Countess of Chester Hospital
NHS Foundation Trust

BOARD OF DIRECTORS AGENDA AND PAPERS

TUESDAY, 26th MARCH 2019

NHS
Countess of Chester Hospital
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS (PUBLIC)
TUESDAY, 26TH MARCH 2019 AT 1.15PM – 3.15PM
TRAINING ROOM 1

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 29th January 2019 and matters arising **(Attached)**	Chair

QUALITY & ASSURANCE

4.	To receive details of the Staff Survey 2018 Results (**Attached**)	Director of People and Organisational Development
5.	To review the Integrated Performance Report as at Month 11 to include: • Finance Report Month 11 **(Attached)**	Executive Team
6.	To receive and approve the Operational Plan 2019/20 and Budget Setting 2019/20 (**to follow**)	Chief Operating Officer / Chief Finance Officer
7.	To receive an update on Never Events and Serious Untoward Incidents **(Verbal)**	Director of Nursing and Quality
8.	To receive and approve the Board Assurance Framework as at Q3 **(Attached)**	Director of Nursing and Quality
9.	To receive an update on Freedom to Speak Up at the Trust **(Attached)**	Director of People and Organisational Development
10.	To receive an update on Kisiizi (**Attached**)	Chief Finance Officer

STRATEGIC DEVELOPMENT

11.	To receive details on the progress of the Integrated Care Partnership to include To receive the Integrated Care in West Cheshire Progress Report **(Attached)** To receive and approve the Cheshire West Integrated Care Partnership Integration Agreement **(Attached)**	ICP Managing Director
12.	To receive a CEO Update **(Verbal)**	Acting Chief Executive
13.	To receive an update on Governor Matters **(Verbal)**	Director of Corporate & Legal Services

FOR NOTING & RECEIPT

14.	To receive the Month 10 and Month 11 letter to NHS Improvement	Chief Finance Officer
15.	To receive the Equality and Diversity Annual Updates to include the Gender Pay Gap Report (Appendix 4)	Director of People and Organisational Development
16.	To receive the minutes of the Quality, Safety and Patient Experience Committee – January 2019	Director of Nursing & Quality
17.	To receive the minutes of the Audit Committee – 20th November 2018	Chief Finance Officer
18.	To receive the Corporate Infection Prevention and Control Assurance – Quarterly Report (retrospective report based upon November 2018 quarterly data update)	Acting Medical Director
19.	Date and Time of Next Meeting: **Board of Directors Meeting** **Tuesday, 21st May 2019 – time and venue to be confirmed**	

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BOARD OF DIRECTORS (PUBLIC)

MINUTES OF THE MEETING HELD ON TUESDAY, 29TH JANUARY 2019 AT 10.45AM – 12.45AM TRAINING ROOM 3&4

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

In attendance:

Mr A O'Connor, Director of Commercial Procurement Services
Mrs D Bryce – Lead for Governance Improvement (minute taker)

FORMAL BUSINESS

B1/19 **WELCOME AND APOLOGIES**

The Chair welcomed members and attendees to the Board meeting.

Apologies were received from Non-Executive Director, Mr Oliver.

B2/19 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

B3/19 **TO RECEIVE AND APPROVE THE BOARD OF DIRECTORS MINUTES OF MEETING HELD ON 18TH DECEMBER 2018 AND MATTERS ARISING**

The Board of Directors minutes of the meeting held on 18th December 2018 were received as a true and accurate record save for the following amendment: the Chief Operating Officer raised that the number of delayed transfers of care recorded on page four as 101 is incorrect and should read *over 30*.

MATTERS ARISING

There were no matters arising.

QUALITY & ASSURANCE

B4/19 **TO RECEIVE A PATIENT STORY**

The Director of Nursing and Quality shared *Joan's Story*, which is based on an actual complaint regarding a patient with complex health issues but is not the patient's real name. The lessons learned by the Trust include listening to families, recognising patients with cognitive impairment and the benefits of effective communication with patients to develop care plans with them. The Chair asked how the lessons learned are received and checked within the Trust. The Director of Nursing and Quality replied that spot checks and clinical rounds are in place monthly, along with a programme of audit. The Managing Director of the ICP raised the link with the patient story to the work started with care homes and suggested there were benefits to sharing the story more widely.

The Board received the patient story, noting the lessons learned, and agree to the patient story being shared out of hospital too by the Managing Director of the ICP.

B5/19 **TO REVIEW THE INTEGRATED PERFORMANCE REPORT AS AT MONTH 9 TO INCLUDE A FINANCIAL UPDATE**

In relation to the constitutional metrics, the Chief Operating Officer raised the following points from the performance report for month 9:

- A decline in A&E performance in December, along with surges in attendances;
- A decline in the 18 week position due to an increase in demand within the first half of the year;
- Achievement of the cancer targets at the end of November and the continuing work underway to prioritise suspected cancer diagnosis; and
- That diagnostic waits remain a challenge and there is a focus on the cancer pathway achievement.

The Director of Nursing and Quality raised the following points from the safety metrics:

- That falls are being monitored very closely, with a focus on areas causing harm;
- The *C'Difficile* infection control position is close to the year-end target of 23 and continues to be scrutinised closely;
- The Director of Nursing and Quality and the Acting Medical Director met with NHS Improvement last week and are about to start an infection prevention improvement programme; and
- An action plan is in place within the Urgent Care Division following the seven mixed-sex accommodation breaches within Cardiology, with Executive oversight.

The Acting Medical Director emphasised the challenge of the acuity of patients currently in the system and stated that a review of all ward patients was taking place the following day to ensure clinical standards are in place. Non-Executive Director, Ms Fallon, asked if there was a trajectory to reach the A&E performance target, recognising that it is winter. The Acting Medical Director responded that there were structural targets around the bed base required and also internal cultural targets with regards to the Emergency Department being ready to hand over patients within 90 minutes; and that this is an area of focus within quarter four of this year and quarter one of 2019/20.

The Acting Chief Executive outlined that the standard is challenging and will be achieved when transformation has taken place across West Cheshire to provide an alternative to the A&E front door.

Non-Executive Director, Mr Higgins, asked if there were particular reasons behind the learning from deaths with regard to the increasing HSMR trend. The Acting Medical Director responded that there were no themes except that acuity is at the highest it has been. The Acting Chief Executive highlighted the potential for better data capture of patient acuity and the potential for some 'unexpected' deaths to be 'expected' deaths with better data capture.

In a response to a question from Non-Executive Director, Mrs Hannah, regarding the detail of how Sepsis reporting can be improved, the Acting Medical Director raised that sepsis screening is an area of current focus in relation to empowering staff to undertake screening, record and do interventions. The Director of Nursing and Quality highlighted the dedicated Sepsis quality improvement programme of work in place.

The Director of People and Organisational Development raised the following points from the *kind* and *effective* metrics:

- Eight of the people related metrics have improved;
- The updated Flu vaccination figure is now at nearly 82% achievement, which is above expectations;
- Staff sickness is higher than expected, although an improvement compared to last year; and
- The variable pay projection is still in a positive position.

FINANCE REPORT FOR MONTH 9 (DECEMBER 2018) AND QUARTER 3

The Director of Finance gave an overview of the Trust's financial position to the end of December 2018 and raised the following points:

- The financial forecast for the year remains at a £12.7m deficit, with the full year forecast previously changing from a £4.3m deficit, to a £12.7m deficit at September (Month 06);
- That the block contract with West Cheshire Clinical Commissioning Group (CCG) is over performing by £385,000, excluding any Therapy changes, although the CCG has recently agreed a payment of £242,000 to the Trust, in relation to the Joint Savings Plan for 2018/19 (which includes a number of planned activity changes);
- The Trust borrowed £1.6m as an Interim Revenue Loan from Department of Health;
- Welsh delayed transfers of care are 23% up, on the corresponding period last year (previously 26% at Month 08), and the Trust continues to have discussions with Wales on the position;
- The Trust has no capital funding available other than what it can borrow for "urgent and necessary" requirements, and there is a governance risk as the Trust has had to start to procure without receiving formal NHS Improvement approval;
- The Director of Finance will present to the Board in March the financial architecture for 2019/20; and
- The need for the Trust to endeavour to stay within the £12.7 deficit forecast for 2018/19.

Non-Executive Director, Mr Higgins, raised that financial projections appear to be on a straight line basis and asked what the risk factor is with this given that the Trust is under winter pressures in quarter 4. The Director of Finance responded that the projection includes the previous year's position and elective activity reduces in winter, but there is a risk that whilst the hospital is busy this could impact on finances, although the additional £242,000 from the CCG may not yet be reflected within the position reported.

In response to a query from the Chair as to whether cost reduction strategy items indicated as 'red' have been included and will be delivered, the Director of Finance informed that these items have not been counted or included.

There was a discussion regarding the progress with obtaining Welsh funding, prompted by Non-Executive Director, Mr Higgins, and the Director of Finance highlighted the recent Executive to Executive contract meeting with Wales, the financial deficits recently reported within the Welsh healthcare system, and the need to get services to work together better. The Acting Chief Executive raised that clarity has been sought from Wales regarding maternity services, a return to previous activity numbers in maternity is not expected and that clarity is being pursued on Welsh elective

activity numbers via the contract meeting.

The Board accepted and received the December, month 9, Performance Report and the Finance Report at Month 9/Quarter 3.

B6/19 **TO RECEIVE DETAILS OF THE NATIONAL PROCUREMENT MODERNISATION**

The Director of Finance referred to the report provided which sets out the changes planned from 1st April 2019, raising that tariff is being top sliced nationally from next year to effectively fund Supply Chain Ltd. Hence, the Trust needs to consider changing its purchasing to reflect the national drive, which will result in some operational changes. The Director of Commercial Procurement Services informed the Board that the new financial model has been considered, along with the impact to the current just-in-time system for goods. A fuller Board report is awaited in March 2019, regarding the potential savings to the Trust.

The Director of Finance also drew the Board's attention to work across Cheshire & Merseyside to bring procurement closer together, and the awaited recommendations from a Deloitte's review.

The Chair raised the previous back-office collaborative work relating to procurement, and asked if these savings proposed will be from the collaborative work. The Director of Finance responded that due to a timing issue that the local collaborative work had not managed to reconfigure procurement services. The Managing Director of the Integrated Care Partnership (ICP) raised the unknowns regarding goods flows with Brexit, and why this had not been mentioned in the report as a significant risk. The Director of Commercial Procurement Services confirmed that this had been kept separate as Brexit is effectively an ongoing large piece of work in liaison with the Department of Health, to review the supplier base.

The Board noted the paper on future national procurement including the future operating model, emergent new funding model, risks/benefits and next steps.

B7/19 **TO RECEIVE AN UPDATE ON NEVER EVENTS AND SERIOUS UNTOWARD INCIDENTS**

The Director of Nursing & Quality reported no never events, since last reporting to the Board and described the high level detail of three Level 2 serious untoward incidents within the Trust which are currently under investigation.

The Board received the verbal update on never events and the detail of the serious untoward incidents under investigation.

B8/19 **TO RECEIVE DETAILS OF THE EU EXIT OPERATIONAL READINESS**

The three key pieces of EU exit readiness work in place were outlined by the Chief Operating Officer

as workforce, medicines management and procurement. The national message regarding medicines management is not to stockpile any drugs and the Chief Pharmacist is leading on this. Procurement is reviewing supply chains and business continuity plans are being checked in relation to preparedness for the three key pieces of work.

Non-Executive Director, Mrs Hopwood, stated that if EU reciprocal arrangements are not in place on 1st April 2019 then her understanding is that Governments will need to make re-charge arrangements for healthcare provision and asked for assurance of processes in place within the Emergency Department to capture the relevant information. The Chief Operating Officer responded that an overseas visitor process is currently in place and it will be expanded, if required. The Director of Finance raised that the Trust can identify overseas visitors but that the eligibility criteria may be different. Non-Executive Director, Mrs Hopwood, asked for this question to be raised within the system again to provide more assurance to the Board. The Chief Operating Officer agreed to share a briefing with the Board.

The Board received the verbal update on EU exit operational readiness and it was agreed that the Chief Operating Officer would share a briefing to provide assurance on processes if EU reciprocal arrangements are not in place on 1st April 2019.

STRATEGIC DEVELOPMENT

B9/19 **TO RECEIVE DETAILS ON THE PROGRESS OF THE INTEGRATED CARE PARTNERSHIP**

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

- There is a focus on GP leadership at care community level;
- Good progress is being made in agreeing delegation from Clinical Commissioning Groups;
- Local Authority engagement is good;
- An integration agreement is under development for the partnership;
- A transformation plan is under development and there is an understanding that transformation funding will be received for each place from the Health and Care Partnership; and
- Pieces of work are underway with partners including:- public health information and understanding care community needs; understanding what people want through work commissioned with the voluntary sector; and a diagnostic review of our current community services.

In response to a question from Non-Executive Director, Ms Fallon, regarding the appetite from other organisations to input resource into the ICP, the Managing Director of the ICP confirmed that the local authority has input resource and that the Countess of Chester has transferred services in. Non-Executive Director, Mrs Hannah, raised that system leaders should have clear proposals on transfers into, and alignment with, the ICP next month and the aim is one budget and one set of management arrangements. The Acting Chief Executive stated that the Countess has transferred therapy services

into the ICP and we need to give confidence that the ICP will improve the offer to patients. The Chair emphasised that reporting and accountability through a single team is key within the ICP.

The Board received the verbal Integrated Care Partnership Update.

B10/19 **TO RECEIVE A CEO UPDATE**

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

- The report from the unannounced CQC inspection and three day CQC Well Led inspection in December has not yet been received, but is due soon;
- The Trust have commissioned their own review of governance which is looking at systems and processes and how to mitigate risks from Divisions to Board;
- A new clinical services strategy is due to be delivered and speciality engagement meetings are currently underway with a cross-Trust workshop planned in March and final recommendations scheduled to come back to the Board;
- Further clarification is awaited of the Health Care Partnership structural arrangements;
- There was discussion at the CEO Providers Forum of working in *place* and the overlap in some programmes of work; and
- The NHS Long Term Plan has recently been published which takes a population health care view, with a focus on transfers of care, modernising outpatient services, addressing health inequalities and providers returning to financial balance by 2023.

Non-Executive Director, Mrs Hannah, commented that it would be useful for the Board to take time out to consider the national strategy and the Health Care Partnership in relation to the emerging ICP and clinical strategy.

The Acting Medical Director reflected on the hidden demand not currently captured in the system such as email and telephone advice. The Acting Chief Executive informed that this advice can often avoid a patient attendance or admission and the Trust could consider making the offer on this more responsive as part of its strategy.

The Chair gave recognition to the important messages within the NHS long term plan, in particular the workforce challenge and the need to take time to address this with place-based workforce planning.

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

B11/19 **TO RECEIVE AN UPDATE ON GOVERNOR MATTERS**

The Director of Corporate & Legal Services informed the Board that the Trust continues to engage and work closely with its Governors. Meetings were held last week with individual Governors to discuss the Governor role and responsibilities. In addition, the Governor's Quality Forum was held on 25th January 2019, with a presentation on operational matters, and feedback from this is being considered.

The Board received the verbal update on Governor matters.

FOR NOTING & RECEIPT

B12/19 **TO RECEIVE THE MONTH 8 AND MONTH 9 LETTERS TO NHS IMPROVEMENT**

The Board received and noted the month 8 and month 9 letters to NHS Improvement.

B13/19 **TO RECEIVE THE MINUTES OF THE QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE**

The Board received and noted the minutes of the Quality, Safety and Patient Experience Committee – November 2018 and December 2018

B14/19 **TO RECEIVE THE MINUTES OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE**

The Board received and noted the minutes of the People and Organisational Development Committee – 27th November 2018.

B13/19 **OTHER BUSINESS RAISED**

The Board were informed by Non-Executive Director, Mrs Hopwood, the Chair of the Audit Committee, that the Audit Committee recently undertook an annual review of effectiveness and wish to establish more formal reporting of committees into the Audit Committee, which she has fed back to the external reviewer.

B14/19 **DATE AND TIME OF NEXT BOARD OF DIRECTORS MEETING**

Tuesday 26th March 2019 – time and venue to be confirmed

Subject	A review of the findings, themes & recommendations from the NHS Staff Survey 2018
Date of Meeting	26th March 2019
Author(s)	Dee Appleton-Cairns, Deputy Director of People & Organisational Development Sophie Hunter, Equality & Diversity Manager
Annual Plan Objective No.	
Summary	This report provides a review of the results of the NHS Staff Survey undertaken in 2018, following the results being released on 26th February 2018. The survey focuses on a reduced number of summary indicators and the results have been presented across 10 key themes. Recommendations and actions have been identified as a result of what our staff have told us through the survey and the progress against these will be overseen by People & Organisational Development Committee
Recommendation(s)	**The Board is asked to:** • Receive and note the content of the report; • Approve the recommendations & associated actions as identified from the Survey. • Approve that People & Organisational Development Committee monitor progress against the action plan as a standing item. • Receive a progress report in advance of the 2019 Survey at a future Board meeting, which is anticipated to be September 2019.
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. Executive Summary

The purpose of this report is to present to the Board of Directors the Trust's summary results from the 2018 National NHS Staff Survey, as detailed in Appendix A, the benchmark report and Appendix B, the directorate report.

The report provides an update on the actions undertaken as a result of what our staff told us in 2017, details the responses compared to the Acute Sector average against the 10 key themes, provides a comparison of the bottom ranking scores year-on-year and analyses the aspect of whether our staff members recommend the organisation as a place of work or received treatment. In addition, we review the overall staff engagement score, the top and bottom ranking scores and as a result of what our staff members are telling us, the proposed recommendations and actions to support their feedback.

We would like to thank all those staff members who received the survey for their feedback about how it feels to work at the Trust and the care we provide to our patients.

2. Background

NHS England released the results of the 2018 NHS Staff Survey on Tuesday 26th February 2019. The feedback in the annual survey suggests that nationally, the NHS is still struggling to provide care against increasing demand, but staff are reporting improvements.

Over 497,000 NHS staff took part in the survey with a response rate of 45.7 per cent and just under 10,000 more people shared their views compared to the 2017 survey.

The main change in the format of this year's survey is a reduced number of summary indicators and instead the questions have been presented in the form of ten main themes:

- equality, diversity & inclusion
- health and wellbeing
- immediate managers (which includes providing support and feedback)
- morale (a new area for 2018)
- quality of appraisals
- quality of care
- safe environment - bullying and harassment
- safe environment - violence
- safety culture
- staff engagement.

3. The Trust's position

The survey ran between October 2018 and December 2018 and unlike in previous years, the Trust surveyed a sample of all substantive staff in post as at 1st September 2018. This was a random sample of 1250 employees, 448 of which responded which is a response rate of 36%. Unfortunately, this response rate is lower than the average response rate for Acute Trusts (44%) which is our benchmarking group. In addition, the decision was made to survey a sample of staff due to the feedback that we were receiving from members of staff around the volume of surveys our staff were being asked to complete. The survey was completed in a paper format and our

survey provider was Quality Health, who selected the sample of staff to be contacted. The survey has then been collated and presented by the Survey Coordination Centre.

This report presents the Trust's results in relation to the concepts of questions, themes & recommendations based on the results for the 2018 National Staff Survey. This is a change to the way in which previous surveys were presented as 'Key Findings' are no longer used as a measurement and they have been replaced by the concept of questions and 'themes' in 2018. For the purposes of making relevant comparisons, scores are added for 2017, though these are referred to as question numbers. This provides an indication of how well the organisation is performing over time and within its benchmarking group.

4. Recommendations

The Board of Directors are asked to receive and note the findings and outcomes of the 2018 National Staff Survey results and the supporting recommendations and action plan.

It is recommended that the Board approves the recommendations that have been identified from the survey and that the actions identified are monitored by the People & Organisational Development Committee, which will review progress as a standing item. A progress report will be provided to a future Board meeting in preparation for the 2019 Survey, which is anticipated to be undertaken in September 2019.

Prepared by:
Dee Appleton-Cairns, Deputy Director of People & Organisational Development
Sophie Hunter, Equality& Diversity Manager
March 2019

Appendix A: Countess of Chester Hospital NHS Foundation Trust - Benchmark Report
Appendix B: Countess of Chester Hospital NHS Foundation Trust – Directorate Report

Section One - What is the NHS Staff Survey?

The NHS Staff Survey is the largest workforce survey in the world and has been conducted every year since 2003. It asks NHS staff in England about their experiences of working for the NHS.

The survey provides essential information to national regulators, stakeholders and employers about the staff experience across the NHS in England.

This report presents the Trust's results for the 2018 National Staff Survey in the form of themes and question scores (Key Findings are no longer used as a measurement and have been replaced by themes in 2018).

A sample of 1250 members of staff (excluding bank & agency workers) were asked to complete the survey. The response ratios were unaffected by this approach as the % return rate was also similar to previous years where a full survey was undertaken. A 36% response rate was received which to 448 members of staff from across the Trust completing the survey. This is compared against a benchmarking sector group of Acute Trusts, which had 89 organisations to benchmark against with a response rate of 44% and 232,401staff surveyed. This level of response is disappointing but is reflective of a recent downward trend and needs to be considered against the future management of the survey i.e. online / paper and full or sample surveys.

Section Two – What have we done as a result of the feedback from the 2017 NHS Staff Survey?

Throughout 2017, a number of initiatives were undertaken to improve the working lives of staff at Countess.

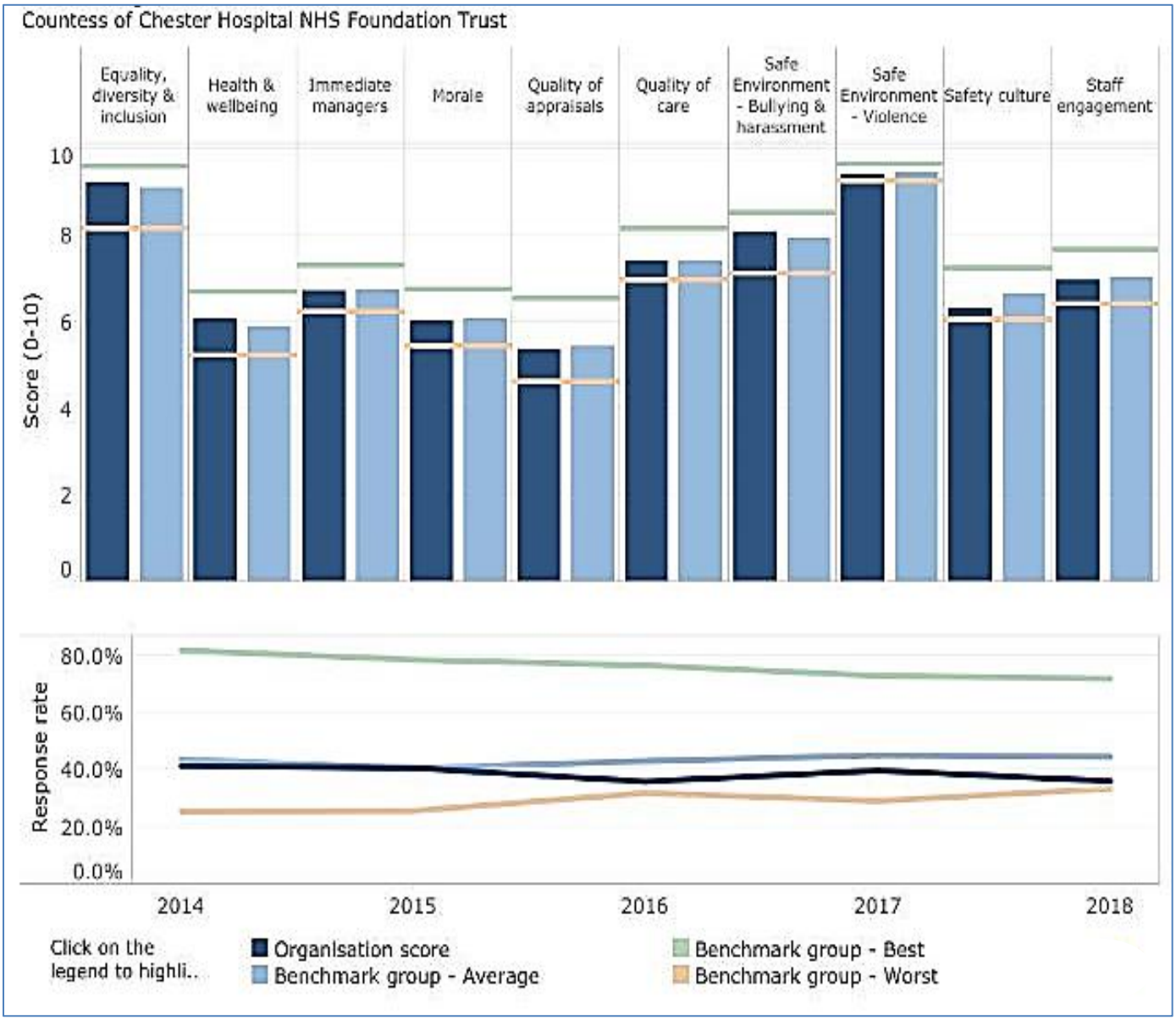
These initiatives included the following:

- Revised and improved the reporting arrangements related to incidents of violence against our staff, with changes made to Datix report to encourage reporting.
- Regular reporting on violent incidents to the Safeguarding Strategy Board.
- Oversight of violent incidents to the Occupational Health & Wellbeing Team.
- Investing more time in security services.
- Introduced quick fix funding with the support of charitable funds were used to improve working environments as a direct result of feedback from the survey. Examples of investments made include
    - Refurbishment of a staff room inside Women's and Children department
    - Equipment to support other areas across the Trust.
- High Performance Workshops for Managers encouraged open dialogue with staff on supporting them in their roles, supporting team members, describing the Trust behavioural standards and providing guidance around any potential performance issues.
- Investment in Health and Wellbeing days and supporting initiatives.

Section Three – How have we performed against the 10 key themes?

The main change in the format of this year's survey is a reduced number of summary indicators and instead the questions have been presented in the form of ten main themes:

- equality, diversity & inclusion
- health and wellbeing
- immediate managers (which includes providing support and feedback)
- morale (a new area for 2018)
- quality of appraisals
- quality of care
- safe environment - bullying and harassment
- safe environment - violence
- safety culture
- And staff engagement.



The Trust performed better than the Acute Average in 3 indicators as follows (all scores are marked out of 10):

Higher than the Acute Average in 3 indicators

- Equality Diversity & Inclusion - 9.2 v 9.1
- Health & Wellbeing – 6.1 v 5.9
- Safe Environment Bullying & Harassment 8.1 v 7.9

Equal to the Acute Average in 3 indicators

- Immediate managers – 6.7
- Quality of care – 7.4
- Safe environment violence – 9.4

Lower than the Acute Average in 3 indicators

- Morale – 6.0 v 6.1
- Quality of appraisals – 5.3 v 5.4
- Safety Culture – 6.3 v 6.6
- Staff engagement – 6.9 v 7.0.

The key domain showing a lower than Acute Average score which, whilst not statistically significant, shows the largest gap is: Safety culture – 6.3 v 6.6.

The 10 key themes are shown in detail within page 7 of the Benchmark Report (Appendix A) and the questions which make up the Safety Culture theme are found on pages 34 and 35 of Appendix A.

Section Four – A Comparison of the bottom Ranking Scores in 2017 & 2018

The bottom 2017 scores were compared to 2018 scores to assess areas of improvement or continued concern.

Analysing the 2017 scores, the Trust had made significant improvements in areas of near misses, where an increase can be seen in staff confidence that staff would be treated fairly in the instance of an error or near miss and that action would be reported and feedback would be given. However, though there was a % rise in staff confidence in this area, the trust is still significantly below its comparators. There is a perception that feedback would not be given on action taken when a near miss is reported. In addition, staff members being encouraged to report near misses fell by 1%.

The Trust maintained its positive 73% score of staff who had received training and development over the last 12 months, which is 3% above the comparator. The Trust also improved significantly regarding staff who had experienced violence from patients / service users, their relatives or other members of the public. This figure fell from 20% to 16% in 2018, which is a clear reflection of the work undertaken in this area.

There was some decline regarding the collection of feedback related to patients:

- The percentage of staff who claim feedback is not collected from patients within their department rose from 16% to 18%.

- The percentage of staff who claimed that they were not updated on patient feedback rose from 26% in 2017 to 27% in 2018.

Section Five - Staff recommending the organisation as a place to work or receive treatment are both above average.

It is encouraging to report that there were improvements around staff recommending the organisation as a place to work or receive treatment and respondents who stated that care of patients was a top priority for the organisation also rose from 70% to 74% in 2018. These are key barometers and we are encouraged to see improvements in these areas.

- The positive score of staff recommending the organisation as a place to work rose in 2018 by 2% from 61% in 2017 to 63% in 2018
- The positive score from recommending the trust as a place to receive treatment rose by 3% from 71% to 74% in 2018.
- Respondents who stated that care of patients was a top priority for the organisation rose from 70% in 2017 to 74% in 2018
- Respondents who thought that the organisation acts on concerns raised by patients rose from 67% to 68%.

Section Six - Significant Changes for 2018

Four questions in the survey showed significant improvement from the 2017 survey:

- Percentage of staff who have experienced physical violence that go on to report it, increased from 65% to 78% against a comparator of 65%.
- Staff satisfaction with pay, this increased from 28% to 33% against a comparator of 34%.
- Staff looking forward to going to work, this increased from 55% to 60% against a comparator of 58%.
- Staff experiencing physical violence from managers. This decreased from 1% to 0% against a comparator of 1%.

One question shows decline:

- Staff knowing how to report unsafe clinical practice. This decreased from 97% to 94% against a comparator of 94% and links with the feedback in other elements of the survey regarding the Safety Culture

Section Seven – How did we do in Staff Engagement in 2018?

The overall 2018 staff engagement score for the Trust is 6.93 (out of 10), showing a small increase since 2017, which is equal to the Acute Average score.

Overall Staff Engagement is measured as an average across three themes. Staff Engagement scores fall between 0 and 10, where the higher the score, the more engaged the staff.

The score is composed of 3 areas, Advocacy (Staff recommendation of the trust as a place to work or receive treatment), Motivation (Staff motivation at work), and Involvement (Staff ability to contribute towards improvement at work).

- Advocacy rose from 6.75 in 2017 to 6.95 in 2018 against a sector score of 6.80.
- Motivation score increased from 7.16 in 2017 to 7.26 in 2018 against a sector score of 7.26, bringing the trust into alignment with the sector.
- Involvement decreased from 6.70 in 2017 to 6.59 in 2018 against a sector score of 6.73.

In summary, the theme of 'Involvement' is lower than the sector score, 'Motivation' is equal to the sector score and 'Advocacy' is higher.

Section Eight – What are our Top Five and Bottom Five Ranking Scores in 2018?

Top Five Ranking Scores in 2018

1	12b	Experienced physical violence at work from managers in the last 12 months.	0%
2	12c	Experienced physical violence at work from other colleagues in the last 12 months.	2%
3	15a	Experienced discrimination at work from patients / service users, their relatives or other members of the public in the last 12 months.	4%
4	16c	The last time you saw an error, near miss or incident that could have hurt staff or patients / service users, did you or a colleague report it?	96%
5	18a	If you were concerned about unsafe clinical practice, would you know how to report it?	94%

Of the 5 top scores for 2018, physical violence at work from managers fell from 1% to 0%; violence from colleagues was lower at 2% having been 3% in 2017, with 2% being the average sector score.

Discrimination fell 1% from 2017 and stands at 2% lower than the average sector score of 6%.

The reporting of near misses was showed at improvement at 96%, compared with a sector average of 95%, which was an area among the bottom scores in 2017 indicating that work in this area has been successful.

Despite its decrease from 97% to 94%, staff knowing how to report unsafe practice was in alignment to the sector average but still remains a key area of work.

Bottom Five Ranking Scores in 2018

1	11g	Have you put yourself under pressure to come to work?	95%
2	4g	There are enough staff at this organisation for me to do my job properly.	25%
3	9d	Senior managers act on staff feedback.	27%
4	9c	Senior managers here try to involve staff in important decisions.	31%
5	5g	[How satisfied are you with] My level of pay.	33%

Of the bottom five scores for 2018, 95% of staff had put themselves under pressure to attend work compared to a 92% comparator and this illustrates a rise of 2% since 2017. This is disappointing and will need to be a key question asked within engagement events with our staff. However, it is worth noting however, that the number of staff who felt under pressure from their manager to attend fell from 28% to 25%.

Staff believing that the organisation was appropriately staffed decreased by 3% to 25%, against a sector score of 29% believing that their organisation has enough staff.

Staff viewing that senior manager's act on staff feedback fell from 29% to 27% against a sector score of 30%, and only 31% of staff felt that senior managers involved staff in important decisions against a sector average of 32%. However, this is an area where the score has marginally increased from 30% in the previous year.

The level of pay featured with 33% of staff being satisfied with their level of pay compared to a sector average of 34%. However, this saw a noticeable rise from 28% in 2017 despite still being in the 2018 bottom five ranking.

Section Nine – Conclusions on what our staff are telling us

The results of the 2018 NHS Staff Survey show that our staff are telling us that the Trust is struggling to provide the level of care they and we aspire to against the increasing levels of demand and activity, which is comparable with the national results. However, it is pleasing to note that some of the actions identified in the results of the 2017 survey, particularly in relation to the reporting in the numbers of staff experiencing violence and knowing how to report it, has improved due to the increased focus around this key concern.

In addition, the option to undertake a random sample instead of a full survey had little or no statistical effect on the outcomes in 2018. We are currently in the process of asking staff, via Survey Monkey, if this is the preferred option for the future and we are also asking them if the preferred method of survey completion would be electronic, paper, or a mix of both. Early feedback has indicated that electronic surveys would be more environmentally sound, save in distribution time and enable people whose first language is not English to complete the survey quicker and easier using the translation tools.

Looking ahead, we have to do more on the focus on our Safety Culture, particularly the reporting of near misses, staff engagement, the pressure colleagues put themselves under to attend work, the quality of our appraisals, the communication and involvement of colleagues across the Trust regarding decisions that affect their work and to continue to create an environment free from discrimination and bullying and harassment.

These key actions have been reflected in both the recommended set of actions identified by the Survey Coordination Centre and in our own Trust Action Plan, which will be further enhanced over time. The People & Organisational Development will monitor and oversee the actions identified within the recommendations, with this being a standing agenda item at future meetings. It is also recommended that a progress report will be presented to the Board later in the year, in preparation for the issuing of the 2019 Staff Survey, which is anticipated in October 2019.

Section Ten – Recommendations & Supporting Action Plan from what our staff are telling us

The format of this year's survey included an analysis not previously supplied which included an extensive list of recommendations as determined by the Survey Coordination Centre, compiled from our findings. From the main areas for improvement at Countess, the following were compiled from the survey as the most relevant and were recommended to the Trust as a start point for their local action plan. Therefore, the Action Plan has now been split by the 10 key domains into Divisional plans and staff groupings to better understand the impact of the scores by area (Appendix B).

Staff Engagement	Identify a number of key improvements that your organisation has achieved in the last year, and where staff have made a significant contribution. Ensure that this message is communicated through all possible channels and in review meetings with individual staff
Equality and Diversity	Ensure that the pathways to jobs with greater responsibility are clear to all staff and that the training and support mechanisms to support job and personal development are signposted plainly to all staff.
Health and Wellbeing	Prioritise the issue of stress at work and analyse ways in which your organisation can meet legitimate problems. Consider organising opportunities for Mental Health First Aid Training for staff.
Immediate Managers	Investigate why some staff do not feel their managers ask their opinion before making decisions which affect their work.
Morale	Investigate why some staff do not feel they are involved in making decisions which affect their work. Understand the reasons staff think about leaving the organisation
Safety Culture	Ensure that the organisation's policies on handling errors, near misses and incidents are transparent and effectively communicated to all staff. Ensure that staff are aware of the organisation's policy and process for raising concerns about unsafe. Ensure staff are given feedback in response to errors and near misses. Urgently investigate why this is not happening.

Senior Managers	Where appropriate, ensure that senior managers involve staff in important decision making processes. Ensure that staff are aware that the organisation seeks feedback from staff on a regular and ongoing basis; and that action is taken as a result of this.

	What	Actions in 2019	Leads	Timescales
Staff Engagement	Identify a number of key improvements that your organisation has achieved in the last year, and where staff have made a significant contribution. Ensure that this message is communicated through all possible channels and in review meetings with individual staff	• Communication plan & blog • We recognise the success of the 'quick fix' initiatives which were positively received. However, we also recognise that not all areas submitted proposals, so we will be exploring the extension of this for another year with the essential support of the fundraising team. • We will continue to communicate this via the screen savers and in the Weekly Round Up.	Communication Team Fundraising Team Leader	w/c 18.03.19
Equality and Diversity	Ensure that the pathways to jobs with greater responsibility are clear to all staff and that the training and support mechanisms to support job and personal development are signposted plainly to all staff.	The promotion of bespoke leadership courses generated by NHS Leadership Academy in particular engagement with groups : • Barometer groups • Workforce Race Equality Standard (WRES) and Gender Pay Gap action plans, and will feature in the upcoming WDES plan. • In addition, leadership training opportunities will be cascaded to staff in all our Equality Groups - Disability, LGBT+, and Faith and Culture. • There is also ongoing continuing work undertaken by the Vocational Learning Team to promote NHS careers to local schools and hard to reach groups within the local community.	Equality and Diversity Manager and Vocational Learning team	**Barometer Groups** 28th March 2019 3rd May 2019 12th July 2019 27th September 2019 1st November 2019 **Engagement sessions** 23rd May 2019 27th June 2019 25th July 2019

				26th September 2019 28th October 2019 28th November 2019
Health and Wellbeing	Prioritise the issue of stress at work and analyse ways in which the Trust can meet legitimate problems. Opportunities for Mental Health First Aid Training for staff.	• The Health and Wellbeing Days of 2018 were very successful and there are plans to continue them in 2019. • We will also be scoping manager's views to determine if they feel that a scaled down version of First Aid Mental Health Training is something that would be beneficial to them.	Occupational Health & Wellbeing	To link with the diagnostic being undertaken with the NHS Workforce Health & Wellbeing Framework
Immediate Managers	Investigate why some staff do not feel their managers ask their opinion before making decisions which affect their work. There is also a seat for a staff member who is able to represent staff that have chosen not to be in a union.	Publicise the ways in which staff can alert Senior Managers to their concerns: • We urge staff to raise specific examples through their Line Managers. • We also have a Freedom to Speak Up Guardian and an Equality Manager to raise issue with. • The Trust has a partnership forum that recognises over 12 unions, we urge staff to talk to their union reps and will be doing wider communication alongside staff side colleagues. • We would welcome applications for the Staff Representative role. This role gives a voice to	Comms Team Staff Partnership Forum Equality Manager Freedom to Speak Up Guardian	**Barometer Groups** 28th March 2019 3rd May 2019 12th July 2019 27th September 2019 1st November 2019 Equality Groups

		non-unionised staff. Staff Concerns to be reported back to the People & OD Committee, and included as a standing item on the agenda. • The continuation of the Trust's Barometer Groups, promotion of feedback, staff equality focus groups (Disability, LGBT, BME) will assist in capturing staff concerns and the groups will be made aware that themes will be fed back to People and OD and Board as appropriate.		**Disability Group** 24th April 2019 24th July 2019 16th October 2019 **LGBT Group** 19th June 2019 10th September 2019 16th December 2019 **Faith and Culture Group** 10th May 2019 9th August 2019 8th November 2019 **Equality Diversity and Human Rights Steering Group** 21st June 2019 18th September

				2019 11th December 2019
Morale	Investigate why some staff do not feel they are involved in making decisions which affect their work. Understand the reasons staff think about leaving the organisation	• To look at the reasons why staff are leaving, a new robust exit interview structure is currently being developed. • The organisation will also launch an 'itchy feet' initiative with the Communication Team, to be included in the Weekly Round Up, to encourage staff to tell us the reasons they are thinking of leaving.	Equality and Diversity Manager Comms Team	**To go through Staff Partnership** Dates TBC
Safety Culture	Ensure that the organisation's policies on handling errors, near misses and incidents are transparent and effectively communicated to all staff. Ensure staff are aware of the organisation's policy and processes for raising concerns about incidents and unsafe practices. Ensure staff are given feedback in response to errors and near misses. Urgently investigate why this is not happening.	• We encourage staff to report risks, concerns, safety and instances of violence in accordance with the structure outlined in policies, • The Chief Executive will lead this workstream and ensure supporting actions are delivered. • Link with the Quality Newsletter for wider action and communication to the Trust. • We will explore feedback mechanisms and methods for improving how feedback and changes can be addressed and communicated, which may include linking in with the FTSU	Chief Executive Freedom to Speak Up Guardian Risk Team	**Start date immediate** **FTSU Guardian start date May 2019**

		Guardian.		
Senior Managers	Where appropriate, ensure that senior managers involve staff in important decision making processes. Ensure that staff are aware that the organisation seeks feedback from staff on a regular and ongoing basis; and that action is taken as a result of this.	• The continuation of the successful 'What's Brewing' is to continue throughout 2019. • Blog from Director of People & OD to launch staff survey results and findings. • Screensavers to be issued at key times throughout the year, with first set issued w/c 18/03/19 with a focus on you said, we have done and communicating what has changed as a result of the feedback. • Leadership Summit May 2019 – key focus on actions for all leaders coming out of the survey with interactive session on the results and supporting actions. • Request for actions by staff group / directorate to be collated by the People & OD team for monitoring by People & OD Committee. • Executive leads in place for key staff groups (Medical and Dental and Nursing and Midwifery) with actions plans to be provided. Executive leads to focus on key themes with quality improvement methodology supporting actions being delivered. • The Quality of Appraisals will also be reviewed, in line with the development of an e-PDR tool and the Appraisal Recovery Plan which is currently being developemed. Assurance on the quality of appraisals within Medical and Dental is	Executive Leads Comms Team Equality Manager	**Leadership Summit** May 2019 **Screensavers** w/c 18/03/19 **POD Dates** April / May 2019 onwards

		currently being collated and will be presented to a future POD meeting.		

Appendix A

NHS_staff_survey_2018_RJR_full.pdf

Appendix B

NHS_staff_survey_2018_RJR_directorate

COUNTESS OF CHESTER

PERFORMANCE REPORT, FEBRUARY 2019

Safe

Indicator	Target	Act.	Alert
All Falls Rate	7	5.24	○
Falls with Harm Rate	0.3	0.26	○
Never Events	0	0	○
Safety Thermometer – Free of new harms %	95	95.4%	○
Q3 Sepsis screening % (Inpatients)	90	69%	○
Q3 Sepsis treatment % (Inpatients)	90	62%	○
Q3 Sepsis screening % (ED)	90	80%	○
Q3 Sepsis treatment % (ED)	90	76%	○
Infection Control: C Difficile	20 YTD	28	○
Infection Control: MRSA	0	0	○
Nurse Staffing	95%	98%	○

Kind

Indicator	Target	Act.	Alert
Friends and Family: A&E	80	80.3%	○
Friends and Family: Inpatient Wards	90	91.8%	○
Friends and Family: Maternity Services	90	100%	○
Open Complaints	40	35	○
Open Complaints > 40 days response time	5	2	○
Open PHSO Complaints	5	3	○
MSA Breaches	0	7	○
Sickness Absence %	3.65	4.36	○
Mandatory Training %	95	93.8	○
Annual Appraisal %	95	85.2	○
Staff Turnover %	10	9.79	○

Effective

Indicator	Target	Act.	Alert
*** ED 4 Hour Wait %**	95	81.1%	○
*** 18 Week RTT %**	92	83.5%	○
*** 6 week Diagnostic Wait %**	99	96.6%	○
*** Cancer Treatment 62 Day %**	85	83.3%	○
Bed Occupancy %	85	95.9%	○
I&E Variance (including PSF)	Plan	£8,370k OVERSPEND	○
Forecast Position/ Run Rate	Plan	+£11m	○
CRS In Year	Plan	-£1,559k	○
Contract Income	Plan	-£1,514k	○
Variable Pay	Less YOY	+£83K	○
Total agency spend £m	£4.8 EOY	£3.98m YTD	○
Total agency shifts over cap rate	Less YOY	-264	○

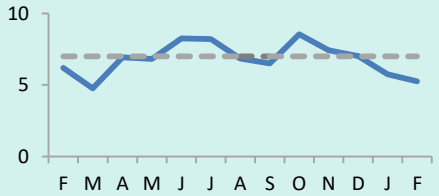
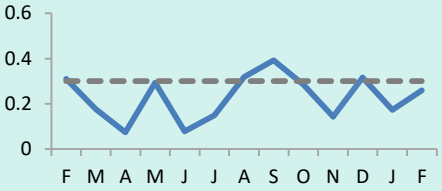
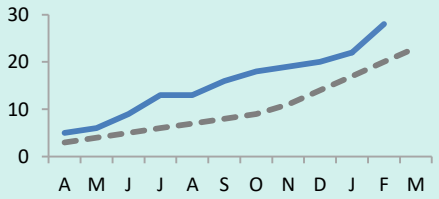
*** Key NHS constitutional target**

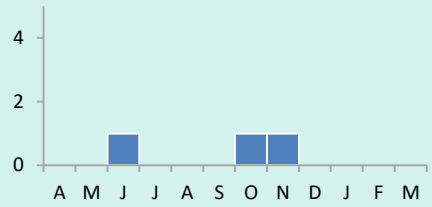
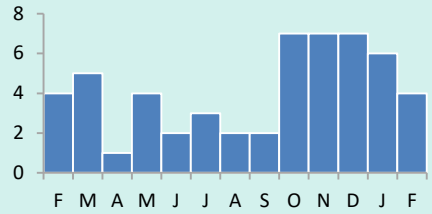
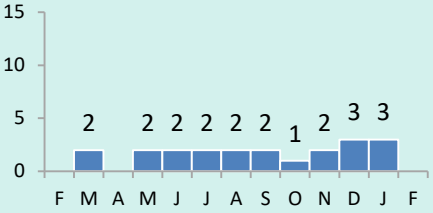
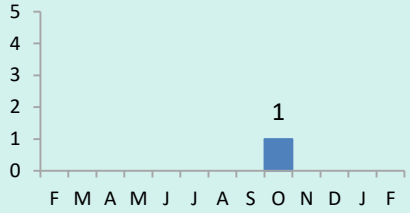
Key ○ Target achieved ○ Target not achieved

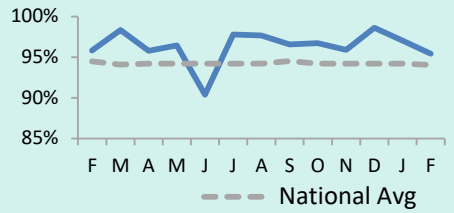
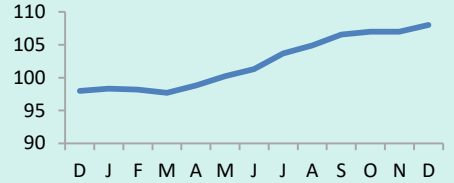
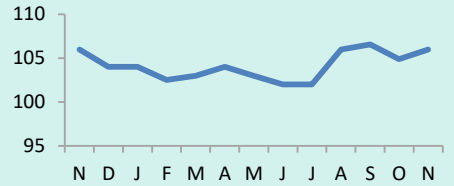
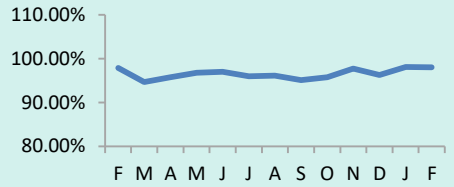
SAFE

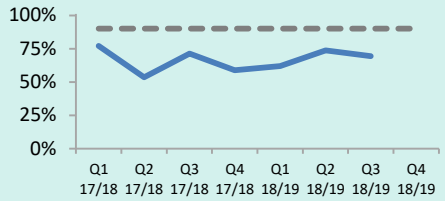
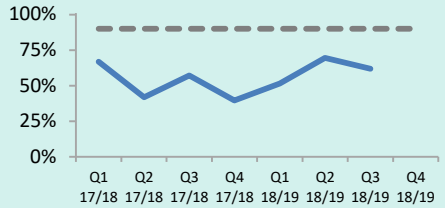
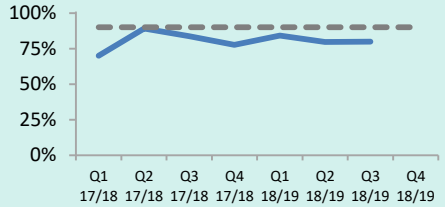
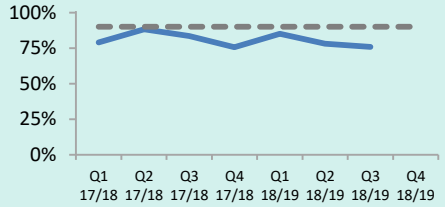
Reducing patient harms

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

Measure	Definition	Threshold	Actual	Comment	Graph
Harms: All Falls Rate	Rate of all falls per 1000 bed days	7	5.24	Performance remains below the threshold.	
Harms: Falls with Harm Rate	Rate of falls with harm per 1000 bed days	0.3	0.26	Performance remains below the threshold.	
Harms: Infection Control – Rate of C. Difficile	Cases of hospital acquired C. Difficile bacteraemia.	23 cases (2018/19)	28 cases (YTD)	6 new cases identified in February. We have exceeded the end of year target for this indicator.	

Measure	Definition	Threshold	Actual	Comment	Graph
Harms: Infection Control – Rate of MRSA	Cases of hospital acquired MRSA bacteraemia.	0 cases (2018/19)	3 cases (YTD)	No new avoidable cases reported for January.	
Harms: Serious Incidents - Level 1	Number of Serious Incidents at Level 1	No specific target but monitoring of trends	4	SI Panel commissioned four level 1 serious incident reviews in February.	
Harms: Serious Incidents - Level 2	Number of Serious Incidents at Level 2	No specific target but monitoring of trends	0	SI Panel commissioned no level 2 serious incident reviews in February.	
Harms: Serious Incidents - Never Events	Number of Never Events reported	0	0	No Never Events reported in February.	

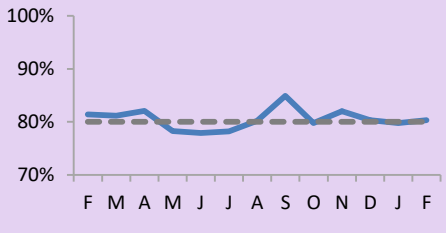
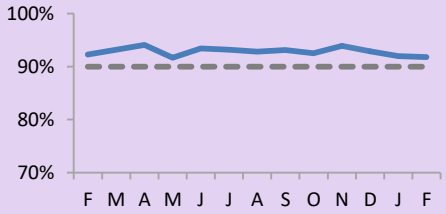
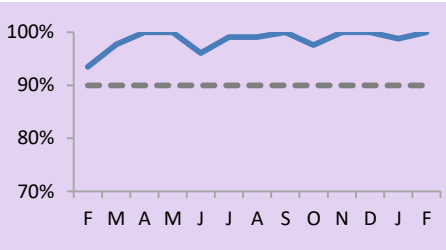
Measure	Definition	Threshold	Actual	Comment	Graph
Harms: Safety Thermometer	Based on monthly Safety Thermometer census. Rate free of new harms should be higher than national average	94.2%	95.4%	Performance remains above the national average.	
Learning from Deaths: Hospital Standard Mortality Rate (HSMR)	Ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death	Alert is red when HSMR is an outlier relative to other Trusts.	108	This measure is based on diagnosis groups that account for approximately 80% of inpatients. The HSMR is above the expected range relative to peers and is currently at an amber status.	
Learning from Deaths: Standardised Hospital Mortality Index (SHMI)	Risk adjusted mortality ratio based on number of expected deaths. National published figure from HSCIC.	Alert is red when SHMI is an outlier relative to other Trusts.	106	This information has been refreshed nationally up to October 2018. The SHMI value is above the expected range relative to peers and is currently at an amber status.	
Nurse Staffing Compliance	Actual versus Planned Staffing Hours	95%	98%	This figure is an overall percentage and should be reviewed alongside the individual ward/department data. See appendix below.	

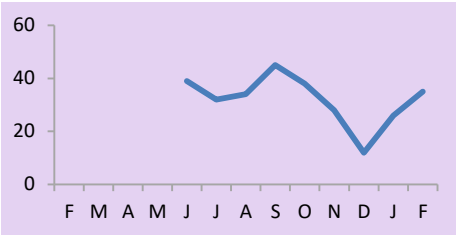
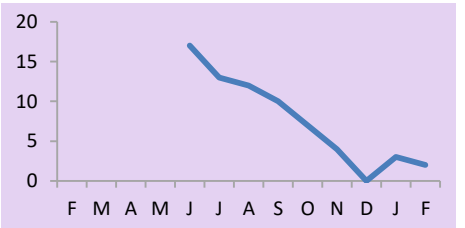
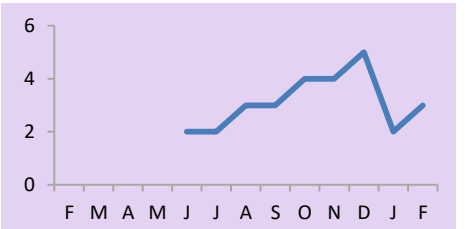
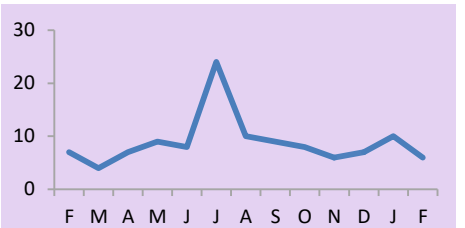
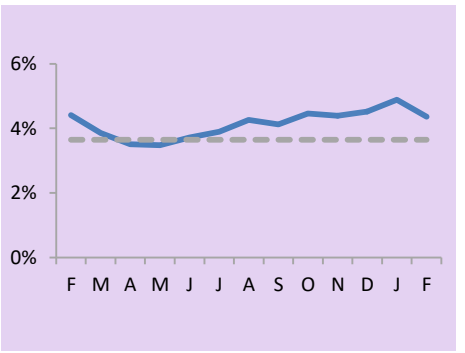
Measure	Definition	Threshold	Actual	Comment	Graph
CQUIN: Sepsis Screening in ED / Inpatient Settings	Timely identification of sepsis in ED	90%	69%	QUARTERLY INDICATOR. Q3 performance for sepsis screening remains below the 90% target.	
CQUIN: Sepsis Screening in ED / Inpatient Settings	Timely identification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

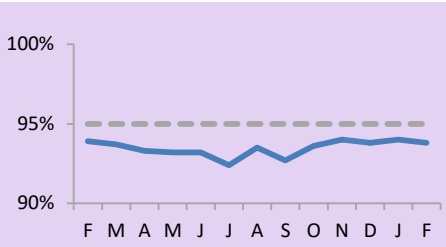
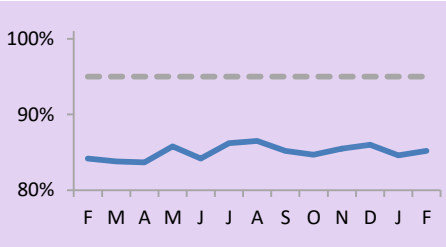
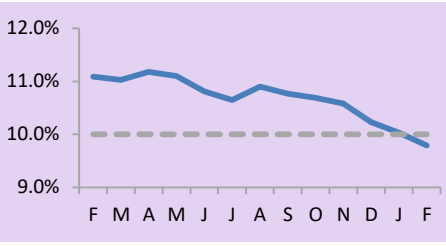
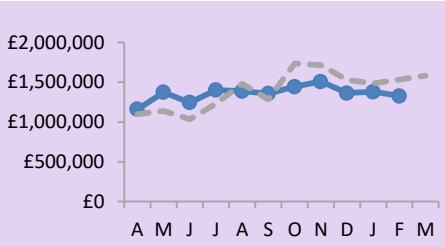
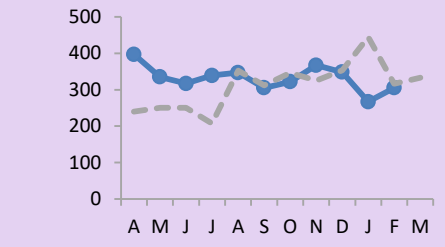
KIND

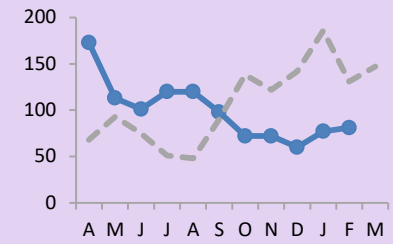
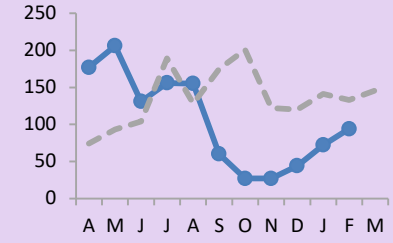
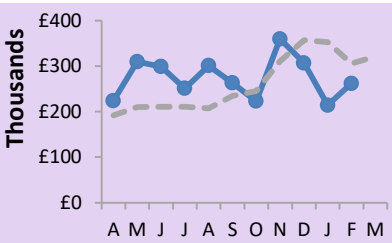
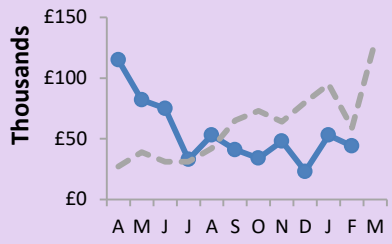
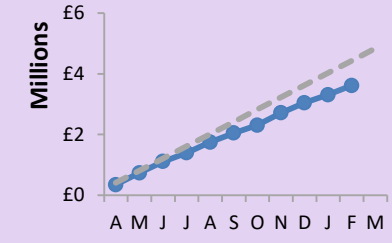
Providing high quality patient care

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

Measure	Definition	Threshold	Actual	Comment	Graph
Friends and Family: % Likely to Recommend A&E	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	80%	80.3%	Performance is above target in February.	
Friends and Family: % Likely to Recommend Inpatient Wards	Response to 'Would you recommend this service to your friends and family' survey leaflet/ text	90%	91.8%	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%	Performance remains above target for maternity services.	

Patient Feedback: Number of Open Complaints	Number of open patient complaints at month end	40	35	The number of open complaints has increased but remains within the expected threshold for this measure.	
Patient Feedback: Number of Complaints Past 40 Day Response Time	Number of Complaints Past 40 Day Response Time	5	2	Performance remains within the expected threshold for this measure.	
Patient Feedback: Number of Complaints Open with PHSO	Number of Complaints being investigated by the PHSO	5	3	Performance remains within the expected threshold for this measure.	
Mixed Sex Accommodation Breaches	Number of non-clinically justified breaches of the single sex accommodation standard	0	7	7 breaches in February were not clinically justified. Exception report provided.	
Sickness Absence	% monthly sickness absence, excluding comfort zone and Bank staff	3.65%	4.36%	Performance has improved since last month. The February absence rate is 4.36%. Exception report provided.	

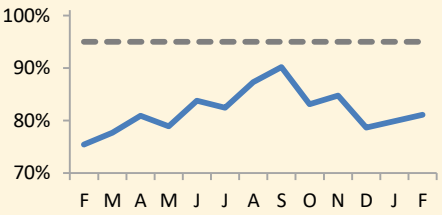
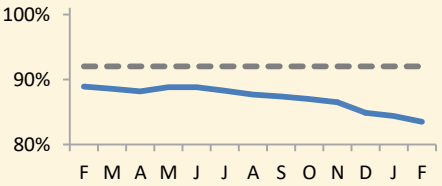
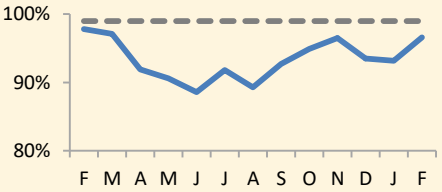
Mandatory Training Compliance	% mandatory training compliance, excluding comfort zone and Bank staff and staff on maternity/long term sick leave	95%	93.8%	Performance has changed slightly since last month. Compliance with the Mandatory Training target has decreased in February to 93.8%.	
Annual Appraisal Compliance	Exclusions as above and also excludes staff with less than 1 year's service.	95%	85.2%	Compliance with the Appraisal target has slightly increased in February to 85.2%. Exception report provided.	
Staff Turnover	Based on headcount in the previous 12 months and on permanent staff only.	10%	9.79%	Performance is within target at 9.79%	
Variable Pay	Reducing and controlling variable pay spend (including overtime, agency, additional clinical activity)	Year on year reduction	-£52K	Variable pay spend decreased in month by £52k to £1,327k. Agency decreased £57k to £304k and Medical Bank (225k) rose by 49k in month. Exception 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	+38	Month 11 shows an increase against January in shifts above the cap, with 305 Medical shifts above cap rates.	

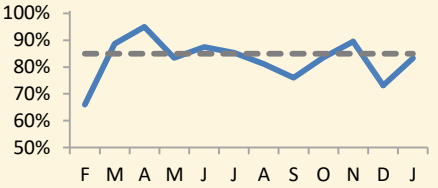
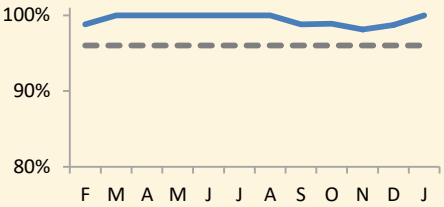
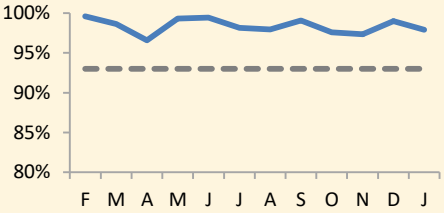
N&M Reduction in Agency Shifts over Cap Rates	Reducing agency shifts over cap rates.	Year on year reduction	+4	In relation to Nursing shifts, 81 shifts were approved above cap rates.	
'Other' Reduction in Agency Shifts over Cap Rates	'Other' consists of Care Packages, Sonographers, Theatres and CRV Dept.	Year on year reduction	+22	Operating Department Practitioner shifts increased to 94 approved over the cap.	
People: Medical Agency Spend	Planning improvements in productivity and efficiency	Year on year reduction	+£48k	Medical Pay is overspent by £1,313k. Agency medical expenditure is £3,015k (7% of the total medical spend).	
People: Nursing Agency Spend	Planning improvements in productivity and efficiency	Year on year reduction	-£9k	Nursing Pay is £1,275k overspent. Agency nursing expenditure is £601k 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	£3.98m YTD	Total Agency spend for M1-11 is £3,989k. (£3,895k was spent during the same period last year). A straight line forecast is just below the agency ceiling.	

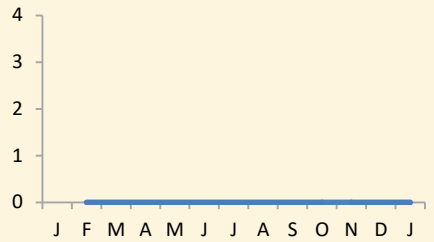
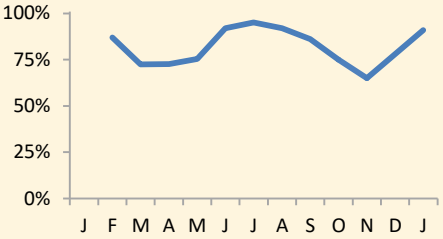
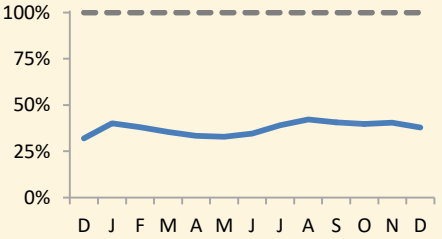
EFFECTIVE

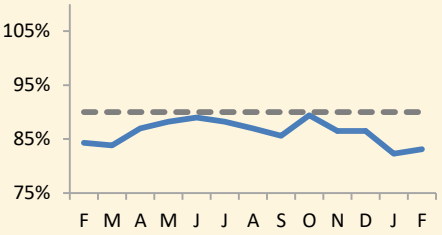
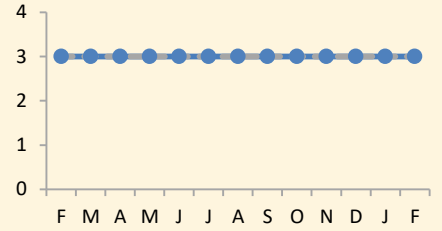
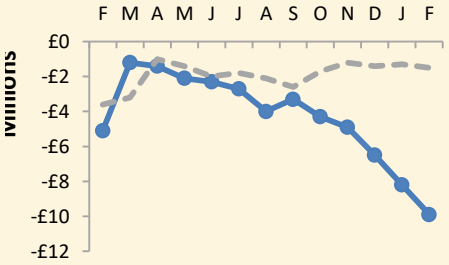
Minimising delay and improving processes

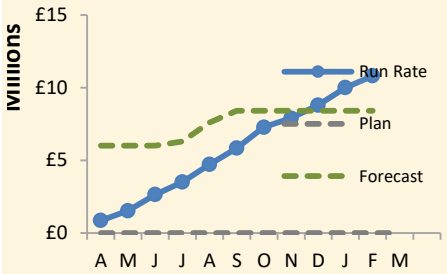
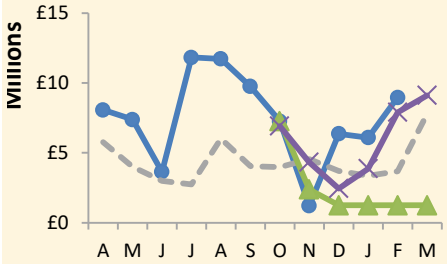
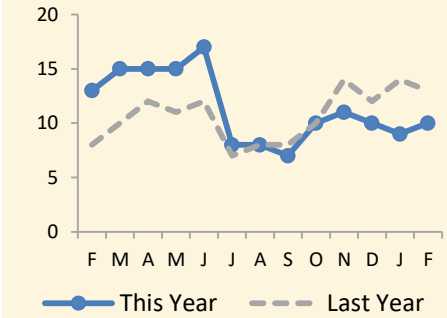
Supporting the Board Assurance Framework:
CR3, CR5, CR6, CR7, CR8, CR9, CR10

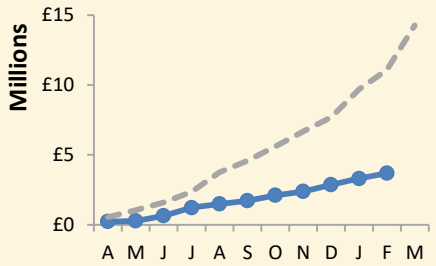
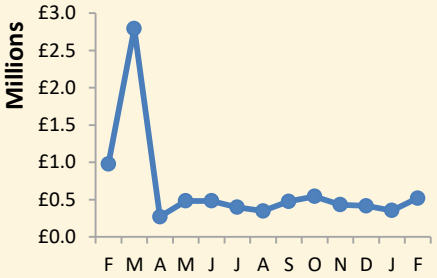
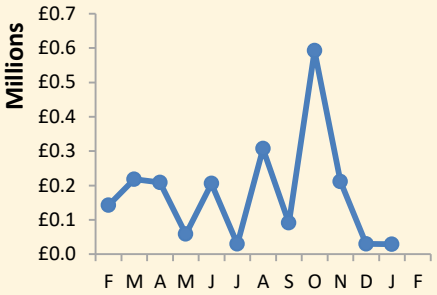
Measure	Definition	Threshold	Actual	Comment	Graph
ED 4 Hour Wait Standard	% A&E attenders seen within 4 hours of arrival	95%	81.1%	Performance has improved to 81.1% in February. Nationally, 84.2% of patients were seen within 4 hours of arrival in February, type 1 nationally 75.7% were seen within 4 hours	
18 Weeks RTT incomplete pathways	Percentage of incomplete pathways for English patients within 18 weeks.	92%	83.5%	Performance has deteriorated during the last month. The RTT incomplete percentage fell to 83.5% in February. The latest national figure for this indicator is 86.7% (January 2019). An exception report is provided.	
Diagnostic Tests within 6 Weeks (DM01)	Diagnostic tests carried out within 6 weeks of request being received.	99%	96.6%	Performance has improved to 96.6% during the last month. The latest national figure for this indicator is 96.4% (January 2019).	

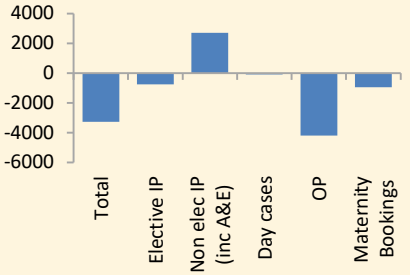
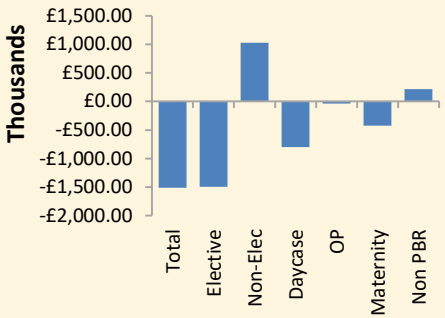
Measure	Definition	Threshold	Actual	Comment	Graph
Cancer Treatments: 62 Day Standard	First treatment for cancer within 62 days of urgent referral through GP 2 week referral route.	85%	83.33%	Performance has improved during the previous month. This indicator is reported one month in arrears. The latest national provisional figure for this indicator is 83.5% (Dec 2018).	
Cancer Treatments: 31 Day Standard	Patients receiving first definitive treatment within 1 month of cancer diagnosis.	96%	100.0%	Performance remains above target. This indicator is reported one month in arrears.	
Cancer Treatments: 14 Day Standard	Patients referred from GP with suspected cancer should have their first appointment within 14 days	93%	97.89%	Performance remains above target. This indicator is reported one month in arrears.	

Measure	Definition	Threshold	Actual	Comment	Graph
Number of Urgent Operations Cancelled on Day	Urgent operations cancelled on the day of the procedure	0	0	Performance is unchanged.	
% Cancelled Operations Rebooked within 28 Days	Patients given a TCI date that is within 28 days of a procedure cancelled on the day.	100%	91%	This indicator is reported a month in arrears to ensure all patients offered rescheduled procedures within 28 days are included.	
Clinical Correspondence: OP Letters within 7 days	100% of outpatient letters to be sent within 7 days.	100%	37.9%	Performance has deteriorated during the previous month. 60% of urgent appointments and 34% of routine appointments had OP letters sent within 7 days. This indicator is reported two months in arrears.	

Measure	Definition	Threshold	Actual	Comment	Graph
Clinical Correspondence: E-Discharge within 24 Hours	Percentage of clinical discharge letters that were sent within 24 hours	90%	83.1%	Performance has improved since last month. An exception report has been created for this indicator.	
Use of Resources	NHS Improvements measure of financial risk	A score of 3 each month (restated)	3	Performance is unchanged. The Trust is currently at a level 4 for Capital Service Capacity, liquidity, I&E Margin ratings, which when combined with Agency expenditure, results in an overall score of 3. Under the Single Oversight Framework 1 is the best score, 4 the lowest. The Trust is currently allocated to a 'segment' of 2, despite the Use of Resources score.	
I&E Plan Variance	Variance to plan	No deviation from plan	£8.370k overspend	As at the end of February 19, we are reporting a £8,370k overspend against plan. Notable pressures include £4,657 lost PSF - A&E m1-11 & Finance m7-11 and (£135k) in relation donated asset transactions, culminating in a reported net adverse position of £3,848k. £4,101k non recurrent support has been required to deliver this position.	

Measure	Definition	Threshold	Actual	Comment	Graph
Run Rate	Run Rate is I&E Variance adjusted for non-recurrent items and CRS profile. Forecast is then derived from run rate and known mitigation.	No deviation from plan	+£11m	Performance has deteriorated. The underlying run rate at the end of February is £10,820k after adjusting for non-recurrent benefit of £3,406k within the position and adjusting the profile to smooth the impact of a back loaded CRS target of £3,566k. This figure is then utilised to provide the forecast after applying known mitigation	
Cash	Cash on deposit <3 month deposit	No deviation from plan	-£5.3m	Performance has deteriorated during the last month. The closing cash balance at the end of February is just under £9.0m, £5.3m ahead of plan. The £3.5m loan drawdown has been requested for March 2019. We received £1.5m in February which was due in March from the CCG. Capital slippage is also contributing to the higher than expected cash balance. The capital loan is still not approved by DHSC.	
Debtor Days	Debtor Days: Trade Debtors divides by income x 365	No target has been set for this indicator	10	Performance has deteriorated during the last month. Debtor days have increased slightly to 10 days from 9. Wirral debtors remain significant but they are attempting to get them cleared, and we are still withholding payments to them, until further payments are received. Local Authority DTOCs invoices remain unpaid.	

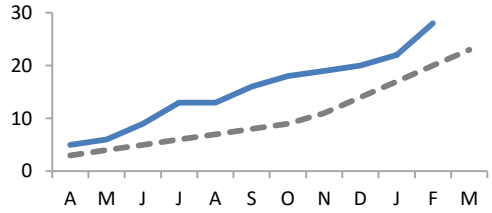
Measure	Definition	Threshold	Actual	Comment	Graph
Capital Expenditure	Capital expenditure performance against plan / forecast out-turn	Performance vs Plan	-£7.4m	YTD capital expenditure of £3.7m is under the original plan by £7.4m. The forecast outturn has been revised to reflect anticipated slippage 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	-£1,559k	The CRS plan for 2018/19 is £10.7m. The CRS programme is £1,559k behind the profiled plan as at February 19. In year 45% of the target has been delivered with 1% in Green or Amber schemes and 54% in Red or Black (unidentified) schemes. The back loading of the CRS target affects the profile target to date by £3,566k; if the target was profiled evenly CRS would be £5,125k behind plan.	
CRS recurrently	Planning improvements in productivity and efficiency	No deviation from plan	16% identified	Recurrently 16% of the £10.7m target has been identified with 2% in Green or Amber Schemes and 82% in Red or Black (unidentified) schemes.	

Measure	Definition	Threshold	Actual	Comment	Graph
Contract Performance (Activity)	YTD Contract performance against Trust Planned activity (English & Welsh)	No deviation from plan	-3,273	All points of delivery are showing an under performance against plan YTD with the exception of non-elective (+2,713). This is made up of 1,785 additional ED attendances and 1,344 additional discharges but is offset by an underperformance on maternity discharges (-416).	
Contract Income	YTD Contract performance against Trust Planned activity (English & Welsh)	No deviation from plan	-£1,514k	Prior to adjustment for the block contract with WCCCG, the February income position is above plan by £1,206k. The block contract adjustment to reflect the over performance on WCCCG offsets this over performance by £2,720k resulting in an adverse position on contract income of £1,514k.	

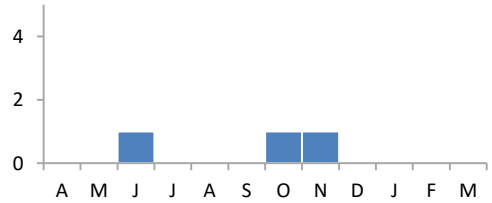
Exception Report

Performance Trend

C Difficile



MRSA



Infection Control

Performance Issue:

C Difficile has been above trajectory for eleven successive months. Additionally, there have been a total of 3 avoidable incidences of MRSA, these occurred in June, October & November.

Planned Remedial Actions:

There is no specific exception report for MRSA bacteraemia, with zero cases reported within month.

There was a sharp increase in cases of C. difficile within February 2019, with 6 hospital onset cases of infection reported. Initial investigation suggests that transmission of infection does not appear to have been a risk factor within month, although these cases have been sent for typing to investigate this further. It is possible that increased influenza activity through January/February 2019, with an associated increase in antibiotic use for secondary bacterial infections, may have had the most influence on this increase in infection. Infection prevention and control focus remains on quality improvement activity for these infections, including antimicrobial stewardship.

Ownership:

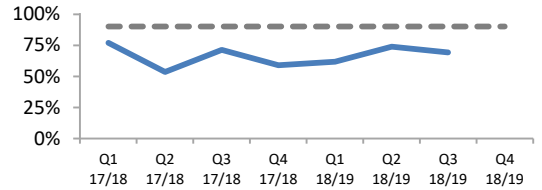
Lead: Samantha Walker, Lead Nurse – Infection Control
Executive Lead: Darren Kilroy, Interim Medical Director
Improvement Timescale: By March 2019

Exception Report

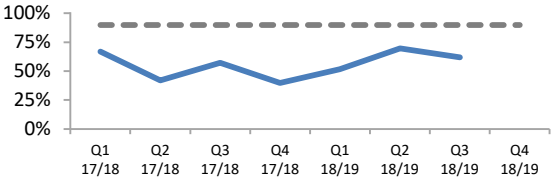
Sepsis screening and treatment CQUIN

Performance Trend

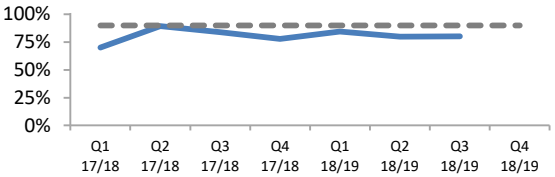
Sepsis screening (ED Patients)



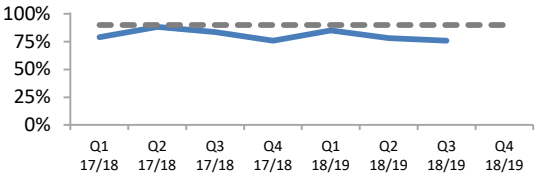
Sepsis screening (Inpatients)



Sepsis treatment (ED)



Sepsis treatment (Inpatients)



Performance Issue:

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

Planned Remedial Actions:

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

Ownership:

Lead: Dr Santokh Singh

Executive Lead: Darren Kilroy, Interim Medical Director

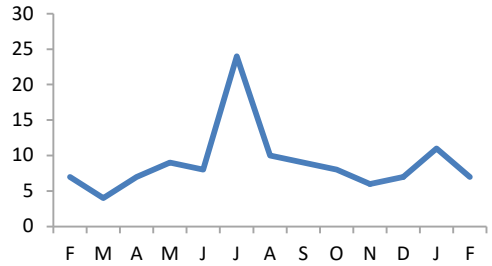
Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Exception Report

Mixed Sex Accommodation Breaches

Performance Trend



Mixed Sex Breaches

Performance Issue:

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

Planned Remedial Actions:

During February, we continue to have a small percentage of mixed sex breaches due to operational pressure; to maintain quality and safety on occasion patients have been mixed to ensure access to the relevant speciality or level of care. Full explanations have been provided to both patients and families affected, no complaints received. It is important to note that the previous issues with CCU step down patients have now been resolved.

Ownership:

Lead: Melanie Kynaston, Associate Director of Nursing

Executive Lead: Alison Kelly, Director of Nursing and Quality

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Exception Report

Sickness Absence

Historic Data

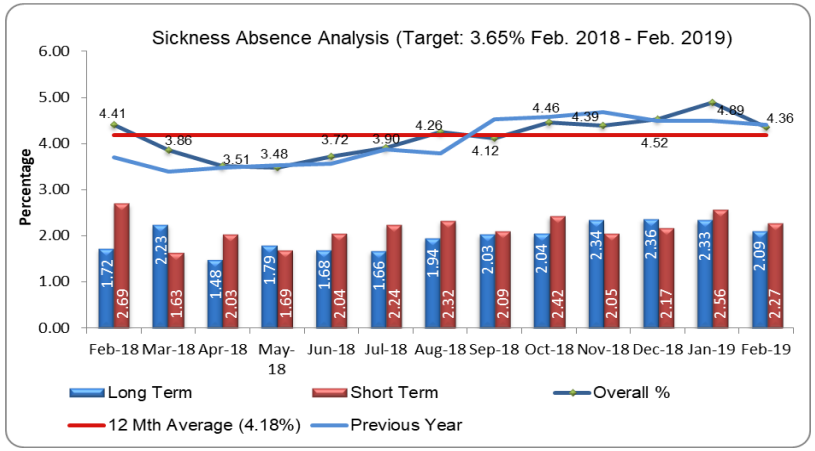


Figure: % Sickness Absence Analysis

Ownership

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

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

The Trust wide sickness absence decreased to 4.89% in February. Long Term cases decreasing to 2.09% and Short term decreasing to 2.27%. Sickness absence within Staff groups highlights that Nursing & Midwifery is reporting at 4.30% and Support Workers (which include Nursing Assistants) reporting at 6.19% in February. When analysing divisional sickness absence, 3 Divisions are above 4% and the Trust target of 3.65%, Planned Care (4.98%), Urgent Care (4.23%), and the newly merged Estates & Facilities (6.16%). Despite these Divisions being above 4% they have all seen a reduction in month. The 6 remaining divisions are under target of 3.65%.

There is still a backlog of OH referrals due to an unforeseen strain on the service. The HRBP team continue to support managers to monitor absence and manage through the Attendance Management Policy.

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 continued backlog of OH referrals. However, the OH team are working through actions to address this. In addition, a schedule of resilience support sessions for staff has been provided which teach techniques to support stress at home and at work. Sign up and feedback has been very good so far and there are plans being developed to take the sessions to front line staff that cannot be released from the ward areas.

Exception Report

Mandatory Training

Performance Trend

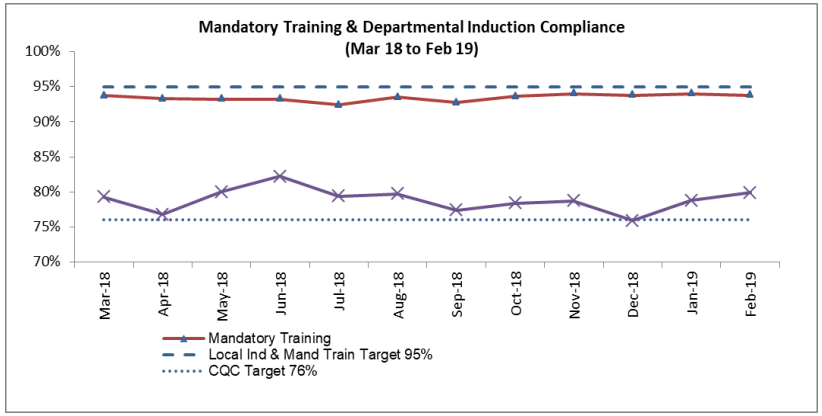


Figure: % mandatory training compliance

Ownership

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

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

Trust compliance remains below target at 93.8%.

Mandatory Training Table February 2019

Position	Division	Compliance
1	Human Resources	97.1%
2	Finance & Performance	96.7%
3	HRWBS	95.3%
4	Nurse Management	95.0%
5	Planned Care	94.5%
6	Corporate Non - Clinical	94.2%
7	Diagnostics and Pharmacy	93.8%
8	Urgent Care	92.3%
9	Estates & Facilities	92.1%
	Total	**93.8%**

Local Induction Table February 2019

Position	Division	Compliance
1	Estates & Facilities	100.0%
2	HRWBS	100.0%
3	Human Resources	100.0%
4	Planned Care	84.7%
5	Nurse Management	83.3%
6	Urgent Care	82.4%
7	Diagnostics and Pharmacy	64.2%
8	Finance & Performance	62.5%
9	Corporate Non - Clinical	42.9%
	Total	**79.9%**

Overall compliance for mandatory training in January has marginally decreased to 93.8%, which falls short of the Trust target of 95%. Local induction compliance for January is 79.9% which is significantly short of the Trust's 95% target and we are working with line mangers to ensure that completed forms are entered onto ESR timely to improve compliance rates, ensuring the correct employees are showing on the report. 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 will improve.

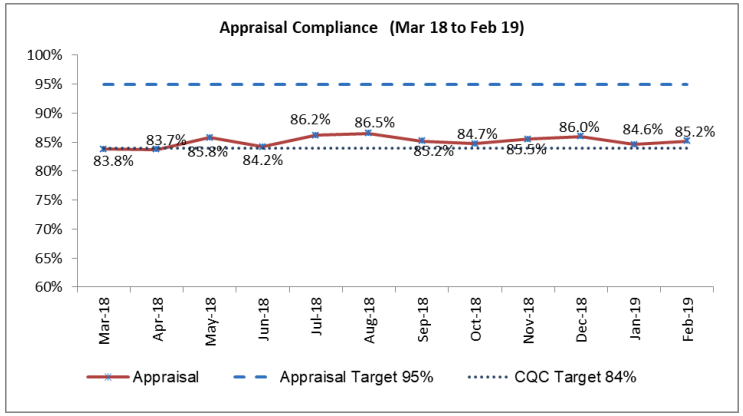
Planned Remedial Actions:

Mandatory training is under review to ensure alignment with recent changes in the Core Skills Framework. Where possible, there will be a move to all subjects being accessed solely by e-learning and the Training and Development Policy is being reviewed and updated to reflect these changes. The new Education Governance board will ratify all changes and agree strategy providing assurance to the People and OD Committee that the Trust strategies for education and training are implemented fully and risks are managed. A safeguarding strategy forum has been created to agree and implement changes to the safeguarding requirements of staff by March 2020.

Exception Report

Appraisals Completed in last 12 months

Historic Data



Performance Issue:

Appraisal compliance has seen an increase in February from 84.6% to 85.2%, this remains below our corporate target of 95%. The increased winter pressures and higher sickness levels in February have contributed to the time available for managers and staff to complete Appraisals. Using a 14 month reporting period has seen an increase in compliance.

Appraisal Table February 2019

Position	Division	Compliance
1	HRWBS	**97.3%**
2	Estates & Facilities	**95.2%**
3	Planned Care	**89.5%**
4	Diagnostics and Pharmacy	**88.1%**
5	Finance & Performance	**84.3%**
6	Urgent Care	**79.4%**
7	Human Resources	**75.4%**
8	Nurse Management	**69.1%**
9	Corporate Non - Clinical	**53.3%**
	Total	**85.2%**

Ownership

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

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Planned Remedial Actions:

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

Turnover

Performance Trend

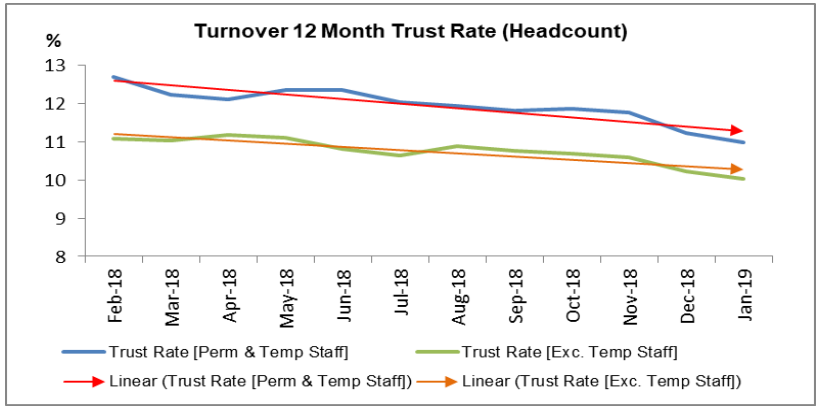


Figure: Based on headcount in the previous 12 months and on permanent staff only.

Ownership

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

Executive Lead: Sue Hodkinson

Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

Currently on target.

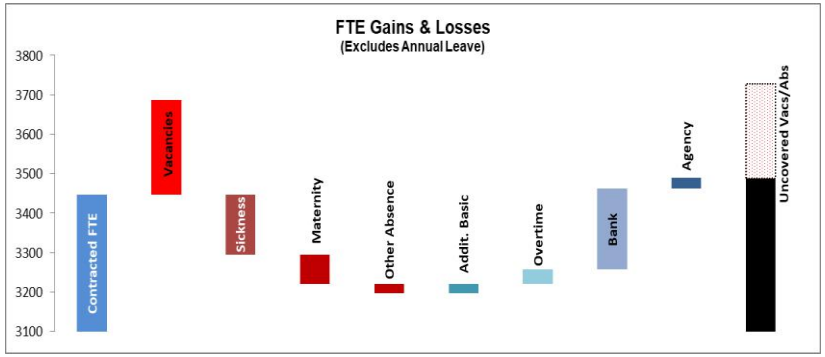
Staff Group - Feb 18 - Jan 19 Excludes Temporary Staff	Turnover %
Add Prof Scientific and Technic	7.86%
Additional Clinical Services	11.22%
Administrative and Clerical	10.03%
Allied Health Professionals	14.40%
Estates and Ancillary	7.54%
Healthcare Scientists	4.62%
Medical and Dental	7.87%
Nursing and Midwifery Registered	10.31%
Trust Totals & Rate	**10.03%**

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. A recruitment and Retention workshop meets every month to focus on these issues and we are also now working with NHSI in cohort 4 Recruitment Direct Support programme which is a National Initiative around this issue.

Variable Pay

Performance Trend



Total Registered Nursing, Midwifery and Health Visiting Staff Vacancy WTE	**82.88**
Of which Registered Midwife Vacancy WTE	5.00
Of whichRegistered Health Visitor Vacancy WTE	0.00
Of which Advanced Care Practitioner Vacancy WTE	0.00
Total Qualified AHP Vacancy WTE	**21.14**
Of which Qualified Physiotherapist Vacancy WTE	0.00
Of which Qualified Occupational Therapist Vacancy WTE	7.35
Of which Qualified Paramedic Vacancy WTE	0.00
Total Medical/Dental Vacancy WTE	**37.00**
Of which Medical/Dental Consultant Vacancy WTE	17.00
Support to Clinical Staff Vacancy WTE	5.87
Support to Nursing Vacancy WTE	34.93
NHS Infrastructure Vacancy WTE	58.33
Total Vacancies	**240.15**
Budgeted FTE Total	3822.18
Trust Vacancy Rate	**6.28%**

Ownership

Lead: Steve Bridge, Planning & Partnerships

Executive Lead: Sue Hodkinson

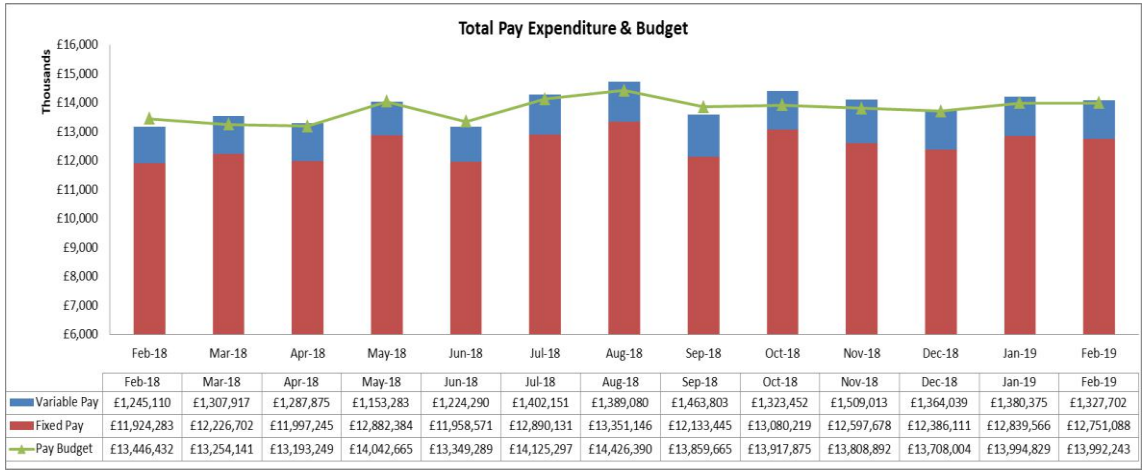
Improvement Objective: Achieve target

Improvement Timescale: By March 2019

Performance Issue:

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

Variable pay spend decreased in month by £52k to £1,327k. Agency increased £42k to £346k and Medical Bank (164k) reduced by 60k in month.



	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Variable Pay	£1,245,110	£1,307,917	£1,287,875	£1,153,283	£1,224,290	£1,402,151	£1,389,080	£1,463,803	£1,323,452	£1,509,013	£1,364,039	£1,380,375	£1,327,702
Fixed Pay	£11,924,283	£12,226,702	£11,997,245	£12,882,384	£11,958,571	£12,890,131	£13,351,146	£12,133,445	£13,080,219	£12,597,678	£12,386,111	£12,839,566	£12,751,088
Pay Budget	£13,446,432	£13,254,141	£13,193,249	£14,042,665	£13,349,289	£14,125,297	£14,426,390	£13,859,665	£13,917,875	£13,808,892	£13,708,004	£13,994,829	£13,992,243

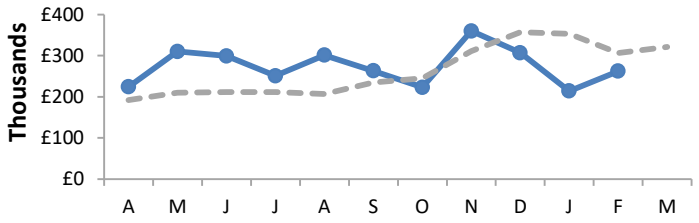
Notes:

The above is being reviewed in terms of presentation in conjunction with the Variable Pay group to focus on key metrics to ensure comparison across other organisations. Vacancies are the difference between the budgeted establishment and actual staff in post. The Workforce and Finance teams are still working towards improving data quality in relation to vacancies. The biggest increase is in NHS Infrastructure vacancies, this includes 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. The coding changes will then support better reporting on the difference between necessary and inexpensive variable pay and expensive variable pay to focus the Trust on where action is required.

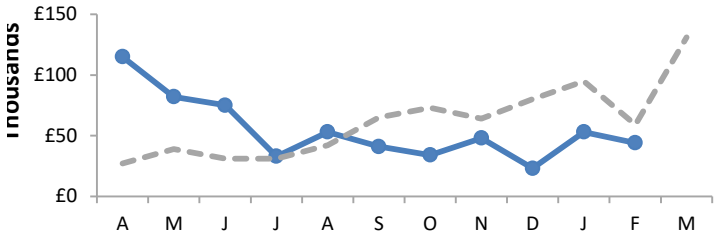
Exception Report

Performance Trend

Medical Agency Spend



Nursing Agency Spend



Ownership

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

Agency Spend

Performance Issue:

Medical Pay is overspent by £1,313k. Agency medical expenditure is £3,015k (7% of the total medical spend). Nursing Pay is £1,275k overspent. Agency nursing expenditure is £601k which is 2% of total trained nursing spend. Total Agency spend for M1-11 is £3,989k. (£3,895k 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 Feb	18/19 Annual Straight Line Projection
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 85,760	£ 81,044	£ 88,412.07
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433	£ 3,014,511	£3,288,557.40
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847	£ 601,044	£ 655,684.65
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820	£ 199,640	£ 217,789.45
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009	£ 92,671	£ 101,096.16
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 4,372,869**	**£ 3,988,911**	**£ 4,351,540**

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

Planned Remedial Actions:

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

A&E 4 Hour Standard

Performance Trend

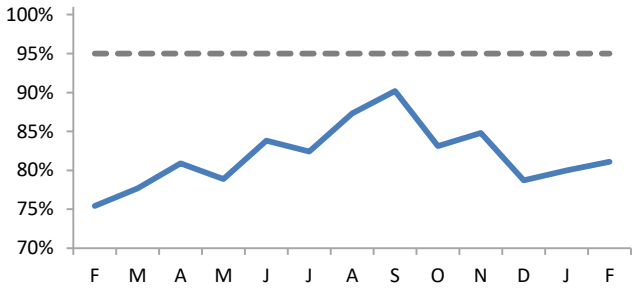


Figure: % ED attenders seen within 4 hours of arrival

Ownership:

Executive Lead: Lorraine Burnett, Chief Operating Officer

Improvement Objective: Return to national standard

(internal trajectory is to return to 90% compliance)

Improvement Timescale: By March 2019

Performance Issue:

The 4 hour A&E target was under the National target in February, achieving 81.1%. Nationally, 84.4% of patients were seen within 4 hours of arrival in January (and, of those, 76.1% were Type 1).

Planned Remedial Actions:

Reduced attendances in February and slight improvement for February at 81% - bed occupancy remained high throughout the month particularly first two weeks, resulting in an increase in medical outliers and assessment areas being bedded and reducing functionality for the following day's attendances and NEL admissions

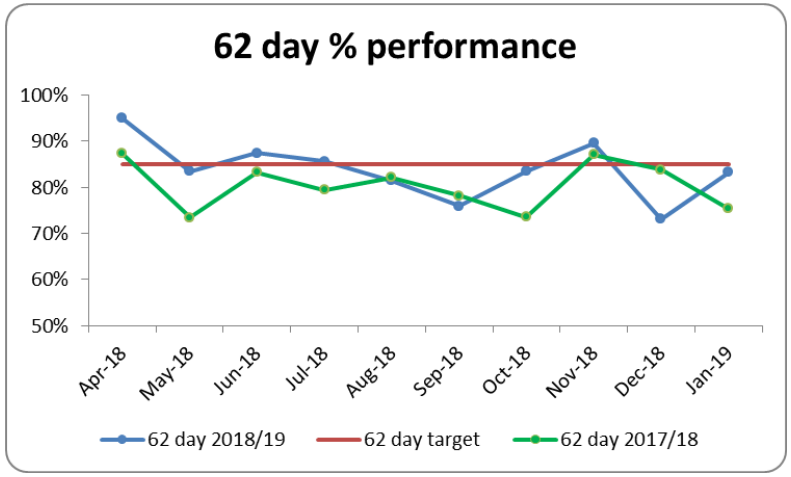
Planned Rapid Improvement Event associated with Co-ordination Centre and part of ED Improvement Programme to take place in March to improve flow from ED and through inpatient wards

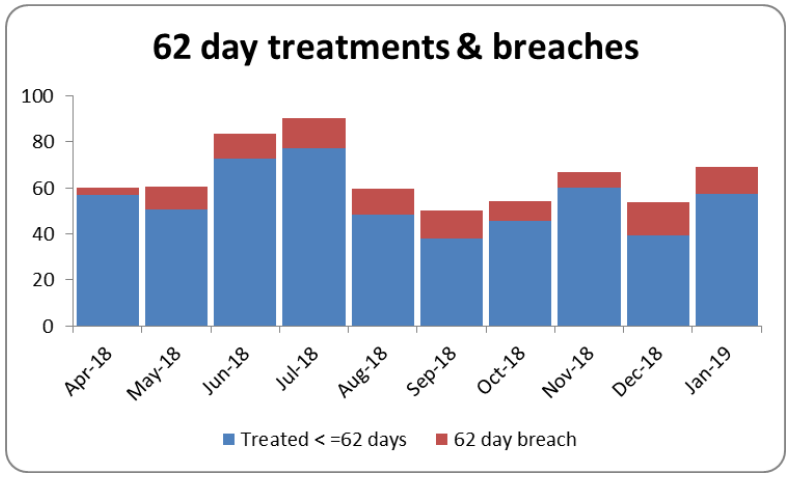
Review of bed occupancy and proposed options to be discussed during March and changes to be implemented as early as possible during Quarter 1 2019/20

The Division continue to manage the operational position each day with presence in ED on a daily basis and robust weekend plans including additional resources to support demand and facilitate discharges.

Exception Report

Performance Trend:





Cancer Treatment - 62 Day Target

Performance Issue:

The 62 day performance for January was an underachievement of the standard at 83.33%.

Breach Overview:

There were 11.5 breaches in January attributable to COCH:

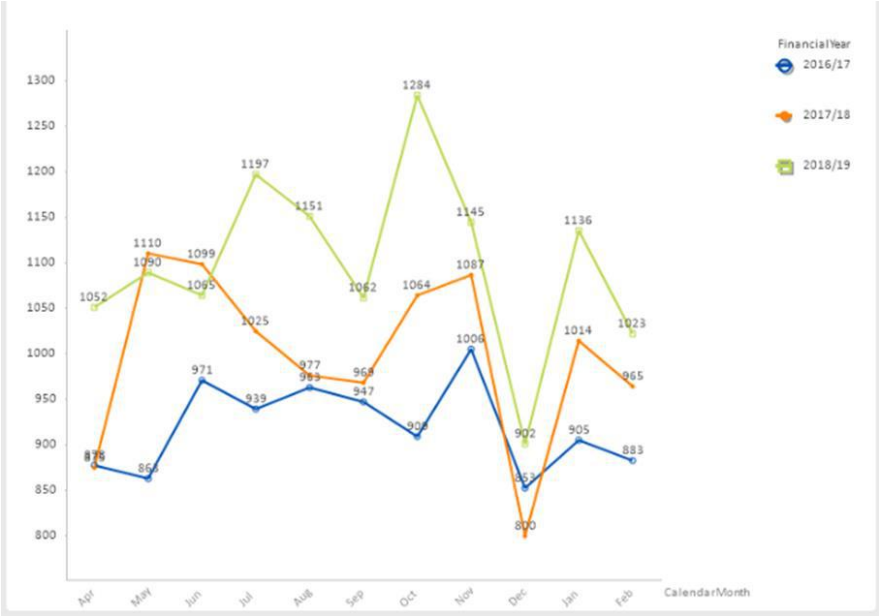
- Urology (4.5 breaches) – reasons include late referrals to tertiary centres – results clinic capacity, patient choice for OPA due to Christmas, diagnostic delay, clinical decision delay due to Christmas.
- Haematology (3.5 breaches) – Two transfers from ENT (day 56) and LGI (day 30). Reasons include delay for OPA (Christmas period), biopsy delay due to patient on medication, patient requested transfer to APH for treatment, and second opinion required for histology.
- Colorectal (2.5 breaches) – All patients were late referrals to CCC for treatment, due to complexity (further investigations required, medication had to be stopped, comorbidities requiring anaesthetic/exercise tests to decide on treatment options, endoscopy delays).
- Gynae (1 breach) – Transfer from LGI to Gynae on day 32. Delays to diagnostics (appointments and report), further tests required and referral to LWH and then to CCC for treatment.

Planned Remedial Actions:

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

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

Referrals



Breaches by Tumour Site Year to Date:

	Total Breaches	% of Trust Breaches
Urology	49	40%
Colorectal	20	16%
Haematology	12	10%
Skin	12	10%
Head & Neck	9	7%
Upper GI	8	6%
Lung	7	6%
Gynae	5	4%
Breast	2	2%
TOTAL	**124**	**100%**

Table: % Breaches by Speciality (April-January)

Urology – Cancer patients are given priority and staffing changes are now in place. A review is being undertaken to set up new telephone clinics and a results clinic.

Upper GI – the Trust has implemented part 1 of the newly commissioned pathway working with the Royal Liverpool university hospital Trust to undertake all specialist Upper GI surgery referred in to COCH. Work continues to agree part 2 of the pathway.

Radiology – demand and capacity work based on IST model to commence April 2019

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

Referrals – the high number of cancer referrals continues with a 10.2% increase in referrals from the previous year, which equates to an additional 1122 referrals year to date, compared to the previous year.

Ownership:

Executive Lead: Lorraine Burnett, Executive Director of Operations
Improvement Objective: Achieve target
Improvement Timescale: By March 2019

Referral to treatment (18 weeks)

Performance Trend

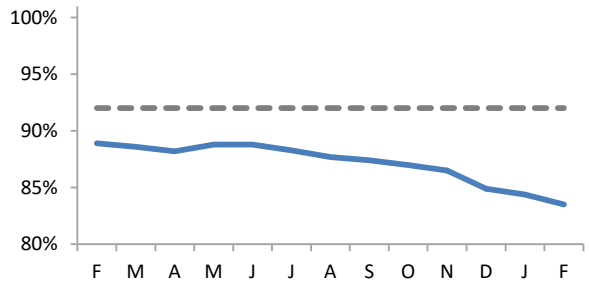


Figure: Percentage of incomplete pathways for English patients within 18 weeks.

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 83.5%.

There continues to be significant RTT pressures across all specialties. There has been a decline in performance in February from January, which is a similar trend to 2017/18. Demand for January and February continues to be higher than the same period last year, 5% growth year on year. Cancer referrals continue to take priority and remain high particularly for Skin and Colorectal tumour sites. Workforce pressures in both Medical and Nursing roles continue to cause pressure due to a lack of available capacity, specifically in the following areas; Urology, Oral Surgery, Gynaecology, Respiratory and General Surgery. Issues relate to unfilled vacancies, long term sickness and HR exclusions.

Planned Remedial Actions:

Specific actions being taken to improve the position include;

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

Diagnostic Tests within Timescale

Performance Trend

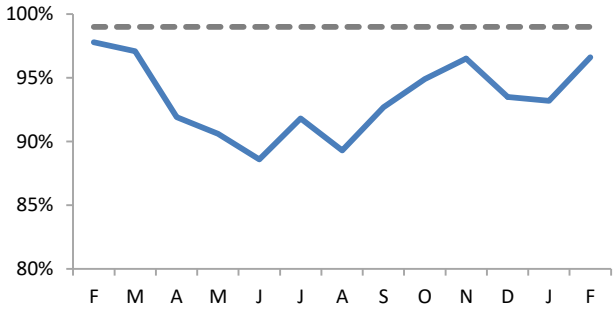


Figure: DM01 - Diagnostic tests carried out within 6 weeks of request being received.

Ownership

Lead: Divisional Directors

Executive Lead: Lorraine Burnett, Chief Operating Officer

Improvement Objective: Achieve target

Improvement Timescale: October 2018

Performance Issue:

DM01 performance rose to 96.6% in February but remains below the 99% target. This target remains volatile due to increasing demand, national workforce pressures and a low threshold to meet the 1%.

Planned Remedial Actions:

Endoscopy - over-performed in January and February, completing additional 18 procedures in February. DM01 performance for February has improved in colonoscopies, flexi sigs, cystoscopies and gastroscopies as a result. All cancer and long-waiting RTT patients are currently being prioritised and further validation is being completed. Actions to date include changes to dating in advance to reduce FTA and cancellation rates by giving more notice to patients, maximising utilisation and we are starting to see improvements relating to this.

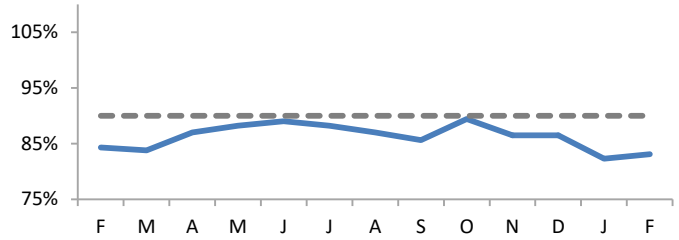
CRV vascular - there is a key piece of work commencing in Urgent Care with CRV undertaking a 'deep dive' into the vascular capacity and demand, reviewing validation process and liaising with Planned Care to make a fundamental change to the provision of service and improve performance. In the interim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

English - Number of exams >6 weeks

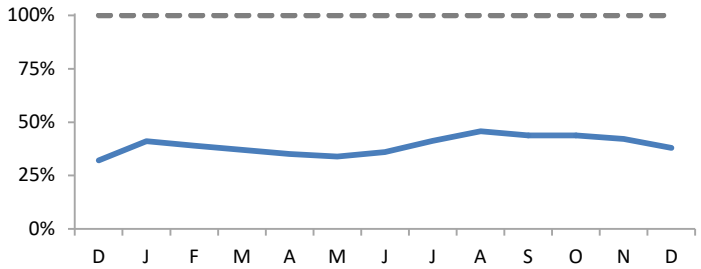
Month End Snapshot	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-18
Magnetic Resonance Imaging	2	10	12	5	9					1	2	4	4
Computed Tomography						1				1	5		
Non-obstetric ultrasound	6	51	177	207	247	165	120	124	80		17		
CRV - Vascular	29	14	2	14	5	12	70	30	8	64	67	128	100
Audiology - Audiology Assessments													
Cardiology - echocardiography			2			7	72	1	1	6	128	93	2
Respiratory physiology - sleep studies	5	3	3	3	2	3	1			1		2	
Colonoscopy	14	19	77	141	192	87	79	64	39	22	25	45	33
Flexi sigmoidoscopy	1	8	3	5	2	1	12	15	34	27	21	8	2
Cystoscopy	17	18	22	49	59	67	120	69	60	23	30	22	21
Gastroscopy	19	12	74	114	100	72	41	43	34	16	24	19	8
Total patients waiting	4228	4623	4578	5738	5382	5073	4822	4758	5001	4657	4872	4713	4953
%<6 weeks	97.8%	97.1%	91.9%	90.6%	88.6%	91.8%	89.3%	92.7%	94.9%	96.5%	93.5%	93.2%	96.6%

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 February.

Contributing Factors:

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

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

Planned Remedial Actions:

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

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

Ownership:

Executive Lead: Darren Kilroy, Interim Medical Director
Improvement Objective: Achieve target
Improvement Timescale: By March 2019

Appendix 1 Nurse Staffing Compliance

Nurse Staffing Heat Map

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

Subject	Financial Position – Month 11, February 2019
Date of Meeting	Trust Board 26th March 2019
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 28th February 2019 (Month 11)
Recommendation(s)	**The Board is asked to note:** o The adverse variance (Month 11) of £8,370k against plan, being made up as follows, namely: o underlying position before Provider Sustainability Funding (PSF) of £3,848k 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 10 but with potential for further deterioration, given operational pressures currently experienced; o The improvement in the delivery of the West Cheshire CCG activity, with the over performance against block moving from £1,995k over to £2,720k over performance year to date (being circa £1,380k over performance if Therapies changes were excluded); o The additional agreed payment from West Cheshire CCG of £242k in recognition of joint financial recovery plan initiatives; o The main continuing pressures, which could threaten the forecast outturn, being principally Medical and Nursing pay pressures, particularly given current operational pressures; o New and emerging pressures; - Firstly, the breakdown of the Trust's Combined Heat & Power (CHP) facility and the resultant increased

	electricity costs of c£2k per day since 12/2/19. An overhaul of the CHP has been agreed at CLG at a cost of c£300k to alleviate this pressure going forward; - Secondly, the recent HMRC notification that +US (formerly Brooksons) should now be standard rated for VAT purposes which will result in an increased charge being levied on the Trust for their services in relation to Medical Agency staff, this is estimated to be a cost pressure of c£100k for the remainder of 18/19, but it is hoped that a new model of working can be introduced to mitigate this as an ongoing pressure; o The cash position of the organisation, and the interim revenue distress funding received to date, together with noting the ongoing cash planning and further drawdown requested in March 2019); o The number of Welsh Delayed Transfers of Care Bed Days, being 2,645 year to date (a deterioration of 10% on the same period last year, previously 17% at Month 10), 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 Quarter 3 & Quarter 4; o The level of non-recurrent resource (£3,406k) required to achieve this position; o The underlying financial pressures, being consistent with other NHS providers, namely: o Winter/additional capacity o Growing elective lists o National A4C Pay award shortfall o Slippage on CRS delivery (Avastin/Lucentis) o Embargo on Subsidiary Companies o Increase in Agency Spend o The critical importance of March 2019, and the close monitoring of NHS Improvement in maintaining the current forecast position; o The underlying significant risks to this current probable forecast outturn, namely: o Circa £0.3m additional income within the position

	for therapies activity (none WC CCG) not previously charged for; o The absence of confirmation of the Trust's "urgent and essential" Capital Loan for 2018/19 remains an outstanding risk, although the Trust has recently received confirmation of circa £1.5m with regards to a Light Emitting Diode (LED) lighting bid across the organisation; o The suggested next steps: o Maintaining good governance, and control, over the last remaining month; 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: [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

Finance & Integrated Governance Committee

Financial Position
Month 11 February 2018/19

1.1 Overview

	Annual Budget 2018/19 £000s	February YTD Budget 2018/19 £000s	February YTD Actual 2018/19 £000s	February YTD Variance 2018/19 £000s
Pre PSF (Deficit)	4,334	7,988	11,836	3,848
PSF (Provider Sustainability Fund)	(7,297)	(6,446)	(1,789)	4,657
Post PSF Control Total	**(2,963)**	**1,542**	**10,047**	**8,505**
Donated Asset Transactions	45	41	(94)	(135)
I&E Surplus	**(2,918)**	**1,583**	**9,953**	**8,370**

The "monitored" financial position i.e. pre Provider Sustainability Fund (PSF) is a **£3,848k adverse variance** at the end of February. The key points to note include:

Income

There is an adverse position on clinical income of £1,514k noting:

- Underlying over performance on the West Cheshire CCG contract is £2,720k, but this is not recognised within the financial position due to the block arrangements;
- The Welsh contract is underperforming by £619k at the end of month 11;
- There is an adverse variance on other English commissioners of circa £895k 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 (£833k) to date.

Expenditure

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

- Nursing pay is £1,275k overspent (including agency spend to date of £601k); and
- Medical pay is £1,313k overspent (including agency spend to date of £3,015k).

The key cost drivers continue to be vacancies, activity pressures, and the number of patients requiring one to one care. Drugs and Medical & Surgical Equipment costs are also overspent, £395k and £312k respectively. This is across a number of specialities and seems to be reflective of current case-mix on the wards.

Cost Reduction Scheme (CRS)

The Cost Reduction Scheme (CRS) is £1,559k behind the profiled plan. The target has been back loaded into later months; if it had been profiled evenly we would be a further £3,566k over spent.

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, plus another £263k in year and £331k recurrently from contingency. Further reserves of £695k have been utilised to support the financial position.

Technical Opportunities

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

1.2 Provider Sustainability Funding (PSF)

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

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

The Trust is required to deliver to financial plan at the end of each quarter to be able to access the associated PSF for financial performance for that period. Therefore, significant non recurrent resource of £3.406m, and deployment of recurrent reserves of £695k, has been specifically released into the position to achieve the required financial performance thus enabling the Trust to access PSF of £1,788k for quarter one and quarter two.

The Trust has an adverse variance on PSF of £4,658k at the end of month 11 with £1,934k loss due to the non-achievement of the required A&E target year to date and £2,724k is due to the non-achievement of the financial performance in October to February.

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 February, both pre and post PSF:

KEY VARIANCES	Annual Budget £000s	Feb YTD Budget £000s	Feb YTD Actual £000s	Feb YTD Variance £000s	Feb YTD Variance % of budget	Movement from Jan £000s
INCOME						
Income - England	(180,625)	(164,766)	(163,302)	1,464	-0.9%	48
Income - Wales	(25,201)	(23,481)	(22,782)	699	-3.0%	75
Other Clinical Income	(12,002)	(11,053)	(11,916)	(862)	7.8%	(168)
Non Patient Income	(15,006)	(13,755)	(14,191)	(436)	3.2%	(26)
INCOME	**(232,834)**	**(213,055)**	**(212,190)**	**865**	-0.4%	**(71)**
PAY						
Nursing	59,990	54,942	56,216	1,275	2.3%	112
Medical	47,865	43,880	45,194	1,313	3.0%	92
Admin & Clerical	21,220	19,410	19,030	(380)	-2.0%	(40)
AHP, Therapies, Diagnostics & Pharmacy	23,407	21,369	21,272	(97)	-0.5%	(29)
Other	14,218	12,818	11,980	(838)	-6.5%	(49)
TOTAL PAY	**166,701**	**152,418**	**153,692**	**1,273**	0.8%	**86**
NON PAY						
Drugs	18,941	17,913	18,307	395	2.2%	4
Medical & Surgical Equipment	11,785	10,825	11,137	312	2.9%	106
Depreciation	4,237	3,884	3,884	0	0.0%	0
CNST	8,206	7,522	7,522	0	0.0%	0
Furniture & Office Equipment, Equip Hire & Computers	3,952	3,516	3,617	101	2.9%	31
Other	29,216	26,525	25,869	(656)	-2.5%	237
TOTAL NON PAY	**76,337**	**70,184**	**70,336**	**152**	0.2%	**378**
CRS	**(5,869)**	**(1,559)**	**0**	**1,559**		**183**
TOTAL - PRE PSF & DONATED ASSET TRANSACTIONS	**4,334**	**7,988**	**11,837**	**3,849**	48.2%	**576**
PSF (Provider Sustainability Fund)	**(7,297)**	**(6,446)**	**(1,789)**	**4,657**	-72.2%	**852**
POST PSF CONTROL TOTAL	**(2,963)**	**1,542**	**10,048**	**8,506**	551.8%	**1,428**
DONATED ASSET TRANSACTIONS	**45**	**41**	**(94)**	**(135)**	-329.3%	**9**
I&E SURPLUS	**(2,918)**	**1,583**	**9,954**	**8,371**	529.0%	**1,437**

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	(85)	(£799,450)	(£551,043)	(£1,350,493)	↓	(£122,056)
Elective Inpatients	(758)	(£1,495,005)	(£516,160)	(£2,011,165)	↓	(£207,521)
Non-Elective Inpatients (exc Maternity)	1,345	£2,038,322	£147,581	£2,185,903	↑	£288,901
Non-Elective Inpatients - Maternity	(416)	(£1,219,624)	£530,873	(£688,750)	↓	(£105,598)
First Outpatients	2,211	£267,556	(£182,813)	£84,744	↑	£5,618
Follow Up Outpatients	(6,915)	(£483,190)	£266,714	(£216,476)	↓	(£5,933)
Outpatient Unbundled & Procedures	512	£175,623	(£141,719)	£33,904	↓	(£1,055)
Maternity	(951)	(£422,709)	£531,506	£108,797	↑	£28,200
A&E Attendances	1,785	£70,861	£98,359	£169,220	↑	£3,855
Best Practice Adj'ts	0	£136,803	(£78,933)	£57,870	↑	£6,401
Drugs & Devices	0	(£54,178)	(£554,331)	(£608,509)	↑	£28,154
AMD	766	£550,818	(£238,254)	£312,564	↑	£32,445
Adult Crit Care & Neonatal	(1,237)	(£1,239,193)	(£333,018)	(£1,572,212)	↓	(£105,693)
Other Non PBR & CQUIN	0	£2,135,769	(£1,698,501)	£437,268	↓	(£18,241)
PBR & Non PBR Variance	**(3,744)**	**(£337,597)**	**(£2,719,738)**	**(£3,057,335)**		**(£172,523)**
Critical Care Risk		£1,543,671		£1,543,671		£140,334
Total Excluding STF Funding		**£1,206,074**	**(£2,719,738)**	**(£1,513,664)**		**(£32,190)**
Sustainability & Transformation funding		**(£4,657,918)**		**(£4,657,918)**		(£851,317)
Total Including STF Funding		**(£3,451,844)**	**(£2,719,738)**	**(£6,171,582)**		**(£883,506)**

At the end of February 2019 (month 11) the total contract income (for all commissioners) is £1,206k above plan prior to the block adjustment, which when applied results in an overall financial underperformance of £1,514k, thus not recognising £2,720k over performance in the position. This is because the over performance is attributed to West Cheshire CCG which is on a block contract and the underperformance has been experienced on Payment by Results (PbR) contracts.

Please note the following key points in relation to income:

- There has been a change in charging for therapies activity, which has previously been counted but not charged for. This change is to ensure consistent treatment in line with neighbouring Trusts, with a value for all commissioners of circa £1,579k for April 2018 to February 2019, and circa £1,340k of this relating to West Cheshire CCG;

- Overall performance on the West Cheshire CCG contract has further improved in month 11 and even excluding the therapies charging change, the West Cheshire CCG contract would be now £1,380k 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 11 despite improved delivery of (West Cheshire) activity. However, the underperformance is lower than in previous months;

- The volume of un-coded activity at month 11 is currently at 4% of total activity. The Trust continues to pursue regular reviews of coding;

- Obstetric deliveries continue to be below plan in February with a cumulative under performance of £1,220k prior to the block adjustment. The pressure within the financial position following the block adjustment is £689k for the first eleven 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 £171k 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 (£833k); and

- Critical Care and Neonatal bed day activity is £1,572k 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 £29k.

2.2 Non-Commissioner Income

At the end of February 2019, non-commissioner income is below plan by £4,008k mainly attributable to:-

- The loss of the PSF monies in relation to A&E (£1,934k) and financial performance (£2,724k) totalling £4,658k; 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	Feb YTD Var	CRS YTD Var	Pressure exc CRS
	£000s	£000s	£000s
Planned Care	2,510	1,145	1,365
Urgent Care	2,829	815	2,014
D&P	310	117	193
Facilities	(162)	(14)	(148)
Estates	(229)	(66)	(163)
Nurse Management	(44)	(2)	(42)
Corporate Services	(404)	(141)	(263)
Central (CRS)	(486)	(295)	(191)
Central Services	2,610	0	2,610
Total (before PSF & Donated Assets)	**6,934**	**1,559**	**5,375**

3.1 Agency Spend & Variable Pay

The agency expenditure position as at February 2019 is shown below with a simple straight line projection, which suggests the Trust will be just under 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 Feb	18/19 Annual Straight Line Projection
Admin & Clerical	£ 119,858	£ 163,219	-£ 180	£ 85,760	£ 81,044	£ 88,412.07
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433	£ 3,014,511	£3,288,557.40
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847	£ 601,044	£ 655,684.65
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820	£ 199,640	£ 217,789.45
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009	£ 92,671	£ 101,096.16
Total	**£ 3,774,873**	**£ 5,097,592**	**£ 3,452,004**	**£ 4,372,869**	**£ 3,988,911**	**£ 4,351,540**

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

The variable pay position for month 11 is shown below, as is the comparison with previous month's performance: -

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

	2016/17 Full Year Spend	2017/18 Full Year Spend	2018/19 YTD Spend
Additional Clinical Activity (WL)	£1,136,104	£1,225,459	£1,449,061
Medical Bank	£1,581,579	£2,025,090	£2,090,636
Additional Basic Pay	£1,487,368	£1,200,461	£855,301
Overtime	£1,167,972	£1,530,417	£1,177,194
Agency Expenditure	£3,452,003	£4,372,869	£3,978,676
Bank Expenditure	£2,809,066	£3,665,410	£5,274,196
Total Variable Pay Expenditure	**£ 11,634,092**	**£ 14,019,705**	**£ 14,825,063**
Pay Budget	**£ 155,020,877**	**£ 157,824,980**	**£ 152,418,398**
Variable Pay as % of Total Pay Budget	**8%**	**9%**	**10%**

3.2 Delayed Transfers of Care

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

Bed Days

Local Authority	2017/18 YTD Total			2018/19 YTD Total			2018/19 Total Variance		
	Health	Social	Total	Health	Social	Total	Health	Social	Total
Cheshire West & Chester	3,248	3,223	6,471	3,872	1,608	5,480	624	(1,615)	(991)
Wales	1,421	984	2,405	686	1,959	2,645	(735)	975	240
Halton	36	55	91	15	22	37	(21)	(33)	(54)
Warrington	61	167	228	79	27	106	18	(140)	(122)
Wirral	94	26	120	24	86	110	(70)	60	(10)
Shropshire	16	4	20	0	0	0	(16)	(4)	(20)
Cheshire East	10	3	13	18	6	24	8	3	11
Wigan	0	3	3	0	0	0	0	(3)	(3)
Stockport	10	0	10	0	23	23	(10)	23	13
Lancashire	2	0	2	0	0	0	(2)	0	(2)
West Sussex	0	0	0	0	0	0	0	0	0
Total	**4,898**	**4,465**	**9,363**	**4,694**	**3,731**	**8,425**	**(204)**	**(734)**	**(938)**

3.3 Bed Base (Countess of Chester & Ellesmere Port)

Bed occupancy remains high and despite a system wide review which identified a shortfall of 15 beds across the 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 and performance can be found in section 4.2.

4.1 February 2019 CRS Performance

CRS performance as at the end of February 2019 is £1,559k behind the profiled plan. Reserves of £695k have been released to support the overall financial position and offset against the CRS target.

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

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

Therefore the CRS performance would be worse by £3,566k if the target had been profiled evenly and hence, the CRS programme would be £5,125k 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: -

NHS
Countess of Chester Hospital
NHS Foundation Trust

2018/19 EFFICIENCY PROGRAMME PERFORMANCE AS AT FEBRUARY 2019

IN YEAR

Division / Department	2017/18 In Year CRS Target	Achieved		Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,515,966	£ 1,198,498	48%	£ 1,317,468	£ 636	£ -	£ 513,718	£ 803,113
Urgent Care	£ 1,754,308	£ 804,492	46%	£ 949,816	£ 43,775	£ 20,489	£ 410,000	£ 475,551
D&P	£ 840,000	£ 681,575	81%	£ 158,425	£ 54,380	£ -	£ 120,000	-£ 15,955
Estates & Facilities	£ 489,724	£ 564,763	115%	-£ 75,039	-£ 0	£ -	£ -	-£ 75,039
Nurse Mgmt	£ 71,791	£ 71,791	100%	-£ 0	-£ 0	£ -	£ -	£ -
Corporate Clinical	£ 7,756	£ 5,090	66%	£ 2,666	£ -	£ -	£ 2,290	£ 376
IM&T	£ 167,599	£ 174,541	104%	-£ 6,942	£ -	£ -	£ -	-£ 6,942
HR	£ 106,018	£ 106,036	100%	-£ 18	-£ 18	£ -	£ -	£ -
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	£ 174,314	1105%	-£ 158,543	£ -	£ -	£ -	-£ 158,543
Central	£ 4,597,684	£ 943,666	21%	£ 3,654,018	£ -	£ -	£ 3,650,000	£ 4,018
TOTAL	**£10,738,872**	£ 4,869,224	45%	£ 5,869,648	£ 98,773	£ 20,489	£ 4,699,478	£ 1,050,907
		45%		55%	1%	0%	44%	10%
						£ 119,263		£ 5,750,386
						1%		54%

2018/19 EFFICIENCY PROGRAMME PERFORMANCE AS AT FEBRUARY 2019

RECURRENT

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

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

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

4.3 Next Steps (Delivery of Recovery Plan Schemes)

The Trust submitted a draft Financial Recovery Plan to NHSI in September, with the required Board Assurance Statement (following after it was approved by the Board). The Trust continues to seek a Turnaround Director. In the meantime, an internal turnaround team has supported the identification and delivery of rapid improvements to the 2018/19 financial position, and is in the process of supporting 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	Feb £k Best	Feb £k Most Likely	Feb £k Worst
Reported Monthly Variance Position	**3,848**	**3,848**	**3,848**
Use of Non Recurrent Resource	3,406	3,406	3,406
Initial Monthly Position	**7,254**	**7,254**	**7,254**
CRS Profile Adjustment	3,566	3,566	3,566
Restated Actual Position	10,820	10,820	10,820
Full Year Variance Projection	**11,804**	**11,804**	**11,804**
Further Risk			
CCG £1m (from Oct 18)	91	91	91
Miscellaneous Pressures		100	300
Therapies Activity not previously charged for			300
Assumes delivery of only green and amber schemes		160	160
Potential Mitigations: -			
Add back use of non recurrent resource within position	(3,406)	(3,406)	(3,406)
Use of Reserves / further balance sheet opportunities (technical)	(371)	(371)	(371)
Delivery of further efficiencies	(5,591)		
Revised Full Year Variance Projection	**2,527**	**8,378**	**8,878**
Planned Deficit Pre PSF	**4,334**	**4,334**	**4,334**
Forecast Deficit Pre PSF	**6,861**	**12,712**	**13,212**

Forecast Position Post PSF	Feb £k Best	Feb £k Most Likely	Feb £k Worst
Forecast Deficit Pre PSF brought forward	6,861	12,712	13,212
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	**2,117**	**10,923**	**11,423**
Control Total Post PSF	**(2,963)**	**(2,963)**	**(2,963)**
Forecast Variance to Control Total Post PSF	**5,080**	**13,886**	**14,386**

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 quarter two reporting and shared the most likely forecast deficit of £12.7m pre PSF. This position has been re-affirmed as part of the quarter three reporting.

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	£ 4,821,177	£ 3,736,932	£ 1,084,245	£ 49,439	£ 5,000	£ 1,027,806	£ 2,000
Collaboration & Integration	£ 520,000	£ -	£ 520,000	£ -	£ -	£ 520,000	£ -
Co-ord Centre & Dashboards	£ 21,000	£ 21,000	£ -	£ -	£ -	£ -	£ -
Drugs	£ 2,213,212	£ 424,791	£ 1,788,421	£ 49,327	£ -	£ 1,739,094	£ -
Outpatients	£ 67,104	£ 67,096	£ 8	£ 8	£ -	£ -	£ -
Patient Flow	£ 631,521	£ 66,032	£ 565,489	£ -	£ 15,489	£ 550,000	£ -
Procurement	£ 716,172	£ 302,494	£ 413,678	-£ 0	£ -	£ 572,221	-£ 158,543
Stranded Patients (DTOCs)	£ 116,511	£ 116,511	£ -	£ -	£ -	£ -	£ -
Theatres	£ 499,812	£ 99,455	£ 400,357	-£ 0	£ -	£ 290,357	£ 110,000
Unidentified	£ 1,132,363	£ 34,913	£ 1,097,450	£ -	£ -	£ -	£ 1,097,450
Grand Total	**£ 10,738,873**	**£ 4,869,224**	**£ 5,869,649**	**£ 98,773**	**£ 20,489**	**£ 4,699,478**	**£ 1,050,907**
		45%			1%		54%

6.1 Quality Impact Assessments Update

There were no QIAs approved in February 2019.

7.0 Capital Expenditure

The slow start to the year in respect of capital spend continues, (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 £3.7m by the end of February, compared to the plan of £11.0m.

The 2018/19 capital loan application has been approved by NHSI (local and national) and has been with DHSC awaiting final approval since October. The Capital regime appears to be 'hardening' even further and it may be that DHSC do not approve the loan at all. This would mean (as it currently stands) that there would be no cash available to fund ANY capital expenditure going forward. The advice from NHSI capital team is that we would need to run out our creditors until we had operational difficulties with non-payment, before we could justify getting 'exceptional' revenue cash to cover the emergency capital spend going forward. This seems to be counter to all public sector guidance around Better Payment Practice Code and being a responsible member of the local business community – and would also potentially put patients at risk if suppliers put our account on stop as a result.

So far this year, the following items have been approved at risk due to the clinical risks outweighing the financial risk: The slow start to the year in respect of capital spend continues, (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 £3.7m by the end of February, compared to the plan of £11.0m.

The 2018/19 capital loan application has been approved by NHSI (local and national) and has been with DHSC awaiting final approval since October. The Capital regime appears to be 'hardening' even further and it may be that DHSC do not approve the loan at all. This would mean (as it currently stands) that there would be no cash available to fund ANY capital expenditure going forward. The advice from NHSI capital team is that we would need to run out our creditors until we had operational difficulties with non-payment, before we could justify getting 'exceptional' revenue cash to cover the emergency capital spend going forward. This seems to be counter to all public sector guidance around Better Payment Practice Code and being a responsible member of the local business community – and would also potentially put patients at risk if suppliers put our account on stop as a result.

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	£1,478,894
Urgent Care	£ 435,317
D&P	£ 257,946
Estates & Facilities	£1,088,514
IM&T	£ 482,931
Central	£ 919,000
Total	**£4,662,602**

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

The £1.5m of PDC for LED lighting across the Trust will generate revenue savings due to the anticipated reduction in energy usage and will form part of the 2019/20 CRS programme. We have received the formal Memorandum of Understanding and a detailed plan for the work is being developed.

8.0 Working Balances and Cash

The closing cash balance at the end of February is £9.0m, which is now £5.3m ahead of plan.

So far this year the Trust has received £3.2m revenue distress funding to offset the impact of the deficit. A further £3.5m will be required in March, to cover the recurrent deficit position and the relevant loan and PDC Dividend payments that are due to go out. Within this figure is also £1.9m to cover the current shortfall in capital payments pending the approval of the loan by DHSC, as advised by NHSI.

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 eleven:

- **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 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;

- **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. 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 including a meeting of both Executive Teams 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 consequences of the **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

February 2019 Statement of Financial Position	2018/19 Actual £000	2018/19 Plan £000	2017/18 Out-Turn £000
Property, Plant and Equipment			
Opening	97,880	84,759	81,508
Capital Spend	3,684	11,084	7,648
Depreciation	(4,017)	(4,016)	(4,324)
Disposals	(92)	(91)	(73)
Revaluation			13,121
Closing	97,455	91,736	97,880
Current Assets			
Opening Cash Balance	9,112	9,112	7,093
Increase/(Decrease)	(143)	(5,419)	2,019
Closing Cash Balance	8,969	3,693	9,112
Inventories	1,759	1,477	1,437
Trade and Other Receivables	13,001	13,580	14,478
Neonatal Designated Account	2,591	1,341	2,591
Total current assets	26,320	20,091	27,618
Liabilities < 1 Year			
Trade and Other Payables and Provisions	(32,934)	(24,843)	(25,282)
Loans (ITFF)	(4,686)	(5,012)	(4,686)
PPP Loan	(37)	(40)	(37)
Total Net Current Assets	(11,337)	(9,804)	(2,387)
Liabilities > 1 Year			
Trade and Other Payables and Provisions	(1,335)	(1,350)	(1,350)
Loans (ITFF)	(31,672)	(30,759)	(31,924)
PPP Deferred Income	(1,598)	(1,597)	(1,658)
PPP Loan	(1,983)	(2,042)	(2,078)
Total Assets Employed	**49,530**	**46,184**	**58,483**
Capital & Reserves			
PDC	64,600	66,005	63,600
Revaluation Reserve	5,625	4,558	5,625
Income & Expenditure Reserve	(20,695)	(24,379)	(10,742)
Total Capital & Reserves	**49,530**	**46,184**	**58,483**

February 2019 Cash Flow Statement	2018/19 Actual £000	2018/19 Plan £000	2017/18 Out-Turn £000
Surplus	(4,496)	4,073	7,332
Working Balance Movements	8,851	554	(6,942)
Donated / Grant Funded Asset Additions	228	90	182
Disposal Proceeds	66	-	12
PPP Income/Interest - non cash movements	(61)	(61)	(67)
	4,588	4,656	517
Other non cash movement	(125)	1,250	-
Capital Expenditure	(4,470)	(12,165)	(4,349)
New PDC	1,000	2,405	266
Purchase of investments	-	-	(2,591)
New Loans	3,216	9,379	14,839
Loan re-payments Principle	(3,469)	(10,218)	(5,129)
PPP Loan Repayments Principle	(33)	(33)	(55)
Interest Payable	(603)	(491)	(590)
Interest Received	92	22	41
PDC Dividend Paid	(339)	(224)	(930)
Cash Inflow / (Outflow)	(143)	(5,419)	2,019
Opening Cash Balance	9,112	9,112	7,093
Closing Cash Balance	**8,969**	**3,693**	**9,112**

Countess of Chester Hospital NHS
NHS Foundation Trust

Operational Plan for 2019/20

Countess of Chester Hospital NHS Foundation Trust

4th April 2019 Submission

Contents

1.0 Strategic Context

Over the next ten years the Trust is facing a significant challenge in West Cheshire because of the continued growth in our aged population. This is impacting currently on our emergency service delivery, and waiting times targets for our patients. Demographic analysis of our population projects another 7,000 people within our locality, with 6,000 of those living beyond the age of 80 years, an increase of 41%. Including Flintshire (our North Wales catchment) the total population will increase by over 13,000 people. This increase in demand, particularly with the elderly, will place significant additional pressure on all of our services, therefore we are exploring new ways of working, both locally and more widely -

1.1 Cheshire & Mersey Health & Care Partnership (STP)

In addition to the key objectives of the Long Term NHS Plan, the challenge of transforming a complex group of organisations and services across such a large and diverse footprint across Cheshire & Merseyside (C&M) is a real one.

To transform our services and become sustainable, we need to mitigate demand, unwarranted variation, duplication, and cost. To achieve this we will be supporting the strategic work streams across Cheshire & Mersey. These are -

- ***Acute Sustainability*** (defining a single aggregated vision and model of care for C&M acute services)
- ***Mental Health & LD Sustainability*** (new pathways and models of crisis care, CAHMS, and integrated physical & MH services)
- ***Carter at Scale*** (designing sustainable back office and clinical support services with reduced duplication and increased efficiencies)
- **Population Health** (focus on reducing high blood pressure, alcohol related harm, and a reduction in prescribed antibiotics)
- **GP Networking** (to co-design new generic models for the future of Primary Care)

The strategic workstreams are in addition to the locality '*Place Based*' integrated care programmes across Cheshire & Merseyside, and a number of other cross cutting and enabling workstreams supporting overall delivery.

1.2 Cheshire West Integrated Care Partnership

We are working with our health and social care partners in West Cheshire to create a new Integrated Care Partnership (CWICP), hosted by the Countess of Chester Hospital, to transform how services are delivered to our most complex and demanding patients.

CW ICP will deliver a Transformation Plan and Programme for 2019/20 building on the work in 2018/19. Based on the Large Scale Change (NHSE) social system model for change methodology, the CW ICP Transformation Plan will include activities (test for change) that support realisation of the following six transformation goals -

1. Understand and actively mobilise the population
2. Actively promoting self-care, self-service and developing community assets
3. Actively divert people to the most effective and efficient access points
4. Support and encourage the flow of people to the right resources
5. Support and encourage people with multiple conditions and complex needs through multiagency teams
6. Support community professionals with resources from the acute

CW ICP will focus on the following programmes to deliver the vison, outcomes and deliverables of the CW ICP Transformation Plan. The programmes are clinically sponsored, have senior management programme leads, and involve representatives from all partner organisations –

- **Care Communities**: *we will develop 9 Care Communities across Cheshire West to deliver our Model of Care.*
- **Intermediate Care**: *we will develop Intermediate Care services which take away services that don't need to be delivered in an acute setting into community.*
- **Long Term Care**: *we will support people living with Long Term Care needs to receive the right services in their community.*
- **Healthy Lives**: *we will support people to enjoy Healthy Lives in their communities.*

We have a shared ambition for a more aligned strategic focus to support organisations to achieve strategic priorities and benefitting from the synergies that undoubtedly exist by bringing workforce and estate into a more collaborative operating model. Variations in our outcomes and efficiency will be reduced at a faster pace by working together under the new leadership model.

Finally, we are developing our Trust Clinical Strategy which, in the context of the pressures and developments described above, will describe clinically the direction and shape of our services over the next five years. This will be supported by a five-year business plan, which will determine our operational plans which will be refreshed year annually.

2.0 Quality, Safety & Patient Experience Planning Priorities

2.1 Commissioning Priorities

At a time of ever-increasing demand for health and care services, the Trust is recognising the growing importance of carefully balancing local needs against the money available. As healthcare is becoming a whole-system approach, the Clinical Commissioning Group (CCG) is exploring with us options of the services it will commission and is also looking at areas that need to be improved or even decommissioned or shared.

We are supporting the CCG approach of identifying initiatives across a number of different programme areas which they believe can deliver service improvements that have good outcomes and are value for money.

To achieve this, the CCG is working closely, not only with us, but with partner organisations like Cheshire & Wirral Partnership NHS Foundation Trust and Cheshire West and Chester Council, to ensure the initiatives complement their plans for improving the delivery of care. The development of the Integrated Care Partnership between local organisations will further develop to ensure services are supporting patients closer to home.

Below are a few examples of some areas of focus from last year, the expectation is that these will further be implemented to ensure continuous improvement and compliance -

- **Improve compliance with NHSI Patient Safety Checklist in the Emergency Department**
  Audit plan amended to reflect more real time collection and monitoring of patient safety in the ED (in the light of current operational challenges)

- **Demonstrate effective use of real time information to manage safe staffing against patient acuity and ward activity**
  Acuity based workforce data now being utilised to support trust-wide establishment reviews. Robust governance processes in place regarding deployment of staff to patient acuity and dependency.

- **Ensure clinical leaders are sharing identified trends with staff in their department /ward from across the triangulation of clinical and non-clinical -**
  - Incident reporting
  - Claims
  - Complaints
  - Local and National Surveys
  - Patient Advice and Liaison Services

  'Safety Briefs' have been amended to ensure key messages are shared. '*Lessons Learned*' communication is shared across the Trust weekly following the Serious Incident review panel. This illustrates themes for learning from incidents, claims, complaints and coroners cases. A monthly Quality Newsletter has been developed by the Associate Medical Director for Safety which will further communicate key quality and safety messages.

- **Provide assurance that improvements to practice are identified through mortality reviews inclusive of deaths within 30 days of discharge and that this routinely disseminated across the Trust and is regularly shared with the Board of Directors in public meetings**
  The Learning From Deaths group and subsequent work plan has gained momentum over the past year and will continue to be an area of focus to reflect the national guidance. A regular report is presented to the Board of Directors and the data that is collated from mortality reviews is now being utilised to support learning and improvements. Various communication mechanisms of sharing are being developed going into this next year.

As well as continuing the areas of focus from last year and those identified in the NHS Standard Contract, our plans going forward for the next financial year will support the local health needs and CCG priorities with their objectives. Some areas that will feature in next year's plan are:

- Access for patients with a learning disability or autism
- Early detection and response to the deteriorating patient
- Improving compliance with Sepsis screening and timely management
- Redesign and relaunch of 'Care Assurance Framework' for quality metrics (expanding into none inpatient areas and the Integrated Care Partnership)
- Further focus on anti-microbial resistance
-

2.2 Seven Day Services

There are changes to the assurance requirements for 2019/20 but this doesn't affect the narrative in respect of the key standards. The main change going forward is that we will be able to utilise individual areas of our services and apply the seven day tests to them as a driver for improvement internally. We will then ensure that changes are reported to a Board level committee via our Quality, Safety & Patient Experience Committee (QSPEC).

Our priority seven day service standards are below which is a positive compliance position -

Seven Day Services Standard	Position
Standard 2: ***Timely consultant review*:** All emergency admissions have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours of arrival at hospital.	Our 2018 performance on Standard 2 has been **95% compliance.** Through 2019/20 we will be closely monitoring this standard to ensure that our excellent compliance remains consistent.
Standard 5: ***Improved access to diagnostics*:** Hospital inpatients have scheduled 7 day access to diagnostic services. Consultant-directed diagnostic tests and reporting available 7 days a week:	Our 2018 performance on Standard 5 has been **97% compliance.** We will, as with Standard 5, be closely monitoring this performance. Changes to particular pathways, as required, may trigger a requirement for focussed work on key

within 1 hour for critical patients; within 12 hours for urgent patients; and within 24 hours for non-urgent patients.	diagnostics.
Standard 6: ***Consultant directed interventions*:** Hospital inpatients must have timely 24 hour access, 7 days a week, to consultant-directed interventions.	Our 2018 performance on Standard 6 has been **100%** and we are monitoring ongoing compliance as required.
Standard 8: ***On-going review in high dependency areas*:** All high dependency patients (including acute medical unit, surgical assessment units and intensive care unit) seen and reviewed by a consultant twice daily, unless it is determined by a senior decision-maker that this would not affect the patient's care pathway; and consultant- directed ward rounds.	Our 2018 performance on Standard 8 has been **98%** and again we will monitor standard compliance.

2.3 Approach to Quality Improvement

The Trust's choices for improvement are based upon reviews of our quality and safety performance and service areas of development, together with a triangulation of commissioning priorities, service user feedback and incident reporting. In-year there has been a real improvement in the response rate to the '*Friends and Family*' test and despite operational challenges, patients continue to indicate a high level of satisfaction. The Trust is working hard to proactively use the valuable information relating to our patient experiences in a meaningful way that supports change. The information from our patients will also be used as a barometer to support the changes underway in our improvement plans.

Our three key areas of improvement continue to be as follows -

- **Safe** – improving and increasing the safety of any care or service provided. Learning when it doesn't have the positive outcome that was expected and putting it right to reduce the risk of it happening again.
- **Kind** – improving the experience as described by 'you', our patient, when using the services for any reason. Using your information to support the changes in a positive way.
- **Effective** – supporting the work across the local system, ensuring the goals optimise health and wellbeing at all stages of illness.

Our revised Quality Improvement Strategy for 2019/20 will continue to reflect our vision of Safe, Kind, and Effective. This will ensure that patient experience, clinical effectiveness and safety remain a real focus throughout any local and regional changes.

2.4 Current Quality Concerns & Key Quality Risks

The Trust is registered with the Care Quality Commission (CQC), and currently there are no conditions attached to this.

We had our unannounced CQC inspection in November 2018 which was then subsequently followed up in December 2018 with the Well-Led review. The unannounced clinical part of the inspection process focused on the urgent care pathway (with a key focus on emergency care and dementia care), and the planned care pathways. We are currently awaiting our outcome report from this.

2018/19 has continued to be a very challenging year for the hospital, as we have struggled to maintain the emergency access standard measure of four hours. We have worked collaboratively with our local system; this has culminated in seeing a reduction in locally 'Stranded' patients. We will continue to work with partners to ensure patients are not staying in hospital for excessive lengths of time. It is anticipated that with further development of the Integrated Care Partnership, this will contribute to allow more patients to be cared for out-of-hospital in a relevant setting.

The Trust has had one 'Never Event' in the 2018/19 year to date , therefore, it continues to focus upon reflective learning including 'human factors', targeting more rigorous standardisation of checks, using tools such as the World Health Organisation (WHO) safety check list. The Trust is working through and implementing the National Safety Standards for Invasive Procedures (NatSIPS). This is and will continue to be monitored on a regular basis via our Quality, Safety & Patient Experience Committee.

Key areas of focus going forward, from a safety perspective, will be to fully implement the Sepsis Quality Improvement programme; this will facilitate learning and awareness of recognising and managing the 'deteriorating patient'. In particular, ensuring the national early warning tool (NEWs2) is fully embedded in practice and audited to monitor compliance.

Significant work has been undertaken in respect of the Falls Quality Improvement Programme. We will continue this work into 2019/20, focusing on implementing the best evidence and continuing to engage with the multi-disciplinary teams.

Ensuring the safety of our patients during operational pressures will continue in particular with compliance against the ED Safety Checklist, and management of our patients in escalated areas of the Trust.

The Trust has seen a slight increase in pressure ulcers in year and therefore a programme of work (supported by the NHSI collaborative) is in place to ensure this position does not deteriorate. The Safety Thermometer work will continue and a number of other metrics will be added to facilitate quality improvements at ward level.

2.5 Summary of the Quality Improvement Plan

We will ensure that our refreshed Quality Improvement Strategy reflects the key national priorities and as well as local areas of risk above. This will also underpin the service improvements that are happening within the Trust to develop our improvement plans.

Our ultimate ambition is for the Countess of Chester Hospital NHS Foundation Trust is to build a culture of continuous improvement. This means that we make improvement a routine daily activity and use Quality Improvement (QI) methodology to help tackle the challenges we are faced with. As the leading institute for healthcare improvement in Sweden, the *Qulturum* in Jönköping promotes, "everyone has two jobs; to do your work and to improve your work." We aim to create this culture here, where everyone routinely comes to work, to improve their work – helping to ensure that we continue to deliver safe, kind and effective care.

To achieve this we will continue to offer the following QI training opportunities –

- ACORN (nurse development programme)
- Foundation Programme (junior doctors)
- QI Basics (1 day introduction programme - monthly)
- Team Approach (training and coaching teams through a project)

Our future QI plans are –

- Re launch the I2I programme (6 x ½ day programme and completion of a project)
- Add a ½ day QI session for our leadership programme

As part of the Model Hospital programme the implementation of the e-rostering staffing system is complete and the utilisation of the *Care Hours Per Patient per Day* work and benchmarked data from the NHSi Model Hospital portal is supporting this programme of work. This will allow the workforce in the future to better meet patients' needs in a safe and effective and efficient way. A key priority going forward will be to implement the recently undertaken nurse staffing establishment review, however a risk-based approach will be required in the context of balancing this with financial pressures.

The on-going work in the programmes outlined, are fundamentally underpinned by the work being driven by the Model Hospital work streams. The culture and performance work programmes implemented will continue to support the changes necessary to empower staff and address the behaviours that are not acceptable and that may have a negative effect on outcomes.

Our HCAI performance during 2018/19 has caused us concern with 3 MRSA Bacteraemia cases during the year, and CDI cases have exceeding our target of 23. In light of this, infection prevention and control remains a high priority, with a zero-tolerance approach to avoidable healthcare associated infection being embedded at all levels of the organisation, contributing to patients receiving safe, high quality, effective care. Infection prevention activity will be centralised around maintaining compliance with the Health and Social Care Act 2008 code of practice on the prevention and control of infections and related guidance. We will focus on key areas of service delivery, including hand hygiene and cleanliness to reduce the risks associated with infections including *Clostridium difficile*, MRSA and infections caused by other antibiotic resistant organisms.

Our Gram-negative Improvement Plan is in place to support the national ambition to reduce gram-negative blood stream infections by 50% by 2021. The current E.coli BSI CCG Quality Premium target is no more than 203 cases of infection.

The plan adopts a whole health economy approach in addressing identified risk factors which contribute to the development of E.coli bacteraemia. Risk factors and associated actions taken include development of an operational action plan focusing on seamless and robust management for patients with urinary catheters; formation of a working group to develop a consistent pathway for the investigation, management and compliance with antimicrobial formulary in relation to recurrent urinary tract infections (UTI) and to develop and implement a targeted communication strategy aimed at raising awareness of the importance of maintaining good hydration amongst local populations, to reduce risks associated with UTI. We are committed to working in partnership with colleagues across the health system to work towards achieving these improvements.

During quarter 4 of 2018/19, the Acting Medical Director (new DIPC) and the Director of Nursing & Quality have commissioned an external review/improvement programme via NHSi to support the agenda above. This will seek to review practice, policy and governance.

It is expected that CQUINS (Commissioning for Quality and Innovation) will from part of the overall plan of a whole system approach to improve care as with previous years but ensuring that a system approach is implemented, ensuring ongoing collaboration with local partners.

2.6 Summary of Quality Impact Assessment Process

The Trust has an agreed Quality Impact Assessment (QIA) process which was refreshed during 2018/19. Quality improvement schemes are ultimately signed off by Darren Kilroy (Acting Medical Director) and Alison Kelly (Director of Nursing and Quality). Monitoring the impact of the schemes is by the Divisional Governance Boards by exception reporting, which in turn is escalated to the Corporate Leaders Group if required.

Currently, projects that will require a Project Initiation Document (PID) which encompasses a Quality Impact Assessment (QIA) are defined by the following criteria -

- If the value of the scheme is over £100k
- If there is a change in clinical practice
- If there is procurement of a different clinical product
- Changes to service delivery (including staffing)
- Changes in income that may have a contractual impact

The project is assessed once all elements of the PID template have been completed. A QIA will be completed as part of the PID to assess whether it has any potential impact on patient care, safety or experience. The PID document includes KPIs and quality indicators as well as assessing impacts against equality, information governance and medical education. The divisions are responsible for monitoring or escalating any risk – this element has been strengthened during 2018/19. A prompt is now also included in the documentation utilised in the Serious Incident Panel review meetings to identify whether any harm to patients may have been a result of a CRS/service change scheme.

If the project is deemed to have an unacceptable level of risk, a review meeting will be initiated with the division to discuss further detail before the project is implemented. If a project is not deemed to have a positive or neutral impact on quality it will be withdrawn.

The QIA is reviewed by the Medical Director and Director of Nursing & Quality for authorisation. A scheme cannot be implemented until this approval has been completed. If a QIA has not been completed adequately or requires additional information, this will be routed back for rework prior to resubmission or rejection in full.

3.0 Operational Delivery

This year despite the rising demands we have has seen significant improvements in operational delivery with a number of key achievements such as the reduction in length of stay and improved theatre utilisation. Capacity to meet demands in a timely way both electively and non-electively remain a pressure into next year and therefore further options and discussion continue across the wider system on how this can be addressed.

A&E – An agreed trajectory is in place, with plans to improve on the four hour national standard. The Trust is launching an ED (A&E) Improvement Programme which will contain a number of work streams including a focus on the front door, assessment areas, workforce and seven day services. Having worked closely with the NHS Improvement ECIP team in the last year, we continue to focus on improving our four hour performance. The development of same day emergency care has seen the trust consistently delivering over 35% of non-elective care pathways without the need for an overnight stay.

Urgent care – Development of our Integrated Care Partnership in West Cheshire has moved on at pace this year with aims of service reconfiguration in the coming year. This will support our focus on managing inpatient length of stay will continue, with the aim of reducing medical outliers wherever possible and keeping the number of stranded patients low. Intermediate care services and the integrated discharge team have transferred to the Integrated Care Partnership as the Trust aims to support partnership and system working.

Elective Care and Theatres – This year has seen an improvement in our theatre utilisation with the introduction of our Theatre Culture improvement work. Over the coming year supported by the introduction of the Coordination Centre we aim to further increase theatre productivity to maximise theatre and elective capacity. The development of an elective short stay unit is reducing cancellations and supporting improvement in reducing elective length of stay.

Outpatients – We have seen significant improvements this year in regard to our booking processes that has seen reductions in DNAs and a reduction in our follow up appointments. Our main focus this year will be to further reduce the number of face-to-face follow-up outpatient appointments via the use of technology and also strive to optimise follow-up outpatient appointments with a view to delivering follow-up ratios in the top 25% of the country. The Trust has continued with the implementation of electronic booking processes as part of the national roll out of E-RS and is continuing its focus on the turn round of clinical correspondence.

Diagnostics – High demand on our diagnostic services continues to place a pressure on these services. We will continue to ensure proactive management of capacity and demand within endoscopy and imaging services. The Trust has been working with the intensive support team and will be completing the NHS Improvement demand and capacity tool to support further understanding of the challenge and solutions.

Referral to Treatment – The Trust will continue to actively manage our RTT times with continued aims to improve current performance. Demand has continued to rise across many services and therefore the ability to maintain and improve waiting times is a pressure both in terms of capacity and also affordability for the wider system.

Cancer – We will continue to focus on our challenges in the achievement of all of our cancer pathway targets. This year we have been supported by the NHSI Cancer Intensive Support Team to improve in a number of areas in particular Urology. This work will continue with the main area of focus on diagnostics and urology.

Key Operational Risks

The key operational risks from our Board Assurance Framework are identified in **Appendix 1.**

4.0 Financial & Activity Planning

The table below summarises the forecast financial performance for 2018/19 and updated plan for 2019/20.

I&E Summary	2018/19 Plan £m	2018/19 FOT £m*	2019/20 Plan £m*
Income	(234.72)	(232.81)	(239.2)
Pay & Non Pay Expenditure	225.63	237.59	247.3
Interest, Dividends & Depreciation	6.13	6.14	7.2
(Surplus)/Deficit prior to impairments	**(2.96)**	**10.93**	**15.3**
(Surplus)/Deficit (excluding PSF/FRF/MRET)	**4.33**	**12.73**	**15.3**
Efficiency Savings incl. in above	**(10.74)**	**(5.14)**	**(4.50)**
SOF Risk Rating	**3**	**4**	**3**

**subject to change between categories*

4.1 2019/20 Financial Plan

4.1.1 Control Totals and Provider Sustainability and Financial Recovery Funds

The notified control totals, Provider Sustainability Funds (PSF) and Financial Recovery Funds (FRF) is as follows:

	2018/19 Plan £m	2018/19 FOT £m	2019/20 Plan £m
Non recurring Provider Sustainability Funding (PSF)	7.297	1.788	3.809
Non recurring Financial Recovery Funding (FRF)	n/a	n/a	3.515
Control Total	2.628 surplus	10.938 deficit	0.0 Breakeven
Agency ceiling total	4.459	4.459	4.576

4.1.2 2018/19 forecast outturn to 2019/20 plan (excluding PSF, FRF and MRET)

The table below provides a summary of the changes between 2018/19 forecast outturn to 2019/20 plan split by 2018/19 underlying performance, national pressures and efficiencies and local pressures and efficiencies

Description	£m
B/fwd Underlying Deficit from 18/19	4.3
2018/19 CRS Recurrent Non Delivery	8.9
Current Cost Pressures 18/19 to Deliver Forecast Outturn	4.5
Current Income Pressures 18/19 in relation to Forecast Outturn (Drugs & In Year Performance)	2.1
Total Underlying deficit 2018/19	**19.8**
Pay Award & Incremental drift	8.1
Additional Non Pay Inflation for 19/20	0.9
Income (Tariff)	(7.4)
CNST (reduced cost)	(0.4)
Central Procurement savings	(1.3)
Efficiencies @ 1.6%	(3.6)
Total National pressures and efficiencies	**(3.7)**
Additional costs - NHS property services - assumed Commissioner funded	0.0
Vascular risk share - year 2 increase	0.1
EPR (Cerner)	-
Growth - expenditure to deliver activity increase	3.0
Growth – income	(3.0)
Clinical Excellence Awards 2019/20	0.2
New Pressures 19/20	2.4
Contract Negotiations	(0.5)
Remove Medical Pay Reserve	(2.1)
Additional Efficiencies @ 0.4%	(0.9)
Local pressures and efficiencies	**(0.8)**

Total Deficit	**15.3**
Less Control Total	**8.0**
Gap to Accepting Control Total	**7.3**

As demonstrated by the table above the Trust is unfortunately unable to accept the 2019/20 control total at this point.

4.1.3 Planning Assumptions

The plan has been built up from the recurrent forecast outturn position for 2019/20, inflation & tariff impacts and current & new pressures identified as part of the business planning process.

The following assumptions have been made to arrive at the planned outturn above –

Commissioner income – tariff	Estimated using 9 months activity 2018/19. Impact of new tariff & MFF changes has been modelled (planning prices). Assumes Wales will pay at published National Tariff rates
Commissioner activity	See activity section
Pay uplift	A4C calculated impact for 2018/19 and 2019/20 pay awards based on published rates, 2% pay uplift for Medical staff from October 2019 and actual incremental drift.
Non pay – general & drugs	£1.2m reserve established (1.8% of non-pay)
CNST Changes	Reduction of £0.40m
Capital Charges	Calculated in line with proposed capital programme
CQUIN	CQUIN not supported by BCU, also assuming CQUIN not withheld at this stage by English commissioners
Central procurement savings	Non pay budgets have been reduced to reflect the savings identified to the trust of the impact of the updated funding model
Growth	The additional costs of delivering growth are equal to expenditure (assumed outsourced/purchase of nursing home beds due to capacity constraints)
Efficiencies	Efficiency plan calculated at 2% of budgets
Capital	2018/19 capital loan will be fully approved and brought forward
Pay – additional pension costs	The impact of changes to NHS pensions for 2019/20 are not included in the current plans
Fines & Penalties	The plan does includes £100k only reduction in income due to the application of contract performance fines and penalties

4.1.4 Alignment with Commissioners

The majority of the Trust's clinical income is derived from contracts with Western Cheshire CCG (75%) & Betsi Cadwaladr University Health Board (12.5%).

The activity assumptions contained within this plan have been aligned with Western Cheshire CGG. The activity plans include agreed assumptions regarding growth but do not include the delivery of the additional backlog of activity required to return the Trust to the required 18 week RTT standard as this is currently not affordable to the system.

We have assumed that the current performance will be consolidated within the Betsi Cadwaladr University Health Board 2019/20 contract baseline.

4.2 Activity & Income

The table below reflects the commissioner aligned assumptions regarding activity growth in 2019/20 that is reflective of local trends. These assumptions do not include the backlog required to achieve 18 weeks RTT as noted above.

Point of Delivery	Annual Growth increase 2019/20
A&E	2.40%
Non-Electives (excluding Paediatrics and Obstetrics)	2.00%
Daycase & Elective	2.00%
Outpatient	2.00%
Referrals	2.00%

The activity table below summarises our activity and income plans for the current period for all commissioners.

Commissioner Income	2018/19 FOT		2019/20 Plan	
	Activity	£,000	Activity	£,000
Day Cases & Elective	40,363	35,582	41,136	37,042
Non Elective IP	32,260	65,323	32,890	71,757
Outpatients	350,264	39,414	355,368	41,374
A&E	81,604	9,245	83,533	10,561
Other & CQUIN	1,135,193	52,166	1,135,193	54,416
Total	**1,639,684**	**201,730**	**1,648,119**	**215,150**

The approach to modelling demand -

- Baseline using latest fully coded activity (April-December) - Split by specialty, Point of delivery, Region (English/Welsh) then extrapolated using seasonal profiles
- Further adjustments made for any further service changes in conjunction with the business managers (Including Demography, screening campaigns, pathway changes, service developments, any known commissioning intentions, any non-recurrent factors that have affected activity, referral patterns and conversion rates)
- Average national tariff (planning prices) applied
- Activity profiled by point of delivery, using number of working days in the month and any known variations e.g. annual leave, rolling half days, bank holiday, historic trends

The approach to modelling capacity

- Modelling undertaken in conjunction with Business Managers and Finance

- Identify theoretical capacity using job plans, adjust for annual leave, bank holidays, DNA/Cancellations, levels of sickness
- Calculate the variance between predicted demand and capacity available
- Identify what resource can be realigned and what is required or can be removed to match capacity to demand.

4.3 Expenditure

The Trust has continued to ring-fence a recurrent contingency reserve of £500k and also a general reserve of £700k.

4.4 Workforce Changes

The table below summarises the workforce changes for the next year which reflects any investments, service changes and efficiency savings detailed previously.

Workforce Numbers	WTE's
Rollover 18/19	3,888
Investments	61
Service Transfers	25
Baseline 19/20	**3,974**

4.5 Agency

The reduction of agency spend remains a key challenge and priority of the trust going into 2019/20. Costs will continue to be managed via medical workforce board, nursing & midwifery workforce board, weekly nurse staffing reviews, monthly confirm & challenge roster sign off sessions, weekly vacancy panel and executive sign off for high cost temporary staff in line with current agency rules, guidance and Standing Financial Instructions. The Trust will also continue to review alternative staffing models and develop recruitment strategies, alongside the utilisation of e-solutions to reduce the time-to-hire, such as TRAC, and the implementation of e-rostering for medical staff, which builds on that established for nursing and midwifery staff.

The Trust is planning to not spend over the notified agency ceiling of £4.576m

4.6 Savings Opportunities & The Model Hospital

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

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

- Process Variation
- Clinical Variation
- People

These will be supported by new Quality Improvement processes, and consolidated business as usual activities. Our planned top schemes plan are shown in Appendix 2, and summarised below –

Process Variation

This work stream comprises three projects –

- **Patient Flow** – building on the work we have done to date to reduce non-elective and elective length of stay in line with national benchmarking. This includes maximising the use of the Coordination Centre, focusing on admission avoidance through use of effective assessment areas, reviewing our 7 day services opportunity and developing an Emergency Department improvement programme.
- **Theatres** – Using the work this year to improve the culture in our theatres we plan to continue to drive theatre efficiency, focussing on start and end times, access and utilisation, and day case rates.
- **Outpatient Efficiencies** – Continue to improve booking processes and maximise clinic capacity through use of technology such as the Electronic Referral Advice and Guidance System. Review different ways of working to reduce the need for face to face follow up appointments in line with patient need and based on national benchmarking.

Clinical Variation

This work stream comprises seven projects -

- **7 Day services** – A review of further opportunities across all services to understand if improvement can be made using national benchmarking.
- **Medicines Management –** Continued review of medicine use across the Trust, ensuring effective use and value for money.
- **Service Reviews –** A structured and standardised review of all specialties across the Trust to better understand opportunities for improvement in areas such as workforce, utilisation of capacity and saving opportunities.
- **Model Ward** – focussing on leadership & culture, operational processes, patient safety and escalation processes using best practice quality improvement techniques. Initial focus is across four of our inpatient wards.
- **Electronic Patient Record** – replacement of our Meditech system and leveraging the benefits as part of the Global Digital Exemplar Fast Follower Programme in Collaboration with the Wirral Hospital.

- **Procurement** – standardising product procurement and pricing to drive best practice and efficiencies, reducing variation in conjunction with our Alliance and Carter partners. Supporting the national drive to standardise procurement processes and buying.
- **Collaboration and Integration** - in West Cheshire, working with our local health and care partners with a focus on the frail elderly, respiratory conditions, risk stratification, enhanced care through integrated working, and community and digital front doors. Also working across Cheshire & Merseyside to develop new sustainable models of back office and clinical support services, as part of the wider Health and Care Programme work.

People

This work stream comprises two projects -

- **Medical Rostering** – building on the work done already with our nursing and midwifery staff to expand e-rostering into our medical staffing groups. This will include job planning and on call rotas.
- **High Performing Culture & Engagement** – continuing with the focus on leadership, accountability, performance management, appraisal and reward and recognition alongside wider engagement linked with the results of the 2018 NHS Staff Survey.

All work will be supported by our Planning and Information Team. All work streams will be underpinned by a number of key areas of work -

- Development of our Trust Clinical Strategy which is a fundamental piece of work that will describe the clinical direction of our Trust over next five years as we seek to match the scope of our services to the demands of our population. In particular this Strategy will support and guide our future plans in regard to workforce and estate.
- A revised Quality Improvement Strategy and approach that will support improvement plans and oversee the development and delivery of QI projects and ensure that meet the objectives across the Trust.
- Refreshing the People & Organisational Development Strategy, to support the implementation of the Trust Clinical Strategy and to recognise the key themes of the national workforce implementation plan.
- National and local benchmarking such as the Model Hospital Portal and GIRFT (Getting it Right First Time).

4.7 Single Oversight Framework

Plan Risk Ratings	Forecast Out-turn 31/03/2019 Year Ending Rating	Plan 30/06/2019 Q1 Rating	Plan 30/09/2019 Q2 Rating	Plan 31/12/2019 Q3 Rating	Plan 31/03/2020 Q4 Rating	Plan 31/03/2020 Year Ending Rating
Capital Service Cover rating	4	4	4	4	4	4
Liquidity rating	4	4	4	4	4	4
I&E Margin rating	4	4	4	4	4	4
Variance From Control Total rating	4	4	4	4	4	4
Agency rating	1	1	1	1	1	1
Plan Risk Rating after overrides	3	3	3	3	3	3

The Trust has always operated with high liabilities, which in previous years have been offset by working capital facilities, and subsequently high cash balances to enable it to achieve 'acceptable' financial risk scores. In the current financial climate, the cash reserves have been used to support planned deficits and the capital program, which when combined with the level of debt repayments, means that the Trust will only be able to return a use of resources score of 3 for the foreseeable future.

4.8 Key Financial Risks

Key financial risks are summarised below:

Risk	Rating	Value	Action/Mitigation
Winter pressures continue above costs identified to deliver non elective growth	High	unknown	Working with our integrated care partners to manage demand and flow through the health and care system.
Welsh Commissioners do not agree to pay at 2019/20 national tariff rates.	High	£1.2m	Continue commissioner discussions and escalate to regulators
Impact of HMRC change in policy regarding direct engagement model	High	£0.75m	Look for alternative delivery models of external locums
The impact of the final agreement regarding the UKs with drawl from the EU on the supply of staff and clinical supplies	Med	unknown	Continue to fully engage and act on guidance provided by Department of Health & NHS England.
Failure of anticipated savings from new procurement model to materialize	Med	£1.3m	Closely monitor and engage with supply chain.
Failure to deliver cost improvement program	Med	£4.5m	Ensure correct alignment of PPD team to most beneficial schemes
			Escalation of STP/ICS solutions
Capital availability	Med	unknown	Dialogue with central team
Failure to meet required GDE fast follower funding milestones resulting in funding being withheld	Low	£3.25m	Ensure correct project management and governance arrangements are in place
No budgeted for impact of change in Asset lives guidance	Med	£0.6m	

Enforcement of contractual performance of fines & penalties by commissioners due to non-acceptance of control total	High	£6.9m	On-going negotiations with commissioners

5.0 Workforce Planning

The Trust is hosting and continuing to support the development of the Cheshire West Integrated Care Partnership (CWICP), along with our other local health and social care partners. Currently we have incorporated our therapies service within the ICP, with the intention of expanding the scope of services included over the next 12 months. This will develop particularly around the development of a full integrated care pathway with an initial focus on Intermediate Care. Initially the model will be based on functional management but, the aim is true integration. The Community Care teams within CWP are currently outside the scope of the ICP, yet their skills are required to ensure an effective care pathway for intermediate care, especially for non-medical prescribing. The ICP is also exploring the possibility of an intermediate care bank of HCAs and District Nurses, Primary Care Nurses and Acute Nurses who can come from any provider in the ICP and work on the Intermediate Care Pathway at any of the providers.

We currently have job plans in paper version for all Band 8a and above therapists and are currently investigating job planning for all AHPs. We are linked in regionally to other organisations exploring this, although we understand that the Circadian pilot was sub-optimal. We use Allocate for rostering all therapists and we are investigating if this is a potential alternative means of moving to e-job planning. This would of course then support the care hours to contacts per day information that we have available to us, and we are therefore hopeful of attaining Level 1 this year for job planning

Following the Trust Carter Review and the ongoing model wards programme, the Trust is updating the E-job planning system for medics and introducing E-Roster for medical staff to build on the previous implementation for other grades of staff. The Trust is also updating its Electronic Patient Record system by implementing Cerner, and this will then be used in conjunction with the other new systems to improve the overall flow of patients. TRAC for Recruitment processes has already been introduced and all of these are working towards more efficient recruitment, reducing the time-to-hire as well as supporting development of a more streamlined Trust on-boarding process.

Whilst the Trust is concerned about agency spend and finds that this is a significant expenditure, the information gathered regionally shows that the Countess of Chester Hospital is averaging in the top five for lowest agency rates paid, particularly in relation to medical staff.

Description of Workforce Challenge	Impact on workforce	Initiatives in Place
Specialist Skills Shortages such as Ultrasonography, Histopathology, junior doctors, clinical coders and more	Shortages can result in low morale and higher than average sickness absence. Failure to meet patient targets and longer than usual waits for patients	We do develop internally where that is a possibility and whilst turnover is not especially high for the trust the geographical location does have an impact on retention. Ultrasonography conversion is only available at Leeds and Bristol and we really need a Cheshire and Mersey Provider.
Interventional radiologists - We have difficulties in recruiting. We are part of the South Mersey Vascular Network and IR is a key component in delivering this clinical service.	Whilst COCH has successfully managed to recruit and retain 4 wte IR consultants the South Mersey network as a whole has struggled which is making the delivery of the service potentially unsustainable going forward unless consultant vacancies across the patch are filled.	There is a potential for a Global Health Exchange team offering a fellowship scheme for radiologists. We have expressed an interest with HEE in offering an IR fellowship locally which would be a real bonus if this moves forward.
Consultant Vacancies - Paying inflated rates for agency and incurring costs with additional payments to maintain service delivery	Pressure on the rosters and staff trying to plan services and manage patient acuity which is resulting in stress and anxiety and increased levels of sickness. Specialty Doctors are being utilised to fill gaps where possible.	working with Agencies, implementation of medical eRoster and ejob planning. Overseas recruitment is being utilised but, this takes significantly more time than traditional recruitment
The Trust is developing new ways of working to reduce the pressure on A&E and so has developed an Urgent Care Treatment Centre and Hospital @ Home service as part of the ICP but, we are now having difficulty recruiting GPs to work in these services due to regional strategies and the nature of the role.	Added pressure on A&E and Integrated discharge/Community services staff. There is also an impact on the ICP as funding and workstreams are being slower to develop. We are looking to recruit these medical staff outside of the GMS contract and be true intermediate care practitioners with a focus on cardiology/respiratory and frailty.	Job descriptions are currently developed but, recruitment has been slow with these being new roles and so promotion of the new ways of working will take place and we are also going to encourage support from advanced Nurse Practitioners and Physicians Associates. GPs engagement in this area is key to the admission avoidance strategy
Creation of Specialist Nursing/Band 6 roles due to Service developments or additional work which are often recruited from internal staff and this further depletes the Band 5 nursing	Ongoing Band 5 shortages	We have been engaging our Practice Development Nurses at Nationwide Job fairs and internal recruitment days, working with our local universities and the next graduation class to identify how we can encourage more new starters in the coming months
Addressing the age profile in certain staff groups e.g. midwifery and increasingly in Nursing and Midwifery	Increasing requirements for flexible retirement and loss of specialist skills and knowledge	Joined NHSI Workforce and Retention programme to evaluate key areas for development including retire and return and flexible working policies
The increasing impact of the Annual and Lifetime Allowance on retention of long serving clinicians and the abilitiy to undertake additional clinical activity	Reduced availability in certain specialties	Implementation of ejob planning and continued recruitment initiatives in hard to fill posts
Developing a Clinical Strategy which will impact on how we address some of the workforce requirements and challenges that come from this.	Creating flexibility and supporting new ways of working	Implementation of the completed strategy

Workforce Risks

There are a total of 45 risks relating to staffing on the Trust Risk Register; however the majority of these cover the same themes of staffing shortages and the potential harm that this could cause. Below are highlights of the key areas where there are ongoing risks which are moderate or high, and cause for concern.

Description of Workforce Risk	Impact of Risk (H,M,L)	Risk response Strategy	Timescales and Progress to date
Coding staff recruitment and retention which also has a detrimental impact on Trust income	Moderate	Using Agency and bank to fill long term gaps, we have a good in-house training programme for developing staff but, retention is still an issue.	A recent consultation will introduce a new structure and introduces a Band 5 role for the first time. The intention is to improve recruitment and retention by creating internal opportunities. The plans have required some initial financial investment, however, the bank and agency use requirement will be reduced/removed.
Staffing issues across the Trust but, especially in Cancer Team; Theatres; Hospital@Home; Colorectal services; Orthopaedics and Elderly Care but affecting all of the Planned and Urgent care divisions	Moderate	Using Agency and bank to fill long term gaps; Hospital at home also has an impact on our ability to optimise discharge	The Hospital@Home service was brought in house at the end of 2018 to better support the staff on an integrated discharge pathway as part of our ICP working
Unable to maintain minimum safe staffing levels across Planned Care and resulting in cancelled procedures	High	Using Agency and bank to fill long term gaps	Workforce Recruitment and Retention groups are working to actively reduce turnover but, it should also be noted that
Lack of speciality Radiology nursing staff out of hours	Moderate	Using Agency and bank to fill long term gaps	Implementation of e-rostering has highlighted areas where rosters were not appropriate and that as been addressed but, where there are shortages it is difficult to fill the roster
Lack of Senior Physiologists, echocardiogram and Vascular Imaging	Moderate	Insufficient capacity and staffing for Vascular scans Affecting Vascular and Echo wait lists	Ongoing recruitment and use of bank and agency
Retention of Medical Staffing Team	High	Using Agency and bank to fill long term gaps, we have a good in-house training programme for developing staff but, retention is still an issue.	Specialist Skills are difficult to retain but, staff are being provided with support and development
Financial implications of reliance on agency staffing	High	Whilst we have a strategy for reducing the Trust reliance on agency staffing the shortages of junior doctors and key specialist personnel means that this is not always possible	Workforce Recruitment and Retention groups are working to actively reduce turnover but, it should also be noted that regionally we are working with other Trusts to reduce the cost of agency staff and ensure that all agencies are complying with the framework
Risk of harm to staff due to high potential of violence and aggression due to speciality of patient cohort	Moderate	The changing patient profile including dementia, mental health issues an delayed discharge sometime result in these issues	Staff training in conflict resolution and additional support for the integrated discharge pathway
Age Profile		Recruitment and retention	

Summary of Long-term Vacancies -

Description of long-term vacancy, including the time this has been a vacant post	WTE Impact	impact on Service Delivery	Initiatives in place, along with timescales
Ultra sonographers - over 2 years	3	Affecting appointments and staff morale	Local training and continued recruitment with occasional use of Agency staff
Consultant histopathologists	2	Potential delays and backlog	Currently advertising for the 3rd time. National shortage compounded by uncertainties in relation to pathology collaboration
Various Consultant vacancies in Urgent care ongoing including A&E	7.5	Difficulty optimising rotas unpredictable working schedules and use of agency staff	working collaboratively with colleagues across the patch for joint working and reducing agency costs. Ongoing recruitment
Various Consultant vacancies in Planned care ongoing	5	Difficulty optimising rotas unpredictable working schedules and use of agency staff	working collaboratively with colleagues across the patch for joint working and reducing agency costs. Ongoing recruitment
Ongoing Mid grade Doctors across the Trust	24	Difficulty optimising rotas unpredictable working schedules and use of agency staff	working collaboratively with colleagues across the patch for joint working and reducing agency costs. Ongoing recruitment
Advanced Nurse Practititioners	2	Intermediate care is struggleing with none medical prescribing which then pales an additional burden on medical prescribing	More ANP vacancies and training places have been identified but, the oout turn will take time

Workforce Transformation

The Countess of Chester Hospital is committed to meeting future workforce demands through the utilisation of the Apprenticeship Levy by expanding apprenticeship training opportunities for new and existing staff. We aim to meet the 2.3% headcount target and maximize our return on investment through the Levy. The Countess of Chester Hospital has always been an enthusiastic supporter of apprenticeships as a way of recruiting fresh talent and supporting staff development. The evolution of new apprenticeship standards provides opportunities to develop career pathways in the NHS.

We are working with Local Health Education Institutions (HEIs) to provide physiotherapy apprenticeships as the HCPC has already agree the requirements for Physiotherapy and Occupational Therapy and we will also be developing future links for Dietetics in the future. Advanced Nurse Practitioner apprenticeship will also be in place in the future and we are hoping to recruit four to intermediate care in the next 12 months.

Roles	**Number Planned**	**Month Planned**	**Comments**
Physician Associate	1	TBC	The first group of starters in 2018 were very successful and the trust is continuing to support this role
Advanced Clinical Practitioner	4	Apr-Jun	Largely for supporting None Medical Prescribing
Nursing Associate	Subject to Plans (Two trainee Nursing associates are beginning shortly)	ASAP - out to advert	The start of an ongoing schedule of development for this new role.
IAPT (High Intensity)	0		
IAPT (Low Intensity)	0		
Other	0		

Apprenticeships	**Number Planned**	**Month Planned**	**Comments**
Registered Nursing, Midwifery and Health visiting staff	*18.0*	*September*	*Dependent on Training places*
All Scientific, Therapeutic and Technical Staff	*7.0*	*September*	*Dependent on Training places*
Allied Health Professionals	*4.0*	*September*	*Dependent on Training places*
Other Scientific, Therapeutic and Technical Staff	*3.0*	*September*	*Dependent on Training places*
Health Care Scientists	*2.0*	*September*	*Dependent on Training places*
Support to clinical staff	*20.0*	*Ongoing*	*Trust rolling Programme of Development*
NHS Infrastructure Support	*10.0*	*Ongoing*	*Trust rolling Programme of Development*

6.0 Membership and Elections

The Trust and our Council of Governors have governor elections and membership recruitment as continuing priorities.

The Director of Corporate and Legal Services, as a member of the Executive Team has specific responsibility for Governors and considers the feedback from the membership regarding their experience during elections. A procurement process was undertaken and a new election provider was appointed for a contractual period of two years. The Trust was able to continue with the improved nomination process and further embedded the option for e-voting which gave the opportunity for increased voting turn out.

As part of the nomination process, the Trust offered one-to-one discussions for potential Governors. This gave the opportunity for them to discuss and ask questions about the role of a Governor with existing Governors, Lead Governor, Chairman of the Trust and Executive Team. The feedback from attendees have made the sessions a regular and valued part of the recruitment process for Governors. The Trust continues to achieve good levels of voting across constituencies.

When a Governor has been elected, there is an induction process which includes meeting the Chairman and other Non-Executive Directors, Lead Governor and the Director of Corporate and Legal Services. Opportunities then arise for the new Governors to meet the other Executive Directors. The induction process outlines the current Trust performance, statutory responsibilities and the important role Governors can play in the life of the Trust. New governors are also encouraged to attend regional Governor Forums for networking and learning.

The Council of Governors have regular training and continued professional development in a range of subjects including quality, safety and patient experience, the development of Integrated Care Partnerships, finance workshops, joint planning workshops, CRS performance, operational patient flow, equality and diversity, Sepsis, safeguarding and CQUINS. Governors undertook the re-appointment of the Chair of the Trust for a further three year term of office. Governors are also an integral part of Trust business with representatives on Committees including A&E Delivery Board, Patient Experience Operational Group, End of Life Care Group, Medical Devices Committee, Chair of Organ Donation Committee, Disability and Equality.

Governors are also in the unique position of meeting as a Governors Quality Forum monthly which keeps them abreast of Trust matters and ensures their own continued professional development, adding value to the relationship between the Board of Directors and Council of Governors. The Chair and other Non-Executive Directors together with members of the Executive Directors regularly attend these meetings.

Engagement with members and the public is a priority for Governors and will continue to be the focus on the Trust's membership Strategy which will include exploring further engagement opportunities with members and the public. The Governors regularly provide feedback to the Trust from members and the public and this now be monitored through the Patient Experience Operational Group. Governors are building links with the local BME community and are planning to hold 'Listening Events' with these groups. A renewed programme of regular visits by Governors to wards and departments within the Trust has been launched (*Gov Rounds*). These are an opportunity for Governors to receive feedback directly from staff, patients and their families. The reports from the Gov Rounds are reviewed and monitored by the Patient Experience Operational Group, along with a regular overarching report to the Governors Quality Forum. Governors also have the opportunity to share their patient stories with the Board of Directors meetings held in public.

The Trust and the Council of Governors are looking at new and innovative ways of recruiting members encouraging online registration and social media interaction.

The Trust proactively communicates three times a year directly with the membership via the Countess Matters publication which features different articles on activities within the Trust and Governor activity. The Trust continues to email members directly, which assists with focussed communication going forward and creates further active engagement with members. The Countess Matters publication is available online on the Trust website and is shared over social media outlets. In terms of enhancing communication between the Trust and Governors, Governors receive the Trust's fortnightly bulletin and monthly Countess Brief.

The Trust and the Council of Governors will continue with the well laid foundations detailed above for engagement with members and the public through 2019/20, and proactively reach out to local interest groups to encourage further engagement and feedback from a diverse range of groups across all constituencies.

7.0 Appendices

Appendix 1 – Key Operational Risks –

BAF Risk CR : Inability to effectively stabilise acute patient flow

A number of actions are in place but gaps in assurance are listed below:
Risk Score 4x4=16

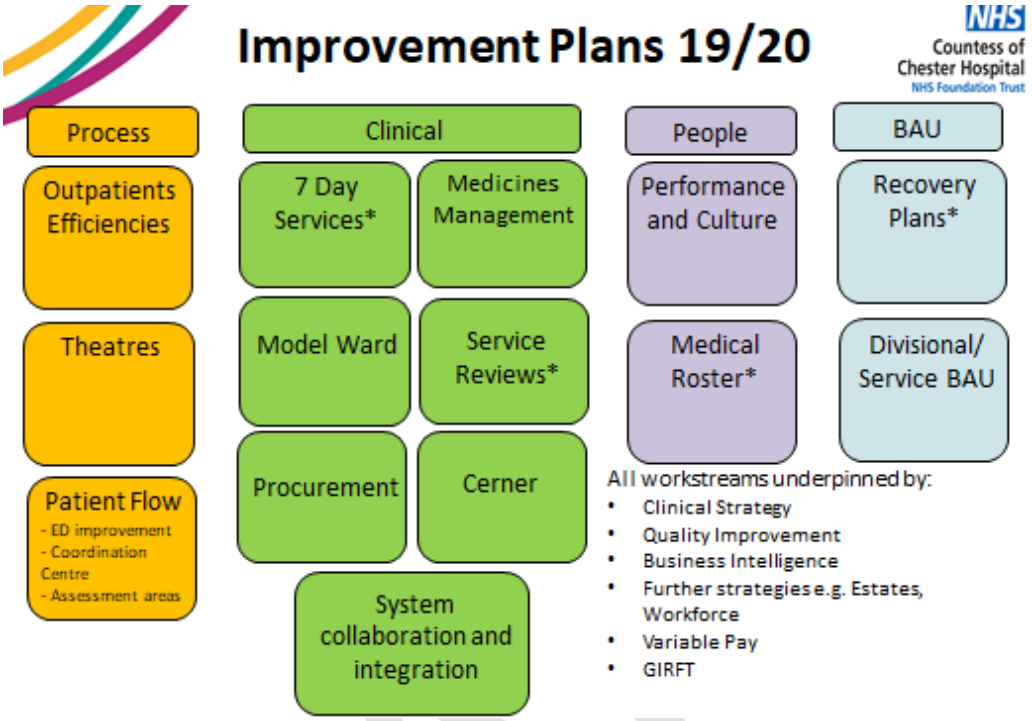
Gaps in Assurance	Actions Being Taken
Insufficient diagnostic capacity to meet demand	Endoscopy recovery plan, including insourcing at weekends, ultrasound recovery plans, including outsourcing of reporting to enable activity sessions. Monitoring of cancer PTL & diagnostic waits to ensure cancer diagnostics are prioritised
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.
Insufficient bed capacity	Daily oversight of admissions and discharges, discharge delays and bed occupancy. Fortnightly exec oversight of >21 LoS days
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.
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
Gaps in medical & nurse staffing	Divisional support to develop workforce plans & alternative roles to be presented via medical pay meeting & Nursing & midwifery workforce group
ED Capacity due to sustained increase in attendances	ED Delivery Board.

BAF Risk CR1 : Failure to comply with Regulatory Compliance Framework

A number of actions are in place but gaps in assurance are listed below:
Risk Score 4x4=16

Gaps In Assurance	Actions Being Taken
Lack of queue oversight due to current EPR	EPR upgrade and manual tracking of follow up PTL
>21 day length of stay patients	Validate bed capacity data and exec oversight for nationally set reduction target
Cancer performance	Implementation of key actions identified in action plan Increased clinical engagement & oversight
18 week failure of incomplete pathway	Development of actions to address 18 weeks and longest waiters
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.
Demands exceeding capacity within budget	Implementation and support to CCG demand management work streams and clinical pathway redesign
Lack of capacity in diagnostic services	Increasing primary care/demand for diagnostics and hospital requires senior oversight, education & training
Lack of sufficient financial resources	Inability to in source/outsource to meet the growth of demand. Short term Business Cases to meet overall capacity
Gaps in medical & nurse staffing	Divisional support to develop workforce plans & alternative roles to be presented via medical pay meeting & Nursing & midwifery workforce group

Appendix 2 – Savings Programme



Top schemes

Sub Division	Detail Scheme Name	Sum of TARGET In Year
Planned Care	Additional Welsh Orthopaedic work	£ 660,000
Planned Care	Closing beds	£ 300,000
Urgent Care	Non-Recurrent Vacancies	£ 180,000
D&I	Led Lighting	£ 150,000
Planned Care	Vacancy savings	£ 150,000
D&I	Vacancy savings	£ 130,000
Planned Care	Vascular income – rehab patients	£ 112,000
IMT	Non Recurrent Vacancies	£ 111,362
Planned Care	Orthodontic therapist income	£ 100,000
Urgent Care	Bed reconfiguration/patient flow	£ 100,000
Urgent Care	BPT - Stroke	£ 100,000
Urgent Care	Reduction in non-pay	£ 100,000
D&I	Porters	£ 75,000
Planned Care	CNST maternity incentivised payment	£ 75,000
D&I	Beckman Contract	£ 50,000
Total		**£ 2,393,362**

NHS
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Subject	Financial Plan 2019/20
Date of Meeting	Trust Board 26th March 2019
Author(s)	Mr. Simon Holden, Director of Finance Mrs. Sue Phillipson, Head of Financial Management
Annual Plan Objective No.	
Summary	This paper outlines the planned budgetary position for 2019/20, in line with the formal submission of the Final Plan (which is required by NHS Improvement on 4th April 2019).
Recommendation(s)	**The Board is asked to note:** o The underlying projected Trust deficit of £15.3m and subsequent inability to accept the notified control total of £8m (i.e. a £7.3m gap to being able to accept the control total); o The setting of a 2% Cost Reduction Scheme (CRS) target equating to £4.5m; o Details of both current, and new, cost pressures addressed within the 2019/20 plan; o The underlying assumptions in relation to the production of the 2019/20 plan; and o A number of potential risks and mitigations in relation to 2019/20 plan. **The Board is, therefore, asked to formally approve the Trust's 2019/20 Financial Plan**
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**	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.

▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

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FINANCIAL PLAN 2019/20

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Appendices

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1) Introduction

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

- The calculation of the forecast underlying Trust Deficit of £15.3m and the gap to the accepting the control total of £7.3m;
- The pressures that have been recognised and funded, within the budget plans;
- The setting of a 2% CRS equating to £4.5m;
- How the efficiency target of £4.5m has been allocated to divisions/departments; and
- The risks that may impact on the Trusts ability to achieve the required CRS of £4.5m and the planned net deficit of £15.3m.

2) Summary of the Underlying Deficit (£15.3m)

The Trust is facing significant financial pressures in 2019/20 which has resulted in a budget delivering a deficit position of £15.3m, after planning to deliver a 2% CRS target.
[NB. A 2% CRS target equates to circa £4.5m.]

The notified control total is £8m, but it has not been possible to accept this control total as there remains residual pressures that total £7.3m.

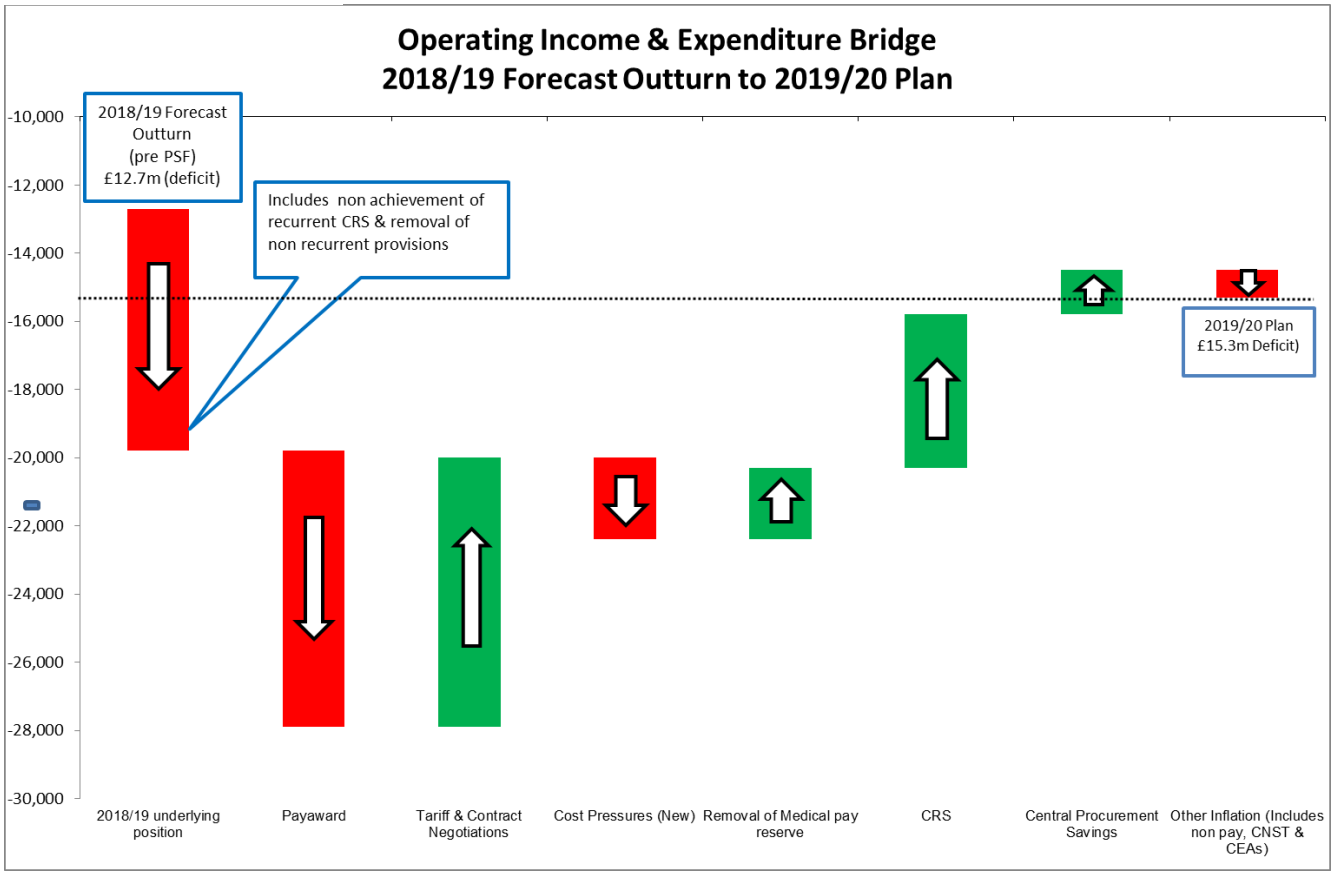
Please find below a high level summary of the overall Trust budget for 2019/20;

		Proposed Budget 2019/20 £000s
Income		
Commissioner Income	£	215,296
Training & Education Income	£	6,793
Other Income	£	17,179
Total Income	**£**	**239,268**
Expenditure		
Pay	£	175,100
Non Pay	£	76,771
Capital Charges	£	7,238
Total Expenditure	**£**	**259,109**
Net Deficit	**£**	**19,841**
CRS for 2019/20	**£**	**4,500**
Planned Net Deficit	**£**	**15,341**

The table below analyses how the underlying deficit has been built up, and this is also shown graphically in the subsequent bridge which depicts how the Trust moved from the underlying brought forward deficit from 2018/19 of £19.8m, to the 2019/20 planned deficit of £15.3m.

2018/19 Forecast Outturn to 2019/20 plan -Summary - (Excluding PSF, FRF & MRET funding)

Description	£m
B/fwd Underlying Deficit from 18/19	4.3
2018/19 CRS Recurrent Non Delivery	8.9
Current Cost Pressures 18/19 to Deliver Forecast Outturn	4.5
Current Income Pressures 18/19 in relation to Forecast Outturn (Drugs & In Year Performance)	2.1
Total Underlying deficit 2018/19	**19.8**
Pay Award & Incremental Drift	8.1
Non Pay Inflation for 19/20	0.9
Income (Tariff)	(7.4)
CNST (reduced cost)	(0.4)
Central Procurement savings	(1.3)
Efficiencies @ 1.6%	(3.6)
Total National Pressures & Efficiencies	**(3.7)**
Additional costs - NHS property services - assumed Commissioner funded	0.0
Vascular risk share - year 2 increase	0.1
EPR (Cerner)	0.0
Growth - Expenditure to deliver activity increase	3.0
Growth - income	(3.0)
Clinical Excellence Awards 2019/20	0.2
New Pressures 19/20	2.4
Contract Negotiations	(0.5)
Remove Medical Pay Reserve	(2.1)
Additional Efficiencies @ 0.4%	(0.9)
Total Local Pressures & Efficiencies	**(0.8)**
Total Deficit	**15.3**
Less Control Total	**8**
Gap to Accepting Control Total	**7.3**



3) Pressures Funded & Reserves Ring Fenced in arriving at the deficit of £15.3m

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

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

4) Target Savings by Division/Department of £4.5m (2%) – Summary

The CRS target for 2019/20 is set at 2%, equating to £4.5m, made up as follows: -

DIVISION	CRS @ 2%
Planned Care	£ 1,618,732
Urgent Care	£ 898,675
ICP	£ 257,268
D&I	£ 822,230
Nurse Mgmt	£ 42,169
Corporate Clinical	£ 1,982
Corporate Non Clinical	£ 295,925
Trust Central Services	£ 539,653
TOTAL	£ 4,476,634

→ See Table below

Corporate Non Clinical	CRS @ 2%
Finance	£ 30,954
HR	£ 69,348
IMT	£ 111,362
PPD	£ 37,085
Procurement	£ 11,242
Trust Admin	£ 35,933
TOTAL	£ 295,925

It is planned that the budgetary profile of the CRS target will be in equal twelfths for 2019/20 and not back loaded as has been the case in previous years.

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

As at March 2019, the current position by divisions / departments against the above targets is shown below. (In addition, for comparison, the overall percentage position identified as at April 2017 & 2018 is also shown).

Sum of TARGET In Year		Column Labels			
Row Labels	Green	Amber	Red	Black	Grand Total
Corporate Clinical				£ 1,982	£ 1,982
D&I	£ 615,000	£ 200,000		£ 7,230	£ 822,230
Finance	£ 27,954		£ 3,000		£ 30,954
Human Resources	£ 11,622	£ 36,500	£ 5,000	£ 16,226	£ 69,348
IMT	£ 60,057	£ 9,485	£ 41,820	£ -	£ 111,362
Nurse Management		£ 42,169			£ 42,169
Planned Care	£ 279,500	£ 190,297	£ 498,486	£ 650,449	£ 1,618,732
PPD	£ 28,085	£ 2,500	£ 6,500		£ 37,085
Procurement		£ 11,242			£ 11,242
Urgent Care	£ 355,000	£ 190,000	£ 124,000	£ 229,675	£ 898,675
Trust Admin	£ 8,100	£ 5,100		£ 22,733	£ 35,933
ICP	£ 12,000	£ 60,000	£ 92,000	£ 93,268	£ 257,268
Central			£ 539,653	£ -	£ 539,653
Grand Total	**£ 1,397,318**	**£ 747,293**	**£ 1,310,459**	**£ 1,021,563**	**£ 4,476,633**
Identified as at Mar 19	**31%**	**17%**	**29%**	**23%**	**100%**
Identified as at Apr 18	**13%**	**9%**	**45%**	**33%**	**100%**
Identified as at Apr 17	**37%**	**16%**	**13%**	**34%**	**100%**

6) Risks

There are a number of risks which could still impact on the Trust's ability to meet its planned deficit of £15.3m including:-

- Ability to deliver recurrently the 2% Cost Reduction Scheme (CRS) of £4.5m;
- Welsh contract risk, initially offering to pay circa 7.6% less than England in 19/20, until further guidance is received on a "Government to Government" basis.
  [NB. This potentially equates to an additional loss of £1.2m, which is not factored into the £15.3m deficit plan];
- New national procurement model expected to deliver £1.3m savings (as per guidance) in Trust's plan for 19/20;
- No provision is included for the impact of the recent change in asset lives guidance in the Trust's plan, resulting in the potential for a further £0.6m pressure;
- No reserves have been ring-fenced for Medical Agency premiums, Winter, Developments or Nursing specifically, other than the Care Quality and Contingency reserves;
- Very limited Contingency at £0.7m (circa 0.3% of turnover)
- Potential for the imposition of fines and penalties if the Control Total is not accepted, and the requirements are not "waived" within the initial Contract;
- Capital availability (including securing the completion of the Urgent Care development);
- Compliance with Constitutional Target standards;

- Maintenance of current improved West Cheshire economy Delayed Transfers of Care (DTOC) standards;
- Lack of any real future Balance Sheet flexibility;
- Medical Pay award assumed to be awarded from October 19 (similarly to 18/19 pay award);
- Impact of HMRC change in policy regarding the direct engagement model;
- Impact of the final agreement regarding the UK's withdrawal from the EU on the supply of staff and clinical supplies; and
- Winter costs continue above the costs identified in the plan, in order to deliver non elective growth.

7) Assumptions

There are a number of assumptions which could also impact on the Trust's ability to meet its planned deficit of £15.3m including:-

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

8) Mitigations

Potential mitigations are as follows:

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

9) Cash

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

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

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

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

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

10) Next Steps

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

- Driving the development of new CRS schemes, effectively reducing the "unidentified" element, which as at March 2019 stands at circa £1m (23%) and continuing with the focus;
- Ensuring that as schemes are identified, and worked up, that there is an impetus to ensure that they are refined and delivered recurrently (i.e. a "shift" left, from black to red, red to amber etc.);
- Review of CRS schemes to ensure that staffing costs, and productivity, are critically challenged;
- Engaging with NHS Improvement, and others (both internally & externally), in seeking assistance to reduce the underlying deficit;
- Actively reflecting on the remaining reserves held centrally to establish whether these could be better managed ; and
- Challenging the Capital Program hard, to establish the absolute priorities (i.e. effectively the 2018/19 commitments brought forward, and also safety concerns), and relating this to the affordability.

Appendix 1

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

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

Appendix 1 (cont'd)

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

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

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

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

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

Appendix 2 – Divisional / Department CRS Scheme Progress as at March 2019

Planned Care

f TARGET In Year	RAG Rating				
Detail Scheme Name	Green	Amber	Red	Black	Grand Total
Orthodontic therapist income	£ 100,000				£ 100,000
Lap Nissens for General Surgery - potentially excluded device	£ 2,500				£ 2,500
Vacancy savings	£ 150,000				£ 150,000
Incremental point savings	£ 5,000				£ 5,000
Procurement Shoulder kit	£ 12,000				£ 12,000
Neonatal pay - non recurrently	£ 10,000				£ 10,000
Outpatients senior nursing restructure		£ 10,000			£ 10,000
Non recurrent non pay savings		£ 15,000			£ 15,000
Apixaban change to aspirin for orthopaedic patients		£ 500			£ 500
Tristel wipes		£ 7,500			£ 7,500
Consumable savings for Anaesthetic Machines re Trial of anesthetising patients in Theatres NOT in anaesthetic room		£ 100			£ 100
ICU Housekeeper - 2.5 hours per week dropped		£ 950			£ 950
Outpatients nursing		£ 20,000			£ 20,000
Theatres Ophthalmic Theatre Consumables		£ 17,247			£ 17,247
Non recurrent - non income orthodontics		£ 40,000			£ 40,000
Drug contract price savings		£ 15,000			£ 15,000
Test referred		£ 10,000			£ 10,000
Maternity pay		£ 50,000			£ 50,000
O&G 3002 spend on 33086 and 33789		£ 2,000			£ 2,000
NNU 3104 spend on 75550		£ 1,000			£ 1,000
Care Packages on call		£ 1,000			£ 1,000
CNST maternity incentivised payment			£ 75,000		£ 75,000
ECT Orthodontics work			£ 17,000		£ 17,000
Closing beds			£ 300,000		£ 300,000
Alder Hey JAG/ENDO consultancy			£ 7,200		£ 7,200

Ethicon devices for General Surgery Laparotomy (£5-10k)			£ 5,000		£ 5,000
Obstetrics early pregnancy private scanning			£ 2,500		£ 2,500
Change Endotracheal Tubes from Malinkrodt to Proact			£ 4,000		£ 4,000
Readjustment of opening times JDSU/ESSU			£ 1,200		£ 1,200
Swap from Steris Prolystica to Serchem Serquat as Sink Detergent			£ 2,016		£ 2,016
Saving opportunity theatres			£ 300		£ 300
ETS Tower			£ 1,220		£ 1,220
Flexi seals			£ 1,000		£ 1,000
NG Tubes (Trial)			£ 1,500		£ 1,500
Uniforms - saving on scrub laundry			£ 500		£ 500
Theatres Sterile procedure packs			£ 15,000		£ 15,000
Theatres Blood sets			£ 6,000		£ 6,000
Alternative Verascope Sheaths			£ 4,050		£ 4,050
Insulin pumps - mandatory switch			£ 5,000		£ 5,000
Endoscopy Extra activity (PbR linked to bowel scoping)			£ 50,000		£ 50,000
Additional Welsh Orthopaedic work				£ 660,000	£ 660,000
HSDU extra work (external contracts). Value TBC.				£ 25,000	£ 25,000
HSDU apprentice 1.00wte n/r vacancy				£ 6,250	£ 6,250
Vascular tariff re EPH and additional spell				£ 112,000	£ 112,000
Review critical care bed base re vascular				£ 12,000	£ 12,000
Welsh work re pelvic floor/pouches (Gen Surg)				£ 15,000	£ 15,000
Theatre rental/opportunities with fertility CHRM				£ 5,000	£ 5,000
Extra Activity theatres				£ 25,000	£ 25,000
Theatres Welsh urogynae activity				£ 5,000	£ 5,000
Unidentified				-£ 214,801	-£ 214,801
	£ 279,500	**£ 190,297**	**£ 498,486**	**£ 650,449**	**£ 1,618,732**

Urgent Care					
f TARGET In Year	RAG Rating				
Detail Scheme Name	Green	Amber	Red	Black	Grand Total
Non-Recurrent Vacancies	£ 180,000				£ 180,000
Freeze on incremental uplifts	£ 5,000				£ 5,000
Drugs Price Savings	£ 50,000				£ 50,000
Reduction in tests referred budget	£ 10,000				£ 10,000
Reduction in non-pay	£ 100,000				£ 100,000
Stoke Bariatric Service SLA	£ 10,000				£ 10,000
Patient Transport Review - Private Taxis		£ 5,000			£ 5,000
Procurement savings		£ 20,000			£ 20,000
Review of SJA Contract		£ 10,000			£ 10,000
Milk Bank Surplus		£ 10,000			£ 10,000
Clinical MD		£ 15,000			£ 15,000
BPT - Stroke		£ 100,000			£ 100,000
BPT - Diabetic Ketoacidosis & Hypoglycaemia		£ 10,000			£ 10,000
BPT - COPD Exacerbation		£ 20,000			£ 20,000
Clatterbridge SLA			£ 24,000		£ 24,000
Bed reconfiguration/patient flow			£ 100,000		£ 100,000
Unidentified				£ 229,675	£ 229,675
	£ 355,000	**£ 190,000**	**£ 124,000**	**£ 229,675**	**£ 898,675**

D&I

f TARGET In Year	RAG Rating			
Detail Scheme Name	Green	Amber	Black	Grand Total
Led Lighting	£ 150,000			£ 150,000
Additional Capacity Car parking income	£ 40,000			£ 40,000
Maintenance Contracts	£ 30,000			£ 30,000
Resale of Medical Equipment	£ 20,000			£ 20,000
Postage	£ 20,000			£ 20,000
Linen	£ 10,000			£ 10,000
Domestics/ Bed Turnaround Team	£ 30,000			£ 30,000
Waste	£ 10,000			£ 10,000
Drugs	£ 50,000			£ 50,000
Beckman Contract	£ 50,000			£ 50,000
Joint Post WUTH Blood Sciences	£ 35,000			£ 35,000
CT Warranty	£ 40,000			£ 40,000
Vacancy savings	£ 130,000			£ 130,000
Porters		£ 75,000		£ 75,000
Comfort Zone Income		£ 30,000		£ 30,000
Parking Charges		£ 30,000		£ 30,000
Pathology Collaboration		£ 30,000		£ 30,000
N/R Income		£ 35,000		£ 35,000
Unidentified			£ 7,230	£ 7,230
	£ 615,000	**£ 200,000**	**£ 7,230**	**£ 822,230**

ICP

f TARGET In Year	RAG Rating				
Detail Scheme Name	Green	Amber	Red	Black	Grand Total
Dietetic Lecturing Chester University	£ 6,000				£ 6,000
Tier 2 Bariatric	£ 6,000				£ 6,000
Hospital at Home operational delivery efficiencies		£ 50,000			£ 50,000
Skill mix therapies		£ 10,000			£ 10,000
Student income from Physio course Glyndwyr University			£ 6,000		£ 6,000
RRT e scheduling and efficiencies			£ 50,000		£ 50,000
Non recurrent vacancies			£ 15,000		£ 15,000
Non pay schemes			£ 5,000		£ 5,000
Dietetic prescribing			£ 16,000		£ 16,000
Unidentified				£ 93,268	£ 93,268
	£ 12,000	**£ 60,000**	**£ 92,000**	**£ 93,268**	**£ 257,268**

Nurse Management		
f TARGET In Year	RAG Rating	
Detail Scheme Name	Amber	Grand Total
Vacancy savings	£ 42,169	£ 42,169
	£ 42,169	**£ 42,169**

Corporate Clinical		
f TARGET In Year	RAG Rating	
Detail Scheme Name	Black	Grand Total
Unidentified	£ 1,982	£ 1,982
	£ 1,982	**£ 1,982**

Finance				
f TARGET In Year	RAG Rating			
Detail Scheme Name	Green	Red	Black	Grand Total
Vacancy savings	£ 20,080			£ 20,080
MIAA Audit Fees	£ 5,168			£ 5,168
Subscriptions	£ 2,706			£ 2,706
Bank and Coin Handling Charges		£ 1,000		£ 1,000
Charitable Fund Recharge		£ 2,000		£ 2,000
	£ 27,954	**£ 3,000**		**£ 30,954**

Human Resources

f TARGET In Year	RAG Rating				
Detail Scheme Name	Green	Amber	Red	Black	Grand Total
East Cheshire Payroll SLA	£ 9,000				£ 9,000
Clinicall Skills External Training Income		£ 14,000			£ 14,000
OH MHFA Course Income			£ 5,000		£ 5,000
Staff Counselling Contract		£ 2,500			£ 2,500
Equality & Diversity SLA Income	£ 2,622				£ 2,622
Medical Education Non Pay		£ 20,000			£ 20,000
Unidentified				£ 16,226	£ 16,226
	£ 11,622	**£ 36,500**	**£ 5,000**	**£ 16,226**	**£ 69,348**

IMT

f TARGET In Year	RAG Rating				
Detail Scheme Name	Green	Amber	Red	Black	Grand Total
Senior Management Restructure	£ 45,007				£ 45,007
Senior Management Restructure			£ 41,820		£ 41,820
Projects Band 6 to Band 5	£ 8,089				£ 8,089
Project Pay	£ 6,961				£ 6,961
MARS Band 6 to Band 4		£ 9,485			£ 9,485
	£ 60,057	**£ 9,485**	**£ 41,820**		**£ 111,362**

PPD

f TARGET In Year	RAG Rating			
Detail Scheme Name	Green	Amber	Red	Grand Total
Maternity not Backfilled	£ 15,000			£ 15,000
Non Recurrent Team restructure	£ 13,085			£ 13,085
Coding Banding Uplift delay Exams		£ 2,500		£ 2,500
Improvement QI income			£ 1,500	£ 1,500
Income Coding Depth			£ 5,000	£ 5,000
	£ 28,085	**£ 2,500**	**£ 6,500**	**£ 37,085**

Procurement		
f TARGET In Year	RAG Rating	
Detail Scheme Name	Amber	Grand Total
Commercial Income Business Case	£ 11,242	£ 11,242
	£ 11,242	£ 11,242

Trust Admin					
f TARGET In Year	RAG Rating				
Detail Scheme Name	Green	Amber	Black	Grand Total	
Legal Services Non Pay	£ 500			£ 500	
Membership Engagement	£ 2,600			£ 2,600	
Travel & Printing TrustSecretary/ Members		£ 2,000		£ 2,000	
Management Admin Support		£ 3,100		£ 3,100	
Vacancy savings	£ 5,000			£ 5,000	
Unidentified			£ 22,733	£ 22,733	
	£ 8,100	£ 5,100	£ 22,733	£ 35,933	

Central			
f TARGET In Year	RAG Rating		
Detail Scheme Name	Red	Black	Grand Total
Case Mix Review	£ 139,653		£ 139,653
Intermediate Care	£ 100,000		£ 100,000
Vascular renegotiation (Spec Com)	£ 200,000		£ 200,000
Bowel Screening SLA	£ 100,000		£ 100,000
	£ 539,653		£ 539,653

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	4x3=12		
CR2 18/19	Unable to meet the demand for services within available resources	Chief Operating Officer	Finance and Integrated Governance	4x3=12	4x4=16	4x4=16		
CR3 18/19	Failure to collaboratively innovate and transform the Trust's clinical services	Medical Director & Deputy Chief Executive	Finance and Integrated Governance	4x3=12	4x3=12	4x3=12		
CR4 18/19	Failure to deliver the Trust's culture, values and staff engagement plan	Director of People & Organisational Development	People & Organisational Development	4x3=12	4x3 =12	4x3 =12		
CR5 18/19	Failure to deliver in year financial plan and manage consequences of delivering a deficit budget	Chief Finance Officer	Finance and Integrated Governance	4x4=16	4x4=16	4x5=20		
CR6 18/19	Failure to comply with Compliance Framework	Chief Operating Officer	Finance and Integrated Governance	4x3=12	4x4=16	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	3x3=9		
CR8 18/19	Failure to maintain Information Governance standards	Director of Corporate & Legal Affairs	Finance and Integrated Governance	3x4=12	3x4=12	3x4=12		
CR9 18/19	Failure to provide appropriate Informatics infrastructure, systems and services that effect high quality patient care in-line with the business	Chief Finance Officer	Finance and Integrated Governance	3x4=12	4x3=12	3x4=12		
CR10 18/19	Failure to recruit, train and retain professional staff	Director of People & Organisational Development	People & Organisational Development	3x4=12	4x4=16	4x4=16		

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 3 2018/19

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-19	TARGET RISK SCORE Mar-20		
	4x2=8	4x3=12	4x3=12	4x2=8	4x2=8		
What is the strategic risk to be controlled?			EXECUTIVE DIRECTOR	BOARD COMMITTEE			
REF	STRATEGIC RISK						
CR1 18/19	**Failure to maintain and enhance the quality and safety of the patient experience and ensure regulatory compliance**		Director of Nursing and Quality	Quality, Safety & Patient Experience Committee		Amber	→

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

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

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

Potential or actual origins that have led to the risk…

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

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

The risks are CONTROLLED by…

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

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

The REPORTING mechanisms are…

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

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

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R6	Patient & Staff Stories	Each Board
R1	QSPEC Dashboard - metrics & nurse staffing (monthly)	Monthly
R1	Clinical Rounds - six month summary report	16.10.18
R1	Consent Policy - verbal update to QSPEC	16.10.18
R1	Falls Project Update - Quarter 2 18/19	16.10.18
R1	Aggregated Report - Complaints, Litigation, Incidents & Coronial Cases (CLIC) Apr-Sept 2018	20.11.18
R1	CQUIN update Quarter 2 18/19	20.11.18
R1	Pressure Ulcers - Quarter 1 & Quarter 2 18/19	20.11.18
R1	Audit feedback in response to incidents - April-September 2018	20.11.18
R1/R6	Infection Prevention & Control Annual Report 2017/18	20.11.18
R1/R6	Safeguarding Children's Annual Report 2017/18	18.12.18
R6	Learning From Deaths - Board of Directors Report	18.12.18
R1/R6	Adult Safeguarding Annual Report 2017/18	18.12.18
R1	Learning From Deaths	18.12.18

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	Q4 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	Q4 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	Q4 18/19
G4	Increase in falls with harm	Quality Improvement Falls Project (RCP Falls programme) in place with dedicated Lead and Therapy support. Review of Trust Falls Group, links to ext. falls strategy	Ref 1362	Q4 18/19
G5	Medicines Safety including Prescribing errors	Profile of medicine safety across the Trust increased; Medicines Safety Group reporting into QSPEC; regular incident reviews in place	Ref 1095/474	Q4 18/19
G6	Gap in provision and knowledge re. Adult Safeguarding	Action Plan in place, training plan under review. Governance re reporting undertaken, MIAA report, July 18 = Limited Assurance	Ref 1785	Q4 18/19
G7	Learning from Deaths	Process of reviewing mortality in place, governance now agreed via L from D committee, ongoing data & dashboard refinement	Ref 1979	Q4 18/19
G8	End of Life (CQC Requires Improvement)	Action Plan in place monitored through the End of Life/Palliative Care group. Further engagement planned	Ref 1817	Q4 18/19
G9	National shortage of a large number of key drugs- potential unknown impact of Brexit	Monitored via Director of Pharmacy and Divisional Governance Assurance Board. Provides updates to QSEPC . National guidance re Brexit & Medication	Ref 1749	Q4 18/19
G10	Increased incidence of c.Difficile and MRSA	Quality Improvement programme to be implemented with NHSi support		Q1 19/20

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST (GUIDANCE TEMPLATE)

Board Assurance Framework - Quarter 3 2018/19

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

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

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

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

INTERDEPENDENCIES: CR1;CR3;CR4;CR5;CR6

Potential or actual origins that have led to the risk…

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

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

The risks are CONTROLLED by…

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

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
C1	Agreed capacity and demand analysis	Green	➔
C2	Monitoring of demand, performance and approved escalation processes	Green	➔
C3	assessment capacity across main emergency care specialities	Green	➔
C4	Early supported discharge & step down beds	Green	➔
C5	operational escalation levels & system wide escalation protocol	Green	➔
C6	Winter Resilience Planning	Amber	➔
C7	Operational dashboards (real-time)	Green	➔
C8	Tracking & Validation teams	Green	➔
C9	AE Delivery Board chaired by CoCH CEO	Green	➔
C10	Tele tracking system	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	Finance and Integrated Governance Committee	Bi -Monthly	Green	➔
R3	Board of Directors	Bi -Monthly	Green	➔
R4	Daily SITREP reporting	Daily	Green	➔
R5	Weekly performance review	Weekly	Green	➔
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 performance meetings	Monthly	Green	➔

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R3	Integrated Performance Report	Feb-19
R5	Weekly Operational Performance meeting	Weekly
R7	West Cheshire A&E Delivery board	Monthly (Mar 19)
R3	Update on winter planning to Board	Sep-18
R3	Quarterly cancer update to board	Mar-19
R6	ICP delivery group	Mar-19
R4	Real-time Dashboards & OPEL reporting	daily
R1	Capacity meetings	daily
R8	Elective care meeting with CCG	Monthly
R5	Weekly PTL review meetings (including cancer)	Weekly
R1	Cancer board	monthly (Mar 19)
R7	NHSi/NHSE resilience reporting	Mar-19
R4	NHSI Tableau analytics	daily

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

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

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

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST (GUIDANCE TEMPLATE)

Board Assurance Framework - Quarter 3 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 therefore 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 3 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

CURRENT ASSURED LEVEL	Movement
Amber	➔

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

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

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

Potential or actual origins that have led to the risk…	*What are the most significant origins (up to 10) which could or have led to the risk?*
REF	ORIGIN
O1	Levels and incidents of Bullying & Harassment against local & national targets
O2	Associated pressures and the impact on culture / values / behaviours
O3	Operational demands and the impact on appraisals / leadership/mandatory training
O4	Quality, Safety, Financial & Operational metrics: Never Events/SUIs
O5	Incidents reported via Freedom to Speak Up
O6	Delivery of National CQUIN targets linked to Health & Well Being.
O7	CQC Well Led Domain requirements & Key Lines of Enquiry, including FTSU
O8	Finding of Annual Staff Survey
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 openness and honesty, duty of candour	Amber	➔
C6	Promotion of Freedom to Speak Up champions across the organisation including union reps.	Amber	➔
C7	Culture workstream included in Model hospital programme and engagement	Green	➔
C8	Developing Coaching programme for individuals and teams.	Amber	➔
C9	Recognising our people both annual with Celebration of Achievement and quickly via Countess Gems	Green	➔
C10	Reporting through to various Boards on progress in each of the CQC domains	Green	➔

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

These are the POSITIVE ASSURANCES received…		
What are the key positive assurances received through reporting that a control has remained effective (up to 20)		
REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
C1/R2	People & OD Strategy documentation & implementation plan to POD	26-Sep-17
C2/R2	Monitoring through High Performance Board that reports back to POD	25-Sep-18
C3/R4	Implementation of What's Brewing with Execs	1-Sep-18
C4/R4	Subscription to NW Leadership Academy and internal leadership courses discussed at EDG	21-Feb-18
R2/R8	Leadership Progs in place - High Performance workshop, QI, leadership summit.	25-Sep-18
C5/R2	Staff Survey/SFFT Report to Board of Directors with associated action plan. Monitored by POD.	27-Mar-18
C7/R2	High Performance Culture work stream investment linked to Model Hospital programme	01-Mar-18
C9/R2	Recognition informal and formal systems in place	04-Sep-18
C9/R4	Monthly Countess Gems, monitor by feedback and twitter	08-Dec-18
R3	Partnership Forum: Staff engagement /staff survey/staff experience/SFFT reviewed monthly	08-Nov-18
R8	Student Experience/Satisfaction Surveys - open all year Multi-Prof Practice Placement meeting	13-Feb-18
C2/R2	Appraisal performance has increased from last year although still not consistent	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	1-Dec-18
C1/R6	Exit Interview / How are we doing interviews implemented. Feedback to SPF on periodic basis.	10-May-18
R2/R6	Exec discussion re Kate Lampard report showing staff/roles/analysis with/without DBS	12-Dec-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	Delivery of High Performance Workshops to all staff	Two cohorts of the programme in place to cover 300 leaders - non-release of staff is not possible due to high pressure in system. 2 hr prog for all staff in dept..	Ref 1881	Q4 18/19
G2	Limited budget so looking at designing in house, limited resource and other priorities in the New Year	Looking to make a decision quickly, content has been drafted and mocked up. Need to trial a pilot.	Ref 1946	Q4 18/19
G3	Communications still falter at middle manager level	Introducing What's Brewing and all staff briefings to eliminate layers and barriers	Ref 1948	Q4 18/19
G4	Limited capacity to release staff to attend training	Looking at more on boarding, e learning opportunities with videos and apps.	Ref 1882	Q4 18/19
G5	FTSU: Revision of policy, processes, resources & comms required	FTSU: Revision of policy, processes, resources & comms required	Ref 1949	Q4 18/19
G6	Communication of Freedom to Speak Up	Encourage reporting via Union Representatives with added protection. Recruitment process to take place in Q4.	Ref 1950	Q4 18/19
G7	Capacity to support Health Economy initiatives such as ACO and STP	Fortnightly / monthly meetings in place. LDS action plan in place, ACO workforce plan in development	Ref 1897	Q4 18/19
G8	Complex employment legislation, managers & staff side will require HR support at a high level	Development sessions being scoped for delivery e.g. investigation training, appeals, tribunals	Ref 1898	Q4 18/19
G9	Delivery of national CQUIN targets linked to Health & Wellbeing	Monitored monthly by Health & Wellbeing Steering Group, discussed at Nursing & Midwifery Board for additional nursing support re flu vaccination programme.	Ref 1901	Q4 18/19
G10	Substantive staff without DBS checks	There is further debate 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 3 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	4x5=20	4x3=12	4x1=4		

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

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

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

INTERDEPENDENCIES:

Potential or actual origins that have led to the risk…

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

REF	ORIGIN		
O1	Identification and operational delivery of efficiency schemes		
O2	High levels of medically optimised patients and delayed transfers of care and associated costs / risk to income		
O3	Financial impact of decreased activity demand and associated loss of income for PbR contracts		
O4	Increase in non elective demand delivered at premium cost		
O5	Medical & nursing pay pressures - gaps and acuity leading to high agency usage		
O6	Need for future investments to maintain safe service delivery		
O7	Additional contractual income of £1m for WCCCG (linked to bed occupancy) not yet received		
O8	Outcome of capital loan is currently unknown		
O9	Potential requirement for revenue distress loan should 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
R5	NHSI quarterly review meeting	4-Oct-18
R10	Audit Committee	20-Oct-18
R1	Board Meeting	18-Dec-18
R3	West Cheshire CCG Contractual Performance Meeting	21-Nov-18
R3	Betsi Contractual Performance Meeting	29/10/18, 17/12/18
R3	NHSE Contractual Performance Meeting	18-Dec-18
R1	Board Session - recovery plan	20-Nov-18
R5	CQC Use of Resources session	19-Nov-18
R8	Annual members meeting	23-Oct-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	Q4 18/19
G2	Control of volumes of medically optimised patients and delayed transfers of care and further activity growth impacting on financial position	Joint working with CCG to control demand and discussions with local councils regarding recharges. A&E Delivery Board tasked with reducing bed occupancy to 85%	Ref 1686	Q4 18/19
G3	Failure to deliver performance improvement trajectory and consequent impact of STF funding	Weekly performance meeting and increased scrutiny at Divisional level alongside A&E Delivery Board .	Ref 1871	Q4 18/19
G4	Failure to deliver activity plan resulting in loss of income to the Trust	Monthly reporting through Division and up to EDG with recovery plans in progress where necessary	Ref 1872	Q4 18/19
G5	Impact of lack of information on Junior doctor rotational gaps and medical and nursing vacancies and ability to secure visas.	Pro-active management to anticipate potential gaps and escalation process with Deanery. Exploring recruitment options for nursing workforce	Ref 620	Q4 18/19
G6	Continued high demand for non elective care requiring Ward 54 to remain open thus depleting the winter reserve with no known additional winter funding externally to date.	Proactive management to staff ward in most efficient way. Regular monitoring of additional costs incurred.	Ref 1870	Q4 18/19
G7	Funding gap for centralised vascular service.	Financial recovery plan currently being progressed with the division	Ref 625	Q4 18/19
G8	The capital loan has not been approved to date.	Escalation process is in place to enable emergency capital to be approved by the Executive team whilst waiting for loan application outcome.	Ref 1868	Q4 18/19
G9	Outcome of STP Bid to support redesign of A&E Department currently unknown.	Other funding sources and smaller development is currently being explored.	Ref 1873	Q4 18/19
G10	Revenue distress loan is likely to be required later in the year.	Daily cashflow forecasting is in place.	Ref 1869	Q4 18/19

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST (GUIDANCE TEMPLATE)

Board Assurance Framework - Quarter 3 2018/19

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

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

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

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

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

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

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

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

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

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

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

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
R2	Integrated performance Report & Risk Register to FIGC	Bi monthly
R3	Integrated performance Report to BoD	Bi monthly
R4	Performance Report to WC Quality & Performance meeting	Monthly
R5	NHSI Improvement trajectory & reports	Quarterly
R9	weekly performance dashboard to COO & DD's	Weekly
R3	Cancer update to Board	Quarterly
R5	Weekly tracking of improvement trajectories	Weekly
R3	Winter planning update to Board	annual (Sept '18)
R5	NHSI daily/monthly performance dashboard	daily
R2	intensive support team improvement reports - A&E & Cancer 62 days	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	Q3 20/21
G2	>21 day length of stay patients	validate bed capacity data and exec oversight for nationally set reduction target	Ref 1686	Q4 18/19
G3	Cancer performance	Implementation of key actions identified in action plan Increased clinical engagement & oversight - 473, 1174, 1177, 1232, 1373	Ref 473	Q4 18/19
G4	18 week failure of incomplete pathway	Development of actions to address 18 weeks and longest waiters	Ref 1224	Q1 19/20
G5	insufficient capacity in ED leading to prolonged waits	Whole system approach to hospital avoidance and effective primary care. Submission of capital plans for new build.	Ref 1594	Q1 19/20
G6	Demands exceeding capacity within budget	Implementation and support to CCG demand management work streams and clinical pathway redesign. Agree PbR contract for 19/20.	Ref 1735	Q1 19/20
G7	Lack of capacity in diagnostic services	Increasing primary care/demand for diagnostics and hospital requires senior oversight, education & training	Ref 1155	Q4 18/19
G8	lack of sufficient financial resources	Inability to in source/outsource to meet the growth of demand. Short term Business Cases to meet overall capacity	Ref 1735	Q4 18/19
G9	gaps in medical & nurse staffing	divisional support to develop workforce plans & alternative roles to be presented via medical pay meeting & Nursing & midwifery workforce group	Ref 1202 Ref 1643	Q4 18/19

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 3 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	Impact on CQC Rating
PC2	Failure to maintain Provider Licence (NHSI)
PC3	Impact on Trust's overall performance
PC4	Reputation of Trust

INTERDEPENDENCIES: CR1;CR6;CR8

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

REF	ORIGIN		
O1	Well Led Review	Amber	➔
O2	Recruitment of substantive Chief Executive Officer	Amber	➔
O3	Outcome of external Governance Review	Amber	✶
O4	Board development	Amber	➔
O5	Re-appointment of Non Executive Directors	Amber	➔
O6	Appointment of Company Secretary	Amber	✶
O7	Interim Director of HR	Green	➔
O8	Acting Medical Director	Amber	➔
O9	Board risk appetite	Amber	✶
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	Green	➔
C3	Control by the Executive Team/Council of Governors/Board of Directors	Green	➔
C4	Support MIAA and KPMG regarding the Well Led review	Green	➔
C5	Aggregated report to be received at Board of Directors regarding Complaints, Litigation and Claims	Amber	➔
C6			
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	Corporate Leadership Group	Bi-weekly	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	29.01.19
R2	Provided an update to the Council of Governors/Governors Quality Forum	22.03.19
R1	Regular communication and discussion with the Chairman	Weekly
R6	Appointment of FTSU Guardian	01.02.19
R1	Receipt of the Board Assurance Framework at Board of Directors	18.12.18
R7	Update to Corporate Leadership Group	07.03.19

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

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

REF	GAP	ACTION PLAN	RISK REGISTER REF	DEADLINE
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 - FTSU Guardian appointed and commences in May 2019	1949/1950	Complete
G2	Trusts Audit Committee are sighted on Integrated Care Partnership developments	Key risks are articulated to the Audit Committee including governance arrangements		Q1 19/20
G3	Final Agreement of ICP Governance arrangements	Monthly ICP Governance meetings established to progress and finalise governance arrangements. ICP Integration agreement being received at Board of Directors in March 2019		Q4 18/19
G4	Development of Executive Review Group	Executive Risk Review Group established. Understanding of the Trust Risk appetite to explored. Session to be held with the Board in Q1 19/20		Q1 19/20
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. Appointment of Company Secretary.		Q1 19/20
G6	Outcomes from the CQC Report	CQC report awaited.		Q1 19/20
G7	Outcomes from External Governance Review	Report awaited.		Q1 19/20
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 3 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 Committee, ICO and STEIS	monthly	green	→
R3	Significant incidents reported through STEIS and ICO	As required	green	→
R4	Audits and research data requests reviewed by the IG Committee and Action Plans tracked	As required	green	→
R5	Information Governance plan updates to the Informatics Board	Quarterly	green	→
R6	Exec Team receives updates on significant risks and issues	Weekly	green	→
R7	Finance & Integrated Governance receives IG Committee minutes	Bi-Monthly	green	→
R8	GDPR/IG Progression reported to IG Committee	Quarterly	green	→
R9	EPR Programme Board/IG Committee	Quarterly	green	→

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
A1	Routine email communications relating to IG alerts and threats	As required
A2	MIAA IG Toolkit Audit - mandatory (Significant Assurance)	Jan-18
A3	2017/18 Information Governance Toolkit Submission 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 Implementation 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 clarification	Interpret GDPR requirements and develop proposals to achieve compliance within existing resources and brief Board as appropriate	51	Q1 19/20
G8	Unknown associated risks with EPR Project and Collaborative working	Discuss with external organisations what their IG strategy was when merging and implementing new systems, link in with ICO and collaborate with WUTH	1953	Q1 19/20
G9	Limited IG Resources within Organisation	Look at business continuity and risk assess team/resources	1954	Q1 19/20

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 3 2018/19

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

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

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

Potential or actual origins that have led to the risk…

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

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

The risks are CONTROLLED by…

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

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

The REPORTING mechanisms are…

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

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

These are the POSITIVE ASSURANCES received…

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

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

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

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

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

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 3 2018/19

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

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

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

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

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

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

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

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

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

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

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

These are the POSITIVE ASSURANCES received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance? E = External Assurance*	DATE LAST REPORTED TO COMMITTEE
C2	Monthly Nursing & Midwifery Board chaired by Director of Nursing & Quality	25-Sep-18
C2	Reviewing skill mix in theatres, discussing local courses with Chester University	01-Jan-19
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 Board	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
C4	Joined cohort 4 of NHSi retention programme	01-Dec-18
C8	Commence recruitment of a qualified librarian	

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

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

REF	GAP	ACTION PLAN / EXCEPTIONS	RISK REGISTER REF	DEADLINE
G1	Increases in turnover for nursing staff / staff working agency shifts in Welsh trusts (no cap)	Retention strategy, weekly bank pay from October, corporate plans re pay review, escalation to BCUHB, surveys in dept with nursing staff, e-roster.	Ref 1951	Q4 18/19
G2	Agencies still charging over capped rate, holding Trusts to ransom	Fortnightly reviews & increased management information from Medical Staffing via Brooksons. Review at MWB. Development of Medical Workforce Strategy (MWS).	Ref 1885	Q4 18/19
G3	Pressures of capacity and demand on staff and ability to manage pressures	Divisional risks item added to each POD meeting as standing item to discuss capacity, demand & pressures. Monitored monthly through HRBPs and triangulation with data.	Ref 1886	Q4 18/19
G4	Medical gaps esp ED & ENT/T&O/Plastics rotas & impact on patient safety / variable pay spend	Recruitment into permanent posts, skill mix review, engagement needed with Medical Leads in hot spot areas through MWB. Development of Medical Workforce Strategy.	Ref 1890	Q4 18/19
G5	The reduction in training & conversion courses is causing a shortage in some clinical areas such as Sonographers	Working with Divisions to develop retention strategy, e.g. Theatres recruitment & retention strategy, apprenticeship strategy & delivery with HEIs.	Ref 1952	Q4 18/19
G6	The funding for training & conversion courses is causing a shortage in some clinical areas such as ODP's	Working with Divisions to develop retention strategy, e.g. Theatres recruitment & retention strategy, apprenticeship strategy & delivery with HEIs.	Ref 1992	Q4 18/19
G7	Completion of recruitment process for qualified librarian and complete library strategy	Working with current librarian to develop strategy and support recruitment process.	Ref 1991	Q4 18/19
G8				
G9				
G10				

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Speak Out Safely / Freedom to Speak Up Update
Date of Meeting	26th March 2019
Author(s)	Sue Hodkinson, Director of People & Organisational Development
Annual Plan Objective No.	
Summary	The purpose of this report is to provide a further update to the Board from the Freedom to Speak Up (FTSU) Committee. This includes a current year position on the Trust's cases in addition to internal actions being progressed to reflect the National Guardians Office (NGO) guidance and expectation.
Recommendation(s)	The Board is asked to receive and note the information contained within this report.
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [x] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Speak Out Safely & Freedom to Speak Up Update (FTSU) to the Board of Directors (March 2019)

1.0 Executive Summary

The purpose of this report is to provide an update to the Board from the Freedom to Speak Up (FTSU) Committee. It will articulate updates on resources, policy, training and awareness, communication and engagement, the national agenda, local data including an overview of the latest Staff Survey Data, from 2018, related to raising concerns and includes initial learning from the CQC Well Led Assessment recently undertaken within the Trust and cases we have received. A significant amount of work, facilitated via the FTSU Committee, has progressed since the last update to the Board (in May 2018). This paper is to provide assurance that progress continues to be made.

The FTSU Committee, which is constituted from the FTSU Guardians across the Trust, continue to hold bi-monthly meetings with all meetings undertaken, except in September 2018. Further to the detail provided in the previous report to the Board, the FTSU Committee has continued to ensure that FTSU becomes 'business as usual'. The sections below will provide an update on each area of the agenda articulating progress to date.

2.0 Progress To Date

2.1 Resources to Support the FTSU Agenda

It has been referenced in the previous Board update that the resource for managing the current FTSU agenda is via the current FTSU Guardians, in addition to their daily workload. It was recognised that this was not sustainable going forward. In light of this, a business case for resourcing was taken to Executive Directors Group and investment was approved.

A recruitment process was undertaken in early 2019 and a Guardian has subsequently been appointed to the post at Band 7 for 2 days per week. This model is in line with the benchmarking undertaken against other organisations of a similar size and complexity. The Guardian appointed is an external appointment to the Trust and has a clinical background, with a start date confirmed for late May 2019.

The post will be reporting to the Chief Executive, with further key meetings required with the Chairman, the Senior Independent Director and other stakeholders across the Trust on a periodic basis. The Guardian will be line managed on a day-to-day basis by the Director of People & OD and an induction plan is currently being developed with the support of the existing Guardians. It is envisaged by the FTSU Committee that the committee will initially remain in place, in order to support the new substantive Guardian in developing the role and position within the organisation. Key objectives that have been identified include:

- A review and revision of the Trust policy and supporting processes, including consultation and approval by staff side colleagues.

- To review and deliver / support the actions identified with the National Guardian's Office Self Review tool, as referenced in section 2.6 of this report.
- To develop a communication strategy to promote awareness of Freedom to Speak Up, the Guardian role and ways to raise concerns within the Trust.
- To develop a champion / ambassador network across the Trust, ensuring that all staff groups and levels of members of staff have the opportunity to raise concerns. This will include considering the training requirements for champions or ambassadors, in line with the National Guardian Office (NGO) training programmes which are available.

It is envisaged that the new Guardian will present to the Board at future meetings, with papers being prepared the Guardian in conjunction with members of the FTSU Committee. A copy of the job description and person specification for the post has been included in Appendix 1.

2.2 Revision of the Speak Out Safety Policy

It is important to note that whilst a review of the Trust's policy is being undertaken in the context of the national agenda, the current Speak Out Safety policy continues to remain extant. A national Policy template is now available including key sections to include which the Trust is utilising. Significant discussion has been undertaken ensuring the Trust's FTSU policy is clear and understandable for members of staff and teams, with supporting flowcharts and SOPs. The draft policy clearly states the roles and responsibilities of key stakeholders in the FTSU process and a key action of the new Guardian will be to review and finalise the policy for consultation with Staff Side colleagues and wider communication, when approved and ratified.

Further discussion and action has taken place to explore the utilisation of the Trust's incident reporting system (Datix) for FTSU, so that there is a consistent approach to raising issues or concerns. This option continues to be explored but the current workings of the system do not assure the committee that anonymity and confidentiality of concerns can be maintained at this stage. As such a separate database continues to be maintained.

It is important to note that the current mechanisms of how to raise concerns under Freedom To Speak Up (i.e. via A FTSU Guardian, confidential telephone line and email address) have been marginally revised with a new email address of coch.freedomtospeakup@nhs.net being established. In addition, colleagues can also raise concerns by contacting extension 3495 and leaving a message.

2.3 Training & Awareness

In respect of training and awareness, we have developed a training template and we have identified further training requirements for all of the Guardians. Training continues to be discussed by the Committee in respect of the formal Guardian training; training for Ambassadors / Champions once the substantive Guardian is in place and awareness sessions for the rest of the Trust. This will be monitored via the FTSU committee meetings and coordinated by the newly appointed Guardian in the future. Members of the Committee have attended regional and national meetings/conferences and have fed back any points of learning to the committee.

2.4 NHS Staff Survey 2018

The NHS Staff Survey 2018 was undertaken in October to December 2018, with a sample of staff surveyed across the Trust. 448 responses were received which equates to a 36% response rate. A series of questions relate to raising concerns within the survey include:

- I would feel secure raising concerns about unsafe clinical practice: 69% against an acute sector average of 69.2%. This is an improvement on the 2017 (67.3%) survey of 1.7%.
- I am confident that my organisation would address my concern: 53.3% against an acute sector average of 56.8%. This has deteriorated by 1.7% from 55% in 2017.
- In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers: 11.2% which is a marginal deterioration of 0.3% from 2017. This is against a sector average of 13.7%.
- In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from other colleagues: 18.8% which is an increase of 2.1% from 2017 (16.1%). This is against a sector average of 20%.
- The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it: 49.2% which is an improvement of 3.2% on 2017 (46%) and is against the sector average of 44.2%.
- I would feel secure raising concerns about unsafe clinical practice: 69% which is an improvement of 1.7% on 2017 (67.3%). This is against a sector average of 69.2%.
- I am confident than my organisation would address my concern: 53.3% which has deteriorated by 1.7% from 2017 (55%). This indicator has declined year-on-year from 2014 (60.5%).

It is encouraging to see that colleagues would feel more secure in raising concerns, are receiving less bullying or harassment from managers and are reporting more concerns of different types. However, the investment in the new substantive FTSU Guardian will support the actions required to address the areas of deterioration and focus required around addressing concerns. The actions required around the Staff Survey linked to FTSU will be incorporated within the wider Trust action plan, which is being monitored by the People & OD Committee.

2.5 Communication & Engagement

As previously stated, the substantive Guardian who joins in late May will be developing a communication strategy to promote awareness of Freedom to Speak Up, the Guardian role and ways to raise concerns within the Trust. In the meantime, FTSU continues to be a key topic for discussion and raising awareness with members of staff at every opportunity, for example on executive walkabouts, clinical area reviews, student forums, Newly Qualified Nurse Induction, Newly Qualified Nurse Forums, Nursing Assistant Update Skills Day, Junior Doctor Forums, Weekly What's Brewing sessions, Trust Induction and High Performance Culture workshops.

2.6 FTSU Self-Review Tool and supporting action plan

The National Guardian's Office has previously published a self-review tool which organisations have been requested to assess against. The committee have reviewed this is detail and this remains a standing item in meetings. A copy of the self-assessment (dated December 2018) is included in Appendix 2. The appointment of the substantive Guardian will support the delivery of the actions identified within this tool and the committee will continue to monitor progress against plan.

2.7 Data Submission to National Database

As previously articulated in the last Board update, the Trust is required to submit speaking up data to the National Guardians Office (NGO) on a quarterly basis for national publication. The Trust's submissions for quarter 1-3 2018/19 are as follows:

Quarter 1

- Number of cases raised (this equates to the number of members of staff involved) – 10
- Number of cases raised anonymously – 1
- Number of cases with element of patient safety / quality – 9
- Number of cases with element of bullying / harassment – 10
- Number of cases where the person speaking up may have suffered some form of detriment – 0

Quarter 2

- Number of cases raised (this equates to the number of members of staff involved) – 0
- Number of cases raised anonymously – 0
- Number of cases with element of patient safety / quality – 0
- Number of cases with element of bullying / harassment – 0
- Number of cases where the person speaking up may have suffered some form of detriment – 0

Quarter 3

- Number of cases raised (this equates to the number of members of staff involved) – 0
- Number of cases raised anonymously – 0
- Number of cases with element of patient safety / quality – 0
- Number of cases with element of bullying / harassment – 0
- Number of cases where the person speaking up may have suffered some form of detriment – 0.

In terms of the national headlines collated by the NGO in Quarter 3, the data received included:

- 3,600 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions
- 957 of these cases included an element of patient safety / quality of care
- 1,466 included elements of bullying and harassment
- 179 related to incidents where the person speaking up may have suffered some form of detriment
- 407 anonymous cases were received
- 11 trusts did not receive any cases through their Freedom to Speak Up Guardian
- 221 out of 227 NHS trusts sent returns.

It is anticipated by the FTSU Committee that once the substantive Guardian is in post, an increase in cases will be observed.

2.8 Learning from the CQC Well-Led Assessment and Cases

The Director of Nursing and Quality represented the Guardians during the CQC Well-Led Assessment. The key lines of enquiry focused on the process of how members of staff raise concerns in addition to the associated roles of the Guardians. The Trust acknowledges the potential conflict of interests with the roles that the current Guardians undertake in addition to their focus on FTSU. This is being addressed with the investment that has been agreed in the substantive Guardian post.

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

3.0 Conclusion and recommendations to the Board of Directors

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

Prepared by:

Sue Hodkinson
Director of People & Organisational Development
March 2019

Appendix 1: Freedom to Speak Up Guardian Job Description and Person Specification

Welcome to the Countess of Chester

Freedom to Speak Up Guardian
Band 7

Your Opportunity

Job Summary

Freedom to Speak Up Guardians help:

- Protect patient safety and quality of care
- Improve the experience for workers
- Promote Learning and improvement

By ensuring that:

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and development

The list below is to outline the main duties involved; however this is subject to change and will vary within the given role. We ask all employees to be flexible in their role, to always ensure we are delivering Safe, Kind and Effective care.

Expectations

1. Operate independently, impartially and objectively, whilst working in partnership with individuals and groups throughout their organisation, including their senior leadership team
2. Seek guidance and support from and, where appropriate, escalate matters to, bodies outside their organisation
3. Support, and contribute to, the national Freedom to Speak Up Guardian network, comply with National Guardian Office guidance, and support each other by providing peer-to-peer support and sharing learning

Role

Freedom to Speak Guardians are responsible for taking action to promote the following outcomes:

1. Workers throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up
    a) Everyone who works in the organisation has appropriate training and easy access to the knowledge and support that need to speak up and support others to speak up
    b) Action is taken to ensure that groups that may face particular barriers to speaking up have the knowledge and support they need
2. Policy Development - Speaking up policies and processes are effective and constantly improved
    a) Local policies and processes are clear and readily available to all staff members, meet minimum standard where they are set, and are regularly reviewed and updated
    b) Feedback on policies and processes is regularly sought to ensure that they are continuously improved and meet the needs of staff
3. Reporting and Governance - Senior leaders role-model effective speaking up

a) Senior leaders receive regular reports from the Freedom to Speak Up Guardian that include information on the number and types of cases that deal with, barriers to speaking up, and details of opportunities for learning and improving
b) The Freedom to Speak Up Guardian presents their reports in person
c) The Freedom to Speak Up Guardian meet regularly with the organisations CEO or equivalent, and other members of the senior leadership team, as appropriate
d) Local measures of the impact of freedom to speak up and the Freedom to Speak Guardian role are agreed and used to monitor progress

4. Communication - All workers are encouraged to speak up
   a) Ensure induction processes include freedom to speak up messages and explain the Freedom to Speak Guardian role
   b) Freedom to speak up messages and details of the Freedom to Speak Up Guardian role are regularly communicated across the organisation, including feedback on matters that workers are speaking up about, and, mindful of preserving confidentiality where needed, action taken in response to them – the impact of the communications are measured
   c) Action is taken to ensure that freedom to speak up messages reach groups that may face particular barriers to speaking up
5. Support - Individuals are supported when they speak up
   a) The Freedom to Speak Up Guardian provides effective and compassionate support and guidance to all staff, developing a local network of champions (or similar), to ensure that they have suitable reach across the organisation
   b) There are alternative routes to progress cases that may otherwise present a Freedom to Speak Up Guardian with a conflict of interest
   c) Cases are recorded according to National Guardian Office guidance
   d) Appropriate action is taken when an issue is brought to the attention of a Freedom to Speak Up Guardian, with confidentiality being respected as appropriate, fair and effective investigation, and regular feedback on progress being given
   e) Individuals who have spoken up do not suffer as a result of speaking up unless it is proven to be vexatious
   f) Feedback is sought from everyone who is supported by a Freedom to Speak Up Guardian
6. Improvements to the Service - Barriers to speaking up are identified and tackled
   a) Sources of information on barriers to speaking up are assessed and used to prioritise areas for improvement
   b) Action is taken to reduce barriers to speaking up
7. Analysis of Information - Information provided by speaking up is used to learn and improve
   a) Any information that indicates a potential risk to patient safety is acted on immediately
   b) Information from cases raised by people speaking up, and barriers to speak up, is brought alongside other intelligence on patient safety, service quality, and staff experience and used to inform organisational learning and development
8. Freedom to speak up is consistent throughout the health and care system, and ever improving
   a) Guidance issued by the National Guardians Office is followed, and feedback on its effectiveness and impact provided
   b) The Freedom to Speak Up Guardian contributes to and supports the national Freedom to Speak Up Guardian network
   c) Intelligence on speaking up, case studies and good practice is shared at regional meetings, across networks, and with the National Guardian's Office
   d) Information requests from the National Guardian's Office are responded to, and the Freedom to Speak Up Guardian supports the National Guardian's Office case review process locally
   e) The Freedom to Speak Up Guardian role-models good speaking up practice and challenges poor practice

f) The Freedom to Speak Up Guardian regularly assesses their own skills and capabilities and takes action to improve
g) The Freedom to Speak Up Guardian offers support and advice to their peers

All employees of the Trust have a responsibility for their own health and wellbeing, to inform their manager and seek timely support via the Trust's Occupational Health and Wellbeing department

All employees of the Trust have the responsibility to comply with the Trusts Infection Prevention and Control policies and procedures at all times. Strict adherence to effective hand hygiene is essential.

Person Specification

	Essential	Desirable
Qualification	1. Degree level qualification or equivalent 2. Plus specialist courses equivalent to a Masters level qualification or experience	1. Masters level qualification in a relevant subject
Knowledge and Experience	1. Knowledge of the Freedom to Speak Up agenda and campaign 2. Excellent administration and report writing skills 3. Experience of working to a Senior Leader in a large organisation 4. Understanding of discrimination, bullying & harassment	1. NHS knowledge and experience 2. Working in a similar role for a public sector organisation
Skills and Abilities	1. The Freedom to Speak Up Guardian role requires a range of skills and competencies. These include, but are not limited to: a) Communication b) Partnership building and relationship management c) Knowledge of speaking up agenda and local systems d) Driving continuous improvement e) Time management and prioritisation f) Measuring effectiveness and impact g) Training and capability building h) Working with senior leaders 2. The following values are upheld by Freedom to Speak Up Guardians: a) Courage – speaking truthfully and	

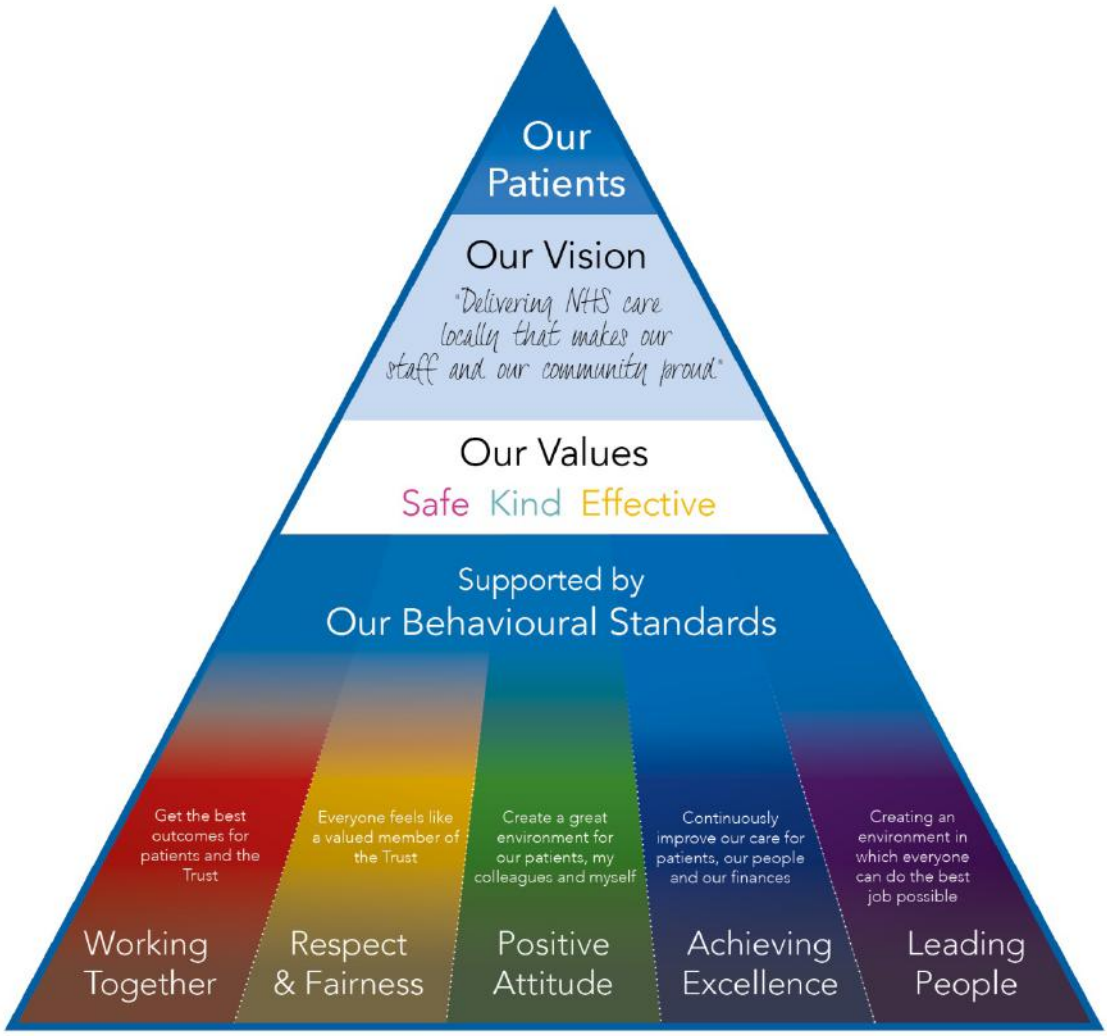
challenging appropriately b) Impartiality – remaining objective and unbiased c) Empathy – listening will and acting with sensitivity d) Learning – seeking and providing feedback and looking for opportunities to improve	

Non Patient Contact:

	What You Need	Conducted By	Essential
Health Screening	Paper documentation & Health Assessment	Occupational Health Nurse	Yes
Maintenance Staff Immunity Required	Hepatitis A	Occupational Health Nurse	Yes – Vaccination recommended
Please note that the above may vary dependent on job role and risk assessments. Should you need further clarification please contact the Occupational Health Department on 01244 365045			

***Safeguarding:** You have a responsibility to respond to any Safeguarding Children or Adult concerns that you encounter in your everyday duties. You must report any concerns as appropriate to your immediate & the relevant Safeguarding Lead within the Trust*

Our Culture


Our Patients
Our Vision
"Delivering NHS care locally that makes our staff and our community proud"
Our Values
Safe Kind Effective
Supported by
Our Behavioural Standards
Get the best outcomes for patients and the Trust
Working Together
Everyone feels like a valued member of the Trust
Respect & Fairness
Create a great environment for our patients, my colleagues and myself
Positive Attitude
Continuously improve our care for patients, our people and our finances
Achieving Excellence
Creating an environment in which everyone can do the best job possible
Leading People

National Guardian
Freedom to Speak Up

NHS
Countess of
Chester Hospital
NHS Foundation Trust

Appendix 2
Freedom to Speak Up self-review tool
Action Plan
(Updated December 2018)

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
Our expectations						
Leaders are knowledgeable about FTSU						
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.		Further comms to be developed to support key messages	All recent FTSU actions shared with Board members	NED rep part of FTSU Group Guidance regularly shared Board updates. Paper going to Board in Jan 2019	Q4 2018/19	Director of People & OD
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.		As per the last Board report, need to share wider learning and integrate FTSU into overall Trusts vision	Comms plan to be developed to raise learning and awareness	Board Update papers (as above)	Q1 2019/20	CEO /FTSU Guardian

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.		People & OD Strategy refresh underway – to be incorporated into this	Talent management /succession planning plan in development. This will link with refresh of P&OD Strategy			Director of P/OD
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.		Need to articulate FTSU plans into overarching vision Develop comms plan articulated above.		N/A	Q1 2019/20	Trust FTSU Guardian/ Head of Comms
Leaders have a structured approach to FTSU						
There is a clear FTSU vision, translated into a robust and realistic strategy that links						To be reviewed by new

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
speaking up with patient safety, staff experience and continuous improvement.						FTSU Guardian
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.		Policy is under review. Speak Out Safely Policy on the intranet	New Policy finalised – awaiting review at Partnership Forum and then ratification at P&OD Committee	Key points of policy will feature in briefing paper to Board Jan 2019 Update: Jan 2019 This has been delayed as further amendments are required	Q1 2019/20	Trust FTSU Guardian

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.		See previous actions These actions will be reviewed once FTSU Guardian in plan (Feb 2018)				
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.						
Leaders actively shape the speaking up culture						

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.		Further awareness to be facilitated by new identified FTSU Guardian		FTSU discussed regularly at a number of Trust Forums. Board updates, People & OD.	Q2 2019/20	FTSU Guardian
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.		Trust has a good reporting culture – continue to embed this across all areas	Further evidence required. Governance Review underway which will support future performance & accountability framework	FTSU discussed regularly at a number of Trust Forums. Board update, People & OD.	Q2 2019/20	CEO/ Board

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.		Corporate Leaders Group members to further engage in ensuring visibility across their areas and the Trust		-What's Brewing - Walkabouts - FTSU agenda - Various Comms mediums - Back to the floor - FTSU student forums in place	Ongoing	CEO & Exec team
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.		Trusts FTSU Guardian to engage with senior leaders and develop FTSU Ambassador		Incorporated into the Trusts culture	End Q1 2019/20	

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
		infrastructure				
Senior leaders model speaking up by acknowledging mistakes and making improvements.		Further embed to support open and transparent culture	Weekly 'learning from Events' comms circulates across the Trust, positive feedback from staff. Quality & Safety newsletter being developed by Associate Medical Director	Learning from incidents shared with sub-Board committee members. Ongoing triangulation of data. Culture of continuous learning	Ongoing	CEO & Exec team

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.		Further communication required Comms plan to be developed			Q2 2019/20	FTSU Guardian with CEO/Exec Team
Leaders are clear about their role and responsibilities						
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.		Structure under review to support current model	Interviews for FTSU Guardian on 30th Jan 2019	Clear structure articulated in Policy – new Guardian to finalise policy and communicate	Q1 2019/20	FTSU Guardian

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
				processes		
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.		Formal meetings not held but awareness of agenda Formalise structure in the review with clear reporting to CEO	See above actions	As above	Q1 2019/20	FTSU Guardian
Other senior leaders support the FTSU Guardian as required.		FTSU Guardian to meet with key leaders to strengthen support and engagement	Induction programme for FTSU Guardian to be developed	Part of business as usual Discussions at senior leadership meetings.	Q1 2019/20	Dir People & OD

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
Leaders are confident that wider concerns are identified and managed						
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.		Data collated to be utilised sensitively in triangulation with other data and intelligence	Data collection process to be reviewed once FTSU Guardian in place	Triangulation across other systems and processes in place	Q2 2019/20	FTSU Guardian
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence		When model has been amended. Policy to be reviewed to reflect processes		Yes. NED FTSU Guardian is also chair of the Quality, Safety & patient Experience Committee	Q1 2019/20	FTSU Guardian

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
as appropriate.						
Leaders receive assurance in a variety of forms						
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.		Need to test this across the wider Trust to gain assurance. Culture Survey to be explored	Comms strategy to be developed as previously mentioned	Board updates	Q1 2019/20	Dir of People & OD/FTSU Guardian
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers		Need to have greater transparency of this	Trust has strong E&D focus – need to ensure FTSU & E&D agenda are aligned in 'speaking up'	E&D Lead advocates FTSU agenda through E&D agenda	Q3 2019/20	E&D Lead/ FTSU Guardian

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
Speak up issues that raise immediate patient safety concerns are quickly escalated			Continue to monitor	Demonstrated in previous cases	ongoing	Dir of Nursing & Quality & Medical Director
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority		Need to undertake deep dive into data to articulate whether there are any themes emerging		Data to be articulated in HR data presented to the Board	Q3 2019/20	Dir People & OD/FTSU Guardian
Lessons learnt are shared widely both within relevant service areas and across the trust		This requires further work Development of Comms strategy as above		Themes to be articulated to Board via next update paper	Q1 2019/20	FTSU Guardian/ CEO

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented		Audit plan to be developed in line with policy		N/A	Q1 2019/20	FTSU Guardian
FTSU policies and procedures are reviewed and improved using feedback from workers		Current policy review to be completed Further forums to be developed		Staff Barometer Group utilised	Q1 2019/20	FTSU Guardian
The board receives a report, at least every six months, from the FTSU Guardian.		Board report to be developed for presentation at next Board meeting (XX)		Regular Board report shared	Q4 2018/19	Dir of People & OD
Leaders engage with all relevant stakeholders						

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.		Ongoing		Views are more widely gathered to shape the wider Trust culture (including FTSU)	ongoing	FTSU Guardian
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.		These will continue to discussed with at regular regulatory and commissioner		FTSU agenda item on external regulatory meetings	Ongoing	FTSU Guardian

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
		meetings				
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).		Further update paper required for the next Board meeting(XX)		FTSU Board papers presented in public Board	Q4 2018/19	FTSU Guardian/ CEO
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.		Data in place. Will be utilised in next Annual Report (18/19)	Planning in place for developing Annual Report		Q4 2018/19	Associate Director of Planning & Performance./ FTSU Guardian

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
Reviews and audits are shared externally to support improvement elsewhere.		This does not currently take place FTSU Guardian to review process for audit and sharing when in post			Q2 2019/20	FTSU Guardian
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture		Action to be part of comms strategy to be developed		Board paper Good relationship with NGO. NGO rep facilitated Trust workshop. Attend FTSU Guardians Regional	Ongoing	

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
				Network Meetings		
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians		Once FTSU guardian model is revised, 'departmental and divisional Ambassadors will support this action FTSU Guardian will be part of the regional FTSU network	Current Trusts Guardians attend the FTSU network meetings as required		Q1 2019/20	FTSU Guardian
Senior leaders request external improvement support			Trust workshop facilitated by NGO –	Liaison with NGO office articulated to the	As required	

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
when required.			supported identification of priorities	Board in last update paper		
Leaders are focused on learning and continual improvement						
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.		Need to articulate evidence around this in future work		Board papers FTSU forms part of general culture of learning & Quality improvement		CEO/Exe Team
Senior leaders and the FTSU Guardian engage with other		Pls see previous point re liaison with NGO &		Attendance at Regional FTSU	ongoing	FTSU Guardian

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
trusts to identify best practice.		regional network		networks		
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.		Further learning from other national case reviews are required	This has taken place	Board papers e.g. Southport & Ormskirk case review	Ongoing as required	CEO/Exe/ NEDs
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the		Quality Improvement is part of Trust culture. Further work required to audit this 'Learning from FTSU to feature in amongst all	Learning' comms is shared weekly across the Trust		Ongoing	CEO/Exe c team

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
organisation.		other learning to support a culture of continuous improvement				
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been						

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
and how they can be overcome; and whether the right indicators are being used to measure success.						
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.		To be finalised when FTSU Guardian in post	Policy update currently underway	Board papers	Q1 2019/20	FTSU Guardian

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told		Audit process to be defined with Policy review				FTSU Guardian
				Various Communications with individuals involved with Speaking Up		

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored		Other NED involvement in cases to provide objectivity and independence				
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.		Need to be more proactive in communicating this			Q3 2019/20 onwards	FTSU Guardian & FTSU Ambassadors

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
Individual responsibilities						
Chief executive and chair						
The chief executive is responsible for appointing the FTSU Guardian.		New structure/model to be implemented. CEO involvement will take place	Recruitment of FTSU underway – for completion by 30th Jan 2019		Q4 2018/19	CEO
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.		Accountability is clear and FTSU Guardian to report directly to the CEO Integrate FTSU agenda into		Embedded in the Trusts culture. High visibility of CEO and executives	Q4 2018/19	CEO

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
		performance culture		across the Trust		
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.		This will be further reflected in the 18/19 report Briefings to be undertaken with CEO and Chair		More FTSU visibility required at Board level	Q4 2018/19	Associate Director of Planning & Performance
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's		Ongoing attendance at relevant workshops and meetings	Fully compliant and engaged with workshops & meetings		ongoing	CEO/ Chair

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
Office.						
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.		FTSU meetings not formally in place as this is not reflected in the current model – this will be actioned with the model review This will be addressed in coming months			Q1 2018/19	CEO/ Chair
Executive lead for FTSU						

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
Ensuring they are aware of latest guidance from National Guardian's Office.		Review of model underway therefore role of Execs/NED to be re-defined	Regular communication shared at FTSU meetings	A number of Execs are FTSU Guardians and have access to NGO	Q1 2019/20	CEO
Overseeing the creation of the FTSU vision and strategy.		Discussions underway with NGO and regulators as to whether a standalone strategy is required				
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment		This is planned against the National Guidance	Process in place including representation from across the Trust as well as		Q4 2018/19	CEO

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
process in accordance with the example job description and other guidance published by the National Guardian.		Interviews on 30th Jan 2019 – open and transparent recruitment in place	FTSU Guardian network involved in recruitment			
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.		Current revised plan will incorporate dedicated time - resources agreed	Role to be reviewed in 12 months' time re effectiveness of role and query any additional resource required		In place	CEO

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
Ensuring that a sample of speaking up cases have been quality assured.		Will be included in audit plan to support			Q3 2019/20	FTSU Guardian/ CEO
Conducting an annual review of the strategy, policy and process.		Further work required on how strategy feeds into Trust strategy	Currently underway re Policy, processes and Guardian model		Q1 2019/20	FTSU Guardian/ CEO
Operationalising the learning derived from speaking up issues.		Themes to be collated and formally shared	Feeding in any learning into Lessons shared comms	Next Board paper needs to articulate any learning	Q3 2019/20	Comms lead/ FTSU Guardian
Ensuring allegations of detriment are promptly and fairly investigated and acted on.		Encompassed into current policy	Evidence of some actions now being part of generic plans e.g. Ward		Ongoing	CEO & Exec team

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
			Manager development			
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.		Further work required to progress this		Board paper update	Q3/4 2019/20	CEO
Non-executive lead for FTSU						
Ensuring they are aware of latest guidance from National Guardian's Office.		NED already receives regular communication	Attendance at NGO training & Conference			FTSU Guardian
Holding the chief executive, executive FTSU lead and the		Planned presentation at March Board re FTSU agenda	Proactive NED Lead with other NEDs involved as required		Q4 2018/19	Board

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
board to account for implementing the speaking up strategy.						
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.		See above		Positive and constructive discussion at Board (Board minutes)	ongoing	Lead Governor
Role-modelling high standards of conduct around FTSU.			This forms part of the Trusts High Performance culture programme	Culture, values and behaviours demonstrated	ongoing	Board

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
			NED does role model the behaviours expected			
Acting as an alternative source of advice and support for the FTSU Guardian.			Has already demonstrated this with previous FTSU cases	Always supporting and challenging but in a professional way	ongoing	NED's
Overseeing speaking up concerns regarding board members.	N/A	No opportunity to test				
Human resource and organisational development directors						

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.		Further support to be provided when required	Good support for FTSU agenda and planned support in place for FTSU Guardian post holder when in post	People & OD Director is a FTSU Guardian. FTSU linked to high performance, values & behaviours culture programme	Q1 2019/20	Director of People & OD

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.		Further work required regarding sharing learning	Trust staff survey results (2017/18) demonstrate improved support for employees from their managers	People & OD Committee mins	ongoing	Director of People & OD
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised		Need to evaluate the effectiveness of the FTSU input into training and education. FTSU Guardian to review current		Good programme of HR Training. FTSU integrated into training & induction for all groups of staff	Q4 2019/20	FTSU Guardian/ Director of People & OD

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
effectively.		position				
Medical Director and Director of Nursing						
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.		121 meetings to be arranged once FTSU Guardian in post re regular patient safety up dates		DoN/MD are FTSU Guardians and able to signpost others and support as required	Q1 2019/20 ongoing	Director of Nursing & Medical Director
Ensuring that effective and, as appropriate, immediate action is taken when potential patient		Actions to be escalated and progressed accordingly		Evidence of immediate actions taken through specific	Ongoing	Director of Nursing & Medical

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	Progress against Actions	How is the board assured it is meeting the expectation? Evidence	Review Date	Lead
safety issues are highlighted by speaking up.				cases		Director
Ensuring learning is operationalised within the teams and departments that they oversee.		Learning from FTSU cases requires further comms. October 2018 further comms in place to support the national FTSU month			Ongoing	Exec team

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Kisiizi and Countess of Chester Hospital Update
Date of Meeting	Board 26th March 2019
Author(s)	Mr Simon Holden - Director of Finance
Annual Plan Objective No.	
Summary	This report is intended to provide an update on the Trust's 10 year partnership, and support, to the Kisiizi Program.
Recommendation(s)	**The Board is asked to note:** • The background and history underpinning the Trust's partnership, and support, to the Kisiizi Program; • The rationale, and mechanism, by which the Trust actively supports this program (linked to the Nigel Crisp 2006 All-Party Parliamentary Group Report on Global Health "How overseas volunteering from the NHS benefits the UK, and the world") • The current Kisiizi Board membership, and the rationale for needing to reinvigorate the project; • The upcoming visits that are planned, together with their timing; and • The suggested next steps, namely: o Seeking Non Executive/Executive Director nominees to support the Kisiizi Board; o Seeking Board level commitment to continuing with this program; and o The need/rationale to re-energise commitment to the Kisiizi project, if it is to continue into the medium term.
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 and Kisiizi

1. Introduction

The Trust has worked in partnership with the Kisiizi Project, for a number of years, having initially been funded from monies received from the Tropical Health Education Trust (THET), and other charitable donations, and being a part of the Countess of Chester Charitable Funds.
The intention of this brief paper is to provide an update on the Project, and also an opportunity to reflect on future relationships.

2. Background/ History

- In 2006, Nigel Crisp, the then Chief Executive of the NHS, was asked by the government to produce a report on how UK expertise could best be used to improve health in developing countries. The recommendations from his report included encouraging UK health professionals to provide intellectual and practical leadership in training and education and increasing access in the developing world to knowledge about best practice derived from high quality research. The anticipated reciprocal benefits of this included healthcare professionals and organisations learning from overseas institutions, and the development of stronger global relationships and health partnerships.
- Peter Herring, the Chief Executive of the Countess of Chester Hospital at the time, and David Wood, Human Resources Director of the Countess of Chester Hospital at the time, were initially instrumental in creating/supporting Kisiizi which started approximately 12 years ago (2007).
- The project has been supported by grant funding from the Tropical Health Education Funding, and monies held in Countess Charitable Funds (although this funding stream has recently ceased).
- Approximately 40 Countess staff have visited Kisiizi over the last 12 years, and 22 Kisiizi members of staff have visited the Countess.

3. Mechanism/ Architecture

- Monies are held in the Countess Charitable Funds (current balance circa £11,000).
- The Countess offers 1 week of paid study leave to staff, and staff take one week of holiday leave (covering the normal two week visit).
- The charity pays for all staff/ volunteers flights and in country private transport.
- The staff/ volunteers pay for hospital accommodation in Kisiizi at £210 (14 nights at £15 per night).
- Projects to date have tended to focus on Pharmacy, Radiology, and Nursing.
- Earlier work has subsequently been recognised by the World Health Organisation (WHO).
- Current aim is to support patient safety and quality improvement.

Kisizzi Board Membership:
Finance - RG

Medical – IH (stepped down)
Occupational Health - KDB
Infection Control - SW
Medical – JS (retired)
Nursing – SH (retired)
Nursing – SW (stepped down)
Medical – SB (nominated new member to join)

4. What Visits are Planned

April 2019 (two weeks)

- Consultant Paediatrician
- Neonatal Nurse

June 2019 (two weeks)

- Radiographer
- Ultra-sonographer

October/ November 2019

- Infection Control
- Catering
- Pharmacist
- Nurse

2020 Plan

- Yet to be agreed

5. Context

- Other organisations have stopped supporting staff time (in similar projects).
- There is a perception that hospital staff are potentially released at times when the hospital is busy, although this is thought to not be substantiated (as visits are scheduled outside of school holidays, and also avoiding other times of pressure).

6. Next Steps

- Countess need to establish a functional Kisiizi Board (including Executive/Non Executive membership).
- Possible high level visit to reinvigorate the project.
- Need formal Countess Trust Board support, and vision.

- Need sustainable Kisiizi Board in next 1 to 2 years, due to impending retirements (and eroding links with the Countess Management Team).
- Commitment given to support April and June 2019 flights, and trip, until directed otherwise.

Countess of Chester & Kisiizi

Celebrating 10 years of partnership

2008-2018

The partnership was established through The Health Education Trust (THET) in 2008. The Partnership is based on trust and mutual respect to promote long term sustainable and collaborative work particularly in the fields of quality and Patient Safety.

The partnership has demonstrated its ability to implement successful projects and bring about improvements in a number of health care areas as well as working within projects that include multi partnership working. The partnership has benefitted from grants received from THET and from working with the World Health Organisation on its implementation of the African Partnership for Patient Safety.

Want to get involved?

Contact Sarah Hoyle—

sarahhoyle5@hotmail.co.uk

Approximately 40 members of staff from the Countess have visited Kisiizi supporting the programmes implemented. In addition the Countess has welcomed 22 members of Kisiizi staff who have spent up to five weeks at the Countess working along health professionals to enhance their skills and knowledge. Some of these visits have been funded by the Commonwealth Fellowship and others from grant monies received.

Equipment donated:-

Ultra sound machine
Portable ultra sound machine
Large quantity of bed linen
X-ray film developer

NHS
Countess of Chester Hospital
NHS Foundation Trust

Subject	Integrated Care in Cheshire West (Progress Report)
Date of Meeting	26th March 2019
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:** • Submission of draft Integration Agreement developed by CWICP Governance Programme for discussion at Board.
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

INTEGRATED CARE IN CHESHIRE WEST – PROGRESS REPORT

PURPOSE

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.

INTEGRATION ACTIVITY HIGHLIGHTS

The following highlights the integration work that has been taking place within the CWICP Programme, including a focus on three main areas of work; what people want, what people need, and what people are getting.

3. What people WANT – Community Conversations / Appreciative Inquiry Model:
   To hear from our communities a series of Community Conversations are being delivered using an Appreciative Inquiry model.
   Cheshire West and Chester Council's Public Health team has commissioned a series of 'Community Conversations' on behalf of CWICP, which are taking place now across the borough, in each of our 9 Care Communities. The programme runs from 1 February to 28 May 2019. The contract was awarded to Cheshire Community Action, a local Third Sector organisation with extensive experience of working with local communities and voluntary sector organisations, including early intervention and prevention services. It is estimated that a total of 47 events will be delivered in the initial phase.

   Key Achievements to date:
   - 31 sessions held with a total of 192 attendees
   - Mix of both service users and carers engaging in sessions, at least 5 instances of spouse attendance
   - 133 online responses, 15 one to one calls completed
   - 10,000 leaflets in circulation, adverts in the free local press and on social media

4. What people NEED – Care Community Intelligence Packs:

Data packs are being produced for each Care Community to understand our population health needs. Cheshire West and Chester Council's Public Health team are leading on the production of a comprehensive needs assessment for each care community, in collaboration with West Cheshire and Vale Royal CCGs and Partner organisations. The working group) is developing an intelligence pack that is bespoke with tailored intelligence data for each of the Cheshire West care communities. It is intended this will include health; social care; and demographic profile indicators and be split into three levels; 1) strategic 2) managerial 3) operational. The initial focus will be the 'strategic' intelligence level, with an aims to have a first iteration by June-2019. Key steps during the next few weeks are to understand which indicators should be included in each level of the pack and to identify the key data sources for the most up-to-date information.

Key Achievements to date:

- A series of project sessions have now taken place with both CCGs and Partner organisations to discuss and review how the intelligence packs can be produced and developed, using information and data that is readily available.

5. What people are GETTING - Community Care Team Diagnostic:
Community Care Team diagnostic to understand the current offer and model against best practice.
An exploratory piece of work is being undertaken to analyses existing care models in the Cheshire West area, with a particular focus on the existing integrated community care teams, including adult social care resources, which are based around GP clusters. The diagnostic is exploring the current models of operation and the interdependencies that exist across our community care teams, in order to propose potential options for even more integrated and efficient working moving forwards.

Key Achievements to date:

- Completion of a baseline literature review of previous 'reviews'
- 49 process maps with 8 teams
- 13 focus groups including staff from care community teams, management, and primary care

6. Transformation: Test for Change workshops:
A series of 'test for change' workshops have begun with Care Community Teams (CCTs) and Countess of Chester representatives looking to improve communications between CoCH wards & CCTs. Ellesmere Port community care team has been working on developing a pre-discharge "huddle" with Bluebell and Poppy wards at Ellesmere Port Hospital (EPH), with the aim to gain a greater understanding of each other's roles and the challenges both teams face. In this initial test representatives from CCTs have attended the Red/Green meetings at EPH twice weekly. Discussing patients with care coordinators from across both hospital and community based teams supports; increased awareness of patients' safely needs, sharing of relevant information where CCTs have prior input with a patient, awareness that patients are in hospital, input into patient care whilst in hospital and in preparation for discharge where community specific support is required. It also allows for the staff to plan accordingly for up-coming discharges, and attend multi-disciplinary meetings.

Further developments include trying to resolving IT access issues for CCT staff while at EPH to assist staff to provide a holistic view to patient care

7. Risk Stratification Tool:
The Risk Stratification tool has now been fully developed. It contains data at patient level from: Primary Care, Secondary Care, Community Care Team, Mental Health, with future inclusion of data from Social Care. The tool has currently been rolled out to 6 of the 7 West Cheshire Primary Care Networks with the system in use across the Practices since December 2018. Bespoke reporting packs are being designed for each Practice to focus MDT sessions.
Using the Risk Stratification tool to identify the top 2% of patients that are 'at risk', a total of 136 patients have been identified and followed-up with appropriate clinical management, including referral to mental health services.

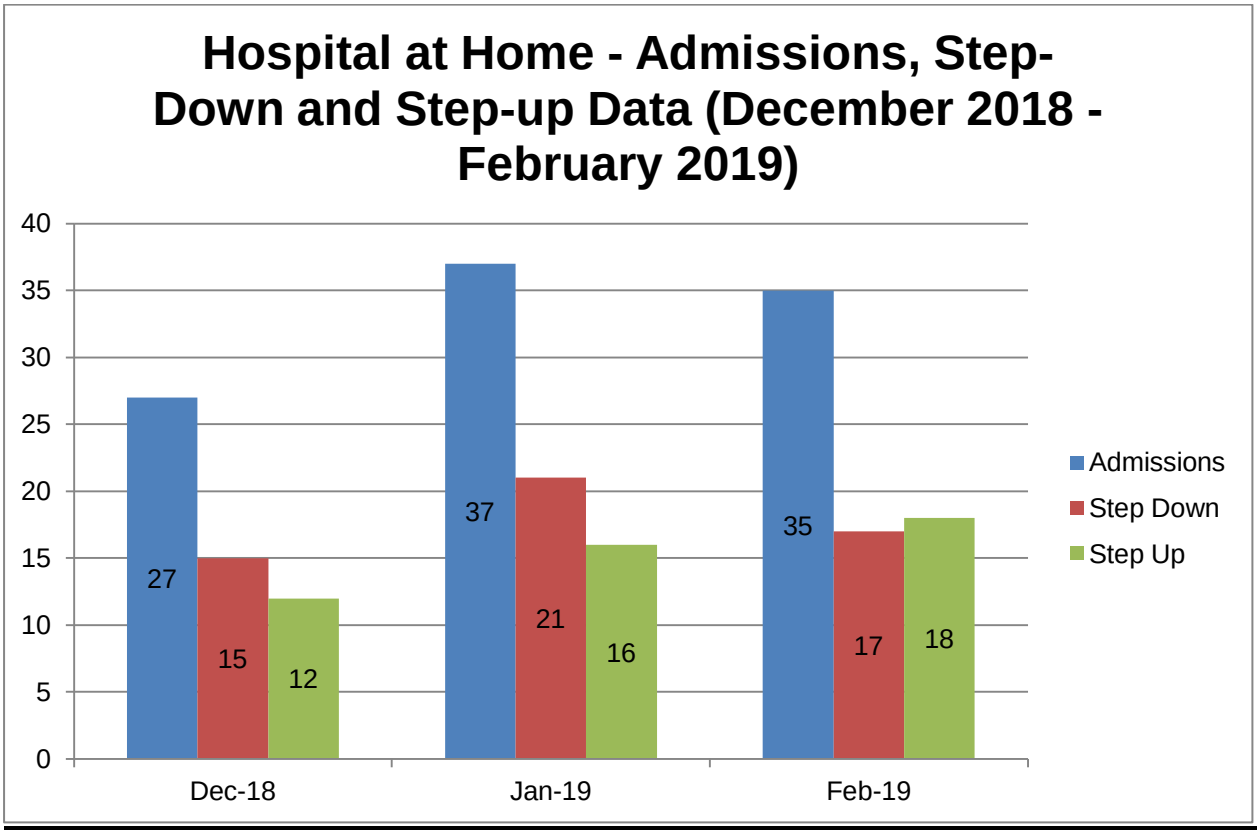
TRANSFER OF INTERMEDIATE CARE AND THERAPY SERVICE

The following highlights the key achievements of Intermediate Care and Joint Therapies teams which were transferred to the CWICP in December 2018.

8. Intermediate Care
Key Achievements for January:
- Hospital at Home January performance: 37 admissions 56% step down 44 % step up. An increase on December. Main patient cohort is COPD. Nursing and residential home referrals now being managed in conjunction with EMU.
- Medically optimised patient reduction to an average 35 daily in acute beds.
- Additional capacity being utilised in rapid response supporting patients to leave hospital who require Packages of Care at home this additional capacity has been funded through Winter CWaC monies.

Performance Summary:
- Reduction in readmissions after 90 days from Intermediate Care bed, in August there was 38% which had reduced to 27th in October.
- Reduction in LOS in Pinetum from 32 days in November to 23 days in December and Ward 32 Intermediate Care Unit, from 13 days in November to 10 days in December.
- National Intermediate care audit results received overall very positive.
- Hospital at Home support 30+ patients at home at any one time, the collaborative working within CWICP is supporting the development of a secondary care shift for higher acuity patients and for their care to be delivered at home (e.g. COPD exacerbations, Heart Failure and Intravenous antibiotics) – see below Table 1 :

Table 1



9. Joint Therapies

Key Achievements for January:

- An average monthly decrease of 178 referrals to Magnetic Resonance Imaging achieved by Musculoskeletal General Practitioner referrals being managed within the Adult Musculoskeletal Assessment and Management Service. The released capacity in plain films and MRIs is having a positive effect on cancer pathways
- ESCAPE-pain programme for patients suffering with Osteoarthritic hips and knees is being delivered within Therapies as part of a national research trial. Of the cohort of 90 patients seen in the programme to date this is demonstrating a reduction in medication being taken by patients and a reduction in referrals required on to secondary care.

Performance Summary:

- Improvement in musculoskeletal GP routine referral wait times in month
- Actions being taken to address 16 plus week therapy waits in Rheumatology, Hyperventilation and Women's Health

GOVERNANCE

10. The Governance Workstream has representation from Partner organisations, and engagement with other areas to share learning i.e. Manchester Local Care Organisation.

11. A draft Integration Agreement has been developed by CWICP Governance Programme. This is the subject of a separate report included on today's agenda.

12. The high level summary of the January 2019 CWICP 'Shadow' Board can be found here. Future minutes of the CWICP Board will be reported routinely to the CoCH Board.

RECOMMENDATION

1. Submission of draft Integration Agreement developed by CWICP Governance Programme for discussion at Board.

Alison Lee
Managing Director, Cheshire West Integrated Care Partnership
March 2019

Cheshire West Integrated Care Partnership

Cheshire West and Chester Council and the NHS working together

NHS Cheshire West and Chester

Countess of Chester Hospital NHS Foundation Trust

Board of Directors

1.	**Date of Meeting:**	26th March, 2019
2.	**Title of Report:**	**Integration Agreement - Cheshire West Integrated Care Partnership**
3.	**Key Messages:**	• The purpose of the Integration Agreement is to align the work of the partners as much as possible, with a view to making better use of their collective resources and providing better care to those who live within the ICP's footprint or receive care from its constituent organisations. • This overarching purpose is supported by the creation of a new collaborative governance model. • Aligned decision making is central to the work of the Cheshire West ICP.
4.	**Recommendations**	a) That the Board agrees the Cheshire West Integrated Care Partnership Integration Agreement and authority for the Chief Executive to sign this agreement on behalf of the Trust.
5.	**Report Prepared By:**	Cheshire West ICP Governance Programme/ Debbie Bryce, Governance Programme Lead.

Cheshire West Integrated Care Partnership

Integration Agreement - Cheshire West Integrated Care Partnership

PURPOSE

1. The purpose of this report is to provide a short narrative on the purpose and basis of the Cheshire West Integrated Care Partnership (ICP) Integration Agreement.

BACKGROUND

2. An Integrated Care Partnership is an alliance of providers collaborating to meet needs of a defined population. Integrated care will bring together the different organisations and services that look after people in Cheshire West to better co-ordinate care, to make sure patient and carer experiences are as joined-up as possible and to support more people to stay healthy and well.

PURPOSE OF THE INTEGRATION AGREEMENT

3. The purpose of the Agreement is to align the work of the parties as much as possible, with a view to making better use of their collective resources and providing better care to those who live within the ICP's footprint or receive care from its constituent organisations.

4. This overarching purpose is supported by the creation of a new collaborative governance model.

5. The Integration Agreement sets out the vision and integration principles of the Cheshire West ICP, which support the overall aims of the ICP as stated below:

   - We will focus on identifying and proactively targeting people who may be rising or high risk;
   - We will focus on optimising outcomes by supporting people to tailor, direct and deliver their own care;
   - We will work together in a true collaborative and integrated way across health and social care;
   - We will design and deploy our workforce in a way and in environments that will support our new vision.

6. The integration agreement is not intended to be legally binding between the partners, however, the partners agree to act in good faith, to honour their respective obligations and to be held to account for delivery of their commitments.

7. It is intended that the arrangements put in place by the Integration Agreement will "go live" from 1st April, 2019, or such other date as the partners agree.

8. It is recognised that the ICP and its governance arrangements will evolve and the Integration Agreement will be reviewed at least annually to make sure it remains fit for purpose and reflects the way in which the ICP operates.

PARTNERS TO THE INTEGRATION AGREEMENT

9. The partners and signatories to the Integration Agreement are:

- Cheshire West and Chester Council (statutory role and service provider)
- Cheshire and Wirral Partnership NHS Foundation Trust (service provider)
- Countess of Chester Hospital NHS Foundation Trust (host and service provider)
- Primary Care Cheshire (representing GP practices as providers in West Cheshire)
- South Cheshire and Vale Royal GP Alliance (representing GP practices as providers in Vale Royal)
- Central Cheshire Integrated Care Partnership

10. The Countess of Chester Hospital NHS Foundation Trust is recognised as the host of the ICP. Its role is that of coordinator.

BASIS FOR ICP DECISION MAKING WITHIN THE AGREEMENT

11. Aligned decision making is central to the work of the Cheshire West ICP; alignment means that the organisations within the ICP retain their own decision-making authority, but have agreed to make their decisions taking into account a vision that is common to all of them, along with common aims and principles.

12. Alignment should help to ensure that the decisions taken by the parties within the ICP mirror each other, or complement each other so as to add up to a cohesive partnership-wide approach to designing and delivering services.

13. Neither the ICP or the ICP Board has legal status. Any decisions of a legally binding nature would still sit with individual partner organisations.

GOVERNANCE

14. The governance arrangements for the ICP will be supported by a Governance Handbook which is currently under development. This Handbook will include the terms of reference for the ICP Board which will be shared with ICP partners for agreement.

RECOMMENDATIONS

15. a) That the Board agrees the Cheshire West Integrated Care Partnership Integration Agreement and authority for the Chief Executive to sign this agreement on behalf of the Trust.

Alison Lee
Managing Director, Cheshire West Integrated Care Partnership
March 2019

Cheshire West Integrated Care Partnership

Cheshire West and Chester Council and the NHS working together

NHS Cheshire West and Chester

[INSERT MEETING TITLE]

1.	**Date of Meeting:**	[Insert Date]
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Cheshire West Integrated Care Partnership

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[Name]
[Job title]
[Month / year]

Cheshire West Integrated Care Partnership

Cheshire West and Chester Council and the NHS working together

NHS Cheshire West and Chester

Governance Framework Integration Agreement

Cheshire West Integrated Care Partnership

FINAL (Version 1)

VERSION CONTROL

Version	Date	Author
1	6th March, 2019	Cheshire West ICP Governance Programme

CONTENTS

Go Live date: 1st April, 2019

This Governance Framework Agreement (the **Agreement**) is made between:

1. **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST** of Countess of Chester Health Park, Liverpool Road, Chester CH2 1UL **("COCH");**
2. **CHESHIRE WEST AND CHESTER COUNCIL of** 58 Nicholas Street, Chester CH1 2NP **("CW&C");**
3. **CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST of** Chester Health Park, Liverpool Rd, Chester CH2 1BQ **("CWP");**
4. **CENTRAL CHESHIRE INTEGRATED CARE PARTNERSHIP of** Leighton Hospital, Crewe, Cheshire CW1 4QJ **("CCICP");**
5. **SOUTH CHESHIRE & VALE ROYAL GP ALLIANCE of** Ashfields Primary Care Centre, 19 Middlewich Road, Sandbach, Cheshire CW11 1EQ (**"SCVRGPA")**
6. **PRIMARY CARE CHESHIRE of** The Helsby and Elton Practice, Lower Robin Hood Lane, Helsby, Frodsham, Cheshire WA6 0BW **("PCC")**

Each a "Partner" and together the "Partners".

The Cheshire West health and care system have set out their vision in their blueprint document titled *'*Design *Blueprint for the West Cheshire Integrated Care Partnership, A Sustainable Future for Health and Wellbeing in Cheshire West'* strategy.

COCH, CWP, CCICP, SCVRGPA, PCC and CW&C (where acting as a provider of services) are together referred to in this Agreement as the "Providers".

1. BACKGROUND

1.1 This Agreement has been developed by the Partners to strengthen their collaborative working arrangements as the Cheshire West Integrated Care Partnership **("CWICP").**

1.2 The Agreement sets out how the Partners will work together in a collaborative and integrated way to achieve the CWICP Vision, Aims and Priorities, in accordance with the CWICP Integration Principles.

An Integrated Care Partnership (ICP) is:

- An alliance of providers collaborating to meet needs of a defined population responsible for:
- A budget to be allocated by Commissioners within the NHS to deliver services under a long-term outcome based contract
- achieving the triple aim of improved health and wellbeing, better quality and sustainable finances.
- Focusing on prevention and proactive care to reduce unwarranted escalation and use of bed-based care.

- actively managing health and wellbeing, improving key risk factors and delivering care tailored to the individual.

1.3 This Agreement does not serve to replace or override in any way the legal and regulatory frameworks applying to, or the statutory functions of, each of the Partners as separate organisations. Rather this Agreement sits alongside and complements such frameworks and functions to set out how the Partners will come together to develop the CWICP through the delivery of system-wide plans to achieve the CWICP Vision, Aims and Priorities thereby improving the health and wellbeing of people living in Cheshire West.

1.4 This Agreement refers to the CWICP and does not include how governance within individual Partner organisations will be delivered. As these arrangements are developing all Partners to this agreement will be updated as to any amendments which may be required to this Agreement.

1.5 It is agreed that with effect from the Go Live Date CoCh will be the Host of the ICP and act on behalf of the ICP in a coordinating role. This coordinating role could include negotiating or preparing proposals on behalf of and with the prior agreement of the other parties and employing staff to undertake work on behalf of the ICP, however, decisions about the work of the ICP that are legally binding will be reserved to decision-makers within each of the individual partners.

1.6 The Host shall arrange that individuals and organisations on the ICP Board have all necessary licences and consents to perform their roles. Where such licence or consent is required from one of the Partners, the respective Partner agrees that it will endeavour to grant such licence or consent;

1.7 It is agreed that where, from the Go Live Date it is proposed that the Host enters into an agreement with a third party on behalf of the ICP the Partners shall discuss, agree and document the basis on which the Host will be indemnified for any Losses incurred by the Host;

1.8 The Host agrees to appoint:

(a) the Chair of the ICP Board as a non-executive director of the Host; and

(b) the Managing Director of the ICP Board as an executive director of the Host.

(c) the Chair and Managing Director of the ICP Board as a committee of the Host's board. The Chair and the Managing Director will have delegated authority to exercise the powers of the Host relating to the operational management of the ICP and as set out in the Host's scheme of reservation and delegation;

1.9 The organisational form of the ICP will be capable of adaptation as the scope of services is agreed over time. Any changes to the organisational form of the ICP will

be agreed by the Partners through unanimous vote;

2. DEFINITIONS AND INTERPRETATION OF THIS AGREEMENT

This Agreement is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

3. PARTNERS TO THIS AGREEMENT

3.1. Additional partners may become parties to this Agreement on execution of a memorandum of adherence to its terms and such other terms as the Partners shall jointly agree at the Integrated Care Partnership Board **("ICPB")**. Any disagreement between the current Partners to this Agreement over the admission of a new Partner will be referred to the Dispute Resolution Procedure for resolution.

3.2. It is acknowledged that there is no statutory framework to determine formal membership of the ICP and therefore signatories of the Agreement, however the following factors have been taken into account to determine membership:

(1) Organisations whose in-scope services will be directly provided by or within the ICP
(2) The organisation agreed as host of the ICP
(3) General Practice because of their registered patient lists and their role in referring, admitting, consulting with and treating patients
(4) The Local Authority because of their statutory role in improving the health and wellbeing of residents and whose services may be directly provided by the ICP in future phases.

3.3. Based on these factors, the following organisations are formal members of the ICP and signatories to this Agreement:

- Cheshire West and Chester Council (statutory role and service provider)
- Cheshire and Wirral Partnership NHS Foundation Trust (service provider)
- Countess of Chester Hospital NHS Foundation Trust (host and service provider)
- Primary Care Cheshire (representing GP practices as providers in West Cheshire)
- South Cheshire and Vale Royal GP Alliance (representing GP practices as providers in Vale Royal)
- Central Cheshire Integrated Care Partnership

3.4. Other providers (no matter how big or small the contract) will in effect be sub-contractors in that services will not be directly provided by the ICP. Relationship/account management with these providers will be a crucial part of the ICP's work.

4. TERM

This Agreement shall commence on the Commencement Date and, unless terminated in accordance with its terms, will continue for an initial term of 3 years and thereafter subject to an annual review of the arrangements under this Agreement by the ICPB.

5. STATUS AND PURPOSE OF THIS AGREEMENT

5.1 The purpose of this Agreement is to set out how the Partners will work together to improve outcomes for the people they collectively serve. This includes raising standards of care and ensuring value for money.

5.2 This Agreement is intended to:

5.2.1 provide clarity on how the Partners will collectively plan, decide and deliver the improvements in health and care which are required now and in future years; and

5.2.2 allow the Partners to build on working together to take strategic decisions together across the whole of Cheshire West to improve the standard of care no matter where people live or the organisation charged with planning or delivering care; and

5.3 This Agreement will be reviewed at least annually by the Partners and updated by agreement of the Partners to reflect any changes to national policy and learning from emerging Integrated Care Systems and Integrated Care Partnerships nationally.

5.4 The Partners acknowledge that the Agreement is not intended to give rise to legally binding commitments between the partners. Despite the general lack of legal obligation, subject to clause 5.5, the Partners have given proper consideration to the terms set out in the Agreement and notwithstanding the good faith consideration that each Partner has afforded the terms set out in this Agreement, the Partners each enter into this Agreement intending to honour all of their respective obligations.

5.5 Clauses 13 (Conflicts of Interest); 14 (Information Sharing and Transparency); 15 (Confidentiality); 18 (Charges and Liabilities); 20 (Counterparts); and Clause 23 (Governing Law and Jurisdiction) will come into force from the Commencement Date and will give rise to lawful commitments under the auspices of the stated legal frameworks set out in these clauses as part of the Partners' engagement with each other and third parties.

6. VISION & AIMS OF THE CWICP

Vision

6.1 The Partners have developed a shared CWICP vision, ambition and purpose for health and care services across Cheshire West and will work together in good faith in accordance with this Agreement to achieve them. The vision is set out in Section 6.2 below.

6.2 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. We will achieve this by joining up delivery of our health and social care and focusing on prevention, early identification and supported self-management, where hospital based care is minimised.

Our vision was agreed to reflect the ambition of the CWICP, which is based on achieving ten outcomes, designed to improve the care provided to the people of Cheshire West.

- people experience improved well being
- our people receive care in a way which increases safety by using effective approaches that mitigate unwarranted risks
- a reduction in avoidable mortality
- an increase in people empowerment and self-care
- an increase in the provision of care closer to home
- a reduction in avoidable admissions and readmissions to hospital
- care is delivered in a fully integrated way, using efficient and effective processes
- people only have to tell their story once
- people have a great experience of care
- care and prevention is financially sustainable

Aims of the CWICP

6.3 The Partners have agreed to work together and to perform their obligations under this Agreement in order to achieve the following overall aims which have guided thinking and choices.

CWICP overall aims:

6.3.1 we will focus on identifying and proactively targeting people who may be rising or high risk

6.3.2 we will focus on optimising outcomes by supporting people to tailor, direct and deliver their own care

6.3.3 we will work together in a true collaborative and integrated way across health and social care

6.3.4 we will design and deploy our workforce in a way and in environments that will support our new vision

7. OBJECTIVES AND INTEGRATION PRINCIPLES OF THE CWICP

7.1 The overall objectives agreed by us are to deliver sustainable, effective and efficient services with significant improvements over the term of the CWICP arrangements (the Integration Objectives). We will agree detailed Integration Objectives after the development of this Agreement.

7.2 In consideration of the mutual benefits and obligations under the Agreement, We will work together to perform the obligations to be set out in the Agreement and, in particular, achieve the Integration Objectives.

7.3 Subject to and in accordance with provisions set out in the Agreement, we will work to the following **Integration Principles**:

- commit to delivery of system outcomes in terms of clinical and adult social care matters, patient / service user experience and resource allocation;
- adopt collective responsibility for identifying, managing and mitigating all risks in performing our respective obligations in this Agreement, with a commitment to using this performance information to consider how to practicably implement a fair share risk and reward scheme;
- commit to delivering the best possible care for the whole population;
- adopt an uncompromising commitment to trust, honesty, collaboration, innovation and mutual support;
- commit to work together and to make system decisions on a Best for System basis;
- establish an integrated collaborative team environment to encourage open, honest and efficient sharing of information, subject to competition law and information governance compliance;

- co-produce with others, especially service users, people with lived experience, families and carers, in designing and delivering, the Service; and
- take responsibility to make unanimous decisions on a Best for System basis.

8. GOVERNANCE AND DECISION MAKING

8.1 The Partners have established a governance model that facilitates a process of aligned decision making to support the delivery of the Cheshire West integrated health and care system.

8.2.1 The CWICP governance structure does not replace or override the authority and accountability of each Partner's board or governing body or cabinet (as

relevant), and each of the Partners remains sovereign and accountable in respect of its statutory duties and functions (as applicable).

8.2.3. The ICPB is not a joint committee of the Partners and is not itself a single committee of any of the Partners. The ICPB is not a separate legal entity in its own right and cannot take decisions as a separate entity. A committee, or any nominated representative of a Partner participating in the ICPB, cannot take a decision which binds any other partner organisation or committee.

8.2.4 All Partners will participate in discussion and debate at the ICPB as part of being a key partner within the CWICP and signing up to the principles set out in this framework. However, decisions will only be taken by a Partner in accordance with its statutory governance procedures and delegated decisions given to officers.

8.2.5 Each Partner must ensure that it's appointed members of the board and its committees attend the meetings of the relevant Governance structure and participate fully and exercise their rights on a best for system basis to achieve the CWICP Vision in accordance with the CWICP Integration Principles.

8.3 CW&C has established a People Overview and Scrutiny Committee responsible for holding to account those who deliver services based on individual need to children and adults. The committee may review and make recommendations for improvement across a number of areas including services relating to health services and the integration of services. CWICP will participate in discussion or debate where requested to do so by the Committee on relevant matters.

8.4 The CWICP Governance structure (Appendix 1) illustrates the CWICP governance framework and the terms of reference for each of the Governance structures are included within the Governance Handbook.

8.5 Clinical Governance and Practice Requirements

8.5.1 The Partners agree that the objectives of the Partnership are for the Partners to work together at all times as a single, integrated, group of providers, and to deliver the Services in accordance with good clinical practice and good industry practice (as applicable) and all applicable laws and regulations.

8.5.2 The Partners will continue to implement their respective organisations professional practice requirements including risk assessment and management policies in accordance with their respective governance frameworks and statutory duties including the statutory responsibilities of the Director of Adult Social Care. This is to assure that the management of clinical/ practice risk is not compromised at service delivery level and that the sensitivity of clinical/ practice escalation processes at local and organisational level remain effective. This is to ensure compliance with Partners'

regulatory requirement, e.g. Regulation 17 "Good Governance" – Health and Social Care Act 2008 (Regulated Activities) Regulations 2014".

8.6 Key Boards & Groups within the System

[The terms of reference for key boards and groups will be detailed within the ICP Governance Handbook.]

Cheshire West and Chester Health & Wellbeing Board

8.6.1 The Cheshire West and Chester Health & Wellbeing Board is a statutory committee of CW&C established under the provisions of the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

8.6.2 The Health and Wellbeing Board is accountable to CW&C for the delivery of the Board's Joint Health and Wellbeing Strategy (2015-2020). This Strategy has been approved by all members of the Board, and contains the overarching vision for health and wellbeing in the Borough

8.6.3 The Board is also accountable to a number of national bodies and organisations for the provisions of information and mandated returns (for example: quarterly Better Care Fund (BCF) performance report).

8.6.4 The primary focus of the Health and Wellbeing Board is the improvement and co-ordination of services related to NHS, social care and related children's and public health. However, this will be within the context that the Board is a lever to improve the Health and Wellbeing of the citizens of Cheshire West.

8.6.5 The CWICP will support, guide and influence the priority programmes of work linked to the delivery of the Board's Joint Health and Wellbeing Strategy (2015-2020). This includes ensuring alignment of system transformational plans and strategies within health and social care.

The specific duties of the Cheshire West and Chester Health and Wellbeing Board ("HWB") can be found in the following link https://www.cheshirewestandchester.gov.uk/your-council/how-we-work/constitution/documents/b2-committees.pdf

Integrated Care Partnership Board

8.6.6 The Integrated Care Partnership Board has been established to develop and implement the system-wide vision for the CWICP.

8.6.7 The ICPB will set strategic direction, agree priorities and delivery plan for Cheshire West's health, social care and wellbeing. The ICPB will have oversight of the development of an Integrated Care Partnership in Cheshire West and the delivery of outcomes by local leadership.

8.6.8 The ICPB will provide strategic leadership and oversight to support achievement of our shared vision and objectives through delivery of the programmes of work required to:

- Transform local health and social care services
- Integrate Services
- Collective system resilience and risk approach
- Apply system leadership to Cheshire West challenges

8.6.9 The specific remit of the ICPB is to:

(i) Take a collective, proactive role in delivering the vision for the Integrated Health and Care System across Cheshire West.

(ii) Develop, oversee the mechanics/approaches and lead on the performance requirements of the Integrated Health and Care System across Cheshire West.

(iii) Develop integrated and joint commissioning aspects of the Integrated Health and Care System in accordance with strategic and local commissioning plans.

(iv) Oversee the development of building a population health management system in order to segment, risk stratify and prioritise future need & demand for care.

(v) Identify collective ICP/local health system risks for aligned approaches to mitigation and/or review, including co-dependencies on proposed service changes across the system.

(vi) Have collective oversight of the development and implementation of sustainable system strategies and transformational plans (including HCP) by the Partners.

(vii) Together have regard to the outputs of public and patient engagement and identify future services which require system wide reviews to improve local population health outcomes.

CWICP Executive Team

8.6.10 The ICP Executive team will advise and be accountable to the ICPB on strategic direction and priorities, develop a transformation plan and be accountable to the ICPB for the delivery of the operational plan for Cheshire West's health, social care and wellbeing.

Its remit includes:

8.6.11 Oversight of the production and delivery of key business plans and cases for investment.

8.6.12 Delivery of the key milestones associated with implementation of strategic plans.

8.6.13 Monthly oversight of the system performance dashboard.

Stakeholder Partnership Forum

8.6.14 The purpose of the Stakeholder Partnership Forum is to ensure that the Partners understand the views of key Stakeholders and provide a clear mechanism within which Stakeholders can help set the future direction and delivery of plans and strategies.

The Stakeholder Partnership Forum will:

8.6.15 Articulate effectively the views and experiences of the population of Cheshire West to the Partners

8.6.16 Provide advice and guidance on the high level design for implementation of service developments, including the effectiveness of mechanisms for engaging with people who use the services of CWICP

8.6.17 Support the Partners to deliver the transformational plans and strategies, including a focus on benefits realisation for local people

8.6.18 Act as a 'critical friend' to challenge any performance issues and improvement plans

8.6.19 Provide an environment to consider and develop thinking about future service development

8.6.20 Seek assurances on the active implementation of co-production across Cheshire West.

Joint Commissioning Committee

8.6.21 The Joint Commissioning Committee is a committee of NHS West Cheshire Clinical Commissioning Group (CCG), NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG. It is set up to manage to the extent permitted the activities of the four CCGs as within it delegated responsibilities.

8.6.22 The Joint Commissioning Committee has the primary purpose of enabling the CCG members to work effectively together to collaborate and take joint decisions in the areas of work they agree.

8.6.23 The principles of joint commissioning across Cheshire include:

(i) Commissioning at scale to help lead to better outcomes
(ii) Meeting the needs of people not organisations
(iii) Reducing unwarranted variation
(iv) Be an enabler for the development of accountable/integrated care systems
(v) Ensuring the local NHS commissions services within its available resources.

Cheshire West and Cheshire People Overview and Scrutiny Committee

8.6.24 Cheshire West and Cheshire People Overview and Scrutiny Committee is responsible for holding to account those who deliver services based on individual need to children and adults, including health and wellbeing and education services. The Committee comprises nine elected members constituted on a politically proportionate basis in line with the political composition of CW&C.

8.6.25 Its functions include reviewing and making recommendations for improvement in relation to any matter that has an impact on the health and wellbeing of people in Cheshire West and Chester, including statutory scrutiny responsibilities relating to health services, public health and health inequalities.

8.6.26 Further information on the People Overview and Scrutiny Committee can be found in the following link: https://www.cheshirewestandchester.gov.uk/your-council/how-we-work/constitution/documents/e1-scrutiny.pdf

9 INTEGRATING HOW WE WORK

9.1 The Partners have agreed clear priorities as to how they will mobilise working together in more integrated ways across the CWICP. The priorities will be signed off by the ICPB each year.

9.2 The Cheshire West ICP has identified long terms outcomes to support CWICP to achieve its overall aims. The draft Outcomes Framework is attached as Appendix 2. It is recognised that the Outcomes Framework is an evolving document which will require ratification by the Commissioners and CW&C.

9.3 The Partners understand that no decision shall be made to make changes to services in Cheshire West or the way in which they are delivered without appropriate public and patient engagement where appropriate, in accordance with the Partners' respective statutory duties.

10 EXCLUSION AND TERMINATION

10.1 Any Partner may exit this Agreement on giving not less than 6 months' written notice to each of the other Partners' representatives on the ICPB or the ICPB may determine the Agreement if there is a dispute which is not capable of resolution in accordance with Clause 15 (*Dispute Resolution Procedure*).

10.2 Where a Partner exits this Agreement, the Partners agree to work together in good faith to agree the necessary changes so that the CWICP continues to be developed for the benefit of people of Cheshire West. The exiting Partner shall procure that all data and other material belonging to any other Partner in respect of the Services shall be delivered to the relevant Partner or deleted or destroyed (as instructed by the relevant Partner) as soon as reasonably practicable.

11 INTELLECTUAL PROPERTY

11.1 In order to meet the CWICP Integration Principles each Partner grants to each of the other Partners a fully paid up non-exclusive licence to use its existing Intellectual Property insofar as is reasonably required for the sole purpose of the fulfilment of that Partner's obligations under this Agreement.

11.2 If any Partner creates any new Intellectual Property through the development of the CWICP, the Partner which creates the new Intellectual Property will grant to the other Partners a fully paid up non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Partner's obligations for the CWICP under this Agreement.

12 CONFLICTS OF INTEREST

The Partners will:

12.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement, the development of the CWICP or operation of the ICPB or any other Governance structure, immediately upon becoming aware of the conflict of interest, or at the latest within 28 days of becoming aware, whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the development and operation of the CWICP;

12.2 not participate in any decision-making in respect of any aspect of the ICPB that could allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement, without the prior consent of the other Partners to participate in that decision-making;

12.3 when appropriate ensure members of the different Governance structures make declarations of interest which are placed in a register and are updated annually or promptly as they acquire new interests or relinquish existing interests; and

12.4 use best endeavours to ensure that their representatives on the ICPB and the other Governance structures comply with the requirements of this Clause 12 when acting in connection with this Agreement or the development and/or operation of the CWICP.

13 INFORMATION SHARING AND TRANSPARENCY

13.1 The Partners will provide to each other all information that is reasonably required in order to achieve the vision, aims and objectives of the CWICP.

13.2 The Partners have responsibilities to comply with Law (including Competition Law). The Partners will make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with Competition Law and, accordingly, each Governance structure will ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

13.2.1 it is essential;

13.2.2 it is not exchanged more widely than necessary;

13.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of this Agreement; and

13.2.4 it may not be used other than to achieve the aims of this Agreement in accordance with the CWICP Integration Principles.

13.3 Subject to compliance with Clauses 13.1 and 13.2 above, the Partners will ensure that they provide the ICPB and other Governance structures with all financial cost resourcing, activity or other information as may be reasonably required so that the ICPB and/or other relevant Governance structure can be satisfied that the ICPB vision, aims and objectives are being satisfied.

13.4 The Commissioners will make sure that each Governance structure procures the establishment of appropriate information barriers between and within the Providers so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Providers who need to see it to achieve the ICPB vision, aims and objectives and for no other purpose whatsoever so that the Partners do not breach Competition Law.

13.5 It is accepted by the Partners that the involvement of the Providers in the ICPB and other Governance structures is likely to give rise to situations where information will be generated and made available to the Providers, which could give the Providers an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Provider with a commercial advantage over a separate Provider). Any Provider will have the opportunity to demonstrate to the reasonable satisfaction of the relevant Commissioner in relation to any competitive procurements that the information it has acquired as a result of its participation in the CWICP, other than as a result of a breach of this Agreement, does not preclude the Commissioners from running a fair competitive procurement in accordance with their legal obligations.

13.6 Notwithstanding Clause 13.5 above, the Commissioners may take such measures as they consider necessary in relation to such competitive procurements in order to comply with their obligations under Law (for example, the Public Contracts Regulations 2015 and the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013) including excluding any potential bidder from the competitive procurement in accordance with the Law governing that competitive procurement.

13.7 The Partners understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHS Improvement and will keep this position under review accordingly.

13.8 The partners will agree to process any personal identifiable data in ways that are consistent with the Caldicott Principles, the General Data Protection Regulation and the Data Protection Act 2018.

13.9 The Partners understand that the ICP Board may meet in public at a future date and as such the papers, agenda and minutes of the meetings will be made available to the public via the partners' website.

14 CONFIDENTIALITY

14.1 Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner. Each Partner shall use Confidential Information received from another Partner solely for the purpose of complying with its obligations under this Agreement and for no other purpose.

14.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

14.3 Each CWICP Partner acknowledges that the others are or may be subject to the Freedom of Information Act 2000 (the "**FOIA**") and may be required to disclose information about this Agreement to ensure their compliance with the FOIA. Each CWICP Partner notes and acknowledges the FOIA and both the respective Codes of Practice on the Discharge of Public Authorities' Functions and on the Management of Records (which are issued under section 45 and 46 of the FOIA respectively) as may be amended, updated or replaced from time to time. The CWICP Partners will act in accordance with the FOIA and these Codes of Practice (and any other applicable codes of practice or guidance applicable from time to time) to the extent that they apply to the work of the CWICP

14.4 The ICP Partners agree that where a Partner receives a FOIA request (the "**Receiving Party**"), the subject of which in its opinion relates to the CWICP, the Receiving Party will provide a copy of the request and its draft response to the other Partners. The Receiving Party will notify the other Partners of a date by which they may make representations as to the contents of the draft response. The Receiving Party shall have regard to any representations received when finalising its response.

14.5 Notwithstanding the provisions of Clause 14.4, the CWICP Partners agree that the decision on whether any exemption applies to a request for disclosure of recorded information is a decision solely for the Receiving Party.

14.6 Nothing in this Clause 14 will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

15 DISPUTE RESOLUTION PROCEDURE

15.1 The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences in respect of this Agreement prior to commencing this procedure.

15.2 The Partners believe that by focusing on their agreed CWICP vision, aims, objectives and CWICP Integration Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the CWICP arrangements set out in this Agreement.

15.3 The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the CWICP (each a "Dispute") when it arises.

15.4 In the first instance the CWICP Executive Team shall seek to resolve any Dispute to the mutual satisfaction of the Partners. If the Dispute cannot be resolved by the CWICP Executive Team within 10 Operational Days of the Dispute being referred to it, the Dispute shall be referred to the Chair for resolution.

15.5 The Chair shall deal proactively with any Dispute on a Best for System basis in accordance with this Agreement so as to seek to reach a unanimous decision. If the [ICPB] reaches a consensus that resolves, or otherwise concludes a Dispute, it will advise the Partners of its decision by written notice.

15.6 If the Chair cannot proactively deal with any dispute in accordance with Clause 15.5, the Partners agree that the Chair, on a Best for System basis, may determine whatever action he / she believes is necessary including the following:

15.6.1 If the Chair cannot resolve a Dispute, he / she may select an independent facilitator to assist with resolving the Dispute; and

15.6.2 The independent facilitator shall:

15.6.2.1 be provided with any information he or she requests about the Dispute;

15.6.2.2 assist the parties to work towards a consensus decision in respect of the Dispute;

15.6.2.3 regulate his or her own procedure subject to prior agreement with the Chair;

15.6.2.4 determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and

15.6.2.5 have its costs and disbursements met by the Partners in Dispute equally.

15.7 If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Clause 15 and only after such further consideration again fails to resolve the Dispute, the ICPB may resolve to:

15.7.1 terminate this Agreement in accordance with Clause 10; or

15.7.2 agree that the Dispute need not be resolved.

16 VARIATIONS

This Agreement may only be varied by written agreement of all of the Partners.

17 CHARGES AND LIABILITIES

17.1 Except as otherwise provided in this Agreement, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Agreement.

17.2 The Partners shall remain liable for any losses or liabilities incurred due to their own or their employees' actions.

18 NO PARTNERSHIP

Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this Agreement.

19 COUNTERPARTS

This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Partner has executed at least one counterpart.

20 NOTICES

20.1 Any notice or other communication given to a Partner under or in connection with this Agreement shall be in writing, addressed to that Partner at its principal place of business or such other address as that Partner may have specified to the other Partner in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

20.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 20.1; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after

posting; if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

21 THIRD PARTY RIGHTS

A person who is not a party to this Agreement shall not have any rights under or in connection with it.

22 GOVERNING LAW AND JURISDICTION

This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and subject to Clause 15 (Dispute Resolution Procedure) the Partners irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

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

Signature	Name & Delegation	For and on behalf of	Date
		The Countess of Chester Hospital NHS Foundation Trust	
		Cheshire West & Chester Council	
		Cheshire and Wirral Partnership NHS Foundation Trust	
		Central Cheshire Integrated Care Partnership	
		South Cheshire & Vale Royal GP Alliance	
		Primary Care Cheshire	

SCHEDULE 1

DEFINITIONS AND INTERPRETATION

Interpretation

1. In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

   1.1 a "person" includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

   1.2 unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular;

   1.3 a reference to a "Clause" or a "Schedule" or an "Appendix" is to a Clause, Schedule or Appendix to this Agreement;

   1.4 a reference to a "Provider" the "Council" or "Commissioners" includes its representatives, successors or permitted assigns;

   1.5 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;

   1.6 any phrase introduced by the terms "including", "include", "in particular" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms;

   1.7 documents in "agreed form" are documents in the form agreed by the Partners and initialled by them for identification and attached to this Agreement; and

Definitions

2. The following words and phrases have the following meanings:

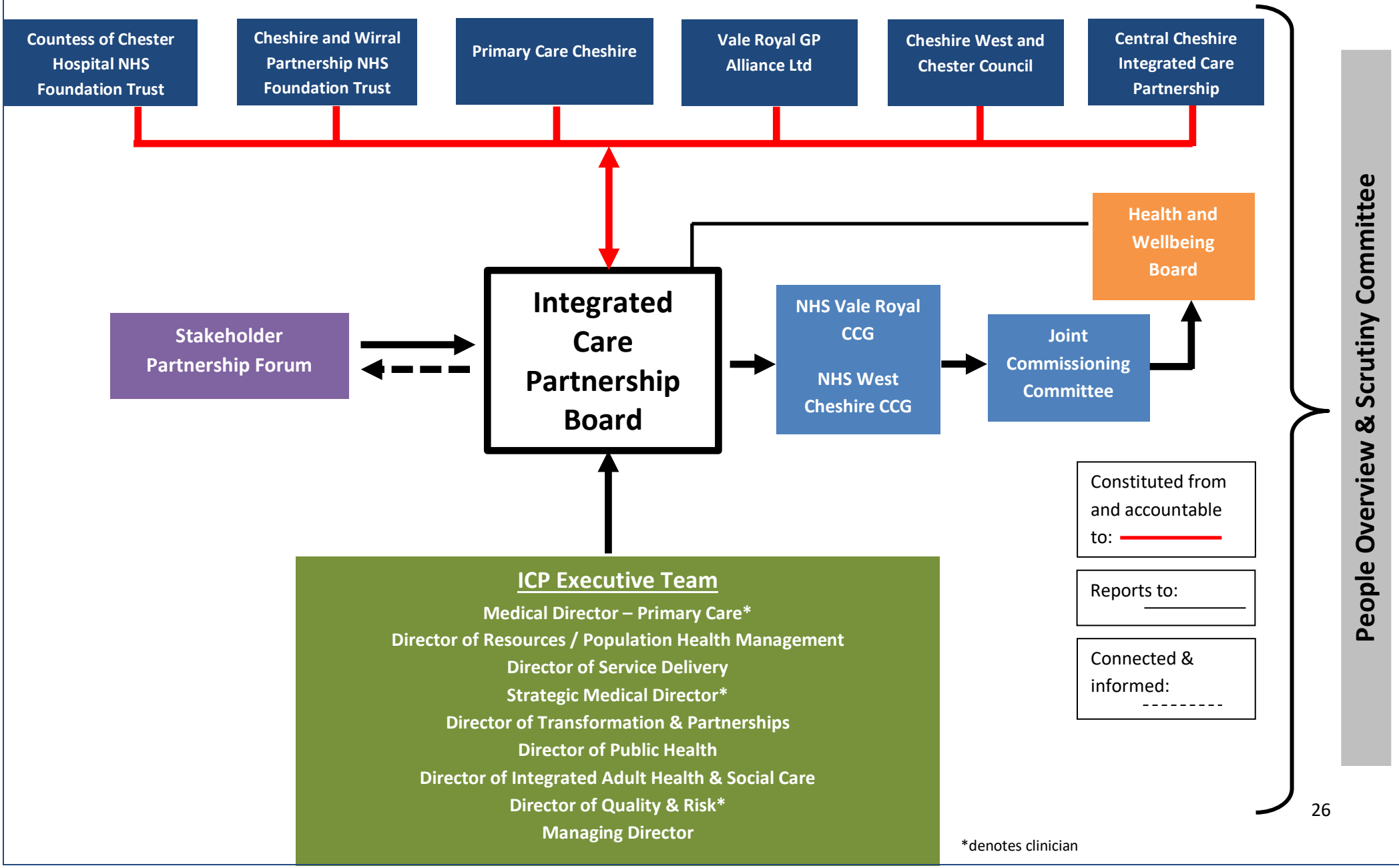
Agreement	this agreement incorporating the Schedules and Appendices
Aligned decision making	this is central to the work of the ICP and means that the partner organisations within the ICP retain their own decision making authority but have agreed to make their decisions taking into account a vision that is common to all of them
Best for System	means best for the achievement of the CWICP vision and aims for the Cheshire West population on the basis of the CWICP Integration Principles
Commencement Date	means the date of this Agreement, 'go-live date'
Competition Law	means the Competition Act 1998 and the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013 and as applied to the healthcare sector by Monitor in accordance with the Health and Social Care Act 2012
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Providers and which that Provider properly considers is of such a nature that it cannot be exchanged with the other Providers without a breach or potential breach of Competition Law
Commissioners	means NHS Vale Royal CCG, NHS West Cheshire CCG and Cheshire West & Chester Council
Confidential Information	means all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement
CWICP	Cheshire West Integrated Care Partnership
Dispute	any dispute arising between two or more of the Partners in connection with this Agreement or their respective rights and obligations under it
Dispute Resolution Procedure	the procedure set out in Clause 15.

FOIA	means the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act
Governance structure(s)	As outlined within the Cheshire West ICP governance structure in Appendix 1
Go-Live Date	**1st April, 2019**, or such other date as the partners agree
Guidance	any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which a Partner has a duty to have regard (whether specifically mentioned in this Agreement or not)
Host	Countess of Chester Hospital NHS Foundation Trust is the host of the ICP and will have a coordinating role for the ICP under collaborative governance arrangements and aligned decision making.
ICPB	Integrated Care Partnership Board
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Law	(i) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; (ii) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; (iii) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; (iv) Guidance;

	(v) National Standards; and (vi) any applicable code.
National Standards	those standards applicable to the Partners under the Law and/or Guidance as amended from time to time
Operational Day	a day other than a Saturday, Sunday or bank holiday in England
Population	the population we serve
Stakeholders	Partners to Cheshire West ICP within the local health system

Appendix 1

Cheshire West Integrated Care Partnership – Governance Framework



*denotes clinician

Appendix 2– CWICP Outcomes Framework

CWICP Outcomes Framework
1. Improve quality of life for users and carers
2. Reduce the number of admissions to hospital following a fall
2i. Emergency hospital admissions due to falls in people aged 65 and over (rate per 100,000 pop)
3.Reducing the gap in health inequalities/life expectancy by highest and lowest wards
3i. The gap in life expectancy at birth (most to least deprived) Male
3i. The gap in life expectancy at birth (most to least deprived) Female
4. Increased proportion of people who use services who have control over their daily life
5. Increase the proportion of people who feel supported to manage their own condition
6. Reduce the number of older people who have a permanent admission to residential and nursing care home
7. Increased proportion of older people (65+) who were still at home 91 days after discharge from hospital into re-ablement or rehabilitation services
8. & 10. Employment of people with long term conditions or mental illness
8i. Employment of people with long term conditions
10i. Employment of people with mental illness
11. Reduction in delayed transfers of care from hospital per 100,000 population
12. Reduction in the number of A&E attendances (for low acuity conditions)
13. Reduce mental health patients presenting in crisis out of hours
14. Services users and carers who find it easy to find information about services

N.B. The priority outcomes are being developed with oversight by CWICP Delivery Group members. These outcomes (in Appendix 2) are currently being tested with ongoing review and development.