Countess of Chester Hospital NHS Foundation Trust

Public Board of Directors – 9th November 2021

Agenda item 14 - Consent Items

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NHS
Countess of Chester Hospital
NHS Foundation Trust

Meeting	**9th November 2021**		**Board of Directors**					
Report	**Agenda item 14(a)**		**Emergency Preparedness Resilience and Response (EPRR) Core Standards Assessment 2020-2021**					
Purpose of the Report	Decision		Ratification	**X**	Assurance		Information	
Accountable Executive	David Coyle				Chief Operating Office			
Author(s)	Matt Innerd				Emergency Planning & Business Continuity Manager			
Board Assurance Framework	Q1 E5	Quality & Safety Business Continuity – Pandemic flu/ virus						
Strategic Aims	To deliver safe care and treatment							
CQC Domains	Well Led							
Previous Considerations	Quality & Safety Committee – 19th October 2021							
Executive Summary	The purpose of this report is to provide assurance to the Committee/Board in regards to the trust's annual Emergency Preparedness Resilience and Response (EPRR) Core Standards Assessment for 2020-2021. This report identifies that the trust currently has an overall rating of "non-compliant" with the NHS England Core Standards for EPRR framework[1]. The trust is partially compliant with 30 of the 46 standards for Acute Trusts and fully compliant with 16 of the 46 (35%). The enclosed report indicates the detail behind each of the partially compliant standards and outlines work required and an estimated timescale for completion in order to achieve full compliance.							
Highlights	• There needs to be a significant piece of work undertaken to review and update the trust's Business Continuity Management system to meet the required alignment with ISO22301 – the International Standard for Business Continuity. By aligning to this standard the trust will achieve full compliance with all 7 Business Continuity Standards. • There needs to be a review of the Trust Major Incident Plan and supporting plans, including training and exercising. Once							

	completed, this will achieve full compliance with another 5 standards. • The trust needs to invest time and resource to its Chemical Biological Radiological and Nuclear (CBRN) capability. Training competencies for frontline staff working in ED need to be met and maintained, in order to ensure the trust has a consistent level of resource available 24/7, should it be required. This will achieve full compliance with another 7 standards. • There needs to be work undertaken to strengthen the governance arrangements around EPRR, this will lead to compliance in another 6 standards. • The level work required to achieve full compliance needs to be sustained in order to ensure that the Trust's compliance levels continue to be met annually. This requires investment in time and resource to ensure the trust is able to effectively meet its requirements under the Civil Contingencies Act 2004.
Recommendation(s)	The Board is requested to**:** • Note the assurance provided within the report • Note the ongoing work to progress the action plan, which will continue to be monitored by the EPRR Strategy Group and reported to Quality Governance Group quarterly. • Ratify the overall EPRR Core Standards Assessment Statement of Compliance, as approved by Quality & Safety Committee.
Corporate Impact Assessment	
Statutory Requirements	Meets the trust compliance with the NHS England Standards for EPRR
Quality & Safety	
NHS Constitution	
Patient Involvement	
Risk	
Financial impact	
Equality & Diversity	
Communication	

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

Countess of Chester Hospital NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Countess of Chester Hospital NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
46	0	30	16
Acute providers: **46** Specialist providers: **38** Community providers: **37** Mental health providers:**37** CCGs: **29**			

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

28/09/2021

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) - Not compliant with the core	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance											
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	Name and role of appointed individual	David Coyle - Chief Operating Officer - Accountable Emergency Officer	Partially compliant	Trust does not currently have a named non executive director for EPRR. Trust Executive and Board to agree named NED for EPRR	David Coyle - AEO	Oct-21	
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	COCH EPRR Strategy - Draft, to be finalised at EPRR Strategy Group 13 Oct 2021	Partially compliant	EPRR Strategy is in draft format. Tabled on Agenda for 13 Oct 21 EPRR Strategy Group Meeting to be signed off. Strategy can then be implemented.	Matt Innerd - EPRR Manager	13-Oct-21	
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Annual EPRR report due to be shared with board at Quality Safety Governanve Meeting (19 Oct)	Partially compliant	EPRR Core Standards report to be presented to board Quality Safety Governance Meeting (19 Oct)	David Coyle - AEO	19-Oct-21	
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	COCH EPRR Strategy - Draft, to be finalised at EPRR Strategy Group 13 Oct 2021 Trust has only had a full time EPRR & BC Manager in post since July 2020. There is a significant amount of work to be undertaken and additional EPRR resource needs to be identified to support the workplan	Partially compliant	Strategy contains all the relevent requirements however is currently in draft format awaiting to be signed off by EPRR Strategy Group. Meeting being held on 13 October	Matt Innerd - EPRR Manager	13-Oct-21	
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	EPRR Lessons Identified Process has been developed, based on existing Lessons Identified Process Best Practice (Greater Manchester LRF). EPRR manager is College of Policing Structured Debrief trained. Process to be embedded within trust incident response and governance arrangements - Draft to be approved at EPRR strategy group meeting 13 Oct	Partially compliant	Process to be signed off at EPRR Strategy, 13 Oct. Further training required to embed Lessons Identified Process across trust for incidents and exercises.	Matt Innerd - EPRR Manager	13-Oct-21	
Domain 2 - Duty to risk assess											
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	EPRR Risks are included in the trust corporate risk register and divisional risk register EPRR risks are reviewed at EPRR Strategy Group quarterly National Risk Register, Community Risk Register and LHRP Risk Register regularly reviewed by EPRR Manager	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Risk Management is referred to in the trust EPRR strategy however more work is required to formally embed EPRR risks within the trust Risk Management System (e.g. EPRR category to flag relevent risks.	Partially compliant	Organisational risk management strategy needs to be reviewed to specficially reference EPRR risks. Trust Risk Management System (Datix) to be reviewed and updated to include greater visibility of EPRR specific risks.	Sharon Parker - Head of Risk	Dec-21	
Domain 3 - Duty to maintain plans											
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Major Incident Plan	Partially compliant	Trust major incident plan requires full review, to incorporate lessons identified during covid-19 response and to reflect latest changes to organisational operational management and on call structures. Plan will be an Incident Repsonse Plan detailing trust approach to management of Major Incidents, Critical Incidents and Business Continuity Incidents. Will incide role specific action cards, response structures in line with JESIP Principles.	Matt Innerd - EPRR Manager	Apr-22	
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Major Incident Plan	Partially compliant	Trust major incident plan requires full review, to incorporate lessons identified during covid-19 response and to reflect latest changes to organisational operational management and on call structures. Plan will be an Incident Repsonse Plan detailing trust approach to management of Major Incidents, Critical Incidents and Business Continuity Incidents. Will incide role specific action cards, response structures in line with JESIP Principles.	Matt Innerd - EPRR Manager	Apr-22	
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Severe Weather Response Plan - Issued July 2021	Fully compliant				

14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Severe Weather Response Plan - Issued July 2021	Fully compliant				
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Major Incident Plan Trust Business Continuty Plan(s)	Partially compliant	The trust does not have a specific named mass casualty plan. Arrangements for managing mass casualties would incorporate use of trust major incident plan and business continuity plan(s) for critical areas affected. Work underwak with Emergency Department to review casualty reception and triage processes to ensure appropriate skills, knowledge and equipment is available to recieve mass casualties at short notice 24/7	Matt Innerd - EPRR Manager	Apr-22	
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Emergency Department Major Incident/Mass Casualty Plan	Fully compliant				
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Hospital Evacuation Plan currently in draft form. Planwill be exercised in October and then finalised. Trust has also submitted evacuation and shelter returns to NHSE to support the RAAC planning.	Partially compliant	Plan to be signed off after exercise, scheduled for October 2021	Matt Innerd - EPRR Manager	Dec-21	
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Lockdown Policy	Fully compliant				
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Major Incident Plan	Partially compliant	Trust does not have a named protected individuals plan, referecne is made in major incident plan to managhement of VIPs. New plan to be developed between Clincial Staff, Commuinications and Security.	Matt Innerd - EPRR Manager Helen Taylor - Communications Manager	Apr-22	
Domain 4 - Command and control											
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	On Call Manager Rota - Tactical on Call On Call Executive Rota - Strategic on Call	Fully compliant				
Domain 5 - Training and exercising											
Domain 6 - Response											
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		Trust incident coordination centre plans need to be updated to reflect changes to location and structure of trust ICC as a result of Covid-19 pandemic	Partially compliant	Trust incident coordination centre plans need to be updated to reflect changes to location of trust ICC as a result of Covid-19 pandemic in line with review of trust Incident Response Plan	Matt Innerd - EPRR Manager	Apr-22	
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	Trust Business Continuity Plans need to be reviewed to ensure they are aligned with ISO22301 and other relevent standards	Partially compliant	BCMS needs to be restarted, building on lessons identified in Covid-19. This needs to be done in line with ISO22301 standard	Matt Innerd - EPRR Manager	Apr-23	
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	Trust Incident Coordination Centre (Silver Control) has been running constantly throughout Covid. Trust Major Incident plan outlines trust process and procedures for completion of situation reports. Trust has access to Resilience Direct Cheshire Resilience Forum Response Pages to submit sitreps to multi-agency incidents should the need arise.	Fully compliant				
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Document shared with clinical EPRR leads Available on trust intranet page. Avilable in Emergency Department.	Fully compliant				

36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Document shared with clinical EPRR leads Available on trust intranet page. Avilable in Emergency Department.	Fully compliant			
Domain 7 - Warning and informing										
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Trust has good links with partner organisations including CCG, NHS England and neighbouring trusts. Trust social media policy needs to be updated. Communications lessons identified are included in the trust lessons identified process - due for signoff october 2021. Trust has a process for logging and managing media requests	Partially compliant	Trust social media policy to be reviewed and updated	Helen Taylor - Head of Communications	Apr-22
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Trust has good links with the media. Trust communications team always consider target audience of messaging. Trust major incident plan includes references to warning and informing	Fully compliant			
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Trust does not currently have a media policy. References to warning and informing prorocols and agreed spokespeople are identified within the major incident plan. Trust communications team and executives are aware of agreed trust media spokespoeple	Partially compliant	Trust to develop a media policy. Strategic leadership in a crisis training for executives to be investigated, with specific reference to media training for major incident management.	Helen Taylor - Head of Communications	Apr-22
Domain 8 - Cooperation										
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	The trust has mutual aid arrangements with other trusts, which has been exercised during the covid-19 padnemic, for example sharing of Peronal Protective Equipment with nighboring truts.	Fully compliant			
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Trust has a draft protocol for sharing of information with police hospital documentation team. References to infromation sharing included in Major Incident Plan - referencing CCA and Data Protection Act.	Partially compliant	Formal information sharing protocol to be reviewed and approved by trust	Matt Innerd - EPRR Manager	Apr-22
Domain 9 - Business Continuity										
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	The trust Business Contnuity Policy needs to be updated and Business Continuity management system needs updating to be in line with ISO22301	Partially compliant	BCMS needs to be reviewed, building on lessons identified in Covid-19. This needs to be done in line with ISO22301 standard to ensure trust is compliant with best practice.	Matt Innerd - EPRR Manager	Apr-23
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Business Continuity management system needs updating to be in line with ISO22301	Partially compliant	BCMS needs to be reviewed, building on lessons identified in Covid-19. This needs to be done in line with ISO22301 standard to ensure trust is compliant with best practice.	Matt Innerd - EPRR Manager	Apr-23
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Action plan in place to ensure trust meets findings from recent MIAA audit.	Partially compliant	Action plan in place to ensure trust meets findings from recent MIAA audit.	Alwyn Price / Leanne Whalley	Apr-22
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Business Continuity management system needs updating to be in line with ISO22301	Partially compliant	BCMS needs to be reviewed, building on lessons identified in Covid-19. This needs to be done in line with ISO22301 standard to ensure trust is compliant with best practice.	Matt Innerd - EPRR Manager	Apr-23
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	EPRR Audit carried out by MIAA in May 2021, included some elements of Business Continuity Governance. As part of review of whole BCMS this needs to be more firmly embedded in line with ISO22301	Partially compliant	BCMS needs to be reviewed, building on lessons identified in Covid-19. This needs to be done in line with ISO22301 standard to ensure trust is compliant with best practice.	Matt Innerd - EPRR Manager	Apr-23
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Business Continuity management system needs updating to be in line with ISO22301 and trust continus improvement strategy	Partially compliant	BCMS needs to be reviewed, building on lessons identified in Covid-19. This needs to be done in line with ISO22301 standard to ensure trust is compliant with best practice.	Matt Innerd - EPRR Manager	Apr-23
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Work was carreid out as part of EU exit preparedness to reivew provider/supplier business continuity arrangements. More formal structures need to be put in place in line with ISO22301 Standard	Partially compliant	BCMS needs to be reviewed, building on lessons identified in Covid-19. This needs to be done in line with ISO22301 standard to ensure trust is compliant with best practice.	Matt Innerd - EPRR Manager	Apr-23

Domain 10: CBRN											
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Staff have access to, and regular use of Toxbase and telephone number for NPIS.	Fully compliant				
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Trust has CBRN Plan.	Partially compliant	Plan needs to be reviewed over next 12 months to relect changes to trust command and control structure and planned relocation of decontamination area due to Same Day Emergency Care Build	Matt Innerd - EPRR Manager Jackie Milliken - CBRN Coordinator Dr David Wilson - ED EPRR Lead	Dec-21
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	Reference to risk assessment in CBRN plan, Risk Assessment to be reviewed as part of planned recolation of CBRN decontamination area for SDEC build.	Partially compliant	Trust plan needs to be reviewd followed by training once CBRN decontamination area relocated due to ongoing building works.	Matt Innerd - EPRR Manager Jackie Milliken - CBRN Coordinator	Dec-21
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	• Rotas of appropriately trained staff availability 24 /7	The trust has a number of trained staff however due to current staffing rotas it is not certain that there will always be a full compliment of trained staff on shift at any one time.	Partially compliant	Further staff traiing required to ensure consistent level of resource avialability 24/7 IOR training day to be set up for Emergency Department. Protected time for training to be allocated to nursing and clinical staff to cover CBRN decontamination training	Jackie Milliken - CBRN Coordinator	Apr-22
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Completed equipment inventories; including completion date	Waiting for extra PRPS suits to be delivered. Inventory has been conducted and stock identified in current decontmaination shed.	Partially compliant	Additonal 10 PRPS suits due to be delivered by NHS England to bring stock holding to 24 PRPS suits. Once CBRN kit relocated to new store, full stocktake and inventory to be completed and regular checklist process put in place	Matt Innerd - EPRR Manager Jackie Milliken - CBRN Coordinator	Jan-22
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	Checks are carried out of the equipment on an ad-hoc basis by Emergency Planning Manager.	Partially compliant	Establish monthly kit check process as part of relocation of CBRN equipment store. Checks to be completed by Emergency Department Staff, with EPRR manager conducting audit of checks.	Matt Innerd - EPRR Manager Jackie Milliken - CBRN Coordinator	Nov-21
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	• Completed PPM, including date completed, and by whom	All PRPS suits are maintnaed and calibrated annually RAMGENE monitor serviced annually. Service records kept by Emergency Planning Manager	Partially compliant	After CBRN kit moved to new storage location, PPM programme to be implemented with Estates team to ensure Decontamination kit are maintaned on a regular basis.	Matt Innerd - EPRR Manager Jackie Milliken - CBRN Coordinator	Nov-21
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	• Organisational policy	suit disposal process outlined in plan	Fully compliant			
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	• Maintenance of CPD records	ED Practice Development Nurse is lead CBRN trainer	Fully compliant			
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	• Maintenance of CPD records	Trust has 8 trained CBRN suit trainers	Fully compliant			
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	All department staff, incluing reception staff have been sent IOR for wider NHS video.	Partially compliant	departmental trainng and awareness programme needs review. All staff working in ED need to confirm they have watched the IOR for wider NHS video. Records to be held by lead CBRN trainer for department	Matt Innerd - EPRR Manager Jackie Milliken - CBRN Coordinator	Nov-21
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		All staff required to wear FFP3 masks are fully tested using portacount machine.	Fully compliant			

NHS
Countess of Chester Hospital
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Meeting	**9 November 2021**		**Board of Directors**					
Report	**Agenda item 14b.**		**Council of Governors Chair's Report**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**x**
Accountable Lead	Bridget Fletcher				Vice Chair			
Author(s)	Keith Haynes Debbie Bryce				Interim Governance Consultant, Deputy Company Secretary			
Board Assurance Framework	G1	Governance Improvement						
Strategic Aims	To develop and improve corporate governance							
CQC Domains	Well Led							
Previous Considerations	N/A							
Summary	This report is intended to provide a summary update of business from the Council of Governors meeting held on 23rd September 2021.							
Recommendation(s)	The Board of Directors is asked to note the report.							
Corporate Impact Assessment								
Statutory Requirements	The Council of Governors holds the non-executive directors individually and collectively to account for the performance of the Board of Directors, and represent the interests of the members of the Trust as a whole and the interests of the public.							
Quality & Safety								
NHS Constitution								
Patient Involvement								
Risk								
Financial impact								
Equality & Diversity								
Communication								

1.0 Key items of business considered

1.1 The meeting of the Council of Governors was held via videoconference on 23rd September, 2021. There was both a public and private session held. The items of business included:-

In public session:

- The written Chief Executive Officer's (CEO) update report, along with verbal update;
- Questions on the Board of Directors meetings held on 13th July 2021 and 14th September along with the July 2021 integrated performance report and finance report;
- Questions in relation to the July and August Quality & Safety Committee meeting; July Audit Committee; and July Finance & Performance Committee, following receipt of the Chair's Reports;
- Governor election results 2021;
- An update on the work of the Membership Engagement Group, including approval of terms of reference; and
- Governors' feedback.

In private session:

- To consider recommendations to trigger the option to extend the contract of the external auditor for a further year; and
- To consider recommendations from the Governor Nominations Committee.

1.2 The Chief Executive made the Council of Governors aware that the Trust had received planning permission for the Same Day Emergency Care Centre (SDEC) and this was now moving forwards to transform urgent care pathways. An update was provided on the current position in relation to Covid-19 activity within the Trust and on the Trust's general activity position where there had been a 30% increase in activity, with escalation areas open, which was resulting in staffing challenges. There were a number of questions raised by governors, including the Trust's elective restoration plans. The actions being taken in this regard were outlined.

1.3 In relation to the minutes of the July Board of Directors meeting there was a governor question raised in relation to the dedicated Board mortality workshop and covering similar issues with the governors at their planned sessions, which was noted.

1.4 In relation to the Integrated Performance Report there was a discussion on incident reporting. The Executive Medical Director noted that the reporting of incidents was part of a safety culture and should be encouraged, and he welcomed the rise in incident rates reported, noting that this was not necessarily a rise in more harm within the hospital as the route cause to some incidents may be within the community. There was also consideration of maternity workforce recruitment, with the Interim Director of Nursing providing an update.

1.5 There was a brief discussion on elective recovery funding as part of the financial position. The Director of Finance advised of the funding flows from the Integrated Care System (ICS) to organisations, based on over-performance of activity.

1.6 The Committee chair's reports were considered and the Vice Chair advised the governors of the incorporation in September reports of the priorities for the committees moving forwards. There were questions raised by governors on the Trust's ward accreditation system and also on the *Limited* assurance

provided within the Emergency Preparedness, Resilience & Response (EPRR) internal audit report. In relation to EPRR, the Director of Finance acknowledged that the assurance level within the report had been affected by a lack of simulation exercises taking place, but that an Emergency Planning & Business Continuity Manager was in place to take forward the action plan.

1.7 The outcome of the recent governor elections was shared ahead of the Annual Member's Meeting, as the positions were uncontested. The Uncontested Report from the Trust's independent election provider, CES, was shared. There was a discussion on the remaining vacant governor positions.

1.8 The Council of Governors formally recorded their thanks to the outgoing governors, including Mr Russell Jackson, Deputy Lead Governor, for his dedication and achievements within the role over the previous eight years.

1.9 The work of the Membership Engagement Group was outlined to assist in improving communication with members and aim to improve the diversity of the membership, along with seeking new members to the Trust. The Council of Governors approved the terms of reference of the Membership Engagement Group.

1.10 Governor feedback topics included the timely issue of discharge letters, with a response provided by the Executive Medical Director which included some difficulties that had been experienced with the Trust's new Electronic Patient Record (EPR) implementation, and that this was being reviewed daily and dialogue with GP's in place.

1.11 In private session, and in line with their duties, the governors considered the contract extension of the Trust's external auditor, KPMG. They were updated on the current position within the national market place in relation to external auditor provision by the Director of Finance. The Council of Governors agreed to formally trigger the option to extend the contract of the Trust's external auditor for one additional year.

1.12 In private session, the governors considered the recommendation from the Governor Nominations Committee. The Council of Governors approved the appointment of Mr Michael Guymer as Non-Executive Director and Ms Pamela Williams as Associate Non-Executive Director, both on a three year term, and subject to the usual pre-employment checks.

2.0 Recommendation

2.1 The Board of Directors is asked to note the report.

Meeting	**9th November 2021**		**Board of Directors**				
Report	**Agenda item 14c.**		**Continuous Improvement Strategy Quarterly Update**				
Purpose of the Report	Decision		Ratification		Assurance	x	Information	
Accountable Executive	Susan Gilby				Chief Executive Officer			
Author(s)	Ian Bett Hollie Salisbury				Director of Transformation Head of Continuous Improvement			
Board Assurance Framework	P1, P2, Q1, E1, E2, E3,							
Strategic Aims	Delivers towards safe and effective care							
CQC Domains	Safe, Effective, Caring, Responsive and Well Led							
Previous Considerations	Quality & Safety Committee – 19th October 2021							
Summary	The purpose of this report is: • To provide the committee with quarterly progress of the CI strategy (Q2).							
Recommendation(s)	The Board is asked to**:-** • Note the progress to date, with further updates planned to Quality & Safety Committee in February 2022.							
Corporate Impact Assessment								
Statutory Requirements	CQC Standards							
Quality & Safety	Improved Quality and Patient Safety							
NHS Constitution	Aid improvement in performance standards							
Patient Involvement	Improved Patient Involvement (Lived Experience Panel)							
Risk								
Financial impact	Improve efficiency and reduce waste							
Equality & Diversity	Ensure all staff received the support through CI							
Communication	Communication to staff across the Trust							

Continuous Improvement Strategy

Quarterly update

October 2021

1.0 Background

Our Continuous Improvement (CI) strategy was developed and later approved by the Quality and Safety Committee in September 2020.

To ensure successful delivery of the strategy a robust plan was created and it was agreed assurance be provided to the Quality and Safety Committee on progress against the plan.

2.0 Purpose

The purpose of this paper is to provide the Committee with progress on the delivery of the CI strategy against the plan and agreed metrics for quarter two 2021.

3.0 Strategy Progress

The CI strategy aims to 'create a culture of CI where our staff come to work to do their work and improve their work'. To help us achieve this aim there are six drivers for change identified;

1. Leadership
2. Governance and Structure
3. Capability
4. Projects and Reporting
5. Communication and Engagement
6. Learning

Although work has commenced on all six drivers there has been a particular focus on leadership and capability and sharing knowledge of our chosen methodology for change, Lean.

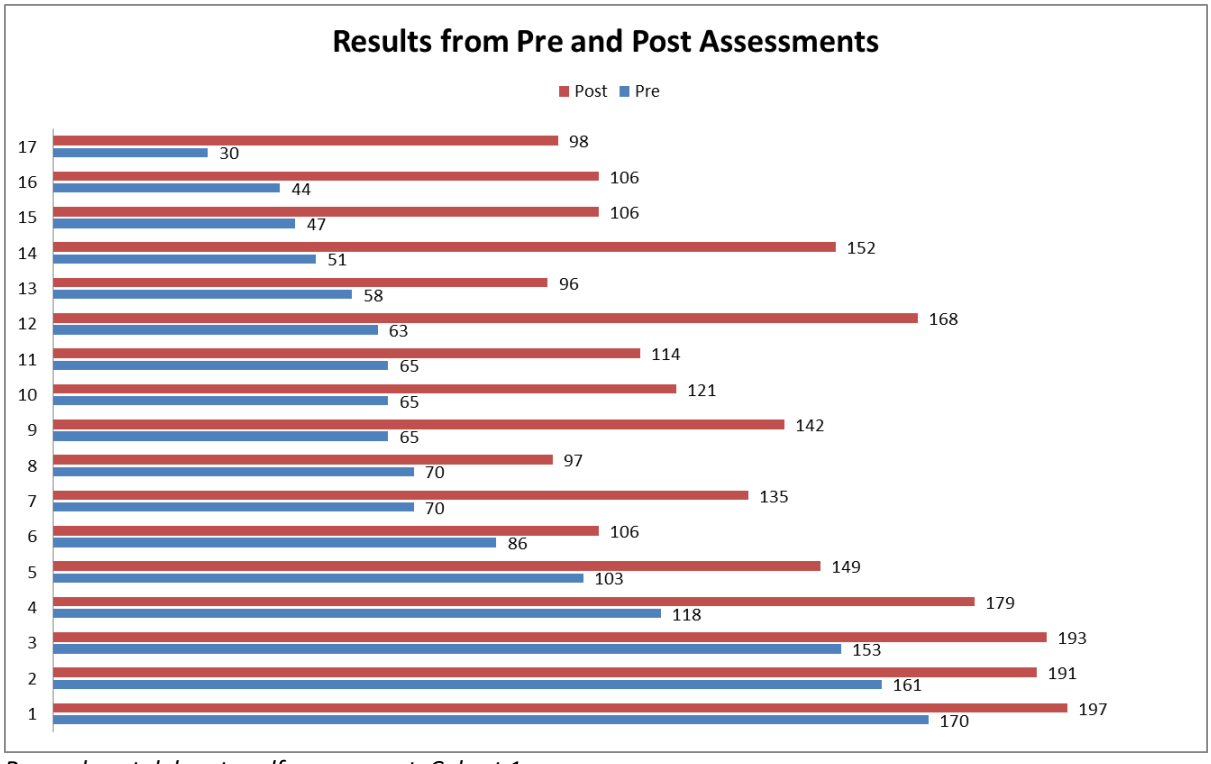
3.1 Leadership - *Leadership for improvement is nurtured at every level of the Trust.*

In September 2020 we launched the first cohort of our in-house developed programme 'Lean for Leaders'. The first cohort concluded in March 2021 with 17 staff attending all sessions. Delegates were given a further two months to work on their organisational improvement project. 13 delegates completed the three learning outcomes required and passed the programme successfully (1 person has left the Trust and 3 deferred until October 2021). For successfully completing all three learning outcomes these individuals are now be recognised as Advanced Lean Practitioners within the Trust.

Lean for Leaders - Cohort 1				
No.	Name		Project Title	Project Reference Number
1	Sarah Holmes	Business Performance Assistant	Standardising Templates	#009
2	Melissa Grant	AMU Ward Manager	Improving MUST score compliance on AMU	#004
3	Mark Perry	AMU Ward Manager	Improving MUST score compliance on AMU	#004
4	Ian Bett	Director of Transformation	Maximising the use of second dose Pfizer vaccines	#003
5	Rachel Kirby	Pharmacist	Sharing learning from incidents, near-misses and trends	#002
6	Carys Jones	Head or Research	Research and Development Invoicing	#001
7	Paula Edwards	Quality Matron	Resource Files for Wards	#007
8	Wendy Davies	Admin Team Leader	Standardising Templates	#009
9	Helen Fullwood	Project Accountant	Research and Development Invoicing	#001
10	Emma Taylor	HRBP	Time to Hire	#005
11	Keisha Shaffi	Head of Recruitment	Time to Hire	#005
12	Cara Williams	Chief Digital Information Officer	Drugs fridge temperature monitoring	#006
13	Darren Kilroy	Medical Director	Reconciliation of Medical Deployment in COVID-19	#008

Delegates and projects submitted from Lean for Leaders Cohort 1

The first of the learning outcomes is to develop a sound knowledge of Lean methodology and the tools that sit within it. To measure this we ask delegates to self-assess themselves against the various Lean tools and techniques that we teach on the programme and then again after the programme had concluded. We are looking for an increase in knowledge, to evidence achievement of this learning outcome. This is also a measure for the teaching faculty on the programme to evidence that we have successfully transferred knowledge. As you can see in figure 1 all 17 staff evidenced an increase in their knowledge of Lean methodology. The knowledge increase demonstrates that staff have the capability to implement Lean methodology and coach and support others in various tools and techniques.



Pre and post delegate self-assessment, Cohort 1

The second learning outcome is to lead an improvement project using lean methodology and the third is to lead others through change. To evidence these learning outcomes we ask delegates to practice and apply what they have learnt during the programme to an improvement project. Delegates are asked to choose a project which is relevant to their area or team and also supports strategic objectives. Some delegates worked together to

maximise efforts. Nine improvement projects were submitted on A3 project reports, our chosen methodology to evidence improvements.

The time required to attend 100% of the session and to achieve the three learning outcomes, whilst in a pandemic, showed great dedication from our leaders and supports the Trust's aim of building our continuous improvement culture. A celebration event was held in July 2021 to mark the Trust's first graduates of the programme. Delegates showcased their projects through presentations and market place stalls. We were also delighted to welcome Dr Joy Furnival who delivered a key note speech 'Leading Improvement: 10 things you need to know about improvement'. Dr Susan Gilby, Chief Executive was present to hand out the delegate awards which consisted of a certificate, lanyard, pin badge and they also each received a digital email banner to add to their email signature – this will visually show who across the organisation has been trained in Lean and to what level.

Lean for Leaders Celebration Event

Cohort two of the programme concluded in July 2021 with 20 staff attending all sessions. Delegates have been given a further two months to work on their organisational improvement projects which are due 29th October. A celebration event is planned on the 25th November.

Cohort 3 has recently commenced with 22 staff starting the programme and Cohort 4 is due to commence in April 2022 with places already being confirmed.

3.2 Capability - *To ensure our staff feel empowered and confident to improve those things that matter most to them.*

We have created and delivered a number of training offers to ensure our staff feel able to improve those things that matter to them. Most recently we have delivered a number of tailored training programmes.

<u>Lean Bite Size (Champion Level)</u>

The programme consists of ten 30 minute training sessions delivered over a five week period and is designed to provide individuals with an introduction to various Lean tools and techniques to support staff back in their place of work. Cohort three of the programme was delivered in June 2021.

Lean Basics (Champion Level)

Lean Basics is a half day introductory programme which is designed to take a deeper look at four basic concepts from Lean methodology. The session equips learners with the knowledge and understanding of the basic tools and theory. Monthly sessions have been delivered since March 2021.

On successful completion of both programmes staff are recognised as 'Lean Champions'. We asked for feedback from each session to ensure we can continually improve for future sessions.

A bespoke Lean Champion programme was also developed and delivered for the Senior Finance team. An improvement project has been identified for the team to progress.

Introduction to Lean (Practitioner Level)

The Practitioner level programme, an Introduction to Lean, is behind schedule to deliver due to the impact of the pandemic. This programme will sit as a core module of the Trusts Leadership programme which is made up of various modules to equip our leaders in the organisation with various leadership skills. This programme will be aimed at:

- Managers and leaders;
- Aspiring team leaders and managers;
- Anyone wishing to undertake an improvement project;
- Anyone on the nurse development programme, Acorn;
- Junior Doctors.

The programme is a one day programme and designed to equip staff with the tools and techniques required to deliver improvements. Participants who successfully complete the programme will be recognised a 'Lean Practitioners'. We plan to launch the programme in March 2022.

Foundation level Programmes

Our strategy sets out that all staff working here will receive 'foundation' training. Either as part of the Welcome Event and/or as part on an eLearning package which is currently in development. Prior to the pandemic face to face training was provided as part of the Welcome Event but this has now been converted to a virtual form, the CI module went live in April 2021. An eLearning package is being developed and tested to support staff as part of their mandatory training and will be live in the coming months.

4.0 Metrics

Throughout the strategy we have included aims and targets which are reflected in the project plan however, we have included a number of numerical metrics to track progress. We agreed that to evidence progress, our success metrics need to reflect our dosing formula.

				Trajectory						
Level	**Training**	**5 Year Target**	**Baseline**	**Year 1 (July 20 - March 21)**	**Year 2 (April 21 - March 22)**	**Year 3 (April 22 - March 23)**	**Year 4 (April 23 - March 24)**	**Year 5 (April 24 - March 25)**	**Total**	**Total**
Foundation	Welcome Event	4000	0	0	400	600	600	600	2200	4000
	Mandatory Training		0	0	360	480	480	480	1800	
Champion	Lean Bite Size	1000	0	20	30	30	40	40	160	1000
	Bespoke Session		0	0	18	20	26	40	104	
	Lean Basics		0	16	120	165	215	220	736	
Practitioner	Bespoke Session	1000	0	0	24	48	80	96	248	1000
	Introduction to Lean		0	0	72	200	240	240	752	
Advanced	Lean for Leaders	200	0	20	40	40	40	60	200	200
Expert	TBC	4	0	0	2	2	0	0	4	4
				56	1066	1585	1721	1776	6204	6204

Foundation Level

298 staff have now received Foundation training as part of the introduction of CI within the Trust Welcome Event. With the introduction of the eLearning package it is anticipated that the number trained will significantly grow over the coming months.

Champion and Practitioner Level

We are behind our trajectory for year one however the number of staff trained has increased in the previous quarter to now 83 staff trained at this level due to the increase in virtual sessions. A review of this model of training is underway to maximise attendance and availability. The Practitioner level training will commence from March 22.

Advanced and Expert Level

It was planned for 2021/22 that three cohorts would take place in the first 12 months which has been achieved. With the assumption that all delegates pass the programme of Lean for Leaders we will be above trajectory by the end of 21/22 with a projected 57 delegates completed. Places are now being booked for cohort 4 next year.

5.0 Next steps

Despite the pandemic significant progress has been made in the last year in driving the support and training in our agreed improvement methodology of Lean. This will continue over the coming three months with a focus on the following areas:

Projects and reporting

As programmes of training are rolled out the numbers of improvement projects will be completed that will provide significant opportunity for shared learning, understand best practice and drive further improvements. A review of potential systems is underway to support the development of a shared virtual location of improvements. We are currently reviewing the existing Trust Datix system to understand if it can be adapted and tested to meet the service specification required.

Communication and engagement

We continue to use various communication methods to communicate with staff in regards to training support as well as support for implementing improvements across the Trust. Particular focus will be to understand from staff how we can support them further to achieve a champion or practitioner level understanding.

A baseline was obtained in last year's Staff Survey in relation to how well staff feel supported in regards to implementing improvement. The staff survey of 2021 is currently live for staff to complete which will provide another 'temperature check' on progress of the impact of the strategy in its first year and opportunities to improve further.

Learning

The implementation of a new CI working group is in development as a forum to support staff in shared leaning and joint improvement.

We continue our close relationship with Toyota to aid our shared learning across both the health and private sector. We are investigating how we can strengthen this relationship further particularly in relation to training opportunities for staff,

6.0 Recommedations

The Board is asked to**:-**

- Note progress to date, with further updates planned to Quality & Safety Committee in February 2022.

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NHS
Countess of Chester Hospital
NHS Foundation Trust

Meeting	**9 November 2021**		**Board of Directors**					
Report	**Agenda item 14 (d)**		**Audit Committee Chair's Report**					
Purpose of the Report	Decision		Ratification		Assurance	**x**	Information	
Author(s)	Ken Gill				Non-Executive Director			
Board Assurance Framework	*See detail within report*							
Strategic Aims	-							
CQC Domains	Well Led							
Previous Considerations	N/A							
Summary	The purpose of this report is to inform Board members of the main priority matters considered and approved by the Audit Committee at its meeting on 1 September 2021; to link these to the Trust's risks/BAF; and to provide assurance on these matters, including any areas of escalation where the committee is not assured, and next steps.							
Recommendation(s)	The Board is asked to**:-** • Note the contents of the report, and consider the areas of escalation							
Corporate Impact Assessment								
Statutory requirements	The Audit Committee is established as a statutory committee of the Board of Directors							
Quality & Safety								
NHS Constitution	-							
Patient Involvement	-							
Risk	Internal Control risks are overseen by the Audit Committee; Financial and performance risks are overseen by the Finance & Performance Committee; Quality & Safety risks are overseen by the Quality & Safety Committee							
Financial impact	-							
Equality & Diversity	-							
Communication	-							

Countess of Chester Hospital NHS Foundation Trust

(a) Main priority items of business considered/agreed, including link to risks and next steps

The Audit Committee met on 1 September 2021 and considered the following main items:

	BAF ref	Priority items of business and assurance provided	Decision(s) and any next steps agreed
1.	-	The Committee discussed the approval previously given for the contract for external audit to be extended within the two-year window that the Governing Council had approved in December 2020 and reached the position that this was appropriate in order to secure the statutory audit process in a challenging set of market circumstances where supply is not guaranteed.	That Governors be informed that the second year of the two-year extension to KPMG's contract be secured and that the Audit Committee fully endorsed the position of Governors in this matter.
2.	G1	The Committee considered the general risk environment in a reserved piece of business with the internal and external auditors. This was informative and beneficial and Committee felt that Board would benefit from having similar sessions built in to its forward plan.	Board should consider building in regular discussions perhaps facilitated by the Internal and External Auditors to test whether the risk environment is appropriately reflected in the Business Assurance Framework and Risk Register of the COCH. Also the risk appetite of the Board should be established.
3.	G1	The risk management arrangements that operate throughout the COCH were considered together with the current Business Assurance Framework documents. Committee concluded that further detail was required at the November meeting on the internal risk management framework operation and also policy arrangements, as the required level of assurance was not received and a refresh is required to the Risk Management Policy.	The Chair of Audit, in seeking to fulfill one of the five key objectives of the Audit Committee, is engaged in discussions to consider how best this area can be developed and improved. Committee will consider how best this can be achieved in its next two meetings.
4.	G1	Work is progressing on ensuring that the approach to reporting progress on implementing internal audit report recommendations is streamlined and improved. Also, engagement in Committee of auditees has begun but more needs to be done. Management engagement with internal audit recommendations is required so that outstanding actions from several years ago are attended to.	A journey of improvement in engagement, reporting and implementing actions agreed is needed in relation to internal audit recommendations.

5.	E7	Cyber security was considered and Committee noted the challenges in making progress to enhance the security of systems, data and information at COCH, This has not progressed at the speed that Committee were comfortable with. This is largely due to capacity issues and the diversion of people capacity to the EPR programme combined with a lack of capacity.	Board should seek further assurance through both Audit and Finance and Performance Committees that the resourcing issues are being addressed so that this risk is being mitigated by appropriate actions.

(b) Items for escalation to Board, including where the Committee is not assured, and why, and any other matters to bring to the Board's attention

1. Board should consider a regular and wider based discussion on the general risk environment at appropriate intervals to ensure that the business assurance framework and risk register reflects that environment. In addition, Board should have a discussion and seek agreement on their risk appetite in the near future.

2. Board should support the Audit Committee in its efforts to improve the approach to internal audit and risk management across COCH. This may need independent, expert review and could enhance our well led credentials.

3. Board should through Audit and Finance and Performance Committees seek assurance that Cyber Security as a substantive risk within the BAF is appropriately resourced and making progress at a speed that matches the nature of that risk.

(c) Recommendation(s)

- The Board is asked to note the contents of this report and consider the areas of escalation.

NHS
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Meeting	**9 November 2021**		**Board of Directors**					
Report	**Agenda item 14 (e)**		**Updated Board Business Cycle 2021/22**					
Purpose of the Report	Decision		Ratification		Assurance		Information	x
Accountable Lead	Keith Haynes		Interim Governance Consultant					
Author(s)	Debbie Bryce		Deputy Company Secretary					
Board Assurance Framework	G1	Governance Improvement						
Strategic Aims	To develop and improve corporate governance							
CQC Domains	Well Led							
Previous Considerations	The previous 2021-22 Board business cycle was included within September 2021 Board of Directors meeting papers.							
Summary/ Highlights	This report provides the updated cycle of business of the Board of Directors for the 2021-22 financial year. The following items have been deferred during November:- • Director of Nursing Bi-annual nurse staffing report. • PLACE Report (subject to issue and subsequent review at Quality & Safety Committee). • ICP Board report within CEO report (recent ICP Board meeting postponed). • F&P Committee annual report (subject to further review of effectiveness).							
Recommendation(s)	• The Board is asked to note the updated business cycle, 2021-22.							
Corporate Impact Assessment								
Statutory Requirements	-							
Quality & Safety	-							
NHS Constitution	-							
Patient Involvement	-							
Risk	-							
Financial impact	-							
Equality & Diversity	-							
Communication	-							

Countess of Chester Hospital NHS Foundation Trust - Board Business Cycle (Version 5, 2021-22 year)

2021-22

Item	Frequency	Lead	09/03/21	20/05/21	08/06/21 Extra-ordinary meeting	13/07/21	14/09/21	09/11/21	18/01/22	08/03/22
GENERAL BUSINESS										
Welcome and apologies for absence	Monthly	N/A	x	x		x	x	x	x	x
Declarations of Interest	Monthly	N/A	x	x		x	x	x	x	x
Minutes of last meeting	Monthly	N/A	x	x		x	x	x	x	x
Action tracker and Matters Arising	Monthly	N/A	x	x		x	x	x	x	x
CEO report	Monthly	Chief Executive Officer	x	x		x	x	x	x	x
Infection Control Board Assurance Framework (BAF)	Each meeting	Dir of Nursing & Quality	x	→		x	x	x	x	x
BAF & Strategic Risk Register	Quarterly	Dir of Corporate Affairs	x			x	x		x	
QUALITY OF CARE										
Patient (or staff) Story	Monthly	Dir of Nursing & Quality	x	x		x	→	x	x	x
GMC National Trainee Survey Results	Annual	Exec Medical Director		→		x				
Quality & Safety Committee Chair Update	Monthly	Non-Exec Director	x	x		x	x	x	x	x
Safeguarding Annual Report	Annual	Dir of Nursing & Quality				→	x			
Quality Impact Assessment Report	Annual	Dir of Nursing & Quality and Exec Medical Director								x
Quality Accounts (*subject to national submission confirmation during pandemic*)	Annual	Dir of Nursing & Quality			delegated authority to Q&S Committee		x			
Patient Experience Annual Report	Annual	Dir of Nursing & Quality				→	x			
Guardian for Safer Working Report	Annual	Exec Medical Director		x			←			
Freedom to Speak Up Guardian Report	6 monthly	Chief Executive Officer / FTSU Guardian				x			x	
Mortality Indicators/ Learning From Deaths Report	Quarterly	Exec Medical Director	x	x		x	x	x		x
CQC Inspection Report	Adhoc	Dir of Nursing & Quality	Adhoc						Adhoc	

Item	Frequency	Lead	09/03/21	20/05/21	08/06/21	13/07/21	14/09/21	09/11/21	18/01/22	08/03/22
Healthcare Acquired Infections Annual Report	Annual	Dir of Nursing & Quality					x			
Director of Nursing Bi-annual Nurse Staffing Report	6 Monthly	Dir of Nursing & Quality		→		x		→	x	
Maternity Incentive Standards Submission**	Annual	Dir of Nursing & Quality				x				
Updates on Clinical Services Strategy	Bi-annually	Exec Medical Director					x			x
PLACE Report (*subject to issue date*)	Annual	Dir of Nursing & Quality		→			→	→		x
OPERATIONAL PERFORMANCE										
Integrated Performance Report	Monthly	Executives	x	x		x	x	x	x	x
Winter Planning	Annual	Chief Operating Officer					x			
FINANCE, USE OF RESOURCE & PERFORMANCE										
Finance Report (inc UoR Indicators)	Monthly	Director of Finance	x	x		x	x	x	x	x
Consultant and Honorary Consultant Appointments	Adhoc	Dir of HR & OD and Exec Medical Director								
National Cost Collection Pre-Submission Report	Annual	Director of Finance	x							
Update on Capital Budget	As required	Director of Finance	x	x		x	→	x	x	x
Finance & Performance Committee Chair Report	Monthly	Non-Exec Director		x		x	x	x	x	x
Finance & Performance Committee Annual Report	Annual	Director of Finance and Chief Operating Officer		→		→	→	subject to further review of effectiveness		
Audit Committee Chair Report	Monthly	Non-Exec Director	x	x			x	x	x	x
Charitable Funds Committee Chair Report (or via *Corporate Trustee*)	Quarterly	Non-Exec Director		x		x		Via Corporate Trustee meeting	x	
Procurement & Commercial Report	Annual	Director of Finance					x*			
Remuneration Committee Annual Report	Annual	Dir of Corporate Affairs/ Dir of HR & OD and Chair								x
Accounts and Annual Report	Annual	Director of Finance and Dir of Corporate Affairs			x					
Estates & Facilities Report	Annual	Chief Operating Officer				→	x*			
STRATEGIC CHANGE										

Item	Frequency	Lead	09/03/21	20/05/21	08/06/21	13/07/21	14/09/21	09/11/21	18/01/22	08/03/22
Revenue Budget	Annual	Director of Finance	x							x
Capital Programme	Annual	Director of Finance	x							x
Trust Board Oversight Report - Radiology Services	Annual	Chief Operating Officer		x						
Emergency Planning & Resilience	Annual	Chief Operating Officer						x		
EU Transition Impact Assessment	As required	Chief Operating Officer								
Health & Safety Annual Report	Annual	Chief Operating Officer					x*			
Inclusion [Strategy or Report]	Annual	Director of HR & OD								
Well-led Framework Review (3 yearly external review linked to CQC Key Lines of Enquiry) and Action Plan	Annual	Dir of Corporate Affairs						x (Board work-shop)		x
Information Governance Annual Report	Annual	Dir of Corporate Affairs				→	x*			
Operating Plan	Annual	Chief Operating Officer and Director of Finance	→	x						x
Strategic Objectives / Corporate Strategy	Adhoc	Chief Executive Officer		x						
Annual Plan (update against strategic objectives)	Quarterly	Chief Executive Officer						x (H2 plan)		x
Digital & Data Strategy and annual update on progress with strategy	Annual	Chief Digital Information Officer							x	
Update on cyber security progress	Bi-annual	Chief Digital Information Officer	x				x*			
Estates Strategy and annual update on progress with strategy	Annual	Chief Operating Officer		→					x	
Communications & Engagement Strategy and annual update on progress with strategy	Annual	Dir of Corporate Affairs						→		
People Strategy and annual update on progress with strategy	Annual	Dir of HR & OD		x						
Electronic Patient Record update report	bi-monthly	Chief Digital Information Officer		x		x	x	x	x	x
Integrated Care Partnership Board Reports (within CEO report)	Six times per year	Chief Executive Officer		x		x	→	→	x	x

Item	Frequency	Lead	09/03/21	20/05/21	08/06/21	13/07/21	14/09/21	09/11/21	18/01/22	08/03/22
LEADERSHIP & IMPROVEMENT CAPABILITY										
Staff related CQUINs	As required	Director of HR & OD								
Annual Review of Rules of Procedure/SFI's	Annual	Director of Finance & Dir of Corporate Affairs		→		→	x			
Annual Organisational Audit for Revalidation	Annual	Exec Medical Director					→	approved via Sept F&P		
Senior Independent Director Annual Report (private)	As required	Non-Exec Director/SID		→						
Gender Pay Gap	Annual	Director of HR & OD	x						x	
Council of Governors Report/Update	Four times per year	Dir of Corporate Affairs		x		x		x	x	
Annual Provider License Self Certification	Annual	Dir of Corporate Affairs			x					
Annual Staff Survey	Annual	Director of HR & OD		x						
Fit and Proper Person Report	Annual	Dir of HR & OD & Dir of Corporate Affairs					→		x	
Public Sector Equality Duty and Equality Delivery System (Workforce Equality Analysis Report - WEAR, WRES and WDES)	Annual	Director of HR & OD	x (ED)			x (WRES & WDES update)	x (WRES & WDES)			
OTHER ITEMS										
Minutes from Quality & Safety Committee	Monthly	N/A	x	x		x	x	x	x	x
Minutes from Finance & Performance Committee	Monthly	N/A	x	x		x	x	x	x	x
Minutes from Audit Committee	Monthly	N/A	x	x		x	x	x	x	x
Any Other Business	Monthly	N/A	x	x		x	x	x	x	x
Questions from the Public	Monthly	N/A				x	x	x	x	x
Review of the Meeting	Monthly	N/A	x	x	x	x	x	x	x	x

Note:

Updates since previous version are shown in blue text.

→ indicates original position of item on business cycle and intention to move forward and reschedule or pick up at an original date scheduled

*Some items within the Board business cycle may be covered within Committee Chair's Reports

**Maternity Incentive Standards will be based on Regional/National requirements. Visibility of Maternity issues will be enhanced at the Board e.g. Ockenden report.