Countess of Chester Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA AND PAPERS

TUESDAY, 2ND FEBRUARY 2016

Chairman Sir Duncan Nichol Chief Executive Tony Chambers

Countess of Chester Hospital NHS
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

TUESDAY, 2ND FEBRUARY 2015 AT 1.15PM

LECTURE HALL

A G E N D A

FORMAL BUSINESS

1.	Welcome and Apologies	Chairman
2.	Declarations of Interest	Chairman
3.	To receive and approve the Board of Directors minutes of meeting held on 14th December 2015, BoD action tracker (December 2015) and matters arising	Chairman

QUALITY & ASSURANCE

4.	To receive a Patient feedback/story	Director of Nursing and Quality
5.	To review the Integrated Performance Report to month 9 **(Attached)**	Executive Team
6.	To receive and approve the Board Assurance Framework (BAF) **(Attached)**	Chief Executive
7.	To receive details of the 6 monthly nurse staffing establishment **(Attached)**	Director of Nursing and Quality
8.	To receive an update on Speak out safely and process changes **(Attached)**	Director of Human Resources and Organisational Development
9.	To receive a update on Never Events and Serious Untoward Incidents	Director of Nursing and Quality

STRATEGIC DEVELOPMENT

10.	To receive the Chief Executive's Report **(verbal)**	Chief Executive
11.	To receive an update on Governor Matters **(verbal)**	Director of Corporate & Legal Services

FOR NOTING & RECEIPT

PLEASE NOTE THESE DOCUMENTS ARE AVAILABLE ON REQUEST ONLY

12.	To receive the Q3 letter to Monitor *(To follow, post submission)*	Deputy Chief Finance Officer
13.	To receive the minutes of the Quality, Safety and Patient Experience Committee 16th November 2015 and 14th December 2015	Director of Nursing and Quality
14.	To receive the minutes of the People and Organisational Development Committee – 24th November 2015	Director of Human Resources and Organisational Development
15.	To receive the minutes of the Audit Committee – 19th October 2015	Director of Corporate and Legal Services
16.	To receive the minutes of the Charitable Funds Committee – 27th October 2015	Director of Corporate and Legal Services
17.	To receive Corporate Infection Prevention and Control Assurance – Quarterly Report (retrospective report based upon August 2015 quarterly data update)	Director of Corporate and Legal Services
18.	Date and Time of Next Meeting: **Board of Directors Meeting** **Tuesday 3rd May 2016 @ Time TBC - Training Room 3 & 4**	

BOARD OF DIRECTORS

MINUTES OF THE MEETING HELD ON MONDAY,
14TH DECEMBER 2015 at 2.15PM
BOARDROOM

		Attendance	
Chairman	Sir D Nichol	☑	
Non Executive Director	Mr A Higgins	☑	
Non Executive Director	Mr J Wilkie	☑	
Non Executive Director	Mr E Oliver	☑	
Non Executive Director	Mrs R Hopwood	☑	
Non Executive Director	Dr E McMahon		☒
Chief Executive	Mr T Chambers	☑	
Medical Director	Mr I Harvey		☒
Chief Finance Officer	Mrs D O'Neill		☒
Director of Nursing & Quality	Mrs A Kelly	☑	
Director of Planning, Partnerships & Development	Mr M Brandreth	☑	
Director of Human Resources and Organisational Development	Mrs S Hodkinson	☑	
Director of Corporate & Legal Services	Mr S P Cross	☑	
Interim Director of Operations	Ms L Burnett	☑	

In attendance:

Mrs C Raggett – Secretary to the Board
Mr I Bett, Associate Director of Performance and Planning

FORMAL BUSINESS

B102/15 **WELCOME AND APOLOGIES**

Sir Duncan welcomed all attendees to the meeting.

Apologies were received from Mrs O'Neill, Dr McMahon and Mr Harvey.

B103/15 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

B104/15 **TO RECEIVE AND APPROVE THE MINUTES OF BOARD OF DIRECTORS' MEETING HELD ON 13TH OCTOBER 2015 AND BOARD ACTION TRACKER AS AT END NOVEMBER 2015**

The Board of Directors minutes of the meeting held on 13th October 2015 were received as a true and accurate record.

The Board noted the Board Action Tracker as at end of November 2015.

MATTERS ARISING
There were no matters arising.

QUALITY & ASSURANCE

B105/15 **TO RECEIVE A PATIENT'S STORY TO INCLUDE:**
A PRESENTATION ON THE PATIENT SERVICE CENTRE PROJECT

The Board received details of a patient's experience when booking appointments and some of the issues the patient had encountered.

Presentation on the Patient Service Centre Project

Mr Brandreth stated that following feedback from the Council of Governors regarding patients receiving numerous letters for one appointment, a review of the service was undertaken and a number of problems were identified.

Mr Bett gave a presentation on the Patient Service Centre Project and detailed the issues and the actions being taken to address them.
(Slides attached)

Mr Brandreth reported that 30% of new outpatient appointments are cancelled and re-booked which costs the Trust approximately £2.5m.

Mr Brandreth stated that the Trust was expecting to be able to demonstrate improvements in the service from April 2016.

Mrs Hopwood asked if the Trust was engaged with primary care to help improve the service. Mr Bett replied that the Trust had identified 2 GP practices to work with to understand the best way forward from both perspectives.

Mr Wilkie asked why these issues had not been previously identified. Mr Brandreth replied that whilst the Trust was aware of some issues, the launch of the new reminder system created a large increase of calls to the appointments hotline. This had not been anticipated and when the problem was investigated, this identified that the issues were worse than expected. A full review has been undertaken and a lot of positive progress has been made including dashboards

being developed to show a real time view of calls.

In response to a question from Sir Duncan, Mr Brandreth stated that a staged implementation plan was in place and that the model hospital work would also address some of the issues.

B106/15 **TO REVIEW THE INTEGRATED PERFORMANCE REPORT TO MONTH 7**

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

Mr Wilkie referred to the sickness information noting that 11 staff members had flu and he asked if the staff had received the flu vaccination. Mrs Hodkinson replied that 2522 staff had received the flu vaccination and that whilst it was not known if the individuals had received the vaccination, the Trust is putting on further flu vaccination sessions for staff.

In response to a question from Mr Wilkie, a discussion took place regarding the variable pay being rated as red and the CRS being rated as green and the impact of the medical agency spend cap from Monitor. Mr Chambers added that negotiations were taking place nationally and regionally to ensure a consistent rate for medical agency staff from the new year.

Mrs Hopwood asked why the levels of medically optimised patients had increased. Ms Burnett stated that this was due to one of the main care homes voluntarily closing to admissions in November 2015. Ms Burnett has raised this with social care and they are recognising the problem and supporting where possible.

In response to a question from Sir Duncan and Mr Wilkie, a full discussion took place regarding the Trust's financial planned deficit of £10.5m and MR Chambers gave a detailed account of how this would be achieved.

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

B107/15 **TO RECEIVE AND APPROVE THE BOARD ASSURANCE FRAMEWORK (BAF)**

Mr Chambers presented the updated Board Assurance Framework (BAF) and outlined the following points:

CR6 15/16 – Mr Chambers stated that this risk related to the long term financial and savings recovery plan for the health system , however following the announcement of the spending review which stated that there would be an increase in NHS funding, this would have an impact on the short term financial position. This gives the Trust the potential opportunity to be in a balance position in the next 12-18 months however, there is a need to continue with efficiency

savings and to take the model hospital forward.

CR1 15/16 – Mrs Kelly stated that this related to patient experience, there are a number of medically optimised patients and it is important that the Trust maintains the quality and safety for these patients. It is also important that staff are supported during pressures. There have been issues with patient identification and there is a need to ensure that the Trust has the right processes and culture in place and linking into the right consent process for every patient. These areas are reviewed at the Quality, Safety and Patient Experience Committee which is chaired by Mr Higgins on a monthly basis.

CR4 15/16 – Mrs Hodkinson stated that this related to culture and staff and the risk was reviewed at each People and Organisational Development Committee and is a key part of the model hospital. The Trust is putting in place coaching sessions from January 2016 and has support from the North West Leadship Academy. The Trust is also receiving feedback and having concerns raised via Speak Out Safely.

Mr Chambers stated that the Trust's risks were in line with being safe, kind and effective and that the organisation would need to deliver some of the actions at a pace over the next 12 – 18 months.

In response to comments from Mr Higgins, a full discussion took place regarding the risks for informatics and if there was a need for specific monitoring. Mr Brandreth stated that the Informatics Strategy would be presented to the Informatics Board in the new year and would then come to the Board for approval in due course.

The Board of Directors approved the Board Assurance Framework.

B108/15 **TO RECEIVE AND APPROVE THE COCH FIT AND PROPER PERSONS POLICY**

Mr Cross presented the Trust's Fit and Proper Persons Policy (for Board members) and stated that the policy now incorporated the CQC guidance.

Mr Cross and Mrs Raggett are undertaking an audit of the Board members personnel files over the next few weeks.

The Board of Directors approved the Trust's Fit and Proper Persons Policy (for Board members).

B109/15 **TO RECEIVE AN UPDATE ON NEVER EVENTS AND SERIOUS UNTOWARD INCIDENTS**

Mrs Kelly reported that there had been a never event in maternity relating to a retained tampon, an investigation was being undertaken into the never event.

Mrs Kelly reported that in November 2015 there were 2level 2 investigations. The outcome of these investigations would be reviewed by QSPEC.

STRATEGIC DEVELOPMENT

B110/15 **TO RECEIVE THE CHIEF EXECUTIVE'S REPORT (VERBAL)**

Mr Chambers gave an update on the following points:

- The Trust's stroke service has been awarded the team of the year for research and innovation as most innovative team and achieved an 'A' rating for its service, one of only two organisations in England to achieve this.
- The Santa dash held at the beginning of December 2015 had been a great success with Mr Brandreth and his family and Mrs Clifton, Public Governor and her family taking part.
- The Trust held its Celebration of Achievement Awards Event on 27th November 2015 at Chester Race Course. This had been a fantastic evening demonstrating the great work of staff.
- The Countess Choir had also performed at the event and were amazing.

Mr Chambers, on behalf of the Board of Directors thanked all the staff for their continued hard work throughout the year and wished them all a very Merry Christmas and Happy New Year.

B111/15 **TO RECEIVE AN UPDATE ON GOVERNOR MATTERS**

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

Mr Cross reported that the Council of Governors had approved the reappointment of Mr Hemmerdinger as deputy Chair of Governors for a further 12 month period to the end of 2016.

Mr Cross reported that the next meeting of the Governors' Quality Forum will be held on Friday 8th January 2016 and Governors were looking forward to the year ahead.

FOR NOTING& RECEIPT

B112/15 **TO RECEIVE THE Q2 FEEDBACK LETTER FROM MONITOR**

The Board received and noted the Q2 feedback letter from Monitor.

B113/15 **TO RECEIVE THE RISK AND PATIENT SAFETY ANNUAL REPORT 2014/15**

The Board received and noted the Risk And Patient Safety Annual Report 2014/15.

Mrs Kelly stated that the report demonstrated the work undertaken over the last 12 months and thanked the team for their hardwork.

B114/15 **TO RECEIVE THE MINUTES OF THE QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE – 21ST SEPTEMBER AND 19TH OCTOBER 2015**

The Board received and noted the minutes of the Quality, Safety and Patient Experience Committee – 21st September 2015 and 19th October 2015.

B115/15 **TO RECEIVE THE MINUTES OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – 22ND SEPTEMBER 2015**

The Board received and noted the minutes of the People and Organisational Development Committee – 22nd September 2015.

B116/15 **TO RECEIVE THE MINUTES OF THE CHARITABLE FUNDS COMMITTEE – 28TH JULY 2015**

The Board received and noted the minutes of the Charitable Funds Committee – 28th July 2015.

B117/15 **TO RECEIVE THE RISK MANAGEMENT STRATEGY – DECEMBER 2015**

The Board received and noted the Risk Management Strategy – December 2015.

B118/15 **TO RECEIVE THE EMERGENCY PREPAREDNESS RESILIENCE RESPONSE PROCESS 2015**

The Board received and noted the Emergency Preparedness Resilience Response Process 2015.

Mrs Kelly stated that Trust is required to complete a self-assessment against the required standards. The Trust has identified 3 gaps however these actions will be completed by the end of December 2015. The trust will also be part of a pandemic flu exercise in the new year.

B119/15 **TO RECEIVE THE DETAILS OF FREEDOM OF INFORMATION REQUESTS – AUGUST 2015 – OCTOBER 2015**

The Board received and noted the details of Freedom Of Information Requests – August 2015 – October 2015.

B120/15 **DATE AND TIME OF NEXT MEETING**

Tuesday 2nd February 2016 – 1.15pm in the Lecture Hall, Countess of Chester Hospital.

BOARD OF DIRECTORS ACTION LOG 2015/16

Meeting Date	Minute Ref:	Issue	Action	Update	Responsibility	Target Date
14.10.15		To receive feedback following the root cause analysis of the 2 MRSA cases in August 2015			Ian Harvey	TBC
14.10.15		To receive details of the review of spend on furniture and computer equipment	Mr Cross to gather information as part of the non-pay work.		Stephen Cross	March 2016
14.10.15		To receive an update on the Culture Work at the Trust with particular focus on communication			Sue Hodkinson	March 2016
14.12.15		To receive the Informatics Strategy for approval			Mark Brandreth	March 2016

	Action has slipped
	Action is not yet complete but on track
	Action complete
*	Moved with agreement

Countess of Chester Hospital NHS
NHS Foundation Trust

Integrated Board Report - December 2015

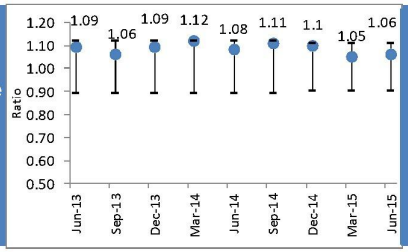
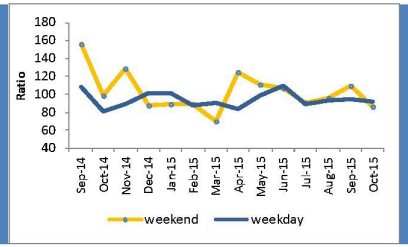
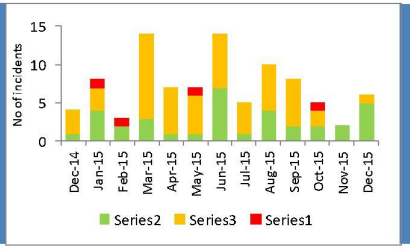
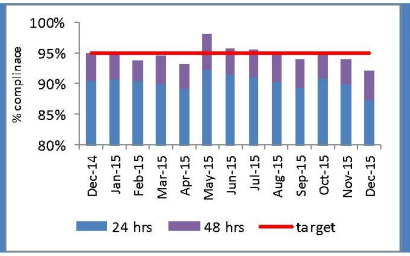
Contents

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

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

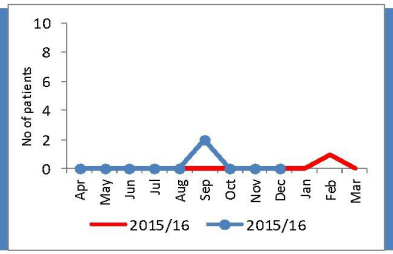
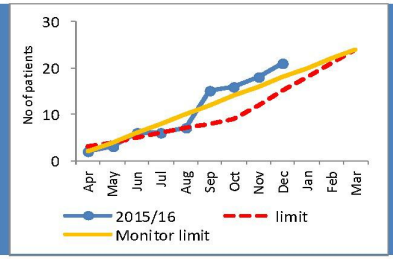
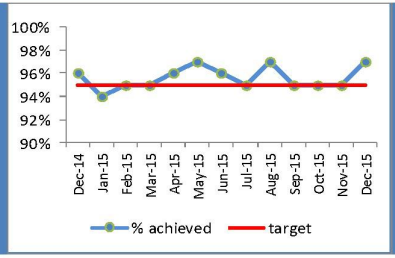
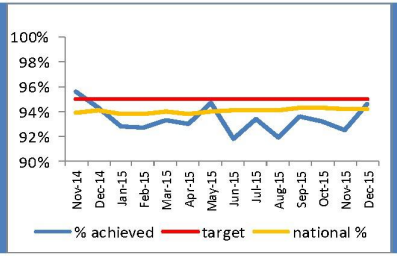
	Description	Current position/comments	Trend	Target
Mortality SHMI	Risk adjusted mortality ratio based on number of expected deaths. National published figure from HSCIC.	This measure does not take into account palliative care codes. It provides a complete picture of hospital deaths and includes deaths within 30 days of discharge showing whether the Trust is within the expected range when compared to the quarterly rebased national baseline. SHMI should not be trended nor directly compared to previous months due to the national data being rebased everytime.		As expected - Blue Above expected - Red Below expected - Green
Mortality HSMR	Ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death	This measure is based on specific diagnosis groups that account for approx 80% of our inpatients. A ratio of greater than 100 means more deaths occured then expected, while a ratio of less than 100 suggests fewer deaths occured than expected.		As expected - Blue Above expected - Red Below expected - Green
Serious Untoward Incidents	Level 2 severe harm or death to patient. Never events are serious largely preventable patient safety incidents	In month there were five level 1 and one level 2 incidents.		No current target but any never event highlighted as red in month
Electronic Discharge for admitted patients	90% of electronic discharges for admitted pts should be sent within 24 hrs, 95% within 48 hrs and all within 2 weeks	Performance for the month of December reduced further below target. See exception report on page 15		90% within 24 hrs per month 95% within 48 hrs per month

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

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

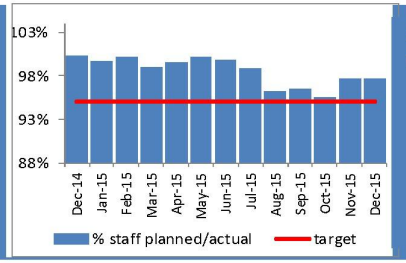
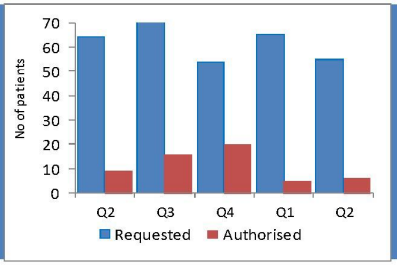
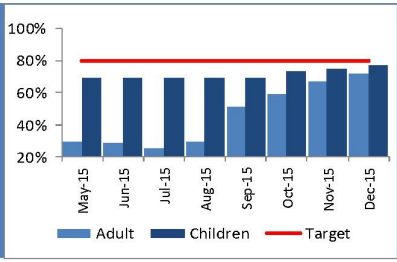
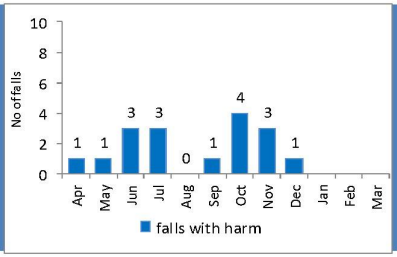
	Description	Current position/comments	Trend	Target
MRSA	Number of cases of hospital acquired MRSA bacteraemia (meticillin-resistant staphylococcus aureusis)	The target for MRSA is zero cases within the year and there were no cases in month.		Zero cases for the year
CDiff	Number of cases of Clostridium Difficile	A maximum of 24 cases has been set for 2015/16 and we have had 21 cases for the year to date. There were 3 cases reported in month. Out of 10 cases where the review is now complete for the year to date, four have demonstrated a lapse in care and lessons learned identified.		24 maximum annual cases exception report if two consecutive months over trajectory
Hand hygiene	Based on ward based hand hygiene audits. Each ward is required to submit two audits each month	Performance has continued to achieve since February 2015.		95% each month
Safety Thermometer	Tool to survey a snapshot of harm free patient care. Includes pressure ulcers, falls, catheters, UTIs and VTE	There was an improvement in the overall score, and although marginally under the 95% target at 94.7%, this is above the national average so an exception report has not been provided for this month. For the patients where a new harm has occured during the patient stay within the Trust, this percentage is 97.4% of patients surveyed who have had harm free care.		Compare to National average Above average - Green Below average - red

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

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

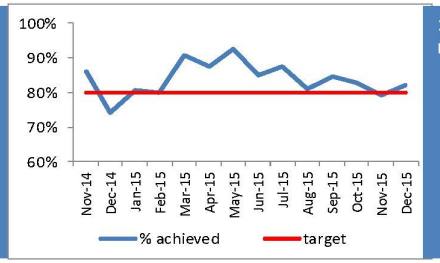
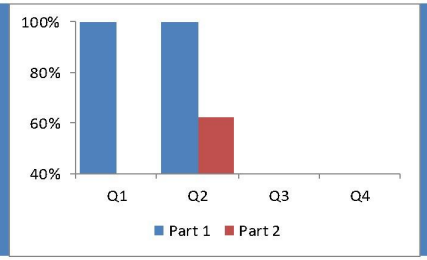
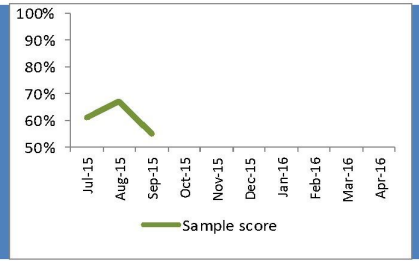
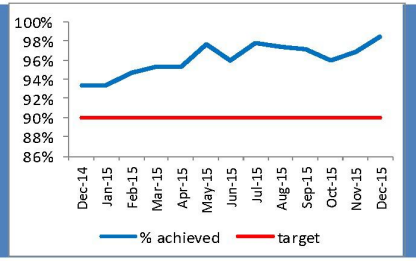
	Description	Current position/comments	Trend	Target
Safe Staffing	Actual staffing compared to planned for registered nurses/ midwives and care staff	Safe staffing remains above the internal 95% target. See pages 28-30 for detailed safe staffing report		>95% per month
DOLs	Number of Deprivation of Liberty applications requested during the quarter	Due to legislative changes in relation to DoLS in March 2014 our practice and criteria for applications in relation to these legal applications has substantially altered thus leading to increases in the numbers required. There is a dip compared to the same quarter last year. Further education is taking place.		No target for this measure but it is considered best practice for this measure to be reported at Board level
Safeguarding training	% of level 2 training undertaken to be split by training for Adults and Children	There is a steady improvement overall. The figures have shown a significant improvement particularly in the adult training. The Director of Nursing & Quality continues to personally focus on those who are non-compliant. Exception report is provided on page 16.		>80% in month
Inpatient Falls with harm	Inpatient falls with moderate or above harm	There was one fall reported with moderate or above harm for the month of December. Please see exception report on 17.		Any falls with harm - red Target is zero cases in month

Are we effective?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

BAF ref: CR3, CR7, CR10

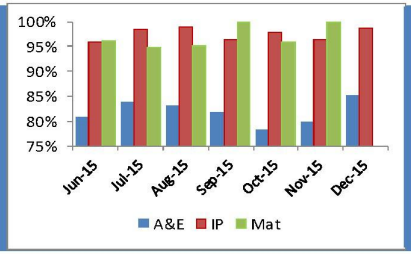
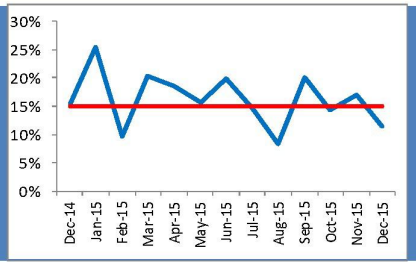
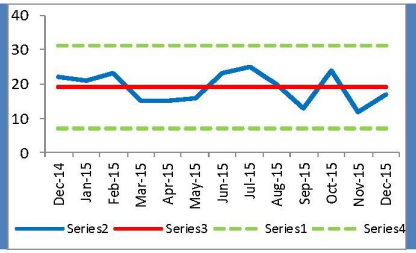
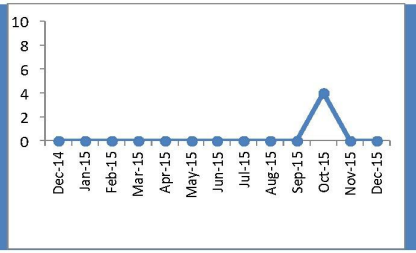
	Description	Current position/comments	13 month rolling trend	Target
Stroke	Western Cheshire CCG Stroke patients who spend at least 90% of their time in hospital on a stroke unit .	Data source changed in October, 90% now calculated using SNNAP data. Target continues to be achieved.		>80% per month
Sepsis	National CQUIN. Random sample audit per month on 2 parts.	Part 1 - If identified as a sepsis patient were they screened following local protocol? Only 1 patient identified in sample for Apr and they were screened. May and June = 0 pts were caught in sample with sepsis Part 2 - If a patient identified as 'Red Flag' or 'Severe' sepsis did they receive IV antibiotics within 1 hr of arrival. The Q3 position will be available on the January report.		CQuIN will be awarded if improvement from baseline, Q1, (or maintained if 100%) is demonstrated
Acute Kidney Injury	National CQUIN. CQuIN will be awarded if improvement from baseline is demonstrated	We have reviewed and set up a system to do a quality check of the data which has led to some changes. The revised data is now shown. In January we will be agreeing with our commissioners a stretch target based on these samplet numbers.		Target to be agreed
Dementia	National CQUIN. % of patients aged 75 or above asked case finding question within 72 hours of admission	There is a continued achievement of this target.		>90%

Are we caring?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

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

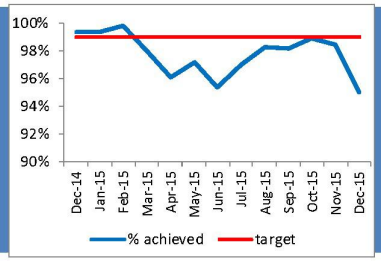
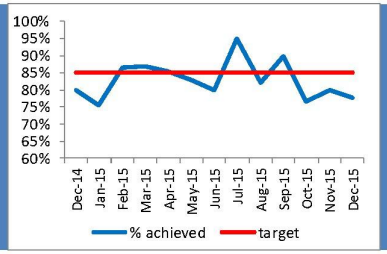
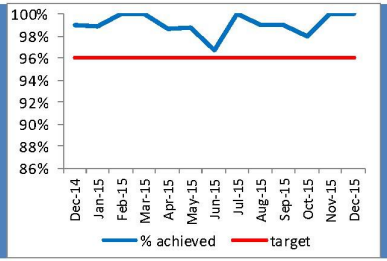
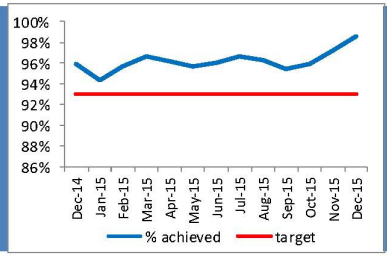
	Description	Current position/comments	Trend	Target
Friends & Family - % likely to recommend	Would patients recommend service to friends & family. Introduced in 2013 for Inpatients, A&E and maternity.	Performance was met for A&E and inpatients. No forms were received for maternity so this measure could not be monitored for this area.		90% for maternity and Inpatients. 80% for A&E
Friends & Family response rate	Number of responses received for IP, A&E and maternity compared to eligible patients	The Trust has secured a new provider from December 2015. There will be a real focus on outpatients to improve the response rate using text messages from January 2016. The Trust has an action plan to improve the overall response rate by the end of the financial year. Therefore at this stage an exception report has not been provided.		>15% per month
Feedback	Monthly Trust complaints and formal thank you letters received by the Trust	In December 2015 the Trust received 17 new formal complaints. 88% of all complaints were responded to within the timescales. The Chief Executives office received eight formal thank you letters for the month of December.		Complaints to be within expected control limits
Mixed Sex accommodation breaches	Number of breaches to the mixed sex accommodati -on standard for non clinical reasons	There were no breaches to the standard within the month of December.		Zero cases per month

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

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

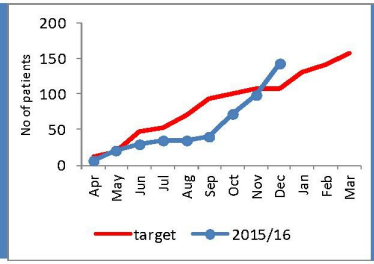
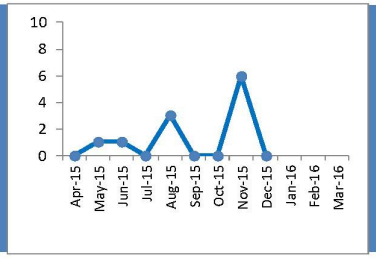
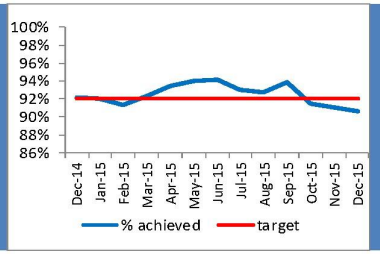
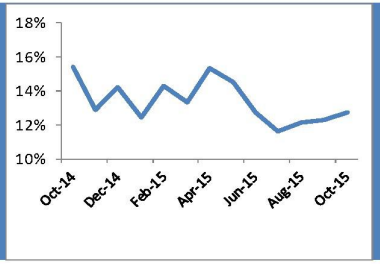
	Description	Current position/comments	13 month rolling trend	Target
Diagnostic 6 week standard	Diagnostic tests to be carried out within 6 weeks of request being received. This is measured on the National DM01 return.	Diagnostics failed the 99% target in December. See page 18 for exception report.		99% per month
Cancer 62 day standard	First treatment for cancer within 62 days of urgent referral through GP 2 week referral route. 85% threshold	The position is under target for December. Further information on the current position can be seen in appendix 2.		85% per Quarter
Cancer 31 day standard	Patients receiving first definitive treatment within 1 month of cancer diagnosis. The threshold is 96%.	The 31 day standard continues to achieve.		96% per Quarter
Cancer 2 week standard	Patients referred from GP with suspected cancer should have their first appointment within 14 calendar days	Performance against this standard continues to be achieved.		93% per Quarter

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

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

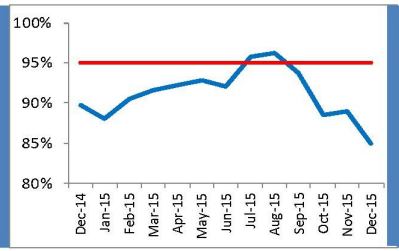
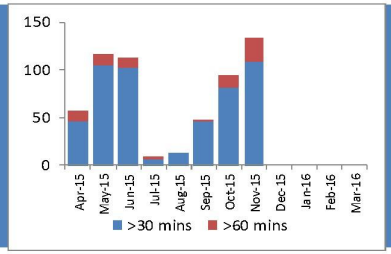
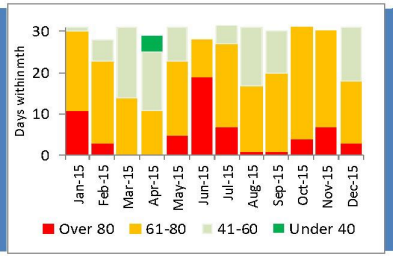
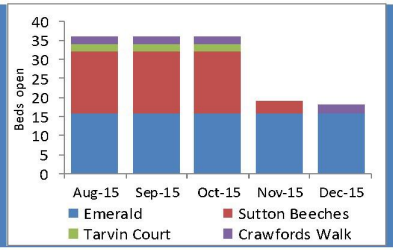
	Description	Current position/comments	Trend	Target
Cancellation due to no beds	Hospital cancellations due to no beds	There were 45 cancellations of patients due to no beds in December. The increase in cancellations relate to the increase in acute pressures detailed in the exception report on page 20. Please note this does not include patients cancelled due to no Critical Care bed which is being tracked separately.		Internal target based on 2012/13 levels
Urgent cancellations	Urgent cancellations for second or subsequent time for non clinical reasons	There were no urgent cancellations for the second or subsequent time in the month of December.		Zero cases per month
RTT incomplete pathways	Percentage of incomplete pathways for English patients within 18 weeks. The threshold is 92%.	RTT incomplete performance remained as forecasted below the target in December. The Trust also has reported 11 patients who have waited over 52 weeks. Exception Report on page 19.		92% per month
Readmission rate	Number of emergency readmissions within 28 days. Excludes patients with diagnosis of cancer, nephrology, obstetrics	This is currently reported two months behind to allow for the readmissions and subsequent coding		No target agreed

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

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

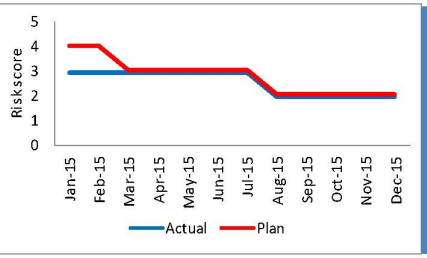
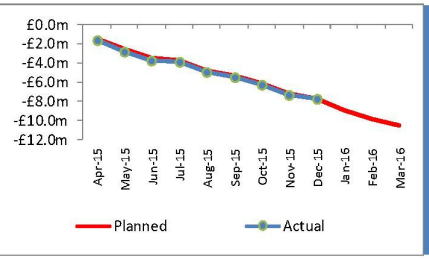
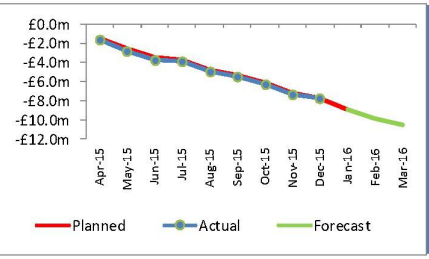
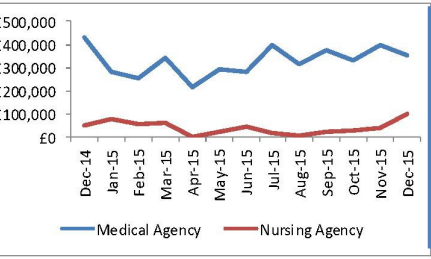
	Description	Current position/comments	13 month rolling trend	Target
A&E 4 hour standard	Maximum wait time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.	Performance was under performance in December. Exception report on page 20		>95% per month
Ambulance handover delays	NWAS Ambulance handovers - number over 30 minutes	Latest data avialable is for November 2015 which has seen an increase in ambulances waiting over 30 minutes. Details on the reasons are included within the exception report on page 20		Zero cases
Medically optimised patients	Number of days within the month where there are medically optimised patients within acute beds	The Trust continues to have a high number of medically optimised patients. See A&E exception report on page 20		Less than 40 medically optimised patients within acute beds each day (target agreed with CCG)
Number of Intermediate care beds	Number of intermediate care beds open in use in the Community	There are currently 16 beds in use on Emerald Ward. There are delays to patients waiting over 21 days due to availability of social care packages and placements. There were no beds open at Sutton Beeches as it is currently closed to admissions. Two beds in use at Crawfords Walk.		No target agreed

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

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

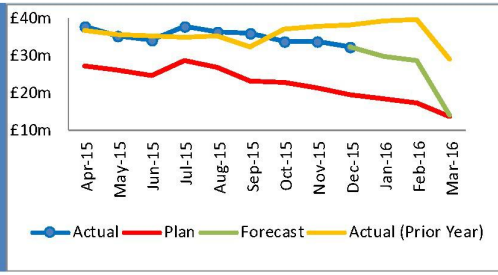
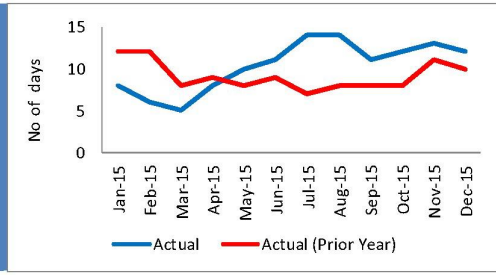
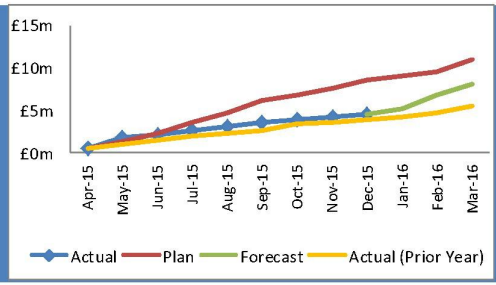
	Description	Current position/comments		
Financial Sustainability Risk Rating	Monitor's (independent regulator) measure of financial risk	Following a change to Monitor's Risk Assessment Framework (RAF), we are currently at a level one for Capital Service Capacity Ratio and the I&E Margin rating resulting in an overall score of 2.		A score of 2 each month (NB: this is restated from 3 following the changes to the RAF)
Normalised net surplus/ deficit	Net income and expenditure after adjusting for hosted services and impairments	Planned deficit YTD is £7.722m, the actual deficit is £7.726m resulting in an adverse performance of £4k. This represents a favourable movement of £44k. The CRS schemes are below plan by £457k at M9. Pressures continue within Medical and Nursing pay including agency spend as well as drugs. However they are mostly mitigated by over achievement of income to date. Exception report on page 21.		As Plan
Forecast Normalised net surplus/	Forecast net income and expenditure after adjusting for hosted services and impairments	At this stage of the year, we are still planning to deliver the £10.5m deficit plan. Action plans are in place to mitigate known financial risks and in addition there are sufficient levels of contingency within reserves to mitigate the current financial pressures and risks being experienced.		As Plan
Agency spend	Planning improvements in productivity and efficiency	Medical Pay is currently overspent by £1,009k, due to agency costs in excess of those anticipated. Agency medical expenditure YTD is £2,962k (9% of the total medical spend). Nursing Pay is currently £614k overspent, however this is largely offset by additional PbR income. Agency nursing expenditure YTD is £267k (0.9% of total trained nursing spend).		For Nursing Agency, spend capped at 3% of total trained nursing spend from Q3.

Are we well led?

Countess of Chester Hospital NHS
NHS Foundation Trust

Board Assurance metrics December 2015

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

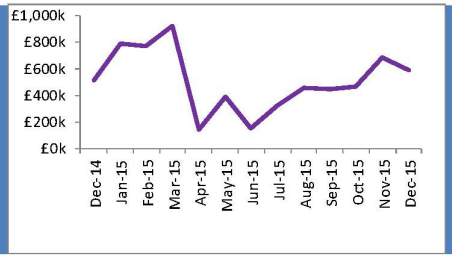
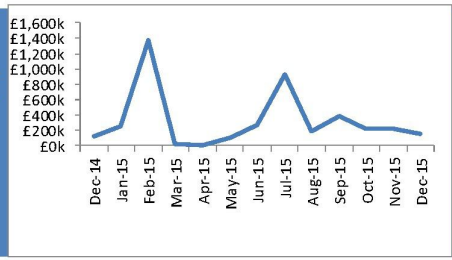
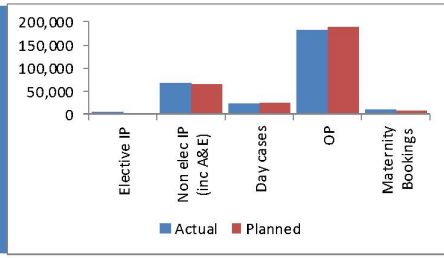
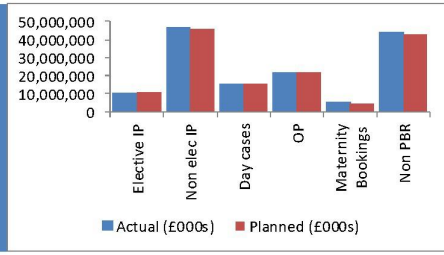
	Description	Current position/comments		
Cash	Cash on deposit <3 month deposit	The closing cash balance at the end of December was £33m which is £13m above plan. This is due primarily to the receipt of the £11m monthly payment on account from West Cheshire CCG. The positive impact of £4m slippage on capital is offset by trade debtors which are currently £3m over plan, as detailed below.		£21m
Debtor Days	Debtor Days: Trade Debtors divides by income x 365	Debtors has stabilised this month, remaining £3m higher than plan primarily due to: - continued over-performance against contract; billed quarterly in arrears, creating a short term increase in debtors; - other amounts in dispute, including £0.7m transitional funding; - amounts due from host CCG relating to prior year.		No target
Capital Expenditure	Capital expenditure performance against plan / forecast out-turn	Capital expenditure is £4m behind plan, due to the PACS refresh not being completed, spend on replacement medical equipment being slower than expected, and backlog maintenance being behind plan. The forecast capital spend for 2015/16 has been revised from £11m to just over £8m as a result of projects not yet started being deferred into 2016/17.		£6.8m

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

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

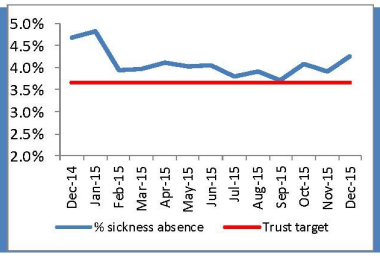
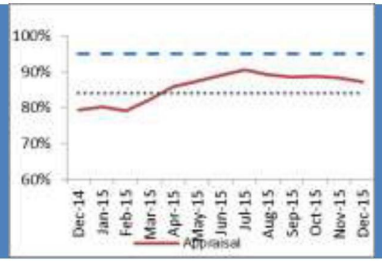
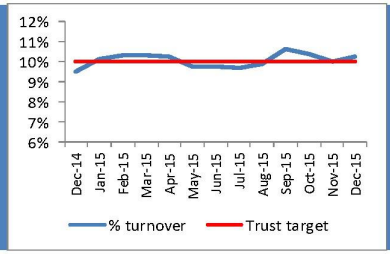
	Description	Current position/comments		
CRS In Year	Planning improvements in productivity and efficiency	Against the £6m annual efficiency target as at M9, £4,532k (76%) has been achieved. Outstanding schemes identified as either Green or Amber total £476k (8%). Red or Black rated schemes (higher risk) total £2,334k, partly reduced by investment slippage to £992k (16%). As at M9 the CRS under achievement results in a £457k adverse variance.		No deviation from plan
CRS Recurrently	Planning improvements in productivity and efficiency	Recurrently £2,484k (41%) in CRS savings have been achieved with £1,552k (26%) identified as either Green or Amber rated schemes and £1,964k (33%) Red or Black rated schemes. Please note detail in the Exception Report on page 22.		No deviation from plan
Contract performance Activity	YTD Contract performance against Trust Planned activity (English & Welsh)	Numbers continue to be above the internal plan on non-elective activity and A&E attendances. The anticipated reduction in antenatal and maternity activity has not materialised resulting in a favourable variance. However, activity numbers are below plan on daycase and outpatient activity.		Actual Activity should be greater than Planned activity
Contract performance Financial Value	YTD Contract performance against Trust Planned Value (English & Welsh)	At the end of month nine the income position is £1,961k above the internal plan year to date as follows:- Elective IP -£31k Non-Elective IP +£1,533k Daycase -£785k Outpatients -£484k Maternity +£671k Non PBR +£1,057k		Actual Value should be greater than Planned Value

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

BAF ref: CR3, CR4, CR6, CR7, CR11

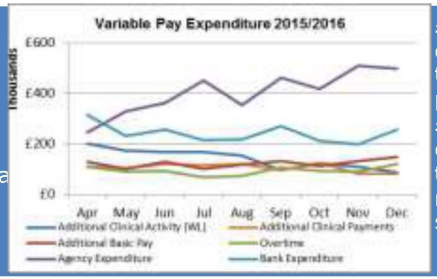
	Description	Current position/comments	13 month rolling trend	Target
Sickness absence	% sickness absence. Monthly rate excludes Comfort zone and Bank staff	Trust wide attendance management levels increased in December to 4.25 from the November figure of 3.92%. This was an improvement based upon the December 2014 level of 4.67%. The rolling 12 month average reduced marginally to 4.06%. There was a reduction in short term absences at 2.09%, with long term absences increasing to 2.16%.		Below 3.65% per month
Mandatory training	Mandatory Training Monthly Rate Excludes Comfort Zone, Bank Staff, Staff on long term sick & mat. leave.	Compliance with Mandatory Training position, pleasingly, increased again this month.Current compliance rate of 91.9%, exceeds the CQC target (76%) but is below the Trust target (95%). When taking into account those already booked to attend, the Trust is still just below the 95% Trust target. Exception report provided on page XX.		95% per month *The CQC target is 76% (the CQC take the results from the Staff Survey)*
Staff with completed appraisal	Appraisal Monthly Rate Exclusions as above and also excludes staff with less than 1 years service.	Compliance with Appraisal position dipped this month which was expected due a combination of high demands on the Trust and leave. The level of appraisal compliance decreased , with us achieving 87.1% in December. This still exceeds the CQC target (84%) but remains below the Trust target (95%). Exception report provided on page XX.		Above 95% per month *The CQC target is 84% (the CQC take the results from the Staff Survey)*
Staff turnover	Turnover Rate Based on the previous 12 months and on permanent staff only. Rate should be under the	Turnover is marginally above target at 10.27%. This is a slight increase on the previous month which was 10.02% and an exception report as been provided.		Below 10% per month

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics December 2015

BAF ref: CR3, CR4, CR6, CR7, CR11

	Description	Current position/comments	Breakdown by type by month	Target
Variable pay	Reducing and controlling variable pay spend (including overtime, agency, additional clinical activity)	Whilst the overall value of variable pay spend reduced month on month, the level of medical agency spend remains high. Total variable pay spend in month 7 was £1.081m (8% of the total pay budget). Further investigation of the data has identified an additional data set related additional clinical payments in radiology, which has been added to the data reviewed on a monthly basis.		£1.1m to be delivered through variable pay savings. £4.5m to be delivered through pay related CRS schemes.

EXCEPTION REPORT

Indicator: eDischarge

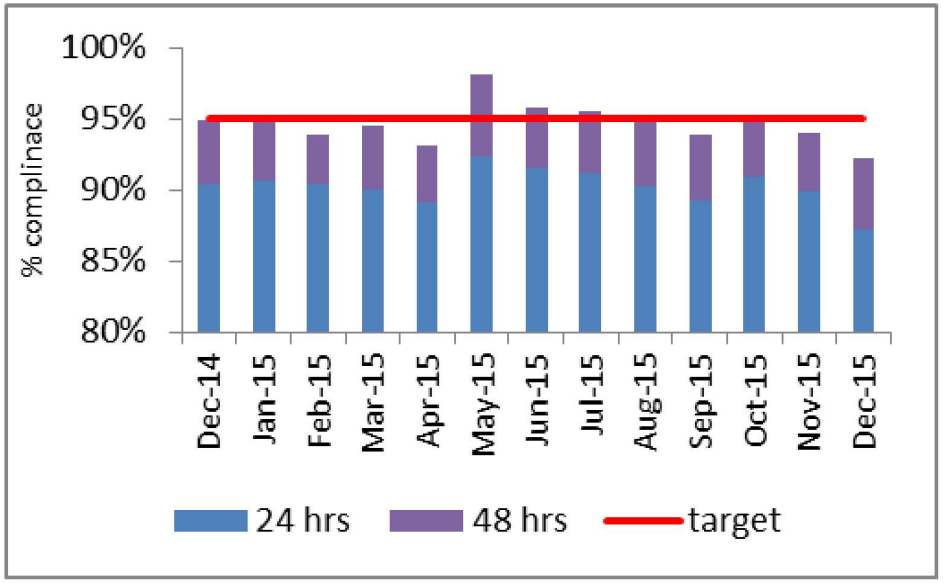
Issue:

The compliance rate reduced in December due to the increased acute pressures seen on site.

Proposed actions:

Divisions to discuss at Divisional Boards and provide action plan as to how to sustain achievement of this target inparticular focussing on specialties of under performance. Progress to be monitored through the Trusts Quality and Safety Executive Committee.

Historic data:



Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:

Executive Lead:

EXCEPTION REPORT

Indicator: Safeguarding training

Issue:

The Trust must maintain at least 80% compliance with groups 1,2,3 and 4 safeguarding children training, the current exception is group 2 which is below the required level of compliance.

Proposed actions:

The actions are continuing with demonstrated improvement and will continue to be closely monitored

Children:

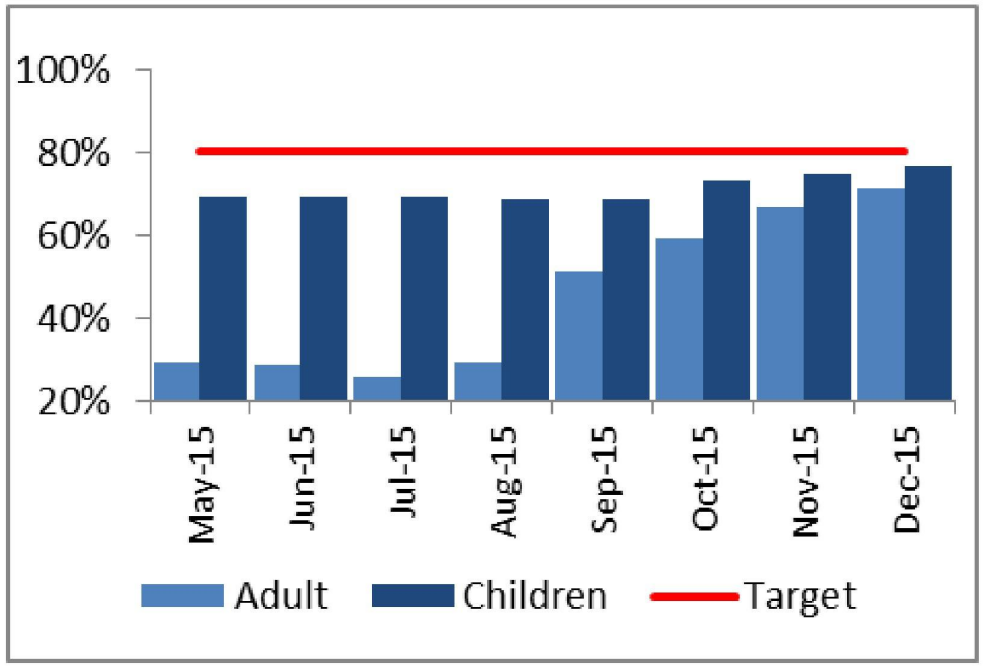
Group 2 staff must complete their training by completing the level 2 Safeguarding Children (secondary care) eLearning module. Training has to be completed every 3 years. Our ongoing action plan has included a monthly report from HR regarding compliance and subsequent briefings to staff regarding the need to complete their training. In addition some face to face group 2 training sessions have taken place. We have designed a written information pack. The CoCH Safeguarding Strategy Board is overseeing this action plan. We are confident that we will improve compliance.

Adults:

The actions identified below have resulted in a steady increase in compliance and will continue.

- Review of Prevent TNA to focus WRAP on those most in need building on TNAs from other health agencies
- Inclusion of Prevent Brief in Safeguarding Adult training for those not captured at induction
- Direct contact to all teams within CoCH to flag non-compliance with adult safeguarding training and direct to training materials
- Direct contact will be reviewed after a quarter and those teams still not compliant
- Adjustments are being made to Mandatory training to trial Safeguarding Adult sessions in workshop format
- An internal internet based MCA and DoLS session with in house video examples is to be built to make MCA and DoLS more accessible to Clinical staff .

Historic data:



Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:	Sian Williams, Deputy Director of Nursing & Quality
Executive Lead:	Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

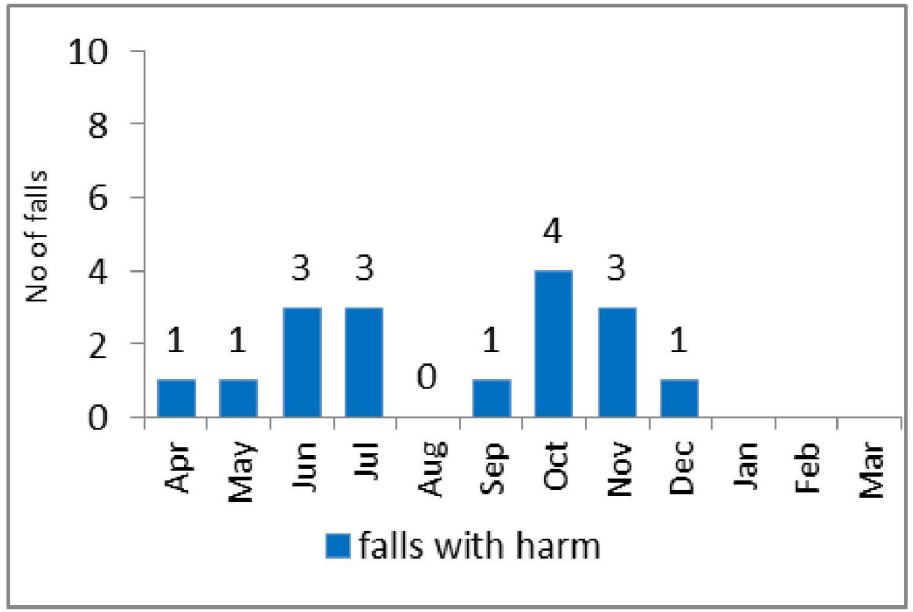
Indicator: Falls with harm

Issue:
One inpatient fall with harm in December which is under review.

Proposed actions:
The Deputy Director of Nursing is monitoring the ongoing actions. Work is being carried out across the Trust to reduce harm from falls. Any fall with harm triggers a red and all falls will be subject to a review. Any learning will be shared. The policy is also being reviewed in light of new guidance. This is a key workstream to 'Sign up to Safety' and it continues to be a focus for 2016/17.

Forecast for improvement:			
Q1	Q2	Q3	Q4

Historic data:



Lead:	Sian Williams, Deputy Director of Nursing & Quality
Executive Lead:	Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

Indicator: Diagnostic 6 week wait

Issue:

The diagnostic 6 week standard failed the standard in December due to increases in breaches for echocardiography, Audiology and Cystoscopy

Proposed actions:

Echocardiography:

Work continues within echocardiography to reduce the number of patient breaches. Staffing resource remains a concern and a workforce strategy meeting has taken place to explore alternatives to support recruitment and retention. Recent vacancies have been advertised twice without any suitable applicants. Staff continue to work additonal hours to support the waiting times. Continue to source external teams to provide additonal capacity and locum suport via a range of agencies. Head of Department to explore with HR support as to how we can how we may be able to recruit from EU and work with local Univeristies. Longer term strategy is to look at the advancements in echocardiography and if this would support the department

Cystoscopy:

There has been a 13% increase in fast tracks over the year. 90 patients have been outsourced to the Nuffield in December/January to manage demand, and there will be a need to continue outsourcing whilst the scoping capacity is reviewed. There is the potential to increase the consultant job plan by one session per week if agreed

Audiology:

Within Audiology there is a workforce issue which has resulted in reduced capacity. The Division has been tasked to resolve this as soon as possible and an action plan is expected

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:

English - Number of exams > 6 weeks

Month End Snapshot	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Magnetic Resonance Imaging	1	1	1		1	2	3	1	6	5			8
Computed Tomography				3	1		1	5	7	8	10	5	
Non-obstetric ultrasound	15			1	1	1	8						4
Audiology - Audiology Assessments					1			1	6	6	2	5	27
Cardiology - echocardiography	4	6	3	51	114	84	130	96	42	52	28	54	137
Respiratory physiology - sleep studies													
Colonoscopy		1											
Flexi sigmoidoscopy													
Cystoscopy	2	9	1	16	11	5	7	8	4	1	9	2	29
Gastroscopy				5							1		
Total patients waiting	3662	2774	3193	3798	3317	3236	3353	3729	3887	4027	4237	4285	4087
% < 6 weeks	99.4%	99.4%	99.8%	98.0%	96.1%	97.2%	95.4%	97.0%	98.3%	98.2%	98.8%	98.5%	95.0%

Lead:	Richard Baird, Lorraine Burnett, Linda Fellowes (Divisional Directors)
Executive Lead:	Mark Brandreth, Deputy Chief Executive

EXCEPTION REPORT

Indicator: RTT 18 weeks incomplete patients/over 52 week waiters

Issue:

Continued impact has been seen due to implementation of RTT refreshed guidelines. There has been a further increase pressure on waiting lists in December due to 45 cancellations due to no inpatient bed being available with a high perentage of cancellations within Trauma and Orthopaedics. These cancellatiosn are due to the increase in medically optomised patients occupying inpatient beds. Due to the complexity of the patients waiting there is limited General Surgery and Urology capacity available within the private sector. Other NHS Trusts have also been unable to support. Consultant absence within Plastic Surgery has also reduced capacity further.

Proposed actions:

Continue to work with alternative providers to transfer suitable patients for inpatient procedure. Re-commence additional daycase lists in Jubilee Centre as capital work allows. Re-advertise Consultant General Surgery post in Feburuary to meet availabilty of trainees.

Additional data: Performance by specialty - December 2015

	<18 wks	Total	
General Surgery	1817	2375	76.51%
Urology	926	1027	90.17%
Trauma & Orthopaedics	965	1160	83.19%
Ear, Nose & Throat (ENT)	1792	1938	92.47%
Ophthalmology	1581	1699	93.05%
Oral Surgery	571	615	92.85%
Neurosurgery	0	0	
Plastic Surgery	506	599	84.47%
Cardiothoracic Surgery	0	0	
General Medicine	361	361	100.00%
Gastroenterology	704	704	100.00%
Cardiology	549	549	100.00%
Dermatology	585	596	98.15%
Thoracic Medicine	518	518	100.00%
Neurology	0	0	
Rheumatology	163	163	100.00%
Geriatric Medicine	137	137	100.00%
Gynaecology	733	772	94.95%
Other	1037	1064	97.46%
Total	12945	14277	90.67%

Forecast for improvement:

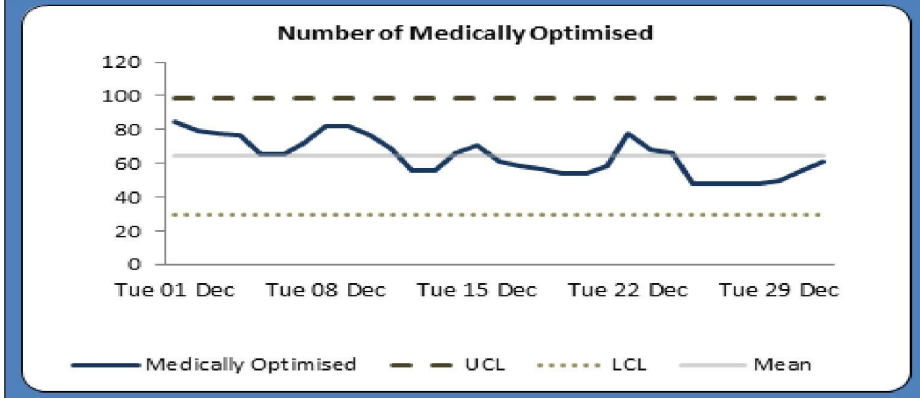
Lead:	Linda Fellowes, Divisional Director, Planned care Division
Executive Lead:	Mark Brandreth, Executive Director, Operations & Planning

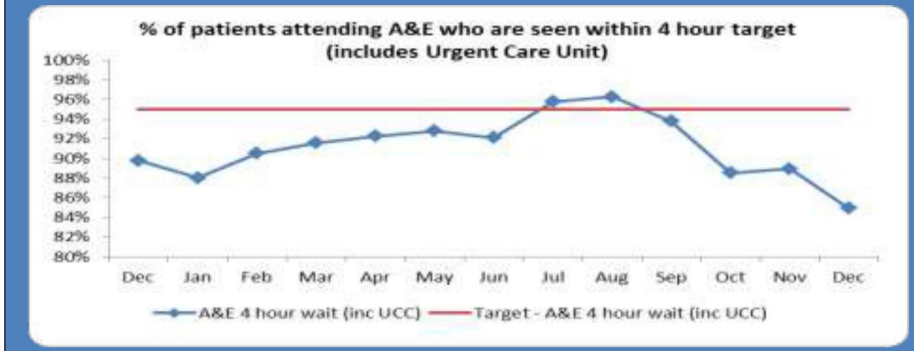
Indicator: A&E 4 hour standard

Issue:
A&E performance has continued to deteriorate due to reduced availability for bed capacity throughout December with continued escalation capacity open and fluctuating medical outlier numbers resulting in a high number of inpatient elective cancellations.

Proposed actions:
There continues to be staffing issues across medical and nursing within the Emergency Department which is being managed. The nursing staff are reviewed daily, and junior doctors are reviewed on a weekly basis and the department is always looking for other alternatives for staffing models. The overall attendances have decreased however our breaches in comparison have increased due to the lower rate of discharges. The medically optimised number continues to be above 70 throughout December with delays for packages of care, placements into care homes and latterly loss of capacity in community. Daily escalation both telephone and face to face and weekly operational systems resilience meetings continue to identify key actions and support the position. A detailed plan for additonal activity during the Christmas & New Year period was prepared and distributed to all teams

Historic data:





Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:	Lorraine Burnett, Divisional Director, Urgent care Division
Executive Lead:	Mark Brandreth, Deputy Chief Executive

EXCEPTION REPORT

Indicator: Normalised Net Surplus / Deficit

Issue:

At the end of month 9, the financial position is on plan (immaterial overspend against plan of £4k). There has been a favourable in month movement of £44k.

Pay:

Additional costs have been incurred to deliver the additional activity and consequently income experienced above plan. This has resulted in budetary overspends relating to Medical and Nursing pay also due to rota gaps, sickness, maternity cover and vacancies which has resulted in additional bank and agency expenditure.

Non pay:

There are activity related pressures resulting in overspends predominantly on Drugs of £474k and Medical & Surgical equipment of £179k that are not fully offset by the notional allocation of PBR funding received for the over performance on activity.

CRS:

CRS underachievement accounts for £457k of the variance.

Exception report is available on page 24.

Income:

Income is significantly over plan, primarily in relation to non elective activity and maternity, which is offsetting the additonal costs incurred to deliver the additional activity reducing the overall deficit.

Forecast:

At this stage in the financial year, we are still planning to deliver the £10.5m deficit plan, actions are in place to mitigate financial risks and are sufficient levels of contingency within reserves to mitigate the current level of financial pressure.

Proposed actions:

Further progress on developing and working up key milestones and savings for the CRS schemes that have been identified in conjunction with the PMO to ensure delivery on track.

Executive leads have been identified to review and reduce variable pay and non pay.

Forecast for improvement:

Q1	Q2	Q3	Q4

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
FINANCIAL PERFORMANCE AS AT 31ST DECEMBER 2015
KEY VARIANCES

	In Month £000s	YTD £000s
PAY		
Nursing	140	614
Medical	74	1,009
Admin & Clerical	(48)	(145)
PTA / PTB	3	(76)
Other	13	(98)
PBR notional funding	(111)	(797)
TOTAL PAY	**71**	**507**
NON PAY		
Drugs	86	474
Med & Surgical Equipment	(6)	179
Patient Appliances	(12)	44
Laundry & Cleaning Equipment	19	56
Outsourcing	5	54
Equipment Hire	0	29
Furniture & Office Equipment	7	43
Computer Hardware & Software	21	47
Other (inc Lab Equip & Consumables £116k, Building	86	366
PBR notional funding	19	(286)
TOTAL NON PAY	**225**	**1,006**
CRS	**(33)**	**457**
INCOME	**(307)**	**(1,966)**
GRAND TOTAL	**(44)**	**4**

EXCEPTION REPORT

Indicator: CRS in Year & Recurrently

Issue:

The CRS has not been delivered as planned as at month 9. This is primarily due to a shortfall in the number of schemes identified resulting in a under delivery to date. There has also been some slippage in the start dates of some schemes. The target delivery profile is based on historical delivery trend resulting in a target as at month 9 of £4,124k. The amount achieved is £3,667k resulting in underachievement of £457k at the end of month 9. Currently there is a risk in year of non delivery of £2.3m of the Efficiency Plan (relating to Red & Black schemes). This reduces to £1m when slippage from planned investments is used to offset. Please see action plan below.

The table shown represents a forecast of the full year effect of CRS schemes.

Proposed actions:

The organisation is currently working with DoH and Lord Carter in relation to support for further efficiency savings opportunities. Initial feedback has now been received and we are reviewing the potential savings identified. To support this, the Trust now has in post an executive lead for Model Hospital. A number of workstreams have been identified and the detail of which are currently being worked up by executive leads. All non-recurrent savings are currently under review to assess the potential for these savings to be made on a recurrent basis.

The Director of HR is leading a group tasked with reviewing all aspects of variable pay for the Trust, to include additional clinical sessions paid, overtime, outsourcing etc.

The Director of Corporate Affairs & Legal Services, is leading a group tasked with reviewing all aspects of non pay expenditure for the Trust, to include drugs, furniture & computers, maintenance etc.

The Divisions / Departments report monthly at the CRS Working Group on progress against green, amber and red rated schemes and pipeline work.

The PPD department is ensuring all PIDS are completed and key milestones delivered.

The High Quality Care Costs Less (HQCCL) work streams are also focusing on delivery of the recurrent CRS.

Forecast for improvement:

Q1	Q2	Q3	Q4

2015/16 EFFICIENCY PROGRAMME PERFORMANCE AS AT DECEMBER 15

IN YEAR

Division / Department	2015/16 In Year CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,200,000	£ 954,636	£ 1,245,364	£ 97,878	£ 83,550	£ 132,500	£ 931,436
Urgent Care	£ 2,200,000	£ 1,115,132	£ 1,084,868	£ 160,834	£ 56,691	£ 61,350	£ 805,993
D&P	£ 580,000	£ 326,056	£ 253,944	£ 15,500	£ 11,000	£ 10,000	£ 217,444
Estates & Facilities	£ 520,000	£ 371,181	£ 148,819	£ 5,177	£ -	£ -	£ 143,642
Nurse Mgmt	£ 36,000	£ 36,000	-£ 0	-£ 0	£ -	£ -	£ -
Medical Photography	£ 3,000	£ 3,000	£ -	£ -	£ -	£ -	£ -
Comms & Engagement	£ 3,000	£ 3,000	£ -	£ -	£ -	£ -	£ -
Corporate Clinical	£ 8,000	£ 8,254	-£ 254	-£ 0	£ -	£ -	-£ 254
IM&T	£ 200,000	£ 162,959	£ 37,041	£ 37,041	£ -	£ -	£ -
HR	£ 107,000	£ 84,952	£ 22,048	£ 48	£ -	£ -	£ 22,000
Trust Administration	£ 28,000	£ 9,500	£ 18,500	£ 2,635	£ 6,388	£ 500	£ 8,977
PPD	£ 20,000	£ 20,000	£ 0	£ 0	£ -	£ -	£ -
Finance	£ 55,000	£ 55,000	£ 0	£ 0	£ -	£ -	£ -
Procurement	£ 40,000	£ 40,000	£ -	£ -	£ -	£ -	£ -
Central		£ 1,341,842	-£ 1,341,842	£ -	£ -	£ -	-£ 1,341,842
TOTAL	£ 6,000,000	£ 4,531,511	£ 1,468,489	£ 319,113	£ 157,629	£ 204,350	£ 787,396
		76%	24%	5%	3%	3%	13%

2015/16 EFFICIENCY PROGRAMME PERFORMANCE AS AT DECEMBER 15

RECURRENT

Division / Department	2015/16 Recurrent CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,200,000	£ 649,544	£ 1,550,456	£ 76,593	£ 431,930	£ 833,388	£ 208,545
Urgent Care	£ 2,200,000	£ 711,397	£ 1,488,603	£ 416,116	£ 346,424	£ 87,653	£ 638,410
D&P	£ 580,000	£ 360,589	£ 219,411	£ 72,000	£ 65,000	£ 100,000	-£ 17,589
Estates & Facilities	£ 520,000	£ 450,199	£ 69,801	£ 8,176	£ 15,000	£ 40,000	£ 6,625
Nurse Mgmt	£ 36,000	£ -	£ 36,000	£ 20,000	£ 10,000	£ 2,747	£ 3,253
Medical Photography	£ 3,000	£ 3,000	£ -	£ -	£ -	£ -	£ -
Comms & Engagement	£ 3,000	£ 3,000	£ -	£ -	£ -	£ -	£ -
Corporate Clinical	£ 8,000	£ 8,000	£ -	£ -	£ -	£ -	£ -
IM&T	£ 200,000	£ 113,127	£ 86,873	£ 73,467	£ -	£ -	£ 13,406
HR	£ 107,000	£ 64,500	£ 42,500	£ -	£ 10,000	£ 12,000	£ 20,500
Trust Administration	£ 28,000	£ 5,500	£ 22,500	£ 1,000	£ 6,388	£ -	£ 15,112
PPD	£ 20,000	£ 20,000	£ -	£ -	£ -	£ -	£ -
Finance	£ 55,000	£ 55,000	£ -	£ -	£ -	£ -	£ -
Procurement	£ 40,000	£ 40,000	£ -	£ -	£ -	£ -	£ -
Central	£ -	£ -	£ -	£ -	£ -	£ -	£ -
TOTAL	£ 6,000,000	£ 2,483,855	£ 3,516,145	£ 667,352	£ 884,742	£ 1,075,788	£ 888,262
		41%	59%	11%	15%	18%	15%

2015/16 EFFICIENCY PROGRAMME PERFORMANCE - MOVEMENT - IN YEAR & RECURRENT

IN YEAR	2015/16 In Year CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
November	£ 6,000,000	£ 4,191,731	£ 1,808,269	£ 542,618	£ 181,678	£ 166,350	£ 917,621
December	£ 6,000,000	£ 4,531,511	£ 1,468,489	£ 319,113	£ 157,629	£ 204,350	£ 787,396
Movement		£ 339,780	-£ 339,780	-£ 223,505	-£ 24,049	£ 38,000	-£ 130,225

RECURRENT	2015/16 Recurrent CRS Target	Achieved to date	Outstanding	Green	Amber	Red	Pipeline
November	£ 6,000,000	£ 2,322,029	£ 3,677,971	£ 762,290	£ 958,827	£ 1,028,526	£ 928,327
December	£ 6,000,000	£ 2,483,855	£ 3,516,145	£ 667,352	£ 884,742	£ 1,075,788	£ 888,262
Movement		£ 161,826	-£ 161,826	-£ 94,938	-£ 74,085	£ 47,262	-£ 40,065

EXCEPTION REPORT

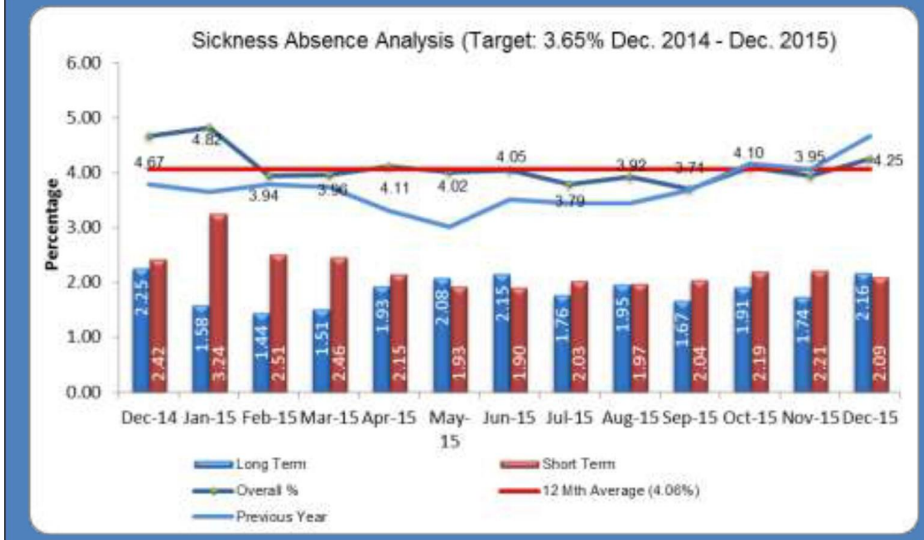
Indicator: Monthly Sickness Absence rate

Issue:
The Trust wide absence rate increased to 4.25% which is below the position from 12 months earlier. The figure remains disappointingly above the target of 3.65%, despite a reduction in short term absences. On investigation, long term absences have increased in month by 24% with a 25% increase in Anxiety/Stress/Depression and Mental Health conditions (21.09WTE), a 35% increase in Other Musculoskeletal conditions and a 59% increase in Injury/Fractures. Short term absence reduced in the following areas: Other musculoskeletal Conditions - 28% reduction (6.2 WTE); Heart Conditions - 100% reduction; Genito-Urinary Conditions - 61% reduction (2 WTE). The absence rates across the region are currently averaging 4.5%, as outlined in the EWIN regional benchmarking data, with the Trust running at 4.06% for the last 12 months.

Proposed actions:
The Occupational Health and Well Being service have continued building upon the wider opportunties for staff to improve their mental or physical health. Alongside the relaxation, reflexology and stress busting sessions the introduction of Pilates to assist with stress and weight loss clinics for the new year have commenced. A further event is being held outside the Staff Restaurant on 15th January 2016 to encourage take up of the recent new events offered. Management and Trade unions met on 21st December to progress the new Attendance Management Policy and explored a new addendum with regards to Compassionate Care leave for those with a partner or child with a terminal illness to provide an alternaitve to sickness absence. We are introducing additional opportunties for training managers on attendance through the Band 6 Deputy Ward Manager development programme commencing this year.

Forecast for improvement:			
Q1	Q2	Q3	Q4

Historic data:



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

EXCEPTION REPORT

Indicator: Mandatory Training Completed In The Last 12 Months

Issue:

The level of Mandatory Training completed has improved again this month at 91.9%, which is above the CQC target (76%) but remains below the Trust target of 95%. An additional measurement is partial compliance where staff who are non-compliant but are booked onto future programmes. This is standing at 94.8%, just below the 95%. Local Induction reduced slightly to 84.1% and remains below the Trust target of 95%. This is receiving focused attention to address reducing compliance.

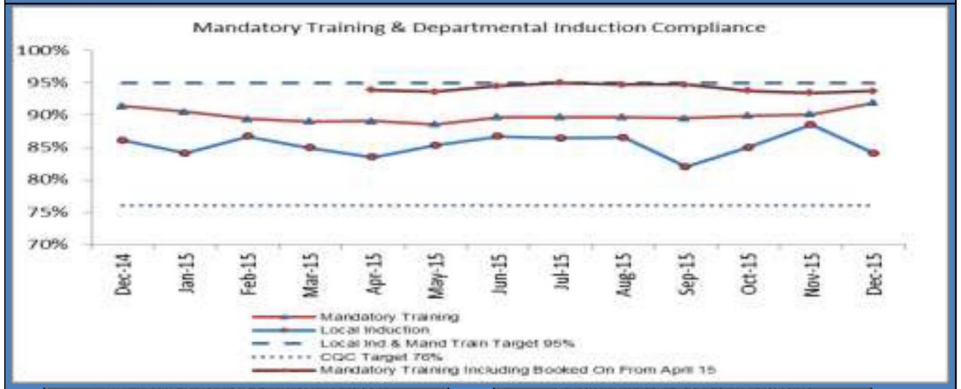
Proposed actions:

The Learning & Development team and those who participate in the Mandatory Training programmes continue where possible to create additional capacity to ensure access is open to as many staff as possible. We are closely monitoring the numbers of DNA's , as creating additional capacity continues to impact on our other work commitments with more details being provided next month. However we are also aware of the demands being placed on our staff in terms of meeting our capacity and demand. Detailed focus on local induction compliance continues as compliance slips again. Overall performance continues to be escalated to the Director of Human Resources & Organisational Development where continuous improvements are not being observed. Revision to the forecast for improvement has been made against Q3 Trust target.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Mandatory Training Table December 2015

Position	Division	Compliance
1	COCH & WUTH Collaboration	98.1%
2	Human Resources	96.6%
3	Facilities	96.3%
4	Finance & Performance	92.7%
5	Planned Care	92.7%
6	Estates	92.5%
7	Diagnosis and Therapies	90.8%
8	Urgent Care	90.4%
9	Corporate Non - Clinical	89.3%
10	Corporate Clinical	85.7%
11	Nurse Management	81.6%
	Total	91.9%

Local Induction Table December 2015

Position	Division	Compliance
1	COCH & WUTH Collaboration	100.0%
2	Corporate Non - Clinical	100.0%
3	Estates	100.0%
4	Facilities	100.0%
5	Planned Care	95.1%
6	Finance & Performance	81.8%
7	Urgent Care	78.0%
8	Human Resources	75.0%
9	Diagnosis and Therapies	68.4%
10	Corporate Clinical	0.0%
11	Nurse Management	-
	Total	84.1%

Lead: Linda Walker, Head of Learning & Development

Executive Lead: Sue Hodkinson

EXCEPTION REPORT

Indicator: Appraisals Completed In The Last 12 Months

Issue:

Performance against the appraisal target of 95% reduced slightly to 87.1 %, which is above the CQC target of 84% but below the Trust target of 95%. This was not unexpected due to a combination of excessive pressures in terms of capacity and demand on our staff and leave.

Where there are issues of reduced compliance, Senior Managers are alerted and urgent action plans are requested in order to bring compliance back into line.

Proposed actions:

Significant emphasis on the importance of appraisal completion remains within Stocktake discussions. Robust monitoring will continue to take place and where there are no signs of improvements, discussions will take place with the Director of HR & Organisational Development.

This winter period is once again challenging, and we have to be mindful of the demands and challenges faced by our workforce. The appraisal agenda, process, quality and compliance is a key area of focus within the Model Hospital programme under the Organisational Culture programme. Revision to the forecast for improvement has been made against Q3 Trust target.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:

Appraisal Table December 2015

Position	Division	Compliance
1	Facilities	[illegible]
2	Human Resources	93.8%
3	COCH & WUTH Collaboration	93.3%
4	Planned Care	91.9%
5	Finance & Performance	87.4%
6	Urgent Care	86.4%
7	Diagnosis and Therapies	79.1%
8	Nurse Management	70.3%
9	Corporate Non - Clinical	56.3%
10	Corporate Clinical	41.7%
11	Estates	39.5%
	Total	87.1%

Lead:	Linda Walker, Head of Learning & Development
Executive Lead:	Sue Hodkinson

EXCEPTION REPORT

Indicator: Turnover

Issue:

The turnover rate has risen slightly this month to 10.27% which is just over target. When reviewing further, the Additional Professional and Technical Staff group demonstrates the highest rate with 21% turnover. This is a small staff group (136 heads) so only a few leavers will provide a higher percentage. Within this group, we have had 35 leavers in the last 12 months (4 Chaplains, 8 Pharmacists, 15 Theatre Practitioners, 7 Technicians (5 of which are Pharmacy Technicians) and 1 Optometrist). The key reasons for members of staff leaving are child dependants (although not significant numbers), which has increased by 83% and work life balance with an increase of 58%.

Proposed actions:

Whilst exit interviews are now in place, further promotion to support completion is required.

A more detailed review of the data and reasons will be provided to the January 2016 POD meeting, where monitoring will be undertaken in more detail.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:

Division - Jan. 15 - Dec. 15 Excludes Temporary Staff	Turnover %
COCH & WUTH Collaboration	16.00
Corporate Clinical	16.67
Corporate Non Clinical	4.35
Diag., Therapies & Pharmacy	7.12
Estates Division	7.14
Facilities Division	8.39
Finance & Performance	7.91
Human Resources	8.16
Nurse Management	2.86
Planned Care Division	11.32
Urgent Care Division	11.51
Trust Totals & Rate	**10.27%**

Staff Group - Jan. 15 - Dec. 15 Excludes Temporary Staff	Turnover %
Add Prof Scientific and Technic	21.13
Additional Clinical Services	7.59
Administrative and Clerical	11.52
Allied Health Professionals	6.70
Estates and Ancillary	7.92
Healthcare Scientists	7.32
Medical and Dental	11.11
Nursing and Midwifery Registered	11.36
Trust Totals & Rate	**10.27%**

Lead:

Executive Lead: Sue Hodkinson

EXCEPTION REPORT

Indicator: Variable Pay

Issue:

To deliver the £4.5m required savings in relation to pay related CRS plans in 15/16, increased focus is being placed on the reduction of variable pay spend across the Trust.

M&D Vacancies	Urgent	Planned	Diag/Radiol	Total
Consultant	2	2	3	**7**
Speciality Doctor	0	1	0	**1**
Middle Grade	1	4	0	**5**
Junior Grade	2	8	0	**10**

Vacancies (FTE)	Urgent Care	Planned Care	Diag/Radiol/Pharm	Total
N&M Registered	17.50	20.79	0.00	**38.29**
Support Staff	3.42	7.43	0.00	**10.85**
Radiographer/Sonographer	0.00	0.00	5.60	**5.60**
Allied Health Professionals	0.00	0.00	1.50	**1.50**
Healthcare Scientist	0.00	0.00	1.00	**1.00**
Pharmacist	0.00	0.00	5.00	**5.00**

Proposed actions:

Month on month, the level of medical and nursing & midwifery registered nurse vacancies has increased and therefore, the level of medical agency spend reflects the vacancy pressures. To support tighter controls & focus, a Trust wide all Staff letter has been issued and a budget holders meeting undertaken. Changes to controls and approval levels are being escalated with further communication to be issued to budget holders by 1st December. 2015

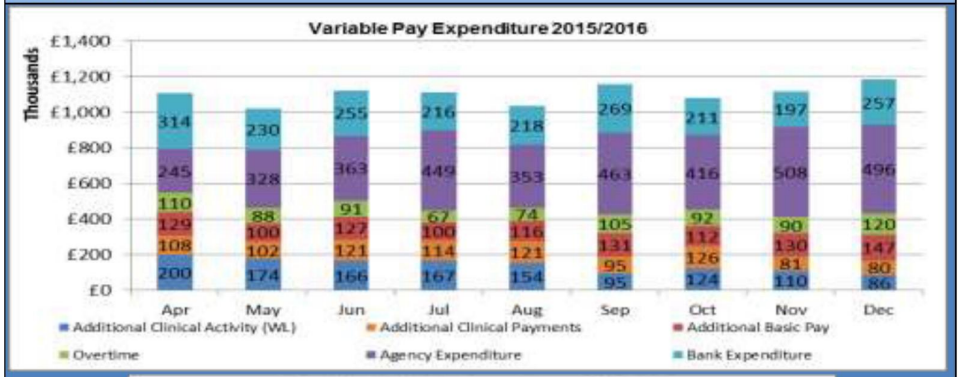
Governance revised to support closer working between the HQCL Process group, focused on Medical agency spend, and the variable pay group, with feedback provided to each POD Committee. Feedback has been submitted to Monitor and regional partners to support medical agency rate reduction and capping.

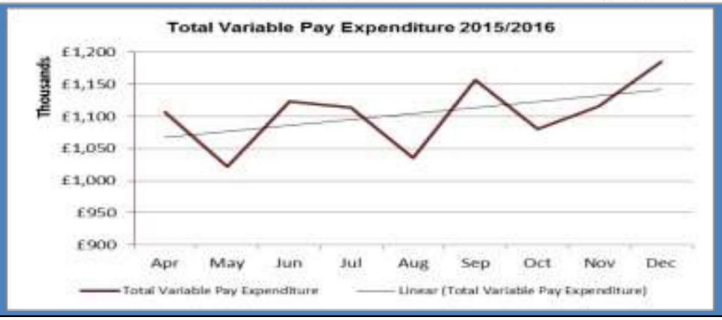
Revision to the forecast for improvement has been made against Trust target.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:





Lead:	Richard Baird, Jane O'Neill, Martin Godfrey, Diane Holder,
Executive Lead:	Sue Hodkinson

Appendix 1 – Safe staffing

Safe Nurse and Midwifery Staffing Level December 2015

1.0 Purpose

The purpose of this paper is to provide an overview of the monitoring and management of nursing and midwifery staffing in the month of December 2015.

2.0 Background

The Trust is committed to ensuring levels of staffing; including registered nurses, midwives and nursing assistants and other clinical ward support staff, match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes an appropriate level and skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, required to provide safe and effective patient care.

3.0 'Real Time' management of staffing levels to mitigate risk

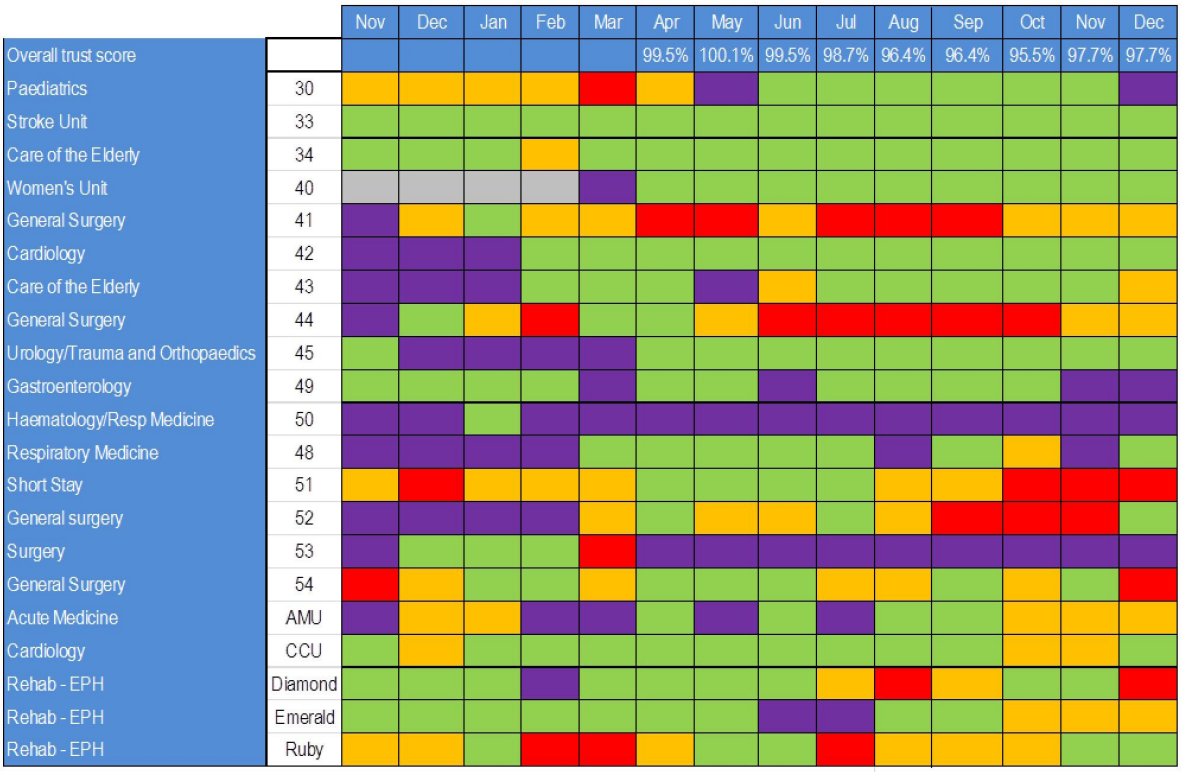
Safe staffing levels are managed on a daily basis. At the 08.30 flow meeting, the Heads of Nursing/Midwifery and Matrons are provided with an overall view of all our in patients wards for the day by shift, registered and unregistered workforce numbers and ratios. Consideration is given to our patient's needs, the bed capacity, occupancy and operational activity within the Trust which may have impacted on safe staffing. Actions are agreed to ensure that all areas are made safe. Any staffing incidents are reviewed daily by the Risk and Safety Team and are reviewed weekly by the Incident Review Panel with the Director of Nursing and Medical Director present (analysis is also provided in a monthly report), particularly in respect of any harm caused – non articulated/attributed

4.0 How did we do in December?

The hospital continues to constantly recruit and this will continue for the foreseeable future.
Capacity challenges have led to the opening of additional beds which have at times pressured the staffing. Nurse Specialists have been requested to support the inpatient wards. The Trust has seen an increased use of nursing agency to support the care needed for the additional patients in the Hospital
The Trust is continuing to monitor any impact of the nursing vacancies via its safety team. The Director of Nursing maintains oversight at a weekly established meeting.

5.0 Individual Wards

Below are results for our wards in December



		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Overall trust score							99.5%	100.1%	99.5%	98.7%	96.4%	96.4%	95.5%	97.7%	97.7%
Paediatrics	30														
Stroke Unit	33														
Care of the Elderly	34														
Women's Unit	40														
General Surgery	41														
Cardiology	42														
Care of the Elderly	43														
General Surgery	44														
Urology/Trauma and Orthopaedics	45														
Gastroenterology	49														
Haematology/Resp Medicine	50														
Respiratory Medicine	48														
Short Stay	51														
General surgery	52														
Surgery	53														
General Surgery	54														
Acute Medicine	AMU														
Cardiology	CCU														
Rehab - EPH	Diamond														
Rehab - EPH	Emerald														
Rehab - EPH	Ruby														
Critical care medicine	ICU														
Neonatal	NNU														
Obstetrics	32														
Labour Ward	35														

Key	
>105%	Monitoring of the use of one to one and the need for additional hours or current workforce
95% to 105%	Hours available match the patient acuity
<95% to 90%	Daily-Shift review
<90%	Daily-Shift review resulting in staff movement if needed-escalation guidance triggered

Countess of Chester Hospital NHS Foundation Trust		Dec-15							
		Registered Nurses/Midwives			Care Staff			All staff	
Specialty	Ward	Planned monthly hours	Actual monthly hours	%	Planned monthly hours	Actual monthly hours	%	% planned hours staffed	Statement of actions to ensure safe staffing levels
Paediatrics	30	2683.5	2669	**99.5%**	713	1793.5	**251.5%**	131.4%	Dependency of the patients has been high and additional staffing has been given.
Obstetrics	32	1782.5	2130.5	**119.5%**	1426	1475.5	**103.5%**	112.4%	
Labour Ward	CLS	4278	4595.5	**107.4%**	885.5	964.7	**108.9%**	107.7%	
Stroke Unit	33	2683.5	2605	**97.1%**	2356	2527	**107.3%**	101.8%	
Care of the Elderly	34	2077.5	2023	**97.4%**	2650.5	2636.5	**99.5%**	98.6%	
General Surgery	40	1426	1355	**95.0%**	434	522.5	**120.4%**	100.9%	
General Surgery	41	1409	1144	**81.2%**	792.5	902	**113.8%**	93.0%	
Cardiology	42	1970.5	1970.2	**100.0%**	1612	1752	**108.7%**	103.9%	
Care of the Elderly	43	2108.5	1967.5	**93.3%**	2697	2519	**93.4%**	93.4%	
General Surgery	44	2156.5	1951	**90.5%**	2170	2060.75	**95.0%**	92.7%	
Urology/Trauma and Orthopaedics	45	2156.5	2052.5	**95.2%**	2511	2523.5	**100.5%**	98.0%	
Respiratory Medicine	48	2637	2356.5	**89.4%**	1767	1961	**111.0%**	98.0%	
Gastroenterology	49	1939.5	1957.5	**100.9%**	1953	2145.5	**109.9%**	105.4%	
Haematology/Resp Medicine	50	2311.5	2273	**98.3%**	1953	2459.7	**125.9%**	111.0%	
Respiratory Medicine	51	2030.5	1766	**87.0%**	2883	2500.5	**86.7%**	86.8%	
General surgery	52	2342.5	1990	**85.0%**	1798	2113	**117.5%**	99.1%	
Surgery	53	1598.5	1655	**713.0%**	713	1780.5	**249.7%**	148.6%	Staffing hours increased due to escalation beds open.
General Surgery	54	2869.5	2452	**85.5%**	2325	2206.5	**94.9%**	89.7%	
Acute Medicine	AMU	4924	4365.5	**88.7%**	2787	2713.4	**97.4%**	91.8%	
Cardiology	CCU	2451	2329	**372.0%**	372	380.5	**102.3%**	96.0%	
Rehabilitation - EPH	Diamond	1488	1213	**81.5%**	2743.5	2559	**93.3%**	89.1%	
Rehabilitation - EPH	Emerald	1255.5	1186.5	**94.5%**	2015	1764.5	**87.6%**	90.2%	
Rehabilitation - EPH	Ruby	1488	1350.5	**90.8%**	2743.5	2745.5	**100.1%**	96.8%	
Critical care medicine	ICU	9269	8369.5	**90.3%**	713	766.25	**107.5%**	91.5%	
Neonatal	NNU	3059	2708.5	**88.5%**	1426	1230	**86.3%**	87.8%	
Total		61711.5	57766.7	93.6%	43726.5	45209.3	103.4%	97.7%	

Appendix 2

Cancer Board Assurance Report

December 2015

Overview of finalised performance for all cancer targets

The following table provides performance for all cancer standards.

	Apr	May	Jun	Quarter 1	July	Aug	Sept	Quarter 2	Oct	Nov
14 Day (93%)	96.10%	95.65%	97.15%	96.35%	96.68%	96.42%	95.47%	96.19%	95.90%	97.21%
14 Day - Breast Symptomatic (93%)	98.11%	96.08%	94.67%	96.09%	92.86%	95.74%	95.83%	94.86%	95.08%	95.60%
31 Day - Diagnosis to Treatment (96%)	100.00%	98.84%	96.70%	98.46%	100.00%	98.95%	99.00%	99.35%	97.87%	100.00%
31 Day - Surgery (94%)	100.00%	100.00%	94.12%	97.67%	100.00%	93.33%	100.00%	97.83%	100.00%	100.00%
31 Day - Drugs (98%)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
62 Day - Referral to Treatment (85%)	86.21%	82.86%	79.83%	82.94%	94.96%	81.98%	89.74%	89.05%	76.98%	79.80%
62 Day - Screening (90%)	100.00%	100.00%	90.48%	94.59%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
62 Day - Upgrade (85%)	100.00%	94.59%	91.30%	95.04%	92.86%	93.33%	81.48%	89.10%	83.72%	100.00%

December Position

The following data is the current December provisional position and subject to validation.

Standard	Target	Trust %	Patients Treated/Seen	Patients Breached
14 Day	**93%**	98.57%	767	11
14 Day - Breast Symptomatic	**93%**	89.06%	64	7
31 Day - Diagnosis to Treatment	**96%**	100%	83	0
31 Day - Surgery	**94%**	100%	14	0
31 Day - Drugs	**98%**	100%	4	0
62 Day - Referral to Treatment	**85%**	77.78%	45	10
62 Day - Screening	**90%**	100%	11	0
62 Day - Upgrade	**89%**	96.67%	15	0.5

14 Day – Breast Symptomatic

The under performance in the month of December predominantly relates to patients choosing to wait beyond the 14 days. The December performance does not place the quarter 3 at risk and therefore is expected to achieve the quarter.

62 Day Referral to Treatment December Performance

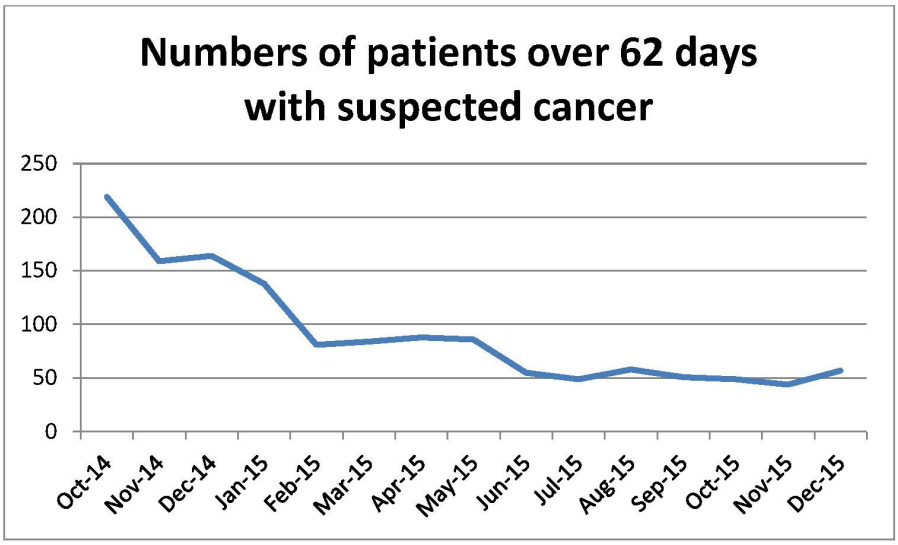
Performance details

There were 10 breaches in December that will now be validated and is subject to reallocations. Initial findings show breaches are broken down under the following specialties:

- Gynaecology – 1 breach
- Head & Neck – 3 breaches
- Lower GI – 1 breach

- Lung – 3 breaches
- Upper GI – 1 breach
- Urology – 1 breach

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



The following table provides a summary of the PTL position week ending 24/12/15 for patients waiting above 62 days and identifies the number of patients over 104 days.

Speciality	PTL between 63 - 103 days	PTL above 104+ Days	Total PTL over 62+ days
Breast			**0**
Colorectal	4		**4**
Gynaecology	1		**1**
Haematology		1	**1**
Head & Neck	8	3	**11**
Lung	3	1	**4**
Skin	1		**1**
Upper GI	20	8	**28**
Urology	3	4	**7**
Grand Total	**40**	**17**	**57**

The number of patients waiting over 104 days has increased by 6 patients in the last month to 17 patients. 10 of these patients have currently been referred to other NHS Acute Providers and are awaiting treatment. These patients continue to be tracked and chased with the appropriate providers to ensure diagnosis/treatment can be commenced as soon as possible.

The remaining seven patients are as follows:

- Haematology – A late referral from the Head & Neck pathway for treatment and patient then has chosen to wait further with a date for an Outpatient appointment in late January.

- Urology – Patient choice for diagnostics (TRUS Bx) in January.
- UGI – 5 patients are currently waiting for the following reasons;
    - Diagnostics, patient booked for barium swallow in early January
    - Patient awaiting MDT review for further clinical decision
    - Awaiting an outpatient clinic appointment
    - Outpatient clinic appointment booked for early January
    - TCI date scheduled for stent in December

The Trust has recently reviewed its process for ensuring all patients over 104 days are clinically reviewed as to ensure lessons are learnt, delays are understood, and no unnecessary harm has come to the patient. This process will compliment current Trust governance processes and will involve a detailed review of each patient by the tumour site lead Consultant and the lead Cancer Clinician. Any lessons learnt will be fed back through existing governance reporting structures and where pathways cut across a number of Trusts, lessons will be shared with those Trusts.

Actions to address performance

Urology continues to be the main concern in relation to achieving performance with now 11 breaches over the last three months. Work with the Urology team continues to streamline the pathway with aims to identify further actions to improve as soon as possible. Current issues remain with capacity for diagnostics including cystoscopy and trus biopsies. The Planned Care Division is currently looking to increase capacity in these areas through additional sessions and the private sector (where clinically appropriate).

Upper GI has shown an increase in patients waiting over 62 days. Meetings have taken place with the clinical team, and plan has been developed to increase capacity in clinics to review patients on the PTL. Highlights of these actions include:

- Additional clinics (including weekends) in January and February this month to see the longest waiting patients
- Review specialist nurse support with aim to increase Outpatient follow up capacity on a routine basis.
- Recruitment to begin on additional Upper GI Consultant vacancy post.

A performance meeting has occurred with Head and Neck (ENT team) to identify improvements. Actions included:

- Extra designated fast track slots for review patients within outpatients
- Review of patients on their PTL to identify if patients can be removed from the fast track pathway. Potentially there are a number of patients on the suspected cancer waiting list that do not require to be treated on a cancer pathway.
- From review of the patients above, identify further pathway improvements.

Appendix 3 Changes to report

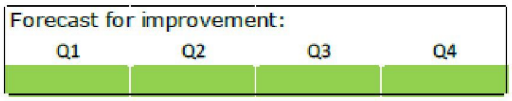
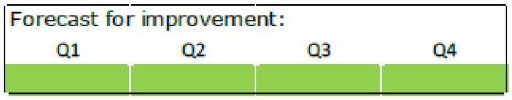
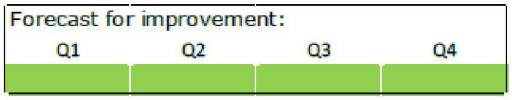
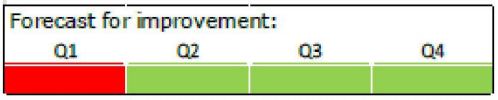
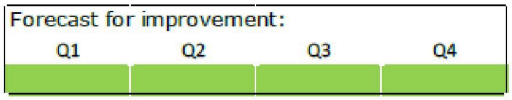
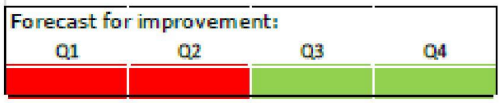
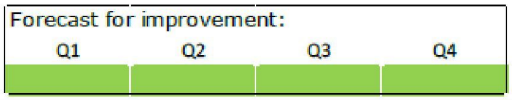
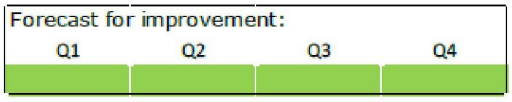
Forecast for Improvement

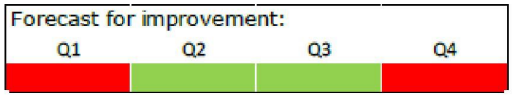
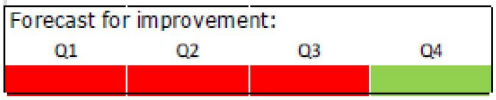
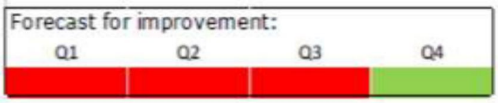
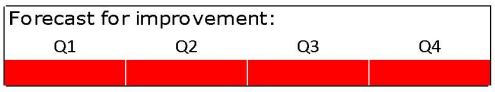
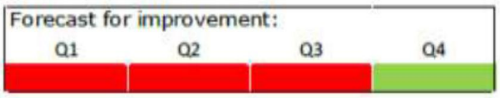
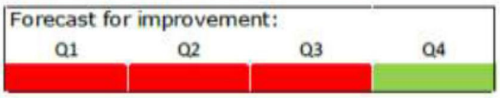
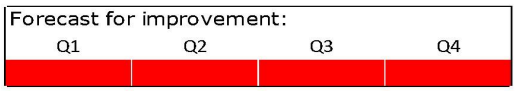
The following table provides a summary of the forecast for improvement for the remainder of the year.

An additional forecast has been added this month in relation to diagnostics and turnover.

Changes have been made this month to the forecast to the following measures:

- 62 day Cancer
- Appraisals
- Mandatory Training
- Variable pay

Area of underperformance (Exception report provided)	**Improvement trajectory**
Serious Untoward Incidents	
Mixed Sex Accommodation	
Safety Thermometer	
E-Discharge	
Safeguarding	
Friends and Family (response rate)	
Diagnostics	
Falls with harm	
Infection Control (Cdif and MRSA)	
62 day Cancer	

18 weeks Incomplete Pathway	
A&E 4 hour standard	
Normalised net surplus/deficit	
CRS delivery	
Sickness Absence	
Appraisals	
Mandatory Training	
Variable Pay	
Urgent Cancellations	

Changes to measures

There were no changes to any measures this month

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

ASSURANCE FRAMEWORK

Q 3 - 2015/16

Presented to Board of Directors 14th December 2015

Master Version Dated: 11/12/2015

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

ASSURANCE FRAMEWORK

CONTENTS

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
CR1 15/16	Failure to maintain and enhance the quality and safety of the patient experience and ensure compliance with CQC Standards	Medical Director / Director of Nursing and Quality	Quality, Safety and Patient Experience	4x2=8	4x2=8	4x2=8	
CR2 15/16	Inability to effectively stabilise acute patient flow	Deputy Chief Executive	Finance and Integrated Governance	4x4=16	4x4=16	4x4=16	
CR3 15/16	Failure to maintain, innovate and transform the Trust's clinical services	Medical Director / Deputy Chief Executive	Finance and Integrated Governance	4x3=12	4x3=12	4x3=12	
CR4 15/16	Failure to develop and deliver the Trust's culture, values and staff engagement plan.	Director of HR and OD	People and Organisational Development	4x3=12	4x3=12	4x3=12	
CR5 15/16	Failure to deliver in year financial plan and manage consequences of delivering a deficit budget	Chief Finance Officer	Finance and Integrated Governance	4x3=12	4x3=12	4x3=12	
CR6 15/16	Failure to develop and deliver a robust long-term whole health economy service, workforce and financial savings and recovery plan	Chief Executive	Finance and Integrated Governance	4x4=16	4x4=16	4x4=16	
CR7 15/16	Failure to comply with Monitor's Compliance Framework - Governance	Deputy Chief Executive	Finance and Integrated Governance	4x4=16	4x4=16	4x4=16	
CR8 15/16	Failure to maintain robust corporate governance and overall assurance	Director of Corporate and Legal Services	Board of Directors	3x2=6	3x1=3	3x1=3	
CR9 15/16	Failure to maintain Information Governance standards	Medical Director	Finance and Integrated Governance	3x4=12	3x4=12	3x4=12	
CR10 15/16	Failure to provide appropriate Informatics infrastructure, systems and services that support the business objectives of the Trust	Chief Finance Officer	Finance and Integrated Governance	4x3=12	4x3=12	4x3=12	
CR11 15/16	Failure to recruit and retain professional staff	Director of HR & OD	People and Organisational Development	4x3=12	4x3=12	4x3=12	

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

Impact Level of Risk Potential/Actual Origins

The extent to which the actual origins of the risk currently impact on the strategic risk.

- The origin of the strategic risk is significantly impacting on the risk.
- The origin of the strategic risk is still impacting on the risk to a limited extent.
- The origin of the strategic risk is no longer impacting on the risk.

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

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2015/16

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-15	TARGET RISK SCORE Mar-16		
	N/A	N/A	4x2=8	4x2=8	3x2=6		

What is the strategic risk to be controlled?					
REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE		
CR1 15-16	**Failure to maintain and enhance the quality and safety of the patient experience and ensure compliance with CQC Standards**	Medical Director / Director of Nursing and Quality	Quality, Safety & Patient Experience Committee	Amber	↓

LINKED CORPORATE PRIORITIES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
	REF	*What are the key potential consequences (up to 4) of the risk?*
Transforming Care for Patients	PC1	Non compliance with regulatory & commissioner contracts
Concentrating on the right services to meet the needs of our patients	PC2	Risk to Registration & Licence to operate
Understanding patient experience	PC3	Poor patient experience - impact on Trust reputation
	PC4	Breach of Monitors terms of authorisation as a Foundation Trust

Based on those reported to Executive Committee on 12 August 2015

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?*		IMPACT LEVEL (Red Amber Green)	
REF	ORIGIN	RAG	
O1	Kirkup Report	Amber	→
O2	Lampard/Saville Report	Amber	→
O3	Berwick Report	Amber	→
O4	CQC Fundamental	Amber	→
O5	Compliance with Trust policies and procedures	Amber	→
O6	Failure to observe Trust values - cultural issues	Amber	→
O7	Demographic/needs of local population	Amber	→
O8	Environment needs/estates issues/use of space	Amber	→
O9	Capacity issues - patient experience	Amber	→
O10	Workforce skills/competencies	Amber	→

The risks are CONTROLLED by… *What are the key controls (up to 10) that are in place to mitigate these risks?*		Strength (Red Amber Green)	Movement
REF	CONTROL	RAG	
C1	Completion and regular review of provider compliance assurance (PCA) framework	Green	→
C2	Monitoring of performance with commissioners including visits	Green	→
C3	Regular reviews CQC IM reports & fundamental standards	Green	→
C4	Quaterley CQC relationship meetings	Green	→
C5	Open communication with commissioners and CQC re any concerns identified by the Trust	Green	→
C6	Staff engagement programme	Amber	→
C7	Montly quaterly metrics and KPIs review	Green	→
C8	Francis report recommendations embedded into dedicated workstreams	Green	→
C9	Clinical Rounds/unannounced clincial reviews	Green	→
C10			

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.*			Strength (Red Amber Green)	Movement
REF	REPORTING MECHANISM	FREQUENC	RAG	
R1	Quarterly, Safety & Patient Experience Committee (NED Chair)	Monthly	Green	→
R2	Quality Compliance Group	Bi-monthly	Green	→
R3	CCG quality performance meetings	Monthly	Green	→
R4	Council of Governors	Bi-monthly	Green	→
R5	Trust Governors Quality Forum	6 weekly	Green	→
R6	Board of Directors	Bi-monthly	Green	→
R7	External Stakeholders visits € e.g. Healthwatch	As required	Green	→
R8	Various groups reporting to he Quality, Safety & Patient Experience Committee i.e. safeguarding strategy	Monthly/bi-monthly	Green	→
R9	Corporate Directors Group	Monthly	Green	→
R10	Patient Experience Operational Group	Monthly	Green	★

These are the POSITIVE ASSURANCES actually received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R6/R9	Integrated Performance report dashboard	01-Sep-15
R1/R6	Francis Report Action Plan	07-Jul-15
R6	Picker Inpatient Survey Results	07-Jul-15
R6	Saville Report Update	07-Jul-15
R6	Adult Safeguarding Annual Report	07-Jul-15
R1	Morecombe Bay/Kirkup Report local response	20-Jul-15
R6	6 Monthly Safer Staffing Review	01-Sep-15
R6	6 Monthly Nursing and Midwifery Strategy Update	01-Sep-15
R6	Patient & Staff Stories	07/07/2015 & 1st Sept 15
R6	Safeguarding Childrens Annual Report	01-Sep-15
R6	Domestic Abuse Annual Report	01-Sep-15
R1	Sign up to Safety Q1 Report	20-Jul-15
R1/R6	Risk and Patient Safety Annual Report	20-Jul-15
R1	Human Tissue Authority Insepction Report	20-Jul-15
R1	Patient Experience Annual Report	21-Sep-15
R1	Patient Experience Operational Group	21-Sep-15
R1	Aggregated Complaints, Claims and Incidents Report	21-Sep-15
R1	Aqua Safety Report (Q1)	21-Sep-15

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in

REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Lack of Side Rooms	Estates Strategy includes a plan for the increase in side rooms. Initial plans in place to supoprt the SMART centre to reduce incidences of HCAI	Q2 15/16	Key point on Estates Strategy - on-going
G2	Mortality (Outlier in Weekend Mortality)	Revise mortality process, link to Datix system, embeded new benchmarking model to supoprt timely review of deaths and trends.	EndQ2 15/16	Completed
G3	Poor Safeguarding Training Compliance (Adult & Children)	Specific actions plans in place to improve compliance above target of 85% (monthly review in place with Direcor of Nursing & Quality	Review Q2 15/16	(on track) Q4 15/16
G4	Poor Compliance with Consent Processes	Consent Group in place with action plan. Policy currently under review. Further clinical engagement required to ensure good compliance. Emphasis on MCA compliance	Q3 15/16	
G5	DoLS - new legislation in place re definition of consent	Process has been reviewed, prioritising risk assessment but full implementation required.	Review end Q2 15/16	Q4 15/16
G6	Poor Compliance with correct Patient Identification (3 Never Events)	Trust Action Plan in place. Clinical lead identified. Close monitoring of incidents being undertaken. Policy under review	Q4 15/16	
G7	Poor compliance of WHO checklist within the Interventional Radioogy Dept	Action Plan in place, aligning audit plan with that of theatres WHO audit. Team development underway. Further clinical engagement required to support culture change	Q3 15/16	
G8	Capacity issues due to lack of social care provision (Demographic changes in the population)	Operations meetings in place, purchasing extra capacity for Winter, risk of increased patient harm due to delays in transfers of care/discharges. Stabilisation plan in place	Review Q3 15/16	
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2015/16

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-15	TARGET RISK SCORE Mar-16		
	N/A	N/A	4X4=16	4x3=12	4x2=8		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR2 15-16	Inability to effectively stabilise acute patient flow	Deputy Chief Executive	Finance and Integrated Governance	Red	→

LINKED CORPORATE PRIORITIES *(up to top 3)*
Driving integrated care in Western Cheshire
Promoting sustainable partnerships
Transforming care for patients

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Demand exceeds capacity leading to long waiting times needs nor detail ?
PC2	Failure to achieve waiting time and financial targets
PC3	Impact on overall viability of the Trust

Based on those reported to Executive Committee on 12 August 2015

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?*		IMPACT LEVEL *Red Amber Green*	
REF	ORIGIN	RAG	
O1	Resilience of community and voluntary sector	Amber	→
O2	Cross border issues	Amber	→
O3	Demographic of local population	Amber	→
O4	Local authority and health constraints on budgets	Amber	→
O5	Historical failure of commissioners to deliver demand management approaches	Red	→
O6	Insufficient understanding of the organisational capacity/specialist staff shortage	Amber	→
O7	Number of medically optimised patients and delayed transfers of care	Red	→
O8	High cost of agency / locum staff (Nursing / Medical Groups)	Red	→
O9	Operational pressures and impact on retention/health and wellbeing appraisals, mandatory training etc	Amber	→
O10			→

The risks are CONTROLLED by… *What are the key controls (up to 10) that are in place to mitigate these risks?*		Strength *Red Amber Green*	Movement
REF	CONTROL	RAG	
C1	Agreed capacity and demand analysis	Amber	→
C2	Daily monitoring of perfromance and improved escalation process	Green	→
C3	Ambulatory Care /Frailty Service	Green	→
C4	Early supported discharge	Green	→
C5	Specialty Business Packs/Plans	Green	→
C6	Winter Resilience Planning	Amber	→
C7			
C8			
C9			
C10			

The REPORTING mechanisms are… *What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.*			Strength *Red Amber Green*	Movement
REF	REPORTING MECHANISM	FREQUENC	RAG	
R1	Finance and Integrated Governance Committee	Bi -Monthly	Green	→
R2	Corporate Directors Group	Monthly	Green	→
R3	Board of Directors	Bi -Monthly	Green	→
R4	Daily reporting	Daily	Green	→
R5	Weekly reporting	Weekly	Green	→
R6	Stabilisation Leadership Board	Monthly	Amber	→
R7	Quarterly performance Reviews with divisions	Quarterly	Green	→
R8	Reporting to Commissioners & Monitor	As required	Green	→
R9	Monitor 2 day review visit	As required	Green	→
R10				

These are the POSITIVE ASSURANCES actually received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R1	Integrated Performance Report	04.02.15
R7	Contract meeting update	Jan-15
R1	STAR Chamber meetings	Dec 14/Jan 15
R2	Approval of performance management system implementation	28.01.15
R4	ESIT report with ED	Mar-15
R2	Introduction of weekly Operation Performance Meeting (Chaired by DOO)	May-15
R2	Stabilisation to Transform Paper	Jun-15
R3	Emergency Department update to Board	Aug-15
R3	Update on winter planning to Board	Oct-15

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Review of patient flow across health system	ESIT review commissioned by CCG	Q2 15/16	Complete
G2	Stabilisation across health system	Roll out of Stabilisation programme of work including urgent care hub, complex care, elective pathways, infection control, medicines management	Q2 15/16	Complete
G3	Patients being discharged appropriately	Roll out of Discharge to Assess	Q2 15/16	Complete
G4	Lack of Community bed capacity and increase in demand	Escalated to System Resiliance Group	Q3 15/16	
G5	Lack of community beds	Potential Trust commissioning of additional community capacity	Q4 14/15	
G6				
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2015/16

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-15	TARGET RISK SCORE Mar-16		
	N/A	N/A	4x3=12	4x3=12	4x1=4		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR3 15-16	Failure to maintain, 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)*
The foundations for change to happen
Concentrating on the right services to meet the needs of our patients
Services focused on improving health

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 commissioner specification or local need
PC3	Failure to develop integrated plan leading to quality and safety being risked by approach to financial savings
PC4	Short term based decision making putting the long term viability of the organisation at risk

Based on those reported to Executive Committee on 12 August 2015

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	IMPACT LEVEL (Red Amber Green) RAG	Movement
O1	Long term contractual and commissioning intentions / regional / local	Amber	→
O2	National specialised service specifications / Royal College standards	Amber	→
O3	Maintaining 24/7 acute rota's / EWTD / Limitations of A4C / Doctor contracts / 7 day services	Amber	→
O4	Planning for Demographics (Patient and Workforce)	Amber	→
O5	Maintaining market share	Amber	→
O6	Future tariff/ Pbr framework / Better Care Fund	Amber	→
O7	Cross border protocols	Amber	→
O8	Lack of integrated system wide plan (strategy, finance and workforce)	Amber	→
O9	Future skills shortages	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	Movement
C1	Operational plan process and production	Green	→
C2	Annual refreshed five year LTFM	Green	→
C3	Financial assumptions based on a shared understanding with commissioners	Green	→
C4	People & OD Strategy	Amber	→
C5	Various partner workshops and networks	Green	→
C6	Nurse staffing review	Green	→
C7	Systematic service review process / Countess 20:20	Green	→
C8	Governor workshops	Green	→
C9	5 year Strategic Plan	Green	→
C10			

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	FREQUENC	Strength RAG	Movement
R1	Corporate Director Group	Monthly	Green	→
R2	Finance and Integrated Governance Committee	Bi-Monthly	Green	→
R3	Board of Directors Meeting	Bi-Monthly	Green	→
R4	Annual General Meeting	Annual	Green	→
R5	Monitor APR process	Annual	Green	→
R6	CCG review meetings	Monthly	Green	→
R7	External submissions	As required	Green	→
R8	CoCH and Wirral Team to Team	As required	Green	→
R9	Strategic Leaders Group	Monthly	Green	→
R10	CRS Working Group	Weekly	Green	→

These are the POSITIVE ASSURANCES actually received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R1	Urology Business case	Mar-15
R8	Urology, Clinical Haematology and Orthoapedics service reviews	Feb-15
R3	Bariatric Paper	Mar-15
R9	Integrated Therapies paper	Jul-15
R10	HQQCL workstreams	Monthly
R8	WUTH strategic workshop & recovery plan	Dec-15
R3	Model hospital development presentations	Nov-15
R5	Monitor feedback letter	Nov-15

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Informatics Strategy	Develop strategy and EPR replacement plan	Q4	Q4 15/16
G2	Long Term Efficiency plan	Development of new CRS approach- external support being considered	Q3	Q3 15/16
G3	People and OD Strategy not communicated across the organisation	To be communicated to all staff groups inline with review of organisation culture. Annual Plan agreed for 15/16. To be discussed at POD March 2015.	Q2	Q1 15/16
G4	Innovation working	Roll out of Innovation work with University	Q2 15/16	Q4 15/16
G5	Stabilisation and Transformation of services	Roll out of Stabilisation workstreams	Q2 15/16	
G6				
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2015/16

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-15	TARGET RISK SCORE Mar-16		
	N/A	N/A	4x3=12	4x3=12	3x3 = 9		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR4 15/16	**Failure to develop and deliver the Trust's culture, values and staff engagement plan.**	Director of HR & OD	People and Organisational Development	Amber	→

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

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

Based on those reported to Executive Committee on 12 August 2015

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	IMPACT LEVEL (Red Amber Green) RAG	
O1	Academic research impact of staff experiences on patient experiences	Green	★
O2	CQC Well Led Domain requirements & key lines of enquiry	Green	↓
O3	Quality, Safety, Financial & Operational metrics: Never Events/SUI's	Green	↓
O4	Feedback from National SOS/SFFT/GMC Trainee Survey/Student Satisfaction Survey	Green	↓
O5	Operational pressures and impact on culture / values / behaviours / appraisals / leadership	Amber	→
O6	Promoting openness and honesty - Speak out Safely, Duty of Candour	Green	→
O7	Research from Model Hospital programme - levels of bullying & harassment within the NHS / COCH, feedback from focus groups	Green	★
O8			
O9			
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 (Red Amber Green) RAG	Movement
C1	Board support for Shaping our Culture with Exec and Non-Exec Leads incl. Exec walkabouts	Green	→
C2	SPF/MSC support to champion - including resource Regular shadowing/walkabouts- SPF /MSC/Head of L&D	Green	→
C3	Creation of Listening points across the Trust including promotion of Speak out Safely and Sign up to Safety	Green	→
C4	Regular Pulse Checking via SFFT/SOS/GMC trainee surveys/Student Exp surveys	Green	→
C5	Improving Communication to front line staff, Countess Briefing, Staff Stories, Health & Well-Being support	Green	↓
C6	Leadership Development Programmes- Countess 20:20, Clinical Leaders Dev. Prog & Releasing Potential Prog.	Green	→
C7	Master Class Programme	Green	→
C8	Development of Coaching skills prog. and Coaches/Mentors/Buddy schemes	Amber	→
C9	Development of Middle Manager /Team Leader programmes. support and skills pathways	Green	→
C10	Reviewing the process for recognising our people & Celebration of Achievement Awards	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	FREQUENC	Strength (Red Amber Green) RAG	Movement
R1	Board of Directors reports	Bi-monthly	Green	→
R2	People and OD Committee	Bi-monthly	Green	→
R3	Partnership Forum / Local Negotiating Committee	Monthly	Green	→
R4	Senior Management Team	Monthly	Green	→
R5	Council of Governors	Bi-monthly	Green	→
R6	HR Performance Board	Bi-monthly	Green	→
R7	Corporate Directors Group	Monthly	Green	→
R8	GMC Trainee Survey (E) Student Experience Survey	Annual/ open all year	Green	→
R9	Multi Disciplinary Education Committee	Bi-monthly	Green	→
R10	SOS and SFFT Surveys	Annual/Quarterly	Green	→

These are the POSITIVE ASSURANCES actually received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R1/ R3	Informal Board and SPF workshops undertaken reviewing culture/ staff experience/engagement	01-Mar-15
R1/R7	Shaping our Culture - Investment in our future. Resourcing paper to CDG agreement to proceed	22-Apr-15
R2/R3	People & OD Committee / SPF- How are we doing for our people monthly report	24-Nov-15
R1/R2	Staff Survey/SFFT Report to Board of Directors with associated action plan. Monitored by POD.	24-Nov-15
R2/R3	NED support- NED Chair and another NED member of People & OD Comm. NED Chair SPF.	24-Nov-15
C5	Staff Engagement - Team Countess Newsletter	24-Nov-15
C7	Master class series - planned throughout the year. Next date planned 28/10/15	28-Oct-15
R2/R9	Leadership Programmes in place - 20:20, Clinical Leaders, Releasing Potential	15-Sep-15
R1/R2	Recognition and Celebration of Achievements informal and formal systems in place	27-Nov-15
C5	Health & Well Being Strategy and Steering group with associated activities and support in place	23-Sep-15
C5	Implementation of Schwartz Rounds, with a commitment to support for 2 years	01-Feb-15
R1/R2/R9	Compliance Reports (Appraisal/Mandatory Training/Local Induction) BOD, People & OD, MDEC	24-Nov-15
C4	Student Experience/Satisfaction Surveys - open all year Multi -Prof Practice Placement meeting	22-Sep-15
C4/R9	GMC Trainee Survey- reported to Multi-Disciplinary Education Committee	02-Jul-15
C5	Staff Open Forums- monthly	18-Nov-15
O7	Focus groups & trust wide survey to support model hospital programme	09-Dec-15
C5	Implementation of Countess Brief & cascade process, supplemented by new intranet	21-Sep-15
O6	Exec attendance at monthly education programmes e.g. CHAPS for SOS discussion.	07-Sep-15
O7	Barometer group established as part of Model Hospital programme, with focus groups undertaken	09/12/2015

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Coaching skills prog. and Coaches/Mentors/Buddy schemes being developed/implemented.	Commence delivery of schemes from October 2015 onwards, following recruitment of resources. Supporting in NWLA coaching skills programme.	Q3 15/16	
G2	Middle Manager /Team Leader programmes. support and skills pathways in development/ implemented	Scoping commenced October 2015 onwards, following recruitment of resources. Will complement CLP, Countess 2020 & Releasing Potential programmes.	Q3 15/16	
G3	MSC support to champion - including resource. Expressions of interest asked for at recent meeting	Topic discussed at June MSC. Expressions of interest are awaited - follow up at next MSC.	Q2 15/16	
G4	Creation of Listening points being developed including Shadowing/walkabout programme	Initial plans developed & delivery of schemes from November 2015 onwards, following recruitment of resources.	Q2 15/16	
G5	Improved Comms/Engagement -reaching front line staff, Team Briefing, Staff Stories being developed	Joint Patient / Staff Exp Comms & Culture group established with joint working across Director of Nursing & Quality & Director of HR & OD, with key leads.	Q2 15/16	
G6	Refreshed Speak out Safely programme to be launched	Review of processes and concerns raised to date undertaken by SOS steering group (June 2015). Next phase of communication under development.	Q2 15/16	
G7	Culture Journey/ Staff Engagement/Experience strategy to be developed	Draft being produced for discussion with stakeholders during July 2015, undertaken in conjunction with revised Learning, Education & Development strategy	Q2 15/16	
G8	Pressures of capacity and demand on staff and ability to manage pressures	Additional standing agenda item added to POD meeting for divisions to raise concerns. Supported by regular OH & 1st of Month walkabouts & other interventions.	Q2 15/16	
G9	Performance Culture project developed as part of Model Hospital programme	SH & IH commissioning support, project plan and series of actions to focus on development of values, behaviours & project to support Performance Culture.	Q3 15/16	
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2015/16

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE			TARGET RISK SCORE		CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	Mar-16	Mar-17		
	4x3=12	4x3=12	4x3=12	4x2=8	4x3=12		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR5 15-16	Failure to deliver in year financial plan and manage consequences of delivering a deficit budget	Chief Finance Officer	Finance & Integrated Governance Committee	Amber	→

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 meeting the Financial Sustainability Risk Rating and subsequent Monitor escalation process
PC2	Negative financial impact on local economy
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

Based on those reported to Executive Committee on 12 August 2015

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	IMPACT LEVEL (Red Amber Green) RAG	Movement
O1	Contract penalties / fines	Red	→
O2	Delivery of CQUIN Schemes	Amber	→
O3	Investment in 7 day services	Amber	→
O4	Recurrent funding of existing transitional schemes	Red	→
O5	Identification and Operational delivery of efficiency schemes	Red	→
O6	Increased demand in emergency care, impact on flow and successful implementation of D2A model	Red	→
O7	Medical & nursing pay pressures - gaps and acuity leading to high agency usage	Red	→
O8	Poor budgetary management and control	Amber	→
O9	Increase in elective demand impacting on exisiting capacity to deliver	Amber	→
O10	Commissioner affordability, consequent intentions and special measures	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	Production of Annual Budget and Monitor Forward Plans and Templates	Green	→
C2	Proactive horizon scanning of potential tender to identify risks and opportunities	Green	→
C3	Robust performance monitoring and financial management control	Amber	→
C4	Budget review meetings and regular updates on efficiency schemes including stock take meetings through the Performance Framework, weekly QFWG meetings and governance arrangements	Amber	→
C5	Variable Pay and Non Pay Control working groups	Amber	→
C6	Workforce planning and international recruitment	Amber	→
C7	Robust contractual monitoring information to inform contract negotiations	Green	→
C8	Audit reports/assessments/reviews	Green	→
C9	Project group established to assess the impact of seven day services	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	FREQUENC	Strength RAG (Red Amber Green)	Movement
R1	Board of Directors	Bi-monthly	Green	→
R2	Finance & Integrated Governance Committee	Bi-Monthly	Green	→
R3	Commissioner contract meetings (WC / BCU / NHSE) (E)	Monthly	Green	→
R4	Finance Sub Committee	Monthly	Green	→
R5	Monitor (E)	Monthly	Green	→
R6	Divisional Board Meetings	Monthly	Green	→
R7	Quality, Safety & Patient Experience Committee	Monthly	Green	→
R8	Council of Governors	Quarterly	Green	→
R9	Corporate Directors Group	Monthly	Green	→
R10	Audit Committee	Quarterly	Green	→

These are the POSITIVE ASSURANCES actually received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R1	Integrated performance Report including exceptions	Monthly
R1	Annual Budget and Efficiency Plans	Need date or frequency
R3	Performance Report to Commissioner Meetings	Monthly
R5	Monitor Templates & Report	Monthly
R7	CQUIN update to Quality, Safety & Patient Experience Committee	Monthly
R10	Annual Report sign off as going concern	Need date or frequency
R3	Agreement of NHSE Contract baseline on 2/7/15	Need date or frequency
R1	Informal feedback from Monitor Visit	Need date or frequency
R6	Implementation of Confirm & Challenge Process with Divisions	Need date or frequency
R6	First stage intervention for budget holder performance	Need date or frequency
R5	Formal feedback from Monitor - No change to financial plan required	Monthly
R3	Agreement of WCCCG Contract	Monthly
R1	Initial feedback from Lord Carter work	Need date or frequency
R5	Quarter two feedback letter from Monitor	Monthly

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Gap and high risk of efficiency plans identified to date	To be risk assessed and monthly meetings with departments to continue to identify further plans	On-going	
G2	Impact of lack of information on Junior doctor rotational gaps and medical vacancies	Pro-active management to anticipate potential gaps and escalation process with Deanery	On-going	
G3	Unknown impact and affordability of 7 day services	Clinical service reviews	On-going	
G4	Control of volumes of medically optimised patients impacting on financial position	Agreement of D2A model	Q2 15/16	
G5	CCG confirmation to continue with existing transformational schemes	CoCh influence and communication of impact if discontinued	Q3 15/16	
G6	Failure to deliver performance and consequent impact of penalties	Divisional action plan in place to deliver RTT	Q3 15/16	

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2015/16

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-16 / Mar-17		
	N/A	N/A	4x4=16	4 x4 = 16 / 3 x 4 = 12		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR6 15/6	Failure to develop and deliver a robust long-term whole health economy service, workforce and financial savings and recovery plan	Chief Executive	Finance & Integrated Governance Committee	Red	→

LINKED CORPORATE PRIORITIES *(up to top 3)*
Driving integrated care in Western Cheshire
Promoting sustainable partnerships
Not expanding the hospital site

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Failure to maintain Monitor Licensing conditions
PC2	Loss of organisational autonomy and control of our own destiny
PC3	Inability to maintain/influence the provision of safe and effective local acute health services

Based on those reported to Executive Committee on 12 August 2015

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	IMPACT LEVEL (Red Amber Green) RAG	
O1	£22bn gap in NHS finances, NET of £8bn additional funding by 2019/20	Red	→
O2	Actual and increasing forecast for underlying recurrent deficits for the Acute sector in West Cheshire - c£23.5m by 2019/20	Red	→
O3	40% growth in the numbers of over 85s living in West Cheshire over the next 5 years	Red	→
O4	12% increase in long term conditions and continued year on year growth in Emergency Admissions (3.5% year on year)	Red	→
O5	Funding reductions in public health c£200m 2015/16	Amber	→
O6	Continued austerity and funding gaps within social care causing knock on pressure in healthcare	Red	→
O7	Workforce demographics, availability and ongoing rota gaps etc.	Red	→
O8	Continued challenge to deliver co-ordinated and integrated health and care services	Red	→
O9	Lack of ability to see the integrated picture of the operational reality of our system in real time	Red	→
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	Estabilished West Cheshire Strategic Leadership Group	Green	→
C2	Stabilisation to Transform Program	Amber	→
C3	Western Cheshire MSCP Vanguard Program	Amber	→
C4	West Cheshire long term financial model	Red	→
C5	West Cheshire Workforce Development Plan	Red	→
C6	Centre for Integrated Health Care Science (Bache Hall)	Amber	→
C7	Lord Carter Review and ongoing work	Amber	
C8			
C9			
C10			

The REPORTING mechanisms are…

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

REF	REPORTING MECHANISM	FREQUENC	Strength RAG (Red Amber Green)	Movement
R1	Board of Directors	Bi-monthly	Green	→
R2	Finance & Integrated Governance Committee	Bi-monthly	Green	→
R3	West Cheshire's Strategic Partnership Board	Monthly	Amber	→
R4	Stabilisation Delivery Committee	Monthly	Red	→
R5	Transformation Delivery Committee	Monthly	Red	→
R6	Corporate Directors Group	Monthly	Green	→
R7				
R8				
R9				
R10				

These are the POSITIVE ASSURANCES actually received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R1	Chief Executive update to Board of Directors	05.05.2015
R3	West Cheshire Strategic Partnership Board update paper on stabilisation program	10.06.15
R3	West Cheshire Strategic Partnership Board update paper on MSCP	10.06.15
R3	Legal advice (Hampson's Report) on establishment agreement for Strategic Leadership Group	10.06.15
R6	Corporate Directors Group - discussion and next steps planning for stabilisation program	24.06.15
	Lord Carter Review Paper published	01-Jun-15
R1	Board Workshop - Model Hospital	14-Dec-15
R4	Relationship Proximity Leadership Workshop	2015 December

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Real time data and system response	Part of rollout work following Lord Carter Review	Q3 15/16	
G2	Invest to save plan c£20m	Workforce, finance, planning, operational and Lord Carter team to produce initial program	14.12.15	
G3	Whole system long term financial model	Part of the system stabilisation plan	Dec-15	Apr-16
G4	16/17 Planning Guidance by Dec 15	Part 1 plan March 2016 and Part 2 System Plan by Q2 2016	Q2 2016	
G5				
G6				
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2015/16

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-15	TARGET RISK SCORE Mar-16		
	N/A	N/A	4X4=16	4x2=8	4x2=8		

What is the strategic risk to be controlled?					
REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE		
CR7 15-16	Failure to comply with Monitor's Compliance Framework - Governance	Deputy Chief Executive	Corporate Directors Group	Red	→

LINKED CORPORATE PRIORITIES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
	REF	*What are the key potential consequences (up to 4) of the risk?*
Transforming Care for Patients	PC1	Monitor escalation process from action plans to formal intervention
Concentrating on the right services to meet the needs of our patients	PC2	Escalation with Commissioners/Area Team/CQC
Understanding patient experience	PC3	Negative publicity & reputational damage
	PC4	Negative impact on staff/patient experience

Based on those reported to Executive Committee on 12 August 2015

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?*		IMPACT LEVEL *Red Amber Green*	
REF	ORIGIN	RAG	
O1	Delivery of Cdiff target/Monitor Board Statement	Green	→
O2	Delivery of Cancer target 62 day	Amber	→
O3	Delivery of A&E target	Red	→
O4	Delivery of the 18 week RTT	Red	→
O5	Number of medically optimised patients and delayed transfers of care	Red	→
O6			
O7			
O8			
O9			
O10			

The risks are CONTROLLED by… *What are the key controls (up to 10) that are in place to mitigate these risks?*		Strength *Red Amber Green*	Movement
REF	CONTROL	RAG	
C1	Daily bed meeting	Green	→
C2	ECIST Review of 4hr target	Amber	→
C3	Clinical Streaming in A&E	Green	→
C4	Ambulatory Care and Early supported discharge to aid patient flow	Green	→
C5	Daily monitoring of cancer patients and improved escalation process	Green	→
C6	Root Cause Analysis for each case of Cdifficile	Green	→
C7	Intensive hygiene regime and monitoring	Green	→
C8	Introduction of Alamac 'Kitbag'	Green	→
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? (E) = External assurance.*			Strength *Red Amber Green*	Movement
REF	REPORTING MECHANISM	FREQUENCY	RAG	
R1	Corporate Directors Group	Monthly	Green	→
R2	Finance & Integrated Governance Committee	Bi-monthly	Green	→
R3	Board of Directors	Bi-monthly	Green	→
R4	Commissioner contract meetings (WC) (E)	Monthly	Green	→
R5	Monitor	Quarterly	Green	→
R6	Quality, Safety & Patient Experience Committee	Monthly	Green	→
R7	Infection Control Committee	Quarterly	Green	→
R8	Council of Governors	Quarterly	Green	→
R9	Urgent Care Working Group (E)	Monthly	Green	→
R10				

These are the POSITIVE ASSURANCES actually received… *What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective.*		
REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R1	integrated performance Report/key exceptions & Risk Register	Monthly
R2	integrated performance Report & Risk Register to FIGC	Bi monthly
R3	integrated performance Report to BoD	Bi monthly
R4	Performance Report to WC Quality & Performance meeting	Monthly
R5	Monitor Templates & Report	1-Jan-15
R7	Efficiency & budgetary position to QVDT meeting	Weekly
	System wide winter plan now monthly item at Urgent Care Working Group	Monthly
	STAR Chamber meetings	Dec 14/Jan 15
R1	Changes to Ward 40 and 53	24.02.15
R2	NHS England 18 week validation report	22.04.15
R2	Cancer 62 day achived February & March	22.04.15
R4	ECIS report with ED	Mar-15
R2	introduction of revised new integrated perfromance report with exception reporting	May-15
R2	External review of 18 week processes	Jun-15
R2	introduction of weekly Operation Performance Meeting (Chaired by DOO)	May-15
R3	Emergency Department update to Board	Aug-15
R3	Winter planning update to Board	Oct-15
R3	Cancer update to Board	Oct-15
R2	Further validation of 18 week position and reported to Board	Nov-15

The GAPS IN CONTROL / NEGATIVE ASSURANCES are… *What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?*				
REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Lack of validity of PTL (18 weeks)	NHS England on site	Q4 14/15	Complete
G2	Medically optimised patients / delayed transfers of care patients	Due diligence on 300 virtual beds ongoing	Q2 15/16	Complete
G3	Cancer performance	Implementation of key actions identified in action plan	Q3 14/15	Ongoing
G4	Performance report	Review and implementation of performance report	Q1 15/16	Complete
G5	18 week rules	Review of current rules and action plan	Q1 15/16	Complete
G6	ED performance relation to workforce	Stabilisation plan for ED doctor breaches in relation to middle grade doctor gaps	Q2 15/16	Complete
G7	18 week failure of incomplete pathway	Development of actions to address 18 weeks and longest waiters	Q3 15/16	
G8	Lack of community beds	Potential Trust commissioning of additional community capacity	Q4 14/15	
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2015/16

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-15	TARGET RISK SCORE Mar-16		
	N/A	3x1=3	3x1=3	3x2=6	3x2=6		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR8 15-16	Failure to maintain robust corporate governance and overall assurance	Director of Corporate & Legal Affairs	Board of Directors	Green	→

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

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

Based on those reported to Executive Committee on 12 August 2015		IMPACT LEVEL Red Amber Green	
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	RAG	
O1	Significant number of changes to Board of Directors membership	Green	→
O2	Review of the Governance Framework	Green	→
O3	Failure to triangulate outcomes of Board committees	Green	→
O4	Health and Social Care 2012 - training for Governors	Green	→
O5	Board development	Green	→
O6			
O7			
O8			
O9			
O10			

The risks are CONTROLLED by…		Strength Red Amber Green	Movement
What are the key controls (up to 10) that are in place to mitigate these risks?			
REF	CONTROL	RAG	
C1	Board Assurance Framework review	Green	→
C2	Revising staffing structure clinical and non-clinical risk teams	Green	→
C3	Control by the Executive Team/COG/BOD	Green	→
C4	Discussions with MIAA and KPMG regarding the Governance Framework	Green	→
C5	Legal services claim management reports	Green	→
C6			
C7			
C8			
C9			
C10			

The REPORTING mechanisms are…			Strength Red Amber Green	Movement
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	RAG	
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 Senior Management Team	Bi-monthly	Green	→
R4	Monitor / CQC / WC CCG	As required	Green	→
R5	Weekly reporting to Execs	As required	Green	→
R6				
R7				
R8				
R9				
R10				

These are the POSITIVE ASSURANCES actually received…		
What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective.		
REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R5	Provided an update at the Weekly Executive meeting	1-Aug-15
R1	Provided an update to the Board of Directors	01.09.15
R2	Provided an update to the Council of Governors/Governors Quality Forum	04.09.15
	Regular communication and discussion with the Chairman	04.09.15
R1	Full refresh of the Board Assurance Framework	1-Dec-15
R1	Provided update to Audit Committee	18.04.15
	Full review of Risk Management Strategy	22.01.14
R5	Executive Team Development Programme underway	07.08.15
R1	Corporate Governance Manual presented to Board	04.03.14
R5	Corporate Directors Group - role of group reviewed and developed	25.02.15
R5	Planning for corporate governance self assessment	1-Feb-15
	People and Organisational Development Comm approved as formal Board Sub-Committee	03.03.15

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…				
What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?				
REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Flow of data from operational meetings through the Governance Framework	SPC to communicate with Board committee chairs/Exec Team to formalise the flow of information from operational committess reporting up to Board Committees	Q1 15/16	Q2 15/16
G2				
G3				
G4				
G5				
G6				
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - 25/11/15

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-16	TARGET RISK SCORE Mar-17		
	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				
CR9	Failure to maintain Information Governance standards	Medical Director	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
IMPACT ON CQC CORE OUTCOMES	PC3	Adverse impact on Trust's reputation resulting from adverse publicity
What are the Outcome Reference Numbers?	PC4	Information Commissioners Office (ICO) impose a fine

REFERENCES OF KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK Based on those reported to Informatics Board	25/11/2015	IMPACT LEVEL	Movement
		Red Amber Green	

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	RAG	
O1	Unintended loss of confidential or valuable data (clinical, corporate & employee) e.g. lost ward handover sheet	amber	→
O2	Misdirection of confidential or valuable data to an individual or individuals e.g. incorrectly addressed letter	amber	→
O3	Incorrect disposal of data media or its content that does not protect confidentiality e.g. confidential waste in a non-confidential bin	amber	↓
O4	Inadequate security practices that enable inappropriate access to confidential/valuable data e.g. generic usernames and passwords	amber	→
O5	Inadequate security controls that enable inappropriate access to confidential/valuable data e.g. paper records accessed on a ward	amber	→
O6	Access to confidential/valuable data is incorrectly provided to individuals e.g. staff granted system access beyond role based needs	green	→
O7	Confidential/valuable data shared to a public domain or an unsecured area inappropriately e.g. provision of payroll details for mailshot	green	→
O8	Confidential or valuable data retained for longer than is mandated by the Department of Health e.g. Meditech records kept indefinitely	amber	→
O9	Security controls/data media used puts at risk access/legibility/accuracy of data e.g. temporary staff without legitimate data access	green	→
O10	Intentional (approved/unapproved) disposal/transfer of confidential/valuable data, inappropriately e.g. child records weeded at 7yrs	amber	→

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	95% of staff undertook Information Governance training within the last ~~2yrs~~ year	red	↓
C2	Information Governance and IT Security policies and procedures	green	→
C3	Use of technology and data sharing agreements to support secure transmission and sharing of data	green	→
C4	Use of encryption to secure data on portable devices	amber	→
C5	Secure disposal of sensitive, confidential and person identifiable waste (paper and electronic)	amber	→
C6	Data flow mapping	amber	→
C7	Maintain up-to-date Information Asset Register	amber	→
C8	Members of the Information Governance Panel and Caldicott Panel fully trained	green	→
C9	Appropriately qualified Information Governance Manager	green	→
C10	Identified and trained Caldicott Guardian and Senior Information Risk Owner	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? (E) = External assurance.			*Red Amber Green*	
REF	REPORTING MECHANISM	FREQUENCY	RAG	
R1	Risks and incident trends reported to the Informatics Board	monthly	green	→
R2	Risks and incidents reviewed by the Caldicott & IG Panel	monthly	green	→
R3	Bi-Annual IG and Annual Caldicott reports to the Informatics Board	bi-annual/ annual	green	→
R4	Significant incidents reported through STEIS	As required	green	→
R5	Significant incidents reported to the Information Commissioners Office	As required	green	→
R6	Audits reviewed by the Informatics Board and Action Plans tracked	As required	green	→
R7	Information Governance plan updates to the Informatics Board	Quarterly	green	→
R8	Exec Team receives updates on significant risks and issues	Weekly	green	→
R9	Finance & Integrated Governance receives Informatics Board minutes	Bi-Monthly	green	→
R10	Audit & research data requests reviewed by Caldicott Panel	monthly	green	→

These are the POSITIVE ASSURANCES actually received…		
What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective.		
REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
A1	Independent review of Information Governance presented to Executive Directors	Dec-13
A2	ICO Data Protection Audit Report (Limited Assurance)	Jul-13
A3	IT Health Check (including Penetration Test) report received	Aug-14
A4	Routine email communications relating to IG alerts and threats	On-going
A5	MIAA IGT Audit - mandatory (Significant Assurance)	Mar-15
A6	2014/15 Information Governance Toolkit Submission 72% - Level 2 Compliance	Mar-15
A7	Bi Annual Information Governance report received by Informatics Board	Jul-15
A8	Annual Caldicott report received by Informatics Board	Nov-15
A9	MIAA Core IT Infrastructure Review (Significant Assurance)	Jan-15
A10	NHS.Net email secure encryption implemented; reviewed and approved by the IG Panel	Jun-15
A11	Information Security Officer - Qualified HealthCare Information Security and Privacy Practitioner	Nov-15

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…				
What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in				
REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G3	Secure disposal of sensitive, confidential and person identifiable paper waste	Let new contract for secure confidential waste bins and disposal	Q1 14/15	Q4 15/16
G4	Extend data flow mapping	Continue work on data flow mapping, assess progress annually	Q4 15/16	
G5	Extend Information Asset Register	Continue work on Asset Register, assess progress annually	Q4 15/16	
G6	Members of the Information Governance Panel and Caldicott complete 15/16 training	Appropriate online training undertaken by all panel members	Q4 15/16	
G7	Dictation devices not encrypted	On-going rollout of digital dictation and replacement of dictation devices without encryption	Q4 16/17	
G9	Electronic equipment including medical devices disposed of without removal of unencrypted confidential patient data	Undertake review of electronic equipment, including medical devices, to understand the risk of unencrypted confidential patient data not being disposed appropriately	Q3 14/15	Q4 15/16

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - 25/11/15

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-16	TARGET RISK SCORE Mar-17		
	4x4=16	4x4=16	4x3=12	4x3=12	4x2=8		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR10	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
IMPACT ON CQC CORE OUTCOMES	PC3	That the staff user experience is suboptimal and does not facilitate the delivery of high quality care
What are the Outcome Reference Numbers?	PC4	That the organisation is unable to deliver current services efficiently and/or plan to meet future service requirements

REFERENCES OF KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK Based on those reported to Informatics Board	25/11/2015	IMPACT LEVEL	Movement

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

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	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	green	→
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	red	→
C6	Up-to-date and fit for purpose Informatics Strategy which is owned by the business	red	→
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…			Strength	Movement
What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.			Red Amber Green	
REF	REPORTING MECHANISM	FREQUENCY	RAG	
R1	Informatics strategy reviewed by the Informatics Board	annual	red	→
R2	Annual Plan reviewed and approved by Informatics Board	quarterly	green	→
R3	Informatics Board monitoring project progress (value >£50k)	as required	green	→
R4	Informatics service Key Performance Indicators	quarterly	green	→
R5	Audits reviewed by the Informatics Board and Action Plans tracked	as required	green	→
R6	Finance & Integrated Governance receives Informatics Board minutes	bi-Monthly	green	→
R7	Risks and Incidents reported and reviewed at Informatics Board, etc.	monthly	green	→
R8	Informatics Stocktake with Executive Directors	quarterly	green	→
R9	5yr Capital Plan reviewed and approved by Informatics Board	6 monthly	green	→
R10	Receives minutes & updates from appropriate Informatics sub-groups	routinely	green	→

These are the POSITIVE ASSURANCES actually received…		
What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective.		
REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
A1	Independent review of Information Governance presented to Executive Directors	11-Dec-13
A2	ICO Data Protection Audit Report (Limited Assurance)	22-Jul-13
A3	IT Health Check (including Penetration Test) report received	9-Aug-14
A4	ICT Asset Management Audit (Significant Assurance)	1-Apr-13
A5	Waiting List Management Report	1-Dec-13
A6	Participated in national Busting Bureaucracy review of data collection	1-Nov-13
A7	IT Service Continuity Review (Significant Assurance)	27-Mar-14
A8	MIAA IGT Audit (Significant Assurance)	31-Mar-15
A9	2014/15 Information Governance Toolkit Submission 72% - Level 2 Compliance	31-Mar-15
A10	Quarterly Informatics Stocktake undertaken with the Executive Directors	12-Aug-15
A11	MIAA VoIP Audit (Significant Assurance)	16-Dec-14
A12	MIAA Core IT Infrastructure Review (Significant Assurance)	19-Jan-15
A13	HSCIC IT Health Check Report	30-Nov-14

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…				
What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?				
REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G3	Disaster recovery and business continuity plans not developed or tested	Develop timetable for review and testing of plans	Q4 15/16	
G4	Senior Informatics team roles, responsibilities and structures not currently fit for purpose	Review and update job descriptions, bandings and structure of the senior Informatics team	Q1 14/15	Q3 15/16
G5	Inadequate Informatics staff development and no professional accreditation	Develop Informatics as a profession Achieve foundation level ISD accreditation	Q4 14/15	Q4 15/16
G11	Absence of Informatics/Digital Strategy	Develop and present new Informatics/Digital Strategy to Board of Directors	Q4 14/15	Q3 15/16
G13	Inadequate information reporting tools	Implement new QlikView reporting solution for 18wks and Quality	Q2 15/16	Q3 15/16

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2015/16

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-15	TARGET RISK SCORE Mar-16		
	N/A	N/A	4x3=12	4x3=12	3x3 = 9		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR11 15-16	Failure to recruit and retain professional staff	Director of HR and OD	People and Organisational Development	Amber	→

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
Transforming care for patients

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Possible reduction in services and poor patient experience / staff experience
PC2	Use of agency staff / increased costs
PC3	Risk to patients / risk to staff, if inadequate cover
PC4	Requirement to outsource activities

Based on those reported to Executive Committee on 12 August 2015

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?*		IMPACT LEVEL Red Amber Green	
REF	ORIGIN	RAG	
O1	Gaps in junior doctors rotas	Red	→
O2	Lack of suitably qualified candidates in specialist clinical skills e.g. ED Consultants/Sonographers/EBME/Endoscopy/Anaesthetics	Amber	→
O3	Tighter UK border controls for non EU countries / Tier 2	Amber	→
O4	Implications of Nurse Revalidation	Amber	→
O5	Age profile/demographic in some staff groups e.g. Midwifery / Nursing	Amber	→
O6	High cost of agency / locum staff (Nursing / Medical) as monitored by the Variable Pay Programme	Red	→
O7	Commissioning changes e.g. tenders	Green	→
O8	7 day services and additional resource requirements	Amber	→
O9	Operational pressures and impact on retention / health and wellbeing, appraisals, mandatory training etc.	Amber	→
O10			

The risks are CONTROLLED by… *What are the key controls (up to 10) that are in place to mitigate these risks?*		Strength Red Amber Green	Movement
REF	CONTROL	RAG	
C1	Development and communication of People & OD Strategy	Amber	→
C2	Medical staffing gaps, fortnightly reviews & increased Management Information from Med Staffing Team	Green	★
C3	Improved recruitment material and website	Amber	→
C4	Relationship management with Deanery	Green	→
C5	Variable pay agenda & steering group	Green	★
C6	Development and exploration of new and extended roles e.g. Advanced Practitioner, physicians associates	Green	→
C7	Monthly monitoring of safer staffing nurse levels	Green	→
C8	Educational & Leadership programmes for all staff groups	Green	★
C9	Experience and engagement (including use of staff stories)	Green	→
C10	Health and Wellbeing Strategy	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.*			Strength Red Amber Green	Movement
REF	REPORTING MECHANISM	FREQUENC	RAG	
R1	Board of Directors reports	Bi-monthly	Green	→
R2	Finance and Integrated Governance Committee	Bi-monthly	Green	→
R3	People and OD Committee including governance structure e.g. MDEC	Bi-monthly	Green	★
R4	Nursing and midwifery workforce bi-monthly Transformation Group	Bi-monthly	Green	→
R5	Partnership Forum / Local Negotiating Committee	Monthly/Bi-monthly	Green	★
R6	Executive Directors Group	Weekly	Green	→
R7	HRWBS Management Board / HR & OD Performance Board	arterly/Bi-mont	Green	★
R8	Annual Deanery visit (E)	Annually	Green	→
R9	GMC trainee survey (E)	Annually	Green	→
R10	University relationships (E)	Quarterly	Green	→

These are the POSITIVE ASSURANCES actually received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R1/R3	Reporting on agency & variable pay spend. Governance & Steering group established.	24-Nov-15
R1/R3	Reporting to Board /POD on workforce KPIs	24-Nov-15
R3/R4	Nursing and midwifery workforce strategic and operational group	11-Nov-15
R3	Reporting on educational support & performance from Multi-Disciplinary Education Committee	2-Jul-15
R5	Partnership Forum: Staff engagement /staff survey/staff experience/SFFT reviewed monthly	3-Dec-15
R1/R3	Staff survey reported to Board of Directors, with associated action plan in place.	1-Mar-15
R3	Sign off Health Education England return 2015 People & OD Committee	Jul-15
R3	NED Chair for People and OD Committee - March 2015 onwards	9-Jul-15
R1	Appraisal Performance Increases to 89.1% (August 2015)	1-Sep-15
C7	Monthly monitoring of safer staffing & 6 monthly report to the BOD	1-Sep-15
R2	Medical Staffing / Nurse Staffing / Nurse revalidation papers presented to POD	2-Sep-15
C10	Occupational Health visits reported to POD Committee/Partnership Forum including H&WB Strategy	24-Nov-15
R6	Executive '1st of the Month' walkabouts reported to EDG	01-Dec-15
C7	Master class series - planned throughout the year. Next date planned 28/10/15	; 28-Oct-15
C10	Implementation of Schwartz Rounds	01-Feb-15
C10	Development & Launch of Carers Strategy to support members of staff as carers.	01-Jun-15
R5	Exit Interview / How are we doing interviews implemented. Feedback to SPF July 2015.	02-Jul-15
R4	Recruitment of nursing internationally - second cohort undertaken with good levels of retention	11-Nov-15
R4	Monthly Nursing & Midwifery Operational group chaired by Director of Nursing & Quality	11-Nov-15
O9	Forerunner Bids undertaken to HENW to support retention, skill mix & practice development	October / November 2015

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Gaps remain in some medical specialties in junior doctors rota	Detailed review of vacancies being undertaken by medical staffing with extensive support in place in focusing on recruitment. Medical vacancies added to Integrated performance report from September 2015. Medical Staffing team establishment made permanent.	Q3 15/16	
G2	People and OD Strategy being developed.	In development for all staff groups in conjunction with key stakeholders, to include increased profile for recruitment, key roles profile etc. Annual Plan 15/16 agreed. Delayed review to link in with Model Hospital workshops.	Q2 15/16	Q4 15/16
G3	Stronger clinical engagement in recruitment processes, e.g. drafting of JDs and commitment for recruitment timescales	Divisions more involved and accountable, fortnightly monitoring, reviewing value based recruitment. Working with regional group & NHS Employers in relation to agency spend across the region. Part of HQCL Process work stream.	Q3 15/16	
G4	Shortage of certain professions e.g. ultra sonographers and nurses	Reported as part of regional workforce planning return July 2015 Working with University and HENW on Sonographers programme & submitted a number of bids to the Forerunner fund options.	Q3 15/16	
G5	Poor performance and recording of appraisal outside of Trust target, impacted by operational pressures	Monitoring and escalation continuing on monthly basis. Significant improvement in performance and now exceeding CQC target of 85%.	Q4 15/16	
G6	Integrated workforce agenda across West Cheshire	Integrated monthly workforce agenda meeting for HRDs and key leads. Integrated People Strategy developed. Supporting Stabilisation & Transformation agenda.	Completed	
G7	Staff Engagement (Staff Survey/SFFT)	Staff Friends & Family issued all quarters 2014/15. Action plan in place and being monitored by Culture risk & POD. Staff Survey group established with supporting communication. Staff experience governance being developed to report to POD Committee.	Completed	
G8	Pressures of activity on staff and ability to manage pressures	Launch of Health and Wellbeing Strategy / Resilience support. Partnership working / Engagement with Unions. Review Staff survey and SFFT results / Staff engagement experience programme, Schwartz Rounds implemented.	Q3 15/16	
G9	Variable pay spend monitoring & controls.	Weekly task & finish group established. Review of Monitor diagnostic tool. Assessing link with CRS plans and focus on spend related to Bank, Agency, Overtime, ACAs as well as developing controls and increased attention and focus on medical gaps and reducing sickness impact /associated costs.	Q4 15/16	
G10				

BOD Item No

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Safe Nurse Staffing Establishment Review
Date of Meeting	3rd February 2016
Author(s)	Sian Williams, Deputy Director of Nursing & Quality Carmel Healey, Head of Nursing (Planned Care) Karen Rees, Head of Nursing (Urgent Care)
Presented by	Alison Kelly, Director of Nursing & Quality
Annual Plan Objective No.	N/A
Summary	This report is to provide assurance both internally and externally, that ward establishments are safe, and that staff are able to provide appropriate levels of care to patients. This is the fifth nursing establishment review following the publication of the Francis Report and its recommendations. The Trust has a duty to ensure that ward staffing levels are adequate and that patients are cared for safely by appropriately qualified and experienced staff. Reviews must be carried out twice a year in line with the national recommendations. In the main, wards at CoCH do comply with the standards; however, there is an emerging theme of some wards requiring additional resources longer term to support safe patient care. However, the National Quality Board guidance (due out in Spring 2016) introducing the Care per Patient Per Day metric will be important in our work in implementing The Model Hospital.
Recommendation(s)	**The Board is asked to: Note the report and recommendations for future action**
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [X] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Countess of Chester Hospital NHS
NHS Foundation Trust

Biannual Safe Nurse Staffing Establishment Review
January 2016

Authors:

Sian Williams - Deputy Director of Nursing & Quality

Carmel Healey - Head of Nursing, Planned Care

Karen Rees - Head of Nursing, Urgent Care

On behalf of Alison Kelly – Director of Nursing & Quality

Date of Paper: January 2016

Date Presented to Public Trust Board:

Date Presented to CCG:

1.0 Introduction

The purpose of this paper is to ensure the Board receives assurance that patient safety is being maintained in regard to staffing numbers and skills.

The report is also to provide an assurance both internally and externally, that ward establishments are safe, and that staff are able to provide appropriate levels of care to patients.

This is the fifth nursing establishment review following the publication of the Francis Report and its recommendations,. The last was in July 2015. The Trust has a duty to ensure that ward staffing levels are adequate and that patients are cared for safely by appropriately qualified and experienced staff. Reviews must be carried out twice a year in line with the national recommendations. The opportunity has been taken to also include non-ward areas, however on this occasion the Emergency Department staffing has been omitted as a separate whole multi-professional workforce review is being undertaken in this area.

2.0 Summary of Key recommendations and actions taken from the July 2015 nurse staffing establishment review:

- **Care Metrics review**

Full review of the care metrics and roll out in the inpatient areas alongside ongoing work to specialty areas. Improvement standards to be set in January 2016

- **Overseas recruitment to support the vacancy challenge**

Two overseas recruitment events have taken place. Two experienced members of our recruitment team have been to Spain. Between 20 and 30 Spanish RNs have been recruited; some have started and the rest will commence over the next few months.

- **Winter planning involving the Ward Managers**

Ward Managers have participated in a workshop. Ideas and suggestion have been used to support the winter plan that the Trust has prepared

- **Ongoing Skill mix review in specialist areas**

Reviews undertaken by the Urgent Care Division have supported the NNU to convert some unregistered staff hours to RN hours. This will ensure the unit meets BAPM standards when the unit is occupied.

- **Participating in the DH efficiency work programme**

This is an area that is now gathering momentum. The wards are keen to be part of the work that allows them to work efficiently and release time. The wards have

gathered data relating to Nursing Hours per Patient per Day (NHPD) to support this work. This data once agreed will allow the wards to match hours of staffing to the acuity of the patient. It will be more accurate if the case for e-rostering is successful.

The hospital is also reviewing the 'specialing' of patients as part of the DH collaborative work.

3.0 Methodology

As in previous reviews, it must be remembered that the most important factor in any review is the professional judgment of the senior nurses. Their views have supported the use of the following objective information:

- Establishments were compared to July 2015
- Patient Acuity information using the Safer Nursing Care Tool (SNCT) to acute adult inpatient wards (as per national guidance)
- National standards for specialty wards e.g. Intensive Care
- Review of Registered to unregistered staff ratios
- Review of staff to bed ratios in line with current national guidance
- Utilisation of beds and bed occupancy
- Use of nursing quality indicators and key safety and outcome measures
- The review covered the general wards on sites as well as the Emergency Department, Intensive Care Unit and Midwifery services

4.0 Establishments were compared to January 2015

In the last 6 months some increase in staffing has been agreed and additional non recurrent funded posts have been given to individual wards. This has been following discussion with the Heads of Nursing for example: Ward 51 (Frailty Unit)

All inpatient wards have been reviewed, with the Heads of Nursing closely supporting their own Divisional areas throughout this process.

The process to report staffing to the DH is well embedded and is underpinned by an agreed policy.

Overall the Trust reports an acceptable level of hours planned against actual the over 95% for 9 months **(Appendix1)**

It has set its own internal rating – many Trusts have set less than 85% as being a red we have used 90%. The areas that are reporting less staff or in some cases additional staff required are also outlined in the paper

5.0 Review of the bank nurse pay costs versus agency pay rates

The Heads of Nursing review all bank and agency expenditure monthly. They take account of staffing expenditure and cost pressures across both Planned and Urgent Care Divisions.

Agency staff are only approved by the HON/ Matron once all other actions have been taken to address nursing gaps, using the Trusts Safe Nursing & Midwifery staffing policy.

As Divisions continue to experience a high level of vacancies, it remains a challenge to recruit to Registered nursing posts, despite going overseas to attract staff.

The impact of this has resulted in an increase in bank and agency expenditure We continue to monitor the fill rate for bank shifts daily and the gaps that remain in certain areas.

The Heads of Nursing monitor their vacancies across the workforce (which have increased again, as we have not been able to recruit to the level required. This has resulted in an increasing reliance on bank and agency staff to cover gaps in order to maintain patient safety.

Nationally there is evidence that demonstrates that an over reliance on temporary staffing does impact on clinical outcomes. This is due to those staff not being familiar with the specialty or able to carry out the necessary skills required. Divisions have offered some short term temporary contracts to certain agency staff who frequently work in the Trust. They are also provided with some additional training this to mitigate the risk of any adverse outcomes.

6.0 Acuity

The Divisions have progressed with some acuity measurement across the inpatient wards. However, this process still requires refinement as the data is not always an accurate reflection of what is actually happening. The Heads of Nursing will mandate this with the Ward Managers going forward to ensure the data is more robustly captured. However going forward this will also be a pivotal part of the Model Hospital matching the nursing workforce to patient needs.

As previously articulated in other reviews there is no national mandated minimum standards for the general adult wards. However NICE guidance in 2015 made

reference to, but stopped short of mandating a 1:8 Registered Nurses to patient ratio on day shifts.

Once again the review does demonstrate that, in the main, this can be achieved with the current establishments on day shifts, when there are no staffing issues. **(Appendix 2)** There are times however that this is not achieved and Ward Managers are expected to work as part of the 'numbers' in order to maintain patient safety.

7.0 Divisional Reviews

7.1 Adult General wards (Planned and Urgent Care)

The Heads of Nursing have reviewed the staffing establishment with each individual Ward Manager and determined the patient ratio numbers. This demonstrates staff to patient ratio meets the recommended NICE guidance of 1:8 for day shifts. This ratio is then supported by the supernumerary Ward Manager. However, this has been challenging to achieve at times due to the number of vacancies.

Some Ward Managers believe there are specific shifts that need to be reviewed. This requires a more in depth review by the Heads of Nursing. (**Appendix 3)**

Using existing staff budget the Heads of Nursing have increased the number of Band 6 Deputy Ward Manager roles on some wards from one to two. This is to enable more robust support for the Ward Manager. Deputy Ward Managers do not have any 'protected time'. However, they will pick up additional responsibilities during their shifts

The Heads of Nursing acknowledge the need to revisit the 5 day supervisory Ward Manager role as it is not always working as envisaged. This will be a supported piece of work this year. There are managers who despite operational challenges are able to achieve a supervisory status. Information from the recently published RCN report demonstrates that the role is inconsistently applied, due in the main to staff to shortages. It also states that there is varying application from 1-2 days, right up to the full five day working week.

One of the Model Hospital work streams is entitled 'Challenging Bureaucracy'. It is envisaged that a number of Ward Managers will be involved in this work to ensure processes are streamlined. This will support the review of the role and the work they do.

Following the previous staffing review in July 2015 the Heads of Nursing have taken actions to determine and reflect what staffing and skill mix is required across both bed owning Divisions with regards to Registered Nurses (RN) and Nursing Assistants (NA)

Some wards have a higher NA to RN ratio this is due in part to temporarily over establishing to cover RN vacancies. However a number of Ward Managers have used their professional judgment to implement a permanent skill mix review. Examples would be Ward 49 and rehabilitation wards at EPH

The Divisions are working closely with the DH Nursing Hours per Patient per Day (NHPPD) to develop the benchmark to support the hospital. Divisions will use this to further support reviewing the workforce requirements to improve efficiencies

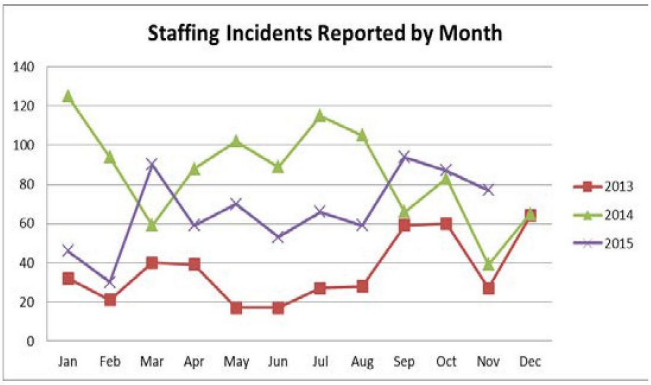
All specialist nurse roles have been / will be reviewed, with an agreed job plans to ensure the roles are efficient & productive.

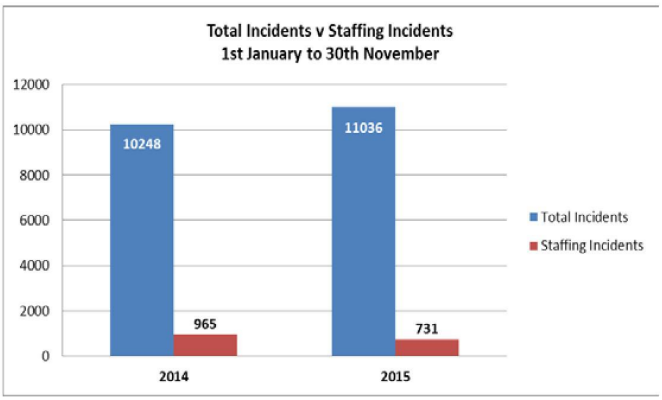
7.2 Escalation

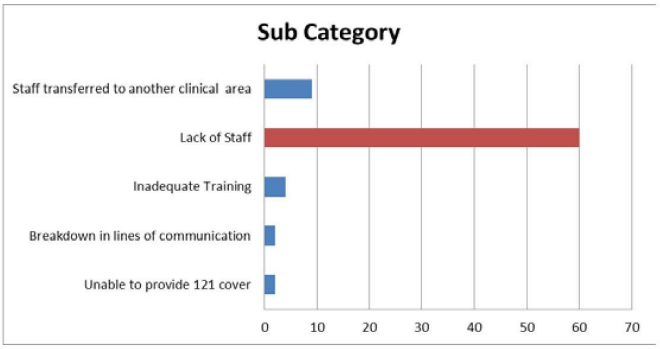
There is little doubt that the opening of additional beds for periods of high activity has caused staffing problems. The winter plan that the Trust put in place was reliant in part on partners supporting this increased acuity, which had been identified as likely to be the end of November onwards. Unfortunately this has not happened in the way the Trust had planned and therefore has led to staffing pressures within the hospital. It has therefore complicated the view of monitoring the previously agreed establishments versus the temporary workforce to support escalation.

This increase in escalation has had an impact in that further support has been required for staff in respect of health and wellbeing.

Staffing Incidents







The Trust remains a high reporter of staffing incidents but the relative harm associated for the incidents is low. For example, in the timeframe 1/11/15-31/12/15 there were 169 staffing incidents and of those 153 were logged as no harm and 16 were low harm. Of the 169 logged incidents the inpatient wards were responsible for 135. ITU, 53, 33 and AMU are the highest reporters. This also triangulates with the red flags file and concurs with the use of beds for escalation on wards 53 and AMU

8.0 Current Staffing Challenges

- As is the case with other Trusts, it is challenging to recruit to registered nursing and specialist posts such as ICU trained.
- As with other organisations, the majority of RNs we employ are newly qualified. it is recognised that enhanced support is needed for these RNs.
- Minimum staffing levels are not always being maintained. This is being risk assessed on a shift by shift basis.
- Some areas are not currently meeting national staffing guidelines i.e. children's unit, Neonatal Unit. This has been identified on the Divisions risk registers and we continue to monitor staffing daily whilst the Trust participates in the regional reviews in line with the Vanguard Model.

- Some Ward Managers are finding it increasingly difficult to work in a supervisory capacity, due to pressures of vacancies and sickness.

- Increasing patient complexity and incidence of dementia is impacting significantly on staff time. It is becoming increasingly challenging to manage due to enhanced supervision being required by many of the patients are who are delayed discharges. Additional training is being implemented to support staff.

9.0 Urgent Care Adult Wards

The benefits to our patients of the Acute Frailty Unit (Ward 51), has been demonstrated by an increase in discharges to a more appropriate care setting and reduced length of stay. As transformation of services continues to benefit patient care there is a requirement to re-profile the beds within Urgent Care to reflect the service need.

- **Identified wards**

  Within Urgent Care, the Ward Managers who do not believe they have the correct skill mix include, AMU 50, and 51

- **AMU** - Urgent Care intends to review the cardiac monitoring guidelines and the need to work closely with clinical teams to have a more robust process for monitoring and de-monitoring of patients. Once this is done a further review will need to happen to support the need of additional staff if it is identified as required. In the last 6 months there has been increase an additional twilight shift – it is believed that this is sufficient as an interim measure

- **Ward 43** – The previous Head of Nursing increased the WTE by in NA Band 2 and also agreed the appointment of a 'care and comfort' assistant. It was agreed to over establish NAs recognizing the increased acuity. This supports the significant % of patients with dementia, hence the need to increase the NAs to reduce the risk of hospital acquired harm. In order to improve the patient experience, plans are in place to re-locate ward 43 to the current ward 50. This will ensure appropriate clinical adjacency to Ward 51. This will also enable further development of the Acute Care Hub and provide a seamless multi-disciplinary approach to patients during their first 72 hours of care.

- **Ward 50** – Haematology /Oncology and diabetic patients are currently managed on this ward. Treatment complexity has increased along with the incidence of dementia. Hence the increase in one further registered nurse on nights e.g. Ward 50 has been identified as a high acuity ward for Clinical Haematology and Diabetes patients and therefore potential infection control

issues. The proposal is to relocate ward 50 to Ward 43, and plan towards a lower bed complement to help reduce the infection control risk. Consideration will also be given to introducing an increased number of en-suite side rooms on Ward 43 Staffing will then be reviewed and agreed with the Ward Manager

- **Ward 51** - Frailty Ward. Due to the increase of the number of delayed discharges the ward is now mixed in its complexity. There is yet to be an agree establishment however the Head of Nursing has supported the ward with transferring staff and the numbers of staff on duty are reflective to the patient need. However this ward requires a long term plan as to its use and then a review of staffing to support the plan.

10.0 Planned Care Adult Wards

As part of the service improvements for patient care, the Planned Care Division opened ward 40. In order to manage nursing costs we split ward 53 and ward 40 budgets.

The Division has continued to try and actively recruit to vacant post but have not been able to fully achieve this to date. As a result, with the agreement of the Divisional Directors we have over established on band 2 nursing assistants in an attempt to mitigate the impact of falling below agreed numbers on each ward.

Within Planned Care the ward managers who do not believe they have the correct skill mix include Wards 44, 45, 53, 52, and 54.

- **Ward 44** – Major colorectal surgery patients are no longer cared for post-operatively to HDU, but managed on the ward. This means the complexity has changed with a high proportion requiring clinical & technical interventions i.e. PICC lines, high use of IV drug medication, TPNs, Epidural EPCA's, stoma care, tracheostomy care. The Ward Manager has suggested in her professional judgement, there is a need to increase of NA and an increase of the RN to 3 per shift on night duty.

- **Ward 45** - An additional NA as this is the orthopedic trauma ward and with delayed discharges as elderly complex patients with social problems. This needs to be worked through as the use of a discharge supporting role for 45 maybe a more effective option

- **Ward 52** – is an acute surgical specialty ward. However, the case mix has changed significantly since September 2015. The 'red flags' such has missed breaks are being documented. Although the WTE appears similar to other surgical wards, this will need to be reviewed as the ward now cares for patients with Tracheostomies

- **Ward 54** – is the Vascular regional unit and the clinicians feel the ward is not conducive to the current case mix given the number of delayed discharges out of area. There is a desire to have a post-operative high dependency area to reduce the need to admit to ICU this would require a review in the nursing staff establishment

11.0 Other Inpatient Area

- **NNU**

The Lead Nurse in Paediatrics and the NNU Manager have undertaken a detailed review which demonstrates national recommended guidance is not always able to be achieved. Plans are underway to proactively skill mix existing posts to support the shortfall. The NNU is a specialist commissioned service and this is likely to undergo a service review as part of the whole health economy and Vanguard Model. The Trust will be part of this review and recommendations are likely to come from this. Monitoring of the area will continue of the incident trends and themes. The Head of Nursing, with the Lead Nurse for Paediatrics/NNU will undertake further analysis of the staffing data and risks.

- **Paediatrics**

A detailed review of Paediatrics has been undertaken. The conclusion as follows demonstrates that during the summer months the Trust is able to comply with staffing guidance and in fact there have been times during the summer months there have been no inpatients in part due to the success of the Hospital at Home service.

The review recommends a number of actions

- Provision of an electronic acuity tool
- Financial support for Advanced Paediatric Nurse Practitioners to be transferred form the medical budget
- Review the provision of a flexible workforce using annualised hours

Once the above work is completed there may be a case for further investment into the ward establishment.

These actions will be monitored by the Lead Nurse and reviewed at the Women and Children's Governance Board

12.0 Quality & Safety

- **Mitigating risk**

The Director of Nursing (DoN) monitors the staffing incidents at the weekly Serious Incident panel (SI). The approval of the DH staffing data that is uploaded monthly

onto the DH UNIFY portal also enables the Director of Nursing not only to review the staffing percentage compliance but also the ward red flags.

It is well embedded that staffing is discussed at the daily 'Patient Flow Meetings'. This meeting takes place 3 times a day, and ward dependency, 'one to ones' and general staffing gaps are discussed. The following actions are agreed to support a reduction of risk:

- Moving staff from one ward to another to cover gaps
- Moving from outpatient areas
- Cohorting patients who require additional support in 'zoned areas'
- Heads of Nursing sanctioning additional staff if required due to a patient safety risk
- Heads of Nursing agreeing the use of agency

Urgent Care has also recently set up an 8:45 Safety Huddle for the Ward Manager or the nurse in charge to attend. Staffing is discussed alongside patient acuity and any safety issues are discussed and actions agreed.

Planned care huddle involves the Matron meeting with all Ward Managers to review the staffing for the whole week (next 7 days). All ward managers then continue to meet daily Monday to Friday at 3pm to plan for the following days elective admissions and develop a plan for patient allocation, and review all staffing each day. The Theatre Clinical Manager meets at 7.30am each day with ITU to discuss all issues for admission, discharges and staffing.

All ward areas and departments run their own safety briefs

13.0 Nurse sensitive Indicators

Using Nurse sensitive indicators is a recognised set of balancing measures. These are also recommended by NICE

13.1 Safety Thermometer

The NHS Safety Thermometer "Classic" allows teams to measure harm and the proportion of patients that are **'harm free'** from **pressure ulcers**, **falls**, **urine infections** (in patients with a catheter) and **venous thromboembolism**.

This is a point of care survey that is intended to be carried out on 100% of patients on one day each month and is possibly the largest patient safety data collection of its kind in the world.

One of the most unique aspects is the concept of a 'harm free care' measure, the proportion of patients who are free from any of the harm measured. However, some of the harms are old and patients are admitted with them.

The new harms in our care is in the main above the 95% threshold.

- **New harms in our care**

Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
405	408	456	384	446	450	409	274	438	456	486	362
18	23	22	12	16	21	13	14	14	14	17	9
95.6	94.4	95.2	96.9	96.4	95.3	96.8	94.9	96.8	96.9	96.5	97.4

- **All harms – please see appendix 4**

There have been some data errors with regards to the definitions. Falls and Pressure Ulcers (PU) have remained a challenge for some wards. These are being monitored by the Matrons using the Ward Manager KPIs. The most recent data with regards to PUs have shown a steady decline.

13.2 Falls

A recent thematic review of falls demonstrated the following:

➢ Of the 574 falls 8.5% (n=49) were reported as being impacted upon by staffing levels; of these the top 3 affected areas were Ward 50 with 18% (n=9), Wards 43 and 51 each reported 12% (n=6). The highest sub category in these incidents was ‘found on floor’ (unwitnessed fall) which equates to 41% (n=20) of the total number of incidents reported as being impacted upon by staffing issues.

➢ Of the 10 incidents reported where a patient sustained harm from the fall, none were reported as being impacted upon by staffing levels.

➢ There is currently no set explanation of particular staffing level issues (sickness, unable to get bank staff for example) so it is difficult to accurately assess from the numerous free text entries the detail of the issues however it appears that obtaining staff for 1-1 supervision or zoned observation is the highest documented staffing issue

Unwitnessed falls are also of concern to the Trust especially if they can be related to staffing levels. Further work will be undertaken to ensure that we are capturing accurate information regarding what the staffing level issue is. This will also provide information in relation to themes for unwitnessed falls, by looking at times of falls, area and ward layout to endeavor to reduce this sub category of falls.

A number of wards are going to use the measles map to robustly monitor incidences.

13.3 Care metrics

The ongoing work for care metrics has been completed within the last 6 months. The current compliance is 96%. The Ward Managers agree this is a much more meaningful and accurate way of monitoring the standards of care they provide on their wards and departments in a timely manner.

14.0 Red Flags

The monitoring of 'red flag' indicators such as staffing and missing breaks is recorded on the S drive. Some wards are more robust at recording these indicators.

At the point of discharge the Trust also collects information from patients with regards other red flags for example – mealtime support and obtaining pain relief in a timely fashion.

14.1 Missed breaks

- **Ward 52** has recently reported an increase of staff missing breaks - this is being monitored by the Matron

- **Ward 50** remains an area that continues to report missed breaks and although there has been a downward trend, this needs closer monitoring by the Head of Nursing and actions agreed. Work is now underway to look at specialty bed capacity- this will support a more in depth staffing review.

The available data is not being reviewed regularly at ward and divisional level. The use of these will be mandated and monitored going forward.

14.2 Overtime

Overall this has increased over the last 6 months **(Appendix 5)** – as a red flag indicator there are a number of wards that are using this – what is not clear however, is this short term absences and/or patient acuity. Nevertheless this need to be addressed in the focused reviews and will also be supported by the Model Hospital and e-rostering programme of work.

Ward/Area	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Total
Total	£21,713	£25,810	£36,488	£32,428	£34,637	£43,973	£195,049

14.3 Patient surveys at discharge

Patients are asked a small number of questions. Information regarding red flags is collected directly from the Ward Manager in addition to a point of discharge short survey, carried out in the discharge from hospital lounge **(Appendix 6)**

Data is also collected from inpatients at the point of discharge demonstrates the following assurance below that:

- When our patients had important questions to ask a nurse, they invariably a response that they could understand.
- Over the last 12 months, the results of the survey show that patients do feel that hospital staff can be approached to discuss their worries and fears with.
- The results also show that when our patients require emotional support, they feel that hospital staff are providing this

15.0 Supervisory Ward Managers

The Ward Managers now work in a supervisory capacity. However, there are times due to staffing challenges, when it is not always achieved. It has been identified however, that the expectations of the role on a daily basis requires clarification. In light of this, some core principles need to be identified; this will be addressed over the next month taking into account the recently published report from the Royal College of Nursing.

16.0 Care Contact Time

The Trust has started its review of front line areas using the 'Care Contact' document for guidance. Two wards have been completed to date and there are plans to continue this. Early feedback has demonstrated areas that could be improved upon.

The results on **(Appendix 7)** show some discrepancies between the amount of time spent on administrative activities between the two ward managers. The results are also affected as Ward Manager A did not record whether she felt her activities were appropriate to her role for the entire duration of her study. As such, to gain a fuller picture, the activity needs to be extended to more ward managers.

This will continue to be rolled out and it is anticipated most in-patient specialties will be completed this year. This will be supported by the Model Hospital approach in ensuring the workforce is flexible to the needs of our services and patients.

17.0 Challenges & Risks

17.1 Recruitment and Retention

Overall the Trust's sickness is lower than the national average, however there are identified 'hot spots'- ICU, Diamond Ward at EPH and the Children's Unit are over 11% with ward 44 being 15% **(Appendix 8)**

Retention of staff still requires focus in some areas and exit interviews are being performed to establish if there are any themes to be addressed. The overall nursing position is illustrated below.

6 Month Total	
Sickness Absence %	Turnover %
3.79%	6.04

17.2 Temporary staffing

Review of the Temporary Staffing Bank with regards to RNs been completed. The following actions have now been completed to increase availability:

- ➢ rolled up bank and leave payment for the nursing staff
- ➢ automatic enrolment onto the temporary staffing bank at commencement of employment in the hospital
- ➢ Dedicated action plan in place to review other options to enhance the current service

18.0 Recommendations and Next Steps

- Utilise the Lord Carter work to review staffing requirements i.e. NHPPD, enhanced supervision, e-rostering and agree a timetable for completion
- Investigate how Allied Healthcare Professionals can help support patient care
- Review retention and recruitment in wards and departments where turnover appears higher
- Support the development of corporately live 'dashboards from f information gained through e-rostering, which supports all the information in one place.
- Monitor the change following the redefinition of the Matrons responsibilities and key performance indicators recently agreed

- Redefine the roles and responsibilities of a supervisory ward manager along with what benefits have been demonstrated
- Continue to support the corporate recruitment work and agree a longer term strategy to reflect the proposed changes and resulting opportunities in the nursing bursary
- Profile posts to demonstrate what the job is, short films on what it is like to work in specific areas and roles, the use of social media to highlight vacancies and what we are looking for
- Support a review on how other health professional to support wards i.e. pharmacy technicians, physiotherapists as part of the ward establishment- trialing of Band 5 pharmacy tech on AMU in Spring
- Heads of Nursing will continually review flexible working arrangements to support staff to remain in post and offer flexible retirements in order to retain expertise
- Specialist nurses will continue to support the wards over the winter period where job plans allow
- Heads of Nursing will support the feasibility of cohort wards for medically optimised delayed discharge patients in one or two wards. This would allow us to review skill mix and reduce the registered nurse requirements with an increase in support workers
- The Heads of Nursing will support the ward manager to use the SCNT tool. This will be supported by the Model Hospital project team and enable an acuity based workforce
- Ongoing work with Lord Carter to review staffing requirements i.e. Nursing hours per patient per day (NHPPD) an enhanced supervision policy has been developed with pilot under way
- Trust is planning to develop e-rostering system as part of the of the Model Hospital plans. The HON will support the project as required
- Heads of Nursing will support the case for further investment in the dementia care team in order to support the wards across both Divisions
- Matron's responsibilities have been redefined and key performance indicators have been agreed.
- Heads of Nursing will outline the need to support over recruitment. This will enable- a timely approach to planning for winter and to have robust plans in place by June each year

19.0 Conclusion

There is an emerging theme of some wards requiring additional resources to support safe patient care.

It is also anticipated in spring 2016, the Trust will receive further guidance from the National Quality Board (NQB). The guidance is likely to recommend the use of Care Hours per Patient per Day. This is similar to NHPPD but will also take into account other disciplines such as physiotherapist etc. This is only likely to be achieved to its maximum with e-rostering being utilised by all disciplines of staff and not solely nursing.

20.0 Recommendation

I would recommend that the Board therefore support my proposal that the Heads of Nursing for the Divisions lead and develop an action plan going forward in the next 3 months and ensure any proposed changes are factored into budget setting for their own areas.

The following areas need to be addressed on the identified wards:

- Robust use of the acuity tool
- Skill mix review in areas identified
- Converting bank and agency spend into permanent posts

In the meantime the Trust will use its current process to support safe staffing numbers whilst the transition into the Model Hospital programme of work is implemented.

Alison Kelly
Director of Nursing and Quality
January 2016

Appendix 1: Staffing Compliance

		Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Overall trust score							99.5%	100.1%	99.5%	98.7%	96.4%	96.4%	95.5%	97.7%	97.7%
Paediatrics	30	93.0%	90.4%	91.8%	92.4%	88.7%	93.7%	110.4%	103.3%	101.9%	100.2%	99.3%	102.8%	103.5%	131.4%
Stroke Unit	33	103.5%	100.6%	103.3%	99.8%	95.5%	96.4%	96.2%	99.3%	103.6%	98.6%	97.3%	97.4%	99.8%	101.8%
Care of the Elderly	34	98.8%	99.5%	102.6%	94.7%	96.1%	98.6%	97.2%	98.3%	96.9%	96.5%	97.3%	99.7%	101.5%	98.6%
Women's Unit	40					107.9%	98.7%	98.5%	95.8%	99.1%	97.8%	96.0%	95.1%	101.5%	100.9%
General Surgery	41	128.3%	93.7%	96.5%	94.8%	91.4%	87.8%	89.8%	90.9%	82.6%	81.6%	87.4%	90.4%	93.5%	93.0%
Cardiology	42	116.3%	106.1%	105.8%	104.9%	104.0%	99.7%	102.4%	102.4%	101.3%	101.7%	99.5%	102.9%	100.5%	103.9%
Care of the Elderly	43	108.3%	111.5%	107.2%	102.1%	98.5%	100.2%	107.5%	92.2%	98.1%	100.6%	98.9%	96.3%	96.7%	93.4%
General Surgery	44	112.1%	105.0%	91.3%	83.9%	98.0%	95.5%	91.0%	87.5%	88.4%	85.7%	87.3%	86.6%	93.2%	92.7%
Urology/Trauma and Orthopaedics	45	102.1%	106.7%	115.0%	117.8%	110.5%	101.8%	101.5%	97.4%	99.4%	99.1%	95.6%	99.8%	98.9%	98.0%
Gastroenterology	49	96.7%	101.0%	100.3%	103.5%	106.7%	102.9%	101.4%	110.4%	101.6%	99.7%	99.6%	100.5%	110.9%	105.4%
Haematology/Resp Medicine	50	110.0%	119.8%	104.9%	106.8%	119.3%	114.5%	114.3%	116.0%	113.0%	109.0%	113.2%	114.9%	108.7%	111.0%
Respiratory Medicine	48	105.2%	110.0%	105.6%	106.6%	99.9%	105.0%	97.6%	101.1%	102.3%	108.9%	98.1%	94.7%	108.7%	98.0%
Short Stay	51	93.1%	72.9%	91.5%	91.2%	93.7%	101.3%	97.8%	97.2%	97.8%	90.1%	93.8%	87.6%	89.2%	86.8%
General surgery	52	109.6%	127.4%	105.4%	110.7%	93.4%	95.1%	91.1%	90.6%	96.3%	90.5%	89.0%	89.3%	88.2%	99.1%
Surgery	53	111.2%	103.0%	101.8%	100.4%	87.9%	118.4%	112.3%	121.5%	128.1%	114.2%	112.3%	110.4%	126.6%	148.6%
General Surgery	54	78.8%	91.6%	95.6%	95.5%	94.3%	99.2%	100.6%	99.8%	94.9%	94.9%	99.8%	93.7%	95.0%	89.7%
Acute Medicine	AMU	108.8%	91.3%	92.6%	105.9%	105.1%	102.1%	110.4%	103.3%	106.0%	97.5%	100.9%	91.1%	94.9%	91.8%
Cardiology	CCU	103.4%	93.3%	99.5%	100.5%	100.6%	101.4%	96.8%	99.4%	104.6%	96.1%	95.4%	94.4%	93.8%	96.0%
Rehab - EPH	Diamond	101.9%	95.5%	100.6%	114.3%	96.6%	98.8%	104.9%	97.8%	93.8%	84.8%	92.9%	97.5%	98.3%	89.1%
Rehab - EPH	Emerald	95.9%	98.2%	100.0%	100.3%	96.9%	97.3%	100.7%	109.6%	107.0%	104.3%	96.5%	90.0%	94.2%	90.2%
Rehab - EPH	Ruby	92.2%	94.5%	95.8%	87.6%	82.6%	94.9%	100.5%	101.6%	88.1%	90.4%	94.4%	93.3%	95.4%	96.8%
Critical care medicine	ICU	99.6%	95.7%	97.9%	101.1%	99.5%	99.0%	97.5%	95.9%	94.7%	93.6%	89.7%	88.3%	91.7%	91.5%
Neonatal	NNU	94.6%	88.7%	80.1%	84.7%	85.3%	86.4%	89.5%	91.9%	91.6%	88.4%	88.1%	88.4%	84.5%	87.8%
Obstetrics	32	102.3%	114.3%	117.2%	100.0%	106.9%	97.4%	101.6%	101.9%	92.7%	95.6%	98.5%	100.8%	102.8%	112.4%
Labour Ward	35	99.1%	103.6%	99.6%	99.2%	101.2%	101.9%	99.9%	99.9%	99.0%	99.2%	101.2%	105.6%	101.8%	107.7%

Key		
>105%		Monitoring of the use of one to one and the need for additional hours or current workforce
95% to 105%		Hours available match the patient acuity
<95% to 90%		Daily-Shift review
<90%		Daily-Shift review resulting in staff movement if needed- escalation guidance triggered

Appendix 2: Ward Nurse Staffing Establishments – December 2015

Planned Care	Number beds	Early	Late	Night	RN to patient ratio (days)*	RN to patient ratio (nights)	**Support Staff Mon-Friday**
40	11	2/1	2/1	2/inter mittent twilight	1:6	1:6	WC/
41*	19- 5 day ward	4/3(T,W,T) 4/2(M,F)	3/2	3/2 If HDU open 2/1 If no HDU	1:5	1:9	WC/
44	28	4/4	3/4	2/2	1:7	1:14	WC/CC
45	28	4/4	3/4	2/3	1:7		WC/CC
53 *	14	2/1	2/1	2/1	1:7	1:7	WC/CC
52*	28	4/3	4/3	2/2	1:7	1:14	WC/CC
54	30	5/4	4/4	3/3	1:8	1:10	WC/CC

Urgent Care	Number beds	Early	Late	Night	RN to patient ratio (days)*	RN to patient ratio (nights)	**Support Staff Mon-Friday**
CCU	10	4/1	3/1	3/0	2:5 & 3:3	1:3	WC
AMU*	30	6/4	6/4	5/2	1:5	1:6	WC/HK
33	28	4/5	4/4	3/2	1:7	1:9	WC/HK
34	28	4/5	3/4	2/3	1:7&1:9	1:14	WC/HK/CC
42	24	3/3	3/2	2/2	1:8	1:12	WC
43	28	4/5	3/4	2/3	1:7&1:9	1:14	WC/HK/CC
48	25	4/4	4/2	3/2	1:6.	1:8	WC/HK/CC
49	28	3/4	3/3	2/2	1:9	1:14	WC/HK/CC
50	28	4/4	4/3	2/2	1:7	1:14	WC/HK
51*	28	3/4	3/4	2/2	1:9	1:14	WC
Ruby ward *	26	3/5	3/3	2/2	1:8	1:13	**Support Staff Mon-Friday**
Diamond *	24	3/4	2/5	2/2	1:8	1:12	WC/
Emerald*	16	2/4	2/3	2/1	1:8	1:16 +CSC	WC/

Patients per RN per shift excludes Supervisory ward manager / Co-ordinator

*Ward 41 - 6 escalation beds open but not funded or staffed recurrently. This is a five day ward

*Ward 53 – 14 beds opened but not fully staffed as per agreed risk assessment. Additional beds are opened without staff under times of bed pressure

* Ward 52 - 6 escalation beds open but not funded or staffed recurrently

* AMU - 6 escalation beds open but not funded or staffed recurrently

* Ward 50 - 12 escalation beds open but not funded or staffed recurrently

* Ward 51 – 28 beds not funded or staffed recurrently

*EPH – escalation variable depending on pressure

Appendix 3: Ward manager Proposals

Wards	Number of Beds	Early	Late	Night	RN to patient ratio (days)	RN to patient ration nights
44	28	4/5	3/5	3/2	1:7/1:9	1:9
45	28	4/5	3/4	2/3	1:7/1:9	1:14
52 *	28	4/4	3/4	3/2	1:7/1:9	1:9
	22	3/3	3/3	2/2	1:7	1:11
53*	20	3/3	3/3	2/2	1:6	1:10
	26	4/3	3/4	3/2	1:6/1:8	1:8
54	30	5/4	4/4	4/3	1:6/1:7	1:7
AMU	30	7/4	7/4	6/2	1:4	1:5
	36	8/5	8/5	7/3	1:4/5	1:5
43	28	4/6	3/4	2/3	1:7/1:9	1:14
50	28	4/5	4/4	3/3	1:7	1:9
51*	28	4/5	3/4	2/3	1:7/1:9	1:14

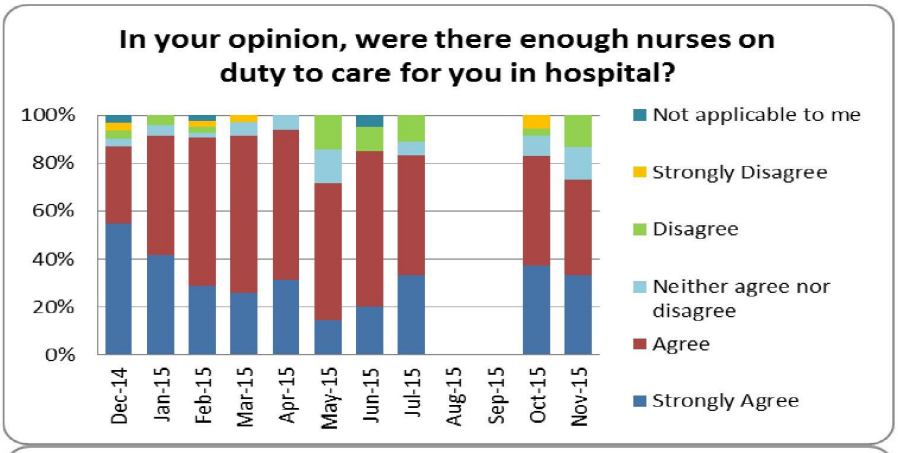
Appendix 4:Safety Thermometer – All harms

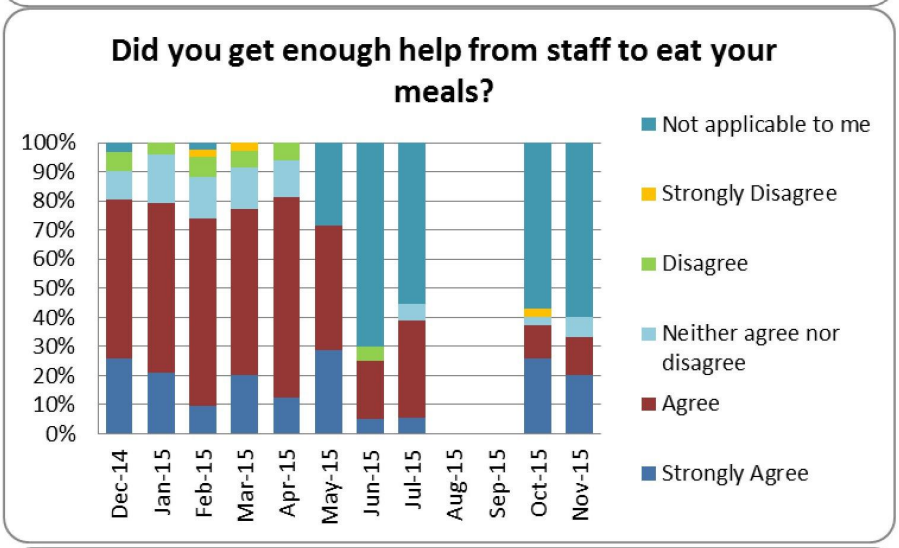
	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Women's Unit - 40	100%	100%	100%	90%	100%	100%	100%	100%	100%	100%	100%	0%
General Surgery - 41	100%	100%	100%	100%	100%	100%	94%	100%	93%	100%	88%	100%
General Surgery - 44	85%	100%	96%	100%	100%	96%	0%	0%	96%	100%	92%	0%
Urology/Trauma and Orthopaedics - 45	96%	89%	0%	96%	100%	85%	96%	96%	96%	92%	93%	100%
Gastroenterology - 49	96%	96%	100%	100%	100%	100%	96%	100%	100%	96%	93%	100%
General surgery - 52	0%	96%	82%	92%	96%	93%	85%	89%	85%	89%	93%	0%
Surgery - 53	96%	0%	100%	100%	100%	100%	100%	100%	100%	90%	96%	0%
General Surgery - 54	93%	100%	85%	100%	93%	97%	95%	88%	87%	93%	96%	92%
Critical care medicine - ICU	71%	64%	75%	80%	71%	85%	83%	93%	83%	100%	63%	100%
Obstetrics - 32	0%	0%	100%	0%	100%	100%	100%	100%	100%	100%	100%	100%
Overall division score	93.1%	95.2%	92.8%	96.3%	96.6%	95.2%	94.5%	95.9%	94.2%	95.5%	93.1%	98.6%
Care of the Elderly - 34	100%	0%	96%	100%	100%	0%	96%	0%	100%	96%	96%	100%
Cardiology - 42	86%	0%	100%	0%	0%	100%	100%	0%	100%	96%	96%	92%
Care of the Elderly - 43	89%	89%	79%	0%	89%	81%	0%	0%	86%	80%	85%	89%
Respiratory Medicine - 48	92%	80%	88%	83%	92%	96%	78%	68%	83%	100%	91%	96%
Haematology/Resp Medicine - 50	96%	92%	96%	89%	89%	71%	82%	0%	0%	92%	93%	88%
Short Stay - 51	87%	93%	96%	89%	95%	96%	96%	93%	89%	93%	96%	0%
Cardiology - CCU	89%	100%	70%	100%	89%	89%	100%	0%	89%	100%	100%	75%
Rehab EPH - Diamond	85%	85%	83%	78%	83%	88%	84%	95%	89%	77%	80%	80%
Rehab EPH - Emerald	0%	94%	88%	100%	93%	100%	100%	100%	94%	100%	100%	93%
Rehab EPH - Ruby	85%	74%	88%	78%	83%	76%	89%	85%	95%	80%	89%	95%
Neonatal - NNU	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Overall division score	90.3%	89.1%	90.2%	88.8%	91.7%	89.2%	92.5%	88.6%	93.1%	91.5%	93.7%	92.0%

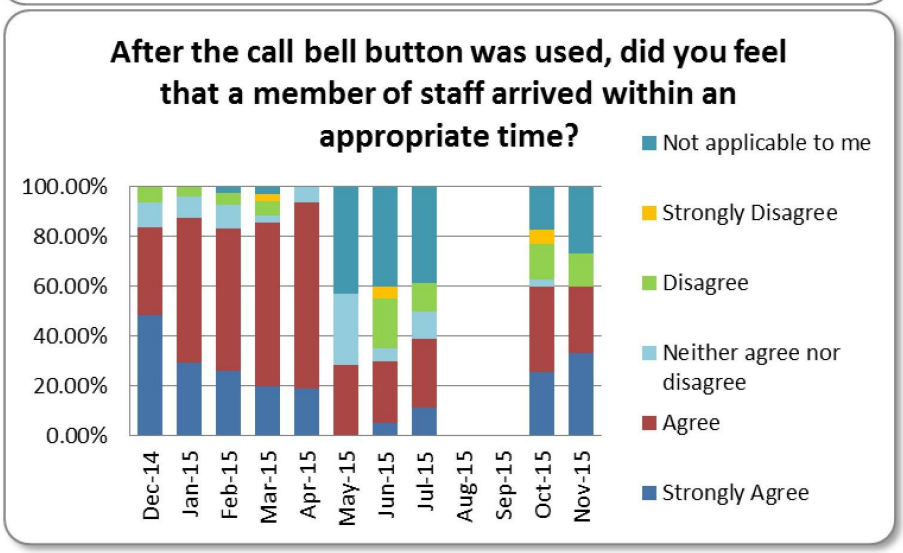
Appendix 5: Nursing Spend Overtime

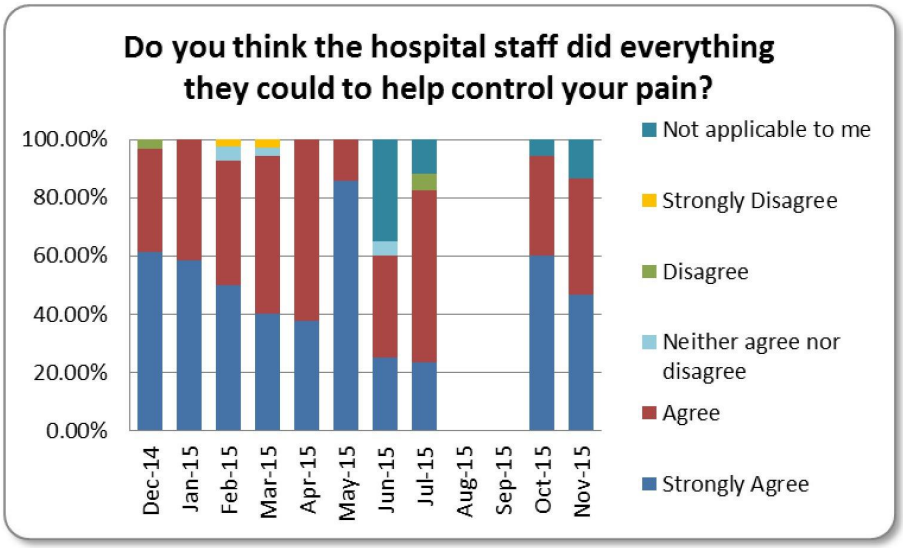
Staff Group - ALL							
Ward/Area	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Total**
210 Accident & Emergency	£5,190	£7,001	£11,799	£7,395	£10,041	£11,264	**£52,690**
210 Acute Medical Unit (Ward 47)	£478	£134	£240	£1,318	£2,383	£3,096	**£7,650**
210 BARIATRIC UNIT	£42	£348	£543			£84	**£1,017**
210 Bridge Ward 44	£350		£170	£387			**£908**
210 Castle Ward (52)	£1,475	£274	£187	£124	£91		**£2,150**
210 Cathedral Ward (42)	£911	£668	£680	£2,067	£1,079	£1,198	**£6,602**
210 Coronary Care Unit		£245				£506	**£751**
210 Critical Care Staffing	£810		£1,224	£2,863	£2,644	£1,540	**£9,082**
210 EPH DIAMOND WARD	£414	£1,162	£708	£636	£342	£1,950	**£5,212**
210 EPH EMERALD WARD	£659	£925	£912	£119		£257	**£2,872**
210 EPH RUBY WARD	£173	£1,035	£252	£142	£86	£727	**£2,414**
210 Foregate Ward (49) - Gastro	£977	£142	£1,586	£1,516	£1,970	£2,520	**£8,710**
210 Haematology Oncology Suite			£581	£264	£184	£326	**£1,355**
210 Hospital Midwifery	£2,542	£6,474	£4,380	£2,534	£3,988	£6,539	**£26,458**
210 Newgate Ward (50)	£960	£276	£1,375	£861	£956	£482	**£4,910**
210 Neonatal Unit	£1,057	£322	£546	£1,541		£1,863	**£5,329**
210 Northgate Ward (48)	£108	£434	£1,610	£547		£490	**£3,190**
210 Palace (45)	£256	£715	£123	£822	£513		**£2,430**
210 Renal Unit (Care)	£1,138	£1,061	£1,072	£1,304	£620		**£5,195**
210 The Childrens' Unit (29 & 30)	£60			£329	£642	£3,178	**£4,209**
210 Tower Ward (53)	£73	£203	£296	£718	£581	£599	**£2,469**
210 Trinity Ward (33)	£1,216	£2,693	£3,181	£1,364	£524	£1,395	**£10,372**
210 Ward (43)	£1,115	£333	£1,476	£3,387	£1,974	£2,084	**£10,370**
210 Ward 54				£57			**£57**
210 Winter Escalation Ward - Acute Frailty Unit	£1,213	£1,364	£3,369	£1,692	£5,561	£3,709	**£16,909**
210 Women's Unit	£497		£179	£439	£459	£165	**£1,739**
Total	**£21,713**	**£25,810**	**£36,488**	**£32,428**	**£34,637**	**£43,973**	**£195,049**

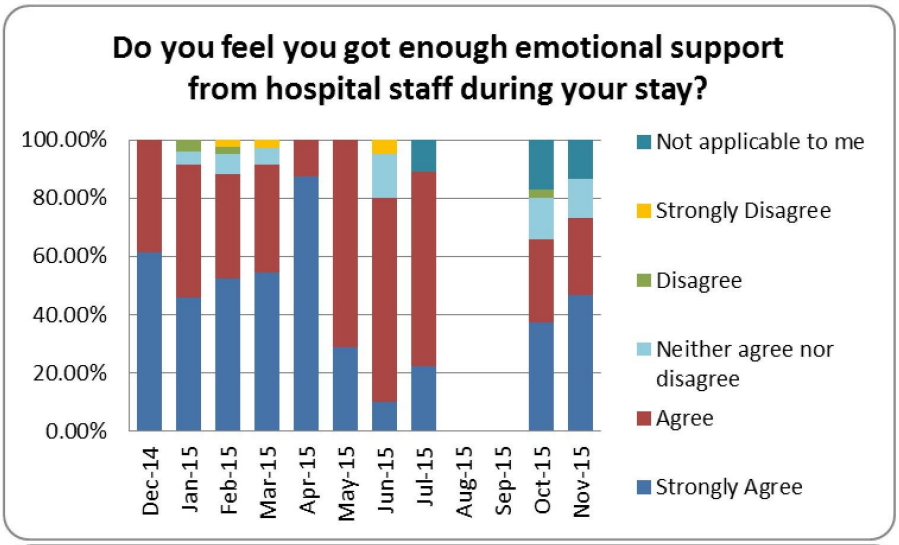
Appendix 6: Discharge Survey

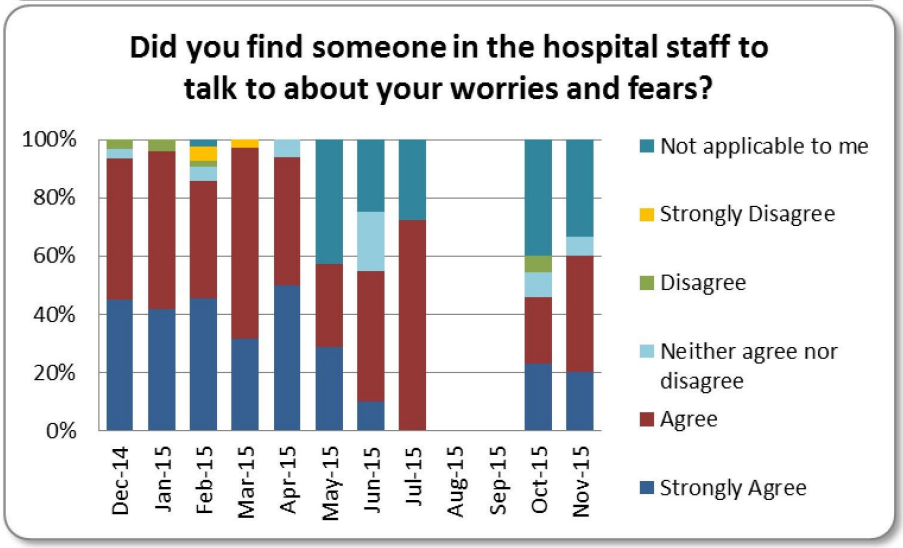







Do you think the hospital staff did everything they could to help control your pain?
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Not applicable to me
Strongly Disagree
Disagree
Neither agree nor disagree
Agree
Strongly Agree


Do you feel you got enough emotional support from hospital staff during your stay?
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Not applicable to me
Strongly Disagree
Disagree
Neither agree nor disagree
Agree
Strongly Agree


Did you find someone in the hospital staff to talk to about your worries and fears?
100%
80%
60%
40%
20%
0%
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Not applicable to me
Strongly Disagree
Disagree
Neither agree nor disagree
Agree
Strongly Agree

Appendix 7: Care Contact –pilot results

	Ward Manager A	Ward Manager B
Number of days recorded	9	3
Period recorded	3/8/15 – 3/9/15	1/12/15 – 4/12/15
Hours of activity recorded	96.5	28.5
Hours recorded as either appropriate or inappropriate to role	19.5	28.5
Hours of activities recorded as appropriate to role	19.5	26.2
Percentage of total time recorded with appropriateness level applied	20.2%	100%
Percentage of this time recorded felt to be appropriate	100%	92%
Hours of time spent on administrative activities	39.25	23
Percentage of time spent on administrative activity	40.6%	80.7%
Hours of time spent on patient care-focused activities	57.25	5.5
Percentage of time spent on patient care-focused activities	59.3%	19.2%

Appendix 8: Ward Sickness %

		Dec-15		6 Month Total	
		Sickness Absence %	Turnover %	Sickness Absence %	Turnover %
	All Trust Registered Nursing & Midwifer	4.66%	0.81	3.79%	6.04
	All Trust Healthcare Support Staff	6.09%	1.07	5.29%	4.80

Division	Area Of Work	% Sickness Absence Rate (FTE)	Turnover %	6 Month % Sickness Absence Rate (FTE)	6 Month Turnover %
210 PLANNED DIVISION		5.91%	1.09	4.73%	
210 PLANNED DIVISION	210 Bridge Ward 44	6.40%	6.06	4.61%	15.38
210 PLANNED DIVISION	210 Castle Ward (52)	0.38%	0.00	2.59%	5.71
210 PLANNED DIVISION	210 Crit Care Staff & Hdu Non Pay	8.61%	0.00	6.35%	9.38
210 PLANNED DIVISION	210 Palace (45)	4.64%	0.00	3.87%	2.35
210 PLANNED DIVISION	210 Tower Ward (53)	5.41%	0.00	3.57%	7.55
210 PLANNED DIVISION	210 Ward 54	5.91%	2.30	4.47%	6.98
210 URGENT CARE DIVISION		5.12%	0.97	4.14%	
210 URGENT CARE DIVISION	210 Accident & Emergency	4.86%	1.01	4.65%	5.18
210 URGENT CARE DIVISION	210 Acute Medical Unit (Ward 47)	2.99%	3.01	3.82%	7.41
210 URGENT CARE DIVISION	210 Cathedral Ward (42)	1.50%	0.00	2.96%	9.38
210 URGENT CARE DIVISION	210 Coronary Care Unit	18.04%	0.00	9.02%	4.00
210 URGENT CARE DIVISION	210 EPH DIAMOND WARD	5.74%	0.00	5.88%	11.59
210 URGENT CARE DIVISION	210 EPH EMERALD WARD	7.34%	0.00	5.16%	0.00
210 URGENT CARE DIVISION	210 EPH RUBY WARD	1.78%	0.00	2.01%	9.52
210 URGENT CARE DIVISION	210 Foregate Ward (49) - Gastro	5.41%	0.00	5.47%	0.00
210 URGENT CARE DIVISION	210 Newgate Ward (50)	6.79%	0.00	4.03%	0.00
210 URGENT CARE DIVISION	210 Nnu	6.81%	0.00	2.89%	5.26
210 URGENT CARE DIVISION	210 Priory Ward (34)	3.09%	0.00	1.95%	2.38
210 URGENT CARE DIVISION	210 The Childrens' Unit (29 & 30)	5.44%	5.66	3.96%	11.01
210 URGENT CARE DIVISION	210 Trinity Ward (33)	2.11%	0.00	3.06%	2.08
210 URGENT CARE DIVISION	210 Ward (43)	6.41%	0.00	5.00%	2.38

BOD Item No

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	**Speak Out Safely Update**
Date of Meeting	2nd February 2016
Author(s)	• Sue Hodkinson, Director of Human Resources & Organisational Development • Alison Kelly, Director of Nursing & Quality
Presented by	Sue Hodkinson, Director of Human Resources & Organisational Development
Annual Plan Objective No.	N/A
Summary	The purpose of this paper is to provide the annual progress report to the Board on the implementation of the Nursing Times "Speak Out Safely" Campaign and to provide recommendations to further support our staff to be able to raise concerns internally and externally.
Recommendation(s)	The Board is asked to receive and note the progress within this report and to support the recommendations that have been identified. Progress to the Board will continue to be reported on an annual basis with updates provided to the People & Organisational Development Committee on a six monthly basis. Further updates will be provided to the Quality & Safety Patient Experience Committee as required.
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" & Raising Concerns – Progress Review (January 2016)

1.0 Introduction

The purpose of this paper is to provide a progress report on the implementation of the Nursing Times "Speak Out Safely" campaign and the process for members of staff raising concerns within the Trust.

2.0 Background

Following successful joint work in late 2013, the Partnership Forum agreed revisions to the Whistleblowing Policy. This Policy was reviewed alongside the Raising Concerns about Patient Care Policy and the two were amalgamated to ensure clarity for staff. This Policy is a Statutory requirement and extremely important in the interests of supporting high quality patient care and in providing a open culture which is supportive in enabling staff to raise concerns at work.

As part of this review, it was agreed that the Trust would commit to supporting the Nursing Times campaign on "Speak Out Safely", which is aimed at encouraging a culture where all staff feel able to speak out about concerns they may have in relation to patient care. Consequently, the Director of HR & OD and Staff Side Chair jointly presented to the Board in February 2014. The Trust has continued to implement the above recommendations and the campaign has been supported by the implementation of the Nursing & Midwifery Strategy. An update on progress was provided to the Board in December 2014.

3.0 Update on progress and actions undertaken to date

As part of the national campaign "Draw the Line" by NHS England and NHS Employers, we have undertaken a self-assessment of our position against 4 elements of review:

- Organisational Commitment
- Support for Managers & Staff
- Communications & Staff engagement
- Continual review & assurance

The findings of this assessment are detailed in Appendix 1 and will be captured as part of the actions to support our staff further.

3.1 Concerns raised by members of staff

In the last review, 15 concerns had been formally logged. A further 9 concerns have since been logged; therefore 24 concerns have been logged via this process since its inception. The key themes of the most recent concerns are as follows:

- 3 Anonymous concerns were raised but for all other concerns, members of staff have disclosed their details.

- A range of departments and staff groups have been identified, but as per the previous review, no recurring trends have been identified.

- Concerns have ranged from poor care practices observed, lack of staff, workload, patient safety, communication, education & team leadership.

- One particular set of concerns resulted in nearly 70 members of being met with over a period of months and a detailed review and associated action plan developed.

All of the concerns raised have been reviewed by the Steering Group with a revision to the process of review to include a timely triage process. Members of staff continue to be contacted when concerns have been raised to thank them for raising this issue. As per the last review, some members of staff have agreed to support in future communication in relation supporting the raising of concerns across the Trust.

3.2 Organisational Commitment

The Board remains committed to supporting all members of staff to raise concerns safely as part of our open and honest culture. We have further developed governance in relation to "Speak out Safely" and our Steering Group continues to meet on a quarterly basis. We have enhanced our confidential database, to capture additional information to support triangulation against other data sources but it recognised that there is further work to do on this, as detailed in the recommendations in section 4.

The Steering Group have met on the following dates:

- 16th March 2015
- 16th June 2015
- 2nd October 2015

In addition, as part of a recent workshop with Partnership Forum, we reviewed the current trust policy and process in detail. The amendments have been captured and will be considered for approval at a future Partnership Forum meeting.

3.3 Support for Managers & Staff

Whilst it is encouraging that further concerns have been raised via the "Speak Out Safely" process, it is recognised that there is further we can do to support the signposting of how concerns can be raised both internally and externally.

Furthermore, we have acted on feedback that we need to make further methods for raising a concern available, alongside Datix, SBAR and the current methods for raising a concern as outlined in the policy. Consequently, we have established a confidential and internal helpline which staff can call at any time (Tel: 01244 (36) 3495) which will be monitored and logged accordingly. We have also set up a dedicated email address as follows: coc-tr.COCH-SpeakOutSafely@nhs.net . These additional methods will require a supporting communication and awareness campaign, which is referenced within the recommendations in this report.

3.4 Communication & Staff Engagement

As part of the regular walkabouts and visits to clinical areas, by Executives, Non-Executives and Governors, members of staff are regularly asked if they feel they can raise concerns safely and if they are aware of the policy and campaign. This has also been supported by regular discussion within the Partnership Forum, and Staff Side colleagues have been extremely supportive of the campaign. Positive responses have been received during walkabouts and visits, though it has been identified that further work needs to be undertaken to embed the campaign and policy further.

In addition, the Director of Nursing & Quality and the Director of HR & Organisational Development consistently attend the Clinical Human Factors education sessions held on a monthly basis, where a slot is allocated to advise clinical staff attending of the ways of raising a concern.

It is recognised that our students across all disciplines will often see situations and the level of patient care provided in a very different perspective to that of a member of staff. Consequently, as an Executive Team, we are regularly engaging and meeting with our students to encourage them to be confident in raising concerns, including regular Speak our Safely sessions with our nursing students. This has been received extremely positively and we are working with our educational partners and Practice Education Facilitators to further encourage this going forward.

3.5 Continual Review & Assurance

In line with the NHS England and NHS Employers "Draw the Line" Raising Concerns campaign, the organisation self-assessment tool has been completed to assess what we are doing well and where we need to focus some further attention. This self-assessment is provided within Appendix One.

In addition, whilst the Steering Group continually review and adapt the processes supporting all staff to raise concerns, it is acknowledged that the self-assessment tool recommends that internal audit review of the process may be beneficial. This will be considered by the Steering Group at their next meeting.

Furthermore, it was recognised that the Director of HR & OD & the Director of Nursing & Quality were supporting the review of the concerns very heavily and the Steering Group agreed steps to address this. This includes once a concern has been received and logged, a triage review process has been established whereby all of the group are made aware of the concern on a timely basis and a series of options for progressing the concern are considered. The group have also considered whether there is a Designated Officer of the Month, so that workload across the group can be managed more effectively. This will be discussed further at their next meeting.

3.6 Trust Feedback into the Freedom to Speak Up: Whistleblowing policy for the NHS Consultation

As a result of the "Freedom to Speak Up" Review by Sir Robert Francis QC, a consultation was undertaken by NHS England, Monitor and NHS Trust Development Authority on a proposed single national whistleblowing policy for the NHS in England.

The Trust has provided a contribution into the consultation and has considered the consultation when making revisions to the revised policy.

4.0 Recommendations for on-going and future actions

Whilst it is encouraging that our self-assessment from the "Draw the Line" campaign indicates that we have made very good progress on how we support all members of staff to be able to raise concerns, when undertaking the assessment as shown in Appendix One, there are number of areas where we need to focus some further attention.

Consequently, a number of recommendations have been identified as follows:

- It is recommended that more apparent methods for raising concerns, with a supporting communication campaign needs to be implemented. This is planned to be delivered by end of March 2016 and will include promoting the revised policy, providing examples of when concerns have been raised, promoting awareness of the process to our bank staff, agency partners and

volunteers, and to provide sign-posting to the various methods of raising a concern internally and externally.

- To review the feedback collated in relation to behaviours, our culture and raising concerns as part of the work led by the Model Hospital Organisational Culture work stream.
- To consider the role of the Staff Governor when supporting the encouragement of raising concerns.
- To develop an agreed process for triangulating data received from SBARs, Datix, Staff Survey, Occupational Health & Wellbeing Department Visits, Exit interviews and concerns raised through "Speak Out Safely" to identify any potential trends.
- To review and implement, where appropriate, the recommendations of the "Freedom to Speak Up" national whistleblowing policy consultation, when published.
- For the Steering Group to consider the use of internal audit to review confidence in the policy, system and processes, as identified as an action in the "Draw the Line" Assessment Tool.

5.0 Conclusion

The Board is asked to receive and note the progress within this report and to support the recommendations that have been identified. Progress to the Board will continue to be reported on an annual basis with updates provided to the People & Organisational Development Committee on a six monthly basis. Further updates will be provided to the Quality & Safety Patient Experience Committee as required.

Prepared by:

- **Sue Hodkinson, Director of Human Resources & Organisational Development**
- **Alison Kelly, Director of Nursing & Quality**

January 2016

NHS Employers

NHS England

DRAW THE LINE

RAISING CONCERNS

TOGETHER WE CAN MAKE A DIFFERENCE

RAISING CONCERNS: Organisation self-assessment tool

Having a healthy open culture where staff feel empowered and supported to challenge, debate and raise concerns as part of normal employment practice, enables organisations to deter wrongdoing and pick up problems early. It also demonstrates to regulators, staff, patients and the public that they are accountable, well managed, and are willing to listen and respond to issues raised. Many NHS organisations have policies and procedures in place to support staff to raise concerns but their effectiveness will depend on a variety of factors. Following the publication of the Freedom to Speak Up report in February 2015, and subsequent recommendations for implementation including the introduction of the Freedom to Speak Up guardian role, many organisations will want to take time to reflect on where they are as an organisation in relation to supporting staff to raise concerns. This tool can help you assess what you are doing well, and where you might need to focus some more attention. For further information and to access online resources, case studies and the rest of the Draw the Line toolkit, please visit the NHS Employers website at: www.nhsemployers.org/raisingconcerns.

We use the term 'staff' throughout this document, but you should also consider how you engage, communicate and support all workers in your organisation including undergraduates, trainees and volunteers.

ORGANISATIONAL COMMITMENT: Being able to show the board or other appropriate governance structure commitment to the principles of your whistleblowing or raising concerns arrangements gives a strong message to staff about the type of culture and behaviours that are acceptable within your organisation. Having buy-in and leadership from management and staff side is important in achieving this.

INDICATOR:	Yes	More work required	Unsure	No
The board are committed to promoting and championing the importance of raising (whistleblowing) concerns.	✔			
As an organisation, we are committed to investigating and taking appropriate action where concerns are raised with us, and have arrangements, including a Freedom to Speak Up guardian or equivalent in place to ensure staff who raise concerns are fully supported to do so.	✔			
Our organisation takes a zero tolerance approach to bullying and clearly communicate the sanctions we will take where staff (at any level) bully or victimise colleagues as a result of them raising concerns.	✔			
We make clear that staff are not required to evidence proof of their concern and will not be penalised if their concern is subsequently found to be misdirected.	✔			
We have clear sanctions in place to deal with concerns that are raised with malicious intent.	✔			

SUPPORT FOR MANAGERS AND STAFF: Formal policies and arrangements are an important starting point, but it is equally important to make sure that managers and staff fully understand their roles and responsibilities, and know how to proceed and respond appropriately to resolve issues quickly. Support such as training, mediation, counselling, and stress management are key to success.

INDICATOR:	Yes	More work required	Unsure	No
Our organisation has a separate policy which clearly differentiates between a grievance and a (whistleblowing) concern so that staff are clear about which process to use.	✔			
Our organisation offers a range of support to staff who raise concerns such as mediation, counselling, stress management and signposting to where they can seek additional independent advice and support e.g. the national Whistleblowing Helpline, legal advice etc.	✔			
Our organisation offers a number of informal and formal platforms which enable staff to raise concerns openly, confidentially and anonymously (e.g. team meetings, staff briefings, as part of the appraisal process, confidential helpline etc.).	✔			
Our organisation offers training for managers and staff to clearly prepare and outline responsibilities to report concerns, and encourage early intervention as part of normal employment practice, before the issue escalates into something more serious.		✔		
We provide all employees with a route map that clearly outlines suitable internal and external reporting routes.		✔		

COMMUNICATIONS AND STAFF ENGAGEMENT: Raising staff awareness about your whistleblowing or raising concerns arrangements is important to ensure that staff know when and how to use them. Clear statements from senior management about the organisation's support for the reporting of wrongdoing through appropriate channels, and openly reporting the type and level of concerns raised and resultant actions, will help to build staff confidence to speak up.

INDICATOR:	Yes	More work required	Unsure	No
Our organisation regularly communicates with *all* staff (including permanent staff, other contracted workers and volunteers) to raise the profile and understanding of our raising (whistleblowing) concerns policy and arrangements.		✔		
We communicate key findings to staff about the level and type of concerns raised and any resultant actions taken, as is appropriate under the scope of confidentiality.		✔		
Staff are consulted and encouraged to feed into any review of the raising (whistleblowing) concerns arrangements to ensure they are fit for purpose and fully support staff to raise concerns and managers to respond professionally and appropriately to concerns raised with them.	✔			
We actively promote good news and success stories at staff briefings, team meetings and on the intranet to encourage and reassure staff.	✔			

CONTINUAL REVIEW AND ASSURANCE: A well-run organisation will periodically review its whistleblowing arrangements to ensure that all staff are aware of them, confident to use them, and are kept up to date with current employment law and best practice. Monitoring the arrangements will also help the board or other appropriate governance structure to demonstrate to regulators that their arrangements are working effectively.

INDICATOR:	Yes	More work required	Unsure	No
Our organisation has systems in place to ensure that all concerns raised are appropriately logged, detailing how each concern has been progressed, and any actions taken as a result of that issue being raised.	✔			
We have appointed a designated officer or freedom to speak up guardian who has lead responsibility to ensure the appropriate training and handling of concerns is in place, and the effectiveness of local systems is discussed at board meetings.	✔			
Arrangements are periodically reviewed as part of our internal audit process to ensure staff are aware of arrangements, are willing to use them and have confidence in the system.		✔		
Data is correlated with information available from other risk management systems – such as: key findings from reviews/surveys, exit interviews, adverse incidents and near misses to identify trends and areas for improvement.		✔		

USEFUL LINKS:

Visit the NHS Employers web pages on:

— Raising concerns at work (whistleblowing): for information about the Draw the Line campaign, the Freedom to Speak Up review, and to access our online toolkit for managers, case studies and further guidance.

— Recruiting for values: to access the values mapping tool, podcasts and case studies.

— Do OD: organisational development: see the latest articles, blogs and case studies which are focused on driving system-wide change in the NHS.

— Staff engagement: to access our staff engagement toolkit, webinars, and guidance on using social media to increase staff engagement.

Gateway number 02948

Blank for supporting information: *Please use this space to evidence strengths and weaknesses against each of the indicators – using local information available to you such as staff and patient experience surveys; notes from staff briefings, meetings, discussions and other relevant information. Our other Draw the Line campaign tools can help facilitate conversations and identify ways to improve these indicators.*

Organisational Commitment

The Trust revised the policies in November 2013 to combine the Whistleblowing and Raising Concerns policy, with the inclusion of the phrase "Speak Out Safely" to the title of the Policy in support of the Nursing Times, Speak out Safely (SOS) Campaign. This was presented to the Board in December 2013 and has been supported by the creation of SOS Steering Group which includes designated officers from the Board and the Staff Side Chair & lead Royal College of Nursing (RCN) representative. This group meets quarterly with the Director of HR & OD & Director of Nursing & Quality being the executive leads.

Support for Managers & Staff

We provide a range of support and platforms to raise concerns. However, we recognise that there is more work that we need to undertake to support our managers and staff in signposting the different methods for raising concerns. In addition, we are adding further mechanisms to support all members of staff in raising concerns, with a monitored internal confidential answer-phone service, a monitored confidential & dedicated email address and raised awareness of the access to the national Whistleblowing helpline.

Communication & Staff Engagement

Whilst the SOS process and policy is regularly communicated, it is acknowledged that we need to raise the profile further across all staff groups, particularly Medical staff, Bank & Agency Staff and our volunteers. A communication campaign to support the additional mechanisms that are available to raise concerns will be taking place in Quarter 4 2015/16, which will include the key findings in relation to the level and type of concerns raised.

Continual Review & Assessment

A comprehensive database has been established and updated on real time to log all concerns raised. This is supported by a newly developed triage process for all concerns, so that they are reviewed promptly by the SOS Steering group. We have appointed 8 designated officers from the Board and from a staffing perspective and the Steering group comprises of a number of the officers who meet on a quarterly basis to review the position and arrangements. The policy is in the process of being reviewed in line with the national consultation and policies, incorporating learnings from the concerns raised. Further review via the internal audit process will be explored.