Countess of Chester Hospital NHS
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

TUESDAY, 7TH JULY 2015 AT 12.30PM

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 May 2015, BoD action tracker (June 2015) and matters arising **(Attached)**	Chairman

QUALITY & ASSURANCE

4.	To receive a patient story	Director of Nursing and Quality
5.	To receive details of the Trust's CQC inspection preparation **(Attached)**	Director of Nursing and Quality
6.	To receive an update on the Francis Report Recommendations Implementation Action Plan **(Attached)**	Director of Nursing and Quality
7.	To review the Integrated Performance Report to month 2 **(Attached)**	Executive Team
8.	To receive an analysis of the Picker Inpatient Survey Results **(Attached)**	Director of Nursing and Quality
9.	To receive an update from the Monitor Visit	Deputy Chief Executive / Chief Finance Officer
10.	To receive the Board Assurance Framework – July 2015 **(Attached separately – A3)**	Chief Executive
11.	To receive and approve the Cost Approval Process **(Attached)**	Chief Finance Officer

11.	To receive a update on Never Events and Serious Untoward Incidents	Director of Nursing and Quality

STRATEGIC DEVELOPMENT

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

FOR NOTING & RECEIPT
PLEASE NOTE THE FOLLOWING DOCUMENTS ARE AVAILABLE ON REQUEST

14.	To receive the minutes of the Quality, Safety and Patient Experience Committee 20th April 2015 and 18th May 2015	Director of Nursing and Quality
15.	Level 2 Root Cause Analysis Investigation Report - Theatre Incident Trend Analysis **(by email only)**	Director of Nursing and Quality
16.	To receive the CoCH response to the Saville Report	Director of Nursing and Quality
17.	To receive the minutes of the People and Organisational Development Committee – 27th March 2015	Director of Human Resources and Organisational Development
18.	To receive the minutes of the Finance and Integrated Governance Committee – 7th April 2015	Director of Corporate and Legal Services
19.	To receive the Corporate Infection Prevention and Control Assurance – Quarterly Report (retrospective report based upon February 2015 quarterly data update)	Medical Director
20.	To receive the Adult Safeguarding Annual Report 2014/15	Director of Nursing and Quality
21.	To receive the LSMS Annual Report 2014/15	Deputy Chief Executive
22.	Date and Time of Next Meeting: **Board of Directors Meeting** **Tuesday 1st September 2015 @ 12.30pm Training Room 3 & 4**	

BOARD OF DIRECTORS

MINUTES OF THE MEETING HELD ON TUESDAY, 5TH MAY 2015 at 12.30pm
TRAINING ROOM 3 & 4

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

In attendance:
Mrs C Raggett – Secretary to the Board
Mr Joe O'Grady – Equality and Diversity Manager

FORMAL BUSINESS

B19/15 **WELCOME AND APOLOGIES**

Sir Duncan welcomed all attendees to the meeting.

There were no apologies received.

B20/15 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

B21/15 **TO RECEIVE AND APPROVE THE MINUTES OF BOARD OF DIRECTORS' MEETING HELD ON 3rd MARCH 2015 AND BOARD ACTION TRACKER APRIL 2015**

The Board of Directors minutes of the meeting held on 3rd March 2015 were received as a true and accurate record.

The Board noted the Board Action Tracker as at April 2015.

MATTERS ARISING
There were no matters arising.

QUALITY & ASSURANCE

B22/15 **TO RECEIVE A PATIENT STORY**

The Board received details of a patient story from the perspective of being the carer of a patient's. The carer gave details of her experience during her husband's stay in hospital following a fall at their home.

The carer gave examples of areas where care of patients has improved since the Trust received the carer's feedback.

The carer felt that if there had been better support in the community to provide care for her husband at home, he would have been able to come home, which may have improved his prognosis and would have at least meant that he could have passed away at home.

Mrs Kelly thanked the Carer for sharing her experience and stated that work is underway to get a joint plan across health and social care for patients. Mrs Kelly added that it was important to recognise and listen to carers.

B23/15 **TO RECEIVE A PRESENTATION ON THE TRUST'S CARERS STRATEGY**

Mrs Hodkinson introduced the Carers Strategy and reported that there were around 500 members of staff who were carers and that it was important that staff were supported.

Mr O'Grady, Equality and Diversity Manager gave a presentation and outlined details of the Trust's Carers Strategy.

Mr O'Grady reported that the strategy had been developed following feedback and experiences of carers at the Trust.

Mr O'Grady stated that the Carers Strategy would be formally launched during the National Carers Week commencing 8th June 2015 and the Schwartz round in June 2015 would focus on carers and training will be rolled out to all staff.

In response to a question from Mr Oliver, a discussion took place regarding the use of the 'This Is Me' and 'All About Me' documents for patients at the Trust. These documents had been developed by the Dementia Society. The Trust is also working with the local networks to share details of the support available for carers.

Mrs Hopwood asked where would a staff member go if they needed real time support. Mr O'Grady replied that there is a dedicated section on the Trust's intranet and there are all recurrent awareness sessions that all staff can attend.

Dr McMahon referred to the educational sector and what actions they were taking to support carers. Mr O'Grady stated that the educational sector, through the Equality Act must have protected time for carers which the Trust does have in place, discussions are also taking place with the University of Chester to explore further support for staff and carers.

Mr Chambers added that it was important for the Trust to support carers now and in the future and that the strategy was an excellent start. Mr Chambers stated that education and support for carers would form part of the work of Bache Hall in terms of developing a system wide approach to provide education, training and support to carers and staff.

Sir Duncan thanked Mr O'Grady for his presentation.

B24/15 **TO RECEIVE AND APPROVE THE PACS BUSINESS CASE**

Mr Brandreth presented the PACS business case to the Board and outlined the following points:

- The PACS system is the system that supports radiology.
- The Trust's current system is now 7 years old and is at the end of its useable life.
- There are 196k images produced a year, which is high volume and high intensity for the system.
- The new contract offers good value for money, is more efficient and would allow the Trust to participate in the regional SPR, which means more effective reporting at night.
- The executive summary of the paper sets out the work and due diligence that has been undertaken.

Mr Brandreth stated that the preferred recommendation would be the capital approach option.

Mr Wilkie stated that in future papers it would be useful to include the full description of the acronyms.

In response to a question from Sir Duncan, a discussion took place regarding the proposed new system not interfacing with the future replacement of Meditech and

how the new PACS system will integrate with the Trust's existing systems.

Mr Higgins asked what discussions had taken place with clinicians around the new PACS system and were they supportive of the proposed new system and contractual arrangements. Mr Brandreth replied that there had been a lot of clinical input in to the business case and the recommendations. The business case had been fully discussed at the Informatics Board which is chaired by Dr Moore, had been indepthly discussed with Dr Rehman, Divisional Medical Director for Radiology, the Divisional Directors and other Divisional Medical Directors.

The Board approved the recommendation for the Trust to proceed with Option 2 – replacement of the PACS system using the Cheshire and Merseyside Consortium solution with integrated reporting and awards contact to Carestream.

B25/15 **TO REVIEW THE INTEGRATED PERFORMANCE REPORT TO MONTH 12 TO INCLUDE:**
A MORTALITY UPDATE

The Board received details on the key issues within the integrated performance report to Month 12.

Mr Brandreth presented the Performance Report for Month 12 and highlighted the following:

- Considerable work is being undertaken to improve the Emergency Department 4 hour target performance.
- The diagnostics target failed around cardiology, there is a national recruitment issue, however the Trust is working hard to recruit to the service.
- The Trust had a planned fail for 18 weeks RTT during Q4, as agreed with the CCG to reduce long waiters on the waiting list.
- Mr Brandreth was pleased to report that the cancer 62 day target was achieved for month 12, but noted that the quarter would still be red. He added that he felt that there had been real improvement in the cancer targets performance.

Mr Harvey presented the mortality report to the Board and reported that the Trust's SHMI rate was 1.11 which remains within the expected range.

Mr Harvey stated that work was continuing on 7 day services so that the Trust's HSMR is below 100, as there is a gap between week days and weekend admissions however, there is no difference in the care given or concerns raised. Mr Harvey added that there had been improvements in the number of discussions with patients in relation to the choice of DNR.

The mortality review has highlighted four cases that need further review and Mr Harvey will provide an update on these in the next mortality report.

Mr Harvey detailed the work being undertaken with primary care and GPS around

those of their patients whose death was not expected, as it is often the case that these patients will not have been seen in hospital prior to their death.

Sir Duncan asked how the learning gained from the mortality reviews was being shared. Mr Harvey replied that there was a huge amount of information gathered during the morality reviews and that a more focussed process was being developed to focus on patients who had a lower risk of death or death was not expected. Mr Harvey would include an addendum in the next mortality report to Board on this subject.

Mr Higgins asked for an update on the levels of falls and pressure ulcers at the Trust. Mrs Kelly replied that a lot of work had been undertaken in these areas as part of the 'Sign Up to Safety' initiative and that the aim was to reduce the number of grade 3 and 4 pressure ulcers, however it was noted that increased awareness does mean an increase in reporting. There are some improvements being made in relation to the documentation, assessments and information entered on Meditech for pressure ulcers.

Mrs Kelly added that in relation to falls, again there is a lot of work being undertaken to reduce the number of falls although this has been impacted on by some patients staying longer in hospital than was needed. Mrs Kelly stated that fall with harm are the main focus and that the Trust has a number of these. Mrs Kelly stated that she was satisfied that the Trust was doing everything that could be done.

Dr McMahon applauded that Cancer Team and their improvement in the cancer target performance. Dr McMahon asked how the cultures and attitudes of the team had helped to improve the performance. Mr Brandreth replied that there is now a full team of cancer trackers and that he and Mr Cross had recently visited the team. The team had a lot of energy, a good atmosphere and a focus on tracking patients rather than following them. The team feel they are also part of the clinical teams and that they can make a difference. The team have also received excellent feedback from the clinicians. Mr Cross added that there was a very positive culture within the team.

In response to a question from Mr Wilkie, a discussion took place regarding safe staffing levels, workforce challenges and the option to recruit staff from abroad. It was noted that a recruitment strategy would be finalised which would have a number of actions going forward. A further discussion took place regarding the allocation and commissioned places for nurses, midwives and doctors at universities and noted the discussions taking place at both local and national level.

Sir Duncan congratulated the team on the reduction in the number of C.Difficile cases and coming in under target. Mr Harvey added that this was the second year that the Trust was under the C.Difficile target.

Mrs O'Neill gave details of the Trust's year financial position and highlighted the

following points:

- The Trust finished the year with a £2.9m deficit which was in line with the revised forecast.
- The Trust has a CoSRR rating of 3.
- The key variances are:
    - £916k gap in the efficiency programme target
    - £921k medical pay overspend.
    - Total expenditure on agency doctors is £2.5m
    - £229k nursing pay overspend.
    - Reduction in income from obstetrics, vascular and bariatrics.
- Mrs O'Neill stated that £3.5m of the 2014/15 efficiency programme had not been achieved recurrently.

Sir Duncan referred to the setting of CRS target and when this was set, was it set as a recurrent target. Mrs O'Neill replied that the target is set as recurrent but this can slip and become non-recurrent.

Mrs Hopwood asked how many doctors equated to the spike in medical spend during November 2014 and December 2014. Mrs O'Neill stated that there is a variable in cost due to the agency price being increased and the availability of doctors can mean that when needing a junior doctor position, there is only a senior doctor available which also increases the cost of the agency doctor. Mrs Hodkinson stated that there are 15 – 20 vacancies per division, discussions are taking place locally and nationally around the issues and the People and Organisational Development Committee are reviewing the issues in more detail and will feedback to a future Board meeting. It was agreed that it would be useful to include the number of WTE posts for medical agency spend in future reports.

In response to a question from Sir Duncan, a discussion took place regarding the allocation of junior doctors from the deanery and the actions being taking in relation to the recruitment of doctors in the UK and abroad.

The Integrated Performance Report for Month 12 was received by the Board.

B26/15 **TO RECEIVE DETAILS OF THE OPERATIONAL PLAN 2015/16**

Mr Brandreth presented the Countess of Chester Hospital NHS Foundation Trust Operational Plan 2015/16 to the Board and highlighted the following points:

- Work on the operational plan started in December 2014 with the joint Board of Directors and Council of Governors workshop.
- The plan details the strategic priorities and how these fit with the Trust's overarching strategy.
- The plan details the work of the 'High Quality Care Costs Less' (HQCCL) programme which is about improving efficiency and productivity and there has been good clinical engagement so far.

- Mr Brandreth stated that the plan has the following paragraph included in relation to the future financial position of the Trust:

  'The Countess of Chester Hospital NHS Foundation Trust (COCH) Board believes that, on the basis of the plans as set out in this document and the extent to which the most vital elements in achieving that Plan fall outside the control of the Trust, at the moment it is unable to give a view on its financial sustainability beyond 2015/16 falling outside of this Plan. '

In response to a question from Mr Higgins, a full and detailed discussion took place regarding the local health systems commissioners and the current negotiations and conversations taking place in relation to the contract and activity levels. Mrs O'Neill stated that an interim agreement had been reached for Q1 between the CCG and the Trust.

Mrs O'Neill presented a separate financial summary to accompany the operational plan and highlighted the following points:

- The Trust is on PbR for Q1 with the CCG.
- There is a still along way to go in contract negotiations due to the misalignment in activity assumptions, as the Trust expects more growth than the CCG.
- The Trust is forecasting a £10.5m deficit for 2015/16 which will give the Trust a CoSRR of 2.
- In terms of financial sustainability in 2016/17, the Trust's cash reserves will be diminished.
- The plan makes reference to a contingency reserve of £650k and non-recurrent monies in support of delivery of Trust's efficiency programme.
- The biggest risk in the plan is the delivery of the £6m savings.
- Mrs O'Neill will review the cash position to see if this can be improved.
- Monitor have reviewed the submission and the Trust will give feedback on where the Trust's plan differ from the commissioners and tariff assumptions.

Mr Higgins asked for clarity around the allocation of £500k non-recurrent monies in relation to the efficiency programme. Mrs O'Neill replied that this money was specifically for support from an external company to assist in the delivery of £6m savings. Mr Higgins stated that whilst this was not cheap, the challenge would be to demonstrate the value of the support. Mrs O'Neill stated that there may be some additional support from the work with Lord Carter which would not have a cost implication for the Trust.

Dr McMahon referred to the Trust's cash position and the 3 options of disposal of

assets. Mrs O'Neill stated that the options were in the early stages and were being discussed with Mr Kevin Eccles, Head of Development Programme. Dr McMahon also referred to the schemes for cash release, Mrs O'Neill stated that options for re-financing were being looked into and that she would provide an update to a future Board meeting.

In response to a question from Mr Wilkie, Mr Brandreth gave details of the HQCCL scheme and the 4 main areas of focus and the actions taken so far to help improve efficiency in these areas.

Sir Duncan referred to the increase in the number of day cases and the reduction in outpatient activity and asked Mrs O'Neill about the income assumptions. A full discussion took place regarding the activity level assumptions and PbR payments and the misalignment of risks and benefits across the local health economy.

The Board approved the Operational Plan 2015/16 for submission to Monitor.

B27/15 **TO RECEIVE A VERBAL UPDATE ON BARIATRIC SERVICES**

Mrs O'Neill gave an update on the Trust position in relation to the bariatric service. The Trust has received an offer of reduction in fees from Pheonix, however there had been no progress in discussions with NHS England to support the tariff. Mrs O'Neill stated that this would need to be escalated appropriately.

B28/15 **TO RECEIVE THE BOARD ASSURANCE FRAMEWORK – APRIL 2015 AND TO APPROVE THE BOARD ASSURANCE FRAMEWORK HEADLINE RISKS 2015/16**

Mr Chambers presented the Board Assurance Framework and stated that a full review had been undertaken at the Corporate Directors' Group.

Mr Chambers reported that 8 risks remain the same, with 2 risks demonstrating an improvement in risk score.

Mr Chambers stated that there had been significant improvement in relation to risk around Information Governance.

Mr Chambers presented the headline risks for 2015/16 and stated that risks had been reviewed and updated with some risks amalgamated and some new risk added.

Sir Duncan stated that the revised risks for 2015/16 were correct and that these would be discussed further at the next Board meeting to see the risk assessment and mitigation being taken.

Mrs Hopwood referred to the risk around workforce, recruitment and retention.

Mr Chambers replied that this issue could form part of a number of the risks. A discussion followed regarding recruitment and retention. It was agreed that a new risk would be added to the Board Assurance Framework 2015/16 regarding recruitment and retention. Mr Oliver stated that the issues around recruitment and retention were being robustly discussed at the People and Organisational Development Committee.

The Board noted and approved the Board Assurance Framework – April 2015 and The Board Assurance Framework Headline Risks 2015/16.

B29/15 **TO RECEIVE AN UPDATE ON NEVER EVENTS AND SERIOUS UNTOWARD INCIDENTS**

Mrs Kelly reported that the Trust had not had any never events during April 2015. There had been 11 serious untoward incidents which included 5 pressure ulcers which are reported through the serious untoward incident process, 3 C.Difficile cases and 3 clinical incidents.

Mr Cross reported that there are currently 11 inquests scheduled for the Trust. Mr Cross is reviewing each inquest and providing support for staff involved in the inquests.

STRATEGIC DEVELOPMENT

B30/15 **TO RECEIVE THE CHIEF EXECUTIVE'S REPORT (VERBAL)**

Mr Chambers deferred his report to the Council of Governors meeting which followed the Board meeting.

B31/15 **TO RECEIVE AN UPDATE ON GOVERNOR MATTERS**

Mr Cross reported that the Governors election process would commence on 1st July 2015 and there will be drop in sessions arranged for potential new governors.

Mr Cross thanked Governors for attending the very informative masterclasses that had been held at the Trust.

FOR NOTING& RECEIPT

B32/15 **TO RECEIVE THE Q4 LETTER TO MONITOR**

The Board received and noted the Q4 letter to Monitor.

B33/15 **TO RECEIVE THE Q3 FEEDBACK LETTER FROM MONITOR**

The Board received and noted the Q3 feedback letter from Monitor.

B34/15 **TO RECEIVE THE MINUTES OF THE QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE – FEBRUARY 2015 & MARCH 2015**

The Board received and noted the minutes of the Quality, Safety and Patient Experience Committee – February 2015 and March 2015.

B35/15 **TO RECEIVE THE MINUTES OF THE AUDIT COMMITTEE – 19th January 2015**

The Board received and noted the minutes of the Audit Committee – 19th January 2015.

B36/15 **TO RECEIVE THE MINUTES OF THE FINANCE AND INTEGRATED GOVERNANCE COMMITTEE – 4th FEBRUARY 2015**

The Board received and noted the minutes of the Finance and Integrated Governance Committee – 4th February 2015.

B37/15 **TO RECEIVE THE ANNUAL REPORT FOR EQUALITY ADHERENCE AND EQUALITY PERFORMANCE ANALYSIS 2014/15**

The Board received and noted the Annual Report for Equality Adherence and Equality Performance Analysis 2014/15.

B38/15 **DATE AND TIME OF NEXT MEETING**

Tuesday, 7th July 2015 – 12.30pm Education and Training Centre, Countess of Chester Hospital.

BOARD OF DIRECTORS ACTION LOG 2014/15 & 2015/16

Meeting Date	Minute Ref:	Issue	Action	Update	Responsibility	Target Date
06.05.14	51/14	Analysis of below average performance for the Trust in the Picker Inpatient Survey	The areas of below average performance in the survey to be benchmarked, reviewed, compared to next set of results and then reported back to Board.	Survey results will be published end of Q4 2015 – results now embargoed until after General Election	Alison Kelly	July 2015*
02.09.14	94/14	There have been a number of incidences in theatres. Mrs Kelly has commissioned an external review.	Mrs Kelly to bring feedback from theatre incidents external review.	Unable to secure external reviewer after lengthy process, internal review undertaken by Head of Patient Safety and result presented to FIGC in June 2015 as review now completed	Alison Kelly	July 2015*
02.09.14	95/14	Francis Report Recommendations Implementation Action plan requires further narrative and RAG rating.	Mrs Kelly to RAG rate action plan and provide further narrative around the actions that are completed and those that remain outstanding.	Action plan to be update and reviewed at Board in 6 months time. Action plan update to be linked with CQC preparation presentation at Board - July 2015	Alison Kelly	July 2015*
02.09.14	95/14	The Board to receive details of the Trust's CQC inspection preparations.	Mrs Kelly to bring a report on the Trust's CQC Inspection preparation work.	First Quality Assurance Group meeting being held with core team during May 2015 based on proposed inspection now	Alison Kelly	July 2015*

BOARD OF DIRECTORS ACTION LOG 2014/15 & 2015/16

Meeting Date	Minute Ref:	Issue	Action	Update	Responsibility	Target Date
				being Q3. Will also present gap analysis of new CQC fundamental standards to FIGC in June 2015 to inform preparation.		
16.12.14	130/14	The Board to consider the national and local picture in education for existing staff	Alison Kelly and Sue Hodkinson to bring assurance to the Board in May 2015	Update to be received to Board following review at POD	Sue H and Alison	September 2015*
03.03.15	B05/15	The Board to receive an update on the improvement of the responses to complaints	Alison Kelly to include an update on performance figures for complaint responses to Board in July 2015		Alison Kelly	July 2015
03.03.15	B07/15	The Board to receive a verbal update on the Bariatric Service at the Trust	Mark Brandreth to give an update to Board in May 2015		Mark Brandreth	Completed – May 2015
03.03.15	B08/15	The Board to further discuss the CR10 Board Assurance Framework risk and IMT	A presentation from John Glover regarding CR10 and IMT to be given to FIGC in April 2015		Debbie O'Neill	Completed – April 2015
05.05.15	B25/15	The Board to receive details of the revised process for the sharing of learning from mortality reviews	Ian Harvey to include an addendum in the next mortality report		Ian Harvey	July 2015
05.05.15	B26/15	The Board to receive details of the options for re-financing	Debbie O'Neill to provide a verbal update		Debbie O'Neill	July 2015
05.05.15	B28/15	The Board to receive completed 2015/16 Board Assurance Framework risk details	Full Board Assurance Framework to be presented to BoD		Tony Chambers	July 2015

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

BOD/July/2015

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	CQC Compliance Review
Date of Meeting	7th July 2015
Author(s)	Sian Williams, Deputy Director of Nursing & Quality Ruth Millward, Head of Risk & Patient Safety
Presented by	Alison Kelly, Director of Nursing & Quality
Annual Plan Objective No.	
Summary	Currently CoCH is within Band 5 of the CQC Intelligence Monitoring and the Trust does not feature within the group of organisations due to be inspected in November 2015. However, it is important that the Trust is prepared for inspection whilst at the same time gaining assurances that there are no areas of concern in respect of the fundamental standards. This paper describes the framework that will be utilised to support CQC inspection requirements whilst providing ongoing monitoring of the CQC standards.
Recommendation(s)	**The Board is asked to:** Note the contents of the paper and to support future actions.
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: ☐ **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

Care Quality Commission [CQC]
Compliance Review
Board of Directors: 7th July 2015

1.0 Executive Summary

The purpose of this paper is to update the Board of Directors on the proposed actions and inform the Board of progress to prepare the organisation for the upcoming CQC inspection. Currently the Trust is in Band 5 CQC Intelligence Monitoring. There is no indication when the Trust will be inspected.

2.0 Background

In April 2015, the Essential Standards of Quality and Safety [the sixteen regulations] were replaced by the new Fundamental Standards [thirteen] which were drafted in response to the second Francis Inquiry report and by law have to be met. The new standards are more concise and descriptive than the old ones; and bring together several topics under one heading. However, the supporting guidance is less detailed; it is believed that this is to ensure that organisations do not just fall into the 'ticking the box' and supports the belief that therefore will be more room for individual judgment in assessing whether they have been met.

In addition to this the CQC will ask five questions. Is the care:

1. **Safe?** Service users, staff and visitors are protected from abuse and avoidable harm
2. **Effective?** People's care, treatment and support achieves good outcomes, promotes a good quality of life and is evidence-based where possible
3. **Caring?** Staff involve and treat people with compassion, kindness, dignity and respect
4. **Responsive?** Services are organised so that they meet people's needs
5. **Well-led?** Leadership, management and governance of the organisation. Assurance that there is delivery of high-quality person-centred care, support for learning and innovation, and promotion of an open and fair culture.

The CQC have developed **Key Lines of Enquiry [KLOEs]** which will also be used in the inspection process to measure the organisation and they are framed under each of the five key questions.

Following inspection organisation will be judged as one of the following:
Outstanding ***Good*** ***Requires improvement*** ***Inadequate.***

There are also ***eight key service areas*** that will be inspected:

- A&E
- acute medical pathway (incl. frail elderly)
- acute surgical pathway (incl. frail elderly)
- critical care

- maternity
- paediatrics
- end of life care and
- outpatients

Part of the inspection will also see the CQC hold listening events for**:**

- For local people to share their views and experiences of their hospital
- For staff groups

Following the inspection the CQC will hold a Quality Summit with local partners to discuss inspection findings/ improvement action needed. As from 1st April 2015, each Trust will have 21 days to display the CQC ratings in a prominent position at the Trust entrances.

3.0 Key Issues/Gaps in Assurance

In order to meet the new CQC monitoring and inspection process the Trust is in the process of reviewing the evidence available and assessed it and categorized it in order to evaluate the thirteen fundamental standards.

The evidence available is:

- CQC mock inspection (mapped from the KLOEs)
- Audit program and assurance map
- Evidence portfolios
- Governance arrangements

Once the baseline assessment is completed the next logical step in the evaluation of evidence is to produce data sets for the eight key services. This may present some difficulties due to the fact that the evidence may not exist or because it is difficult to extrapolate into the key services given the current set up of division and pathways that cross a number of areas. It may be more workable to break down the organisation into wards and departments and present the data in that format. This would allow for easier delegation of accountabilities and monitoring in divisions.

The organisation also needs to assess itself against the five questions. This should perhaps be under taken at divisional level then at executive level against the eight key services if possible and needs to be done following the review of all the thirteen fundamental standards and the CQC mock inspections.

Accountability:

The Trust has already developed clear lines of responsibility from ward to board. The Executive and Operational Leads will need to drive the fundamental standards agenda. The Divisions will be expected to ensure progress and ward managers and clinical medical leads driving improvements at ward level.

4.0 Next Steps

- Executive and Operational Leads review of the fundamental standards and KLOE with development of action plans to drive improvement by August 2015 [Appendix 1]

- Executive assessment of the five questions against the eight key services with action plan for improvement by August 2015

- Divisional assessment of the governance checklist for the division – with action plan for improvement by August 2015 [Appendix 2]

- Divisional assessment of the five questions for the division - with action plan for improvement by August 2015

- Review of the evidence document management system which we have in place [s drive files] and decide if it would be of value to procure a new system to enable ward to board review of evidence and gap analysis and thus reporting

- Assess the provision of staff and skill to manage the project of CQC proposal [Appendix 3]

- Continued implementation of the CQC project plan [Appendix 4]

5.0 Conclusion

Whilst much work has been done, further work is required as follows:

- Key lines of accountability from ward to board

- The review of the fundamental standards has produced a high level understanding of areas that need further development in terms of evidence, monitoring or governance.

- Further development of portfolio of evidence of the information at ward and departmental level – for example nursing and midwifery audits, infection control audits.

- The CQC mock inspection programme needs to be up scaled to ensure that all wards are inspected from July 2015.

- Continue to build on engaging and communicating with our staff. Continued visibility of the Board within the Trust is essential in developing our engaging culture.

6.0 Recommendations

The Board is asked to review the attached documents and to agree to the outline project proposal in the 'next steps and recommendations' above.

Sian Williams, Deputy Director of Nursing
Ruth Millward, Head of Risk & Patient Safety
July 2015

[Appendix 1 – Template]

CQC - Compliance Review						
Standard		**Leads**	**Evidence folders complete?**	**Rating**	**Concerns**	**Actions underway / *actions required***
5	**Fit and Proper Person Directors**	*Executive:* *Operational:*	**yes**	Good	No current concerns regarding fitness of Directors	
9	**Person centred care**					
10	**Dignity and Respect**					
11	**Need for Consent**					
12	**Safe Care and Treatment**					
13	**Safeguarding**					
14	**Nutrition and Hydration**					
15	**Premises and Equipment**					
16	**Complaints**					

CQC - Compliance Review						
Standard		**Leads**	**Evidence folders complete?**	**Rating**	**Concerns**	**Actions underway / *actions required***
17	**Good Governance**					
18	**Staffing**					
19	**Fit and Proper Persons**					
20	**Duty of Candour**					

[Appendix 2 – Template]

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good Requires improvement Inadequate***
S1	**S1 What is the track record on Safety?**	1. What is the safety performance over time, based on internal and external information? 2. How does safety performance compare to other similar services? 3. Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally? **4.** Have safety goals been set? How well performance against them is monitored using information from a range of sources?			
S2	Are lessons learned and improvements made when things go wrong?	1. Are people who use services told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result? 2. When things go wrong, are thorough and robust reviews or investigations carried out? Are all relevant staff and people who use services involved in the review or investigation? 3. How are lessons learned, and is action taken as a result of investigations when things go wrong? **4.** How well are lessons shared to make sure action is taken to improve safety beyond the affected team or service?			
S3	Are there reliable systems, processes and	1. Are the systems, processes and practices 2. that are essential to keep people safe identified, put in place and communicated to staff?			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good*** ***Requires improvement*** ***Inadequate***
	practices in place to keep people safe and safeguarded from abuse?	3. Do staff receive effective mandatory training in the safety systems, processes 4. and practices? 5. Is implementation of safety systems, processes and practices monitored and improved when required? 6. Are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements? 7. Do staff understand their responsibilities and adhere to safeguarding policies and procedures? 8. How are standards of cleanliness and hygiene maintained? 9. Are reliable systems in place to prevent and protect people from a healthcare-associated infection? 10. Does the design, maintenance and use of facilities and premises keep people safe? 11. Does the maintenance and use of equipment keep people safe? 12. Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.) 13. Do arrangements for managing medicines, medical gases and contrast media keep people safe? (This includes obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.) **14.** Are people's individual records managed			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good Requires improvement Inadequate***
		in a way that keeps people safe? (This includes ensuring people's records are accurate, complete, legible, up to date and stored securely).			
S4	How are risks to people who use services assessed, and their safety monitored and maintained?	1. How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available? 2. How do actual staffing levels compare to the planned levels? 3. Do arrangements for using bank, agency and locum staff keep people safe at all times? 4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? 5. How do staff identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing medical emergencies or behaviour that challenges? **6.** 6. How do arrangements for handovers and shift changes ensure people are safe?			
S5	How well are potential risks to the service **anticipated** and **planned** for in advance?	1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing? 2. What arrangements are in place to respond to emergencies and major incidents?			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good Requires improvement Inadequate***
		3. How often are these practised and reviewed? **4.** How is the impact on safety assessed and monitored when carrying out changes to the service or the staff?			
E1	Are people's needs assessed and care and treatment delivered in line with legislation, standards and evidence based guidance?	1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies). 2. Do people have their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice? How is this monitored to ensure compliance? 3. Is discrimination, including on grounds of age, disability, , gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation avoided when making care and treatment decisions? 4. How are people's nutrition and hydration needs assessed and met? 5. How is the pain of an individual person assessed and managed? 6. How is technology and equipment used to enhance the delivery of effective care and treatment? **7.** 7. Are the rights of people subject to the Mental Health Act (MHA) protected and do staff have regard to the MHA Code of Practice?			
E2	How are people's care	1. Is information about the outcomes of people's care and treatment routinely			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good Requires improvement Inadequate***
	and treatment outcomes monitored and how do they compare with other services?	collected and monitored? 2. Does this information show that the intended outcomes for people are being achieved? 3. How do outcomes for people in this service compare to other similar services and how have they changed over time? 4. Is there participation in relevant local and national audits, benchmarking, accreditation, peer review, research and trials? 5. How is information about people's outcomes used and what action is taken as a result to make improvements? **6.** Are staff involved in activities to monitor and improve people's outcomes?			
E4	How well do staff, teams and services work together to deliver effective care and treatment?	1. Are all necessary staff, including those in different teams and services, involved in assessing, planning and delivering people's care and treatment? 2. How is care delivered in a coordinated way when different teams or services are involved? 3. Do staff work together to assess and plan on-going care and treatment in a timely way when people are due to move between teams or services, including referral, discharge and transition? **4.** When people are discharged from a service is this done at an appropriate time of day, are all relevant teams and services informed and is this only done when any on-going care is in place?			
E5	Do staff have all the information	1. Is all the information needed to deliver effective care and treatment available to relevant staff in a timely and accessible			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good Requires improvement Inadequate***
	they need to deliver effective care and treatment to people who use services?	way? (This includes test and imaging results, care and risk assessments, care plans and case notes.) 2. When people move between teams and services, including at referral, discharge, transfer and transition, is all the information needed for their on-going care shared appropriately, in a timely way and in line with relevant protocols? **3.** How well do the systems that manage information about people who use services support staff to deliver effective care and treatment? (This includes coordination between different electronic and paper-based systems and appropriate access for staff to records.)			
E6	Is people's consent to care and treatment always sought in line with legislation and guidance?	1. Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004? 2. How are people supported to make decisions? 3. How and when is a person's mental capacity to consent to care or treatment assessed and, where appropriate, recorded? 4. When people lack the mental capacity to make a decision, do staff make 'best interests' decisions in accordance with legislation? 5. How is the process for seeking consent monitored and improved to ensure it meets responsibilities within legislation and follows relevant national guidance? 6. Do staff understand the difference			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good Requires improvement Inadequate***
		between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty? **7.** Is the use of restraint of people who lack mental capacity clearly monitored for its necessity and proportionality in line with legislation and is action taken to minimise its use?			
C1	Are people treated with kindness, dignity, respect and compassion while they receive care and treatment?	1. Do staff understand and respect people's personal, cultural, social and religious needs, and do they take these into account? 2. Do staff take the time to interact with people who use the service and those close to them in a respectful and considerate way? 3. Do staff show an encouraging, sensitive and supportive attitude to people who use services and those close to them? 4. Do staff raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes? 5. How do staff make sure that people's privacy and dignity is always respected, including during physical or intimate care? 6. When people experience physical pain, discomfort or emotional distress do staff respond in a compassionate, timely and appropriate way? **7.** 7. Do staff respect confidentiality at all times?			
C2	Are people who use services and those close to	1. Do staff communicate with people so that they understand their care, treatment and condition? 2. Do staff recognise when people who use			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good*** ***Requires improvement*** ***Inadequate***
	them involved as partners in their care?	services and those close to them need additional support to help them understand and be involved in their care and treatment and enable them to access this? (This includes language interpreters, sign language interpreters, specialist advice or advocates.) 3. How do staff make sure that people who use services and those close to them are able to find further information or ask questions about their care and treatment? **4.** Are people who use services and those close to them routinely involved in planning and making decisions about their care and treatment			
C3	Do people who use services and those close to them receive the support they need to cope emotionally with their care, treatment or condition?	1. Do staff understand the impact that a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially? 2. Are people given appropriate and timely support and information to cope emotionally with their care, treatment or condition? 3. What emotional support and information is provided to those close to people who use services, including carers and dependants? 4. Are people who use services empowered and supported to manage their own health, care and wellbeing and to maximise their independence? **5.** How are people enabled to have contact with those close to them and to link with their social networks or communities?			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good Requires improvement Inadequate***
R1	Are services planned and delivered to meet the needs of people?	1. Is information about the needs of the local population used to inform how services are planned and delivered? 2. How are commissioners, other providers and relevant stakeholders involved in planning services? 3. Do the services provided reflect the needs of the population served and do they ensure flexibility, choice and continuity of care? 4. Where people's needs are not being met, is this identified and used to inform how services are planned and developed? 5. 5. Are the facilities and premises appropriate for the services that are planned and delivered 6.			
R2	Do services take account of the needs of different people, including those in vulnerable circumstances ?	1. How are services planned to take account of the needs of different people, for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation? 2. How are services delivered in a way that takes account of the needs of different people on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation? 3. How are services planned, delivered and coordinated to take into account of people with complex needs, for example those living with dementia or those with a learning disability? 4. Are reasonable adjustments made so that disabled people can access and use			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good Requires improvement Inadequate***
		services on an equal basis to others? 5. 5. How do services engage with people who are in vulnerable circumstances and what actions are taken to remove barriers when people find it hard to access or use services?			
R3	Can people access care and treatment in a timely way?	1. Do people have timely access to initial assessment, diagnosis or urgent treatment? 2. As far as possible, can people access care and treatment at a time to suit them? 3. What action is taken to minimise the time people have to wait for treatment or care? 4. Does the service prioritise care and treatment for people with the most urgent needs? 5. Where there is an appointments system, is it easy to use and does it support people to access appointments? 6. Is care and treatment only cancelled or delayed when absolutely necessary? 7. Are cancellations explained to people, and are people supported to access care and treatment again as soon as possible? 8. 7. Do services run on time, and are people kept informed about any disruption?			
R4	How are people's concerns and complaints listened and responded to and used to improve the	1. Do people who use the service know how to make a complaint or raise concerns, are they encouraged to do so, and are they confident to speak up? 2. How easy is the system to use? 3. Are people treated compassionately and given the help and support they need to make a complaint?			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good*** ***Requires improvement*** ***Inadequate***
	quality of care?	4. Are complaints handled effectively and confidentially, with a regular update for the complainant and a formal record kept? 5. Is the outcome explained appropriately to the individual? 6. Is there openness and transparency about how complaints and concerns are dealt with? 7. How are lessons learned from concerns and complaints and is action taken as a result to improve the quality of care? 8. Are lessons shared with others?			
W1	Is there a clear vision and a credible strategy to deliver good quality?	1. Is there a clear vision and a set of values, with quality and safety the top priority? 2. Is there are a robust, realistic strategy for achieving the priorities and delivering good quality care? 3. How have the vision, values and strategy been developed? 4. Do staff know and understand what the vision and values are? 5. Do staff know and understand the strategy and their role in achieving it? 6. Is progress against delivering the strategy monitored and reviewed?			
W2	Does the governance framework ensure that responsibilities are clear and that quality, performance and risks are	1. Is there an effective governance framework to support the delivery of the strategy and good quality care? 2. Are staff clear about their roles and do they understand what they are accountable for? 3. How are working arrangements with partners and third party providers managed? 4. Are the governance framework and			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good Requires improvement Inadequate***
	understood and managed?	management systems regularly reviewed and improved? 5. Is there a holistic understanding of performance, which integrates the views of people with safety, quality, activity and financial information? 6. Are there comprehensive assurance system and service performance measures, which are reported and monitored, and is action taken to improve performance? 7. Are there effective arrangements in place to ensure that the information used to monitor and manage quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified? 8. Is there a systematic programme of clinical and internal audit, which is used to monitor quality and systems to identify where action should be taken? 9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? 10. Is there alignment between the recorded risks and what people say is 'on their worry list'?			
W3	How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote	1. Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis? 2. Do leaders have the capacity, capability, and experience to lead effectively? 3. Do the leaders understand the challenges to good quality care and can they identify the actions needed address them?			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good*** ***Requires improvement*** ***Inadequate***
	good quality care?	4. Are leaders visible and approachable? 5. Do leaders encourage appreciative, supportive relationships among staff? 6. Do staff feel respected and valued? 7. Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority? 8. Is the culture centred on the needs and experience of people who use services? 9. Does the culture encourage candour, openness and honesty? 10. Is there a strong emphasis on promoting the safety and wellbeing of staff? 11. 11. Do staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality care?			
W4	How are people who use the service, the public and staff engaged and involved?	1. How people's views and experiences' gathered and acted on to shape and improve the services and culture? 2. How are people who use services, those close to them and their representatives actively engaged and involved in decision-making? 3. Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? 4. How do leaders prioritise the participation and involvement of people who use services and staff? 5. Do both leaders and staff understand the value of staff raising concerns? 6. Is appropriate action taken as a result of concerns raised?			

CQC Compliance Review					
Key line of enquiry		**Prompts**	**What evidence do you expect to see?**	**Gaps in assurance**	**Assessment of compliance:** ***Outstanding Good*** ***Requires improvement*** ***Inadequate***
W5	How are Services continuously improved and sustainability ensured?	1. When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? 2. Are there examples of where financial pressures have compromised care? 3. In what ways do leaders and staff strive for continuous learning, improvement and innovation? 4. Are staff focused on continually improving the quality of care? 5. How are improvements to quality and innovation recognised and rewarded? 6. How is information used proactively to improve care?			

Divisional assessment of the governance checklist for the Division
(To be utilised with action plan for improvement by August 2015 [Appendix 2])

Guidance on Areas for Communication, Discussion and Assurance within Divisional, Speciality and Ward/Department Level Meetings

In order to strengthen assurance and demonstrate well led governance across the organisation, this tool has been developed to assist wards and departments in developing their understanding of the CQC fundamental standards and key lines of enquiry [KLOE].

It is expected that these topic areas are considered for inclusion in divisional meetings, speciality team meetings and ward and department areas [where appropriate]. It may therefore be useful to have standardised agendas to assist this and the frequency of progress reviews.

Divisional Governance Checklist – What and where (Info should be appropriate to Service and area)

Topic	Divisional	Speciality	Ward/Department
Patient experience and feedback			
Complaints and PALS • Issues Reported • Investigation progress • Learning			
Clinical Audits • Plan versus progress • Outcome and learning • Changes in practice			
NICE / National / Professional guidance • Baseline assessment • Compliance • Risk assessment • Outstanding assessments or guidance • Links to audit plan			
Mortality • Feedback • Reviews • Learning and service change			
Mandatory training compliance			
Appraisal training compliance			
Essential training and staff competency			
Incidents • Trends • Reported incidents • Investigation progress • Learning • Serious Incidents /never events			
Claims • Any received / reported • Investigation progress • Learning from investigations			
Inquests • Any received / reported			

• Investigation progress • Learning from investigations • HM Coroners Regulation 28 reports			
Risk register • New risks • Reviews of existing • Escalation • Updates of mitigation and escalation			
Central Alerting System (CAS alerts. Device Alerts etc.			
Internal alert cascade			
Safeguarding Adult and Children updates e.g. DOLS or case reviews, MCA			
Infection prevention and control • Monitoring • Surveillance			
Equipment • Availability • Assurance re Competency assessments			
Service/Business developments and risks / CIP Governance issues impacting from these • Annual plan • Business case progression			
Service improvement • Improvement work streams • CQC action plan			
Policies Procedures and guidelines • New and reviewed - Corporate • New and reviewed – Local			
Performance metrics • Monitoring • Recovery plan			
External service reviews • External			
Safe Staffing levels • Monitoring and exceptions			
Sickness absence Management			
Ward quality dash boards • Status • Work plan and progress			

Assess the provision of staff and skill to manage the project of CQC proposal [Appendix 3]

CQC compliance proposal – Project Staffing

1.0 Introduction
In order for the organisation to secure a positive outcome from the inspection expected in Autumn 2015, there has been a review of the capacity and current skills available within the Trust's Risk & Patient Safety Team. To support the collation of a portfolio of evidence and ensure that a consistency of communications around the CQC fundamental standards and KLOE, additional funding has been secured.

This will provide flexibility within the Risk & Patient Safety Team to deliver a significant project in such a tight time scale as well as keeping abreast of the day job which is equally important in order to meet compliance in the inspection.

The posts funded on a temporary basis are:

SharePoint Co-ordinator: Band 4
The key responsibilities of the post are to ensure:

that there is a clear process for ratification,

that there is a standardised format for all documentation,

that the SharePoint document library is cleansed to ensure that all documents are current,

that the process for transfer of documents onto SharePoint is timely and

that live documents are only held within the SharePoint management system.

There has been an uplift of a Band 3 member from the Risk & Patient Safety Team to this position. The Band 3 post has been backfilled at Band 2. Additionally, there has been an uplift of a Band 5 member from the Risk & Patient Safety Team to Band 6 in recognition of the importance of the Datix Risk Management software in supporting the collation of evidence. All appointments have been made of a temporary basis for 12 months.

CQC Assurance Lead: Band 7
The key responsibilities of the post are to ensure:

that there is a logical and thorough approach to the collation and validation of the evidence provided by the Departmental Heads

that there is monitoring of the progress of the project, ensuring that the project delivers on time

that there are processes to identify and manage risks to the project's success

that there are regular progress reports presented to the Executive Team, Board of Directors, Quality Safety and Patient Experience Committee and Corporate Directors Group regarding the outcome of the 'mock' internal CQC inspections, assessments of the fundamental standards and assessment of the organization against the 5 key questions.

Recommendation:
The Risk & Patient Safety Team wish to thank the Board for their support in funding the above positions on a temporary basis.
Continued implementation of the CQC project plan [Appendix 4]

Continued implementation of the CQC project plan [Appendix 4]

Gantt Chart: Preparation for introducing new standards and the CQC visit –2015

Action	Lead	March			April					May				Jun				July				Aug				Sep			
Set up Project team	AK																												
Site visits	AK																												
Identify additional resource requirements	RM																												
Review Evidence Portfolios/ update to reflect new fundamentals	RM																												
Identify gaps in evidence and develop action plans	RM																												
Review current CQC risk register entries and update	RM																												
Add new CQC risks	RM																												
Review data packs developed and agree forward plan	RM																												
Develop a Communication Strategy	AK																												
Deploy Mock CQC Inspection Programme	AK																												
Develop specialist areas inspection check lists	RM																												
CQC Newsletters /Lessons Learnt	RM																												
Develop information flow forward for board assurance	RM																												
Roll out of ward to Board assurance process; report to DMTs & Board monthly	RM																												
Timetable for Staff Engagement Events	AK																												
Timetable for external partner engagement	AK																												

Develop CQC audit plan (additional assurance)	RM																												
Deploy CQC audit plan	MS																												
CQC file maintenance	RM																												
Progress reports to BoD/QSPEC/CDG	RM																												

BOD Item No /July/2015

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Update on progress on implementing the Francis recommendations
Date of Meeting	7th July 2015
Author(s)	Sian Williams, Deputy Director of Nursing & Quality
Presented by	Alison Kelly, Director of Nursing & Quality
Annual Plan Objective No.	
Summary	The last report on progress of the implementation of the Francis recommendations was presented to the Board in September 2014. This paper provides a further update on progress. Going forward, key elements will be incorporated into established workstreams.
Recommendation(s)	**The Board is asked to:** Note the progress within the attached action plan and to support on-going actions.
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: ☐ **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

Update on progress of implementing the Francis recommendations (July 2015)

1.0 Introduction

The purpose of this briefing is to further update the Board on the progress of the Trust's implementation of the Francis report.

2.0 Background

Following the Government's initial response to the Francis Inquiry, "Patients First and Foremost", six independent reviews were commissioned to report on key additional issues that were identified by Francis.

The Francis Inquiry contained 290 recommendations centred around the following themes:

- A structure of fundamental standards and measures of compliance, accepted and embraced by the public and healthcare professionals with rigorous and clear means of enforcement
- Openness, transparency and candour throughout the system
- Improved support for compassionate, caring and committed nursing
- Strong, patient centred leadership
- Accurate, useful and relevant information

The Trust has continued to implement the recommendations supported by a number of other reports that have subsequently underpinned the recommendations in more detail. The previous update was formally presented to the Board of Directors in September 2014.

3.0 Update on Government Response

In the Government's published response in November 2013 ('Hard Truths – the journey to putting patients first'), the Government called for a cultural shift, built on candour and continuous improvement, which recognised and addressed variations in quality: "Being honest and open about this and creating an environment in which problems are prevented, detected quickly and addressed firmly and in the interests of patients is the basis for re-establishing public trust".

The response was divided into 5 chapters:

- Preventing problems
- Detecting problems quickly
- Taking action promptly
- Ensuring robust accountability
- Ensuring staff are trained and motivated

Appendix 1 outlines in broad terms the progress mapped to the 5 chapters to date and the work in progress.

This is a continual journey for the Trust and work will continue to fully embed this in the Trust's culture. This is being supported by the identified work streams and will continue to ensure the Trust delivers safe, kind and effective care to its patients.

4.0 Conclusion

The Board is asked to note the progress within the attached plan since the last report and to support on-going actions. Key areas of the Francis Report are being addressed in separate pieces of work within the Trust and will be presented separately to the Board going forward.

Sian Williams
Deputy Director of Nursing & Quality
July 2015

Chapter	Recommendations/ Action	Trust Progress of Actions (July 15)	Exec Lead	Monitoring Committee/Group
1. Preventing Problems	Culture and Patient Safety	Raised at Leadership Briefings Monthly 'Countess Briefing' to be developed Culture /Comms group in place Comms/Engagement Strategy approved (Delivery Plan to be approved in **Aug 15**) Dedicated resource identified to support 'Culture' development work Involvement in AQUA & Haelo regarding implementation of service improvement methodology into culture	Director of Nursing & Quality/Medical Director Director HR and OD	People & Organisational Development Committee Clinical Directors Group
	Openness, Transparency and Candour	Serious Incident panels and incident handling now ensures that Duty of Candour is raised. Duty of Candour section mandated in Datix reporting process Candour leaflet for staff in development	Director of Nursing & Quality Director of Nursing & Quality	Quality, Safety & Patient Experience Committee
	Listening to Patients, learning from complaints	Use of real time feedback - this is now embedded. Using work to gain feedback following the Open and Honest project. Increased meetings with patients and families to learn and make improvement	Director of Nursing & Quality	Quality, Safety & Patient Experience Committee
		Complaints review completed. Implementation of the recommendations from the Clwyd/Hart report with an associated action plan. Improvement plan in place to improve complaint response rates – demonstrating improvement in May 15 Complaint policy reviewed, to be re-launched in **Aug 15**		Quality, Safety & Patient Experience Committee

		Patient stories have been implemented at Board and other meetings. Video development and patient attendance at meetings/Board	Director of Nursing & Quality	
	Safe Staffing	Staffing review completed – this will be repeated bi-annually and reported to the Board.	Director of Nursing & Quality	People & OD Committee Quality, Safety & Patient Experience Committee
		Work is now complete and monthly staffing is reported on NHS Choices and the Trust's website 'Open and Honest'- also reported via the Integrated Performance Report Recommendations have been implemented for the National Quality Board re. Nursing e.g. staffing numbers published on a shift by shift basis at ward level alongside the recommendations. 'Care Contact' work underway identifying whether the workforce is being utilised effectively (links to the Lord Carter project)	Director of Nursing & Quality	People & OD Committee
		Systems in place to monitor incidents. Monthly updates to QS&PE Committee.	Director of Nursing & Quality/Medical Director	Quality, Safety & Patient Experience Committee
		Use of an acuity tool to support staff review. National guidance from NICE now published. Guidance also published for Maternity (with ED Guidance due June 15) National review underway with Chief Nursing Officer for England .	Director of Nursing & Quality	

2. Detecting problems quickly	CQC inspections to look more closely at records	Review of the whole risk management process now well underway in the Trust. Changes so far have been recognition of risk on the Executive Risk Register and cross-referencing to the Board Assurance Framework. Process agreed re: the escalation and de-escalation of risks (this is monitored monthly)	Director of Nursing & Quality/Director of Corporate & Legal Affairs	Quality, Safety & Patient Experience Committee Corporate Directors group
	Fundamental Standards and Enhanced Quality Standards	Nursing recruitment using values and behaviours fully embedded (same approach used for Registered and non-registered nurses). Recruitment training is in place CQC Intelligence Monitoring Band 5 (July 15) Gap analysis of the CQC Fundamental standards being undertaken with Divisions **(July 15)** Paper proposing outline framework being presented to Board of Directors **(July 15)**	Director of Nursing & Quality/Director of HR & OD	
	Working Together	Full mortality case reviews now in operation on all deaths – reporting to the Board. Above process being further reviewed **(July 15)** to be linked to the Datix monitoring system (to further enhance triangulation of themes and trends) Procurement of alternative Benchmarking Tool (HED) allows greater transparency of data and timely monitoring of mortality of trends (as well as a number of other key metrics)	Medical Director	Quality, Safety & Patient Experience Committee
	Quality Surveillance Groups (QSG)	Trust fully participates in monthly QSG with partner organisations to ensure lessons are learned across the whole health economy CoCH currently trialling an Escalation Framework (supported by NHS England, North) to support early detection of issues/risks	Director of Nursing & Quality/Director of Operations & Planning	Quality, Safety & Patient Experience Committee

	'Speak Out Safely' (Raising concerns and Whistleblowing policy)	Full review of raising concerns. The Trust has joined the Nursing Times 'Speak Out Safety' campaign. It included a high profile launch and will continue with regular awareness raising. 'Speak out Safety' (SoS) group of Responsible Officers in place Policy is in place with full staff side engagement. Confidential database of concerns and actions in place. Formal Trust launch being planned for **Sept 15** Review of 'Freedom to Speak Up' recommendations being reviewed (for presentation at the BoD **Sept 15**) 'Speak out Safely'/Exec session incorporated into CHAPS training Specific SoS sessions in place for students (all non-medical professions) facilitated by Director of Nursing & Quality and Head of therapies	Director of Nursing & Quality/Director of HR & OD	People & OD Committee
	Clear strong Governance: role of Boards	Full review and agreement of structures below the Board with the lines of accountability being clear. Board development sessions held with AQUA and Haelo re: safety culture Further development and integration of Governors into Quality, Safety & Patient Experience agenda. Governors are a key part of the Quality/Safety agenda, and are involved in a number of projects Further development of Governors training and development. Relationships between Governors, CQC and Health watch have continued to be developed. Series of announced and unannounced visits by Health watch and Governors continue	Director of Corporate & Legal Affairs Director of Nursing & Quality/Director of Corporate & Legal Affairs	

3. Taking action promptly	Clear and meaningful ratings	Full review of the Integrated Performance Report undertaken reflecting the CQC domains	Director of Operations & Planning	Corporate Directors Group Finance & Integrated Governance Committee
	Clear risk based interventions	Systems in place to monitor concerns/risks via risk management processes	Director of Nursing & Quality	Quality, Safety & Patient Experience Committee
		Appropriate use of the quality indicators - Ward Managers KPIs agreed and in use		
		Review of the care metrics for wards and departments. Pilots are underway – roll out to be completed by Aug 15		Nursing & Midwifery Board
4. Ensuring robust accountability	Levels of Accountability	Full review of the structures and lines of accountability below the Board undertaken Corporate Governance Manual in place Full compliance with Monitor's Corporate Governance Statement **(June 15)**	Director of Corporate & Legal Affairs	

	Holding to account	Leadership training for senior staff is in place Further cohorts now complete. Will continue to include new starters. Specific Clinical Leaders programme underway (with MCH and WUTH) Use of performance/quality indicators in the 'kit bag' for Divisions to monitor performance. Divisional Stocktakes in place to monitor all measures with Executive Team scrutiny and challenge Performance Management Framework in place Associate Director of Performance & Planning in post	Director of HR & OD Director of Operations & Planning	
	High professional standards/Professional regulation	Medical revalidation in place. Trust has a Revalidation Officer in place Process to fully implement Nursing & Midwifery Revalidation in place(national start date **Jan 16**) Director of Nursing & Quality sits on the revalidation Board (NHS England, North) Appraisal processes under review – including temporary staff. Appraisal rates are demonstrating a steady increase. Review of tools and quality elements is on-going.	Medical Director Director of Nursing & Quality Director of HR & OD	Nursing & Midwifery Board People & OD Committee People & OD Committee
	Fit and Proper persons test for Board level appointments	Full review of the guidance underway – training planned Further review undertaken as new appointments made to Board.	Director of Corporate & Legal Affairs Director of HR & OD	People & OD Committee

	Internal scrutiny and challenge	Quality Impact Assessments undertaken by the Medical Director and Director of Nursing & Quality on all service reviews and proposed developments relating to the Trusts Cost Improvement Programme	Director of Nursing & Quality/Medical Director	Finance & Integrated Governance Committee
5. Ensuring staff are trained and well-motivated	Staff Engagement	Annual staff survey complete – 53% return – actions to be agreed from issues identified. Communication & Engagement Strategy approved (see point 1) Staff survey action plan in place Staff Friends & Family implemented April 2014, positive feedback re: CoCH being a place to work. Trust questions added to gain further feedback Staff focus group being developed Communications function moved to Director of Nursing & Quality portfolio (with close working with the Director of HR & OD) Delivery Plan to be finalised by **Aug 15** Monthly Executive walkabouts in place Further review being undertaken regarding NED walkabouts	Director of HR & OD Director of Nursing & Quality Director of HR & OD Director of Nursing & Quality Director of Corporate & Legal Affairs	People & OD Committee

	Education and Training	Review of the induction of clinical staff. Formal Preceptorship programme in place for all new nurses Practice Development team in place supporting registered and un-registered nurses in practice (to support retention) Review of Junior induction complete Director of Medical Education in post Closer links with multi-professional education including continuing to strengthen working relationships with Chester University. Memorandum of Understanding signed July 2014 Development of the Bache Hall partnership with University of Chester Senior Manager in place to facilitate Bache Hall partnership with wider partners Development of a Research & Development Strategy.	Director of Nursing & Quality/ Director of HR & OD Medical Director	People & OD Committee
	Support workers training and development	Agreed recommendations of the Kavanagh report placed into Education Strategy. Specific Practice Development role introduced to support Care Support Workers in practice and to also support the implementation of the Care Certificate Plan in place to support CoCH care support workers to accessing routes to their nurses training (with University of Chester)	Director of Nursing & Quality	Nursing & Midwifery Board People & OD Committee
	Leadership culture	See Point 4	Director of HR & OD	People & OD Committee

	Compassionate Care	Review undertaken of complaints service. Themes are addressed via Induction and training. Review of complaints policy completed. Plan in place to support Clywd/Hart report. (See point 1)	Director of Nursing & Quality	Quality, Safety & Patient Experience Committee
	Value based recruitment	Year 2 of the implementation of the Nursing & Midwifery Strategy is underway (including a review of recruitment process based on values) Further Nursing & Midwifery Strategy update will be presented to the Board late 2015	Director of Nursing & Quality	Nursing & Midwifery Board

Countess of Chester Hospital NHS
NHS Foundation Trust

Integrated Board Report - May 2015

Contents

Metrics by CQC domain:	**Page number:**
Safe	2-4
Effective	5
Caring	6
Responsive	7-9
Well led	10-14

Exception reports:

Serious untoward events	15
Electronic Discharge	16
Diagnostic waits	17
Cancer 62 day	18
RTT admitted wait	19
A&E 4 hour standard	20
Normalised Net Surplus/Deficit	21
CRS	22
Sickness absence	23
Appraisal	24
Mandatory training	25
Variable pay	26

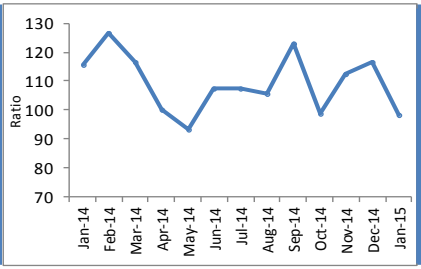
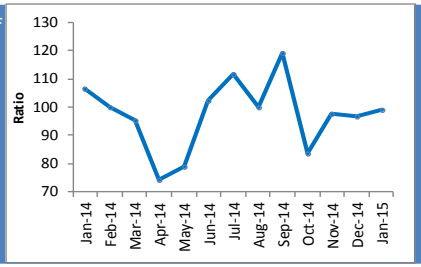
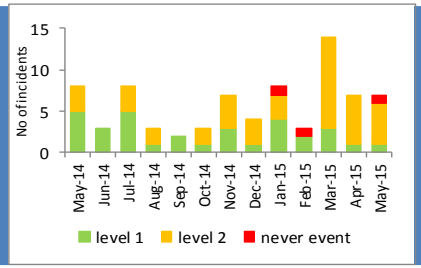
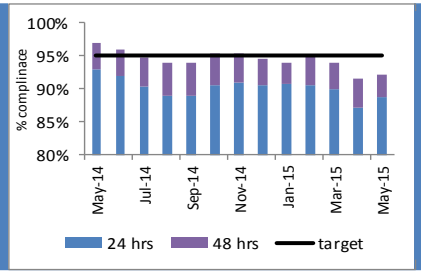
Appendices:

Mortality report	27
Safe staffing	28-29
Changes to report	30

Are we safe?

Countess of Chester Hospital NHS Foundation Trust — Board Assurance metrics May 2015

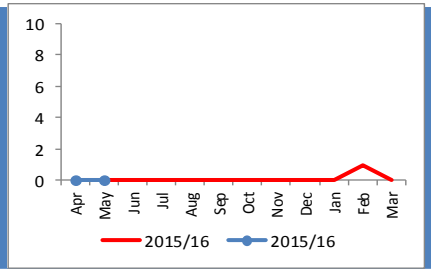
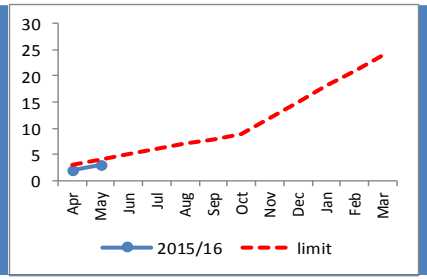
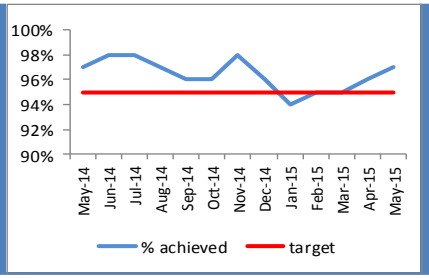
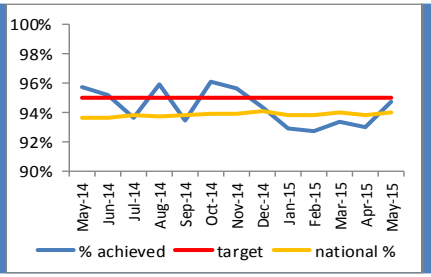
BAF ref: CR1, CR2, CR3, CR6, CR7, CR10

	Description	Current position/comments	Trend	Target
Mortality SHMI	Risk adjusted mortality ratio based on number of expected deaths. Data source is the HED clinical benchmarking tool.	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. The SHMI shows whether the Trust is within the expected range when compared to the national baseline and this is rebased on a quarterly basis. See appendix 1 for full mortality report. The next quarterly update is due in July.		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 only includes approx 80% of in hospital deaths. The target for HSMR is set nationally and changes according to whether the Trust is within the expected range. See appendix 1 for full mortality report. The next quarterly update is due in July.		As expected - Blue Above expected - Red Below expected - Green
Serious Untoward Incidents	Level 2 severe harm or death to patient. Never events are serious largely preventable pt safety incidents	The level 1 incident relates to a fall. All 5 of the level 2 investigations relate to pressure ulcers, three grade 3 deterioration and two new grade 3. All were heel related. See exception report on page 15 for additional detail on never event		No current target but any Never event highlighted as red in month
Electronic Discharge for admitted patients	90% of electronic discharges for admitted pts should be sent within 24 hrs, 95% within 48 hrs and all within 2 weeks	The number of patients without an electronic discharge within 2 weeks was 9 in May, this compares to 14 in April. Within the Planned Care Division the main area of concern relates to Vascular Surgery and within the Urgent Care Division the main concern relates to Gastroenterology. See page 16 for exception report.		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 May 2015

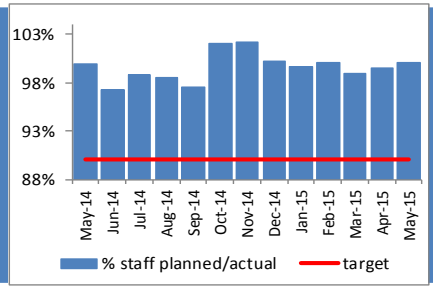
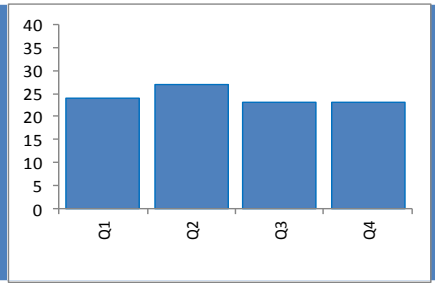
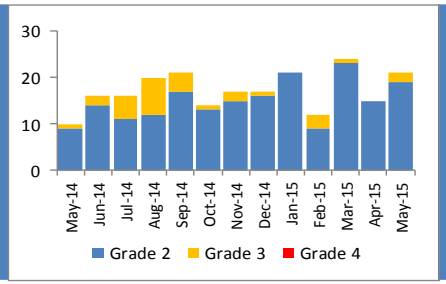
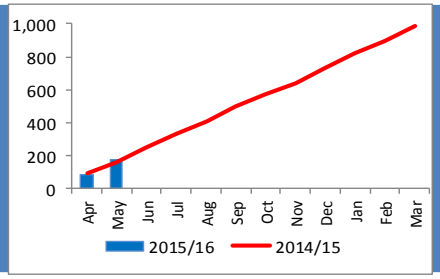
BAF ref: CR1, CR2, CR3, CR6, CR7, CR10

	Description	Current position/comments	Trend	Target
MRSA	Number of cases of hospital acquired MRSA bacteraemia (meticillin-resistant staphylococcus aureusis)	The target for MRSA is zero cases within the year. There were no cases in May		Zero cases for the year
CDiff	Number of cases of Clostridium Difficile	The graph shows the number of cumulative patients during the financial year. A maximum of 24 cases has been set for 2015/16. There was 1 case in May.		24 maximum annual cases
Hand hygiene	Based on ward based hand hygiene audits. Each ward is required to submit a min of two audits each month	There is a focus on ensuring compliance with basic hand hygiene. This is being lead by the Medical Director and Director of Nursing and Quality		95% each month
Safety Thermometer	Tool to survey a snapshot of harm free patient care. Includes pressure ulcers, falls, catheters, UTIs and VTE	There was an improvement in the safety thermometer for May to 94.7%. An exception report has not been provided this month based on the improvement, however should performance deteriorate in June then an exception report will be provided		95% each month

Are we safe?

Countess of Chester Hospital NHS Foundation Trust — Board Assurance metrics May 2015

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

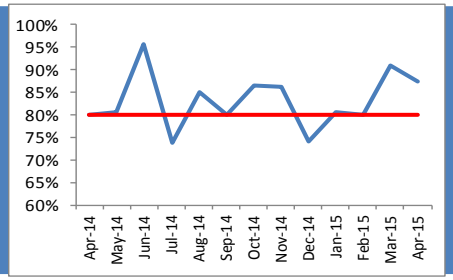
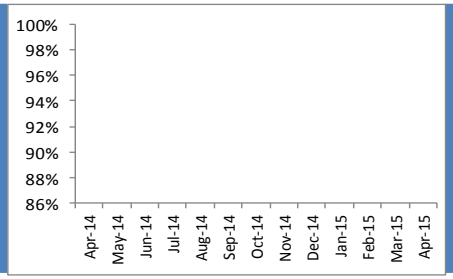
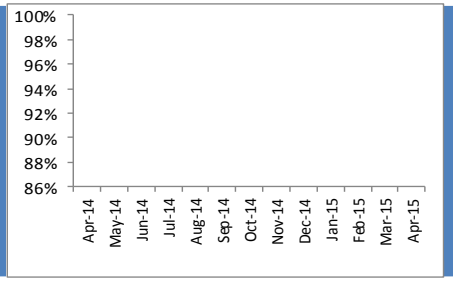
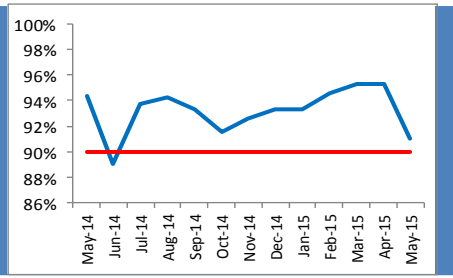
	Description	Current position/comments	Trend	Target
Safe Staffing	Actual staffing compared to planned for registered nurses/ midwives and care staff	Some additional bed capacity has remained open throughout April and additional staffing has been needed to safely staff these areas. See pages 28 and 29 for detailed safe staffing report		>90% per month
Safe-guarding referrals	Number of adult safeguarding referrals sent from COCH to social services during the quarter	Overall low level concerns appear to remain consistent and safeguarding referrals have increased slightly during April		>10 referrals in quarter
Pressure ulcers	New pressure ulcers by grade acquired within hospital	Reduction in the number of pressure ulcers reported for May		Target not agreed for this measure
Inpatient Falls	Inpatient falls - cumulative figure compared to previous year	One of the falls for May resulted in moderate harm which is under a level 1 investigation		Reduction on 2014/15 levels

Are we effective?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics May 2015

BAF ref: CR3, CR7, CR10

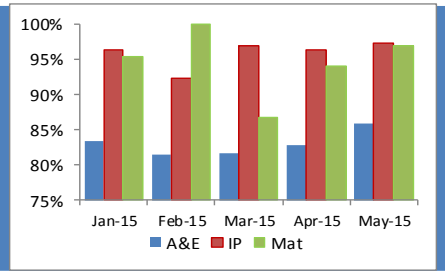
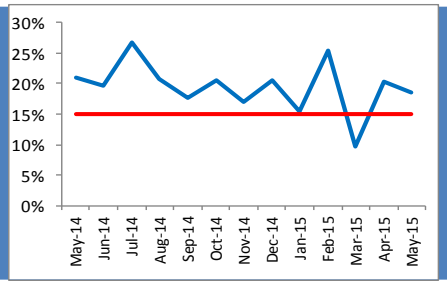
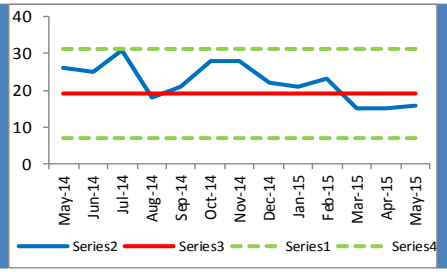
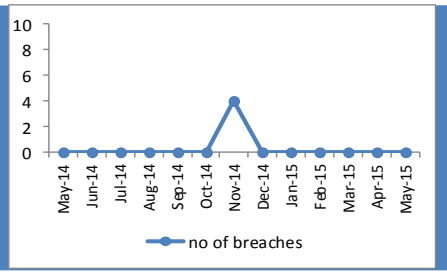
	Description	Current position/comments	13 month rolling trend	Target
Stroke	Western Cheshire CCG Stroke patients who spend at least 90% of their time in hospital on a stroke unit	The stroke target was above the standard in April which has now achieved for the last four months. Continued focus in this area continues to ensure sustainable achievement of the standards. TIA performance was 85.7% against the target of 60% and this standard also continues to be met		>80% per month
Sepsis	Patient being admitted who met criteria for severe sepsis and screened. Antibiotics within an hour of presenting.	The first reporting of this metric to the Department of Health is to include data for Quarter 1. Work continues to develop the relevant metrics so that this standard can be reported by the agreed date		Target not agreed for this measure
Acute Kidney Injury	Discharge summary to include stage of AKI, medicine review, blood tests requested on discharge and frequency of blood tests.	The first reporting of this metric to the Department of Health is to include data for Quarter 1. Work continues to develop the relevant metrics so that this standard can be reported by the agreed date		Target not agreed for this measure
Dementia	% of patients aged 75 or above asked case finding question within 72 hours of admission	This is a national CQUIN. The data is collected through the Meditech system as standard and there is a continued achievement of this target		>90%

Are we caring?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics May 2015

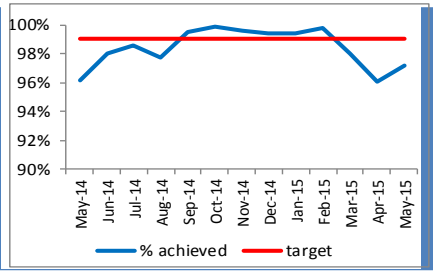
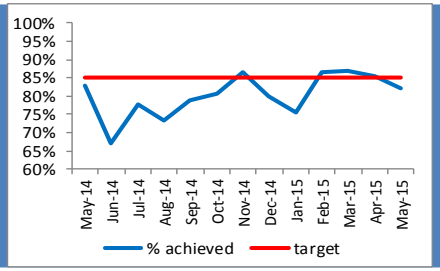
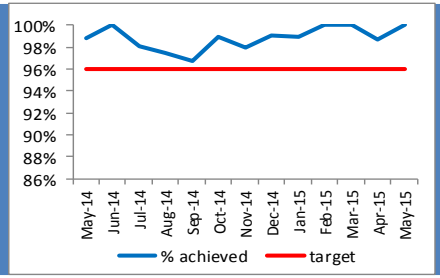
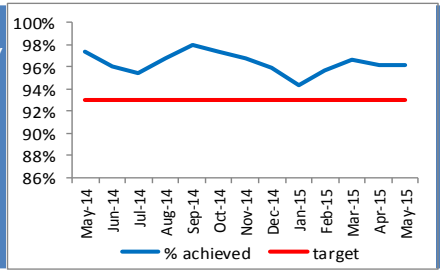
BAF ref: CR1, CR4, CR6, CR7, CR10

	Description	Current position/comments	Trend	Target
Friends & Family - % likely to recommend	Would patients recommend service to friends & family. Introduced in 2013 for Inpatients, A&E and maternity.	Outpatient and day case services were introduced from April 2015. The 'likely to recommend' has improved for all three areas currently measured in May		Target not agreed for this measure
Friends & Family response rate	Number of responses received for IP, A&E and maternity compared to eligible patients	Work continues to improve the response rate		>15% per month
Complaints	Monthly Trust complaints received by the Trust	In May 2015 the Trust received 16 new formal complaints. 63% of all complaints were sent out within time, up from 54% in April		To be within expected control limits
Mixed Sex accommodation breaches	Number of breaches to the mixed sex accommodati -on standard for non clinical reasons	There were no breaches to this standard in the month of May		Zero cases per month

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust — Board Assurance metrics May 2015

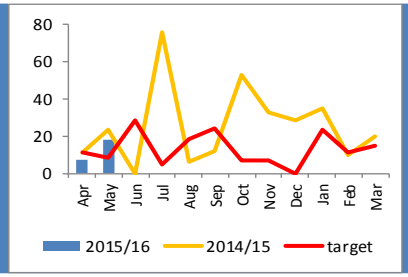
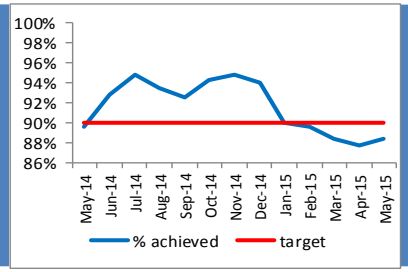
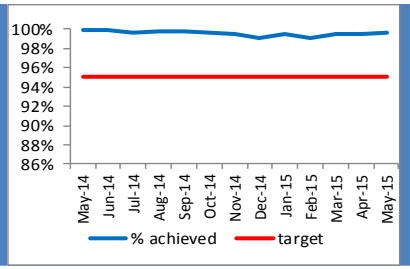
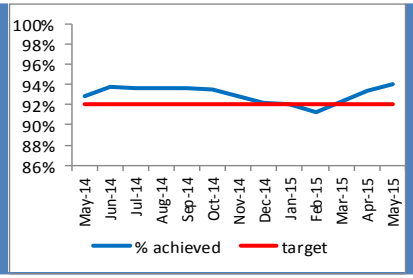
BAF ref: CR3, CR5, CR6, CR7, CR8, CR9, CR10

	Description	Current position/comments	13 month rolling trend	Target
Diagnostic 6 week standard	Diagnostic tests to be carried out within 6 weeks of request being received. This is measured on the National DM01 return.	Diagnostics failed the target for the third month due to the increased number of breaches in echocardiography. 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	Performance for April is fully validated and has now achieved the month at 85.6% which was the third month of achievement in a row. May performance currently stands at 82.2% but this is currently unvalidated and will be confirmed in the next report. 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%.	Cancer 31 day continues to achieve with full achievement in quarter 4 and now continued achievement in April. This is a result of the continued improvement work within Cancer Services		96% per Quarter
Cancer 2 week standard	Patients referred from GP with suspected cancer should have their first appointment within 14 calendar days	Due to continued close monitoring and immediate actions this standard has fully achieved in quarter 4 and has continued to do so in April and May		93% per Quarter

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust — Board Assurance metrics May 2015

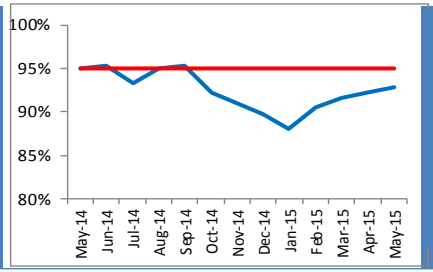
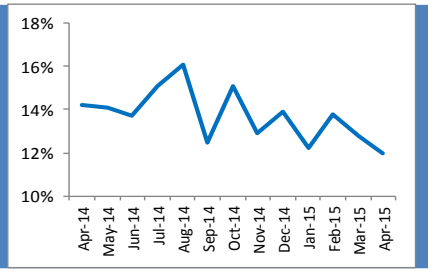
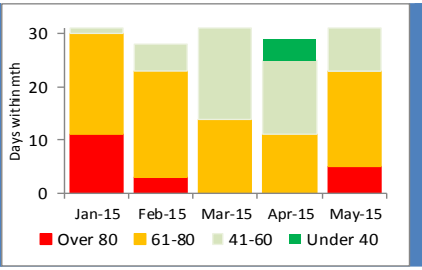
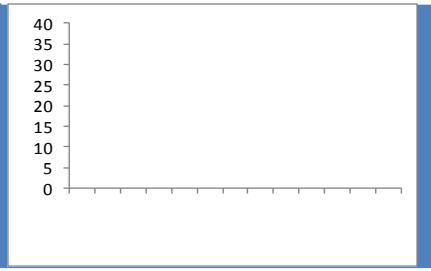
BAF ref: CR3, CR5, CR6, CR7, CR8, CR9, CR10

	Description	Current position/comments	Trend	Target
Cancellation due to no beds	Hospital cancellations due to no beds	There were 18 cancellations of patients due to no beds in May. An ambitious target of returning to 2012/13 levels continues to be the aim for the ongoing work in relation to theatres scheduling and improving patient flow.		Internal target based on 2012/13 levels
RTT admitted pathways	Percentage of completed pathways for English patients closed within 18 weeks. The threshold is 90%.	The admitted target was a fail for May. The Trust will fail this standard for quarter 1. The issue relates to the long waiters within General Surgery, Orthopaedics, ENT and Oral Surgery. See page 19 for exception report		90% per month
RTT non-admitted pathways	Percentage of non-admitted pathways for English patients closed within 18 weeks. The threshold is 95%.	All specialties were within the 95% target for non admitted pathways		95% per month
RTT incomplete pathways	Percentage of incomplete pathways for English patients within 18 weeks. The threshold is 92%.	General Surgery and Oral Surgery were under the 92% target		92% per month

Are we responsive?

Countess of Chester Hospital NHS Foundation Trust — Board Assurance metrics May 2015

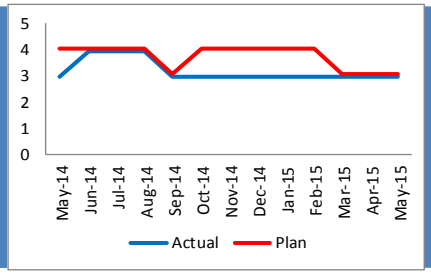
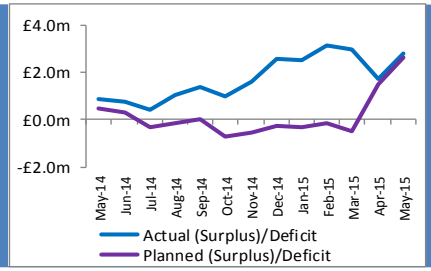
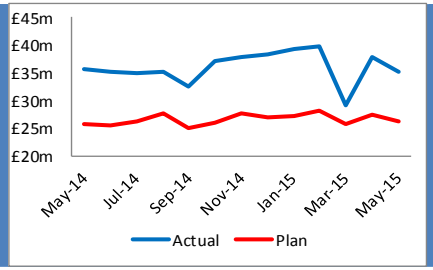
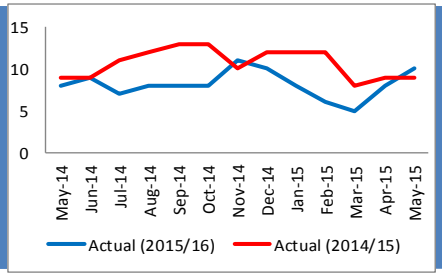
BAF ref: CR3, CR5, CR6, CR7, CR8, CR9, CR10

	Description	Current position/comments	13 month rolling trend	Target
A&E 4 hour standard	Maximum wait time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.	Although the 4 hour standard has improved for May the 95% target was not met. An action plan has been developed to focus on the delivery of this standard. See page 20 for exception report		>95% per month
Readmission rate	Number of emergency readmissions within 28 days. Excludes patients with diagnosis of cancer, nephrology, obstetrics	New metric from April 2015		Target not agreed for this measure
Medically optimised patients	Number of days within the month where there are medically optimised patients within acute beds	There was a deterioration in ther number of medically optmised patients during the month of May. There were not any days within the month with less than 40 patients. 5 days within the month had over 80 patients. Please note the additional exception narrative is detailed in the A&E 4 hour standard exception report		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 in use in the Community	Work is underway to develop the metric to measure and monitor from July 2015		

Are we well led?

Countess of Chester Hospital NHS Foundation Trust — Board Assurance metrics May 2015

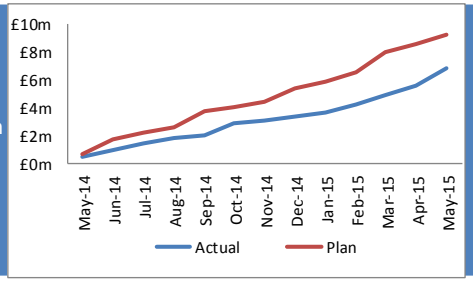
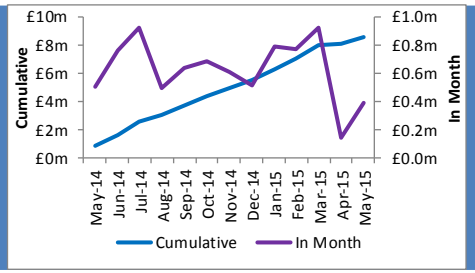
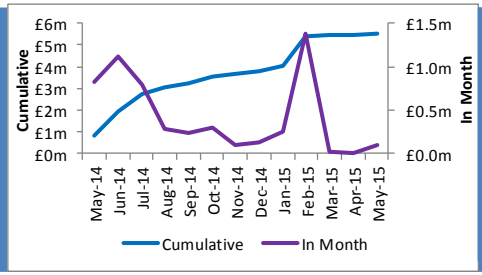
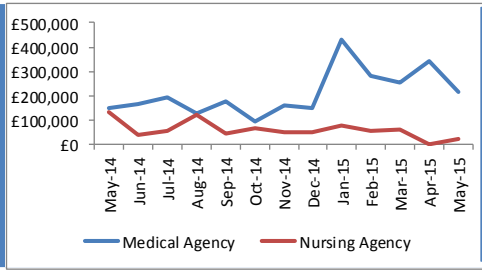
BAF ref: CR3, CR5, CR6, CR7, CR8, CR9,

	Description	Current position/comments	13 month rolling trend	
Continuity of Service Risk (COSR)	Monitor's (independent regulator) measure of financial risk	Planned and actual CoSR score is 3. There is a year to date operating (EBITDA) deficit of £(1.6)m against a plan of £(1.4)m, and the Liquidity Ratio is 12.9 days		A score of 3 each month
Normalised net surplus/deficit	Net income and expenditure after adjusting for hosted services and impairments	Planned deficit to date is £2.6m and we are reporting a adverse performance against this of £181k. Slight favourable in month movement of £30k. Unachieved efficiency schemes account for £160k of this variance with pressures also in relation to activity delivery . Continuing high levels of Medical Agency expenditure have been incurred. Please see Exception report in page 21		As Plan
Cash	Cash on deposit < 3 month deposit	Cash is £35m and £9m above plan, due to the receipt of the monthly payment on account from the West Cheshire CCG, offset by an increase in debtors		£26m
Debtor Days	Debtor Days: Trade Debtors divides by income x 365	Debtor days is heavily influenced by significant over-performance during the year, which is billed quarterly in arrears. There is usually a reduction in March as certain NHS bodies still operate to cash limits. The May increase is affected by cumulative un-billed over performance and contracts/slas still to be agreed		Monitor against previous year

Are we well led?

Countess of Chester Hospital NHS Foundation Trust — Board Assurance metrics May 2015

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

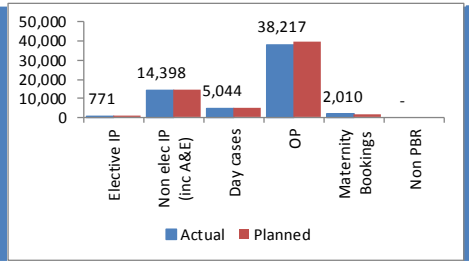
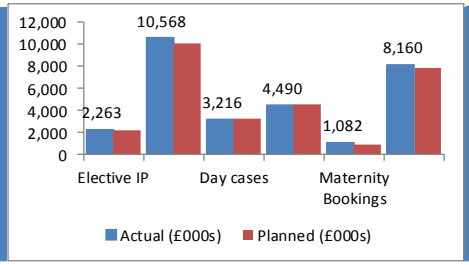
	Description	Current position/comments	13 month rolling trend	
Capital Expenditure	13 month rolling cumulative capital expenditure	On a 13 month rolling basis expenditure is £2.4m behind plan, due to expected equipment purchases related to the SMART Centre being underspent, as well as some IM&T projects taking longer than anticipated. Earlier than planned commissioning of the CT scanner has reduced the gap a little.		£9.2m
CRS In Year	Planning improvements in productivity and efficiency	Against the £6m annual efficiency target, as at M2, £691k (12%) in CRS savings have been identified with £5,309k (88%) outstanding. As at M2 the under achievement against the CRS savings plan is giving a £160k adverse variance. Please note detail in Exception Report on page 22		No deviation from plan
CRS Recurrently	Planning improvements in productivity and efficiency	Recurrently £116k (2%) in CRS savings have been identified with £5,884k (98%) outstanding. Please note detail in Exception Report on page 22		No deviation from plan
Agency spend	Planning improvements in productivity and efficiency	Medical Pay is currently overspent by £41k , due to agency costs in excess of those anticipated. Agency medical expenditure for the first 2 months of the year is £510k. Nursing Pay is currently £30k overspent, £17k of this variance relates to agency nurse expenditure. Agency nursing expenditure for the first 2 months of the year is £20k.		Target not agreed for this measure

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics May 2015

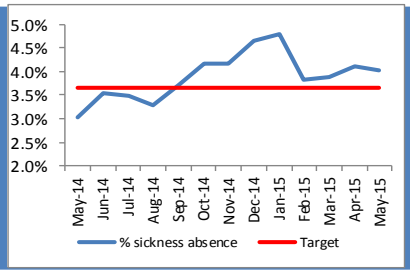
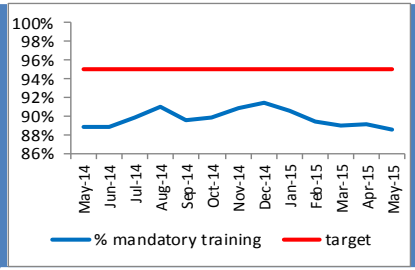
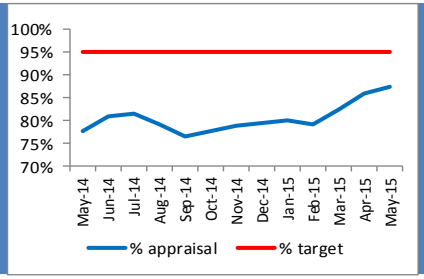
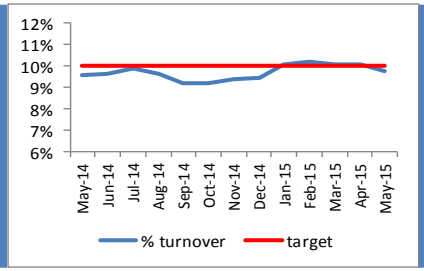
BAF ref: CR3, CR5, CR6, CR7, CR8, CR9,

	Description	Current position/comments		
Contract performance	YTD Contract performance against Trust Planned activity (English & Welsh)	Above plan on elective, emergency and antenatal maternity activity. However, below plan on daycase and outpatient activity.		Actual Activity should be greater than Planned activity
Contract performance	YTD Contract performance against Trust Planned Value (English & Welsh)	Above plan on elective, emergency, antenatal maternity activity as well as critical care activity. However, below plan on daycase and outpatient activity.		Actual Value should be greater than Planned Value

Are we well led?

Countess of Chester Hospital NHS Foundation Trust — Board Assurance metrics May 2015

BAF ref: CR3, CR4, CR6, CR7

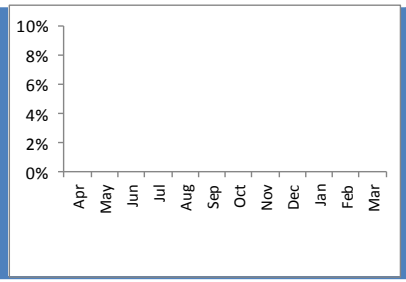
	Description	Current position/comments	13 month rolling trend	Target
Sickness absence	% sickness absence. Monthly rate excludes Comfort zone and Bank staff	Trust wide attendance management levels reduced in May to 4.01% from the April figure of 4.08%. The rolling 12 month average is now 3.98% exceeding the 3.65% Trust target. Whilst there was a further reduction on short term absence, the long term absence hit its second highest level in over 12 months at 2.08%. Additional detail is provided on the exception report on page 23		Below 3.65% per month
Mandatory training	Mandatory Training Monthly Rate Excludes Comfort Zone, Bank Staff, Staff on long term sick & mat. leave.	Mandatory Training Compliance has dipped slightly to 88.6% and this is our lowest rate in the last 13 months. Additional detail is provided on the exception report on page 24		95% per month
Staff with completed appraisal	Appraisal Monthly Rate Exclusions as above and also excludes staff with less than 1 years service.	Highest ever compliance rate since electronic records began in 2008. We need to maintain focus, increase momentum and ensure the quality of appraisal is good. Additional detail is provided on the exception report on page 25		Above 95% per month
Staff turnover	Turnover Rate Based on the previous 12 months and on permanent staff only. Rate should be under the	Turnover continues to remain at a consistently low rate. It has dropped slightly this month bringing it under target.		Below 10% per month

Are we well led?

Countess of Chester Hospital NHS Foundation Trust

Board Assurance metrics May 2015

BAF ref: CR3, CR4, CR6, CR7

	Description	Current position/comments	13 month rolling trend	Target
Variable pay	Variable pay as a percentage of the total pay budget	First time reporting. Based on month 1 the current forecast (straight line) is for variable pay to account for 8% of the total pay budget. Work continues to develop this metric so that this can be reported on in July. Due to the importance in relation to variable pay an exception report has been provided on page 26		Target not agreed for this measure

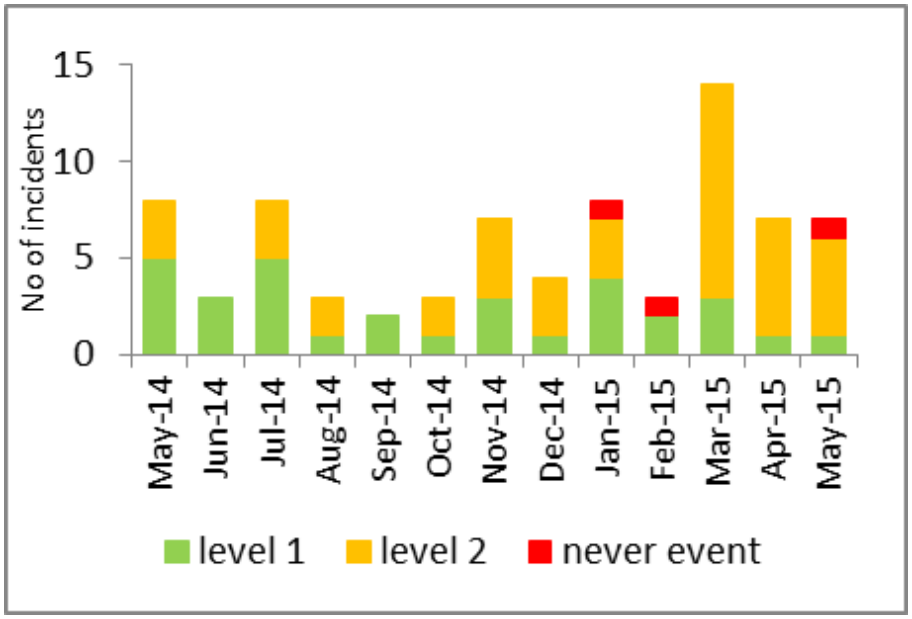
EXCEPTION REPORT

Indicator: Serious Untoward Events (Never Events)

Issue:
In May 2015 there was a third never event this year, the previous two were in January and February 2015.

Proposed actions:
A root cause analysis is underway for all three cases. These are being reviewed on an individual basis but are also being assessed for any common themes. Outcomes and recommendations will be reported to Board through QSPEC in due course. In the meantime staff have been reminded to be rigorous in following agreed policies and processes that are already in place to avoid such occurrences happening again. Staff are being supported through this process. Patients and their families are being kept up to date and are involved in the review. Once completed arrangements will be made for each of the families to meet with one of the executive board members to deliver the outcome and offer an apology.

Historic data:



Forecast for improvement:			
Q1	Q2	Q3	Q4

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

EXCEPTION REPORT

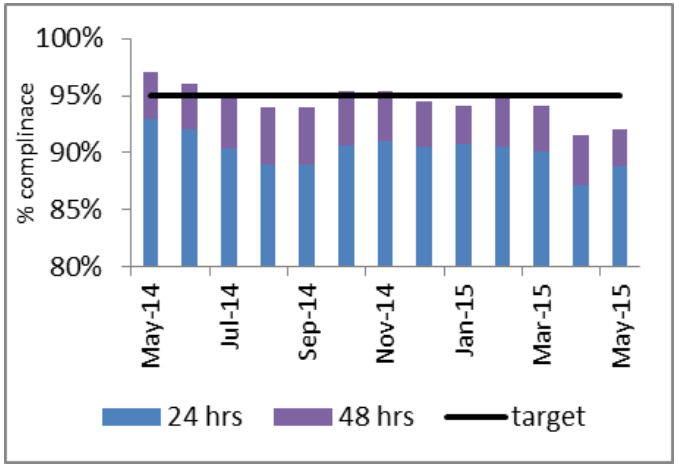
Indicator: E-Discharge

Issue:
Both measures regarding e-discharge within 24 and 48 hours are currently not achieving the target. The highest areas of non compliance are in the specialties of Vascular Surgery, Orthopaedics and General Medicine

Proposed actions:
As part of the weekly monotoring actions are in place with the areas highlighted above that are not achieveing the target. These actions include: - Issues regarding discharges taken place on sites external to the main site of COCH being addressed to ensure full compliance - The importance of this has target been communciated across the failing specialties by Clinical Directors - A review of junior medical staffing rotas to provide more time for completion - The importance of this task to be communicated at medical staffing induction - Weekend discharges remain an issue and areas on how to improve this are being reviewed - Investigation into how patients can be assigned to specialist areas and not within General Medicine as to ensure clinical teams are aware of the need for completion - Continual review by Deputy Chief Executive at weekly operational performance meeting

Forecast for improvement:			
Q1	Q2	Q3	Q4

Historic data:



Lead:	Divisional Directors
Executive Lead:	Mark Brandreth, Deputy Chief Executive

EXCEPTION REPORT

Indicator: Diagnostic 6 week wait

Issue:

The diagnostic 6 week standard has been breached for three consecutive months due to issues within the echocardiography service. This includes workload across the echo service, workforce, process and systems and issues with equipment

Proposed actions:

Workforce: As an interim, extra evening and weekend lists based on staff availability however as we enter into summer period this is proving more difficult. We have recently recruited two part-time Band 7 echocardiographers with one being in post from end of July and the other September. Further recruitment is on-going and we are now looking to agencies for support over the summer. There is a national shortage of echocardiographers

Process & Systems: exploring options to increase throughput and reviewing systems and process to see if they can be improved or streamlined. Echo protocol has been revised and working with IM&T to make some changes to the Order Entry screens on Meditech to provide additional justification for ordering

Equipment - working closely with suppliers and EBME to gain early resolution on issues. Procurement of replacement equipment as part of 2015/16 replacement programme.

Working to stabilise the wait times by the end of June 2015

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:

English - Number of Exams > 6 weeks

Month End Snapshot	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Magnetic Resonance Imaging	18				1		3	1	1	1		1	2
Computed Tomography											3	1	
Non-obstetric ultrasound	82	32	3	44	5			15			1	1	1
Audiology - Audiology Assessments					2	1	1					1	
Cardiology - echocardiography	32	27	37	24	2	2	1	4	6	3	51	114	84
Respiratory physiology - sleep studies											1		
Colonoscopy									1				
Flexi sigmoidoscopy													
Cystoscopy	9	9	13	12	6	2	10	2	9	1	16	11	5
Gastroscopy											5		
Total patients waiting	**3962**	**3474**	**3738**	**3329**	**3506**	**3614**	**3567**	**3662**	**2774**	**3193**	**3798**	**3317**	**3236**
% < 6 weeks	**96.20%**	**98.00%**	**98.60%**	**97.70%**	**99.54%**	**99.9%**	**99.6%**	**99.4%**	**99.4%**	**99.8%**	**98.0%**	**96.1%**	**97.2%**

Lead:	Divisional Directors
Executive Lead:	Mark Brandreth, Deputy Chief Executive

EXCEPTION REPORT

Indicator: 62 day cancer performance

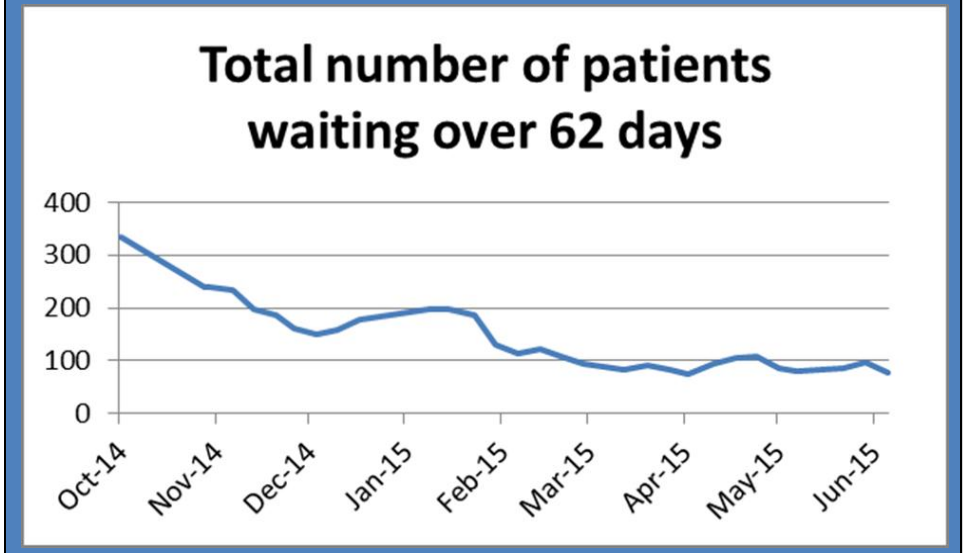
Issue:
Since the previous month's report and after validation and reallocations the current validated position for April has shown an achieved position of 85.59% for the 62 day standard. This is now the third month in a row where by this standard and all cancer standards have achieved. There were 8 breaches in April for Urology (4), Lung (1), Skin (1), Gynae (1) and Head & Neck (1). The unvalidated pre-allocation position for May currently stands at 82.18% against the 85% standard. There are currently 9 breaches for the month. These will now be validated. The quarter position (April and May) currently stands at 83.96%. Progress continues to made in reducing the overall number of patients waiting on the suspected cancer pathway with particular focus on those patients waiting over 62 days.

Proposed actions:
The tumour sites that remain the concern in relation to performance are Upper GI and Urology. Some high level actions include: - Temporarily increasing capacity in UGI to see patients and reduce the backlog. - Reviewing urology at the beginning of the pathway for those patients suspected of prostate cancer. - Changing the diagnostic codes on Meditech for ordering of diagnostics in Radiology, to enable cancer patients to be clearly identified when booking appointments. Actions continue to improve the pathways and reduce the number of patients waiting over 62 days however, as this occurs this will potentially increase the number of patient breaches and therefore the risk to short term performance.

Forecast for improvement:			
Q1	Q2	Q3	Q4

Historic data:

Number of patients 63+ days on cancer PTL



Lead:	Ian Bett, Associate Director of Performance & Planning
Executive Lead:	Mark Brandreth, Deputy Chief Executive

EXCEPTION REPORT

Indicator: RTT 18 weeks admitted patients

Issue:

The Trust reported a 'planned' 18 week fail position for quarter 4 of 2014/15 in order to treat a cohort of long waiting patients who were waiting over 40 weeks. It was planned that performance would achieve from April onwards. The performance in April was 87.8% against a target of 90% and May subsequently 88.5%. This performance will result in an overall failure of Q1 as compliance guidance states that if any one month fails, then this will result in a failure for the quarter.

Proposed actions:

It should be noted that NHS England intend to change the current 18 week reporting. The standards will change with sole focus on the 18 week incomplete pathways. The key areas failing 18 week target are General Surgery, Ophthalmology and OMFU. Additional clinical capacity is required in these areas. A business case to increase capacity has been prepared and is progressing through the governance structure for approval. Consultant recruitment in Ophthalmology is in progress. OMFU is led by a single handed consultant who has a split job plan between COCH and Aintree Hospital. It is likely that a short term locum will be required to support this service. The focus of the division is to reduce the percentage of patients on the 'incomplete pathway' and hence improve overall performance for 18 weeks from July going forward. Actions are in place and monitored weekly to ensure compliance of the standard is achieved from Q2 onwards. An external review of 18 weeks and plans associated has been commissioned at the end of June to provide further assurance.

Forecast for improvement:

Additional data: Performance by specialty

	Apr-15			May-15		
	<18 Wks	Total	%	<18 Wks	Total	%
General Surgery	186	224	83.0%	163	192	84.9%
Urology	158	165	95.8%	189	197	95.9%
Trauma & Orthopaedics	115	126	91.3%	116	136	85.3%
Ear, Nose & Throat (ENT)	84	97	86.6%	60	69	87.0%
Ophthalmology	158	183	86.3%	180	196	91.8%
Oral Surgery	53	108	49.1%	65	117	55.6%
Neurosurgery	0	0		0	0	
Plastic Surgery	143	148	96.6%	134	148	90.5%
Cardiothoracic Surgery	0	0		0	0	
General Medicine	1	1	100.0%	3	3	100.0%
Gastroenterology	43	43	100.0%	31	31	100.0%
Cardiology	64	64	100.0%	33	33	100.0%
Dermatology	0	0		0	0	
Thoracic Medicine	5	5	100.0%	2	2	100.0%
Neurology	0	0		0	0	
Rheumatology	0	0		0	0	
Geriatric Medicine	1	1	100.0%	1	1	100.0%
Gynaecology	94	98	95.9%	107	107	100.0%
Other	48	50	96.0%	67	69	97.1%
Total	**1153**	**1313**	**87.8%**	**1151**	**1301**	**88.5%**

Lead:	Linda Fellowes, Divisional Director, Planned care Division
Executive Lead:	Mark Brandreth, Deputy Chief Executive

EXCEPTION REPORT

Indicator: A&E 4 hour standard

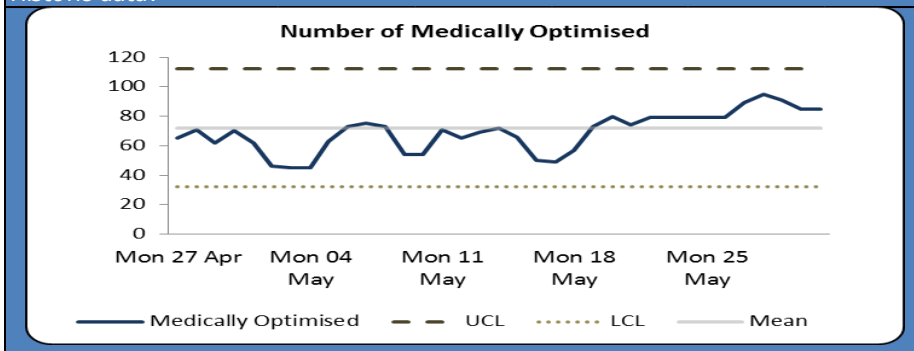
Issue:
A&E 4 hour standard has not been met since September 2014.

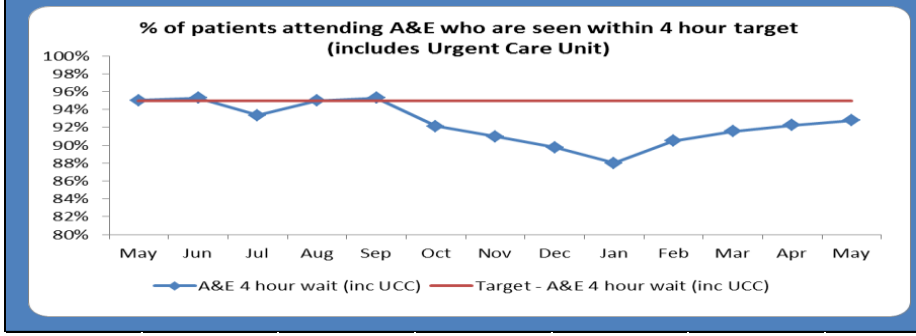
Proposed actions:
The position remains significantly below expectations. There are weekly breach meetings to examine and understand the reasons for the high number of ED Dr breaches. The divisional management team are supporting the clinical proposals regarding changes to medical and nurse staffing and continuing to support the department to improve the patient pathway. The number of medically optimised patients has again risen due to waits for social care which impacts on in-patient bed capacity and ED flow.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:





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

EXCEPTION REPORT

Indicator: Normalised Net Surplus / Deficit

Issue:
Adverse performance of £181k against plan. CRS under achievement accounts for £160k of this variance however fortuitous gains have been made, including slippage against planned investments which have contributed £200k to the CRS programme as at M2. Expenditure pressures are being experienced in relation to delivery of activity as follows: -Drugs £71k & Outsourcing / Insourcing £130k with no corresponding income being received to offset these pressures. Income in excess of what was anticipated for emergency activity, has been able to offset the pressures detailed above to help the bottom line. Medical Pay is currently overspent by £41k , due to agency costs in excess of those anticipated. Agency medical expenditure for the first 2 months of the year is £510k. Nursing Pay is currently £30k overspent, £17k of this variance relates to agency nurse expenditure. Agency nursing expenditure for the first 2 months of the year is £20k.

Proposed actions:
Letters sent from Finance Director to all budgets holders after month 1 reported position based on their m1 performance, to highlight the financial pressures being experienced by the Trust. Action plans to be developed within divisions / departments to bring back any overspending areas to a balanced position. Further progress on developing and working up key milestones and savings for the CRS schemes that have been identified in conjunction with the PMO.

Forecast for improvement:

Q1	Q2	Q3	Q4

DIVISIONAL / DEPARTMENT FINANCIAL PERFORMANCE AS AT MAY 2015

Divisional Variances	Apr Var £000s	May Var £000s	Movement £000s	CRS £000s	Pressure exc CRS £000s
Planned Care Division	187	460	273	187	273
Urgent Care Division	290	332	42	247	85
Diagnostics & Pharmacy Division	46	64	18	84	(20)
Facilities	60	74	14	44	30
Estates	14	-4	(18)	28	(32)
Nurse Management	5	18	13	7	11
Corporate Services	25	7	(18)	62	(55)
Other (inc Contract Income)	(412)	(764)	(352)	(499)	(265)
EBITDA	**215**	**187**	**(28)**	**160**	**27**
Net Interest Received	(4)	(6)	(2)		
Govt Interest & Dividend			0		
RETAINED (surplus) / DEFICIT	**211**	**181**	**(30)**		

EXCEPTION REPORT

Indicator: CRS in Year & Recurrently

Issue:

CRS not delivered as planned as at m2, despite profiling the target as per historical delivery, i.e. less in the earlier months of the year and more in the later months of the year.

Target at month 2 was £702k, achieved £542k, underachievement as at m2 is £160k.

In Year, of the £6m target, £691k 12% achieved, £1,449k schemes RAG rated as Green, £833k as Amber, £2,111 Red and £916k not identified .

Recurrently of the £6m target, £116k 2% achieved, £1,460k schemes RAG rated as Green, £811k as Amber, £3,613 Red.

Proposed actions:

Director of HR leading a group tasked with reviewing all aspects of variable pay for the Trust, to include ACAs, overtime, outsourcing etc.

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

Divisions / Departments report monthly at FQWP on progress against green, amber and red rated schemes

Divisions / Departments report fortnightly at FQWP on progress against black (unidentified or pipeline) schemes

PPD to ensure all PIDS are completed, and key milestones adhered too.

Currently working with DoH and Lord Carter in relation to support for further efficiency savings opportunities with plans currently being drawn up.

Forecast for improvement:

Q1	Q2	Q3	Q4

2015/16 EFFICIENCY PROGRAMME PERFORMANCE AS AT MAY 2015

IN YEAR

Division / Department	2015/16 In Year CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,200,000	£179,934	£ 2,020,066	£ 834,830	£320,625	£ 327,000	£537,611
Urgent Care	£ 2,200,000	£147,533	£ 2,052,467	£ 136,583	£160,667	£1,717,784	£ 37,433
D&P	£ 580,000	£ 33,912	£ 546,088	£ 81,988	£ 68,500	£ 6,000	£389,600
Estates	£ 240,000	£ 12,134	£ 227,867	£ 177,668	£ 34,000	£ -	£ 16,199
Facilities	£ 280,000	£ 32,354	£ 247,646	£ 100,646	£147,236	£ 16,000	-£ 16,236
Nurse Mgmt	£ 36,000		£ 36,000	£ 46	£ 25,000	£ -	£ 10,954
Medical Photography	£ 3,000		£ 3,000	£ -	£ -	£ -	£ 3,000
Comms & Engagement	£ 3,000		£ 3,000	£ 12,750	£ -	£ -	-£ 9,750
Corporate Clinical	£ 8,000		£ 8,000	£ 3,802	£ -	£ -	£ 4,198
IM&T	£ 200,000	£ 41,272	£ 158,728	£ 32,862	£ 8,113	£ 14,750	£103,004
HR	£ 107,000		£ 107,000	£ 17,250	£ 45,796	£ 29,375	£ 14,579
Trust Administration	£ 28,000	£ 3,500	£ 24,500	£ 4,500	£ 9,145	£ -	£ 10,855
PPD	£ 20,000		£ 20,000	£ 6,003	£ 13,997	£ -	£ -
Finance	£ 55,000	£ 39,500	£ 15,500	£ -	£ -	£ -	£ 15,500
Procurement	£ 40,000		£ 40,000	£ 40,000	£ -	£ -	£ -
Central		£200,442	-£ 200,442	£ -	£ -	£ -	-£200,442
TOTAL	**£6,000,000**	**£690,581**	**£5,309,420**	**£1,448,928**	**£833,078**	**£2,110,909**	**£916,505**
		12%	88%				

EFFICIENCY PROGRAMME PERFORMANCE AS AT MAY 2015

RECURRENT

Division / Department	2015/16 Recurrent CRS Target	Achieved to date	Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,200,000	£ -	£ 2,200,000	£ 953,764	£347,250	£ 784,000	£114,986
Urgent Care	£ 2,200,000	£ 13,000	£ 2,187,000	£ 38,000	£192,333	£2,678,488	-£721,821
D&P	£ 580,000	£ 25,000	£ 555,000	£ 120,000	£122,000	£ 20,000	£293,000
Estates	£ 240,000	£ -	£ 240,000	£ 117,000	£ 74,000	£ 40,000	£ 9,000
Facilities	£ 280,000	£ 15,000	£ 265,000	£ 118,000	£ 28,000	£ 58,000	£ 61,000
Nurse Mgmt	£ 36,000	£ -	£ 36,000	£ -	£ -	£ -	£ 36,000
Medical Photography	£ 3,000	£ -	£ 3,000	£ -	£ -	£ -	£ 3,000
Comms & Engagement	£ 3,000	£ -	£ 3,000	£ 12,750	£ -	£ -	-£ 9,750
Corporate Clinical	£ 8,000	£ -	£ 8,000	£ -	£ -	£ -	£ 8,000
IM&T	£ 200,000	£ 41,272	£ 158,728	£ 42,302	£ 32,450	£ 25,000	£ 58,976
HR	£ 107,000	£ -	£ 107,000	£ 14,000	£ 14,500	£ 57,500	£ 21,000
Trust Administration	£ 28,000	£ 3,500	£ 24,500	£ 4,500	£ -	£ -	£ 20,000
PPD	£ 20,000	£ -	£ 20,000	£ -	£ -	£ -	£ 20,000
Finance	£ 55,000	£ 18,000	£ 37,000	£ -	£ -	£ -	£ 37,000
Procurement	£ 40,000	£ -	£ 40,000	£ 40,000	£ -	£ -	£ -
Central	£ -	£ -	£ -	£ -	£ -	£ -	£ -
TOTAL	**£6,000,000**	**£115,772**	**£5,884,228**	**£1,460,316**	**£810,533**	**£3,662,988**	**-£ 49,609**
		2%	98%				

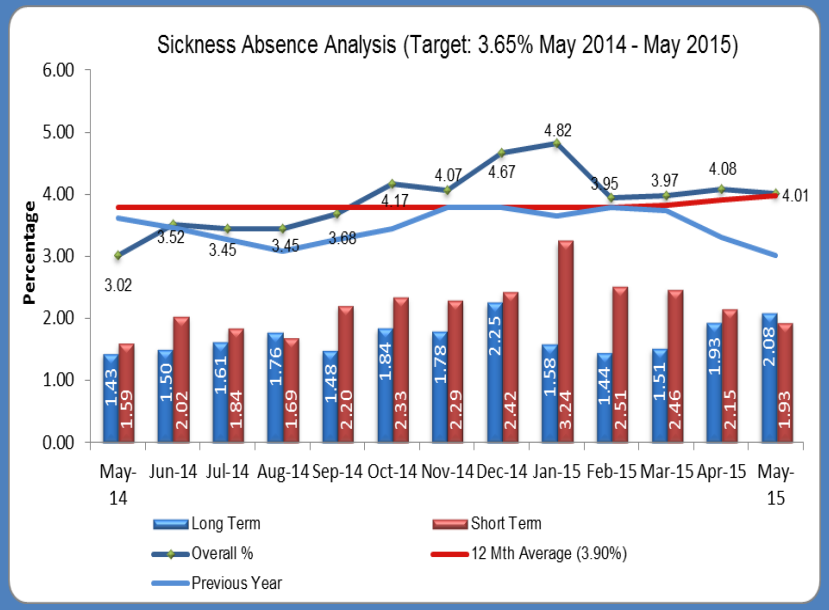
EXCEPTION REPORT

Indicator: Monthly Sickness Absence rate

Issue:
The significant increase in the long term absences from April to May have occurred across a variety of illness reasons: a 32% increase in Other Musculoskeletal absences (11WTE), Pregnancy related up 53% in month (5.65 WTE) and significant increases in Fractures and Chest/Respiratory conditions (10 WTE). Cases of depression, stress and anxiety continue to be the most common reason for absence, particularly long term absence. The Health and Well Being Strategy that is presently being rolled out within the Trust will continue to develop the wider support available to staff who may be carers or have other personal issues affecting their health. The absence rates across the region are currently averaging 4.5% as highlighted by EWIN regional benchmarking data. The Trust remains in shared equal second lowest absence rates (3 Trusts on same rate) of all Acute Trusts, with St Helens and Knowsley NHS Foundation Trust reporting the lowest rate at 3.7%.

Proposed actions:
Interventions into supporting attendance continue alongside the Health and Well Being Strategy, these include the Attendance Management Policy review with a joint group of Management and Staff Side representatives considering adjustments to the current policy; training managers on handling absences from work and the support required and procedures to be followed (over 50 managers trained so far in 2015); attendance hot spot anaylsis and support for managers in those areas; and provision of data to assist early interventions alongside Occupational Health input.

Historic data:



Forecast for improvement:

Q1	Q2	Q3	Q4

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

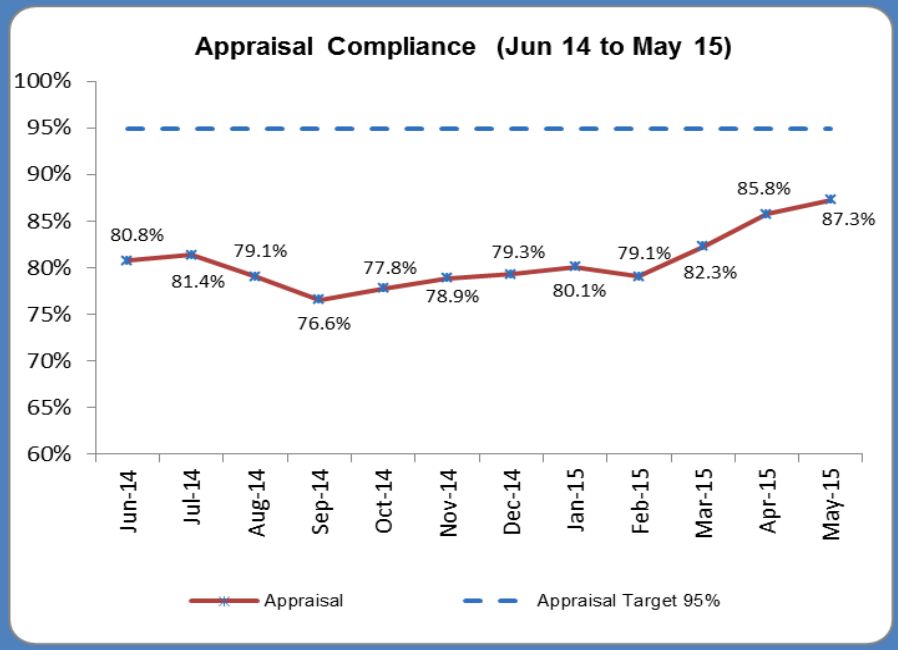
EXCEPTION REPORT

Indicator: Appraisals Completed In The Last 12 Months

Issue:
Highest ever compliance rate since electronic records began in 2008. We need to maintain focus, increase momentum and ensure the quality of appraisal is not affected.

Proposed actions:
Maintaining and improving requires focus and momentum. Areas where there is no improvement or that show deterioration over a 2 month period will be notified to the Director of HR & OD. The L&D Team are supporting across the Trust looking at different/improved ways to undertake appraisal including team appraisals, linking into future requirements for revalidation for Nurses, learning from the Midwifery teams in their approach and exploring an e-appraisal tool that also highlights potential talent. There will be a presentation at the next People & OD Committee July 2015.

Historic data:



Forecast for improvement:			
Q1	Q2	Q3	Q4

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

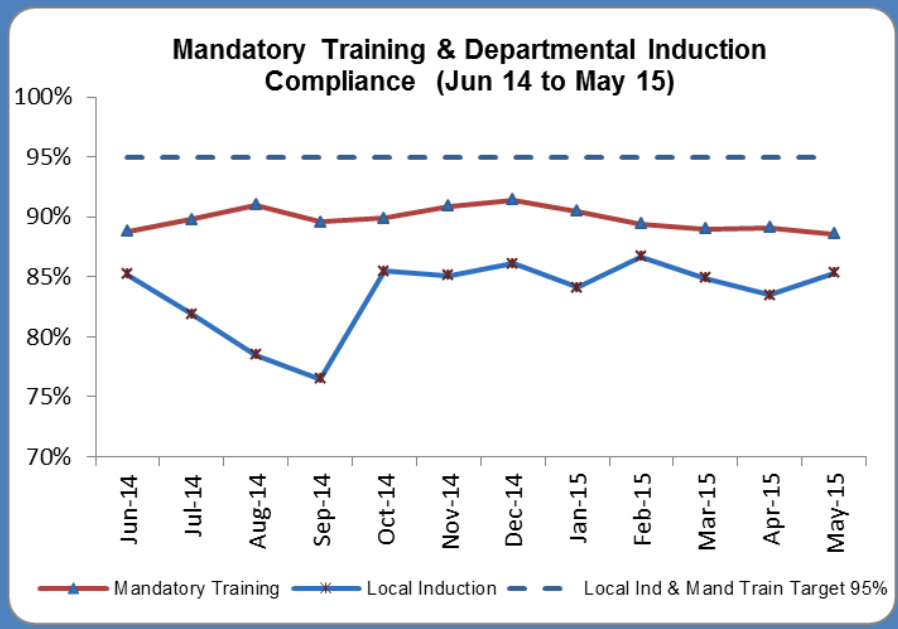
EXCEPTION REPORT

Indicator: Mandatory Training Completed In The Last 12 Months

Issue:
Mandatory Training Compliance has dipped slightly to 88.6% and this is our lowest rate in the last 13 months. Partial compliance stands at 93.5% i.e. out of date but booked onto a future programme. Capacity and demand issues has caused cancellation of places and DNA's leading to lost places on programmes. Local Induction requires the same focus.

Proposed actions:
Five additional programmes have been arranged to accommodate staff and to make up for DNA's (over booking is already used to try to manage this but on the day DNA's are a regular occurence). Areas where there is no improvement or that show deterioration over a 2 month period will be notified to the Director of HR & OD, as per the process with Appraisal compliance.

Historic data:



Forecast for improvement:

Q1	Q2	Q3	Q4

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

EXCEPTION REPORT

Indicator: Variable Pay

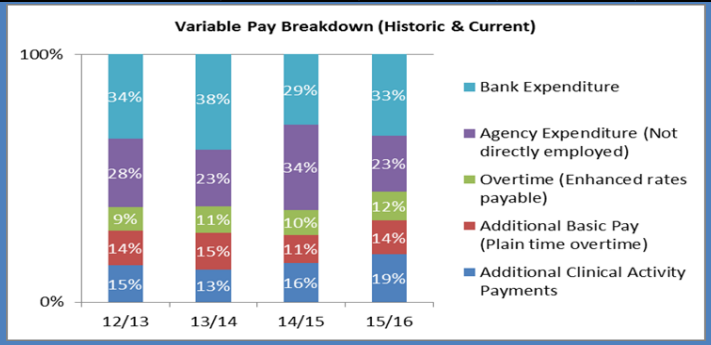
Issue:

To deliver the £4.5m required savings in relation to CRS plans in 15/16, increased focus is being placed on the reduction of variable pay cost across the Trust. Sue Hodkinson, Director of HR & OD, is the Executive Lead.

Proposed actions:

Strategic group meeting undertaken on the 12th June with the following agreed: definition of what is variable pay, agreement on the areas of focus, proposed actions, agreement of roles & responsibilities, as well as assessment, monitoring & governance outlined. Weekly monitoring to be established with board reporting undertaken via People & OD Committee and Board reports.

Historic data:



Type	2015/16
Additional Clinical Activity Payments	£ 181,803
Additional Basic Pay (Plain Time overtime)	£ 129,047
Overtime (Enhanced Rates payable)	£ 110,007
Agency Expenditure (Not directly Employed)	£ 213,138
Bank Expenditure	£ 310,649
Total Variable Pay Expenditure	£ 181,803
Pay Budget	£ 11,865,000
Variable Pay as % of Total Pay Budget	8%

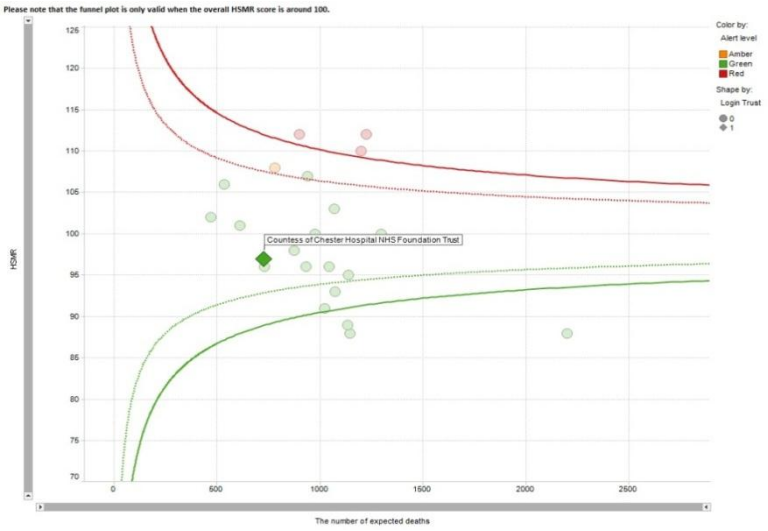
Forecast for improvement:

Q1	Q2	Q3	Q4

Lead:	Richard Baird, Martin Godfrey, Diane Holder, Linda Cunningham
Executive Lead:	Sue Hodkinson

Appendix 1 – Mortality report

As reported last month the most recent SHMI published on NHS Choices is for October 2013 – September 2014 and is 1.11 which remains within expected, the upper limit was 1.12. The rate of palliative care coding was 31.95% which may be a factor in our HSMR generally being lower. The most recent HSMR is for the year 14-15 and is 97.22. There remains a difference between weekday, 94.56, and weekend, 106.21.

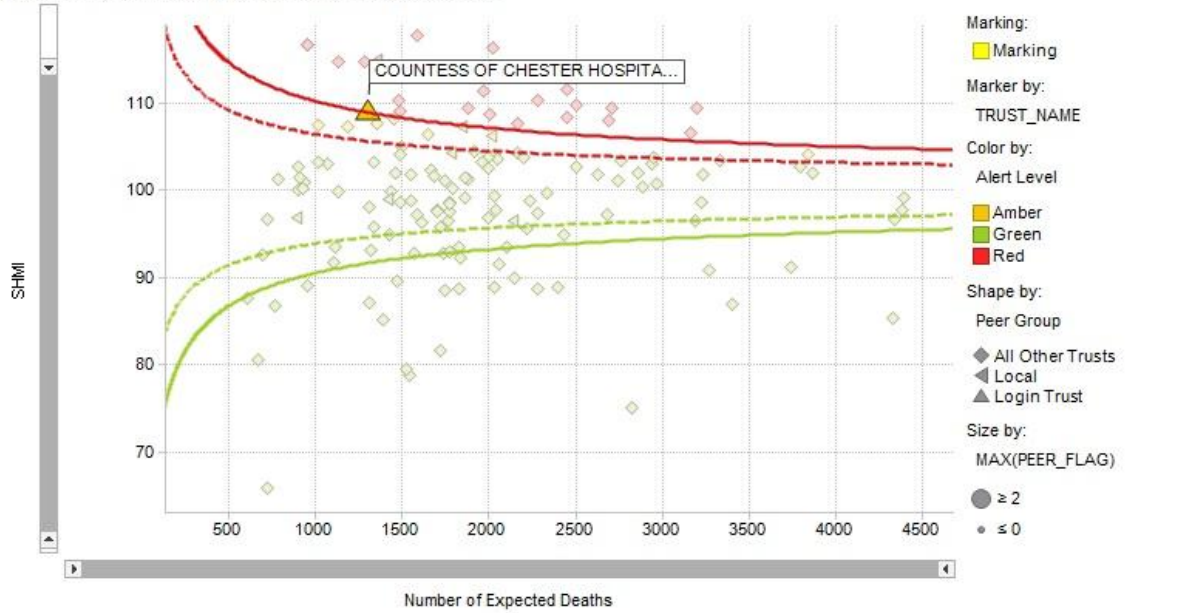


T

The most recent SHMI available from HED, with a monthly refresh as opposed to the quarterly refresh of the NHS Information Centre which is 6 months behind, is 109.28 for Jan-Dec 2014.

Figure 1.2: Poisson Distribution (PD) Funnel Plot

Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.



Appendix 2 – Safe staffing

Countess of Chester Hospital NHS Foundation Trust		May-15						
		Registered Nurses/Midwives			Care Staff			All staff
Specialty	Ward	Planned monthly hours	Actual monthly hours	%	Planned monthly hours	Actual monthly hours	%	% planned hours staffed
Paediatrics	30	2683.5	2532	**94.4%**	713	812.9	**114.0%**	110.4%
Obstetrics	32	1782.5	1827.5	**102.5%**	1426	1433.5	**100.5%**	101.6%
Labour Ward	CLS	4278	4250.8	**99.4%**	870.5	890.5	**102.3%**	99.9%
Stroke Unit	33	2668.5	2599.5	**97.4%**	2356	2235	**94.9%**	96.2%
Care of the Elderly	34	2050.5	1983.5	**96.7%**	2650.5	2584	**97.5%**	97.2%
General Surgery	40	1426	1411.5	**99.0%**	465	450.5	**96.9%**	98.5%
General Surgery	41	1223	1152.5	**94.3%**	685	560.5	**81.8%**	89.8%
Cardiology	42	1955.5	1920	**98.2%**	1612	1732	**107.4%**	102.4%
Care of the Elderly	43	2081.5	2165	**104.0%**	2697	2970.5	**110.1%**	107.5%
General Surgery	44	2141.5	1924	**89.8%**	2170	2001	**92.2%**	91.0%
Urology/Trauma and Orthopaedics	45	2141.5	2087.5	**97.5%**	2511	2637	**105.0%**	101.5%
Respiratory Medicine	48	2622	2428.5	**92.6%**	1767	1853.5	**104.9%**	97.6%
Gastroenterology	49	1924.5	2016	**104.8%**	1953	1914.5	**98.0%**	101.4%
Haematology/Resp Medicine	50	2296.5	2395.5	**104.3%**	1953	2462.5	**126.1%**	114.3%
Respiratory Medicine	51	2030.5	1895.5	**93.4%**	2170	2212.5	**102.0%**	97.8%
General surgery	52	2327.5	2001	**86.0%**	1798	1758	**97.8%**	91.1%
Surgery	53	1426	1480	**103.8%**	1085	1340.5	**123.5%**	112.3%
General Surgery	54	2854.5	2588	**90.7%**	2325	2620.5	**112.7%**	100.6%
Acute Medicine	AMU	4080	4303.5	**105.5%**	2170	2595	**119.6%**	110.4%
Cardiology	CCU	2436	2183.5	**89.6%**	372	536	**144.1%**	96.8%
Rehabilitation - EPH	Diamond	1955.5	1689.5	**86.4%**	2170	2638.5	**121.6%**	104.9%
Rehabilitation - EPH	Emerald	1255.5	1209.5	**96.3%**	2015	2084	**103.4%**	100.7%
Rehabilitation - EPH	Ruby	1813.5	1586	**87.5%**	2743.5	2994	**109.1%**	100.5%
Critical care medicine	ICU	9269	9345.5	**100.8%**	1085	745	**68.7%**	97.5%
Neonatal	NNU	3041	2884.5	**94.9%**	1426	1115	**78.2%**	89.5%
Total		61079.5	59328.3	97.1%	42475.5	44364	104.4%	100.1%

		Nov	Dec	Jan	Feb	Mar	Apr	May
Paediatrics	30							
Stroke Unit	33							
Care of the Elderly	34							
Women's Unit	40							
General Surgery	41							
Cardiology	42							
Care of the Elderly	43							
General Surgery	44							
Urology/Trauma and Orthopaedics	45							
Gastroenterology	49							
Haematology/Resp Medicine	50							
Respiratory Medicine	48							
Short Stay	51							
General surgery	52							
Surgery	53							
General Surgery	54							
Acute Medicine	AMU							
Cardiology	CCU							
Rehab - EPH	Diamond							
Rehab - EPH	Emerald							
Rehab - EPH	Ruby							

Critical care medicine	ICU							
Neonatal	NNU							
Obstetrics	32							
Labour Ward	35							

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

Monitoring of the use of one to one and the need for additional hours or current workforce

Hours available match the patient acuity

Daily-Shift review

Daily-Shift review resulting in staff movement if needed-escalation guidance triggered

Appendix 3 Changes to report

A review of the Integrated Board Report has recently been completed and a number of changes have been made this month with a new revised format this month. As part of this a number of measures have been removed from the new report and these measures will form part of the assurance metrics for the sub - board committees. The table below highlights the measures removed as of this month and a monthly log will be included in this report in the future for completeness to highlight any changes in metrics from the previous for month.

Area	Metric	Date Added/deleted	Committee to take responsibility for metric	Comment
Quality & Safety	Care Metrics	May-15	QSPEC	
Quality & Safety	Dementia questions 2 & 3	May-15	QSPEC	Question 1 remains on report as a metric
Quality & Safety	Litigation, Claims & Inquests	May-15	QSPEC	
Quality & Safety	VTE	May-15	QSPEC	
Quality & Safety	Hospicom responses	May-15	QSPEC	
Quality & Safety	Healthwatch Enter & View visits	May-15	QSPEC	
Quality & Safety	Advancing Quality CQUINs	May-15	QSPEC	National CQUINs on report and other metrics escalated as appropriate
Quality & Safety	Mental Capacity Assessments & DOLs	May-15	QSPEC	
Quality & Safety	CDiff lapses in care	May-15	To be agreed	Part of Monitor reporting requirements
Operational performance	Cancer targets	May-15	CDG/Cancer performance group	14 day, 31 day and 62 day standards shown on report and others will be reported by exception
Operational performance	Ambulance handovers	May-15	CDG	Report by exception
Operational performance	No of referrals	May-15	CDG	
Operational performance	Monitor table – summary of performance	May-15	To be agreed	
Finance	Performance against IN-YEAR monitor Plan for various metrics	Not currently included in May's draft Board Report	To be agreed	
Finance	Forecast out-turn for various metrics	Not currently included in May's draft Board Report	To be agreed	
HR		Metrics that have been reviewed to be agreed at People & OD committee	People & OD committee	

BOD/July/2015

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Inpatient Survey 2014
Date of Meeting	7th July 2015
Author(s)	Alison Kelly, Director of Nursing & Quality Sian Williams, Deputy Director of Nursing & Quality
Presented by	Alison Kelly, Director of Nursing & Quality
Annual Plan Objective No.	
Summary	The paper outlines the results of the Inpatient Survey 2014. Generally the results are similar to that of the 2013 report. It is pleasing to note that areas of concern from the 2013 survey have shown improvement in the most recent report.
Recommendation(s)	**The Board is asked to:** Note the contents of the paper and to support future actions.
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: ☐ **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

Inpatient Survey 2014 Report
Countess of Chester Hospital NHS Foundation Trust

1.0 Background to the survey

The results presented here are from the Inpatient Survey 2014, carried out by Picker Institute Europe on behalf of the Countess of Chester Hospital NHS Foundation Trust. This survey is part of a series of annual surveys required by the Care Quality Commission for all NHS Acute Trusts in England. The Picker Institute was commissioned by 78 trusts to undertake the Inpatient Survey 2014.

2.0 Survey methodology

Patients were sent a questionnaire to their home address, along with a covering letter from the Trust's Chief Executive, a multiple language sheet offering help with the survey, and a freepost envelope. Patients wishing to complete the survey filled it in and returned it to the Picker Institute. Non-responders were sent a reminder card after 2-3 weeks and another questionnaire after a further 2-3 weeks.

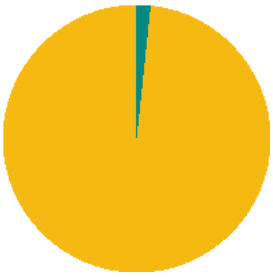
3.0 About our respondents

A total of 850 patients from our Trust were sent a questionnaire. 825 patients were eligible for the survey, of which 383 returned a completed questionnaire, giving a response rate of 46%. The average response rate for the 78 'Picker' Trusts was 45%. This shows a 1% increase on the 2013 response rate.

4.0 Our results at a glance

The latest survey has highlighted the many positive aspects of the patient experience. The majority of our patients reported that they are highly appreciative of the care they receive. However, it is evident that there is also room for improving the patient experience.

4.1 Have we improved since the 2013 survey?



A total of 62 questions were used in both the 2013 and 2014 surveys.
Compared to the 2013 survey, our Trust is:

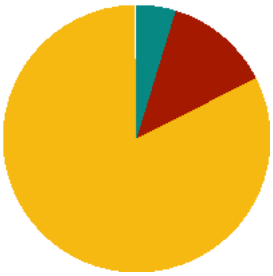
- Significantly BETTER on 1 question
- Significantly WORSE on 0 questions
- The scores show no significant difference on 59 questions

The Trust has improved significantly on the following questions:

Lower scores are better

	2013	2014
Nurses: did not always get clear answers to questions	36 %	28 %

4.2 How do we compare with others?



The survey showed that our Trust is:

- Significantly BETTER than average on 3 questions
- Significantly WORSE than average on 8 questions
- The scores were average on 51 questions

The positive news is that the Trust has not worsened in any areas of the previous year's results that were identified as areas of concern. The improvements appear to reflect the importance that the Trust has been placing on improving the communication not just between staff, but more importantly with patients. However, the negative issues identified above from benchmarking the results are also echoed in a number of patient complaints and concerns that the Trust has also received in year, so it is clear we have a theme around communication at the point of discharge.

Your results were significantly better than the 'Picker average' for the following questions:		
	Lower scores are better	
	Trust	**Average**
Planned admission: should have been admitted sooner	16 %	25 %
Doctors: talked in front of patients as if they were not there	20 %	24 %
Surgery: what would be done during operation not fully explained	18 %	24 %

4.3 How can we make it better for our patients?

.
What is pleasing to see is that none of the previous years 'new areas' for concern appear in this year's results. This reflects the increased attention the Trust has paid to the areas identified. It reinforces that the work the Trust has put into improve identified areas can make a difference to our patients.

It is clear from the results below that there are number of improvements that need to be made to our patient's journey. Our complaints have also highlighted an increase in the number of cancellations and the inconvenience that it causes to our patients and their families, however it is unclear as to why we are worse than average.

Worse than average scores

For the last 3 years however the Trust has been below the Picker average on the question relating to patients being asked for their views on the care they have received. This is despite the opportunity to use Hospicom (real time feedback) and the Friends and Family Test. It is impossible to say why this is the case, however there is a role for the ward mangers to raise this option for patients and their families.

In areas where we are significantly worse, there are ongoing plans to support an improvement.

Your results were significantly worse than the 'Picker average' for the following questions:		
	Lower scores are better	
	Trust	**Average**
Planned admission: admission date changed by hospital	30 %	21 %
Hospital: patients using bath or shower area who shared it with opposite sex	16 %	12 %
Hospital: bothered by noise at night from other patients	44 %	39 %
Discharge: not given any written/printed information about what they should or should not do after leaving hospital	39 %	31 %
Discharge: not fully told purpose of medications	30 %	24 %
Discharge: not told how to take medication clearly	30 %	24 %
Discharge: not told who to contact if worried	26 %	19 %
Overall: not asked to give views on quality of care	75 %	68 %

For example, 'admission date changed by hospital' remains an issue despite the Trust focussing work on the pathways that support patients in other settings or at home. Capacity also remains an issue.

There is a continued focus on our patients experience and there have been a number of initiatives to support this:

- Establishing a Patient Experience Operational Group
- Training of Patient Experience volunteers
- Discharge pathway work
- Promotion of Discharge Booklet - agreed in early 2014
- Focus Groups being arranged and supported by Healthwatch
- Review and refresh of Hospicom use

5.0 CQC – Picker

The overall responses for the rest of the survey demonstrate that the Trust is "average" However, using the CQC scoring which is slightly different, it puts the Trust in the 'as expected area'.

- Overall experience 8.2/10 - About the same
- Overall view of inpatient services for feeling that overall they had a good experience 8.2/10 - About the same

All but one question was reported as 'about the same'. The one question where the Trust performed 'worse' was 'Changes to admission dates', scoring 8.7 out of 10.

6.0 Going forward

Continued work is underway to support the areas identified to ensure responses in the future are more positive and "better than average" about the Trust and the care it gives. Work is also underway to try and improve staff experiences as this has been linked to improved patient experience.

Overall, the Trust falls mainly in the 'average' or 'about the same' areas. Using the Patient Experience Group will ensure a real focus is maintained on patient experience.

Alison Kelly
Director of Nursing and Quality
June 2015

BOD Item No /July/2015

Countess of Chester Hospital NHS
NHS Foundation Trust

Board of Directors

Subject	Costing Approval Process
Date of Meeting	7th July 2015
Author(s)	Helen Fullwood, Costing & Performance Advisor
Presented by	Debbie O'Neill, Chief Finance Officer
Annual Plan Objective No.	
Summary	This paper provides an overview of the costing process and national requirements and subsequent Board approval as required by Monitor
Recommendation(s)	**The Board is asked to:** The Board of Directors are asked to give their approval that they are satisfied with the trusts costing process and systems, and will submit its reference costs in accordance with the guidance.
Risk Score	**N/A**
FOIA Status: *FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.* **Applicable Exemptions:** ▪ **Prejudice to effective conduct of public affairs** ▪ **Personal Information** ▪ **Info provided in confidence** ▪ **Commercial interests**	Please tick the appropriate box below: [x] **A. This document is for full publication** [ ] **B. This document includes FOIA exempt information** [ ] **C. This whole document is exempt under the FOIA** IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Countess of Chester Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

7TH JULY 2015

Costing Process & System Approval

1.0 Introduction

A requirement by Monitor & DoH of the 2014/15 Reference Cost Submission is for the Board to approve the costing process that supports reference costs.

This paper will:

- Provide a brief summary of the purpose & history of reference costs and costing in the NHS
- Set out the national requirements of the submission
- Provide a summary of the costing process in this organisation including the outcome of recent audits
- Ask the Board of Directors to approve the costing process prior to submission

2.0 Purpose & History of Reference Costs

The Department of Health (DoH) have collected reference costs – retrospective average costs of delivering different health care services since 1997/98. These costs have been used to set prices since Payment by Results (PBR) were introduced in 2003/04 & the scope extended from Inpatient specialty averages to most services now being covered (Inpatient, Outpatient, A&E, Critical Care, Direct Access, Community and Mental Health).

Since 2005/06 the DoH has encouraged the use of Patient Level Information Costing Systems (PLICs) to improve the quality of cost information and each organisations understanding of its costs.
Recent national surveys have shown that 80% of provider organisations have either implemented or are in the process of implementing or are planning to implement PLICs.

3. National Costing Standards & Guidance

3.1 Monitors Provider Licence

The License contains obligations for providers that will allow Monitor to fulfil its new duties in relation to price setting. Including capturing information (including cost information) in line with guidance, requirements to submit this information to Monitor and providing assurance on accuracy
(See **Appendix A** for more detail on the licence conditions relating to pricing)

3.2 Costing Principles

Six Universal principles produced by Monitor intended to provide high level guidance & overview of approved approach to costing:

Stakeholder engagement	Effective costing requires input from a wide range of stakeholders, including non-finance staff
Consistency	For some costing purposes, a consistent approach is required across or within organisations
Data Accuracy	Accurate costing relies on the quality of the underlying input data
Materiality	Costing effort should be focused on material costs and activities
Causality & Objectivity	Costing should be based on an understanding of causality to minimise its subjectivity
Transparency	Costing should be transparent & auditable

3.3 Clinical Costing Standards

Published by the Healthcare Financial Management Association (HFMA) & strongly advocated by monitor the costing standards aim to support & drive improvement for organisations in deriving costs at patient & service user level. (See **Appendix B** for a summary of the Standards published)

It provides prescriptive & detailed instruction on the classification of costs (Direct/Indirect/Overhead & Variable/Semi Fixed/Fixed) & grouping of costs (medical staff, wards, drugs, theatres etc…) to ensure a consistent approach that makes the information produced more comparable.

The guidance also sets out a number of methodologies that can be used to allocate costs from Gold Standard (Actual Usage) down to accepted proxies & advises how to prioritise based on the availability of data systems & materiality.

HFMA also provide a tool that assesses the quality & robustness of patient level costs (Materiality & Quality Score)

3.4 Reference Costs Guidance

Provides technical guidance on the completion of the reference cost submission, reconciliation & covers principles specific to reference costs **(Appendix C)**

Defines which currency activity should be reported in and how to treat different costs (what to include/exclude)

Defines submission, timetable (See **Appendix E** for 2014/15 Timetable) & sign off process (Director of Finance sign off)

Provides self-assessment document (**Appendix D)**

Provides links and instruction to the reference cost grouper and submission worksheets.

4.0 Costing Process at Countess of Chester

4.1 History & Overview of Costing Process

The trust began the implementation of patient level information costing system (PLICs) & specialty reporting in 2007/08 Before that costing was only completed annually to complete the reference cost submission with that information being used for internal management purposes on an ad hoc basis

Administration of the Specialty reporting system sits with the Commissioning & Contracts team within finance supported by the Information department. The system is updated on a monthly basis following the completion of the finance month end process. This information is then made available to the management team (including medical staff) with the use the web based reporting tool Qlikview.

4.2 COCH application of costing principles

Principle	Principle Description	Application
Stakeholder engagement	Effective costing requires input from a wide range of stakeholders, including non-finance staff	The implementation of PLICs involved extensive consultation with service leads. The system is reviewed on a continuous basis. Meetings with Finance leads of each division are scheduled each month which identifies changes or improvements needed. Further 'deep dives' take place during each year where activity, coding, allocations & income distribution are reviewed and presented to service teams. SLR information is included in trust reporting and has been formally championed by the current medical director
Consistency	For some costing purposes, a consistent approach is required across or within organisations	For Reference Costs all costs will be mapped to standard groupings. Where national guidance is unclear clarification is sought from local reference groups or DH directly. Team members attend periodic national costing events allowing best practise to be shared & networks to be established.
Data Accuracy	Accurate costing relies on the quality of the underlying input data	The main patient activity used for PLICs and reference costs are from the same source used in our PBR process that has undergone Internal and Audit Commission audits in recent years. The reference cost submission also underwent an Audit Commission Audit of the 2009/10 submission. Where there are known issues with data quality steps have been taken to reduce the impact this can have on costing information (for e.g. where theatre time is not accurate an average procedure time is used in its place)

Materiality	Costing effort should be focused on material costs and activities	Agreement with divisions & allocation development is focused on areas with largest financial value
Causality & Objectivity	Costing should be based on an understanding of causality to minimise its subjectivity	Allocation methods meet the highest level achievable based on best practise within the constraints of the information & resources available
Transparency	Costing should be transparent & auditable	The flow of activity is documented through the costing system of data transfer process. Any changes for Reference costs outside the system are also documented by the system administrator

4.3 Reference Cost Process

1. •DoH releases Reference Cost guidance
2. •Assessment made of differences to internal PLICs - classification of costs, currencies, inclusions/exclusions
3. •Information & allocation changes needed identified and actioned in activity sources & allocation set ups
4. •Coded & Grouped Activity Refreshed for relevant period in Data warehouse (using Ref Cost Grouper & only activity needed for Ref costs) This is then reconciled to internal reporting information & external sources where possible (for e.g. SUS)
5. •Activity Transformed into format needed for Costing Software
6. •Conditions applied & Activity information imported into costing system (includes IP/OP/Theatres/Labs/Pharmacy/CC/A&E/Rad/ECG)
7. •Non patient activity information updated from various sources
8. •Costs imported from Ledger & Categorised (Fixed/Semi Fixed/Variable, Direct/Indirect/Overhead, Cost Groups)
9. •Calculation ran & the checked to ensure all costs are allocated to patient level
10. •Any further adjustments needed post calculation to ensure compliance to Ref Cost Guidance made (for e.g. Exclusion of Activity)
11. •Information extracted from Costing system & Reference Cost workbooks completed - resolving any validations
12. •Reconciliation statement is then completed and reconciled to final accounts
13. •Costs are then sense checked & benchmarked against previous internal returns & national information available. Any issues identified are then investigated & corrected
14. •Where possible information is shared with Service Leaders & Clinicians for a further sense check
15. •Self Assessment Qulaity Checklist is completed (Appendix D)
16. •Return is then presented to Deputy & CFO for Sign Off
17. •Return is then submitted & signed off by CFO

4.4 Audit Outcomes

The trust was selected to be audited as part of the national data assurance framework – reference cost audit of the 2012/13 submission. The trust was selected as it was deemed low risk. The overall judgement was found to be Accurate.

The recommendations were primarily focused on formalising processes in place for the production of reference costs & formalising the review processes (Appendix F). All recommendations have been actioned.

5.0 Board approval of processes & systems

The Board of Directors are asked to sign off that they are satisfied with the trusts costing process and systems, and will submit its reference costs in accordance with the guidance.

Specifically, the Board of Directors are required to confirm that:

(a) Costs will be prepared with due regard to the principles and standards set out in Monitor's *Approved Costing Guidance (4.2)*

(b) Appropriate costing and information capture systems are in operation (4.1 & 4.2 Data Accuracy)

(c) Costing teams are appropriately resourced to complete the reference costs return accurately within the timescales set out in the reference costs guidance (4.1)

(d) Procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference costs return. (4.3 – Step 15)

Appendix A – Monitor Licence Conditions

Pricing Condition 1: Recording of information	Under this licence condition, Monitor may require licensees to record information, particularly information on their costs, in line with approved guidance that we will publish. The licence condition is worded in a way that any cost and other information that may be required can be collected from both licensees and their sub-contractors. This licence condition may also require licensees to record other information, such as quality and outcome data, in line with our guidance and for the purposes of carrying out our pricing functions. The rationale for the inclusion of a separate licence condition, in addition to Pricing Condition 2, which covers the provision of information, is to facilitate prompt and straightforward compliance with Pricing Condition 2. If information on costs was not recorded as required, it could be difficult for licensees to provide it to us at the time requested
Pricing Condition 2: Provision of information	Having recorded the information in line with Pricing Condition 1 above, Monitor can then require licensees to submit this information. Having access to consistently recorded and accurate information, particularly on the costs of providing NHS services, will be essential for us to fulfil our pricing responsibilities. In the absence of such information, it will be very difficult for us to set prices at the appropriate level
Pricing Condition 3: Assurance report on submissions to Monitor	It will be important that the information we collect for setting prices is of high quality. For this reason, we have included Pricing Condition 3, under which Monitor may require licensees to submit an assurance report confirming the accuracy of the information they have provided. We are aware that the requirement to submit such an assurance report will have associated costs. We will bear this in mind when deciding to ask for assurance reports, and will only require them when we believe that the benefits outweigh the costs in terms of ensuring the accuracy of pricing data.

Appendix B – HFMA Clinical Costing Standards

1.	Classification of direct, indirect and overhead costs	All general ledger costs need to be classified as Direct, Indirect or overhead
2.	Creation of cost pool groups & cost pools	All service costs need to be grouped into associated cost pool groups
3.	Allocation of Costs	Where possible costs should be allocated on an informed activity basis, using an appropriate driver. Organisations should consider the materiality of a resource when considering the amount of effort & data collection required to provide information to drive costs
4.	Classification of costs into fixed and variable categories	All costs are to be classified as variable, fixed or semi-fixed
5	Work in progress	Should be costed in accordance with the materiality of WIP to each organisation
6.	Treatment of Income	Income should be clearly identifiable for internal reporting without being netted off from cost
7.	Treatment of non-patient care activities	The costs of clinical training & education, R&D should be separately identified from the costs of providing patient care
8.	Data integrity	Organisations should ensure the quality & integrity of the patient-level information used in the costing process
8a.	Data Matching	Organisations should ensure that resources allocated using feeder systems are matched as accurately as possible to individual patients
9.	Quality assessment & measurement	Organisations should document & measure the materiality & quality score of their costing process. This should be evidenced by a MAQs
10.	Audit	Audit should be undertaken regularly to assure that: - Costing data is materially accurate - The costing standards have been followed - Processes exist to ensure that cost data is robust

Appendix C – Reference Cost Principles

1. Calculated on a full absorption basis to identify the full cost (including redundancy & reorganisation costs) of all services listed
2. Are allocated and apportioned accurately by maximising direct charging and where this is not possible using standard methods of apportionment
3. Are matched to services that generate them to avoid cross subsidisation
4. Are retrospective & reconciled to the audited accounts
5. Are average unit costs, irrespective of the underlying data supporting their calculation
6. Include the costs of drugs or devices against the relevant HRGs, even if they are excluded from the national tariff
7. Emphasise the cost of delivering the service & not the funding streams that are used to recover the costs.

Appendix D – Self Assessment Quality Checklist

Check	Response
Total costs: The reference costs quantum has been fully reconciled to the signed annual accounts through completion of the reconciliation statement workbook in line with guidance	Fully reconciled to within +/- 1% of the signed annual accounts
	Fully reconciled to within +/- 1% of the draft annual accounts [state reason]
Total activity: The activity information used in the reference costs submission to report admitted patient care, outpatient attendances and A&E attendances has been fully reconciled to provisional Hospital Episode Statistics and documented	Fully reconciled and documented
	Partly reconciled
	n/a – reconciliation completed but to another source [state reason]
	Not reconciled
Sense check: All relevant unit costs under £5 have been reviewed and are justifiable	All relevant unit costs under £5 reviewed and justified [state reason]
	n/a – no relevant unit costs under £5 within the submission
Sense check: All relevant unit costs over £50,000 have been reviewed and are justified	All relevant unit costs over £50,000 reviewed and justified [state reason]
	n/a – no relevant unit costs over £50,000 within the submission
Sense check: All unit cost outliers (defined as unit costs less than one-tenth or more than ten times the previous year's national mean average unit cost) have been reviewed and are justifiable	All unit cost outliers reviewed and justified [state reason]
	n/a – no unit cost outliers within the submission
Benchmarking: Data has been benchmarked where possible against national data for individual unit costs and for activity volumes (the previous year's information is available in the National Benchmarker)	All cost and activity data within the submission has been benchmarked using the National Benchmarker prior to submission
	All cost and activity data within the submission has been benchmarked using another benchmarking process [state]
	Some but not all cost and activity data within the submission has been benchmarked using the National Benchmarker prior to submission
	Some but not all cost an activity data within the submission has been benchmarked using another benchmarking process [state]
	No benchmarking performed on the cost data prior to submission
Data quality: Assurance is obtained over the quality of data for 2014-15	An external audit has been performed on data quality
	An internal audit has been performed on data quality
	Internal management checks have provided assurance over data quality
	Assurance has been obtained over data quality but not for 2014-15
	No assurance has been obtained over data quality
Data quality: Where issues have been identified in	All exceptions have been resolved and the risk of

the work performed on the 2014-15 data and systems, these issues have been resolved to mitigate the risk of inaccuracy in the 2014-15 reference costs submission	inaccuracy in the 2014-15 reference costs submission fully mitigated
	Some exceptions have been resolved but not all Exceptions have yet to be resolved
	n/a – no exceptions noted
Data quality: All other non-mandatory validations as specified in the guidance and workbooks have been considered and any necessary revisions made	All non-mandatory validations have been considered and necessary revisions made
	All non-mandatory validations have been considered and some but not all necessary revisions have been made [specify and state reason]
	Some non-mandatory validations have been considered and necessary revisions made [specify and state reason]
	No non-mandatory validations have been investigated [state reason]
	n/a – no non-mandatory validations have occurred

Appendix E

2014/15 Reference Cost Timetable

Date	Milestone
February 2015	*Reference costs guidance for 2014-15* published Re-release of draft REFC and SPELLS workbooks
23 March 2015	Release of HRG4+ 2014-15 Reference Costs Grouper and documentation
April 2015	Release of Unify2 compliant REFC and SPELLS test workbooks
May 2014	Release of Unify2 compliant REFC and SPELLS final workbooks
22 June 2015	Reference costs collection window opens
24 July 2015	Deadline for initial REFC (and SPELLS if appropriate) submissions
30 July 2015	Last possible date for Finance Directors sign off REFC.
31 July 2015	Reference costs collection window closes
August – September 2015	Analysis of data
September 2015	Release of draft Reference Cost Index (RCI) on Unify2
October 2015	Publication of national schedules of reference costs, final RCIs and source data

Appendix F – Audit Recommendations

Recommendation	Priority	Comments
Introduce formal documentation for the different aspects of the costing process	Low	Documentation regarding system usage to be updated & customised specifically for reference cost reporting. Adjustment of PLICs to Ref costs documentation to be clarified & updated in line with current guidance
The trust should broadens its review of non-mandatory validations for future submissions	Low	Build more time into trust ref costs timescale & develop methods for testing based on common non mandatory validations based on 1213 local validations
Introduce a formal review process across all areas to strengthen clinical engagement	Low	Research with costing accountants already network with the different approaches taken & assess suitability for trust
Introduce review of reference costs submission at a senior level	High	ensure part of new deputy post responsibilities
Introduce a formal review process for cost apportionments	Low	Schedule reviewing apportionments over the year developed by Costing & Performance Advisor. Review to completed by Financial Management & Possibly some information colleagues on agreement with relevant managers
Reclassify costs incorrectly identified as overheads	Low	Review & change in system
Implement a formal system of data quality checks for community services data	Low	Put in place standard checks & time in place to check for return
Use the district valuer's report to apportion depreciation	Low	access report from financial accountant and ensure updated in system & reviewed annually
Use the reference costs grouper software to assign HRGs to activity	Low	Ensure time & resources are dedicated that all activity can be ran through grouper not just inpatients
Work with pharmacy and individual departments to identify areas where more detailed information for costing is available.	High	Agree manual process and resource implications for validation for 13/14 costing return by finance & pharmacy department. Begin discussions for long term solution along with wider commissioning issues

Links

1. **Monitor approved costing guidance**
   https://www.gov.uk/government/publications/approved-costing-guidance

2. **The new NHS provider licence**
   http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-8

3. **Acute Health Clinical Costing Standards 2015/16** http://www.hfma.org.uk/NR/rdonlyres/B0D84D96-0F62-42B4-A655-FBB1DCD869B2/0/AcutestandardsFeb15.pdf

4. **Reference costs guidance for 2014-15**

   https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402356/Reference_costs.pdf

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

ASSURANCE FRAMEWORK

Q 1 - 2015/16

Presented to Board of Directors 7th July 2015

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

ASSURANCE FRAMEWORK

CONTENTS

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

Strategic risks will be reviewed as part of the annual business planning process and can also be identified in-year. They are managed as part of a complex process as opposed to discrete events. The Trust Board needs to be satisfied that strategic risks are being properly identified and managed robustly.

Risk score= consequence/impact x likelihood

The matrix below can be used to calculate a risk score, which will determine what category the risk falls within, that score informing follow up action, its urgency, and the required performance management to ensure the risk is managed effectively.

LIKELIHOOD	CONSEQUENCE / IMPACT				
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
	Almost no impact on achievement of objectives	Small impact on achievement of objectives	Sgnificant impact on the achievement of objectives	Major impact on the achievement of objectives	Objectives could not be achieved
1 Rare	**1**	**2**	**3**	**4**	**5**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
3 Possible	**3**	**6**	**9**	**12**	**15**
4 Likely	**4**	**8**	**12**	**16**	**20**
5 Almost Certain	**5**	**10**	**15**	**20**	**25**

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency(broad descriptors of frequency)	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

A fuller description and explaination of the impact and likelihood categories are contained within the Risk Management Strategy and Policy

Impact Level of Risk Potential/Actual Origins

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

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

Controls

The extent to which the controls in place are satisfactory impacting on the mitigation of the strategic risk.

- Effective control partially in place and thus only impacting in a limited way on the mitigation of the strategic risk.
- Effective control in place but only partially impacting on the mitigation of the strategic risk.
- Effective control in place and positively impacting on the mitigation of the strategic risk.

Reporting

The extent to which the reporting to a committee is providing assurance against each of the controls.

- Reporting to a committee is in place, but is not regular and only provides limited assurance against each of the controls.
- Reporting to a committee is in place, regular but not always providing assurance against each of the controls.
- Reporting to a committee is in place, regular and providing assurance against each of the controls.

Movement

The direction from last reported quarter

- ↓ Indicates improvement from last reported quarter
- → Indicates same level from last reported quarter
- ↑ Indicates slippage or further required work from last reported quarter
- ★ New item added since last quarter

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

Board Assurance Framework - Quarter 1 2015/16

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE				CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-15	TARGET RISK SCORE Mar-16	
	N/A	N/A	4x2=8	4x2=8	3x2=6	

What is the strategic risk to be controlled?					
REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE		
CR1 15-16	**Failure to maintain and enhance the quality and safety of the patient experience and ensure compliance with CQC Standards**	Medical Director / Director of Nursing and Quality	Quality, Safety & Patient Exeperience Committee	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	Non compliance with regulatory & commissioner contracts
	PC2	Risk to Registration & Licence to operate
	PC3	Poor patient experience - impact on Trust reputation
IMPACT ON CQC CORE OUTCOMES	PC4	Breach of Monitors terms of authorisation as a Foundation Trust
What are the Outcome Reference Numbers?		

Based on those reported to Executive Committee on 16 April 2013

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

The risks are CONTROLLED by…

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

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	Quaterley CQC relationship meetings	Green	★
C5	Open communication with commissioners and CQC re any concerns identified by the Trust	Green	★
C6	Staff engagement programme	Amber	★
C7	Montly quaterly metrics and KPIs review	Green	★
C8	Francis report recommendations embedded into dedicated workstreams	Green	★
C9	Clinical Rounds/unannounced clincial reviews	Green	★
C10	Clinical Audit programme	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	Quality Compliance Group	Bi-monthly	Green	★
R3	CCG quality performance meetings	Monthly	Green	★
R4	Council of Governors	Bi-monthly	Green	★
R5	Trust Governors Quality Forum	6 weekly	Green	★
R6	Board of Directors	Bi-monthly	Green	★
R7	External Stakeholders visits € e.g. Healthwatch	Ad hoc	Green	★
R8	Various groups reporting to he Quality, Safety & Patient Experience Committee i.e. safeguarding strategy	Monthly/bi-monthlu	Green	★
R9	Corporate Directors 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
R6/R9	Integrated Performance report dashboard	monthly
R1/R6	Quality Account report approved by the Board of Directors	19-May-15
R1	Thematic review, serious incidents and Patient ID action plan	16-Mar-15
R1	CQC intelligence monitoring reports	15-Jun-15
	External visit reports	Various
R1	Consent Audit (Dec 14 Results)	18-May-15
R1/R3	Morecombe Bay/Kirkup Report investigation report (gap analysis)	20-Apr-15
R1/R3	Audits/reports re: key CQUIN work streams	18-Jun-15
R1/R9	CQC Band 6 quarterly monitoring	19-Jan-15
R1	Coroners notification process Re; DOLS	19-Jan-15
R1	Patient experience group established (TOR)	16-Feb-15
R1	Quality elements of the performance dashboard	15-Jun-15
	Patient & Staff Stories	ongoing
R1/R6	Quality Strategy/Sign up to Safety Plan	20-Apr-15
R1/R6	Nurse staffing review complete	04-Feb-15
R1	WHO Safety Checklist Audit Report	18-May-15
R1	IR WHO Checklist Action Plan & IR Update	15-Jun-15
R1/R6	CQC Fundamental Care Standards Framework	15-Jun-15
R1/R6	Adult Safeguarding Annual report	15-Jun-15

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

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

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

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

STRATEGIC RISKS

IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-15	TARGET RISK SCORE Mar-16		
N/A	N/A	4X4=12	4x3=12	4x2=8		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR2 15-16	Inability to effectively stabilise acute patient flow	Deputy Chief Executive	Finance and Integrated Governance	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	Demand exceeds capacity leading to long waiting times
	PC2	Failure to achieve waiting time and financial targets
	PC3	Impact on overall viability of the Trust
IMPACT ON CQC CORE OUTCOMES		
What are the Outcome Reference Numbers?		

		IMPACT LEVEL	Movement
		Red Amber Green	

Potential or actual origins that have led to the risk…

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

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

The risks are CONTROLLED by…

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

REF	CONTROL	Strength RAG (*Red Amber Green*)	Movement
C1	Agreed capacity and demand analysis	Amber	★
C2	Daily monitoring of perfromance and improved escalation process	Green	★
C3	Ambulatory Care /Frailty Service	Green	★
C4	Early supported discharge	Green	★
C5	Specialty Business Packs/Plans	Green	★
C6			
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 RAG (*Red Amber Green*)	Movement
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 Laedership Board	Monthly	Amber	★
R7	Quarterly performance Reviews with divisions	Quarterly	Green	★
R8	Reporting to Commissioners & Monitor	Ad hoc	Green	★
R9	Monitor 2 day review visit	Ad hoc	Green	★
R10				

These are the POSITIVE ASSURANCES actually received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R1	Integrated Performance Report	04.02.15
R7	Contract meeting update	Jan-15
R2	Frailty launch	01-May-14
R2	Winter resilience plans (urgent and planned)	01/09/2014
R2	Mobilisation of additional winter capacity	27.10.14
R1	STAR Chamber meetings	Dec 14/Jan 15
R2	Approval of performance management system implementation	28.01.15
R4	ESIT report with ED	Mar-15
R2	Introduction of weekly Operation Performance Meeting (Chaired by DOO)	May-15
R2	Stabilisation to Transform Paper	Jun-15

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

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

REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Review of patient flow across health system	ESIT review commissioned by CCG	Q2 15/16	
G2	Stabilisation across health system	Roll out of Stabilisation programme of work including urgent care hub, complex care, elective pathways, infection control, medicines management	Q2 15/16	
G3	Patients being discharged appropriately	Roll out of Discharge to Assess	Q2 15/16	
G4				
G5				
G6				
G7				
G8				
G9				
G10				

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

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-15	TARGET RISK SCORE Mar-16		
	N/A	N/A	4x3=12	4x3=12	4x1=4		

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR	BOARD COMMITTEE		
REF	STRATEGIC RISK				
CR3 15-16	**Failure to maintain, innovate and transform the Trust's clinical services**	Medical Director / Deputy Chief Executive	Finance & Integrated Governance Committee	Amber	★

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	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
IMPACT ON CQC CORE OUTCOMES	PC4	Short term based decision making putting the long term viability of the organisation at risk
What are the Outcome Reference Numbers?		

REFERENCES OF KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK Based on those reported to Executive Committee on 16 April 2013		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	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 Startegic 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 Groups	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	Ad hoc	Green	★
R8	CoCH and Wirral Team to Team	Ad hoc	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

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

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

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

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

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-15	TARGET RISK SCORE Mar-16		
	N/A	N/A	4x3=12	4x3=12	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	★

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	Poor Staff Experience- impact on Trust reputation and ability to recruit and retain
	PC2	Poor Patient Experience - impact on Trust reputation/ increase in complaints
IMPACT ON CQC CORE OUTCOMES	PC3	Non-compliance with regulatory/commissioners contracts e.g. Well Led domain CQC
What are the Outcome Reference Numbers?	PC4	Possible reduction in Safety/Quality/Performance/Staffing indicators

REFERENCES OF KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK Based on those reported to Executive Committee on 16 April 2013		IMPACT LEVEL	Movement

Potential or actual origins that have led to the risk… *What are the most significant origins (up to 10) which could or have led to the risk?*			
REF	ORIGIN	RAG (Red Amber Green)	
O1	National reports & recommendations: Francis/Berwick/Keogh	Amber	★
O2	CQC Well Led Domain requirements & key lines of enquiry	Amber	★
O3	Quality, Safety, Financial & Operational metrics: Never Events/SUI's	Amber	★
O4	Feedback from National SOS/SFFT/GMC Trainee Survey/Student Satisfaction Survey	Amber	★
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			
O8			
O9			
O10			

The risks are CONTROLLED by… *What are the key controls (up to 10) that are in place to mitigate these risks?*		Strength (Red Amber Green)	Movement
REF	CONTROL	RAG	
C1	Board support for Shaping our Culture with Exec and Non-Exec Leads incl. Exec walkabouts	Green	★
C2	SPF/MSC support to champion - including resource Regular shadowing/walkabouts- SPF /MSC/Head of L&D	Green	★
C3	Creation of Listening points across the Trust including promotion of Speak out Safely and Sign up to Safety	Green	★
C4	Regular Pulse Checking via SFFT/SOS/GMC trainee surveys/Student Exp surveys	Green	★
C5	Improved Comms/Engagement -reaching front line staff, Team Briefing, Staff Stories, Health & Well-Being support	Amber	★
C6	Leadership Development Programmes- Countess 20:20, Clinical Leaders Dev. Prog & Releasing Potential Prog.	Green	★
C7	Master Class Programme	Green	★
C8	Development of Coaching skills prog. and Coaches/Mentors/Buddy schemes	Amber	★
C9	Development of Middle Manager /Team Leader programmes. support and skills pathways	Green	★
C10	Recognition & Celebration of Achievement	Green	★

The REPORTING mechanisms are… *What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.*			Strength (Red Amber Green)	Movement
REF	REPORTING MECHANISM	FREQUENC	RAG	
R1	Board of Directors reports	bi monthly	Green	★
R2	People and OD Committee	bi monthly	Green	★
R3	Partnership Forum / Medical Staff 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	Informal Board and SPF workshops undertaken reviewing culture/ staff experience/engagement	01-Mar-15
R1/R7	Shaping our Culture - Investment in our future. Resourcing paper to CDG agreement to proceed	22.April.15
R2/R3	People & OD Committee / SPF- How are we doing for our people monthly report	various dates in 2015
R1	Staff Survey/SFFT Report to Board of Directors with associated action plan. Monitored by POD.	01-Mar-15
R2/R3	NED support-.NED Chair and another NED member of People & OD Comm. NED Chair SPF.	01-Mar-15
C5	Staff Engagement - Team Countess Newsletter	01-Nov-14
C7	Master class series ongoing	various dates in 2015
R2/R9	Leadership Programmes in place - 20:20, Clinical Leaders, Releasing Potential	various dates in 2015
R1/R2	Recognition and Celebration of Achievements informal and formal systems in place	various dates in 2015
C5	Health & Well Being Strategy and associated activities and support in place	various dates in 2015
C5	Implementation of Schwartz Rounds	01-Feb-15
R1/R2/R9	Compliance Reports (Appraisal/Mandatory Training/Local Induction) BOD, People & OD, MDEC	various dates in 2015
C4	Student Experience/Satisfaction Surveys - open all year Multi -Prof Practice Placement meeting	various dates in 2015
C4/R9	GMC Trainee Survey- reported to Medical Education Committee	01-Jul-14
C5	Staff Open Forums- monthly	various dates in 2015
R9	Multi Disciplinary Education Committee- updates/ progress on Learning, Education & Development	various dates in 2015

The GAPS IN CONTROL / NEGATIVE ASSURANCES are… *What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?*				
REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Coaching skills prog. and Coaches/Mentors/Buddy schemes being developed/implemented.	Initial plans being put into place. Further progress will be achieved once additional resources have been recruited. Closing date for vacancies 25.6.15	Q3	
G2	Middle Manager /Team Leader programmes. support and skills pathways in development/ implemented	Initial plans being put into place. Further progress will be achieved once additional resources have been recruited. Closing date for vacancies 25.6.15	Q3	
G3	MSC support to champion - including resource. Expressions of interest asked for at recent meeting	Topic discussed at June MSC. Expressions of interest are awaited - update with Ian Harvey early July	Q2	
G4	Creation of Listening points being developed including Shadowing/walkabout programme	Initial plans developed. Further progress will be achieved once additional resources recruited.	Q2	
G5	Improved Comms/Engagement -reaching front line staff, Team Briefing, Staff Stories being developed	Comms & Culture group established with joint working across Director of Nursing & Quality & Director of HR & OD, with key leads.	Q2	
G6	Refreshed Speak out Safely programme to be launched	Review of processes and concerns raised to date undertaken by SOS steering group (June 2015). Next phase of communication under development.	Q2	
G7	Culture Journey/ Staff Engagement/Experience strategy to be developed	Draft being produced for discussion with stakeholders during July 2015, being done in conjunction with revised Learning, Education & Development strategy	Q2	
G8	Pressures of capacity and demand on staff and ability to manage pressures-lack of engagement/ time to participate	Maintain watch & analysis of participation and results of regular pulse checks/surveys, feedback from shadowing/walkabouts, cultural intelligence & escalation.	ongoing	
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

Board Assurance Framework - Quarter 1 2015/16

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

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

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	Not meeting COSRR2 and subsequent Monitor escalation process
	PC2	negative financial impact on local economy
	PC3	Inability to maintain safe and effective local services
IMPACT ON CQC CORE OUTCOMES	PC4	Potential liquidity impact and theerfore ability to fund future investments/capital programme
What are the Outcome Reference Numbers?		

		IMPACT LEVEL Red Amber Green	Movement

Potential or actual origins that have led to the risk…

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

REF	ORIGIN	RAG	Movement
O1	Contract penalties / fines	Amber	★
O2	Delivery of Cquin Schemes	Amber	★
O3	Investment in 7 day services	Amber	★
O4	Recurrent funding of existing transitional schemes	Red	★
O5	Identification and Operational delivery of efficiency schemes	Red	★
O6	Increased demand in emergency care, impact on flow and successful implementation of D2A model	Red	★
O7	Medical & nursing pay pressures - gaps and acuity leading to high agency usage	Red	★
O8	Poor budgetary management and control	Amber	★
O9	Increase in elective demand impacting on exisiting capacity to deliver	Amber	★
O10	Commissioner affordability and consequent intentions	Amber	★

The risks are CONTROLLED by…

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

REF	CONTROL	Strength RAG (Red Amber Green)	Movement
C1	Production of Annual Budget and Monitor Forward Plans and Templates	Green	★
C2	Proactive horizon scanning of potential tender to identify risks and opportunities	Green	★
C3	Robust performance monitoring and financial management control	Amber	★
C4	Budget review meetings and regular updates on efficiency schemes including stock take meetings through the Performance Framework, weekly QFWG meetings and governance arrangements	Amber	★
C5	Variable Pay and Non Pay Control working groups	Amber	★
C6	Workforce planning and international recruitment	Amber	★
C7	Robust contractual monitoring information to inform contract negotiations	Green	★
C8	Audit reports/assessments/reviews	Green	★
C9	Project group established to assess the impact of seven day services	Green	★

The REPORTING mechanisms are…

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

REF	REPORTING MECHANISM	FREQUENC	Strength RAG (Red Amber Green)	Movement
R1	Board of Directors	Bi-monthly	Green	★
R2	Finance & Integrated Governance Committee	Bi-Monthly	Green	★
R3	Commissioner contract meetings (WC / BCU / NHSE) €	Mthly	Green	★
R4	Finance Sub Committee	Mthly	Green	★
R5	Monitor (E)	Mthly	Green	★
R6	Divisional Board Meetings	Mthly	Green	★
R7	Quality, safety & Patient Experience Committee	Mthly	Green	★
R8	Council of Governors	Qrtly	Green	★
R9	Corporate Directors Group	Mthly	Green	★
R10	Audit Committee	Qrtly	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	Mthly Integrated performance Report including exceptions	
R1	Annual Budget and Efficiency Plans	
R3	Performance Report to Commissioner Mthly Meetings	
R5	Mthly Monitor Templates & Report	
R7	Mthly CQUIN update to Quality, Safety & Patient experience Committee	
R10	Annual Report sign off as going concern	
R3	Agreement of NHSE Contracrt baseline on 2/7/15	
R1	Informal feedback from Monitor Visit	
R6	Implementation of Confirm & Challenge Process with Divisions	
R6	First stage intervention for budget holder performance	

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

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

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

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

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-16	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	★

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	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
IMPACT ON CQC CORE OUTCOMES		
What are the Outcome Reference Numbers?		

REFERENCES OF KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK Based on those reported to Executive Committee on 16 April 2013		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	£22bn gap in NHS finances, NET of £8bn additional funding by 2019/20	Red	★
O2	Actual and increasing forecast for underlying recurrent deficits for the Acute sector in West Cheshire - c£23.5m by 2019/20	Red	★
O3	40% growth in the numbers of over 85s living in West Cheshire over the next 5 years	Red	★
O4	12% increase in long term conditions and continued year on year growth in Emergency Admissions (3.5% year on year)	Red	★
O5	Funding reductions in public health c£200m 2015/16	Amber	★
O6	Continued austerity and funding gaps within social care causing knock on pressure in healthcare	Red	★
O7	Workforce demographics, availability and ongoing rota gaps etc.	Red	★
O8	Continued challenge to deliver co-ordinated and integrated health and care services	Red	★
O9	Lack of ability to see the integrated picture of the operational reality of our system in real time	Red	★
O10			

The risks are CONTROLLED by…

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

REF	CONTROL	Strength RAG	Movement
C1	Estabilished West Cheshire Strategic Leadership Group	Green	★
C2	Stabilisation to Transform Program	Amber	★
C3	Western Cheshire MSCP Vanguard Program	Amber	★
C4	West Cheshire long term financial model	Red	★
C5	West Cheshire Workforce Development Plan	Red	★
C6	Centre for Integrated Health Care Science (Bache Hall)	Amber	★
C7	Lord Carter Review and ongoing work	Amber	★
C8			
C9			
C10			

The REPORTING mechanisms are…

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

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

These are the POSITIVE ASSURANCES actually received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R1	Chief Executive update to Board of Directors	05.05.2015
R3	West Cheshire Strategic Partnership Board update paper on stabilisation program	10.06.15
R3	West Cheshire Strategic Partnership Board update paper on MSCP	10.06.15
R3	Legal advice (Hampson's Report) on establishment agreement for Strategic Leadership Group	10.06.15
R6	Corporate Directors Group - discussion and next steps planning for stabilisation program	24.06.15
	Lord Carter Review Paper published	01-Jun-15
	Countess of Chester Hospitals cost base review (£20m reduction plan)	on-going

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

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

REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Real time data and system response	Part of rollout work following Lord Carter Review	on-going	
G2	Invest to save plan c£20m	Workforce, finance, planning, operational and Lord Carter team to produce initial program	Q2 15/16	
G3				
G4				
G5				
G6				
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

Board Assurance Framework - Quarter 1 2015/16

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-15	TARGET RISK SCORE Mar-16		
	N/A	N/A	4X4=16	4x2=8	4x2=8		

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

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	Monitor escalation process from action plans to formal intervention
	PC2	Escalation with Commissioners/Area Team/CQC
	PC3	Negative publicity & reputational damage
IMPACT ON CQC CORE OUTCOMES	PC4	Negative Impact on staff/patient experience
What are the Outcome Reference Numbers?		

		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	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 CDiff	Green	★
C7	Intensive hygiene regime and monitoring	Green	★
C8	Introduction of Alamac 'Kitbag'	Green	★
C9			
C10			

The REPORTING mechanisms are…

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

REF	REPORTING MECHANISM	FREQUENC	Strength RAG (Red Amber Green)	Movement
R1	Corporate Directors Group	Mthly	Green	★
R2	Finance & Integrated Governance Committee	Bi-monthly	Green	★
R3	Board of Directors	Bi-monthly	Green	★
R4	Commissioner contract meetings (WC) (E)	Mthly	Green	★
R5	Monitor	Qrtly	Green	★
R6	Quality, safety & Patient Experience Committee	Mthly	Green	★
R7	Infection Control Committee	Quarterly	Green	★
R8	Council of Governors	Quarterly	Green	★
R9	Urgent Care Working Group (E)	Monthly	Green	★
R10				

These are the POSITIVE ASSURANCES actually received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R1	Integrated performance Report/key exceptions & Risk Register	25.02.15
R2	Integrated performance Report & Risk Register to FIGC	04.02.15
R3	Integrated performance Report to BoD	16.12.14
R4	Performance Report to WC Quality & Performance meeting	19.02.15
R5	Monitor Templates & Report	1-Jan-15
R6	CQUIN update to Quality, Safety & Patient experience Committee	15.09.14
R7	Efficiency & budgetary position to QVDT meeting	
R8	Integrated Performance Update	16.12.14
R3	Cancer Paper to Board of Directors	02.09.14
R1	IST report and action plan	22.01.14
	Changes to cancer team leadership	Aug-14
	System wide winter plan now monthly item at Urgent Care Working Group	
	Escalation of Number of medically optimised/delayed transfers of care to Social Services	
	Cancer 62 day update performance report	Jan-15
	STAR Chamber meetings	Dec 14/Jan 15
R1	Changes to Ward 40 and 53	24.02.15
R2	NHS England 18 week validation report	22.04.15
R2	Cancer 62 day achived February & March	22.04.15
R4	ECIS report with ED	Mar-15
R2	Introduction of revised new intehrated 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

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

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

REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G1	Lack of validity of PTL (18 weeks)	NHS England on site	Q4 14/15	Complete
G2	Medically optimised patients / delayed transfers of care patients	Due diligence on 300 virtual beds ongoing	Q2 15/16	Complete
G3	Cancer performance	Implementation of key actions identified in action plan	Q3 14/15	Q1 15/16
G4	Performance report	Review and implementation of performance report	Q1 15/16	Complete
G5	18 week rules	Review of current rules and action plan	Q1 15/16	Q2 15/16
G6	ED perfromance relation to workforce	Stabilisation plan for ED doctor breaches in relation to middle grade doctor gaps	Q2 15/16	
G7				
G8				
G9				
G10				

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

Board Assurance Framework - Quarter 1 2015/16

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-15	TARGET RISK SCORE Mar-16		
	N/A	N/A	3x2=6	3x2=6	3x2=6		

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	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	Significant increase in NHSLA contributions
	PC2	Failure to maintain Provider Licence (Monitor)
	PC3	Impact on Trust's overall performance
IMPACT ON CQC CORE OUTCOMES	PC4	Reputation of Trust
What are the Outcome Reference Numbers?		

REFERENCES OF KEY OPERATIONAL RISKS IMPACTING ON THIS STRATEGIC RISK Based on those reported to Executive Committee on 16 April 2013		IMPACT LEVEL	Movement
		Red Amber Green	

Potential or actual origins that have led to the risk…	*What are the most significant origins (up to 10) which could or have led to the risk?*		
REF	ORIGIN	RAG	
O1	Significant number of changes to Board of Directors membership	Green	★
O2	Review of the Governance Framework	Green	★
O3	Failure to triangulate outcomes of Board committees	Green	★
O4	Health and Social Care 2012 - training for Governors	Green	★
O5	Board development	Green	★
O6			
O7			
O8			
O9			
O10			

The risks are CONTROLLED by…	*What are the key controls (up to 10) that are in place to mitigate these risks?*	Strength *Red Amber Green*	Movement
REF	CONTROL	RAG	
C1	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.*		Strength *Red Amber Green*	Movement
REF	REPORTING MECHANISM	FREQUENCY	RAG	
R1	Regular updates to Board of Directors and Board committees	monthly	Green	★
R2	Regular updates to Council of Governors/Governors Quality Forum	As required	Green	★
R3	Updates to Senior Management Team	Bi-monthly	Green	★
R4	Monitor / CQC / WC CCG	As required	Green	★
R5	Weekly reporting to Execs	As required	Green	★
R6				
R7				
R8				
R9				
R10				

These are the POSITIVE ASSURANCES actually received…		
What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective.		
REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
R5	Provided an update at the Weekly Executive meeting	11.06.14
R1	Provided an update to the Board of Directors	04.03.14
R2	Provided an update to the Council of Governors/Governors Quality Forum	04.03.14
	Regular communication and discussion with the Chairman	1-Feb-15
R1	Full refresh of the Board Assurance Framework	04.02.14
R1	Provided update to Audit Committee	14.04.14
	Full review of Risk Management Strategy	22.01.14
	Executive Team Development Programme underway	1-Feb-15
R1	Corporate Governance Manual presented to Board	04.03.14
R5	Corporate Directors Group - role of group reviewed and developed	25.02.15
R5	Planning for corporate governance self assessment	1-Feb-15
	Establishment of finance sub-committee	05.05.15
	People and Organisational Development Comm approved as formal Board Sub-Committee	03.03.15

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

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

STRATEGIC RISKS	IMPACT x LIKELIHOOD = RISK SCORE				CURRENT ASSURED LEVEL	Movement
	INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE		
				Mar-16 / Mar-17		
	N/A	N/A	3x4=12	4x3=12 / 4x3=12		

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE	CURRENT ASSURED LEVEL	Movement
CR9 15-16	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 Executive Committee on XXXX		IMPACT LEVEL	Movement
		Red Amber Green	

Potential or actual origins that have led to the risk…	*What are the most significant origins (up to 10) which could or have led to the risk?*		
REF	ORIGIN	RAG	
O1	Unintended loss of confidential or valuable data (clinical, corporate & employee) e.g. lost ward handover sheet	Amber	★
O2	Misdirection of confidential or valuable data to an individual or individuals e.g. incorrectly addressed letter	Amber	★
O3	Incorrect disposal of data media or its content that does not protect confidentiality e.g. confidential waste in a non-confidential bin	Green	★
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 access to data	Green	★
O10	Intentional (approved/unapproved) disposal/transfer of confidential/valuable data, inappropriately e.g. child records weeded at 7yrs	Amber	★

The risks are CONTROLLED by…		Strength	Movement
What are the key controls (up to 10) that are in place to mitigate these risks?		*Red Amber Green*	
REF	CONTROL	RAG	
C1	**95%** of staff undertook Information Governance training within the last 2yrs	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…			Strength	Movement
What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.			*Red Amber Green*	
REF	REPORTING MECHANISM	FREQUENCY	RAG	
R1	Risks and incident trends reported to the Informatics Board	monthly	Green	★
R2	Risks and incidents reviewed by the Caldicott & IG Panel	monthly	Green	★
R3	Bi-Annual IG and Annual Caldicott reports to the Informatics Board	bi-annual/ annual	Green	★
R4	Significant incidents reported through STEIS	As required	Green	★
R5	Significant incidents reported to the Information Commissioners Office	As required	Green	★
R6	Audits reviewed by the Informatics Board and Action Plans tracked	As required	Green	★
R7	Information Governance plan updates to the Informatics Board	Quarterly	Green	★
R8	Exec Team receives updates on significant risks and issues	Weekly	Green	★
R9	Finance & Integrated Governance receives Informatics Board minutes	Bi-Monthly	Green	★
R10	Audit & research data requests reviewed by Caldicott Panel	monthly	Green	★

These are the POSITIVE ASSURANCES actually received…

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

REPORT REF	POSITIVE ASSURANCE *What is the report received that provided that assurance?*	DATE LAST REPORTED TO COMMITTEE
A1	Independent review of Information Governance presented to Executive Directors	Dec-13
A2	ICO Data Protection Audit Report (Limited Assurance)	Jul-13
A3	IT Health Check (including Penetration Test) report received	Aug-14
A4	Routine email communications relating to IG alerts and threats	On-going
A5	Assurance on workforce Information Governance included in HR Annual Plan	Jun-14
A6	MIAA IGT Audit - mandatory (Significant Assurance)	Mar-15
A7	2014/15 Information Governance Toolkit Submission 72% - Level 2 Compliance	Mar-15
A8	MIAA IGT Audit - review IGT requirements not covered by 14/4/14 audit (Significant Assurance)	Aug-14
A9	Bi Annual Information Governance report received by Informatics Board	Jan-15
A10	Annual Caldicott report received by Informatics Board	Oct-14
A11	MIAA Core IT Infrastructure Review (Significant Assurance)	Jan-15
A12	MIAA IGT Pre-Audit (Limited Assurance) - review of 16 of the 45 Standards	Dec-14
A13	NHS.Net email secure encryption implemented; reviewed and approved by the IG Panel	Jun-15

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

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

REF	GAP	ACTION PLAN	AGREED DEADLINE	REVISED DEADLINE
G3	Secure disposal of sensitive, confidential and person identifiable paper waste	Let new contract for secure confidential waste bins and disposal	Q1 14/15	Q4 15/16
G4	Extend data flow mapping	Continue work on data flow mapping, assess progress annually	Q4 15/16	
G5	Extend Information Asset Register	Continue work on Asset Register, assess progress annually	Q4 15/16	
G6	Members of the Information Governance Panel and Caldicott complete 15/16 training	Appropriate online training undertaken by all panel members	Q4 15/16	
G7	Dictation devices not encrypted	On-going rollout of digital dictation and replacement of dictation devices without encryption	Q4 16/17	
G8	Potential for research and publications to be undertaken without appropriate patient consent	Review policies relating to research and publications to ensure appropriate consent models	Q2 14/15	Q1 15/16
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	Q3 15/16
G10	Unable to send confidential data to non-NHSmail email accounts encrypted	Adopt and implement new NHSmail email encryption service amending policies and SOP's as required	Q2 15/16	Q1 15/16

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

Board Assurance Framework - Quarter 1 2015/16

STRATEGIC RISKS

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

What is the strategic risk to be controlled?					
REF	STRATEGIC RISK	EXECUTIVE DIRECTOR	BOARD COMMITTEE		
CR10 15-16	**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	POTENTIAL CONSEQUENCES OF THE RISK *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 Executive Committee on XXXX		IMPACT LEVEL	Movement

Potential or actual origins that have led to the risk…

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

REF	ORIGIN	RAG (Red Amber Green)	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 (Red Amber Green)	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	Red	★
C7	Audit programme including Pen Testing, Coding, Backup & Resilience, IGT, Asset Management, Data Quality, etc.	Green	★
C8	IT infrastructure, desktop and mobile assets supported, maintained and replaced in-line with best practice	Amber	★
C9	Comprehensive user training programme (initial and refresher) across all assets under management	Red	★
C10	Appropriately resourced, qualified, knowledgeable, motivated, well trained and sustainable workforce	Amber	★

The REPORTING mechanisms are…

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

REF	REPORTING MECHANISM	FREQUENCY	Strength RAG (Red Amber Green)	Movement
R1	Informatics strategy reviewed by the Informatics Board	annual	Red	★
R2	Informatics programme progress reported to the 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	monthly	Green	★
R8	Informatics Stocktake with Executive Directors	quarterly	Green	★
R9	Annual Plan reviewed and approved by Informatics Board	quarterly	Green	★
R10	5yr Capital Plan reviewed and approved by Informatics Board	6 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	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	Informatics Board constituted and meeting monthly reporting to Finance & Integrated Governance	25-Feb-14
A8	IT Service Continuity Review (Significant Assurance)	27-Mar-14
A9	MIAA IGT Audit (Significant Assurance)	31-Mar-15
A10	2014/15 Information Governance Toolkit Submission 72% - Level 2 Compliance	31-Mar-15
A11	MIAA IGT Audit - Review IGT requirements not covered by 14/4/14 audit (Significant Assurance)	9-Aug-14
A12	Quarterly Informatics Stocktake undertaken with the Executive Directors	18-Feb-15
A13	MIAA VoIP Audit (Significant Assurance)	16-Dec-14
A14	MIAA Core IT Infrastructure Review (Significant Assurance)	19-Jan-15
A15	MIAA IGT Pre-Audit (Limited Assurance) - Review of 16 of the 45 Standards	12-Dec-14
A16	HSCIC IT Health Check Report	30-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	Disaster recovery and business continuity plans not developed or tested	Develop timetable for review and testing of plans	Q4 15/16	
G4	Senior Informatics team roles, responsibilities and structures not currently fit for purpose	Review and update job descriptions, bandings and structure of the senior Informatics team	Q1 14/15	Q2 15/16
G5	Inadequate Informatics staff development and no professional accreditation	Develop Informatics as a profession Achieve foundation level ISD accreditation	Q4 14/15	Q4 15/16
G11	Absence of Informatics/Digital Strategy	Develop and present new Informatics/Digital Strategy to Board of Directors	Q4 14/15	Q2 15/16
G12	Remote connections for Meditech and N3 contain a number of single points of failure	Undertake assessment of remote connection single points of failure and develop a set of recommendations for consideration	Q1 15/16	
G13	Inadequate information reporting tools	Implement new ClikView reporting solution for A&E, 18wks and Quality	Q2 15/16	

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

STRATEGIC RISKS

IMPACT x LIKELIHOOD = RISK SCORE					CURRENT ASSURED LEVEL	Movement
INITIAL RISK SCORE	PREVIOUS QUARTER RISK SCORE	CURRENT RISK SCORE	TARGET RISK SCORE Apr-15	TARGET RISK SCORE Mar-16		
N/A	N/A	4x3=12	4x3=12	3x3 = 9		

What is the strategic risk to be controlled?					
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	★

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	Possible reduction in services and poor patient experience/staff experience
	PC2	Need to outsource services
	PC3	Use of agency staff / increased costs
IMPACT ON CQC CORE OUTCOMES	PC4	Risk to patients / risk to staff, if inadequate cover
What are the Outcome Reference Numbers?		

		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	Gaps in junior doctors rotas	Red	★
O2	Lack of suitably qualified candidates in specialist clinical skills e.g. ED Consultants/Sonographers/EBME/Endoscopy/Anaesthetics	Amber	★
O3	Tighter UK border controls for non EU countries / Tier 2	Amber	★
O4	Implications of Nurse Revalidation	Amber	★
O5	National pay and pensions agenda and potential for industrial action	Green	★
O6	Age profile/demographic in some staff groups EG Midwifery/Nursing	Amber	★
O7	High cost of agency / locum staff (Nursing / Medical Groups)	Red	★
O8	Commissioning changes e.g. tenders	Green	★
O9	7 day services and additional resource requirements	Amber	★
O10	Operational pressures and impact on retention/health and wellbeing appraisals, mandatory training etc.	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	Development and communication of People & OD Strategy	Amber	★
C2	Medical staffing gaps, fortnightly reviews	Green	★
C3	Improved recruitment material and website	Amber	★
C4	Relationship management with Deanery	Green	★
C5	Medical staffing admin team	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	Countess 2020 and other development programmes e.g. Clinical Leaders programme, releasing Potential Programme	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	FREQUENCY	Strength RAG	Movement
R1	Board of Directors reports	bi-monthly	Green	★
R2	Finance and Integrated Governance Committee	bi-monthly	Green	★
R3	People and OD Committee	bi-monthly	Green	★
R4	Nursing and midwifery workforce bi-monthly Transformation Group	bi-monthly	Green	★
R5	Partnership Forum	Monthly	Green	★
R6	Executive Directors Group	Weekly	Green	★
R7	HR & Wellbeing Business Services Management Board / HR Performance Board	quarterly	Green	★
R8	Annual Deanery visit (E)	Annually	Green	★
R9	GMC trainee survey (E)	Annually	Green	★
R10	University relationships (E)	On-going	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	Reporting on agency & variable pay spend. Task & Finish Group established.	May-15
R2	Regular reports to Board on workforce trajectory.	1-Mar-15
R3	Nursing and midwifery workforce strategic and operational group	Monthly.
R4	Multi-Disciplinary Education Committee	Various dates In 2015
R5	Partnership Forum: Staff engagement /staff survey/staff experience/SFFT reviewed monthly	Monthly.
R6-a	Staff survey reported to Board of Directors, with associated action plan in place.	1-Mar-15
R6-b	Sign off HEE return - People & OD Committee	Jul-15
R3	NED Chair for People and OD Committee - March 2015 onwards	1-Mar-15
R1	Appraisal Performance increases to 89% (June 2015)	1-Jun-15
R3	Staff engagement/survey review group established	Various dates in 2015
C7	Monthly monitoring of safer staffing	Monthly.
R3	Occupational Health visits reported to POD Committee / Partnership Forum	Various dates in 2015
R2	Medical Staffing / Nurse Staffing / Nurse revalidation papers presented to POD	Jun-15
C10	Health & Wellbeing Strategy group established & meeting on a monthly basis.	Monthly.
R1	Speak Out Safely progress paper	Dec-14
C10	Implementation of Schwartz Rounds	Feb-15
R3	Receipt of national recognition e.g. HSJ/Navajo/Leadership Academy	Various dates In 2014/15
R10	University of Chester and opportunities for education/innovation/research	Various dates In 2014/15
R6	Executive '1st of the Month' walkabouts reported to EDG	Jun-15
R6	Masterclass series implemented	Various dates in 2014/15
R1	Informal Board and SPF workshops undertaken reviewing culture and engagement	Mar-15
C10	Development & Launch of Carers Strategy to support members of staff as carers.	Jun-15
R5	Exit Interview / How are we doing interviews implemented. Feedback to SPF June 2015.	Jun-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	Gaps remain in some medical specialties in junior doctors rota	Action plans in place for Urgent care recruitment requirements over next 12 months. Further escalation with Deanery, looking at alternative workforce options. Full team in medical staffing in place with analysis of gaps & actions. Reports to POD Jun 15 & July 2015.	Q2	On-going
G2	People and OD Strategy being developed.	In development for all staff groups in conjunction with key stakeholders, to include increased profile for recruitment, key roles profile etc. Annual Plan 15/16 agreed. To be presented to POD September 2015.	Q3	Q2 15/16
G3	Stronger clinical engagement in recruitment processes, e.g. drafting of JDs and commitment for recruitment timescales	Divisions more involved and accountable, fortnightly monitoring, reviewing value based recruitment. Working with regional group & NHS Employers in relation to agency spend across the region. Part of HQCL Process work stream.	Q3	On-going
G4	Shortage of certain professions e.g. ultra sonographers and nurses	Reported as part of regional workforce planning return July 2015 Working with University and HENW on Sonographers programme & exploring Forerunner fund options.	Q3	On-going
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%.	Q3	On-going
G6	Integrated workforce agenda	Integrated monthly workforce agenda meeting for HRDs and key leads. Integrated People Strategy developed. Supporting Stabilisation & Transformation agenda.	Q4	Q1 15/16
G7	Staff Engagement (Staff Survey/SFFT)	Staff Friends & Family issued all quarters 2014/15. Action plan in place and being monitored by Culture risk & POD. Staff Survey group established with supporting communication. Staff experience governance being developed to report to POD Committee.	Q2	Ongoing
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.	Q2	Ongoing
G9	Variable pay spend monitoring & controls.	Weekly task & finish group established. Review of Monitor diagnostic tool. Assessing link with CRS plans and focus on spend related to Bank, Agency, Overtime, ACAs as well as developing controls and increased attention and focus on medical gaps and reducing sickness impact /associated costs.	Q4	
G10				