NHS
Countess of Chester Hospital
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS (PUBLIC)
TUESDAY, 18TH DECEMBER 2018 AT 9.30AM – 11.30AM
BOARDROOM

A G E N D A

FORMAL BUSINESS

1.	Welcome and Apologies	Chair
2.	Declarations of Interest	Chair
3.	To receive and approve the Board of Directors minutes of meeting held on 23rd October 2018 and matters arising **(Attached)**	Chair

QUALITY & ASSURANCE

4.	To review the Integrated Performance Report as at Month 7 to include: • Finance Report for Month 8 (November 2018) • Capital Program Update **(Attached)**	Executive Team
5.	To receive details of the Governance for the Approval of Loans from NHS Improvement **(Attached)**	Chief Finance Officer
6.	To receive details of the PLACE Report 2018 **(Attached)**	Director of Nursing and Quality
7.	To receive details of the Flu Campaign 2018 **(Attached)**	Interim Director People and Organisational Development
8.	To receive the Director of Infection Prevention and Control Annual Report 2017/18 **(Attached)**	Acting Medical Director
9.	To receive the Learning from Deaths 6 monthly report (**Attached**)	Acting Medical Director
10.	To receive and approve the Board Assurance Framework at Q2 **(Attached)**	Acting Chief Executive/Director of Nursing & Quality
11.	To receive an update on Never Events and Serious Untoward Incidents **(Verbal)**	Director of Nursing and Quality

STRATEGIC DEVELOPMENT

12.	To receive details on the progress of the Integrated Care Partnership **(Attached)**	ICP Managing Director
13.	To receive a CEO Update **(Verbal)**	Acting Chief Executive
14.	To receive an update on Governor Matters **(Verbal)**	Director of Corporate & Legal Services

FOR NOTING & RECEIPT

15.	To receive the Month 6 and Month 7 letter to NHS Improvement	Chief Finance Officer
16.	To receive the Safeguarding Children Annual Report 2017/18	Director of Nursing & Quality
17.	To receive the Safeguarding Adults Annual Report 2017/18	Director of Nursing & Quality
18.	To receive the minutes of the Audit Committee – 18th September 2018	Chief Finance Officer
19.	To receive the minutes of the Quality, Safety and Patient Experience Committee – 16th October 2018	Director of Nursing & Quality
20.	To receive the minutes of the People and Organisational Development Committee – 25th September 2018	Interim Director of People & Organisational Development
21.	To receive Corporate Infection Prevention and Control Assurance – Quarterly Report (retrospective report based upon August 2018 quarterly data update)	Acting Medical Director
22.	To receive the Annual Statement of Fire Safety 2018	Director of Nursing & Quality
23.	To receive details of the Education and Training Self-Assessment Report 2018	Interim Director People and Organisational Development
24.	To receive the Standing Financial Instructions, Scheme of Delegation Table A & Table B and Variable Pay Approval Levels	Chief Finance Officer
25.	To receive the Cerner Millennium Electronic Patient Record (EPR)_Memorandum of Understanding	Chief Finance Officer

26.	To receive the Procurement PTP refresh	Chief Finance Officer
27.	To receive the Reference Costs 201718 Update	Chief Finance Officer

28. Date and Time of Next Meeting:
Board of Directors Meeting
Tuesday, 29th January 2019 – time and venue to be confirmed

BOARD OF DIRECTORS (PUBLIC)

MINUTES OF THE MEETING HELD ON TUESDAY, 23RD OCTOBER 2018 AT 1.00PM
LECTURE HALL

		Attendance	
Chair	Sir D Nichol	☑	
Non Executive Director	Mr A Higgins	☑	
Non Executive Director	Mr E Oliver	☑	
Non Executive Director	Mrs R Hopwood	☑	
Non Executive Director	Ms R Fallon	☑	
Non Executive Director	Mrs C Hannah	☑	
Acting Chief Executive	Dr S Gilby		☒
Acting Medical Director	Dr D Kilroy		☒
Chief Finance Officer	Mr S Holden	☑	
Director of Nursing & Quality/Acting Deputy Chief Executive	Mrs A Kelly	☑	
Director of People and Organisational Development	Mrs S Hodkinson		☒
Director of Corporate & Legal Services	Mr S P Cross	☑	
Chief Operating Officer	Ms L Burnett	☑	
Deputy Director of People & Organisational Development	Mrs D Appleton-Cairns	☑	

In attendance:

Mrs C Raggett – Assistant Trust Secretary
Mr R Howorth – Informatics Director

FORMAL BUSINESS

B65/18 **WELCOME AND APOLOGIES**

Sir Duncan welcomed all attendees to the Board meeting.

Apologies were received from Dr Gilby as she had long a standing holiday commitment. Apologies were also received from Dr Kilroy and Mrs Hodkinson.

Sir Duncan advised the Board that Dr Gilby had been appointed at the Acting Chief Executive and this would be reviewed in March 2019. Dr Kilroy had been appointed as Acting Medical Director and Mrs Kelly as Acting Deputy Chief Executive and these positions would also be reviewed in March 2019.

B66/18 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

B67/18 **TO RECEIVE AND APPROVE THE BOARD OF DIRECTORS MINUTES OF MEETING HELD ON 24TH JULY 2018 AND MATTERS ARISING**

The Board of Directors minutes of the meeting held on 24th July 2018 were received as a true and accurate record save for the following amendment: Ms Hannah stated that under item 52/18, this should read as Vale Royal also the minutes should read Northwich and Winsford not Knutsford.

MATTERS ARISING

There were no matters arising.

QUALITY ASSURANCE

B68/18 **TO REVIEW THE INTEGRATED PERFORMANCE REPORT AS AT MONTH 6 TO INCLUDE A FINANCIAL UPDATE**

Ms Burnett presented the new format performance report for month 6.

Ms Burnett highlighted the following points from the constitutional metrics:

- The hospital is very busy and this is reflected in the performance report.
- The 4 hour A&E target is currently at 90.2%, whilst not achieving the 85% target, it is a real improvement. This is above the Trust's internal target and is above the national position which is 89%.
- The RTT 18 weeks target is at 87.4% against a target of 92%. This fall in performance is due to the Trust consolidating vascular services. The Trust is working through the long waiting list and there will be no vascular patients waiting over a year by the end of the financial year.
- The diagnostic test target performance is a concern with performance at 92.7% against a target of 99%. Some patients are waiting longer than 6 weeks for their diagnostic tests. There has been a 25% growth in the number of referrals to endoscopy with an increase in referrals for cancer, which has an impact on routine investigations.
- The 62 day cancer target has dropped slightly to 81.2%, however the target has been achieved in the previous 2 months. There are some patients on the list who have been waiting a long time. Once the patient is treated that becomes a breach, so there will be more breaches in month. Ms Burnett is expecting performance to increase over the coming months.

- The bed occupancy rate is currently at 95.3% against a target of 85%. It is expected that this level will increase in October.

Mrs Kelly highlighted the following points from the safety metrics:

- The falls position has improved however, falls with harm to patients remain a focus for the Trust.
- The Trust had a Never Event in October 2018. Mrs Kelly was disappointed but this does reflect the current pressures within the Trust. The never event has been reviewed and all processes were followed correctly. The Never Event was due to human endeavour with doctors going above and beyond for the patient. The learning from this Never Event is to make sufficient time. There was no harm to the patient.
- C.Difficile is above trajectory and exceeds the level expected at this time of year. The Trust is monitoring this and will be reminding staff about the importance infection control processes. The Trust has had a MRSA case in October 2018 which is currently being investigated. The Trust is commissioning an external review into the infection control service to see if there is anything that requires improvement or can be added to support staff and patients.
- Mixed sex accommodation breaches have improved, however this remains a challenge due to the bed occupancy levels. There are some mixed sex accommodation breaches within cardiology and the team have an action plan to address this. Any such breaches are discussed with the patient and their families.
- There has been good feedback from the patients in the Friends and Families survey results.

Mrs Appleton-Cairns highlighted the following points from the Kind and effective metrics:

- Variable pay is off plan to deliver at year end however, the position is improved in month. Additional checks have been put in place for sign off agency rates over the cap for medical and dental staff. Any such rates are now required to be signed off by the Chief Executive and Medical Director. Mrs Appleton-Cairns is hopeful that these actions will reduce the level of variable pay further.
- The sickness absence rate is currently above the target. Where there are shifts to be covered or gaps in staffing, the Trust is asking staff to do extra shifts. To support staff the Trust has invested in resilience training which gives techniques to handle the pressure.
- There have 1500 members of staff vaccinated for flu to date. The flu campaign has been so successful that the Trust ran out of vaccines. Priority was given to front line staff and additional supplies have now been received.
- The level of mandatory training is slightly down as there are not as many sessions available as the Trust would like and this is being reviewed. However, if the number of staff currently booked on mandatory training were included in the figures then this would be at over 95% of staff.
- The number of staff who have had an appraisal, is an improving position.
- The levels of staff turnover are also an improving position.

FINANCE

Mr Holden gave a detailed overview of the Trusts financial position at Q2 and highlighted the

following points:

- For the first 6 month of this financial year, the submitted monthly accounts have shown a favourable position however, the Trust has used its non-recurrent reserves to support this position. However, for delivering an "on target" position , the Trust has received additional Provider Sustainability Funding , specifically for hitting the financial target.
- The forecast deficit had been £11.9m, although this has now been revised to a forecast deficit of £12.7m. The Board will recall that the forecast deficit at the start of the financial year was £4.3m so the Trust is currently circa £8m off plan. Mr Holden advised the Board that NHSI had been sighted on the financial position, and kept informed. The rationale for the deterioration is not operational, it is due in part in reduction of income of £1,000k on the block contract with West Cheshire CCG. The Trust is finding delivery of the CRS programme a challenge. Medical pay is currently overspent by £100k, although the nursing pay has maintained a constant position in September 2018.
- The CRS programme is on plan at Q1 and Q2 although not for Q3 and Q4, as the CRS programme is back loaded in terms of delivery of schemes.
- It is important that the Trust despite the deficit financial position, ensure that everything it does is to the best quality to ensure that the Trust is safe, kind and effective.

Ms Burnett was pleased to report to the Board that the Trust had been awarded some national capital monies for the changes needed for A&E Sir Duncan asked when would the changes be made in A&E? MS Burnett replied that the planning notices had been submitted and that the Trust hoped to receive planning permission within the next 3 weeks. The surveys are underway and the clinicians are being consulted as to what will work best for them. The trust had also utilised some of its internal capital monies to fund a short stay elective unit within the Jubilee day case unit.

Mrs Fallon congratulated the team for achieving 90% in A&E and acknowledged the hard work of the teams. Mrs Fallon asked about the sustainability of delivery of 90% in A&E, when considering the impact of the build and the operational pressures on the service and how Ms Burnett was assured that this level would be sustained. Ms Burnett replied that team in A&E had waited a long time for improvements to their area and were committed to maintaining a service during the estate works. The operational teams know what actions need to be taken to support performance and the data from teletracking is providing real transparency across the Trust. This enables the teams to turn performance around after an extremely busy day and whilst there is no capacity for an attendance surge, Ms Burnett is assured that the managers and team know how to get back on track.

Mr Higgins referred to the diagnostics target and in particular to the pressure in the Interventional Radiation service which had been discussed in detail at the Quality, Safety and Patient Experience Committee. Mr Higgins noted that some of the clinicians in the radiology team are nearing their exposure doses which indicate the pressures that the services are under.

Sir Duncan gave a detailed overview regarding the financial deficit of £12.7m and the ongoing actions being taken to continue making efficiencies and economies and ensure that the hospital delivers against this revised target (i.e. it cannot get any worse). Sir Duncan outlined the wider context of how the Trust benchmarks on efficiency costs (i.e. NHS Reference Costs) which is currently 7-8% cheaper than other acute trusts. Sir Duncan also summarised the position in relation

to the payment for treatment of patients from Wales. Sir Duncan added that the Executive Team would discuss the amount of payment for patients from Wales with the Betsi Cadwalladr Health Board.

The Board received the Performance Report for Month 6.

B69/18 **TO RECEIVE DETAILS OF THE PATIENT EXPERIENCE ANNUAL REPORT 2017/18**

Mrs Kelly presented the Patient Experience Annual Report 2017/18 to the Board and highlighted the following points:

- There has been significant work on the patient experience agenda during 2017/18.
- There have been changes within the Patient Experience Team and they are now under the leadership of the MS Kynaston, Associate Director of Nursing, Corporate.
- A full review of how the Trust responds to complaints and the process around that has been undertaken in year.
- There is detailed plan of work for the Patient Experience Operational Group with a number of different parties now attending the meeting to engage the agenda.
- There is improving compliance on complaints and those acknowledged within 3 days and responses within 40 days as agreed with families.
- There are more positive comments about staff attitude than negative comments. This demonstrates that the behaviours work is starting to have an impact and that staff are being addressed if they do not reflect the values of the Trust.

The Board noted the progress to date with regards to patient experience.

Sir Duncan thanked Mrs Kelly and the team for their hard work.

B70/18 **TO RECEIVE DETAILS OF THE EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) ASSURANCE 2018-19**

Mrs Kelly presented the details of the Emergency Preparedness, resilience and response (EPRR) assurance 2018-19 to the Board.

Mrs Kelly reported that the Trust has been assessed and is compliant with all standards. Mrs Kelly has been the executive lead for EPRR for the last 5 years and going forward, Ms Burnett will now be the executive lead.

Mrs Hopwood asked if the report covered the Trust's response to technology incidents such as system failures and also Brexit. Mrs Kelly replied that cyber security agenda does come under the EPRR agenda. The Trust has recently undertaken a table top exercise around a cyber security incident and an incident response would be set up if the Trust had such an incident. The Trust was not impacted significantly following the national cyber incident last year which was a testament to the IMT teams at the Countess. There is some work being undertaken regarding Brexit nationally. Ms Burnett added that that at her first meeting that Brexit may be discussed. Ms Burnett stated that following the national cyber incident last year, NHSi asked for all of the Executive's mobile

numbers. NHSi were then able to contact the Ms Burnett following the Grenfell Tower incident which worked well. There are business continuity plans across the organisation and cyber security is built into these.

Mrs Hopwood asked about medicines management and Brexit. Ms Burnett stated that Dr Green, Director of Pharmacy was addressing this.

B71/18 **TO RECEIVE AN UPDATE ON NEVER EVENTS AND SERIOUS UNTOWARD INCIDENTS**

Mrs Kelly reported that there had been two level 2 serious incidents regarding failure to escalate a deteriorating patient which are being investigated. The Trust is also rolling out NEWS2 across the wards which assists in identifying the deteriorating patient and this will be reviewed to measure how effective this has been.

Mrs Kelly had reported in agenda item B68/18 regarding the never event. Sir Duncan asked if the Never Event was the same as another never event. Mrs Kelly replied that this was a different Never Event as it was due to human error. There were 2 individuals trying to do their best for the patient as quickly as possible although there some issues identified in clarity of roles. All the appropriate paperwork was completed and correct processes followed. Mrs Kelly will update the Board further once the investigation has been completed.

STRATEGIC DEVELOPMENT

B72/18 **TO RECEIVE AN UPDATE ON CERNER IMPLENTATION**

Mr Holden gave an overview of the Trust's Fast Follower status with Wirral, and the implementation of the new electronic patient record Cerner. The Trust has now received the funding to support the transition (circa £5m), and highlighted that the implementation costs are potentially over and above the funding (circa £2m excess, per Business Case).

Mr Howorth gave an update on the position of the implementation since the original Business Case had been presented to Board:

- The original Business Case was costed on an implementation date of September 2018, with a go live date of October 2019. This was dependant on an upgrade for Wirral University Teaching Hospital which was scheduled to take place in the summer 2018. This has now unfortunately been delayed until November 2018, which means that the Countess programme is now delayed.
- Cerner also need to have the ability to absorb the workload. Cerner have therefore put forward a proposal to the Trust to potentially start the programme in January 2019, with a go live date of March 2020.
- The new dates would impact on Trust as over 3,200 staff would need to be trained during the very busy winter period.
- Both Trusts have rejected the proposal from Cerner, and have agreed a revised go live date of 25th May 2020 as this would the optimum time to go live for the organisation. Feedback from other organisations who implemented new systems have stated that the May Bank Holiday is good time.
- The new proposal means that there is an operational, and financial, impact of a further 9

months.

- A large amount of the additional cost is around the dual running of systems. The Trust is hoping to offset some of these costs following discussions with the Cerner Executive team around the scheduling of updates.

Mr Higgins asked about the risks assessments for the dual running. Mr Howorth stated that from an organisational perspective the Trust will be in a better position in January 2019. There is a reasonable window to develop successful implementation and to replicate what we do safely and efficiently. There will not be a phased approach to the implementation with a number of key milestones. Cerner have a wealth of experience of go live for implementation so the Trust is looking to them for guidance and advice. The system will only go live when it is safe and effective to do so.

Mr Holden stated that the delay had a cost implication of circa £750k and as stated the Trust is trying to mitigate this in discussion with Cerner. Ms Burnett added that the operational teams are very close to the implementation with risk registers in place and a lot of work is being undertaken to inform the implementation plan.

Sir Duncan referred to the additional costs of £750k and asked where the delay had risen from. Mr Holden stated that there were shared risks with Wirral and the Countess although the delay was due to the Cerner update being delayed. There are meetings being held with Cerner and an executive to executive meeting with Wirral and the Countess to discuss this in detail. Mr Holden added that the Trust was purchasing a collaborative version of Cerner with Wirral, which means that the Trust is adopting the Wirral ways of working.

Mr Higgins suggested that as the implementation progressed that the Board could receive regular updates. Sir Duncan concurred with Mr Higgins's comment.

The Board noted the details of the Cerner Implementation paper and the next steps required to firm up on the proposed new date, strengthen the implementation arrangements and mitigate the risks (both financial and operational).

B73/18 **TO RECEIVE AND APPROVE THE STRATEGIC PATHOLOGY COLLABORATION WIRRAL & WEST CHESHIRE: CURRENT POSITION AND NEXT STEPS**

Ms Burnett presented the paper on the strategic pathology collaboration Wirral & West Cheshire which detailed the current position and the next steps.

Ms Burnett stated that there is work going on with the Cheshire and Merseyside footprint. The Trust and Wirral already have the joint microbiology service and a joint manager has already been appointed. The Cerner project also gives an opportunity to bring services together and drive quality and productivity improvements whilst reducing costs.

Ms Burnett sought approval from the Board to support the establishment of a joint pathology service within an NHS partnership arrangement. A paper would be brought back to Board for approval detailing who would host the service and how the service would work. One of the big drivers for change is that the contract for the managed service for the equipment expires in 2020

and there would be savings available if this were to become a joint contract with Wirral.

Sir Duncan noted that the Countess is cheaper and more efficient than other trusts and asked about risk share and gains. Ms Burnett replied that she would need to get more detail about how the service would work in the best interests of both hospitals and the risk sharing arrangements. The microbiology service is already a shared service and it is the same people involved in this project so there would be more detail available at the next Board report.

Sir Duncan added that the Board was not against the principal but that it was important to have clear direction on that benefits and risk sharing arrangements. Ms Burnett stated that this information would be included in the next Board report.

The Board supported the establishment of a joint pathology services within an NHS partnership with a paper to be brought to Board in 3 months time.

B74/18 **TO RECEIVE DETAILS ON THE PROGRESS OF THE INTEGRATED CARE PARTNERSHIP**

Mrs Hannah, gave a detailed overview of the progress of the Integrated Care Partnership (ICP) and noted the following points:

- Ms Alison Lee has been appointed as the Managing Director of the ICP with effect from 1st September 2018. Ms Lee will be presenting a paper to the Board in December 2018.
- There has been progress in relation to governance issues to facilitate the ICP working across the Cheshire West system. An integration agreement being developed which sets out the principles and rules about how organisations work together, due to the complexities of a number of health care providers and the local authority. It is expected that a detailed paper will be brought to Boards in January 2019 for approval.
- NHSE are due to complete a national consultation on contracting arrangements as the current arrangements do not reflect integrated care partnerships. It is expected that new arrangements could be in place by April 2019.
- Conversations are also taking place with local providers as to which services could transfer to the ICP.
- There has been good progress on developing the 9 care communities along with a exciting community engagement project to get input from local people. This will help to help shape each care community and ensure arrangements are tailored to local circumstances.

B75/18 **TO RECEIVE AN UPDATE ON BOARD AND GOVERNOR MATTERS**

Mr Cross thanked the Governors for their continued supported.

Mr Cross reported that the Annual Members Meeting would be held after the Board meeting.

Mr Cross advised the Board that 3 governors terms of office had to come to an end and he

expressed thanks on behalf of the Board to Tom Bateman, Helen Clifton and Sue Bagby for their commitment and support as Governors.

B76/18 **TO RECEIVE A PATIENT STORY**

Mrs Kelly introduced Mr Michael Hemmerdinger (Partnership Governor) to the Board.

Mr Hemmerdinger gave a detailed account of his observations during his wife's recent experience of care and treatment at the Countess of Chester Hospital NHS Foundation Trust where he gave some positive and negative feedback.

Mrs Kelly thanked Mr Hemmerdinger for his very detailed patient story. Mrs Kelly stated that she would like to invite Mr Hemmerdinger along to come and present his story to the Ward Managers' meeting. It was clear from the experience that some of the behaviours and values were not right and some of the processes are not being effective, safe or kind. Mrs Kelly added that Mr Hemmerdinger's patient story would also be discussed at the next Executive Directors Group to see how this could be shared. Mrs Kelly also added that it may helpful for Mr Hemmerdinger to come to the model ward programme as they could learn a lot from the experience and make further improvements.

Mr Hemmerdinger thanked the Board for listening to his observations and stated that he hoped that communications with patients would be improved by the implementation of Cerner. Mrs Kelly stated that teletracking is also helping to keep the right patient in the right bed.

Mr Cross, on behalf of the Board wished Mr Hemmerdinger's wife a continued good recovery.

Sir Duncan and Mrs Hopwood asked about the issues with medications. Ms Burnett stated that she would discuss the issues with Dr Green, Director Pharmacy and invite him to come along to QSPEC. Mrs Kelly added that she would ask Dr Green for a briefing paper to understand what improvements are being made to infrastructure in pharmacy.

Sir Duncan thanked Mr Hemmerdinger for his very detailed and helpful patient story.

FOR NOTING & RECEIPT

B77/18 **TO RECEIVE THE MONTH 4 AND MONTH 5 LETTERS TO NHS IMPROVEMENT**

The Board received and approved the month 4 and month 5 letters to NHS Improvement.

B78/18 **TO RECEIVE AND APPROVE THE CONFLICTS OF INTEREST POLICY 2018**

The Board received and approved the Conflicts of Interest Policy 2018.

B79/18 **TO RECEIVE THE MINUTES OF THE AUDIT COMMITTEE – 22ND MAY 2018**

The Board received and noted the Audit Committee held on 22nd May 2018.

B80/18 **TO RECEIVE THE MINUTES OF THE QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE – JULY 2018 AND SEPTEMBER 2018**

The Board received and noted the Quality, Safety and Patient Experience Committee– July 2018 and September 2018 (there was no meeting held in August 2018).

B81/18 **TO RECEIVE THE MINUTES OF THE FINANCE AND INTEGRATED GOVERNANCE COMMITTEE– 26TH JUNE 2018**

The Board received and noted the Finance and Integrated Governance Committee held on 26th June 2018.

B82/18 **TO RECEIVE THE MINUTES OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – 17TH JULY 2018**

The Board received and noted the minutes of the People and Organisational Development Committee held on 17th July 2018.

B83/18 **TO RECEIVE THE MINUTES OF THE CHAIRTABLE FUNDS COMMITTEE – 10TH APRIL 2018**

The Board received and noted the minutes of the Charitable Funds Committee held on 10th April 2018.

B84/18 **TO RECEIVE CORPORATE INFECTION PREVENTION AND CONTROL ASSURANCE – QUARTERLY REPORT (RETROSPECTIVE REPORT BASED UPON MAY 2018 QUARTERLY DATA UPDATE)**

The Board received and noted the minutes of Corporate Infection Prevention And Control Assurance – Quarterly Report (Retrospective Report Based Upon May 2018 Quarterly Data Update).

B85/18 **DATE AND TIME OF NEXT MEETING**

Tuesday 18th December 2018, 9.30am – 11.30am, Boardroom.

COUNTESS OF CHESTER

PERFORMANCE REPORT, OCTOBER 2018

Safe

Indicator	Target	Act.	Alert
All Falls Rate	7	8.54	○
Falls with Harm Rate	0.3	0.28	○
Never Events	0	1	○
Safety Thermometer – Free of new harms %	95	96.8	○
Q2 Sepsis screening % (Inpatients)	90	69.6	○
Q2 Sepsis treatment % (Inpatients)	90	78.2	○
Q2 Sepsis screening % (ED)	90	73.8	○
Q2 Sepsis treatment % (ED)	90	79.7	○
Infection Control: C Difficile	9 YTD	18 YTD	○
Infection Control: MRSA	0	2 YTD	○

Kind

Indicator	Target	Act.	Alert
Friends and Family: A&E	80	79.8	○
Friends and Family: Inpatient Wards	90	92.5	○
Friends and Family: Maternity Services	90	97.6	○
Open Complaints	40	38	○
Open Complaints > 40 days response time	0	7	○
Open PHSO Complaints	0	4	○
MSA Breaches	0	8	○
Sickness Absence %	3.65	4.46	○
Mandatory Training %	95	93.6	○
Annual Appraisal %	95	84.7	○
Staff Turnover %	10	10.69	○

Effective

Indicator	Targe	Act.	Alert
* ED 4 Hour Wait %	95	83.1	○
* 18 Week RTT %	92	87.0	○
* 6 week Diagnostic Wait %	99	94.9	○
* Cancer Treatment 62 Day %	85	76.0	○
Bed Occupancy %	85	95.9	○
I&E Variance (including PSF)	Plan	+£2,588k	○
Forecast Position/ Run Rate	Plan	+£8.4m	○
CRS In Year	Plan	-£470k	○
Contract Income	Plan	-£1,350k	○
Variable Pay	Less YOY	-£291K	○
Total agency spend £m	£4.8 EOY	£2.5m YTD	○
Total agency shifts over cap rate	Less YOY	-264	○

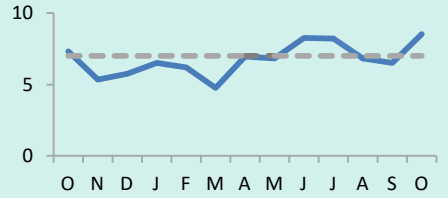
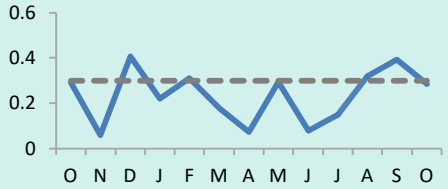
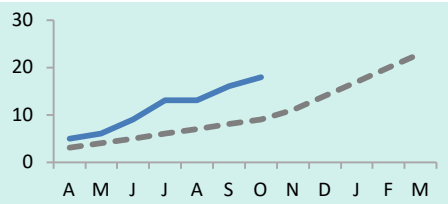
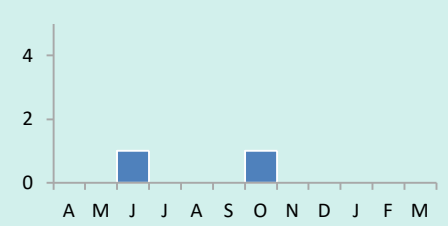
*** Key NHS constitutional target**

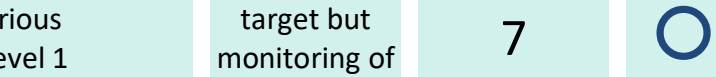
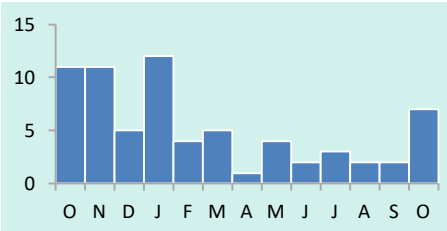
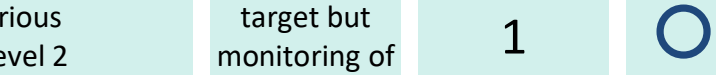
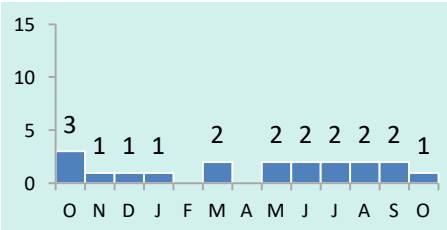
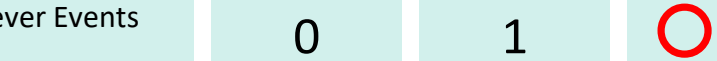
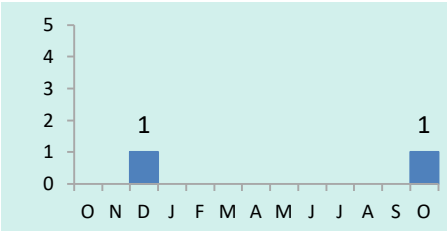
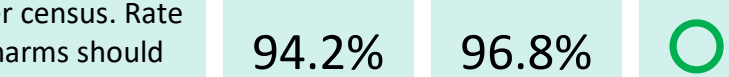
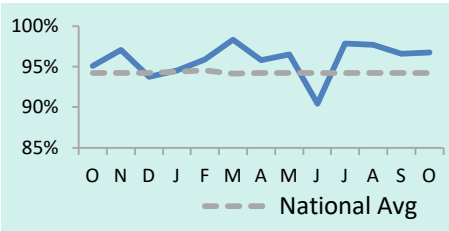
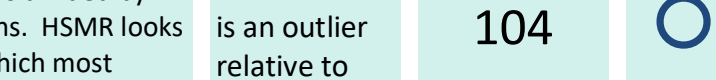
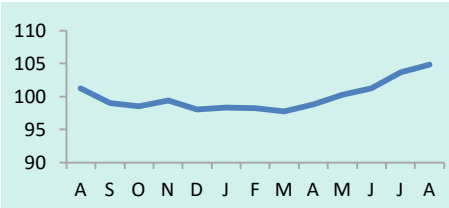
Key ○ Target consistently achieved ○ Performance below target during previous 3 months ○ Target not achieved over previous 3 months

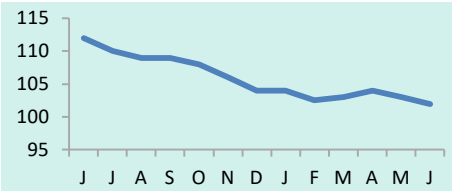
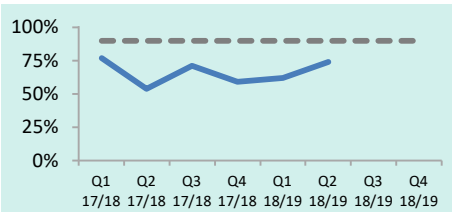
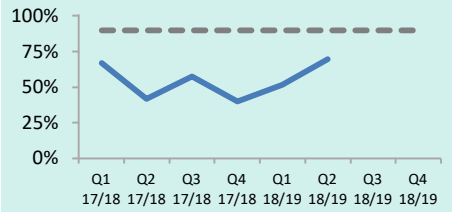
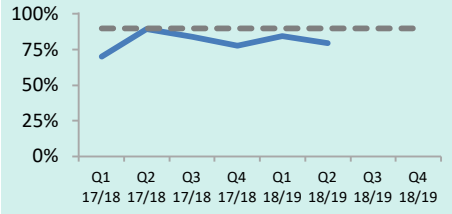
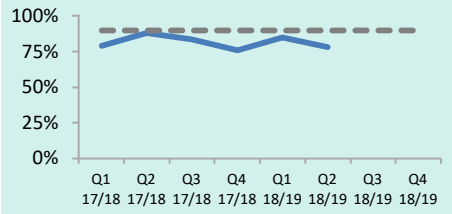
SAFE

Reducing patient harms

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

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Harms: All Falls Rate	Rate of all falls per 1000 bed days	7	8.54	○	Performance is WORSE than last month.	
Harms: Falls with Harm Rate	Rate of falls with harm per 1000 bed days	0.3	0.28	○	Performance is BETTER than last month.	
Harms: Infection Control – Rate of C. Difficile	Cases of hospital acquired C. Difficile bacteraemia.	23 cases (2018/19)	18 cases (YTD)	○	Performance is BETTER than last month. 2 new cases identified in October. We are 9 cases above trajectory YTD.	
Harms: Infection Control – Rate of MRSA	Cases of hospital acquired MRSA bacteraemia.	0 cases (2018/19)	2 cases (YTD)	○	Performance is WORSE than last month. One new case of MRSA reported in October. One case reported previously in June.	

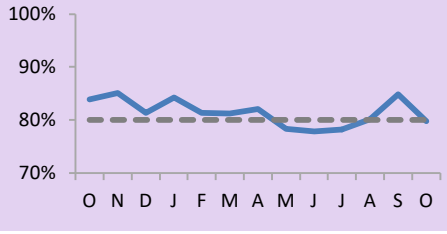
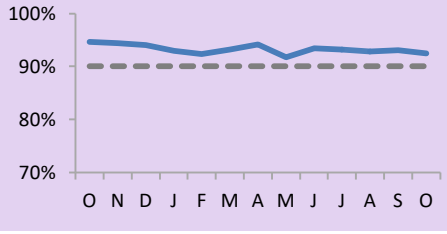
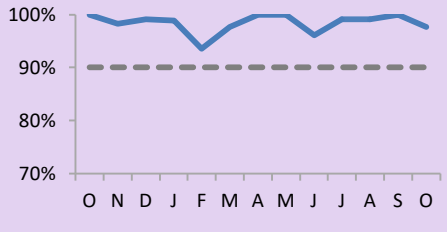
Measure	Definition	Threshold	Actual	Status	Comment	Graph
Harms: Serious Incidents - Level 1	Number of Serious Incidents at Level 1	No specific target but monitoring of trends	7		Performance is WORSE. SI Panel commissioned seven level 1 serious incidents reviews in October.	
Harms: Serious Incidents - Level 2	Number of Serious Incidents at Level 2	No specific target but monitoring of trends	1		Performance is BETTER. SI Panel commissioned one level 2 incident review in October.	
Harms: Serious Incidents - Never Events	Number of Never Events reported	0	1		Performance is WORSE. One never event was reported in October. This was a wrong site-block in main theatre. A full investigation is underway.	
Harms: Safety Thermometer	Based on monthly Safety Thermometer census. Rate free of new harms should be higher than national average	94.2%	96.8%		Performance is BETTER and remains above the national average.	
Learning from Deaths: Hospital Standard Mortality Rate (HSMR)	Ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death	Alert is red when HSMR is an outlier relative to other Trusts.	104		Performance is WORSE. This measure is based on diagnosis groups that account for approximately 80% of inpatients.	

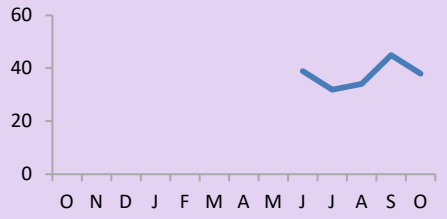
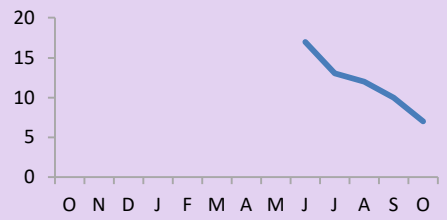
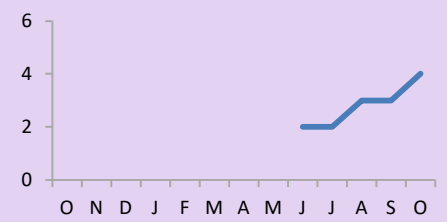
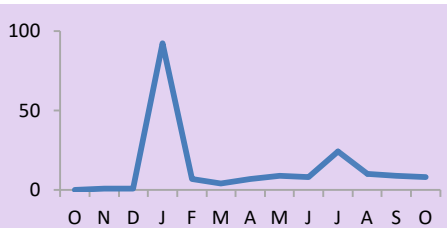
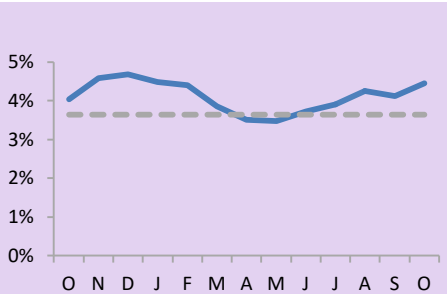
Measure	Definition	Threshold	Actual	Status	Comment	Graph
Learning from Deaths: Standardised Hospital Mortality Index (SHMI)	Risk adjusted mortality ratio based on number of expected deaths. National published figure from HSCIC.	Alert is red when SHMI is an outlier relative to other Trusts.	102		Performance is WORSE. This information has been refreshed nationally up to July.	
CQUIN: Sepsis Screening in ED / Inpatient Settings	Timely identification of sepsis in ED	90%	73.8%		QUARTERLY INDICATOR. Q2 performance for sepsis screening is BETTER than the previous quarter.	
CQUIN: Sepsis Screening in ED / Inpatient Settings	Timely identification of sepsis for inpatients	90%	69.6%		QUARTERLY INDICATOR. Q2 performance for sepsis screening is BETTER than the previous quarter.	
CQUIN: Sepsis Treatment in ED / Inpatient Settings	Timely treatment of sepsis in ED	90%	79.7%		QUARTERLY INDICATOR. Q2 performance for sepsis screening is WORSE than the previous quarter.	
CQUIN: Sepsis Treatment in ED / Inpatient Settings	Timely treatment of sepsis in inpatient settings	90%	78.2%		QUARTERLY INDICATOR. Q2 performance for sepsis screening is WORSE than the previous quarter.	

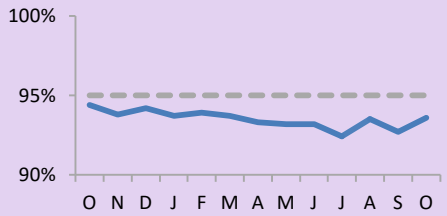
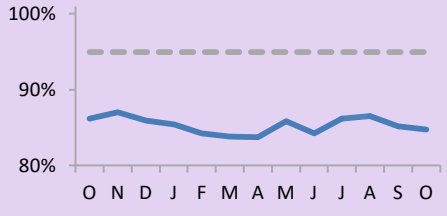
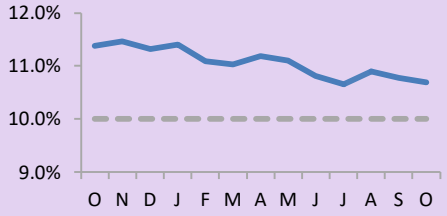
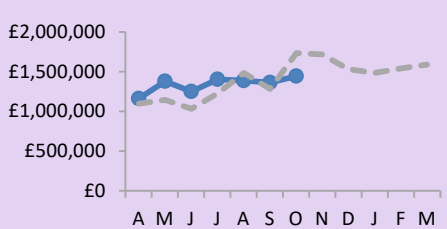
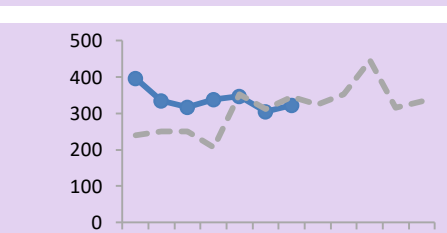
KIND

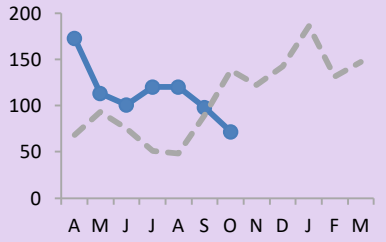
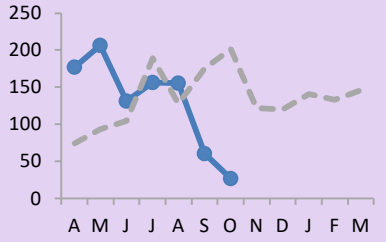
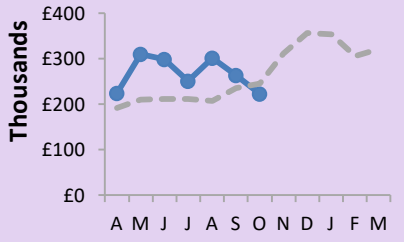
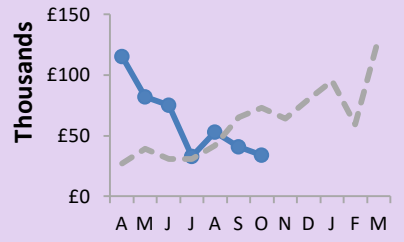
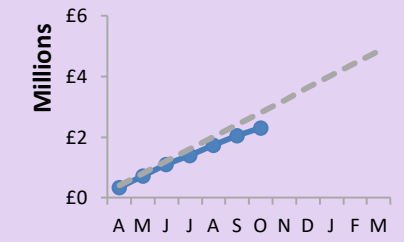
Providing high quality patient care

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

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Friends and Family: % Likely to Recommend A&E	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	80%	79.8%		Performance is WORSE than last month. The patients likely to recommend has reduced to just below target.	
Friends and Family: % Likely to Recommend Inpatient Wards	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	90%	92.5%		Performance remains above target for inpatient stays.	
Friends and Family: % Likely to Recommend Maternity Services	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	90%	97.6%		Performance remains above target for maternity services.	

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Patient Feedback: Number of Open Complaints	Number of open patient complaints at month end.	40	38		Performance is BETTER than last month.	
Patient Feedback: Number of Complaints Past 40 Day Response Time	Number of Complaints Past 40 Day Response Time	5	7		Performance is BETTER than last month.	
Patient Feedback: Number of Complaints Open with PHSO	Number of Complaints being investigated by the PHSO	0	4		Performance is WORSE than last month.	
Mixed Sex Accommodation Breaches	Number of non-clinically justified breaches of the single sex accommodation standard	0	8		Performance is BETTER than last month. 8 breaches in October were not clinically justified.	
Sickness Absence	% monthly sickness absence, excluding comfort zone and Bank staff	3.65%	4.46%		Performance is WORSE than last month. The absence rate increased to 4.46%, above the Trust target of 3.65% and when comparing to local trusts, our absence rate is significantly less. The rate for the same period in 2017, was 4.04% & the rolling 12 month average was 4.14%, against 4.69% regionally (NHS Digital July 2018). Short term absence increased to 2.42%, while long term absence decreased to 2.04%.	

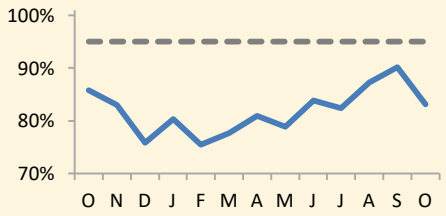
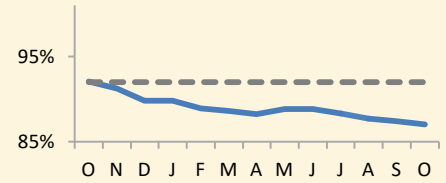
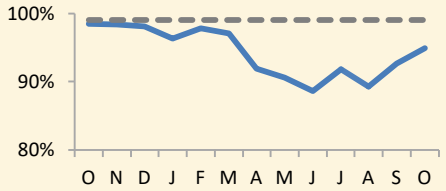
Measure	Definition	Threshold	Actual	Status	Comment	Graph
Mandatory Training Compliance	% mandatory training compliance, excluding comfort zone and Bank staff and staff on maternity/long term sick leave	95%	93.6%		Performance is BETTER than last month. The Trust compliance target increased in October with Mandatory Training standing at 93.6%, still exceeding the CQC target (76%) but 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 95.7% compliance.	
Annual Appraisal Compliance	Exclusions as above and also excludes staff with less than 1 year's service.	95%	84.7%		Performance is WORSE than last month. Compliance with the Appraisal target has slightly decreased in October to 84.7%. This exceeds the CQC target (84%) but feedback from across the Trust is that this is symptomatic with the increased pressures across the Trust. An exception report has been provided.	
Staff Turnover	Based on headcount in the previous 12 months and on permanent staff only.	10%	10.69%		Performance is BETTER than last month The Trust Turnover rate increased in October and remained just above target at 10.69%. This rate is based on a headcount; turnover by FTE also remained above target at 10.50%. An exception report has been provided.	
Variable Pay	Reducing and controlling variable pay spend (including overtime, agency, additional clinical activity)	Year on year reduction	-£291K		Performance is BETTER than last month. Variable pay spend decreased in month £1,443k, this is due in part to revisions to the report. Both agency & locum costs continue to be high with costs of £187k and £310k in month. Extract report is provided, detailing gaps in vacancies along with bank & agency usage.	
M&D Reduction in Agency Shifts over Cap Rates	Reducing agency shifts over cap rates.	Year on year reduction	-24		Performance is BETTER than last month. Month 7 shows a decrease against September in shifts above the cap, with 322 Medical shifts above cap rates.	

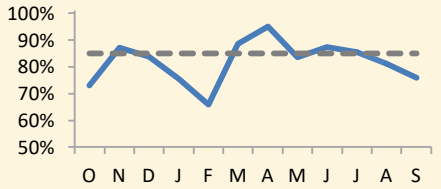
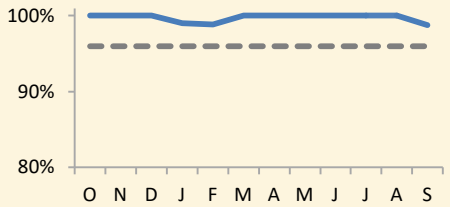
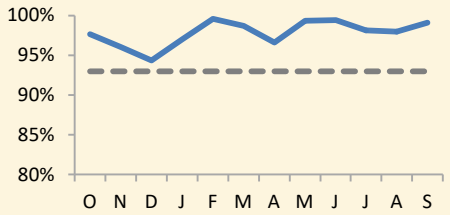
Measure	Definition	Threshold	Actual	Status	Comment	Graph
N&M Reduction in Agency Shifts over Cap Rates	Reducing agency shifts over cap rates.	Year on year reduction	-66		Performance is BETTER than last month. In relation to Nursing shifts, 72 shifts were approved above cap rates.	
'Other' Reduction in Agency Shifts over Cap Rates	'Other' consists of Care Packages, Sonographers, Theatres and CRV Dept.	Year on year reduction	-174		Performance is BETTER than last month. Operating Department Practitioner shifts increased to 27 approved over the cap.	
People: Medical Agency Spend	Planning improvements in productivity and efficiency	Year on year reduction	-£22k		Performance is BETTER than last month. Medical Pay is overspent by £713k. Agency medical expenditure is £1,872k (7% of the total medical spends)	
People: Nursing Agency Spend	Planning improvements in productivity and efficiency	Year on year reduction	-£39k		Performance is BETTER than last month. Nursing Pay is £842k overspent. Agency nursing expenditure is £433k which is 2% of total trained nursing spend.	
People: Total Agency Spend within Budget	Planning improvements in productivity and efficiency	Total agency spend capped at 4.459 for 18/19	£2.5m YTD		Performance is WORSE. Total Agency spend for M1-7 is £2,532k. (£2,148k was spent during the same period last year). A straight line forecast is just below the agency ceiling.	

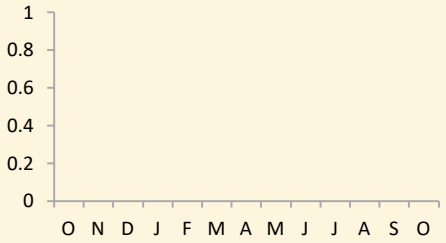
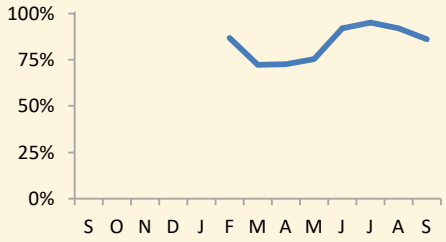
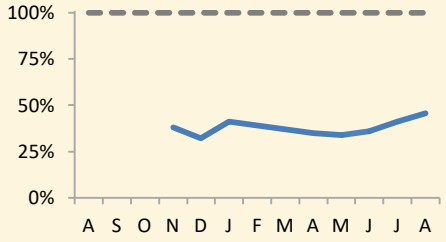
EFFECTIVE

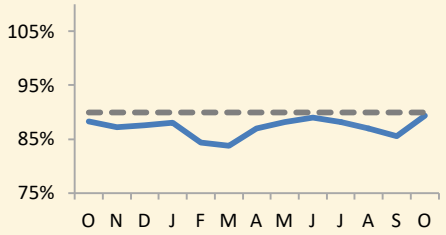
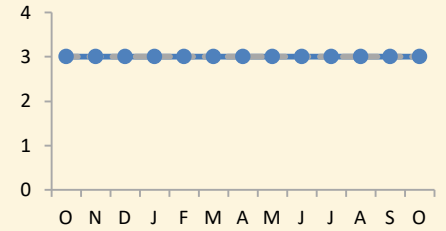
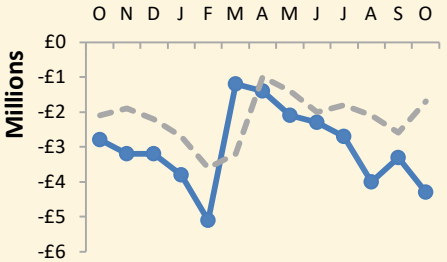
Minimising delay and improving processes

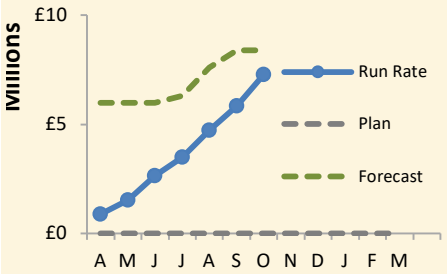
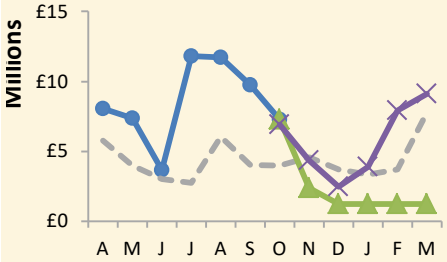
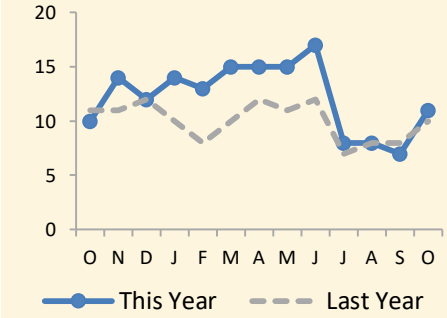
Supporting the Board Assurance Framework:
CR3, CR5, CR6, CR7, CR8, CR9, CR10

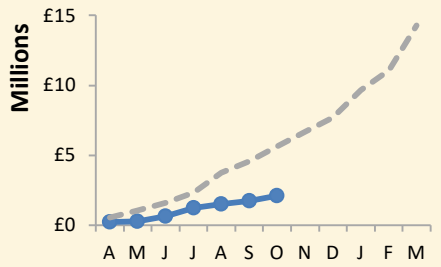
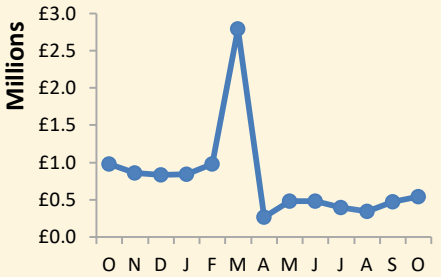
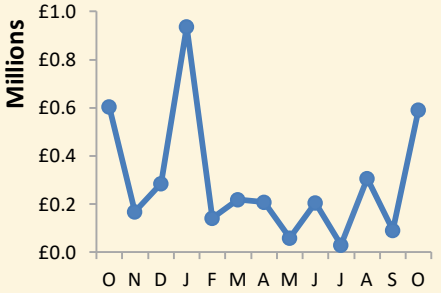
Measure	Definition	Threshold	Actual	Status	Comment	Graph
ED 4 Hour Wait Standard	% A&E attenders seen within 4 hours of arrival	95%	83.1%	O	Performance is WORSE than last month. Nationally, 89.0% of patients were seen within 4 hours of arrival in October. An exception report is provided.	
18 Weeks RTT incomplete pathways	Percentage of incomplete pathways for English patients within 18 weeks.	92%	87.0%	O	Performance is WORSE. The RTT incomplete percentage fell to 87.0% in October. The latest national figure for this indicator is 86.7% (September 2018). An exception report is provided.	
Diagnostic Tests within 6 Weeks (DM01)	Diagnostic tests carried out within 6 weeks of request being received.	99%	94.9%	O	Performance is BETTER than last month. There has been a 2.2% improvement. The latest national figure for this indicator is 97.1% (June 2018).	

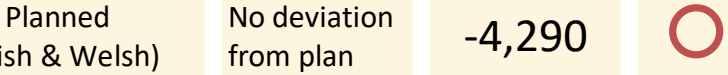
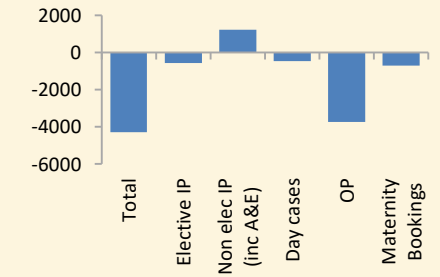
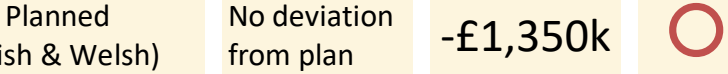
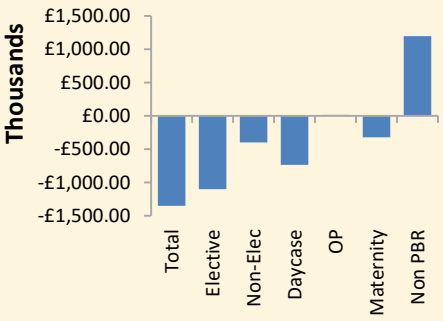
Measure	Definition	Threshold	Actual	Status	Comment	Graph
Cancer Treatments: 62 Day Standard	First treatment for cancer within 62 days of urgent referral through GP 2 week referral route.	85%	76.0%		Performance is WORSE than last month. The latest national figure for this indicator is 79.4% (August 2018).	
Cancer Treatments: 31 Day Standard	Patients receiving first definitive treatment within 1 month of cancer diagnosis.	96%	98.8%		Performance is WORSE than last month. However this measure continues to achieve target.	
Cancer Treatments: 14 Day Standard	Patients referred from GP with suspected cancer should have their first appointment within 14 days	93%	99.06%		Performance is BETTER than last month. This measure continues to achieve target.	

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Number of Urgent Operations Cancelled on Day	Urgent operations cancelled on the day of the procedure	0	0		Performance is UNCHANGED.	
% Cancelled Operations Rebooked within 28 Days	Patients given a TCI date that is within 28 days of a procedure cancelled on the day.	100%	86%		Performance is WORSE than last month. This indicator is reported a month in arrears to ensure all patients offered rescheduled procedures within 28 days are included. This indicator is reported one month in arrears.	
Clinical Correspondence: OP Letters within 7 days	100% of outpatient letters to be sent within 7 days.	100%	45.7%		Performance is BETTER than last month. Overall performance is 45.7% but approximately 70% of urgent letters were sent within timescale. This indicator is reported two months in arrears.	

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Clinical Correspondence: E-Discharge within 24 Hours	Percentage of clinical discharge letters that were sent within 24 hours	90%	89.4%		Performance is BETTER than last month. An exception report has been created for this indicator.	
Use of Resources	NHS Improvements measure of financial risk	A score of 3 each month (restated)	3		Performance is UNCHANGED. The Trust is currently at a level 4 for Capital Service Capacity, liquidity 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.	
I&E Plan Variance	Variance to plan	No deviation from plan	£2,588k overspend		As at the end of October18, we are reporting a £2,588k overspend against plan. Notable pressures include £984k lost A&E PSF m1-7, lost Finance PSF £511k m7 and (£105k) in relation donated asset transactions, culminating in a reported net adverse position of £1,198k. £3,918k non recurrent support has been required to deliver this position.	

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Run Rate	Run Rate is I&E Variance adjusted for non-recurrent items and CRS profile. Forecast is then derived from run rate and known mitigation.	No deviation from plan	+£8.4m		Performance is UNCHANGED. The underlying run rate at the end of October is £7,287k after adjusting for non-recurrent benefit of £3,293k within the position and adjusting the profile to smooth the impact of a back loaded CRS target of £2,796k. This figure is then utilised to provide the forecast after applying known mitigation.	
Cash	Cash on deposit <3 month deposit	No deviation from plan	+£3.3m		Performance is WORSE than last month. The closing cash balance at the end of October is £7.3m, £3.3m ahead of plan. Our forecast has now been revised to reflect the out-turn deficit and we will shortly be applying for interim revenue funding for the December 2018. A revised capital plan has been submitted for the loan application, and we are waiting to hear the outcome.	
Debtor Days	Debtor Days: Trade Debtors divides by income x 365	No target has been set for this indicator	11		Performance is WORSE than last month. Debtor days have fallen slightly to 11 days, due primarily to late payment of contract invoices and quarterly SLA billing. Local Authority DTOCs invoices remain unpaid. The on-going dispute with NHS Property Services has been resolved, which should mean that our reciprocal debtor position will be reduced once payment of the agreed rent is made.	

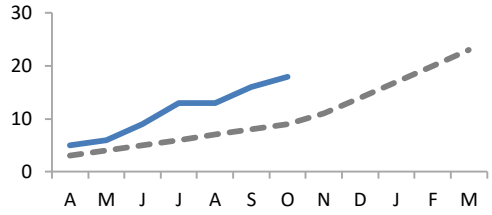
Measure	Definition	Threshold	Actual	Status	Comment	Graph
Capital Expenditure	Capital expenditure performance against plan / forecast out-turn	No deviation from plan	-£3.5m		Performance is BETTER than last month. YTD capital expenditure of £2.1m is under the original plan by £3.5m . The forecast outturn has been revised to reflect anticipated slippage due to the late approval of the loan and external delays in the Cerner project. The Trust's capital loan has been approved by NHSI and is with DHSC for review. The Trust has been awarded £2m PDC to improve the A&E.	
CRS in year	Planning improvements in productivity and efficiency	No deviation from plan	-£470k		Performance is WORSE than last month. The CRS plan for 2018/19 is £10.7m. The CRS programme is £470k behind the profiled plan as at October 18. In year 33% of the target has been delivered with 7% in Green or Amber schemes and 60% in Red or Black (unidentified) schemes. The back loading of the CRS target affects the profile target to date by £2,796k, if the target was profiled evenly CRS would be £3,266k behind plan	
CRS recurrently	Planning improvements in productivity and efficiency	No deviation from plan	14% identified		Performance is BETTER than last month. Recurrently 14% of the £10.7m target has been identified with 6% in Green or Amber Schemes and 80% in Red or Black (unidentified) schemes.	

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Contract Performance (Activity)	YTD Contract performance against Trust Planned activity (English & Welsh)	No deviation from plan	-4,290		Performance is BETTER than last month. All points of delivery are showing an under performance against plan YTD with the exception of non-elective (+1,210). This is made up of 1,049 additional ED attendances and 415 additional discharges but is offset by an underperformance on maternity discharges (-253)	
Contract Income	YTD Contract performance against Trust Planned activity (English & Welsh)	No deviation from plan	-£1,350k		Performance is WORSE than last month. Prior to adjustment for the block contract with WCCCG, the September income position is below plan by £2,002k. The block contract adjustment to reflect the underperformance on WCCCG offsets this underperformance by £1,003k resulting in an adverse position on contract income of £999k.	

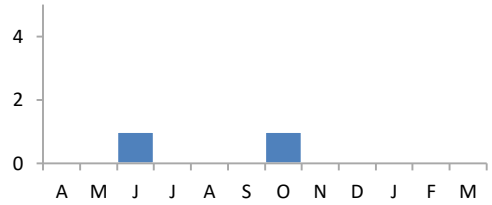
Exception Report

Performance Trend

C Difficile



MRSA



Infection Control

Performance Issue:

C Difficile has been above trajectory for seven successive months. There have also been 2 incidences of MRSA; one during June and one during October.

Planned Remedial Actions:

Investigation within the preceding month identified the following risk factors in the cases of *C.difficile* infection: Prior exposure to antimicrobials and prolonged hospital admissions. The risk reduction strategy continues to include:

- Case by case C. difficile surveillance, with robust feedback methodology including early identification of any increased incidence
- Weekly multidisciplinary C. difficile wards rounds
- Antimicrobial stewardship programme
- Daily Consultant Microbiologist ward rounds within Critical Care
- Taking the opportunity for antimicrobial stewardship ward rounds within other specialities
- Robust infection prevention and control practices, including hand hygiene, rapid patient isolation and environmental/equipment cleaning
- Root cause analysis process for each case of infection, sharing any identified learning from these investigations with clinical teams to support improvement
- Communication systems to support the workforce to remain informed on progress and for the promotion of best practice
- Recent screensavers
- Monthly infection prevention and control message via fortnightly round-up
- 'Ark' trial to support antimicrobial stewardship

MRSA bacteraemia investigation meeting held Monday 29th October 2018, with investigation report in progress at this time. The investigation identified this as an avoidable infection and the learning identified will be shared through established communication routes.

Ownership:

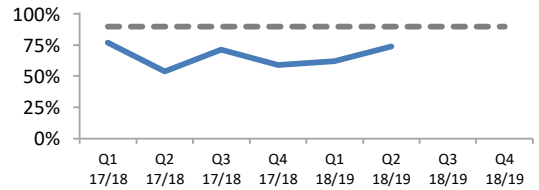
Lead: Samantha Walker, Lead Nurse – Infection Control
Executive Lead: Darren Kilroy, Interim Medical Director
Improvement Timescale: By March 2019

Exception Report

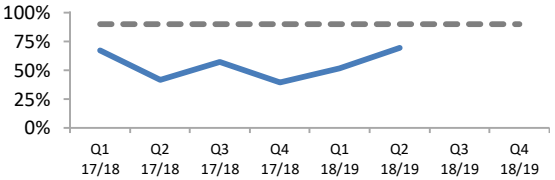
Sepsis screening and treatment CQUIN

Performance Trend

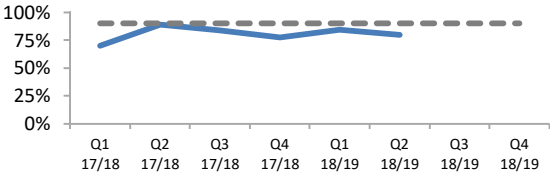
Sepsis screening (ED Patients)



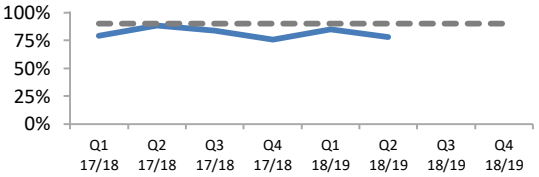
Sepsis screening (Inpatients)



Sepsis treatment (ED)



Sepsis treatment (Inpatients)



Performance Issue:

The Sepsis CQUIN screening improved again in Quarter 2 for both Inpatients and ED, but was still below the year-end target. Treatment of Sepsis continues to perform well but also remains slightly below the year-end target.

Planned Remedial Actions:

The sepsis steering group has been re-established with wider clinical membership and the work programme continues to be progressed. Key achievements during Q2 include, implementation of NEWs2 (track and trigger) and the launch of the Sepsis Trust standardised pathway in the identified pilot wards (ward 43, 44, 45, 48 and 49).

Ownership:

Lead: Dr Santokh Singh

Executive Lead: Darren Kilroy, Interim Medical Director

Improvement Objective: Achieve target

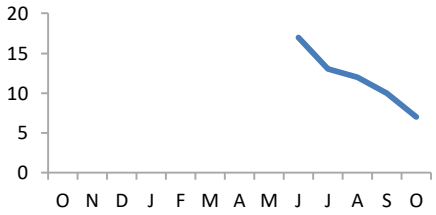
Improvement Timescale: By March 2019

Exception Report

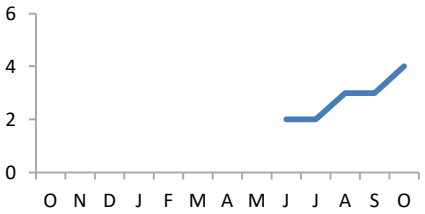
Complaints over 40 days / With PHSO

Performance Trend

Complaints over 40 day old at month end



Number of complaints with PHSO



Performance Issue:

- In October there were 7 complaints that were still open after the 40 day timescale for closure, this position continues to improve month on month
- There were 4 complaints being investigated by the Public Health Service Ombudsman at month end

Planned Remedial Actions:

A small number of complaints exceeded the 40 day target for a number of reasons (e.g. complexity, staff absences, on-going serious incident investigations).

Where it is clear that the 40 day target is unlikely to be met the complainant is informed and the complaint escalated to the relevant Divisional Senior Management Team.

All complainants have a right to escalate a complaint to the Public Health Service Ombudsman if they feel their issue has not been satisfactorily resolved.

Ownership:

Lead: Jonathan Roberts

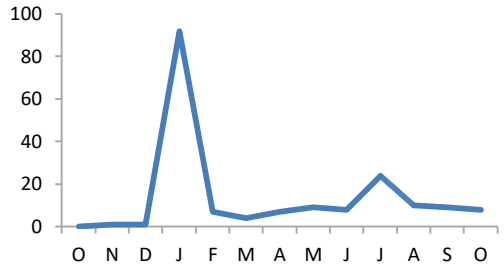
Executive Lead: Alison Kelly, Director of Nursing

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Mixed Sex Accommodation Breaches

Performance Trend



Mixed Sex Breaches

Performance Issue:

- In October there were 8 Mixed Sex breaches that were not clinically justified.

Planned Remedial Actions:

7 of the 8 cases related to delayed step down from CCU to the coronary care ward. Work continues to improve the position and ensure patients are stepped down within 24 hours of the decision being made.

Ownership:

Lead: Melanie Kynaston, Associate Director of Nursing

Executive Lead: Alison Kelly, Director of Nursing

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Sickness Absence

Historic Data

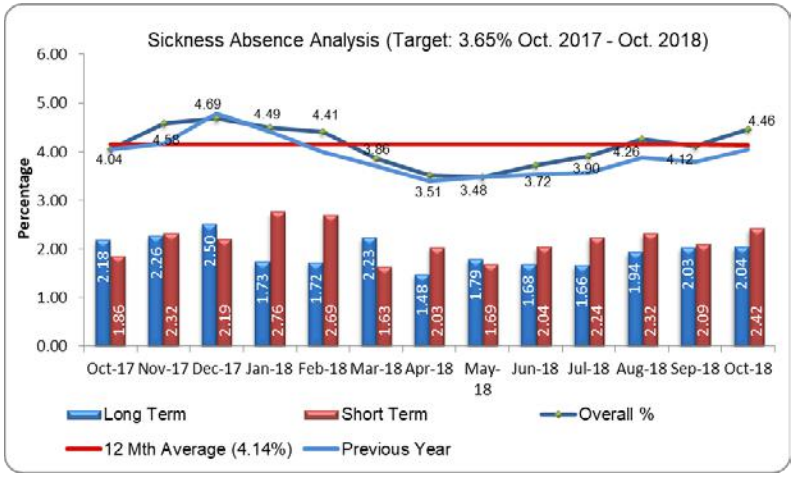


Figure: % mandatory training compliance

Ownership

Lead: Dee Appleton-Cairns, Deputy Director of HR

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

The Trust wide sickness absence increased to 4.46% from last month. This is due to long term sickness stabilising with short term cases increasing to 2.42%. Sickness absence within Staff groups highlights that Nursing & Midwifery is reporting a decrease to 4.18% and Support Workers (which include Nursing Assistants) decreasing for the second month to 4.00%. When analysing divisional sickness absence, Planned Care is slightly up at 4.36%. Absence in Urgent Care has decreased to 4.09%. The Human Resources Division has decreased significantly at 4.93% and Facilities is at 6.32% both due to a small number of long term sick cases which due to their nature are being sensitively managed. There is still a backlog of OH referrals due to an unforeseen strain on the service.

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 for Occupational Health via CWP to provide support during a very busy and stressful time. This continues to cause a cost pressure within Occupational Health and there is still a backlog of OH referrals. The annual flu campaign is now under way with 64% front line staff vaccinated in the first few weeks; this is up on last year. The HR division has put on a schedule of resilience support sessions for staff, the courses teach techniques to cope with stress at home and at work in readiness for the winter period, sign up and feedback has been very good so far. There are plans to take the sessions to front line staff that cannot be released from the ward areas.

Mandatory Training

Performance Trend

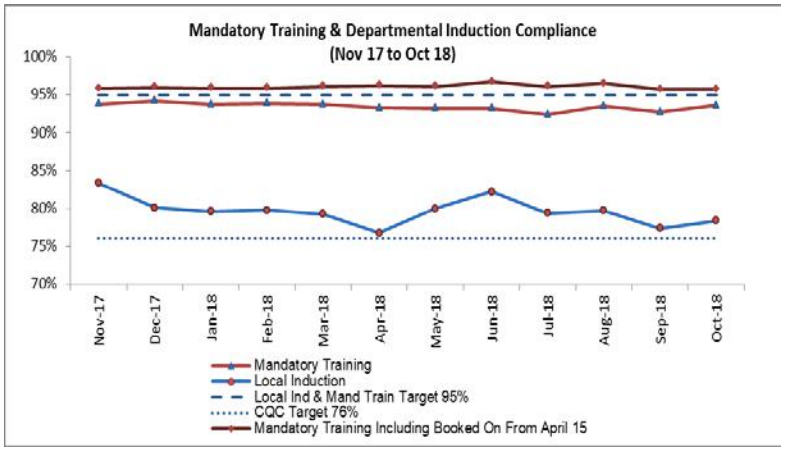


Figure: % mandatory training compliance

Forecast for improvement:

Q1	Q2	Q3	Q4

Ownership

Lead: Dee Appleton-Cairns, Deputy Director of HR

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

Trust compliance remains below target at 93.6%.

Mandatory Training Table October 2018

Position	Division	Compliance
1	Corporate Clinical	100.0%
2	Estates	97.8%
3	Facilities	96.1%
4	HRWBS	95.7%
5	Nurse Management	95.1%
6	Human Resources	94.8%
7	Finance & Performance	94.3%
8	Planned Care	93.5%
9	Diagnostics and Pharmacy	93.4%
10	Urgent Care	92.9%
11	Corporate Non - Clinical	92.3%
	Total	93.6%

Local Induction Table October 2018

Position	Division	Compliance
1	Facilities	100.0%
2	Planned Care	87.9%
3	Urgent Care	82.5%
4	HRWBS	77.8%
5	Estates	75.0%
6	Human Resources	66.7%
7	Diagnostics and Pharmacy	66.7%
8	Finance & Performance	40.0%
9	Corporate Non - Clinical	40.0%
10	Nurse Management	20.0%
11	Corporate Clinical	0.0%
	Total	78.4%

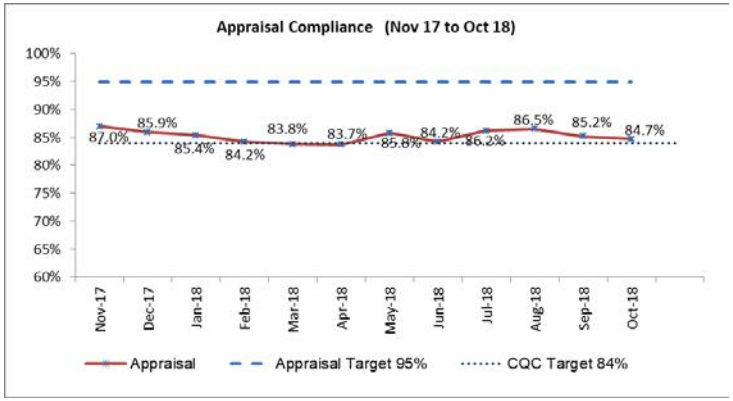
Overall compliance for mandatory training in October is 93.6%, which is an improvement on September's figures but still falls short of the Trust target. Local induction compliance for October is 78.4% which is a small improvement on September's figures but significantly short of the Trust's 95% target. We continue to perform poorly against our own Corporate target of 95%, which we have failed to achieve in the last 12 months reporting period. Mandatory training is currently being reviewed in terms of trust provision with the appointment of Sallie Kelsey our new Head of Clinical Education. It is hoped that by streamlining the provision and encouraging uptake of e-learning this figure can improve in the future.

Planned Remedial Actions:

The TNA for mandatory training is under review to ensure alignment with recent changed in the Core Skills Framework. Where possible there will be a move to all subjects being accessed purely by e-learning and Training and Development Policy is being developed to reflect this. A proposal to report purely on Core Skills Framework Subjects is being developed. Plans to review local induction systems and processes are in place.

Appraisals Completed in last 12 months

Historic Data



Ownership

Lead: Dee Appleton-Cairns, Deputy Director of HR

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

This month has seen a decrease in Appraisal compliance to 84.7%, which is only just above the CQC target standard of 84%, which we have only failed to achieve once in the last 12 months. However performance against our corporate target of 95% remains poor.

Appraisal Table October 2018

Position	Division	Compliance
1	HRWBS	97.1%
2	Estates	95.0%
3	Facilities	91.7%
4	Planned Care	90.3%
5	Nurse Management	88.9%
6	Corporate Non - Clinical	85.7%
7	Diagnostics and Pharmacy	84.6%
8	Urgent Care	78.2%
9	Finance & Performance	73.7%
10	Human Resources	66.7%
11	Corporate Clinical	45.5%
	Total	**84.7%**

Planned Remedial Actions:

The roll out of the "Trust Behavioural Standards" workshops continues to highlight the importance of the appraisal process. HR Business Partners continue to highlight the compliance rate in the monthly divisional reports & at governance boards, stressing the importance of completing appraisals on a timely basis.

Turnover

Performance Trend

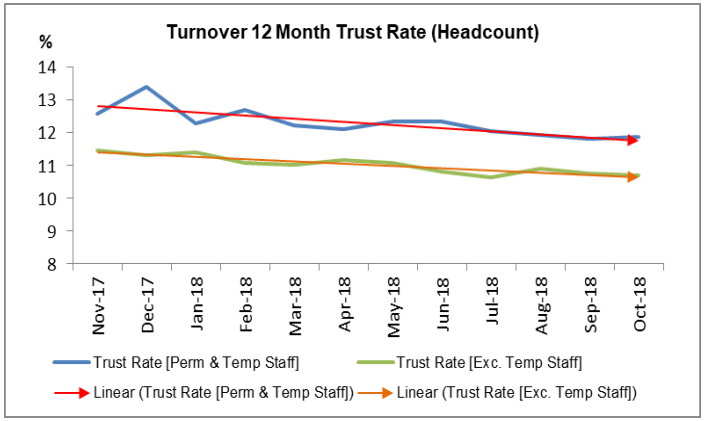


Figure: Based on headcount in the previous 12 months and on permanent staff only.

Forecast for improvement:

Q1	Q2	Q3	Q4

Ownership

Lead: Dee Appleton-Cairns, Deputy Director of HR

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

Turnover is at 10.69% decreasing in month, compared to 10.77% last month. The rate based on FTE is also above target at 10.50%. Staff groups over target are: Additional Clinical Services at 11.69%, represents 106 leavers in the last year, 76 of which were Healthcare Assistants and 4 were Healthcare Support Workers. Allied Health Professionals at 14.01%, represents 36 leavers in the last year. Admin and Clerical increased slightly to 11.52% representing 104 leavers in the last 12 months (5 of which were MARs plus 17 age retirements). Nursing & Midwifery Registered Staff decreased to 11.11% with 19 Midwives, 90 Staff Nurses, 9 Specialist Nurses & 6 Nurse Managers leaving the Trust in the last year. Trends will be continually monitored.

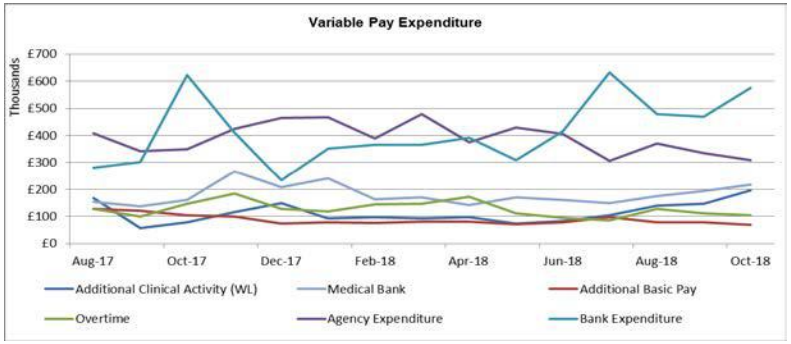
Staff Group - Nov 17 - Oct 18 Excludes Temporary Staff	Turnover %
Add Prof Scientific and Technic	8.66%
Additional Clinical Services	11.69%
Administrative and Clerical	11.52%
Allied Health Professionals	14.01%
Estates and Ancillary	6.78%
Healthcare Scientists	5.76%
Medical and Dental	8.90%
Nursing and Midwifery Registered	11.11%
Trust Totals & Rate	**10.69%**

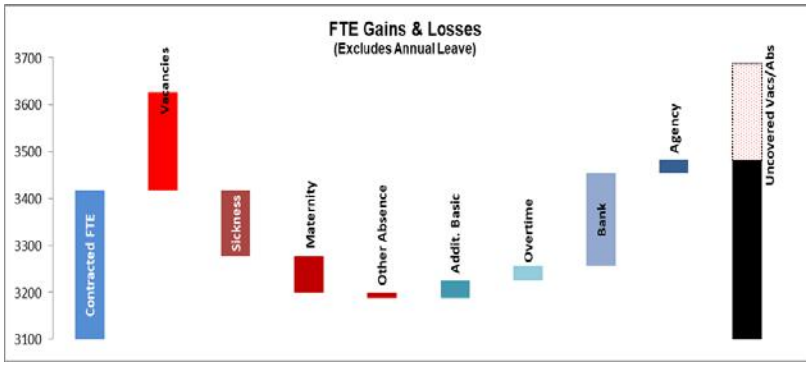
Planned Remedial Actions:

Significant focus is being placed on retention of staff particularly within the nursing, midwifery and medical staff groups, working on identifying area and ways in which we can encourage staff to remain with the trust. It is important to note that the North West average based on headcount is 14.65% (15.26% for Acute Trusts) according to Iview at April 2018.

Variable Pay

Performance Trend





Ownership

Lead: Jane Hayes Green, Project Manager

Executive Lead: Sue Hodkinson

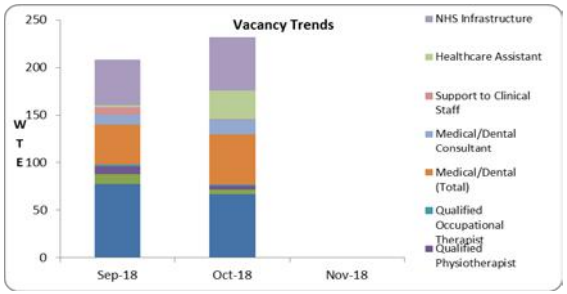
Improvement Objective: Achieve target

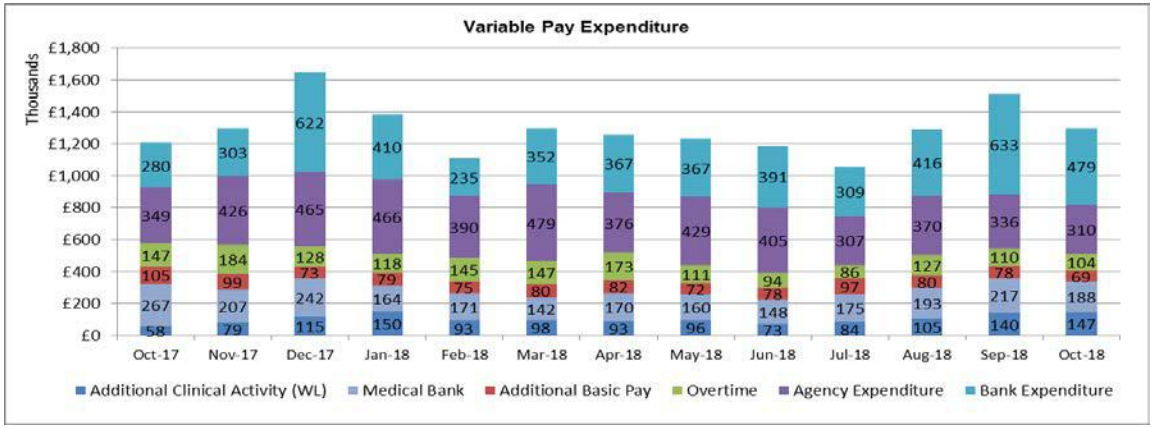
Improvement Timescale: By March 2019

Performance Issue:

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

	WTE		
NHSI Staff Group	Sep-18	Oct-18	Nov-18
Registered Nursing & Midwifery	78	67	
Qualified AHP	10	5	
Qualified Physiotherapist	8	4	
Qualified Occupational Therapist	2	1	
Medical/Dental (Total)	42	53	
Medical/Dental Consultant	10	15	
Support to Clinical Staff	8	1	
Healthcare Assistant	2	30	
NHS Infrastructure	48	56	





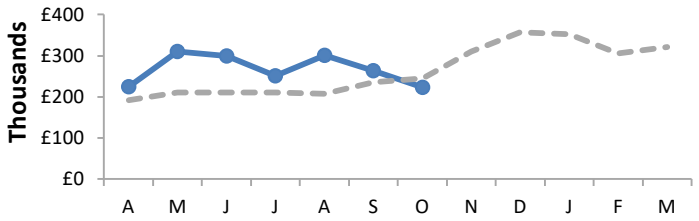
Planned Remedial Actions:

We have changed the way vacancies are calculated & recorded this has resulted in an apparent increase in this figure. It is only a change to recording and does not change our actual vacancy position. This is to bring us in line with other Trusts (discussed at a meeting in Leeds with HEE & NHSI) and uses the difference between the budgeted establishment and actual staff in post as the vacancy position. The biggest increase is in NHS Infrastructure vacancies which include Admin & Clerical, Ancillary, Estates and Security. This has resulted in some categories appearing to have different vacancy numbers e.g. Infrastructure was included under Support to clinical Staff.

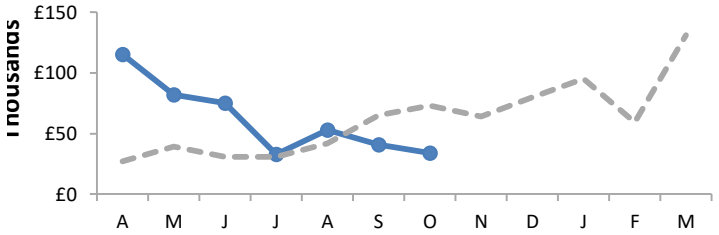
Agency Spend

Performance Trend

Medical Agency Spend



Nursing Agency Spend



Ownership

Lead: Jane Hayes Green, Project Manager

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve Plan

Improvement Timescale: By March 2019

Performance Issue:

Medical Pay is overspent by £713k. Agency medical expenditure is £1,872k (7% of the total medical spend). Nursing Pay is £842k overspent. Agency nursing expenditure is £433k which is 2% of total trained nursing spend. Total Agency spend for M1-7 is £2,532k. (£2,148k was spent during the same period last year). A straight line forecast is just below the agency ceiling.

Contributing Factors:

Agency Spend by Staff Group	14/15	15/16	16/17	17/18	18/19 YTD to Oct	18/19 Annual Straight Line Projection	Projected Yearly Movement
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 85,760	£ 25,952	£ 44,490	-£ 41,270
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433	£ 1,871,753	£ 3,208,719	-£ 59,714
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847	£ 432,800	£ 741,942	-£ 5,905
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820	£ 118,526	£ 203,188	£ 31,368
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009	£ 83,448	£ 143,053	£ 44,044
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 4,372,869**	**£ 2,532,479**	**£ 4,341,392**	**-£ 31,477**
Agency Ceiling 2018/19						£ 4,459,000	

Planned Remedial Actions:

See actions proposed under Variable Pay

Exception Report

A&E 4 Hour Standard

Performance Trend

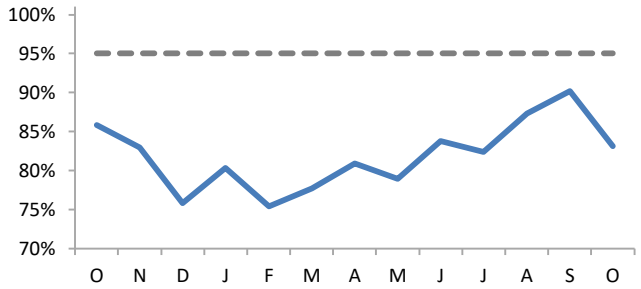


Figure: % ED attenders seen within 4 hours of arrival

Performance Issue:

The 4 hour A&E target was under the National target in October, achieving 83.1%. Nationally, 89.0% of patients were seen within 4 hours of arrival in October.

Planned Remedial Actions:

The Trust ran a perfect week w/c 22nd October and saw 3 days at over 90%, this was achieved through the support of the senior management and nursing team and engagement with various parties from across the organisation with a focus on patient flow including morning discharges, utilising Teletracking , discharge lounge and timely flow from ED.

High levels of bed occupancy means a surge on demand particularly out of hours and increased utilisation of assessment areas for both planned and urgent care, which has an adverse impact the following day in terms of functionality to meet the days non elective and elective demand.

The division continue to focus on zero length of stay non-elective admissions, and managing all delays patients to maintain an optimum length of stay and flow through the organisation.

Ownership:

Executive Lead: Lorraine Burnett, Chief Operating Officer

Improvement Objective: Return to national standard

(internal trajectory is to return to 90% compliance)

Improvement Timescale: By March 2019

Exception Report

Referral to treatment (18 weeks)

Performance Trend

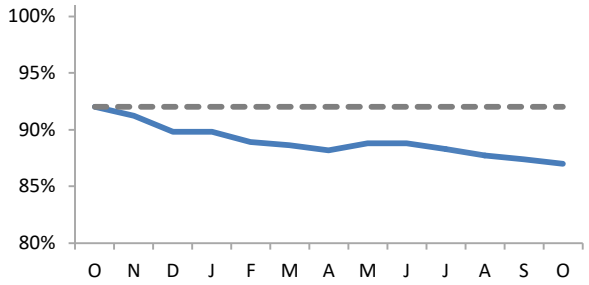


Figure: Percentage of incomplete pathways for English patients within 18 weeks.

Ownership

Lead: Divisional Directors

Executive Lead: Lorraine Burnett, Chief Operating Officer

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue: RTT performance remains under the 92% target at 87.0%.

Contributing Factors:

The majority of specialties with RTT issues are predominantly workforce related. In the areas where we have now recruited (General Surgery & T&O) the position has improved. This coupled with increase in demand, especially Cancer & Urgent has meant that the RTT position has deteriorated to accommodate our most clinically urgent patients. The Elective Short Stay Unit will be operational from 10th December, giving more capacity in the system. In October our worst performing specialties are Urology (80.8%), Oral Surgery (80.5%), ENT (81.7%) and General Surgery (83.3% - including vascular surgery)

Planned Remedial Actions:

Urology – The Improvement efficiencies group is starting again in December. Additional clinical staff are being sourced to deliver additional activity to improve performance but this is off-set with long term sick leave both in the unit and extended planned leave in the Consultant team. The Consultant team have piloted a fast track telephone triage clinic, this was successful and will be rolled out upon completion of nursing recruitment which is likely to be around Feb 2019.
Oral Surgery - Workforce gaps, sickness and exclusions have led to a reduction in capacity. There has also been an increase in cancer referrals which has impacted capacity therefore there are plans underway to recoup some of this lost capacity through additional activity sessions, converting clinic capacity into theatre sessions
ENT – Junior doctor recruitment has been an issue which has meant routine outpatient activity has declined due to a vacant registrar post. Locum Consultant leaves 23rd Nov and out to advert. Advert also to go back out for permanent consultant post. Due to issues with nursing staff we have been unable to run extra clinics until now. Additional weekend clinics have been set up at the end of November into December to start clearing backlog.
General Surgery – Upper GI Consultant started 1st Oct, and a second post will be out for advert shortly following Royal College approval. This addition to the CSOW rota means fewer sessions require backfilling. Additional sessions continue to be provided to meet the increase in demand.
Vascular –All Lymphedema and Renal Access patients have been validated and removed from the PTL which has improved the RTT position. We will continue to see patient pathways at 52+ weeks until March 2019. We continue to try and realign capacity to meet demand, but clinic room space at spoke sites is causing some difficulties, as is the allocation of Vascular trained nurses in Outpatients. Meetings are taking place at spoke sites to address these issues. COCH performance slightly down, but will improve once the Band 5 ASM is in place, and micromanagement of PTL recommences.

Exception Report

Cancer Treatment - 62 Day Target

Performance Trend:

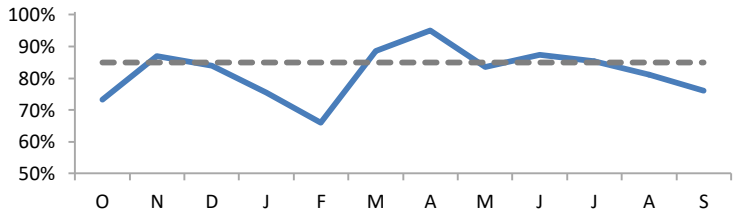


Figure: Cancer 62 Day Target 85%

	Before Day 38	After Day 38	% of Total Transfers - After Day 38
Urology	8	22	43%
Lower GI	2	7	14%
Lung	13	7	14%
Upper GI	6	5	10%
Gynaecology	8	4	8%
Head & Neck	1	4	8%
Breast	7	1	2%
Haematology	0	1	2%
Other/Sarcoma	2	0	0%
Skin	0	0	0%
TOTAL	**47**	**51**	**100%**

Table: % of Transfers to Tertiary Centre by speciality (Treatment Commenced) (April-September)

Performance Issue:

The 62 day performance for September was an underachievement of the standard – 76.0%. The number of patients above 62 days continues to remain high for patients on a 62 day pathway. The Trust continues to experience patients being transferred late to tertiary centres.

Contributing Factors:

There were 14 breaches in September (12 attributable to COCH).
Contributing factors were:

- Hospital cancellation of TCI
- Cancellation of diagnostic tests/TCI due to patient choice
- Capacity issues affecting Radiology diagnostics
- Late referral to tertiary centres
- Doctor vacancies/lack of capacity

Planned Remedial Actions:

- Review of Urology pathway with IST planned for this month.
- Urology Efficiencies group commenced with Cancer as work stream. Positive results from pilot telephone triage clinics – aim to commence when vacant posts recruited too.
- UGI pathway changed finalising operational pathway between COCH and Liverpool.
- Endoscopy – current capacity pressures are being addressed with extra lists at weekends, which are continuing until mid-December.
- Specific action plans for tumour sites to address and resolve issues and optimise pathways in line with regional or local agreements.

Ownership:

Executive Lead: Lorraine Burnett, Chief Operating Officer
Improvement Objective: Achieve target
Improvement Timescale: By March 2019

Diagnostic Tests within Timescale

Performance Trend

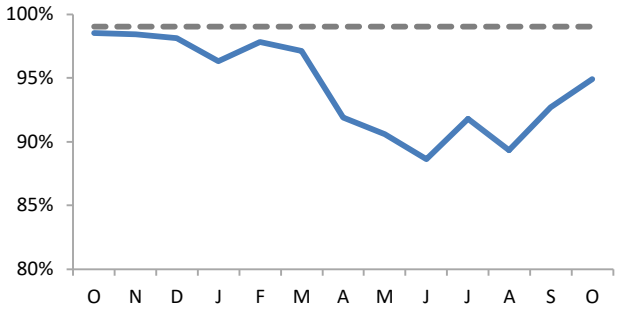


Figure: DM01 - Diagnostic tests carried out within 6 weeks of request being received.

Ownership

Lead: Divisional Directors

Executive Lead: Lorraine Burnett, Chief Operating Officer

Improvement Objective: Achieve target

Improvement Timescale: October 2018

Performance Issue:

DM01 performance has improved by 2.2% in October but remains below the 99% target.

Planned Remedial Actions:

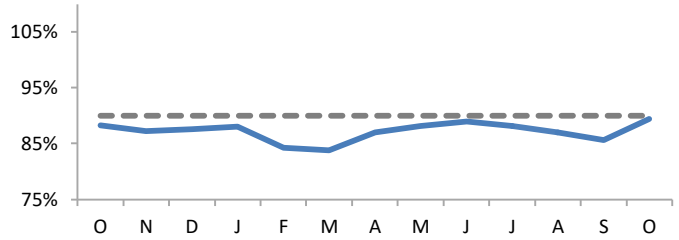
Endoscopy - Overall Endoscopy performance is improving. This is being addressed via extra weekend lists with insourcing company (MHS – Managed Health Care Services) which are running throughout October to mid-December. All cancer and long-waiting RTT patients are currently being prioritised and will continue to be. Every session is being backfilled internally where possible and we saw another improvement in the DM01 result across OGD, colon and flexi-sig procedures in the last month with an improvement expected for cystoscopy also in November.

English - Number of exams >6 weeks

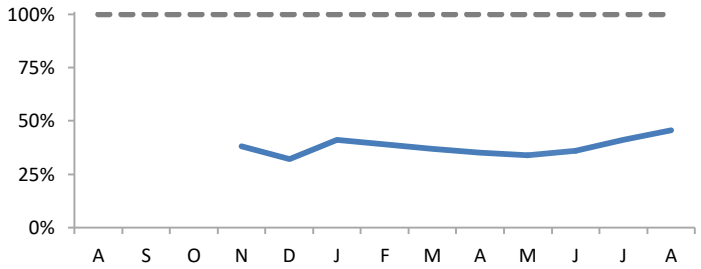
Month End Snapshot	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Magnetic Resonance Imaging			5	5	2	10	12	5	9				
Computed Tomography	1		1	4						1			
Non-obstetric ultrasound	3	5	7	13	6	51	177	207	247	165	120	124	80
CRV - Vascular	19	10	13	56	29	14	2	14	5	12	70	30	8
Audiology - Audiology Assessments													
Cardiology - echocardiography	3	7	5	10			2			7	72	1	1
Respiratory physiology - sleep studies		1	2	2	5	3	3	3	2	3	1		
Colonoscopy	6	8	8	20	14	19	77	141	192	87	79	64	39
Flexi sigmoidoscopy		2	9	3	1	8	3	5	2	1	12	15	34
Cystoscopy	14	14	16	12	17	18	22	49	59	67	120	69	60
Gastroscopy	12	20	18	54	19	12	74	114	100	72	41	43	34
Total patients waiting	3872	4215	4399	4799	4228	4623	4578	5738	5382	5073	4822	4758	5001
%<6 weeks	98.5%	98.4%	98.1%	96.3%	97.8%	97.1%	91.9%	90.6%	88.6%	91.8%	89.3%	92.7%	94.9%

Exception Report

Performance Trend



% e-discharge letters sent within 24 hours



% Outpatient letters sent within 7 days

Clinical Correspondence

Performance Issue:

Neither of the clinical correspondence targets were achieved in October.

Contributing Factors:

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

Planned Remedial Actions:

eDischarge - actions are 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 working group met in October to discuss a breakdown of letters produced by specialties and an analysis of outpatient letter performance by urgency/routine. Both routine and urgent appointments have seen an improvement in performance since June and approximately 70% of urgent letters are now being sent within timescale.

Ownership:

Executive Lead: Darren Kilroy, Interim Medical Director

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

COUNTESS OF CHESTER

PERFORMANCE REPORT, NOVEMBER 2018

Safe

Indicator	Target	Act.	Alert
All Falls Rate	7	7.43	○
Falls with Harm Rate	0.3	0.14	○
Never Events	0	0	○
Safety Thermometer – Free of new harms %	95	95.9%	○
Q2 Sepsis screening % (Inpatients)	90	69.6	○
Q2 Sepsis treatment % (Inpatients)	90	78.2	○
Q2 Sepsis screening % (ED)	90	73.8	○
Q2 Sepsis treatment % (ED)	90	79.7	○
Infection Control: C Difficile	11 YTD	19 YTD	○
Infection Control: MRSA	0	3 YTD	○

Kind

Indicator	Target	Act.	Alert
Friends and Family: A&E	80	82.0	○
Friends and Family: Inpatient Wards	90	93.9	○
Friends and Family: Maternity Services	90	100.0	○
Open Complaints	40	28	○
Open Complaints > 40 days response time	0	4	○
Open PHSO Complaints	0	4	○
MSA Breaches	0	6	○
Sickness Absence %	3.65	4.39	○
Mandatory Training %	95	94.0	○
Annual Appraisal %	95	85.5	○
Staff Turnover %	10	10.58	○

Effective

Indicator	Targe	Act.	Alert
* ED 4 Hour Wait %	95	84.6	○
* 18 Week RTT %	92	86.5	○
* 6 week Diagnostic Wait %	99	96.5	○
* Cancer Treatment 62 Day %	85	83.5	○
Bed Occupancy %	85	95.7	○
I&E Variance (including PSF)	Plan	+£3,742k	○
Forecast Position/ Run Rate	Plan	+£8.4m	○
CRS In Year	Plan	-£741k	○
Contract Income	Plan	-1,013k	○
Variable Pay	Less YOY	-£204K	○
Total agency spend £m	£4.8 EOY	£2.9m YTD	○
Total agency shifts over cap rate	Less YOY	-187	○

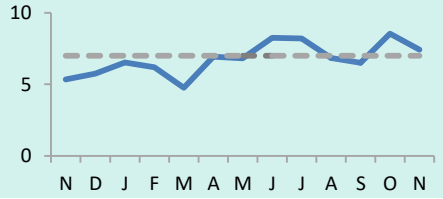
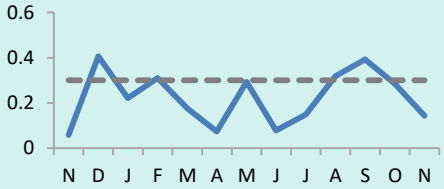
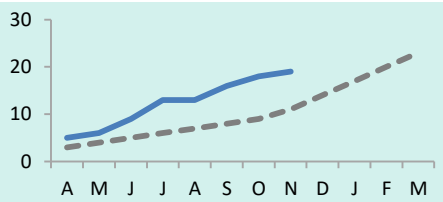
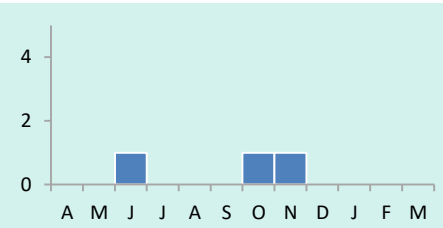
*** Key NHS constitutional target**

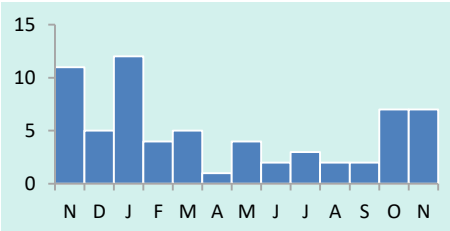
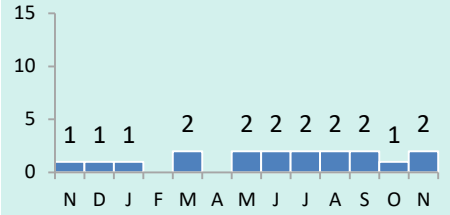
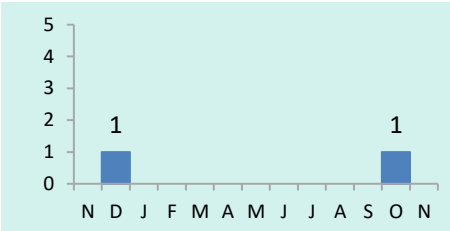
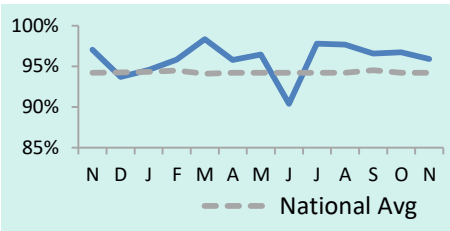
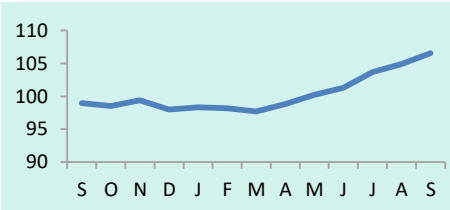
Key ○ Target consistently achieved ○ Performance below target during previous 3 months ○ Target not achieved over previous 3 months

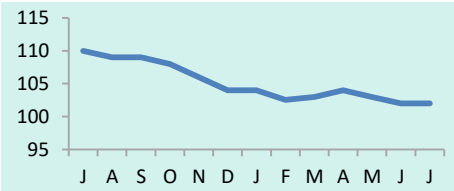
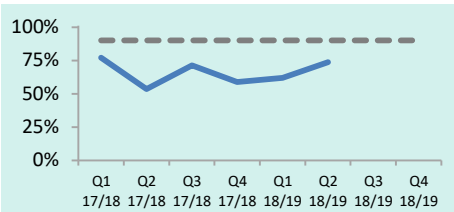
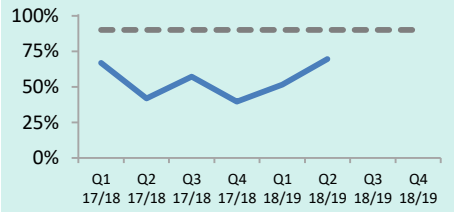
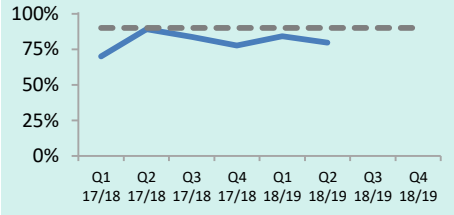
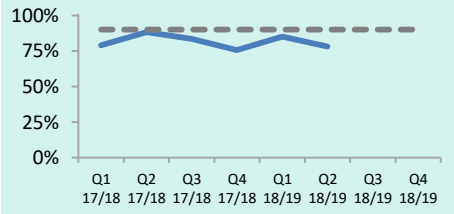
SAFE

Reducing patient harms

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

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Harms: All Falls Rate	Rate of all falls per 1000 bed days	7	7.43	○	Performance is BETTER than last month.	
Harms: Falls with Harm Rate	Rate of falls with harm per 1000 bed days	0.3	0.14	○	Performance is BETTER than last month.	
Harms: Infection Control – Rate of C. Difficile	Cases of hospital acquired C. Difficile bacteraemia.	23 cases (2018/19)	19 cases (YTD)	○	Performance is BETTER than last month. 1 new case identified in November. We are 8 cases above trajectory YTD.	
Harms: Infection Control – Rate of MRSA	Cases of hospital acquired MRSA bacteraemia.	0 cases (2018/19)	3 cases (YTD)	○	Performance is WORSE than last month. One new case of MRSA reported in November.	

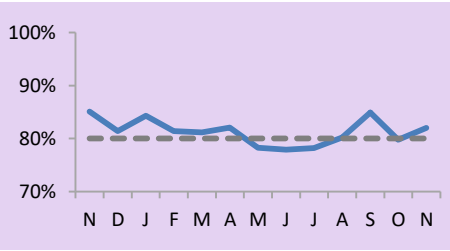
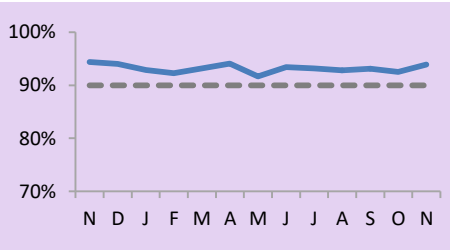
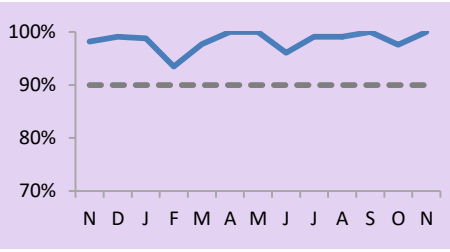
Measure	Definition	Threshold	Actual	Status	Comment	Graph
Harms: Serious Incidents - Level 1	Number of Serious Incidents at Level 1	No specific target but monitoring of trends	7		Performance is BETTER than last month. SI Panel commissioned five level 1 serious incident reviews in November.	
Harms: Serious Incidents - Level 2	Number of Serious Incidents at Level 2	No specific target but monitoring of trends	2		Performance is BETTER than last month.	
Harms: Serious Incidents - Never Events	Number of Never Events reported	0	0		Performance is BETTER than last month. No Never Events reported in November.	
Harms: Safety Thermometer	Based on monthly Safety Thermometer census. Rate free of new harms should be higher than national average	94.2%	95.91%		Performance is WORSE than last month but remains above the national average.	
Learning from Deaths: Hospital Standard Mortality Rate (HSMR)	Ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death	Alert is red when HSMR is an outlier relative to other Trusts.	107		Performance is WORSE. This measure is based on diagnosis groups that account for approximately 80% of inpatients.	

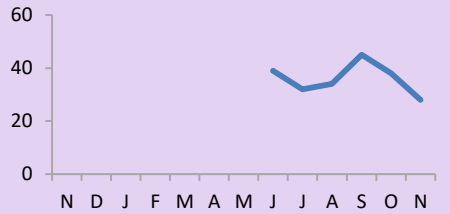
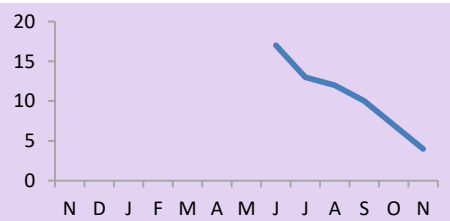
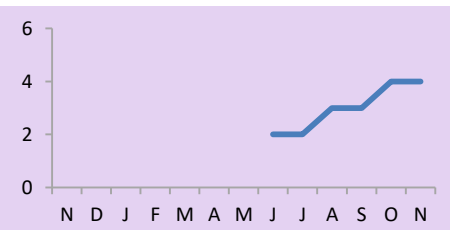
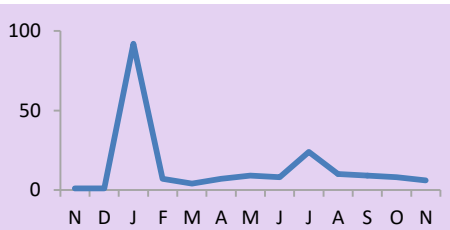
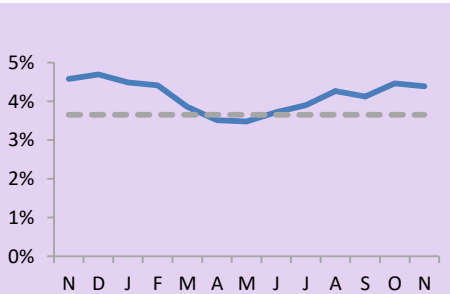
Measure	Definition	Threshold	Actual	Status	Comment	Graph
Learning from Deaths: Standardised Hospital Mortality Index (SHMI)	Risk adjusted mortality ratio based on number of expected deaths. National published figure from HSCIC.	Alert is red when SHMI is an outlier relative to other Trusts.	102		Performance is WORSE. This information has been refreshed nationally up to July.	
CQUIN: Sepsis Screening in ED / Inpatient Settings	Timely identification of sepsis in ED	90%	73.8%		QUARTERLY INDICATOR. Q2 performance for sepsis screening is BETTER than the previous quarter.	
CQUIN: Sepsis Screening in ED / Inpatient Settings	Timely identification of sepsis for inpatients	90%	69.6%		QUARTERLY INDICATOR. Q2 performance for sepsis screening is BETTER than the previous quarter.	
CQUIN: Sepsis Treatment in ED / Inpatient Settings	Timely treatment of sepsis in ED	90%	79.7%		QUARTERLY INDICATOR. Q2 performance for sepsis screening is WORSE than the previous quarter.	
CQUIN: Sepsis Treatment in ED / Inpatient Settings	Timely treatment of sepsis in inpatient settings	90%	78.2%		QUARTERLY INDICATOR. Q2 performance for sepsis screening is WORSE than the previous quarter.	

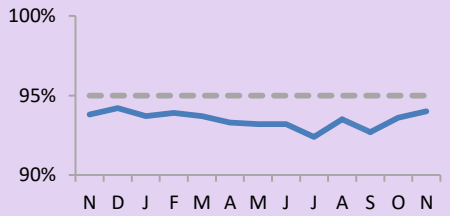
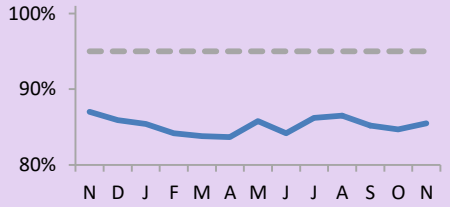
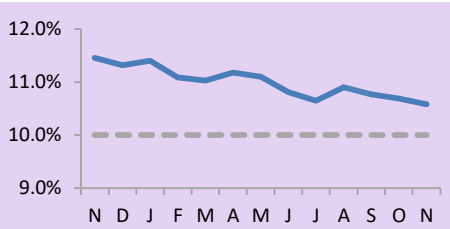
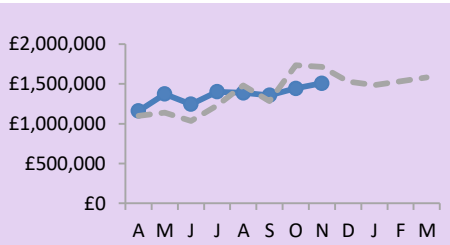
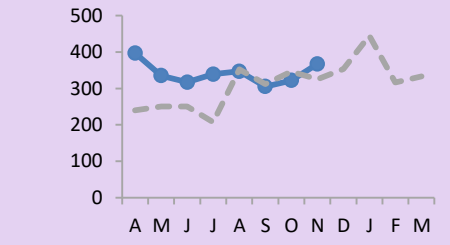
KIND

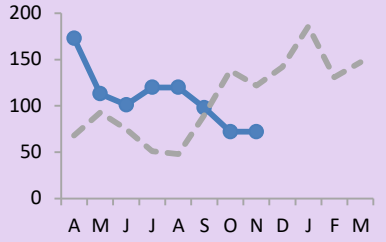
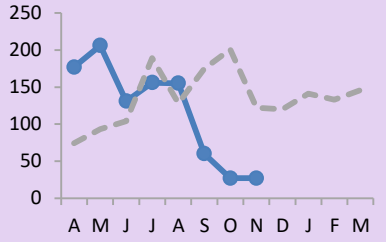
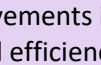
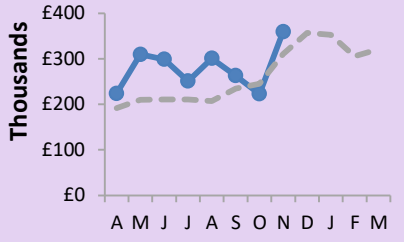
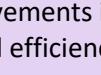
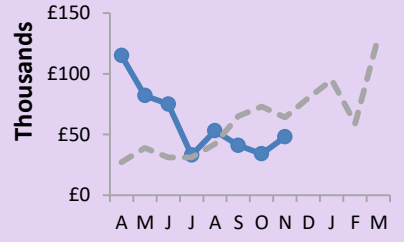
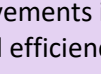
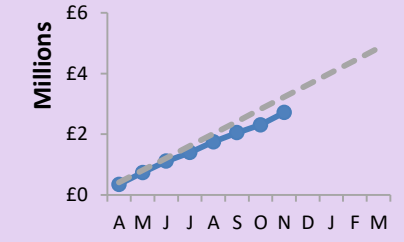
Providing high quality patient care

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

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Friends and Family: % Likely to Recommend A&E	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	80%	82.0%		Performance is BETTER than last month and remains above target.	
Friends and Family: % Likely to Recommend Inpatient Wards	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	90%	93.9%		Performance is BETTER than last month . Performance remains above target for inpatient stays.	
Friends and Family: % Likely to Recommend Maternity Services	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	90%	100.0%		Performance is BETTER than last month . Performance remains above target for maternity services.	

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Patient Feedback: Number of Open Complaints	Number of open patient complaints at month end.	40	28		Performance is BETTER than last month.	
Patient Feedback: Number of Complaints Past 40 Day Response Time	Number of Complaints Past 40 Day Response Time	5	4		Performance is BETTER than last month and is now above target.	
Patient Feedback: Number of Complaints Open with PHSO	Number of Complaints being investigated by the PHSO	0	4		Performance is UNCHANGED since last month.	
Mixed Sex Accommodation Breaches	Number of non-clinically justified breaches of the single sex accommodation standard	0	6		Performance is BETTER than last month. 6 breaches in November were not clinically justified.	
Sickness Absence	% monthly sickness absence, excluding comfort zone and Bank staff	3.65%	4.39%		Performance is BETTER than last month. The November absence rate decreased to 4.39%, above the Trust target of 3.65% and when comparing to local trusts, our absence rate is significantly less. The rate for the same period in 2017, was 4.58% & the rolling 12 month average was 4.13%, against 4.69% regionally (NHS Digital July 2018). Short term absence decreased to 2.05%, while long term absence increased to 2.34%.	

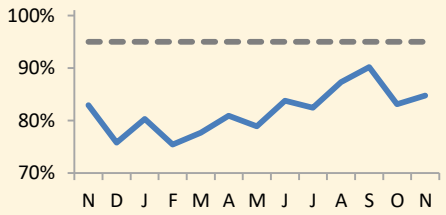
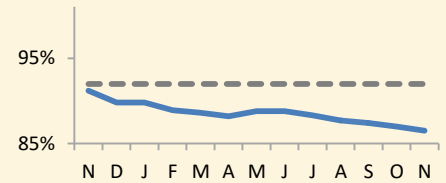
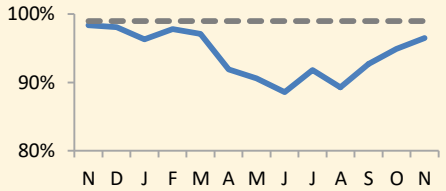
Measure	Definition	Threshold	Actual	Status	Comment	Graph
Mandatory Training Compliance	% mandatory training compliance, excluding comfort zone and Bank staff and staff on maternity/long term sick leave	95%	94.0%		Performance is BETTER than last month. The Trust compliance target increased in November with Mandatory Training standing at 94%, slightly below Trust target of 95%. When taking into account those already booked to attend, the Trust continues to exceed the Trust target, reporting a slightly higher 96.2% compliance.	
Annual Appraisal Compliance	Exclusions as above and also excludes staff with less than 1 year's service.	95%	85.5%		Performance is BETTER than last month. Compliance with the Appraisal target has slightly increased in November to 85.5%, still significantly below the Trust target of 95%. Feedback from across the Trust is that this is symptomatic with the increased pressures to allow time for completions of Appraisals.	
Staff Turnover	Based on headcount in the previous 12 months and on permanent staff only.	10%	10.58%		Performance is BETTER than last month The Trust Turnover rate decreased in November and remained just above target at 10.58%. This rate is based on a headcount, turnover by FTE also remained above target at 10.40%. An exception report has been provided.	
Variable Pay	Reducing and controlling variable pay spend (including overtime, agency, additional clinical activity)	Year on year reduction	-£204K		Performance is WORSE than last month. Variable pay spend increased in month £1,509k, this is due in part to revisions to the report. Both agency and locum costs continue to be high with costs of £274k and £433k in month. Extract report is provided, detailing gaps in vacancies along with bank and agency usage.	
M&D Reduction in Agency Shifts over Cap Rates	Reducing agency shifts over cap rates.	Year on year reduction	+42		Performance is WORSE than last month. Month 7 shows a decrease against September in shifts above the cap, with 367 Medical shifts above cap rates.	

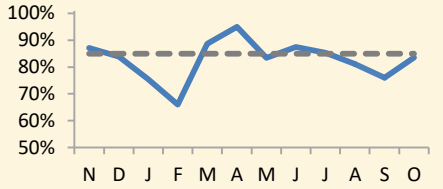
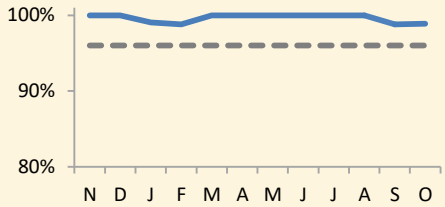
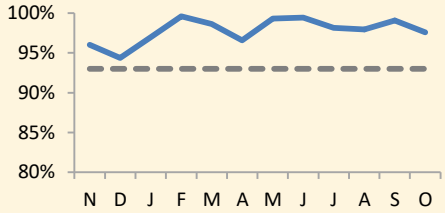
Measure	Definition	Threshold	Actual	Status	Comment	Graph
N&M Reduction in Agency Shifts over Cap Rates	Reducing agency shifts over cap rates.	Year on year reduction	-50		Performance is WORSE than last month. In relation to Nursing shifts, 72 shifts were approved above cap rates.	
'Other' Reduction in Agency Shifts over Cap Rates	'Other' consists of Care Packages, Sonographers, Theatres and CRV Dept.	Year on year reduction	-95		Performance is WORSE than last month. 27 Operating Department Practitioner shifts were approved over the cap.	
People: Medical Agency Spend	Planning improvements in productivity and efficiency	Year on year reduction	+£49k		Performance is WORSE than last month. Medical Pay is overspent by £986k. Agency medical expenditure is £2,977k (7% of the total medical spends)	
People: Nursing Agency Spend	Planning improvements in productivity and efficiency	Year on year reduction	-£16k		Performance is WORSE than last month. Nursing Pay is £967k overspent. Agency nursing expenditure is £481k which is 2% of total trained nursing spend.	
People: Total Agency Spend within Budget	Planning improvements in productivity and efficiency	Total agency spend capped at 4.459 for 18/19	£2.9m YTD		Performance is BETTER than last month. Total Agency spend for M1-7 is £2,532k. (£2,148k was spent during the same period last year). A straight line forecast is just below the agency ceiling.	

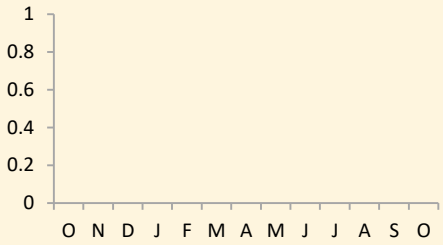
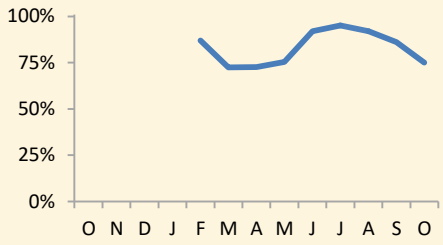
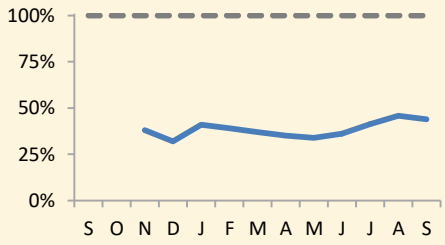
EFFECTIVE

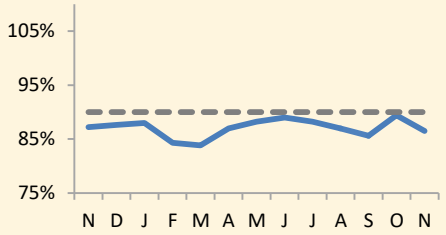
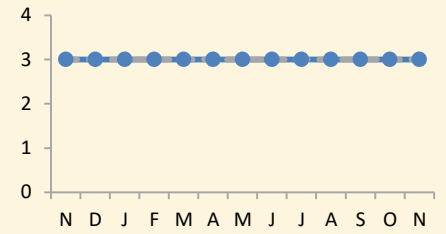
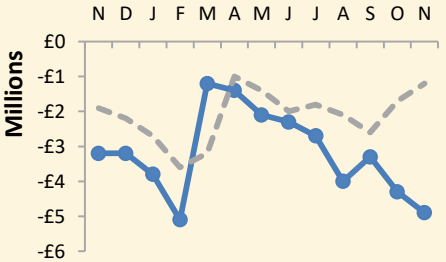
Minimising delay and improving processes

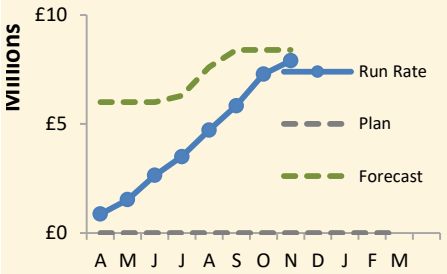
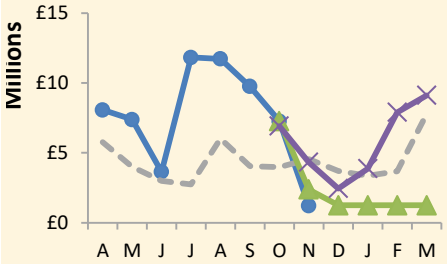
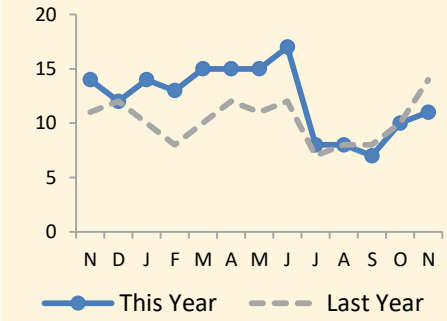
Supporting the Board Assurance Framework:
CR3, CR5, CR6, CR7, CR8, CR9, CR10

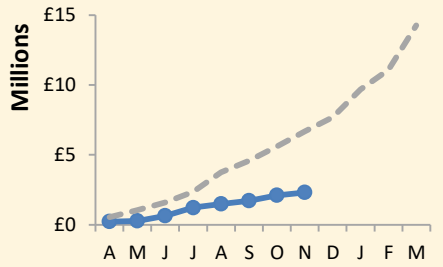
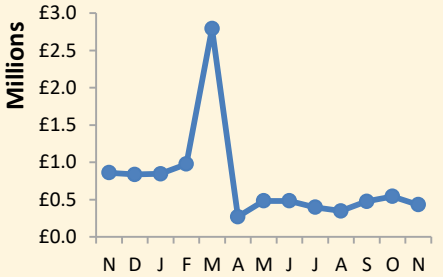
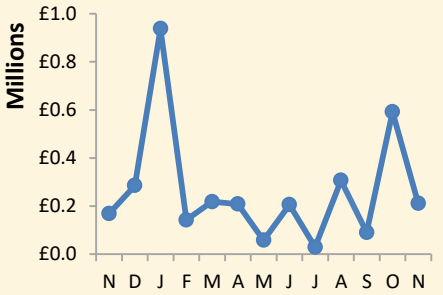
Measure	Definition	Threshold	Actual	Status	Comment	Graph
ED 4 Hour Wait Standard	% A&E attenders seen within 4 hours of arrival	95%	84.8%	O	Performance is BETTER than last month. Nationally, 87.6% of patients were seen within 4 hours of arrival in November. An exception report is provided.	
18 Weeks RTT incomplete pathways	Percentage of incomplete pathways for English patients within 18 weeks.	92%	86.5%	O	Performance is WORSE than last month. The RTT incomplete percentage fell to 86.5% in November. The latest national figure for this indicator is 87.1% (October 2018). An exception report is provided.	
Diagnostic Tests within 6 Weeks (DM01)	Diagnostic tests carried out within 6 weeks of request being received.	99%	96.5%	O	Performance is BETTER than last month. There has been a 2.2% improvement. The latest national figure for this indicator is 97.7% (October 2018).	

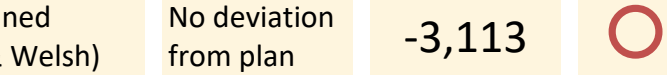
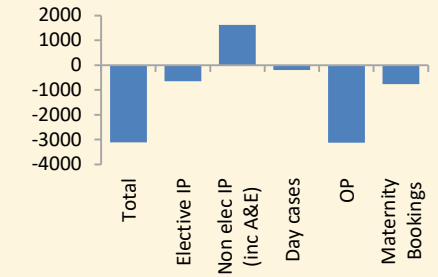
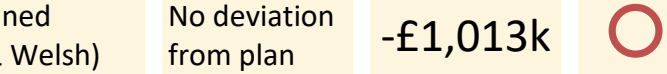
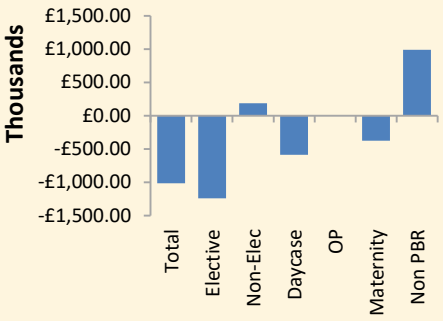
Measure	Definition	Threshold	Actual	Status	Comment	Graph
Cancer Treatments: 62 Day Standard	First treatment for cancer within 62 days of urgent referral through GP 2 week referral route.	85%	83.5%		Performance is BETTER than the previous month. This indicator is reported one month in arrears. The latest national figure for this indicator is 78.4% (Oct 2018).	
Cancer Treatments: 31 Day Standard	Patients receiving first definitive treatment within 1 month of cancer diagnosis.	96%	98.9%		Performance is BETTER than the previous month. This measure continues to achieve target. This indicator is reported one month in arrears.	
Cancer Treatments: 14 Day Standard	Patients referred from GP with suspected cancer should have their first appointment within 14 days	93%	97.6%		Performance is WORSE than the previous month. However this measure continues to achieve target. This indicator is reported one month in arrears.	

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Number of Urgent Operations Cancelled on Day	Urgent operations cancelled on the day of the procedure	0	0		Performance is UNCHANGED.	
% Cancelled Operations Rebooked within 28 Days	Patients given a TCI date that is within 28 days of a procedure cancelled on the day.	100%	75%		Performance is WORSE than the previous month. This indicator is reported a month in arrears to ensure all patients offered rescheduled procedures within 28 days are included. This indicator is reported one month in arrears.	
Clinical Correspondence: OP Letters within 7 days	100% of outpatient letters to be sent within 7 days.	100%	43.8%		Performance is WORSE than the previous month. Overall performance is 43.8% but approximately 70% of urgent letters were sent within timescale. This indicator is reported two months in arrears.	

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Clinical Correspondence: E-Discharge within 24 Hours	Percentage of clinical discharge letters that were sent within 24 hours	90%	86.5%		Performance is WORSE than last month. An exception report has been created for this indicator.	
Use of Resources	NHS Improvements measure of financial risk	A score of 3 each month (restated)	3		Performance is UNCHANGED. The Trust is currently at a level 4 for Capital Service Capacity, liquidity 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.	
I&E Plan Variance	Variance to plan	No deviation from plan	£3,742k overspend		As at the end of November 18, we are reporting a £3,742k overspend against plan. Notable pressures include £1,203k lost A&E PSF m1-8, lost Finance PSF £1,022k m7 & 8 and (£99k) in relation donated asset transactions, culminating in a reported net adverse position of £1,616k. £3,958k non recurrent support has been required to deliver this position.	

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Run Rate	Run Rate is I&E Variance adjusted for non-recurrent items and CRS profile. Forecast is then derived from run rate and known mitigation.	No deviation from plan	+£8.4m		Performance is UNCHANGED. The underlying run rate at the end of November is £7,903k after adjusting for non-recurrent benefit of £3,298k within the position and adjusting the profile to smooth the impact of a back loaded CRS target of £2,989k. This figure is then utilised to provide the forecast after applying known mitigation.	
Cash	Cash on deposit <3 month deposit	No deviation from plan	-£3.3m		Performance is WORSE than last month. The closing cash balance at the end of November is £1.2m, £3.3m behind plan. Our forecast has now been revised to reflect the out-turn deficit and we have applied for interim revenue funding of £2.9m for December 2018. A revised capital plan has been submitted for the loan application, and we are waiting to hear the outcome.	
Debtor Days	Debtor Days: Trade Debtors divides by income x 365	No target has been set for this indicator	11		Performance is WORSE than last month. Debtor days have risen to 11 days. Wirral debtors are creeping up but we are currently withholding payments to them until they clear some significant invoices. Local Authority DTOCs invoices remain unpaid. The ongoing dispute with NHS Property Services has been resolved.	

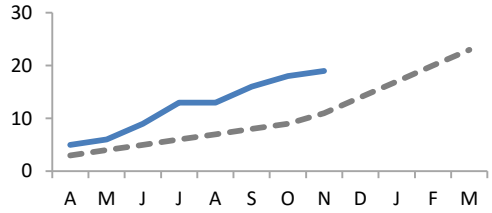
Measure	Definition	Threshold	Actual	Status	Comment	Graph
Capital Expenditure	Capital expenditure performance against plan / forecast out-turn	Performance vs Plan	-£4.4m		Performance is BETTER than last month. YTD capital expenditure of £2.3m is under the original plan by £4.4m. The forecast outturn has been revised to reflect anticipated slippage due to the late approval of the loan and external delays in the Cerner project. The Trust's capital loan has been approved by NHSI and is with DHSC for final approval. The PDC funded A&E scheme is progressing.	
CRS in year	Planning improvements in productivity and efficiency	No deviation from plan	-£741k		Performance is WORSE than last month. The CRS plan for 2018/19 is £10.7m. The CRS programme is £741k behind the profiled plan as at November 18. In year 37% of the target has been delivered with 10% in Green or Amber schemes and 53% in Red or Black (unidentified) schemes. The back loading of the CRS target affects the profile target to date by £2,989k; if the target was profiled evenly CRS would be £3,730k behind plan.	
CRS recurrently	Planning improvements in productivity and efficiency	No deviation from plan	16% identified		Performance is BETTER than last month. Recurrently 16% of the £10.7m target has been identified with 5% in Green or Amber Schemes and 79% in Red or Black (unidentified) schemes.	

Measure	Definition	Threshold	Actual	Status	Comment	Graph
Contract Performance (Activity)	YTD Contract performance against Trust Planned activity (English & Welsh)	No deviation from plan	-3,113		Performance is BETTER than last month. All points of delivery are showing an under performance against plan YTD with the exception of non-elective (+1,210). This is made up of 1,049 additional ED attendances and 415 additional discharges but is offset by an underperformance on maternity discharges (-253)	
Contract Income	YTD Contract performance against Trust Planned activity (English & Welsh)	No deviation from plan	-£1,013k		Performance is WORSE than last month. Prior to adjustment for the block contract with WCCCG, the November income position is above plan by £233k. The block contract adjustment to reflect the overperformance on WCCCG offsets this overperformance by £1,246k resulting in an adverse position on contract income of £1,013k.	

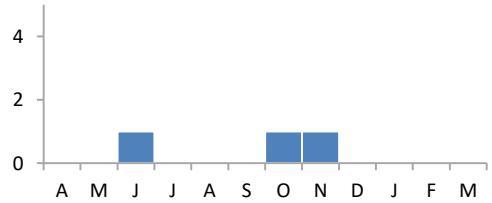
Exception Report

Performance Trend

C Difficile



MRSA



Infection Control

Performance Issue:

C Difficile has been above trajectory for seven successive months. Additionally, there have now been 3 incidences of MRSA in June, October & November.

Planned Remedial Actions:

The number of cases of *C. difficile* infection attributable to the Trust fell below the 2018/19 trajectory for November 2018, so there is no exception reporting specific to this month for *C. difficile* infection. However, the Trust remains above trajectory for the surveillance year to date and focus will remain on the *C. difficile* infection reduction strategy, including:

- Case by case surveillance, with robust feedback methodology including early identification of any increased incidence
- Weekly multidisciplinary wards rounds
- Antimicrobial stewardship programme
- Daily Consultant Microbiologist ward rounds within Critical Care
- Robust infection prevention and control practices, including hand hygiene, rapid patient isolation and environmental/equipment cleaning
- Root cause analysis process for each case of infection, sharing any identified learning from these investigations with clinical teams to support improvement
- Communication systems to support the workforce to remain informed on progress and for the promotion of best practice

MRSA bacteraemia:

With a further case of MRSA bacteraemia reported for November 2018, focus for improvement includes strengthening important messages for all staff through the Executive Team, including:

- Infection prevention and control is the responsibility of each member of staff
- The importance of getting the basics right for every patient every time
    - Clean hands, equipment & environment
    - Correct personal protective equipment
    - Patient isolation (risk assessment)

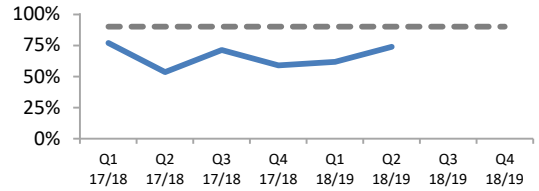
Ownership:

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

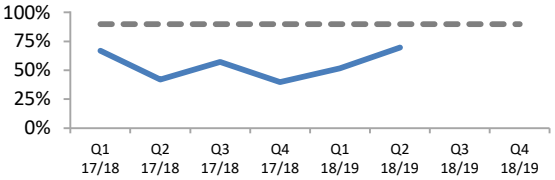
Sepsis screening and treatment CQUIN

Performance Trend

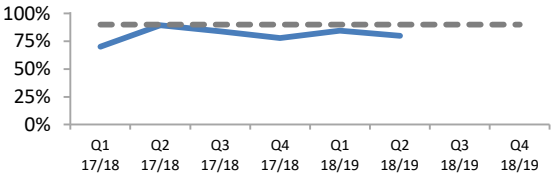
Sepsis screening (ED Patients)



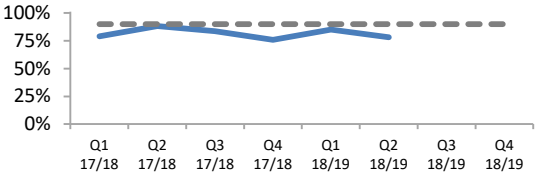
Sepsis screening (Inpatients)



Sepsis treatment (ED)



Sepsis treatment (Inpatients)



Performance Issue:

The Sepsis CQUIN screening improved again in Quarter 2 for both Inpatients and ED, but was still below the year-end target. Treatment of Sepsis continues to perform well but also remains slightly below the year-end target.

Planned Remedial Actions:

The sepsis steering group has been re-established with wider clinical membership and the work programme continues to be progressed. Key achievements during Q2 include, implementation of NEWs2 (track and trigger) and the launch of the Sepsis Trust standardised pathway in the identified pilot wards (ward 43, 44, 45, 48 and 49).

Ownership:

Lead: Dr Santokh Singh

Executive Lead: Darren Kilroy, Interim Medical Director

Improvement Objective: Achieve target

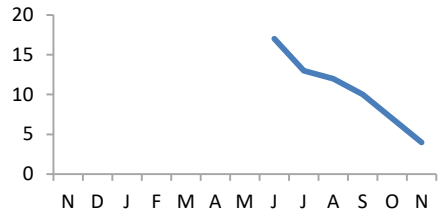
Improvement Timescale: By March 2019

Exception Report

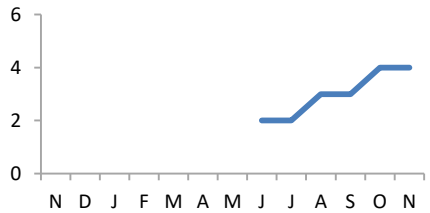
Complaints over 40 days / With PHSO

Performance Trend

Complaints over 40 day old at month end



Number of complaints with PHSO



Performance Issue:

- In November there were 4 complaints that were still open after the 40 day timescale for closure, this position continues to improve month on month
- There were 4 complaints being investigated by the Public Health Service Ombudsman at month end

Planned Remedial Actions:

A small number of complaints exceeded the 40 day target for a number of reasons (e.g. complexity, staff absences, on-going serious incident investigations).

Where it is clear that the 40 day target is unlikely to be met the complainant is informed and the complaint escalated to the relevant Divisional Senior Management Team.

All complainants have a right to escalate a complaint to the Public Health Service Ombudsman if they feel their issue has not been satisfactorily resolved.

Ownership:

Lead: Jonathan Roberts

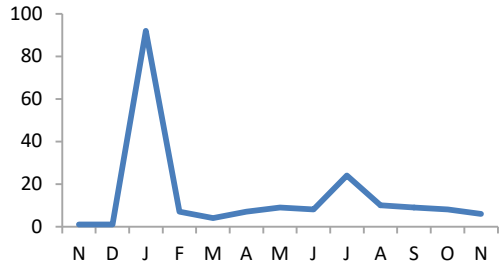
Executive Lead: Alison Kelly, Director of Nursing and Quality

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Mixed Sex Accommodation Breaches

Performance Trend



Mixed Sex Breaches

Performance Issue:

- In November there were 6 Mixed Sex breaches that were not clinically justified.

Planned Remedial Actions:

MSA breaches are related to delayed step down from CCU to the coronary care ward. Work continues to improve the position and ensure patients are stepped down within 24 hours of the decision being made. A divisional action plan is in place, which the Director of Nursing and Quality has oversight of. Full explanations are provided to both patients and families in respect of delays in being stepped down, no complaints received.

Ownership:

Lead: Melanie Kynaston, Associate Director of Nursing

Executive Lead: Alison Kelly, Director of Nursing and Quality

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Exception Report

Sickness Absence

Historic Data

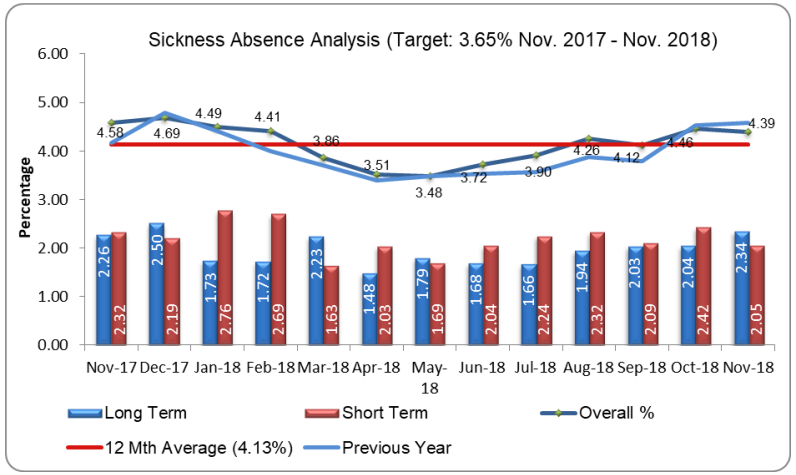


Figure: % mandatory training compliance

Ownership

Lead: Dee Appleton-Cairns, Deputy Director of HR

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

The Trust wide sickness absence decreased to 4.39% from last month. Long Term cases increasing to 2.34% and Short term decreasing to 2.05%. Sickness absence within Staff groups highlights that Nursing & Midwifery is reporting at 4.25% and Support Workers (which include Nursing Assistants) reporting at 6.72% in November. When analysing divisional sickness absence, 5 Divisions are above the Trust target of 3.65%, Planned Care (4.97%), Urgent Care (4.19%), Human Resources (4.68%), Diagnostics (4.15%) and the newly merged Estates & Facilities (4.62%). For both Human Resources and Estates & Facilities the number of Long Term cases have decreased in reducing the overall percentage with more cases due to be ended in December. There is still a backlog of OH referrals due to an unforeseen strain on the service.

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 for Occupational Health via CWP to provide support during a very busy and stressful time. This continues to cause a cost pressure within Occupational Health and there is still a backlog of OH referrals. The annual flu campaign is now drawing to a close with only 15 vacancies left and over 75% of staff having received a flu vaccine. The HR division has put on a schedule of resilience support sessions for staff, the courses teach techniques to cope with stress at home and at work in readiness for the winter period, sign up and feedback has been very good so far. There are plans to take the sessions to front line staff unable be released from the ward areas.

Mandatory Training

Performance Trend

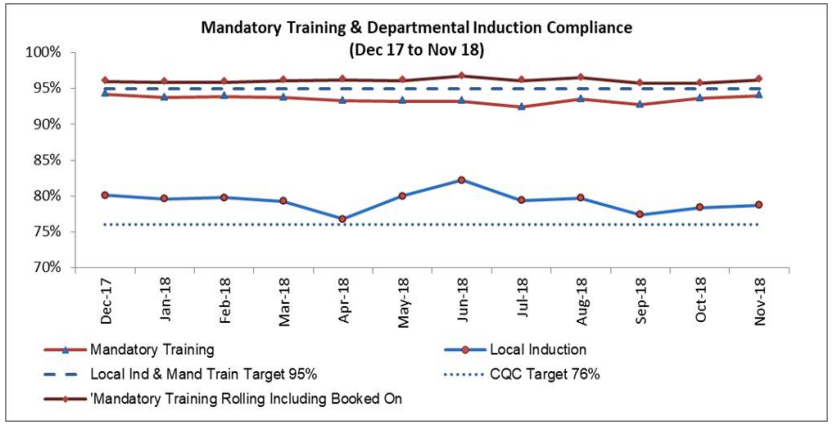


Figure: % mandatory training compliance

Ownership

Lead: Dee Appleton-Cairns, Deputy Director of HR

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

Trust compliance remains below target at 94.0%.

Mandatory Training Table November 2018

Position	Division	Compliance
1	Human Resources	98.5%
2	Estates & Facilities	97.6%
3	Finance & Performance	97.3%
4	Nurse Management	96.4%
5	Diagnostics and Pharmacy	94.8%
6	Planned Care	94.1%
7	HRWBS	93.2%
8	Corporate Non - Clinical	93.1%
9	Urgent Care	91.7%
	Total	94.0%

Local Induction Table November 2018

Position	Division	Compliance
1	Estates & Facilities	100.0%
2	Human Resources	100.0%
3	Finance & Performance	90.0%
4	Planned Care	86.0%
5	HRWBS	85.7%
6	Urgent Care	76.6%
7	Diagnostics and Pharmacy	69.1%
8	Nurse Management	66.7%
9	Corporate Non - Clinical	30.0%
	Total	78.7%

Overall compliance for mandatory training in November has increased to 94.0%%, which is an improvement on October's figures but still falls short of the Trust target.
Local induction compliance for October is 78.7% which is a small improvement on October's figures but significantly short of the Trust's 95% target.
We continue to perform poorly against our own Corporate target of 95%, which we have failed to achieve in the last 12 months reporting period. Mandatory training is currently being reviewed in terms of trust provision with the appointment of Sallie Kelsey our new Head of Clinical Education. It is hoped that by streamlining the provision and encouraging uptake of e-learning this figure can improve in the future.

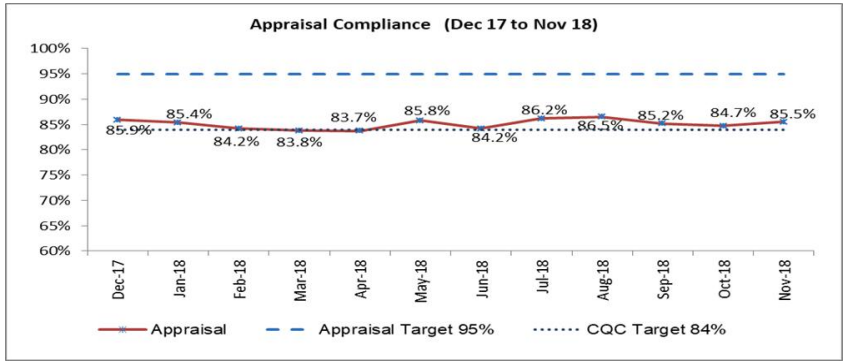
Planned Remedial Actions:

The TNA for mandatory training is under review to ensure alignment with recent changed in the Core Skills Framework. Where possible there will be a move to all subjects being accessed purely by e-learning, Training and Development Policy is being developed to reflect this. A proposal to report purely on Core Skills Framework Subjects is being developed. Plans to review local induction systems and processes are in place.

Exception Report

Appraisals Completed in last 12 months

Historic Data



Performance Issue:

Appraisal compliance has seen an increase in November from 84.7 to 85.5%, this remains below our corporate target of 95%. The only division to achieve this target was HRWBS at 97.0%, with Estates and Facilities just under at 94.1% and Planned Care (91%%) the only other division above 90%. There needs to be particular focus on the divisons below 80% - Urgent Care (78.8%), Nurse Management (77.6%), Human Resources (70.8%), Corporate Non-Clinical (62.1%) - to improve compliance in these areas and acheive trust target overall in 2019.

Appraisal Table November 2018

Position	Division	Compliance
1	HRWBS	97.0%
2	Estates & Facilities	94.1%
3	Planned Care	91.0%
4	Diagnostics and Pharmacy	87.4%
5	Finance & Performance	82.0%
6	Urgent Care	78.8%
7	Nurse Management	77.6%
8	Human Resources	70.6%
9	Corporate Non - Clinical	62.1%
	Total	**85.5%**

Ownership

Lead: Dee Appleton-Cairns, Deputy Director of HR

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Planned Remedial Actions:

The roll out of the "Trust Behavioural Standards" workshops continues to highlight the importance of the appraisal process. HR Business Partners continue to highlight the compliance rate in the monthly divisional reports & at governance boards, stressing the importance of completing appraisals on a timely basis. Guides to inputting appraisals via ESR have also been sent out monthly to ensure the input is accurate and timely.

Turnover

Performance Trend

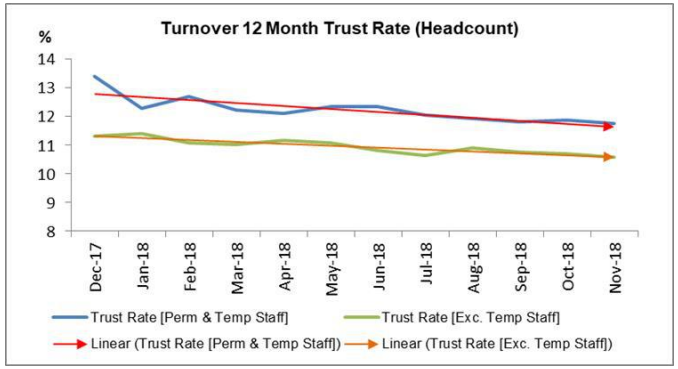


Figure: Based on headcount in the previous 12 months and on permanent staff only.

Ownership

Lead: Dee Appleton-Cairns, Deputy Director of HR

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

Turnover is at 10.58% decreasing in month, compared to 10.69% last month. The rate based on FTE is also above target at 10.40%. Staff groups over target are: Additional Clinical Services at 11.71% - represents 93 leavers in the last year, 71 of which were Healthcare Assistants. Allied Health Professionals at 13.57% - represents 31 leavers in the last year. Admin & Clerical decreased slightly to 10.85% - representing 84 leavers in the last 12 months (5 of which were MARs plus 21 age retirements). Nursing & Midwifery Registered Staff decreased to 11.11% with 12 Midwives, 77 Staff Nurses, 7 Specialist Nurses & 6 Nurse Managers leaving the Trust in the last year. Trends will be continually monitored.

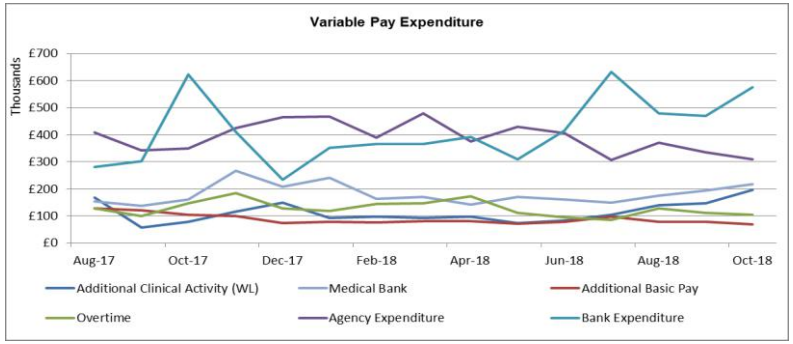
Staff Group - Nov 17 - Oct 18 Excludes Temporary Staff	Turnover %
Add Prof Scientific and Technic	7.94%
Additional Clinical Services	11.71%
Administrative and Clerical	10.85%
Allied Health Professionals	13.57%
Estates and Ancillary	8.08%
Healthcare Scientists	5.76%
Medical and Dental	8.38%
Nursing and Midwifery Registered	11.11%
Trust Totals & Rate	**10.58%**

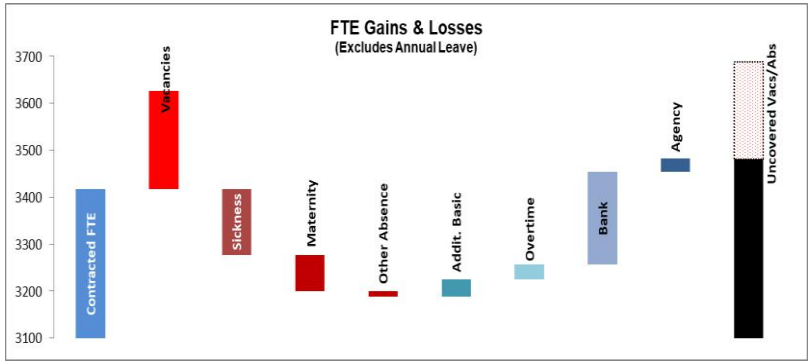
Planned Remedial Actions:

Significant focus is being placed on retention of staff particularly within the nursing, midwifery and medical staff groups, working on identifying area and ways in which we can encourage staff to remain with the trust. It is important to note that the North West average based on headcount is 14.65% (15.26% for Acute Trusts) according to Iview at April 2018.

Variable Pay

Performance Trend





Ownership

Lead: Jane Hayes Green, Project Manager

Executive Lead: Sue Hodkinson

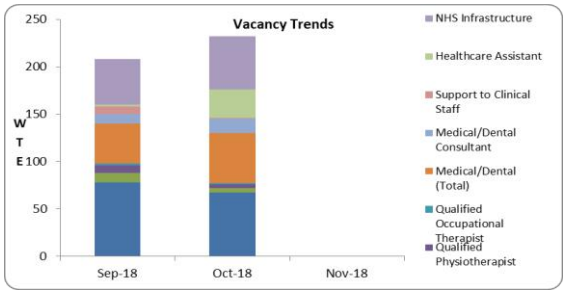
Improvement Objective: Achieve target

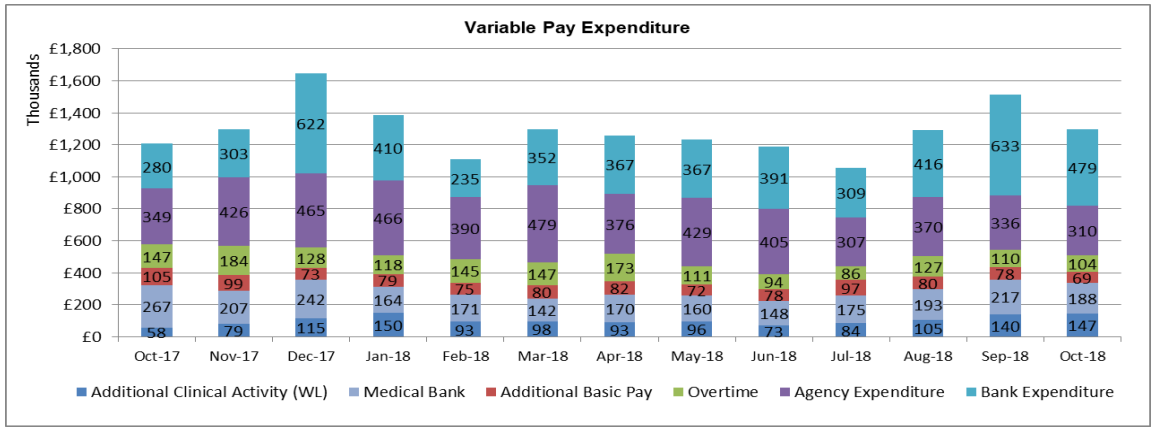
Improvement Timescale: By March 2019

Performance Issue:

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

	WTE		
NHSI Staff Group	Sep-18	Oct-18	Nov-18
Registered Nursing & Midwifery	78	67	
Qualified AHP	10	5	
Qualified Physiotherapist	8	4	
Qualified Occupational Therapist	2	1	
Medical/Dental (Total)	42	53	
Medical/Dental Consultant	10	15	
Support to Clinical Staff	8	1	
Healthcare Assistant	2	30	
NHS Infrastructure	48	56	





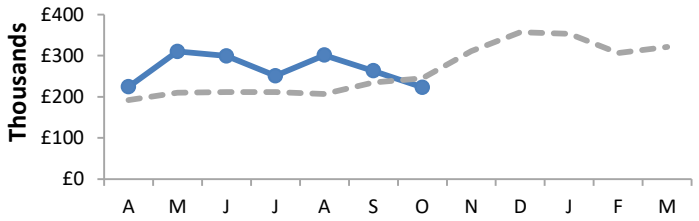
Planned Remedial Actions:

We have changed the way vacancies are calculated & recorded this has resulted in an apparent increase in this figure. It is only a change to recording and does not change our actual vacancy position. This is to bring us in line with other Trusts (discussed at a meeting in Leeds with HEE & NHSI) and uses the difference between the budgeted establishment and actual staff in post as the vacancy position. The biggest increase is in NHS Infrastructure vacancies which include Admin & Clerical, Ancillary, Estates and Security. This has resulted in some categories appearing to have different vacancy numbers e.g. Infrastructure was included under Support to clinical Staff.

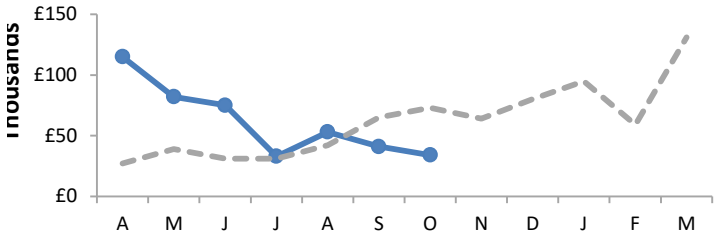
Agency Spend

Performance Trend

Medical Agency Spend



Nursing Agency Spend



Ownership

Lead: Jane Hayes Green, Project Manager

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve Plan

Improvement Timescale: By March 2019

Performance Issue:

Medical Pay is overspent by £713k. Agency medical expenditure is £1,872k (7% of the total medical spend). Nursing Pay is £842k overspent. Agency nursing expenditure is £433k which is 2% of total trained nursing spend. Total Agency spend for M1-7 is £2,532k. (£2,148k was spent during the same period last year). A straight line forecast is just below the agency ceiling.

Contributing Factors:

Agency Spend by Staff Group	14/15	15/16	16/17	17/18	18/19 YTD to Oct	18/19 Annual Straight Line Projection	Projected Yearly Movement
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 85,760	£ 25,952	£ 44,490	-£ 41,270
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433	£ 1,871,753	£ 3,208,719	-£ 59,714
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847	£ 432,800	£ 741,942	-£ 5,905
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820	£ 118,526	£ 203,188	£ 31,368
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009	£ 83,448	£ 143,053	£ 44,044
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 4,372,869**	**£ 2,532,479**	**£ 4,341,392**	**-£ 31,477**
Agency Ceiling 2018/19						**£ 4,459,000**	

Planned Remedial Actions:

See actions proposed under Variable Pay

A&E 4 Hour Standard

Performance Trend

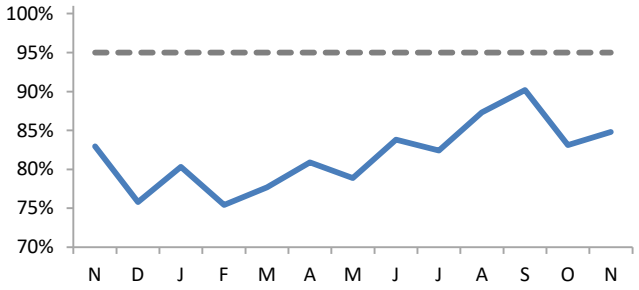


Figure: % ED attenders seen within 4 hours of arrival

Ownership:

Executive Lead: Lorraine Burnett, Chief Operating Officer

Improvement Objective: Return to national standard

(internal trajectory is to return to 90% compliance)

Improvement Timescale: By March 2019

Performance Issue:

The 4 hour A&E target was under the National target in November, achieving 84.78%. Nationally, 87.6% of patients were seen within 4 hours of arrival in November.

Planned Remedial Actions:

During November our ED attendances saw a decrease compared to October and we ended the month 84.78% which was an improvement on previous month

Overall performance was challenged during November with continued high bed occupancy were we saw more NEL admissions than discharges during the month. GPU assessment utilised as escalation capacity for 18 out of 30 days and SAU assessment 7 out of 30 days, which results in reduced capacity and flow. This has also resulted in a slight increase in NEL length of stay and also a decrease in 0 length of stay for NEL admissions

Increased capacity meetings have been in place during each working day with Matrons and Senior Management working to promote discharges and improve flow across Divisions. Urgent Care have increased weekend consultant presence on AMU and in GPU & ED to increase discharges and support the weekend capacity issues

We continue to look at resource opportunities associated with ED workforce and ED Consultant currently working to realign the doctor rota to ensure resources match demand

Exception Report

Performance Trend

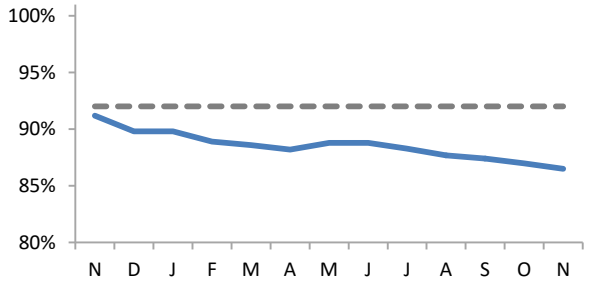


Figure: Percentage of incomplete pathways for English patients within 18 weeks.

Ownership

Lead: Divisional Directors

Executive Lead: Lorraine Burnett, Chief Operating Officer

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Referral to treatment (18 weeks)

Performance Issue: RTT performance remains under the 92% target at 86.5%.

Contributing Factors:

In November our worst performing specialties are Urology (80.8%), Oral Surgery (80.5%), ENT (81.7%) and General Surgery (83.3% - including vascular surgery)

Planned Remedial Actions:

Oral Surgery – Workforce gaps, sickness and exclusions have led to a reduction in capacity. There has also been an increase in cancer referrals which has impacted capacity therefore there are plans underway to recoup some of this lost capacity through additional activity sessions.**ENT** – Junior doctor recruitment remains an issue and has meant routine outpatient activity has declined due to a vacant registrar post. The Locum Consultant left 23rd Nov and we have recruited a further Locum for the duration of December. Advert also to go back out for permanent consultant post. Due to issues with nursing staff we have been unable to run extra clinics until now. Additional weekend clinics have been set to start clearing backlog.

T&O Elective work has been cancelled to facilitate trauma, contributinh towards not being able to improve RTT. We are looking at validation, extended sessions and different ways of working to speed up pathways which will all contribute positively to an increase in RTT.
Plastics Plans are in place for trials of different ways of working and a bid has been submitted for extra staff via the cancer alliance. Additional theatre lists are being set up with some due to run in December and extra clinics are in place over the Christmas and New year period for fast tracks which will help to ensure they are seen timely, whilst also protecting our RTT patients.
Urology - The Improvement efficiencies group is starting again. Additional clinical staff are being sourced to deliver additional activity to improve performance. We have a new locum starting in January for a twelve month period, along with Hot Weeks throughout January / February and March, so Urology performance will improve moving forwards.
General Surgery –Second Consultant post for UGI to go out once JD approved by Royal College. Additional outpatient sessions continue to be provided to meet the increase in demand.
Vascular –We continue to try and realign capacity across all three sites to meet demand. Clinic room space and trained nurse availability at spoke sites still causing difficulties.
Endoscopy
Endoscopy position has improved in month again with continuing additional sessions being carried out to meet increased demand.

Exception Report

Cancer Treatment - 62 Day Target

Performance Trend:

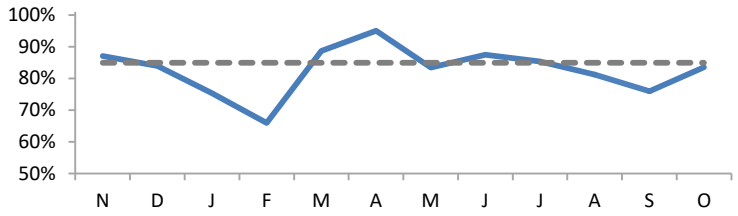


Figure: Cancer 62 Day Target

Breaches by Tumour Site:

	Total breaches
Urology	33
Colorectal	13
Skin	10
Head & Neck	7
Lung	5.5
Upper GI	4.5
Haematology	3
Gynae	3.5
Breast	1
Other	0.5
	81

Table: % Breaches by Speciality (April-October)

Performance Issue:

The 62 day performance for October was 83.5% which was an improvement from September, but still below the 85% standard.

Contributing Factors:

There were 9 breaches in October attributable to COCH.

4 of the 9 breaches were complex, 1 was due to medical reasons, 1 needed repeat diagnostics before transferring to tertiary centre, 1 patient was transferred to another specialty and 2 patients were due to capacity delays

Planned Remedial Actions:

- Completion of IST pathway work with Urology in January
- Urology Efficiencies group commenced with Cancer as work stream. Positive results from pilot telephone triage clinics – aim to commence when vacant posts recruited too
- UGI specialist surgical pathway and SOP completed
- Endoscopy – current capacity pressures are being addressed with extra lists at weekends, which are continuing during December
- Support worker posts are now delivering workshops and patient sign up to remote surveillance is on trajectory
- Transformation bids submitted to Cancer Alliance in conjunction with CCG to support 62 performance

Ownership:

Executive Lead: Lorraine Burnett, Executive Director of Operations

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Diagnostic Tests within Timescale

Performance Trend

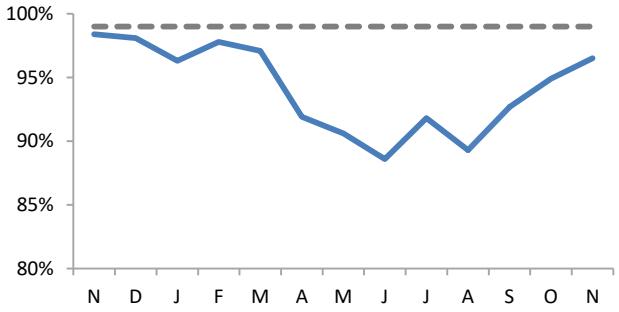


Figure: DM01 - Diagnostic tests carried out within 6 weeks of request being received.

Ownership

Lead: Divisional Directors

Executive Lead: Lorraine Burnett, Chief Operating Officer

Improvement Objective: Achieve target

Improvement Timescale: October 2018

Performance Issue:

DM01 performance has improved by 1.6% in November but remains below the 99% target.

Planned Remedial Actions:

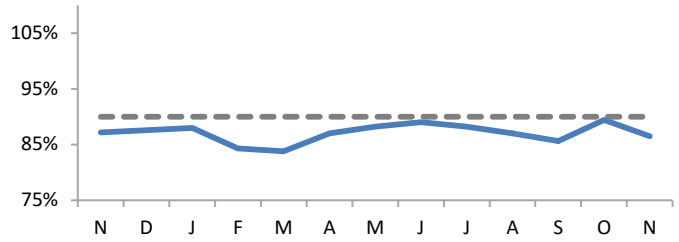
Endoscopy - Overall Endoscopy performance is improving. This is being addressed via extra weekend lists with insourcing company (MHS – Managed Health Care Services) which are running throughout October to mid-December. All cancer and long-waiting RTT patients are currently being prioritised and will continue to be. Every session is being backfilled internally where possible and we saw another improvement in the DM01 result across OGD, colon and flexi-sig procedures in the last month with an improvement expected for cystoscopy also in November.

English - Number of exams >6 weeks

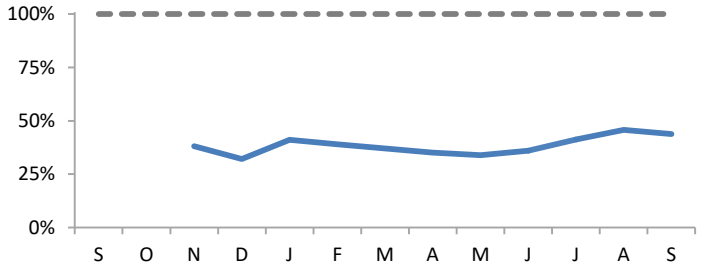
Month End Snapshot	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Magnetic Resonance Imaging		5	5	2	10	12	5	9					1
Computed Tomography		1	4						1				1
Non-obstetric ultrasound	5	7	13	6	51	177	207	247	165	120	124	80	
CRV - Vascular	10	13	56	29	14	2	14	5	12	70	30	8	64
Audiology - Audiology Assessments													
Cardiology - echocardiography	7	5	10			2			7	72	1	1	6
Respiratory physiology - sleep studies	1	2	2	5	3	3	3	2	3	1			1
Colonoscopy	8	8	20	14	19	77	141	192	87	79	64	39	22
Flexi sigmoidoscopy	2	9	3	1	8	3	5	2	1	12	15	34	27
Cystoscopy	14	16	12	17	18	22	49	59	67	120	69	60	23
Gastroscopy	20	18	54	19	12	74	114	100	72	41	43	34	16
Total patients waiting	4215	4399	4799	4228	4623	4578	5738	5382	5073	4822	4758	5001	4657
%<6 weeks	98.4%	98.1%	96.3%	97.8%	97.1%	91.9%	90.6%	88.6%	91.8%	89.3%	92.7%	94.9%	96.5%

Exception Report

Performance Trend



% e-discharge letters sent within 24 hours



% Outpatient letters sent within 7 days

Clinical Correspondence

Performance Issue:

Neither of the clinical correspondence targets was achieved in November.

Contributing Factors:

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

Planned Remedial Actions:

eDischarge - actions are 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 working group met in October to discuss a breakdown of letters produced by specialties and an analysis of outpatient letter performance by urgency/routine. Both routine and urgent appointments have seen an improvement in performance since June and approximately 70% of urgent letters are now being sent within timescale.

Ownership:

Executive Lead: Darren Kilroy, Interim Medical Director

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Countess of Chester Hospital
NHS Foundation Trust

BOARD OF DIRECTORS AGENDA AND PAPERS

TUESDAY, 18TH DECEMBER 2018

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Financial Position – Month 8, November 2018
Date of Meeting	Trust Board 18th December 2018
Author(s)	Simon Holden, Director of Finance Jennie Birch, Deputy Director of Finance
Annual Plan Objective No.	
Summary	This paper is intended to provide details of the Trust's financial position, as at 30th November 18 (Month 8)
Recommendation(s)	**The Board is asked to note:** o The adverse variance (Month 08) of £3,742k against plan, being made up as follows, namely: o underlying position before Provider Sustainability Funding (PSF) of £1,617k adverse, being the monitored year to date position; o the underlying forecast outturn position for the year, before PSF, resulting in probable outturn of £12.7m deficit (against an agreed deficit plan of £4.3m), being the same forecast outturn as at Month 7 but with potential for further deterioration, given operational pressures currently experienced; o The significant improvement in the delivery of the West Cheshire CCG activity within the month, with the under performance against block moving from £467k under to £1,246k over performance year to date (being circa £271k over performance if Therapies changes were excluded); o The main pressures, which could threaten the forecast outturn, being principally Medical and Nursing pay pressures, particularly given current operational pressures; o The cash position of the organisation, and the recent interim revenue distress funding received, together with noting the ongoing cash planning (and probable further drawdowns); o The number of Welsh Delayed Transfers of Care Bed Days, being 2,220 year to date (a deterioration of 26% on the same period last year), and a comparable improvement on

	the Cheshire West & Chester position; o The achievement of Months 1 to 6 PSF Finance Funding (of £1,789k), but the anticipated non-receipt for Month 7 & 8; o The level of non-recurrent resource (£3,298k) required to achieve this position; o The underlying financial pressures, being consistent with other NHS providers, namely: o Winter/additional capacity o Growing elective lists o National A4C Pay award shortfall o Slippage on CRS delivery (Avastin/Lucentis) o Embargo on Subsidiary Companies o Increase in Agency Spend o The critical importance of Quarter 3 & Quarter 4 reporting (per NHS Improvement protocols) for indicating "off plan" trajectory; o The underlying significant risks to this current probable forecast outturn, namely: o Circa £1.7m additional income within the position for therapies activity not previously charged for; and potentially o Circa £1m miscellaneous pressures; All resulting in a "potential" outturn of circa £15m deficit (against an agreed deficit plan of £4.3m), pre Provider Support Funding; and o The suggested next steps: o To note the critical nature of the December 2018 (Quarter 3) actual outturn position, given the volatility to date, and potential for PSF support; o Maintaining good governance, and control; and o Implementing the identified Turnaround Measures, as matter of urgency, wherever possible, subject to the Quality Impact Assessments (QIAs).
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: [ ] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [X] **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

Finance & Integrated Governance Committee

Financial Position
Month 8 November 2018/19

1.1 Overview

	Annual Budget 2018/19 £000s	November YTD Budget 2018/19 £000s	November YTD Actual 2018/19 £000s	November YTD Variance 2018/19 £000s
Pre PSF (Deficit)	4,334	5,204	6,821	1,617
PSF (Provider Sustainability Fund)	(7,297)	(4,013)	(1,789)	2,224
Post PSF Control Total	**(2,963)**	**1,191**	**5,032**	**3,841**
Donated Asset Transactions	45	30	(69)	(99)
I&E Surplus	**(2,918)**	**1,221**	**4,963**	**3,742**

The "monitored" financial position i.e. pre Provider Sustainability Fund (PSF) is a **£1,617k adverse variance** at the end of November. The key points to note include:

Income

There is an adverse position on clinical income of £1,013k noting:

- Underlying over performance on the West Cheshire CCG contract is £1,246k, but this is not recognised within the financial position due to the block arrangements;
- The Welsh contract is underperforming by £359k at the end of month 8;
- There is an adverse variance on other English commissioners of circa £654k and is attributable predominantly to critical care activity within the NHS England contract; and
- The loss of the additional £1m funding from West Cheshire CCG that was included in the plan profiled between October to March has been accounted for (£333k) to date.

Expenditure

The most significant pressures on the expenditure position continue to be nursing pay which is £967k overspent (of which, agency spend to date is £481k) and medical pay expenditure which is £986k overspent (including agency spend to date £2,232k). The key cost drivers continue to be vacancies, activity pressures and the number of patients requiring one to one care. Please see Appendices A&B for further details of the pressures being experienced in both areas.

Cost Reduction Scheme (CRS)

The Cost Reduction Scheme (CRS) is £741k behind the profiled plan. The target has been back loaded into later months; if it had been profiled evenly we would be a further £2,989k behind plan.

Reserves

Ward 54 is now open on a permanent basis alongside additional beds on wards 46, 34 and Bluebell. This has utilised in full the winter reserve and a further £150k in year and £331k recurrently from contingency. Further reserves of £660k have been utilised to support the financial position.

Technical Opportunities

Use of non-recurrent resource of £3,298k has been used to support the position to ensure receipt of PSF for the first two quarters of the year.

1.2 Provider Sustainability Funding (PSF)

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

Provider Sustainability Funding	Q1	Q2	Q3	Q4	Total
Financial Performance (70%)	766,185	1,021,580	1,532,370	1,787,765	5,107,900
A&E Performance Performance (30%)	328,365	437,820	656,730	766,185	2,189,100
Total	**1,094,550**	**1,459,400**	**2,189,100**	**2,553,950**	**7,297,000**
Weighted %	15%	20%	30%	35%	100%

The Trust is required to deliver to financial plan at the end of each quarter to be able to access the associated PSF for financial performance for that period. Therefore, significant non recurrent resource of £3.298m, and deployment of recurrent reserves of £625k, has been specifically released into the position to achieve the required financial performance thus enabling the Trust to access PSF of £1,788k for quarter one and quarter two.

The Trust has an adverse variance on PSF of £2,226k at the end of month 8 with £1,204k loss due to the non-achievement of the required A&E target year to date and £1,022k is due to the non-achievement of the financial performance in October and November.

Under achievement of PSF nationally (at year end) is redistributed based on a centrally determined (unknown) funding formula. For 2017/18 this included pound for pound matching for any over performance on the control total and an additional share for all organisations that signed up to the control total irrespective of delivery. It is anticipated that the Trust will not be eligible for any additional PSF due the deterioration of the financial position.

1.3 Income and Expenditure Summary

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

KEY VARIANCES	Annual Budget £000s	Nov YTD Budget £000s	Nov YTD Actual £000s	Nov YTD Variance £000s	Nov YTD Variance % of budget	Movement from Oct
INCOME						
Income - England	(179,934)	(121,135)	(119,991)	1,144	-0.9%	(54)
Income - Wales	(24,967)	(17,112)	(16,759)	353	-2.1%	(225)
Other Clinical Income	(11,460)	(7,656)	(8,453)	(797)	10.4%	(113)
Non Patient Income	(14,678)	(9,929)	(10,229)	(299)	3.0%	(8)
INCOME	**(231,039)**	**(155,833)**	**(155,431)**	**401**	-0.3%	**(400)**
PAY						
Nursing	961	39,792	40,759	967	2.4%	126
Medical	47,366	31,686	32,673	986	3.1%	273
Admin & Clerical	21,184	13,986	13,748	(238)	-1.7%	(56)
AHP, Therapies, Diagnostics & Pharmacy	23,405	15,466	15,409	(57)	-0.4%	(8)
Other	14,169	9,783	9,044	(738)	-7.5%	(38)
TOTAL PAY	**107,086**	**110,713**	**111,633**	**920**	0.8%	**297**
NON PAY						
Drugs	18,978	13,115	13,377	261	2.0%	55
Medical & Surgical Equipment	11,393	7,730	7,827	97	1.2%	129
Depreciation	4,382	2,921	2,921	0	0.0%	0
CNST	8,206	5,471	5,471	0	0.0%	0
Furniture & Office Equipment, Equip Hire & Computers	3,919	2,546	2,605	59	2.3%	12
Other	29,313	19,270	18,408	(862)	-4.5%	53
TOTAL NON PAY	**76,192**	**51,054**	**50,609**	**(445)**	-0.9%	**249**
CRS	**(6,793)**	**(741)**	**0**	**741**		**272**
TOTAL - PRE PSF & DONATED ASSET TRANSACTIONS	**(54,555)**	**5,193**	**6,811**	**1,617**	31.1%	**418**
PSF (Provider Sustainability Fund)	**(7,297)**	**(4,013)**	**(1,789)**	**2,224**	-55.4%	**729**
POST PSF CONTROL TOTAL	**(61,852)**	**1,180**	**5,022**	**3,841**	325.4%	**1,147**
DONATED ASSET TRANSACTIONS	**45**	**30**	**(69)**	**(99)**	-330.0%	**6**
I&E SURPLUS	**(61,807)**	**1,210**	**4,953**	**3,742**	309.2%	**1,153**

Please note: (Favourable) / adverse

2.1 Commissioner Income

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

Point of Delivery	Activity Variance YTD (actual activity delivered compared to funded baseline where (x)/x is underperformance / overperformance)	Value Variance YTD (financial value variance of activity units delivered compared to funded baseline where (x)/x is underperformance / overperformance)	Block Adjustment relating to West Cheshire CCG where (x)/x represents over performance not paid for / underperformance not penalised for	Value Variance attributable to Welsh and Other English Commissioners (where (x)/x is underperformance / overperformance)	RAG	Movement from Previous Period
Daycases	(200)	(£585,070)	(£357,708)	(£942,777)	↓	(£48,279)
Elective Inpatients	(644)	(£1,242,110)	(£232,812)	(£1,474,922)	↓	(£179,048)
Non-Elective Inpatients (exc Maternity)	650	£918,565	£694,046	£1,612,611	↑	£349,169
Non-Elective Inpatients - Maternity	(290)	(£829,099)	£335,964	(£493,135)	↓	(£57,634)
First Outpatients	2,129	£283,783	(£188,752)	£95,031	↓	(£16,909)
Follow Up Outpatients	(5,882)	(£429,666)	£263,580	(£166,086)	↓	(£29,957)
Outpatient Unbundled & Procedures	627	£157,038	(£100,847)	£56,191	↑	£21,742
Maternity	(762)	(£373,034)	£418,972	£45,938	↑	£24,475
A&E Attendances	1,260	£107,121	£37,171	£144,293	↑	£24,181
Best Practice Adj'ts	0	(£8,142)	£34,469	£26,327	↑	£252
Drugs & Devices	0	£104,391	(£564,135)	(£459,743)	↓	(£97,862)
AMD	362	£214,883	£12,840	£227,722	↑	£29,633
Adult Crit Care & Neonatal	(958)	(£1,005,342)	(£199,066)	(£1,204,408)	↓	(£65,304)
Other Non PBR & CQUIN	0	£1,797,324	(£1,399,541)	£397,783	↑	£261,504
PBR & Non PBR Variance	**(3,709)**	**(£889,358)**	**(£1,245,817)**	**(£2,135,175)**		**£215,963**
Critical Care Risk		£1,122,670		£1,122,670		£121,068
Total Excluding STF Funding		**£233,312**	**(£1,245,817)**	**(£1,012,505)**		**£337,031**
Sustainability & Transformation funding		**(£2,225,585)**		**(£2,225,585)**		(£729,700)
Total Including STF Funding		**(£1,992,273)**	**(£1,245,817)**	**(£3,238,090)**		**(£392,669)**

At the end of November 2018 (month 8) the total contract income (for all commissioners) is £233k above plan prior to the block adjustment, which when applied results in an overall financial underperformance of £1,013k, thus not recognising £1,246k over performance in the position. This is because the over performance is attributed to West Cheshire CCG which is on a block contract and the under performance has been experienced on Payment by Results (PbR) contracts.

Please note the following key points in relation to income:

- There has been a change in charging for therapies activity, which has previously been counted but not charged for. This change is to ensure consistent treatment in line with neighbouring Trusts, with a value for all commissioners of circa £1,150k for April to November 2018, and circa £975k of this relating to West Cheshire CCG;

- Overall performance on the West Cheshire CCG contract has significantly improved in month 8 and even excluding the therapies charging change, the West Cheshire CCG contract would be now £271k above the agreed contract baseline;

- Welsh and non-West Cheshire English activity which are paid for via the national tariff are underperforming resulting in a net underperformance within the financial position for month 8 despite improved delivery of (West Cheshire) activity;

- The volume of un-coded activity at month 8 is currently at 6% of total activity. The Trust continues to pursue regular reviews of coding;

- Obstetric deliveries are still below plan in November with a cumulative under performance of £829k prior to the block adjustment. The pressure within the financial position following the block adjustment is £493k for the first eight months of the financial year and predominantly relates to Welsh activity. Obstetric bookings are also below plan but this is mitigated by the block contract for West Cheshire patients. The previous reduction in the number of Welsh women booking to have their care at the Countess, has started to materialise in the numbers of deliveries;

- The net overall non-PBR position is showing an over performance of £110k following the block adjustment which largely relates to critical care which is explained below; and the loss of the additional £1m funding from West Cheshire CCG that was included in the plan profiled between October to March has been accounted for (£333k); and

- Critical Care and Neonatal bed day activity is £1,204k below (for all Commissioners) the internal funded levels of activity within the plan year to date after the application of the block adjustment. This was in part anticipated and a risk reserve established as part of the 2018/19 budget setting. The application of the risk reserve has resulted in an under performance of £82k.

2.2 Non-Commissioner Income

At the end of November 2018, non-commissioner income is below plan by £1,612k mainly attributable to:-

- The loss of the PSF monies in relation to A&E performance of £2,226k; and

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

3.0 Key Variances

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

Divisional Variances	Nov YTD Var	CRS YTD Var	Pressure exc CRS
	£000s	£000s	£000s
Planned Care	1,760	961	799
Urgent Care	1,766	682	1,084
D&P	256	108	148
Facilities	(102)	(21)	(81)
Estates	(54)	(41)	(13)
Nurse Management	(37)	(16)	(21)
Corporate Services	(279)	(101)	(178)
Central (CRS)	(988)	(832)	(156)
Central Services	(1,124)	0	(1,124)
Total (before PSF & Donated Assets)	**1,198**	**740**	**458**

3.1 Agency Spend & Variable Pay

The agency expenditure position as at November 2018 is shown below with a simple straight line projection, which suggests the Trust will be just over the agency ceiling should this expenditure extrapolate in this way. The previous year's full year expenditure figures are also shown for comparison:-

Agency Spend by Staff Group	14/15	15/16	16/17	17/18	18/19 YTD to Nov	18/19 Annual Straight Line Projection
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 85,760	£ 39,228	£ 58,843
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433	£ 2,232,350	£ 3,348,525
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847	£ 481,011	£ 721,517
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820	£ 139,923	£ 209,884
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009	£ 84,309	£ 126,463
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 4,372,869**	**£ 2,976,821**	**£ 4,465,231**

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

The variable pay position for month 7 is shown below (although Month 8 remains outstanding) as is the comparison with previous month's performance: -

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Additional Clinical Activity (WL)	£ 96,253	£ 72,869	£ 83,557	£ 104,828	£ 140,342	£ 146,800	£ 196,243
Medical Bank	£ 170,001	£ 159,831	£ 148,181	£ 174,522	£ 192,785	£ 217,039	£ 187,564
Additional Basic Pay	£ 81,765	£ 71,566	£ 77,576	£ 97,283	£ 79,551	£ 78,052	£ 69,408
Overtime	£ 172,810	£ 111,476	£ 94,082	£ 85,607	£ 127,253	£ 110,446	£ 104,493
Agency Expenditure	£ 375,766	£ 428,800	£ 404,881	£ 306,956	£ 370,401	£ 335,858	£ 310,211
Bank Expenditure	£ 391,280	£ 308,742	£ 416,014	£ 632,955	£ 478,748	£ 575,608	£ 455,531
Total Variable Pay Expenditure	**£ 1,287,875**	**£ 1,153,283**	**£ 1,224,290**	**£ 1,402,151**	**£ 1,389,080**	**£ 1,463,803**	**£ 1,323,452**
Pay Budget	**£13,193,249**	**£14,042,665**	**£13,349,289**	**£14,125,297**	**£14,426,390**	**£13,859,665**	**£13,917,875**
Variable Pay as % of Total Budget	**10%**	**8%**	**9%**	**10%**	**10%**	**11%**	**10%**

	2016/17 Full Year Spend	2017/18 Full Year Spend	2018/19 YTD Spend
Additional Clinical Activity (WL)	£1,136,104	£1,225,459	£840,891
Medical Bank	£1,581,579	£2,025,090	£1,249,923
Additional Basic Pay	£1,487,368	£1,200,461	£555,201
Overtime	£1,167,972	£1,530,417	£806,167
Agency Expenditure	£3,452,003	£4,372,869	£2,532,873
Bank Expenditure	£2,809,066	£3,665,410	£3,258,878
Total Variable Pay Expenditure	**£ 11,634,092**	**£ 14,019,705**	**£ 9,243,934**
Pay Budget	**£ 155,020,877**	**£ 157,824,980**	**£ 96,914,430**
Variable Pay as % of Total Pay Budget	**8%**	**9%**	**10%**

3.2 Delayed Transfers of Care

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

Bed Days

Local Authority	2017/18 YTD Total			2018/19 YTD Total			2018/19 Total Variance		
	Health	Social	Total	Health	Social	Total	Health	Social	Total
Cheshire West & Chester	2,237	2,841	5,078	2,903	1,219	4,122	666	(1,622)	(956)
Wales	1,097	665	1,762	619	1,601	2,220	(478)	936	458
Halton	36	45	81	15	22	37	(21)	(23)	(44)
Warrington	55	143	198	79	27	106	24	(116)	(92)
Wirral	80	11	91	17	48	65	(63)	37	(26)
Shropshire	16	4	20	0	0	0	(16)	(4)	(20)
Cheshire East	10	3	13	18	6	24	8	3	11
Wigan	0	3	3	0	0	0	0	(3)	(3)
Stockport	10	0	10	0	23	23	(10)	23	13
Lancashire	0	0	0	0	0	0	0	0	0
West Sussex	0	0	0	0	0	0	0	0	0
Total	**3,541**	**3,715**	**7,256**	**3,651**	**2,946**	**6,597**	**110**	**(769)**	**(659)**

3.3 Bed Base (Countess of Chester & Ellesmere Port)

Bed occupancy remains high and despite a system wide review which identified a shortfall of beds across they system, Commissioners are yet to respond. Discussions are underway with the CCG regarding winter capacity and the requirement for the cost to be shared across the system.

4.0 Cash Releasing Savings (CRS)

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

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

Divisional and departmental targets can be found in section 4.2.

4.1 November 2018 CRS Performance

CRS performance as at the end of November 2018 is £741k behind the profiled plan. Reserves of £660k have been released to support the overall financial position and offset against the CRS target.

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

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

Therefore the CRS performance would be worse by £2,989k if the target had been profiled evenly and hence, the CRS programme would be £3,730k off plan should an even target profile been adopted.

4.2 In Year & Recurrent CRS Performance

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

2018/19 EFFICIENCY PROGRAMME PERFORMANCE AS AT NOVEMBER 2018

	IN YEAR								
Division / Department	**2017/18 In Year CRS Target**	**Achieved**		**Outstanding**	**Green**	**Amber**	**Red**	**Pipeline**
Planned Care	£ 2,515,966	£ 824,804	33%	£ 1,691,162	£ 203,925	£ 110,000	£ 537,985	£ 839,252
Urgent Care	£ 1,754,308	£ 526,299	30%	£ 1,228,009	£ 317,932	£ 125,611	£ 410,000	£ 374,465
D&P	£ 840,000	£ 566,277	67%	£ 273,723	£ 260,716	£ -	£ 120,000	-£ 106,993
Estates & Facilities	£ 489,724	£ 512,352	105%	-£ 22,628	-£ 0	£ -	£ -	-£ 22,628
Nurse Mgmt	£ 71,791	£ 69,613	97%	£ 2,178	£ 2,178	£ -	£ -	£ -
Corporate Clinical	£ 7,756	£ 5,090	66%	£ 2,666	£ -	£ -	£ 2,290	£ 376
IM&T	£ 167,599	£ 167,599	100%	-£ 0	-£ 0	£ -	£ -	£ -
HR	£ 106,018	£ 87,846	83%	£ 18,172	£ 17,377	£ 795	£ -	£ -
Trust Administration	£ 108,457	£ 83,129	77%	£ 25,328	£ -	£ -	£ 1,000	£ 24,328
Finance	£ 52,470	£ 52,470	100%	-£ 0	-£ 0	£ -	£ -	£ -
PPD	£ 11,328	£ 8,858	78%	£ 2,470	£ -	£ 2,470	£ -	£ -
Procurement	£ 15,771	£ 132,318	839%	-£ 116,547	£ -	£ -	£ -	-£ 116,547
Central	£ 4,597,684	£ 908,666	20%	£ 3,689,018	£ -	£ -	£ 3,650,000	£ 39,018
TOTAL	**£ 10,738,872**	£ 3,945,322	37%	£ 6,793,550	£ 802,126	£ 238,876	£ 4,721,275	£ 1,031,271
		37%		63%	7%	2%	44%	10%
						£ 1,041,003		£ 5,752,547
						10%		54%

2018/19 EFFICIENCY PROGRAMME PERFORMANCE AS AT NOVEMBER 2018

	RECURRENT							
Division / Department	**2017/18 Recurrent CRS Target**	**Achieved**		**Outstanding**	**Green**	**Amber**	**Red**	**Pipeline**
Planned Care	£ 2,515,966	£ 268,148	11%	2,247,818	£ 170,000	£ -	£ 604,904	£ 1,472,914
Urgent Care	£ 1,754,308	£ 638,163	36%	1,116,145	£ 32,000	£ 126,169	£ 410,000	£ 547,976
D&P	£ 840,000	£ 242,275	29%	597,725	£ 79,592	£ -	£ 170,000	£ 348,133
Estates & Facilities	£ 489,724	£ 234,184	48%	255,540	£ 25,000	£ 50,000	£ 65,000	£ 115,540
Nurse Mgmt	£ 71,791	£ 5,000	7%	66,791	£ 5,169	£ -	£ 9,795	£ 51,827
Corporate Clinical	£ 7,756	£ 5,090	66%	2,666	£ -	£ -	£ 2,290	£ 376
IM&T	£ 167,599	£ 6,705	4%	160,894	£ 80,007	£ 3,295	£ -	£ 77,592
HR	£ 106,018	£ 35,464	33%	70,554	£ 1,000	£ 11,000	£ 20,563	£ 37,991
Trust Administration	£ 108,457	£ 33,027	30%	75,430	£ -	£ -	£ 1,000	£ 74,430
Finance	£ 52,470	£ 30,251	58%	22,219	£ -	£ -	£ -	£ 22,219
PPD	£ 11,328	£ 3,000	26%	8,328	£ -	£ -	£ -	£ 8,328
Procurement	£ 15,771	£ 15,771	100%	-	£ -	£ -	£ -	£ -
Central	£ 4,597,684	£ 185,832	4%	4,411,852	£ -	£ -	£ 5,100,000	-£ 688,148
TOTAL	**£ 10,738,872**	£ 1,702,909	16%	9,035,962	£ 392,768	£ 190,464	£ 6,383,552	£ 2,069,178
		16%		84%	4%	2%	59%	19%
						£ 583,232		£ 8,452,730
						5%		79%

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

		realised e.g. - Opportunity savings identified but plans not yet worked up accurately - Cross divisional issues to address - Potential negative impact on quality/safety - Requires investment?
Black	Yet to be activated	High Risk - Pipeline schemes with no value/milestones etc identified - Unidentified balance

4.3 Next Steps (Delivery of Recovery Plan Schemes)

The Trust submitted a draft Financial Recovery Plan to NHSI in September, with final submission due with the Board Assurance Statement (being approved by the Board). Consideration is currently being given to the appointment of a Turnaround Director. In the meantime, an internal turnaround team has been identified to focus on opportunities for rapid improvement to the 2018/19 financial position, and support the planning for 2019/20.

Continual reviews of the following are also being pursued to support delivery of the central target: -

- Exploration of Alternative Delivery Models;
- Implementation of Allocate for Medical Workforce;
- Benefits realisation from Teletracking;
- Integrated Care Programme / Collaborations;
- Joint efficiency programme with the CCG;
- Exploration of further income generation opportunities;
- Review of reserves; and
- Review of balance sheet provisions, and the potential to review accounting policies.

5.0 Forecast

The table below shows the current best, most likely and worst case forecasts for year-end:-

Forecast Position Pre PSF	Nov £k Best	Nov £k Most Likely	Nov £k Worst
Reported Monthly Variance Position	**1,616**	**1,616**	**1,616**
Use of Non Recurrent Resource	3,298	3,298	3,298
Initial Monthly Position	**4,914**	**4,914**	**4,914**
CRS Profile Adjustment	2,989	2,989	2,989
Restated Actual Position	7,903	7,903	7,903
Full Year Variance Projection	**11,855**	**11,855**	**11,855**
Further Risk			
CCG £1m (from Oct 18)	(500)	(500)	(500)
Miscellaneous Pressures		(250)	(1,000)
Potential Mitigations: -			
Add back use of non recurrent resouce within position	3,298	3,298	3,298
Use of further balance sheet opportunities (technical)	600	600	600
Use of Reserves	316	316	316
Delivery of further efficiencies	5,595		
Assumes delivery of only green and amber schemes			(158)
Revised Full Year Variance Projection	**2,546**	**8,391**	**9,299**
Planned Deficit Pre PSF	**4,334**	**4,334**	**4,334**
Forecast Deficit Pre PSF	**6,880**	**12,725**	**13,633**

Forecast Position Post PSF	Nov £k Best	Nov £k Most Likely	Nov £k Worst
Forecast Deficit Pre PSF brought forward	6,880	12,725	13,633
Total PSF available	(7,297)	(7,297)	(7,297)
Loss of Q1 A&E Performance PSF	328	328	328
Loss of Q2 A&E Performance PSF	437	437	437
Loss of Q3 A&E Performance PSF	0	657	657
Loss of Q4 A&E Performance PSF	0	766	766
Loss of Q3 Financial Performance PSF	0	1,532	1,532
Loss of Q4 Financial Performance PSF	1,788	1,788	1,788
Forecast Position Post PSF	**2,136**	**10,936**	**11,844**
Control Total Post PSF	**(2,963)**	**(2,963)**	**(2,963)**
Forecast Variance to Control Total Post PSF	**5,099**	**13,899**	**14,807**

In accordance with NHSI protocol, the Trust is able to change the forecast position at the end of each quarter. As the most likely forecast is a £8.3m variance to a Pre PSF deficit position of £4.3m (resulting in a total Pre PSF deficit of £12.7m), the Trust gave an indication to NHSI at part of month six reporting and shared the most likely forecast deficit of £12.7m pre PSF.

6.0 Model Hospital Update

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

Model Hospital Programme	Sum of TARGET In Year	Sum of ACHIEVED In Year	Sum of VARIANCE In Year	Green	Amber	Red	Pipeline
Business as usual	£ 4,653,349	£ 3,223,041	£ 1,430,308	£ 288,002	£ 36,265	£ 1,014,040	£ 92,000
Collaboration & Integration	£ 520,000	£ -	£ 520,000	£ -	£ -	£ 520,000	£ -
Co-ord Centre & Dashboards	£ 21,000	£ 21,000	£ -	£ -	£ -	£ -	£ -
Drugs	£ 2,403,398	£ 210,154	£ 2,193,244	£ 454,116	£ -	£ 1,739,128	£ -
Outpatients	£ 67,104	£ 67,096	£ 8	£ 8	£ -	£ -	£ -
Patient Flow	£ 701,358	£ 58,747	£ 642,611	£ -	£ 92,611	£ 550,000	£ -
Procurement	£ 715,349	£ 224,146	£ 491,203	£ -	£ -	£ 607,750	-£ 116,547
Stranded Patients (DTOCs)	£ 87,625	£ 87,625	£ -	£ -	£ -	£ -	£ -
Theatres	£ 478,957	£ 18,600	£ 460,357	£ 60,000	£ 110,000	£ 290,357	£ -
Unidentified	£ 1,090,731	£ 34,913	£ 1,055,818	£ -	£ -	£ -	£ 1,055,818
Grand Total	**£ 10,738,871**	**£ 3,945,322**	**£ 6,793,550**	**£ 802,126**	**£ 238,876**	**£ 4,721,275**	**£ 1,031,271**
					10%		54%

6.1 Quality Impact Assessments Update

There have been no new QIAs approved in month 8.

7.0 Capital Expenditure

There has been a slow start to the year in terms of capital spend, (predominantly due to the absence of the capital loan) which represents the brought forward items from 2017/18 and the emergency capital approved at CLG, with actual spend of £2.4m by the end of November, compared to the plan of £6.7m.

The 2018/19 capital loan application has been approved by NHSI (local and national) and is now with DHSC awaiting final approval, including a capital reforecast, showing what we can realistically spend by the end of the financial year.

Based on the experience of the previous year, the approval process could prove to be a protracted one, and as in the previous year critical expenditure is being approved 'at risk' prior to the loan being approved.

So far this year, the following items have been approved at risk due to the clinical risks outweighing the financial risk:

Division / Department	Approved at CLG
Planned Care	£ 534,775
Urgent Care	£ 115,207
D&P	£ 747,044
Estates & Facilities	£ 877,176
IM&T	£ 225,711
Central	£ 779,000
Total	**£ 3,278,913**

Further details by scheme can be found in the Capital Update Paper – December 2018 submitted to Board.

In response to a specific request to all Trusts from NHSI, we have re-profiled our 2018/19 capital spend in the light of the significant delays inherent in the loan application process. As a result we anticipate slippage of around £4.3m of the main capital program into 2019/20.

In addition, in relation to the PDC funded Cerner project, due to the externally driven delay, the milestones are currently being re-drawn with NHS Digital, with only £1m (of £2.5m planned) expected to be spent this financial year.

Planning permission was recently received for the renovation of the emergency department and work is in progress.

8.0 Working Balances and Cash

The closing cash balance at the end of November is £1.2m, which is now £3.3m behind plan, primarily due to being 'off control' position.

Following the submission of the 'off control-total' forecast at Month 6, the Trust applied for interim revenue distress funding, of which, £1.6m has now been approved (December 2018). The latest forecast now projects an interim revenue requirement for the rest of the financial year of between £5-6m, reflecting the worsening financial position and, in particular, the loss of Q3-4 PSF funding, but assuming Q2 PSF and the capital loan are eventually received.

The £2m recently awarded to renovate the emergency department is to be made available as PDC, and the Trust will be able to draw the cash as the project progresses to mitigate the cash flow impact.

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

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

9.0 Key Risks and Mitigation

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

- **Additional contractual income** of £1m has been assumed from West Cheshire CCG but to date this has not been formally confirmed. The most likely forecast assumes non receipt of these monies.

The position also includes charges made for therapies activity which has always been counted for but only charged for this month;

- **The CRS target for 2018/19** is a significant risk with a significant proportion unidentified 10% or red rated 44%. Divisions and departments continue to identify and implement schemes, organisation wide schemes are being pursued and a review of reserves and balance sheet opportunities is underway. Model hospital data available on the portal is reviewed monthly within the CRS working Group. The Trust is now on fortnightly monitoring with NHSI in relation to CRS delivery. The Trust is working with the CCG to identify joint initiatives to aid efficiency across the system. The most likely forecast assumes delivery of all blue, green and ambers schemes and a further £274k;

- **Non Elective Activity and Winter Costs** – ward 54 is now permanently open fully utilising the winter reserve and part of the contingency. No additional funding has been received from any of the commissioners to support winter pressure despite a system wide demand and capacity review which identified the requirement for additional beds. Bed occupancy remains high compounded by increased A&E attendances and DTOCs. Discussions are underway with the CCG with support from our regulators NHSI to secure additional support for the cost of winter. The most likely forecast assumes costs incurred by the Trust will be a similar rate to that currently experienced;

- **Delayed Transfers of Care (DTOCs)** - remain high, and contribute to the requirement to keep escalation capacity open, with a disproportionate number relating to Welsh patients. Discussion are on-going with Welsh Health and Social Care commissioners but no financial support has been received to date;

- **Elective activity** – there is an under performance on the elective baseline which has been partly mitigated by the West Cheshire block. This represents a risk going forward into the next financial year. The opening hours of the Jubilee Day Case have been extended from October onwards and capital works have been instructed to enable inpatient elective capacity be ring fenced and thus maintain the position throughout winter. The most likely forecast assumes activity performance will continue at a similar rate for the remainder of the financial year;

- The nursing and medical pay expenditure is the main source of over spending. Maintaining or reducing the current level of expenditure remains a risk. Senior medical and nurse management colleagues have a number of controls and initiatives in place to keep this to a minimum;
- **The proposed capital programme** looks to replace urgent and necessary items to enable business to continue as usual, however, a loan application will be required to proceed with purchases approved. The proposed application has still not been approved; and
- Potential financial implications of **capital VAT implications** in the absence of establishing an alternative delivery model have not been included within the current financial position and

forecast. It is hoped this will be mitigated by the delay in implementation of the capital programme and subsequent depreciation charges.

Appendix 1: Statement of Financial Position and Cash Flow Statement

November 2018 Statement of Financial Position	2018/19 Actual £000	2018/19 Plan £000	2017/18 Out-Turn £000
Property, Plant and Equipment			
Opening	97,880	84,759	81,508
Capital Spend	2,382	6,678	7,648
Depreciation	(2,921)	(2,921)	(4,324)
Disposals	(66)	(66)	(73)
Revaluation			13,121
Closing	97,275	88,450	97,880
Current Assets			
Opening Cash Balance	9,112	9,112	7,093
Increase/(Decrease)	(7,895)	(4,559)	2,019
Closing Cash Balance	1,217	4,553	9,112
Inventories	1,746	1,466	1,437
Trade and Other Receivables	13,841	12,584	14,478
Neonatal Designated Account	2,591	1,891	2,591
Total current assets	19,395	20,494	27,618
Liabilities < 1 Year			
Trade and Other Payables and Provisions	(23,383)	(24,537)	(25,282)
Loans (ITFF)	(4,686)	(5,012)	(4,686)
PPP Loan	(37)	(39)	(37)
Total Net Current Assets	(8,711)	(9,094)	(2,387)
Liabilities > 1 Year			
Trade and Other Payables and Provisions	(1,350)	(1,350)	(1,350)
Loans (ITFF)	(29,581)	(28,694)	(31,924)
PPP Deferred Income	(1,619)	(1,614)	(1,658)
PPP Loan	(2,015)	(2,052)	(2,078)
Total Assets Employed	**53,999**	**45,646**	**58,483**
Capital & Reserves			
PDC	64,079	65,105	63,600
Revaluation Reserve	5,625	4,558	5,625
Income & Expenditure Reserve	(15,705)	(24,017)	(10,742)
Total Capital & Reserves	**53,999**	**45,646**	**58,483**

November 2018 Cash Flow Statement	2018/19 Actual £000	2018/19 Plan £000	2017/18 Out-Turn £000
Surplus	(996)	2,894	7,332
Working Balance Movements	694	1,410	(6,942)
Donated / Grant Funded Asset Additions	166	66	182
Disposal Proceeds	66	-	12
PPP Income/Interest - non cash movements	(44)	(44)	(67)
	(1,502)	4,326	517
Other non cash movement	-	700	-
Capital Expenditure	(2,949)	(7,548)	(4,349)
New PDC	479	1,505	266
Purchase of investments	-	-	(2,591)
New Loans	-	7,035	14,839
Loan re-payments Principle	(3,189)	(9,939)	(5,129)
PPP Loan Repayments Principle	(24)	(24)	(55)
Interest Payable	(439)	(406)	(590)
Interest Received	68	16	41
PDC Dividend Paid	(339)	(224)	(930)
Cash Inflow / (Outflow)	(7,895)	(4,559)	2,019
Opening Cash Balance	9,112	9,112	7,093
Closing Cash Balance	**1,217**	**4,553**	**9,112**

Appendix A

Nursing Pay Position - November 2018 - Key Overspending Areas

Division	Cost Centre	Annual Budget £000s	WTE	Total Budget YTD £000s	Total Spend YTD £000s	Variance YTD £000s	YTD Variance as a % of YTD Budget	Unfunded Specials (inc in Total Spend YTD) £000s	Unfunded Mat Leave (inc in Total Spend YTD) £000s	Agency inc in Total Spend YTD £000s	Reasons for Overspend
Urgent Care	Emergency Department	3,257	81.71	2,176	2,376	200	9%		10	20	Time Critical Nurses 3.20 wte Band 6 over budgeted establishment in year
Urgent Care	Rapid Response Team	981	31.61	660	753	93	14%		13	-	Band 6 1.00 wte Respiratory ESD over established & Band 5 1.00 wte over established
Urgent Care	Ward 47 - Acute Medical Unit	2,508	75.98	1,671	1,760	89	5%		11	77	Band 2 covering Band 5 vacancies, plus 1 wte Band 6 over establishment to cover GPU rota
Urgent Care	IMCU	1,038	34.07	682	723	41	6%	1	-	8	Over established 0.96 wte Band 4 previously funded from winter monies £19k YTD pressure. Also sickness cover £17k YTD
Urgent Care	Ward 51 - Acute Frailty Unit	1,244	41.06	853	914	61	7%	12	6	4	Bank Band 2 to cover sickness £15k YTD
Urgent Care	Bluebell Ward - Eph	2,000	67.48	1,339	1,407	68	5%	6	2	25	Bank Band 2 to cover sickness £55k YTD
Urgent Care	GP Assessment Unit	185	6.48	127	195	68	54%		3	7	Band 5 0.92 wte over established YTD pressure £25k & Band 4 0.64 wte over established YTD pressure £10k
Urgent Care	Ward 49 - Foregate Ward	1,110	35.03	743	809	66	9%	3		32	Pressure relates to previous months when over established on Band 2s £34k YTD pressure
Planned Care	Palace Ward (45)	999	30.52	666	788	122	18%	32		12	Money previously taken to CRS (28 beds to 21 beds) Currently ward back up 28 beds + 1 additional = 29 beds and not funded at this level
Planned Care	Anaesthetic Support	-	-	-	83	83		-	-	3	Premium payments
Planned Care	Theatres 3,4 &5	553	14.55	365	453	88	24%	-	-	-	Premium payments
Planned Care	Bridge Ward (44)	1,058	32.24	704	779	75	11%	6		18	4 Band 5 vacancies covered by Bank Band 5 & Band 2
Planned Care	SAU	136	4.05	87	119	32	36%	-	-	-	Band 7 1.00 wte over established, currently being analysed
Planned Care	Nurse Management	1,040	20.54	739	691	- 48	-6%	-	-	-	Band 8a 1.00 wte unfunded post
Grand Total	**Total**	**16,109**	**475.32**	**10,812**	**11,850**	**1,038**	**10%**	**60**	**45**	**206**	

Appendix B

Medical Pay Position - November 2018 - Key Overspending Areas

Division	Cost Centre	Annual Budget £000s	WTE	Total Budget YTD £000s	Total Spend YTD £000s	YTD Variance £000s	YTD Variance as a % of YTD Budget	Agency (inc in Total Spend YTD) £000s	ACAs (inc in Total Spend YTD) £000s	Reasons for Overspend
Planned Care	Urology	741	7.00	491	722	**231**	**47%**	187	81	Training monies for 2 wte ST1/2 posts retracted 5/6 years ago and posts still filled, plus in Nov 1.00 wte over established staff grade. Also agency cover for Consultant
Planned Care	Vascular Surgery	1,451	14.00	971	1,154	**183**	**19%**	51	55	1.40 wte vacancy at ST3+ covered by locum & agency £42k, Consultant ACAs £45k, ST1/2 & F2 combined over establishment £95k
Planned Care	Ear Nose And Throat	1,093	11.14	730	907	**177**	**24%**	339	18	ST3 1.00 wte vacancy & 3.00 wte ST1/2 vacancies covered by agency
Planned Care	Plastic Surgery	954	11.66	635	797	**162**	**26%**	151	7	1.00 wte ST3 vacancy & 3.00 wte ST1/2 vacancies covered by agency
Planned Care	Ophthalmology	1,486	15.60	984	1,134	**150**	**15%**	90	80	Consultant cover costs £64k YTD mainly ACAs, plus staff grade vacancy covered by agency but new starter due
Planned Care	Anaesthetics	6,337	61.35	4,197	4,334	**137**	**3%**	21	84	2 wte F2s over established in month, previous pressure relates to covering 3 wte staff grade vacancies
Planned Care	Paediatrics Medical	2,388	26.83	1,594	1,731	**137**	**9%**	124	3	ST3 vacancies & ST1/2 vacancy covered by agency
Planned Care	Trauma And Orthopaedics	2,335	24.75	1,566	1,677	**111**	**7%**	117	24	1.00 wte ST3 vacancy £87k pressure YTD, 1.00 wte ST1/2 £67k ytd
Planned Care	OMFU	810	9.55	536	598	**62**	**12%**	-	33	5th ST1/2 , we have a budget for 4, HEE fund us for 5 , PC budget needs increasing. But looking to reduce to 4 posts from Apr 19
Planned Care	O&G	2,877	29.17	1,918	1,959	**41**	**2%**	84	16	ST3 & ST1/2 agency usage in M8 - no gaps, being analysed
Urgent Care	Emergency Department -M	2,960	34.78	1,959	2,530	**571**	**29%**	558	57	6 wte Specialty Doctor gaps, 0.30 wte consultant gap, 1.91 wte ST1/2 gaps (£340K) covered by agency £558k. Locums to cover extra work pressures £353k YTD
Urgent Care	Acute Medicine Staff	1,499	16.68	993	1,175	**182**	**18%**	39	58	0.07 wte over establishment on Consultant £23k YTD, 2 locum consultants in post £35k YTD, currently 1 agency consultant £44k YTD. ST1/2 currently 1.22 wte over established £11k YTD, and £12k over YTD for extra cover work pressures
Total		**24,931**	**263**	**16,574**	**18,718**	**2,144**	**13%**	**1,761**	**516**	

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Capital Programme Update – December 2018
Date of Meeting	Trust Board 18th December 2018
Author(s)	Simon Holden, Director of Finance Sue Phillipson, Head of Financial Management
Annual Plan Objective No.	
Summary	This paper is intended to provide an update on the Trust Capital Programme for 2018/19. Reviewing the original plan, spend to date and forecast spend for the year, for both Capital Loan Funded schemes and PDC Funded schemes
Recommendation(s)	**The Board is asked to note:** • The "most likely" forecast spend, against both Capital Loan funded schemes and Public Dividend Capital (PDC) funded schemes; • Within the Capital Loan funded schemes, the items already approved by Executive Team & Corporate Leadership Group (CLG) to effectively purchase some items in advance of the loan being confirmed (of £3,279k), and the risk associated with this; • The uncertainty for future capital planning decisions, due to capital loan funding notification being significantly delayed for the last 2 years, and the resultant potential impact on clinical care; and • The further risk (of £2,060k) with regards to "urgent and necessary" capital, which will need to be sanctioned in early January 2019, potentially at risk, in order to both minimise clinical risk, and also ensure that monies are spent before 31 March 2019 in line with plans already submitted to NHS Improvement.
Risk Score	**N/A**

FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [ ] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [X] **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.

Trust Board
Capital Programme Update
December 2018

1. Overview

The Trust capital loan application was submitted at the beginning of the financial year 2018/19. To date we have not received any confirmation that our loan application has been successful and latest intelligence suggests that we may not receive this until January 2019. Please find below a summary of both the Capital Loan funded schemes and PDC funded schemes, detailing requested funding against forecast spend for 2018/19:-

Description	Funding Requested £000s	Forecast Spend 2018/19 £000s
Capital Loan Funded	6,959	5,279
PDC Funded:-		
- Fast Follower PAS	2,500	1,000
- ED Extension & Refurb	2,000	2,000
Total	**11,459**	**8,279**

2. Capital Loan Funded Schemes

The Capital Loan Application of £6,959k (approved at Board in May 2018) comprises only items deemed to be 'Urgent and Necessary' totalling £6,430k and £529k to support repayment of previous capital loans over and above depreciation.

In advance of the receipt of the loan funding, in November, we were asked by NHSI to provide a forecast of our capital spend in 2018/19. We estimated this to be £5,279k based on expenditure already incurred to date and items that had been submitted to CLG for approval in advance of receipt of the loan where the operational risk was deemed to be greater than the financial risk. In the table below is a breakdown by Division of the following information: -

- The items included within the £6,959k original loan application.
- The Forecast Expenditure for 2018/19 submitted to NHSI in November 2018.

- Of this Forecast Expenditure, the items already approved at CLG and being progressed, which total £3,279k and represent a significant financial risk to the Trust if the capital loan is not approved.
- The further 'Urgent and Necessary' items awaiting CLG approval, which totals £2,060k. Again as mentioned above this would represent a significant financial risk to the Trust if the loan is not approved.
- The production of a revised Forecast Expenditure for 2018/19 as at December 2018.

DIVISION	EQUIPMENT	Original Plan (Loan Application Figure)	Forecast Expenditure as at Nov 18	Approved at CLG	Awaiting Approval at CLG	Revised Forecast 18/19
Central	Capital Staffing	£ 250,000	£ 250,000	£ 250,000		£ 250,000
Central	Loan repayment above depreciation	£ 529,000	£ 529,000	£ 529,000		£ 529,000
Central Total		£ 779,000	£ 779,000	£ 779,000	£ -	£ 779,000
D&P	BF - 1 Ultrasound scanner Breast	£ 51,871	£ 47,768	£ 47,768		£ 47,768
D&P	BF - 2 Cytotoxic isolators	£ 60,876	£ 60,876	£ 60,876		£ 60,876
D&P	CT scanner (advanced)	£ 564,000	£ 564,000	£ 564,000		£ 564,000
D&P	Microscope with teaching arm(s)	£ 14,902	£ 14,902		£ 14,902	£ 14,902
D&P	Replacement of Pharmacy Robot.	£ 480,000	£ -			£ -
D&P	TEMPERATURE MONITORING SYSTEM	£ 60,000	£ 60,000		£ 60,000	£ 60,000
D&P	Ultrasound Machine	£ -	£ 74,400	£ 74,400		£ 74,400
D&P	US Breast unit	£ 192,000	£ -			£ -
D&P Total		£ 1,423,649	£ 821,946	£ 747,044	£ 74,902	£ 821,946
EDTC HR	Defibrillators	£ 140,000	£ 140,000		£ 140,000	£ 140,000
EDTC HR Total		£ 140,000	£ 140,000	£ -	£ 140,000	£ 140,000
Estates and Facilities	150 litre steam heated cooking kettles	£ 24,000	£ -			£ -
Estates and Facilities	BF - Cancer Tracker conversion	£ 50,000	£ 55,716	£ 55,716		£ 55,716
Estates and Facilities	BF - Chilled water plant JDSC	£ 31,029	£ 31,029	£ 31,029		£ 31,029
Estates and Facilities	BF - Distribution Boards 52, 53, 42, 46, 47 and A&E	£ 59,693	£ 59,693	£ 18,355	£ 41,338	£ 59,693
Estates and Facilities	BF - Equipment and Controls Heating and Ventilation Plant Room 2 (further use of CHP waste heat may be possible as part of this project)	£ 529,200	£ -			£ -
Estates and Facilities	BF - Exec Relocation	£ 56,138	£ 56,138	£ 56,138		£ 56,138
Estates and Facilities	BF - Fire Alarm upgrades, Fire Compartmentation works (that includes works arising from risk assessments and audits	£ 60,000	£ 6,000			£ -
Estates and Facilities	BF - Medical Gases, Electrical upgrade Neonatal Unit	£ 75,000	£ -			£ -
Estates and Facilities	BF - Theatre 9	£ 589,650	£ 589,650	£ 589,650		£ 589,650
Estates and Facilities	BF - Theatre Chillers	£ 38,029	£ -			£ -
Estates and Facilities	BF - Washing machine replacement	£ 6,000	£ -			£ -
Estates and Facilities	Chiller Haygarth	£ 17,000	£ -			£ -
Estates and Facilities	Community Dental Ventilation	£ 30,000	£ 30,000		£ 30,000	£ 30,000
Estates and Facilities	Cooker	£ 11,000	£ 11,370	£ 11,370		£ 11,370
Estates and Facilities	JDSC EXTENSION	£ -	£ 50,000	£ 50,000		£ 50,000
Estates and Facilities	JDSC Lift	£ 19,000	£ -			£ -
Estates and Facilities	LED lighting	£ 24,000	£ 3,332	£ 12,692		£ 12,692
Estates and Facilities	Nurse Call Ward 46/54/Antenatal	£ 54,000	£ 54,000		£ 26,000	£ 26,000
Estates and Facilities	Plant Room 11 supplying heating and hot water to Wards 48,49,50,51 and ward 60	£ 60,000	£ -			£ -
Estates and Facilities	Ride on scrubber/drier	£ 21,600	£ -			£ -
Estates and Facilities	Staff Restaurant heating system upgrade	£ 18,000	£ 18,000		£ 18,000	£ 18,000
Estates and Facilities	Steamer	£ 11,000	£ -	£ 9,288		£ 9,288
Estates and Facilities	Substation D - retention > order value (16/17)	£ -		£ 2,474		£ 2,474
Estates and Facilities	Substation E (Emergency Standby Generator)	£ -	£ 40,000	£ 40,464		£ 40,464
Estates and Facilities	Vacuum Plant in Women and Children's Building is non compliant, AGSS individual systems required	£ 96,000	£ 96,000		£ 96,000	£ 96,000
Estates and Facilities Total		£ 1,880,339	£1,100,928	£ 877,176	£ 211,338	£1,088,514

IM&T	Air Handling Units Data Centre 1	£	27,000	£	26,923	£	26,923			£	26,923
IM&T	BF - EPR - Tech Fund - outstanding balance from NHS Digital monies not spent (I Giffins) to be used to purchase computer hardware required to provide Cerner access to wards	£	43,808	£	43,792	£	43,792			£	43,792
IM&T	BF - Network Access Control	£	144,000	£	144,000	£	144,000			£	144,000
IM&T	Ensure evolve servers are on Microsoft SQL Platform - one off	£	15,000	£	15,000			£	15,000	£	15,000
IM&T	KACE supports the trusts virtualised infrastructure maximisation of server resources. Revenue cost to support Server Patching Tool Set above	£	5,000	£	5,000			£	5,000	£	5,000
IM&T	NAGOIS early warning to prevent outages	£	10,000	£	10,000			£	10,000	£	10,000
IM&T	PACS (Breast Screening Programme)	£	-							£	-
IM&T	Pager Replacement	£	77,220	£	77,220			£	77,220	£	77,220
IM&T	Server and License Refresh (Cyber Security) (windows 2008)	£	75,000	£	75,000			£	75,000	£	75,000
IM&T	Server Patching Tool Set (Security Patches)	£	25,000	£	25,000			£	25,000	£	25,000
IM&T	Teletracking	£	-	£	10,996	£	10,996			£	10,996
IM&T	Virtual Server Rolling Refresh	£	50,000	£	50,000			£	50,000	£	50,000
IM&T Total		**£**	**472,028**	**£**	**482,931**	**£**	**225,711**	**£**	**257,220**	**£**	**482,931**
Planned Care	Anaesthetic machine / Vent	£	58,145	£	58,145			£	58,145	£	58,145
Planned Care	Automatic Tourniquet	£	5,254	£	-					£	-
Planned Care	BF - 2 Europrobe Sentinel Node Machines (Breast Surgery)	£	40,000	£	40,000	£	40,000			£	40,000
Planned Care	BF - 3 Anaesthetic machines	£	54,000	£	54,000			£	54,000	£	54,000
Planned Care	BF - 3 Ultrasound scanners CLS / ANC	£	120,077	£	111,437	£	111,437			£	111,437
Planned Care	BF - 8 CPAP / Bipap devices	£	69,000	£	69,000	£	69,000			£	69,000
Planned Care	BF - Duoscope 25	£	49,975	£	49,975			£	49,975	£	49,975
Planned Care	BF - ENT Power control Units	£	90,000	£	90,000			£	90,000	£	90,000
Planned Care	BF - Fetal Monitor	£	9,909	£	9,909			£	9,909	£	9,909
Planned Care	BF - Fetal Monitoring	£	27,198	£	2,037	£	2,037			£	2,037
Planned Care	BF - Patient trolley	£	9,137	£	9,137			£	9,137	£	9,137
Planned Care	BF - Slitlamp	£	28,320	£	28,320			£	28,320	£	28,320
Planned Care	BF 1T240 Bronchoscope	£	116,640	£	116,640			£	116,640	£	116,640
Planned Care	Bladder Scanner (urology)	£	9,504	£	9,504			£	9,504	£	9,504
Planned Care	Blood Scavenging System	£	28,800	£	28,800	£	28,800			£	28,800
Planned Care	Colposcope	£	15,161	£	15,161			£	15,161	£	15,161
Planned Care	Defibrillator monitor & rec & AED	£	94,479	£	94,479			£	94,479	£	94,479
Planned Care	Defibrillator monitor & rec & pacer	£	21,281	£	21,281			£	21,281	£	21,281
Planned Care	Fetal Monitor	£	21,279	£	21,279			£	21,279	£	21,279
Planned Care	Fundus Camera	£	83,585	£	37,000	£	37,000			£	37,000
Planned Care	HSDU Autoclave	£	-	£	-	£	71,667			£	71,667
Planned Care	Humphrey Field Analyser	£	77,371	£	77,371			£	77,371	£	77,371
Planned Care	Microscope	£	12,263	£	12,263			£	12,263	£	12,263
Planned Care	OPERATING TABLE, MODEL MR	£	50,400	£	-					£	-
Planned Care	ORTHOSTAR OPERATING TABLE	£	244,800	£	132,706	£	132,706			£	132,706
Planned Care	Slit lamp	£	86,400	£	86,400			£	86,400	£	86,400
Planned Care	STILLE IMAGIQ TABLE	£	79,200	£	79,200			£	79,200	£	79,200
Planned Care	Surgical Diathermy	£	28,645	£	32,178	£	32,178			£	32,178
Planned Care	Synoptophore	£	21,600	£	21,600			£	21,600	£	21,600
Planned Care	THEATRE INSTRUMENTS	£	100,381	£	9,950	£	9,950			£	9,950
Planned Care	TJF 240 Duodenoscope	£	201,600	£	201,600			£	201,600	£	201,600
Planned Care Total		**£**	**1,854,403**	**£**	**1,519,372**	**£**	**534,775**	**£**	**1,056,264**	**£**	**1,591,039**

Urgent Care	9 BIPAPS	£ 77,625	£ 77,625		£ 77,625	£ 77,625
Urgent Care	BF - Central System Support - AMU & Stroke	£ 38,877	£ 38,877	£ 38,877		£ 38,877
Urgent Care	BF - Measure Dose Dosimeter - CRV (KOKO)	£ 5,872	£ 5,872	£ 5,872		£ 5,872
Urgent Care	Defibrillators	£ 173,700	£ 173,700		£ 173,700	£ 173,700
Urgent Care	Development of Older Persons Assessment Unit (EMU)	£ 45,000	£ 45,000	£ 45,000		£ 45,000
Urgent Care	ECG Machine ED		£ -			£ -
Urgent Care	Echocardiography & vascular ultrasound machine	£ 68,785	£ 68,785		£ 68,785	£ 68,785
Urgent Care	Ward 34 Additional Bay	£ -	£ 25,458	£ 25,458		£ 25,458
Urgent Care Total		£ 409,859	£ 435,317	£ 115,207	£ 320,110	£ 435,317
Grand Total		**£ 6,959,278**	**£5,279,494**	**£3,278,913**	**£2,059,834**	**£5,338,747**

3. PDC Funded Capital

- **Fast Follower PAS**
  £2,500k PDC funding has been approved to support this development in 18/19. Forecast spend for the year is £1,000k. The Trust has been offered a revised funding profile in line with the current spend forecast. Therefore the funding will be available in future years to align with the revised projected spend profile.

- **ED Extension & Refurbishment**
  £2,000k PDC funding has been approved to support this development in 18/19. Forecast spend for the year is £2,000k.

4. Summary

The Trust Board are asked to note the progress made against both Capital Loan funded and PDC funded capital schemes and acknowledge the expenditure incurred to date in advance of receipt of the capital loan and subsequent financial risk should the capital loan not be received.

BOD Item No

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Cash Requirements from December 2018
Date of Meeting	18th December 2018
Author(s)	Ray Thomas, Assistant Director of Finance
Presented by	Simon Holden, Director of Finance
Annual Plan Objective No.	
Summary	This paper is intended to brief the Board on the likely interim revenue financing required for the remainder of 2018/19, and to ask the Board to pass a resolution accepting the terms of the loans (latest draft attached) and to identify, and update, the authorised signatories.
Recommendation(s)	**The Board is asked to** pass a resolution as follows: (A) approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party; (B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; (C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party; and (D) confirming the Borrower's undertaking to comply with the Additional Terms and Conditions To this end it is suggested that the Board authorise either of: • Dr Susan Gilby Acting Chief Executive; and • Simon Holden Director of Finance to approve the loan agreements and other documents referred to above, including any subsequent utilisation request.
Risk Score	**N/A**

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

Countess of Chester Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS
18 December 2018

Revenue Cash Requirements 2018/19

1) INTRODUCTION

On the current trajectory the Trust will have exhausted its cash reserves in the December 2018. This is due to the combined effect of:

- non-receipt of Quarter 2 2018/19 Provider Sustainability Funding (PSF);
- underlying revenue deficits;
- capital loan repayments; and
- the delays in receiving Department of Health and Social Care (DHSC) approval for the interim capital loan submitted earlier in the year.

The latest forecast for 2018/19 is a net revenue cash requirement as follows:

Cash Requirement 2018/19	**£000**
Revenue	5,531
Possible increase due to urgent capital	2,567
Total potential forecast revenue borrowing	**8,098**

We understand that, until the interim capital loan is approved by DHSC, any urgent capital that has been committed by the Trust may be temporarily added to the interim revenue loan. This requires DHSC approval on a case by case basis, however, and so is not guaranteed.

Therefore, a separate loan agreement is required for each monthly drawdown.

In order to enter into any of the required loan agreements the Board must approve the terms of the loans. Unfortunately, NHS Improvement is unwilling to commence the loan application process until the Trust anticipates running out of cash in the following month.

However, the Interim Loan Agreement has not changed substantively since the Board approved the Interim Loan Agreement during 2017/18, and so this paper is intended to allow the Board to agree a “in principle” regime, similarly to previous years, for loans to be signed.

From a practical perspective, it would seem sensible to leave the amount of the loans undefined, and simply say that the Board Resolution will cover the required revenue amounts which will be reported to the Board as part of the regular Monthly Finance Report.

2) DISTRESS REVENUE FINANCE

In order to support the Trust’s revenue cash requirement, an application must be made to NHS Improvement (who then review and pass to DHSC).

The loan has no requirement for repayment of the principle until a future date, generally around 3 to 4 years from the date of signature, when the entire amount falls due. NHSI / DHSC are currently considering options to improve the current loan process which will include "tidying up" the large number of individual loans currently in existence across the provider sector.

In practice, The Trust is required to submit 13 week daily cash-flows to support any financing request.

Significantly, there remains a requirement for the Trust to sign up to a list of actions around the delivery of certain national initiatives (***Schedule 8*** of the loan agreement), namely:

- Setting of surplus/deficit and capital limits
- Nursing Agency Expenditure
- Professional Services Consultancy Spend
- Very Senior Manager Pay Costs
- Estate Costs
- Surplus Land
- Procure 21
- Financing and Accounting and Payroll
- Bank Staffing
- Procurement
- Crown Commercial Services
- EAA and non-EAA Patient Cost Reporting

It is also stated that compliance with these standards will be monitored, although (to date) this has not been the case. Nonetheless, the Board must accept that it may be monitored against compliance with these NHS standards in the future. This may be more enormous given the fact that the Trust is now in formal turnaround.

A copy of the last Interim Revenue Loan drawn, in March 2018, is attached for information.

3) BOARD RESOLUTION

In order to enter into the required Loan Agreements in the future, the Board is required to pass a resolution as follows:

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

To this end it is suggested that the Board authorise either of:

- Dr Susan Gilby — Acting Chief Executive; and
- Simon Holden — Director of Finance

to approve the Loan Agreements, and other documents referred to above, including any subsequent utilisation request.

Whilst it is accepted that at this stage, we cannot confirm the exact amount of loans that will be required, the resolution should allow the Trust to react quickly as the actual financing requirements become clear, without the need for calling an Extraordinary Board to approve the required documentation at short notice.

Any significant changes in any of the Loan Agreement terms would be brought back for the Board to consider before any further commitment was made.

Ray Thomas
Assistant Director of Finance
December 2018

Appendices:
Loan Agreement – Blank – ISUCL

DATED 2018

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
(as Borrower)

and

THE SECRETARY OF STATE FOR HEALTH
(as Lender)

£3,720,000.

UNCOMMITTED SINGLE CURRENCY INTERIM REVENUE SUPPORT FACILITY AGREEMENT

REF NO: DHPF/ISUCL/RJR/2018-02-28/A

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THIS AGREEMENT is dated 2018 and made between:

(1) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST** of **The Countess of Chester Health Park, Liverpool Road, Chester, CH2 1UL** (the **"Borrower" which expression shall include any successors in title or permitted transferees or assignees**); and

(2) **THE SECRETARY OF STATE FOR HEALTH** as lender (the **"Lender" which expression shall include any successors in title or permitted transferees or assignees**).

IT IS AGREED as follows:

1. DEFINITIONS AND INTERPRETATION

1.1 Definitions

In this Agreement:

"Account" means the Borrower's account held with the Government Banking Service.

"Act" means the National Health Service Act 2006 as amended from time to time.

"Additional Terms and Conditions" means the terms and conditions set out in Schedule 8.

"Agreed Purpose" means working capital expenditure for use only if it has insufficient working capital available as set out under the Terms of this Agreement, to maintain the provision of the Borrower's services in its capacity as an NHS Body. For the purposes of this agreement, working capital expenditure shall include repayment of outstanding loans under any working capital facility provided by the Lender to the Borrower.

"Authorisation" means an authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration.

"Available Facility" means the Facility Amount less:

(A) all outstanding Loans; and

(B) in relation to any proposed Utilisation, the amount of any Loan that is due to be made on or before the proposed Utilisation Date.

"Availability Period" means two years from and including the date of this Agreement. The Availability Period may be extended, at the Borrower's option, subject to no outstanding Event of Default. Any extension can be for a period of up to twelve months, subject to the Availability Period expiring no later than the Final Repayment Date.

"Business Day" means a day (other than a Saturday or Sunday) on which banks are open for general banking business in London.

"Capital Limit" means the overall maximum net inflow/outflow from investing activities incurred by the Borrower as set by the Lender for any relevant financial year

"Cash Balance" means the Borrower's available cash balances, whether held within the Government Banking Service or otherwise, on the Utilisation Date to the Monday preceding the 18th day of the following Month.

"Cashflow Forecast" means the Borrower's current rolling 13 week cashflow forecast in a form to be agreed with the Lender from time to time (and as prepared on behalf of the Borrower's Board). The forecast must include all utilisations and proposed utilisations under any agreement with the Lender for the relevant period.

"Compliance Framework" means the relevant Supervisory Body's frameworks and/or any replacement to such frameworks for monitoring and assessing NHS Bodies and their compliance with any consents, permissions and approvals.

"Dangerous Substance" means any natural or artificial substance (whether in a solid or liquid form or in the form of a gas or vapour and whether alone or in combination with any such other substance) capable of causing harm to the Environment or damaging the Environment or public health or welfare including any noxious, hazardous, toxic, dangerous, special or controlled waste or other polluting substance or matter.

"Default" means an Event of Default or any event or circumstance specified in Clause 18 (*Events of Default*) which would (with the expiry of a grace period, the giving of notice, the making of any determination under the Finance Documents or any combination of any of the foregoing) be an Event of Default.

"Default Rate" means the official bank rate (also called the Bank of England base rate or BOEBR) plus 300 basis points per annum.

"Deficit Limit" means the Surplus/Deficit outturn for the Borrower set by the Lender for any relevant financial year before impairments and transfers.

"Environment" means the natural and man-made environment and all or any of the following media namely air (including air within buildings and air within other natural or man-made structures above or below ground), water (including water under or within land or in drains or sewers and inland waters), land and any living organisms (including humans) or systems supported by those media.

"Environmental Claim" means any claim alleging liability whether civil or criminal and whether actual or potential arising out of or resulting from the presence at on or under property owned or occupied by the Borrower or presence in or escape or release into the environment of any Dangerous Substance from any such property or in circumstances attributable to the operation of the Borrower's activities or any breach of any applicable Environmental Law or any applicable Environmental Licence.

"Environmental Law" means all statutes, instruments, regulations, orders and ordinances (including European Union legislation, regulations, directives, decisions and judgements applicable to the United Kingdom) being in force from time to time and directly enforceable in the United Kingdom relating to pollution, prevention thereof or protection of human health or the conditions of the Environment or the use, disposal, generation, storage, transportation, treatment, dumping, release, deposit, burial, emission or disposal of any Dangerous Substance.

"Environmental Licence" shall mean any permit, licence, authorisation, consent or other approval required by any Environmental Law or the Planning (Hazardous Substances) Act 1990.

"Event of Default" means any event or circumstance specified as such in Clause 18 (*Events of Default*).

"Facility" means the uncommitted interim support facility made available under this Agreement as described in Clause 2 (*The Facility*).

"Facility Amount" means **£3,720,000.** at the date of this Agreement and thereafter that amount to the extent not cancelled, reduced or transferred by the Lender or the Borrower (as may be amended by the Lender from time to time).

"Final Repayment Date" means 18 March 2021.

"Finance Documents" means:

(A) this Agreement; and

(B) any other document designated as such by the Lender and the Borrower.

"Financial Indebtedness" means any indebtedness for or in respect of:

(A) moneys borrowed;

(B) any amount raised by acceptance under any acceptance credit facility;

(C) any amount raised pursuant to any note purchase facility or the issue of bonds, notes, debentures, loan stock or any similar instrument;

(D) the amount of any liability in respect of any lease or hire purchase contract which would, in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies, be treated as a finance or capital lease;

(E) receivables sold or discounted (other than any receivables to the extent they are sold on a non-recourse basis);

(F) any amount raised under any other transaction (including any forward sale or purchase agreement) having the commercial effect of a borrowing;

(G) any derivative transaction entered into in connection with protection against or benefit from fluctuation in any rate or price (and, when calculating the value of any derivative transaction, only the marked to market value shall be taken into account);

(H) any counter-indemnity obligation in respect of a guarantee, indemnity, bond, standby or documentary letter of credit or any other instrument issued by a bank or financial institution; and

(I) the amount of any liability in respect of any guarantee or indemnity for any of the items referred to in paragraphs (A) to (H) above.

"Government Banking Service" means the body established in April 2008 being the banking shared service provider to government and the wider public sector incorporating the Office of HM Paymaster General (OPG).

"Interest Payment Date" means the last day of an Interest Period.

"Interest Period" means, in relation to a Loan, the period determined in accordance with Clause 9 (*Interest Periods*) and, in relation to an Unpaid Sum, each period determined in accordance with Clause 8.3 *(Default interest).*

"**Interest Rate**" means 1.50% per annum, or other applicable interest rate that shall be notified by the Lender to the Borrower in respect of each Loan upon Utilisation.

"Licence" means the licence issued by Monitor to any person who provides a health care service for the purposes of the NHS.

"Limits" means the Deficit Limit and/or the Capital Limit where set out in the Finance Document

"Loan" means a loan made or to be made under the Facility or the principal amount outstanding for the time being of that loan.

"Material Adverse Effect" means a material adverse effect on:

(A) the business or financial condition of the Borrower;

(B) the ability of the Borrower to perform any of its material obligations under any Finance Document;

(C) the validity or enforceability of any Finance Document; or

(D) any right or remedy of the Lender in respect of a Finance Document.

"Minimum Cash Balance" means £1,252,000

"**Monitor**" means the sector regulator for health care services in England or any successor body to that organisation

"Month" means a period starting on one day in a calendar month and ending on the numerically corresponding day in the next calendar month, except that:

(A) (subject to paragraph (C) below) if the numerically corresponding day is not a Business Day, that period shall end on the next Business Day in that calendar month in which that period is to end if there is one, or if there is not, on the immediately preceding Business Day;

(B) if there is no numerically corresponding day in the calendar month in which that period is to end, that period shall end on the last Business Day in that calendar month; and

(C) if a period begins on the last Business Day of a calendar month, that period shall end on the last Business Day in the calendar month in which that period is to end,

provided that the above rules will only apply to the last Month of any period.

"NHS Body" means either an NHS Trust or an NHS Foundation Trust , or any successor body to that organisation**.**

"NHS Improvement" means the body incorporating the roles of Monitor and the NHS Trust Development Authority and acting as the health sector regulator providing healthcare transformation, regulatory and patient safety expertise.

"NHS Trust Development Authority" means the body responsible for monitoring the performance of NHS Trusts and providing assurance of clinical quality, governance and risk in NHS Trusts, or any successor body to that organisation;

"Original Financial Statements" means a certified copy of the audited financial statements of the Borrower for the financial year ended 31st March 2016.

"Participating Member State" means any member state of the European Communities that adopts or has adopted the euro as its lawful currency in accordance with legislation of the European Community relating to Economic and Monetary Union.

"Party" means a party to this Agreement.

"Permitted Security" means:

(A) normal title retention arrangements arising in favour of suppliers of goods acquired by the Borrower in the ordinary course of its business or arising under conditional sale or hiring agreements in respect of goods acquired by the Borrower in the ordinary course of its business;

(B) liens arising by way of operation of law in the ordinary course of business so long as the amounts in respect of which such liens arise are not overdue for payment;

(C) any existing Security listed in Schedule 7;

(D) any Security created or outstanding with the prior written consent of the Lender; and

(E) any other Security securing in aggregate not more than £150,000 at any time.

"Relevant Consents" means any authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration of whatsoever nature necessary or appropriate to be obtained for the purpose of entering into and performing the Borrower's obligations under the Finance Documents.

"Relevant Percentage" means in respect of each Repayment Date, the percentage figure set opposite such Repayment Date in the Repayment Schedule.

"Repayment Dates" means the repayment dates set out in the Schedule 6 (Repayment Schedule).

"Repayment Instalment" means each instalment for the repayment of the Loan referred to in Clause 6.2.

"Repayment Schedule" means the repayment schedule set out in Schedule 6 (*Repayment Schedule*).

"Repeating Representations" means each of the representations set out in Clause 14 (*Representations*) other than those under Clauses 14.9, 14.10, 14.12.2 and 14.16.2.

"Security" means a mortgage, charge, pledge, lien or other security interest securing any obligation of any person or any other agreement or arrangement having a similar effect.

"Supervisory Body" means NHS Improvement, incorporating and representing both of the bodies previously known as the NHS Trust Development Authority and Monitor..

"Tax" means any tax, levy, impost, duty or other charge or withholding of a similar nature (including any penalty or interest payable in connection with any failure to pay or any delay in paying any of the same).

"Tax Deduction" means a deduction or withholding for or on account of Tax from a payment under a Finance Document.

"Test Date" means the Utilisation Date and each Interest Payment Date.

"Unpaid Sum" means any sum due and payable but unpaid by the Borrower under the Finance Documents.

"Utilisation" means a utilisation of the Facility.

"Utilisation Date" means the date of a Utilisation, on which a drawing is to be made under the Facility, such date to be the Monday preceding the 18th day of any month.

"Utilisation Request" means a notice substantially in the form set out in Schedule 2 (*Utilisation Request*).

"VAT" means value added tax as provided for in the Value Added Tax Act 1994 and other tax of a similar nature, whether imposed in the UK or elsewhere.

1.2 **Construction**

1.2.1 Unless a contrary indication appears, any reference in any Finance Document to:

(A) the **"Lender"**, the **"Borrower"** the **"Supervisory Body"** or any **"Party"** shall be construed so as to include its successors in title, permitted assigns and permitted transferees;

(B) **"assets"** includes present and future properties, revenues and rights of every description;

(C) a **"Finance Document"** or any other agreement or instrument is a reference to that Finance Document or other agreement or instrument as amended or novated;

(D) **"indebtedness"** shall be construed so as to include any obligation (whether incurred as principal or as surety) for the payment or repayment of money, whether present or future, actual or contingent;

(E) a **"person"** includes any person, firm, company, corporation, government, state or agency of a state or any association, trust or partnership (whether or not having separate legal personality) or two or more of the foregoing;

(F) a **"regulation"** includes any regulation, rule, official directive, request or guideline (whether or not having the force of law) of any governmental, intergovernmental or supranational body, agency, department or regulatory, self-regulatory or other authority or organisation;

(G) **"repay"** (or any derivative form thereof) shall, subject to any contrary indication, be construed to include **"prepay"** (or, as the case may be, the corresponding derivative form thereof);

(H) a provision of law is a reference to that provision as amended or re-enacted;

(I) a time of day is a reference to London time; and

(J) the word **"including"** is without limitation.

1.2.2 Section, Clause and Schedule headings are for ease of reference only.

1.2.3 Unless a contrary indication appears, a term used in any other Finance Document or in any notice given under or in connection with any Finance Document has the same meaning in that Finance Document or notice as in this Agreement.

1.2.4 A Default (other than an Event of Default) is **"continuing"** if it has not been remedied or waived and an Event of Default is **"continuing"** if it has not been waived or remedied to the satisfaction of the Lender.

1.3 **Third party rights**

1.3.1 Except as provided in a Finance Document, the terms of a Finance Document may be enforced only by a party to it and the operation of the Contracts (Rights of Third Parties) Act 1999 is excluded.

1.3.2 Notwithstanding any provision of any Finance Document, the Parties to a Finance Document do not require the consent of any third party to rescind or vary any Finance Document at any time.

2. THE FACILITY

2.1 Subject to the terms of this Agreement, the Lender makes available to the Borrower an uncommitted sterling interim support facility in an aggregate amount equal to the Facility Amount under the terms of which the Lender may, in its sole and absolute discretion, provide Loans to the Borrower from time to time, unless the Lender, in its sole and absolute discretion, has previously notified the Borrower of the termination of the Facility.

2.2 This agreement is not, nor shall it be deemed to constitute, a commitment on the part of the Lender to make any extension of credit to or for the account of the borrower and may not be relied upon by the Borrower for any financing.

2.3 The Lender reserves the right to revoke or withdraw this agreement and the facility in its sole and absolute discretion at any time.

2.4 The Facility shall be utilised by the Borrower for the purposes of and/or in connection with its functions as an NHS Body.

3. PURPOSE

3.1 Purpose

The Borrower shall apply all Loans towards financing or refinancing the Agreed Purpose.

3.2 Pending application

Without prejudice to Clause 3.1 *(Purpose)*, pending application of the proceeds of any Loan towards financing or refinancing the Agreed Purpose, the Borrower must deposit such proceeds in the Account.

3.3 Monitoring

The Lender is not bound to monitor or verify the application of any amount borrowed pursuant to this Agreement.

4. CONDITIONS OF UTILISATION

4.1 Initial conditions precedent

The Borrower may not deliver the first Utilisation Request unless the Lender has received all of the documents and other evidence listed in Schedule 1 (*Conditions precedent*) in form and substance satisfactory to the Lender or to the extent it has not received the same, it has waived receipt of the same. The Lender shall notify the Borrower promptly upon being so satisfied.

4.2 Further conditions precedent

The Lender will only comply with a Utilisation Request if on the date of the Utilisation Request and on the proposed Utilisation Date:

4.2.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware;

4.2.2 the Repeating Representations to be made by the Borrower with reference to the facts and circumstances then subsisting are true in all material respects; and,

4.2.3 the Borrower has provided to the Lender its most recent 13 week cash flow forecast, together with any other information that may from time to time be required.

5. UTILISATION

5.1 Utilisation

5.1.1 The Borrower may take Loans from time to time hereunder, subject to receipt by the Lender from the Borrower, of a Utilisation Request in accordance with this Agreement and an appropriate Cashflow Forecast.

5.1.2 The Utilisation Request must be for an amount not greater than the amount specified under Clause 5.4.2

5.1.3 Where agreed by the Lender, the proceeds of a Utilisation may be used to repay outstanding loans under any working capital facility between the Lender and the Borrower provided that:

(A) Such agreement is granted by the Lender;

(B) any request is included in the Cashflow Forecast; and

(C) that such repayment is received by the Lender on the same working day as the Utilisation.

5.2 Delivery of a Utilisation Request

The Borrower may utilise the Facility by delivery to the Lender of a duly completed Utilisation Request not later than 11.00 a.m. five Business Days before the proposed Utilisation Date unless otherwise agreed.

5.2.1 The Borrower may only issue one Utilisation Request per Month unless otherwise agreed.

5.3 Completion of a Utilisation Request

The Utilisation Request is irrevocable and will not be regarded as having been duly completed unless:

(A) the proposed Utilisation Date is a Business Day within the Availability Period; and

(B) the currency and amount of the Utilisation comply with Clause 5.4 (*Currency and amount*).

5.4 Currency and amount

5.4.1 The currency specified in the Utilisation Request must be sterling.

5.4.2 The amount of each proposed Loan must be an amount which is not more than the amount required to maintain a Cash Balance equivalent to the Minimum Cash Balance for a period from the Utilisation Date to the Monday preceding the 18th day of the following Month

5.4.3 The amount of each proposed Loan must be an amount which is not more than the Available Facility and which is a minimum of £150,000 or, if less, the Available Facility.

5.5 **Payment to the Account**

The Lender shall pay each Loan:

5.5.1 by way of credit to the Account and so that, unless and until the Lender shall notify the Borrower to the contrary, the Lender hereby consents to the withdrawal by the Borrower from the Account of any amount equal to the relevant Loan provided that any sums so withdrawn are applied by the Borrower for the purposes for which the relevant Loan was made;

5.5.2 if the Lender so agrees or requires, on behalf of the Borrower directly to the person to whom the relevant payment is due as specified in the relevant Utilisation Request; or

5.5.3 in such other manner as shall be agreed between the Lender and the Borrower.

6. PAYMENTS AND REPAYMENT

6.1 **Payments**

6.1.1 The Borrower shall make all payments payable under the Finance Documents without any Tax Deductions, unless a Tax Deduction is required by law.

6.1.2 The Borrower shall promptly upon becoming aware that it must make a Tax Deduction (or that there is any change in the rate or the basis of a Tax Deduction) notify the Lender accordingly.

6.1.3 If a Tax Deduction is required by law to be made by the Borrower, the amount of the payment due from the Borrower shall be increased to an amount which (after making any Tax Deduction) leaves an amount equal to the payment which would have been due if no Tax Deduction had been required.

6.1.4 If the Borrower is required to make a Tax Deduction, the Borrower shall make that Tax Deduction and any payment required in connection with that Tax Deduction within the time allowed and in the minimum amount required by law.

6.1.5 Within thirty days of making either a Tax Deduction or any payment required in connection with that Tax Deduction, the Borrower shall deliver to the Lender evidence reasonably satisfactory to the Lender that the Tax Deduction has been made or (as applicable) any appropriate payment paid to the relevant taxing authority.

6.2 **Repayment**

The Borrower shall repay the aggregate value of all outstanding Loans drawn under the Facility in full on or before the last day of the current Availability Period as set out in Schedule 6 *(Repayment Schedule).*

6.3 **Reborrowing**

The Borrower may not reborrow any part of the Facility which is repaid or prepaid.

7. PREPAYMENT AND CANCELLATION

7.1 **Illegality**

If it becomes unlawful in any applicable jurisdiction for the Lender to perform any of its obligations as contemplated by this Agreement or to fund or maintain all or any part of the Loans:

7.1.1 the Lender shall promptly notify the Borrower upon becoming aware of that event;

7.1.2 upon the Lender notifying the Borrower, the Available Facility will be immediately cancelled; and

7.1.3 the Borrower shall repay such Loans on the last day of the Interest Period for Loans occurring after the Lender has notified the Borrower or, if earlier, the date specified by the Lender in the notice delivered to the Borrower (being no earlier than the last day of any applicable grace period permitted by law).

7.2 **Voluntary cancellation**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than fourteen days' prior notice, cancel the whole or any part (being a minimum amount of £100,000) of the Facility Amount.

7.3 **Voluntary prepayment of Loans**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than thirty days' prior notice, prepay the whole or any part of any Loan (but, if in part, being an amount that reduces the amount of the Loan by a minimum amount of £250,000).

7.4 **Restrictions**

7.4.1 Any notice of cancellation or prepayment given by any Party under this Clause 7 shall be irrevocable and, unless a contrary indication appears in this Agreement, shall specify the date or dates upon which the relevant cancellation or prepayment is to be made and the amount of that cancellation or prepayment.

7.4.2 Any prepayment under this Agreement shall be made together with accrued interest on the amount prepaid without premium or penalty and applied against the outstanding Repayment Instalments in inverse order of maturity.

7.4.3 The Borrower shall not repay or prepay all or any part of the Loan or cancel all or any part of the Available Facility except at the times and in the manner expressly provided for in this Agreement.

7.4.4 No amount of the Available Facility cancelled under this Agreement may be subsequently reinstated.

7.5 **Automatic Cancellation**

At the end of the Availability Period the undrawn part of the Available Facility will be cancelled.

8. INTEREST

8.1 **Calculation of interest**

The rate of interest on each Loan for each Interest Period is the Interest Rate.

8.2 **Payment of interest**

The Borrower shall pay accrued interest on each Loan on the last day of each Interest Period.

8.3 **Default interest**

8.3.1 If the Borrower fails to pay any amount payable by it under a Finance Document on its due date, interest shall accrue on Unpaid Sums from the due date up to the date of actual payment (both before and after judgment) at the Default Rate. Any interest

accruing under this Clause 8.3 shall be immediately payable by the Borrower on demand by the Lender.

8.3.2 Default interest (if unpaid) arising on an overdue amount will be compounded with the overdue amount at the end of each Interest Period applicable to that overdue amount but will remain immediately due and payable.

9. INTEREST PERIODS

9.1 Interest Payment Dates

The Interest Period for each Loan shall be six Months, provided that any Interest Period which begins during another Interest Period shall end at the same time as that other Interest Period (and, where two or more such Interest Periods expire on the same day, the Loans to which those Interest Periods relate shall thereafter constitute and be referred to as one Loan).

9.2 Shortening Interest Periods

If an Interest Period would otherwise overrun the relevant Repayment Date, it shall be shortened so that it ends on the relevant Repayment Date.

9.2A Payment Start Date

Each Interest Period for a Loan shall start on the Utilisation Date or (if already made) on the last day of its preceding Interest Period.

9.3 Non-Business Days

If an Interest Period would otherwise end on a day which is not a Business Day, that Interest Period will instead end on the next Business Day in that calendar month (if there is one) or the preceding Business Day (if there is not).

9.4 Consolidation of Loans

If two or more Interest Periods end on the same date, those Loans will be consolidated into and be treated as a single Loan on the last day of the Interest Period.

10. PREPAYMENT AMOUNT

10.1.1 If all or any part of the Loans are subject to a voluntary prepayment pursuant to Clause 7.3 (*Voluntary prepayment of Loans*), the Borrower shall pay to the Lender on the relevant prepayment date the Prepayment Amount in respect of the same.

10.1.2 For as long as the Secretary of State for Health remains the Lender, the Lender will consider waiving the Prepayment Amount in cases where the Borrower can demonstrate to the Lender's satisfaction that the voluntary prepayment results from the Borrower's proper use of genuine surplus funds resulting from a sale of assets or trading activities.

11. INDEMNITIES

11.1 Currency indemnity

11.1.1 If any sum due from the Borrower under the Finance Documents (a **"Sum"**), or any order, judgment or award given or made in relation to a Sum, has to be converted from the currency (the **"First Currency"**) in which that Sum is payable into another currency (the **"Second Currency"**) for the purpose of:

(A) making or filing a claim or proof against the Borrower;

(B) obtaining or enforcing an order, judgment or award in relation to any litigation or arbitration proceedings,

the Borrower shall as an independent obligation, within five Business Days of demand, indemnify the Lender against any cost, loss or liability arising out of or as a result of the conversion including any discrepancy between (A) the rate of exchange used to convert that Sum from the First Currency into the Second Currency and (B) the rate or rates of exchange available to that person at the time of its receipt of that Sum.

11.1.2 The Borrower waives any right it may have in any jurisdiction to pay any amount under the Finance Documents in a currency or currency unit other than that in which it is expressed to be payable.

11.2 **Other indemnities**

The Borrower shall, within five Business Days of demand, indemnify the Lender against any cost, loss or liability incurred by the Lender as a result of:

11.2.1 the occurrence of any Event of Default;

11.2.2 a failure by the Borrower to pay any amount due under a Finance Document on its due date;

11.2.3 funding, or making arrangements to fund, all or any part of the Loans requested by the Borrower in a Utilisation Request but not made by reason of the operation of any one or more of the provisions of this Agreement (other than by reason of default or negligence by the Lender alone); or

11.2.4 the Loans (or part of the Loans) not being prepaid in accordance with a notice of prepayment given by the Borrower.

11.3 **Indemnity to the Lender**

The Borrower shall promptly indemnify the Lender against any cost, loss or liability incurred by the Lender (acting reasonably) as a result of:

11.3.1 investigating any event which it reasonably believes is a Default; or

11.3.2 acting or relying on any notice, request or instruction which it reasonably believes to be genuine, correct and appropriately authorised.

11.4 **Environmental indemnity**

The Borrower shall promptly indemnify the Lender within five Business Days of demand in respect of any judgments, liabilities, claims, fees, costs and expenses (including fees and disbursements of any legal, environmental consultants or other professional advisers) suffered or incurred by the Lender as a consequence of the breach of or any liability imposed under any Environmental Law with respect to the Borrower or its property (including the occupation or use of such property).

12. MITIGATION BY THE LENDER

12.1 **Mitigation**

12.1.1 The Lender shall, in consultation with the Borrower, take all reasonable steps to mitigate any circumstances which arise and which would result in any amount becoming payable under or pursuant to, or cancelled pursuant to Clause 7.1

(Illegality) including transferring its rights and obligations under the Finance Documents to another entity owned or supported by the Lender.

12.1.2 Clause 12.1.1 does not in any way limit the obligations of the Borrower under the Finance Documents.

12.2 **Limitation of liability**

12.2.1 The Borrower shall indemnify the Lender for all costs and expenses reasonably incurred by the Lender as a result of steps taken by it under Clause 12.1 (Mitigation).

12.2.2 The Lender is not obliged to take any steps under Clause 12.1 (Mitigation) if, in its opinion (acting reasonably), to do so might be prejudicial to it.

13. COSTS AND EXPENSES

13.1 **Enforcement costs**

The Borrower shall, within three Business Days of demand, pay to the Lender the amount of all costs and expenses (including legal fees) incurred by the Lender in connection with the enforcement of, or the preservation of any rights under, any Finance Document.

14. REPRESENTATIONS

The Borrower makes the representations and warranties set out in this Clause 14 to the Lender on the date of this Agreement.

14.1 **Status**

14.1.1 It is an NHS Body in accordance with the provisions of the Act.

14.1.2 It has the power to own its assets and carry on its business as it is being conducted.

14.2 **Binding obligations**

The obligations expressed to be assumed by it in each Finance Document are legal, valid, binding and enforceable obligations.

14.3 **Non-conflict with other obligations**

The entry into and performance by it of, and the transactions contemplated by, the Finance Documents to which it is party do not and will not conflict with:

14.3.1 any law or regulation applicable to it;

14.3.2 its constitutional documents; or

14.3.3 any agreement or instrument binding upon it or any of its assets.

14.4 **Power and authority**

It has the power to enter into, exercise its rights under, perform and deliver, and has taken all necessary action to authorise its entry into, performance and delivery of, the Finance Documents to which it is a party and the transactions contemplated by those Finance Documents.

14.5 **Validity and admissibility in evidence**

All Authorisations required:

14.5.1 to enable it lawfully to enter into, exercise its rights and comply with its obligations in the Finance Documents to which it is a party; and

14.5.2 to make the Finance Documents to which it is a party admissible in evidence in its jurisdiction of incorporation,

have been obtained or effected and are in full force and effect.

14.6 **Relevant Consents**

14.6.1 All Relevant Consents which it is necessary or appropriate for the Borrower to hold have been obtained and effected and are in full force and effect.

14.6.2 There exists no reason known to it, having made all reasonable enquiries, why any Relevant Consent might be withdrawn, suspended, cancelled, varied, surrendered or revoked.

14.6.3 All Relevant Consents and other consents, permissions and approvals have been or are being complied with.

14.7 **Governing law and enforcement**

14.7.1 The choice of English law as the governing law of the Finance Documents will be recognised and enforced by the courts of England and Wales.

14.7.2 Any judgment obtained in England in relation to a Finance Document will be recognised and enforced by the courts of England and Wales.

14.8 **Deduction of Tax**

It is not required to make any deduction for or on account of Tax from any payment it may make under any Finance Document.

14.9 **No filing or stamp taxes**

It is not necessary that the Finance Documents be filed, recorded or enrolled with any court or other authority in any jurisdiction or that any stamp, registration or similar tax be paid on or in relation to the Finance Documents or the transactions contemplated by the Finance Documents.

14.10 **No default**

14.10.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.10.2 No other event which constitutes a default under any other agreement or instrument which is binding on it or to which its assets are subject which might have a Material Adverse Effect might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.11 **No misleading information**

14.11.1 All factual information provided by or on behalf of the Borrower in connection with the Borrower or any Finance Document was true and accurate in all material respects as at the date it was provided or as at the date (if any) at which it is stated.

14.11.2 Any financial projections provided to the Lender by or on behalf of the Borrower have been prepared on the basis of recent historical information and on the basis of reasonable assumptions.

14.11.3 Nothing has occurred or been omitted and no information has been given or withheld that results in the information referred to in Clause 14.12.1 being untrue or misleading in any material respect.

14.12 **Financial statements**

14.12.1 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) were prepared in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies and/or any other guidance with which NHS Bodies are (or in the case of the Original Financial Statements were) required to comply.

14.12.2 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) fairly represent its financial condition and operations during the relevant financial year.

14.12.3 There has been no material adverse change in the business or financial condition of the Borrower since the date to which its financial statements most recently delivered to the Lender were made up.

14.13 **Ranking**

Its payment obligations under the Finance Documents rank at least pari passu with the claims of all its other unsecured and unsubordinated creditors, except for obligations mandatorily preferred by law.

14.14 **No proceedings pending or threatened**

No litigation, arbitration or administrative proceedings of or before any court, arbitral body or agency which, if adversely determined, might reasonably be expected to have a Material Adverse Effect have (to the best of its knowledge and belief) been started or threatened against it.

14.15 **Environmental Matters**

14.15.1 It is and has been in full compliance with all applicable Environmental Laws and there are, to the best of its knowledge and belief after reasonable enquiry, no circumstances that may prevent or interfere with such full compliance in the future, in each case to the extent necessary to avoid a Material Adverse Effect and the Borrower has not other than in the ordinary course of its activities placed or allowed to be placed on any part of its property any Dangerous Substance and where such Dangerous Substance has been so placed, it is kept, stored, handled, treated and transported safely and prudently so as not to pose a risk of harm to the Environment.

14.15.2 It is and has been, in compliance in all material respects with the terms of all Environmental Licences necessary for the ownership and operation of its activities as presently owned and operated and as presently proposed to be owned and operated.

14.15.3 It is not aware, having made reasonable enquiries, of any Environmental Claim.

14.16 **Repetition**

The Repeating Representations are deemed to be made by the Borrower by reference to the facts and circumstances then existing on the date of each Utilisation Request and on the first day of each Interest Period.

15. INFORMATION UNDERTAKINGS

The undertakings in this Clause 15 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

15.1 Financial statements

The Borrower shall supply to the Lender its audited financial statements for each financial year and its financial statements for each financial half year (including any monitoring returns sent to the appropriate Supervisory Body), in each case when such statements are provided to the appropriate Supervisory Body.

15.2 Requirements as to financial statements

15.2.1 Each set of financial statements delivered by the Borrower pursuant to Clause 15.1 (Financial statements) shall be certified by a director of the Borrower, acting on the instructions of the board of directors of the Borrower, as fairly representing its financial condition as at the date as at which those financial statements were drawn up.

15.2.2 The Borrower shall procure that each set of financial statements delivered pursuant to Clause 15.1 (Financial statements) is prepared in accordance with any applicable Audit Code for NHS Bodies and any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies or in the case of the Original Financial Statements in accordance with such guidelines with which NHS Bodies are required to comply.

15.3 Information: miscellaneous

The Borrower shall supply to the Lender:

15.3.1 copies or details of all material communications between the Borrower and the relevant Supervisory Body, including all relevant official notices received by the Borrower promptly after the same are made or received and, upon the Lender's request, any other relevant documents, information and returns sent by it to the appropriate Supervisory Body;

15.3.2 copies or details of all material communications between the Borrower and its members or its creditors (or in each case any class thereof), including all official notices received by the Borrower promptly after the same are made or received and upon the Lender's request any and all other documents dispatched by it to its members or its creditors (or in each case any class thereof), promptly after they are sent to such members or creditors;

15.3.3 details of any breaches by the Borrower of the Compliance Framework;

15.3.4 details of any breaches by the Borrower of the Licence or the terms of their Licence;

15.3.5 details of any other financial assistance or guarantee requested or received from the Secretary of State for Health other than in the ordinary course of business promptly after the same are requested or received;

15.3.6 upon the Lender's request, information regarding the application of the proceeds of the Facility;

15.3.7 promptly upon becoming aware of them, the details of any litigation, arbitration and/or administrative proceedings which are current, threatened or pending against the Borrower which would reasonably be expected to have a Material Adverse Effect;

15.3.8 promptly, such further information regarding the financial condition, business and operations of the Borrower as the Lender may reasonably request to the extent the same are relevant to the Borrower's obligations under this Agreement or otherwise significant in the assessment of the Borrower's financial performance and further to the extent that the disclosure of information will not cause the Borrower to be in breach of any obligation of confidence owed to any third party or any relevant data protection legislation; and

15.3.9 any change in the status of the Borrower after the date of this Agreement

15.4 **Notification of default**

15.4.1 The Borrower shall notify the Lender of any Default (and the steps being taken to remedy it) promptly upon becoming aware of its occurrence.

15.4.2 Promptly upon a request by the Lender, the Borrower shall supply a certificate signed by two of its directors (acting on the instructions of the board of directors of the Borrower) on its behalf certifying that no Default is continuing (or if a Default is continuing, specifying the Default and the steps, if any, being taken to remedy it).

15.5 **Other information**

The Borrower shall promptly upon request by the Lender supply, or procure the supply of, such documentation and other evidence as is reasonably requested by the Lender (for itself or on behalf of a prospective transferee) in order for the Lender (or such prospective transferee) to carry out and be satisfied with the results of all necessary money laundering and identification checks in relation to any person that it is required to carry out pursuant to the transactions contemplated by the Finance Documents.

16. GENERAL UNDERTAKINGS

The undertakings in this Clause 16 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

16.1 **Authorisations**

The Borrower shall promptly:

16.1.1 obtain, comply with and do all that is necessary to maintain in full force and effect; and

16.1.2 supply certified copies to the Lender of any Authorisation required under any law or regulation of its jurisdiction of incorporation to enable it to perform its obligations under the Finance Documents and to ensure the legality, validity, enforceability or admissibility in evidence in England of any Finance Document.

16.2 **Compliance with laws**

The Borrower shall comply in all respects with all laws to which it may be subject, if failure so to comply would materially impair its ability to perform its obligations under the Finance Documents and shall exercise its powers and perform its functions in accordance with its constitutional documents.

16.3 **Negative pledge**

16.3.1 The Borrower shall not without the prior written consent of the Lender (such consent not to be unreasonably withheld or delayed) create or permit to subsist any Security over any of its assets save for any Permitted Security.

16.3.2 The Borrower shall not:

(A) sell, transfer or otherwise dispose of any of its assets on terms whereby they are or may be leased to or re-acquired by it;

(B) sell, transfer or otherwise dispose of any of its receivables on recourse terms;

(C) enter into any arrangement under which money or the benefit of a bank or other account may be applied, set-off or made subject to a combination of accounts; or

(D) enter into any other preferential arrangement having a similar effect,

in circumstances where the arrangement or transaction is entered into primarily as a method of raising Financial Indebtedness or of financing the acquisition of an asset.

16.4 **Disposals**

16.4.1 The Borrower shall not in a single transaction or a series of transactions (whether related or not) and whether voluntary or involuntary sell, lease, transfer or otherwise dispose of any material asset without the prior written consent of the Lender.

16.4.2 Clause 16.4.1 does not apply to:

(A) any sale, lease, transfer or other disposal where the higher of the market value or consideration receivable does not (in aggregate) in any financial year exceed 10% of the total net assets of the Borrower as at the end of the most recent financial year end for which audited financial statements have been published.

(B) any sale, lease, transfer or other disposal expressly identified in Schedule 8..

16.5 **Merger**

Without prejudice to Clause 16.4 (disposals) the Borrower shall not, without the prior written consent of the Lender, enter into nor apply to the relevant Supervisory Body (including pursuant to Section 56 of the Act) to enter into any amalgamation, demerger, merger or corporate reconstruction.

16.6 **Guarantees**

The Borrower will not, without the prior written consent of the Lender, give or permit to exist any guarantee or indemnity by it of any obligation of any person, nor permit or suffer any person to give any security for or guarantee or indemnity of any of its obligations except for guarantees and indemnities:

16.6.1 made in the ordinary course of the Borrower's business as an NHS Body ; and

16.6.2 which when aggregated with any loans, credit or financial accommodation made pursuant to Clause 16.7 (*Loans*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.7 **Loans**

The Borrower will not make any investment in nor make any loan or provide any other form of credit or financial accommodation to, any person except for investments, loans, credit or financial accommodation:

16.7.1 made in the ordinary course of the Borrower's business as an NHS Body ;

16.7.2 made in accordance with any investment policy or guidance issued by the relevant Supervisory Body; and

16.7.3 which when aggregated with any guarantees or indemnities given or existing under Clause 16.6 (*Guarantees*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.8 **Consents**

The Borrower must ensure that all Relevant Consents and all statutory requirements, as are necessary to enable it to perform its obligations under the Finance Documents to which it is a party, are duly obtained and maintained in full force and effect or, as the case may be, complied with.

16.9 **Activities**

The Borrower will not engage in any activities other than activities which enable it to carry on its principal purpose better, if to do so may, in the Lender's opinion, have a Material Adverse Effect.

16.10 **Environmental**

The Borrower shall:

16.10.1 obtain, maintain and comply in all material respects with all necessary Environmental Licences in relation to its activities and its property and comply with all Environmental Laws to the extent necessary to avoid a Material Adverse Effect;

16.10.2 promptly upon becoming aware notify the Lender of:

(A) any Environmental Claim current or to its knowledge threatened;

(B) any circumstances likely to result in an Environmental Claim; or

(C) any suspension, revocation or notification of any Environmental Licence;

16.10.3 indemnify the Lender against any loss or liability which:

(A) the Lender incurs as a result of any actual or alleged breach of any Environmental Law by any person; and

(B) which would not have arisen if a Finance Document had not been entered into; and

16.10.4 take all reasonable steps to ensure that all occupiers of the Borrower's property carry on their activities on the property in a prudent manner and keep them secure so as not to cause or knowingly permit material harm or damage to the Environment (including nuisance or pollution) or the significant risk thereof.

16.11 **Constitution**

The Borrower will not amend or seek to amend the terms of its authorisation as an NHS Body or the terms of its constitution without the prior written consent of the Lender, in each case if to do so would be reasonably likely to have a Material Adverse Effect.

16.12 **The relevant Supervisory Body**

The Borrower will comply promptly with all directions and notices received from the relevant Supervisory Body to the extent failure to do so might have a Material Adverse Effect and will, upon the Lender's request, provide reasonable evidence that it has so complied.

16.13 **Additional Terms and Conditions**

The Borrower will comply promptly with the Additional Terms and Conditions.

17. COMPLIANCE FRAMEWORK

17.1 **Compliance**

The Borrower shall ensure at all times that it complies with its Licence and/or any other terms and conditions set by the relevant Supervisory Body.

17.2 **Advance Notification**

Without prejudice to the Borrower's obligations under Clause 17.1 (*Compliance*), if the Borrower becomes aware at any time after the date of signing of the Agreement that it is or is likely to breach any of the terms referred to in Clause 17.1 and/or a material failure under the requirements of the Compliance Framework is likely, it shall immediately notify the Lender of the details of the impending breach.

18. EVENTS OF DEFAULT

Each of the events or circumstances set out in this Clause 18 is an Event of Default.

18.1 **Non-payment**

The Borrower does not pay on the due date any amount payable pursuant to a Finance Document at the place at and in the currency in which it is expressed to be payable unless:

18.1.1 its failure to pay is caused by administrative or technical error; and

18.1.2 payment is made within two Business Days of its due date.

18.2 **Compliance Framework and Negative Pledge**

Any requirement of Clause 17 (*COMPLIANCE FRAMEWORK*) or Clause 16.3 (*Negative Pledge*) is not satisfied.

18.3 **Other obligations**

18.3.1 The Borrower does not comply with any term of:

(A) Clause 15.5 (*Notification of default*); or

(B) Clause 16 (*General Undertakings*).

18.3.2 The Borrower does not comply with any term of any Finance Document (other than those referred to in Clause 18.1 (*Non-payment*), Clause 18.2 (*Compliance Framework and Negative Pledge*) and Clause 18.3.1(*Other obligations*) unless the failure to comply is capable of remedy and is remedied within ten Business Days of the earlier of the Lender giving notice or the Borrower becoming aware of the failure to comply.

18.4 **Misrepresentation**

Any representation or statement made or deemed to be made by the Borrower in any Finance Document or any other document delivered by or on behalf of the Borrower under or in connection with any Finance Document is or proves to have been incorrect or misleading in any material respect when made or deemed to be made.

18.5 **Cross default**

18.5.1 Any Financial Indebtedness of the Borrower is not paid when due nor within any originally applicable grace period.

18.5.2 Any Financial Indebtedness of the Borrower is declared to be or otherwise becomes due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.3 Any commitment for any Financial Indebtedness of the Borrower is cancelled or suspended by a creditor of the Borrower as a result of an event of default (however described).

18.5.4 Any creditor of the Borrower becomes entitled to declare any Financial Indebtedness of the Borrower due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.5 No Event of Default will occur under this Clause 18.5 if the aggregate amount of Financial Indebtedness or commitment for Financial Indebtedness falling within Clauses 18.5.1 to 18.5.4 is less than £250,000 (or its equivalent in any other currency or currencies).

except that for as long as the Secretary of State for Health remains the Lender, the provisions of Clause 18.5 relate to Financial Indebtedness owed to any party but do not apply to amounts owed to other NHS bodies in the normal course of business where a claim has arisen which is being disputed in good faith or where the Borrower has a valid and contractual right of setoff.

18.6 **Insolvency**

18.6.1 The Borrower is unable or admits inability to pay its debts as they fall due, suspends making payments on any of its debts or, by reason of actual or anticipated financial difficulties, commences negotiations with one or more of its creditors with a view to rescheduling any of its indebtedness.

18.6.2 A moratorium is declared in respect of any indebtedness of the Borrower.

18.7 **Insolvency proceedings**

Any corporate action, legal proceedings or other procedure or step is taken:

18.7.1 in relation to a composition, assignment or arrangement with any creditor of the Borrower; or

18.7.2 in relation to the appointment of a liquidator, receiver, administrator, administrative receiver, compulsory manager or other similar officer in respect of the Borrower or any of its assets; or

18.7.3 in relation to the enforcement of any Security over any assets of the Borrower,

or any analogous action, proceedings, procedure or step is taken in any jurisdiction.

18.8 **Appointment of a Trust Special Administrator**

An order, made as required under The Act for the appointment of a Trust Special Administrator.

18.9 **Creditors' process**

Any expropriation, attachment, sequestration, distress or execution affects any asset or assets of the Borrower having an aggregate value of £250,000 and is not discharged within ten Business Days.

18.10 **Repudiation**

The Borrower or any other party to a Finance Document repudiates any of the Finance Documents or does or causes to be done any act or thing evidencing an intention to repudiate any Finance Document.

18.11 **Cessation of Business**

Other than with the prior written approval of the Lender, the Borrower ceases, or threatens to cease, to carry on all or a substantial part of its business or operations.

18.12 **Unlawfulness**

It is or becomes unlawful for the Borrower or any other party to a Finance Document to perform any of its obligations under any Finance Document.

18.13 **Material adverse change**

Any event or circumstance or series of events or circumstances occurs which, in the reasonable opinion of the Lender, has or is reasonably likely to have a Material Adverse Effect.

18.14 **Additional Terms and Conditions**

In the reasonable opinion of the Lender, the Borrower fails to make reasonable efforts to comply with the Additional Terms and Conditions.

18.15 **Acceleration**

On and at any time after the occurrence of an Event of Default which is continuing the Lender may by notice to the Borrower:

18.15.1 cancel the Facility whereupon it shall immediately be cancelled; and/or

18.15.2 declare that all or part of the Loans, together with accrued interest, and all other amounts accrued or outstanding under the Finance Documents be immediately due and payable, whereupon they shall become immediately due and payable; and/or

18.15.3 declare that all or part of the Loans be payable on demand, whereupon they shall immediately become payable on demand by the Lender.

19. ASSIGNMENTS AND TRANSFERS

19.1 **Assignments and transfers by the Lender**

Subject to this Clause 19, the Lender may:

19.1.1 assign any of its rights; or

19.1.2 transfer by novation any of its rights and obligations,

to another entity owned or supported by the Lender or to a bank or a financial institution or to a trust, fund or other entity which is regularly engaged in or established for the purpose of

making, purchasing or investing in loans, securities or other financial assets (the **"New Lender"**).

19.2 **Conditions of assignment or transfer**

19.2.1 The consent of the Borrower is required for an assignment or transfer by the Lender, unless:

(A) the assignment or transfer is to an entity owned or supported by the Lender; or

(B) a Default is continuing.

19.2.2 The consent of the Borrower to an assignment or transfer must not be unreasonably withheld or delayed. The Borrower will be deemed to have given its consent twenty Business Days after the Lender has requested it unless consent is expressly refused (and reasons for such refusal are given) by the Borrower within that time.

provided that nothing in this Clause shall restrict the rights of the Secretary of State for Health to effect a statutory transfer.

19.3 **Disclosure of information**

The Lender may disclose to any person:

19.3.1 to (or through) whom the Lender assigns or transfers (or may potentially assign or transfer) all or any of its rights and obligations under the Finance Documents;

19.3.2 with (or through) whom the Lender enters into (or may potentially enter into) any transaction under which payments are to be made by reference to, any Finance Document or the Borrower;

19.3.3 to whom, and to the extent that, information is required to be disclosed by any applicable law or regulation;

19.3.4 which are investors or potential investors in any of its rights and obligations under the Finance Documents and only to the extent required in relation to such rights and obligations;

19.3.5 which is a governmental, banking, taxation or other regulatory authority and only to the extent information is required to be disclosed to such authority,

any information about the Borrower and/or the Finance Documents as the Lender shall consider appropriate if, in relation to Clauses 19.3.1, 19.3.2 and 19.3.4 the person to whom the information is to be given has agreed to keep such information confidential on terms of this Clause 19.3 provided always that the Lender shall comply with any relevant data protection legislation.

19.4 **Assignment and transfer by the Borrower**

The Borrower may not assign any of its rights or transfer any of its rights or obligations under the Finance Documents.

20. ROLE OF THE LENDER

20.1 **Rights and discretions of the Lender**

20.1.1 The Lender may rely on:

(A) any representation, notice or document believed by it to be genuine, correct and appropriately authorised; and

(B) any statement made by a director, authorised signatory or authorised employee of any person regarding any matters which may reasonably be assumed to be within his knowledge or within his power to verify.

20.1.2 The Lender may engage, pay for and rely on the advice or services of any lawyers, accountants, surveyors or other experts.

20.1.3 The Lender may act in relation to the Finance Documents through its personnel and agents.

20.1.4 Notwithstanding any other provision of any Finance Document to the contrary, the Lender is not obliged to do or omit to do anything if it would or might in its reasonable opinion constitute a breach of any law or a breach of a fiduciary duty or duty of confidentiality.

20.2 **Exclusion of liability**

20.2.1 Without limiting Clause 20.2.2, the Lender will not be liable for any omission or any act taken by it under or in connection with any Finance Document, unless directly caused by its gross negligence or wilful misconduct.

20.2.2 The Borrower may not take any proceedings against any officer, employee or agent of the Lender in respect of any claim it might have against the Lender or in respect of any act or omission of any kind by that officer, employee or agent in relation to any Finance Document and any officer, employee or agent of the Lender may rely on this Clause. Any third party referred to in this Clause 20.2.2 may enjoy the benefit of or enforce the terms of this Clause in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

20.2.3 The Lender will not be liable for any delay (or any related consequences) in crediting an account with an amount required under the Finance Documents to be paid by the Lender if the Lender has taken all necessary steps as soon as reasonably practicable to comply with the regulations or operating procedures of any recognised clearing or settlement system used by the Lender for that purpose.

20.2.4 The Lender shall not be liable:

(A) for any failure by the Borrower to give notice to any third party or to register, file or record (or any defect in such registration, filing or recording) any Finance Document; or

(B) for any failure by the Borrower to obtain any licence, consent or other authority required in connection with any of the Finance Documents; or

(C) For any other omission or action taken by it in connection with any Finance Document unless directly caused by its gross negligence or wilful misconduct.

21. PAYMENT MECHANICS

21.1 **Payments**

21.1.1 The Borrower shall receive notification 10 working days prior to each payment required under a Finance Document, the Borrower shall make the same available to the Lender (unless a contrary indication appears in a Finance Document) for value on the due date at the time and in such funds specified by the Lender as being customary

at the time for settlement of transactions in the relevant currency in the place of payment.

21.1.2 Payment shall be collected through Direct Debit from a Borrower's account with the Government Banking Service.

21.2 **Distributions to the Borrower**

The Lender may (with the consent of the Borrower or in accordance with Clause 22 (*Set-off*)) apply any amount received by it for the Borrower in or towards payment (on the date and in the currency and funds of receipt) of any amount due from the Borrower under the Finance Documents or in or towards purchase of any amount of any currency to be so applied.

21.3 **Partial payments**

If the Lender receives a payment that is insufficient to discharge all the amounts then due and payable by the Borrower under the Finance Documents, the Lender shall apply that payment towards the obligations of the Borrower in such order and in such manner as the Lender may at its discretion decide.

21.4 **No set-off**

All payments to be made by the Borrower under the Finance Documents shall be calculated and be made without (and free and clear of any deduction for) set-off or counterclaim.

21.5 **Business Days**

21.5.1 Any payment which is due to be made on a day that is not a Business Day shall be made on the next Business Day in the same calendar month (if there is one) or the preceding Business Day (if there is not).

21.5.2 During any extension of the due date for payment of any principal or Unpaid Sum under this Agreement, interest is payable on the principal or Unpaid Sum at the rate payable on the original due date.

21.6 **Currency of account**

21.6.1 Subject to Clauses 21.6.2 to 21.6.5, sterling is the currency of account and payment for any sum due from the Borrower under any Finance Document.

21.6.2 A repayment of the Loan or Unpaid Sum or a part of the Loan or Unpaid Sum shall be made in the currency in which the Loan or Unpaid Sum is denominated on its due date.

21.6.3 Each payment of interest shall be made in the currency in which the sum in respect of which the interest is payable was denominated when that interest accrued.

21.6.4 Each payment in respect of costs, expenses or Taxes shall be made in the currency in which the costs, expenses or Taxes are incurred.

21.6.5 Any amount expressed to be payable in a currency other than sterling shall be paid in that other currency.

21.7 **Change of currency**

21.7.1 Unless otherwise prohibited by law, if more than one currency or currency unit are at the same time recognised by the central bank of any country as the lawful currency of that country, then:

(A) any reference in the Finance Documents to, and any obligations arising under the Finance Documents in, the currency of that country shall be translated into, or paid in, the currency or currency unit of that country designated by the Lender (after consultation with the Borrower); and

(B) any translation from one currency or currency unit to another shall be at the official rate of exchange recognised by the central bank for the conversion of that currency or currency unit into the other, rounded up or down by the Lender (acting reasonably).

21.7.2 If a change in any currency of a country occurs, this Agreement will, to the extent the Lender (acting reasonably and after consultation with the Borrower) specifies to be necessary, be amended to comply with any generally accepted conventions and market practice in the London interbank market and otherwise to reflect the change in currency.

22. SET-OFF

The Lender may set off any matured obligation due from the Borrower under the Finance Documents against any matured obligation owed by the Lender to the Borrower, regardless of the place of payment, booking branch or currency of either obligation. If the obligations are in different currencies, the Lender may convert either obligation at a market rate of exchange in its usual course of business for the purpose of the set-off.

23. NOTICES

23.1 Communications in writing

Any communication to be made under or in connection with the Finance Documents shall be made in writing and, unless otherwise stated, may be given in person, by post, fax or by electronic communication.

23.2 Addresses

The address and fax number (and the department or officer, if any, for whose attention the communication is to be made) of each Party for any communication or document to be made or delivered under or in connection with the Finance Documents is:

23.2.1 in the case of the Borrower, that identified with its name below; and

23.2.2 in the case of the Lender, that identified with its name below,

or any substitute address, email address, fax number or department or officer as the Borrower may notify to the Lender by not less than five Business Days' written notice.

23.3 Delivery

23.3.1 Any communication or document made or delivered by one person to another under or in connection with the Finance Documents will only be effective:

(A) if by way of fax, when received in legible form; or

(B) if by way of letter, when it has been left at the relevant address or five Business Days after being deposited in the post postage prepaid in an envelope addressed to it at that address,

and, if a particular department or officer is specified as part of its address details provided under Clause 23.2 (*Addresses*), if addressed to that department or officer.

23.3.2 Any communication or document to be made or delivered to the Lender will be effective only when actually received by the Lender and then only if it is expressly marked for the attention of the department or officer identified with the Lender's signature below (or any substitute department or officer as the Lender shall specify for this purpose).

23.4 **Electronic communication**

23.4.1 Any communication to be made between the Borrower and the Lender under or in connection with this Agreement and any other Finance Document may be made by electronic mail or other electronic means, if the Borrower and the Lender:

(A) agree that, unless and until notified to the contrary, this is to be an accepted form of communication;

(B) notify each other in writing of their electronic mail address and/or any other information required to enable the sending and receipt of information by that means; and

(C) notify each other of any change to their address or any other such information supplied by them.

23.4.2 Any electronic communication made between the Borrower and the Lender will be effective only when actually received in readable form and only if it is addressed in such a manner as the Borrower and the Lender, as the case may be, specify for this purpose.

24. CALCULATIONS AND CERTIFICATES

24.1 **Accounts**

In any litigation or arbitration proceedings arising out of or in connection with a Finance Document, the entries made in the accounts maintained by the Lender are *prima facie* evidence of the matters to which they relate.

24.2 **Certificates and Determinations**

Any certification or determination by the Lender of a rate or amount under any Finance Document is, in the absence of manifest error, conclusive evidence of the matters to which it relates.

24.3 **Day count convention**

Any interest, commission or fee accruing under a Finance Document will accrue from day to day and is calculated on the basis of the actual number of days elapsed and a year of 365 days or, in any case where the practice in the London interbank market differs, in accordance with that market practice.

25. PARTIAL INVALIDITY

If, at any time, any provision of the Finance Documents is or becomes illegal, invalid or unenforceable in any respect under any law of any jurisdiction, neither the legality, validity or enforceability of the remaining provisions nor the legality, validity or enforceability of such provision under the law of any other jurisdiction will in any way be affected or impaired.

26. REMEDIES AND WAIVERS

No failure to exercise, nor any delay in exercising, on the part of the Lender, any right or remedy under the Finance Documents shall operate as a waiver, nor shall any single or partial

exercise of any right or remedy prevent any further or other exercise or the exercise of any other right or remedy. The rights and remedies provided in this Agreement are cumulative and not exclusive of any rights or remedies provided by law.

27. AMENDMENTS AND WAIVERS

Any term of the Finance Documents may only be amended or waived in writing.

28. COUNTERPARTS

Each Finance Document may be executed in any number of counterparts, and this has the same effect as if the signatures on the counterparts were on a single copy of the Finance Document.

29. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with English law.

30. DISPUTE RESOLUTION

The Parties agree that all disputes arising out of or in connection with this Agreement will be settled in accordance with the terms of Schedule 5.

This Agreement has been entered into on the date stated at the beginning of this Agreement.

SCHEDULE 1: CONDITIONS PRECEDENT

1. Authorisations

1.1 A copy of a resolution of the board of directors of the Borrower:

(A) approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; and

(C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.

(D) Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions

1.2 A certificate of an authorised signatory of the Borrower certifying that each copy document relating to it specified in this Schedule 1 and provided to the Lender is correct, complete and in full force and effect as at a date no earlier than the date of this Agreement.

2. Financial Information

Updated financial statements of the Borrower unless otherwise available.

3. Finance Documents

3.1 This Agreement (original).

3.2 The original or certified copy (as the Lender shall require) of any Finance Document not listed above.

4. General

4.1 A copy of any other Authorisation or other document, opinion or assurance which the Lender considers to be necessary or desirable in connection with the entry into and performance of the transactions contemplated by any Finance Document or for the validity and enforceability of any Finance Document.

4.2 Evidence that the fees, costs and expenses then due from the Borrower pursuant to Clause 13 (*Costs and expenses*) have been paid or will be paid by the first Utilisation Date.

SCHEDULE 2: UTILISATION REQUEST

From:[ ]

To: The Secretary of State for Health

Dated:

Dear Sirs

Countess Of Chester Hospital NHS Foundation Trust – £
dated [ ] (the "Agreement")

1. We refer to the Agreement. This is a Utilisation Request. Terms defined in the Agreement have the same meaning in this Utilisation Request unless given a different meaning in this Utilisation Request.

2. We wish to borrow a Loan on the following terms:

Proposed Utilisation Date:	[ ] (or, if that is not a Business Day, the next Business Day)
Amount:	[ ] or, if less, the Available Facility
Payment Instructions:	[*Relevant account to be specified here*]

3. We confirm that each condition specified in Clause 4.2 (Further conditions precedent) is satisfied on the date of this Utilisation Request.

4. We represent and warrant that the Loan will be applied solely towards working capital requirements of the Borrower in its requirement as an NHS Trust/NHS Foundation Trust.

5. This Utilisation Request is irrevocable.

Yours faithfully

……
authorised signatory for and on behalf of the Board of Directors
Countess Of Chester Hospital NHS Foundation TrustCountess Of Chester Hospital NHS Foundation Trust

SCHEDULE 3: NOT USED

SCHEDULE 4: ANTICIPATED DRAWDOWN SCHEDULE

NOT USED.

SCHEDULE 5: DISPUTE RESOLUTION

1. NEGOTIATION

If any claim, dispute or difference of whatsoever nature arising out of or in connection with this Agreement ("**Dispute(s)**") arises, the Parties will attempt in good faith to settle it by negotiation. Each Party will nominate at least one management representative ("**Authorised Representative**") who shall attend and participate in the negotiation with authority to negotiate a solution on behalf of the Party so represented.

2. MEDIATION

It shall be a condition precedent to the commencement of reference to arbitration that the Parties have sought to have the dispute resolved amicably by mediation as provided by this paragraph 2.

2.1 Initiation of Mediation Proceeding

(A) If the Parties are unable to settle the Dispute(s) by negotiation in accordance with paragraph 1 within 15 days, either Party may by written notice upon the other initiate mediation under this paragraph 2. The notice initiating mediation shall describe generally the nature of the Dispute.

(B) Each Party's Authorised Representative nominated in accordance with paragraph 1 shall attend and participate in the mediation with authority to negotiate a settlement on behalf of the Party so represented.

2.2 Appointment of Mediator

(A) The Parties shall appoint, by agreement, a neutral third person to act as a mediator (the "Mediator") to assist them in resolving the Dispute. If the Parties are unable to agree on the identity of the Mediator within 10 days after notice initiating mediation either party may request the Centre for Effective Dispute Resolution ("CEDR Solve") to appoint a Mediator.

(B) The Parties will agree the terms of appointment of the Mediator and such appointment shall be subject to the Parties entering into a formal written agreement with the Mediator regulating all the terms and conditions including payment of fees in respect of the appointment. If the Parties are unable to agree the terms of appointment of the Mediator within 10 days after notice initiating mediation either Party may request CEDR Solve to decide the terms of appointment of the Mediator

(C) If the appointed Mediator is or becomes unable or unwilling to act, either Party may within 10 days of the Mediator being or becoming unable or unwilling to act follow the process at paragraph 2.3 to appoint a replacement Mediator and paragraph 2.4 to settle the terms of the appointment of the replacement Mediator.

2.3 Determination of Procedure

The Parties shall, with the assistance of the Mediator, seek to agree the mediation procedure. In default of such agreement, the Mediator shall act in accordance with CEDR Solve's Model Mediation Procedure and Agreement. The Parties shall within 10 days of the appointment of the Mediator, meet (or talk to) the Mediator in order to agree a programme for the exchange of any relevant information and the structure to be adopted for the mediation.

2.4 **Without Prejudice/Confidentiality**

All rights of the Parties in respect of the Dispute(s) are and shall remain fully reserved and the entire mediation including all documents produced or to which reference is made, discussions and oral presentations shall be strictly confidential to the Parties and shall be conducted on the same basis as "without prejudice" negotiations, privileged, inadmissible, not subject to disclosure in any other proceedings whatever and shall not constitute any waiver of privilege whether between the Parties or between either of them and a third party. Nothing in this paragraph 2.4 shall make any document privileged, inadmissible or not subject to disclosure which would have been discloseable in any reference to arbitration commenced pursuant to paragraph 3.

2.5 **Resolution of Dispute**

If any settlement agreement is reached with the assistance of the Mediator which resolves the Dispute, such agreement shall be set out in a written settlement agreement and executed by both parties' Authorised Representatives and shall not be legally binding unless and until both parties have observed and complied with the requirements of this paragraph 2.5. Once the settlement agreement is legally binding, it may be enforced by either party taking action in the High Court.

2.6 **Failure to Resolve Dispute**

In the event that the Dispute(s) has not been resolved to the satisfaction of either Party within 30 days after the appointment of the Mediator either party may refer the Dispute to arbitration in accordance with paragraph 3.

2.7 **Costs**

Unless the Parties otherwise agree, the fees and expenses of the Mediator and all other costs of the mediation shall be borne equally by the Parties and each Party shall bear their own respective costs incurred in the mediation regardless of the outcome of the mediation.

3. **ARBITRATION**

3.1 If the Parties are unable to settle the Dispute(s) by mediation in accordance with paragraph 2 within 30 days, the Dispute(s) shall be referred to and finally determined by arbitration before an Arbitral Tribunal composed of a single Arbitrator.

3.2 Any reference of a Dispute to arbitration shall be determined in accordance with the provisions of the Arbitration Act 1996 and in accordance with such arbitration rules as the Parties may agree within 20 days after notice initiating arbitration or, in default of agreement, in accordance with the Rules of the London Court of International Arbitration which Rules are deemed to be incorporated by reference into this clause.

3.3 London shall be the seat of the arbitration.

3.4 Reference of a Dispute to arbitration shall be commenced by notice in writing from one Party to the other Party served in accordance with the provisions of Clause 23 (Notices).

3.5 The Arbitral Tribunal shall be appointed as follows.

(A) Within 14 days of receipt of any notice referring a Dispute to arbitration the Parties shall agree the identity of the person to act as Arbitrator. In default of agreement or in the event the person so identified is unable or unwilling to act, either party shall be

entitled to request the President for the time being of the Chartered Institute of Arbitrators to appoint an Arbitrator for the Dispute and the parties shall accept the person so appointed.

(B) If the Arbitrator becomes unwilling or unable to act, the procedure for the appointment of a replacement Arbitrator shall be in accordance with the provisions of paragraph 3.5(A).

3.6 The language of the arbitration shall be English.

SCHEDULE 6: REPAYMENT SCHEDULE

Repayment Date	Relevant Percentage
18 March 2021	100%

SCHEDULE 7: PERMITTED SECURITY – EXISTING SECURITY

NONE

SCHEDULE 8: ADDITIONAL TERMS AND CONDITIONS

1. Surplus/Deficit and Capital Limits

1.1. The Lender has set a Surplus/Deficit Limit and/or a Capital Limit for the Borrower in consultation with the relevant Supervisory Body.

1.2. The Borrower understands and accepts these Limits in the recognition that any net expenditure in excess of the relevant Limit(s) cannot be funded by the Lender based upon the assumptions made by the Lender at the date of this Agreement.

1.3. The Borrower undertakes not to put forward any Utilisation Requests on this or any other Facility with the Lender that would result in Limits being exceeded by the Borrower without the explicit agreement of the Lender.

1.4. In the event that a utilisation is likely to lead to a Limit being exceeded, the Borrower shall inform the Lender two calendar months before any such utilisation may be submitted.

1.5. The Borrower will make no assumptions in any financial planning in relation to any financial support from the Lender beyond financing previously agreed to support the relevant Limit(s).

1.6. Limits may be adjusted by the Lender from time to time in consultation with the relevant Supervisory Body.

1.7. Performance against Limits will be monitored by the relevant Supervisory Body.

2. Nursing agency expenditure:

2.1. The Borrower undertakes to comply with nursing agency spending rules as set out in the letter of 1 September 2015 from David Bennett and Robert Alexander to NHS Foundation Trust and Trust Chief Executives as may be updated from time to time. In particular, the Borrower undertakes to:

2.1.1. Procure all nursing agency staff through approved frameworks unless such action is otherwise authorised by the relevant Supervisory Body.

2.1.2. Implement an annual maximum limit for agency nursing expenditure as a percentage of the total nursing staff budget as set out in the letter of 01 September 2015 or as otherwise notified by the relevant Supervisory Body.

2.1.3. Implement any additional controls as may be required by the relevant Supervisory Body in relation to the planned introduction of price caps.

2.2. The Borrower additionally undertakes to Implement the NHS Employers Five High Impact Actions

3. Professional Services Consultancy Spend

3.1. The Borrower will not enter into any contract for the procurement of professional consultancy services with a value in excess of £50,000 without the prior approval of the relevant Supervisory Body. The value of multiple contracts issued in respect similar Terms of Reference will be aggregated, as though a single contract had been issued, in respect of the application of this clause.

4. VSM Pay Costs

4.1. Where the borrower is authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the views of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.2. Where the borrower is not authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the approval of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.3. The Borrower undertakes to implement the requirements in respect of the treatment of "off - payroll" workers included in the letter from David Nicholson to Chairs and Chief Executives of 20th August 2012, or any subsequent guidance issued by the Lender.

4.4. The Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England to all newly appointed VSMs except where existing statutory terms take precedence. In addition the Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England for existing VSMs where Section 16 is referenced in their contracts of employment.

5. Estate Costs

5.1. The Borrower undertakes to examine the overall running costs of Estates and Facilities against a benchmark group of similar NHS Trusts within 3 months from the date of this Agreement. Where higher than average costs are identified, and there is no valid reason for this, the Borrower will put in place an action plan to reduce these costs to match the agreed benchmark level. DH will need to satisfy itself that the benchmark is reasonable and plan is deliverable.

6. Surplus Land

6.1. The Borrower shall ensure that it has in place an up to date estates strategy covering a period at least 3 years from the date of this Agreement. The estates strategy should be informed by discussions with commissioners about clinical service requirements and consider options for rationalising the estate and releasing surplus land.

6.2. The report required in clause 6.1 shall identify surplus land and potentially surplus land to be released during the period from the date of this Agreement date to 31 March 2020.

6.3. The Borrower shall provide the Lender with a copy of its estate strategy within 6 weeks of the date of this Agreement or at a date otherwise agreed with the Lender. The Lender will need satisfy itself that the strategy is complete and deliverable for this condition to be satisfied.

7. Procure21

7.1. The Borrower will use the P21+ Procurement Framework for all publicly funded capital works, unless otherwise agreed with the relevant Supervisory Body.

7.2. Where the Borrower proposes to use an alternative procurement route, the Borrower will submit a business case to the relevant Supervisory Body for approval demonstrating that an alternative procurement route offers better Value for Money than the P21+ Procurement Framework.

8. Finance and Accounting and Payroll

8.1. The Borrower undertakes to commission NHS Shared Business Services to complete a baseline assessment of the Borrower's finance and accounting and payroll services to assess the benefit of the use, or increased use, of an outsourced service provider. The Borrower will provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

8.2. Where the assessment by NHS Shared Business Services supports the case for the use, or increased use, of an outsourced service provider, the Borrower will undertake an appropriate market testing exercise or use existing Government Framework Agreements to procure an outsourced service provider within a timescale to be agreed with the Lender.

9. Bank Staffing

9.1. The Borrower will undertake an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency to assess the benefit of the use, or increased use of an Outsourced Staff Bank provider. The Borrower commits to provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

9.2. Where an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency supports the case for the use of Outsourced Staff Bank provider, the Borrower will undertake an appropriate market testing exercise or use an existing Government Framework Agreement to procure an Outsourced Staff Bank provider within a timescale to be agreed with the Lender.

10. Procurement

10.1. The Borrower shall provide third party non-pay spend to the lender in a format specified by the Lender, within 6 months of the date of this Agreement, and at least annually thereafter, on the request of the Lender,

10.2. The Borrower shall test the savings opportunities of increasing usage of the NHS Supply Chain and future editions and/or replacements of the NHS Catalogue within 6 months of the date of this Agreement and at least annually thereafter, on the request of the Lender,

10.3. Any savings identified through the process set out in 10.2 will be pursued by the Borrower. Any identified savings which the Borrower does not intend to pursue must be notified to the Lender along with the reasons for not doing so.

10.4. The Borrower will provide the Lender with current copies of its medical capital equipment asset register, medical equipment maintenance schedule, and capital medical equipment procurement plans within 6 months of the date of this Agreement, and at least annually thereafter on the request of the Lender.

11. Crown Commercial Services ("CCS")

11.1. The Borrower undertakes to test the scope of savings opportunities from CCS within 6 months of the date of this Agreement, subject to appropriate CCS resources being available to support this undertaking. Any savings identified as part of this process which the Borrower does not intend to pursue must be notified to the Lender with the reasons for not doing so.

11.2. The Borrower additionally undertakes to provide details of its relevant requirements in support of all future collaborative procurements including e-auctions.

12. EEA and non-EEA Patient Costs Reporting

12.1. The Borrower undertakes to:

12.1.1. Become a member of the EEA portal and actively report EHIC and S2 patient activity on the portal

12.1.2. Provide an overview of the patient identification, billing and costs recovery systems in place with any planned improvements (for EEA and non-EEA patients)

12.1.3. Participate and collaborate with local/national commissioners in the development of the new ""risk sharing"" model for non-EEA chargeable patients.

13. On request of the Lender, the Borrower agrees to provide timely information and enable appropriate access to parties acting on behalf of the Lender for the purposes of appropriate tracking and reporting of progress delivering the conditions set out within this Schedule.

SIGNATORIES

Borrower

For and on behalf of COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

By:

Name:

Position:

Address: The Countess of Chester Health Park,
Liverpool Road,

Chester,

CH2 1UL

Email: simonholden2@nhs.net

Attention: Simon Holden

Lender

The Secretary of State for Health

By:

Name:

Address: Department of Health,
2nd Floor
Quarry House,
Quarry Hill,
Leeds, LS2 7UE

Email: providerfinance@dh.gsi.gov.uk

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	PLACE (Patient Led Assessment of the Care Environment)
Date of Meeting	18th December 2018
Author(s)	Mr Russ Morrow, Head of Facilities/Ms Linda Cunningham, Facilities Manager
Presented by	Mrs Alison Kelly, Director of Nursing & Quality
Annual Plan Objective No.	
Summary	This was the sixth 'PLACE' annual assessment of the patients' environment. The assessment is conducted by a team of patient representatives and healthcare staff, inspecting the cleanliness, food, privacy & dignity, maintenance of the environment and the dementia & disability arrangements in place at CoCH. The criteria included are not standards but they do represent those aspects of health care which patients and the public have identified as important. This paper provides the Board of Directors at CoCH (including EPH), the recent 2018 assessment results, which are generally positive.
Recommendation(s)	**The Board is asked to:** Note the results and content of this paper and to support on-going actions.
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.

PLACE – Patient Led Assessments in Care Environments

1 Background

A patient-led assessment of the care environment (PLACE) is the system for assessing the quality of the hospital environment. The annual PLACE assessment applies to all hospitals delivering NHS funded care, including day treatment centres and hospices. Information will be used in the CQC's Intelligent Monitoring (IM) process. IM is an analysis used to inform the CQC's new inspection programme about which Trust's could be prioritised for inspection.

PLACE assessments put patient views at the centre of the assessment process, and use information gleaned directly from patient assessors to report how well a hospital is performing in the areas assessed – privacy and dignity, cleanliness, food, general building maintenance, disability and dementia. The dementia arrangements assessment shall be completed in all areas where dementia patients may be present. The only areas exempt from the 'dementia' criteria assessment at the CoCH are paediatric and maternity areas. PLACE focuses entirely on the care environment and does not include clinical care provision or staff behaviour.

Patients undertake an important role in carrying out the assessments (patients in this context includes relatives, visitors, advocates, members of the public and other patient representatives e.g. Healthwatch, patient governors). At least 50% of each assessment team must be made up of patients.

The Health & Social Care Information Centre (HSCIC) (also known as NHS Digital) set national assessment periods; these vary slightly each year but generally occur in the spring period. All hospitals that participate in PLACE are required to publish their PLACE results (following analysis by HSCIC)

In addition to the main PLACE assessment, CoCH undertakes additional quarterly 'internal' PLACE assessments to ensure standards are maintained.

It is important to note, that the PLACE scores represent a 'snap shot' in time and should in no way be seen as a negative view of our two sites, but an assessment of the viewed environment during a specific date and time. The scores received have allowed us to see where our future efforts should be concentrated and where we can make some real impact in areas that are not quite as strong as other areas of the 2018 assessment.

2 Assessment timetable, areas covered and interim results

The assessments for the Countess of Chester Hospital NHS Foundation Trust and Ellesmere Port Hospital were completed as follows:

2.1 18th April 2018 at Ellesmere Port Hospital

As a consequence of sickness within the assessment team, the assessment for Ellesmere Port Hospital was undertaken & completed by one team. In maintaining the requirements of PLACE, the assessment team was made up of three patient assessors and three Trust personnel both clinical and non-clinical. The CoCH PLACE Facilitator gave an oversight of the assessment prior to the inspection to make all assessors aware of the requirements of the assessment

The areas covered were:

- Ward areas
- Outpatient areas
- Communal Areas
- External areas
- Food

2.2 17th and 24th April at Countess of Chester Hospital

On 17th April 2018 there were three patient assessors with representatives from Trust Governors and three Trust personnel both clinical and non-clinical. On 24th April 2018 the team consisted of two patient assessors with a representative from Trust Governors and two Trust personnel both clinical and non-clinical. An external validator was present and this was reciprocated with Wirral University Teaching Hospitals during their PLACE assessments.

The areas covered were:

- Ward areas
- Outpatient areas
- Communal areas
- External areas
- Food
- A&E

3.0 Results – overall impression

Both hospital sites scored well with very positive comments from patient assessors.

3.1 First Impressions question

"Based on your first impressions on entering the ward, how confident are you that the environment in this ward supports good care?"

The majority of areas assessed resulted in a score of:

Very confident = A
or
Or confident = B

5 wards that were assessed as part of the 'initial impression' question found the score recording ***'not very confident'.***
Nb: However, it is worth noting that following the full ward(s) visit in much greater detail, the assessment found the 'lasting impression' improved to very confident and confident**.**

3.2 Last Impressions question

"Having carried out the PLACE assessment on this Ward, how confident do you now feel that the environment in this ward supports good care?"

All areas assessed resulted in a score of:

Very confident = A
or
Or confident = B

The summary statements completed by the Patient Representatives as part of the Patient Assessment Summary Sheet read as follows:

17th April 2018 Countess of Chester
"Given that this hospital is over 40 years old, there is limited scope to improve storage on Wards and other facilities"
"The hospital felt clean and calm and the lunchtime food was delicious with a wide variety of choice".
"All staff appeared caring and motivated"
"We like the refurbished and redesigned bed areas with sliding doors but appreciate that this reduced the number of beds on ward"

24th April 2018 Countess of Chester
Westminster Eye Clinic – "Despite previous suggestions from PLACE assessments, the décor and seating need urgent attention". "There is evidence of unhygienic toys in the children's waiting area"
"The PLACE assessment at the Countess of Chester seems to be working; improvements have been made from previous PLACE recommendations"
"One member of staff moving from one Ward to another failing to use the hand gel"

18th April 2018 Ellesmere Port
"The old hospital is very clean, light and airy". "Patients appear content and well cared for". "Lunchtime food was delicious and varied". "Housekeepers were seen to go the 'extra mile' to make lunch enjoyable".

4.0 National Results
Results were published nationally on the 16th August 2018 and were as follows:

4.1

Countess of Chester Hospital						
Assessed Areas	Cleanliness %	Food %	Privacy & Dignity %	Condition, Appearance & Maintenance %	Dementia	Disability
National average	98.47%	90.70%	84.16%	94.33%	78.89%	84.19%
CoCH 2018	**99.21%**	**88.24%**	**75.71%**	**92.34%**	**54.46%**	**72.81%**
CoCH 2017	*99.52%*	*88.09%*	*71.97%*	*96.16%*	*64.07%*	*74.78%*

4.2

Ellesmere Port Hospital						
Assessed Areas	Cleanliness %	Food %	Privacy & Dignity %	Condition, Appearance & Maintenance %	Dementia	Disability
National average	98.47%	90.70%	84.16%	94.33%	78.89%	84.19%
EPH 2018	**99.80%**	**86.65%**	**81.33%**	**97.82%**	**69.90%**	**87.65%**
EPH 2017	*99.57%*	*93.27%*	*77.27%*	*95.08%*	*66.58%*	*74.33%*

4.3 How we compare to the 'Average National Score'

With exception to the cleanliness aspects of the assessment, the Countess of Chester was slightly below the national average in all other assessed target criteria. The cleaning level/results achieved is in line with the Trusts expectation, but should not be taken for granted. To achieve a score of 99.21% in an Acute Trust in today's 2018 NHS is a feat in itself, an Acute Trust is probably the most challenging environment to both clean and maintain the level of cleanliness required as part of delivering safe & effective healthcare.

Ellesmere Port Hospital scored extremely well in the cleanliness aspects of the place criteria, achieving an excellent 99.8%. once again, the cleaning level/results achieved is in line with the Trusts expectation, but should not be taken for granted for the very same reasons at the CoCH site.
At EPH, two further elements of the PLACE criteria scored above the national average, those of 'Condition, Appearance & Maintenance' and that of 'Disability'

When the scores are brought together to give us an overall organisational score, the assessed area results are as follows:

Organisational Score						
Assessed Areas	Cleanliness %	Food %	Privacy & Dignity %	Condition, Appearance & Maintenance %	Dementia	Disability
National average	98.47%	90.70%	84.16%	94.33%	78.89%	84.19%
Both sites combined	**99.26%**	**88.00%**	**76.19%**	**92.81%**	**55.78%**	**74.08%**

As an organization, we can be pleased that our cleaning arrangements exceed the national average at both sites.
As a Trust, it is clear we have some work and focus on the remaining assessed areas of the PLACE, although in 'Food' &' Condition, Appearance & Maintenance' we are moving closer to the target and fully expect to exceed the national average during 2019 PLACE process.

An action plan to help us mitigate and challenge our current status is underway and will be proposed and discussed at the September PLACE Committee. The Director for Nursing & Quality is the Exec Lead for PLACE and has recently presented an opportunity for PLACE

Committee members/Facilities Managers to integrate within the 'Patient Experience Operational Group' (PEOG).
The opportunity is intended to create a wider platform for the PLACE Committee to seek further subject matter experts as part of the wider PLACE criteria and share learning and experience between the two groups and their common objectives.

The remainder of 2018 up to the start of PLACE 2019 will focus efforts in the areas where the scores show much work is still required. The efforts will see a revived action plan that aims to tackle the areas of PLACE that require more focus and attention, as detailed in the following sections.

4.4 Privacy Dignity and Wellbeing

The assessment of Privacy Dignity and Wellbeing includes infrastructural/organisational aspects such as the provision of outdoor/recreation areas, changing and waiting facilities, access to television, radio, computers and telephones. It also includes the practicality of male and female services such as sleeping and bathroom/toilet facilities, bedside curtains sufficient in size to create a private space around beds and ensuring patients are appropriately dressed to protect & maintain individual dignity.

The score for our Countess Site was 75.71% and our Ellesmere Port site was 81.33%.
The majority of wards in a modern 'acute' Trust (CoCH) do not have separate treatment or days rooms within the ward environment; as a consequence, final scores were impacted when applying the PLACE criteria to the assessed environment. Ellesmere Port Hospital, as a direct consequence of its age and the 'then' design of hospitals, does have 'day room/areas' within the ward environment, resulting in a much different set of scores when assessed against this specific PLACE criteria.

In ward environment, PLACE criteria also looks at provision for patients having access to their own secure facility that enables the security of personal effects with the patient holding the key or access code during their stay in hospital.

The PLACE criteria looks at seating provision in outpatient departments, and whilst it was assessed there was adequate seating at the time of assessment, in the Therapies Department, it was viewed/assessed that our seating provision did not cater for clients and patients of different sizes and ages.
In addition, we received a negative response regarding clients/patients seated in the waiting areas being able to hear other clients/patients conversations being conducted at the main reception desks in Outpatient clinics at both of our sites.

4.5 Dementia

The criteria within the Dementia area of PLACE focus on flooring (type, style and colour), general and specific décor and signage, but also includes such criteria as availability of handrails and appropriate seating, and to a lesser extent, the food being made available.

All questions as part of this criteria required a ***yes/no*** response.
This domain draws heavily on the the work of The Dementia Services Development Centre at Stirling University in conjunction with the Kings Fund.

The items included in the assessment do not constitute the full range of issues requiring assessment which, in total, are too numerous to include. However they do include a number of key issues and all Health Care organisations are encouraged to undertake more comprehensive assessments using one of the recognised environmental assessment tools available.
This is the third year the dementia assessment has been undertaken, with this year's results showing the Countess at 54.46%, whilst Elllesmere Port Hospital was scored 69.90%.

During the assessment it was observed that not all toilets at our Countess site had both text and picture signs and that toilet doors were not painted in a single colour to distinguish them from other doors. It is noted that Ellesmere Port Hospital has seen much improvement in these areas.
There are handrails in the majority of toilets that are of a colour that contrasts with the floor and walls but no toilet seats were of a contrasting colour. A negative response was noted regarding the lack of handrails in the Ward areas.

A further area where marks were lost was the lack of prominent signs displaying the ward and hospital name, the lack of a large face clock visible in all areas, the day and date not being visible and doors and handles to staff areas not being painted the same colour as the walls. Further negatives were as a result of our inability to remove or cover mirrors in the bathrooms.
Additional positive scoring was impacted as a result of some fitted flooring surfaces are not noise absorbent/reducing and may appear shiny. It is noted that Ellesmere Port Hospital has seen much improvement in these areas and has such floor surfaces in some of its wards.

5.0 PLACE Action Plans (COCH/EPH)

The action plans for both the Countess of Chester and Ellesmere Port Hospital are being completed and will see renewed energy in the areas where progress is needed.
It is our intention to capitalise on our recent joining of the Patient Experience forum and utilise clinical colleagues, their experience and their areas of focus in addressing our 'joint' areas for action to the benefit of our patients and clients.
The action plans will be discussed in detail at the PLACE Committee and the PEOG forums and include key deliverables for close down and completion in a realistic and timely manner.

It is our expectation, that both of our sites will be much better prepared, briefed and looking forward to the 2019 PLACE process.

6.0 Recommendations

The Board of Directors is asked to note the results and content of this paper and to support ongoing actions when published for both sites.

Russ Morrow/Linda Cunningham
Head of Facilities/Facilities Manager
August 2018

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Flu Campaign 2018
Date of Meeting	Board 18th December 2018
Author(s)	Kathryn de Beger, Occupational Health & Wellbeing Manager
Annual Plan Objective No.	
Summary	This report is intended to provide an update on staff flu vaccination plan 2018.
Recommendation(s)	**The Board is asked to:** • Note the content of the report.
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [X] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

1. Introduction

This information paper details the OH activity in support of the 2018/19 flu vaccination campaign at Countess of Chester Hospital. We have been instructed by NHS Employers in a letter dated 7 September 2018 to our Chief Executive that we must publish a self-assessment for the board that details our performance against the recommended best practice management checklist. (Appendix 1)

2. Background / Current Position

Last year, 2017/18, at the end of the campaign, 82% of frontline staff were vaccinated and 3147 vaccines were administered, this ran from 1st October 2017 to end February 2018.

The national target this year remains at vaccinating 75% of frontline staff, but this year NHS Employers have proposed to strive to vaccinate 100% of healthcare workers with direct patient contact, in high risk areas. In addition, there is the requirement to capture the percentage of staff that have declined the vaccine, and collate anonymised reasons for the decline to be vaccinated.

To date (12.12.18) 79% of our front line staff have been vaccinated and 3,176 staff have had their flu vaccine. The campaign will continue until the end of December 2018, but staff will still be able to access vaccination through Occupational Health in January 2019.

The Countess historically always has had a good uptake of vaccine from our health care workers and has been in the top 20 Trusts nationally for the past few years. There will however, always be some staff that refuses to have a vaccine and this will impact on attaining 100%.

3. Operational Plan 2018

This year our Occupational Health operational planning meetings started in June 2018, including discussions at Partnership Forum, P&OD committee, IPC committee and Nursing and Midwifery Board.

This plan is based on collaborative working and the following factors:

- Committed leadership and promotion at all levels of the Organisation
- Effective communications plan
- Flexible accessibility for all Trust staff
- Funding for Flu Bank Nurses and prices
- Incentives for uptake

The plan sets out to achieve the following:

- To ensure that staff are aware of what is expected of them in terms of the benefits of being vaccinated.

- To ensure staff are given the correct facts about the flu vaccination in order to eliminate rumours/myths to enable an informed choice about vaccination. This will be facilitated with the support of Communication team.
- OH engagement at meetings in the lead up to the campaign to rally support for divisional/departmental peer vaccinators and to ensure 'buy in' from organisation as to the multifaceted benefits of vaccination.
- Enable staff the opportunity to be vaccinated as easily as possible, acknowledging the work pressures, by facilitating drop in clinics, walkabouts to all hospital areas, flu to you by using bleep, evening, night and weekend availability, including early morning vaccination (available from 7am).

4. Vaccination campaign

Vaccinations have been available from 8th October 2018 and will be available until 28th February 2019. The majority of vaccinations have taken place in October / November I

Monthly data submissions of uptake are reported nationally on IMMFORM.

5. Resources

The campaign is delivered by the Occupational Health and Wellbeing team with support from trained peer vaccinators and by flu bank nurses.

6. Conclusion

The attached appendix demonstrates our delivery of best practice in the effective delivery of the flu campaign for our workforce. Despite the desire to achieve 100% uptake amongst our frontline staff by NHS employers we will likely have a cohort of employees who chose to make an informed decision and decline the offer of the vaccine. We will continue to capture the reasons as to refusal where possible as this information will be submitted to Public Health England.

7. Recommendation

For the Trust to have assurance in this campaign and the effective execution of the plan.

Author: Kathryn de Beger

Date: 12th December 2018

A	Committed leadership	Evidence	Trust self-assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Board support at commencement of campaign. Plan submitted to IPC and P&OD committees. Staff declining offer of vaccine asked to complete anonymised form to capture reasons for refusal.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.	QIV ordered for HCW's	
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt.	Regular updates at various Trust meetings, throughout the campaign.	
A4	Agree on a board champion for flu campaign	Executive Director of People & OD and Executive Director of Nursing and Quality.	
A5	Agree how data on uptake and opt-out will be collected and reported	Occupational Health team with support from Workforce team.	
A6	All board members receive flu vaccination and publicise this	Flu vaccine offered to all Board members, photographs taken (with consent) and promoted.	
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Bank Nurses, OH nurses and Peer vaccinators trained August and September 2018. Meetings with key stakeholder groups.	
A8	Flu team to meet regularly from August 2018	Regular review meetings with OH team, from July 2018, with support from IPC lead nurse.	
B	Communications plan		
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions	Comprehensive communication plan delivered by communication team.	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Accessibility through a diverse delivery plan, including drop in clinics, outside staff restaurant, 'bleep us and we will	

		come to you', flu nurses on night and weekend shifts etc, with open access to all employees, all communicated through Communication team.	
B3	Board and senior managers having their vaccinations to be publicised	Photographs captured and promotion through Trust media.	
B4	Flu vaccination programme and access to vaccination on induction programmes	Delivered at induction day and mandatory training sessions.	
B5	Programme to be publicised on screensavers, posters and social media	Established communication plan detailing clinic times and availability of flu nurses through all media channels.	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Weekly figures submitted to the key stakeholders and headline figures communicated by Communication team.	
C	Flexible accessibility		
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	Support from senior leadership for identified peer vaccinators, at Countess and EPH.	
C2	Schedule for easy access drop in clinics agreed (3)	All clinics offer on a 'no appointment needed' drop in format. Flu nurses have had a bleep and will attend any ward or department at request.	
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6)	As well as daily availability, Flu nurses have undertaken night shifts and weekend shifts, attended evening department meetings, and early morning 7am.	
D	Incentives		
D1	Board to agree on incentives and how to publicise this (3,6)	Prize Draw on 14th December as well as a flu fighter pen for the first 2,500 staff who had their vaccine.	
D2	Success to be celebrated weekly (3,6)	Feature in Trust publications, intranet front page, and key messages / uptake on social media weekly.	

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Subject	Annual Report 2017/18
Date of Meeting	18th December 2018
Author(s)	Samantha Walker, Lead Nurse, Infection Prevention & Control. Presented by Dr Darren Kilroy, Acting Medical Director
Annual Plan Objective No.	
Summary	Infection prevention is an essential component of quality healthcare provision, for the delivery of safe, kind and effective care. Ensuring that we have robust infection prevention and control system and process routinely embedded at all levels of the organisation is crucial to ensuring that avoidable infections do not occur. This report provides an overview of activity and compliance in respect of this agenda during 2017/18
Recommendation(s)	The Board is asked to note: the assurance provided within the report and to note the actions for 18/19
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

Director of Infection Prevention and Control Annual Report

1st April 2017 – 31st March 2018

1. Executive Summary

Infection prevention is an essential component of quality healthcare provision, for the delivery of safe, kind and effective care. Ensuring that we have robust infection prevention and control system and process routinely embedded at all levels of the organisation is crucial to ensuring that avoidable infections do not occur.

The emergence of antimicrobial resistance is recognised as an international threat. Although the UK government is determined that access to working antimicrobials will be sustained into the future for healthcare, antimicrobial resistance places an even greater emphasis on the need for infection prevention as resistance to the drugs that we use to treat infections increases, rendering them ineffective. In support of the 2017/19 Quality Premium scheme for Clinical Commissioning Groups, the Trust has also been working collaboratively with partners within West Cheshire to reduce the number of Gram-negative bloodstream infections across the whole health economy, as part of the broader healthcare agenda for infection prevention and control and antimicrobial stewardship.

The Trust maintained the intensity of both infection prevention and control and antimicrobial stewardship throughout 2017/18, sustaining our 'zero tolerance' approach to avoidable infection from 'board to ward'. Focus remained on risk assessment and risk reduction strategies, with routine implementation of prevention and control measures within practice being essential to achieving this aim.

To ensure that high quality care is delivered safely and that the risks associated with developing a healthcare associated infection are reduced, it is essential that these risk reduction strategies include robust systems to monitor and evaluate how infection prevention and control system and/or process is implemented in practice, including strategies to disseminate any lessons learned for improvement in real time. Communication strategy plays a key part in this, ensuring that resources are targeted appropriately and that the workforce remains informed.

Compliance monitoring throughout 2017/18 demonstrated:

- **1 avoidable case of MRSA bacteraemia identified, against the objective of zero avoidable MRSA bacteraemia within year.**
- **29 cases of *Clostridium difficile* infection reported, against an objective of no more than 24 cases within year.**
- **Hand hygiene compliance maintained at or above the 95% minimum compliance level across the year – compliance only dropping slightly below 95% during two months (August and November 2017).**
- **The Trust maintained an 'unconditional' registration status with the Care Quality Commission.**

The challenge of maintaining focus on infection prevention and control throughout 2018/19 will remain, with it being essential that learning is taken forwards, to drive improvement at every opportunity.

2. Infection Prevention and Control Arrangements

The Infection Prevention and Control Team experienced some changes during 2017/18, with Dr Ken Mutton joining the team as a locum Consultant Microbiologist, providing cover during a period of maternity leave within year.

The substantive team structure remains at:

- 3wte Consultant Microbiologists
- 1wte administrative support for Consultant Microbiologists
- 1wte Lead Nurse – Infection Prevention and Control
- 2wte Infection Prevention and Control Nurses
- 1wte Infection Prevention and Control Support Nurse
- 1wte administrative support for the Infection Prevention and Control Nurse Team

The Medical Director also continued within the role of Director of Infection Prevention and Control.

Infection Control Committee meetings were held bi-monthly to maintain the focus on infection prevention and control activity within the organisation, with the committee scheduled for January 2018 cancelled due to operational pressures within the organisation (all such meetings were cancelled during this period). The Director of Infection Prevention and Control role also included the provision of assurance reports to the Board of Directors on a quarterly basis, with healthcare associated infection objectives being discussed at each Board Meeting (monthly), supported by the Infection Prevention and Control Team.

3. Infection Prevention and Control Budget

There is Board approval to financially support infection prevention and control activity, including any identified outbreak of infection to ensure appropriate management and control.

Staffing budgets fall within Pathology/Corporate Nursing budgets, with finance also identified to support the ongoing training and development of the team.

4. Corporate Infection Prevention and Control Assurance Framework

The corporate infection prevention and control assurance framework within the Trust is structured to ensure engagement and ownership at all levels of the organisation from Board to ward, with the operational process supporting the overarching Trust strategy of zero tolerance to avoidable healthcare associated infections.

Each division and certain appropriate speciality areas feed into this framework (see Figure 1.) to provide assurance that the Trust is compliant with all aspects of the Health and Social Care Act (2008): code of practice on the prevention and control of infections and related guidance (2015 version).

Evidence of assurance is contained centrally within the corporate infection prevention and control assurance plan, fed by evidence supplied on a quarterly basis by division and speciality areas and ensuring that appropriate evidence is consistently available to support compliance. Self-assessment scores based on this evidence are calculated to generate a balanced scorecard, detailing compliance scores for each element of the Health and Social Care Act 2008 (see figure 2.).

A comparison between the existing self-assessment framework duties (balanced scorecard) and the compliance criterion within the Health and Social Care Act 2008 (2015 version) forms part of the corporate assurance plan (see Figure 2.1), with existing systems and processes continuing to support operational activity.

The assurance reporting framework to the Infection Control Committee, plus the Quality, Safety and Patient Experience Committee and Trust Board, incorporates a structured reporting timetable to ensure that required systems are in place and that any areas of non-compliance are reported.

This framework not only provides internal assurance to the organisation; the established systems and processes also maintain the Trusts' unconditional HCAI registration status with the Care Quality Commission and are readily available to provide assurance to other external regulators if required.

Figure 1. Corporate Infection Prevention and Control Assurance Reporting Framework

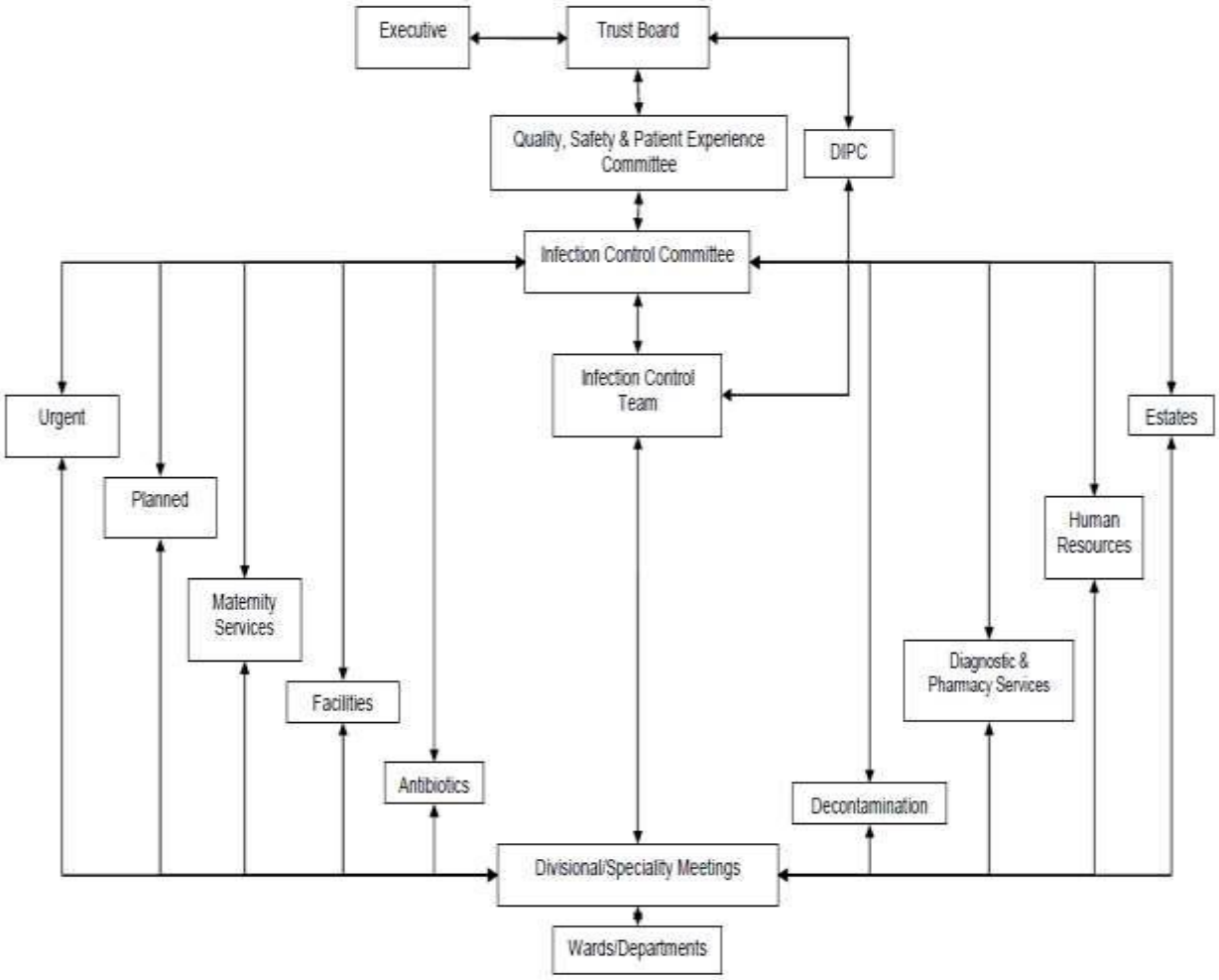


Figure 2. Health and Social Care Act 2008 – Balanced Scorecard

Code of Practice
for the Prevention and Control of Healthcare Associated Infections (HCAI)
Self Assessment Tool
Balanced Scorecard: Repeat Self Assessment Summary
25/08/17, 24/11/17 and 23/02/18

Overall Status					
25/08/17	100%	24/11/17	100%	23/02/18	100%

Key		
	100%	Full compliance
	71% - 99%	Action required
	50% - 70%	Urgent action required
	=< 49%	Trust priority

Core Duty 2: Duty to have in place appropriate management systems for infection prevention and control (IPC)		Core Duty 3: Duty to assess risks of acquiring HCAI and to take action to reduce or control such risks		Core Duty 4: Duty to provide and maintain a clean and appropriate environment for health care	
25/08/17	100%	25/08/17	100%	25/08/17	100%
24/11/17	100%	24/11/17	100%	24/11/17	100%
23/02/18	100%	23/02/18	100%	23/02/18	100%

Core Duty 5: Duty to provide information on HCAI to patients and the public		Core Duty 6: Duty to provide information when a patient moves from the care of one health care body to another		Core Duty 7: Duty to ensure co-operation	
25/08/17	100%	25/08/17	100%	25/08/17	100%
24/11/17	100%	24/11/17	100%	24/11/17	100%
23/02/18	100%	23/02/18	100%	23/02/18	100%

Core Duty 8: Duty to provide adequate isolation facilities		Core Duty 9: Duty to ensure adequate laboratory support		Core Duty 10: Duty to adhere to policies and protocols applicable to infection prevention and control	
25/08/17	100%	25/08/17	100%	25/08/17	100%
24/11/17	100%	24/11/17	100%	24/11/17	100%
23/02/18	100%	23/02/18	100%	23/02/18	100%

Core Duty 11: Duty to ensure that health care workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention/control of HCAI	
25/08/17	100%
24/11/17	100%
23/02/18	100%

Figure 2.1 Health and Social Care Act 2008 comparison

Current Infection Prevention & Control Assurance Self-assessment	Health & Social Care Act 2008 (2015 version)
Core Duty 2: Duty to have in place appropriate management systems for infection prevention and control (IPC).	**Compliance criterion 1:** Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
Core Duty 3: Duty to assess risks of acquiring HCAI and to take action to reduce or control such risks.	**Compliance criterion 5:** Ensure prompt identification of people who have or at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
Core Duty 4: Duty to provide and maintain a clean and appropriate environment for health care.	**Compliance criterion 2:** Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Core Duty 5: Duty to provide information on HCAI to patients and the public. **Core Duty 6:** Duty to provide information when a patient moves from the care of one health care body to another.	**Compliance criterion 4:** Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
Core Duty 7: Duty to ensure co-operation.	**Compliance criterion 6:** Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Core Duty 8: Duty to provide adequate isolation facilities.	**Compliance criterion 7:** Provide or secure adequate isolation facilities.
Core Duty 9: Duty to ensure adequate laboratory support.	**Compliance criterion 8:** Secure adequate access to laboratory support as appropriate.
Core Duty 10: Duty to adhere to policies and protocols applicable to infection prevention and control.	**Compliance criterion 9:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
Core Duty 11: Duty to ensure that health care workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention/control of HCAI.	**Compliance criterion 10:** Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
No self-assessment section included within current self-assessment tool – antimicrobial stewardship activity is monitored through the Antimicrobial Stewardship Committee	**Compliance criterion 3:** Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

5. Surveillance and Reporting of Health Care Associated Infection

Establishing robust HCAI surveillance systems is important to continually support a zero tolerance culture within health care organisations. Surveillance is essential for many reasons including quality assurance, early outbreak identification, benchmarking between organisations and the provision of accurate information on progress to healthcare workers. Surveillance data can also provide evidence to guide how improvements in clinical practice assist in reducing the incidence of HCAI.

The Infection Prevention and Control Team has developed robust HCAI surveillance systems to ensure that all data is collected, collated and disseminated through established communication routes in real time, and that national mandatory surveillance data reporting requirements are met within the required timeframes.

National mandatory surveillance data reporting requirements are regularly reviewed by NHS England and Public Health England, and are used as a quality measure by other monitoring bodies such as Monitor and the Care Quality Commission.

National mandatory surveillance requirements were expanded from 1st April 2017 to incorporate the enhanced surveillance programme for Gram-negative bloodstream infections (GNBSI) and now include:

- Meticillin resistant *Staphylococcus aureus* bacteraemia (MRSA)
- *Staphylococcus aureus* bacteraemia (MSSA)
- Gram-negative bloodstream infection
    - *Escherichia coli* bacteraemia (E. coli)
    - *Klebsiella species* bacteraemia
    - *Pseudomonas aeruginosa* bacteraemia
- *Clostridium difficile*
- Infections associated with surgical orthopaedic procedures

5.1 MRSA Bacteraemia

The national objective for MRSA bacteraemia reduction for 2017/18 remained unchanged at zero avoidable infections for all healthcare providers.

The national mandatory system for post-infection review (PIR) continued, supported by the document 'Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections'. This national approach to MRSA bacteraemia investigation supports commissioners and providers to deliver zero tolerance on MRSA bacteraemia, as detailed within the planning guidance 'Everyone Counts: Planning for Patients 2013/14 to 2018/19'.

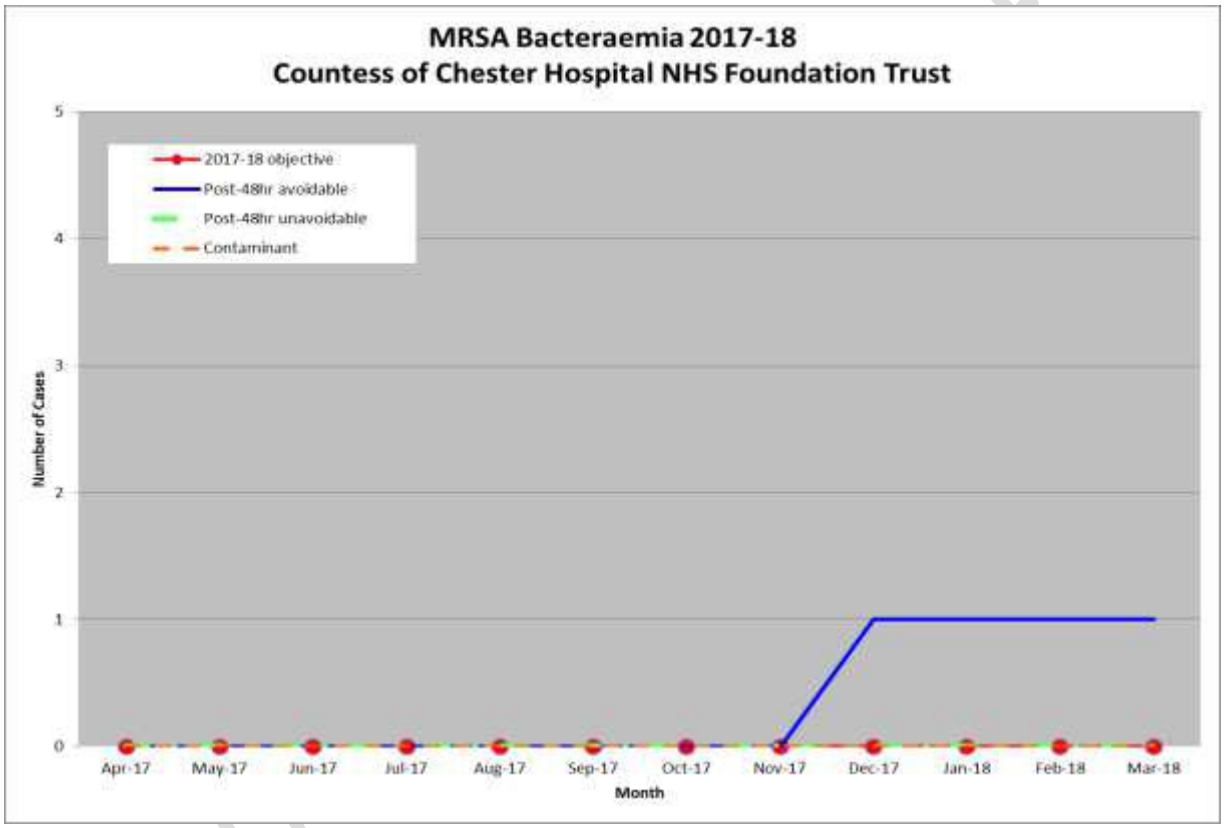
The Trust reported MRSA bacteraemia within year that was identified as avoidable following investigation. Focus for continued improvement within the Trust was aimed at maintaining the established systems of prevention, identified through lessons learned during the investigation of this case of infection, focussing on evidence based best practice and key clinical procedures, including:

- MRSA screening
- Insertion and ongoing management of invasive devices

As very few cases of MRSA bacteraemia are now being identified, it is becoming increasingly difficult to identify trends for improvement. However, every opportunity is taken for learning that is shared through well-established systems for the dissemination of key messages throughout the Trust, to ensure that risk reduction strategies for this infection continue to be appropriately focussed.

MRSA bacteraemia data submission is via the national HCAI data capture system. The data includes MRSA detected in blood cultures only and does not include MRSA carriage on or within other body sites.

Figure 3. Trust attributable MRSA bacteraemia cases 2017/18



5.2 *Clostridium difficile* Infection (CDI)

The Department of Health CDI objective for the Trust for 2017/18 remained unchanged from the previous year at **no more than 24 cases attributable to the organisation within year**, with the potential for significant financial penalties on a case by case basis if this objective was exceeded. The Trust reported 29 cases of C. difficile infection within year, exceeding this objective by 5 cases of infection.

Figure 3.1 CDI Cases against objective 2017/18

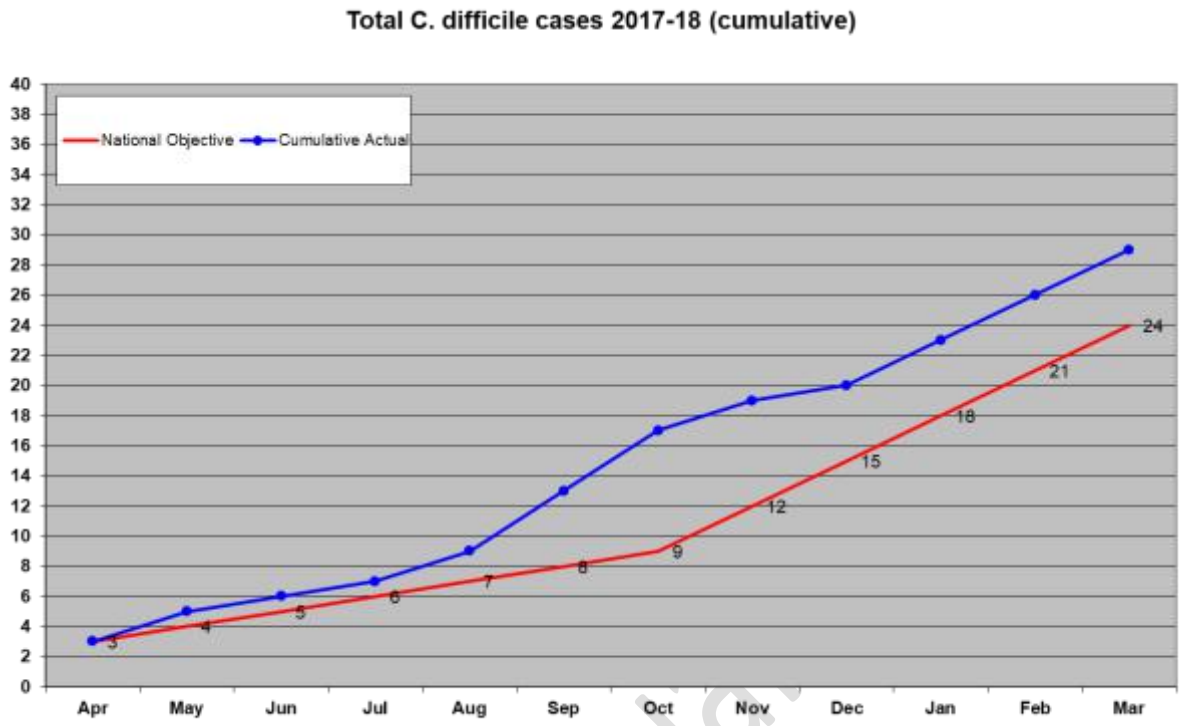
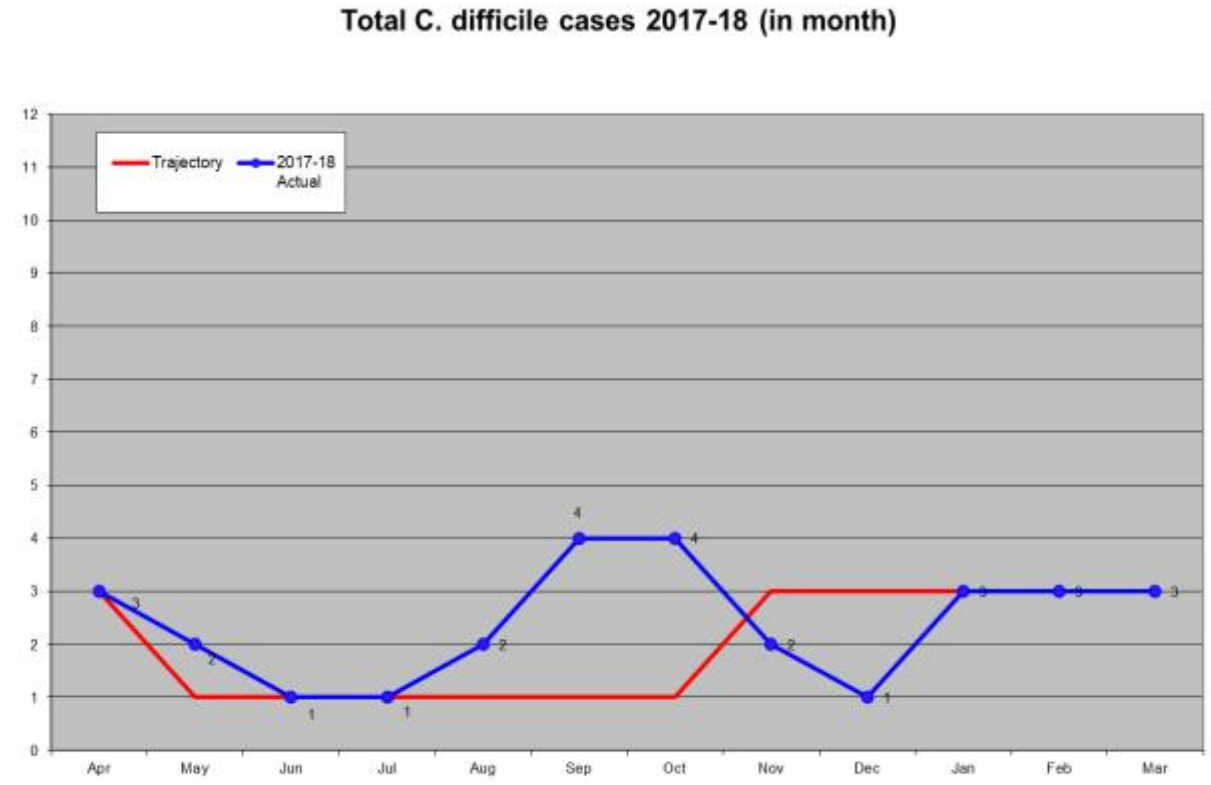


Figure 3.2 CDI Cases per month against trajectory 2017/18



The data identifies a rise in the number of cases of CDI identified during August – October 2017, although this fell back to within trajectory for the remainder of the surveillance year. The requirement to ensure that robust measures to reduce the risks associated with developing CDI are sustained throughout the Trust remained a key priority for all healthcare workers. The focus for CDI reduction continued to be supported by evidence based practice and learning from local root cause analyses investigation of each case of infection, plus regional and national learning for improvement.

The CDI risk reduction strategy within year included:

- Maintaining the case by case C. difficile surveillance with robust feedback methodology, including the early identification of any period of increased incidence
- Maintaining weekly multidisciplinary C. difficile wards rounds
- Reinforcement of the antibiotic stewardship policy, including use of proton pump inhibitors
- Further development of the Antimicrobial Stewardship Committee
- Daily Consultant Microbiologist antimicrobial ward rounds within Critical Care
- Maintaining and increasing combined antimicrobial stewardship ward rounds within other specialities
- Maintaining robust infection prevention and control practices Trust-wide, including hand hygiene, patient isolation and environmental/equipment hygiene
- Further consideration and development of methods to provide antimicrobial data to support Divisions and Consultant teams with antimicrobial stewardship
- Re-enforce an open and honest root cause analysis process for each CDI case, emphasising ownership and responsibility of this investigation process for clinical teams
- Continuing with the established quarterly case review process to identify whether cases resulted from a lapse in care, by reviewing systems and processes via a locally developed proforma
- Robust communication systems to ensure that the workforce remains informed on progress and that learning is widely disseminated, including the promotion of best practice.

5.3 Antimicrobial Stewardship

Antimicrobial stewardship programmes have been implemented widely as an effective approach to address the worldwide problem of increasing antibiotic resistance. This is a multi-disciplinary response with aims to optimise clinical outcomes while minimising unintended consequences of antimicrobial use, including toxicity, selection of pathogenic organisms (such as *Clostridium difficile*), and the emergence of antibiotic resistance. Thus, the careful and responsible use of antimicrobials is an essential part of patient safety.

The AMS (Antimicrobial Stewardship) Committee was set up within the Trust during November 2011 following the publication of Department of Health Advisory Committee Guidance on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) on antimicrobial stewardship in hospitals (England).

The AMS Committee is chaired by a Consultant Microbiologist and follows an inter-professional strategy. The committee is multidisciplinary with clinician representation from a cross-section of specialities (including Consultants and junior doctors), together with senior Pharmacy and Infection Prevention and Control Team input. The Committee reports to the DIPC/Infection Control Committee and works closely with the Drugs & Therapeutic Committee.

During 2017/18 the main activities of the AMS Committee and the AMS programme were focussed on achieving the **Antibiotic CQUIN targets**.

Indicator 2c: Clinical antibiotic review between 24-72hrs of initiation in patients with sepsis who are still inpatients at 72hrs

- Appropriate clinical review by:
  - Infection (infectious diseases/clinical microbiologist) senior doctor
  - Infection pharmacist
  - Senior member of the clinical team (ST3 or above)

- Documented outcome recorded as one of the following:
  - Stop
  - IV to oral switch
  - OPAT (Outpatient Parenteral Antibiotic Therapy)
  - Continue with new review date
  - Continue with no review date
  - Change antibiotic with escalation to broader spectrum antibiotic
  - Change antibiotic with de-escalation to a narrower spectrum antibiotic
  - Change antibiotic as a result of blood culture results

Indicator 2d: Reduction in antibiotic consumption per 1,000 admissions

There are three parts to this indicator:

- Total antibiotic consumption per 1,000 admissions - as measured by Defined Daily Dose (DDD)
- Total consumption of carbapenem per 1,000 admissions - as measured by Defined Daily Dose (DDD)
- Total consumption of piperacillin-tazobactam per 1,000 admissions - as measured by Defined Daily Dose (DDD)

January-December 2016 was used as the baseline period.
Based on the Trust's performance in 2016/17 the following were required for 2017/18:

- 2% reduction in total antibiotic consumption per 1,000 admissions
- 1% reduction in carbapenem consumption per 1,000 admissions
- 1% reduction in piperacillin-tazobactam consumption per 1,000 admissions

5.3.1 CQUIN Achievements during 2017/18

2c - Evidence of review within 72 hours:

Result		Target
Q1	97% compliant	(≥25% compliant with 72 hr review)
Q2	91% compliant	(≥50% compliant with 72 hr review)
Q3	95% compliant	(≥75% compliant with 72 hr review)
Q4	91% complaint	(≥90% compliant with 72 hr review)

2d - Antibiotic consumption:

Total antibiotic usage per 1,000 admissions:
11.1% increase

(2% reduction required - indicator failed. 2% reduction in total antibiotic usage required for 2018/19)

Total usage of carbapenems per 1,000 admissions:
7.5% reduction
(1% reduction required – indicator achieved. 2% reduction in carbapenem usage required for 2018/19)

Total usage of piperacillin-tazobactam per 1,000 admissions:
21.3% reduction
(1% reduction required – indicator achieved)

5.3.2 Changes for 2018/19

Indicator 2c: Antibiotic review:

In addition to the 2017/18 requirements there also needs to be an IV to oral switch assessment. Where appropriate an IV to oral switch decision was made. If the decision was for the patient to remain on IV antibiotics, a documented rationale for not switching needs to be clearly documented:

- Patient is nil by mouth or not absorbing
- No oral antibiotic option available
- Patient not clinically improving
- Deep seated infection
- Based on microbiology/ID consultant/Infection Pharmacist advice

Indicator 2d: Antibiotic consumption:

For 2018/19 CQUIN the piperacillin-tazobactam indicator has been removed from the CQUIN and replaced with a target to increase the proportion of antibiotic usage within the Access group of the WHO AWaRe category (either 55% or above of the total antibiotic consumption, or increase by 3% from the baseline calendar year 2016). Our baseline is 39.4% use of the antibiotics in the Access group, so we will aim for the 3% increase.

Several **actions** were taken during this financial year to reduce further unnecessary antibiotic consumption at our Trust (total, carbapenem and Tazocin usage).

- Data surveillance/review was performed regularly on AMS Committee meetings, trends and changes were analysed and action plans were created if necessary.
- Carbapenem usage was addressed with the following actions:
    - Trust-wide restriction on meropenem usage was implemented according to which all meropenem prescriptions longer than 7 days has to be discussed with Medical Microbiology Consultant
    - Active involvement of Pharmacists – notify clinical teams to discuss prolonged meropenem course with Medical Microbiology Consultants
    - Setting up notification on Electronic prescribing system to discuss prolonged (>7 days) meropenem usage with Medical Microbiology Consultants
    - Involve Locum Microbiologists in the discussion to ensure cautious use/ recommendation of carbapenems
    - Further audit on meropenem prescriptions specifically focusing on highest meropenem users (Respiratory and Elderly Care Wards)
    - Review antibiotic Formulary recommendations for infections where meropenem is most frequently used as escalation treatment(e.g.: hospital acquired pneumonia)

- Wide range of education and teaching programs were held to inform and involve clinicians in reduction of unnecessary antibiotic usage and achieve Antibiotic CQUIN.
    - Medical Unit Meetings
    - Foundation Doctor teaching
    - CMT teaching
- Regular microbiology ward rounds continued to review antibiotic usage in selected patient groups (sepsis, ICU, *C. difficile*, orthopaedic ward rounds, hematology MDT)
- Microbiology Consultant authorisation was implemented for all Ertapenem prescriptions
- Further review of local antibiotic Formulary to reduce broad spectrum antibiotic usage
- Regular (quarterly) antibiotic point prevalence audits
- Antibiotic awareness week actions:
    - 1 clinical case quiz was sent per day for 4 days to all junior doctors, with pharmacists and Consultants also participating
    - The cases were based on the treatment of the following conditions:
        - Community acquired pneumonia
        - Extended Spectrum Beta-Lactamases (ESBLs)
        - MRSA
        - *C. difficile*
    - Each day the quizzes were marked and a winner chosen
    - At the end of the week there was a main prize draw for everyone who participated in all 4 quizzes
    - Those who participated in all 4 quizzes were awarded a certificate for their portfolio
    - In total 19 participated in all 4 cases, and 44 took part in at least 1 case

- Audits
    - Several audits have taken place over the last 12 months, involving various members of the group:
        - Antibiotic point prevalence audits (quarterly)
        - Gentamicin prescribing audit
        - Antibiotic prescribing and antibiotic review in Paediatrics
        - Bluebell ward Start Smart then Focus Antimicrobial Stewardship audit
        - Evaluation of Carbapenem prescribing
        - Ertapenem prescribing in Q3 2017/18
        - Use of broad spectrum antibiotics in Haematology
        - Ward 45 Start Smart then Focus Antimicrobial Stewardship audit
        - Use of Tazocin and adherence to antibiotic guidelines following recent changes due to the Tazocin shortage
        - Clinical audit of *Staphylococcus aureus* bacteraemia
        - Clinical audit on management of *C. difficile* infections

- Teaching and Presentations
    - Teaching has been provided across the trust by various members of the group, in subjects relevant to antimicrobial use
        - April 2017: FY1 doctor teaching about multi-resistant organisms
        - June 2017: Foundation year 1 doctor antibiotic induction
        - December 2017: Antimicrobial Stewardship presentation given at the community advanced nurse forum
        - October 2017: Teaching FY1 doctors about influenza
        - January 2018: CMT Teaching about C. difficile infections
        - January 2018: FY2 teaching about blood cultures
        - February 2018: FY1 teaching about C. difficile infections

        - March 2018: Presentation at MUM Meeting about C. difficile and S. aureus bacteraemia audits

- Antimicrobial Guidelines and Formulary
    - The following antimicrobial guidelines have been updated within the last 12 months:
        - Urosepsis/pyelonephritis
        - Fournier's gangrene
        - GI infections
        - Spontaneous Bacterial Peritonitis (SBP)
        - Vascular post-op/graft infections
        - ESBLs
        - Candidiasis
        - Community Acquired Pneumonia
        - Teicoplanin guideline
        - Influenza guideline

In addition the review of all sections of the local Antibiotic Formulary is continuing.

- Ward rounds
    - Regular ward rounds by Consultant Medical Microbiologists continued on a daily basis on critical care area and on patients with positive blood cultures, with representation from clinicians and pharmacists.
    - Weekly multidisciplinary meetings with Haematology Consultants/ junior doctors/ pharmacist continued as well as the weekly orthopaedic and multidisciplinary *C. difficile* ward rounds.
    - Ward rounds not only provide an opportunity for antimicrobial review but also a chance to teach junior doctors about prudent antibiotic usage.

- Clinical advice
    - The written referral system allows timely and effective consultation about antibiotic usage in selected cases between Medical microbiology Consultants and clinicians.
    - The service allows optimising antimicrobial prescribing, and also teaching on an informal basis.

- Meetings and professional development
    - Members of the Antimicrobial stewardship team attended several meetings, courses and conferences to update their knowledge and understand the national/ international/ local challenges and opportunities of antimicrobial stewardship.
    - Antibiotic Pharmacists are members of the North West antimicrobial pharmacists group and attend regular meetings.
    - Regular participation at Medical Unit Meetings, Grand Rounds and Laboratory Lunchtime Meetings
    - Representation at the BSAC meeting on Unfriendly Fungi (Nov 2017)
    - Participation at Future-learn E-learning course: Challenges in Antibiotic Resistance: Gram-negative bacteria (British Society for Antimicrobial Chemotherapy)
    - Participation at the European Society for Medical Microbiologists and Infectious Diseases (ESCMID) Conference

Further aims and strategies of the Antimicrobial Stewardship Program include:

- Ensure proper clinical engagement in antimicrobial stewardship efforts and achieving CQUIN targets
- Implement ARK Trial

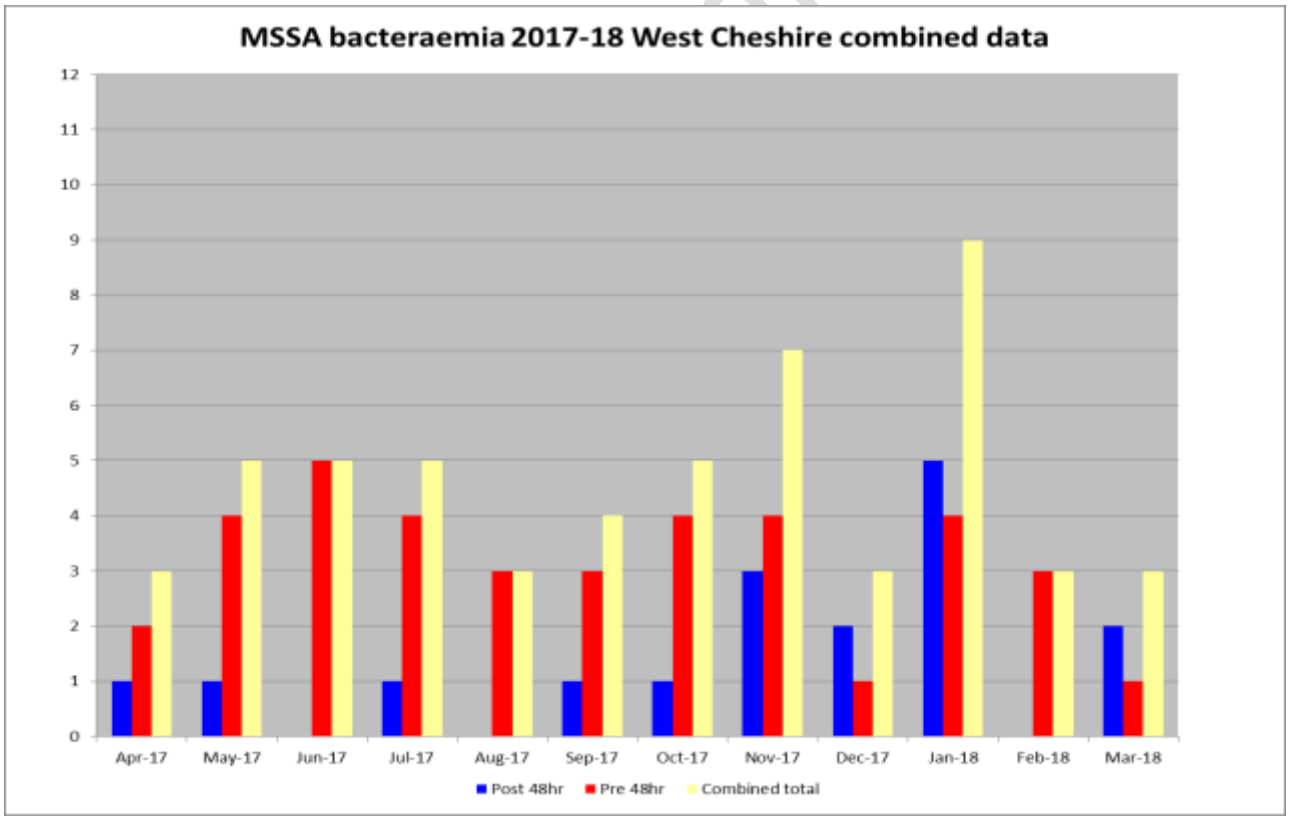
- Regular review of the local Antibiotic Formulary in view of national requirements, antimicrobial shortages and local resistance figures
- Harmonise Trust and Primary Care Formularies to ensure joint healthcare approach
- Horizon scanning for new antimicrobials to ensure potential antibiotic treatment for patients with multi-resistant infections
- Development of an AMS/ antibiotic treatment educational methods / strategies to increase AMS understanding/awareness of junior doctors

5.4 *Staphylococcus aureus* bacteraemia *(MSSA)*

Mandatory surveillance for MSSA bacteraemia continued through 2017/18, as part of the national surveillance programme. Data collection is via the national HCAI data capture system (see figure 3.3 below), with robust surveillance systems in place.

Objectives for the reduction of MSSA bacteraemia have not been set and it is not planned that these will be introduced for 2018/19. However, local understanding from the surveillance data is that this infection continues to develop predominantly within the community setting.

Figure 3.3 MSSA bacteraemia cases 2017/18



5.5 Gram-negative bloodstream infection (GNBSI)

2017/18 saw the introduction of the national ambition to reduce GNBSI by 50% by 2021, with the plan initially focussing on a reduction in *E. coli* bacteraemia. This national ambition was set as an initial two year quality premium for Clinical Commissioning Groups (CCG), identifying a reduction ambition of 10% in all *E. coli* bacteraemia reported at CCG level, independent of the time of onset of infection. The quality premium ambition for West Cheshire CCG was set at no more than 203 cases of *E. coli* bacteraemia within year, with 2016 surveillance data used as the baseline for improvement.

As a result, the national mandatory surveillance programme was expanded from April 2017 to include:

- Gram-negative bacteraemia surveillance for *Klebsiella* species and *Pseudomonas aeruginosa*, in addition to the existing surveillance programme for *E. coli* bacteraemia.
- Apportionment of *E. coli* bacteraemia using the national two day algorithm to identify if the onset of infection occurred in the community or hospital.
- Link to the 'Mandatory enhanced MRSA, MSSA and Gram-negative bacteraemia, and *Clostridium difficile* infection surveillance protocol' included.
- Additional data collection to record risk factors for GNBSI as part of an enhanced surveillance programme.

This enhanced surveillance programme for GNBSI involved surveillance data sourced from both primary and secondary care, with data entry responsibilities sitting with the acute organisation. Combined primary and secondary enhanced surveillance data was reported for part of the surveillance year, through collaborative working with the primary care infection prevention and control service. Secondary care enhanced surveillance data reported for the full surveillance year. As for MSSA bacteraemia, local surveillance data identifies that GNBSI predominantly develop within the community setting

Initial improvement work followed the actions recommended within the national resource for preventing healthcare associated GNBSI and included:

- A self-assessment of compliance with the Health and Social Care Act (2008): code of practice on the prevention and control of infections and related guidance (2015 version)
- A review of local surveillance data to understand activity
- A collaborative review of enhanced risk factor surveillance data to determine whether there were common themes to identify as priority areas for action
- Development of an improvement plan based on outcomes of the preceding review/assessment
- Develop a programme for review by monitoring local surveillance data

A collaborative improvement plan to support the reduction of *E. coli* bacteraemia was developed as a result of this work, with whole health economy multidisciplinary working groups developed to assess and implement identified actions. As there were no emerging themes from the risk factor data review, a lead was taken from the national guidelines to steer this improvement plan and included areas of practice relating to:

- Urinary catheter management
- Management of recurrent urinary tract infection
- Compliance with local antimicrobial formulary for first-line treatment of urinary tract infection
- High impact interventions

The following charts include surveillance data as locally reported for West Cheshire CCG and do not include any repatriated case data from cases reported out of area.

Figure 3.4 **Gram-negative bacteraemia 2017/18 – inclusive of *E. coli, Klebsiella* species and *Pseudomonas aeruginosa***

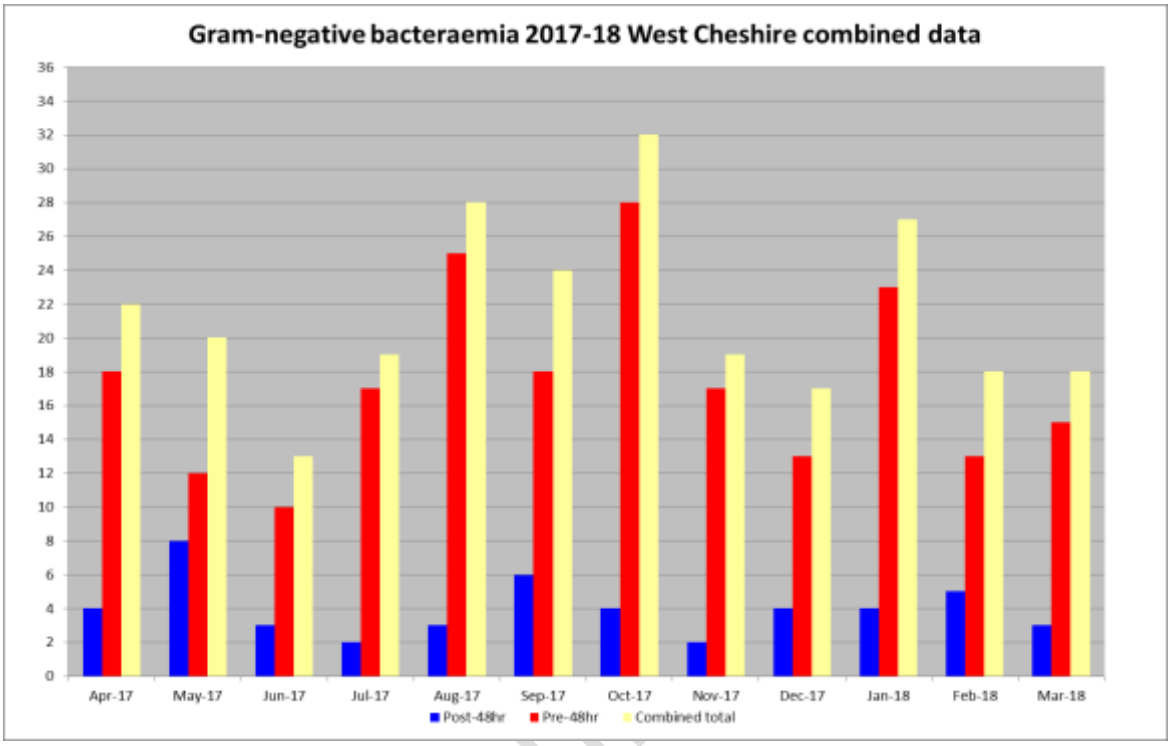


Figure 3.5 ***E. coli* bacteraemia cases 2017/18**

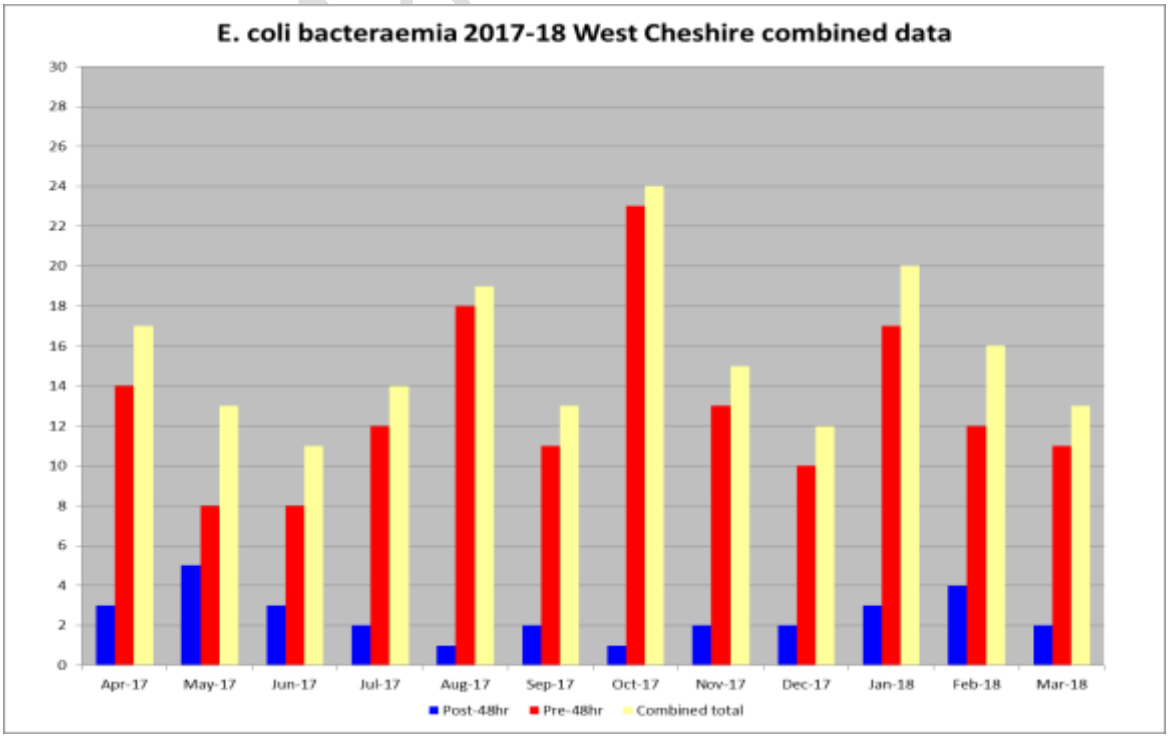


Figure 3.6 ***Klebsiella*** **species bacteraemia cases 2017/18**

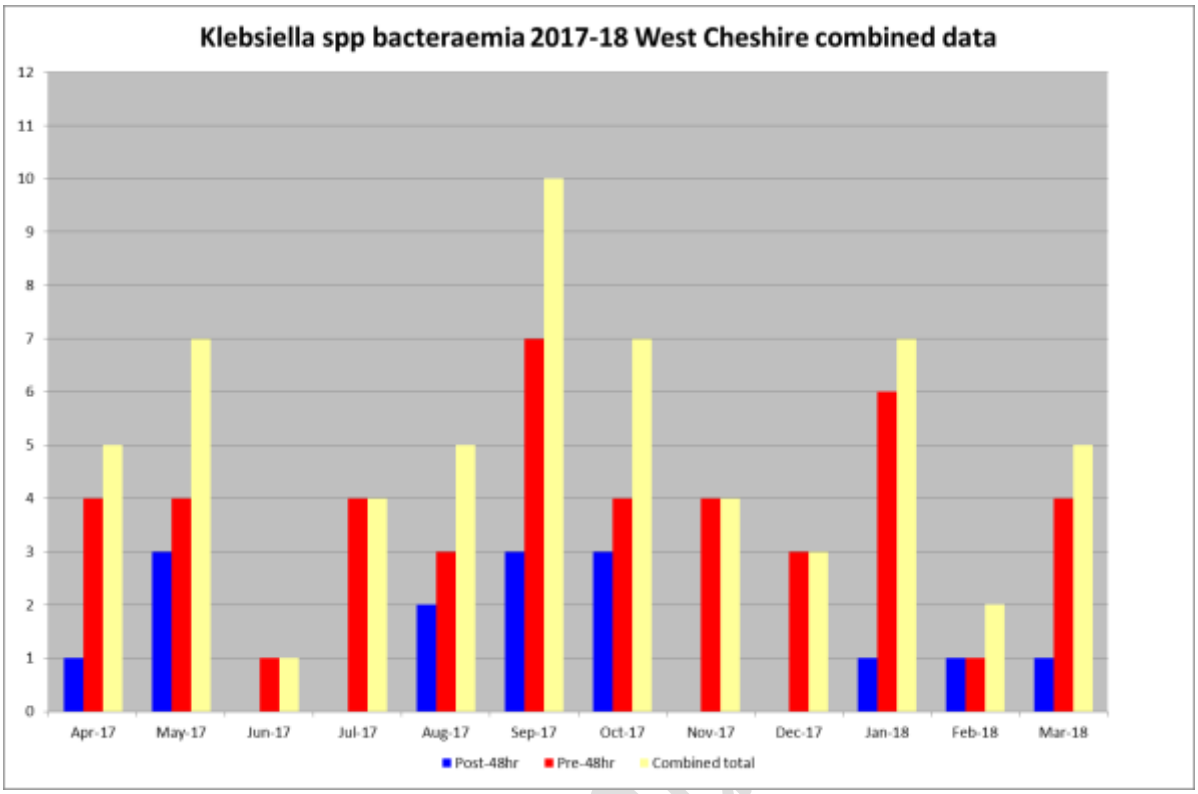
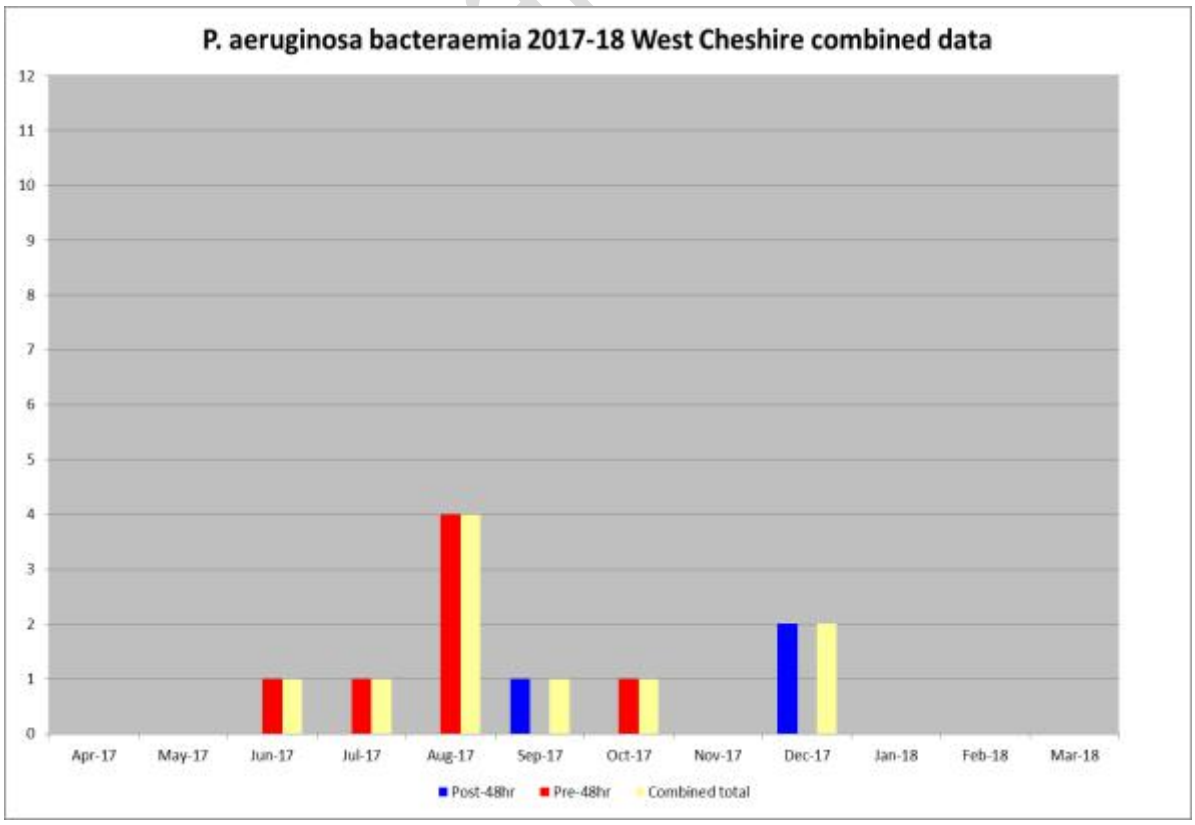


Figure 3.7 ***Pseudomonas aeruginosa*** **bacteraemia cases 2017/18**



5.6 Surgical Site Infection Surveillance

The Trust's surgical site infection surveillance programme continues to be co-ordinated and facilitated by the Infection Prevention and Control Team, with surveillance at an operational level being undertaken by appropriately trained ward/departmental staff.

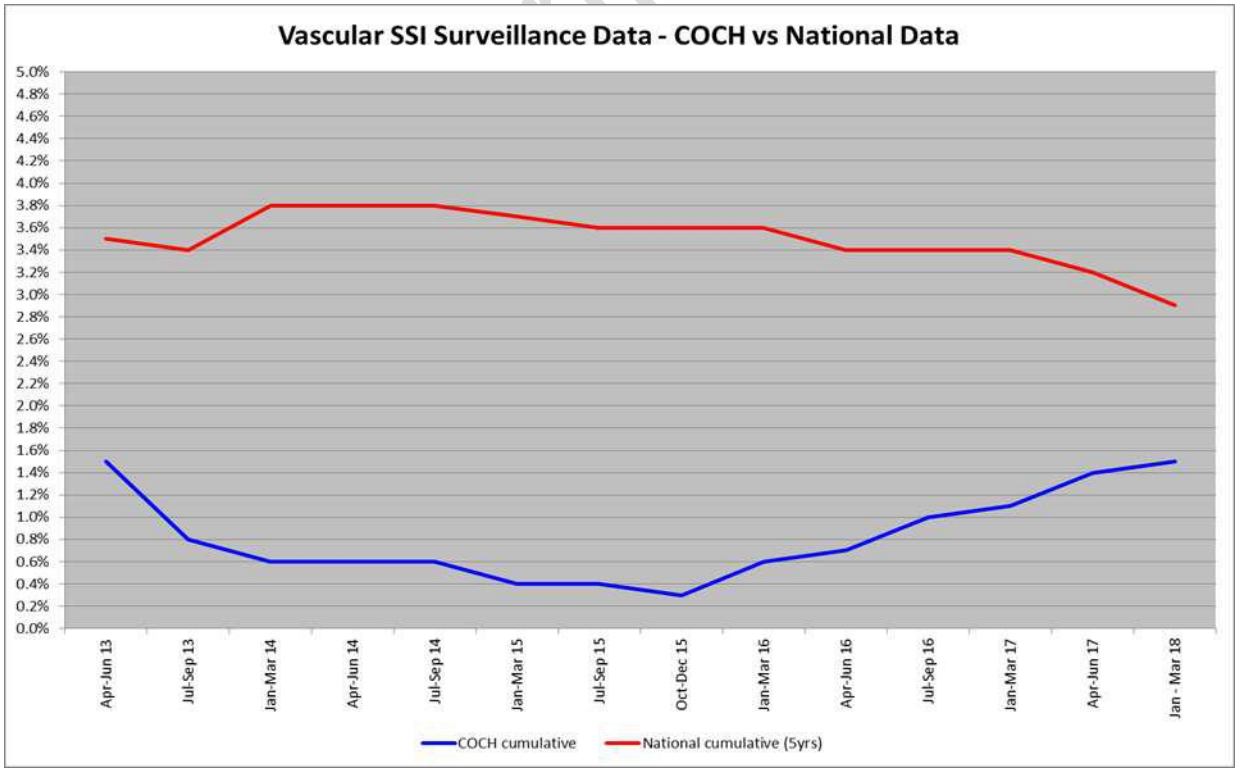
During 2017/18, the Trust maintained the planned surgical site infection surveillance programme throughout the year. This programme is undertaken as part of the national surveillance system, co-ordinated via Public Health England. There is a robust data dissemination process established, where reports produced centrally by Public Health England are disseminated to the corresponding clinical teams. Surgical site infection surveillance data is also made widely available for staff to access via the S-drive.

Trust cumulative data for surgical site infection is calculated locally to provide an accurate benchmark against the national distribution of surgical site infection incidence, by category of surgical procedure, for the last 5 years (inpatient and re-admission).

Surgical site infection surveillance was undertaken for the following surveillance categories within year:

- Vascular procedures
- Hip replacement procedures
- Knee replacement procedures
- Repair of neck of femur procedures

Figure 3.8 Vascular Procedures

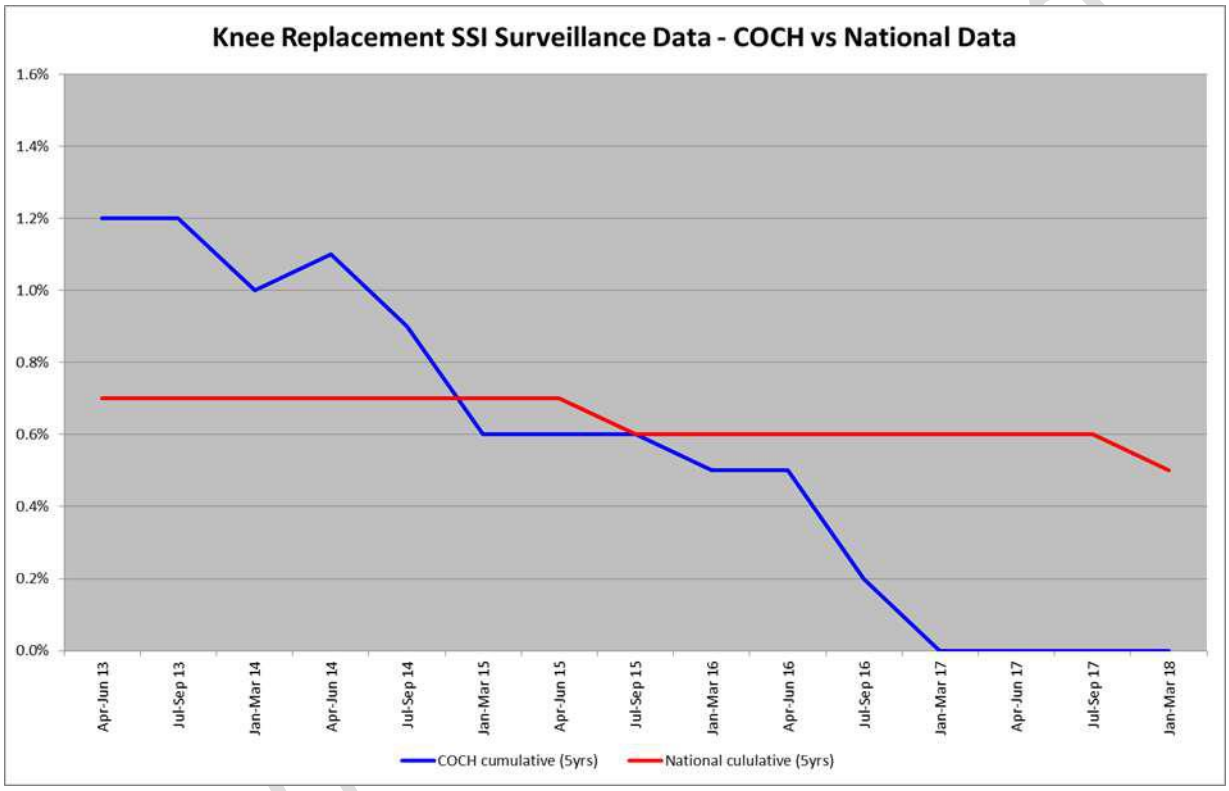


In context, there is a 1.5% incidence of vascular surgical site infection as of the January – March 2018 surveillance period. This is below the national incidence for this type of infection.

Vascular SSI Identification April 2013 – March 2018

	Number of SSI identified
During Admission	3
On Re-admission	9
Total	12

Figure 3.9 Knee Replacement Procedures

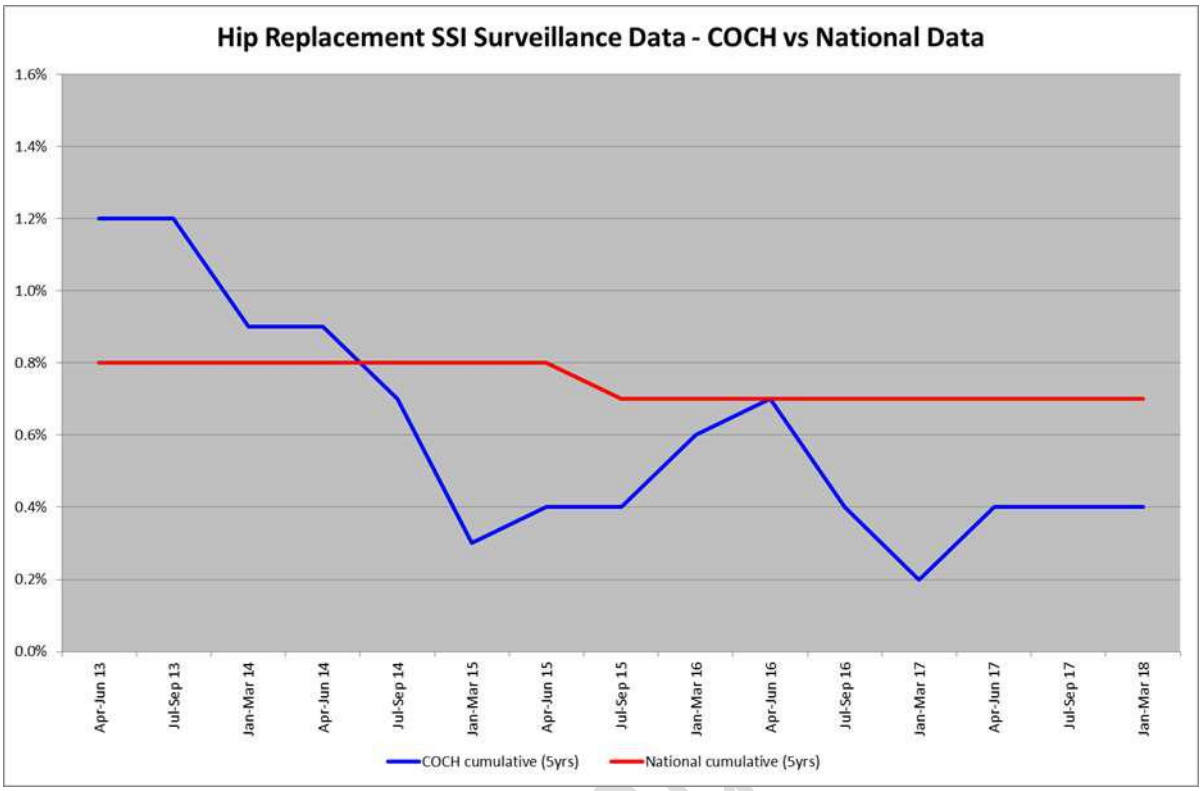


In context, there is a 0% incidence of knee replacement surgical site infection as of the January – March 2018 surveillance period. This is below the national incidence for this type of infection.

Knee Replacement SSI Identification April 2013 – March 2018

	Number of SSI identified
During Admission	0
On Re-admission	0
Total	0

Figure 3.10 Hip Replacement Procedures

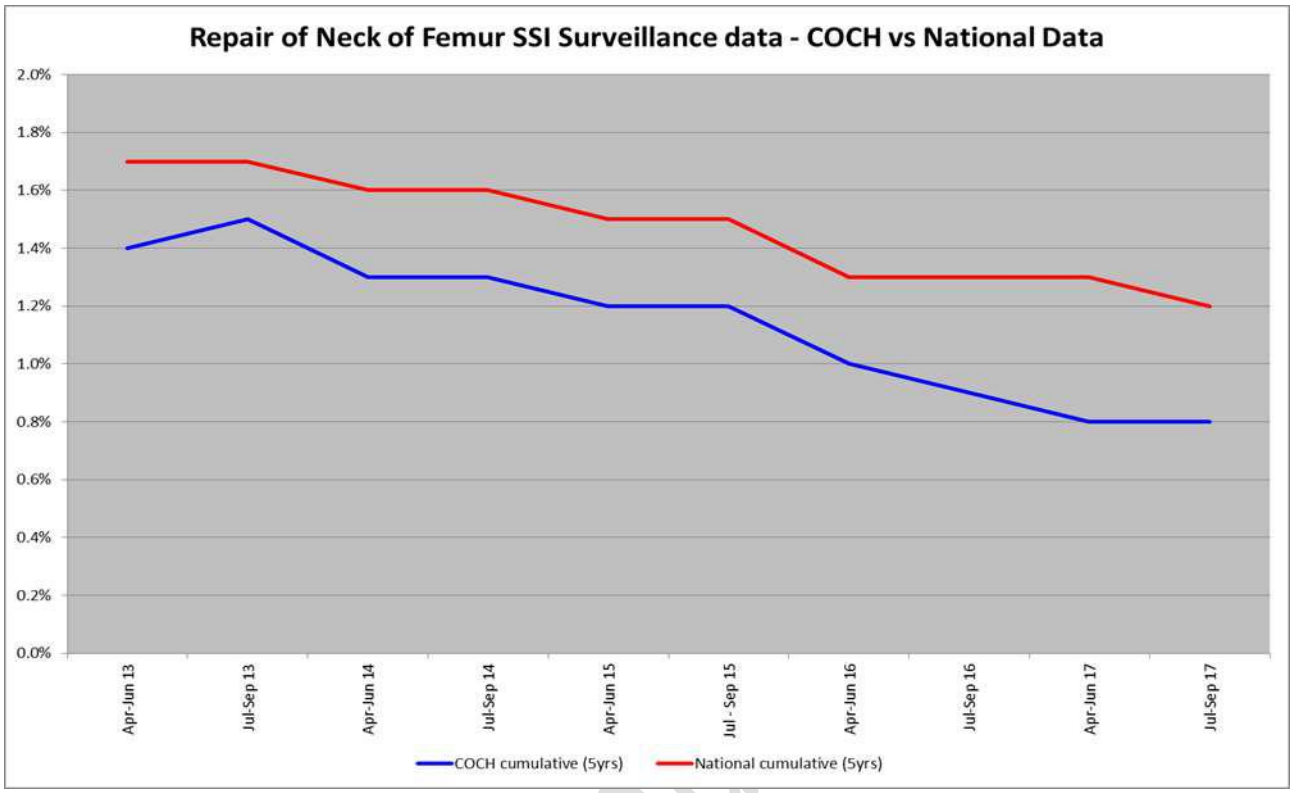


In context, there is a 0.4% incidence of hip replacement surgical site infection as of the January – March 2018 surveillance period. This is below the national incidence for this type of infection.

Hip Replacement SSI Identification April 2013 – March 2018

	Number of SSI identified
During Admission	**1**
On Re-admission	**1**
Total	**2**

Figure 3.11 Repair of Neck of Femur Procedures



In context, there is a 0.8% incidence of repair of neck of femur surgical site infection as of the July – September 2017 surveillance period. This remains below the national incidence for this type of infection. (Note: repair of neck of femur surgical site infection surveillance undertaken for six months April – September 2017).

Repair of Neck of Femur SSI Identification October 2012 – September 2017

	Number of SSI identified
During Admission	**6**
On Re-admission	**1**
Total	**7**

5.7 Other Alert Organism Surveillance

Other 'alert' organisms are included within the Trust surveillance programme, including all MRSA positive cases (non-bacteraemia related), Haemolytic *Streptococcus* (Group A), Norovirus, Adenovirus, Rotavirus, Shigella, Salmonella, Campylobacter, E. coli 0157, Listeria, *Neisseria meningitides*, *Mycobacterium tuberculosis*, extended-spectrum beta-lactamase (ESBL) producing organisms, Acinetobacter, *Pseudomonas aeruginosa*, Vancomycin Resistant *Enterococcus* (VRE), carbapenemase-producing *Enterobacteriaceae* (CPE), plus others as appropriate. Data is disseminated to relevant staff groups on a monthly basis.

6 MRSA Screening Programme

MRSA screening for all elective cases and emergency admissions has been established within Trust policy for a number of years. 2017/18 saw a continuation of the work to embed MRSA screening within day to day clinical practice.

Monitoring compliance with MRSA screening also remains as part of external reporting requirement within the HCAI assurance framework that is reported to Commissioners on a monthly basis. A monitoring system to reflect compliance is established, with compliance data disseminated internally on a monthly basis, to inform and improve on practice.

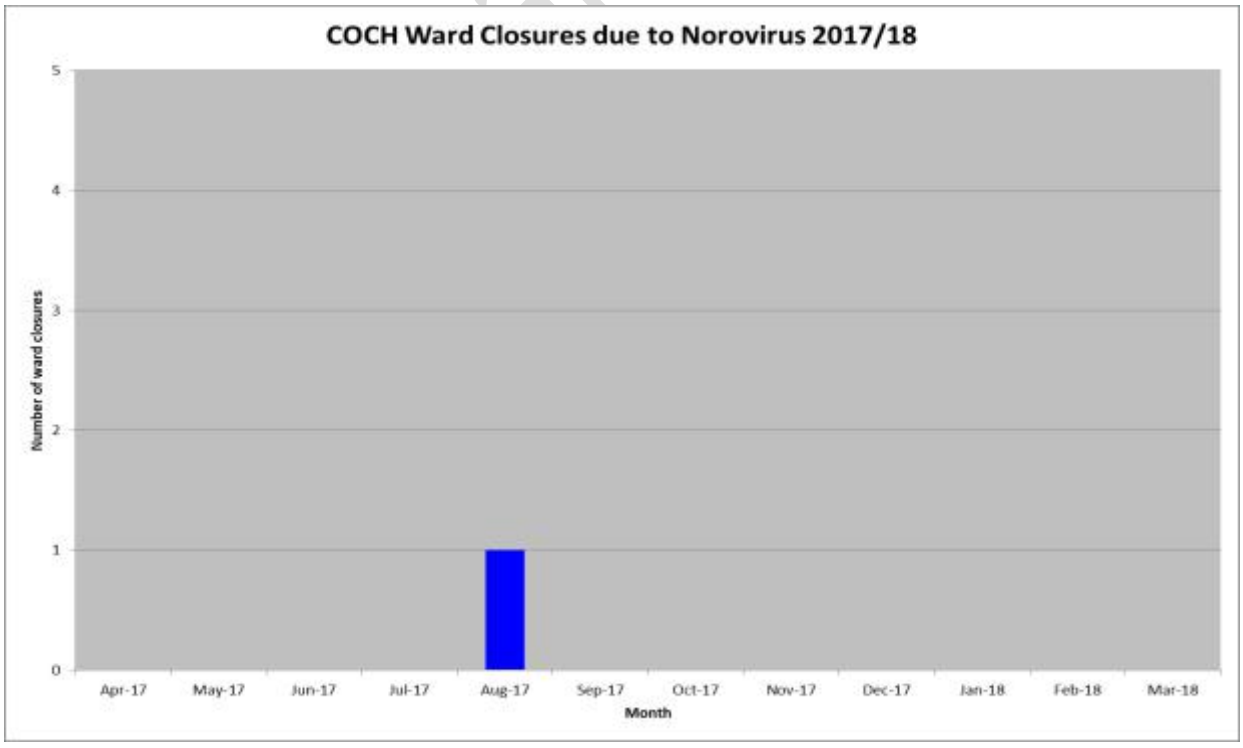
Compliance with MRSA screening fluctuated throughout the year, with screening compliance for elective admissions routinely outperforming screening compliance for emergency admissions. Programmes aimed at demonstrating sustainable improvement will continue through 2018/19.

7. Untoward Incidents Including Outbreak Management

7.1 Norovirus Outbreak Synopsis

Viral gastroenteritis outbreaks impact on patient well-being (sometimes significantly), operational capacity and service management. Therefore, it is essential that effective outbreak prevention, management and control systems are in place to limit the impact of these outbreaks. The effectiveness of locally developed infection prevention and control measures was demonstrated during 2017/18, with a single ward closure due to Norovirus within year.

Figure 4 Norovirus Outbreak Data 2017/18



- The need for this ward closure was identified through established surveillance systems

- The ward was closed for a total of 4 days
- A total of 24 bed days were lost due to this ward closure
- Norovirus (a cause of viral gastroenteritis) was identified as the cause

Prompt implementation of established outbreak management and control measures are essential and contributed to limit the effect that this infection has within our organisation. Management and control measures included:

- Prompt isolation of all diarrhoeal cases assists in limiting the transmission of all enteric pathogens, including Norovirus.
- Ensuring that any ward remains closed for the duration of an outbreak is the most important measure to limit the overall impact that Norovirus outbreaks have on an organisation.
- Immediately informing clinician teams once an outbreak has been identified, ensuring that patient discharges are expedited.
- Daily clinical rounds by the Infection Prevention and Control Team, once an outbreak is suspected, to ensure that ward staff feel supported and to promote adherence to the required infection prevention and control measures.
- Ongoing surveillance of cases, with accurate monitoring of symptoms, ensures that the length of any outbreak is kept to a minimum.
- A minimum of daily outbreak meetings between the Infection Prevention and Control Team and relevant managers (including bed managers), to ensure that all symptomatic patients are promptly recognised and appropriately isolated in single rooms or cohort areas wherever possible.
- Information dissemination to all appropriate staff groups including outbreak updates and policy requirements, ensuring that the workforce remains informed.

Signage within public areas also continued throughout 2017/18, improving communication with the wider population about how visitors to the hospital can help to prevent Norovirus outbreaks occurring.

All outbreaks are reported to Public Health England plus Commissioners and the Community Infection Prevention and Control Team, with an outbreak synopsis report tabled for each outbreak at the following Infection Control Committee. This reporting process aids communication with wider healthcare provision and identifies any learning that may improve on future outbreak management and control.

7.3 Vancomycin Resistant *Enterococcus* (VRE)

Enterococci are bacteria that are commonly found in the bowels of most humans. Vancomycin Resistant *enterococci* (VRE) are enterococci that are resistant to the glycopeptide group of antibiotics (Vancomycin and Teicoplanin). VRE commonly cause wound infections, bacteraemia and infections of the abdomen and pelvis, with the highest risk patients being those that are immunocompromised, receive treatment in specialist units such as Critical Care, have a prolonged hospital stay or have had previous treatment with certain other antibiotics. Established case by case surveillance systems for VRE have been maintained through 2017/18 to facilitate the rapid recognition of any potential outbreak, ensuring the early implementation of interventions for prevention, management and control. No VRE outbreaks were identified during 2017/18.

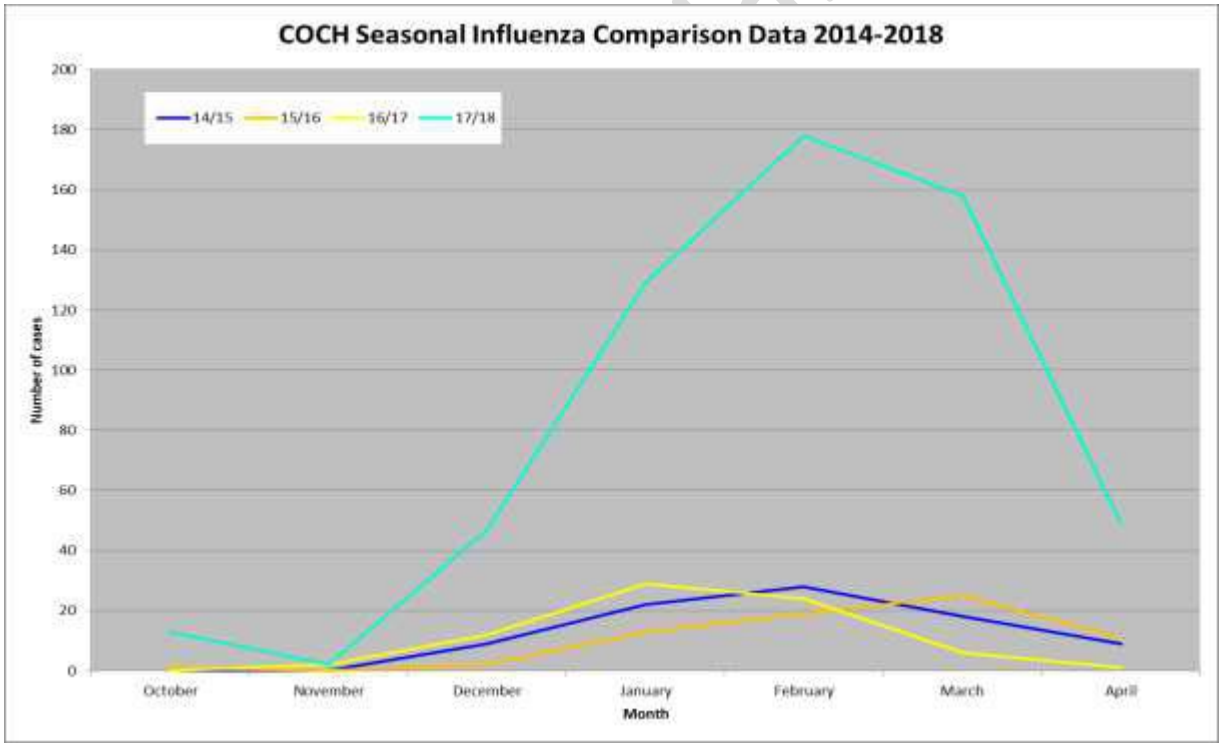
7.4 Carbapenemase Producing *Enterobacteriaceae* (CPE)

Enterobacteriaceae are bacteria that usually live harmlessly in the gut of humans. Carbapenemase-producing Enterobacteriaceae (CPE) are Enterobacteriaceae that are resistant to carbapenem antibiotics (Meropenem, Ertapenem and Imipenem). CPE can cause wound infections, bacteraemia and infections of the urinary tract, with the highest risk patients being those that are immunocompromised, receive treatment in specialist units such as Critical Care, have a prolonged hospital stay or have had previous treatment with certain other antibiotics. As for VRE, established case by case surveillance systems for CPE have been maintained through 2017/18 to facilitate the rapid recognition of any potential outbreak, ensuring the early implementation of interventions for prevention, management and control. No CPE outbreaks were identified during 2017/18.

7.5 Seasonal Influenza - Winter 2017/18

Winter 2017/18 saw high levels of influenza activity being reported within the acute Trust, which impacted on operational activity within the organisation. A retrospective comparison of positive influenza results from specimens collected within the acute Trust demonstrates the extraordinary influenza activity that took place over the influenza season.

Figure 5. Local influenza comparison data from 2014 to 2018



An outbreak of influenza was identified on a medical ward during October 2017, with outbreak control meetings, plus implementation of management and control actions (including ward closure) bringing this outbreak to a rapid close. Influenza outbreak duration was a total of eight days with sixty-four bed days lost.

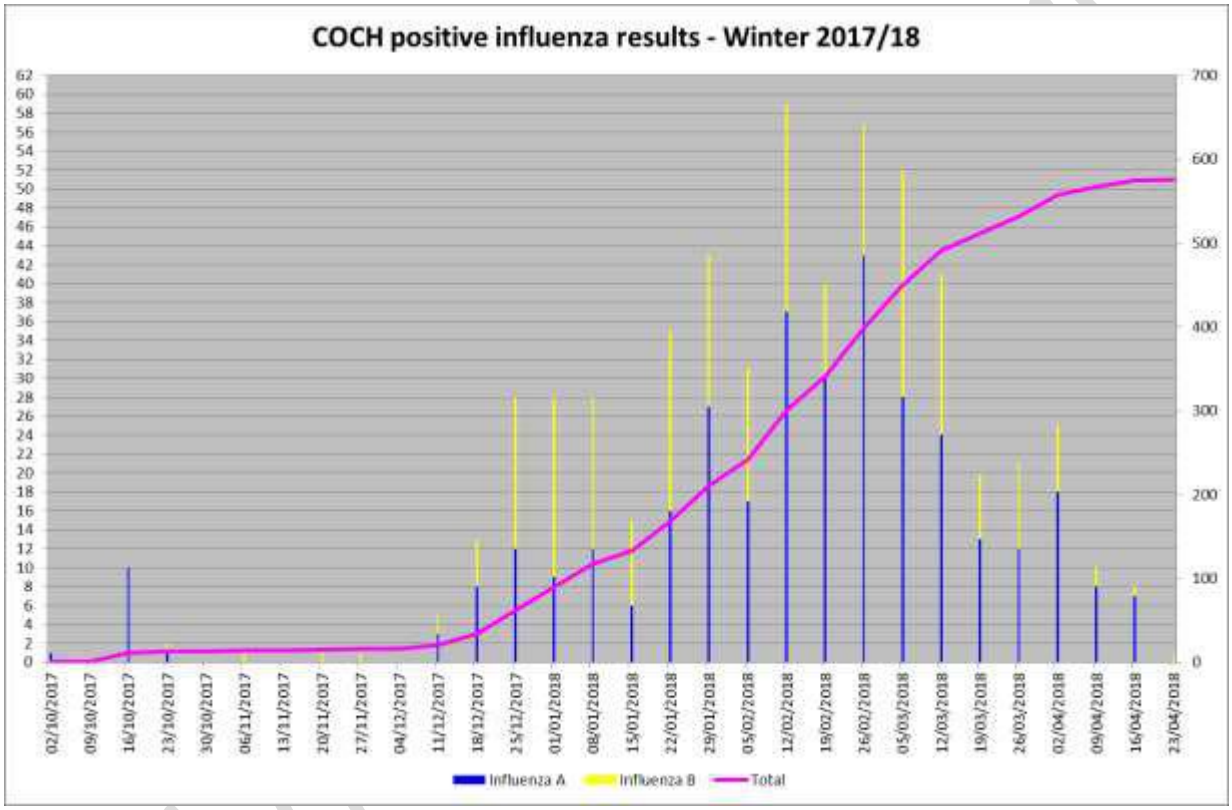
Local influenza surveillance was concurrent with the regional and national surveillance data with co-circulation of influenza A and influenza B. A total of 576 positive influenza results were reported

from specimens collected within the acute Trust during the winter months (compared to a total of 73 positive influenza results during winter 2016/17).

Influenza testing via PCR during the influenza season continued to demonstrate the benefit of having access to rapid test results.

National influenza surveillance programmes were heightened from January 2018 for the remainder of the influenza season, as influenza activity rose nationally, with the Trust reporting influenza activity on a daily basis in support of this.

Figure 5.1. Local influenza surveillance data by week for winter 2017/18



Extensive planning took place to prepare for seasonal influenza prior to the influenza season commencing, with Occupational Health continuing to lead on an excellent staff influenza vaccination campaign.

8. Infection Prevention and Control Audit Activity

8.1 Audit Programme

The infection prevention and control audit programme is undertaken by the Infection Prevention and Control Nurse Team, utilising a nationally recognised, evidence based audit tool developed by the Infection Prevention Society in conjunction with the Department of Health. The audit tool encompasses the full range of standard principles of infection prevention and control.

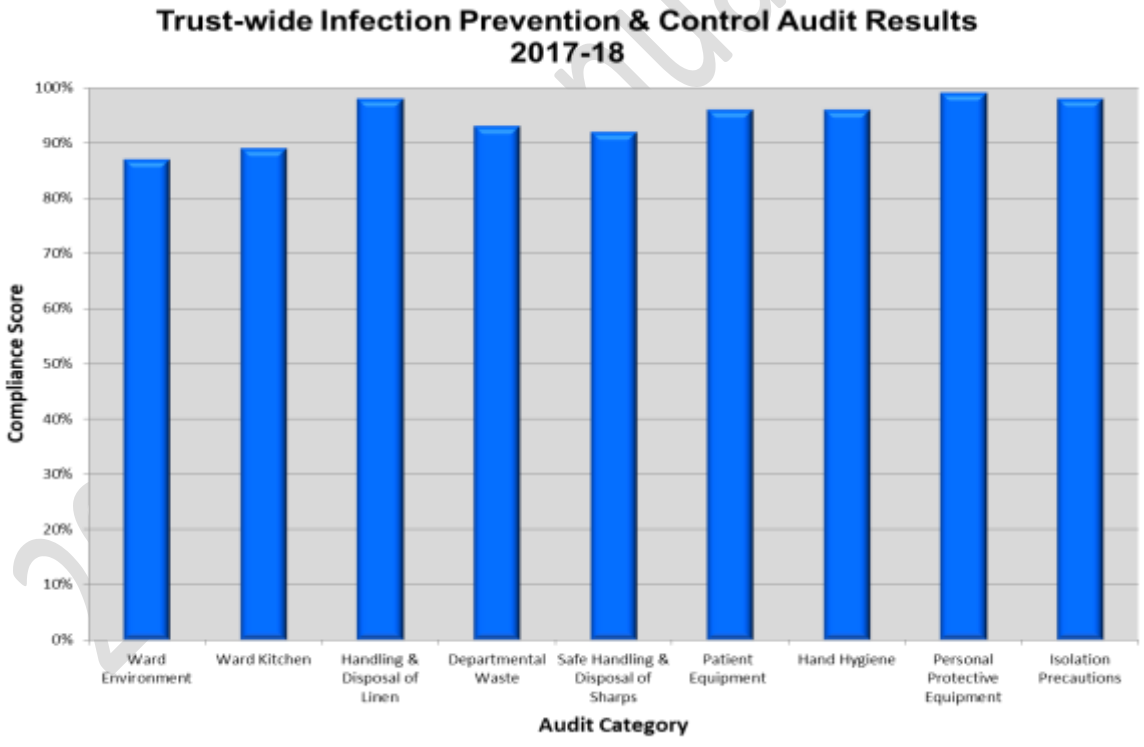
A summary of the 2017/18 infection prevention and control audit programme is as follows:

- A total of 33 audits were undertaken, including inpatient and outpatient areas of the Trust.
- Verbal feedback was provided at the time of each audit.
- Formal feedback on audit findings includes a chart detailing the compliance score for each audit criteria, plus an action plan template for the ward/department to complete to address any identified areas for improvement.
- Results are fed back for action to Ward/Department Manager, Matron, Associate Directors of Nursing and Consultant Microbiologists, plus identified others as relevant.
- Action plans are detailed for return to Infection Prevention and Control within a specified timescale.

Levels of compliance remained similar to previous data, with improvement noted for Handling and Disposal of Linen, Safe Handling and Disposal of Sharps, Patient Equipment, Personal Protective Equipment and Isolation Precautions. Levels of compliance were reduced in three out of nine audit criteria including Ward Kitchens, Departmental Waste and Hand Hygiene.

Work to improve and sustain high standards remained ongoing throughout the year, with support provided to address specific areas of non-compliance identified within individual areas/departments.

Figure 5 Trust-wide Infection Prevention and Control Audit Results 2017/18



Other Trust-wide audits have been undertaken as part of the annual infection prevention and control audit programme, with appropriate dissemination of results across the organisation. These include:

- Hand hygiene compliance, including the availability of hand hygiene facilities
- Safe handling and disposal of sharps

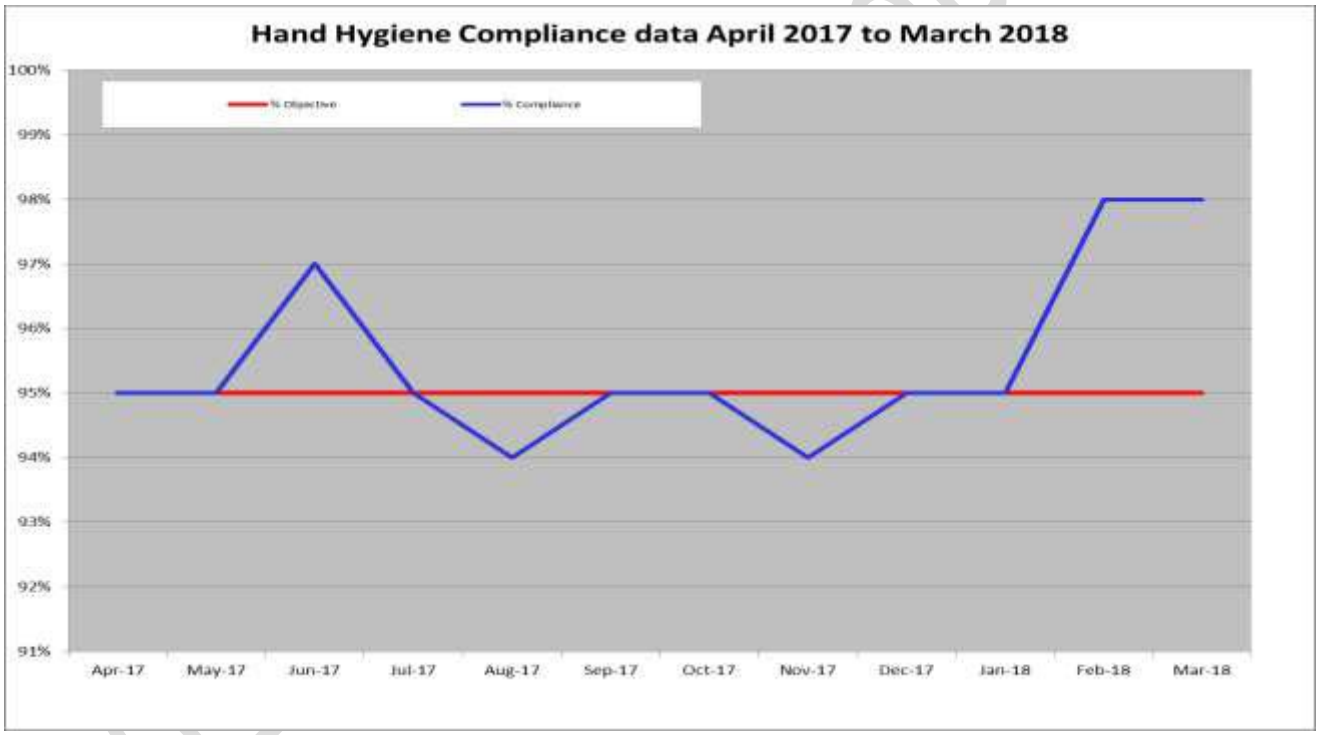
8.2 Hand Hygiene Compliance Monitoring

The corporate hand hygiene compliance monitoring process is established within both inpatient and outpatient areas. The chart below outlines Trust performance during 2017/18, with the Trust aim of achieving 95% compliance as minimum sustained throughout the year, except for a dip in compliance during August and November 2017.

Hand hygiene compliance monitoring data is disseminated to all staff on a monthly basis, to ensure that staff remain aware of how the organisation is performing, highlighting areas for improvement in conjunction with policy requirements.

As routine adherence to required hand hygiene practices is key to ensuring that avoidable infections do not occur, the promotion of hand hygiene remains a high priority and is embedded within all infection prevention and control training.

Figure 6 Trust-wide Hand Hygiene Compliance 2017/18



8.3 High Impact Interventions

High impact interventions are a suite of evidence-based monitoring tools that have been developed to provide assurance that key clinical procedures or care processes are performed effectively, reducing risks associated with healthcare associated infection.

The Trust has a robust rolling programme for high impact intervention monitoring embedded within the care provider divisions, including:

- Central line insertion
- Ongoing care of central lines
- Peripheral cannulation

- Ongoing care of peripheral cannula
- Urinary catheterisation
- Ongoing care of urinary catheters
- Renal dialysis catheter insertion
- Ongoing care of renal dialysis catheters
- Regular observation for ventilated patients
- *Clostridium difficile*
- Enteral feeding
- Chronic wound management

These monitoring tools work on a peer review system with compliance scores indicating whether all required stages of any process have been completed correctly for every patient, on every occasion. The Divisional Facilitator analyses compliance data on a monthly basis, developing performance reports for dissemination and learning for relevant wards/departments. Monitoring outcomes are also discussed at divisional infection prevention and control/quality meetings.

Work has commenced within year to redesign and re-launch this High Impact Intervention programme, following publication of the revised High Impact Intervention evidence-based approach at a national level. A gap analysis was completed and work commenced to build local resources in support of identified improvements. This is an extensive project and will continue through 2018/19.

9. Training and Education Programme

The Infection Prevention and Control Team delivers a well-established infection prevention and control training and education programme at all levels of the organisation that includes all healthcare workers, in clinical and non-clinical roles. This is aimed at ensuring that the workforce has the necessary knowledge and understanding to deliver services safely and effectively.

A synopsis of the infection prevention and control training and education programme is:

- Trust Welcome Event – To ensure that all new starters are informed of Trust expectation in relation to infection prevention and control, including the importance of routine adherence to policies and procedure. Key aspects of infection prevention and control are also included within the local induction packs that new starters receive and is further re-enforced during local induction requirements.

- Mandatory training – Staff groups across all areas and specialities of the organisation attend risk management mandatory training including senior clinicians and executives. Attendance requirements are as specified within the Trust Training Needs Analysis.

- Scheduled training and education programmes for Nurse Cadets, Nursing Assistants, Porters, Student Nurses and newly qualified Staff Nurses are established.

- Additional infection prevention and control training is routinely provided for all medical students and junior doctors.

- All training and educational materials are compliant with Health and Social Care Act (2008) criteria and are updated if national recommendations or evidence base alters. They also focus on key areas for improvements in practice, identified during any root cause analysis or audit process, and highlight Trust policy and procedure in relation to healthcare associated infection reduction.

- A rolling programme of practical hand hygiene training is established Trust-wide. The required equipment and training pack are stationed in designated areas around the Trust and moved to a different area each month on a rolling programme. A database is kept of all staff members that participate in this activity.

- Other ad hoc training and education takes place whenever the requirement for this is identified and can be related to any aspect of infection prevention and control. An established system is in place to facilitate this via the Trust's Training Directory.

- All methods of communication available to the Trust are utilised by the Infection Prevention and Control Team to ensure that information is distributed through all levels of the organisation in a varied manner, dependant on the content, with the team working closely with the Communications and Engagement Team. This may include poster development, training videos, on-line power point presentations, screensavers, emails, contributions to the Fortnightly Round-Up, etc.

- Professional development of the Infection Prevention and Control Team also remains ongoing, with team members accessing training courses/national updates as relevant.

10. Policy Review and Development Programme

The Trust has a robust infection prevention and control policy review and development programme, co-ordinated through the Trust's document management system (SharePoint). Infection prevention and control policies are evidence based and available for any member of staff to access at all times, with the availability and importance of routine adherence to policy being consistently re-enforced during staff training and education.

Policies may also be revised, re-written or developed if the available evidence base changes or novel practices or micro-organisms are identified. This may be ad hoc, but also forms part of the policy review and development programme. Any changes to policy are ratified through the Infection Control Committee and these changes are communicated to staff via established systems.

11. Decontamination

The Trust has an identified Decontamination Lead who has responsibility for providing assurance via representation on the Infection Control Committee. This incorporates both sterilisation services (HSDU) and decontamination of endoscopes, as per national requirements and ties in with the corporate infection prevention and control assurance framework.

There are robust systems and processes in place for both the management of medical devices and decontamination of these, including a Medical Devices Group that is chaired by the Director of Infection Prevention and Control.

Key personnel concentrate expertise around this area of practice within the organisation and aim to provide a corporate approach to all aspects of medical device and decontamination management. Any non-compliance with decontamination procedures are reported via the Trust incident management system to ensure that issues are escalated/addressed at the earliest opportunity.

The Equipment Library and Decontamination Unit (ELDU) service is monitored via Facilities. The unit has responsibility for cleaning items of equipment that are generically used across the organisation, but have no requirement to be sterilised. This maintains the improved standards of cleaning/disinfection for items of equipment that were previously cleaned at ward/departmental level.

The Infection Prevention and Control Team worked closely with the Co-ordination Centre and the ELDU within year on a significant project, to ensure a robust process for decontaminating patient badges, in support of the Teletracking system being introduced into the organisation.

12 Other Infection Prevention and Control Activities

12.1 Procurement

Equipment purchased by the Trust is subject to a structured assessment process prior to purchase, as detailed within the policy for the purchase of medical devices. Infection prevention and control is included within this process, ensuring that any item of equipment is fit for purpose and can be appropriately decontaminated.

The Infection Prevention and Control Team continue to work with procurement and commodities to facilitate procurement, also providing expertise for any relevant tendering process, whether for equipment or external service provision.

12.2 Service Development

Ensuring infection prevention and control involvement within any service development is included within the corporate infection prevention and control assurance framework and devolved to individual Divisions within assurance plans.

Estates have established processes for involving the Infection Prevention and Control Team within all building/refurbishment projects undertaken within the organisation. Collaborative working occurs from the earliest opportunity, through the planning/design stage, undertaking risk assessments prior to any works commencing plus ongoing monitoring, with a final infection prevention and control assessment of the completed work prior to clinical activity commencing. This ensures that the risks associated with building/refurbishment work within any health care environment are controlled and that the resulting facility achieves infection prevention and control standards, as detailed within the associated evidence base.

12.3 Water Safety

The Trust has an established Water Safety Group including Estates, Consultant Microbiologist and Infection Prevention and Control Nurse membership, reporting to the Infection Control Committee.

The focus of the Water Safety Group is to assess and maintain Trust compliance with current relevant guidelines and legislation relating to the safe management of water systems, including the control of waterborne pathogens such as *Pseudomonas aeruginosa* and *Legionella*.

This work includes design, installation, commissioning, testing, monitoring and operation of the water systems within the Trust. This is to enable prompt action if issues are identified, promoting good practice and protecting vulnerable patients.

Work also commenced within year to revise the Water Safety Group meeting programme, including Terms of reference and membership that will be taken forward and progressed during 2018/19.

12.4 Patient Flow and Bed Management

The Infection Prevention and Control Team regularly liaise with patient flow managers through established processes. Information sharing includes availability of single rooms within the organisation, to aid appropriate isolation at the earliest opportunity, management and control of any identified infection related bed closures to facilitate patient flow, plus the management and control of outbreaks.

The Infection Prevention and Control Nurse Team routinely undertake risk assessments to assist in maintaining operational capacity, while maintaining patient safety. This is facilitated by the team's clinical caseload, ensuring that all relevant microbiological results are reported in real time and that individual cases are regularly reviewed, to ensure that patient management is appropriate and that patient isolation is not unnecessarily prolonged.

It has been recognised corporately that the emergence of antimicrobial resistant organisms continues to put increasing pressure on the organisation's capacity to isolate patients, due to insufficient single rooms within the existing footprint. Work remains ongoing to identify methods to address this.

12.5 Occupational Health

The Infection Prevention and Control Team maintains a close working relationship with Occupational Health, assisting with various workforce related activities including risk assessments for individual staff members, policy and guideline reviews and staff vaccination campaigns.

12.6 Infection Prevention and Control Link Practitioner Programme

The Trust has an active Infection Prevention and Control Link Practitioner programme (IPCLP) including members of staff from varying areas of service delivery, including allied health professions.

Link practitioners are a valuable asset to the Trust's infection prevention and control programme, acting as role models for their colleagues, demonstrating good practice and raising infection prevention and control awareness within their clinical area, having a positive influence on practice.

IPCLP study days occur twice per year and are a useful resource for disseminating infection prevention and control related information in more detail, providing enhanced knowledge and training for the IPCLP to take back to their individual areas.

During 2017/18, the Infection Prevention and Control Team further developed the role of the Link Practitioner to incorporate support of the Trust's infection prevention and control audit programme. This involved the development and pilot of a simplified, evidence-based infection prevention and control audit tool that focusses on the standard principles of infection prevention and control. Following the successful pilot it is planned for this audit process to be rolled out during 2018/19, with the intention for this be undertaken on a three month rolling programme.

12.7 Domestic Services

The Infection Prevention and Control Nurse Team works in close partnership with Facilities Managers on all aspects of cleanliness and the environment, including regular attendance at PLACE meetings (Patient-Led Assessments of the Care Environment).

The national PLACE programme is service user focussed and patient-led, with multiple patient representatives being involved within the assessment process, reviewing cleanliness, buildings and facilities, food, hydration, privacy, dignity and well-being. The organisation is able to demonstrate consistently high standards of cleanliness via the regular programme of cleanliness monitoring that is conducted in-house, supported by PLACE assessment reports.

Meetings between Facilities and infection prevention and control occur on a bi-monthly basis to problem-solve and develop improvements in practice, monitoring any projects that are in progress. Facilities staff having an essential role within strategic planning for the infection prevention and control programme, including environmental cleaning, equipment and decontamination library, waste handling and disposal and linen services.

13 Infection Prevention and Control Objectives for 2018/19

Infection prevention and control remains essential to the delivery of safe, kind and effective healthcare services, ensuring that avoidable healthcare associated infections do not occur.

The key performance indicators for MRSA bacteraemia and C. difficile infection reduction continue to be a significant national and local challenge; with the reduction objectives for this organisation for 2018/19 set at:

- MRSA bacteraemia objective of zero avoidable cases within year
- C. difficile objective of no more than 23 cases within year

Infection prevention and control activity will continue to focus on the following objectives:

- To have zero avoidable MRSA bacteraemia cases within year
- To have 23 or less cases of Clostridium difficile infection within year
- To maintain focus on antimicrobial stewardship strategies, incorporating the 'Start Smart Then Focus' approach, to support a reduction in clinically inappropriate antibiotic prescription and consumption
- To consistently maintain 95% compliance or above with hand hygiene practices
- To continue collaborative working towards a reduction in the number of Gram-negative bloodstream infections within the local health economy, with the quality premium for Clinical Commissioning Groups to reduce E. coli bacteraemia by 10% within year being extended to 2018/19. This equates to a West Cheshire health economy objective of no more than 203 cases of E. coli bacteraemia within year.
- To maintain local surveillance systems, ensuring that Trust responsibilities are met, as part of the national mandatory surveillance programme for healthcare associated infection.

In support of these objectives, the planned focus for infection prevention and control for 2018/19 remains consistent with previous years, as follows:

1. The corporate infection prevention and control assurance framework, incorporating the *Health and Social Care Act (2008): code of practice on the prevention and control of infections and related guidance*; ensuring that this continues to support all related infection prevention and control activity, including healthcare associated infection registration requirements with the Care Quality Commission.

2. Maintain established systems for promoting best practice to reduce the number of *Clostridium difficile* infections via shared learning from investigations and national evidence base, including:
    - Case by case surveillance, with robust feedback methodology including early identification of any increased incidence of infection
    - Weekly multidisciplinary *Clostridium difficile* infection ward rounds
    - Daily Consultant Microbiologist ward rounds within Critical Care
    - Antimicrobial stewardship ward rounds within other specialities
    - Robust infection prevention and control practices including hand hygiene, rapid patient isolation and cleanliness within the environment and for equipment
    - Investigation process for each case of infection, sharing any learning with teams to support continuous improvement
    - Communication systems to support the workforce in remaining informed on progress and for the promotion of best practice

3. Maintain established systems for promoting best practice to reduce the number of bacteraemia cases due to antibiotic resistant organisms, including MRSA, Carbapenemase-producing *Enterobacteriaceae* (CPE) and Vancomycin resistant *Enterococcus* (VRE), via learning from root cause analyses and national evidence base.

4. Continue to strengthen antimicrobial stewardship across the organisation, ensuring appropriate antimicrobial use and risk reduction associated with antimicrobial resistance, utilising the information and resources provided by the 'Start Smart Then Focus' approach.

5. Continue collaborative working across West Cheshire Clinical Commissioning Group, in support of the national ambition to reduce the number of Gram-negative bloodstream infections across the whole health economy.

6. Maintain the infection prevention and control surveillance programme, including surgical site infection surveillance.

7. Maintain systems of 'alert organism' review to ensure that colonised patients or those with associated infections are treated promptly and appropriately to their benefit and for wider public health within the patient population.

8. Utilise local surveillance to promptly identify outbreaks or periods of increased infection incidence, including but not exclusive of C. difficile, MRSA, plus other multidrug resistant organisms.

9. Maintain training and education programmes for all staff groups, consistently reinforcing the routine implementation of infection prevention and control standards and antimicrobial stewardship for all patients, all of the time.

10. Maintain the infection prevention and control audit programme, including monitoring of key clinical practices, to reduce infection risks associated with invasive devices or procedures.

11. Maintain established levels of cleanliness, both within the environment and for equipment, ensuring compliance with national cleaning frequencies and working collaboratively with Facilities.

12. Maintain a system of policy development and review in conjunction with revised or emerging evidence-base.

13. Ensure that the healthcare environment is fit for purpose, working collaboratively with Estates and Facilities.

14. Ensure that healthcare workers remain adequately protected from infection risks within the workplace and do not as individuals pose an infection risk to others.

15. Maintain systems of information dissemination to ensure that the workforce remains informed and engaged on performance against agreed objectives for healthcare associated infection reduction, adapting these as circumstances dictate.

16. Maintain systems to provide accurate healthcare associated infection information for patients, visitors and other healthcare providers to minimise risks associated with the transmission of infection, working collaboratively with healthcare providers.

17. Continually assess any new developments in infection prevention and control (regionally, nationally or internationally) to inform and improve on practice.

This activity is not exhaustive and is routinely monitored via the corporate infection prevention and control assurance framework, adapting systems and processes to the needs of service provision as required.

The Trust Board will continue to receive a quarterly assurance report, as a minimum, with key surveillance data being reported on a monthly basis at all levels of the organisation. Infection prevention and control assurance will also be reported to commissioners on a monthly basis via established reporting frameworks.

Infection Prevention and Control Team
September 2018

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Learning from Deaths Board Report – 6 monthly update
Date of Meeting	Board of Directors – 18th December 2018
Presented By / Author(s)	Mr David Semple, Responsible Officer / Associate Medical Director
Annual Plan Objective No.	
Summary	This report is intended to provide on the progress by the Trust in relation to the "The National Guidance on Learning from Deaths (National Quality Board, March 2017)".
Recommendation(s)	**The Board is asked to note the progress made to date.**
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.

Introduction

The publication "The National Guidance on Learning from Deaths (National Quality Board, March 2017)", has led to the introduction of a new standardised framework for the way NHS Trusts report, investigate and learn from patient deaths. This should ultimately lead to better quality investigations and improved embedded learning.

The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust is required to collect and publish specified information on deaths quarterly. This should be through a paper and Board item to a public board meeting in each quarter to set out the Trusts policy and approach (by end of Q2) and publication of the data and learning points by Quarter 3 .The Trust should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subject to review, how many of these deaths were judged more likely than not to have been due to problems in care.
This is the second Board Report on Learning from Deaths following the introduction of the new framework.

Learning from Deaths Group

This multi-disciplinary, multi-professional group is responsible for overseeing the process of mortality review; highlighting areas for particular investigation, tracking reviews and assuring that learning has been disseminated. The LFD group continues to meet on a monthly basis and is chaired by a NED. The membership includes:

- Non-Executive Director (Chair)
- Medical Director (Executive lead for mortality)
- Director of Nursing and Quality
- Associate Medical Director for Safety and Quality
- Associate Director for Risk and Safety
- Divisional Medical Directors (Planned and Urgent Care)
- Divisional Nursing Leads (Planned and Urgent Care)
- Trust Governor
- Coding Team Leader
- Analyst
- Assistant Trust Secretary
- Chair of the Supportive and End of Life Group
- Associate Specialist and Junior Doctor Representation
- Safeguarding Lead Nurse and Learning Disability Co-ordinator (as required)

The principle functions of the group include

- To provide a quarterly report to the Board which demonstrates that the Trust is responding to, and learning from, the death of patients in the Trust's care, and builds into a statutory annual Quality Account

- To review the findings from learning from death reviews on a monthly basis

- To ensure that M&M meetings, the short mortality audit findings, formal mortality SJR and SI investigation's, and the learning derived from those, reporting mechanisms are properly established and working so assurance can be given to the Board

- To receive the policies and reports that give assurance of the quality of the mortality review process, to include NICE, NCEPOD and clinical audit

- To ensure that the trust fulfils its responsibility to involve the bereaved in the review process if they wish and to feed back the findings of any case review or investigation to them

- To review the data available from clinical benchmarking (HED) relating to mortality and to use this to determine particular areas of focus for future case record reviews

- To review mortality indices (SHIMI and HSMR) on a monthly basis

- To receive details of serious clinical incidents involving patient death and ensure that the Trust's response and the learning from these is shared across the organisation and that, when necessary, these direct future case record reviews

Mortality Review Process

1. Mortality & Morbidity Meetings

These departmental meetings will continue in their current format with learning disseminated within the relevant departments and escalated through the Divisional Governance Boards.

2. Mortality Screening Audit Form

A short mortality screening audit form is to be introduced in January 2019 which will be used to review ALL deaths in the Trust which will complement the current speciality M&M review process and also feed into the SJR process. This review process will be undertaken by senior clinicians alongside senior members of the coding team. Deaths identified using this tool where care is deemed to be suboptimal will be put forward for a formal structured judgement review. Lessons learned will be discussed at the LFD Group and fed back to the divisions via the Governance Boards and individual clinicians.

3. Structured Judgement Review Process

A SJR blends traditional, clinical-judgement based review methods with a standard format. The objective of the review method is to look for strengths and weaknesses in the care process, to provide information

about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. The quality of care is assessed against a scale of excellent, good, adequate, poor or very poor. Each case is reviewed by a single reviewer.
The SJR breaks down the care into phases:

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

Explicit judgement comments are made about each phase of care. This allows the reviewer to concisely describe how and why they assess the quality of care provided and it also provides a commentary in a way that other health professionals can understand. Commentary on holistic care is just as important as that on the technical care provided, particularly where complex end-of-life care discussions should have been held. Overall phase of care comments are intended to bring the reviewer to a judgement on the whole care episode.

Each phase of care is given an overall score:

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

Research suggests that an overall score of 1 or 2 might happen in fewer than 10% of cases. An overall score of 2 or under will trigger a second-review process (see below).

Each SJR is completed within the new Datix platform for mortality review and analysis. Case note review using the SJR takes up expensive clinical resource and it is expected that each review may take between 1 - 4 hours depending on the complexity of the case. At present we have 10 doctors (SAS and Consultants) who have been trained in SJR. Ultimately the plan is that each reviewer would review a maximum of two cases per month. This would equate to one PA of clinical time per month which needs to be built into job plans. Up until 6th December 2018 59 deaths have been reviewed using the SJR methodology.

An initial quality assurance of the completed SJR forms by the AMD revealed the forms were being completed to a very high standard. A quality assurance meeting is held by the AMD with the trained reviewers on a quarterly basis.

4. Secondary Reviews

Any death given an overall score of 2 or less (care was deemed to be poor or very poor) by the primary reviewer is automatically sent for a secondary review. Since April 2018 only one case has had an overall score of 2. In this case the secondary review also deemed the care to be poor although it was felt that this

did not ultimately impact on the death and therefore was not felt to be avoidable. However a number of lessons were learnt from these reviews and this has been fed back to the clinicians involved in the care. Although the principle of the SJR is for the reviews (both primary and secondary) to be carried out by a single person it has been agreed at the Learning from deaths group that any case going for secondary review will now be reviewed by the Associate Medical Director for Quality & Safety along with the Nursing Lead for the appropriate Division.

5. Deaths Reviewed as part of SI process

If questions arise in relation to the care of someone who has died then this maybe raised as a clinical incident with a resultant SBAR. These cases are reviewed at the Serious Incident panel and if appropriate a formal SI investigation maybe initiated rather than a SJR.
For deaths in 2018 a number of deaths have been or are currently being reviewed through an SI investigation

- Level 1 Investigations – Three deaths have been reviewed

- Level 2 Investigations – Eight deaths (Three of which are ongoing)

One of these deaths was reviewed using the SJR process where overall care was deemed to be satisfactory. However as some questions were raised in relation to processes, and also that the case is due to go to the Coroner, it was felt a formal SI investigation was needed to answer these questions (This review is ongoing).
One of the level 2 deaths has been reviewed by the Coroner and another two are awaiting a coroner's inquest.

LeDeR

The Learning Disabilities Mortality review programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. A key priority is to support local areas to review the deaths of people with learning disabilities.
Only one death in 2018 was reviewed using the LeDeR process.

See LeDeR Process Flowchart – Appendix 1

Mortality Data / Dashboard

HED data

Figure 1: The Trust is at Alert Level **GREEN** for HSMR relative to peers.
HSMR: 105 (Sept 17 – Aug 18)

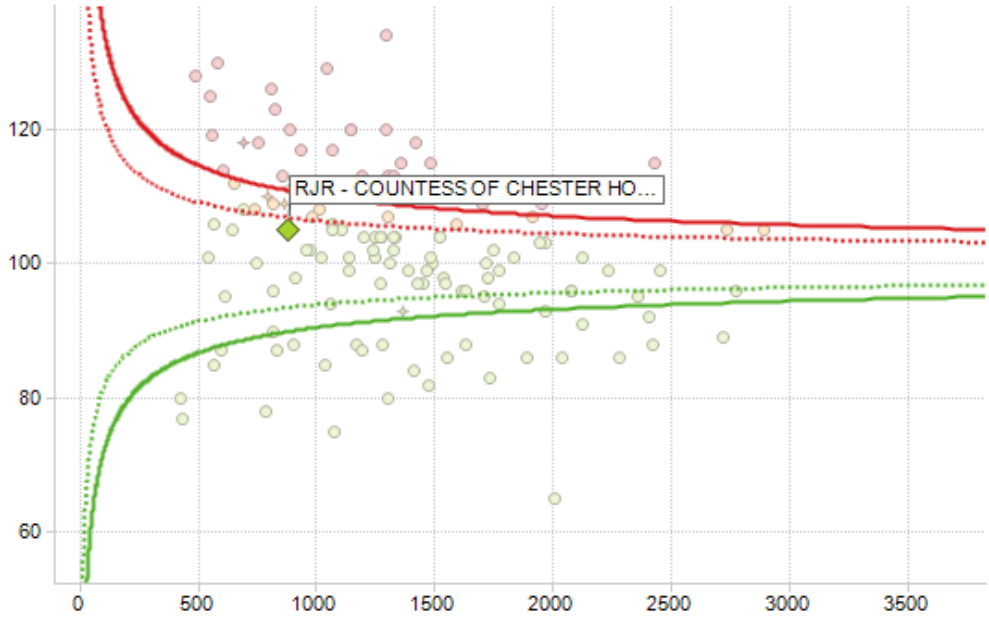
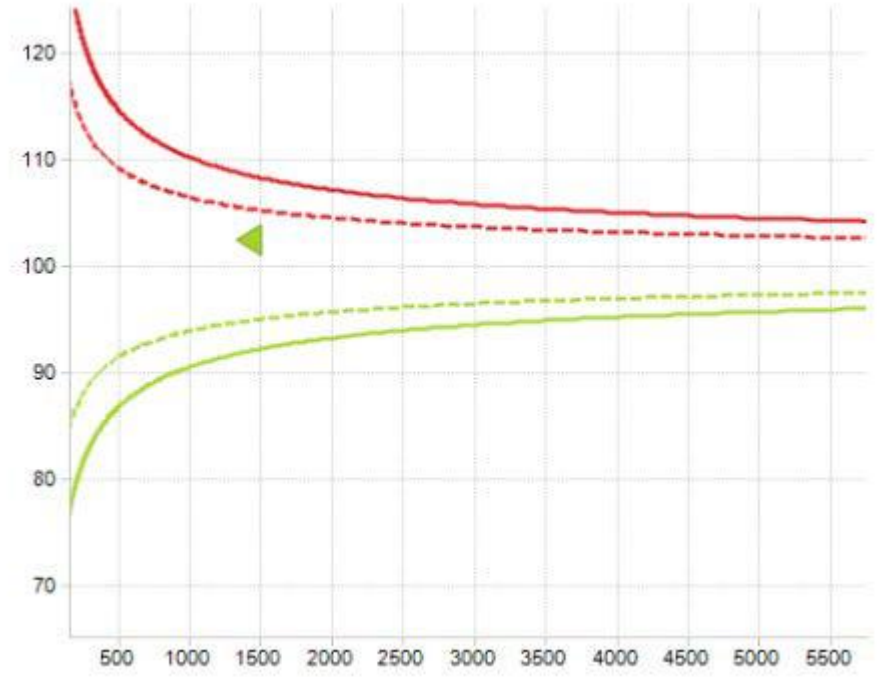


Figure 2: The Trust is at Alert Level **GREEN** for SHMI relative to peers.
SHIMI: 102 (Aug 17 – Jul 18)



The Trust's HSMR and SHIMI remain in the 'as expected range'.

Mortality Dashboard

NHS Mortality: Structured Judgment Reviews November 18

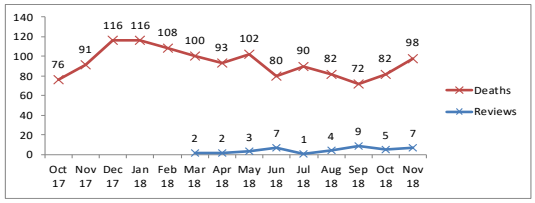
Department of Health

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP <3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
98	82	7	5	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
180	244	12	14	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
699	971	38	2	1	0

Adult inpatient deaths (excluding maternity) / Number of structured judgement reviews completed



Total Deaths Reviewed by RCP Methodology Score

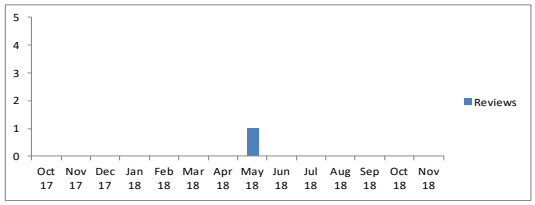
Score 1 Care - Very Poor (Probably Avoidable)			Score 2 Care - Poor (Possibly avoidable)			Score 3 Care - Adequate			Score 4 Care - Good			Score 5 Care - Excellent		
This Month	0	-	This Month	0	-	This Month	3	-	This Month	4	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	5	-	This Quarter (QTD)	7	-	This Quarter (QTD)	0	-
This Year (YTD)	0	-	This Year (YTD)	1	-	This Year (YTD)	12	-	This Year (YTD)	25	-	This Year (YTD)	0	-

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

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

Total Number of Deaths in Scope	Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
	This Month	Last Month	This Month	Last Month
	0	0	0	0
Criteria to be determined	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
	0	0	0	0
	This Year (YTD)	Last Year	This Year (YTD)	Last Year
	1	0	0	0

Total Deaths Reviewed Through the LeDeR Methodology



Themes / Learning from SJR

A number of themes have been identified on the initial SJR's although most have had no impact on the actual death. However they are important to note as improvements should lead to better care for future patients.

Issues identified include

- Inadequate documentation – A number of proforma's not completed -
  - Acute Medicine Post-take Review form (reverse side)
  - Sepsis proforma
  - VTE proforma
  - Catheterisation form
- Delay in escalation of high MEWS (NEWS 2) score's – contacting the clinical outreach / ICU teams
- Delay in involvement of senior clinician's
- Inadequate recording of fluid balance charts
- Lack of senior involvement in death certification

Dissemination of learning

Learning from the SJR's has been disseminated to each division via the DMD and the Divisional Directors of Nursing to be discussed at the governance boards.
Going forward dissemination of learning will be the principle focus of the LFD's group.

Challenges / Next Steps

- Increase the number of clinicians trained in the SJR process and to make this more multidisciplinary
- Ensure a robust formal QA process is developed for SJR's
- Embed the new mortality audit form and develop a group led by the AMD of senior clinicians and coders
- Continue to review the function and TOR's of the Learning from Death Group (annually)
- To ensure any learning from deaths is disseminated to divisions, departments, teams and individual clinicians
- To show that the learning from reviews is actually learnt and ultimately reduces the number of "avoidable deaths"
- To use learning to drive QI within the Trust
- To work more closely with bereaved families and carers
- To understand the role of the new Medical Examiner

Summary

The learning from Deaths Group has been established since September 2017. The group meets monthly and is responsible for overseeing the process of mortality review and assuring the Trust Board that learning from patients deaths has been disseminated. The group is chaired by a Non-Executive Director and has senior medical and nursing leadership.

In its first year a key focus for the group has been on training a cohort of medical staff to undertake Structured Judgement Review (SJR) and establishing a process whereby the learning from reviews is consolidated and disseminated to clinical teams within the Trust. A further element of the process includes connecting the learning from groups already established within the Trust Governance Framework such as Serious Incident Panel, Mortality and Morbidity meetings and the Supportive and End of Life Group.

To date 10 clinicians have been trained in SJR and 59 SJR's have been undertaken. In one case the overall care was deemed to be poor and this case went for a second review although it was felt the poor care did not ultimately influence the patient's death.

Through the SJR process themes for improvement have been identified and this will be a focus for the Learning from Deaths Group going forward. Whilst not exhaustive other challenges the group needs to address include a multidisciplinary approach to SJR, Quality Assurance of reviews, embedding Quality Improvements and working more closely with bereaved families.

Appendix 1

LeDeR Process Flow chart

LeDeR Process Flowchart.pdf

Appendix 2

National Mortality Case Record Review (NMCRR) Annual Report 2018

NMCRR Annual Report 2018.pdf

Appendix 3

National Quality Board – Guidance for NHS Trusts on working with bereaved families and carers – July 18

learning-from-deaths -working-with-families

Appendix 4 – Acronyms

LFD Group – Learning from Deaths Group
NED – Non Executive Director
M&M meeting – Mortality and Morbidity meeting
SJR – Structured Judgement Review
SI Investigation – Serious Incident Investigation
NICE – National Institute for Health and Care Excellence
NCEPOD – National Confidential Enquiry into Patient Outcome and Death
HED – Healthcare Evaluation Data
SHIMI – Summary Hospital Level Mortality Indicator
HSMR – Hospital Standardised Mortality Ratio
AMD – Associate Medical Director
LeDeR – Learning Disabilities Mortality Review
VTE – Venous thromboembolism
MEWS – Modified Early Warning Score
NEWS 2 – National Early Warning Score
ICU – Intensive Care Unit
DMD – Divisional Medical Director
QA – Quality Assurance
TOR – Terms of Reference
QI – Quality Improvement

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

ASSURANCE FRAMEWORK

CONTENTS

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

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
ASSURANCE FRAMEWORK - KEY

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

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

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

Risk score= consequence/impact x likelihood

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

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

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

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

Controls

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

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

Reporting

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

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

Movement

The direction from last reported quarter

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

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 2 2018/19

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

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

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

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

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

Potential or actual origins that have led to the risk…

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

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

The risks are CONTROLLED by…

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

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

The REPORTING mechanisms are…

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

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

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R6	Patient & Staff Stories	Each Board
R1	Falls Quality Improvement Project Plan (ongoing)	17.07.18
R1	QSPEC Dashboard - metrics & nurse staffing (monthly)	Monthly
R1	Medicines management Annual Report	15.05.18
R1	Risk & Safety Annual Report (2017/18)	15.05.18
R1	CRS - Governance Structure & Approach (QIA Process)	17.04.18
R1	NNU Final Action Plan	20.02.18
R1	Falls Project Update (Q1)	17.07.18
R1	Aggregated Learning Report - Complaints, Incidents, Inquests	15.05.18
R1	Learning From Deaths (M12 report)	19.06.18
R1	Quality Schedule - Assurance Report	19.06.18
R1	Kirkup Report (Morcambe Bay) - updated actions	19.06.18
R6	Learning From Deaths - Board of Director Report	22.05.18
R6	Quality Account (2017/18)	22.05.18
R1	Patient Experience Annual Report	18.09.18

GAPS IN CONTROL (as reflected in Divisional Risk Registers)

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

REF	GAP	ACTION PLAN / EXCEPTIONS	RISK REGISTER REF	DEADLINE
G1	NNU risks	Police investigation continues, Director of Legal & Corp Affairs as single point of contact. Staff support in place. Unit Activity, acuity & staffing monitored daily	Ref 1508	Q3 18/19
G2	Poor Compliance with Trust Policy (including Consent) and Processes (5 Never Events in 16/17)	Invasive Procedures, Safety & Quality Group established with revised ToR. Natssips agenda incorporated into agenda - development of work plan required (18/19	Ref 1640	Q3 18/19
G3	Capacity issues due to lack of social care provision and flow issues within the Trust	System wide programme of improvement in place. Winter resilience being planned. ICP in development.	Ref 1334	Q3 18/19
G4	Increase in falls with harm	Quality Improvement Falls Project (RCP Falls programme) in place with dedicated Lead and Therapy support. Review of Trust Falls Group, links to ext. falls strategy	Ref 1362	Q3 18/19
G5	Medicines Safety including Prescribing errors	Profile of medicine safety across the Trust increased; Medicines Safety Group reporting into QSPEC; regular incident reviews in place	Ref 1095/474	Q3 18/19
G6	Gap in provision and knowledge re. Adult Safeguarding	Action Plan in place, training plan under review. Governance re reporting undertaken, MIAA report, July 18 = Limited Assurance	Ref 1785	Q3 18/19
G7	Learning from Deaths	Process of reviewing mortality in place, governance now agreed via L from D committee, ongoing data & dashboard refinement	Ref 1979	Q3 18/19
G8	End of Life (CQC Requires Improvement)	Action Plan in place monitored through the End of Life/Palliative Care group. Further engagement planned	Ref 1817	Q3 18/19
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST (GUIDANCE TEMPLATE)

Board Assurance Framework - Quarter 2 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-19	TARGET RISK SCORE Mar-20		
	4x4 = 16	4x3 = 12	4x4=16	4x2=8	4x2=8		

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

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

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

INTERDEPENDENCIES: CR1;CR3;CR4;CR5;CR6

Potential or actual origins that have led to the risk…	*What are the most significant origins (up to 10) which could or have led to the risk?*
REF	ORIGIN
O1	lack of resilience of community sector and social care
O2	Cross border issues
O3	Demographic of local population
O4	constraints on budgets across west Cheshire system
O5	failure of commissioners to commission sufficient capacity to meet demand
O6	Insufficient understanding of the organisational capacity/specialist staff shortage
O7	Number of medically optimised patients and delayed transfers of care
O8	High cost of variable pay & national cap on expenditure
O9	Operational pressures and impact on retention/health and wellbeing appraisals, mandatory training etc.
O10	Rising demand for services

The risks are CONTROLLED by…		Strength	Movement
What are the key controls (up to 10) that are in place to mitigate these risks?		*Red Amber Green*	
REF	CONTROL	RAG	
C1	Agreed capacity and demand analysis	Green	→
C2	Monitoring of demand, performance and approved escalation processes	Green	→
C3	assessment capacity across main emergency care specialities	Green	→
C4	Early supported discharge & step down beds	Amber	→
C5	operational escalation levels & system wide escalation protocol	Green	→
C6	Winter Resilience Planning	Amber	→
C7	Operational dashboards (real-time)	Green	→
C8	Tracking & Validation teams	Green	
C9	AE Delivery Board chaired by CoCH CEO	Green	
C10	Monthly contract and performance meetings	Amber	

The REPORTING mechanisms are…			Strength	Movement
What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective?			*Red Amber Green*	
REF	REPORTING MECHANISM	FREQUENCY	RAG	
R1	Finance and Integrated Governance Committee	Bi -Monthly	Green	→
R2	Risk & Performance Committee	Monthly	Green	→
R3	Board of Directors	Bi -Monthly	Green	→
R4	Daily SITREP reporting	Daily	Green	→
R5	Weekly performance review	Weekly	Green	→
R6	ICP delivery board	Monthly	Green	→
R7	A&E Delivery Board	Monthly	Green	→
R8	Reporting to Commissioners, NHSI & NHSE	As required	Green	→
R9	Contract and performace meetings	Monthly	Green	→
R10				

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R3	Integrated Performance Report	Sep-18
R5	Weekly Operational Performance meeting	Weekly
R7	West Cheshire A&E Delivery board	Monthly (Sept 18)
R3	Update on winter planning to Board	Sep-18
R3	Quarterly cancer update to board	Jul-18
R6	ICP workstream including whole system demand & capacity review	Sep-18
R4	Real-time Dashboards & OPEL reporting	ongoing
R2	Capacity meetings	daily
R8	Elective care meeting with CCG	Monthly
R5	Weekly PTL review meetings (including cancer)	Weekly
R2	Cancer performance meeting	monthly (Sept 18)
R7	NHSi/NHSE Winter Plan assurance	Jul-18

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

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

REF	GAP	ACTION PLAN / EXCEPTIONS	RISK REGISTER REF	DEADLINE
G1	insufficient diagnostic capacity to meet demand	endoscopy recovery plan, including insourcing at weekends, ultrasound recovery plans, including outsourcing of reporting to enable activity sessions. Monitoring of cancer PTL & diagnostic	Ref 1864	Q3 18/19
G2	lack of sufficient financial resources	Inability to in source/outsource to meet the growth of demand. Short term Business Cases to meet overall capacity being produce via Trust process.	Ref 1735	Q4 18/19
G3	insufficient bed capacity	daily oversight of admissions and discharges, discharge delays and bed occupancy. Fortnightly exec oversight of >21 LoS days	Ref 1334	Q3 18/19
G4	operational excellence & quality improvement	integration of services across organisations to enable new models of care with best use of available resources. Managing director appointed to transform services.	Ref 1956	Q3 18/19
G5	insufficient demand management control leading to growth	implementation of E-RS to support triage of referrals. Joint plan with WCCCG to control demand for elective care	Ref 1366	Q4 18/19
G6	gaps in medical & nurse staffing	divisional support to develop workforce plans & alternative roles to be presented via medical pay meeting & Nursing & midwifery workforce group	Ref 1202 Ref 1643	Q4 18/19
G7	ED Capacity due to sustained increase in attendances	ED Delivery Board. Awaiting decision re funding to support refurbishment of ED	Ref 1594	Q4 18/19
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST (GUIDANCE TEMPLATE)

Board Assurance Framework - Quarter 2 2018/19

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

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

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

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

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

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

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

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

The REPORTING mechanisms are…			Strength	Movement
What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective?			*Red Amber Green*	
REF	REPORTING MECHANISM	FREQUENCY	RAG	
R1	Finance and Integrated Governance Committee	Bi-Monthly	Green	
R2	Board of Directors Meeting	Bi-Monthly	Green	
R3	ICP Leaders Group	Monthly	Green	
R4	People and OD Committee	Bi-Monthly	Green	
R5	WWC Alliance Exec Steering Group	Monthly	Green	
R6	WWC Clinical Services Collaboration Committee	Monthly	Green	
R7	CCG review meetings	Monthly	Green	
R8	Corporate Leadership Group	Weekly	Green	
R9	Annual General Meeting	Annual	Green	
R10	ICP Clinical Advisory Group	Monthly	Green	

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R4	Medical Workforce Board	20-Sep-18
R3	ICP workstream including whole system demand & capacity review	Sep-18
R4	Variable Pay Review	Sep-18
R4	Electronic Job Planning and Roster Management software procured	01-Aug-18
R4	Reprovision of existing junior doctor rosters in trauma care to match increased demand	06-Sep-18
R1	EPR Programme Board launch with Specialty Clinical Lead appointment process	01-Aug-18
R8	~~Corporate Leaders Group timings amended to enable Clinical Leads to attend and engage in the corporate~~ agenda with consistency	Ongoing - evidenced by diary
R7	Monthly 1-1 meetings between Trust MD and CCG established Nov 2018	Ongoing - evidenced by diary
R8	Scheduled 1-1 recurring meetings with all Clinical Leads on a monthly basis across the Trust	Ongoing - evidenced by diary
R4	Specialty Doctor Engagement Project : 1-1 meetings with all Trust SAS Grade Doctors	Ongoing - evidenced by diary
R4	NHS England 7 Day Services Programme (North West)	01-Sep-18

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

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

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

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 2 2018/19

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

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

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

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

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

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

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

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

These are the POSITIVE ASSURANCES received…		
What are the key positive assurances received through reporting that a control has remained effective (up to 20)		
REPORT REF	**POSITIVE ASSURANCE** *What is the report received that provided that assurance? E = External Assurance*	**DATE LAST REPORTED TO COMMITTEE**
C1/R2	Review of People & OD Strategy documentation & implementation plan to POD	26-Sep-17
C2/R2	Monitoring through High Performance Board that reports back to POD	25-Sep-18
C3/R4	Implementation of Countess Brief & cascade process, supplemented by weekly Whats Brewing with Execs	25-Apr-18
C4/R4	Subscription to NW Leadership Academy and internal leadership courses discussed at EDG	21-Feb-18
R2/R8	Leadership Progs in place - High Performance workshop, QI, Clinical leaders programme	25-Sep-18
C5/R2	Staff Survey/SFFT Report to Board of Directors with associated action plan. Monitored by POD.	27-Mar-18
C7/R2	High Performance Culture work stream investment linked to Model Hospital programme	01-Mar-18
C9/R2	Recognition and Celebration of Achievements informal and formal systems in place	4th September 2018
C9/R4	Introduction of Countess Gems, monitor by feedback and twitter	08-May-18
R3	Partnership Forum: Staff engagement /staff survey/staff experience/SFFT reviewed monthly	13-Sep-18
R8	Student Experience/Satisfaction Surveys - open all year Multi -Prof Practice Placement meeting	13.02.18
C2/R2	Appraisal performance has increased from last year although still not consistant	21-Sep-18
R2	Health & Well Being Strategy & performance reported to POD	28-Mar-17
R1/R2/R10	Reporting to Board /FIGC/POD on workforce KPIs	25-Sep-18
C1/R6	Exit Interview / How are we doing interviews implemented. Feedback to SPF on periodic basis.	10-May-18
R2/R6	Papers & updates following the Kate Lampard report showing staff/roles/dept analysis with/without DBS	

The GAPS IN CONTROL (as reflected in Divisional or Executive Risk Registers)				
What are the remaining key gaps in the controls (up to 10)				
REF	**GAP**	**ACTION PLAN / EXCEPTIONS**	**RISK REGISTER REF**	**DEADLINE**
G1	Delivery of High Performance Workshops to all staff	Two cohorts of the programme in place to cover 300 leaders - non-release of staff is not possible due to high pressure in system. 2 hr prog for all staff in devpt.	Ref 1881	Q3 18/19
G2	Limited budget so looking at designing in house, limited resource and other priorities in the New Year	Looking to make a decision quickly, content has been drafted and mocked up. Need to trial a pilot.	Ref 1946	Q3 18/19
G3	Communications still falter at middle manager level	Introducing Whats Brewing and all staff briefings to eliminate layers and barriers	Ref 1948	Q3 18/19
G4	Limited capacity to release staff to attend training	Looking at more on boarding, e learning opportunities with videos and apps.	Ref 1882	Q3 18/19
G5	FTSU: Revision of policy, processes, resources & comms required	FTSU: Revision of policy, processes, resources & comms required	Ref 1949	Q3 18/19
G6	Communication of Freedom to Speak Up	Encourage reporting via Union Representatives with added protection	Ref 1950	Q3 18/19
G7	Capacity to support Health Economy initiatives such as ACO and STP	Fortnightly / monthly meetings in place. LDS action plan in place, ACO workforce plan in development	Ref 1897	Q3 18/19
G8	Complex employment legislation, managers & staff side will require HR support at a high level	Development sessions being scoped for delivery e.g. investigation training, appeals, tribunals	Ref 1898	Q3 18/19
G9	Delivery of national CQUIN targets linked to Health & Wellbeing	Monitored monthly by Health & Wellbeing Steering Group, discussed at Nursing & Midwifery Board for additional nursing support re flu vaccination programme.	Ref 1901	Q3 18/19
G10	Substantive staff without DBS checks	There is further debate to be had at EDG to establish risk and options for consideration		Q4 18/19

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 2 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-19	TARGET RISK SCORE Mar-20		
	4x5=20	4x4=16	4x4=16	4x3=12	4x1=4		

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

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

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

INTERDEPENDENCIES:

Potential or actual origins that have led to the risk…

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

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

The risks are CONTROLLED by…

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

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

The REPORTING mechanisms are…

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

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

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R1	Integrated performance Report including exceptions	Monthly
R3	Performance Report to Commissioner Meetings	Monthly
R5	NHSI Monitoring Templates & Reports	Monthly
R7	CQUIN update to Quality, Safety & Patient Experience Committee	Monthly
R1	Monthly Finance Board Report	Monthly
R5	NHSI Fortnightly CRS returns	Fortnightly
R2	Weekly CRS Group	Weekly
R2	NHSI quarterly review meeting	9-Aug-18
R10	Audit Committee	18-Sep-18
R10	Risk & Performance Committee	23-Jul-18
R1	Board Meeting	25-Sep-18
R3	West Cheshire CCG Contractual Performance Meeting	27-Sep-18
R3	Betsi Contractual Performance Meeting	24-Sep-18
R3	NHSE Contractual Performance Meeting	25-Jul-18
R3	Maxwell Stanley Coding Review	24-Jun-18
R3	Joint Efficiency Programme Launch with CCG	17-Sep-18

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

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

REF	GAP	ACTION PLAN	RISK REGISTER REF	DEADLINE
G1	Gap and high risk of efficiency plans	To.be risk assessed and monthly meetings with departments to continue to identify further plans. Joint working with CCG for system wide savings. Review of NHSI checklist. Identification of non recurrent savings to support 17/18 plan.	Ref 1830	Q3 18/19
G2	Control of volumes of medically optimised patients and delayed transfers of care and further activity growth impacting on financial position	Joint working with CCG to control demand and discussions with local councils regarding recharges. A&E Delivery Board tasked with reducing bed occupancy to 85%	Ref 1686	Q3 18/19
G3	Failure to deliver performance improvement trajectory and consequent impact of STF funding	Weekly performance meeting and increased scrutiny at Divisional level alongside A&E Delivery Board .	Ref 1871	Q4 18/19
G4	Failure to deliver activity plan resulting in loss of income to the Trust	Monthly reporting through Division and up to EDG with recovery plans in progress where necessary	Ref 1872	Q3 18/19
G5	Impact of lack of information on Junior doctor rotational gaps and medical and nursing vacancies and ability to secure visas.	Pro-active management to anticipate potential gaps and escalation process with Deanery. Exploring recruitment options for nursing workforce	Ref 620	Q3 18/19
G6	Continued high demand for non elective care requiring Ward 54 to remain open thus depleting the winter reserve with no known additional winter funding externally to date.	Proactive management to staff ward in most efficient way. Regular monitoring of additional costs incurred.	Ref 1870	Q3 18/19
G7	Funding gap for centralised vascular service.	Financial recovery plan currently being progressed with the division	Ref 625	Q3 18/19
G8	The capital loan has not been approved to date.	Escalation process is in place to enable emergency capital to be approved by the Exceutive team whilst waiting for loan application outcome.	Ref 1868	Q3 18/19
G9	Outcome of STP Bid to support redesign of A&E Department currently unknown.	Other funding sources and smaller development is currently being explored.	Ref 1873	Q3 18/19
G10	Revenue distress loan is likely to be required later in the year.	Daily cashflow forecasting is in place.	Ref 1869	Q3 18/19

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST (GUIDANCE TEMPLATE)

Board Assurance Framework - Quarter 2 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-19	TARGET RISK SCORE Mar-20		
	4x4 = 16	4x3 = 12	4x4=16	4x2=8	4x2=6		

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

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

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

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

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

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

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

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

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

REF	REPORTING MECHANISM	FREQUENCY	Strength RAG (Red Amber Green)	Movement
R1	Risk & Performance Committee	Monthly	Green	
R2	Finance & Integrated Governance Committee	Bi-monthly	Green	
R3	Board of Directors	Bi-monthly	Green	
R4	Commissioner contract meetings (WC) (E)	Monthly	Green	
R5	NHSI monthly oversight meetings	Quarterly	Green	
R6	Quality, Safety & Patient Experience Committee	Monthly	Green	
R7	Infection Control Committee	Quarterly	Green	
R8	Council of Governors	Quarterly	Green	
R9	Performance meeting	weekly	Green	

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R1	Integrated performance Report/key exceptions & Risk Register	Monthly
R2	Integrated performance Report & Risk Register to FIGC	Bi monthly
R3	Integrated performance Report to BoD	Bi monthly
R4	Performance Report to WC Quality & Performance meeting	Monthly
R5	NHSI Improvement trajectory & reports	Quarterly
R9	weekly performance dashboard to COO & DD's	Weekly
R3	Cancer update to Board	Quarterly
R5	Weekly tracking of improvement trajectories	Weekly
R3	Winter planning update to Board	Sep-18
R2	Introduction of weekly Operation Performance Meeting (Chaired by COO)	Weekly
R5	NHSI daily/monthly performance dashboard	daily
R1	intensive support team improvement reports - A&E & Cancer 62 days	Jul-18

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

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

REF	GAP	ACTION PLAN / EXCEPTIONS	RISK REGISTER REF	DEADLINE
G1	lack of queue oversight due to current EPR	EPR upgrade and manual tracking of follow up PTL	Ref 1818	Q4 18/19
G2	>21 day length of stay patients	validate bed capacity data and exec oversight for nationally set reduction target	Ref 1686	Q4 18/19
G3	Cancer performance	Implementation of key actions identified in action plan Increased clinical engagement & oversight - 473, 1174, 1177, 1232, 1373	Ref 473	Q3 18/19
G4	18 week failure of incomplete pathway	Development of actions to address 18 weeks and longest waiters	Ref 1224	Q3 17/18
G5	insufficient capacity in ED leading to prolonged waits	Whole system approach to hospital avoidance and effective primary care. Submission of capital plans for new build.	Ref 1594	Q4 18/19
G6	Demands exceeding capacity within budget	Implementation and support to CCG demand management work streams and clinical pathway redesign	Ref 1735	Q3 18/19
G7	Lack of capacity in diagnostic services	Increasing primary care/demand for diagnostics and hospital requires senior oversight, education & training	Ref 1155	Q3 18/19
G8	lack of sufficient financial resources	Inability to in source/outsource to meet the growth of demand. Short term Business Cases to meet overall capacity	Ref 1735	Q4 18/19
G9	gaps in medical & nurse staffing	divisional support to develop workforce plans & alternative roles to be presented via medical pay meeting & Nursing & midwifery workforce group	Ref 1202 Ref 1643	Q4 18/19
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 2 2018/19

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

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

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

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

INTERDEPENDENCIES: CR1;CR6;CR8

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

REF	ORIGIN		
O1	Well Led Review	Amber	➔
O2	Recruitment of substantive Chief Executive Officer	Amber	✶
O3	Failure to triangulate outcomes of Board committees	Amber	➔
O4	Board development	Amber	➔
O5	Recruitment/re-appointment of Non Executive Directors	Green	➔
O6	Appointment of ICP Member(s) to COCH Board	Green	➔
O7	Interm Director of HR	Amber	✶
O8	Acting Medical Director	Amber	✶
O9			
O10			

The risks are CONTROLLED by… Strength: *Red Amber Green*

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

REF	CONTROL	RAG	Movement
C1	Board Assurance Framework review	Green	➔
C2	Revising staffing structure clinical and non-clinical teams	Amber	➔
C3	Control by the Executive Team/Council of Governors/Board of Directors	Green	➔
C4	Support MIAA and KPMG regarding the Well Led review	Green	➔
C5	Aggregated report to be received at Board of Directors regarding Complaints, Litigation and Claims	Green	✶
C6			
C7			
C8			
C9			
C10			

The REPORTING mechanisms are… Strength: *Green*

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

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

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R5	Provided an update at the Weekly Executive meeting	Weekly
R1	Provided an update to the Board of Directors	25th September 2018
R2	Provided an update to the Council of Governors/Governors Quality Forum	21st Setpember 2018
R1	Regular communication and discussion with the Chairman	Weekly
R6	Workshop held regarding FTSU	1st May 2018
R1	Receipt of the Board Assurance Framework at Board of Directors	22nd May 2018

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

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

REF	GAP	ACTION PLAN	RISK REGISTER REF	DEADLINE
G1	Further review of resources and processes to support required for Freedom To Speak Up	Review Trust policy, review FTSU processes of investigation & resources required	1949/1950	Q3 18/19
G2	Trusts Audit Committee are sighted on Integrated Care Partnership developments	Key risks are articulated to the Audit Committee including governance arrangements		Q3 18/19
G3	Final Agreement of ICP Governance arrangements	Monthly ICP Governance meetings established to progrees and finalise governance arrangements		Q3 18/19
G4	Refresh of Risk and Performance Committee	Refresh of membership and business of Risk and Performance Committee being undertaken		Q3 18/19
G5	Changes in Board structure and Executive Scheme of Delegation	Review of Changes in Board structure and Executive Scheme of Delegation being undertake at Executive Directors Group		Q3 18/19
G6				
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Q2 2018/19

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

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

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

INTERDEPENDENCIES:	

Potential or actual origins that have led to the risk…

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

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

The risks are CONTROLLED by…

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

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
C1	95% of staff undertook Information Governance training within the last 2 years	green	→
C2	Information Governance and IT Security policies and procedures including DPIAs and ISAs	green	→
C3	Use of encryption to secure data on portable devices	amber	→
C4	Secure disposal of sensitive, confidential and person identifiable waste (paper and electronic)	amber	→
C5	Data flow mapping	amber	→
C6	Maintain up-to-date Information Asset Register	amber	→
C7	Members of the Information Governance Committee fully trained including IG Manager	green	→
C8	Identified and trained Caldicott Guardian and Senior Information Risk Owner	green	→
C9	IG Project Management Board work to control new EPR Implementation	amber	→

The REPORTING mechanisms are…

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

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

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
A1	Routine email communications relating to IG alerts and threats	As required
A2	MIAA IG Toolkit Audit - mandatory (Significant Assurance)	Jan-18
A3	2017/18 Information Governance Toolkit Sumission 82% - Level 2 Compliance	Jan-18
A4	Bi-Annual SIRO Report received by Informatics Board	Nov-17
A5	IG and Caldicott Panel minutes reported to FIG	Bi-Monthly
A6	MIAA Core IT Infrastructure Review (Significant Assurance)	Jan-15
A7	NHS.Net email secure encryption implemented; reviewed and approved by the IG Panel	Jun-15
A8	Information Security Officer - Qualified HealthCare Information Security and Privacy Practitioner	Nov-15
A9	Information Governance Spot Check Audits Undertaken	Monthly
A10	IT Security Manager is Certified Information Systems Security Professional	Sep-16
A11	Cross Departmental cover for IG Team	As required
A12	Qualified GDPR Practitioner - IG Team trained and certification passed	Nov-17
A13	GDPR Implemention Work Plan developed and supported by IG Panel Attendees	May-18
A14	New reporting mechanism to Audit Committee developed	Nov-17

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

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

REF	GAP	ACTION PLAN	RISK REGISTER REF	DEADLINE
G1	Secure disposal of sensitive, confidential and person identifiable paper waste	Review contract to improve security of confidential waste storage	765	Q1 19/20
G2	Extend data flow mapping	Continue work on Data Flow Mapping, focus on Level 3 assets	973	Q1 19/20
G3	Extend Information Asset Register	Continue work on Asset Register, focus on Level 3 assets	973	Q1 19/20
G4	Colleagues across the Trust are fully trained in Information Governance	Appropriate online training undertaken by staff members	1800	Q1 19/20
G5	Dictation devices not encrypted	On-going rollout of digital dictation and replacement of dictation devices without encryption	767	Q1 19/20
G6	Electronic equipment including medical devices disposed of without removal of unencrypted confidential patient data	Undertake risk assessments for all medical devices containing unencrypted confidential patient data	767	Q1 19/20
G7	General Data Protection Regulation (GDPR) fully implemented - national clarifitcation	Interpret GDPR requirements and develop proposals to achieve compliance within existing resources and brief Board as appropriate	51	Q1 19/20
G8	Unknown associated risks with EPR Project and Collaborative working	Discuss with external organisations what their IG strategy was when merging and implementing new systems, link in with ICO and collaborate with WUTH	1953	Q1 19/20
G9	Limited IG Resources within Organisation	Look at business continuity and risk assess team/resources	1954	Q1 18/19

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Q2 2018/19

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

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

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

Potential or actual origins that have led to the risk…

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

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

The risks are CONTROLLED by…

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

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

The REPORTING mechanisms are…

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

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

These are the POSITIVE ASSURANCES received…

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

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

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

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

REF	GAP	ACTION PLAN	RISK REGISTER REF	DEADLINE
G1	Informatics Strategy requires review	Informatics Strategy will be reviewed in the context of Global Fast Follower application and provurement of new Electronic Patient Record (EPR)	Ref 1980	Q3 18/19
G2	Review of IT Leadership	Formalise the senior IT leadership structure	Ref 1981	Q3 18/19
G3	Reducing the threat of a Cyber Security attack	Assess implmentation of network Access control systems and physical processes to mitigate risks. Cyber Attack'table top' exercise planned for Jan 2018	Ref 1753, 1688, 1475	Q4 17/18
G4	Informatics Board requires reinstating, taking into account the work of the EPR programme board	To work with CFO and Director of Nursing & Quality to establish new Board framework	ref 1929	Q3 18/19

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 2 2018/19

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

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

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

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

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

Potential or actual origins that have led to the risk… *What are the most significant origins (up to 10) which could or have led to the risk?*	
REF	ORIGIN
O1	National and local staff shortages; including those with specialist clinical skills e.g. Nurses/ED/Sonographers/Anaes/CRV/Theatres
O2	High cost of agency / locum staff (Nursing/Medical/ODPs) as monitored by the Variable Pay work stream
O3	Tighter UK border controls for non EU countries / Tier 2 / Impact of Brexit
O4	Age profile/demographic in some staff groups e.g. Midwifery / Nursing
O5	National Pay restraint & impact on recruitment and retention into NHS / Trust, impact of Bursary removal
O6	Sustainability and efficiency of services within financial envelope
O7	Impact of no agency cap rates in Wales & staff working cross-border for higher rates
O8	
O9	
O10	

The risks are CONTROLLED by…		Strength	Movement
What are the key controls (up to 10) that are in place to mitigate these risks?		*Red Amber Green*	
REF	CONTROL	RAG	
C1	Development & assessment of new and/or extended roles such as Adv.Practice, PAs and Apprenticeships	Green	→
C2	Monitoring of Medical staffing agency usage	Green	→
C3	Rolling programme of recruitment including Europe and	Green	→
C4	Development of Retention strategies and retraining opportuni	Amber	→
C5	Staff engagement across the Trust including promotion of Freedom to Speak Up and High Performance Culture	Green	→
C6	High Performance Culture work stream within Model Hospital programme	Green	→
C7	High Performance Culture work stream within Model Hospital programme	Green	→
C8	ACO, STP, LDS, Streamlining and collaboration across the health economy	Amber	↑
C9			
C10			

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

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
C2	Monthly Nursing & Midwifery Board chaired by Director of Nursing & Quality	25-Sep-18
C2	Reviewing skill mix in theatres, discussing local courses with Chester University	10-May-18
R1/R2/R9	Compliance Reports (Appraisal/Mandatory Training/Local Induction) BOD, People & OD, MDEC	22-Sep-18
R8/R9	GMC Trainee Survey- reported to Multi-Disciplinary Education Committee	08-May-18
R8/R9	Regular Pulse Checking via SFFT/SOS/GMC trainee surveys/Student Exp surveys	18-Jul-18
R8	Exec attendance at monthly education programmes e.g. CHAPS for FTSU discussion.	21-Sep-18
C3	Medical agency spend / recruitment and retention strategy reviewed by Medical Workforce Bd	21-Jun-18
C4/R4	European & International Nurse Recruitment plan in development	23-Apr-18
C5/R4	E-roster / Safe care implementation in progress & increased notice of rosters	27-Sep-18
C9	Monthly LDS HRD Meetings, Regional Collaborative Bank led by Dir of People & OD, Streamlining	13-Sep-18
C2/R2	Apprenticeship Strategy & delivery presented to POD, PF and CLG	25-Sep-18

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

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

REF	GAP	ACTION PLAN / EXCEPTIONS	RISK REGISTER REF	DEADLINE
G1	Increases in turnover for nursing staff / staff working agency shifts in Welsh trusts (no cap)	Retention strategy, weekly bank pay from October, corporate plans re pay review, escalation to BCUHB, surveys in dept with nursing staff, e-roster	Ref 1951	Q3 18/19
G2	Agencies still charging over capped rate, holding Trusts to ransom	Fortnightly reviews & increased management information from Medical Staffing via Brooksons. Review at MWB. Development of Medical Workforce Strategy (MWS).	Ref 1885	Q3 18/19
G3	Pressures of capacity and demand on staff and ability to manage pressures	Divisional risks item added to each POD meeting as standing item to discuss capacity, demand & pressures. Monitored monthly through HRBPs and triangulation with data.	Ref 1886	Q3 18/19
G4	Medical gaps esp ED & ENT/T&O/Plastics rotas & impact on patient safety / variable pay spend	Recruitment into permanent posts, skill mix review, engagement needed with Medical Leads in hot spot areas through MWB. Development of MWS.	Ref 1890	Q3 18/19
G5	The reduction in training & conversion courses is causing a shortage in some clinical areas such as ODP's, Sonographers	Working with Divisions to develop retention strategy, e.g. Theatres recruitment & retention strategy, apprenticeship strategy & delivery with HEIs	Ref 1952	Q3 18/19
G6				
G7				
G8				
G9				
G10				

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Integrated Care in Cheshire West (Progress Report)
Date of Meeting	18th December 2018
Author	Alison Lee – Managing Director, Cheshire West Integrated Care Partnership
Annual Plan Objective No.	N.A
Summary	This report is intended to provide a progress update on the Cheshire West Integrated Care Partnership (ICP).
Recommendation(s)	**The Board is asked to note:** • The Board is asked to note the progress on joining up care and the development of Cheshire West Integrated Care Partnership.
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
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NHS Foundation Trust

INTEGRATED CARE IN CHESHIRE WEST – PROGRESS REPORT

PURPOSE

1. This paper is to update the Board on progress in developing the Cheshire West Integrated Care Partnership (CWICP).

BACKGROUND

1. The vision of local health and care partners is that the people of Cheshire West will live longer, healthier lives at home, or in a homely setting. People will be at the centre of all decisions and receive support to the highest standards of quality and safety.

2. We will achieve this by joining up delivery of our health and social care and focussing on prevention, early identification, supported self-management and providing care closer to home. The aim is to see care provided in the most appropriate setting and as a result, the demand for hospital- based care decrease over time.

3. Health and social care partners in Cheshire West have been pursuing these objectives over the last two years and are now progressing with the third phase of integration work through the Cheshire West ICP. The CWICP is focusing on the Cheshire West 'Place' – the population within the boundary of Cheshire West and Chester Council and covering the patients of West Cheshire and Vale Royal Clinical Commissioning Groups.

4. A System Leadership Group, including chairs, chief executives and their equivalents from partnership organisations, oversee the development of integrated care and the ICP. Partners have agreed that the Countess of Chester Hospital NHS Foundation Trust (CoCH) will host the CWICP. Accordingly, the chair of the CWICP is now a non-executive director of the CoCH Board. The Managing Director (lead executive) for the CWICP is now in place and is a non-voting member of the Board, enabling the hosting and associated delegation agreements to operate within effective governance arrangements.

   The organisations that form the Partners of the CWICP are:

   - **The Countess of Chester NHS Foundation Trust**
   - **Cheshire West and Chester Council**
   - **Primary Care Cheshire (GP Federation)**
   - **South Cheshire and Vale Royal GP Alliance**
   - **Cheshire and Wirral Partnership NHS Foundation Trust**
   - **Central Cheshire Integrated Care Partnership**

   The ICP will be held accountable for achieving a set of pre-agreed outcomes within a given budget commissioned by NHS West Cheshire and NHS Vale Royal Clinical Commissioning Group.

GOVERNANCE

5. Partners acknowledge the importance of ensuring appropriate and effective financial and quality governance arrangements are in place to support integration and have agreed that more formal integration and delegation agreements between partners are now drawn up.

6. System leaders (including health and social care commissioners) have committed to develop future contracting arrangements to support integrated care with a long-term goal to work towards a prime provider contract. There is an objective to implement some change for the 2019/20 financial year to better reflect new care models. A draft service specification for the first phase of services to be delivered within the CWICP has been shared by the CCGs.

7. The shadow CWICP board met for the first time in November 2018. Membership of the CWICP board will be a combination of an executive or non-executive representative from each Partner organisation and the senior leadership team of the Integrated Care Partnership. This is subject to final agreement and confirmation from each CWICP partner, following internal governance discussions. The formal governance arrangements will require sign off by each CWICP Partner in early 2019.

8. The minutes of the July and September System Leadership Group can be found here. Future minutes of the CWICP Board will be reported routinely to the CoCH Board.

INTEGRATION ACTIVITY HIGHLIGHTS

The following points highlight the integration work that has been taking place within the ICP Programme:

- To support the development of Cheshire West Care Communities, additional psychological support for people with long term conditions is being rolled out in Ellesmere Port. Community nursing staff in the Integrated Care Teams are being supported to access health care records of patients they are caring for.
- GP practices are starting to provide a COPD review service.
- The Mouthcare Matters programme is being delivered in care homes to assist improvements in the respiratory conditions of residents.
- The delivery of respiratory rescue packs within primary care is increasing.
- West Cheshire GP practices are being supported to access risk stratification tools to assist in the early identification of at risk patients, supporting reduced hospital admissions.
- Community- based falls awareness training will be delivered in quarter four 2018-19.
- A localised approach to deliver a Digital Minor Illness Referral Service (DMIRS) in General Practice to Community Pharmacy is being developed.

- A CWICP Integration Agreement is being developed with engagement from partners.
- A Digital Strategy is being developed. Work is ongoing to ensure effective and efficient use of existing buildings across the partnership.
- Development of an outcomes framework is progressing with 15 priority outcomes
- As part of Working Together Across Cheshire (a single management team and potential merger of the Cheshire CCGs) work is underway to agree what CCG activities would be best delivered by CWICP as part of population health management

Budget and Funding:

9. Transformation work is being support by a £600k Transformation Fund award from the Cheshire & Merseyside Health and Care Partnership (HCP). The Fund is monitored by the CWICP-PMO with support from West Cheshire CCG finance department, and governed by CWICP Delivery Group.

NEXT PHASE TRANSFORMATION PLAN

10. A Transformation Plan for CWICP is being developed. A wider stakeholder event took place on the 8th November 2018, from which the PMO will produce, a draft Transformation Plan for the CWICP Board in January 2019 for consideration. The PMO will also be working with the current workstreams to understand which workstream activities will be transitioned into the Transformation Plan.

11. The PMO is undertaking a review of the current transformation work by means of face-to-face review sessions and completion of personal questionnaires with core workstream members during November and December 2018. The review will also include collection of input from across the wider system. A Programme Review report will be presented at the CWICP Board in January 2019, to accompany the next phase Transformation Programme plan.

COMMUNICATION AND ENGAGEMENT

12. The overarching approach to the delivery of ICP-related communications and engagement activity is as follows:

    i. Set the vision of the ICP to priority internal and public audiences.
    ii. Engage and consult with key stakeholder groups.
    iii. Communicate progress of changes in advance and during implementation.

13. An ongoing challenge to the delivery of effective communications and engagement activity in the ICP remains the variation in awareness and understanding of the ICP, its vision and priorities amongst staff and other priority stakeholders. This continues to pose a risk to the reputation and success of the partnership.

14. To date, the cascade of information about the development of the ICP has been inconsistent across partners. Improvement in this regard will require the support of senior leaders, managers, spokespeople and communications and engagement teams across the partnership.

15. To effectively convey the vision to stakeholders, leadership around change management and key spokespeople from each partner organisation is required. Roles are to both champion the ICP and enable stakeholders to understand, support and contribute.

16. To support consistent communication and engagement across the partnership, the communications and engagement workstream has developed a "toolkit" of materials for use by senior leaders, managers, communications teams and key spokespeople within each partner organisation.

Compilation of ICP related Presentations

17. Recent public engagement activity to discuss the development of the CWICP has taken place at the Annual General Meetings (AGM) of both NHS Vale Royal CCG and NHS West Cheshire CCG, at the West Cheshire Patient Participation Group Chairs and Patient Support Group Forum, and with the Cheshire West Adult Social Care and Health Stakeholder Network. As part of these discussions people have been consulted on possible branding options for the CWICP in order to develop a clear identity that resonates with both the public and frontline staff.

18. To continue the discussion about the CWICP and the development of our 'Care Communities', we are planning a series of 'community conversations' with residents across Cheshire West using an 'Appreciative Inquiry' approach. It is anticipated that this work will begin in January 2019.

19. The communications and engagement strategy for the CWICP will need to be reviewed and refreshed in light of the outcomes of both the transformation event and the community conversations in order that the strategy fits with the developing Transformation Plan for 19/20.

TRANSFER OF INTERMEDIATE CARE AND THERAPY SERVICE

20. From 3rd December intermediate care and therapy services transferred to the CWICP. The services transferred focus on delivering priorities around community and primary care, supporting older people and improving the management of long-term conditions.

This includes:

- Inpatient and outpatient therapists
- Intermediate care units (ward 34), Poppy and Bluebell at Ellesmere Port Hospital
- Rapid response team
- Community therapies (cardiac rehabilitation, respiratory and stroke early supported discharge community nutrition and diabetes, community occupational therapy and physiotherapy paediatric therapy)
- Integrated discharge team
- Hospital at Home (from April 1st 2019)

21. This equates to 345wte staff and a budget of £12.3M. There is no change to staff employment but they will be functionally managed within CWICP.

22. The CWICP services will continue to work closely with divisions within the Countess, but with the added benefit of being able to work alongside community and GP colleagues to support more patients in the community.

23. As part of this transfer Alison Swanton (Head of Therapies) will be recognised as Associate Director of Service Delivery, Integrated Care. Alison has joined the ICP team as a senior manager alongside Ali Wheeler reporting to Alison Lee, Managing Director.

24. There is both nursing and therapy professional leadership within the transferring staff. Medical leadership will remain within the Urgent care division with the addition of a GP lead over the next few months. Executive level professional leadership remains unchanged.

25. Governance for services will be through existing Therapies and Intermediate care governance groups with dual reporting directly to Countess of Chester Board Sub Committees and the CWICP Delivery Group. There will be representation by either Managing Director / Associate Director or named deputies' representation within committees.

26. From January 2019 current HR data, performance metrics and financial position reported under Urgent Care will be separated to reflect the CWICP service delivery. The new agreed system metrics for the CWICP will then be incorporated into existing reports.

27. It is envisaged that corporate support to the CWICP services will largely remain unchanged.

28. A series of drop ins and walk-abouts have been arranged to discuss with staff what the transfer will mean for them and to also draw on practical examples of how the CWICP can take integration forward.

RECOMMENDATION

1. The Board is asked to note the progress on joining up care and the development of Cheshire West Integrated Care Partnership.

Alison Lee
Managing Director, Cheshire West Integrated Care Partnership
December 2018