Countess of Chester Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA AND PAPERS

TUESDAY, 6TH SEPTEMBER 2016

Countess of Chester Hospital NHS
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

TUESDAY, 6TH SEPTEMBER 2016 AT 2.00PM

TRAINING ROOM 3 & 4

A G E N D A

FORMAL BUSINESS

1.	Welcome and Apologies	Chairman
2.	Declarations of Interest	Chairman
3.	To receive and approve the Board of Directors minutes of meeting held on 5th July 2016, BoD action tracker (August 2016) and matters arising	Chairman

QUALITY & ASSURANCE

4.	To receive a Staff Story and a presentation on the People and Organisational Development Strategy **(Attached)**	Director of Human Resources and Organisational Development
5.	To review the Integrated Performance and Finance Report as at Month 4 **(Attached)**	Executive Team
6.	To receive a progress update on the Digital Road Map for the Countess of Chester Hospital NHS Foundation Trust including: **(Attached)** • Approval of Full Business Case for a Patient and Asset Tracking System - Executive Summary. • Update and overview of progress on Electronic Patient Record System and future replacement options.	Chief Executive/Model Hospital Programme Director
7.	To receive a briefing on the implementation of the Junior Doctors Contract **(Attached)**	Director of Human Resources and Organisational Development
8.	To receive the Third annual report on medical appraisal and revalidation **(Attached)**	Medical Director
9.	To receive the 6 monthly update on Nurse Staffing **(Attached)**	Director of Nursing and

		Quality
10.	To receive details of the Workforce Race Equality Standard (WRES) **(Attached)**	Director of Human Resources and Organisational Development
11.	To receive and approve the Board Assurance Framework (BAF) **(Attached)**	Chief Executive
12.	To receive a update on Never Events and Serious Untoward Incidents	Director of Nursing and Quality
STRATEGIC DEVELOPMENT		
13.	To receive a CEO Update **(Verbal)**	Chief Executive / Director of Nursing and Quality
14.	To receive an update on Governor Matters **(verbal)**	Director of Corporate & Legal Services
FOR NOTING & RECEIPT (Available on request only)		
15.	To receive the final signed Reference Cost Submission	Chief Finance Officer
16.	To receive the Q1 Letter to NHS Improvement and feedback letter from NHS Improvement	Chief Finance Officer
17.	To receive the PLACE Assessment 2016	Director of Nursing and Quality
18.	To receive the minutes of the Quality, Safety and Patient Experience Committee – 20th June 2016	Director of Nursing and Quality
19.	To receive the minutes of the People and Organisational Development Committee - 26th May 2016	Director of Human Resources and Organisational Development
20.	To receive Corporate Infection Prevention and Control Assurance – Quarterly Report (retrospective report based upon May 2016 quarterly data update)	Medical Director
21.	To receive details of the Freedom of Information Requests received by the Trust – April 2016 to July 2016 *(via separate email)*	Director of Corporate and Legal Services
22.	Date and Time of Next Meeting:	

Board of Directors Meeting
Tuesday 6th December 2016 @ Time TBC - Training Room 3 & 4

BOARD OF DIRECTORS

MINUTES OF THE MEETING HELD ON MONDAY,
5TH JULY 2016 at 10.45AM
TRAINING ROOM 3 & 4

		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	Ms R Fallon	☑	
Chief Executive	Mr T Chambers	☑	
Medical Director	Mr I Harvey	☑	
Chief Finance Officer	Mrs D O'Neill	☑	
Interim Chief Finance Officer	Mr S Holden	☑	
Director of Nursing & Quality	Mrs A Kelly	☑	
Director of Human Resources and Organisational Development	Mrs S Hodkinson	☑	
Director of Corporate & Legal Services	Mr S P Cross	☑	
Director of Operations	Ms L Burnett	☑	
Programme Director, Model Hospital	Mr I Bett	☑	

In attendance:

Mrs C Raggett – Secretary to the Board
Mrs S Williams, Deputy Director of Nursing
Mrs C Edwards, Matron
Ms F Vella, Ward Manager

FORMAL BUSINESS

B41/16 **WELCOME AND APOLOGIES**

Sir Duncan welcomed attendees to the meeting.

There were no apologies.

B42/16 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

B43/16 **TO RECEIVE AND APPROVE THE MINUTES OF BOARD OF DIRECTORS' MEETING HELD ON 3RD MAY 2016 AND BOARD ACTION TRACKER AS AT END OF JUNE 2016**

The Board of Directors minutes of the meeting held on 3rd May 2016 were received as a true and accurate record.

The Board noted the Board Action Tracker as at end of June 2016.

MATTERS ARISING

Ms Burnett updated the Board on the paediatrics hospital at home and stated that the Trust had been working together on the patient pathway and identified some cost efficiencies which will support the continuation of the service within budget. Ms Burnett and the team have met with 3 members of the support group and have assured them that the service will continue.

Sir Duncan advised the Board that as it is good practice to rotate the role of Deputy Chairman and stated that Mrs Hopwood would now become Deputy Chairman and Mr Higgins would remain as Senior Independent Director.

QUALITY & ASSURANCE

B44/16 **TO RECEIVE A PATIENT STORY – KATE'S CORNER**

Mrs Kelly presented a patient story to the Board regarding the experience of a patient who had been discharged home but had subsequently been readmitted. The team at Ellesmere Port Hospital had identified that the patient and her family could have been more prepared for her discharge home. Mrs Edwards and Ms Vella had developed a plan for the family to stay at Ellesmere Port Hospital for one or two nights to see how to care for their family member in a supported environment which facilitated an improved discharge for the patient, who has made an excellent recovery and continues to improve at home.

Mrs Kelly stated that Mrs Edwards and her team after their experience with the patient, felt that family and carers needs are not always recognised and that the benefits of being able to learn how to look after in a patient in a supported environment would make a huge difference to patient. The Trust has established Kate's Corner which is a room where family and carers can come and learn how to look after the patient and prepare them for discharge, in an environment which is comfortable and gives them an opportunity for privacy and dignity. Kate's Corner also allows families the opportunity to say their goodbyes towards the end of life which has been very appreciated by patients and their families.

Mrs Kelly stated that the family feel Kate's Corner is a wonderful asset at

Ellesmere Port Hospital and hope that other families can get the benefits that they received.

Mrs Edwards and Ms Vella stated that they felt that the establishment of the Kate's Corner and the support for families was a highlight of their career.

Sir Duncan reflected that the effort that the team had out into Kate's Corner was not always supported by social services and health visitors. Mrs Kelly stated that Kate's Corner was a fantastic achievement however there were further conversations needed with social services and health visitors.

Sir Duncan thanked Mrs Edwards and Ms Vella for their hard work and care for the family in the establishment of Kate's Corner.

B45/16 **CEO UPDATE – TO RECEIVE A PRESENTATION ON THE CQC INSPECTION OUTCOME**

Mr Chambers and Mrs Kelly gave a detailed presentation on the CQC inspection report which had given the Trust an overall rating of 'Good' and highlighted the following points:

- The Trust had given the CQC a CQC a presentation during the inspection and the report has reflected this and identifies the Trust as being safe, kind and effective.
- The Trust is working on making the patient experience world class, focussing on safety, kindness and doing the right thing for patients.
- The Trust is in the top 20% of Trusts with a 'Good' rating, which was awarded when the Trust was incredibly busy.
- The Trust was awarded a 'Good' rating however for 'are services responsive' the Trust was given a 'Requires Improvement'.
- The Chester site was a 'Requires Improvement' relating to flow and cancelled operations. The Trust has had difficulties around discharging patients at the end of life. The end of life care requires improvement however this in part to the system issues.
- Ellesmere Port Hospital got an overall rating of 'Good'.
- The Trust had a lot of areas of outstanding practice.
- Mrs Kelly stated that the Trust had received regulations notices and was required to provide action plans for improvement within 2 weeks. The action plans will be monitored by the CQC and the Trust's internal governance processes.
- Mrs Kelly stated that report had some should dos and some must dos, and these were being reviewed in line with work already being undertaken across the Trust.
- Mrs Kelly will provide an update on the actions taken to a future Board meeting.

Mrs Fallon asked about the process going forward with the CQC. Mrs Kelly stated

that there is a 2 week turnaround for action plans for the regulation notices and that the already established regular quarterly meetings with the CQC would continue. The Trust will focus on the areas for improvement particularly around end of life care and flow.

Sir Duncan stated that this was a very good report and a credit to everyone.

B46/16 **TO REVIEW THE INTEGRATED PERFORMANCE REPORT TO MONTH 2 TO INCLUDE A FINANCIAL UPDATE**

The Board received details on the key issues within the integrated performance report to Month 2 and the following points were raised:

- Ms Burnett stated that the target for e-discharge within 48 hours was being achieved.
- MS Burnett stated that stroke unit's performance is continuing to improve which is due to the excellent work by the clinicians and the team.
- Ms Burnett reported that there has been a reduction in cancellations compared to last year however, there was an urgent operation cancelled for the second time.
- Ms Burnett reported that there has been an improvement in the A&E trajectory but June 2016 had been a difficult month.
- Ms Burnett reported that the 6 week diagnostic target had just been missed but had improved.
- Ms Burnett reported that the RTT target was improving and that the planned care division were in the middle of the recovery plan for the target.
- Ms Burnett was concerned about the 62 day cancer target has there has been some significant challenges in head and neck speciality and the urology speciality. Work is being undertaken with these teams to support delivery of the target.

Sir Duncan asked about the current levels of C.Difficile. Mr Harvey stated that the C.Difficile levels were on trajectory which was good news and there had been no cases of MRSA.

Mr Holden outlined the Trust's current financial position and highlighted the following points:

- The Trust is currently £200k off plan.
- There are overspends in nursing and medical staffing however the position did improve during month 2.
- There is an overspend for outsourcing which had not been budgeted for however, outsourcing was being utilised to deliver activity.
- The CRS is off plan by £146k and it was noted that the monthly target was lower in the early part of the year and then increased towards the year end. Some CRS schemes are due to deliver savings later in the year. The CRS schemes are reviewed weekly to monitor progress.

Mrs Hopwood asked about A&E and how this was predicted to achieve the 4 hour target in quarter 2. Ms Burnett replied that there was a lot of data about keeping bed occupancy down which gives the Trust flow which provides a better chance for the Trust to achieve the target. There are a lot of plans in place in the Model Hospital programme to reduce length of stay and bed occupancy.

In response to a question from Mrs Hopwood, Ms Burnett gave details of the work being undertaken with social care, the development of social care capacity and noted that good progress has been made with the right people now round the table.

Mr Wilkie referred to the profiling for the CRS schemes and how schemes will be delivered later in the year. Mr Holden stated that the profiling and plan had been agreed with Monitor and that the Trust is focussed on delivering the plan. The Trust is challenging delivery of schemes on a weekly basis to ensure delivery at year end.

In response to a further question from Mr Wilkie, a full discussion took place regarding the profiling of CRS schemes and these influence the forecast finance position at year end. Mr Holden gave details of the schemes considered at Executive level. Mrs O'Neill added that the CRS risk register will progress and become more robust. It was agreed that a Finance Committee would be held later in July 2016. Mr Higgins referred to the support for managers who are having to make decisions regarding CRS on the shop floor. Mr Chambers stated that this would be discussed further at the Finance Committee in July 2016 however it was noted that the Executive Team did provide support and rigour and this is appreciated by staff.

Mr Holden gave further details of the CRS working group weekly meetings and how the meeting is to support managers to deliver schemes and that the weekly vacancy panel is about having rigour around vacancies, to date only a small number of vacancies have been deflected.

Sir Duncan summarised the discussion regarding the financial position and stated that the Finance Committee later in July 2016 would focus on the issues raised at the Board meeting.

Ms Fallon stated that it would be helpful to have further information on the 62 day cancer target, RTT and any patients waiting over 52 weeks. Sir Duncan agreed that these would be included on the agenda.

In response to a question from Mrs Hopwood regarding medical agency spend, a full discussion took place regarding the current gaps in rotas for medical staff. Mrs Hodkinson stated that there has been a lot of work undertaken regarding the August rotation for junior doctors and any issues have been raised with the appropriate Deanery. Mr Harvey added that there medical staff have been very

proactive on the monitor of gaps and the application of the annual leave policy. Mr Harvey stated that whilst there are some inconsistencies with agencies at the moment, following a meeting with a best practice Trust, an action plan has been developed to address these and also how the Trust holds the agencies and locum doctors to account for the rates that they charge.

The Integrated Performance Report for Month 2 was received by the Board.

B47/16 **TO RECEIVE DETAILS OF THE PICKER INPATIENT SURVEY 2015**

MRs Kelly gave a detailed presentation of results of the Picker Inpatient Survey 2015 and highlighted the following points:

- 542 patients responded to the survey which gave a response rate pf 45% which was a slight increase from the previous year.
- The Trust performed better on 4 questions, the same on 57 questions and worse on 1 question compared to the previous year.
- Areas for improvement included toilets, food and continuing to improve the discharge process.
- The results now include a heat map which highlight the areas for improvement and the action plans to address these will be monitored at the Patient Experience Group (PEG).
- The terms of reference for the PEG will include the work for Model Hospital and will establish a task and finish group to take forward some of the actions from the survey.

Sir Duncan stated that the results gave a good picture of patient experience and thanked Mrs Kelly for her presentation.

B48/16 **TO RECEIVE AND APPROVE THE BOARD ASSURANCE FRAMEWORK HEADLINE RISK**

Mr Chambers presented the Board Assurance Framework (BAF) headline risks for 2016/17 to the Board and reported that the Executive Team and senior leaders had reviewed the risks for 2015/16. Reassuringly the risks previously identified remain and the headline risks will be populated for discussion at the next Board meeting.

The Board of Directors approved the Board Assurance Framework headline risks for 2016/17.

B49/16 **TO RECEIVE AND APPROVE THE COSTING PROCESS APPROVAL 2015/16**

Mr Holden gave details of the costing process approval for 2015/16. Mr Holden advised that all Trust have to follow the same rules for costing and asked the Board to approve the Trust to use the national set of reference costs.

The Board of Directors approved the Costing Process Approval 2015/16.

B50/16 **TO RECEIVE AN UPDATE ON NEVER EVENTS AND SERIOUS UNTOWARD INCIDENTS**

Mrs Kelly reported that there had been no never events in April 2016 and May 2016. There had been 2 serious incidents in the mortuary and a review of processes was being undertaken at the Quality, Safety and Patient Experience Group.

STRATEGIC DEVELOPMENT

B51/16 **TO RECEIVE AN UPDATE ON COLLABORATION WITH WIRRAL UNIVERSITY TEACHING HOSPTAL, TO INCLUDE DETAILS OF THE STRATEGIC ESTATES PARTNERSHIP (SEP)**

Mr Chambers gave an update on collaboration with the Wirral University Teaching Hospital (WUTH) and stated that the collaboration with WUTH was to look at how the 2 Trusts could use their resources better. One particular area of focus was around the Strategic Estates Partnership (SEP).

Mr Holden gave a detailed presentation on the SEP proposal and highlighted the following points:

- The Trust has been discussing with WUTH as to how the 2 Trusts could use their estate better.
- The paper is seeking approval from the Board to go out procurement to appoint a private partner, which would then form a joint venture partner with the Countess and WUTH.
- The costs would be shared across both Trusts and the Countess procurement team will be leading on this.
- The Trusts will seek to procure a joint venture for 12 years and will approach the partner on a scheme by scheme basis and both parties would need to agree before any schemes were commenced.
- Mr Holden stated that the panel to consider the shortlist of partners would include a Board member.
- All schemes would be brought to Board for discussion on a case by case basis.
- Mr Holden asked the Board to approve the appointment process.

A full and robust discussion took place with Board about costing, monitoring, governance, the quality of partner required, the high level of due diligence that is required and some of the future schemes that could be considered for the SEP.

The Board of Directors approved the SEP to go to the procurement stage.

B52/16 **TO RECEIVE AN UPDATE ON GOVERNOR MATTERS**

Mr Cross gave an update on the following points:

- The Council of Governors election process will commence in July 2016 with vacancies across all 3 public constituencies.
- The election process for the Deputy Chair of Governors/Lead Governor has stated and two candidates have put themselves forward. Mr Cross will keep Board informed.
- The Annual Members meeting will be held on 4th October 2016 and Mr Cross asked Board members for any suggestions for the service showcase.
- The Governors have given 2 presentations to public groups, U3a and the Heart Support Group in Chester both of which were very well received.

FOR NOTING& RECEIPT

B53/16 **TO RECEIVE THE LSMS ANNUAL REPORT 2015/16**

The Board received and noted the LSMS Annual Report 2015/16.

B54/16 **TO RECEIVE THE CHILDREN'S SAFEGUARDING ANNUAL REPORT 2015/16**

The Board received and noted the Children's Safeguarding Annual Report 2015/16.

B55/16 **TO RECEIVE THE ADULT'S SAFEGUARDING ANNUAL REPORT 2015/16**

The Board received and noted the Adult's Safeguarding Annual Report 2015/16.

B56/16 **TO RECEIVE THE MINUTES OF THE QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE – 18TH APRIL 2016 AND 16TH MAY 2016**

The Board received and noted the minutes of the Quality, Safety and Patient Experience Committee – 18th April 2016 and 16th May 2016.

B57/16 **TO RECEIVE THE MINUTES OF THE FINANCE AND INTEGRATED GOVERNANCE COMMITTEE – 5TH APRIL 2016**

The Board received and noted the minutes of the Finance and Integrated Governance Committee – 5th April 2016.

B58/16 **TO RECEIVE THE MINUTES OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – 12TH APRIL 2016**

The Board received and noted the minutes of the People and Organisational Development Committee – 12th April 2016.

B59/16 **TO RECEIVE THE CORPORATE INFECTION PREVENTION AND CONTROL ASSURANCE – QUARTERLY REPORT (RETROSPECTIVE REPORT BASED ON FEBRUARY 2016 QUARTERLY DATA UPDATE)**

The Board received and noted the Corporate Infection Prevention And Control Assurance – Quarterly Report (Retrospective Report Based On February 2016 Quarterly Data Update).

B60/16 **DATE AND TIME OF NEXT MEETING**

Tuesday 6th September 2016 – 2.00pm in Training Room 3 & 4, Countess of Chester Hospital.

BOARD OF DIRECTORS ACTION LOG 2016/17

Meeting Date	Minute Ref:	Issue	Action	Update	Responsibility	Target Date
14.10.15		To receive an update on the Culture Work at the Trust with particular focus on communication			Sue Hodkinson	October 2016
03.05.16		Session on Sepsis with Council of Governors		Planned session at Annual Members Meeting 04.10.16	Alison Kelly	October 2016
03.05.16		Session on the Trust's risk register to be held with Non Executive Directors			Alison Kelly	October 2016
03.05.16		Nursing and Midwifery performance dashboard to be shared with the Board			Alison Kelly	TBC
05.07.16		Update on CQC inspection report actions			Alison Kelly	December 2016
05.07.16		Update on 62 day cancer target, RTT, patients waiting over 52 weeks to be given at the FIGC in October 2016			Lorraine Burnett	October 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

People and Organisational Development

Our plans for 2016 to 2018

Foreword

We talk a lot about our hopes and ambitions for the future here at The Countess. Our vision is to deliver NHS care locally that makes our staff and our community proud. Our values are summarised as being safe, kind and effective in everything that we do.

Our hospitals cost more than £210m each year to run. Most of this money is to pay our people – the talented doctors, surgeons, nurses, midwifes, therapists, pharmacists, healthcare assistants, domestics and porters as well as the vast range of highly experienced support staff in corporate or administrative roles. We are a service industry, and it is our people who make our care and our hospital great. So it makes sense that we all share a role in looking after each other - be this through supporting, nurturing or developing colleagues to help us each be the best version of ourselves that we can be.

Over the last year, as we have moved forward with our plans to be The Model Hospital more than 2,000 colleagues contributed towards focus groups, team discussions and surveys to revisit the strengths of our Team Countess culture. We want to 'bottle' the specialness that makes this hospital so friendly and dependable for our patients. However, there is a 'but' here and it is a big one. To do this effectively in the current NHS climate, we must take a tougher stance on behaviours that do not belong here or play any part in our future. Collectively we have agreed the new standards of behaviour we want to see and encourage in everyone which are:

- Working together
- Respect and fairness
- Having a positive attitude
- Achieving Excellence
- Leading our people

Our People and Organisational Development Strategy sets out our commitment over the next two years to looking after each and every one of the 3,900 members of staff, volunteers and governors working here with these behaviours in mind. We know what we need to do to and how we are going to do it. We hope the approach described in this document gives you the assurances that this hospital continues to be a place where you want to come to work, care for patients, recommend to others and contribute towards our future.

With best wishes,

Sue Hodkinson,
Director of Human Resources & Organisational Development

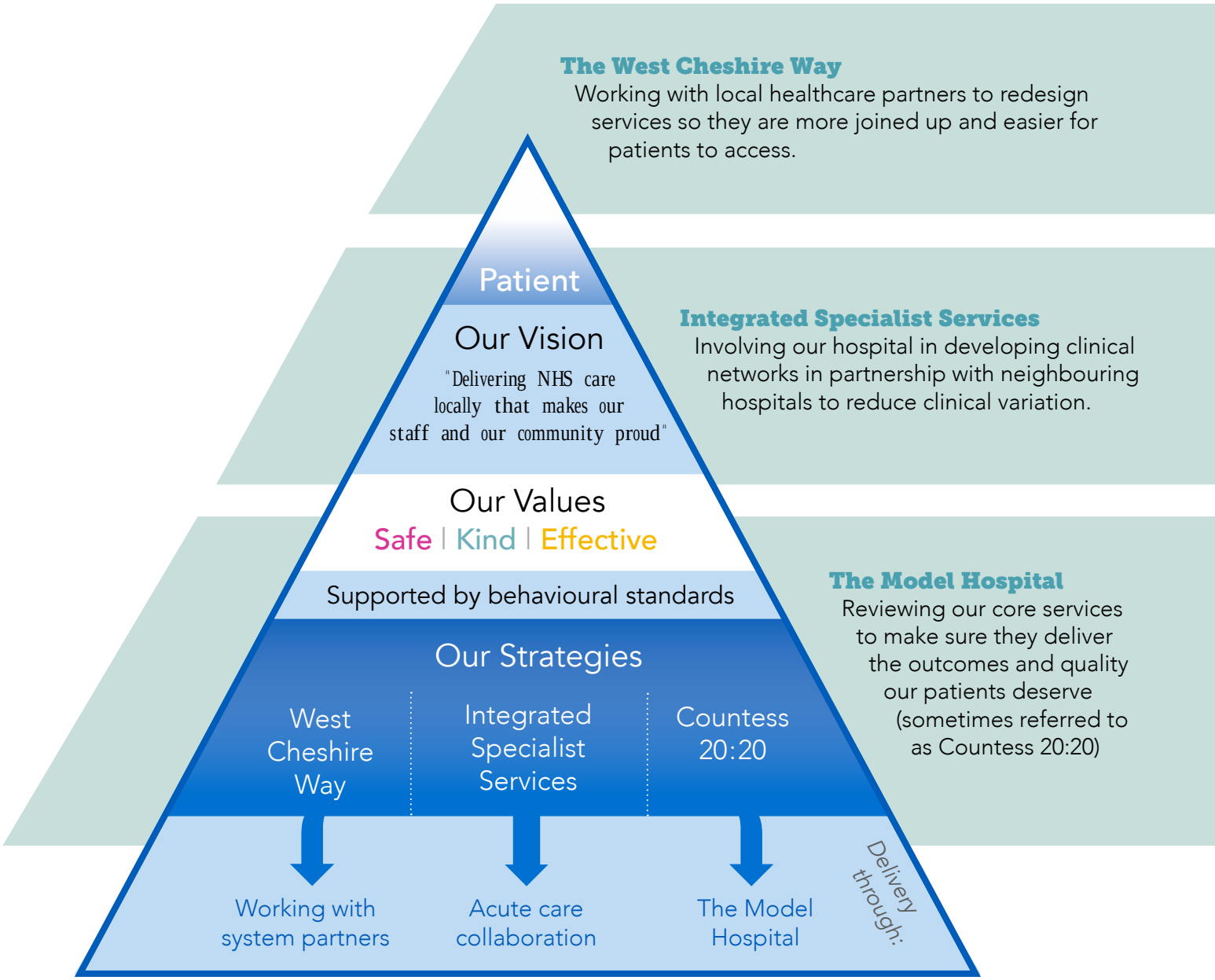
Ed Oliver,
Non-Executive Director and Chair of the People & Organisational Development Committee

How this fits with the bigger picture...

Our people are involved in delivering three key strategic programmes:

- The West Cheshire Way
- Integrated Specialist Services
- The Model Hospital

These are all ambitious transformational change programmes. They are dependent on us each contributing towards new ways of working, collaboration with other providers in through forging of new relationships. Without the engagement and motivation of our people, they will not succeed. This People and Organisational Development Strategy describes the wider range of enabling activities that will be delivered over the next two years.



Introducing our Behavioural Standards

Everyone working at The Countess can make a significant contribution towards our People and Organisational Development Strategy by adopting our new behavioural standards which are set out below:

Safe | Kind | Effective

Working Together

to get the best outcomes for patients and the Trust

Safe | Kind | Effective

Respect and Fairness

so that everyone feels like a valued member of the Trust

Safe | Kind | Effective

Positive Attitude

to create a great environment for our patients, my colleagues and myself

Safe | Kind | Effective

Achieving Excellence

to continuously improve our care for patients, our people and our finances

Safe | Kind | Effective

Leading People

by creating an environment in which everyone can do the best job possible

You can find out more information about our behavioural standards from the intranet, your line manager or any member of the Human Resources team.

What this strategy will deliver...

We will focus on three changes:

- Organisational culture
- Operational excellence
- Organisational renewal

Change 1: Organisational culture

How we do things at The Countess

We want to be the most clinically led and engaged organisation in the NHS, with our clinicians leading improvements and innovation, raising and acting on any concerns while supported to enjoy the day job and provide the best possible experience for their patients. We will deliver improvements in a number of areas…

1. In looking at our **values and behaviours** we will develop a more formal approach to how we recognise when we get our behaviours right and address instances when we get it wrong. We will re-energise what our values and behaviours mean for us all as well as exploring personal accountability in delivering change.
2. Monitoring and increasing the options available for feedback to ensure a positive **staff experience** will be ramped up. This will deliver a shift in our staff engagement activities so there is a greater contribution to decisions about day to day working life, suggestions for improvement and shaping plans for the future while there is so much change happening in the NHS regionally.
3. A strengthened **Leadership Framework** will see us building on the successes of recent initiatives such as our Countess 20:20 Leadership Programme, Master Classes with guest speakers, and we will develop a bespoke leadership programme that helps us to implement our new performance framework, manage our behavioural standards and lead our people effectively.
4. **Career development pathways** will be established to train and develop staff to ensure they can undertake their current jobs, and be prepared to take on promotion opportunities. This work will focus on developing people to their full potential and will include a growth in apprenticeships.
5. Providing **coaching and mentoring** support throughout the organisation will be common practice. This will be achieved through a coaching skills programme to increase capability in this area, as well as a system for matching colleagues with an appropriate coach or mentor.
6. **Reward and recognition** will remain at the heart of how we work and value our people. There will be continued award and celebration events, with an emphasis on increased frequency

and support for more informal team-led recognition activities, including profiling of positive patient feedback about individual staff delivering outstanding patient care.

7. **Compliance** with mandatory training, core skills and appraisals will be made clearer for our staff to understand through devising bespoke learning pathways. Partnering arrangements with the University of Chester and other educational providers will remain a priority, particularly to support new national requirements to encourage apprenticeships.
8. The introduction of a new **performance framework** system linked to our new behavioural standards will see regular and supportive development conversations between line managers and the people they are responsible for looking after in work.
9. Our **policies and procedures** will continue to be reviewed and developed, drawing on the feedback from our Staff Partnership Forum and Local Negotiating Committee (LNC). During times of significant organisational change, we recognise the contribution from staff representatives to help us get the engagement and communication with our workforce right.
10. A new model for **medical management** will see a revamped structure with clearer lines of accountability for our doctors. The intention is to generate greater interest in medical leadership roles that have more involvement in decision making and running our hospitals and clinical services.

Change 2: Operational excellence

Working with new systems and processes

We know there is more we can always do to make the day job easier, particularly through the introduction of new systems or processes or use of technology. We will deliver specific changes in the following areas:

1. Developing our **acuity based workforce**, which means we can match staffing levels to meet patient need.
2. Supporting the introduction of **E-rostering** and other systems with appropriate supporting policies and reporting to enable a demand driven approach and a reduction in costs associated with temporary staff.
3. Task and finish group activity to address **variable pay** spending, with new controls, guidance and policies to help the organisation achieve its cost improvement plans in this area.
4. **Recruitment** to values will see revamped of recruitment processes to ensure the right behaviours are at the heart of how we attract, recruit and retain our staff.

5. A new approach to **talent management** and succession planning means we will support the recruitment of local people, particularly the young in apprenticeship roles. A more structured approach to ensuring a pipeline of talented of individuals ready for key roles and promotions.
6. Our contribution to **operational blueprints** as part of The Model Hospital will be essential, embedding and monitoring key standards for sickness absence, appraisal compliance, turnover and retention and mandatory training.
7. The Countess approach to **equality and diversity** is nationally recognised. We will continue to build on our work to date in ensuring our Disability Equality Group, Age Equality and Adult Safeguarding Group, Culture Faith and Belief Group and Gender and Sexual Equality Group meet regularly and contribute to the effective governance of the organisation.

Change 3: Organisational renewal

Continuously improving support for our people

1. Protecting the **health and wellbeing** of our people will continue to be at the forefront of our plans, with the delivery of the Health and Wellbeing Strategy. We know a healthy workforce results in significant quality, financial, business and performance benefits as well as improved patient care – and we want to do even more to keep our people well and happy in work.
2. **Attendance management** remains high on our list of priorities in terms of close monitoring and effective processes to support and address any issues, as well as practical options to keep people fit and healthy.
    - Stress management courses, mindfulness courses, resilience sessions and counselling services will remain available to everyone working at The Countess.
    - Flu vaccinations are provided, with the organisation committing to an uptake of 75% by the end of each calendar year
    - More work is underway to increase smoking cessation services, and set the right example for patients around keeping our hospitals smoke-free sites.
    - There is fast track access to physiotherapy services for any people who experience back pain or musculoskeletal issues. This is done quickly via either a GP or occupational health referral.
    - There will be a step change in our approach to nutritional awareness, with a reduction in availability of sugary drinks or foods and more promotional activity attached to healthy options.

3. Our **HR and Wellbeing Business Service** (a shared service with Wirral University Teaching Hospitals) is set to embark on a new programme of activity to become more commercially attractive to new customer organisations supported by the delivery of a new marketing strategy. At the same time it will continue to provide essential transactional HR services.

4. The **Payroll and Pensions** team will continue to support the delivery of accurate and timely payroll services, and accessible information sessions to help people working here understand any changes to national terms and conditions which may affect them now or in the future.

5. **Supporting *The Model Hospital*** sees us working towards providing quality, low cost, fully integrated back office functions, and progressing our acute care collaboration plans.

6. As a leading organisation in our use of the **Electronic Staff Record** we have an improved version of the system in planning that managers and team members will soon be able to use to maintain their records, including a remotely accessible version.

Patient

Our Vision

"Delivering NHS care locally that makes our staff and community proud"

Our Values and Behaviours

Safe Kind Effective

Countess 20:20

The Model Hospital

Organisational Culture

- Performance Framework incl. Values & Behaviours
- Staff Experience
- Leadership Framework
- Career Development Pathways
- Coaching & Mentoring
- Reward recognition
- Compliance
- Performance management
- Policies and processes
- Medical Management

Operational Excellence

- Acuity based workforce
- E-Rostering
- Variable pay
- Recruitment to Values
- Talent Management
- Operational Blueprints
- People Metrics
- Attendance Management
- Turnover & Retention
- Equality & Diversity

Integrated Specialist Services

Acute Care Collaboration

Organisational Renewal

- Health & Wellbeing Strategy
- Attendance Management
- Resilience & Mindfulness
- Flu Campaign
- Smoking cessation
- Physiotherapy Services
- Nutritional Awareness
- HR Shared Services
- Supporting The Model Hospital
- Electronic Staff Record
- Payroll & Pensions

West Cheshire Way

The Model System	Partnership and Collaboration	Workforce Repository & Planning Tool (WRaPT)

Meeting regulatory requirements

NHS Improvement	**Care Quality Commission**	**Health Education England / North West**
International Recruitment Cost Reduction Strategy Annual Plan & Report	Quality Report Staff Opinion Survey Staff Friends & Family	HEE Workforce Plan Apprenticeship development Talent for Care & Widening Participation

BOD Item No

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	**People & Organisational Development Strategy 2016-18**
Date of Meeting	6th September 2016
Author(s)	• Dee Appleton-Cairns, Deputy Director of Human Resources • Sue Hodkinson, Director of Human Resources & Organisational Development
Presented by	Sue Hodkinson, Director of Human Resources & Organisational Development
Annual Plan Objective No.	N/A
Summary	Our People & Organisational Development strategy sets out our commitment over the next two years in relation how we will support the delivery of our Vision, to deliver NHS care locally that makes our staff and our community proud, and our values – Safe, Kind and Effective. The strategy supports the launch of our new Trust Behavioural Standards, developed by our staff as part of the Model Hospital programme and to be lived by us all. The strategy underpins the three strategic pillars of our Trust-wide and system plans. It has been reviewed and discussed within various forums, particularly Partnership Forum and People & Organisational Development Committee. A summary of the strategy has also been provided.
Recommendation(s)	The Board is asked to receive and note: • the detailed Strategy and Delivery plan, • the summary of the Strategy • and the new Trust Behavioural Standards. The People & Organisational Development Committee will monitor progress against the plan, with an annual progress report provided to the Board.
Risk Score	**N/A**

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

Countess of Chester Hospital NHS
NHS Foundation Trust

2016-18 People and Organisational Development Strategy & Delivery Plan

Author: Dee Appleton-Cairns, Deputy Director of HR
Date to People & Organisational Development Committee: 19th July 2016
Date: 30th August 2016

Version No.	Date	Author	Comments
V1-20	May – August 2016	DAC with contributions from HRSMT, Partnership Forum, People & OD Committee	Presented at May/June/July Partnership Forum and/or People & OD Committee
V21	26th August 2016	Sue Hodkinson	Amendments Sue Hodkinson
Final V22	30th August 2016	Dee Appleton Cairns	Amendments D Appleton Cairns

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Foreword

We talk a lot about our hopes and ambitions for the future here at The Countess. Our vision is to deliver NHS care locally that makes our staff and our community proud. Our values are summarised as being safe, kind and effective in everything that we do.

Our hospitals cost more than £210m each year to run. Most of this money is to pay our people – the talented doctors, surgeons, nurses, midwifes, therapists, pharmacists, healthcare assistants, domestics and porters as well as the vast range of highly experienced support staff in corporate or administrative roles.

We are a service industry, and it is our people who make our care and our hospital great. So it makes sense that we all share a role in looking after each other - be this through supporting, nurturing or developing colleagues to help us each be the best version of ourselves that we can be.

Over the last year, as we have moved forward with our plans to be *The Model Hospital* and more than 2,000 colleagues contributed towards focus groups, team discussions and surveys to revisit the strengths of our Team Countess culture.

We want to 'bottle' the specialness that makes this hospital so friendly and dependable for our patients. However, there is a 'but' here and it is a big one. To do this effectively in the current NHS climate, we must take a tougher stance on behaviours that do not belong here or play any part in our future. Collectively we have agreed the new standards of behaviour we want to see and encourage in everyone which are:

- Working together
- Respect and fairness
- Having a positive attitude
- Achieving Excellence
- Leading our people

Our People and Organisational Development Strategy sets out our commitment over the next two years to looking after each and every one of the 3,900 individuals working here with these behaviours in mind.

We know what we need to do to and how we are going to do it. We hope the approach described in this document gives you the assurances that this hospital continues to be a place where you want to come to work, care for patients, recommend to others and contribute towards our future.

With best wishes,

Sue Hodkinson
Director of Human Resources and Organisational Development

Ed Oliver
Non-Executive Director and Chair of the People & Organisational Development Committee

Executive Summary

Meeting our ambitions for our patients and service users rests with our staff – engaging, empowering and recognising our people will make sure they can each be the best version of themselves and continuously drives improvement in the delivery of services.

At the heart of delivering this objective are our values. These are the principles that determine the way we behave and what we believe in. They help bring us together as a family, giving us a common culture.

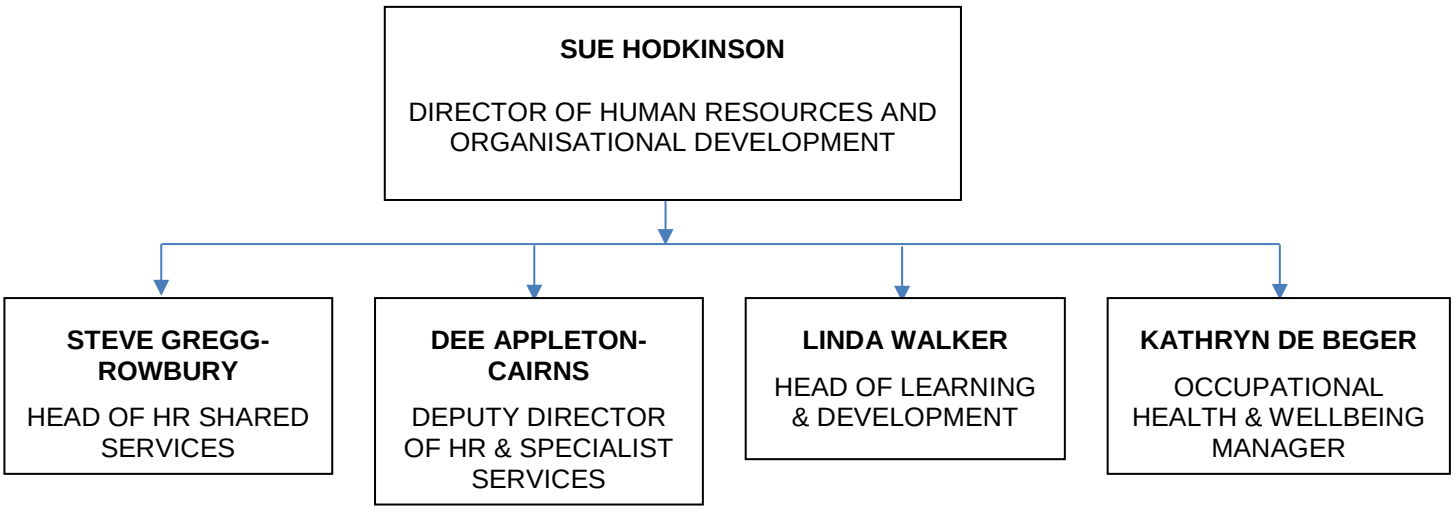
Our vision is to ***provide care that makes our patients and staff proud*** by being ***safe, kind and effective***. Therefore, our Trust strategy continues to be based upon adopting a future model of care where the Trust plays a key role as a locality based accountable provider of care for urgent acute and ambulatory patients, built on three key programmes.

- **The Model Hospital** – Countess 20:20 reviewing our core services to ensure they deliver the outcomes and quality our patients deserve.
- **Integrated Specialist Services** – Acute Care Collaboration - providing the right services to meet the needs of our patients, either as part of clinical network or as a specialist centre in our own right.
- **West Cheshire Way** – Partnership & Collaboration - working with our local healthcare and other partners to drive service re-design and integrate care for the residents of Western Cheshire.

The People and Organisational Development Strategy will support the work streams that underpin the Trust's three strategic pillars and this strategy details our plans for delivery over the next two years.

People Services Structure

The People Services teams consist of four elements under the direction of Sue Hodkinson, Executive Director. The HR & Wellbeing Business Service (HR Shared Service), Learning & Development and Occupational Health & Wellbeing teams supporting income generation by the provision of services to partners and third parties.



HR AND WELLBEING BUSINESS SERVICES

INCLUDES:

Recruitment

Payroll

Pensions

Electronic Staff Records (ESR)

Staffing Solutions (Bank)

HR AND SPECIALIST SERVICES

INCLUDES:

Specialist advice and Employment Relations

Policy Development

Workforce Planning

Equality and Diversity

Business Partnering

Medical Staffing

Service Development

LEARNING AND DEVELOPMENT

INCLUDES:

Clinical Education and Resuscitation Skills

Manual Handling

Learning and Development

Practice Education Facilitators

Medical Education (Undergraduate and Postgraduate)

Multi-Disciplinary Library and Knowledge

OCCUPATIONAL HEALTH & WELLBEING

INCLUDES:

Flu vaccination programme

Resilience

Smoking Cessation

Staff Wellbeing

2016-18 People Services Strategic Delivery Plan on a Page

Notwithstanding the strategy's operational & delivery plan, there is the cultural challenge that we face, to lead and deliver a new agenda built around the Model Hospital. This will focus on the characteristics of the Model Hospital - Value, High Reliability, Operational Transparency & Accountability, and they require collective leadership at every level and aspiring everyone to be the best they can be. This is in addition to ensuring that the recommendations from a wide range of current and future reviews into the NHS and patient care, new governance and patient safety improvement requirements, safe staffing, to name but a few, are put in place and that other guidance is followed.

Operational Context

The Model Hospital

Like many of its peers, the Trust faces immense financial challenges; it is currently a £210m enterprise that needs to reduce its spend by £20m by 2017 and £44.2m by 2020. More than 100 cost-reduction programmes have been initiated throughout the hospital, along with several other enabling programmes. Without rigorous implementation support, these well-intentioned initiatives risk becoming resource-intensive and piecemeal, making it very difficult for the Trust to succeed in delivering the necessary savings.

So we are becoming the first Model Hospital. Our vision is to be measurably the most efficient local hospital in the NHS, through delivering **Safe**, **Kind** and **Effective** care.

- **Safe:** to care for our patients by ensuring no never events, reductions in incidences of harm.
- **Kind:** to care for our people by making the Trust a better place to work.
- **Effective:** to care for our resources by removing £20m from our cost base.

The Model Hospital will focus upon value, placing a premium on value when seen from a patients and carers perspective and placing a premium on value when seen from a staff members' perspective.

The Model Hospital will focus upon high reliability with an emphasis on the first 72 hours, reducing variation, risk and waste, zero waiting and removing process for the sake of process. The Model Hospital will focus upon operational transparency with an integrated picture of operational reality in real time, end-to-end coordination and operational planning and demand with supply alignment.

Lord Carter of Cole's report on Operational productivity and Performance in English NHS Acute hospitals makes a number of recommendations that have been integrated into this strategy at a local level.

One of the recommendations is that NHS Improvement should develop a national people strategy and implementation plan by October 2016. This will set out a timetable for simplifying system structures,

raising people management capacity, build greater engagement and create an engaged and inclusive environment for all colleagues by significantly improving leadership capability from “ward to board”, so that transformational change can be planned more effectively, managed and sustained.

The key points of the future national people strategy which are reflected in our People and Organisational Development strategy and delivery plan include:

Workstream	**Lead**	**Delivered by:**
Leadership Framework	L Walker	Implementing a clear set of leadership capabilities used in the selection and performance management of leaders
Performance Framework	L Walker	Engaging with staff with regular performance reviews ensuring that a culture of continuous improvement is developed
Turnover & Retention	D Appleton-Cairns	Developing management practices to gain a better understanding of the reasons for high levels of staff attrition
Attendance Management	D Appleton-Cairns & K De Beger	Improving sickness absence, which will require common definition and improved collection of data managed as part of the operational management scorecard and process
Values & Behaviours	L Walker	A reduction in the high rates of bullying and harassment with a sustained campaign led personally by each Trust Chief Executive
Policies & Processes	D Appleton-Cairns	Trusts creating an environment that is fair and transparent, which requires polices, practices and agreements to be reviewed to ensure that they are clear, simple and swift to operate
Recruitment to Values	S Hodkinson	Mandating the use of a trust and national level succession planning processes

As part of the Model Hospital, there is a need for an enabling organisational infrastructure. The infrastructure includes a set of management practices common to successful organisations. They are key to overcoming the sorts of structural, organisational and cultural impediments that inhibit optimal productivity and efficiency.

The need for these changes is most clearly demonstrated by the importance of realising the wealth of talent and expertise possessed by all those who work in the NHS. It is clear from the annual staff survey that the culture in trusts is not always conducive to problem solving and engagement. This type of culture directly affects motivation and morale, and the degree to which people are prepared to give their best at work.

The adoption of the nine management practices Lord Carter's paper recommends will provide the momentum to create that shift and are reflected in the People and OD strategy.

Values-based behavioural framework	Developing a values-based behavioural framework – agreeing at the very outset the trust's underpinning values, determining their behavioural implications for all occupational groups and roles, and informing any system and process redesign
Patient-centred organisation	Moving towards a patient-centred organisation design – ensuring structure, workflow and resource allocation is designed around the patient through each stage of their hospital journey, as opposed to being designed around functional specialisms
Structural improvements	Adopting basic structural improvements – ensuring adherence to best practice management spans and layers, consistency of roles, and defining clearly individual accountabilities and decision rights
Leadership strategy	Developing a Board-sponsored leadership strategy – based on business need and a clear set of expectations, and encompassing all leaders from Board to frontline; including recruitment, engagement, development, talent management and succession planning
Operational management process	Implementing a comprehensive operational management process – a regular and highly disciplined series of Ward to Board management meetings that drive operational performance, cost reduction, increased efficiency and continuous improvement
Dashboards	In tandem with this process, adopting the Model Hospital dashboards - a series of upwardly cascading metrics that provide a balanced view of patient, people and financial performance at any given management level of the organisation
Individual performance framework	Instituting an individual performance framework – a process for appraising both task and behavioural performance for every individual in the trust, including a range of feedback mechanisms such as 360s, peer review, colleague survey results and actions; linking this to positive and negative consequences including reward, development, career progression
Engagement	Building engagement across all occupational groups – harnessing the ideas and viewpoints of everyone in the trust, paying particular attention to clinical engagement and the role of the Clinical Leader

Staff Survey	Repurposing the colleague opinion survey – reflecting more appropriately targeted questions and surveying sections of the workforce on a rolling monthly or bi-monthly basis to deliver a more timely pulse of people's views, and using the outcomes as a key metric in all managers' performance appraisals

Integrated Specialist Services

As an acute hospital, the Trust faces significant challenges as a result of demographic change, rising demand and a limited supply of some professional groups. Bringing all of these factors together, it is clear that the current model of acute hospital care, service and estate needs to change if acute hospitals are to be sustainable.

In addition, with the onset of the Five Year Forward View (5YFV) by NHS England, the challenge of coalescing a complex group of organisations across such a large and diverse Sustainability & Transformation Plan (STP) footprint across Cheshire & Merseyside is a real one.

As a 'system architect', the Trust recognises the need to pursue the models of care that will deliver the greatest benefits to our local population, therefore together with our Model Hospital programme and the West Cheshire Way system programme, the Trust will focus on further local collaborations with this programme of work

To transform all of our services, we need to reduce demand, reduce unwarranted variation and reduce cost. Supporting this we will be supporting the four priorities across the STP footprint to make our health and care system sustainable in the near, medium and long-term. These are:

- Demand management and prevention at scale
- Reducing variation and improving quality through hospital reconfiguration
- Reducing cost through back and middle office collaborative productivity
- Changing how we work together to deliver the transformation

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

- Shared corporate & back-office functions services.
- Investment synergies across our workforce, estate, research, education and training and technology.

West Cheshire Way

The *West Cheshire Way* is a system-wide vision for how the providers of care within West Cheshire will deliver care to the people of West Cheshire over the next five to ten years. The vision sets out to;

- Improve self-care.
- Work across boundaries.
- Support and care for people in their own communities.
- Improve the management of long term conditions.

The Trust is playing a leading role in the development of an integrated care system.

How will the Strategy support The Model Hospital?

1. The Model Hospital

1.1 Organisational Culture

Our aim is to be the most clinically led and engaged organisation in the NHS by focusing on the culture of the organisation, how we do things at the Countess and having motivated staff who feel able to contribute towards improvements and innovations at work and where their positive staff experience will support the patient experience. We are committed to openness, transparency and candour enabling all staff to feel they are able to raise concerns about patient care safely, without fear of victimization, and supporting us each of us to be the best version of ourselves that we can be.

Values & Behaviours

The key to providing safe, kind and effective care to patients is supporting and valuing our staff. The introduction of the Trust Behavioural Standards as part of the work within the Model Hospital programme has been designed by our staff and will be lived by us all, and is introduced as part of the launch of this strategy.

Over 2000 items of feedback were collated, themes identified and the set of behavioural standards, to be lived by everyone have been produced. Collectively, we have agreed the new standards of behaviour we want to see, encourage and recognise in everyone are:

- **Working Together:** to get the best outcomes for patients and the Trust
- **Respectful and Fair:** so that everyone feels like a valued member of the Trust
- **Positive Attitude:** to create a great environment for our patients, my colleagues and myself
- **Achieving Excellence:** to continuously improve our care for patients, our people and our finances
- **Leading People:** by creating an environment in which everyone can do the best job possible.

Further details of the new Trust Behavioural Standards can be found in Appendix 1.

In addition, the LEAD programme will play an integral part in being a key enabler in meeting our Trust goals and helping to shape a healthy culture. To embrace the continuous learning, education and development ethos of the Trust; the creation of pathways aligned to Trust objectives to guide staff through their development will be a critical part of our overall people strategy.

Staff Experience

It is well researched that an excellent staff experience contributes to an excellent patient experience. Valuing the contribution of staff, involving them in decisions that affect them in their day to day working life, encouraging contributions to improvements and innovation and effective, clear continuous communication at all levels throughout the organisation, giving all staff a voice, is a key enabler to realising our vision.

Leadership Framework (including Master Classes)

We aim to have capable and confident leaders at all levels, who live our values and who act in line with our leadership behaviours in an ever changing, fast moving environment. As part of the performance excellence framework we will implement a clear set of behaviours, capabilities and competencies that will be used in their selection and performance management. Excellent collective leadership embedded throughout the Trust, will support and encourage the empowerment of staff to deliver continuous change and improvements in their workplace. We will build on the success of our COCH 20:20 Leadership Programme to shape future development programmes.

Our leaders require continuous learning, education and development and support to maintain their focus in what are extremely challenging and demanding times of change across the NHS and social care. Our programme of master classes will continue to evolve as we endeavour to provide development that enables our leaders to keep pace with the far reaching changes that are necessary to enhance and improve models of care across health and social care. Involving, sharing and engaging with our partners across a wide range of services will be paramount in ensuring we develop relationships to the mutual benefit of our patients and staff.

Career Development Pathways (including Apprenticeships)

We aim to have a skilled, flexible and talented workforce, with individuals who are able to adapt to our future needs. Our policy is to train and develop all staff through training and staff development measures in order to ensure that they can undertake their current responsibilities as effectively as possible, to be fit and prepared to take on promotion opportunities and to enable them to develop to their full potential. The Trust accepts its wider responsibility to plan jointly with its staff their careers and recognises that the process will be most effective when members of staff are fully involved in their future.

As part of the Model Hospital, there is a need for an enabling organisational infrastructure. The need for these changes is most clearly demonstrated by the importance of realising the wealth of talent and expertise possessed by all those who work in the NHS. The adoption of the nine management practices Lord Carter's paper recommends will provide the momentum to create that shift and are reflected in the Trust People strategy for 2016/17.

Coaching & Mentoring

Supporting the development of our staff is essential in maintaining the focus of our workforce. Providing coaching and mentoring opportunities for staff in order to aid that development will be a key priority in our people strategy. In order to ensure we adopt a coaching culture, a coaching skills programme is being cascaded across the organisation.

Reward & Recognition

We want to provide a high quality and consistent service that is valued by our patients, their relatives and others who come in to contact with us. Our people can make this happen, supported by the right mechanisms for managing performance, rewarding and recognising excellence and recognising talent through career development. We will continue to develop, promote and celebrate the achievements of our staff by rewards and recognition Schemes including the Outstanding Achievements Awards and the annual Celebration of Achievement Awards Ceremony. We will recognise outstanding examples of patient care, team working and staff endeavours. In addition we will continue to encourage the embedding of regular, appropriate day to day feedback and thanks to our staff in acknowledgement of the great work that is done by our teams every day.

Compliance (including mandatory training, core skills and appraisal)

For both our clinical and non- clinical workforce we will:-

- Devise learning pathways for development across bands, including opportunities for development for Nursing Assistants and other Band 1-4 including the Care Certificate, Pre Degree pathways, Widening Access, Asst. Practitioner, the new Nurse Associate roles and apprenticeship pathways, including working with schools and colleges to encourage consideration of the NHS as a future career.

- Support the widening and adoption of service improvement techniques and innovation across the workforce.

- In line with the recently published Health Education Patient Safety report, we will focus on how education and training interventions can actively improve patient safety by embedding Clinical Humans Factors, the use of simulation and other Patient Safety Programmes into our development pathways.

- Support the wider agenda on the partnership with the University of Chester and other local HEI's and FE's. This will be necessary to support the opportunities that will be available in terms of supporting students undertaking health care related degrees and related placement opportunities. In addition there will be significantly increased numbers and levels of apprenticeship qualifications that will be made available in the light of the new Apprenticeship Levy. It is crucial to be actively involved in and work closely with, our education institutions in order to ensure we take every opportunity to be the Employer of Choice and encourage the recruitment of newly qualified staff and support our apprentice workforce. Working in partnership we will look to increase opportunities for research, education and innovation including that related to our medical workforce.

Performance & Behaviour Framework

The fundamental goal of having a performance framework is to promote and improve employee productivity and effectiveness. It is a continuous process where managers and staff work together to plan, monitor and review work objectives and his or her overall contribution to the Trust.

Effective managers provide feedback to and receive feedback from staff continuously, rather than rely on appraisals. This allows the manager to determine what motivates their staff to work hard, evaluate what obstacles are making it difficult for them to effectively do their jobs, and make adjustments. As a result, we will be developing wider feedback mechanisms, including 360 feedback, based our new behavioural standards. We will developing a range of pathways to support, recognise and reward positive performance and behaviour, and we develop further ways of engaging with our members of staff, including regular check-ins with our Staff Barometer group.

Policies & Procedures

The Trust adopts HR policies to retain staff by giving opportunities for personal and professional development, maintaining and improving the quality of working life and providing health and welfare services. The Trust strives to be regarded as an employer that it is desirable to work for, an employer that treats its staff reasonably, acts compassionately and an employer which contributes to the life of the local community. In order to maintain good employee relations, the Trust recognises the appropriate trade unions and encourages membership of them.

The Trust will consult with staff representatives on proposed courses of action and negotiate and/or consult on conditions of service, and significant organisational changes. The Trust will, as far as practicable, seek and consider the views of staff before decisions are finalised. Measures are taken to confront and discourage all forms of undesirable or discriminatory behaviour, by encouraging best practice in all its activities, monitoring procedures for recruitment and promotion etc., incorporating equal opportunities considerations into training courses, and by acting quickly on inappropriate behaviour.

Members of staff are enabled to maximise their contribution to the workplace by reviewing working practices and procedures, introducing new systems and investigating and promoting improved methods of care and learning. All staff will have the opportunity to participate in a jointly operated system of staff development and performance appraisal in order to provide effective opportunities for open discussion and identify action needed.

Medical Management

For those in clinical practice, an appreciation of leadership and management skills in the health care setting is increasingly important. The Trust will provide opportunities for Clinicians to develop the knowledge, skills and values to enable them to practice more confidently. This includes supporting the Medical Leadership workstream as part of the Model Hospital programme.

The Trust is supporting the enhancement and contribution of the medical profession, providing opportunities to:

- Promote better medical leadership at all levels
- More effective team working
- Increase evidence based services underpinned by a strong data analysis
- Doctors as role models for doctors in training and other health professionals
- Doctors as advocates for health services and the health needs of the population.

1.2 Operational Excellence

We know there is more we can always do to make the day job easier, particularly through the introduction of new systems or processes or use of technology. Through the strategy, we will provide support & professional advice, both transactionally and transformationally, on the following current systems implementations, as well as potential future systems such as Patient Asset Tracking.

Acuity based Workforce

An acuity based staff deployment approach brings information on actual staff levels together with the numbers and needs of patients. It provides a real-time shift-by-shift view of required versus actual staffing across the Trust. It will empower managers, matrons, ward managers and nurses. Accessible on a desktop computer, tablet or phone, matrons, ward managers and nurses can take a census of patients acuity & dependency, see who is rostered on a shift, track attendance and sickness of those staff, request bank or agency cover if needed.

Everyone gets an instant view of whether the staffing level is deemed safe as the system will apply the appropriate acuity and dependency calculations for that ward or service type. The software will allow nurse directors, matrons and site managers to see a site wide view of staffing levels – as well as the ward specific views. Fully informed it provides for 'just in time' changes, redeploying staff where appropriate and updating staffing and staffing level information there and then.

While this is happening, the system is updating the roster which means the rosters are updated and accurate ready for payroll, future reporting for the Model Hospital Care Hours per Patient per Day (CHPPD) requirements, Unify returns and establishment reviews.

E-Rostering

Key to the Trusts e-rostering approach is to set an effective foundation prior to rollout with the following key areas:

- Create a Roster Policy that details the Trust's requirements, framework and escalation policy. This defines, for example, common Trust rules and the approvals process necessary to ensure rostering is effective. The roster then tracks and enforces this policy.

- Create a Key Performance Indicator (KPI) based reporting structure to give clear visibility of the effectiveness of each rostering area. This will help highlight issues to the appropriate management level.

- Perform an establishment review, to ensure that the Ward's demand (requirement) is in line with the budgeted establishment. Discrepancies will be identified and addressed, ideally before rostering rollout begins. This is critical, as it ensures that the future Demand Driven rostering is being performed on the correct demand. As mentioned in the National Audit Office report on temporary staff use, "Setting the right establishment levels is an effective way for organisations to reduce their demand for temporary staff."

Variable Pay

The teams have been heavily involved in the group tasked at making significant savings through Variable Pay. The team are involved in researching, monitoring, setting controls and writing guidance and policies to assist the Trusts wider stance of achieving its CRS pay targets as well as tracking the overall pay bill. The targeted saving is reliant upon actions being taken to back up the issues discovered when exploring overtime, additional basic pay, Additional Clinical Activity, Bank Usage and Agency usage, with a particular focus on Medical Agency spend.

Recruitment to Values

As part of our organisational culture programme of work, we will be developing our Trust wide recruitment strategy. This particularly includes how we recruit to our values and behaviours. As part of this, we will be reviewing all recruitment processes to ensure that "Safe, Kind and Effective" and our new behavioural standards are the heart of how we attract, recruit and retain our staff.

Talent Management and Succession Planning

Attracting skilled talent to take up positions within the Trust is the first step in the talent management cycle. As a local organisation serving local people, it is important to maximise talent locally by encouraging local people to work for us, this benefits the local economy in terms of reduced unemployment rates. In addition where possible we will support the recruitment of local people, particularly young people into apprenticeship roles. It is also beneficial to the organisation to recruit local individuals as we are able to tap into the knowledge of local people, who are our staff as well as customers.

However it is not sufficient to simply attract individuals with high potential; developing, managing and retaining those individuals as part of a planned strategy for talent and succession planning is equally important, In addition identifying existing talented individuals and indeed, supporting all staff in understanding their aspirations and maximising enjoyment and performance at work can only be of benefit to the organisation.

In terms of succession planning, introducing a more structured approach, as an integral part of the People and OD Strategy, the Trust can be confident that the organisation has a reliable pipeline of talented people who are being prepared for key roles and promotions.

Operational Blueprints

A wealth of data is already reported our how we support and develop our members of staff. However, with this new strategy, we will be supporting the development of advancements in people based metrics, as part of the design of the operational blueprints and building on how these are presented from a Ward to Board perspective. These include the development of performance metrics which can be found in appendix 3.

Equality & Diversity

We will build on our regionally and nationally recognised programme of work to support Equality and Diversity within the Trust. The Trust has recently been recognised as an Equality and Diversity Partner and the programme supports participating trusts to progress and develop their equality performance and to build capacity in this area. At the same time the programme provides an opportunity for partners to offer advice, guidance and demonstrations of good practice in equality and diversity management to the wider NHS. We are one of 22 Trusts to have been approved to be part of this programme and organisations are awarded partner status after they have demonstrated that they are delivering against six measurable criteria:

- improving patient access and experience
- empowered, engaged and well supported staff
- inclusive leadership at all levels
- better health outcomes for all
- demonstration of commitment to the partners programme and benefits the organisation will receive from taking part.

We pride ourselves in communicating with stakeholders both internally and as part of our wider community in work around around Equality and Diversity and our robust governance structure is headed up by the Equality Diversity and Human Rights Strategy Group, which reports into the People and Organisational Development Committee.

Sub Group	Lead	Regularity of meetings	Number of meetings
Disability Equality Group	Deafness Support Network / Flintshire Access Forum	Quarterly	Four

Age Equality & Adult Safeguarding Group	E&D Manager	Quarterly	Four
Culture Faith & belief Group	Acute Directorate Manager	Quarterly	Four
Gender & Sexuality Equality Group	TransForum / Unique Transgender Network	Quarterly	Four

The Workforce Race Equality Standard (WRES)

Implemented by NHS England in July 2015, it is a set of key indicators outlining how the Trust can demonstrate data and engagement evidence on how Black and Minority Ethnic (BME). Staff are evidenced within recruitment, HR Formal procedures and leadership & development. It also sets standards to outline actions the Trust will undertake to improve ESR and training data capture and engage with its BME staff. The Trust met all 2015 WRES action plan objectives and published its 2016 WRES report on 29/7/2016. A new WRES action plan outlines targets in 2016-2017 to scope the introduction of a BME staff network and improvements in data analysis of the access to non-mandatory training and personal development.

The Equality Delivery System 2 (EDS2)

An equality performance assessment framework introduced in January 2012 by NHS England. It covers 18 outcomes around Patient Care, Quality, safety, Workforce and Leadership domains. The Countess has attained recurrent high grading from assessors, with 15 outcomes being rates as Achieving and the remaining three outcomes being rated as Excelling. It remains on target in 2016-2017 to continue its high quality assessment when the assessment and grading phase with internal and external stakeholder groups is verified by Health Watch in March 2017.

2. Supporting Integrated Specialist Services - Organisational Renewal

Health & Wellbeing Strategy

Occupational Health has a pivotal strategic role in the delivery of safe, kind and effective patient care through promoting and protecting the overall health and well-being of staff. This is key to supporting the Trust meet its objectives and deliver the Countess vision of providing local NHS care that makes our community and our staff proud and to do that, we need to support and enable 'people at their best'. Employee health and wellbeing influences whether people are able to work at their peak and are critical success factors for individual and organisation performance. A healthy workforce results in significant quality, financial, business, productivity and performance benefits, as well as most importantly, improvements in patient care.

Attendance Management

A combination of factors play into improving absence rates and these include the provision of up to date information, a c*onsistently applied policy, management development and individual hotspot support from Human Resources* with back up provision of Occupational Health services.

Trust Target	Trust Target FTE-Days Lost to Sickness Absence	Average % Over 12 Months (Apr. 15 To Mar.16)
3.65%	30187.66	4.01%

Although Sickness Absence is currently above the Trust target, it compares favourably regionally and nationally. This is due to keen processes, managerial support and an effective, accredited Occupational Health department.

The Trust has introduced a range of schemes for staff by offering physical activity with an emphasis on promoting active travel, building physical activity into working hours and reducing sedentary behaviour. Opportunities for staff include; the involvement in the NHS NW Games, Trust choir, fitness classes, running clubs and team games and Pilates on site.

Resilience & Mindfulness

Occupational Health has introduced a range of accessible and supportive mental health initiatives for staff. They offer support to staff such as stress management courses, line management training, mindfulness courses, Resilience sessions and counselling services.

Flu Campaign

Influenza is also a highly transmissible infection. The patient population found in hospital is much more vulnerable to severe effects. Healthcare workers may transmit illness to patients even if they are mildly infected. The Trust is committed to achieving an uptake of flu vaccinations by frontline clinical staff of 75% by the 31 December 2016.

Smoking Cessation

The Trust is exploring how we support our staff, patients, carers and visitors to enable a no-smoking site. This includes a monthly multi-disciplinary steering group who are leading a range of interventions which will be launched in late 2016.

Physio Services for staff with Musculo Skeletal issues

The Trust has improved access to physiotherapy services, the service has a fast track option for staff suffering from musculoskeletal (MSK) issues to ensure staff who are referred via GPs or Occupational Health and can access it in a timely manner.

Nutritional Awareness

We have achieved a step-change in the health of the food offered on Trust premises working with our Dieticians. Looking ahead ,in line with the national CQUIN , our focus includes:-

- removing price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS), such as; pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food;
- removing the advertisements for sugary drinks and foods high in fat, sugar and salt (HFSS);
- stop the promotion of sugary drinks and foods high in fat, sugar and salt (HFSS) at checkouts

HR & Wellbeing Business Services (HR Shared Services): our Collaboration with Wirral University teaching Hospital NHS Foundation Trust

In our fifth year operating as a collaboration of HR transactional services between Countess of Chester Hospital NHS Foundation Trust and Wirral University Teaching Hospitals NHS Foundation Trust, we have delivered significant reductions in staffing costs each year since the collaboration began in 2011. Having successfully re-negotiated Payroll & Pensions SLAs with our three additional clients, we have 100% customer retention whilst operating lean staffing levels. Furthermore, we have maintained consistently high payroll accuracy, shift fill rates and vacancy turnover.

HRWBS is now embarking on a programme of activity to become more commercially attractive to new customer organisations and generate more income for our sponsoring Trusts, whilst also remodelling internal business processes to manage a high volume of administration tasks.

The changes the NHS is facing undoubtedly holds some challenging adjustments to national terms and conditions with the implementation of the Junior Doctor contract, Pensions Auto-Enrolment, Annual Tax Allowance thresholds and much more. Our Payroll and Pensions Service and expertise will be integral to implementing these initiatives with minimal impact.

Supporting the Model Hospital

Recommendation seven in the Carter review (2016) typifies the operational model in which HRWBS is working towards; providing quality, low-cost, fully integrated back office functions. Having the first Model Hospital as one of our sponsoring Trusts is a vital springboard to promoting our service and showcases how effective collaborative working can be, evidenced by the previous five years.

Moreover, highlighted by the Carter review, we know that the NHS is yet to achieve a consistent standard to using the Electronic Staff Record (ESR), resulting in a missed opportunity to better understanding the NHS workforce. In HRWBS, we consider ourselves to be the custodians of workforce data for our customers, and our development strategy is built around ensuring ESR, and related workforce tools, are the single version of the truth in relation to staffing data.

In readiness for the Acuity Based Workforce work stream of the Model Hospital, our Staffing Solutions team already hold the relevant skills and expertise of using the new BanksStaff booking system which will be implemented . We are will also be delivering the implementation of Employee On-Line, a new remote method of accessing shifts booked and available for staff.

To support the work already completed by the Variable Pay work stream, we have an opportunity to review how we process each type of additional payment. Our aim in the Payroll team is to provide a solution which offers live data, pre-payroll, for all additional staffing payments, to make more informed decisions around spend during the month.

Electronic Staff Record

Our Trust has long been recognised nationally as a leading organisation in our use of the ESR. Re-procured by the Department of Health (DoH) for five more years, our new ESR supplier in IBM, plan a scheme of developments labelled *ESR Enhance*, which will see a much improved version of the system our managers and employees use to maintain their HR records. Consequently, we have an opportunity to capitalise on further efficiencies and improve the way in which we use ESR;

- Employee accessing their own HR record via mobile devices, from home or anywhere;
- Communications tool to send key messages to the workforce;
- Links to local policies and Trust information;
- Accessing online payslips and P60s;
- Employees take ownership of their personal development;

- Value added appraisal system, providing a wide range of metrics for tracking Talent and performance monitoring;
- Improved Manager experience in using ESR for HR transactions;
- Integrated with e-Roster;
- Free electronic expenses solution;
- Better integration with finance systems and tighter Establishment Control

Marketing Strategy

HRWBS will use each development as a proof of concept to promote what is achievable through better use of systems and effective collaboration with internal and regional partners. Examples of best practice case studies and promotion across our local networks is a vital strategy to marketing and growing our service.

Across the three regional clusters in the North West, a two year programme for Streamlining Staff Movements is launching in spring 2016 which will improve the way in which we share workforce data as people move around the NHS. Funded by Health Education North West in the first year, the programme will primarily focus on reducing duplication of pre-employment checks and helping speed up applicant clearing processes. HRWBS will use our existing model of collaboration to ensure we seen across local networks as an organisation leading the change. Key components of the Streamlining programme will be;

- Improving our 'time to hire' *and* 'time to clear'
- Improved use of NHS Jobs and Vacancy Management
- Standard, factual references for select staff groups
- DBS update service
- Core Skills Training Framework
- Occupational Health data transfer between employers

Our external facing website, www.hrwbs.com will be updated progressively over the next 2 years to become an integral tool for our customers to access data, via a client login portal, relating to their Trust's workforce but also our own Service's KPIs.

Payroll & Pensions

With five client organisations, our Payroll and Pensions team provide an excellent value for money service which is flexible and responsive to meet the ever-changing needs of local benefits and rewards initiatives. Often overlooked, an annual pay bill of circa £420m for over 18,000 employees is processed by the team with a consistently high accuracy KPI average of 99.45%.

As a bespoke offering to the Trust, on top of providing a day to day advice center, our Pensions team will continue to support the delivery of information sessions to help our employees understand changes to

national terms and conditions such as annual allowance thresholds and sessions to plan for retirement. A well informed workforce can help our people plan for retirement and understand their options for flexible retirement and supporting our people with a comprehensive pensions service will underpin our strategy towards an ageing workforce.

How will the Strategy support the West Cheshire Way?

3. Supporting the West Cheshire Way - Cross Organisational Working

Partnership & Collaboration

Working with partners across the Sustainability & Transformation Planning footprint and West Cheshire, we will be developing key actions and performance success criteria around the demanding regional and national people agenda. This includes supporting the Streamlining Programme, which focuses on reducing variation in recruitment, pre-employment checks and mandatory training across organisations to streamline staff movement.

WRAPT (Workforce Repository and Planning Tool)

The development of the WRAPT tool that enables the collection, analysis and modelling of workforce information from organisations and providers across the whole health and social care economy. It is a flexible tool which at its core establishes the relationship between workforce capacity and service activity. It has benefits for both this organisation and also for the wider joined up Health economy.

The Trust has been nominated in becoming the host Trust for the WRAPT Specialist for the local Vanguard group. This will enable training and wider dissemination of the knowledge and usage of the tool.

Workforce

We will continue to look at our headcount and look for ways to become more efficient and cost effective.

- Controlling Variable Pay
- Red Circling Senior roles
- Managing Turnover
- Managing Attendance
- Managing Performance

Through collaboration we will consider:

- Shared Roles
- Physician Assistants
- Apprenticeships
- Outsourcing
- Streamlining
- Shared Services

Money saving schemes:

- Tax efficient Relocation Packages
- Bank Rates & weekly pay
- Additional Unpaid Leave
- Reduction in Hours
- Flexible Retirements

4. Meeting our Regulators Needs - Governance & Support

4.1 NHS Improvement

The Trust monitors all agency spend with regard to Medical staff, Nurses and Theatre staff and reports those shifts costing above the national agency caps to NHS Improvement weekly. These are also reported to the Board through the Integrated performance report and a recently commissioned Task & Finish Group has been established to provide further executive focus on reducing medical agency spend.

International Recruitment

The Trust will continue to recruit internationally for hard to fill roles such as nurses and theatre staff. It will also look to other continents for suitably qualified Medical staff at middle grade levels particularly around specialties such as A and E.

4.2 Care Quality Commission

Quality Report

There are a number of areas within the Quality Report which require submission of data in relation to Staff Engagement, specifically the NHS Staff Survey and Staff Friends and Family Test. Assistance is sought to ensure that the Trust is robust and action plans to address issues raised by our staff.

NHS Staff Opinion Survey

This is the prime source of evidence that the CQC use to gauge staff's engagement within the Trust, and monitor responses in addition to utilising the data as part of their inspection process. Responses are used to set the CQC targets in relation to mandatory training and appraisal compliance.

Staff Friends and Family Test (SFFT)

The data from the SFFT is used very much in the same way as the NHS Staff Survey data and is more real-time indicator of the engagement of staff in relation to recommendation to receive treatment and recommendation to work at the Trust.

4.3 Health Education England / North West Workforce Plans

Annual Plan & Reports

To plan for a highly skilled, affordable workforce by forecasting and identifying future needs. Exploring new recruitment markets and making the Countess an attractive proposition for desirable applicants by exploring different forms of social media. We will look at opportunities to collaborate with partners across

the health economy looking for efficiencies and opportunities to improve pathways for the benefit of patients. Support the operational areas with reviews of services and structures, look to adapt roles to meet the future needs of our services.

Apprenticeship Development & Levy

The introduction of the new Apprenticeship Levy will require the Trust to completely rethink their workforce planning for the future workforce. In order to fully utilise the mandated financial investment and work towards meeting the public sector target requirements, we will need to be innovative in the recruitment and retention of our staff and adopt supportive measures to ensure these staff are mentored and appropriately supported within the workplace to undertake their apprenticeship qualifications.

Talent for Care & Widening Participation

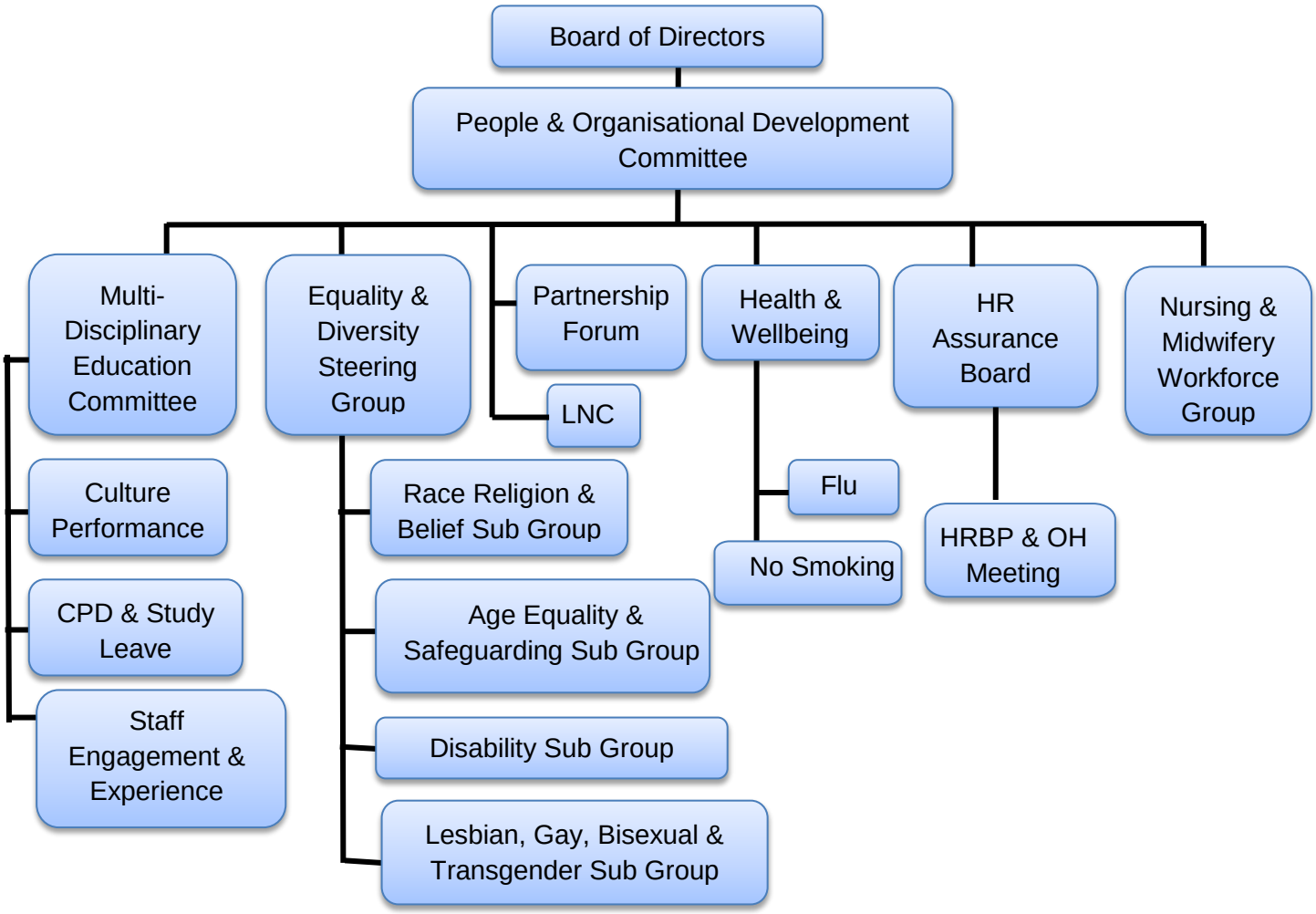
Our commitment to our staff and in particular our support staff within Bands 1-4 the Trust supports the Talent for Care and Widening Participation agendas. Our priorities will be to enhance the opportunities available to increase our volunteer contingent and provide increased opportunities to encourage community involvement which will also support the experience of patients. Working closely with our local schools, colleges and universities we aim to enhance our interactions with our local community to develop a more structured programme of work experience and work placements, with the aim of increasing awareness of the career opportunities available within our Trust and the wider health and social care arena.

The widening participation agenda will work in tandem with this, as we work closely with our community to support programmes to ensure inclusivity and open up more opportunities to become valued employees as a part of the Trust.

5. Trust Governance & Assurance

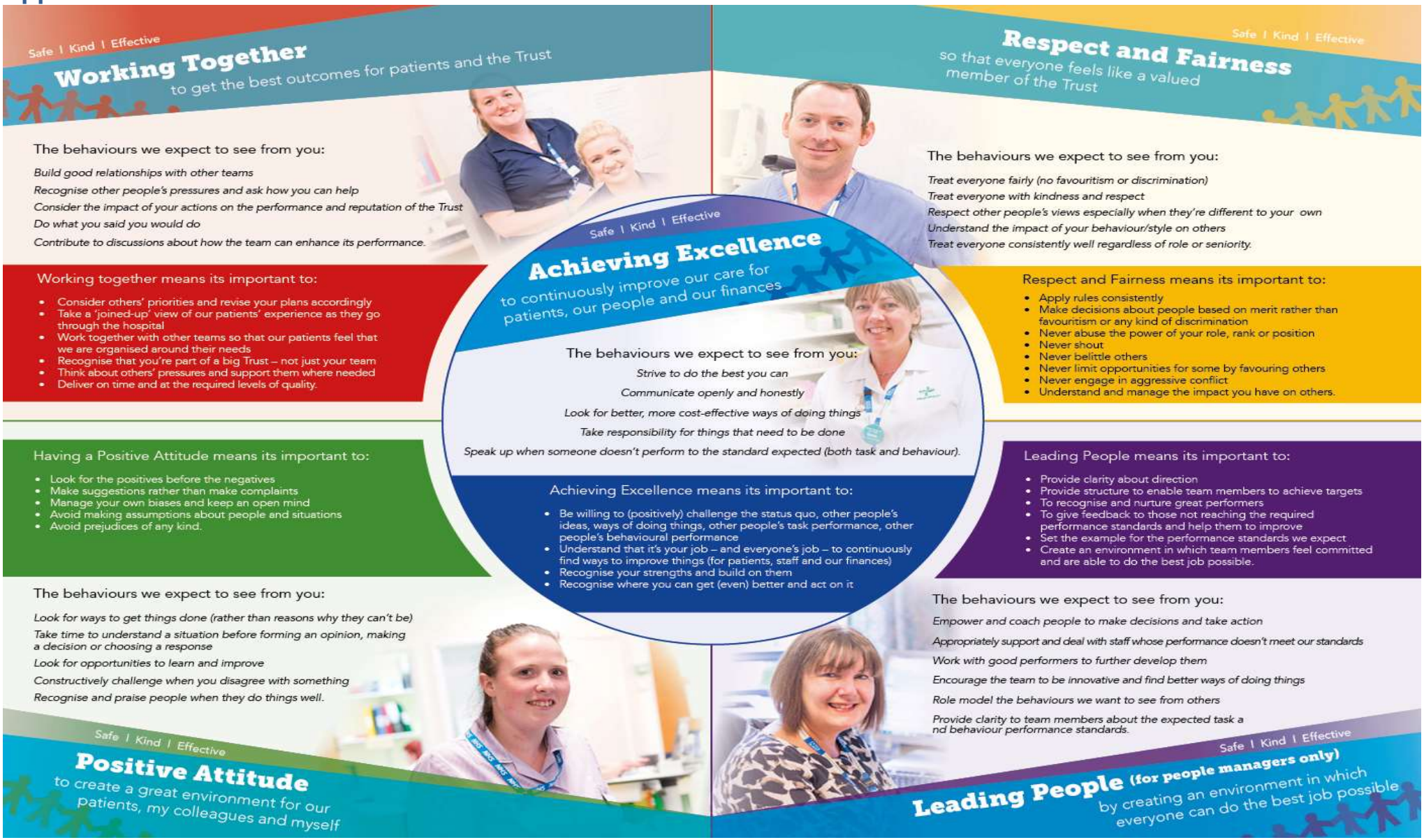
The Strategy and delivery plan will be monitored by a robust governance and assurance structure. This tiered approach feeds the assurances required by the Board of the impact of changes made to staffing and its impact positively or otherwise on patient care. This system allows a transparent view of services and acts as an early warning system.

This structure has a heavy involvement of Non-Executive Directors, governors and staff side colleagues who monitor staff based decisions. It provides direct input from all areas of the Trust and provides qualitative and quantitative measures for comparison locally, regionally and nationally.



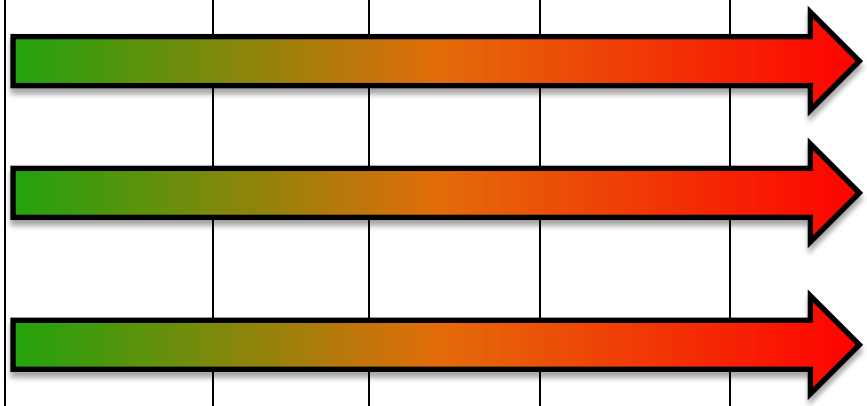
EXTERNAL GOVERNANCE & SUPPORT		
NHS IMPROVEMENT	**CARE QUALITY COMMISSION**	**HEALTH EDUCATION ENGLAND/NORTH WEST**

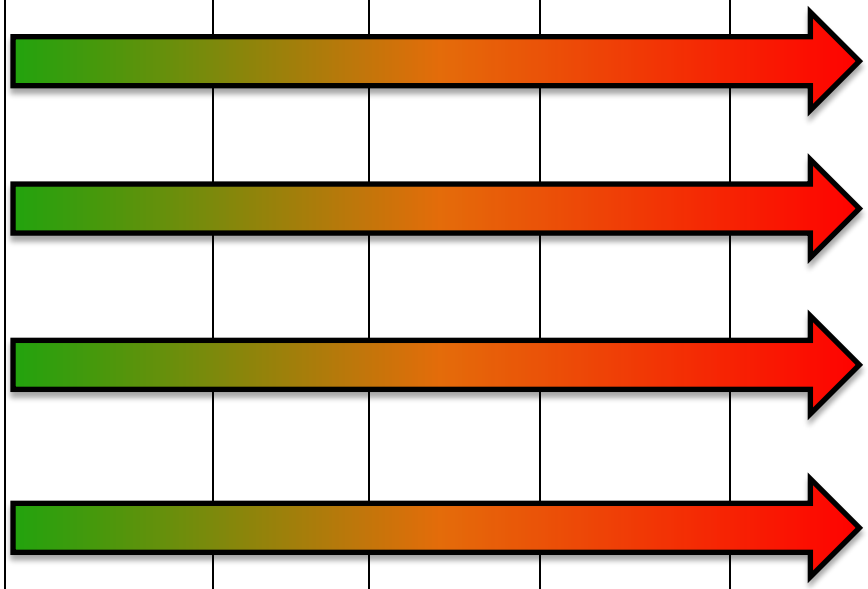
Appendix 1: The Trust Behavioural Standards

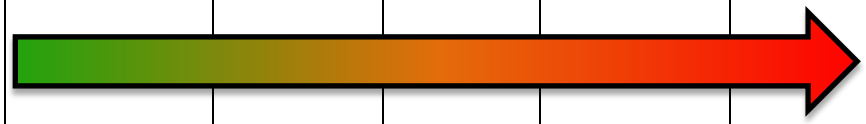
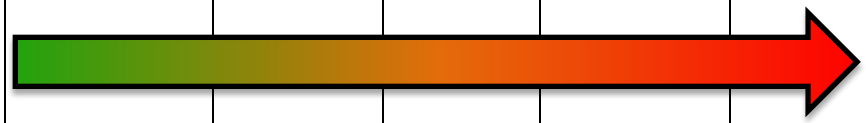
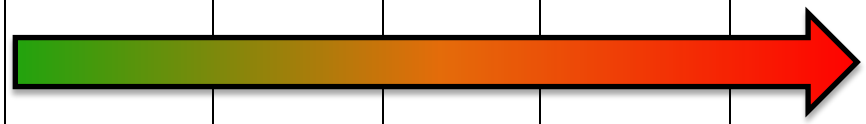


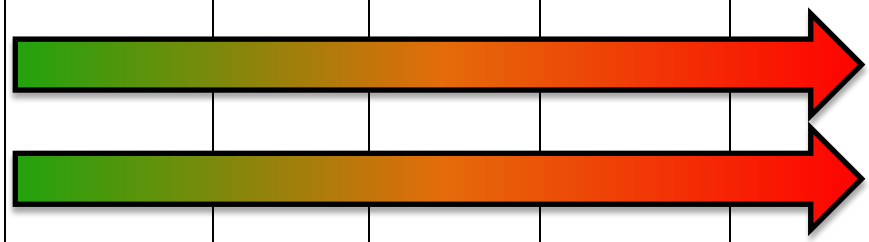
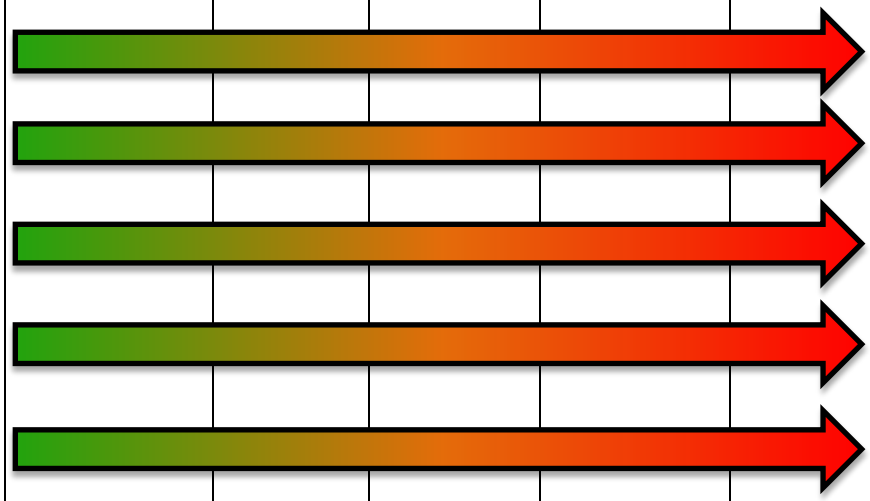
Appendix 2: People Services Strategic Delivery Plan

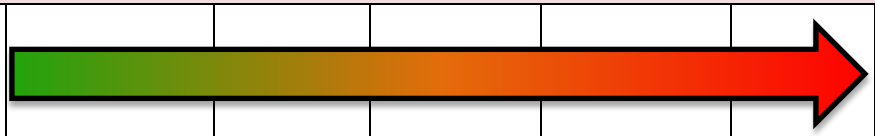
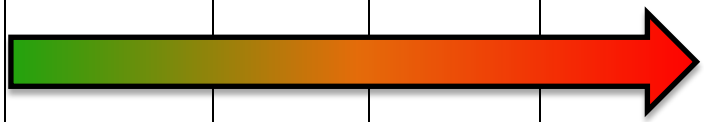
COUNTESS 20:20 The Model Hospital	Lead	Quarter 1 April - June	Quarter 2 July - Sept	Quarter 3 Oct - Dec	Quarter 4 Jan - March	Year 2	Actions & Deliverables
Organisational Culture							
Leadership Framework **Leadership strategy** **Medical Management**	**L Walker & D Appleton Cairns**						**Implementing a clear set of leadership capabilities used in the selection and performance management of leaders.** **Developing a Board-sponsored leadership strategy – based on business need and a clear set of expectations, and encompassing all leaders from Board to frontline; including recruitment, engagement, development, talent management and succession planning**
Performance Framework **Values- based behavioural And performance framework**	**L Walker**						**Engaging with staff with regular performance reviews ensuring that a culture of continuous improvement is developed.** **Developing a values-based behavioural framework – agreeing at the very outset the trust's underpinning values, determining their behavioural implications for all occupational groups and roles, and informing any system and process redesign.** **Instituting an individual performance**

							management system – a process for appraising both task and behavioural performance for every individual in the trust, including a range of feedback mechanisms such as 360s, peer review, colleague survey results and actions; linking this to positive and negative consequences including reward, development, career progression
Values & Behaviours **Staff experience** **Engagement** **Staff Survey**	**L Walker**						**A reduction in the high rates of bullying and harassment with a sustained campaign led personally by each Trust Chief Executive.** **Building engagement across all occupational groups – harnessing the ideas and viewpoints of everyone in the trust, paying particular attention to clinical engagement and the role of the Clinical Leader.** **Repurposing the colleague opinion survey – reflecting more appropriately targeted questions and surveying sections of the workforce on a rolling monthly or bi-monthly basis to deliver a more timely pulse of people's views, and using the outcomes as a key metric in all managers' performance appraisals**

Policies & Processes	**D Appleton Cairns**		**Creating an environment that is fair and transparent, which requires polices, practices and agreements to be reviewed to ensure that they are clear, simple and swift to operate** **Adopting basic structural improvements – ensuring adherence to best practice management spans and layers, consistency of roles, and defining clearly individual accountabilities and decision rights** **Implementing a comprehensive operational management process – a regular and highly disciplined series of Ward to Board management meetings that drive operational performance, cost reduction, increased efficiency and continuous improvement** **In tandem with this process, adopting the Model Hospital dashboards - a series of upwardly cascading metrics that provide a balanced view of patient, people and financial performance at any given management level of the organisation**
	Operational Excellence		

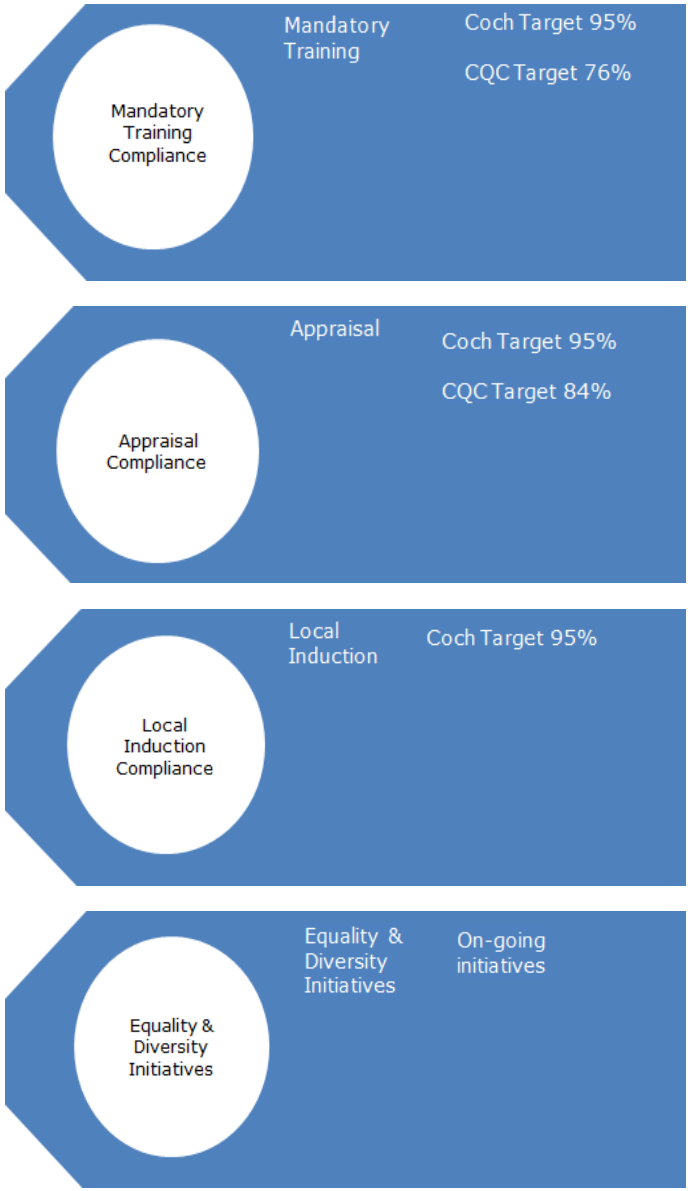
Acuity Based Workforce & E-Rostering	**S Hodkinson**						**Moving towards a patient-centred organisation design – ensuring structure, workflow and resource allocation is designed around the patient through each stage of their hospital journey, as opposed to being designed around functional specialisms**
Variable Pay	**S Hodkinson**						
Recruitment to Values **Equality & Diversity**	**S Hodkinson**						**Mandating the use of a trust and national level succession planning processes along with the use NHS Executive Search to provide a candidate shortlist for executive appointments before external recruitment consultancies are considered**
Attendance Management	**D Appleton Cairns**						**Improving sickness absence, which will require common definition and improved collection of data managed as part of the operational management scorecard and process**
Turnover & Retention	**D Appleton Cairns**						**Developing management practices to gain a better understanding of the reasons for high levels of staff attrition.**

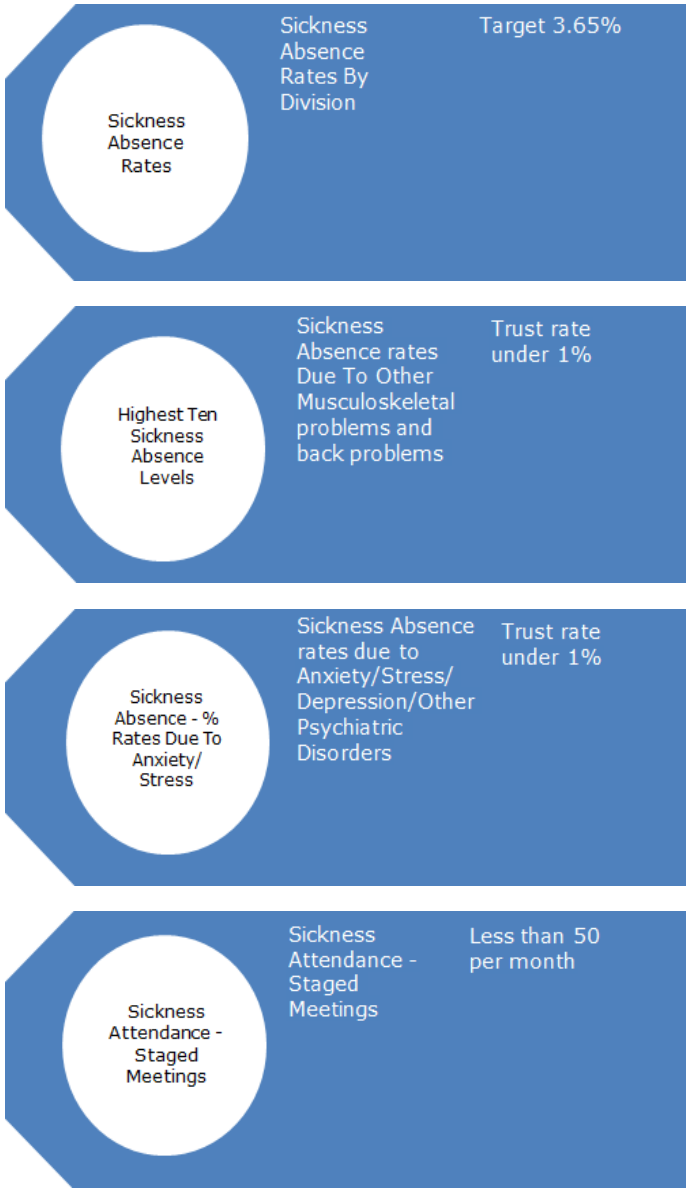
INTEGRATED SPECIALIST SERVICES Acute Care Collaboration	Lead	Quarter 1 April - June	Quarter 2 July - September	Quarter 3 October - December	Quarter 4 January - March	Year 2	Actions & Deliverables
Organisational Renewal							
Health & Wellbeing Strategy Attendance Management Smoking Cessation	K de Beger						Improving sickness absence and increasing percentage of staff able to remain in work with support. Stop Smoking Group to present Business case option appraisal to Executive Directors Group
CQUIN Staff Health and Wellbeing standards: - Flu Campaign - Physio Services - Nutritional Awareness - Mental health initiatives - Physical activity initiatives	K de Beger						Meet by CQUIN National standards by: Implement a staff vaccination campaign to achieve 75% frontline staff vaccinated by December 31st 2016. Improve fast track referral for all staff to access physiotherapy in timely manner. Stop the promotion and advertising of sugary drinks and foods high in fat, sugar and salt on site. Actively promote healthy eating choices. Developing a programme of initiatives

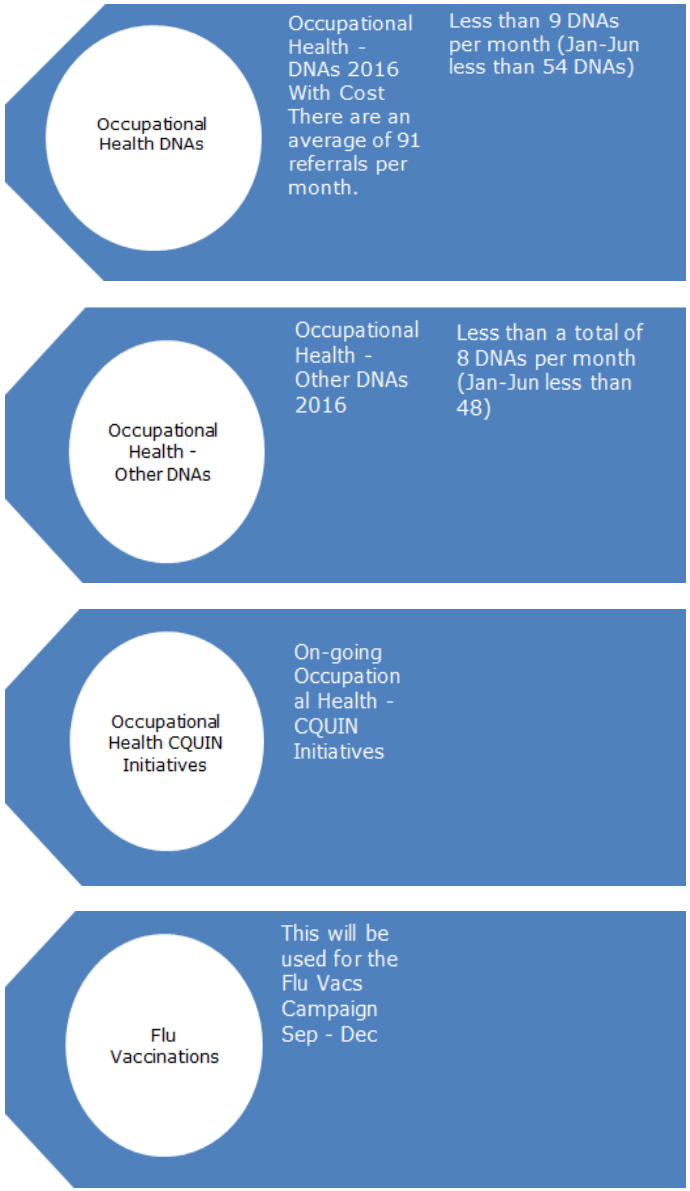
							including: free mindfulness sessions, reduced rate mindfulness courses, resilience sessions, staff counselling and 1:1 with mental health nurse. **Develop a comprehensive programme of physical activities staff can access including: Pilates on site, football, netball, rounders games, participate in NHS Games, organised lunch time walks, Nordic walking in Country park.**
	HR & Wellbeing Business Services						
Payroll & Pensions	**S Gregg-Rowbury**						**Renew the ESR Manager Self-Service Payroll functions whilst supporting the introduction of ESR2 when it is available, and collaborate with the e-Roster project to have a clear strategy for workforce systems.**
Recruitment							**Improve the experience of our new starters to reduce pre-employment bureaucracy and delays. Moreover, introducing a new standard for recruitment metrics to better understand our vacancy position.**
Streamlining Staff Movements						**On-going regional programme until**	**Positioning ourselves as a leading organisation in the way we use employment data from previous NHS employers, facilitating speedier**

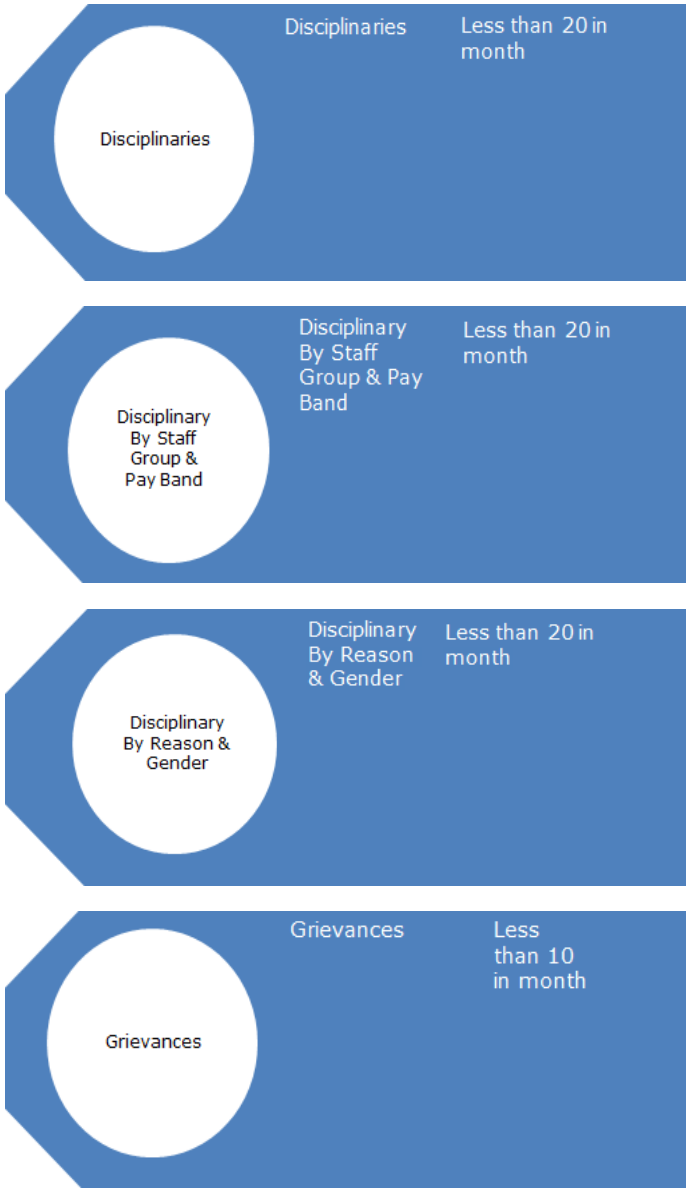
						2018	recruitment and induction processes.
Commercial Strategy							**Creating the model payroll and recruitment offices of the future to deliver reduced staffing costs and overheads to compete with established providers. We will develop our online resources to provide a client login for service metrics and KPIs.**
Shared Services Supporting Model Hospital **New BankStaff Module** **Electronic Staff Record**	**S Gregg-Rowbury**	 					**Supporting the deployment of a new BankStaff module integrated with the e-Roster project, incorporating e-timesheets for bank employees to reduce paper flows and better shift management.** **In response to Lord Carter's observations of poor management of ESR, we will be introducing ways to reconcile ESR with the Finance ledger and give greater reporting on Establishment Control. A key aspect to this will be Employee's taking ownership of their ESR record whilst benefiting from e-payslips and P60s.**

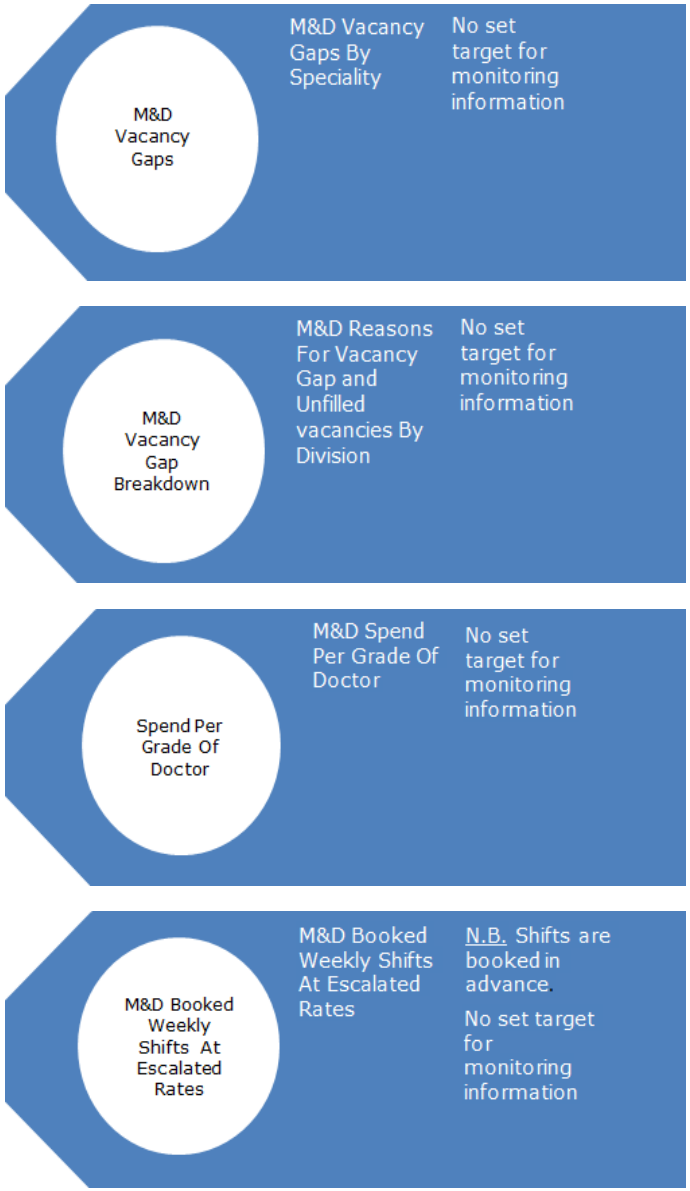
Appendix 3: Operational Blueprints

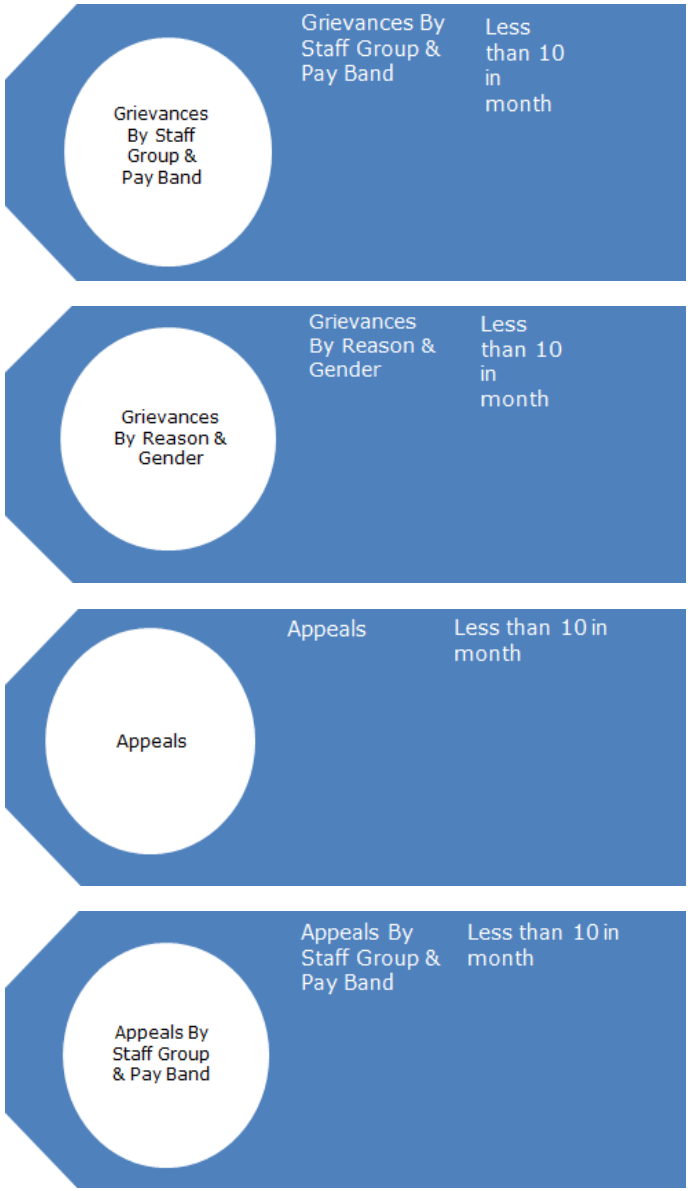




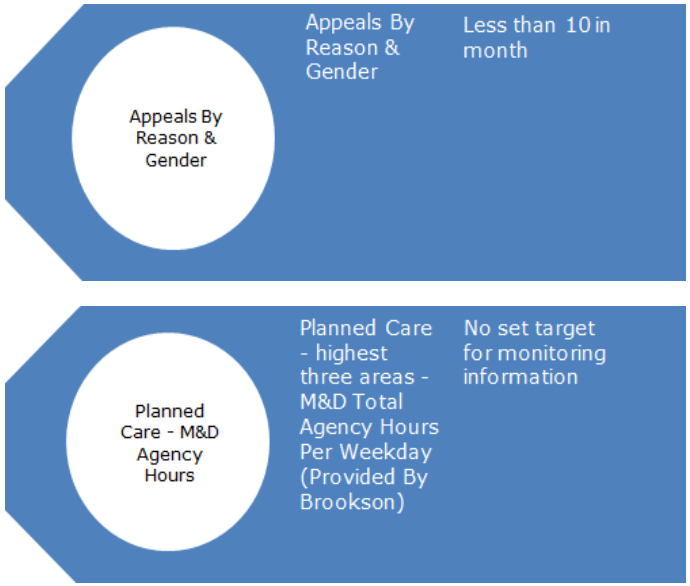

Occupational Health DNAs
Occupational Health - DNAs 2016 With Cost There are an average of 91 referrals per month.
Less than 9 DNAs per month (Jan-Jun less than 54 DNAs)
Occupational Health - Other DNAs
Occupational Health - Other DNAs 2016
Less than a total of 8 DNAs per month (Jan-Jun less than 48)
Occupational Health CQUIN Initiatives
On-going Occupational Health - CQUIN Initiatives
Flu Vaccinations
This will be used for the Flu Vacs Campaign Sep - Dec


Disciplinaries
Disciplinaries
Less than 20 in month
Disciplinary By Staff Group & Pay Band
Disciplinary By Staff Group & Pay Band
Less than 20 in month
Disciplinary By Reason & Gender
Disciplinary By Reason & Gender
Less than 20 in month
Grievances
Grievances
Less than 10 in month


M&D Vacancy Gaps
M&D Vacancy Gaps By Speciality
No set target for monitoring information
M&D Vacancy Gap Breakdown
M&D Reasons For Vacancy Gap and Unfilled vacancies By Division
No set target for monitoring information
Spend Per Grade Of Doctor
M&D Spend Per Grade Of Doctor
No set target for monitoring information
M&D Booked Weekly Shifts At Escalated Rates
M&D Booked Weekly Shifts At Escalated Rates
N.B. Shifts are booked in advance.
No set target for monitoring information


Grievances By Staff Group & Pay Band
Grievances By Staff Group & Pay Band
Less than 10 in month
Grievances By Reason & Gender
Grievances By Reason & Gender
Less than 10 in month
Appeals
Appeals
Less than 10 in month
Appeals By Staff Group & Pay Band
Appeals By Staff Group & Pay Band
Less than 10 in month


M&D Total Spend and Savings
M&D Total Agency Spend and Savings (Provided By Brookson)
Target less than £120K per month
Urgent Care - M&D Agency Hours
Urgent Care - highest three Areas - M&D Total Agency Hours Per Weekday (Provided By Brookson)
No set target for monitoring information


Appeals By Reason & Gender
Appeals By Reason & Gender
Less than 10 in month
Planned Care - M&D Agency Hours
Planned Care - highest three areas - M&D Total Agency Hours Per Weekday (Provided By Brookson)
No set target for monitoring information

Countess of Chester Hospital NHS
NHS Foundation Trust

Integrated Board Report - July 2016

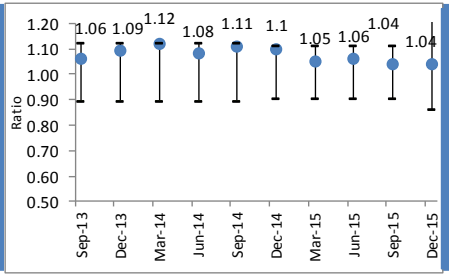
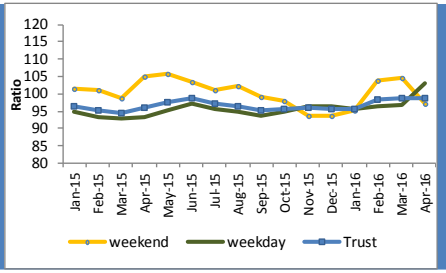
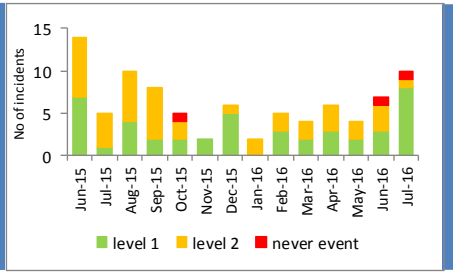
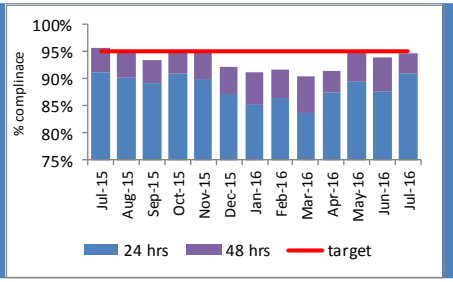
Contents

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics July 2016

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

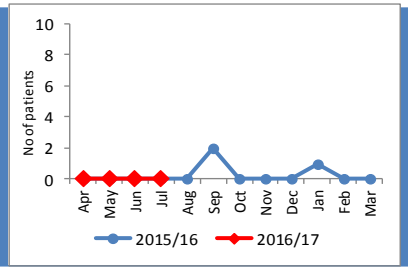
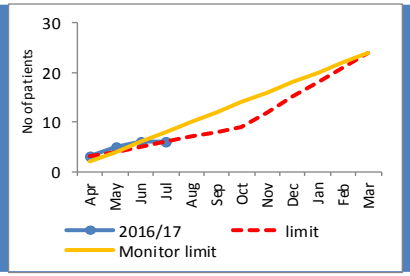
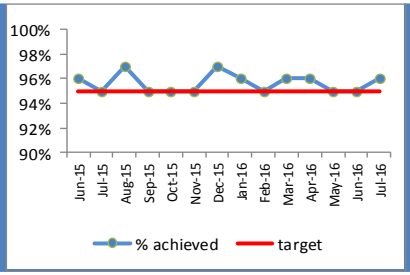
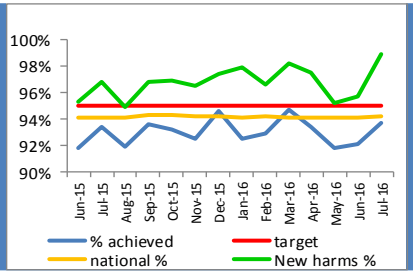
	Description	Current position/comments	Trend	Target
Mortality SHMI	Risk adjusted mortality ratio based on number of expected deaths. National published figure from HSCIC.	This measure does not take into account palliative care codes. It provides a complete picture of hospital deaths and includes deaths 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. The chart is a rolling 12 months		As expected - Blue Above expected - Red Below expected - Green
Serious Incidents	Level 2 severe harm or death to patient. Never events are serious largely preventable patient safety incidents	There were eight level 1 incidents, one level 2 incident and one never event in July. The never event related to a retained swab. See exception report on page 15.		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 July improved to meet the 90% within 24 hour target and was slightly under the 95% within 48 hours target at 94.8%.		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 July 2016

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

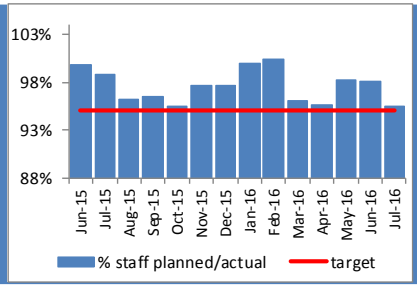
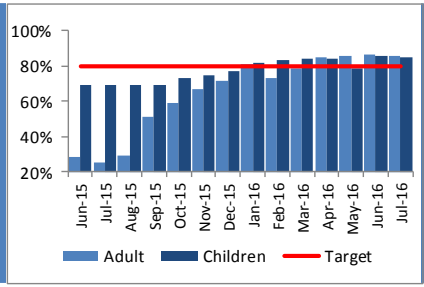
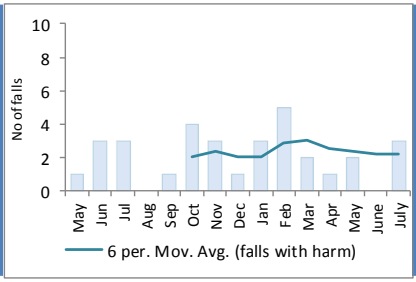
	Description	Current position/comments	Trend	Target
MRSA	Number of cases of hospital acquired MRSA bacteraemia (meticillin-resistant staphylococcus aureusis)	The target for MRSA is zero cases within the year and there were no new cases within the month. Although there was one case assigned to COCH in June following local investigation, this is an unavoidable case so will not count towards the Trust objective of zero avoidable MRSA bacteraemia.		Zero avoidable cases for the year
CDiff	Number of cases of Clostridium Difficile	A maximum of 24 cases has been set for 2016/17 at the same level as 2015/16. There were no new cases reported in the month of July.		24 maximum annual cases
Hand hygiene	Based on ward based hand hygiene audits. Each ward is required to submit two audits each month	Hand Hygiene practices is above target in July with a 96% level of compliance.		95% each month
Safety Thermometer	Tool to survey a snapshot of harm free patient care. Includes pressure ulcers, falls, catheters, UTIs and VTE	The overall score for new harms in July is 98.9% which is an improvement from June. Individual reports on clinical areas are now shared with each ward manager to monitor improvement		Compare to National average Above average - Green Below average - red

Are we safe?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics July 2016

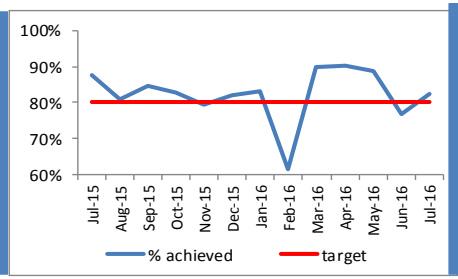
BAF ref: CR1, CR2, CR3, CR6, CR7, CR10

	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 at 95.5%. See appendix 1 for detailed safe staffing report		>95% per month
Safeguarding training	% of level 2 training undertaken to be split by training for Adults and Children	The training compliance for both adult and childrens safeguarding training was above the 80% target in the month of July.		>80% in month
Inpatient Falls with harm	Inpatient falls with moderate or above harm	There were three inpatient falls with moderate or severe harm within the month of July. See exception report on page 15		Target : 0 Graph shows 6 month rolling average - will show 12 months once data has been collated.

Are we effective?

Countess of Chester Hospital NHS Foundation Trust — Board Assurance metrics July 2016

BAF ref: CR3, CR7, CR10

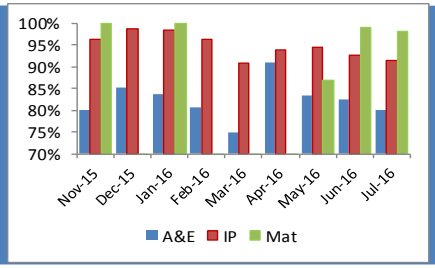
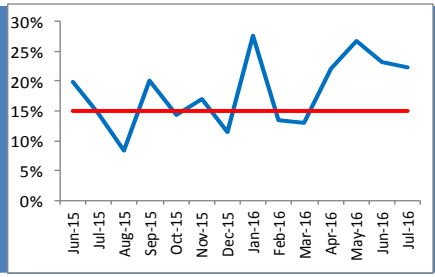
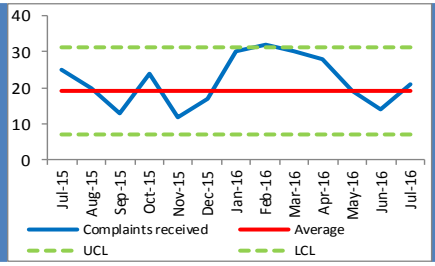
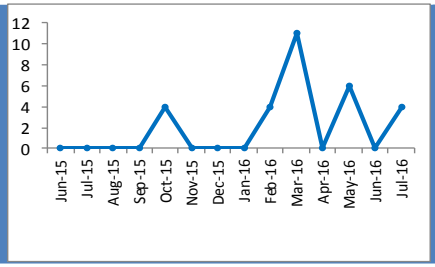
	Description	Current position/comments	13 month rolling trend	Target
Stroke	All Stroke patients who spend at least 90% of their time in hospital on a stroke unit	The target was met in the month of July		>80% per month
Sepsis 1	National CQUIN	Percentage of people appropriate for sepsis screening who were screened Part 1 - A&E Setting Part 2 - Inpatient Setting		New indicator, due to be reported in Q2
Antibiotics	National CQUIN.	Reduced percentage of patients being prescribed antibiotics		New indicator, due to be reported in Q2
Antibiotics	National CQUIN.	Antibiotics review within 72 hours		New indicator, due to be reported in Q2

Are we caring?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics July 2016

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

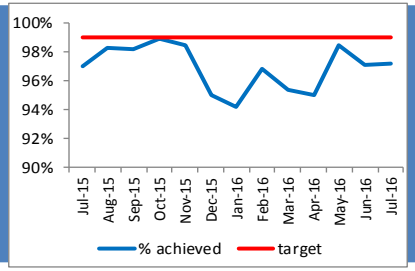
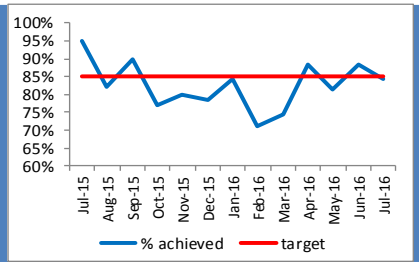
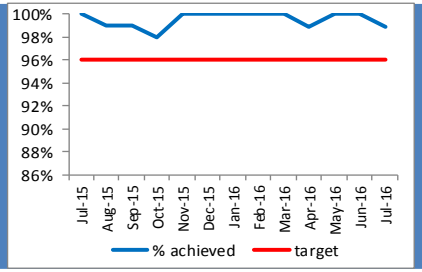
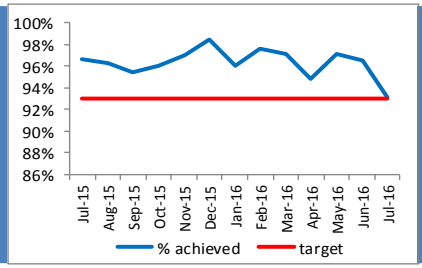
	Description	Current position/comments	Trend	Target
Friends & Family - % likely to recommend	Would patients recommend service to friends & family. Introduced in 2013 for Inpatients, A&E and maternity.	Performance is on target for A&E and above target for inpatients and maternity.		90% for maternity and Inpatients. 80% for A&E
Friends & Family response rate	Number of responses received for IP, A&E and maternity compared to eligible patients	The response rate for July was above target at 22.4%.		>15% per month
Feedback	Monthly Trust complaints and formal thank you letters received by the Trust	In July 2016 the Trust received 21 new formal complaints. The Chief Executives office received ten formal thank you letters for the month of July.		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 four breaches to this standard within the month of July. This related to one patient on the Respiratory Support unit but affected three other patients on the bay. See exception report on page 16		Zero cases per month

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics July 2016

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

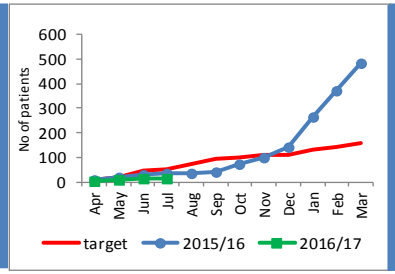
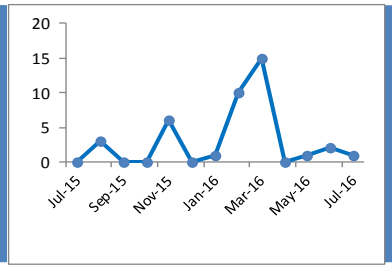
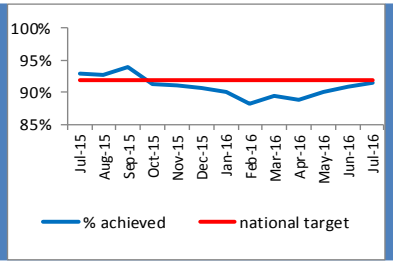
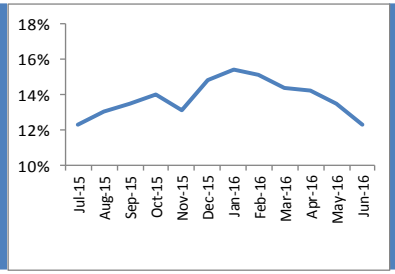
	Description	Current position/comments	13 month rolling trend	Target
Diagnostic 6 week standard	Diagnostic tests to be carried out within 6 weeks of request being received. This is measured on the National DM01 return.	The diagnostics figure was below the national 99% target at 97.2% in July but above the improvement trajectory of 94.8%. See page 17 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 unvalidated figure for July is slightly under the 85% target at 84.4%. See page 18 for exception report.		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. The reduction in the month of July is mainly because of Lower GI due to capacity issues.		93% per Quarter

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics July 2016

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

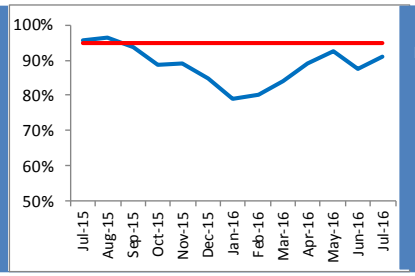
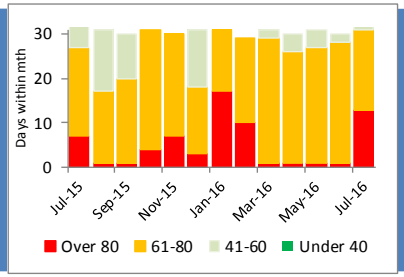
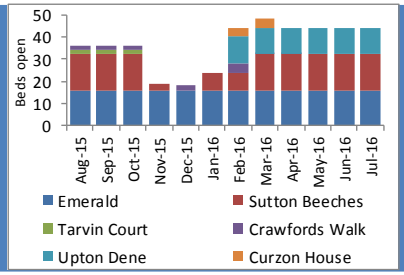
	Description	Current position/comments	Trend	Target
Cancellation due to no beds	Hospital cancellations due to no beds	There were two cancellations due to no beds in July. This is an improvement on the cumulative position at this time last year. Please note this does not include patients cancelled due to critical care beds which are tracked separately.		Internal target based on 2012/13 levels
Urgent cancellations	Urgent cancellations for second or subsequent time for non clinical reasons	There was one urgent cancellation for the second or subsequent time in the month of July.		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 July at 91.6% which is above the 91.0% improvement trajectory. The Trust also has reported 5 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 July 2016

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

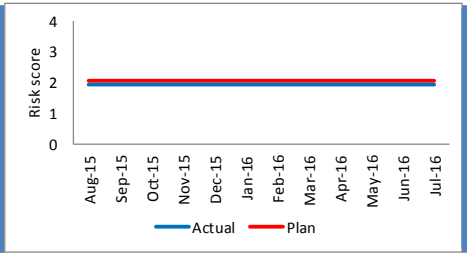
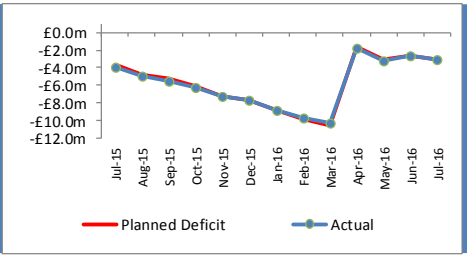
	Description	Current position/comments	13 month rolling trend	Target
A&E 4 hour standard	Maximum wait time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.	Performance in July was 90.92% and remains under the 95% performance. It was also under the 92% Monitor trajectory. Exception report on page 20.		>95% per month
Medically optimised patients	Number of days within the month where there are medically optimised patients within acute beds	There were 13 days within the month of July where there were over 80 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 were 44 available intermediate care beds for the month of July. In July 28 beds on the Intermediate Care Unit opened at COCH (previously ward 34).		No target agreed

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics July 2016

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

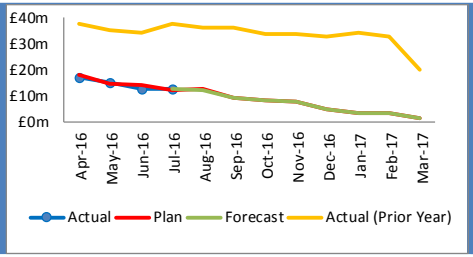
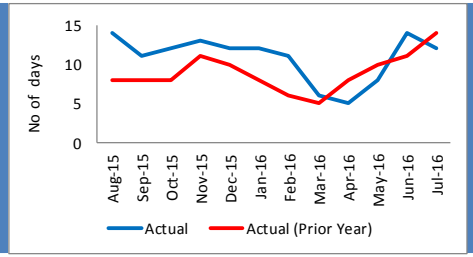
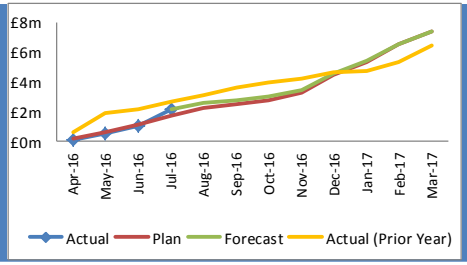
	Description	Current position/comments		
Financial Sustainability Risk Rating	Monitor's (independent regulator) measure of financial risk	The Trust is currently at a level one for Capital Service Capacity Ratio and the I&E Margin rating resulting in an overall score of 2.		A score of 2 each month
Normalised net surplus/ deficit	Net income and expenditure after adjusting for hosted services and impairments	In June the Trust submitted a revised plan which changed our planned deficit to £3.95m. At July we are reporting an overspend against plan of £61k, due to failure to met the A&E 4 hr target in July and the subsequent loss of S&T funding. The CRS programme is currently behind plan by £154k.		As Plan

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics July 2016

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

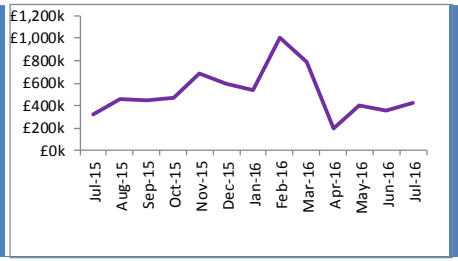
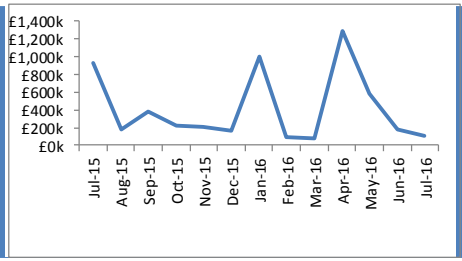
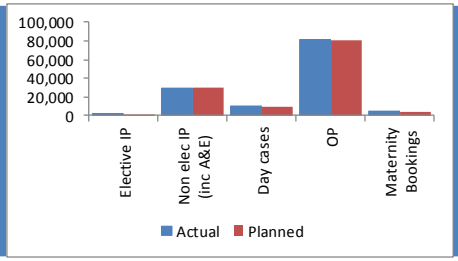
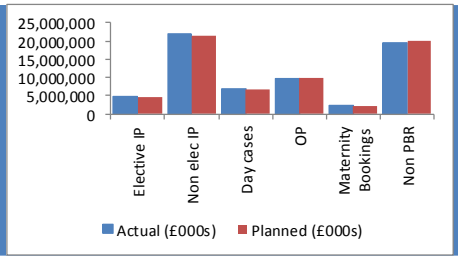
	Description	Current position/comments		
Cash	Cash on deposit <3 month deposit	The closing cash balance at the end of July was £12.4m which is £0.3m ahead of plan. The block contract 'catch-up' invoice of £2m, noted in last months report has been paid in July. We continue to press NHSI on the need to start discussions around a rolling working capital facility, but they appear reluctant to engage fully until the DH finalises the distress funding rules.		£12.4m
Debtor Days	Debtor Days: Trade Debtors divides by income x 365	Debtors have reduced due to the payment of the contract invoice noted above. There are also some amounts in respect of Wirral FT that are being escalated, but these are offset by an increase in our corresponding creditors account, and so there is no impact on cash.		No target
Capital Expenditure	Capital expenditure performance against plan / forecast out-turn	As at July 2016 the capital programme is £0.4m ahead of the original Monitor plan, due to the completion of the 2015/16 brought forward ward refurbishments being slightly ahead of the profile in the plan.		£1.787m

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics July 2016

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

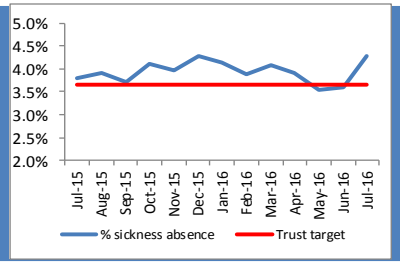
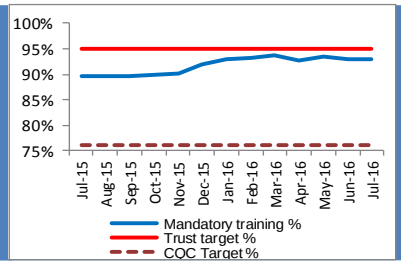
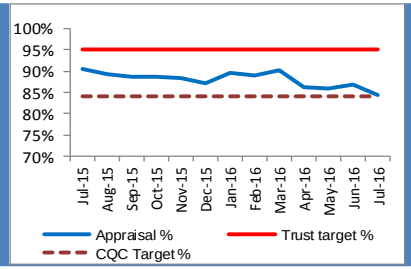
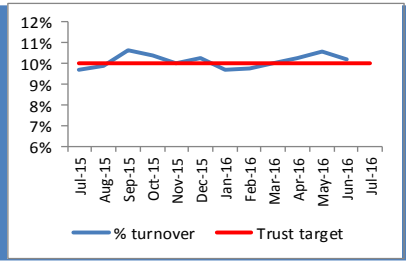
	Description	Current position/comments		
CRS In Year	Planning improvements in productivity and efficiency	Based on the £6.141m orginal plan, at the end of July the CRS programme is £154k behind the profiled plan. Exception Report on page 20. The Trust still has no plans for delivery of the remaining £3m gap required by NHS improvement to meet the £3.950 deficit control total		No deviation from plan
CRS Recurrently	Planning improvements in productivity and efficiency	Based on the £6.141m original plan, recurrently £2,147k (35%) in CRS savings have been achieved. Of the outstanding £1,579k (26%) is in Green and Amber schemes and £2,415k (39%) is in Red and Black schemes. Exception Report on page 20. As mentioned above, there is no plan in place for the £3m gap.		No deviation from plan
Contract performance Activity	YTD Contract performance against Trust Planned activity (English & Welsh)	Activity slightly below plan for Elective activity. Maternity booking activity was also lower than planned. Outpatient Procedures Activity for Ophthalmology & Dermatology are higher than planned		Actual Activity should be greater than Planned activity
Contract performance Financial Value	YTD Contract performance against Trust Planned Value (English & Welsh)	As at the end of July the income position is above plan year to date :- Elective IP £50k Non-Elective IP £465k Daycase £404k Outpatients £65k Maternity -£81k Non PBR* -£625k *-£942k relates to adjustment to block contract with Western Cheshire CCG		Actual Value should be greater than Planned Value

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics July 2016

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

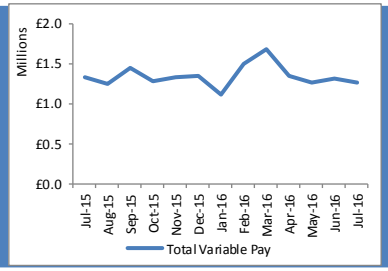
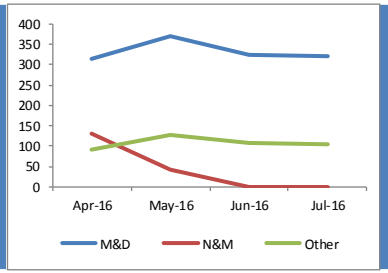
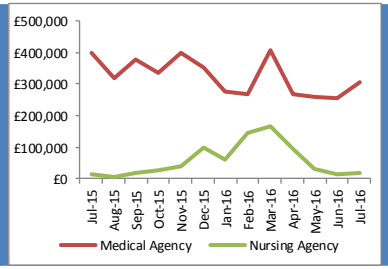
	Description	Current position/comments	13 month rolling trend	Target
Sickness absence	% sickness absence. Monthly rate excludes Comfort zone and Bank staff	Trust wide attendance management levels have increased significantly to 4.28%, which is now above the Trust target of 3.65%. In July 2015, this rate was 3.79%. The rise in this months rate has caused a slight increase in the rolling 12 month average which is now 3.95%, with short term absence increasing to 2.25% and long term increasing to 2.03%.		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 moved marginally this month. The current compliance rate of 93% exceeds the CQC target (76%) but remains below the Trust target (95%). When taking into account those already booked to attend, the Trust continues to exceed the Trust target , reporting 96% compliance.		95% per month *The CQC target is 76% (the CQC take the results from the Staff Survey)*
Staff with completed appraisal	Appraisal Monthly Rate Exclusions as above and also excludes staff with less than 1 years service.	Compliance with the Appraisal target reduced slightly this month to 84.3%, which continues to exceed the CQC target. Further details are provided within the exception report but hotspots include Clinical and Non clinical Corporate areas.		Above 95% per month *The CQC target is 84% (the CQC take the results from the Staff Survey)*
Staff turnover	Turnover Rate Based on headcount in the previous 12 months and on permanent staff only.	Turnover has decreased almost bac k to target this month at 10.09%.This rate is based on a headcount, turnover by FTE remains under target at 9.86%.		Below 10% per month

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics July 2016

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)	Variable pay costs have reduced to £1.106m with reductions in agency, bank and additional clinical payments spend. However, costs have increased on waiting list payments, which is due to 18 week focus, & the impact of industrial action. Additional basic pay has increased on the March position whilst overtime payments have remained static.		To not exceed £4.843m agency expenditure ceiling (circa £500k saving). To deliver variable savings target at 2014/15 level
Agency Shifts Over Cap Rates	M&D Agency shifts over cap rates. 'Other' consists of Care Packages, Theatres and the CRV Dept.	Reported on a weekly basis to NHS Improvement, the Trust monitors the number of agency shifts paid above the cap rates. Month 3 demonstrates a positive position with all staff groups reporting reductions. It is important to highlight excellent performance within nursing over the quarter, with a 99% reduction in shifts over the cap.		To reduce the number of agency shifts paid above the cap in all staff groups
Agency spend	Planning improvements in productivity and efficiency	Medical Pay is currently overspent by £61k. Agency spend is £1,088k ytd (7% of the total medical spend). Nursing Pay is £152k overspent. Agency nursing expenditure YTD is £161k which is 1.2% of total trained nursing spend. Total Agency spend for months 1 to 4 is £1,421k, compared to £1,386k for the same last year.		Total Agency ceiling set at £4,843k for 16/17

EXCEPTION REPORT

Indicator: Serious untoward incidents/falls

Issue:
There was an increase in the number of serious incidents reported. 3 falls reported within the month of July with moderate or severe harm.

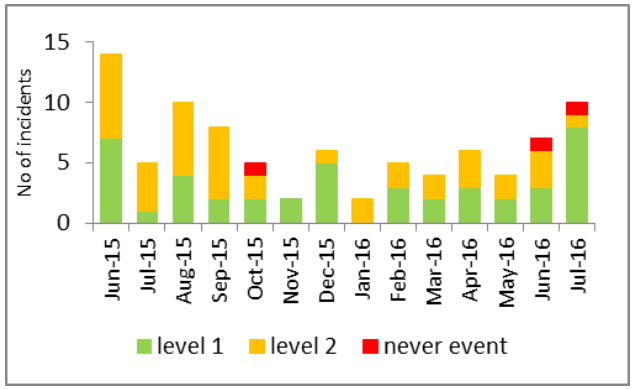
Increase in level one - The Trust has ensured that it is robustly reporting all STEIS incidents relating to maternity and neonatal care. Neonatal admissions 37 weeks and above are reported as unexpected admissions to the neonatal unit. The other incidents relate to falls and a pressure ulcer.

Never event - this related to a retained surgical swab. This is subject to a level two investigation. This event is not related to the previous never event reported for June but both cases are subject to an investigation which is ongoing.

Falls - The three falls reported for July happened prior to the thematic review being disseminated. This review was undertaken over a number of months and there are a number of actions which are being progressed throughout the Trust. Although pressure ulcers remain low in numbers the Trust is also doing undertaking a thematic review during the Autumn/Winter. Any learning will be reported back to QSPEC.

Forecast for improvement:			
Q1	Q2	Q3	Q4

Historic data:



Lead:	Ruth Milllward, Head of Risk & Patient Safety
Executive Lead:	Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

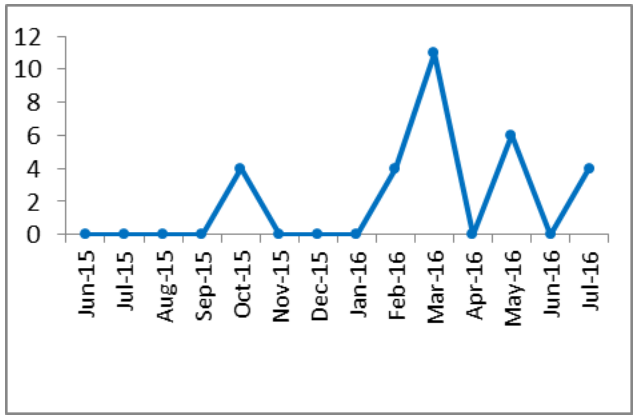
Indicator: Mixed sex accommodation breaches

Issue:
The breaches within recent months have related in the majority of cases to the Respiratory Support Unit and the Hyper acute stroke area. Although it may only relate to one individual, all patients affected in the ward area are reported as a breach.

Actions
In both areas there continues to be issues of stepping patients down in to other wards due to general bed capacity. We continue to highlight patients ready to step out of these areas in a proactive way and a recent walkaround determined that there is no option to subdivide the ward, so this will have to be managed more proactively. This will be a challenge over the Winter period.

Forecast for improvement:			
Q1	Q2	Q3	Q4

Historic data:



Lead:	Divisional Directors/Heads of Nursing
Executive Lead:	Lorraine Burnett, Director of Operations

EXCEPTION REPORT

Indicator: Diagnostic 6 week wait

Issue:

The diagnostic 6 week standard failed the standard in July mainly due to breaches for non obstetric ultrasound, echo and cystoscopy

Echo

Diagnostic waits could not be sustanied during July due to annual leave and lack of available agency staff. The Division have interviews planned for August and will continue to work through options to improve.

Ultrasound

The ultrasound breaches mainly relate to MSK, in particular for Rheumatology and also related to a growth in GP referrals.

Cystoscopy - A change in the clinical model resulted in a temporary reduction in capacity. Proposal in place to improve this figure to increase capacity.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:

English - Number of exams > 6 weeks

Month End Snapshot	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Magnetic Resonance Imaging	1	6	5			8	47	22	82	110	25	0	5
Computed Tomography	5	7	8	10	5		3						
Non-obstetric ultrasound						4	10		21	82	14	75	47
Audiology - Audiology Assessments	1	6	6	2	5	27	23	10	12				
Cardiology - echocardiography	96	42	52	28	54	137	136	89	82	4	19	19	30
Respiratory physiology - sleep studies							4	3	1	1		4	5
Colonoscopy													
Flexi sigmoidoscopy							1	1					
Cystoscopy	8	4	1	9	2	29	17	10	6		6	14	28
Gastroscopy				1									1
Total patients waiting	3729	3887	4027	4237	4285	4087	4177	4266	4428	3916	4321	3889	4066
% < 6 weeks	97.0%	98.3%	98.2%	98.8%	98.5%	95.0%	94.2%	96.8%	95.4%	95.0%	98.5%	97.1%	97.2%

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

EXCEPTION REPORT
Indicator: 62 day cancer

Issue:

The 62 day performance for July is a provisional underachievement of the standard. There were 7 breaches in July, which will now be validated. Initial findings show breaches are broken down under the following specialties:

- Head & Neck – 3 breaches
- Skin – 1 breach
- UGI – 3 breaches

Proposed actions:

Urology continues to be a pressure on the performance of the Cancer 62 day target and there are approx. 7 patients (including late referrals to tertiary centres) whose treatment may now be August/September. At present, capacity pressures within the pathway are for cystoscopy diagnostic procedures – this has been escalated and being addressed.

Head and Neck has become a concern and will impact on the Trust's performance. There are approx. 10 patients on the PTL who are a concern (including late referrals to UHA), which will be COCH breaches in either August or September.

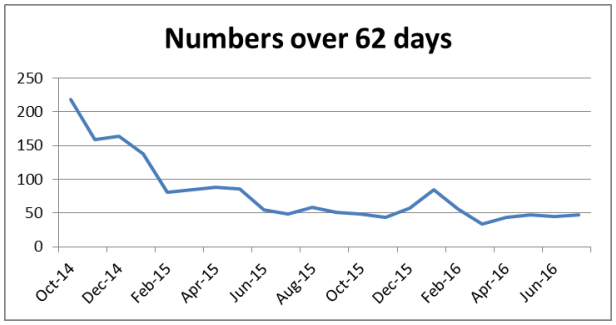
The performance meetings continue with H&N, and a meeting held at the in August with the following actions:-
o A new process has started on the 1st August for ENT patients to be sent to Radiology following a clinic appointment for a scan to be booked directly with the team. These patients will also be given a review appointment for 3 weeks when they leave clinic. This is to improve and reduce delays in the pathway and hence a timely referral to UHA before day 38.
o The team have amended their clinic templates to increase the number of F/T slots for both new and review, so positive impact should be seen in near future.

The UGI PTL remaining around the 100 patients. Concerns still remain for number of patients waiting over 62 days, and therefore this continues to be monitored closely.

Forecast for improvement:

Q1	Q2	Q3	Q4

Supporting PTL data:



Speciality	PTL between 63 and 103 days	PTL above 104+ Days	Total PTL over 62+ days
Breast	1		1
Colorectal	3		3
Gynaecology	6		6
Haematology		1	1
Head & Neck	9	4	13
Lung	6		6
Skin	2	2	4
Upper GI	4	1	5
Urology	7	1	8
Grand Total	**38**	**9**	**47**

Lead:
Executive Lead: Lorraine Burnett, Director of Operations

EXCEPTION REPORT

Indicator: RTT 18 weeks incomplete patients/over 52 week waiters/urgent cancellations for second or subsequent time

Issue:

Backlog accrued due to cancelled operations during the winter period. Plastic Surgery is the main area of concern for the Division due to sustained non-compliance. General Surgery has again improved month on month and is on trajectory target. The General Surgery % is in line with the Trajectory target for September 2016. Urology has reduced in month however there are plans to address demand issues in Outpatients.

The Trust is on trajectory to achieve 18 weeks in September. Trajectory target is 91% for July, actual achieved is 91.6%

Proposed actions:

General Surgery have agreed to run additional activity for a sustained period to reduce the backlog . Plastic surgery are working additional sessions to manage backlog. Both specialties continue to validate and manage waiting lists accordingly in line with the Access Policy. Urology will be targetting patients in the Outpatient setting running some additional activity. All other specialties are on plan to recover by September 2016

There was one urgent patient cancelled for the second or subsequent time within the month of July. This was due to the requirement for an HDU bed.

Additional data: Performance by specialty - July 2016

Specialty	<18 wks	Total	%
General Surgery	1670	1976	84.51%
Urology	972	1167	83.29%
Trauma & Orthopaedics	983	1115	88.16%
Ear, Nose & Throat (ENT)	1772	1873	94.61%
Ophthalmology	1514	1600	94.63%
Oral Surgery	732	799	91.61%
Neurosurgery	0	0	
Plastic Surgery	459	614	74.76%
Cardiothoracic Surgery	0	0	
General Medicine	336	341	98.53%
Gastroenterology	588	607	96.87%
Cardiology	566	582	97.25%
Dermatology	718	720	99.72%
Thoracic Medicine	434	444	97.75%
Neurology	0	0	
Rheumatology	209	210	99.52%
Geriatric Medicine	192	198	96.97%
Gynaecology	868	919	94.45%
Other	1096	1146	95.64%
Total	13109	14311	91.60%

Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:	Linda Fellowes, Divisional Director, Planned care Division
Executive Lead:	Lorraine Burnett, Director of Operations

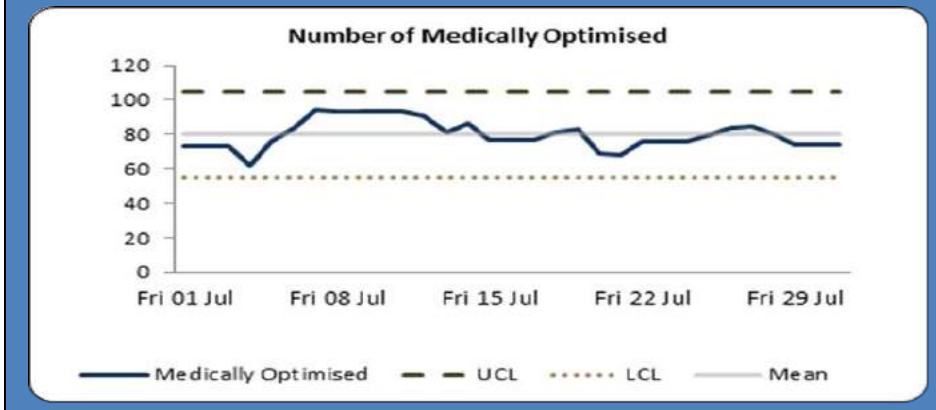
EXCEPTION REPORT

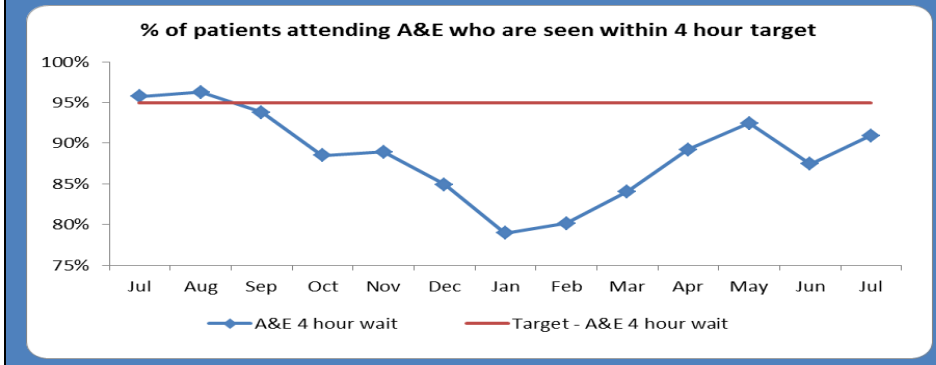
Indicator: A&E 4 hour standard

Issue:
Failure of ED 4 hour target in July and below the 92% Monitor trajectory.

During July performance has improved although not suffiiciently to meet with the improvement trajectory. Medical staffing continues to be a key issue however this is managed daily across management, medical staffing and ED department to work to mitigate issues where possible. Recently introduced table top discussion when performance significantly dips in any one day to identify any key issues and put process in place to avoid. During July we also started a 24/7 ANP rota focussing on weekends and Monday's to help support the rota overnight.

Historic data:





Forecast for improvement:

Q1	Q2	Q3	Q4

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

EXCEPTION REPORT

Indicator: Normalised Net Surplus / Deficit

Issue:
At the end of July, we are reporting a £61k overspend against plan. This adverse variance has been caused by the failure to achieve the A&E 4 hour target in July and the subsequent loss of the Sustainability &Transformational funding in relation to this. However it must be noted that £125k of the contingency reserve and £350k of non recurrent funds relating to historical provisions have been released to achieve this financial position. The profiling of Cost Reduction Schemes (CRS) assumes delivery of increased savings later in the year and is off plan by £154k to M4. **Pay:** Pay has moved favourably in month by £72k. There are however pressures within nursing pay £152k overspent YTD. Unfunded beds are still open - 6 beds, Ward 53 in Planned Care £24k overspent. Rapid Response Team is £64k overspent, Ward 41 £36k overspent & ICU £34k overspent. Medical Pay is £61k overspent YTD, this is reflective of a similar spend level to 15/16 so not showing any inroads into reducing pay back to 2014/15 levels. **Non pay:** Medical & Surgical Equipment £131k variance YTD, mainly activity related spend in theatres. Outsourcing - £169k variance YTD, predominantly Ophthalmology & T&O. Building / Engineering / EBME £75 YTD variance - overspend being driven by vacancies and the subsequent use of contractors to cover service. Included in Other is the £74k YTD pressure related to Upton Dene nursing beds. **CRS:** The CRS programme is currently £154k behind plan as at M4. **£3m gap:** There are still no plans in place to breach this gap. We will commence conversations with NHS Improvement regarding the £3m at the Q1 review meeting. As a result of our concern in this area the Q4 forecast for CRS is Red.

Proposed actions:
The Model Hospital team is undergoing a "refocussing" exercise to ensure they are focussing their efforts on the areas that will yield maximum savings for the year end. Weekly CRS sessions are continuing with increased focus on variable pay, in particular the use of agency. A weekly Agency and vacancy meeting has been set up to focus on the high value area of Medical Pay, clinically led by Janardhan Rao. In addition the Executive Team are currently review potential HR actions to reduce the overall pay bill for the Trust.

Forecast for improvement:

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

FINANCIAL PERFORMANCE AS AT 31ST JULY 2016

KEY VARIANCES	Apr YTD Variance £000s	May YTD Variance £000s	June YTD Variance £000s	July YTD Variance £000s	Movement £000s
PAY					
Nursing	95	70	167	152	(15)
Medical	28	20	40	61	21
Admin & Clerical	(58)	(94)	(128)	(156)	(28)
AHP, Therapies, Diagnostics & Pharmacy	(18)	(8)	(3)	(33)	(30)
Other	(26)	(49)	(33)	(53)	(20)
TOTAL PAY	**21**	**(61)**	**43**	**(29)**	**(72)**
NON PAY					
Outsourcing	10	109	157	169	12
Furniture & Office Equipment, Equip Hire & Computers	11	22	12	6	(6)
Drugs	(22)	20	22	(9)	(31)
Medical & Surgical Equipment	19	(23)	96	131	35
Laboratory Equipment	(3)	29	40	9	(31)
Building / Engineering / EBME	22	40	38	75	37
Other	22	86	204	390	186
TOTAL NON PAY	**59**	**283**	**569**	**771**	**202**
Non Pay - use of Contingency Reserve			(125)	(125)	0
Non Pay - CNST Provision for additional contributions identified as part of year end audit that can now be released	(187)	(187)	(187)	(187)	0
Income - Historical PCT monies identified as part of year end audit that can now be released	(163)	(163)	(163)	(163)	0
TOTAL USE OF RESERVES / PROVISIONS	**(350)**	**(350)**	**(475)**	**(475)**	**0**
CRS	**172**	**146**	**155**	**154**	**(1)**
Income	283	178	(292)	(360)	(68)
INCOME	**283**	**178**	**(292)**	**(360)**	**(68)**
TOTAL	**185**	**196**	**0**	**61**	**61**

EXCEPTION REPORT

Indicator: CRS in Year & Recurrently

Issue:

Following on from the submission of the revised plan to Monitor on 23rd June 2016 and acceptance of the £3.95m control total deficit, the impact on the CRS plan is as follows: -

Original Plan £6.141m.

Additional Plan £2.711m - fully met from review of asset lives, property revaluations and tariff gain.

Further Unidentified CRS of £3.000m

The tables opposite and narrative below focus on the original CRS target of £6.141m.

The CRS target for 2016/17 of £6,141k has been profiled for delivery as per previous years performance. As at the end of July the target is £1,525k and £1,371k has been delivered giving an adverse performance to date of £154k.

In year £2,817k (46%) has been achieved, while £1,485k (24%) is RAG rated Green or Amber and £1,839k (30%) is RAG rated Red or Black.

Recurrently £2,147k (35%) has been achieved, while £1,579k (26%) is RAG rated Green or Amber and £2,415 (39%) is RAG rated Red or Black.

The £3m Gap has not been considered in this area, as covered in the I& E exception report and therefore does not impact on the RAG rating below.

Proposed actions:

Alongside traditional methods of delivering CRS within the divisions, by each budget holder, the Trust has invested in the Model Hospital programme, incorporating the previous High Quality Care Costs Less (HQCCL) workstreams to facilitate and accelerate delivery of the Cost Reduction Programme. A number of workstreams have been identified as follows:

1. Performance, Culture & Management
2. Medical Management
3. Stock
4. Bureaucracy Busting
5. Acuity-Based Care
6. Operational Dashboards
7. Re-imagining Supply
8. Operational Blueprints
9. Acute Care Collaboration
10. Care Collaboration and Navigation
11. Variable Pay - this workstream supports the above 10 schemes.

Each workstream has an Executive lead, with some schemes more fully developed than others. It is imperative that these schemes progress as quickly as possible, with the Model Hospital resource directed accordingly. Model Hospital are reviewing theses schemes to ensure their resource is focussed on the areas that will yield the maximum financial benefit for the Trust.

In addition, further actions have been implemented by the Executive team as follows:

- Executive review of all vacancies
- Executive and Clinically led weekly review of Medical Agency and vacancies
- Weekly review of medical agency spend
- Review of Upton Dene usage

Forecast for improvement:

Q1	Q2	Q3	Q4

2016/17 EFFICIENCY PROGRAMME PERFORMANCE AS AT JULY 2016

IN YEAR

Division / Department	2016/17 In Year CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,479,117	£ 1,126,896	£ 1,352,221	£ 204,344	£ 275,721	£ 435,755	£ 436,401
Urgent Care	£ 2,117,644	£ 348,064	£ 1,769,580	£ 164,070	£ 478,906	£ 909,950	£ 216,654
D&P	£ 443,608	£ 282,330	£ 161,278	£ 62,075	£ 7,500	£ -	£ 91,703
Estates & Facilities	£ 507,712	£ 246,738	£ 260,974	£ 45,000	£ 97,047	£ -	£ 118,927
Nurse Mgmt	£ 59,166	£ 31,765	£ 27,401	£ 7,000	£ 5,235	£ -	£ 15,166
Corporate Clinical	£ 13,375	£ 2,000	£ 11,375	£ -	£ -	£ 11,375	£ -
IM&T	£ 234,285	£ 137,395	£ 96,890	£ 76,567	£ 14,073	£ 6,250	£ -
HR	£ 102,806	£ 57,682	£ 45,124	£ 18,965	£ 3,000	£ 9,000	£ 14,159
Trust Administration	£ 76,751	£ 38,806	£ 37,945	£ 2,800	£ 25,895	£ 1,500	£ 7,750
PPD	£ 16,075	£ 16,075	£ -	£ -	£ -	£ -	£ -
Finance	£ 54,493	£ 57,845	-£ 3,352	-£ 3,352	£ -	£ -	£ -
Procurement	£ 24,005	£ 211,134	-£ 187,129	£ -	£ -	£ -	-£ 187,129
Appointments Hotline	£ 12,211	£ -	£ 12,211	£ -	£ -	£ -	£ 12,211
Central		£ 260,690	-£ 260,690	£ -	£ -	£ -	-£ 260,690
TOTAL	**£ 6,141,248**	**£ 2,817,420**	**£ 3,323,828**	**£ 577,470**	**£ 907,376**	**£ 1,373,830**	**£ 465,152**
		46%	54%	9%	15%	22%	8%

2016/17 EFFICIENCY PROGRAMME PERFORMANCE AS AT JULY 2016

RECURRENT

Division / Department	2016/17 Recurrent CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,479,117	£ 973,398	£ 1,505,719	£ 189,183	£ 120,250	£ 613,169	£ 583,117
Urgent Care	£ 2,117,644	£ 267,293	£ 1,850,351	£ 25,068	£ 644,595	£ 1,351,670	-£ 170,982
D&P	£ 443,608	£ 212,239	£ 231,369	£ 126,415	£ 10,000	£ -	£ 94,954
Estates & Facilities	£ 507,712	£ 170,000	£ 337,712	£ 60,000	£ 265,000	£ -	£ 12,712
Nurse Mgmt	£ 59,166	£ 28,000	£ 31,166	£ 14,000	£ 1,000	£ 16,166	£ -
Corporate Clinical	£ 13,375	£ 2,000	£ 11,375	£ -	£ -	£ 11,375	£ -
IM&T	£ 234,285	£ 95,912	£ 138,373	£ 55,423	£ 22,541	£ 60,409	£ -
HR	£ 102,806	£ 51,271	£ 51,535	£ 17,000	£ 3,000	£ 9,000	£ 22,535
Trust Administration	£ 76,751	£ 36,159	£ 40,592	£ 2,800	£ 25,895	£ 1,500	£ 10,397
PPD	£ 16,075	£ 16,075	£ -	£ -	£ -	£ -	£ -
Finance	£ 54,493	£ 57,845	-£ 3,352	-£ 3,352	£ -	£ -	£ -
Procurement	£ 24,005	£ 211,134	-£ 187,129	£ -	£ -	£ -	-£ 187,129
Appointments Hotline	£ 12,211	£ -	£ 12,211	£ -	£ -	£ -	£ 12,211
Central	£ -	£ 25,392	-£ 25,392	£ -	£ -	£ -	-£ 25,392
TOTAL	**£ 6,141,248**	**£ 2,146,718**	**£ 3,994,530**	**£ 486,537**	**£ 1,092,281**	**£ 2,063,289**	**£ 352,423**
		35%	65%	8%	18%	34%	6%

CRS DIVISIONAL PERFORMANCE AS AT JULY 16

Division / Department	Target to July	Achieved to July	Var to July	Var to June	Var in month
Planned Care	£ 826,372	£ 468,486	£ 357,886	£ 341,742	£ 16,144
Urgent Care	£ 705,881	£ 153,328	£ 552,554	£ 420,304	£ 132,250
D&P	£ 147,869	£ 140,836	£ 7,034	-£ 68	£ 7,102
Estates & Facilities	£ 169,237	£ 133,405	£ 35,833	£ 35,833	-£ 0
Nurse Mgmt	£ 19,722	£ 18,432	£ 1,290	£ 1,792	-£ 502
Corporate Clinical	£ 4,458	£ 545	£ 3,913	£ 2,980	£ 933
IM&T	£ 78,095	£ 78,268	-£ 173	-£ 1,438	£ 1,265
HR	£ 34,269	£ 23,826	£ 10,443	£ 8,824	£ 1,619
Trust Administration	£ 25,584	£ 15,521	£ 10,063	£ 8,128	£ 1,935
PPD	£ 5,358	£ 5,358	£ 0	£ 4,019	-£ 4,019
Finance	£ 18,164	£ 19,281	-£ 1,117	£ -	-£ 1,117
Procurement	£ 8,002	£ 70,378	-£ 62,377	-£ 46,783	-£ 15,594
Appointments Hotline	£ 4,070	£ -	£ 4,070	£ 3,053	£ 1,017
Central	-£ 521,355	£ 243,762	-£ 765,117	-£ 623,267	-£ 141,850
TOTAL	**£ 1,525,728**	**£ 1,371,425**	**£ 154,303**	**£ 155,119**	**-£ 816**

EXCEPTION REPORT

Indicator: Monthly Sickness Absence rate

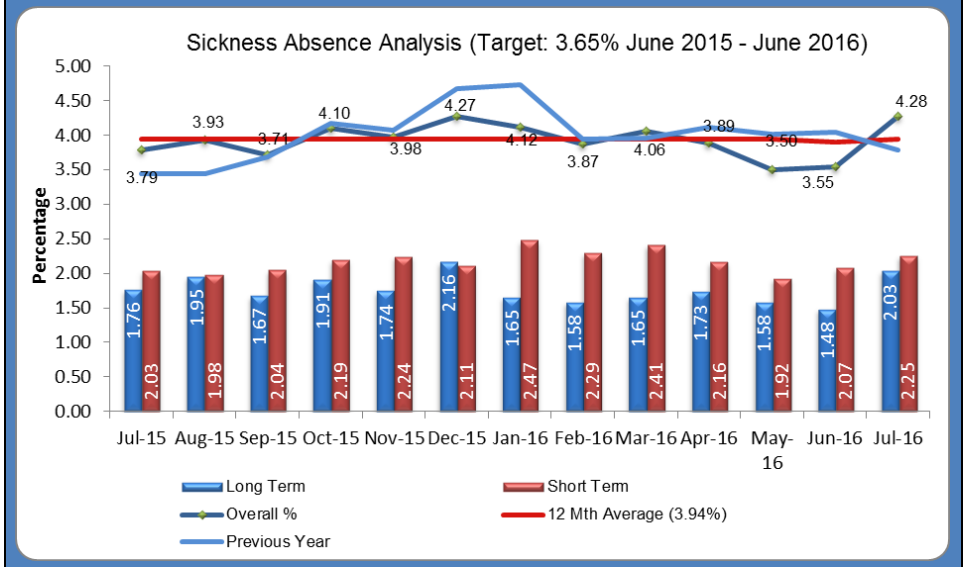
Issue:

The Trust wide absence rate rose to 4.28% in July. The increase is attributable to long term sickness rising from 1.48% to 2.03% and short term absence increased from 2.07% to 2.25%. On investigation, long term absences increased in the following three areas: a 153% increase in Gastrointestinal problems (2.96 WTE), a 58% increase in Tumours & Cancers (2.1 WTE) and a 20% increase in Stress/Anxiety (3.5 WTE). Short term absences increased in the following two areas: Back problems increased by 37% (1.5 WTE) and Other Musculosketal problems by 77% (1.58 WTE). Against our peers, absence rates across the region are currently averaging 4.9%, as outlined in EWIN regional benchmarking data (April 16). However, the Trust is performing favourably against this with our rolling 12 month average now running at 3.95%.

Proposed actions:

From a proactive perspective, the Occupational Health and Well Being service are continuing to offer a range of support for staff to improve their mental and physical health. Alongside the mindfulness, reflexology and stress busting sessions, and additional physical activities including participation in the Cheshire & Warrington Team Games, the introduction of a specialist stress clinic has been very well received. The work alongside the Dietetics service and staff canteen team has improved information available to staff on what they are eating and we are working with therapy colleagues regarding a new pathway to support musculo-skeletal intervention, supporting the delivery of national CQUIN targets. This activity is alongside the management development and support available to Divisions and the revisions to the Trust policy in conjunction with Union colleagues.

Historic data:



Forecast for improvement:

Q1	Q2	Q3	Q4

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 increased slightly this month to 93%, which exceeds the CQC target (76%) but remains just 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 continues to stand at 96%, maintaining our position above the 95% target. Local Induction has reduced to 85.9%. Maintaining consistent focused attention to address areas of reducing compliance is key. With the introduction of the new incremental pay policy and the link to compliance, this is assisting us in continuing improvements across the Trust and resulted in an amendment to the forecast for improvement in Q3 & Q4.

Proposed actions:

The Learning & Development team and those who participate in the Mandatory Training programmes continue to create additional capacity to ensure access is open to as many staff as possible. We monitor the numbers of DNA's and detailed focus on all of our measures of compliance continues and is showing sustained improvement. Overall performance is escalated to the Director of Human Resources & Organisational Development where continuous improvements are not being observed. Educational sessions on the new incremental policy have taken place with Ward Managers and further awareness of the changes will be undertaken ready for full launch in October 2016. The Divisional Managers will receive the details of areas of non-compliance supported by the reminder regarding the responsibilities for both staff and managers in relation to the new incremental policy.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:

Mandatory Training Table July 2016

Position	Division	Compliance
1	COCH & WUTH Collaboration	97.7%
2	Estates	97.5%
3	Facilities	94.7%
4	Planned Care	94.3%
5	Finance & Performance	94.0%
6	Human Resources	93.8%
7	Corporate Clinical	93.3%
8	Diagnostics and Pharmacy	92.4%
9	Corporate Non - Clinical	92.0%
10	Urgent Care	91.3%
11	Nurse Management	89.2%
	Total	93.0%

Local Induction Table July 2016

Position	Division	Compliance
1	Human Resources	100.0%
2	Nurse Management	100.0%
3	Planned Care	98.8%
4	Urgent Care	84.0%
5	Diagnostics and Pharmacy	75.7%
6	Corporate Non - Clinical	60.0%
7	COCH & WUTH Collaboration	50.0%
8	Facilities	50.0%
9	Finance & Performance	37.5%
10	Corporate Clinical	0.0%
11	Estates	-
	Total	85.9%

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 this month by to 84.3%. This remains marginally above the CQC target of 84% but remains below the Trust target of 95%. Where there are any issues of reduced compliance, Senior Managers are alerted and urgent action plans are requested in order to bring compliance back into line.

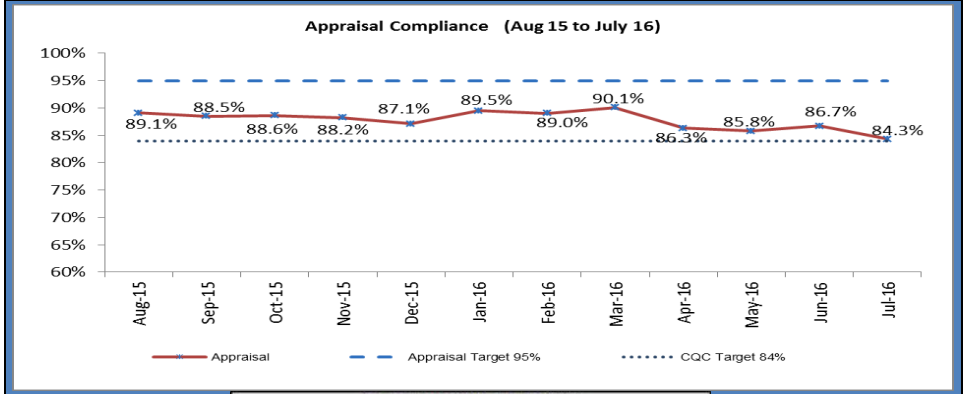
Proposed actions:

Robust monitoring continues to take place and where there are no signs of improvements, discussions will take place with the Director of HR & Organisational Development. The appraisal agenda, process, quality and compliance is a key area of focus within the Model Hospital programme under the Performance Culture programme. The introduction of the new incremental policy will support in improving our compliance over the coming months, hence the amendment to the forecast for improvement in Q3 and Q4, which is in line with the full launch of the policy in October 2016. Currently, line managers and all members of staff should be ensuring that appraisals are planned so incremental pay will not be affected from October. All Divisional Managers will receive the details of areas of non-compliance supported by the reminder regarding responsibilities related to the new policy.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Appraisal Table July 2016

Position	Division	Compliance
1	Facilities	98.9%
2	Human Resources	96.4%
3	COCH & WUTH Collaboration	94.3%
4	Estates	92.5%
5	Planned Care	92.1%
6	Diagnostics and Pharmacy	86.5%
7	Urgent Care	76.6%
8	Corporate Clinical	71.4%
9	Nurse Management	70.6%
10	Finance & Performance	63.9%
11	Corporate Non - Clinical	57.6%
	Total	84.3%

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

EXCEPTION REPORT

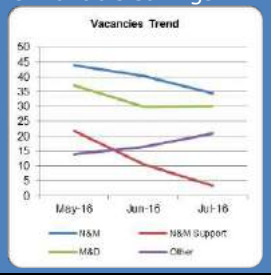
Indicator: Variable Pay

Issue:

To not exceed £4.843m agency expenditure ceiling. To deliver variable savings target (to be determined).

M&D Vacancies	Urgent	Planned	Diag/Radiol	Total
Consultant	2	2.8	0	**4.8**
Speciality Doctor	4	3	0	**7**
Middle Grade	4.1	7.4	0	**11.5**
Junior Grade	0.5	6.4	0	**6.9**
Total	**10.6**	**19.6**	**0**	**30.2**

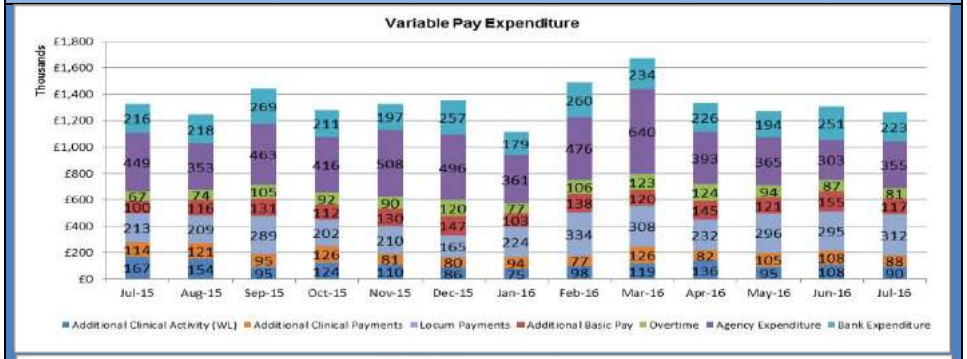
Vacancies (FTE)	Urgent Care	Planned Care	Diag/Radiol/Pharm	Total
N&M Registered	18.50	15.97	0.00	**34.47**
Support Staff	0.00	3.20	0.26	**3.46**
Radiographer/Sonographer	0.00	0.00	7.00	**7.00**
Allied Health Professionals	0.00	0.00	8.00	**8.00**
Healthcare Scientist	0.00	0.00	0.00	**0.00**
Pharmacy Support	0.00	0.00	4.00	**4.00**
Pharmacist	0.00	0.00	2.00	**2.00**
Total	**18.50**	**19.17**	**21.26**	**58.93**

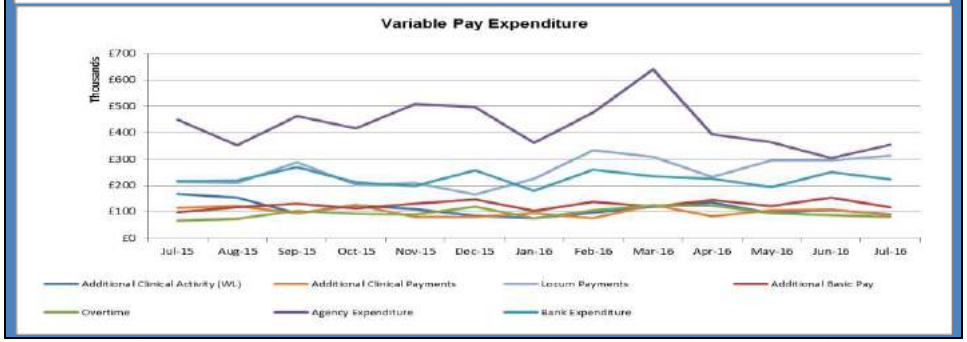


Proposed actions:

The level of medical vacancies has remained static month-on-month but remains of concern but recruitment leads are now in place in the majority of specialities and a first meeting has taken place. From mid-August, there will be no junior agency doctors due to proactive over-establishment to mitigate costs. The weekly Medical Pay Spend Review Board has been established with executive oversight and the medical lead to support medical pay/agency cost reduction has been appointed. Nursing vacancies have reduced and a series of actions are being put in place as identified in the recruitment & retention strategy. Additional schemes are being developed to address Pay / Variable Pay spend.

Historic data:





Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:	Richard Baird, Divisional Director
Executive Lead:	Sue Hodkinson

EXCEPTION REPORT

Indicator: Turnover

Issue:

Turnover has reduced to almost being on target at 10.09%. The rate based on FTE is now below target at 9.86%. The staff groups largely over target are Additional Professional Scientific and Technical Staff at 18.75%, which represents 27 leavers in the last year, 12 of which were ODPs and another 8 were Pharmacy Technicians, with no trends regarding the reason for leaving recorded on ESR. Admin. & Clerical Staff at 11.90%, representing 85 leavers in the last year. Nursing & Midwifery Registered Staff at 11.58% with 115 leavers in the last year, this includes 8 Midwives and 103 Staff Nurses. 27 of these took either flexi or age retirement, 33 were due to relocation and 16 due to external promotion.

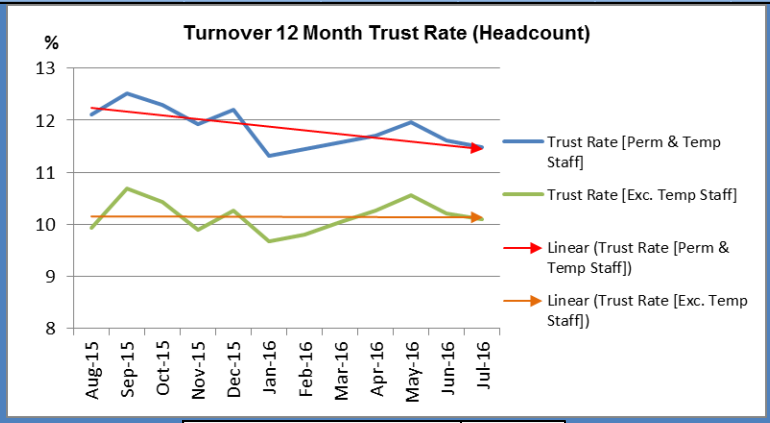
Proposed actions:

We will be continuing to monitor the rates over the next few months and providing further breakdowns, alongside analysis of exit interview responses to understand any trends. A series of actions are in place with the Theatre team to support retention of staff.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Staff Group - Aug 15 - Jul 16 Excludes Temporary Staff	Turnover %
Add Prof Scientific and Technic	18.31
Additional Clinical Services	7.74
Administrative and Clerical	12.08
Allied Health Professionals	9.77
Estates and Ancillary	7.96
Healthcare Scientists	7.23
Medical and Dental	5.08
Nursing and Midwifery Registered	11.27
Trust Totals & Rate	**10.09**

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

EXCEPTION REPORT

Indicator: Agency Spend

Issue:
Medical Agency spend is £1,088k ytd (7% of the total medical spend). Agency nursing expenditure YTD is £161k which is 1.2% of total trained nursing spend. Total Agency spend for months 1 to 4 is £1,421k, compared to £1,386k for the same period last year. Using a straight line forecast would indicate that full year spend will be £4.3m, below the £4.8m agency cap set by NHS Improvement. However, if spend follows the same trajectory as in 2015/16 the forecast expenditure would be £5.7m, above the NHS Improvement agency cap.

Proposed actions:
One of the key workstreams as part of the Variable Pay group is focused on medical agency spend and improving and controlling our position to enable a reduction of spend against the agency cap. Analysis is currently being undertaken by speciality, with the assignment of recruitment leads and revisions to recruitment proceses. Addressing the number of medical agency shifts above the price cap is a further area of focus. The enhanced data provided by the implementation of Direct Engagement is providing awareness of trends of premium shift usage and the use of Direct engagement has provided £96k savings in 4 months, which is greater than planned. Action plans are required from each of the divisions to address agency usage and spend.

Forecast for improvement:

Q1	Q2	Q3	Q4

Staff Group	13/14 £	14/15 £	15/16 £	16/17 to M4 £	16/17 Straight Line Projection £
Admin & Clerical	194,881	119,858	163,219	-	- 1,083
Medical	1,486,646	2,531,112	3,911,032	1,088,107	3,264,322
Nursing	208,260	830,776	642,734	160,950	482,850
Allied Health Professional	72,710	177,384	218,871	39,915	119,744
Health Care Scientists	141,450	115,743	161,736	132,212	396,637
Total	**2,103,946**	**3,774,873**	**5,097,592**	**1,421,184**	**4,262,470**

Appendix 1 – Safe staffing

Ward Summary

Countess of Chester Hospital NHS Foundation Trust		July							
		Registered Nurses/Midwives			Care Staff			All staff	Statement of actions to ensure safe staffing levels
Specialty	Ward	Planned monthly hours	Actual monthly hours	%	Planned monthly hours	Actual monthly hours	%	% planned hours staffed	
Paediatrics	30	2658	2577	**97.0%**	713	795	**111.5%**	100.0%	
Obstetrics	32	2658	1701	**64.0%**	1426	1097	**76.9%**	68.5%	
Stroke Unit	33	2668.5	2553	**95.7%**	2356	2634	**111.8%**	103.2%	
Intermediate Care	34	2050.5	629	**30.7%**	2650.5	989	**37.3%**	34.4%	
Labour Ward	35	4278	4247	**99.3%**	870.5	917.5	**105.4%**	100.3%	
General Surgery	40	1426	1220	**85.6%**	434	751	**173.0%**	106.0%	
Cardiology	42	1955.5	1916.2	**98.0%**	1612	1752.5	**108.7%**	102.8%	
Care of the Elderly	43	2081.5	1676.5	**80.5%**	2697	2125	**78.8%**	79.6%	
General Surgery	44	2141.5	2042.5	**95.4%**	2170	2206	**101.7%**	98.5%	
Urology/Trauma and Orthopaedics	45	2141.5	1856.5	**86.7%**	2511	3179.5	**126.6%**	108.2%	
Respiratory Medicine	48	2622	2300	**87.7%**	1767	2006.5	**113.6%**	98.1%	
Gastroenterology	49	1890.5	1869.5	**98.9%**	1953	2098.5	**107.5%**	103.2%	
Haematology/Resp Medicine	50	2296.5	2004.5	**87.3%**	1953	2443.5	**125.1%**	104.7%	
Respiratory Medicine	51	2030.5	1873	**92.2%**	2883	2762.5	**95.8%**	94.3%	
General surgery	52	2327.5	1886	**81.0%**	1798	2482	**138.0%**	105.9%	
General Surgery	54	2854.5	2711.775	**95.0%**	2325	2208.75	**95.0%**	95.0%	
Acute Medicine	AMU	5185.5	4531.5	**87.4%**	2723	2535	**93.1%**	89.4%	
Cardiology	CCU	2428.5	2092.5	**86.2%**	372	701.5	**188.6%**	99.8%	
Rehabilitation - EPH	Diamond/Ruby	1488	2166	**145.6%**	2743.5	4665	**170.0%**	161.4%	
Rehabilitation - EPH	Emerald	1255.5	1133.5	**90.3%**	2015	2072	**102.8%**	98.0%	
Critical care medicine	ICU	9269	8804.5	**95.0%**	1085	715	**65.9%**	91.9%	
Neonatal	NNU	3059	2673.5	**87.4%**	1426	1081	**75.8%**	83.7%	
Total		60766	54464.975	89.6%	40483.5	42217.75	104.3%	95.5%	

RAG Report

		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Overall trust score		98.7%	96.4%	96.4%	95.5%	97.7%	97.7%	98.1%	100.4%	96.1%	95.9%	98.6%	98.1%	95.5%
Paediatrics	30													
Obstetrics	32													
Stroke Unit	33													
Therapies Intermediate Care Unit	34													
Labour Ward	35													
Women's Unit	40													
General Surgery	41													
Cardiology	42													
Care of the Elderly	43													
General Surgery	44													
Urology/Trauma and Orthopaedics	45													
Respiratory Medicine	48													
Gastroenterology	49													
Haematology/Resp Medicine	50													
Short Stay	51													
General surgery	52													
Surgery	53													
General Surgery	54													
Acute Medicine	AMU													
Cardiology	CCU													
Rehab - EPH	Diamond													
Rehab - EPH	Emerald													
Critical care medicine	ICU													
Neonatal	NNU													
Rehab - EPH	Ruby													
Diamond/Ruby	Diamond Ruby													

Key
>105%
95% to 105%
<95% to 90%
<90%

The Trust continues to use a small number nursing agency hours to maintain safe patient care. This tends to support the more challenging areas to recruit to. The Trust continues to actively recruit RNs in the vacancies. We are on target to see the first ward 'go-live' with e-rostering in August. This will be start to our full hospital roll out and is fully supported by the Ward Managers. There is a large recruitment scheduled to take place for Nursing Assistants in August. The Trust is currently reviewing the recruitment process to ensure this is both productive and efficient
The Trust is continues to monitor any impact of the nursing vacancies via its safety team. The Director of Nursing maintains oversight at a weekly established meeting.

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Progress update on the Digital Road Map for the Countess of Chester Foundation Trust: 1. Full Business Case for a Patient and Asset Tracking System; Executive summary. 2. Update and overview of progress on Electronic Patient Record System and future replacement options.
Date of Meeting	6th September 2016
Author(s)	Rob Howorth – Deputy Director of Informatics Frankie Morris – Deputy Chief Finance Officer
Presented by	John Glover – Director of IM&T Ian Bett; Model Hospital Programme Director Rob Howorth; Deputy Director Informatics, Model Hospital
Annual Plan Objective No.	
Summary	Over the past 12 months the trust has been exploring and reviewing priorities and technology options in support of transactional and transformational changes that underpin Safe, Kind and Effective care. These have been shared and discussed widely and provide on overview of technology changes and procurements over the next 5 years. In keeping with the recommendations in Lord Carter's review of productivity and efficiency in the NHS, this is an opportunity to open up our transparency and responsiveness to patient care in ways we never thought possible. The proposal is to: - Synchronise our EPR replacement inline with the wider Cheshire and Wirral STP digital road map procurement plan. - Move to immediate implementation of a Patient and Asset Tracking system which will completely change the way in which we plan and organise our workforce around patient need, and manage flow through the hospital. This paper should be read alongside:

	- The Full Business Case for the implementation of a patient and asset tracking system, which has a more restricted circulation due to its commercially sensitive nature. - The Outline Business Case for the replacement of Meditech v5.6, which has a restricted circulation due to its commercially sensitive nature.
Recommendation(s)	The Board is asked to: 1. Support and approve procurement of a Patient and Asset Tracking System. 2. Delegate authority to the Chief Executive Officer and his representatives to negotiate an appropriate risk sharing agreement and commercial partnership with an appropriate supplier, that will be selected from an approved procurement framework, and let the contract. 3. Approve Electronic Patient Record OBC 4. Recognise ongoing procurement and funding as an important part of the Cheshire and Wirral Sustainability and Transformation Plan.
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: ☑ **A. This document is for full publication** ☐ **B. This document includes FOIA exempt information** ☐ **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

Business case title	**Full Business Case For A Patient & Asset Tracking System (PAATS) EXECUTIVE SUMMARY**			
Division	**Corporate**			
Lead Manager	**Ian Bett**			
Paper Author(s)	**Rob Howorth – Deputy Director of Informatics Frankie Morris – Deputy Chief Finance Officer Paul Marchant – Model Hospital Project Manager**			
Date to QVDT	16th of Aug 2016	**Agreed to proceed**	**Yes**	~~No~~
Date to EDG	17th of Aug 2016	**Agreed to proceed**	**Yes**	~~No~~
Date to CDG	24th of Aug 2016	**Agreed to proceed**	**Yes**	~~No~~
Date to Trust Board	06th of Sept 2016	**Agreed to proceed**	**Yes**	**No**

Version Control

Version No.	Date	Author	Comments
1	8th Aug 2016	Rob Howorth	Drafted by Rob Howorth with Frankie Morris and Paul Marchant. Formatted By Craig Brothwood
1.1	8th Aug 2016		Amendments from Gill Galt and Paul Marchant
1.2	9th Aug 2016		FM amendments via Frankie Morris
1.2.1	9th Aug 2016		Updated staffing lists via Paul Marchant
1.2.2	10th Aug 2016		Amendments from Ian Bett
1.2.3-4-5	11th Aug 2016		Amendments from Frankie Morris, Paul Marchant and Paul Miles
2.0	30th Aug 2016		Amendments from Rob Howorth

1 – Introduction

From the outset, as part of our plans to be The Model Hospital we have been clear about the fundamental role that technology and information plays in enabling organisational change and achieving operational excellence. Building on healthcare systems and practices for managing patient flow in the United States, it is our plan to introduce a Patient and Asset Tracking System (PAATS) here at The Countess of Chester Hospital with support and involvement from our operational and clinical staff. In keeping with the recommendations in Lord Carter's review of productivity and efficiency in the NHS, there is an opportunity to increase transparency and our responsiveness to patient care in ways we never thought possible.

This paper provides a summary of the proposed implementation of a Patient and Asset Tracking system here at the Countess. Further details can be found within the Full Business Case.

What is a Patient and Asset Tracking system (PAATS)?

A PAATS completely changes the way in which we all work by wrapping our workforce around patient need, and managing flow through the hospital. It makes use of small infrared sensors at key locations of patient care e.g. above patient beds, at entrance points to wards and theatres, outside cupboards and at hand gel dispensers. These sensors provide real time mapping information about a patient's status by detecting discreet electronically chipped devices in security cards for staff, a re-usable wristband for patients or tags on essential equipment.

On the ward…

A PAATS will allow our clinical and operational staff to view live patient flow data and status to understand what is happening in every patient bay. We will be able to see at a glance if a bed is vacant, or if a patient is due to be discharged that day or within the next 48 hours. Simple symbols indicate whether they have been seen by the key clinical staff as part of the patient pathway like the occupational therapist, social care worker, physiotherapist or dietician as part of their discharge planning. On a more practical level, a timer shows when that patient was last seen by a member of staff which will allow us to monitor in real time direct clinical care time. We will be able to see if there are any alerts specific to the patient in the bed, perhaps they are a falls risk and trigger an onscreen warning if they have vacated the bed unexpectedly.

In a central Coordination Centre…

In the hospital there will be a central Coordination Centre. Within this it will be staffed by senior nurse staff working across a range of screens, showing Trust wide bed status and patient flow and capacity through inpatient and theatres. We will be able to see how many clinical staff are around a patient bed at any one time. They can see when a bed on ward becomes free after a patient tracker is deactivated, the bed making team is automatically notified when a bed needs cleaning and fresh linen is required. Porters are automatically notified that a patient needs collecting from one area of the hospital and moved to another. Equipment services are automatically notified of any specific patient needs regarding hoists or bariatric chairs. There is a clear view of timeframes for beds becoming available, and the logistical services work together to seamlessly support a better flow of patients through the hospital.

Key principles for staff to understand…

- The main drive for introducing the tracking system is to support improved patient care and to complement work already underway around delivering an acuity based workforce, as part of our e-rostering implementation.
- This kind of patient tracking system has already proven effective in pockets of the NHS. In Wolverhampton, it was initially piloted to support increased self-compliance and awareness with hand hygiene practices. A sensor activates on plunging of hand gel dispensers, and records instances of staff decontaminating their hands. It

prompted significant improvements in this area and led the hospital to implement tracking capability in other areas including managing their patient flow.

- We are interested in greater transparency and personal accountability in how we work together to improve patient care and work more efficiently across our services. We are not interested in spying or snooping on where colleagues are at any given point in time. We trust our staff, and know that our people come to work here every day for the right reasons.
- With this system we will improve our tracking of costly and high volume assets. Nurses will be able to find the equipment they need to treat their patients quickly. We are not proud about it, but the reality is that every day, every week, every month we lose equipment - be these beds, electronic pumps or even bariatric chairs. This costs the hospital money and cannot continue.
- This tracking capability offers added protection for staff. They can be used to trigger an alarm if there is a personal safety issue. They can also be used to access data about dates and timeframes when an individual has direct patient contact. Learning from other hospitals shows this information has provided reassurance and evidence in management of complaints, and on rare occasions in coroner inquests

What it will mean for the patient…

Patients will receive a simple tracker that is attached to the existing patient identification wristband. This will allow staff to monitor the precise location of the patient and their safety; to monitor the amount of clinical care (in hours and minutes) that a patient has received; to locate in real time the clinical devices that are required for their treatment; to track their progress to discharge. These direct benefits to the patient in relation to their care will be the visible benefits to patients. There is significant academic research that demonstrates a correlation between increases in hospital acquired infection rates and excess length of stay; there is evidence that suggests the incorrect placement of a patient in a ward (an outlier) can increase the patient length of stay by up to 5 times that of a non-outlying patient. Evidence from sites that have implemented PAAT systems demonstrate that the number of patients outlying decreases significantly, as does the length of stay. Evidence also indicates that PAAT technology can increase hand hygiene significantly which also has a positive impact on hospital acquired infections. The PAAT technology can be used to identify patients with infections, but importantly track other patients and members of staff that have been in contact with that particular patient. The quality benefits of PAAT system for the patient will be significant and numerous.

What it will deliver in keeping us safe, kind and effective…

A shift from…	A shift to…
Safe:	
Difficulties managing winter bed pressures and delivering the 4 hour target	Whole hospital ownership around working together to manage bed pressures and targets
Repeat instances of patient bed moves and increased risk of patient harm	Right bed first time, reduced moves, and reduced risk of harm to patients
Time spent looking for key individuals during a crisis situation (e.g. a major incident)	Ability to search and find the location of staff at any given moment
Time spent looking for patients who may be missing or absconded	An improved security system that triggers an immediate alert if a patient is somewhere they should not be or at risk
Not achieving 100% compliance of hand hygiene practices	Improved self-awareness and culture of hand hygiene practices, leading to reduced risk of infections
Labour intensive tracking of high risk patients	Real time identification of high risk patients e.g. falls and infection
A colleague mistakenly walking off a ward with keys to an essential cupboard e.g. controlled drugs	An improved security system that triggers an immediate alert if a set of keys are taken outside of the area they should be

Kind:	
Patient or families complaining about the perceived attentiveness of clinical staff	Detailed evidence of dates, timeframes for any staff and patient interactions as a means of reassurance to patients and protection for staff

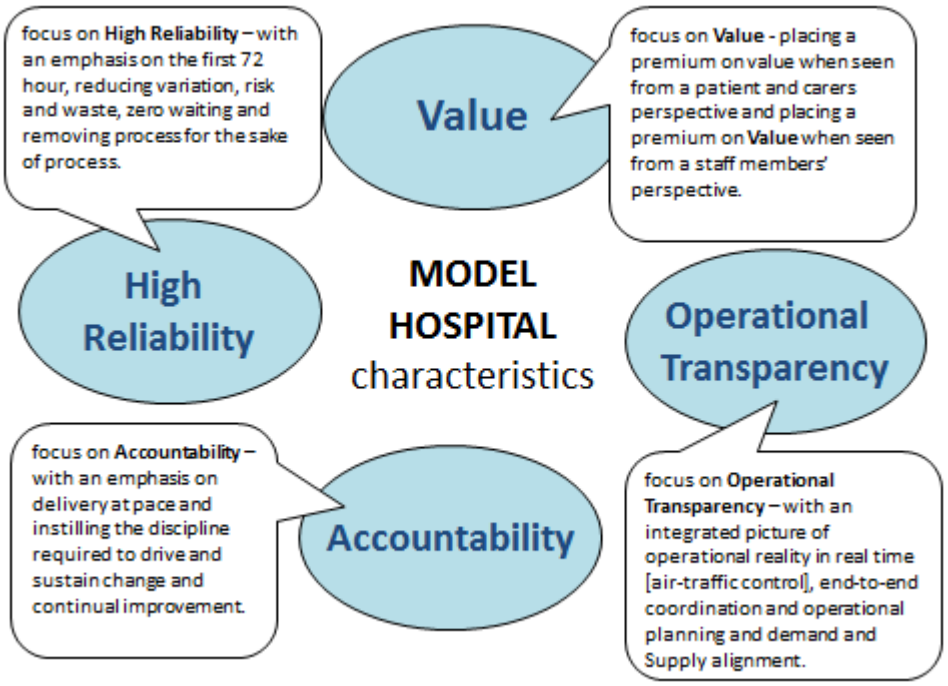
Effective:	
Resource intensive collection of bed status information three times a day using manual and paper based systems	Automated population of bed status information using electronic systems and displays available in real time, all of the time
Time spent by nurses looking for key medical equipment	Key medical Equipment (including beds) can be tag and tracked. The location of any given piece of equipment can be displayed in real-time saving significant time in searching for equipment.
Time spent by nurses continuously reviewing individual patient treatment plans (in Meditech) to understand their stage in discharge, and updating wider teams	Visual displays in all ward areas clearly outlining where a patient is in their discharge journey
A reactive system for coordinating logistical services when a bed is vacant e.g. bed making, porters etc. that may cause delays for patients	An automated, responsive / pre-emptive system for scheduling logistical services in a way that reduces delays for patients
Limited understanding where our high volume or high cost equipment is at any given time	Immediate oversight of where all equipment is, and a reduction in equipment being hired or lost

2 Summary of Case

The full business case (FBC) assesses the benefits, costs and strategic requirement for the procurement of a Patient and Asset Tracking System (PAATS). The Trust has identified that implementation of a Patient and Asset Tracking System would help address a number of immediate operational pressures, providing complementary technology to the Model Hospital programme and enable a number of longer term strategic objectives which are outlined in the Sustainability and Transformation Plan (STP). The Trust's goal to become a high reliability organisation will benefit significantly from an investment in PAATS. High reliability organisations have the following characteristics:

1. High levels of operational sensitivity and situational awareness
2. Proactive management of the unexpected – an ability to notice the unexpected in the making and takes actions to control/prevent it
3. High leverage of technology and the transformation of data into actionable information
4. Having a centralised and well organised Coordination Centre (Associated costs can be found in Appendix A)

Model Hospital Principles



The characteristics of an HRO correlate closely with those of the Model Hospital programme, indeed the attributes of a PAAT system also echo the principles of the Model Hospital programme.

Within the FBC, only two options have been considered – do nothing or procure a PAATS. The Trust could look to invest in an asset tracking system that only tracks assets but this would not deliver the desired benefits or enable the strategic objectives of the STP. Therefore this option is not considered within this FBC.

Following the Carter Report; the subsequent work and engagement with Lord Carter and his team, it was identified that investment in a PAATS would bring significant benefit to the Trust. The Trust's decision to progress this to an FBC has been informed through a number of site visits in the UK to Trusts that have already implemented this kind of technology.

2.1 Why are we doing this?

The Trust has experienced a significant growth in operational pressures over the last few years due to increases in demand, see table 1. These pressures manifest in a variety of ways throughout the Trust:

- A failure to meet national targets, increased patient cancellations leading to rework and additional cost
- Increases in acute medical pressures on bed capacity
- Decreased flow of patients through the organisation and increased costs

In the current financial climate the Trust cannot afford to run its services in this way, it has to become more efficient and more resilient. 8.3% of the Cheshire and Merseyside population are aged 75+; 32% of the population live in the most deprived areas. These demographics typically cause increases in demand from the most complex cohort of patients.

Demand on the Trust over the last 3 full financial years

	2013/2014	2014/2015	2015/2016
ED Attendances	68,184	68,313	78,764
Elective Procedures	45,858	47,820	46,052
Op Activities	469,601	476,170	479,297
Average LOS	4.29	4.12	4.13

- Type 3 ED attendances started at COCH in 2015/16
- No exclusions are made for elective work i.e. all work included in the above numbers
- OP includes both PbR and non-PbR for both new and follow ups

Whilst the procurement and implementation of a PAATS will not provide the answer to these challenges, it will provide the tools and support the processes needed to create a culture shift that can address these challenges. The provision of the system in isolation will not be the panacea to the Trust's ails; it is important that the transformational elements are also implemented otherwise the system will not enable the delivery of the benefits. However, leveraging this type of technology will support the Trust's strategic aim of becoming a High Reliability Organisation (HRO).

2.2 The Model Hospital and PAATS

Considerable work has already commenced on the Model Hospital Programme. There are a number of work streams that seek to address similar issues that a PAATS could alleviate. It is considered that the implementation of a PAATS would complement the activity of the Model Hospital and not duplicate or conflict with it. The Model Hospital Programme seeks to change process and behaviour, which the intelligent implementation of a PAATS would support and further enable. The Model Hospital Programme streams which would interact and be supported by a PAATS are summarised below:

Re-imagining Supply – A PAATS provides end to end visibility of the hospital, its patients and resources, which will enable intelligent flow management in real time of patients and resource. The reimagining supply work stream is actively analysing and modelling the flow of patients through the hospital. A PAATS would actively enable many of the activities in this programme

Care Coordination – At the heart of this work stream is Win's Story; arguably a good deal of the poor care and experience that was evidenced in Win's story was cultural, and will be addressed by the scheduled work. A PAATS will contribute significantly to staff awareness as to the patient location, the level of care they are receiving (Care Hours per patient per day), their general acuity and other markers of care and readiness for discharge. Ultimately a PAATS will contribute to the culture of "get it right first time" which supports the delivery of an HRO.

Operational Blue Prints – This work programme is proactively redesigning clinical services to ensure maximum efficiency – both from a clinical and resource perspective. PAATS enable the tracking of patients and resources, and have additional functionality to enable real time scheduling and tracking in theatres. This type of functionality will improve and complement the on-going work of the Operational Blue Print work stream.

Nursing Acuity – One of the key components of a PAATS is the ability to measure the amount of time a clinical member of staff spends with a patient at the bedside. Whilst this does not measure the quality of the interaction there is an inference that a more acutely ill patient will require more clinical time. One of the core tenets of the Nursing Acuity work stream is to measure the acuity of patients (i.e. how unwell the patient is) and redistribute clinical time accordingly. Being able to

measure the amount of clinical time a patient receives per day – in real time will further support the realisation of this ambition. A PAATS will provide this functionality and the ability to measure Care Hours per patient per day in real time, working effectively alongside the e-rostering tool to deliver a complete acuity based approach.

Stock – Part of the core functionality of a PAATS is of course the ability to track and manage assets (i.e. clinical equipment). Currently the Trust has no ability to actively track the whereabouts of valuable clinical assets; whilst this is not currently in scope of the Stock work stream the savings associated and clinical improvements (no time wasted to locate devices, EBME able to service/repair devices according to schedule) it is intended that if the Trust decides to procure PAATS then the Stock programme scope would be extended to include this functionality and associated processes.

Medical Management/Performance and Culture – The implementation of a PAATS will provide functionality to record staff activity which will enable the efficient and timely allocation of staffing to reflect the needs of the organisation. This data will be recorded into a repository that can be analysed to support appraisal and development processes and more proactive planning, forecasting and simulation analyses to inform job planning and further hospital transformation.

2.3 The Sustainability and Transformation Plan (STP) and PAATS

The Cheshire and Wirral Local Delivery System (LDS) plan makes explicit reference to high reliability processes driven by real time clinical and operational technology platforms; the plan also references the proposal to invest in a real time operational performance management system to enable proactive management of the system.

The STP looks to shift the focus of the delivery of care from an organisation basis to a population base, in this case the population of Cheshire and Wirral (approximately 1million citizens). In order to manage and deliver that strategic aim, oversight of the entire resources in the region will be a core foundation. In the United States of America there are significant health care organisations that manage and deliver population health care via a federation of hospitals; these are typically managed by an organised Coordination Centre that leverage PAATS type technology that enable the real time tracking of patients and resources across multiple locations.

Clearly a system wide strategic aim such as this will not be an immediate deliverable in this stage of implementing a PAATS; however proving the benefit of such a technology in a single locality and a wider Accountable Care Organisation (ACO) will pave the way for its adoption in the region. Investment at this stage is not limiting and the technology is scalable.

2.4 Understanding the benefits and the cost of ownership

The Trust has worked with key Consultants and Operational Managers to explore the implementation of PAATS, to understand the costs and the benefits associated with each strategic area and the potential savings (both cash releasing and non-cash releasing) that could be achieved with its implementation. This work has included input from a system supplier. The analysis is fully considered in the financial case of the FBC.

2.5.1 The Strategic Case

The Strategic Case describes the key drivers for the investment. The key drivers for this investment are summarised below:

- Provide real time tracking of patients and improve patient flow
- Enable real time visual bed management
- Enable the monitoring of clinical hours per patient per day, therefore improving patient acuity management
- Support the intelligent and proactive allocation of staffing on the basis of clinical need
- Enhance the efficient utilisation of clinical space by leveraging real time information and technology
- Allow for the live monitoring of physical asset location

- Allow for the development of an intelligent and proactive infection control management culture utilising patient and staff tracking, and the interaction with hand hygiene technology
- The development of a Coordination Centre and the realising Trust's ambition to develop into an HRO
- Support the ambitions outlined in the STP, utilising modern PAATS technology throughout the Cheshire and Wirral region

2.5.2 The Economic Case

The Economic case identifies and evaluates two long-list options described above and assesses them against a series of indicators – Critical Success Factors (CSFs), Risks and Benefits. The summary of these assessments are below:

ASSESSMENT CRITERIA	OPTION 1		OPTION 2	
	Do Nothing		Patient and Asset Tracking system (PAATS)	
	Score	Rank	Score	Rank
Critical Success Factors	53	2	130	1
Risk	70	1	40	2
Benefits	36	2	62	1
RANK	151	**2**	228	**1**

The analysis of the assessment indicates that the investment into a PAATS is the preferred option.

2.5.3 The Financial Case

The full costs of a PAATS including supplier costs, implementation, Trust capital outlay and on-going staffing changes are reflected in the FBC over the 6 and half year project (18 month implementation and 5 year running). For this cost, the Trust has identified a significant Return on Investment (ROI) that will offset the costs detailed in the FBC.

The Return on Investment is based on the following key areas:

- Reduction in bed base costs
- Increased theatre utilisation resulting in reduced costs of our theatres
- Increased efficiency of our portering services

Key points to note are:

- If the full ROI is not delivered, the payment to the supplier will be adjusted down according to the terms of the contract.
- Assumed no initial payment to the supplier until April 2018
- Using the Baseline ROI identified in the FBC, the project will breakeven during the implementation period
- The terms of the contract will be subject to legal, technical and VAT review
- We have applied to the NHS England Transformation Fund for this funding. However, if that is not forthcoming we will use a combination of capital slippage and non-recurrent VAT reclaims that have been repaid this year. In Year 2 the ROI projected will be used to fund the investment, with the residual costs being funded through planned capital investment.

- There is a need for the Trust to invest in a bed making team to achieve a number of ROI including reduction in bed stock through efficiencies in bed turnaround times and faster patient flow.

2.5.4 The Commercial Case

The Commercial case identifies a number of recommendations, these are:

- That the Trust utilises a procurement framework to select a system provider
- That the preferred system provider is on the list of accredited system suppliers that would enable the Trust to qualify for the Clinical Utilisation Review (CUR) CQUIN
- That the Trust utilises external legal expertise to devise a mutually acceptable contract
- The Trust selects a supplier that is willing to enter into a partnership type agreement which has an explicit risk share agreement between the supplier and the Trust, and ensures that the Trust will only pay for contracted services as and when benefits are delivered. This will be a core element of the contract.
- Consideration should be given within the contract to ensure that other NHS organisations in the STP can utilise the system without having to engage in protracted procurement processes

The contract length should be between 5 to 8 years with an option to extend further if required.

2.5.5 The Management Case

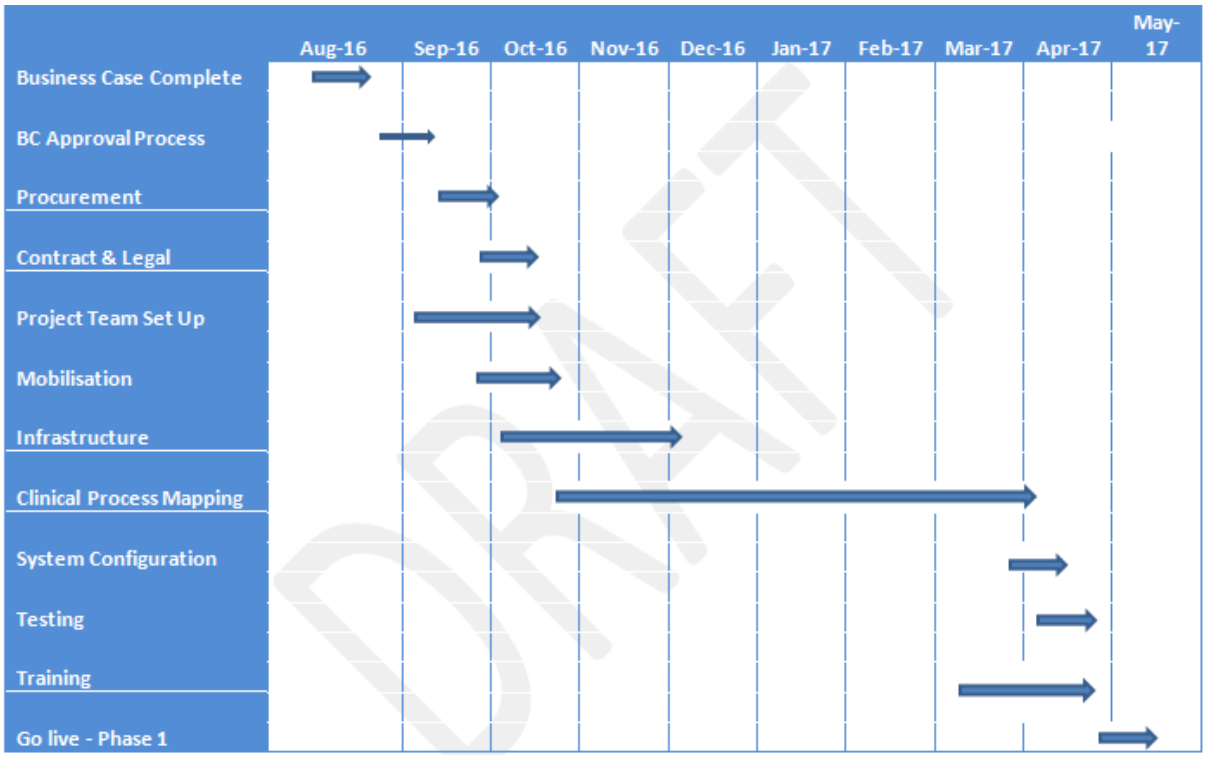
The Management case reviews the implementation effort that will be required to implement a PAATS. This is clearly a complex solution to implement and will impact on a wide sector of the Trust staff. As the Trust is seeking a commercial partnership with a preferred bidder it is expected that this will also include considerable implementation support from the supplier. A summary of the effort required by the Trust is detailed below:

Role	Duration	Role	Band	WTE
Core Team				
Project Manager	18 months	Project management	7	1.0
Technical Lead	10 months	Technical management	6	1.0
Clinical and Operational Lead	18 months	Operational and clinical management	8a	1.0
Operational Support Manager	18 months	Operational coordination	5	1.0
Data Analyst	18 months	Data analyst	6	1.0
System Trainer (in hours)	2 months	System training	5	1.0
Estates Technician	8 months	Facilitation of wiring/cabling/other estates work	6	0.5

Key Stakeholders - Input required	
Clinical Staff	
Ward Manager & Matrons	Bed management system/patient tracking, buy in and KPI setting
Patient Flow Manager	Patient flow
Consultants	Clinical Lead
ED Consultant/Senior Nurse	ED implementation
Specialist Nursing Groups	Workflow design, e.g. EOL and diabetes
Allied Health professionals (AHP's)	Care Progression indicators (referral system)

Therapies	Patient flow
Operational Staff	
Business Performance Managers	Support the design of workflows
Clinical Site Coordinator	Bed management system/patient tracking
Theatre Manager	Theatre implementation
Discharge Liaison	Discharge planning and processes
Radiology and Pharmacy	Workflow design, data capture
Domestic Supervisor	Housekeeping functionality implementation
Portering Manager	Portering functionality implementation
EBME Manager	Asset tracking implementation
Equipment Library Manager	
Nuclear Medicine	Tagging keys, monitor access to nuclear assets
Infection Control/HSDU	Support data capture, advise on workflow, implementation,
Unions	Early engagement to support staff groups
Comms Team and internet team	Strategy communication to all staff
Human Resources	HR issue resolution/expert advice
Finance Lead	Linking activities to budget
Service Improvement	Process mapping
Director of Operations	Executive Leadership
Director of HR and OD	Executive Leadership
Director of Nursing	Executive Leadership

The implementation of a PAATS will consist of three distinct phases, a high level schedule is detailed below; this phase will enable the Trust to start using the technology at a primary level. Phase 2 will see the implementation of the Real Time Location System which enables the precise tracking of patients and assets; Phase 3 will deliver the Central Coordination Centre. Phases 2 and 3 are not currently planned; it is anticipated that these will developed during phase 1 of the programme in conjunction with the supplier.



3. Recommendations to the Board

1. Support and approve procurement of a Patient and Asset Tracking System.
2. Delegate authority to the Chief Executive Officer and his representatives to negotiate an appropriate risk sharing agreement and commercial partnership with an appropriate supplier that will be selected from an approved procurement framework and let the contract.

BOD Item No

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	**Report on the implementation of the Junior Doctor Contract**
Date of Meeting	6th September 2016
Author(s)	• Sue Hodkinson, Director of Human Resources & Organisational Development • Sue Hughes, Medical Staffing Manager
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 assurance to the Board on our actions to implement the new contract and Terms & Conditions of Service (TCS). Supporting our Junior Doctors and our wider workforce during the implementation is paramount and as such, this will continue to be monitored through People & Organisational Development Committee.
Recommendation(s)	The Board is asked to receive and note the report.
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: **X** **A. This document is for full publication** **B. This document includes FOIA exempt information** **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Introduction of the new Junior Doctor Contract

1.0 Introduction

The purpose of this paper is to provide a report to the Board of Directors on the progress of the implementation of the new Junior Doctors contract.

2.0 Background

On 6th July 2016, following the announcement by the British Medical Association (BMA) that their members had voted against the proposed new junior doctors contract, the Secretary of State for Health announced his decision to introduce the new Terms and Conditions of Service (TCS). Subsequently, NHS Employers have issued a series of documents to enable Trusts to commence work on the implementation and the transition to the new TCS. The timeline is as follows:

Date	
July 2016	Appoint guardians
26 July 2016	Guardian conference
3 August 2016	2016 contract is live
October 2016	Transition to the 2016 TCS for: Obstetrics trainees taking up new appointments at ST3 and above
November / December 2016	Transition to the 2016 TCS for: F1 doctors taking up next appointments F2 doctors taking up next appointments and sharing rotas with F1 doctors
February / April 2017	Transition to the 2016 TCS for: Psychiatry trainees taking up next appointments (all grades) Pathology trainees (lab based) (all grades) Paediatrics trainees taking up next appointments (all grades) Surgical trainees (all disciplines) taking up next appointments (all grades) F2 doctors and GP trainees (ST1/2) taking up next appointments and sharing rotas with any of the above
August / October 2017	Transition to the 2016 TCS for: All remaining trainees taking up next appointments (all grades) All new starters (all grades)

The new contract applies only to doctors in training and does not apply to Trust grade doctors. As the vast majority of our trainees are employed via a Lead Employer arrangement through St Helens & Knowsley Hospitals NHS Trust, we are working closely with the Lead Employer to implement in line with their timescales.

The implementation is complex as our trainees (with the exception of Foundation year 1 and Foundation year 2 doctors) are not employed by the Trust, but via a Lead Employer arrangement. Transition to the new contract for the trainees hinges on how long the trainee has been on the rotation scheme as to

whether they move to the new contract at the time scale specified, or if they remain on old contract for the duration of their training or current contract. The Trust directly employs F1 and F2 doctors and will be implementing the new contract for F1s in December 2016. F2 doctors will transition to new contract depending on which specialty they are in.

3.0 Update on progress and actions undertaken to date

- From the new terms and conditions of service (TCS), we have had to review all junior doctors rotas, of which there are 32 in total, and identify those rotas that do not meet with any of the new 16 rules as stipulated within the TCS. The Medical Staffing Team are planning to meet with juniors and leads in each rota group to agree changes in line with the new contract before their implementation date and this is planned to be completed within the next quarter.
- A Steering Group, with executive oversight, has been established to oversee the implementation process and to provide support, if needed, where there is cause for concern around the implementation process, rota discussions or a lack of engagement within a specific area.
- Part of the new TCS requires the Trust to appoint a Guardian of Safe Working. The role is to ensure the juniors have a recognised appointed person to review any concerns raised over safe working practice and education. There have been a number of expressions of interest in this role from the consultant body, and we are planning to hold interviews in the near future.
- The Guardian will be supported by the Medical Staffing Team who will be recording all concerns via an exceptions report completed by the trainees when they have been working more hours than their rota requires; they have a concern about the lack or standard of training; or they have not been able to take their break. There are financial implications for specialities if exceptions reports are submitted and this will be managed by the Guardian. Rotas will need to be robust enough and working practices changed to avoid exception reports being raised. The Medical Staffing Team will have access to an electronic system which will record and be able to pull off exception reports for the Guardian who is required to submit reports to the Trust Board and Lead Employer on both a quarterly and annual basis.
- A weekly return has to be submitted by the Medical Staffing Manager via Unify to NHS Improvement to report on the progress of implementing the contract, rotas changes and the appointment of a Guardian.
- The Medical Staffing Managers within Cheshire and Merseyside are networking and linking in to Lead Employer to ensure there is a consistent approach in implementation.
- Regular updates on implementation are channelled through the People and Organisational Development Committee so they can receive assurance on progress & ensure our juniors and wider workforce is supported ahead of and during transition to the new TCS.

Further information on the Junior Doctors Contract can be found by accessing the NHS Employers website on the following link:
http://www.nhsemployers.org/your-workforce/need-to-know/junior-doctors-2016-contract

4.0 Conclusion

The Board is asked to receive and note the progress within this report. Progress will be monitored by the People & Organisational Development Committee with a standing item received at each meeting.

Prepared by:

- **Sue Hughes, Medical Staffing Manager, August 2016**

Third annual report on medical appraisal and revalidation

2015-16

1. Executive summary

As of 31st March 2016 there were 255 doctors with a prescribed connection to the Countess of Chester Hospital NHS FT, which includes 16 permanent new starters and 42 temporary starters. There have been 192 completed appraisals within the appraisal year. However, all 197 doctors eligible for appraisal within the year were appraised within the 15 month window allowed by NHS England's Annual Organisation Audit.

In the year 2015-2016, 73 recommendations were completed on time; there were no late or missed recommendations.

2. Purpose of the Paper

The purpose of this paper is to update the Board on the appraisal and revalidation of doctors who have a prescribed connection to the Trust.

Medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work. It is a protected time, once a year, for each doctor to focus, with a trained colleague, on their scope of work. This includes:

- looking back at achievements and challenges and lessons learnt, including reviewing the previous year's personal development plan objectives
- looking forwards to their aspirations, learning needs and the recording of new personal development plan objectives.

Revalidation is the process by which the General Medical Council will confirm the continuation of a doctor's licence to practise in the UK. Its purpose is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise

3. Background

Revalidation aims to give patients greater confidence that their doctors are up to date in the area(s) of medicine in which they practise. It also supports doctors in maintaining and developing their practice throughout their career in medicine, by ensuring that they have the opportunity to regularly reflect on how they can change and improve their practice.

Every doctor holding a licence to practise is legally required to revalidate, usually every five years, by having a regular appraisal based on the GMC's core guidance

for doctors, Good Medical Practice. Successful revalidation means the doctor can continue to hold a licence to practise.

Revalidation started on 3 December 2012 when Professor Sir Bruce Keogh was revalidated. It is expected that the majority of licensed doctors will be revalidated by March 2016. Thereafter, revalidation will be a 5 year rolling programme with a doctor requiring 5 annual appraisals.

Designated Body

Most licensed doctors have a connection with one organisation that will provide them with a regular appraisal and help them with revalidation. This organisation is called their 'designated body'.

Responsible Officer

Each designated body must have a Responsible Officer (RO). The RO is usually the Medical Director or their deputy. The Responsible Officer Regulations 2010 state that the RO is responsible for making recommendations about doctors' fitness to practise to the GMC. This responsibility to make recommendations about doctors' revalidation cannot be delegated. The RO does not make the decision about a doctor's revalidation; the GMC does so based on the RO's recommendation.

The RO is not responsible for putting in place local systems to support revalidation – this is the designated body's responsibility, but the RO must ensure that these systems are sufficiently robust to support revalidation.

Provider organisations have a statutory duty to support their ROs in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards / executive teams will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Recommendations

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

The RO may make one of three recommendations to the GMC:

- a positive recommendation that the doctor is up to date, fit to practise and should be revalidated
- request a deferral because they need more time or more information to make a recommendation about the doctor. This might happen if the doctor takes an extended break from practice. Deferral does not affect the licence to practise. It has no negative connotations
- notify the GMC that the doctor has failed to engage with appraisal or any other local systems or processes that support revalidation.

In last year's report it was reported that not all doctors with a prescribed connection to the Trust had had an appraisal and also that there had been one late recommendation to the GMC.

4. Governance Arrangements

In addition to the RO, the Trust has an Appraisal Lead, an Appraisal and Revalidation Manager and an Appraisal and Revalidation Assistant.

The Lead and Manager meet weekly and the RO and Lead meet monthly.

The appraisal timetable is maintained on a spreadsheet by the Manager and is reviewed regularly with the Lead. The documentation required for the RO to make a recommendation, appraisal and 360 MSF, is kept in a file on the "S" drive in date order linked to the doctor's recommendation date.

An accurate list of prescribed connections is maintained by cross referencing GMC Connect with a list of permanent staff maintained by Medical Staffing with doctors added or removed by the RO or Manager as indicated.

Both the RO and Lead attend the relevant networks to maintain their knowledge of current legislation and best practice.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

There are 255 doctors with a prescribed connection to the Trust. Of these, 16 are new starters to permanent posts and 42 are starters to temporary, longer-term, posts whose first appraisal at the Trust has not fallen within the period of this report. Within the period April 2015 – March 2016 there were 197 completed appraisals.

(See **Appendix A;** Audit of all missed or incomplete appraisals audit)

b. Appraisers

We have 66 trained appraisers, an increase of 7 on last year's report. The training used is that for strengthened appraisal developed by the Revalidation Support Team. The Lead hosts an Appraiser Support Group every 6 months.

c. Quality Assurance

For the appraisal portfolio:

- The Appraisal and Revalidation Manager ensures that all Trust data and documents are attached to the electronic form sent out to the doctor for completion 6 weeks before the planned appraisal date.
- The appraiser receives the completed form and supporting information a minimum of 2 weeks before the appraisal to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is available and appropriate and confirms that the appraisal will go ahead.
- The completed form, once signed off by the doctor and the appraiser, is reviewed by the Divisional Medical Director and signed off by them to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard.
- The appraisal outputs are reviewed and signed off by the RO to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs

For the individual appraiser:

- The appraiser receives a feedback form completed by the doctor and includes this, together with any reflection and any appropriate continuing professional development in their appraisal portfolio. The feedback is reviewed by the Lead and is, if necessary, cross-referenced with the appraisal document and the Lead provides further feedback to the appraiser regarding the standard of the process.
- An annual record of the appraiser's participation in appraisal calibration events such as reflection on ASG (Appraisal Support Group) meetings is included in the appraiser's portfolio.

For the organisation:

- As part of their appraisal doctors are expected to have reflected on any complaints or significant events and to indicate what lessons have been learnt and how their, and possibly their speciality's, practice has changed to reflect those lessons.
- In the event that a doctor does not forward a completed form with supporting data to their appraiser the Lead emails them reminding of their responsibilities. In the event that they fail to act the RO will contact the doctor to inform them

that if no action is taken within two weeks of the email the GMC will be contacted and informed that the doctor is not engaging in the appraisal process.

- Ongoing programme of rolling QA assessment of approximately 1:4 appraisal inputs and outputs by Appraisal & Revalidation Lead using Excellence2 tool.
- All outputs reviewed by appropriate Divisional Medical director before sign-off. Any concerns forwarded to Appraisal & Revalidation Lead (ARL) to assess and act as appropriate.

(See **Appendix B;** Quality assurance audit of appraisal inputs and outputs)

d. Access, security and confidentiality

Appraisal summaries are stored on the "S" drive with access restricted to the RO, Lead and Manager. The electronic form and supporting information is forwarded by secure email only. Additional paper supporting material is now being phased out but is delivered by hand to the individual. Supporting data is anonymised.

There have been no information governance breaches.

e. Clinical Governance

Data made available for doctors by the Trust:

Clinical incident data
PALS and complaints data
Ongoing/settled claims data
HED clinical activity data
Annual and study leave trackers
Mandatory training attendance record

In addition, it is expected that patient and colleague feedback will be included at least once in every 5 year cycle of revalidation. This is achieved by 360^0 MSF, which to ensure that it falls within the 5 years is carried out 3 yearly using the Equiniti 360 Clinical tool.

6. Revalidation Recommendations

This report covers the period April 2015 – March 2016.

Number of recommendations: 73 recommendations for 72 doctors

All 73 recommendations were completed on time.

Positive recommendations: 69

Deferrals requests: 4

All deferral requests were to collect more information, for example, in doctors new to the Trust. In one case a positive recommendation was subsequently made in year.

Non engagement notifications: 0

Both the average and median number of days between the date of submission of recommendation and the last date of submission required by the GMC were 28 days.

(See **Appendix C;** Audit of revalidation recommendations)

7. Recruitment and engagement background checks

Pre-employment checks include an identity check with proof of address, a right to work check (including work permits if applicable), occupational heath review, Disclosure and Barring Service (formerly CRB) and confirmation of professional registration.

Post-employment/appointment checks include references (3 for Consultant, 2 for non-Consultant), checking of GMC registration, CCT certificate check for sub Consultant, and a report from the previous Responsible Officer

(See **Appendix E;** Audit of recruitment and engagement background)

8. Monitoring Performance

Doctors' performance is monitored by review of HED clinical benchmarking data, 360 MSF and the review of incidents, complaints and claims by the SUI panel, which the RO sits on, both individually and looking for trends.

9. Responding to Concerns and Remediation

Currently there are no doctors on a remediation programme.

The policy applied is:

Medical And Dental Staff Remediation Through Re-Skilling, Rehabilitation And Targeted Support Policy which is based on the "The Back on Track framework for further training – Restoring practitioners to safe and valued practice", National Clinical Assessment Service (NCAS), version 1 – December 2010 and "Good Medical Practice", GMC, 2013.

(See **Appendix D;** Audit of concerns about a doctor's practice)

10. Recommendations

The Board is asked to accept the report, which will be shared, along with the annual audit, with the higher level responsible officer.

The Board is also asked to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations

(See **Appendix F;** Statement of Compliance)

Appendix A – Audit of all missed or incomplete appraisals

Doctor factors (total)	**5**
Maternity leave during the majority of the 'appraisal due window'	*0*
Sickness absence during the majority of the 'appraisal due window'	*1*
Prolonged leave during the majority of the 'appraisal due window'	*0*
Suspension during the majority of the 'appraisal due window'	*0*
New starter within 3 month of appraisal due date	*0*
New starter more than 3 months from appraisal due date	*0*
Postponed due to incomplete portfolio/insufficient supporting information	*0*
Appraisal outputs not signed off by doctor within 28 days	*0*
Lack of time of doctor	*1*
Lack of engagement of doctor	*0*
Other doctor factors	*1*
(describe) ***Absence from practice due to personal/family circumstances***	
Appraiser factors	**Number**
Unplanned absence of appraiser	*0*
Appraisal outputs not signed off by appraiser within 28 days	*0*
Lack of time of appraiser	*1*
Other appraiser factors (describe)	*0*
(describe)	
Organisational factors	**Number**
Administration or management factors	*1*
Failure of electronic information systems	*0*
Insufficient numbers of trained appraisers	*0*
Other organisational factors (describe)	*0*

1. Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

Total number of appraisals completed		**197**
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	Number audited **55**	Number acceptable **54**
Scope of work: Has a full scope of practice been described?	Number **55**	Number **55** *Although more detail advised in some*
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	Number **55**	Number **55** *Although more detail and reflection advised in some*
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	Number **55**	Number **55** *Although more detail and reflection advised in some*
Patient feedback exercise: Has a patient feedback exercise been completed?	Yes/No *In line with ongoing rolling programme of 360 MSF within the trust*	**12**
Colleague feedback exercise: Has a colleague feedback exercise been completed?	Number **55**	Number **12**
	In line with ongoing rolling programme of 360 MSF within the trust	
Review of complaints: Have all complaints been included?	Number **55**	Number **55**
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	Number **55**	Number **54** *One incident not declared and action taken*
Is there sufficient supporting information from all the doctor's roles and places of work?	Number **55**	Number **54** *Action taken*
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which	Number **55**	Number **55**

precedes the revalidation recommendation (yr 5)? • Have all types of supporting information been included?		
Appraisal Outputs		
Appraisal Summary	Number **197**	Number **190** All became acceptable after action by ARL and revision by appraiser
Appraiser Statements	Number **197**	Number **197**
Personal Development Plan (PDP)	Number **197**	Number **193** All became acceptable after action by ARL and revision by appraiser

Appendix C – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[1]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				3
Capability concerns (as the primary category) in the last 12 months		2		2
Conduct concerns (as the primary category) in the last 12 months				
Health concerns (as the primary category) in the last 12 months		1		1
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2015 who have undergone formal remediation between 1 April 2014 and 31 March 2015. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				1
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				1
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies				0

[1] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	1
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	1
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	6
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	2
Number of NCAS assessments performed	0

Appendix D – Audit of revalidation recommendations

Revalidation recommendations between 1 April 2015 to 31 March 2016	
Recommendations completed on time (within the GMC recommendation window)	73
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	73
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	n/a
New starter/new prescribed connection established within 2 weeks of revalidation due date	n/a
New starter/new prescribed connection established more than 2 weeks from revalidation due date	n/a
Unaware the doctor had a prescribed connection	n/a
Unaware of the doctor's revalidation due date	n/a
Administrative error	n/a
Responsible officer error	n/a
Inadequate resources or support for the responsible officer role	n/a
Other	n/a
Describe other	
TOTAL [sum of (late) + (missed)]	0

Appendix E – Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	16
Temporary employed doctors	69
Locums brought in to the designated body through a locum agency: ***individual doctors 136*** ***Total no. of bookings: 222***	136
Locums brought in to the designated body through 'Staff Bank' arrangements	18
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	0
TOTAL	239

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	16	16	16	16	16	16	16	16	16	16	16	16	16	16	0	16
Temporary employed doctors	69	69	69	69	69	69	69	69	69	69	69	69	69	69	0	69
Locums brought in to the designated body through a locum agency	136	136	136	136	136	136	136	0	0	136	136	136	0	0	0	136

Locums brought in to the designated body through 'Staff Bank' arrangements	18	18	18	18	18	18	18	18	18	18	18	18	0	0	0	18
Doctors on Performers Lists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	239	239	239	239	239	239	239	87	87	239	239	239	239	239	0	239

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery					
Medicine					
Psychiatry					
Obstetrics/Gynaecology					
Accident and Emergency					
Anaesthetics					
Radiology					

Pathology					
Other					
Total in designated body (This includes all doctors not just those with a prescribed connection)					
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less					
3 days to one week					
1 week to 1 month					
1-3 months					
3-6 months					
6-12 months					
More than 12 months					
Total					

BOD Item No

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Safe Nurse Staffing Establishment Review (January-June 2016)
Date of Meeting	6th September 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 sixth nursing establishment review. 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 do comply with the standards. However, in respect of the Lord Carter work and the commencement of the Model Hospital programme of work, the methodology in which the nursing workforce will be utilised will change – details of this are contained within this report
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 - June 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: August 2016

Date Presented to Public Trust Board: September 2016

Date Presented to CCG:

1.0 Introduction

The purpose of this paper is to ensure the Board receives its biannual assurance that patient safety is being maintained in regard to staffing numbers and skills. This is in line with National Quality Board Recommendation and supports the recommendations of the Francis report.

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 sixth nursing establishment review following the publication of the Francis Report and its recommendations. The last was presented in January 2016 covering the previous 6 months.

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 on inpatient ward areas.

2.0 Summary of Key recommendations and actions taken from the January 2016 nurse staffing establishment review:

- **Utilise the Lord Carter work to review staffing requirements**

  Work is now well underway to support the implementation of Care Hours per Patient per Day (CHPPD). This is supporting the implementation of e-rostering and acuity work.

- **Investigate how Allied Healthcare Professionals can help support patient care**

  There is a trial commencing July 2016 of the use or Pharmacy Technicians to support administration of Medicines on AMU.

  Urgent Care plan to open a therapy led ward in July 2016. This will support the alternative ways of collaborative working using other Allied Health care Professionals (AHP).

- **Review retention and recruitment in wards and departments where turnover appears higher**

  The Trust now has an agreed nursing Recruitment & Retention strategy which supports the areas identified. The Divisions have also completed the

workforce plans recognising that there may be an increase of staff leaving as a number of nurses are approaching retirement age.

- **Support the development of corporately live 'dashboards from information gained through e-rostering, which supports all the information in one place**.

  The use of the 'Red Flags' will cease in its current format with the introduction of an operational dashboard in line with the Model Hospital programme. '*Qlikview'* - Scoping and development is underway.

- **Monitor the change following the redefinition of the Matrons responsibilities and key performance indicators recently agreed**

  We have developed and implemented the New Matron KPIs. One of the indicators is that there is a visible presence in the clinical areas which is a challenge at times. The Matrons across all areas have in the last 6 months worked as an integrated team developing the role and agreeing standardising processes and working practices with the ward managers

- **Redefine the roles and responsibilities of a supervisory ward manager along with what benefits have been demonstrated**.

  A review of the supervisory ward manager is being incorporated into the Model Hospital programme of work in respect of acuity based work. Work that the RCN have led on into reviewing the role will be utilised.

- **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**

  And

- **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**

  This is part of the Recruitment & Retention Strategy - with plans in place, supported by the Trust's Communication Team.

- **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**

  This work is being undertaken within the Divisions and is ongoing to consider all such options**.**

- **Specialist nurses will continue to support the wards over the winter period where job plans allow**

  The Heads of Nursing are working with the Business Performance Managers (BPMs) to review all job plans to ensure they meet capacity and demand in all services. A review of roles such as Advanced Nurse Practitioners is also taking place. Standardising job description will support increase efficiency, productivity as well as improve outcomes

- **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 Intermediate Care Unit will open in July, followed by the planned reconfiguration of beds across both Divisions which will release an escalation/decant ward. This will allow medically optimised patients to be cared for in an appropriate rehabilitation focused environment.

- **The Heads of Nursing will support the ward manager to use the Safer Care Nursing Tool (SCNT). This will be supported by the Model Hospital project team and enable an acuity based workforce**

  Due to the impending e-roster rollout, this has not been actioned but will be addressed. Work is underway to use CHPPD (Care Hours Per Patient Per Day) as per national guidance.

- **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**

  The matrons are working together across both divisions reviewing the enhanced supervision policy to make any necessary amendments following (The practicality of reaching this 'aspiration' is being discussed at Director of Nursing levels regionally.)pilot. This will then be tested again on a number of wards. This piece of work has also involved the therapy staff. The intention is to have this embedded before the end of the year.

- **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**

  The implementation will start in August 2016. The Head of Nursing will ensure a robust data collection.

- **Further investment is required in the dementia care team in order to support all wards across both Divisions**.

The service is currently under review. The model will change to concentrate on the greatest area of need. Other wards are being supported by a rapid response service from Liaison Psychiatry Service.

- **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**

  Since the last review the financial position has worsened. A winter plan is to be agreed and meetings continue to discuss options both internally and across the system. There are still recruitment challenges so over establishing may well not be possible. We are unable to recruit to the current vacancies, currently making over recruitment of Registered Nurses possible. It is envisaged that once e-rostering is more embedded, there will be improved transparency into how our nursing and midwifery workforce is utilised.

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 January 2016
- 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 2016

Overall the Trust reports an acceptable level of hours planned against actual, over 95% for 9 months.

The Trust has set its own internal rating – many Trusts have set less than 85% as rated ‘red’, we have used 90%.This will be reviewed in line with the implementation of e-rostering and will be more reflective of acuity. The areas that are reporting lower

staffing levels and 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 (HoN) review all bank and agency expenditure monthly. They take account of staffing expenditure and cost pressures across both Planned and Urgent Care Divisions.

More recently a review of the process has been undertaken to ensure the sign off process is robust and auditable.

Variable pay is monitored regularly at both Divisional and Corporate levels. Processes have once again been reviewed particularly relating to overtime payments and are only approved by the Head of Nursing. In the last six months there has been an agreed process for the approval of over the cap agency rates. This means the use of agencies that the Trust has to pay more per shift/hour to maintain patient safety is now signed off by the Director of Nursing & Quality.

In the last two months the use of over cap payments have decreased in nursing to zero, however they do remain a challenge to reduce in areas such as theatres for Operating Department Practitioners/Theatre Practitioners. A separate Action Plan is being developed to address recruitment challenges in this area.

Despite the Trust actively recruiting over the last six months there remains a high level of vacancies. The Trust therefore took the decision to once again go to Spain to recruit. This brings the total number of overseas nurses recruited to 30. Although the recruitment challenges continue there is little doubt that the vacancy situation would have been considerably worse without the overseas recruitment programme.

6.0 Measuring Patient Acuity

As previously articulated in other reviews there are no national mandated minimum standards for the general adult wards in England. However NICE guidance in 2015 made reference to, but stopped short of mandating a 1:8 Registered Nurses to patient ratio on day shifts.

Recent clarification from the CQC deputy Professor Ted Baker stated ‘it is for hospital Boards to endorse and agree recommendation of staffing levels rather than just be dictated to base levels on arbitrary guidance’. He said ‘Trusts are being asked to assess their own staffing standards in a more sophisticated way and be able to demonstrate and justify that they have achieved safe staffing’. This will be supported by the implementation of e-rostering.

With this in mind the Trust has made the decision not to use the information from SCNT for the review this time in light of the wider Model Hospital work plan. The

Trust Ward Managers are well engaged with e-rostering and there has been additional work from them to ensure accurate data collection in respect of flexible working and shift patterns. It was felt to be more important to ensure that the acuity preparation needed for the Model Hospital work was of a greater significance going forward.

7.0 Divisional Reviews

- **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 in some areas.

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 shortages. It also states that there is varying application from 1-2 days, right up to the full five day working week.

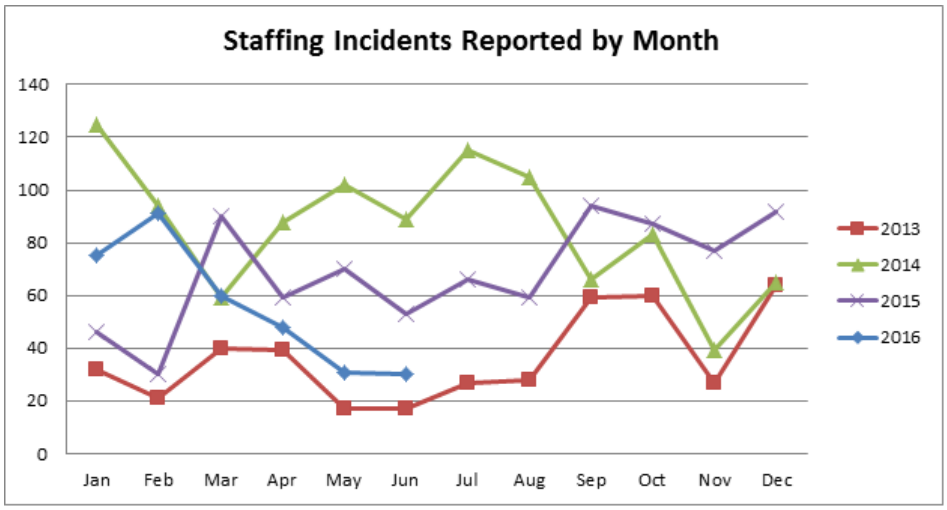
The Trust is highly supportive of Ward Managers who use their professional judgment to use a lower skill mix than the 60/40 that most wards have. As long as the areas are reviewing balancing measures such as the Safety Thermometer measures to ensure that it does not compromise patient safety. Examples would be Ward 49 and rehabilitation wards at EPH where the Registered : Non-Registered ratio is lower.

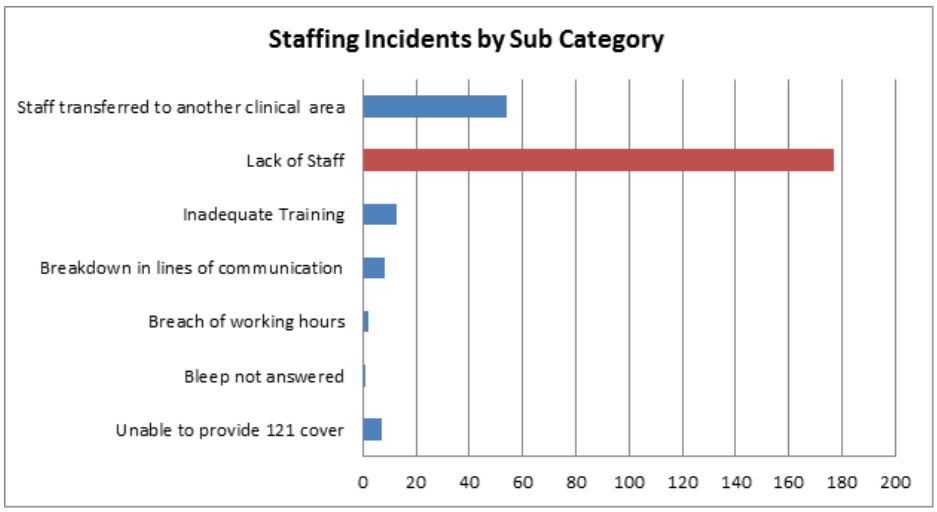
All specialist nurse roles have been reviewed and are in possession of an agreed job plan to ensure the roles are efficient & productive. The Heads of Nursing are near completing the full review of the educational requirements of the nurse specialists as well as the Advanced Nurse Practitioners (ANP).This will ensure a consistent high level of performance and will underpin the expectations of the role going forward, this will include how Specialist and Advanced Nurse Practitioners support general wards.

Both Divisions have plans to reconfigure their bed capacity to ensure the service model is improved with the right patient in the right place. This work is ongoing and we need to add caution, as the staffing establishments will change as the new bed model is implemented over the next three months. The ward managers have been fully involved in assessing the staffing and developing the service models.

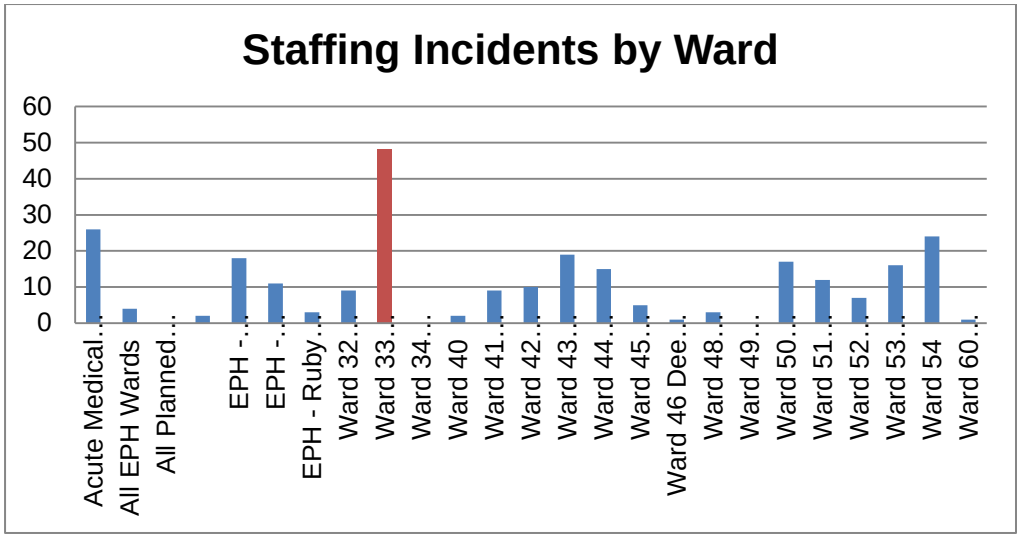
- **Staffing Incidents**

The Trust remains a high reporter of staffing incidents but the relative harm associated for the incidents is low (Appendix 1).





AMU, ward 54 and ward 33 are the highest reporters. Ward 33 regularly reports the loss of the third RN on nights. This also triangulates with the red flags file which ward 33 uses consistently.



The nursing 'pool' (a group of nurses recruited to work flexibly as required across the Trust) exists to support the wards and has seen the addition of Registered Nurses to its compliment of 7 Healthcare Assistants. The 2 RNs however are leaving the Trust shortly, as this has worked well, further recruitment will take place. This aims to mitigate the risk of short term absences.

- **Escalation**

There is little doubt that the opening of additional beds for periods of high activity causes staffing problems. This was also highlighted by the Care Quality Commission (CQC) review in February 2016. The Trust was rated as 'Good' however the Inspectors made comments re. staffing numbers in a small number of areas. The use of escalation beds did cause staffing pressures and winter plan discussions as previously articulated have involved the ward managers in developing plans going forward.

8.0 Current Staffing Challenges and Opportunities

- As is the case with other Trusts, it is challenging to recruit to registered nursing and specialist posts such as Theatres in particular for ODPs/theatre practitioners. The Division is currently working through a solution as this is becoming a real cost pressure due to over cap agency rates. Whilst there are odd shifts within ITU the position has vastly improved.

- Due to a national shortage of commissioned training places for nursing, recruitment continues to be a challenge - this is not forecast to change for the next 3 years. The ceasing of the NHS bursary scheme and its subsequent change to loans may also add to the pressure however this may also allow Trust an unlimited commission of places.

- Agreed minimum staffing levels are a challenge at times. This is being risk assessed on a shift by shift basis to mitigate harm.

- Some areas are not currently meeting national staffing guidelines as outlined by the CQC visit i.e. Children's Unit, Neonatal Unit (NNU). Nationally only one NNU reaches the agreed standards . The practicality of reaching this 'aspiration' is being discussed at Director of Nursing levels regionally. These areas are currently identified on the Division risk registers.

- Work is underway to review the paediatric model of care and staffing numbers, skills and competencies will be part of the review. This will support the actions following the CQC visit.

- The roll out of e-rostering is likely to bring a period of change and a feeling of uncertainty for some staff. However it will also allow staff the transparency of rota management as well as bank availability.

- The proposed new role of Associate Nurse is high profile nationally, this will look at a role that will support RNs and is likely to on the NMC register and will have competencies in place to defined tasks such as administration of medicines.

- EU - the leaving of the EU has already been felt by the agency which supports our recruitment in Spain. The uncertainty surrounding time frames etc. may cause further problems.

9.0 Urgent Care Adult Inpatient 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. Within Urgent Care, the Ward Managers do not believe they have the correct skill mix in the following areas, AMU, 50, and 51. However, this will change once we move into the new bed model.

- **AMU** - Urgent Care has reviewed 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. The Division has now agreed to support the funding of the 8 escalation beds which will then become permanent bed base, this will allow for permanent staffing to be in place**.**

- **Ward 43** - It was agreed to over establish Healthcare Assistants (HCAs) recognising the increased dependency of patients. This supports the significant percentage of patients with dementia, hence the need to increase the HCAs 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 patients with acute diabetes related conditions are currently treated and cared for on this ward. Treatment complexity has increased and this has led to the required increase of a further registered nurse on nights. 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 has been given to increase in the number of en-suite side rooms on Ward 43 to 10. Staffing will then be reviewed and agreed with the Ward Manager to reflect the change in layout of the ward.

- **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 a staffing establishment agreed, however the Head of Nursing has supported the ward with transferring staff and the numbers of staff on duty are reflective of the patients' needs. The Division has agreed to fund the staffing establishment required to become a permanent bed base. It is anticipated that this will be agreed July/August.

- **Ward 34 –** In July this ward will become the new Intermediate Care Unit which will comprise 26 beds; the staffing establishment has changed to reflect the ward requirements. The case mix of the patients cared for on ward 34 will no longer require support by medical teams. The staffing compliment will be from both nursing and therapy and this will make up the agreed establishment.

10.0 Urgent care - Other areas

- **NNU**

The Lead Nurse in Paediatrics and the NNU Manager have undertaken a detailed review which demonstrates national recommended guidance like in many other units is not always achieved. This is dependent on the agreed level of dependency of the unit as well as occupancy. In the meantime 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 in respect of 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 the Paediatric service is in progress following proposed changes to the Paediatric Hospital at Home service. Once the review is complete we will have a plan for how the service will function and be staffed going forward. The multi-professional team are involved in the review.

11.0 Planned Care - Inpatient Wards

As part of the service improvements to improve patient experience, the Planned Care Division opened ward 40. The Division are about to move to its new bed model and the ward staffing establishments will change. The ward managers have been working together to ensure the appropriate safe skill mix is in place for these changes.

The Division has continued to try and actively recruit to vacant posts but have not been able to fully achieve this to date.

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. high use of intravenous drug medication, artificial nutrition, Epidural infusions, stoma care, and tracheostomy care. The Ward Manager has suggested in her professional judgment, there is a need to increase both HCAs and Registered Nurses, especially on night duty. The recent transfer of surgical tracheostomy patients to ward 52, following an extensive multi-professional training programme, is likely to reduce the acuity. The Division will revisit staffing establishment following the reconfiguration of beds. In the interim, safety metrics are monitored closely with staffing levels and patient acuity.

- **Ward 45** - This is the orthopedic trauma ward, with delayed discharges as elderly patients with complex social problems are managed on this unit. An additional HCA is required but this needs to be worked through as the use of a discharge supporting role maybe a more effective option. There is also a need to review the fractured neck of femur pathway to reduce the impact of delayed discharges; this may also have an impact on the skill mix required.

- **Ward 52** – is an acute surgical specialty ward. However, the case mix has changed significantly since September 2015. (The ‘red flags’ such as missed breaks are being documented.) Although the staffing establishment appears

similar to other surgical wards, this will need to be reviewed as the ward now cares for patients with tracheostomies, therefore creating a higher dependency of patient.

- **Ward 54** – is the vascular regional unit and the clinicians feel the ward is not conducive to the current patient 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 and skill mix. The belief from the Division is that eRostering will be of support to Ward 54 as it will enable to match staffing to acuity. Ward 54 is part of the early implementer group and should be up and running by the end of August 2016. This will enable a full review of current staffing.

12.0 Midwifery

The past six months booking numbers have reduced slightly and are more in line with 2014. It is recognised that staffing does not current meet current guidelines, however monitoring of all incidents and 'red flags' ensures that the risk is managed. The recent CCQ Inspection identified no significant risks in relation to midwifery staffing levels and acknowledged the current ratio.

13.0 Quality & Safety

- **Mitigating risk**

There is a well-established process whereupon 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 flag' indicators.

It is a well embedded process 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
- The use of bank, and only if absolutely necessary to maintain patient safety, will agency be considered. This is authorized by the Heads of Nursing.

Feedback form the Urgent Care 08:45 Safety Huddle has been very positive by the ward managers. Staffing is discussed alongside patient acuity and any safety issues are discussed and actions agreed. This has led to a sense of cross ward working and risk management of potential patient safety issues.

A similar process takes place in the Planned Care huddle with all Ward Managers reviewing the staffing for the whole week (next 7 days). All ward managers then 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 continue to run their own safety briefs/huddles. These were commended in the recent CQC visit.

14.0 Nurse sensitive Indicators

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

- **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.

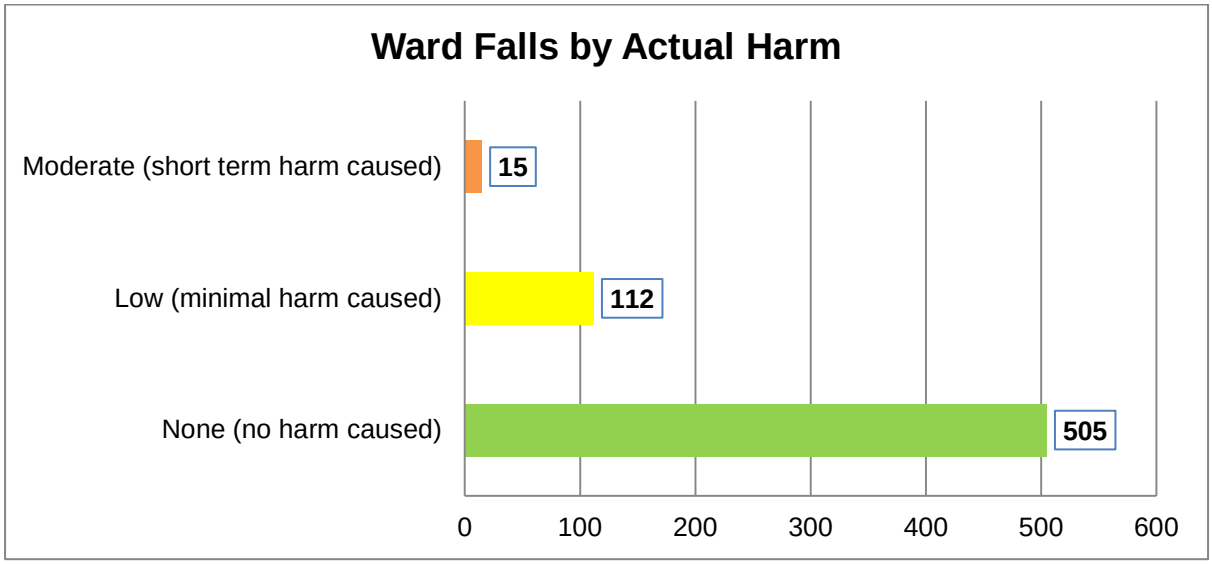
- **All harms**

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.

- **Falls**

A recent thematic review of falls demonstrated that there were missed opportunities to provide adequate falls prevention measures in place to prevent or reduce the patient's risk of falls sufficiently. Of note the staffing incidents do not appear to hugely correlate with fall numbers except for ward 33.



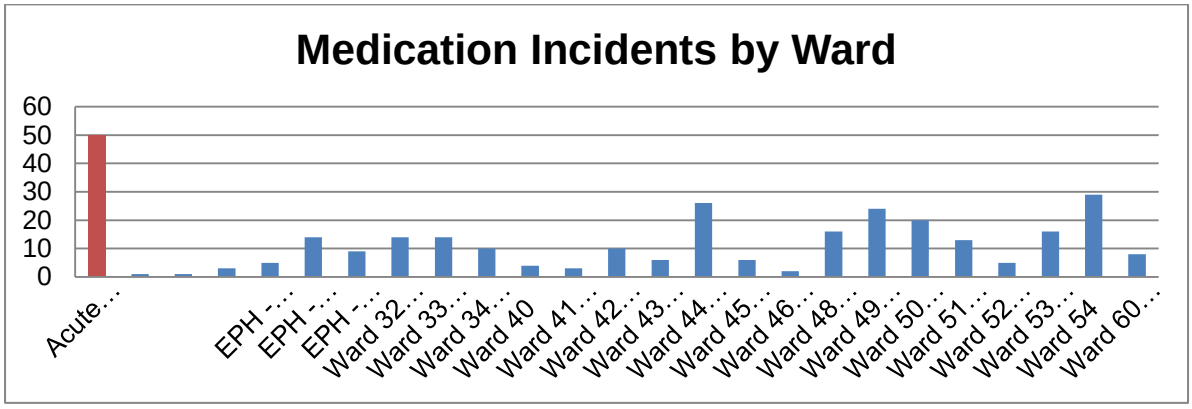
Appendix 2 demonstrates that ward 34 has a high number of falls compared to other designated older persons wards. The lay out does differ from the conventional ward. This then is followed by the Frailty Unit, with the emphasis on rehabilitation, this maybe a contributing factor. Of note the harms from the fall appear low. This trend will be monitored once the ward moves have completed.

A number of Ward Managers and a Matron have recently agreed to lead a working group to improve practice in this area.

- **Medication incidents**

The graph below displays the medication errors in totality. However most of the errors relate to prescribing of medicines and are reported by the pharmacy staff. There have been a small number of medication administration errors at ward level by nurses. MAU is supporting a pilot using pharmacy technicians as opposed to nurses to administer medicines, as this area is extremely busy and delays of administration

tend to be higher there. This pilot is running for a year and is supported by Health Education.



- **Care metrics**

The care metrics work has been revised in year and the current compliance is 95-96%. Metrics will continue to be undertaken monthly by Ward Managers. When a full years data has been collected then an agreed target will be set and monitored. If the ward achieves the target for 3 months then the suggestion will be for bi-monthly care metrics. Going forward, this data will form part of the Nursing & Midwifery framework.

15.0 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 than others.

Work is now being undertaken to build a live dashboard using 'Qlikview' to support ward managers in the use of red flags.

The Department of Health is also proposing the use of a national nursing dashboard

- **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. There also remains the problem to fill vacancies. Variable pay which includes overtime has continued to be a real focus for the nursing teams, however despite this there has been an increase in comparison to the previous six months.

Ward/Area	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Total
Total	£29,708	£47,473	£58,566	£53,045	£38,675	£34,144	£261,611

16.0 Patient Feedback

We survey our patients in a number of ways. The information obtained from the surveys is a helpful barometer of the patients' perception to any nurse delays.

- **Annual Survey**

The annual survey from 2015 patients rated the care over all as 87% equating to a CQC score of 7+out of 10. This once again puts the Trust in the average section. However the specific question:

Nurses: sometimes, rarely or never enough on duty?

Demonstrated a higher score than the average Trust this demonstrates that our patients believe that at times there not enough nurses on duty.

- **Friends and Family**

Friends and Family Test (FFT) at the Countess has evolved significantly in 2016. In mid-January this year we started working with a new supplier.

The table below shows results in the first six months this year.

	Inpatients		Outpatients		AED	
	Responses Recieved	Rating	Responses Recieved	Rating	Responses Recieved	Rating
January	1223	98%	5546	91%	562	83%
February	740	98%	6754	92%	499	79%
March	629	97%	6003	92%	498	74%
April	1727	94%	4030	91%	496	83%
May	2131	94%	4838	91%	636	84%
June	2139	93%	4637	91%	595	82%

Our overall ratings for OP and IP have stayed above 90% i.e. the number of people who have given us a 1 or 2 (Extremely Likely or Likely to recommend) whereas there is still some work to do within our AED. This maybe reflective of the capacity issues which invariably leads to patient delays.

All ward and department managers have full access to the dashboard which summaries the results as well as allowing them to 'drill down' to their specific area.

- **Complaints**

Overall the number of complaints has decreased. Reassuringly the number of complaints in relations to poor nursing care has also seen a decrease. There is an emerging theme however with regards to discharges and this may be due to increased pressure that nurses feel in relation to flow. This can lead to some discharge arrangements not being followed up. This will be monitored going forward.

17.0 Staffing Challenges

6 Month Total			
Sickness Absence %	Turnover %	Starters	Leavers
4.14%	5.76	63	64
5.66%	3.32	55	22

Turnover is similar to previous six months. Broken down by wards there are 'hot spots' (Appendix 3).

- **Attendance**

Overall the Trust's sickness is higher than the previous six months. This is not uncommon for winter months. However the Trust recognises that there are potential other reasons for absence and is participating in the national CQUIN for Health and wellbeing. A number of actions are underway – healthy eating, Occupational Health (OH) drop-ins, as well the OH team walkabouts. Increasingly there has been a focus resilience support for front line team as well as their managers.

- **Recruitment**

The Nursing team are continuing the active recruitment process. The Recruitment and Retention Strategy supports the work that is being done. A number of ways have now been agreed, supported by the communications team, to refresh the approach that we have taken in the past. Of concern and identified in the workforce plans is the ageing workforce. Up to 50% of the nursing workforce could retire in the next 3 years

- **Retention**

The turnover of nursing staff has decreased slightly and work is ongoing to decrease this further. The 'Acorn' programme financially supported by Health Education England was launched in the past few months.

Acorn *'Growing Our Own and Keeping Them Rooted'* programme is a sustainable development tool for nurses bands five through to seven. The Countess of Chester Recruitment and Retention Strategy (2016) states that 'real flexibility' is required to recruit and retain our nursing workforce through strategic approaches to succession planning. The Acorn programme echoes this goal in its approach, which appreciates the diverse learning needs and career aspirations of our nursing workforce.

- **Temporary staffing**

Review of the Temporary Staffing Bank with regards to Registered Nurses was completed last year. A number of actions were agreed. The following actions have now been completed to increase availability:

➢ *rolled up bank and leave payment for the nursing staff*

This was actioned but has not seen an increase of availability. Therefore a decision was taken to pay bank Registered Nurses at mid-point instead of the bottom the pay scale. Unfortunately this has made no difference either

➢ *automatic enrolment onto the temporary staffing bank at commencement of employment in the hospital*

This has had a small impact but not significant

➢ *Dedicated action plan in place to review other options to enhance the current service*

18.0 Conclusion

The last six months have been a challenge at times, the usual brief respite following the winter months has not happened. This has further affected the staff resilience.

There is little doubting the staffing remains a challenge at times. The number of vacancies has peaked at 40 WTE Registered Nurses, however a number of these are within non-ward areas (Theatres). The acuity work and e-rostering will support the safe staffing mandate by establishing a transparent process when decisions are made to move staff.

It must also be noted, however, there may be a number of areas that will require an investment in staffing or a permanent transfer of resources is required. The workforce will change again once service model changes are completed within the bed owning Divisions.

There is a concern amongst the Ward Managers going forward particular for the next winter ahead. The managers have been part of the winter planning to ensure there helpful suggestions are explored

The Trust has now very recently received further guidance from the National Quality Board (NQB). The guidance has mandated the use of Care Hours per Patient per Day (CHPPD). This is to ensure that Trust counts the valuable hours that Nursing Assistants and Registered Nurses contribute to nursing and then the Trust will make a judgment on the percentage split of registered to unregistered based on a number of factors which will differ from ward to ward and other specialties. This is only likely to be achieved to its maximum with e-rostering being utilised by all disciplines of staff and not solely nursing**.**

- **Cost of Care Data collection**

Lord Carter's Report, "Operational productivity and performance in English NHS Acute hospitals: Unwarranted variation", recommended that metrics were developed to analyse worker deployment. To support this recommendation a Nursing and Midwifery dashboard has been developed in the Model Hospital. This dashboard includes measures of quality, workforce deployment and resource utilisation.
As part of this dashboard two metrics have been developed which measure the comparative cost of nursing and care staff working in inpatient care areas. This will support the current Nursing & Midwifery dashboard under development.

To collect the ward level cost of inpatient care to support these metrics, the Department of Health will be adding a worksheet into the NHS Foundation Trust financial returns on a quarterly basis. The initial data collection will take place in the Month 4 collection (in order to support the roll out of the national Nursing Dashboard for September). With further collections planned for Month 6, 9 and 12. The data collected will be used in the future as part of the staffing reviews.

19.0 Recommendation

The recent CQC visit and subsequent report highlighted a number of concerns regarding the staffing. Of particular concern was staff feedback on the surgical wards regarding patient increased acuity leading to the nurses believing they are short staffed. The Trust has responded to the QCQ concerns and there are number of actions being progressed by Divisions.

The number of vacancies has remains higher than the Trust would have liked this is despite intensive recruitment. As the ward reconfigurations take place throughout the coming year some of these vacancies will be filled.

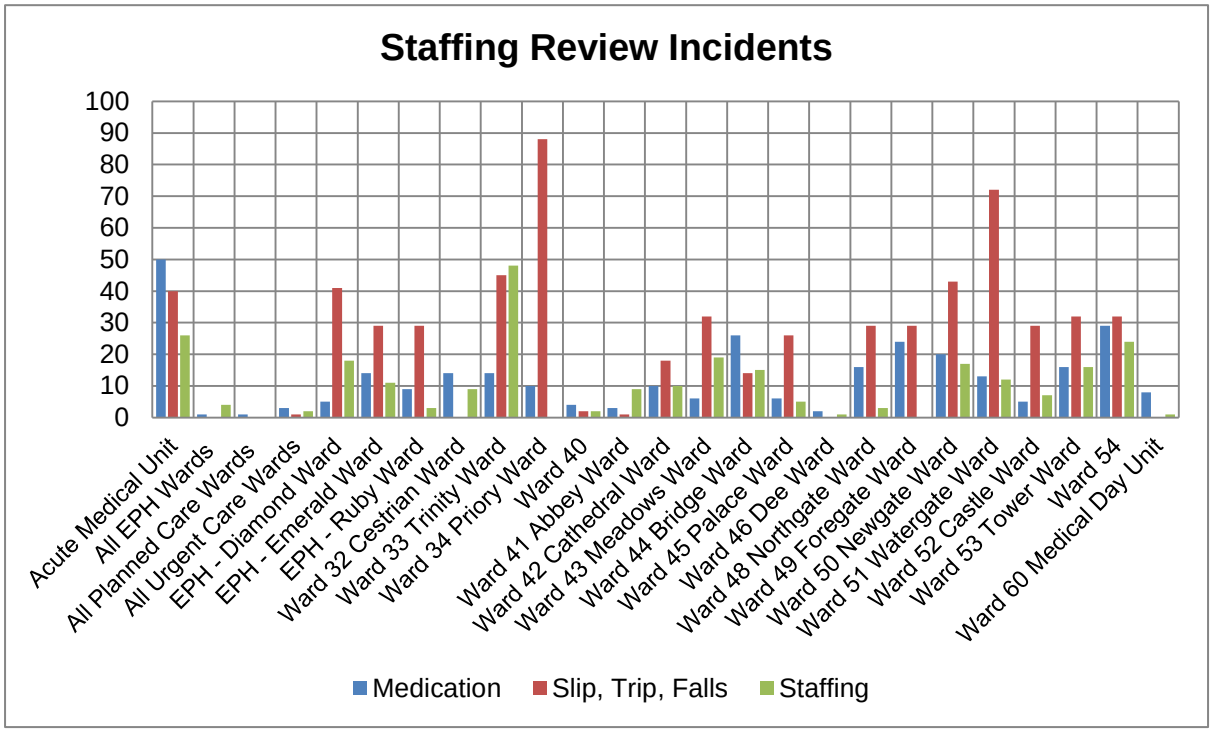
I would recommend that the Board support my proposal that the Model Hospital work now being undertaken, supporting e-rostering and acuity will develop the future staffing levels going forward.

The Divisions will complete the ward moves and then in 6 months start to use the data gathered by the acuity work to help support the decision making to determine staffing levels to meet patient safety. I believe it would be prudent to allow this to happen.

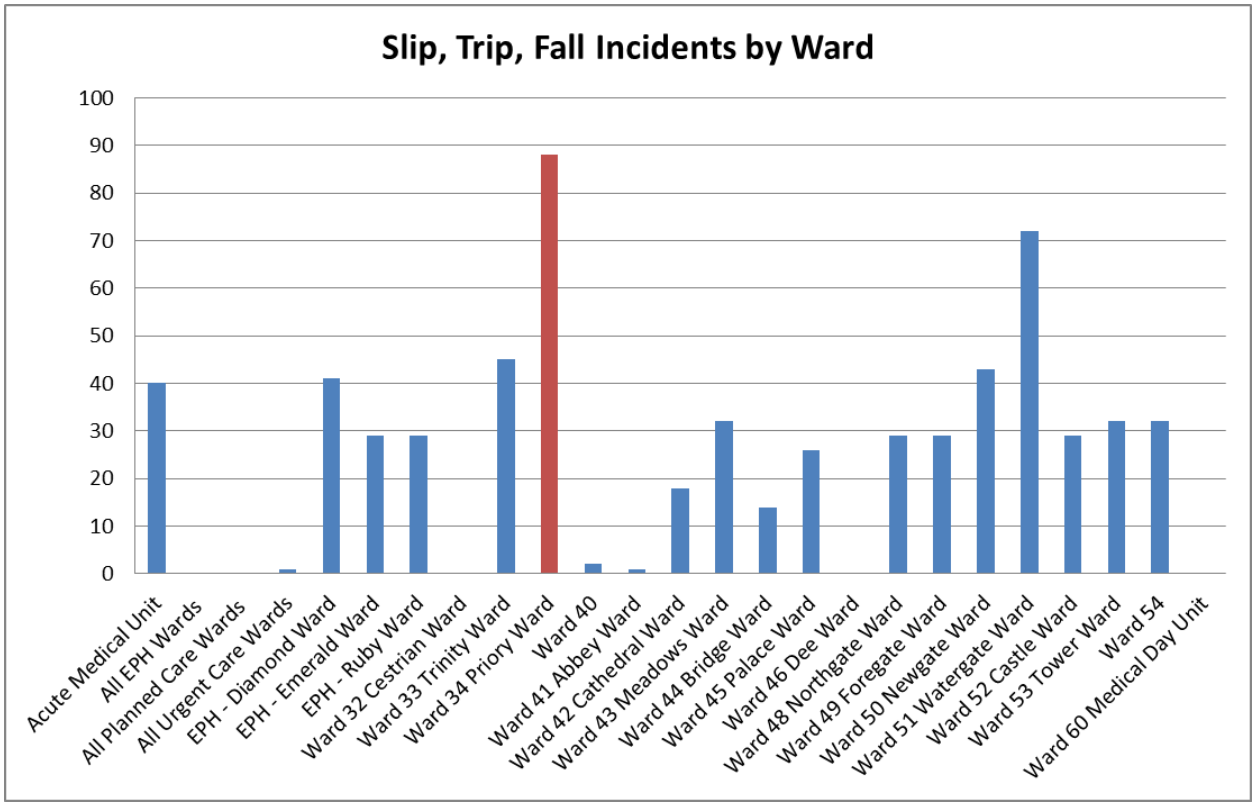
However I will continue to oversee the monitoring of the safety and balancing measures going forward on a regular basis to ensure that Divisions are mitigating any risks thus ensuring patient safety is maintained throughout these changes.

Alison Kelly
Director of Nursing and Quality
August 2016

Appendix 1



Appendix 2



Appendix 3 : In patient Ward Sickness and Staff turnover (January-June 16)

Safe Staffing Report In Line With National Quality Board Expectations

		6 Month Total			
		Sickness Absence %	Turnover %	Starters	Leavers
	All Trust Registered Nursing & Midwifery	4.14%	5.76	63	64
	All Trust Healthcare Support Staff	5.66%	3.32	55	22

Division	Area Of Work	6 Month % Sickness Absence Rate (FTE)	6 Month Turnover %	Starters	Leavers
210 PLANNED DIVISION		4.57%	4.81	16	13
210 PLANNED DIVISION	210 Bridge Ward 44	3.80%	6.06	5	2
210 PLANNED DIVISION	210 Castle Ward (52)	2.90%	2.94	0	1
210 PLANNED DIVISION	210 Crit Care Staff & Hdu Non Pay	6.13%	4.15	5	4
210 PLANNED DIVISION	210 Palace (45)	3.94%	7.41	2	3
210 PLANNED DIVISION	210 Tower Ward (53)	6.74%	4.26	1	1
210 PLANNED DIVISION	210 Ward 54	2.26%	4.65	3	2
210 URGENT CARE DIVISION		4.24%	5.80	44	35
210 URGENT CARE DIVISION	210 Accident & Emergency	4.04%	5.00	10	5
210 URGENT CARE DIVISION	210 Acute Medical Unit (Ward 47)	4.57%	5.93	11	4
210 URGENT CARE DIVISION	210 Cathedral Ward (42)	2.70%	9.52	3	3
210 URGENT CARE DIVISION	210 Coronary Care Unit	6.78%	12.77	3	3
210 URGENT CARE DIVISION	210 EPH DIAMOND WARD	8.22%	6.56	0	2
210 URGENT CARE DIVISION	210 EPH EMERALD WARD	6.84%	12.31	2	4
210 URGENT CARE DIVISION	210 EPH RUBY WARD	4.10%	6.35	3	2
210 URGENT CARE DIVISION	210 Foregate Ward (49) - Gastro	2.60%	9.38	1	3
210 URGENT CARE DIVISION	210 Newgate Ward (50)	3.20%	8.45	2	3
210 URGENT CARE DIVISION	210 Nnu	4.97%	0.00	2	0
210 URGENT CARE DIVISION	210 Priory Ward (34)	4.01%	4.88	1	2
210 URGENT CARE DIVISION	210 The Childrens' Unit (29 & 30)	1.91%	3.88	3	2
210 URGENT CARE DIVISION	210 Trinity Ward (33)	3.10%	2.22	0	1
210 URGENT CARE DIVISION	210 Ward (43)	5.39%	2.27	3	1

BOD Item No

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	**Report on the NHS Workforce Race Equality Standard (WRES)**
Date of Meeting	6th September 2016
Author(s)	• Joe O'Grady Equality & Diversity Manager
Presented by	Sue Hodkinson, Director of Human Resources & Organisational Development
Annual Plan Objective No.	N/A
Summary	The purpose of this report is to provide a briefing on progress by the Trust in regard to the NHS Workforce Race Equality Standard (WRES). This work stream is reported into the People & Organisational Development Committee.
Recommendation(s)	The Board is asked to note the briefing and related actions and support any recommendations that may emerge from the People & Organisational Development Committee.
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.

People & Organisational Development Committee Report
NHS Workforce Race Equality Standard

1.0 Introduction

The purpose of this report is to provide a briefing to the Board on the NHS England Workforce Race Equality Standard (WRES). The paper details the actions that have been undertaken in order for the Trust to demonstrate it is adherence to the requirements of the WRES and to the NHS England WRES implementation team, who report into the national NHS Equality and Diversity Council.

2.0 Background

The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Consequently, the NHS Workforce Race Equality Standard (WRES) was introduced in April 2015, after engaging and consulting key stakeholders including other NHS organisations across England. It is included in the NHS standard contract for 2016/17. NHS Trusts produced and published their first WRES baseline data on 1 July 2015 and are subsequently required to publish their WRES reports annually by 1st of August; along with an annual WRES action plan which must be approved by Board.

3.0 Update on progress and actions undertaken to date

The Trust submitted its inaugural WRES report to NHS England and the local Commissioners in 2015. It also implemented a WRES action plan, which set objectives to improve the capacity to provide data evidence against the parameters of the WRES submission template. At the inaugural WRES conference in London on 20th of June 2016, the WRES action plan formulated by the Countess of Chester for 2015 -2016 was cited as an example of best practice by the NHS England WRES implementation team in the NHS WRES annual report.

The Trust met all its 2015-2016 WRES action plan objectives and has published an annual progress report on its website. The second WRES report on the Trust has been published on 29th of July 2016, along with an updated annual WRES action plan. This has been approved by the Equality Diversity and Human Rights Strategy Group and People & Organisational Development Committee in July 2016.

On 27th of July 2016, the Trust also submitted the required data into the UNIFY2 portal developed by the NHS England WRES implementation team. To demonstrate further assurance, the Trust has developed a WRES page within the Equality Diversity and Human Rights section of the Trust website, which includes WRES resources and historical submissions to NHS England.

4.0 Recommendations for on-going and future actions

The Trust has made significant progress in year one of the WRES and plans to undertake further consultation with members of staff who are from Black and Minority Ethnic (BME) backgrounds within the year 2 activities. All objectives within the 2016-2017 year WRES action plan will be monitored by the Equality Diversity and Human Rights Strategy Group and reported to the People & Organisational Development Committee on a bi-annual basis.

5.0 Conclusion

The Board is asked to receive and note the progress within this report and to support the annual action plan. 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 Equality Diversity and Human Rights Strategy Group as required.

WRES action plan 2016 to 2017.pdf

CoCH-wres-reporting -template-2015-to-2(

Prepared by:

- **Joe O'Grady Equality & Diversity Manager**

August 2016

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

ASSURANCE FRAMEWORK

Q1 16/17

Presented to Board of Directors 06.09.16

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

ASSURANCE FRAMEWORK

CONTENTS

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
CR1 16/17	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			
CR2 16/17	Inability to effectively stabilise acute patient flow	Director of Operations	Finance and Integrated Governance	4x4=16			
CR3 16/17	Failure to maintain, innovate and transform the Trust's clinical services	Medical Director / Deputy Chief Executive	Finance and Integrated Governance	4x3=12			
CR4 16/17	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			
CR5 16/17	Failure to deliver in year financial plan and manage consequences of delivering a deficit budget	Chief Finance Officer	Finance and Integrated Governance	4x4=16			
CR6 16/17	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			
CR7 16/17	Failure to comply with Monitor's Compliance Framework - Governance	Director of Operations	Finance and Integrated Governance	4x4=16			
CR8 16/17	Failure to maintain robust corporate governance and overall assurance	Director of Corporate and Legal Services	Board of Directors	3x1=3			
CR9 16/17	Failure to maintain Information Governance standards	Medical Director/ Director of Nursing and Quality	Finance and Integrated Governance	3x4=12			
CR10 16/17	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			
CR11 16/17	Failure to recruit and retain professional staff	Director of HR & OD	People and Organisational Development	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 business.*

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 2016/17

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	4x2=8	4x2=8	3x2=6		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
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)*
Safe, Kind & Effective
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	Non compliance with regulatory & commissioner contracts
PC2	Risk to Registration & Licence to operate
PC3	Poor patient experience - impact on Trust reputation
PC4	Breach of Monitors terms of authorisation as a Foundation Trust

Based on those reported to CDG 27.7.16

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	Kirkup Report	green	↓
O2	Lampard/Saville Report	green	↓
O3	Workforce skills/competencies	Amber	↓
O4	CQC Fundamental Standards	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	Capacity issues - patient experience		
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 RAG (Red Amber Green)	Movement
C1	Completion and regular review of provider compliance assurance (PCA) framework	Green	→
C2	Monitoring of performance with commissioners including visits	Green	→
C3	Regular reviews CQC IM reports & fundamental standards	Green	→
C4	Quarterly CQC relationship meetings	Green	→
C5	Open communication with commissioners and CQC re any concerns identified by the Trust	Green	→
C6	Staff engagement programme	Green	→
C7	Monitoring of performance with commissioners including visits	Green	→
C8	Quarterly reviews on CQC Actions Plans (following formal Inspection in Feb 2016)	Green	→
C9	Clinical Rounds/unannounced clincial reviews	Green	→

The REPORTING mechanisms are…

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

REF	REPORTING MECHANISM	FREQUENC	Strength RAG (Red Amber Green)	Movement
R1	Quarterly, Safety & Patient Experience Committee (NED Chair)	Monthly	Green	→
R2	Patient Experience Operational Group	Monthly	Green	→
R3	CCG 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 Bioard	Monthly/bi-monthly	Green	→
R9	Corporate Directors 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	6 monthly Nurse Staffing update	03.05.16
R6	Patient & Staff Stories	Each Board
R1	WHO Q3 reports (theatres, radiology, maternity)	Quarterly 16.05.16
R1	Regulation 28 Action Plan - update on all cases	16.05.16
R1	End of Life Care - Dying in Hospital Audit Report	18.04.16
R1	Consent For Intimate examinations (appendix to policy)	16.05.16
R1	Patient Experience Operational Group - 6 monthly report	16.05.16
R1	AQuA Qaurterly Mortality Report	16.05.16
R1	Palliative/End of Life Care (update on action plans)	20.06.16
R1	Thematic Review of Incidents associtated with Diabetic ketoacidosis	20.06.16
R1	National In Patient Survey Report (2015-16)	20.06.16
R1		
R1		
R1		
R1		
R6		
R1		
R1		

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 in some CQC Standards (following formal Inspection in Feb 2016)	Action plans in place - being monitored quarterly via QSPEC	Quarterly reviews (Q3 16/17)	
G2	NNU risks	Action plan in place Weekly exec monitoring re operational activity and risks External review to commence 01.09.16		
G3	Poor Compliance with correct Patient Identification (3 Never Events)	Refocus on key actions to be taken, incorportae learning and Human Factors into training programmes. Safe Surgery Group being established	review progress Q3 16/17	
G4	Poor Compliance with Consent Processes	Consent Group in place with action plan. Policy due for ratification. Further clinical engagement required to ensure good compliance.	Q3 16/17	
G5	DoLS & mental Capacity Act Awareness	Process has been reviewed, prioritising risk assessment. All safeguarding adult training under review	Q3 16/17	
G6	Capacity issues due to lack of social care provision and flow issues within the Trust	System confefence calls/meetings in place, Winter resilience being planned, risk of increased patient harm and poor patientexperience	Q4 16/17	
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2016/17

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	TARGET RISK SCORE Mar-17		
	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	Director of Operations	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 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	Red	↑
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	Amber	↓
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)	Amber	↓
O9	Operational pressures and impact on retention/health and wellbeing appraisals, mandatory training etc	Green	↓
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	Agreed capacity and demand analysis	Amber	→
C2	Daily monitoring of perfromance and improved escalation process	Green	→
C3	Ambulatory Care /Frailty Service/GPAU/Intermediate Care	Green	→
C4	Early supported discharge	Green	→
C5	Specialty Business Packs/Plans	Green	→
C6	Winter Resilience Planning	Amber	→
C7	Operational dashboards (realtime)	Amber	★
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	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	Amber	↑
R8	Reporting to Commissioners & Monitor	As required	Green	→
R9	System resilience Group	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	Jun-16
R7	Contract meeting update	Jun-16
R2	Weekly Operational Performance meeting	Jul-16
R9	Utilisation management review	Jun-16
R4	ESIT report with ED	Mar-15
R5	Introduction of weekly operational resilience group (led by CCG)	May-16
R2	Launch of Model Hospital Re-imaging supply project	Apr-16
R3	Emergency Department update to Board	Jull 16
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	Sufficient assessment capacity	Patient flow project and Model Hospital re-imagining supply project	Q3 16/17	
G2	Sufficient operating and theatre sessions	Divisional management oversight and recovery plasn	Q3 16/17	
G3	Referral management	CCG leading a planned care monthly meeting	Q4 16/17	
G4	Sufficient social services availability of of packages of care and nursing home placements	Director of Operations chairing intergrated services group/reimagining supply	Q4 16/17	
G5	Community services able to avoid admission and enable discharge	Director of Operations chairing intergrated services group/reimagining supply	Q4 16/17	
G6				
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2016/17

STRATEGIC RISKS

IMPACT x LIKELIHOOD = RISK SCORE					
INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-16	TARGET RISK SCORE Mar-17	CURRENT ASSURED LEVEL
N/A	N/A	4x3=12	4x3=12	4x1=4	Amber

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE	Movement
CR3 15-16	Failure to maintain, innovate and transform the Trust's clinical services	Medical Director / Deputy Chief Executive	Finance & Integrated Governance Committee	→

What is the strategic risk to be controlled?

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 (Red Amber Green) 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 (Red Amber Green) 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
R3	Paediatric business case	Jan-16
R8	Dr Louise Davies EDG presentation - integrated discharge	Mar-16
R1	COCH review of commissioning intentions	Mar-16
R8	West Cheshire system long term financial model (LTFM)	Mar-16
R8	System financial control proposal letter to NHS Improvement	Apr-16
R1	Anaesthetics/critical care business case	Jan-16

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	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	Draft presented to POD April 2016 - revisions in progress for BOD approval July 2016	Q1 16/17	
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	Failure to recruit to key clinical posts	Acute Care Collaborative and Culture/Performance Framework streams of Model Hospital	Q4 16/17	
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2016/17

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	TARGET RISK SCORE Mar-17		
	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	Delivery of national CQUIN targets linked to health & wellbeing	Amber	★
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 Culture, Performance & Behaviour workstream 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	Performance Culture workstream within Model hospital	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-16
R1/R7	Culture, Performance & Behaviour workstream investment linked to Model Hospital programme	01-Jun-16
R2/R3	People & OD Committee / SPF- How are we doing for our people monthly report	19-Jul-16
R1/R2	Staff Survey/SFFT Report to Board of Directors with associated action plan. Monitored by POD.	01-Apr-16
R2/R3	NED support- NED Chair and another NED member of People & OD Comm. NED Chair SPF.	28.01.16
C5	Monthly CPB project board meeting established with feedback into WF programme & finance working group	01-Jul-16
C7	Master class series - planned throughout the year.	24.03.16
R2/R9	Leadership Programmes in place - 20:20, Clinical Leaders, Releasing Potential	22.03.16
R1/R2	Recognition and Celebration of Achievements informal and formal systems in place	01-Jun-16
C5	Health & Well Being Strategy reported to POD	28.01.16
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	19-Jul-16
C4	Student Experience/Satisfaction Surveys - open all year Multi -Prof Practice Placement meeting	19-Jul-16
C4/R9	GMC Trainee Survey- reported to Multi-Disciplinary Education Committee	01-Jun-16
C5	Countess brief open forums undertaken on monthly basis	25-Jul-16
O7	Focus groups & trust wide survey to support model hospital programme	28.01.16
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.	01.03.16
O7	Barometer group established as part of Model Hospital programme, with focus groups undertaken every 8 wks	01/06/2016

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	Behaviour framework development to support implementation of 360 process	Feedback gathered from 2000+ items of feedback, behaviour framework in development with proposed set of 360 questions being piloted on EDG & Theatres staffing.	Q2 16/17	
G2	Middle Manager /Team Leader programmes. support and skills pathways in development/ implemented	Scoping commenced October 2015 onwards, following recruitment of resources. Built into CPB workstream. Implementation from October 2016.	Q1 16/17	Q2 16/17
G3	Staff survey results 2015 and associated action plan to address gaps in assurance.	Discussed at POD 28.01.16 with action plan developed and discussed in April 2016 POD, with paper to BOD in May 2016. Standing agenda item at POD/SPF.	Q2 16/17	
G4	Pressures of capacity and demand on staff and ability to manage pressures	Divisional risks item added to each POD meeting as standing item to discuss capacity, demand & pressures. Monitored monthly through HRBPs and triangulation with data.	Q2 16/17	
G5	Engagement with union colleagues on project	Standing item at Partnership forum, additional hours allocated to support engagement	Q2 16/17	
G6	Delivery of national CQUIN targets linked to Health & wellbeing	Monitored monthly by Health & wellbeing steering group, discussed at Nursing & Midwifery Board for additional nursing support re flu vaccination programme.	Q3 16/17	
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2016/17

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	Mar-17		
	4x3=12	4x3=12	4x4=16	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	Red	↑

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

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Not achieving the required Risk Rating and subsequent NHSI 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		IMPACT LEVEL	
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*	
REF	ORIGIN	RAG	
O1	Non receipt of STF monies	Red	★
O2	Delivery of CQUIN Schemes	Amber	→
O3	Future investments	Amber	→
O4	Identification and Operational delivery of efficiency schemes	Red	↓
O5	Increased activity demand	Amber	→
O6	Medical & nursing pay pressures - gaps and acuity leading to high agency usage	Amber	→
O7	Poor budgetary management and control	Amber	→
O8			
O9			
O10			

The risks are CONTROLLED by…		Strength	Movement
What are the key controls (up to 10) that are in place to mitigate these risks?		*Red Amber Green*	
REF	CONTROL	RAG	
C1	Production of Annual Budget and Monitor Forward Plans and Templates	Green	→
C2	Proactive horizon scanning of risks and opportunities	Green	→
C3	Robust performance monitoring and financial management control	Amber	→
C4	Budget review meetings and regular updates on efficiency schemes through weekly CRS meetings, monthly Model Hospital Board and governance arrangements	Amber	→
C5	Variable Pay working group	Amber	→
C6	Workforce planning and international recruitment	Amber	→
C7	Robust contractual monitoring information to inform contract negotiations	Green	→
C8	Audit reports/assessments/reviews	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	FREQUENC	RAG	
R1	Board of Directors	Bi-monthly	Green	→
R2	Finance & Integrated Governance Committee/Finance Committee	Bi-Monthly	Green	→
R3	Commissioner contract meetings (WC / BCU / NHSE) (E)	Monthly	Green	→
R4	Model Hospital Board	Monthly	Green	→
R5	NHSI (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	1-May-16
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	1-May-16
R3	Agreement of NHSE Contract baseline	
R1	Informal feedback from Monitor Visit	1-Feb-16
R6	Implementation of Confirm & Challenge Process with Divisions	26.02.16
R6	First stage intervention for budget holder performance	26.02.16
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	1-Feb-16
R5	Quarter two feedback letter from Monitor	Monthly
R10	Annual External Audit of Accounts	28-Apr-16
	Fortnightly variable pay review with increased data and interogation	1-Mar-16
R4	Combined Model Hospital/CRS reporting	14-Jul-16

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	To be risk assessed and monthly meetings with departments to continue to identify further plans. Joint working with CCG for system wide savings. Further discussions with NHSI re: £3m balance outstanding	On-going	
G2	Impact of lack of information on Junior doctor rotational gaps and medical vacancies	Pro-active management to anticpate potential gaps and escalation process with Deanery	On-going	
G3	Affordability of 7 day services and other investments	Clinical service reviews / Cheshire STP and ACO/ACA priorities	On-going	
G4	Control of volumes of medically optimised patients and further activity growth impacting on financial position	Joint working with CCG to control demand	On-going	
G5	Failure to deliver performance improvement trajectory and consequent impact of STF funding	Weekly performance meeting and increased scrutiny at Divisional level	Q3	

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2016/17

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	TARGET RISK SCORE 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
Delivering the Model Hospital

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	Movement
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 Cheshire and Mersey c£1b by 2020/21	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 (Red Amber Green) RAG	Movement
C1	Estabilished West Cheshire Strategic Leadership Group	Green	➔
C2	System Controlled total agreed	Green	➔
C3	Model system transforamtion plan	Amber	➔
C4	West Cheshire long term financial model	Green	➔
C5	West Cheshire Workforce Development Plan	Red	➔
C6	Acute Care Collaboration with Wirral	Amber	➔
C7	Cheshire and Mersey STP plans ongoing	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 (Red Amber Green) RAG	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	Provider Federation Board with Wirral	Monthly	Red	➔
R5	Model Hospital Programme Board	Monthly	Green	➔
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
	Weekly Provider CEO Meetings	
	West Cheshire SLG - Independant Chair	
	Joint planning meetings with Finance, Commissioning between CCG and COCH	
	Bi-weekly CEO meetings between COCH and WUTH	
	Refresh of planning leadership linked with Model Hospital and Model System	
	West Cheshire ACO development on-going	
	Cheshire and Wirral Clinical Strategy underway	
	Strategic Estates Partner Proposal	BOD 05.07.16
	Team to Team meeting with CWP and COCH	23rd August 2016

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	Sustainable and Affordable Clinical Services	MD's to produce outline C&W Clinical Strategy	Q2 2016	
G2	C&M STP	Working Group & CEO Group established		
G3	West Cheshire ACO	SLG overseeing development	Apr-17	
G4				
G5				
G6				
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2016/17

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	TARGET RISK SCORE Mar-17		
	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**	Director of Operations	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?*

REF	ORIGIN	IMPACT LEVEL (Red Amber Green) 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	Amber	↓
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?*

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
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	Waiting list validation	Amber	★
C9			
C10			

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

REF	REPORTING MECHANISM	FREQUENC	Strength RAG (Red Amber Green)	Movement
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	System Resilience Group	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 System Resilience Group	Monthly
R5	Weekly tracking of improvement trajectories	Jun-16
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 June 2016	Jun-16
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)	Validation and tracking	Q2 16/17	
G2	Medically optimised patients / delayed transfers of care patients	Reduction in DTC plan within Better Care Fund	Q2 16/17	
G3	Cancer performance	Implementation of key actions identified in action plan	Q3 14/15	Ongoing
G4	18 week failure of incomplete pathway	Development of actions to address 18 weeks and longest waiters	Q3 16/17	
G5	Validation commenced March 2016	Action plan underway	Q4 16/17	
G6				
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2016/17

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	TARGET RISK SCORE Mar-17		
N/A	3x1=3	3x1=3	3x1=3	3x1=3		

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE		
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

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	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	Board development	Green	→
O5			
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?

REF	CONTROL	Strength (Red Amber Green) RAG	Movement
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…

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	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	20.07.16
R1	Provided an update to the Board of Directors	05.07.16
R2	Provided an update to the Council of Governors/Governors Quality Forum	05.07.16
	Regular communication and discussion with the Chairman	20.07.16
R1	Full refresh of the Board Assurance Framework	05.07.16
R1	Provided update to Audit Committee	18.04.16
	People and Organisational Development Comm approved as formal Board Sub-Committee	03.03.15
	Executive Internal Governance Review of Scheme of Delegation for Executive Directors	1-Apr-16

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	Complete
G2				
G3				
G4				
G5				
G6				
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2016/17

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-17	Mar-18		
	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
	PC3	Adverse impact on Trust's reputation resulting from adverse publicity
IMPACT ON CQC CORE OUTCOMES	PC4	Information Commissioners Office (ICO) impose a fine
What are the Outcome Reference Numbers?		

REFERENCES OF KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK Based on those reported to Informatics Board	28/06/2016	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	Movement
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…

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

REF	CONTROL	Strength RAG	Movement
C1	95% of staff undertook Information Governance training within the last 2 years	green	→
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…

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

REF	REPORTING MECHANISM	FREQUENCY	Strength RAG	Movement
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-16
A6	2015/16 Information Governance Toolkit Submission 76% - Level 2 Compliance	Mar-16
A7	Bi Annual SIRO report received by Informatics Board	Feb-16
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 place?

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	Q2 16/17
G4	Extend data flow mapping	Continue work on Data Flow Mapping, focus on Level 3 assets	Q4 16/17	
G5	Extend Information Asset Register	Continue work on Asset Register, focus on Level 3 assets	Q4 16/17	
G6	Members of the Information Governance Panel and Caldicott complete 16/17 training	Appropriate online training undertaken by all panel members	Q4 16/17	
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	Q1 16/17

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2016/17

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-17	TARGET RISK SCORE Mar-18		
4x4=16	4x4=16	4x3=12	4x2=8	4x2=8		

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE		
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)*	REF	*What are the key potential consequences (up to 4) of the risk?*
	PC1	That patients receive poor quality care or experience avoidable harm
	PC2	That patients experiences poor quality clinical outcomes which are below published national and international standards
	PC3	That the staff user experience is suboptimal and does not facilitate the delivery of high quality care
IMPACT ON CQC CORE OUTCOMES	PC4	That the organisation is unable to deliver current services efficiently and/or plan to meet future service requirements
What are the Outcome Reference Numbers?		

REFERENCES OF KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK Based on those reported to Informatics Board	28/06/2016	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	Movement
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…

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

REF	CONTROL	Strength RAG	Movement
C1	Good programme and project governance (e.g. industry standard methodologies, business change & benefits)	amber	→
C2	Information Governance, IT Security and Informatics Services policies, plans and procedures	green	→
C3	Appropriate membership and governance arrangements for the Informatics Board and its sub-groups	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	green	→
C7	Audit programme including Pen Testing, Coding, Backup & Resilience, IGT, Asset Management, Data Quality, etc.	green	→
C8	IT infrastructure, desktop and mobile assets supported, maintained and replaced in-line with best practice	amber	→
C9	Comprehensive user training programme (initial and refresher) across all assets under management	red	→
C10	Appropriately resourced, qualified, knowledgeable, motivated, well trained and sustainable workforce	amber	→

The REPORTING mechanisms are…

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

REF	REPORTING MECHANISM	FREQUENC	Strength RAG	Movement
R1	Informatics strategy reviewed by the Informatics Board	annual	green	→
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-16
A9	2015/16 Information Governance Toolkit Submission 76% - Level 2 Compliance	31-Mar-16
A10	Quarterly Informatics Stocktake undertaken with the Executive Directors	18-Nov-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
A14	Completed HSCIC Digital Maturity Assessment	15-Jan-16
A15	MIAA IT Service Management Audit (Significant Assurance)	13-Apr-16
A16	North West Informatics Skills Development Network Accreditation (Foundation Level)	15-Mar-16

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	Q2 16/17
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	Q1 16/17

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Board Assurance Framework - Quarter 1 2016/17

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	4x3=12	4x3=12 / 3x3 = 9		

What is the strategic risk to be controlled?					
REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE		
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?

REF	ORIGIN	IMPACT LEVEL (Red Amber Green) RAG	
O1	Gaps in junior doctors rotas	Red	→
O2	Lack of suitably qualified candidates in specialist clinical skills e.g. ED Consultants/Sonographers/Anaesthetics/CRV/Theatres	Amber	→
O3	Tighter UK border controls for non EU countries / Tier 2	Amber	→
O4	Implications of Nurse Revalidation	Green	↓
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 workstream	Red	→
O7	Implications of national junior doctor contract implementation	Amber	→
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?

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
C1	Development of People & OD Strategy	Green	→
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 workstream as part of Model Hospital programme	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.

REF	REPORTING MECHANISM	FREQUENC	Strength RAG (Red Amber Green)	Movement
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 through work stream.	19-Jul-16
R1/R3	Reporting to Board /FIGC/POD on workforce KPIs	19-Jul-16
R3	Medical agency spend / requirements weekly review group established	5-Aug-16
C5	Implementation of Direct Engagement with savings and increased management information	1-Apr-16
R5	Partnership Forum: Staff engagement /staff survey/staff experience/SFFT reviewed monthly	14-Jun-16
R1/R3	Staff survey reported to POD, with associated action plan in place.	28.01.16
R3	Sign off Health Education England return 2015 People & OD Committee	01-Apr-16
C1	Review of People & OD Strategy documentation & implementation plan to POD	19-Jul-16
R1	Appraisal Performance increased and reviewed at POD	19-Jul-16
C7	Monthly monitoring of safer staffing & 6 monthly report to the BOD	1-Apr-16
R3	Medical Staffing / Nurse Staffing / Nurse revalidation papers presented to POD	1-Apr-16
C10	Occupational Health visits reported to POD Committee/Partnership Forum including H&WB Strategy	01-Apr-16
R6	Executive '1st of the Month' walkabouts reported to EDG	01-Jul-16
C7	Master class series - planned throughout the year.	24.03.16
C10	Implementation & continuation of Schwartz Rounds, wellbeing interventions	01-Apr-16
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 on periodic basis.	14-Jun-16
R4	Recruitment of nursing internationally - second cohort undertaken with good levels of retention	01-Apr-16
R4	Monthly Nursing & Midwifery Operational group chaired by Director of Nursing & Quality	01-Jun-16
O7/R3	Implementation group established for JD contract. Risk monitored by POD	19-Jul-16

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	Impact of agency spend cap of £4.8m monitored by NHS Improvement	Variable pay workstream now as part of Model Hospital programme, medical lead identified & weekly review meeting focused on commissioned requirements and divisional plans. Implemented from 05/08/16 with Medical Director, HRD & Finance, Medical Staffing	Q2 16/17	
G2	People and OD Strategy being developed.	Strategy developed and reviewed by key stakeholders at both Partnership Forum, People & OD Committee. Presentation to Board September 2016.	Q2 16/17	
G3	Increased medical engagement in recruitment processes, e.g. drafting of JDs and commitment for recruitment timescales	Recruitment leads obtained in majority of specialties, review via weekly medical agency spend review group. Engagement sessions undertaken with Medical staff Committee & Local Negotiating Committee. Enhanced reporting available from medical staffing team.	Q2 16/17	
G4	Shortage of ODPs, CRV, middle grade doctors & impact on agency spend	Revised payment rates piloted to provide shift cover internally. Included on HEE workforce planning return. Recruited F2s early to employed posts to mitigate agency spend. Implementation of overseas medical student programme Feb 2017	Q3 16/17	
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%. Full implementation of incremental policy October 2016	Q3 16/17	
G6	Integrated workforce agenda across STP Footprint	HRDs met once to identify scope of opportunities, challenges. In the process of prioritising areas of focus and developing action plan with reporting to Acute Care Collaboration Board and STP governance arrangements. Focus on transactional	Q4 16/17	
G7	Staff Engagement (Staff Survey/SFFT)	Staff survey 2015 results received and action plan developed. Standing item at SPF and POD. BOD paper May 2016. Monitored via Culture, Performance & Behaviour workstream.	Q3 16/17	
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. Standing item at POD for	Q3 16/17	
G9	Impact of changes in EU in attraction / recruitment (e.g. Nursing, Radiologists)	Working with partner organisations to explore impact on nursing supply, Nursing & Midwifery Recruitment strategy implemented with actions in progress. Continued monitoring and reporting at POD required.	Q2 16/17	
G10				