 62 day breaches to identify trends - TBC how this will be provided back to the clinical team	Claire Gale	TBC	GREEN	Open	
IP 4.3	Breach reporting review	Specialty review of 104+ day breaches to identify trends - TBC how this will be provided back to the clinical team	Claire Gale	TBC	GREEN	Open	
IP 5.1	Weekly clinical review 100+ day patients	Clinical team to review long waiters at the end of local MDT; dependency on MDT workstream to ensure only appropriate patients are listed for discussion to facilitate	Liz Redmond	TBC	GREEN	Open	

3. MDT

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
MDT 1.1	Clinical & Operational review of all MDTS (identify best pratice)	Identify process which clearly identifies the breach date to Radiology and other clinical teams	Liz Redmond / Claire Gale / Ruth Buckley	TBC	GREEN	Open	
MDT 1.2	Clinical & Operational review of all MDTS (identify best pratice)	Go over tracker highlights/breach dates	Cancer Services Team	TBC	GREEN	Open	
MDT 1.3	Clinical & Operational review of all MDTS (identify best pratice)	Clinical lead to identify best practice and also gaps	Liz Redmond / Jed Hawe	TBC	GREEN	Open	
MDT 1.4	Clinical & Operational review of all MDTS (identify best pratice)	Create proforma to ensure right person has all correct key information	Site Specific Clinical Leads / Claire Gale	TBC	GREEN	Open	
MDT 1.5	Clinical & Operational review of all MDTS (identify best pratice)	Standardised MDT agendas	Liz Redmond / Clinical Leads	TBC	GREEN	Open	
MDT 1.6	Clinical & Operational review of all MDTS (identify best pratice)	Catalina to observe MDT meetings to learn where improvement is needed	Catalina MacDonald	Mar-18	GREEN	Open	
MDT 1.7	Clinical & Operational review of all MDTS (identify best pratice)	Clinical team to review long waiters at the end of local MDT; dependency on MDT workstream to ensure only appropriate patients are listed for discussion to facilitate	Liz Redmond	TBC	GREEN	Open	
MDT 1.8	Clinical & Operational review of all MDTS (identify best pratice)	Clinical teams to improve COSD data capture	Liz Redmond	TBC	GREEN	Open	
MDT 2.1	Reduce inappropriate referrals to MDT - decision making vs diagnostic review	Each MDT have a list to highlight correct patients	Claire Gale / Lisa Barrett-Prew	TBC	AMBER	Open	
MDT 2.2	Reduce inappropriate referrals to MDT - decision making vs diagnostic review	Create forum to discuss Urgent Complex Benign	Liz Redmond	TBC	AMBER	Open	
MDT 2.3	Reduce inappropriate referrals to MDT - decision making vs diagnostic review	Title in every lead clinician job plan to set aside for information 48 hours prior to MDT	Liz Redmond / Ian Harvey	TBC	GREEN	Open	
MDT 3.1	Inter MDT referral process	Meet tertiary trusts to establish cut off method/tech e.g. video conference	Site Specific Clinical Leads / Claire Gale	TBC	GREEN	Open	
MDT 3.2	Inter MDT referral process	COCH representation at tertiary MDT meetings and local MDT's	Site Specific Clinical Leads / Claire Gale	TBC	GREEN	Open	
MDT 3.3	Inter MDT referral process	Look at speed of internal MDT referral process and improve information	Claire Gale / Cancer Services Team	TBC	GREEN	Open	

4. Optimal Clinical Pathways

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
OCP 1.1	Review of Regional / Local Site Specific Pathways	Source current / previously designed / drafted clinical pathways	Jackie Davies / Claire Gale	Jan-18	GREEN	Closed	
OCP 1.2	Review of Regional / Local Site Specific Pathways	Centrally held documentation; provide access to latest files / versions via sharepoint	Jackie Davies / Denise Wood	Feb-18	GREEN	Open	
OCP 1.3	Review of Regional / Local Site Specific Pathways	Process for managing action plans - monthly review meetings with divisions / sharepoint etc	Jackie Davies / Joe Downie / Karen Townsend / Denise Wood	Feb-18	GREEN	Open	
OCP 1.4	Review of Regional / Local Site Specific Pathways	Develop Governance Process around pathway reviews and implementation	Jackie Davies / Hollie Salisbury	TBC	GREEN	Open	
OCP 2.1	Review of Regional (Cancer Alliance) Site Specific Pathways	Head & Neck - Clinical review / gap analysis of regional pathway - develop local implementation action plan	Jackie Davies / Ceri Rogers	Monthly Review	GREEN	Closed	Completed action plan - to be reviewed monthly and updated accordingly
OCP 2.2	Review of Regional (Cancer Alliance) Site Specific Pathways	Colorectal - Clinical review / gap analysis of regional pathway - develop local implementation action plan	Jackie Davies / Claire Smith / Laura Bennett	Monthly Review	GREEN	Closed	Completed action plan - to be reviewed monthly and updated accordingly
OCP 2.3	Review of Regional (Cancer Alliance) Site Specific Pathways	Lung - Clinical review / gap analysis of regional pathway - develop local implementation action plan	Jackie Davies / Ian Benton / Rachel Mountfield	Monthly Review	GREEN	Open	Draft plan to be converted into standardised documentation and returned to the clinical team for review
OCP 2.4	Review of Regional (Cancer Alliance) Site Specific Pathways	Gynaecology - Clinical review / gap analysis of regional pathway - develop local implementation action plan	Jackie Davies / Emma-Jayne Punter	TBC	GREEN	Open	Arrange initial meeting to draft / develop action plan
OCP 2.5	Review of Regional (Cancer Alliance) Site Specific Pathways	Urology (prostate) - Clinical review / gap analysis of regional pathway - develop local implementation action plan	Jackie Davies / Kirsty Roberts / Ninaad Awsare / April Davis	TBC	GREEN	Open	Initial meeing comenced in January, draft pathway for proposed for prostate pathway - arrange further meeting to discuss progress
OCP 2.6	Review of Regional (Cancer Alliance) Site Specific Pathways	Vague Symptoms - Clinical review / gap analysis of regional pathway - develop local implementation action plan	Jackie Davies / Habeeb Braimo / Helen Thomas	TBC	AMBER	Open	Awaiting appointment of WUTH CNS; arrange meeting to draft / develop action plan
OCP 2.7	Review of Regional (SLA) Site Specific Pathways	Upper GI - Clinical review / gap analysis of local & regional pathway - develop local implementation action plan	Jackie Davies / Jim Evans / Kate Holloway / Debbie Gilligan / April Davies	TBC	AMBER	Open	Pathway review meeting commenced in January, proposed pathway drafted (process mapping session) for proposed SLA with the Royal Liverpool developed - arrange meeting to discuss / progress
OCP 3.1	Review of Local (CoCH) Site Specific Pathways	Breast - Clinical review / gap analysis of local pathway - develop local implementation action plan	Jackie Davies / Emma-Jayne Punter	TBC	GREEN	Open	Arrange initial meeting to draft / develop action plan
OCP 3.2	Review of Local (CoCH) Site Specific Pathways	Plastics - Clinical review / gap analysis of local pathway - develop local implementation action plan	Jackie Davies / Nicola Peate / Loretta Lloyd	Nov-17	GREEN	Closed	Completed - speciality to review action plan if further actions are required
OCP 3.3	Review of Local (CoCH) Site Specific Pathways	Haematology - Clinical review / gap analysis of local pathway - develop local implementation action plan	Jackie Davies / Richard James	TBC	GREEN	Open	Arrange initial meeting to draft / develop action plan
OCP 3.4	Review of Local (CoCH) Site Specific Pathways	Dermatology - Clinical review / gap analysis of local pathway - develop local implementation action plan	Jackie Davies / Gill Mort	TBC	GREEN	Open	Arrange initial meeting to draft / develop action plan
OCP 3.5	Review of Local (CoCH) Site Specific Pathways	Develop timed local clinical pathways (benchmarking); note triggers for escalation	Jackie Davies	TBC	GREEN	Open	
OCP 3.6	Review of Local (CoCH) Site Specific Pathways	Review possible role for a radiology tracker	Jackie Davies / Ruth Buckley	TBC	GREEN	Open	Have initial meeting to discuss options - action could move to diagnostics plans if agreed to proceed

5. Technology & Data

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
T&D 1.1	Live Cancer PTL	Put cancer PTL into test by end of week commencing 08/01/2018	Denise Wood	Jan-18	GREEN	Closed	
T&D 1.2	Live Cancer PTL	Pilot escalation meeting week commencing 15/01/2018	Denise Wood	Jan-18	RED	Open	
T&D 1.3	Live Cancer PTL	Discuss with operational staff best way to take live PTL and dashboards forward	Denise Wood / Jackie Davies	Jan-18	RED	Open	
T&D 1.4	Live Cancer PTL	Ensure Somerset data flows live and fully validated	Claire Gale	Jan-18	GREEN	Closed	
T&D 1.5	Live Cancer PTL	Tracker team to input data onto PTL	Cancer Services Team	Feb-18	GREEN	Closed	
T&D 1.6	Live Cancer PTL	Fully Operational Live Cancer PTL	Denise Wood	Feb-18	GREEN	Closed	
T&D 2.1	Live Diagnostics Dashboard	Assess number of patients currently waiting for a diagnostic test	Denise Wood / Kath Sliwka	Feb-18	GREEN	Closed	
T&D 2.2	Live Diagnostics Dashboard	Assess and analyse - Time from request to exam	Denise Wood / Kath Sliwka	Feb-18	GREEN	Closed	
T&D 2.3	Live Diagnostics Dashboard	Establish escalation process back onto PTL if wait is excessive based on targets	Denise Wood / Kath Sliwka	Feb-18	GREEN	Closed	
T&D 2.4	Live Diagnostics Dashboard	Kath Sliwka to test and amend where necessary (dashboard already built, needs refining)	Katherine Sliwka	Feb-18	GREEN	Closed	
T&D 2.5	Live Diagnostics Dashboard	Kath Sliwka to give training to Radiology staff re use of dashboard	Katherine Sliwka	Feb-18	GREEN	Closed	
T&D 2.6	Live Diagnostics Dashboard	Go live with dashboard	Ruth Buckley	Feb-18	GREEN	Closed	
T&D 3.1	Cancer Dashboard	Agree final spec with clikhealth for dashboard * Cancer performance data - 16/03/2018 * Pathology data - 02/03/2018 * Capacity & Demand (eRS) - 16/03/2018 * Infographic for front page - 16/03/2018	Denise Wood	16/03/2018	GREEN	Open	
T&D 4.1	Cancer Data Warehouse	Jackie Davies and Denise Wood to meet Simon Chambers re extended role	Denise Wood / Jackie Davies	Jan-18	GREEN	Closed	
T&D 4.2	Cancer Data Warehouse	Obtain SQL scripts from Shrewsbury	Jackie Davies	Feb-18	GREEN	Closed	

T&D 4.3	Cancer Data Warehouse	Scope requirements for routine and ad-hoc cancer reporting from warehouse (NOT Somerset)	Denise Wood / Jackie Davies / Simon Chambers	Mar-18	GREEN	Open	
T&D 4.4	Cancer Data Warehouse	Further Actions Post Scoping Exercise	Denise Wood / Jackie Davies / Simon Chambers	Mar-18	GREEN	Open	
T&D 5.1	Electronic Local and Regional MDT Referrals	Regional CARP form (via email) option on Somerset to link but nobody has pursued, investigate and use where applicable following consultation	Claire Gale	Mar-18	GREEN	Open	
T&D 5.2	Electronic Local and Regional MDT Referrals	re Local - learn from Lung & Gynae and replicate where applicable	Claire Gale	Mar-18	GREEN	Open	
T&D 6.1	Patient Choice & Appointment	Ensure link to eRS workgroup is established (via Helen Nowakowska)	Claire Gale / Jackie Davies	Jan-18	AMBER	Open	Actions to be updated post initial meeting
T&D 6.2	Patient Choice & Appointment	Meet with Helen Nowakowska and plan next steps	Claire Gale / Jackie Davies	Feb-18	AMBER	Open	
T&D 6.3	Patient Choice & Appointment	Arrange to publish fast track appointments on system (1st Consultant Appointment)	Helen Nowakowska	TBC	AMBER	Open	
T&D 6.4	Patient Choice & Appointment	No flag at Appointments Hotline - investigate how this becomes clearly visible & flows to meditech	Claire Gale & Helen Nowakowska	TBC	AMBER	Open	
T&D 6.5	Patient Choice & Appointment	Possible changes to interface - work with Meditech (possible cost)	Paul Miles / Claire Gale / Helen Nowakowska	TBC	AMBER	Open	
T&D 6.6	Patient Choice & Appointment	Possible workaround - log in to EVERY referral and see if it is a FT	TBC	TBC	AMBER	Open	
T&D 7.1	Electronic Breach Reporting	Claire Gale to send blank copy of current breach report form to Paul Miles	Claire Gale	Jan-18	GREEN	Closed	
T&D 7.2	Electronic Breach Reporting	PM to log workload request for assessment by informatics (take acount of electronic signature and confidentiality)	Paul Miles	Feb-18	GREEN	Closed	
T&D 7.3	Electronic Breach Reporting	Link with internal processes group to avoid cross over	Denise Wood / Claire Gale / Jackie Davies	Jan-18	GREEN	Closed	
T&D 7.4	Electronic Breach Reporting	Once solution identified further actions to be confirmed	Denise Wood	Mar-18	GREEN	Open	
T&D 8.1	ICE / Radiology Pilot	Currently in pilot phase with one GP in one Practice (Lache) (Improvements to prostate patthway), Pilot successful, issue is switch one system off and turn new one on	Angela Kendell / Ruth Buckley	Jan-18	GREEN	Closed	
T&D 8.2	ICE / Radiology Pilot	Plan on how old is switched off and new is swtched on (the 'switch over')	Angela Kendell / Ruth Buckley	Feb-18	GREEN	Open	
T&D 8.3	ICE / Radiology Pilot	Roll out to all GPs in the Lache	Angela Kendell / Ruth Buckley	Mar-18	GREEN	Open	

T&D 8.4	ICE / Radiology Pilot	Plan roll out across all 36 GP practices across Western Cheshire	Angela Kendell / Ruth Buckley	Mar-18	GREEN	Open	
T&D 8.5	ICE / Radiology Pilot	Roll-Out & on-going engagement with all GPs (escalating to CCGs where applicable)	Angela Kendell / Ruth Buckley	Mar-18	GREEN	Open	
T&D 8.6	ICE / Radiology Pilot	Ensure enagagement with in-house IT services at GP practices	Angela Kendell / Ruth Buckley	Mar-18	GREEN	Open	
T&D 9.1	Digital Dictation	Validate roll out plan, focusing on head & neck and urology to meet deadlines for typing	Paul Miles (Jo Jones / Ceri Rogers / Kirsty Roberts)	Feb-18	GREEN	Open	
T&D 9.2	Digital Dictation	Investigated whether there is an option for trackers to listen to DD files for early identification of outcomes etc	Paul Miles (Jo Jones / Claire Gale)	Feb-18	GREEN	Open	
T&D 10.1	Direct Ordering Post MDT	Gynae showing best practice - Investigate and plan on how to replicate where applicable (also discuss with MDT group)	Denise Wood / Claire Gale / Nerys Edwards	Mar-18	GREEN	Open	
T&D 10.2	Direct Ordering Post MDT	Once best practice identified plan to roll out to other specialities	Denise Wood / Claire Gale / Nerys Edwards	Apr-18	GREEN	Open	
T&D 11.1	Direct Ordering Post MDT	Transfer to 'Diagnostics Table'	Ruth Buckley	May-18	GREEN	Open	
T&D 12.1	Meditech Link to Somerset	Post upgrade patients not transferring over to Somerset from Meditech	Paul Miles / Claire Gale / Brian White	Jun-18	GREEN	Open	

6. Workforce, Education, Engagement

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
WEE 1.1	Develop a Communication Engage Strategy for Cancer and Clinical Meetings	Set Up Bi-Weekly Meeting - 1 hr	Sue Hodkinson	Jan-18	GREEN	Closed	
WEE 1.2	Develop a Communication Engage Strategy for Cancer and Clinical Meetings	Meet with Liz Redmond (invite to first meeting)	Sue Hodkinson	TBC	GREEN	Open	
WEE 1.3	Develop a Communication Engage Strategy for Cancer and Clinical Meetings	Communications Team involvement - initially Gill Rutter, who will allocate ongoing lead	Mel Kynaston	TBC	GREEN	Open	
WEE 1.4	Develop a Communication Engage Strategy for Cancer and Clinical Meetings	Identify Educational Lead to support initiative	Sue Hodkinson	TBC	GREEN	Open	
WEE 1.5	Develop a Communication Engage Strategy for Cancer and Clinical Meetings	Get driver summaries of other work streams to Sue Hodkinson	Jackie Davies	Feb-18	GREEN	Open	Cancer improvement programme driver document circulated; identify sharde drive location for all groups to access all action plans
WEE 1.6	Develop a Communication Engage Strategy for Cancer and Clinical Meetings	Helen Thomas to invite Joanna Martin to join the group	Helen Thomas	TBC	GREEN	Open	
WEE 1.7	Develop a Communication Engage Strategy for Cancer and Clinical Meetings	Get more specialist nurses involved	Helen Thomas	Jan-18	GREEN	Closed	
WEE 1.8	Develop a Communication Engage Strategy for Cancer and Clinical Meetings	Meet with Manager lead on each MDT stream to ensure complementing / not duplicating other sites	Helen Thomas	TBC	GREEN	Open	
WEE 1.9	Develop a Communication Engage Strategy for Cancer and Clinical Meetings	Other leads need to feed into this group with their various Driver Diagrams / Project Plans	Sue Hodkinson	TBC	GREEN	Open	
WEE 1.10	Develop a Communication Engage Strategy for Cancer and Clinical Meetings	Understand new regional guidance - engage principles for the forum	Mel Kynaston	TBC	GREEN	Open	
WEE 2.1	Evaluate CNS Workforce	Peer assessment required	Mel Kynaston	TBC	GREEN	Open	
WEE 2.2	Evaluate CNS Workforce	Identify number of CNS and where there GAPS / resource	Helen Thomas	TBC	GREEN	Open	
WEE 2.3	Evaluate CNS Workforce	Nursing - consequences against ratio. Job plans are they site specific? Dual roles in some areas.	Mel Kynaston	TBC	GREEN	Open	
WEE 2.4	Evaluate CNS Workforce	Define HR Business Partner to support this project	Sue Hodkinson	TBC	GREEN	Open	
WEE 2.5	Evaluate CNS Workforce	CNS Career Pathway (minor surgery etc.)	Mel Kynaston	TBC	GREEN	Open	
WEE 2.6	Evaluate CNS Workforce	Lack Skin Cancer Nurse in Plastics	Mel Kynaston	TBC	GREEN	Open	
WEE 3.1	Recruitment / Rentention of Key Staff Groups	Funding presently for 2 years from Cancer Transformation only - is this ongoing?	Helen Thomas	TBC	GREEN	Open	

Appendix 2 – Clinical pathways

Action Log – Head &Neck

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
H&N 1.1	1st OPA By Day 7	Demand and capacity modelling to be completed and relevant resources identified	Jackie Davies	Oct-17	GREEN	Closed	
H&N 1.2	1st OPA By Day 7	ENT increase FT slots from 17 to 21 per week plus catch-up of an additional 21 slots	Emma Wright	Nov-17	GREEN	Closed	Commencing October to deliver in November 2017 - completed
H&N 1.3	1st OPA By Day 7	OMFU increase FT slots from 6.25 per week to 9 per week plus catch-up of an additional 9 slots	Emma Wright	Nov-17	GREEN	Closed	Commencing in November to fully deliver in December 2017 - completed
H&N 1.4	1st OPA By Day 7	Monitor and review 7 day compliance month on month	Stacey Kneen	On-going	GREEN	Open	Monitor from January 2018 (? 21 ENT FT capacity, continue to monitor ? increase additional FT slot per clinic x3)
H&N 1.5	1st OPA By Day 7	Fast track clerks to escalate for capacity at 7 days (versus 14 days)	Appointments	Jan-18	GREEN	Closed	Escalations are now being made inline with the capacity changes - completed
H&N 1.6	1st OPA By Day 7	FT specific slots to be highlighted to radiology and pathology to begin to align investigations (progression to one stop clinics)	Stacey Kneen	Jan-18	GREEN	Open	Email radiology and pathology where FT slots are located, SK will review the coversion of FT patients to imaging and histology.
H&N 1.7	1st OPA By Day 7	Progress triage of FT referrals to identify appropriate FT slot type	H&N CNS	Jun-18	GREEN	Open	Awaiting H&N CNS to be appointed
H&N 1.8	1st OPA By Day 7	FT specific slots for thyroid and neck lump to be identified; analysis of triage to understand % split	H&N CNS	Jun-18	GREEN	Open	Awaiting H&N CNS to be appointed - completed for thyroid (December 2017 for neck lump slots) Ceri Rogers to discuss with Clinical Lead to identify any interim solutions
H&N 1.9	1st OPA By Day 7	Piloting Medisec Digital Dictation plus within both ENT and OMFU to improve typing turnaround times by identifying FT patient letters enabling better priority	Jo Jones / Stacey Kneen	Feb-18	GREEN	Open	Review: January typing within 7 days, pilot DD+ equipment audit being undertaken (confirm roll out date). Equipment audit completed, require x4 microphones (x1 clinic room and x3 consutlant offices). In clinic training for doctors required (SK to update JJ)
H&N 2.1	Local CNS support available by day 7	Drafting Macmillan Partnership Application for October submission for in year funding of a two year funded Head & Neck CNS full time post (Trust must commit to permanent funding after 2 years)	Jackie Davies / Helen Thomas	Oct-17	GREEN	Closed	Funding approval received November 2017; job description to be completed, matched and submitted to vacancy panel for approval
H&N 2.2	Local CNS support available by day 7	Additional part-time ENT CNS post to be funded in year by the ENT capacity pot (post will support 18 week activity and provide support / cross cover to Macmillan post)	Jackie Davies	Feb-18	GREEN	Closed	Rejected business case for additional temporary post; ? HT ? Crosscover with WUTH CNS

H&N 2.3	Local CNS support available by day 7	Business case for CNSs to be submitted locally at CLG for approval prior to advertisement	Jackie Davies	Feb-18	GREEN	Closed	Business case to be submitted to CRS 20.02.18 and CLG 21.02.18
H&N 3.1	2nd OPA by day 14	Demand and capacity modelling to be completed and resources identified for both ENT and OMFU to deliver 2nd OPA within 14 days	Ceri Rogers	Feb-18	GREEN	Open	Review discharges from 1st OPA within 7 day, identify capacity requirement (will need to be aligned with radiology to ensure capacity for USS and OPG and results reporting within 14 days)
H&N 3.2	2nd OPA by day 14	Interim measure urgent follow up slots x2 slots on each ENT clinic stream with a comment advising "FOR SECS USE ONLY" ensuring appropriate use for specific / identified patients (continued monitoring / increase slots as required) commenced in September 2017	Emma Wright	On-going	GREEN	Open	Initial change applied in September 2017; continued monitoring required (Stacey Kneen) ? Capacity for DF and urgent slots (non cancer)
H&N 3.3	2nd OPA by day 14	Interim measure within ENT to be applied to OMFU; identify if required and number of slots needed within OMFU - apply changes	Ceri Rogers	Feb-18	GREEN	Open	Ceri Rogers to discuss with OMFU Clinical Lead
H&N 4.1	Results by day 14	Referrals for imaging to be identified as cancer / FT specific; communicated to all clinicians	Claire Gale	Sep-17	AMBER	Open	Action undertaken - conitunes to remain an issue, included within Cancer Improvement Programme to identify solution
H&N 4.2	Results by day 14	Increase in cancer / FT capacity for CT	Ruth Buckley	Sep-17	AMBER	Open	Radiology update required
H&N 4.3	Results by day 14	Increase in cancer / FT capacity for MRI being investigated	Ruth Buckley	Jan-18	AMBER	Open	Radiology update required
H&N 4.4	Results by day 14	Improve reporting times by recruiting to current radiology vacancies	Ruth Buckley	Dec-17	AMBER	Open	Radiology update required
H&N 5.1	Biopsy by day 19	Need to investigate / review pathology capacity and reporting times	TBC	TBC	AMBER	Open	Need to identify contact to lead action
H&N 5.2	Biopsy by day 19	Interim measure FT specific slots to be highlighted to pathology to begin to align investigations (progression to one stop clinics)	TBC	TBC	AMBER	Open	Need to identify contact to lead action
H&N 6.1	Endoscopy required / not required by day 19	Communication regarding where endoscopy should take place will be with Mr Tandon (AUH / COCH Consultant link) or in his absence, Mr Jeff Lancaster (or any of the Consultant Surgical Oncology team at AUH) clinical team to ensure all of the COCH team are aware that this communication should take place asap (Action agreed at AUH / CoCH meeting September 2017)	Jackie Davies / Claire Gale	Sep-17	GREEN	Closed	Action agreed at AUH / CoCH meeting September 2017
H&N 7.1	MDT meeting by day 28 / Referral to tertiary centre by day 38	Clarification received from AUH regarding the deadline for Referrals for MDT discussion and the timing of all relevant documentation and results to enable a patient to be discussed; ensure all CoCH MDT coordinators / trackers / radiology / pathology are fully aware of deadlines (Action agreed at AUH / CoCH meeting September 2017)	Jackie Davies / Claire Gale	Sep-17	GREEN	Closed	Action agreed at AUH / CoCH meeting September 2017
H&N 7.2	MDT meeting by day 28 / Referral to tertiary centre by day 38	COCH to set up local MDT meeting (Thursday lunchtime) where patients who require SMDT discussion are escalated to the Radiology department to ensure scan reports are available (October 2017)	Liz Redmond	Oct-17	AMBER	Open	Update required
H&N 7.3	MDT meeting by day 28 / Referral to tertiary centre by day 38	Patient checklist devised by H&N team at AUH to be shared with CoCH for use by MDT coordinators	Stacey Kneen	TBC	AMBER	Open	Needs to be reviewed

Action Log - Colorectal

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
COL 1.1	Date First Seen By Day 7	Increase telephone FT slots to 15 per week (3x5 per week)	Claire Smith	Jun-17	GREEN	Closed	
COL 1.2	Date First Seen By Day 7	Develop telephone FT review proforma (exclusion criteria for face to face)	Claire Smith	Jun-17	GREEN	Closed	
COL 1.3	Date First Seen By Day 7	Increase face to face FT slots to 16 (2x8 per week)	Laura Bennett / Claire Smith	Jun-17	GREEN	Closed	
COL 1.4	Date First Seen By Day 7	Increase telephone FT slots to 16 per week (2x8 per week)	Claire Smith	Jan-18	GREEN	Closed	
COL 1.5	Date First Seen By Day 7	Increase face to face FT slots to 20 (2x10 per week)	Laura Bennett / Claire Smith	Jan-18	GREEN	Closed	
COL 1.6	Date First Seen By Day 7	Analysis of FT referrals to understand the split between telephone and face to face reviews - identify current triage % split	Jackie Davies / Claire Smith	Jan-18	AMBER	Open	Continue to monitor via dashboard
COL 1.7	Date First Seen By Day 7	Demand and capacity modelling to identify gap to deliver 1st OPA by day 7	Jackie Davies	Jan-18	AMBER	Open	Review data JD / DG to meet week commencing 26.02.18
COL 1.8	Date First Seen By Day 7	Increase capacity for telephone / face to face FT slots based on analysis	Laura Bennett / Claire Smith	Mar-18	GREEN	Open	Continue to monitor via dashboard
COL 1.9	Date First Seen By Day 7	Identify catch-up to reduce overall waiting time to OPA, to be funded via capacity pot	Jackie Davies / Laura Bennett	Mar-18	GREEN	Open	Continue to monitor via dashboard
COL 1.10	Date First Seen By Day 7	Extend CNS triage of referrals to identify patients suitable for straight to right test (STRT) route (utilise new Cancer Support Worker role to facilitate) Need to include marker to facilitate tracking on each pathway	Claire Smith	Feb-18	GREEN	Open	Cancer support worker interview to commence 01.03.18

COL 1.11	Date First Seen By Day 7	FT face to face slots to be highlighted to radiology and pathology to align investigations where possible	Jackie Davies	Feb-18	GREEN	Open	JD to speak with LC regarding FT capacity and conversion to radiology and pathology
COL 2.1	Endoscopy Day 7 or 14 (pathway dependant)	Develop diagnostics workstream action plan; as per Cancer Improvement Programme	Joe Downie / Ruth Buckley	Feb-18	GREEN	Open	
COL 2.2	Endoscopy Day 7 or 14 (pathway dependant)	Colorectal review of scoping; identify scopists and patient groups	Kirsty Roberts	Apr-18	GREEN	Open	Demand and capacity modelling of endoscopy for general surgery
COL 2.3	Endoscopy Day 7 or 14 (pathway dependant)	Liaise with surveillance regarding scoping capacity; query reduction in demand creating additional capacity, which could be used to support colorectal	Kirsty Roberts	Apr-18	GREEN	Open	
COL 2.4	Endoscopy Day 7 or 14 (pathway dependant)	Identify CoCH representative participating in the Endoscopy Delivery Group; understand / influence regional initiatives ? JAG involvement	Anna Murray	Feb-18	GREEN	Open	Extend representation of the Endoscopy Delivery Group to Kirsty Roberts (JD to email AM)
COL 2.5	Endoscopy Day 7 or 14 (pathway dependant)	Interim solution / mitigation to 'Endoscopy 14 Day' radiology protected slots for CT and MRI post endoscopy	Jackie Davies	TBC	GREEN	Open	(3x CTs and 2x MRIs) twice weekly (suggested days - Tues, Thurs or Fri) Jackie Davies to speak to Ruth Buckley
COL 3.1	Full Imaging Report Day 10 or 17 (pathway dependant)	Identify CoCH representative participating in the Imaging Programme Board; understand / influence regional initiatives	Ruth Buckley	Feb-18	GREEN	Open	
COL 3.1	Full Imaging Report Day 10 or 17 (pathway dependant)	Analysis of CTVC reporting times (? Which investigations are currently being out sourced (agreement of reporting within 5 days)	Ruth Buckley	Feb-18	GREEN	Open	
COL 4.1	Normal Result 7-9 Days	Patients who have normal results will be provided information via telephone call / letter to prevent patients attending clinic either on the same day or within 2 days of diagnostic test	Claire Smith	Jan-18	GREEN	Closed	
COL 5.1	OPA Post MDT (within 2 Days)	Current capacity reviewed; no clinics on a Wednesday which means that the current timeframe is within 3 days - based on cost and time to alter the agreement is to remain at 3 days	Laura Bennett / Claire Smith	N/A	GREEN	Closed	
COL 6.1	Tracking / PTL Management	Develop criteria led removal of non-cancer patients from FT pathway	Mike Johnson / Claire Smith	Mar-18	GREEN	Open	Initial discussions to commence in February
COL 6.2	Tracking / PTL Management	Marker for patients who have accessed straight to right test (STRT) need to be identifiable via MDT and tracked against the optimum pathway	Claire Smith / Anna Ganguzza	Jan-18	GREEN	Open	MDT Coordinator to identify STRT on the MDT sheet from week commencing 29th January - trial different way of working and highlight best practice
COL 6.3	Tracking / PTL Management	Weekly clinical review of Colorectal PTL; ensure all patients are ? Cancer and removed when appropriate	Claire Smith / Anna Ganguzza	Jan-18	GREEN	Open	Initial discussions have commenced between the cancer and colorectal clinical leads. Claire Smith and Anna Ganguzza meet weekly to go through the PTL, queries to raised to the relevant consultant

Action Log - Upper GI

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
UGI 1.1	SLA Arrangements (current)	Served noticed on the SLA with Wrexham Maelor (to cease March 31st 2018)	Laura Bennett	Dec-17	GREEN	Closed	Completed
UGI 1.2	SLA Arrangements (proposed)	Arrange meeting with Royal Liverpool to discuss future SLA agreement	Jackie Davies / Laura Bennett	Mar-18	GREEN	Open	Proposted March date - JD to discuss arrangements and agenda
UGI 2.1	Patient Pathway Review	Pathway mapping session to draft proposed pathway	Jackie Davies / Jim Evans / Kate Holloway / Debbie Gilligan / April Davis	Feb-18	GREEN	Open	Draft pathway completed - to be reviewed by the clinical team, once agreed progress with gap analysis and action plan with BPM
UGI 3.1	Date First Seen by Day 7	ANP Band 7 - additional post to support telephone review, cancer / non cancer post	Laura Bennett	Apr-18	GREEN	Open	Interviews to commence Apr-18
UGI 3.2	Date First Seen by Day 7	Develop telephone review (to improve the number of patients first seen by day 7)	Laura Bennett	May-18	GREEN	Open	Subject to appointment of ANP post
UGI 4.1	Diagnostics	Analysis of diagnostic turn around times	Darren Rowlands	Mar-18	GREEN	Open	Further clarity required

Action Log – Urology

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
UROL 1.1	Clinical Engagement	Urology CNS - Clinical engagement regionally - prostate pathway	Kirsty Roberts / Karen Beckett	Dec-17	AMBER	Closed	
UROL 1.2	Clinical Engagement	Urology Consultant - Clinical engagement regionally (Ninaad Awsare) prostate pathway	Kirsty Roberts / Ninaad Awsare	Dec-17	AMBER	Closed	
UROL 2.1	Regional Optimal Pathway	Document action plan to deliver optimal prostate pathway (regional)	Kirsty Roberts / Jackie Davies / Ninaad Awsare / Karen Hopkins / Paul McGovern / Claire Gale / Karen Becket/ April Davis / Daniel Kelly	Feb-18	GREEN	Open	Initial pathway meeting held 31.01.18 - next actions to be documented. KR / JD to discuss gap analysis and implementation plan.
UROL 3.1	Cancer Support Worker	Band 4 Cancer Support Worker role (cancer) funded 2 years Cancer Alliance	Kirsty Roberts / Karen Hopkins	Apr-18	GREEN	Open	Interviews to commence 8th March 2018
UROL 4.1	Urology CNS	Band 7 CNS vacancy - new post ANP January 2018 (cancer / non-cancer)	Kirsty Roberts / Lucy Parry	Mar-18	GREEN	Open	Submitted to vacancy panel, approval received and will be advertised in March 2018
UROL 4.2	Urology CNS	Band 6 CNS vacancy - recruitment January 2018	Kirsty Roberts / Lucy Parry	Mar-18	GREEN	Open	Submitted to vacancy panel, approval received and will be advertised in March 2018
UROL 5.1	Date First Seen by Day 7	7 Day OPA - additional clinics x2 (catch-up) 30 slots	Emma Smith	Dec-17	GREEN	Closed	
UROL 5.2	Date First Seen by Day 7	Fast track clerks to escalate for capacity at 7 days (versus 14 days)	Appointments	Dec-17	AMBER	Open	Escalations are not always within 7 days, highlight to HN and discuss how to progress
UROL 5.3	Date First Seen by Day 7	Monthly review of 7 Day OPA capacity (ACA funded via capacity pot)	Emma Smith	Jan-18	GREEN	Open	On-going monitoring
UROL 6.1	Cancer Reporting	Collaboration - meeting with APH to discuss options around cancer data reporting	Jackie Davies / Claire Gale / Jonathan Clark / Lynsey Gorman	Apr-18	GREEN	Open	Initial pathway meeting held in January - next actions to be documented

Action Log – Plastics

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
PLAS 1.1	62 Day	Recruit to registrar vacancies	Loretta Lloyd / Medical Staffing	Jul-17	GREEN	Closed	Completed
PLAS 1.2	62 Day	Additional activity if required funded via capacity pot	Loretta Lloyd	On-going	GREEN	Open	
PLAS 1.3	62 Day	Criteria led removal of non-cancer patients from FT pathway	Aftab Siddiqui	Nov-17	GREEN	Closed	Completed
PLAS 1.4	62 Day	Additional LA added to the beginning of an inpatient list (FT patient)	Nicola Peate	Aug-17	GREEN	Closed	Completed
PLAS 1.5	62 Day	Additional opportunity for further backfill progressed once full compliment of registrars appointed (GP list)	Nicola Peate	Sep-17	GREEN	Closed	Completed
PLAS 1.6	62 Day	Reviewed pathway for pathological diagnosis outcome; reduce patient attendences	Nicola Peate	Sep-17	GREEN	Closed	Completed
PLAS 1.7	62 Day	Discussion / review of possible photography assisted pathway allocation (dermatology / plastics)	Loretta Lloyd / Nicola Peate	Apr-18	GREEN	Open	Date for delivery TBC - initial discussions commenced
PLAS 2.1	Local CNS Support Available	? Options to facilitate a plastics CNS (review original dermaology business case) look at possible funding options	Loretta Lloyd / Jackie Davies	Sep-18	GREEN	Open	Review H&N Macmillan bid
PLAS 2.1	MDT	Exploring options progressing with to a weekly MDT	Loretta Lloyd	Mar-18	GREEN	Open	Date for delivery TBC - initial discussions commenced
PLAS 3.1	Upgrade	Criteria led addition of ? Cancer patients to FT pathway	Aftab Siddiqui	Jul-17	GREEN	Closed	Completed

Action Log - Breast

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
GYN 1.1	1st OPA By Day 7	Additional step within triage to identify if patients require USS scan	Emma-Jayne Punter	Apr-18	GREEN	Open	
GYN 1.2	1st OPA By Day 7	Improve utilisation of USS within outpatients; x5 dedicated USS within radiology department per day (pending approval)	Emma-Jayne Punter	n/a	GREEN	Closed	Radiology unable to support, EJP to review further options
GYN 1.3	1st OPA By Day 7	PMB increase FT slots from 5 to 12.5 per week plus catch-up of an additional slots 12.5	Emma-Jayne Punter	Apr-18	GREEN	Open	
GYN 1.4	1st OPA By Day 7	Fast track clerks to escalate for capacity at 7 days (versus 14 days) when completed	Appointments	Apr-18	GREEN	Open	
GYN 1.5	1st OPA By Day 7	Implementation of nurse led pelvic mass clinics (previously reviewed by consultants)	Emma-Jayne Punter	TBC	GREEN	Open	Meeting 23.02.18 to review timescales for delivery and implementation
GYN 2.1	Hysteroscopy By Day 21	Review hysteroscopy with 1st OPA capacity and align where appropriate	Emma-Jayne Punter	Apr-18	GREEN	Open	
GYN 3.1	Patient Instigated Delays	Review - consider audit on patient instigated delays	Nerys Edwards / Stacey Kneen	Mar-18	GREEN	Open	
GYN 4.1	Inapproriate GP Referrals	Undertake / review audit regarding inappropriate referrals - link with CCG and GP Lead	Jed Hawe / April Davis	Apr-18	GREEN	Open	
GYN 5.1	Surgical Capacity	Additional clinic and theatre capacity required to account for lead clinical lead and bank holidays (clinical activity delivered on a Monday so adversely affected by bank holidays) essentially a single handed led practice	Emma-Jayne Punter	Apr-18	GREEN	Open	
GYN 6.1	SMDT meeting by day 31 / Referral to tertiary centre by day 38	Clarification received from LWH regarding the deadline for Referrals for MDT discussion and the timing of all relevant documentation and results to enable a patient to be discussed	Jackie Davies	Jul-18	GREEN	Open	
GYN 6.2	SMDT meeting by day 31 / Referral to tertiary centre by day 38	Require CNG agreement on when the referral is actually dated from ? SMDT or other date	Jed Hawe / Jackie Davies	May-18	GREEN	Open	
GYN 6.3	SMDT meeting by day 31 / Referral to tertiary centre by day 38	Require CNG agreement that the tertairy centres will agree to the current guidelines on what is required fro diagnosis and what is actual staging and treatment planning from an investigation point of view	Jed Hawe / Jackie Davies	May-18	GREEN	Open	
GYN 7.1	Regional Ovary Pathway	Contact Cancer Alliance for finalised pathway; review and develop gap analysis and action plan	Jackie Davies	Mar-18	GREEN	Open	

Action Log - Gynaecology

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
GYN 1.1	1st OPA By Day 7	Additional step within triage to identify if patients require USS scan	Emma-Jayne Punter	Apr-18	GREEN	Open	
GYN 1.2	1st OPA By Day 7	Improve utilisation of USS within outpatients; x5 dedicated USS within radiology department per day (pending approval)	Emma-Jayne Punter	n/a	GREEN	Closed	Radiology unable to support, EJP to review further options
GYN 1.3	1st OPA By Day 7	PMB increase FT slots from 5 to 12.5 per week plus catch-up of an additional slots 12.5	Emma-Jayne Punter	Apr-18	GREEN	Open	
GYN 1.4	1st OPA By Day 7	Fast track clerks to escalate for capacity at 7 days (versus 14 days) when completed	Appointments	Apr-18	GREEN	Open	
GYN 1.5	1st OPA By Day 7	Implementation of nurse led pelvic mass clinics (previously reviewed by consultants)	Emma-Jayne Punter	TBC	GREEN	Open	Meeting 23.02.18 to review timescales for delivery and implementation
GYN 2.1	Hysteroscopy By Day 21	Review hysteroscopy with 1st OPA capacity and align where appropriate	Emma-Jayne Punter	Apr-18	GREEN	Open	
GYN 3.1	Patient Instigated Delays	Review - consider audit on patient instigated delays	Nerys Edwards / Stacey Kneen	Mar-18	GREEN	Open	
GYN 4.1	Inapproriate GP Referrals	Undertake / review audit regarding inappropriate referrals - link with CCG and GP Lead	Jed Hawe / April Davis	Apr-18	GREEN	Open	
GYN 5.1	Surgical Capacity	Additional clinic and theatre capacity required to account for lead clinical lead and bank holidays (clinical activity delivered on a Monday so adversely affected by bank holidays) essentially a single handed led practice	Emma-Jayne Punter	Apr-18	GREEN	Open	
GYN 6.1	SMDT meeting by day 31 / Referral to tertiary centre by day 38	Clarification received from LWH regarding the deadline for Referrals for MDT discussion and the timing of all relevant documentation and results to enable a patient to be discussed	Jackie Davies	Jul-18	GREEN	Open	
GYN 6.2	SMDT meeting by day 31 / Referral to tertiary centre by day 38	Require CNG agreement on when the referral is actually dated from ? SMDT or other date	Jed Hawe / Jackie Davies	May-18	GREEN	Open	
GYN 6.3	SMDT meeting by day 31 / Referral to tertiary centre by day 38	Require CNG agreement that the tertairy centres will agree to the current guidelines on what is required fro diagnosis and what is actual staging and treatment planning from an investigation point of view	Jed Hawe / Jackie Davies	May-18	GREEN	Open	
GYN 7.1	Regional Ovary Pathway	Contact Cancer Alliance for finalised pathway; review and develop gap analysis and action plan	Jackie Davies	Mar-18	GREEN	Open	

Action Log - Lung

Action No:	Milestone	Action	Owner	Date Due by	RAG Status	Status	Action Update
LUNG 1.1	Radiology Pathway - Abnormal CXR direct to CT	i. Review capacity / demand for all abnormal CXR that would need urgent direct CT thorax ii. Rewrite SOPs for CT booking & administration	Ruth Buckley	Sep-18	GREEN	Open	
LUNG 1.2	Radiology Pathway - Abnormal CXR direct to CT	i. Review process of notification of results ii. Consider how the clinical lung team receive / access results	Ruth Buckley / Ian Benton	Sep-18	GREEN	Open	
LUNG 1.3	Radiology Pathway - Abnormal CXR direct to CT	i. Consider reporting terminology ii. Coded 'flags' in report (not available within Meditech)	Gerry Doyle	Sep-18	GREEN	Open	Dependency on Cerner for coded flags
LUNG 2.1	Lung Cancer Referral Pathway	i. Rewrite local cancer referral pathway	Ian Benton	Sep-18	GREEN	Open	
LUNG 2.2	Lung Cancer Referral Pathway	i. Single point of entry following abnormal CT ii. Other route for CTs elsewhere (similar to current process on referral)	Ian Benton / Richard James	Sep-18	GREEN	Open	
LUNG 2.3	Lung Cancer Referral Pathway	Lung CNS team to receive all abnormal CT results; i. CNS to contact patient & GP (if primary care) ii. CNS to contact patient & GP and Secondary care team (if ED, or Outpatient)	Ian Benton / Rachel Mountfield	Sep-18	GREEN	Open	
LUNG 2.4	Lung Cancer Referral Pathway	i. Triage for investigations / appropriate tests ii. Review other routes to clinic for non cancer (but urgent indications follow CT) iii. Communication of referrals iiii. Booking of Ix / registering with Meditech	Ian Benton	Sep-18	GREEN	Open	
LUNG 2.5	Lung Cancer Referral Pathway	Booking of specific RESPLUNG appts. - managing the appointments timescales of Ix if pre-booked	Richard James	Sep-18	GREEN	Open	
LUNG 3.1	Role of CNS / Lung Support Worker	i. Develop role and responsibilities ii. Extend working relationship with Cancer Services Coordinator / tracker iii. Map job role	Rachel Mountfield	Jun-18	GREEN	Open	
LUNG 4.1	Therapeutic MDT	i. Job planning ii. Patient triage iii. Route of access iv. Streamlined v. Communication / outputs vi. Combined MDT with WUTH (room, location, attendees, support, SOP)	Ian benton / Richard James	Sep-18	GREEN	Open	
LUNG 5.1	Diagnostic MDT (Radiology Meeting)	i. Job planning ii. Location iii. Admin support (pathway support) iv. Communication of outcomes etc	Ian benton / Ruth Buckley / Richard James	Sep-18	GREEN	Open	
LUNG 6.1	Molecular Testing	i. Regional issue ii. Stream line process here ?SOP	TBC	Regional / Network	GREEN	Open	
LUNG 7.1	Data Monitor / Audit	i. Pathway monitoring (cancer tracker) ii. Data flow re: radiology pathway iii. Tracking patients in / through pathway iv. Timelines v. £5k funding approval Cancer Alliance (laptop, IT resource, Band 4 uplift (increased skill versus time)	Jun-18	Ian Benton	GREEN	Open	

BOD Item No / /

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	CoCH inaugural Gender Pay Gap Report
Date of Meeting	
Author(s)	Joe O'Grady E&D Manager Steve Gregg-Rowbury- Head of HR & Wellbeing Business Services
Presented by	Sue Hodkinson Director of People and Organisational Development
Annual Plan Objective No.	
Summary	This is the inaugural Gender Pay Gap Report (GPGR), which was mandated from April 2017, by the Government Equalities Office (GEO) and applies across all sectors, including pubic authorities as defined under Schedule 149 of the Equality Act (2010). Subsequent GPGRs will be required on an annual basis. The report provides data on pay and gender, that is taken from Electronic Staff Records and this has been inputted into a format set out by the GEO, with a narrative to interpret the data sets and highlight any statistically significant dynamics. The report concludes with an interim action plan which will be reviewed by the People and Organisational Development Committee.
Recommendation(s)	**The Board is asked to:** • Consider the findings of the inaugural analysis • Approve the interim action plan • Approve the submission of the report to the Government Equalities Office, as per Equality Act requirements
Risk Score	**N/A**

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Gender Pay Gap Report 2018

The Countess of Chester Hospital NHS Foundation Trust (CoCH) is committed to embedding equality and human rights across the whole organisation and to reducing inequality between any of the protected characteristics in the workplace. Under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, CoCH is required to report annually on gender pay gap, utilising a reporting framework set out by the Government Equalities Office (GEO) and to register with the GEO and submit its annual Gender Pay Gap Report (GPGR).

Gender pay gap definition:
The gender pay gap is a figure that shows the difference in the average pay between all men and women in a workforce. The gender pay gap is the difference between women's and men's average salary earnings, expressed as a percentage of men's earnings. It is a measure of women's overall position in the paid workforce and does not compare like roles.

How is this different to Equal Pay?
In contrast, 'equal pay' is a more specific legal concept that deals with the pay differences between men and women carrying out comparable jobs. While the gender pay gap focuses on an average across the whole organisation across a variety of different role and pay bands. A large difference in the gender pay gap does not necessarily indicate unequal pay, which is determined by what people earn in comparable jobs.

What will the Gender Pay Gap show?
The gender pay gap can indicate that there is some practice to address with regards to if women are in roles that are paid less than men, and potentially, the reasons for this. This may be due to varied reasons, examples of which are listed below. An organisation can look to put together an action plan to improve their Gender Pay Gap.

Examples of potential gender pay gap dynamics in organisations:

- discrimination and bias in hiring and pay decisions
- women and men working in different industries and different jobs, with female-dominated industries and jobs attracting lower wages
- women's disproportionate share of unpaid caring and domestic work
- lack of workplace flexibility to accommodate caring and other responsibilities, especially in senior roles

- women's greater time out of the workforce impacting career progression and opportunities.
- Lack of confidence among female staff seeking pay increases/leadership roles
- Occupational segregation
- Market-rate salaries. There's absolutely nothing wrong with setting market-rate salaries, but when this happens in sectors typically dominated by male workers, a gender pay gap can easily surface as a result.

The range of reasons as to why gender pay gap exists across different organisations in all of the workforce sectors is a complex issue. It is important to note that a gender pay gap does not equate to the existence of an equal pay problem, though a gender pay gap may be a catalyst for organisations to look into any reasons as to why the gap exists.

CoCH Gender Pay Gap Report 2018:

The Mandatory Gender Pay Gap Reporting proposes that organisations should, for the first mandatory report, capture data as a snapshot on 5 April 2017 and then publish their findings no later than 4 April 2018. This cycle will then continue year on year going forward with organisations being required to maintain the data on their websites for three years in order to show progress made.

Table 1

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	19.5181	13.5360
Female	14.0938	12.2980
Difference	5.4243	1.2379
Pay Gap %	27.7912	9.1456

Table 2

Quartile	Female	Male	Female %	Male %
1	852.00	175.00	82.96	17.04
2	839.00	191.00	81.46	18.54
3	871.00	158.00	84.65	15.35
4	749.00	281.00	72.72	27.28

Analysis:

The tables above follow the GEO defined gender pay reporting format for all the workforce establishment, as per the regulations. Table 1 shows in column 2, the mean (average) difference in hourly rate by gender and determines that women are paid £5.42 per hour less than their male colleagues, which is equivalent to a pay gap of 27.8%.

In column 3, the difference in hourly rate by gender is calculated as a median hourly rate, as per GEO reporting requirements. In column 3 the data demonstrates that the median figure for women is that they are paid £1.24 per hour less than men, which is equivalent to a pay gap of 9.1%.

Table 2 provides a gender make-up by quartile, of the whole workforce establishment. Quartile 1 represents staff paid on lower salaries, with Quartile 4 representing the highest paid cohort of employees. Women account for 72.2% in quartile 4. The total percentage of women across the whole organisation 80.5% (1), so quartile 4 shows an underrepresentation of women, with all other quartiles being slightly above the overall workforce figure for women of 80.5%.

Table 3

	Female		Male			
Pay Band	Headcount	Average Hourly Rate	Headcount	Average Hourly Rate	Difference in Hourly Rate	Percentage Difference
Band 1	200	9.64	65	9.79	0.15	2%
Band 2	1138	9.84	208	9.78	-0.06	-1%
Band 3	344	9.85	82	10.48	0.63	6%
Band 4	204	11.24	47	11.36	0.12	1%
Band 5	733	14.92	102	13.66	-1.26	-9%
Band 6	474	17.27	68	16.34	-0.93	-6%
Band 7	244	20.17	47	19.81	-0.36	-2%
band 8a	66	22.97	16	23.00	0.03	0%
Band 8b	12	27.77	8	25.66	-2.11	-8%
Band 8c	10	33.96		36.64	2.68	7%
Band 8d		39.37		40.08	0.72	2%
Band 9	0	0		45.22	0	0%
Consultant (2)	56	45.06	121	46.46	1.40	3%
Other Medical &Dental	79	24.57	75	26.75	2.18	8%
Senior Managers (3)	7	38.88	6	36.03	-2.85	-8%

Table 3 above provides a pay band based representation of the workforce establishment. Headcounts of less than 6 are not shown to adhere to information governance guidelines. It can be seen from table 3, that in certain pay bands, women have a higher hourly

payment rate than their male counterparts. This was mentioned as a possibility, in the earlier section of this report. In the pay band group in table 3 *'Senior Managers'* there is a slightly higher female headcount, however this group doesn't include Medical Leads who are counted in the *'Consultant'* cohort. It is important to note from the earlier data for quartile 4, which is the highest paid cohort of employees, that women accounted for 72.2%, rather than the workforce total of 80.5%. The gender make-up in the *Consultan*t cohort is statistically significant, in what is the highest hourly rate paid group of employees at an average £45.76. Women in this cohort account for just 31.6% of employees.

Table 4

Gender	Avg. Pay	Median Pay
Male	13,360.71	11,934.30
Female	8,483.82	5,967.20
Difference	4,876.89	5,967.10
Pay Gap %	36.50	50.00

Table 5

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	15.00	3757.00	0.40
Male	49.00	908.00	5.40

The two tables above provide information on bonus payments to employees and gender, including headcount (table 5) for this reporting period. This relates predominantly to Clinical Excellence Awards payments. It can be seen from table 4, that women were paid as a mean average £4,876.89 and as a median £5,967.10 less than their male counterparts, pay gaps of 36.5 and 50% respectively.

Preliminary action plan:
In order to address its Gender Pay Gap, CoCH will consider initiatives with regard to reducing gender pay gap and building on its inclusive values and high equality performance rating. This can be seen overleaf:

Action	Responsible	Evidence	Time scale	RAG
Set up a Gender pay gap working group that will oversee analysis and planning on gender pay gap reduction, to include membership from Human Resources, Council of Governors, Executive lead, Equality and Diversity, Staff Side, HR Business Services and Learning and Development.	People and Organisational Development Committee	Gender Pay Gap Working Group established Minutes Briefings Reports Terms of reference Action plans	May 2018	
Formulate a three year action plan and report on gender pay gap working group activity and recommendations into to People and Organisational Development Committee, Equality Diversity and Human Rights Strategy Group and Gender and Sexuality Equality Group. The working group will be monitored by the People and Organisational Development Committee.	Gender Pay Gap Working Group	3 year action plan formulated Presentations / briefings to POD Committee, Board, Equality Diversity and Human Rights Strategy Group Evidence of 3 year action plan ratification by executive committee recorded	July/August 2018	
Utilise strategic communications to promote policies and functions to support all staff to develop and undertake opportunities such as: Flexible working Carers Strategy initiatives Shared parental leave Continuing Professional Development	Gender Pay Gap Working Group Communications Team	Round Up Staff Side communications Engagement activities Presentations Audit Focus groups	Ongoing	

Action	Responsible	Evidence	Time scale	RAG
Career progression workshops Leadership development programmes				
Consider positive action options in roles and pay bandings where men or women may be under-represented, within recruitment and development programmes.	People and Organisational Development Committee	Briefings Action plans GRGR updates	Ongoing	
Review gender pay gap analysis in line with the local Clinical Excellence Awards.	Medical Workforce Board	Minutes Recommendations	September 2018	
Publicise gender pay gap data and collaborate with regional colleagues to look at benchmarking, share best practice and initiatives.	E&D Manager HR & Wellbeing Business Services Gender Pay Gap Working Group	Annual GPGR submission to GEO within required timeframes Benchmarking reports Minutes Joint working initiatives	GPGR - Annually by 31st March Ongoing	

Notes:
1 – Source CoCH Workforce Equality Analysis Report (2017)
2 – Consultant pay band cohort includes some Senior Managers
3 – Senior Managers cohort does not include Medical Senior Leads
4 – The data has been extracted using the national Gender Pay Gap Reporting via the Electronic Staff Records

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March 2018