NHS
Countess of Chester Hospital
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS (PUBLISHED ITEMS)
Tuesday 30th July 2024, 8.30am – 11.30am
Boardroom, 1829 Building

A G E N D A

Chair: Mr I Haythornthwaite

Time	Agenda Number	Agenda Item	Lead	Page Number	Decision Required
FORMAL BUSINESS					
8.30 am	1.	Welcome, apologies and Chair's opening remarks (verbal)	Trust Chair		For noting
8.30 am	2.	Declarations of Conflicts of Interest with agenda items (verbal)	Trust Chair		For noting
8.30 am	3.	Maintaining Focus and Oversight on Quality of Care and Experience in Pressurised Services (to be presented on the day)			
8.45 am	4.	Service Showcase (to be presented on the day)			
9.00 am	5.	Minutes of the previous meeting held on 4th June 2024 (attached)	Trust Chair	5 - 17	For approval
9.05 am	6.	To consider any matters arising and action log (attached)	Trust Chair	18	For noting
		a) Urology Patient Story update (verbal update)	Chief Operating Officer / Medical Director		For noting
		b) Maternity Services – Update in relation to Postpartum haemorrhage (verbal update)	Director of Midwifery		For noting
		c) Clinical Audit Annual Report 2023/24 (attached)	Medical Director	19 - 47	For noting
9.15 am	7.	Chief Executive Officer's Report (attached)	Chief Executive Officer	48 - 54	For noting
9.25 am	8.	Board Assurance Framework and Risk Appetite Statement (2024/25) (attached)	Director of Governance, Risk & Improvement	55 - 76	For assurance / For approval
9.35 am	9.	High Risks Report (attached)	Director of Governance Risk & Improvement	77 - 80	For noting

QUALITY OF CARE					
9.40 am	10.	Maternity Safety Support Programme (MSSP) Exit Recommendation (attached)	Director of Midwifery / National Maternity Improvement Advisory, NHS England	81 - 84	For noting / For approval
9.50 am	11.	CQC Improvement Plan including Well Led (attached)	Director of Nursing & Quality / Deputy Chief Executive	85 - 140	For assurance
10.00 am	12.	Controlled Drugs (CD) Annual Report 2023/24 (attached)	Chief Pharmacist	141 - 146	For assurance
OPERATIONAL PERFORMANCE					
10.10 am	13.	System Oversight Framework Report (to follow) Operational Performance Quality Safety Finance Human Resources & People	 Chief Operating Officer Director of Nursing & Quality/ Deputy Chief Executive Medical Director Chief Finance Officer Interim Chief People Officer		
10.20 am	14.	COCH response to the independent infected blood inquiry (attached)	Pathology Service Manager	147 - 163	For assurance
Comfort Break – 10.30am – 10.40am					
LEADERSHIP, IMPROVEMENT, CAPABILITY, ORGANSIATION DEVELOPMENT AND PEOPLE					
10.40 am	15.*	Council of Governors Update Report (attached)	Director of Governance, Risk & Improvement	164 - 165	For noting

10.40 am	16.	Anchor Institution (attached)	Director of Strategic Partnerships	166 - 176	For assurance
COMMITTEE CHAIR'S REPORTS					
10.50 am	17.	People & Organisation Development Committee Chair's Report – 11th June 2024 (attached)	Non-Executive Director	177 - 178	For assurance
10.55 am	18.	Quality & Safety Committee Chair's Report – 4th July 2024 (attached)	Non-Executive Director	179 - 181	For assurance
11.00 am	19.	Finance & Performance Committee Chair's Report – 19th June 2024 (attached)	Non-Executive Director	182 - 183	For assurance
11.05 am	20.	Audit Committee Chair's Report – 23rd July 2024 (verbal)	Non-Executive Director		For assurance
GOVERNANCE					
11.10 am	21.	Code of Governance Compliance Checklist – June 2024 (attached)	Director of Governance, Risk & Improvement	184 - 186	For assurance
11.15 am	22.	Provider Licence Compliance 2023/24 (attached)	Director of Governance, Risk & Improvement	187 - 189	For assurance
ITEMS FOR NOTING					
11.20 am	23.	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 30th April 2024 b) Approved minutes of the People & Organisation Development Committee – 9th April 2024 c) Approved minutes of the Finance & Performance Committee – 17th April 2024 and 26th April 2024 d) Approved minutes of the Operational Management Board – 23rd May 2024 **Other items:** e) Board of Directors Workplan 2024/25 f) Cheshire & Merseyside Acute Specialist Trust (CMAST) Leadership Board Update - July 2024	Trust Chair		For noting

OTHER ITEMS					
11.20 am	24.	Any Other Business (verbal)	Trust Chair		For noting
11.25 am	25.	Questions from Governors and members of the Public relating to items on the meeting agenda - ***Questions to be submitted in writing in advance of the meeting to:*** coch.membershipenquiriescoch@nhs.net ***by Friday 26th July 2024.***	Trust Chair		For noting
11.30 am	26.	Closing remarks (verbal)	Trust Chair		For noting
11.30 am	27.	**Date & Time of next meeting:** The next public meeting of the Board of Directors will be held on the Tuesday 24th September 2024. **Future Dates:** Tuesday 26th November 2024 Tuesday 28th January 2025 Tuesday 25th March 2025			For noting

**** Papers are 'for information' unless any Board member requests a discussion.***

NHS
Countess of Chester Hospital
NHS Foundation Trust

MINUTES OF THE PUBLIC BOARD OF DIRECTORS

Tuesday 4th June 2024, 8.30am – 11.30am

Boardroom, 1829 Building

Members	04/06/ 2024					
Trust Chair, Mr I Haythornthwaite	☑					
Chief Executive Officer, Ms J Tomkinson OBE	☑					
Non-Executive Director, Mr D Williamson	☑					
Non-Executive Director, Mr P Jones	☒					
Non-Executive Director, Mr M Guymer	☑					
Non-Executive Director, Mrs P Williams	☑					
Non-Executive Director, Professor A Hassell	☑					
Non-Executive Director, Mrs W Williams	☑					
Non-Executive Director, Mrs S Corcoran	☒					
Chief Operating Officer, Ms C Chadwick	☑					
Medical Director, Dr N Scawn	☑					
Director of Nursing & Quality/Deputy Chief Executive , Ms S Pemberton	☑					
Director of Strategic Partnerships, Mr J Develing	☑					
Chief Digital & Data Officer, Mr J Bradley	☒					
Interim Chief People Officer, Mrs D Herring	☒					
Chief Finance Officer, Mrs K Edge	☑					

In Attendance						
Director of Governance, Risk & Improvement, Mrs K Wheatcroft	☑					
Acting Director of Corporate Affairs, Mrs L Leadsom *(Minutes)*	☑					
Interim Deputy Chief People Officer, Ms V Wilson (on behalf of Mrs D Herring)	☑					
Interim Director of Digital, Mr D Reilly (on behalf of Mr J Bradley)	☑					
Director of Midwifery, Ms N Macdonald (item 8) via MS Teams	☑					
Chester Operational Manager – Milk Bank, Ms L Atherton (item 4)	☑					
Deputy Director of Nursing & Quality, Ms M Kynaston (item 12)	☑					
Head of Nursing, Ms N Hayes (item 12)	☑					
Public Governor – Ms R Overington via MS Teams	☑					
Staff Governor, Ms P Edwards	☑					
Staff Governor, Mrs C Price	☑					
Consultant in Anaesthesia and Intensive Care Medicine, Dr K Tizard via MS Teams	☑					

FORMAL BUSINESS		
PB1/ 06/24	**Welcome, apologies and Chair's opening remarks** The Trust Chair, Mr Ian Haythornthwaite, welcomed members to the meeting. Apologies were noted from Non-Executive Directors, Ms S Corcoran and Mr P Jones, Chief Digital and Data Officer, Mr J Bradley and Interim Chief People Officer, Mrs D Herring.	
PB2/ 06/24	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest raised in relation to agenda items.	
PB3/ 06/24	**Patient Story** *To note, this was presented following item PB4/06/24.* The Director of Nursing & Quality / Deputy Chief Executive, Ms S Pemberton, presented a patient story to the Board of Directors relating to the care and treatment provided by the Emergency Department and the Urology Department. It was noted that this story had previously been shared with the Operational Management Board and the Division will also be undertaking a full review of this case, with an update to be provided back to the next Board of Directors.	
PB4 06/24	**Service Showcase – Milk Bank** *To note, this was presented following item PB2/06/24.* The Operational Manager – Milk Bank, Ms L Atherton, provided an overview of the services provided by the Milk Bank noting that this is the largest NHS milk bank in England and supports over 70 neonatal units across England and Wales. Ms L Atherton updated that the Memory Milk Gift Initiative launched in October 2021 and supported 168 families to donate in 20 months and outlined the next steps for the service. The Chief Executive Officer, Ms J Tomkinson, acknowledged the passion and enthusiasm of Ms L Atherton and the team in providing this service and expressed thanks to all on behalf of the Trust.	
PB5/ 06/24	**Minutes of the previous meeting held on the 26th March 2024** The minutes of the previous meeting held on the 26th March 2024 were formally approved as a true and accurate record, subject to previous Non-Executive Director, Mr K Gill's, attendance being updated to not in attendance.	
PB6/ 06/24	**Matters arising and action log** The Board of Directors received the updated action log and noted that one action remains open with a due date of September 2024.	
PB7/ 06/24	**Chief Executive Officer's Report** The Chief Executive Officer, Ms J Tomkinson, provided an overview of the relevant local, regional, and national issues: • The Executive Team and a number of senior colleagues met with the Care Quality Commission (CQC) on 15th May 2024 and whilst recognising there are ongoing actions, there are clear areas where improvement has been sustained. A comprehensive pack of information was produced by the Trust to support the meeting and this was commended by the CQC along with the timely engagement being demonstrated through fortnightly meetings and information requests.	

- Good progress is being made in response to the NHS Staff Survey results which were published in early March.
- On 13th May 2024, the new Wellbeing Hub opened and will be open 24/7 for staff and a long-term programme of events is in place to provide long term access to wellbeing support and learning for staff.
- A series of roadshows have been held to seek the views of staff on culture and civility at the Trust. The Interim Deputy Chief People Officer, Ms V Wilson, advised that the Trust Civility Statement has now been agreed and this will now progress into the delivery and embedding phase. Non-Executive Director, Mr M Guymer, queried of the 4 suggested statements if there was 1 clear favourite across staff and Ms V Wilson confirmed that there was.
- The Trust is relaunching the use of a Team Engagement and Development Tool (TED) as part of the new ward accreditation programme and this has been mapped to the CQC Well Led indicators and it supports the organisation to have a standardised approach to measuring team engagement.
- To mark International Nurses Day and International Day of the Midwife, an award ceremony hosted by Sue Pemberton was held on 9th May 2024 to celebrate the role of nurses, midwives and healthcare assistants. Eight awards were presented.
- In May 2024, the annual Apprenticeship Awards took place to recognise the individuals contribution to the Trust and its patients and a number of awards were presented.
- On 31st May 2024, 47 staff covering a wide range of roles across the organisation, were recognised for a range of long service milestones at the Trust, the majority of which were for 25 years.
- On 30th May 2024, the Trust marked 40 years since the Countess of Chester Hospital (as it is currently known) was officially opened by HRH The Princess of Wales.
- The Annual Members' Meeting will be held on Wednesday 25th September 2024.
- The Same Day Emergency Care (SDEC) facility was officially opened by Samantha Dixon, MP for Chester on Friday 24th May 2024.
- An improvement week was held between 20th and 24th May 2024 within urgent and emergency care services with a focus on enhancing patient experiences and safety.
- The Trust continues to collaborate with colleagues across Cheshire and Merseyside to address the challenging financial situation faced by NHS Trusts in the ICB, noting that the Trust has now embarked on an ambitious cost reduction programme to address these challenges and deliver savings of £20m.
- In April 2024, due to the significant and sustained improvements made at the Trust, the criteria to exit the Recovery Support Programme (RSP) were agreed. The Trust is continuing to work collaboratively with the Cheshire and Merseyside Integrated Care Board to agree the move to a reduced level of oversight from July 2024. It is hoped that the Trust will exit the RSP completely in September 2024.
- A preliminary hearing was held on 16 May 2024 at Chester Racecourse as a procedural update on the Thirlwall Inquiry and its work since launch in

	November 2023. The Chair of the Inquiry, Lady Justice Thirlwall, confirmed that substantive hearings will begin on 10th September 2024 and will last until at least the end of 2024. • Lucy Letby's request for an appeal was heard by a panel of three judges on 25th April 2024 at the Court of Appeal in London and it was announced on 24th May that this application has been denied. A retrial of one count of attempted murder will begin in June 2024. • An update was provided on recent Executive Director appointments to the Trust. • The Chair and CEO of Cheshire and Merseyside Integrated Care Board (ICB) will be visiting the Trust on 5th June 2024 and this will provide an opportunity to showcase the improvements delivered. **The Board of Directors noted the update report provided.**	
PB8/ 06/24	**Maternity Service Update – Quarter 4 2023/24** The Director of Midwifery, Ms N Macdonald, provided an update position in relation to the Perinatal (Maternity and Neonatal) services at the Trust and provided an overview of all requirements that need Board level sign off for the Maternity Incentive Scheme (MIS), formally known as the Clinical Negligence Scheme for Trusts (CNST). Ms N Macdonald provided an overview of the Cheshire and Mersey Maternity Provider's standardised Quarterly Perinatal Board report template for January – March 2024 noting that this is a requirement of the Local Maternity & Neonatal System (LMNS). Ms N Macdonald updated that a successful safety champions walk-around was conducted in April 2024 with no safety concerns raised by staff. Ms N Macdonald updated that a letter had been received from NHS England on 17th May 2024 which reaffirmed the commitment to providing safer, more personalised, and more equitable care, with funding allocations for ICBs to support these initiatives. The Chief Executive Officer, Ms J Tomkinson, advised that she had met with the Director of Research Operations (Liverpool Heart & Chest Hospital) on 3rd June 2024 to discuss the maternity voices role and that she would update Ms N Macdonald of the outcome following the meeting. Non-Executive Director, Professor Andrew Hassell, requested an update regarding the Maternity & Neonatal Voices Partnership (MNVP) being on hold due to unresolved financial hosting arrangements and Ms N Macdonald clarified that the funding has been established noting that this would be discussed further with the ICB and LMNS to clarify further. **The Board of Directors noted the update report provided.**	
PB9/ 06/24	**Integrated Incidents, Complaints, Claims and Inquests Quarter 4 2023/24** The Director of Nursing & Quality / Deputy Chief Executive, Ms S Pemberton, provided an update in relation to the number of reported patient safety incidents noting that this has remained stable with a reduced number of catastrophic, severe and moderate harm incidents. Ms S Pemberton outlined that Divisions continue to monitor trends and themes and undertake appropriate level	

investigations. Ms S Pemberton highlighted the incident themes as delayed diagnosis or treatment, skin integrity and falls, security/violence and aggression, staffing and medication safety highlighting prescribing and administration issues, all areas of which are being investigated further to ensure learning is identified and communicated across the Trust.

Ms S Pemberton outlined the concerns being received are becoming more complex and are subsequently open for longer to allow time for meetings with be held with the services and to ensure they are appropriately resolved. It was noted that 61.5% of concerns are closed in 2 working days or less and 81% of concerns are closed in 10 working days or less, noting that the process for the management of concerns is currently being reviewed to further support this process. 31% of all communication concerns are linked to appointment issues, whereby patients have been subjected to an appointment delay that they are unhappy with, have not been contacted about their appointment and are following this up, or have tried to arrange their appointment and have been unsuccessful via the service. A review of all concerns is being undertaken by the Deputy Director of Quality & Governance, Ms F Altintas, to understand the themes further as part of a deep dive.

Ms S Pemberton updated that there are a total of 158 open potential claims, where disclosure of medical records has taken place with litigation in mind, without formal allegations made to date, with learning from claims now included within this report. Ms S Pemberton updated that the Trust published its PSIRF policy and plan on the public facing website on 8th April 2024 noting that all associated policies to patient safety incidents have been updated to align to PSIRF principles.

Non-Executive Director, Mr D Williamson, acknowledged that it is excellent to receive this integrated report which provides a level of assurance to the Board of Directors and queried the timeframes for the changes to the Datix system to be actioned. Ms S Pemberton advised that the Trust has been transitioning to the patient safety learning system but this is now resolved and Datix fields will now be updated to reflect this. Mr D Williamson suggested it would be beneficial for the report to include a volume tracker chart for Serious Incidents and complaints going forward and it was agreed for this data to be included in future reports.

The Chief Executive Officer, Ms J Tomkinson, acknowledged the positive grip and control measures that Ms S Pemberton has across all areas as mentioned within the report and expressed thanks for the improvements to date. Ms J Tomkinson highlighted the feedback via the Trusts Friends and Family Test question shows that a large proportion of patients rate their care as good or very good and that the average FFT positive score for this quarter is an improved 92%.

Non-Executive Director, Professor A Hassell, acknowledged the excellent report and the level of assurance provided.

Non-Executive Director, Ms W Williams, acknowledged the positive FFT data reported and Ms S Pemberton added that responses are reviewed daily and this will also be triangulated as part of the ward accreditation process.

The Trust Chair, Mr I Haythornthwaite, also acknowledged the improvements to date, however, queried how the figures reported compare to other Trusts. Ms S

	Pemberton explained that the Trust needs to further understand the data being collated and provided to enable this to be benchmarked against other Trusts, noting this also links to the requirements for the targeted improvement for concerns. It was agreed this reporting would be discussed with the Director of Governance, Risk & Improvement, Mrs K Wheatcroft, for a future report. Mr I Haythornthwaite expressed thanks to Ms S Pemberton for the progress made to take to improve across all aforementioned areas. **The Board of Directors noted the assurance provided within the report.**	
PB10/ 06/24	**a) <u>CQC Improvement Plan</u>** The Director of Nursing & Quality / Deputy Chief Executive, Ms S Pemberton, provided an update on progress with the Trusts Improvement Plan in response to the regulatory breaches identified within the CQC's report and reflected within the subsequent CQC ratings. Ms S Pemberton highlighted that it was flagged at the CQC Engagement Meeting of the need for this action plan to be updated to include further progress updates and outcomes, which will be updated with Executive Leads ahead of this being presented back to the next Board of Directors. Ms S Pemberton updated that progress has been noted within the following areas: • Patient and Family Experience Strategy launch • CQC Registration of Tarporley Hospital • Harms improvement • Patient Safety Learning Group and incident review • Nurse Safer staffing • Review of accreditation system • Complaints management • Maternity improvement plan • Urgent & Emergency Care (UEC) Improvement Plan • Executive visibility / walkabouts • Electronic Patient Record (EPR) Optimisation • Listening events, culture & civility work and staff survey action plans • Establishment of leadership development programmes It was noted that continued areas of focus include: • Health Inequalities • Staff Feedback / Survey • Induction, Training and Appraisal Management • Medication Safety • Medical Staffing • Trust Strategy roll out including Trust Strategies (including Quality & Safety, Finance and Divisional) • E discharge • Mental health and community services collaborative • Board Assurance Framework and Risk management developments • Mandatory training	

- Safer waiting list management
- Medicines management
- Mental health and community services collaborative
- Board Assurance Framework and Risk management developments
- Policy management and review
- Mandatory training
- Safer waiting list management
- Medicines Management

Non-Executive Director, Mr D Williamson, requested a further update relating to EPR optimisation and divisional progress across specialities and the Interim Director of Digital, Mr D Reilly, advised that this will be managed via local EPR governance procedures and feedback is being collated. It was noted that this will be provided through the regular progress updates against this plan.

The Board of Directors noted the assurance of the progress against the consolidated action plan and noted that progress against this action plan will be tracked through the Executive Directors Group and reported to the Board of Directors, together with outcomes also being reported going forward.

b) Consolidated Well Led Action Plan

Ms S Pemberton provided assurance on progress with the consolidated Well Led action plan noting that Progress has been noted within the following areas:

- Executive visibility / walkabouts
- Launch of the Patient & Family Experience Strategy
- Establishment of leadership development programmes
- Board and sub-committee TOR's and workplans
- Wellbeing Hub
- Quality priorities
- Listening events, culture & civility work and staff survey action plans
- Fit and Proper Person Test (FPPT) Framework
- Launch of staff networks
- Patient Safety Oversight Group and Patient Safety Learning meetings
- Learning from deaths
- Clinical audit

Continued areas of focus include:

- Trust Strategies (including Quality & Safety, Finance and Divisional)
- Board development programme
- Staff survey action plans
- Board Assurance Framework and Risk management developments
- Policy management and review
- 7 day services
- Closure of SI's and embedding of PSIRF
- Mandatory training
- NICE guidance
- Cerner optimisation

	• Safer staffing • Organisational learning Non-Executive Director, Mr D Williamson, queried if the June / July 2024 target dates are achievable and Ms S Pemberton advised that any updates to dates would be discussed with her in the first instance as part of the executive monthly review. **The Board of Directors noted the assurance of the progress against the consolidated action plan and noted that progress against this action plan will be tracked through the Executive Directors Group and reported to the Board of Directors, together with outcomes also being reported going forward.**	
PB11/ 06/24	**Quality & Safety Committee Chair's Report – 30th April 2024** Non-Executive Director, Professor A Hassell, presented the Chair's report and highlighted the five areas to be highlighted to the Board of Directors: **NatSSIPs and LocSSIPS –** The Committee had felt there was limited assurance provided as the Trust is significantly behind other organisations in terms of a consistent approach, audit of compliance and assurance. It was noted that assurance has also been requested by the Integrated Care Board (ICB) in these areas, for the ICB contract meeting to be held in May 2024. **Resuscitation Trolley Compliance** – The Committee had felt there was limited assurance provided as trolley compliance remains below the 90% target for the past 7 months. It was noted that this has been escalated via the Operational Management Board (OMB) for the Divisions to progress. **Transfusion Training Compliance** – The Committee had felt there was limited assurance provided as the compliance rate remains at an unacceptable level (42%) and the pace to address compliance is of concern. **Clinical Audit** - Concerns were raised that 34 audits of 2023/24 have no assurance or are overdue. **Unendorsed Results** –The Committee had felt there was limited assurance as there remains a large volume of unendorsed results (57,917), with some dating back to July 2021 and clinical incidents have also been reported in relation to unendorsed results and communication of urgent results. It was noted that updates against each of the aforementioned areas have been scheduled to be reported back to future Quality & Safety Committee meetings. The Trust Chair, Mr I Haythornthwaite, queried if there is no assurance regarding the clinical audit or if they are not being completed and the Medical Director, Dr N Scawn, explained that a review has been undertaken within the Clinical Audit Department with the Head of Quality now leading on this piece of work. Dr N Scawn clarified that the audit documentation was not being completed which has impacted on the compliance rating, however, would clarify this further and provide an update back to the next Board of Directors. Non-Executive Director, Mr M	

	Guymer, queried the total number of audits completed and Dr N Scawn also agreed to clarify this as part of the update. Mr I Haythornthwaite requested further information relating to the unendorsed results and Dr N Scawn advised that the Deputy Medical Director is due to meet with another NHS Trust on 10th June 2024 to gain information relating to this process and options will then be explored regarding duplicating this process at the Trust. The Chief Executive Officer, Ms J Tomkinson, advised that this ongoing issue had also been discussed at the Operational Management Board held on the 23rd May 2024 and that it was agreed for the Consultant – Rheumatology, Mrs T Barnes, to review this further and provide an update regarding the plan to clear the backlog and to prevent the backlog going forward to the next OMB to be held in June 2024. **The Board of Directors noted the report.** *To note, a comfort break was held from 10.10am – 10.20am.*	
PB12/ 06/24	**Striving for Excellence Ward Accreditation Programme** *To note, this was presented following item PB3/06/24.* The Trust Chair, Mr I Haythornthwaite, welcomed the Deputy Director of Nursing & Quality, Ms M Kynaston and the Head of Nursing, Ms N Hayes to the Board of Directors. Ms M Kynaston outlined that the Trust has been using a Care Assurrance Framework (CAF) tool, as part of a 'Ward Accreditation Programme' since 2019 and that most wards and departments achieved 'gold' (good) ratings in the 2022/23 assessments. However, the ratings awarded did not triangulate with other assurance mechanisms; for example, safety metrics, quality standards and experience, as reported by patients, families, and staff. Therefore, the programme was paused in November 2023 whilst the tool was revised, and the programme strengthened. Ms N Hayes explained that the framework has been reviewed and revised to ensure it is fit for purpose and the review working group recommended adoption of the University College London (UCL) 'Ward Accreditation Programme'. However, with the imminent changes in the CQC assessment framework, the opportunity was also taken to design the programme using the newly implemented 'We Statements', inclusive of the 34 statements across five domains. Ms N Hayes outlined that behind each of the five domains are care statements that are measured using the CQC 'We Statement' criteria. It was noted that the number of criteria differs depending on the statement under assessment and the measuring tool provides details of the evidence required to achieve the criteria and each criterion is scored, and these are aggregated into an overall percentage score for the domain under assessment. Ms N Hayes confirmed that the framework has been piloted and this has evidenced the 'Striving for Excellence' accreditation programme is a robust tool that will support wards and departments to reduce unwarranted variation, drive continuous improvement in patient outcomes, and increase patient satisfaction and staff experience. Ms N Hayes advised that a trial of this has been completed	

	on AMU and a second trial will be held on the Care of the Elderly ward prior to this being launched in July 2024. Non-Executive Director, Mr D Williamson, acknowledged the excellent progress and that this has been approached with best practice methods across the country, together with the piloting to date. The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, acknowledged the work progressed since the external well led review and queried the timescales for this to be undertaken across all areas. Ms N Hayes recognised the commitment required for this and advised that 1 area per week will be undertaken. Non-Executive Director, Professor A Hassell, queried how recognition will be noted across all areas and Ms S Pemberton advised that this will be discussed at the Executive Directors Group regarding linking this to the staff award scheme, and areas will also receive a certificate and letter from Ms S Pemberton, as part of this process. Ms S Pemberton expressed thanks to Ms N Hayes and all staff involved for the work completed to date to progress this. **The Board of Directors approved the 'Striving for Excellence' programme and agreed to the roll out of the programme in July 2024.**	
PB13/ 06/24	**IR(ME)R Inspection - Nuclear Medicine submitted action plan and closure letter** The Board of Directors noted the submitted action plan and closure letter.	
PB14/ 06/24	**Finance & Performance Committee Chair's Report – 17th April 2024** Non-Executive Director, Mrs P Williams, presented the Chair's report and confirmed that there were no new items agreed for escalation to the Board of Directors from the Committee. Mrs P Williams confirmed that Laboratory Information Management System (LIMS) business case was re-presented to the Committee to review implications, risks and benefits to enable a decision to be made under previously agreed delegated authority from the Board of Directors. Further assurance was requested in relation to the 12 risks identified with mitigations to be included and a further single item Finance & Performance Committee was held on the 26th April 2024 with an updated risk information provided. The Committee confirmed approval of the recommendations within the report and supported the formal approval of the business case. **The Board of Directors noted the report.**	
PB15/ 06/24	**Audit Committee Chair's Report – 16th April 2024** Non-Executive Director, Mr M Guymer, presented the Chair's report and confirmed that there were no new items agreed for escalation to the Board of Directors from the Committee. Mr M Guymer explained that the Committee had received an update with regards to the Bank and Agency Review Final Report 2023/24 which received limited assurance from Mersey Internal Audit Agency (MIAA). The Committee felt assured with regards to the updates provided and progress made relating to the nursing aspects, however, were not assured with regards to the medical aspects. It was agreed for a further update with regards to	

	the Medical Staffing elements to be provided to the next Committee to be held in July 2024. Mr M Guymer confirmed that the Committee had also reviewed and approved the Head of Internal Audit Opinion Report 2023/24, noting that the overall opinion provides 'moderate' assurance. **The Board of Directors noted the report.**	
PB16/ 06/24	**People & Organisation Development Committee Chair's Report – 9th April 2024** Non-Executive Director, Mrs W Williams, presented the Chair's report and highlighted the two areas to be highlighted to the Board of Directors: • The Committee received an update with regards to the Leadership Development Programmes Implementation, which was highlighted as a risk for the available funding to deliver the programmes. It was agreed to bring back actions taking place back to a future Committee. • The Committee received the Employee Wellbeing – Annual Report with concerns raised within the Committee regarding the cohort of international nurses and their pastoral care, c350 staff members. The Interim Deputy Chief People Officer, Ms V Wilson, updated that the Leadership Development Programmes provide an opportunity to focus on who needs what, with specific interventions, to ensure maximum value. The Director of Nursing & Quality / Deputy Chief Executive, Ms S Pemberton, advised that she met with 6 of the Trusts international nurses on 3rd June 2024 who were very engaged and acknowledged the need to work with all nurses regarding career pathways and the different levels of experience and knowledge across the Trust. Non-Executive Director, Professor A Hassell, queried if the invite was shared with all international nurses, noting the low level of attendance and Ms S Pemberton advised this was shared across, however, not all nurses felt they were able to attend. The Trust Chair, Mr I Haythornthwaite, queried how the leadership development programmes will be funded given the Trusts financial position and Mrs W Williams advised that alternative delivery options are being explored including utilising the skills of existing HR and Wellbeing staff with external support also. Ms V Wilson explained that there is also the option to access resources collectively across Cheshire & Merseyside and also to ensure the Trust is maximising the use of the North West Leadership Academy. **The Board of Directors noted the report.**	
PB17/ 06/24	**Council of Governors Update Report** The Board of Directors noted the update report.	
PB18/ 06/24	**Revised Terms of Reference: People & Organisation Development Committee, Audit Committee, Quality & Safety Committee and Finance & Performance Committee** The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, explained that following the outcome of an external Committee Effectiveness review, the	

	Terms of Reference for the People and Organisation Development Committee, Quality & Safety Committee, Audit Committee and Finance & Performance Committee had been updated with a number of amendments proposed to each. It was noted that the updated Terms of Reference for each Committee have been agreed by members of each Committee also. **The Board of Directors formally approved the revised Terms of Reference for** • **People and Organisation Development Committee** • **Quality & Safety Committee** • **Audit Committee** • **Finance & Performance Committee**	
PB19/ 06/24	**a) <u>Fit and Proper Person checks Report</u>** The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, outlined that the purpose of this report is to provide assurance that an annual check has been undertaken for the Board of Directors to confirm their continuing compliance with the 'Fit and Proper Persons' (FPPT) requirements. It was noted that the results of these checks are detailed within the report and assurance was provided that no areas of concern have been identified. Mrs K Wheatcroft confirmed that the new NHS England FPPT framework was published in 2023/24 and this has been adopted fully in the Trust's FPPT Policy, with enhanced DBS checks being completed for all Board of Directors every 3 years, as part of this process. **The Board of Directors noted the assurance provided within the report.** **b) <u>Board of Directors – Register of Interests</u>** Ms K Wheatcroft outlined that the purpose of this report is to provide an update in relation the Trust's Register of Interests for both Executive Directors and Non-Executive Directors. It was noted that Board member interests are refreshed and published on the Trust's website on an annual basis, or following any amendments to this register as required. **The Board of Directors noted the contents of the Register of Interests.**	
PB20/ 06/24	**<u>Non-Executive Director Roles</u>** The Trust Chair, Mr I Haythornthwaite, advised that NHS England / Improvement published 'A new approach to Non-Executive Director champion roles' in December 2021. It was noted that this paper details the Trusts proposed approach, including designated champion roles for the Wellbeing Guardian, Freedom to Speak Up, Doctors Disciplinary, Maternity Board Safety Champion and Security Management and alignment to Committees for the other roles. **The Board of Directors approved the proposed champion roles in accordance with the approach to Non-Executive Director champion roles.**	
PB21/	**<u>Items for noting and receipt</u>**	

06/24	**The Board of Directors noted the following minutes and Chair's reports which had been approved by the relevant Committees:** a) Approved minutes of the Quality & Safety Committee – 7th March 2024 b) Approved minutes of the People & Organisation Development Committee – 13th February 2024 c) Approved minutes of the Finance & Performance Committee – 27th February 2024 d) Approved minutes of the Audit Committee – 21st February 2024 e) Approved minutes of the Operational Management Board – 28th March 2024 f) Research and Innovation Committee Chair's Report – 3rd May 2024 **The Board of Directors noted the following items:** g) Board of Directors Workplan 2024/25 h) CMAST Briefing – March 2024 i) CMAST Trust Board Update – April and May 2024 j) System Oversight Framework	
PB22/ 06/24	**Any other business** The Medical Director, Dr N Scawn, provided an update in response to the queries raised earlier in the meeting regarding clinical audit (item PB11/06/24); it was confirmed that the audits are taking place in the majority, however reports are not being completed which is impacting on the compliance rating. The Trust Chair, Mr I Haythornthwaite, expressed concerns in relation to the process and Dr N Scawn advised he would provide further information and assurance regarding this within the clinical audit annual report and also within future quarterly reports. The Chief Executive Officer, Ms J Tomkinson, highlighted that this process requires strengthening at pace and it was agreed for an update report to be provided to the next Board of Directors to be held in July 2024.	
PB23/ 06/24	**Questions from Governors and members of the Public relating to items on the meeting agenda** No questions were raised.	
PB24/ 06/24	**Closing remarks** The Trust Chair, Mr I Haythornthwaite, expressed thanks to all members for their input to the reports and discussions during the meeting. *To note, the meeting was closed at 10.50am.*	
PB25/ 06/24	**Date & Time of next meeting** The next meeting will be held on Tuesday 30th July 2024 (timings to be confirmed).	

Board of Directors Action Log - Updated 23rd July 2024

Action No.	Meeting Date	Allocated To	Agenda Item Number	Issue / Action Raised	Action Details	Action Update / Outcome	Due Date	Status
26	26/03/2024	Clinical Director of Research	PB5/03/24	Non-Executive Director, Mr D Williamson, acknowledged the energy from the team and queried of the reporting of the outcomes for patients from this.	It was agreed for feedback to be provided in future reports to the Board of Directors together with further information relating to research trials to	**Update 17th May 2024** - To be included in the next quarterly update in September 2024.	30/09/2024	Open
27	26/03/2024	Director of Nursing & Quality/Deputy Chief Executive and Director of Midwifery	PB13/03/24	Maternity Services Quarterly Update Report – 1st October 2023 – 31st December 2023 - Non-Executive Director, Prof A Hassell, queried if there is any benefit in the department visiting another unit with positive figures for PPH.	The Director of Nursing & Quality/ Deputy Chief Executive, Ms S Pemberton and Mrs Macdonald agreed to discuss this following the meeting.	**Update 17th May 2024** - Verbal update to be provided to the Board of Directors to be held in July 2024.	30/07/2024	Open
29	04/06/2024	Director of Nursing & Quality / Deputy Chief Executive	PB9/06/24	Integrated Incidents, Complaints, Claims and Inquests Quarter 4 2023/24 - Mr D Williamson suggested it would be beneficial for the report to include a volume tracker chart for Serious Incidents and complaints going forward.	It was agreed for this data to be included in future reports.	**Update 23rd July 2024** - This will be reflected within the next quarterly report to be provided to the Board of Directors to be held in September 2024	30/09/2024	Open
30	04/06/2024	Director of Nursing & Quality / Deputy Chief Executive and Director of Governance, Risk & Improvement	PB9/06/24	Integrated Incidents, Complaints, Claims and Inquests Quarter 4 2023/24 - The Trust Chair, Mr I Haythornthwaite, also acknowledged the improvements to date, however, queried how the figures reported compare to other Trusts.	Ms S Pemberton explained that the Trust needs to further understand the data being collated and provided to enable this to be benchmarked against other Trusts, noting this also links to the requirements for the targeted improvement for concerns. It was agreed this reporting would be discussed with the Director of Governance, Risk & Improvement, Mrs K Wheatcroft, for a future report.	**Update 23rd July 2024** - This will be reflected within the next quarterly report to be provided to the Board of Directors to be held in September 2024	30/09/2024	Open
31	04/06/2024	Medical Director	PB11/06/24	The Trust Chair, Mr I Haythornthwaite, queried if there is no assurance regarding the clinical audit or if they are not being completed and the Medical Director, Dr N Scawn, explained that a review has been undertaken within the Clinical Audit Department with the Head of Quality now leading on this piece of work. Dr N Scawn clarified that the audit documentation was not being completed which has impacted on the compliance rating, however, would clarify this further and provide an update back to the next Board of Directors. Non-Executive Director, Mr M Guymer, queried the total number of audits completed and Dr N Scawn also agreed to clarify this as part of the update.	Update to be provided back to clarify and provide further information of the process and detail within the report to the next Board of Directors.	**Update 22nd July 2024 -** Clinical Audit Annual Report 2023/24, as previously presented to the Quality & Safety Committee, provided to the Board of Directors to provide further clarity following the queries raised at the last Board of Directors meeting held in June 2024. Further verbal update to be provided at the Board of Directors to be held on 30th July 2024.	30/07/2024	Open

Meeting	**30th July 2024**				**Board of Directors**			
Report	**Agenda item 6c.**				**Clinical Audit Annual Report 2023/2024**			
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Dr Nigel Scawn				Medical Director			
Author(s)	Amanda Sadler Liz Kanwar				Head of Clinical Audit Head of Quality			
Board Assurance Framework	BAF 14	Failure to deliver Quality & Safety agenda						
Strategic Aims	To deliver safe care and treatment							
CQC Domains	Safe Effective Caring Responsive Well Led							
Previous Considerations	Quality & Safety Committee – 4th July 2024							
Executive Summary	The purpose of this report is to provide assurance in relation to the activity within clinical audit for 2023/24. The report summarises the audits registered within the financial year and the closure of actions following audit completion, including a sample of the learning from audits completed. The assurance rating for clinical audit was introduced in August 2023 and this report highlights assurance ratings where they are available. All audits that are rated as limited or very limited assurance have plans in place to reaudit and have an action plan to support. Summary to include recovery plan for NICE guidance to ensure review and compliance across the Trust.							
Highlights	• 309 clinical audits registered April 2023 – March 2024 • 344 actions identified following completion of audits, 63 (18%) of these actions remain outstanding for completion. • Overdue audits highlighted by division. • Learning and outcomes from clinical audit. • National mandated audit programme update. • Education delivery programme. • NCEPOD summary. • NICE guidance summary.							

Recommendation(s)	The Board of Directors is asked to note the assurance provided within the report.
Corporate Impact Assessment	
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status
Quality & Safety	Failure to deliver Quality & Safety agenda
NHS Constitution	Not applicable
Patient Involvement	Not applicable
Risk	Not applicable
Financial impact	Not applicable
Equality & Diversity	Not applicable
Communication	Not applicable

Trust Audit Status and Assurance Annual Report
April 2023 - March 2024

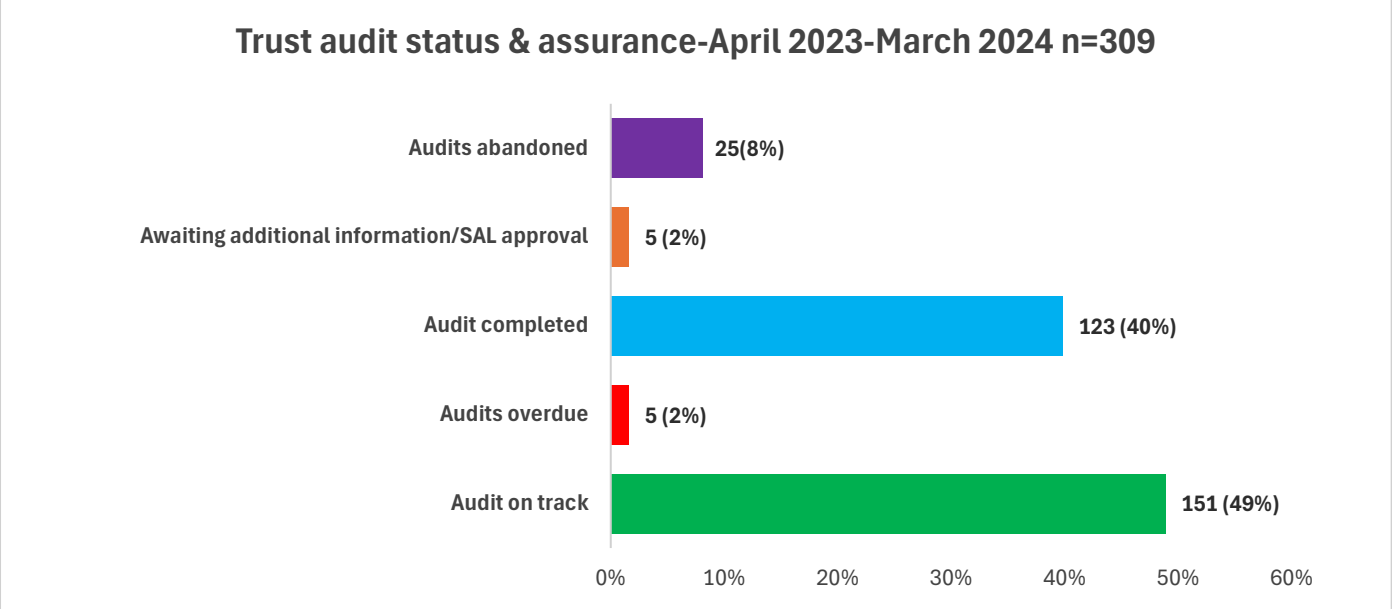
Month: 1st April 2023 - 31st March 2024
Forum Presented at: Quality & Safety Committee
Author: Amanda Sadler, Head of Clinical Audit

CLINICAL AUDIT

This paper summarises the current audit status for the Trust from April 2023 - March 2024. This report aligns with the local Clinical Audit Policy and summarises learning identified through clinical audits. The data presented is obtained from DATIX Assurance Module and collated within the annual Clinical Audit Programme Plan document, held, and maintained by the clinical audit team.

Trust Audit status summary: National & Local (n=309) registered audits April 2023-March 2024

On track	Audits Overdue	Audits completed	Awaiting additional information/Speciality Audit Lead (SAL) approval	Audits abandoned
151	5	123	5	25



In March 2024 all outstanding and overdue audits were reviewed, and contact made with relevant leads to establish reasons for incomplete audits. From communications received to date the majority of audits have been completed, it is the summary documentation and assurance rating documentation that is incomplete. The clinical audit team are working with clinicians to support population of the summary documentation and assurance documentation to ensure completion and relevant learning identified.

Many of the audits that have been recorded as abandoned have been open for a significant period of time, many having extensions granted throughout the COVID period.

Reason for audit recorded as abandoned below:

Clinician left Trust	Clinician decision	Duplicate Registration	Amended to Quality Improvement Programme (QIP)	Capacity	Alternative Audit	No documentation to support audit	Other
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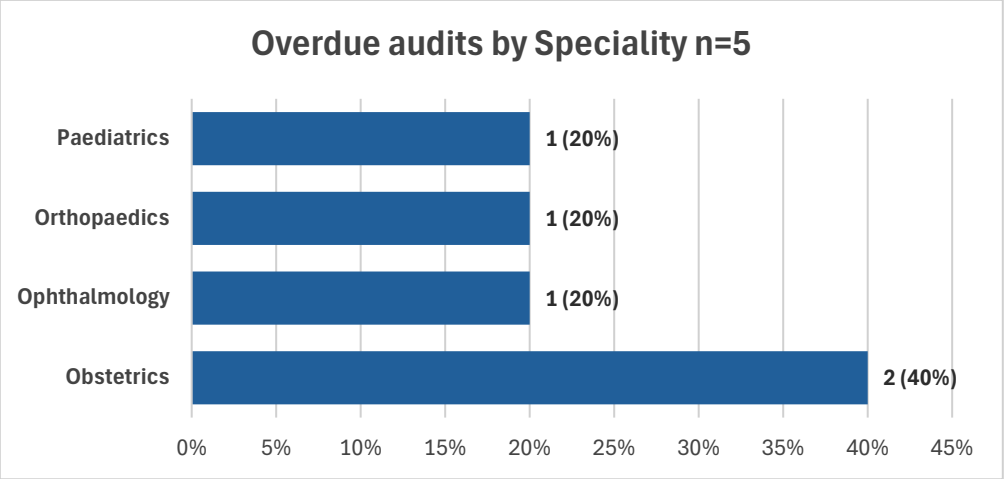
The 5 overdue audits date back to early 2023 and sit in the following specialities at time of report.



Assurance Levels

The assurance grading given for each completed audit is informed by the scoring below as set out within the updated clinical audit policy.

Assurance Level RAG	Calculation of assurance and rationale
Full	To be used 90-100% of standards achieved a score of 90% or above and rated green
Significant	To be used when 65%-89% of standards have achieved a score of 90% or above and rated green.
Limited	To be used when 35-64% of standards have achieved a score of 90% or above and rated green
Very Limited	To be used when 0-34% of standards have achieved a score or 90% or above and rated green.

123 audits have been completed within this reporting period. All audit outcomes are available from The Clinical Audit Department on request.

Example: Improvement areas arising from audit

Unique identifier	Title of clinical audit	Learning
25711	**Point prevalence oxygen audit.**	**Background and rationale** Oxygen is considered a drug and is associated with harm as well as significant benefit. It is therefore important to be prescribed and that patients' saturations are monitored so oxygen can be provided in a controlled manner. National oxygen guidelines state that all patients receiving oxygen should have it prescribed with the correct dose / delivery and this should be recorded and adjusted, as necessary. **Aims and objectives.** To assess compliance with oxygen prescribing as per local and national guidelines. **Methodology** Wards will be visited and any patients on oxygen noted by direct observation. This will then be followed by a cross check against CERNER prescription records for O2. This will be done on 1 day and in all areas to ensure a complete overview snapshot. **Key findings** **<u>Point prevalence oxygen audit 26/10/2023</u>** All patients on all wards excluding ED and ICU on 26/10/2023. All pts using O2 were identified and cross referenced against prescriptions and current O2 saturations. We also reviewed all pts on the electronic database as inpatients and identified oxygen prescriptions. **<u>For all patients admitted from prescription data</u>** We identified current pts in COCH = 529 Of these 103 had oxygen prescribed. 19.7% Of those prescribed oxygen 72 (70%) had a target saturation range specified **<u>Reviewing patients directly on wards</u>** We identified 44 patients in the hospital using oxygen. Of those 66% had an oxygen prescription in place 76% of patients with prescriptions had a saturation target range specified. Of those, 82% of documented saturations were within the specified target range.

Data per ward *(excludes ED and ICU due to practical reasons of performing audit).*

Ward	No of patients on oxygen	Number (%) prescribed
50	2	2 (100%)
51	3	3 (100%)
48	7	6 (86%)
49	2	2 (100%)
CCU	2	2 (75%)
AMU	8	4 (50%)
53	4	1 (25%)
52	3	0 (0%)
41	2	0 (0%)
42	2	2 (100%)
43	1	1 (100%)
Poppy ward	1	1 (100%)
RSU	6	5 (83%)

Other wards reviewed, including paediatric and maternity areas, had no oxygen use reported so do not appear in the table.

Conclusion

Oxygen is considered a drug and is associated with harm as well as significant benefit. It is therefore important to be prescribed and that patients' saturations are monitored so oxygen can be provided in a controlled manner. Oxygen prescription is taking place in the trust and 66% of patients using O2 had it prescribed. There is work to do to ensure that in the remaining 34% these prescriptions are available. We have identified areas of good practice and areas where we can target O2 education and awareness. The current audit data would suggest that the vascular wards are an area that may benefit from targeted awareness and training.

Previous year Overall Assurance Level RAG	Overall Current Year Assurance Level RAG	Rationale
NA	**Significant**	

Implementation of action plan
Since the audit has taken place, there has been work to include mandatory oxygen prescribing on Cerner for all patients excluding Obstetric areas. An oxygen compliance audit is undertaken and reported quarterly to QGG and this has shown a significant improvement in oxygen prescribing.

Have there been any Lessons Learned?
O2 should be prescribed and an appropriate range in place. We noted a gap in this taking place and areas within the trust that can be a focus of education.

Have there been any changes in practice?
A 'pop up' prescription reminder is now generated on CERNER.

		Is there any improvement in patient care? Care is now much improved as there has been a significant improvement in O2 prescribing. **SMART Action required:** Include oxygen prescribing on CERNER **Responsible Lead:** S Scott **Evidence required of action complete:** Completed and in place **Date to be completed:** 1/1/2024 **BRAG:**

Further examples of Learning Identified through Clinical Audits completed between April 2023-March 2024

Unique identifier	Title of clinical audit	Service	Learning identified.
25717	Urinary Catheter Management	Clinical Improvement & Assurance (Clinical Audit)	Increase of 61% in the documentation of urinary catheters in the appropriate section of EPR. Amendment to EPR to allow for the recording of long- or short-term catheters – this has now been completed
25667	Re-audit (3rd cycle) anaesthetic practices employed in the management of elderly patients with hip fractures in COCH from Oct 2023 till end of Jan 2024	Anaesthetics	Improved COCH anaesthetic practices for management of traumatic hip fractures.
25712	Patient Satisfaction Audit - Anaesthetics	Anaesthetics	Change in practice will occur when there is a change in guidance relating to starvation prior to theatre. This is due to come into place in April 2024. Hopefully, this change in practice will improve patient care and overall satisfaction and outcome
25648	Re-audit Wet Age-related Macular Degeneration (AMD) referral pathway-prospective audit Jun22-Feb23	Ophthalmology	1. Encourage opticians to use the dedicated referral proformas for suspected wet AMD in primary care 2. Increase appointments (staffing issues/lack of capacity)-a reasonable solution is Optical Coherence Tomography (OCT) Angiography

			3. Lack of injection capacity-which raises the need for a second Injection room
25692	Management of wrist and ankle fractures referred to orthopaedics	Orthopaedics	i) Need to ensure full neurovascular assessments are performed and documented during clerking for all patients presenting with wrist and ankle fractures. ii) Need to ensure neurovascular assessments are performed and documented following fracture manipulations (allowing for limitations from plaster of Paris application). - Clinicians were made aware of audit findings. - Posters were created and distributed throughout A&E.
25640	Consent Form Audit (2nd cycle) - Plastic Surgery department	Plastic Surgery	Adequate documentation of consent forms is necessary to comply with guidelines set locally and at national level.
25694	Polypharmacy and deprescribing in the elderly	Acute Medicine	No identified learning
25707	Re-audit - Tissue Donation in the Emergency Department	ED	Information is available within the department for tissue donation, but more is needed to be done in this topic. It may be that discussion is too difficult with a bereaved family or that people are just not aware. By implementing a trolley into the department with this readily available it may increase the uptake.
25711	Point prevalence oxygen audit	Respiratory	O2 should be prescribed and an appropriate range in place. We noted a gap in this taking place and areas within the trust that can be a focus of education.
25716	Maternal position at Spontaneous Vaginal Delivery and Lithotomy use	Obstetrics	No assurance or changes in practice or lessons learnt or improvement in patient care yet. Will be re-audited.

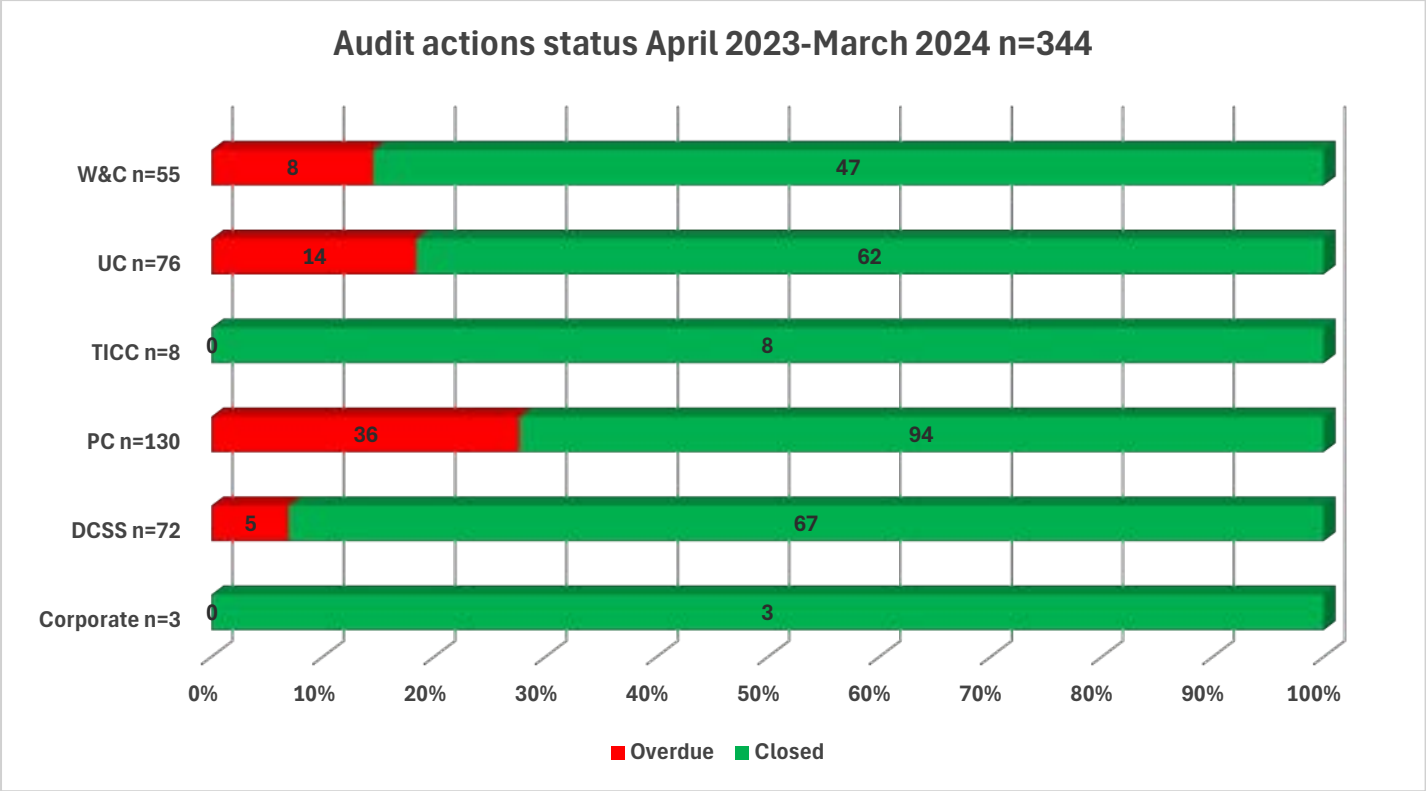
Assurance performance of audits closed April 2023-March 2024

Division	Full Assurance	Significant assurance	Limited assurance	Very limited assurance	*Unable to rate assurance status
Corporate Services n=9		2 22%			7 78%
Diagnostic & Clinical Support Service n=12		1 8%	4 33%	1 8%	6 50%
Therapies & Integrated Community Care Services n=5	1 20%		1 20%		3 60%
Planned Care n=54	13 24%	8 15%	14 26%	2 4%	17 31%
Urgent Care n=24	4 17%	4 17%	4 17%	1 4%	11 46%
Women & Childrens n=19		4 21%	1 5%	1 5%	13 68%

*** Audit report sent to CA Team before assurance report template was introduced in August 2023**

Where an audit demonstrates limited assurance/very limited assurance, the results are sent to the Divisions where they are highlighted in the monthly governance reports. These audits are then expected to be repeated and have a supported action plan.

Audit actions status April 2023- March 2024 n=344 Actions



All outstanding actions have been highlighted at Divisional Governance meetings.

The clinical audit team have set a local KPI to reduce open actions by 10% per month. This involves the team contacting audit leads to request updates on all outstanding actions with request for confirmation of completion of actions to allow audits to be closed.

Actions closed -April 2023-March 2024 n=281= 82% closed in this period
Actions outstanding n=63

NATIONAL MANDATED AUDITS

The Clinical Audit team have reviewed all the mandated clinical audits to ensure compliance and assurance. In 2023/24 there was a selection of mandated audits that were not completed due to lack of resource. Following review and work with clinical teams, all mandated audits now have allocated resource to ensure compliance.

Programme	Progress
National Health Records	Health Records audit completed for last 2 quarters of 2023/24. This audit is on a 'rolling programme' with a sample of patient case notes being reviewed monthly.
National COPD & Asthma	Data collection and input was established for patients discharged with diagnosis of asthma and COPD from April 2024. Clinical leadership is in place to support ongoing evaluation of care and initiation of improvements
Consent	Corporate consent audit completed for last 2 quarters of 2023/24. Identified areas (Interventional Radiology/ endoscopy) were audited separately with increased volume of patients reviewed. Audit now on 'rolling programme' to cover larger volumes of case records in each speciality.
National Inflammatory Early Arthritis Audit	Audit in process re-established in April 2024
Patient Related Outcomes Measure (PROMs)	Local PROMS programme in place across elective hip and knee replacement surgery to support National PROMs
Improving Quality in Crohn's and Colitis (IQICC)	Not applicable for 2024/25 as NHS England have put audit on hold.
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer1,4	Breast Team have commenced data collection for this audit.
National Comparative Audit of Blood Transfusion:	Transfusion team have commenced data collection for this audit commencing April 2024.
National Ophthalmology Database – No IM&T support	Unable to participate until digital solution is implemented.

Outstanding Mandated Audit Executive Summaries

The Trust participated in 47 nationally mandated audits. In the reporting period, the following Executive summaries were outstanding:

- National Bowel Cancer Audit* (NBOCA) -Still awaiting executive summary. Head of Clinical Audit has partially completed and sent a copy to audit lead.
- National Oesophago-Gastric Cancer Audit (NOGCA)- No update on audit status/ awaiting executive summary. Head of Clinical Audit has partially completed and sent a copy to audit lead.
- Royal College Emergency Medicine Consultant Sign off- Published April 2023-Audit lead aware. Awaiting executive summary
- National Audit of Inpatient Falls 2023 (NAIF)-Published November 2023. Audit lead aware. Awaiting executive summary

** June 2024: National Bowel Cancer Audit (NBOCA) executive summary received.*

EDUCATION

Clinical Audit training for junior doctors is underway and the first session was delivered in March 2024 at Junior Doctors Induction Day. Moving forward the Clinical Audit Team will present an introduction to Clinical Audit at all Junior doctor's induction days and on request by the Divisions. A guide to undertaking a Clinical Audit has been designed into a booklet for dissemination. Copies are available at training sessions and on the Trust intranet.

NATIONAL CONFIDENTIAL ENQUIRY INTO PATIENT OUTCOME AND DEATH (NCEPOD)

NCEPOD is an organisation in which currently practising clinicians review the management of patients undergoing medical and surgical care by undertaking confidential surveys and reviewing care provision and resources in the units carrying out the care. The surveys cover all units which provide the care being considered and the results are disseminated widely in regular reports in which comments and recommendations are made to suggest ways in which healthcare practice can be improved to the public benefit.

The Trust has participated in 9 NCEPOD requests through 2023/24, 3 of these remain active in terms of questionnaire completion and data submission.

NCEPOD: Currently Active

The following NCEPOD requests have been received by the Trust. At time of this report the clinician questionnaires are with the relevant teams for completion.

- NCEPOD End of Life-Clinician Questionnaire assigned to Clinical Lead.
- NCEPOD Juvenile Idiopathic Arthritis-Awaiting Organisational Questionnaire assigned to Clinical Lead.
- NCEPOD ICU Rehabilitation-Clinician questionnaires assigned to Clinical Leads (x6) and case note extraction requested.

NCEPOD: Outstanding in terms of completion of recommendations

The following NCEPOD reports have been received by the Trust. Work is underway to review the reports and enact the recommendations.

- **NCEPOD Testicular torsion** (Report received: February 2024) With Clinical Lead for review and recommendation checklist to be completed.
- **NCEPOD Non-Invasive Ventilation (**Report received: 2017) *Limited assurance: placed on the Risk Register.*
- **NCEPOD Heart Failure** (Report received: December 2018) *Entered on to the Risk register until fully compliant.* 2 remaining recommendations outstanding.
- **NCEPOD Dysphagia in Parkinson Disease (**Report received: August 2021) Awaiting response from SALT on 2 remaining recommendations.
- **NCEPOD Epilepsy** (Report received: December 2022) Report published sent to clinical lead and BPM for completion of recommendation checklist.
- **NCEPOD Crohn's Disease** (Report received: July 2023) Report published, and recommendation checklist sent General Surgery for completion.

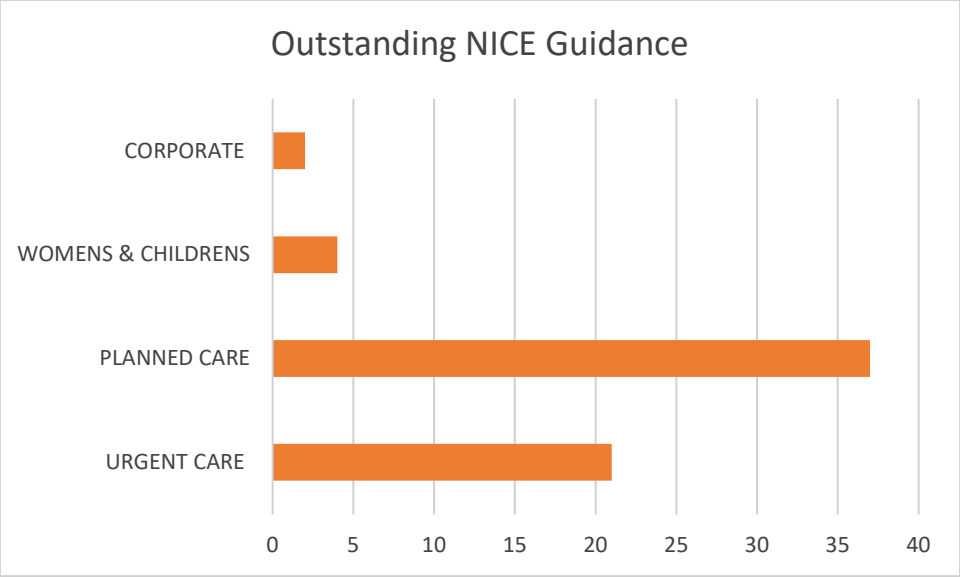
NICE GUIDANCE

A publication of all updated revised NICE guidance is shared with the Trust on a monthly basis. This guidance includes:

- Highly Specialised Technology
- Technology appraisals
- NICE guidance
- Diagnostic guidance
- Interventional Procedure guidance

Each piece of guidance is logged onto Datix management system and disseminated through identified leads within specialities and governance business partners to review and provide assurance. On 31st March 2024 there are currently 64* sets of guidelines that require evidence submission to provide assurance.

As part of the recovery plan a revised proforma has been devised to support the provision of assurance. All NICE guidance on datix is currently being reviewed to ensure it is relevant to the Trust and that it has been shared with the appropriate lead for review. The Head of Quality is meeting with leads in each area to review guidance and provide assurance. This process is supporting the reduction in open guidance.



The NICE compliance is monitored through the Quality Governance Group and reported locally at divisional governance meetings.

As at June 2024, a total of 45 currently remain outstanding.

CAPACITY WITHIN THE CLINICAL AUDIT TEAM

Clinical Audit team will have reduced workforce from 01/04/2024. Team reduction from 2.24 WTE to 1.52 WTE (Band 5) due to long term ill health within the team. Temporary members of staff have been seconded to undertake corporate and national audits. Actions have been initiated to reduce the risk to the national clinical audits and corporate audit compliance.

RECOMMENDATIONS

The Board of Directors is asked to note the assurance provided within the report.

Trust Audit Status and Assurance Annual Report
April 2023 - March 2024

Month: 1st April 2023 - 31st March 2024
Forum Presented at: Quality & Safety Committee
Author: Amanda Sadler, Head of Clinical Audit

CLINICAL AUDIT

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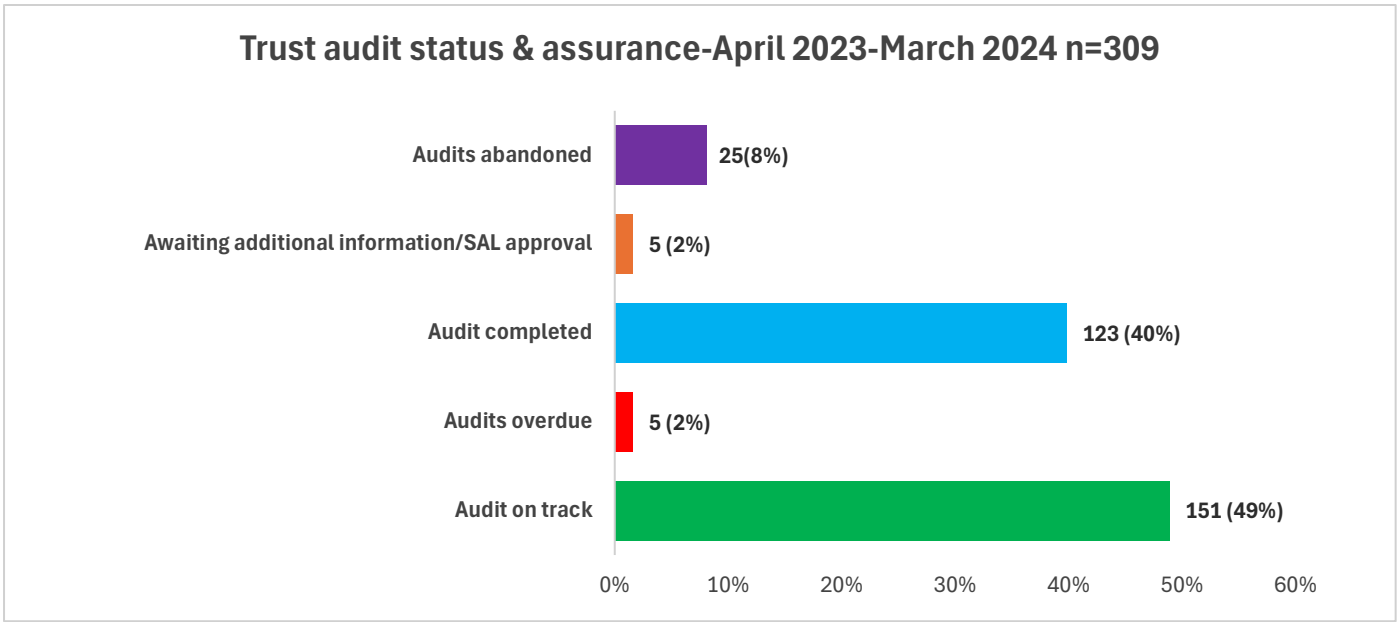

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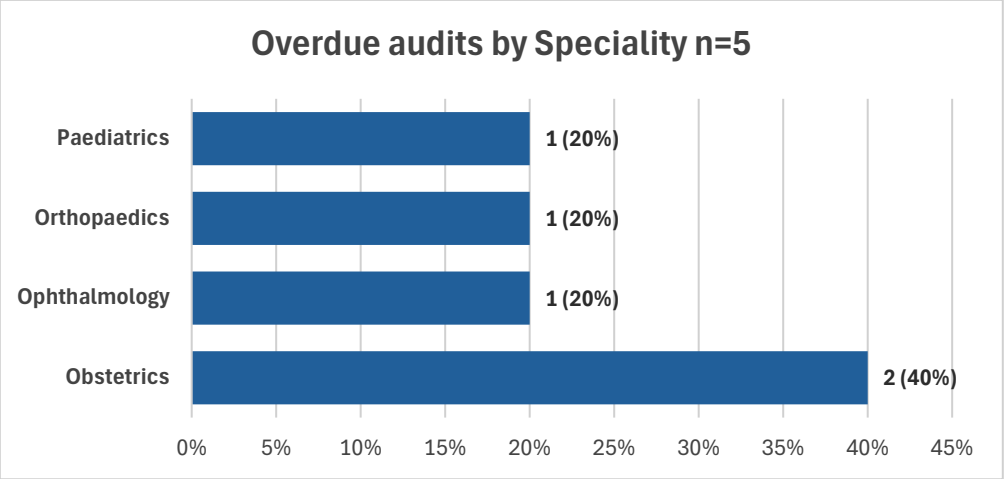

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123 audits have been completed within this reporting period. All audit outcomes are available from The Clinical Audit Department on request.

Example: Improvement areas arising from audit

Unique identifier	Title of clinical audit	Learning
25711	**Point prevalence oxygen audit.**	**Background and rationale** Oxygen is considered a drug and is associated with harm as well as significant benefit. It is therefore important to be prescribed and that patients' saturations are monitored so oxygen can be provided in a controlled manner. National oxygen guidelines state that all patients receiving oxygen should have it prescribed with the correct dose / delivery and this should be recorded and adjusted, as necessary. **Aims and objectives.** To assess compliance with oxygen prescribing as per local and national guidelines. **Methodology** Wards will be visited and any patients on oxygen noted by direct observation. This will then be followed by a cross check against CERNER prescription records for O2. This will be done on 1 day and in all areas to ensure a complete overview snapshot. **Key findings** **<u>Point prevalence oxygen audit 26/10/2023</u>** All patients on all wards excluding ED and ICU on 26/10/2023. All pts using O2 were identified and cross referenced against prescriptions and current O2 saturations. We also reviewed all pts on the electronic database as inpatients and identified oxygen prescriptions. **<u>For all patients admitted from prescription data</u>** We identified current pts in COCH = 529 Of these 103 had oxygen prescribed. 19.7% Of those prescribed oxygen 72 (70%) had a target saturation range specified **<u>Reviewing patients directly on wards</u>** We identified 44 patients in the hospital using oxygen. Of those 66% had an oxygen prescription in place 76% of patients with prescriptions had a saturation target range specified. Of those, 82% of documented saturations were within the specified target range.

Data per ward *(excludes ED and ICU due to practical reasons of performing audit).*

Ward	No of patients on oxygen	Number (%) prescribed
50	2	2 (100%)
51	3	3 (100%)
48	7	6 (86%)
49	2	2 (100%)
CCU	2	2 (75%)
AMU	8	4 (50%)
53	4	1 (25%)
52	3	0 (0%)
41	2	0 (0%)
42	2	2 (100%)
43	1	1 (100%)
Poppy ward	1	1 (100%)
RSU	6	5 (83%)

Other wards reviewed, including paediatric and maternity areas, had no oxygen use reported so do not appear in the table.

Conclusion

Oxygen is considered a drug and is associated with harm as well as significant benefit. It is therefore important to be prescribed and that patients' saturations are monitored so oxygen can be provided in a controlled manner. Oxygen prescription is taking place in the trust and 66% of patients using O2 had it prescribed. There is work to do to ensure that in the remaining 34% these prescriptions are available. We have identified areas of good practice and areas where we can target O2 education and awareness. The current audit data would suggest that the vascular wards are an area that may benefit from targeted awareness and training.

Previous year Overall Assurance Level RAG	Overall Current Year Assurance Level RAG	Rationale
NA	**Significant**	

Implementation of action plan

Since the audit has taken place, there has been work to include mandatory oxygen prescribing on Cerner for all patients excluding Obstetric areas. An oxygen compliance audit is undertaken and reported quarterly to QGG and this has shown a significant improvement in oxygen prescribing.

Have there been any Lessons Learned?

O2 should be prescribed and an appropriate range in place. We noted a gap in this taking place and areas within the trust that can be a focus of education.

Have there been any changes in practice?

A 'pop up' prescription reminder is now generated on CERNER.

		Is there any improvement in patient care? Care is now much improved as there has been a significant improvement in O2 prescribing.

SMART Action required	Responsible Lead	Evidence required of action complete	Date to be completed	BRAG
Include oxygen prescribing on CERNER	**S Scott**	**Completed and in place**	**1/1/2024**	

Further examples of Learning Identified through Clinical Audits completed between April 2023-March 2024

Unique identifier	Title of clinical audit	Service	Learning identified.
25717	Urinary Catheter Management	Clinical Improvement & Assurance (Clinical Audit)	Increase of 61% in the documentation of urinary catheters in the appropriate section of EPR. Amendment to EPR to allow for the recording of long- or short-term catheters – this has now been completed
25667	Re-audit (3rd cycle) anaesthetic practices employed in the management of elderly patients with hip fractures in COCH from Oct 2023 till end of Jan 2024	Anaesthetics	Improved COCH anaesthetic practices for management of traumatic hip fractures.
25712	Patient Satisfaction Audit - Anaesthetics	Anaesthetics	Change in practice will occur when there is a change in guidance relating to starvation prior to theatre. This is due to come into place in April 2024. Hopefully, this change in practice will improve patient care and overall satisfaction and outcome
25648	Re-audit Wet Age-related Macular Degeneration (AMD) referral pathway-prospective audit Jun22-Feb23	Ophthalmology	1. Encourage opticians to use the dedicated referral proformas for suspected wet AMD in primary care 2. Increase appointments (staffing issues/lack of capacity)-a reasonable solution is Optical Coherence Tomography (OCT) Angiography

			3. Lack of injection capacity-which raises the need for a second Injection room
25692	Management of wrist and ankle fractures referred to orthopaedics	Orthopaedics	i) Need to ensure full neurovascular assessments are performed and documented during clerking for all patients presenting with wrist and ankle fractures. ii) Need to ensure neurovascular assessments are performed and documented following fracture manipulations (allowing for limitations from plaster of Paris application). - Clinicians were made aware of audit findings. - Posters were created and distributed throughout A&E.
25640	Consent Form Audit (2nd cycle) - Plastic Surgery department	Plastic Surgery	Adequate documentation of consent forms is necessary to comply with guidelines set locally and at national level.
25694	Polypharmacy and deprescribing in the elderly	Acute Medicine	No identified learning
25707	Re-audit - Tissue Donation in the Emergency Department	ED	Information is available within the department for tissue donation, but more is needed to be done in this topic. It may be that discussion is too difficult with a bereaved family or that people are just not aware. By implementing a trolley into the department with this readily available it may increase the uptake.
25711	Point prevalence oxygen audit	Respiratory	O2 should be prescribed and an appropriate range in place. We noted a gap in this taking place and areas within the trust that can be a focus of education.
25716	Maternal position at Spontaneous Vaginal Delivery and Lithotomy use	Obstetrics	No assurance or changes in practice or lessons learnt or improvement in patient care yet. Will be re-audited.

Assurance performance of audits closed April 2023-March 2024

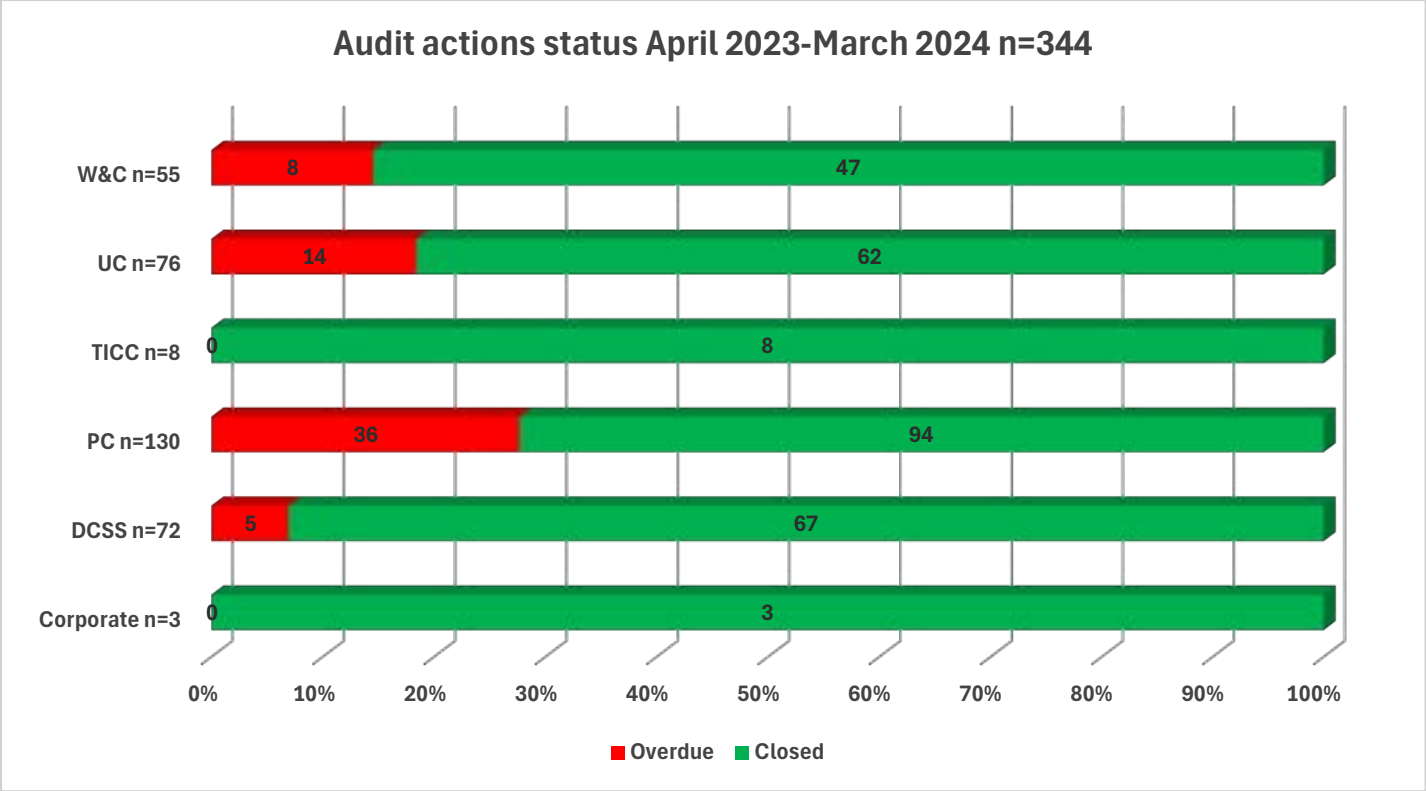
Division	Full Assurance	Significant assurance	Limited assurance	Very limited assurance	*Unable to rate assurance status
Corporate Services n=9		2 22%			7 78%
Diagnostic & Clinical Support Service n=12		1 8%	4 33%	1 8%	6 50%
Therapies & Integrated Community Care Services n=5	1 20%		1 20%		3 60%
Planned Care n=54	13 24%	8 15%	14 26%	2 4%	17 31%
Urgent Care n=24	4 17%	4 17%	4 17%	1 4%	11 46%
Women & Childrens n=19		4 21%	1 5%	1 5%	13 68%

*** Audit reports sent to Clinical Audit Team before assurance report RAG rating system was introduced in August 2023**

Where an audit demonstrates limited assurance/very limited assurance, the results are sent to the Divisions where they are highlighted in the monthly governance reports. These audits are then expected to be repeated and have a supported action plan.

Please see appendix one for summary of audits demonstrating limited or very limited assurance

Audit actions status April 2023- March 2024 n=344 Actions



All outstanding actions have been highlighted at Divisional Governance meetings.

The clinical audit team have set a local KPI to reduce open actions by 10% per month. This involves the team contacting audit leads to request updates on all outstanding actions with request for confirmation of completion of actions to allow audits to be closed.

Actions closed -April 2023-March 2024 n=281= 82% closed in this period
Actions outstanding n=63

NATIONAL MANDATED AUDITS

The Clinical Audit team have reviewed all the mandated clinical audits to ensure compliance and assurance. In 2023/24 there was a selection of mandated audits that were not completed due to lack of resource. Following review and work with clinical teams, all mandated audits now have allocated resource to ensure compliance.

Programme	Progress
National Health Records	Health Records audit completed for last 2 quarters of 2023/24. This audit is on a 'rolling programme' with a sample of patient case notes being reviewed monthly.
National COPD & Asthma	Data collection and input was established for patients discharged with diagnosis of asthma and COPD from April 2024. Clinical leadership is in place to support ongoing evaluation of care and initiation of improvements
Consent	Corporate consent audit completed for last 2 quarters of 2023/24. Identified areas (Interventional Radiology/ endoscopy) were audited separately with increased volume of patients reviewed. Audit now on 'rolling programme' to cover larger volumes of case records in each speciality.
National Inflammatory Early Arthritis Audit	Audit in process re-established in April 2024
Patient Related Outcomes Measure (PROMs)	Local PROMS programme in place across elective hip and knee replacement surgery to support National PROMs
Improving Quality in Crohn's and Colitis (IQICC)	Not applicable for 2024/25 as NHS England have put audit on hold.
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer1,4	Breast Team have commenced data collection for this audit.
National Comparative Audit of Blood Transfusion:	Transfusion team have commenced data collection for this audit commencing April 2024.
National Ophthalmology Database – No IM&T support	Unable to participate until digital solution is implemented.

Outstanding Mandated Audit Executive Summaries

The Trust participated in 47 nationally mandated audits. In the reporting period, the following Executive summaries were outstanding:

- National Bowel Cancer Audit* (NBOCA) -Still awaiting executive summary. Head of Clinical Audit has partially completed and sent a copy to audit lead.
- National Oesophago-Gastric Cancer Audit (NOGCA)- No update on audit status/ awaiting executive summary. Head of Clinical Audit has partially completed and sent a copy to audit lead.
- Royal College Emergency Medicine Consultant Sign off- Published April 2023-Audit lead aware. Awaiting executive summary
- National Audit of Inpatient Falls 2023 (NAIF)-Published November 2023. Audit lead aware. Awaiting executive summary

** June 2024: National Bowel Cancer Audit (NBOCA) executive summary received.*

EDUCATION

Clinical Audit training for junior doctors is underway and the first session was delivered in March 2024 at Junior Doctors Induction Day. Moving forward the Clinical Audit Team will present an introduction to Clinical Audit at all Junior doctor's induction days and on request by the Divisions. A guide to undertaking a Clinical Audit has been designed into a booklet for dissemination. Copies are available at training sessions and on the Trust intranet.

NATIONAL CONFIDENTIAL ENQUIRY INTO PATIENT OUTCOME AND DEATH (NCEPOD)

NCEPOD is an organisation in which currently practising clinicians review the management of patients undergoing medical and surgical care by undertaking confidential surveys and reviewing care provision and resources in the units carrying out the care. The surveys cover all units which provide the care being considered and the results are disseminated widely in regular reports in which comments and recommendations are made to suggest ways in which healthcare practice can be improved to the public benefit.

The Trust has participated in 9 NCEPOD requests through 2023/24, 3 of these remain active in terms of questionnaire completion and data submission.

NCEPOD: Currently Active

The following NCEPOD requests have been received by the Trust. At time of this report the clinician questionnaires are with the relevant teams for completion.

- NCEPOD End of Life-Clinician Questionnaire assigned to Clinical Lead.
- NCEPOD Juvenile Idiopathic Arthritis-Awaiting Organisational Questionnaire assigned to Clinical Lead.
- NCEPOD ICU Rehabilitation-Clinician questionnaires assigned to Clinical Leads (x6) and case note extraction requested.

NCEPOD: Outstanding in terms of completion of recommendations

The following NCEPOD reports have been received by the Trust. Work is underway to review the reports and enact the recommendations.

- **NCEPOD Testicular torsion** (Report received: February 2024) With Clinical Lead for review and recommendation checklist to be completed.
- **NCEPOD Non-Invasive Ventilation (**Report received: 2017) *Limited assurance: placed on the Risk Register.*
- **NCEPOD Heart Failure** (Report received: December 2018) *Entered on to the Risk register until fully compliant.* 2 remaining recommendations outstanding.
- **NCEPOD Dysphagia in Parkinson Disease (**Report received: August 2021) Awaiting response from SALT on 2 remaining recommendations.
- **NCEPOD Epilepsy** (Report received: December 2022) Report published sent to clinical lead and BPM for completion of recommendation checklist.
- **NCEPOD Crohn's Disease** (Report received: July 2023) Report published, and recommendation checklist sent General Surgery for completion.

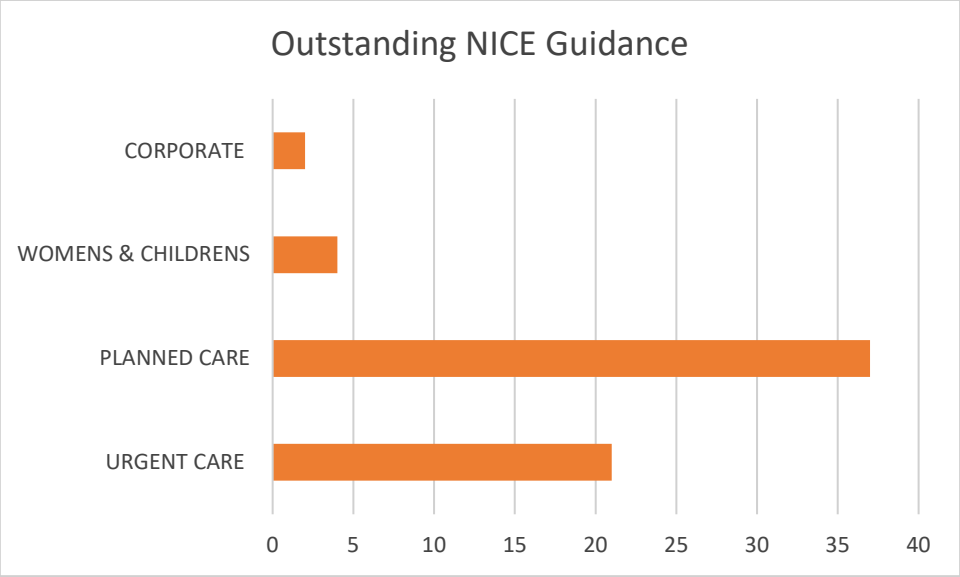
NICE GUIDANCE

A publication of all updated revised NICE guidance is shared with the Trust on a monthly basis. This guidance includes:

- Highly Specialised Technology
- Technology appraisals
- NICE guidance
- Diagnostic guidance
- Interventional Procedure guidance

Each piece of guidance is logged onto Datix management system and disseminated through identified leads within specialities and governance business partners to review and provide assurance. On 31st March 2024 there are currently 64* sets of guidelines that require evidence submission to provide assurance.

As part of the recovery plan a revised proforma has been devised to support the provision of assurance. All NICE guidance on datix is currently being reviewed to ensure it is relevant to the Trust and that it has been shared with the appropriate lead for review. The Head of Quality is meeting with leads in each area to review guidance and provide assurance. This process is supporting the reduction in open guidance.



The NICE compliance is monitored through the Quality Governance Group and reported locally at divisional governance meetings.

As at June 2024, a total of 45 currently remain outstanding.

CAPACITY WITHIN THE CLINICAL AUDIT TEAM

Clinical Audit team will have reduced workforce from 01/04/2024. Team reduction from 2.24 WTE to 1.52 WTE (Band 5) due to long term ill health within the team. Temporary members of staff have been seconded to undertake corporate and national audits. Actions have been initiated to reduce the risk to the national clinical audits and corporate audit compliance.

RECOMMENDATIONS

The Quality and Safety Committee is asked to note the risk, issues and assurance provided within the report and support the actions outlined.

Appendix One

Diagnostics & Clinical Support Services

Audits reported as limited or very limited assurance.

Pharmacist Review of AKI	Pharmacy	Limited assurance	Yes-01/03/2026. Action plan in placed
Evaluation of current inpatient prescribing of intravenous meropenem	Pharmacy	Limited assurance	Yes-No set date to re-audit. All actions have been implemented.
Time taken to report chest Radiographs for NG tube placement	Radiology	Limited assurance	Re-audit not indicated-All actions have been implemented.
CT head: Lens Exclusion - Re-Audit	Radiology	Limited assurance	A re-audit with no plans have come out of this re-audit actions from previous audit have been implemented. AS to contact SAL to advise further re-audit.
Radiology on-call analysis	Radiology	Very limited assurance	No re-audit stated-Action plans are in place.

Therapies & Clinical Support Services

Countess of Chester Hospital-Ward 41 Hip Sprint Audit	Therapies and Integrated Community Care	Physiotherapy	Limited assurance	Re-audit stated as 24/05/2024.

Planned Care

Extraction site in anterior resection	Planned Care	Colorectal	Limited assurance	Initial Audit to be repeated : No set date to re-audit.
Identifying Difficult Airways in Intensive Care 'ID-ACCT'	Planned Care	Critical Care	Limited assurance	Initial Audit complete.No re-audit stated. Difficult to draw conclusion as small sample size
ENT FDS 28 day Audit	Planned Care	ENT	Limited assurance	Re-audited complete: full assurance
US guided FNAC adequacy in head and neck service	Planned Care	ENT	Limited assurance	Reaudit: No re-audit date stated. Action plan in place
Surgical Tracheostomy	Planned Care	ENT	Limited assurance	Intial audit complete -Re-audit 23/09/2024. Actions implemented.
Complication rate of adeno/tonsillectomy in ENT	Planned Care	ENT	Limited assurance	Initial audit. Re-audit 14/10/2024. 2/3 actions implemented.

Re-audit Wet AMD referral pathway-prospective audit Jun22-Feb23	Planned Care	Ophthalmology	Limited Assurance	Reaudit. No repeat audit stated.
Compliance of Countess of Chester Hospital with GIRFT guidance on Cauda Equina Syndrome part 2	Planned Care	Orthopaedics	Limited Assurance	Initial audit:-no date stated but re-audit following the implementation of the guidance
Compliance of COCH with GIRFT guidance on Cauda Equina Syndrome 1st cycle	Planned Care	Orthopaedics	Limited Assurance	Re-audit undertaken. ID 25331. Action implemented. Further e-audit underway-Conclusion date June 2024. audit overdue conclusion date.
Management of wrist and ankle fractures referred to orthopaedics	Planned Care	Orthopaedics	Very Limited	Initial Audit. Re-audit stated as 01/04/2024. Not re-registered as 1st cycle completed in April 2024. Action implemented.
Audit of plastic surgery trauma waiting times	Planned Care	Plastic Surgery	Limited Assurance	Initial Audit: Re-audit stated as 31/12/2023. Not re-audit as yet
Plastics consent form Audit	Planned Care	Plastic Surgery	Limited Assurance	Initial Audit: re-audit undertaken. ID 25640. Actions implemented.
Consent Form Audit (2nd cycle) - Plastic Surgery department	Planned Care	Plastic Surgery	Limited Assurance	Re-audit: repeat re-audit set for August 2024. 1/2 actions implemented.
Vascular theatre start times	Planned Care	Vascular	Limited Assurance	Reaudit: repeat re-audit stated as 07/12/2024.
Re-audit of Compliance with the national standards for Vascular MDT outcome reporting at SMArt MDT Meetings 2023	Planned Care	Vascular	Limited Assurance	Reaudit: repeat re-audit stated as 07/12/2024.
A Local Audit Assessing Completeness of Morbidity and Mortality Records in Vascular Surgery in a Tertiary Centre in the UK	Planned Care	Vascular	Very Limited	Initial audit - Re-audit stated as 31/12/2023. Not re-audit as yet

Urgent Care

Polypharmacy and deprescribing in the elderly	Urgent Care	Acute Medicine	Limited assurance	Initial Audit: re-audit stated as 30/05/2025
Door to needle times in neutropenic sepsis	Urgent Care	Clinical Haematology	Very limited assurance	Reaudit: second re-audit stated as 31/12/2025

Review of foot care for patients presenting with diabetic foot problems	Urgent Care	Diabetes/Endocrinology	Limited assurance	Initial Audit: re-audit stated as 30/09/2024.
Frequency of HIV testing in patients with bacterial pneumonia, in the Emergency Department at the Countess of Chester Hospital.	Urgent Care	ED	Limited assurance	Initial Audit: Re-audit undertaken due for completion in August 2024.
Re-audit - Tissue Donation in the Emergency Department	Urgent Care	ED	Limited assurance	Reaudit: No secondre-audit stated. Actions have been implemented.

Women & Children

Progesterone Use in Early Pregnancy	Women and Children	Gynaecology	Very limited assurance		Initial Audit: Re-audit when guideline implemented, and pathways agreed. 12/12
Surgical Site Infection Audit in Postnatal Women	Women and Children	Obstetrics	**Limited assurance**		Initial Audit: re-audit stated April 2024.4/5 actions have been implemented.

Meeting	**30th July 2024**		**Board of Directors**					
Report	**Agenda item 7.**		**Chief Executive Officer's Report**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Jane Tomkinson				Chief Executive Officer			
Author(s)	Karan Wheatcroft				Director of Governance, Risk and Improvement			
Board Assurance Framework	ALL	Relevant across all BAF areas						
Strategic Aims	Purposeful Leadership							
CQC Domains	Well-led.							
Previous Considerations	-							
Executive Summary	The purpose of this report is to provide an overview of the relevant local, regional, and national issues for consideration alongside the strategic objectives and wider Board agenda.							
Highlights	Updates included in the report: • CMAST CEO meeting • Financial Improvement Support • System Improvement Board (SIB) • Health scrutiny panel • BAME Assembly annual report • Fuller Inquiry • Organ donation – Letter from NHS Blood and Transplant • Women's and children's strategy launch and building update • Civility statement • Staff awards • Staff networks • MET team planned launch sept • Retrial verdict • Thirlwall update • Chair second term • Lead governor • Governor elections							
Recommendation(s)	The Board of Directors is asked to note the contents of this report.							
Corporate Impact Assessment								
Statutory Requirements	Meets the Trust compliance with Foundation Trust status							
Quality & Safety	Covered within the report							

NHS Constitution	To aid improvement in line with performance standards
Patient Involvement	To be monitored via feedback from patient enquiries, complaints and compliments
Risk	Alignment with the Board Assurance Framework and Corporate Risk Register
Financial impact	Collaboration is expected to be more efficient and should result in a more pragmatic response to any financial challenges within Cheshire & Merseyside
Equality & Diversity	Meets Equality Act 2010 duties and PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published on the Trust's website as part of the Council of Governors meeting paper pack.

Chief Executive Officer's Report – July 2024

This report provides an update on local Trust matters and wider system updates.

1. CMAST Leadership Board

The CMAST Leadership Board met on the 5th July 2024. The meeting focussed on:

- System financial position and financial improvement support
- Women's services programme
- Efficiency at scale progress and priorities

2. Financial Improvement Support

Given the overall financial position of Cheshire and Merseyside ICS as reported for month 2, NHS England has assessed the system as being at high risk of overspending against the plan submitted for the year and hence not meeting the system statutory requirement to breakeven. Therefore the system has agreed with NHS England that we will engage external support to urgently review the financial position of the Countess of Chester Hospital NHS Foundation Trust and wider system. This will focus on actions that can be taken to immediately reduce the rate of expenditure and to ensure that the financial plan for the year is delivered. This proactive support will cover controls over areas such as workforce, and will also look carefully at our efficiency plans to make sure that they are deliverable, or to take action where this is not the case. The support will be expected to show rapid results, and should be in place for around 8 weeks. Any decisions to reduce spending will be subject to routine governance and oversight, to make sure that service delivery, quality and patient safety are not adversely impacted

The Trust is currently responding to a document request to support this review.

3. System Improvement Board (SIB)

The SIB met on the 19th July 2024. The Trust presented an update on the improvement journey and achievements against the SIB exit criteria, which will now be considered by NHS England.

4. Health and Scrutiny Panel

The work of the Health and Scrutiny Panel was paused during the pre-election period. The Trust will now present the Quality Accounts 2023/24 to the Cheshire West and Chester Council's Health Overview and Scrutiny Committee on 30th July 2024.The Scrutiny Committee has confirmed that it is aware that the statutory deadline for publication of the accounts has passed but would still like to formally receive them at Committee.

5. BAME Assembly Annual Report

The North West Regional BAME Assembly was established in 2020 as a strategic advisory group for senior NHS leaders from black, Asian and minority ethnic backgrounds. The Assembly has recently published its 2023/24 annual report. Key achievements included supporting organisations

on their journey to implement the anti-racist framework, hosting the annual conference, and facilitating a range of speakers and events. The Trust is one of 27 in the Region to commit to the implementation of the anti-racist framework.

6. Fuller Inquiry

The Trusts review of the recommendations in response to the Fuller Inquiry was undertaken earlier in 2024, encompassing a detailed piece of work which demonstrated a small number of opportunities for improvement. The Trust was selected by the Fuller Inquiry Team to participate in the second stage of the Inquiry's work looking at the arrangements in place across the wider NHS. As part of this process, the Trust has submitted a range of documents, that support the procedures and practices for safeguarding the deceased. Interviews with the Inquiry Team have also been held with the CEO, a number of Directors, and key leads from the Trust. This is not a review of the Trust but an opportunity for the Inquiry to use this feedback, alongside information from other organisations to inform their review of the arrangements in place across the wider NHS.

7. Organ Donation – letter from NHS Blood and Transplant

The Trust has received a letter of recognition from NHS Blood and Transplant regarding our contribution to organ donation in 2023/24. In summary, from 7 consented donors, the Countess Of Chester Hospital NHS Foundation Trust facilitated 6 actual solid organ donors resulting in 9 patients receiving a transplant during the time period. Additionally, 19 corneas were received by NHSBT Eye Banks from your Trust.

When compared with national data, during the time period the letter confirmed that the Trust:

- Was in line with the national average for the referral of potential organ donors
- Was exceptional for Specialist Nurse presence when approaching families to discuss organ donation. A Specialist Nurse was present for 9 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.
- Referred 43 patients to NHSBT's Organ Donation Services Team; 34 met the referral criteria and were included in the UK Potential Donor Audit. There was a further 1 audited patient that was not referred.

In the North West, 36% of the population have registered an NHSBT Organ Donor Register (ODR) opt in decision. This compares to 42% of the population nationally.

8. UK Covid-19 Public Inquiry - Module 1 Report

On the 18th July 2024, Rt Hon Baroness Hallett, Inquiry Chair for the UK Covid-19 Public Inquiry published her first report. The report detailed the findings from Module 1 - Government planning and preparedness. The report sets out 10 recommendations, including those relating to institutes, structures and leadership; strategy; learning from experience; and the approach to emergency preparedness, resilience and response.

9. Women and Children's Strategy launch and building update

Our Women and Children's strategy has been launched. This aligns to our Trust strategy and sets out the ambitions to build on our vision to ensure safe, high-quality services for women and children to:

- Exceed national targets – where we need to do more we will act fast to improve and evidence this
- Achieve outstanding and good ratings with the care regulator
- Aim to take more healthcare to patients in their home or the most appropriate place
- Ensure we have enough of the right staff in the right place at all times
- Learn from our mistakes and be compassionate to those families involved.

We have also reached a significant milestone in the construction of our new Women and Children's Building. In June, we held a *topping out* ceremony which marked the completion of the building's frame and the start of the countdown to completion. We are on track for the building's internal fit-out will be completed by the end of 2024 and expected opening in summer 2025.

10. Civility Statement

A new civility statement for staff has been introduced, as part of our focus on staff wellbeing and developing a compassionate and inclusive culture. Dedicated roadshows encouraged staff from across the Trust to get involved and started valuable conversations around civility and kindness. The statement was developed and chosen by our staff and aims to ensure our colleagues feel safe, heard and can work together as a team:

> *"We will always treat everyone with respect and kindness, be polite and professional, listen and help each other whenever we can."*

This is a reminder for all staff to live these behaviours and carry them with them into their day-to-day interactions with each other and patients.

11. Staff Awards

We have introduced a number of awards to better recognise the achievements of our staff – individuals and teams – and to show the value we all have in the work we do. We are currently reviewing our first employee of the month and team of the month nominations for July 2024.

In advance of our annual celebration event we have also launched a range of staff awards, with nominations open to recognise excellence and achievements from across the Trust, focusing on the people and teams who have gone above and beyond to improve care, safety and culture.

12. Staff Networks

We are continuing to support our staff networks, recognising that they are all at different stages of development. We have seven Staff Networks to support our colleagues:

- BAME

- Carers
- Disability and Wellness
- Faith and Belief
- LGBTQ+
- Neurodiversity
- Women's

On Tuesday 25th June our LGBTQ+ Network were joined by Richard Euston (CEO) from Chester Pride. He talked to colleagues in the wellbeing hub about Chester Pride, The Charity, and why the event is important to the community.

13. Medical Emergency Team (MET) Launch

In September 2024, we will launch our new Medical Emergency Team (MET) which will be there to support our teams in responding to acutely unwell or deteriorating patients. This is an important development which will have a significant impact on patient safety, reducing harm and making sure we have the right medical support in place to support deteriorating patients.

14. Letby Retrial Verdict

On 2nd July 2024, following a four week retrial at Manchester Crown Court, the jury found Lucy Letby guilty of the attempted murder of Baby K. The retrial was for one of the charges against Lucy Letby which the jury had been unable to reach a verdict on in August 2023. Sentencing took place on Friday 5th July 2024.

15. Thirlwall Inquiry Update

The Trust continues to respond to the requests of the Inquiry and the police investigations.

In terms of the inquiry the Trust has:

- Submitted a significant amount of data by way of disclosure of relevant (or potentially relevant) material.
- Responded to a number of rule 9 corporate statement requests.
- Supported the process of dissemination of rule 9 requests from the Inquiry for individual statements from both current and former staff, and signposted both current and former staff to legal support with statement preparation where requested.
- Provided legal submissions on the livestreaming of evidence during the Inquiry oral hearings at the Preliminary Hearing which was held on 16th May 2024.
- Continued to provide both legal and pastoral support to staff.

Investigations relating to Lucy Letby's career footprint are ongoing, as is the investigation into corporate manslaughter at the Countess of Chester Hospital.

16. Chair Second Term

The Council of Governors met on 11th July 2024 and I am pleased to confirm the approval of a second term of office for the Trust Chair, Ian Haythornthwaite, which will commence in September

2024. The process also included approval by NHS England and the Cheshire and Merseyside Integrated Care Board.

17. Lead Governor

Peter Folwell and Caroline Stein, have announced that they will be stepping down from their governor roles this year. As Lead Governor and Deputy Lead Governor respectively, they have made a significant contribution to the Trust, representing the views of patients, families and the local community. The Chair will lead a process with the Council of Governors to appoint a new Lead Governor.

18. Governor Elections

Our Governor election process commenced on 8th July 2024 and the closing date for entries is Friday 2nd August 2024. We have 10 public governor positions available across Chester & rural Cheshire, Ellesmere Port & Neston, Flintshire and the remainder of England & Wales.

Meeting	**30th July 2024**		**Board of Directors**					
Report	**Agenda item 8.**		**Board Assurance Framework and Risk Appetite Statement (2024/25)**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Karan Wheatcroft				Director of Governance, Risk and Improvement			
Author(s)	Karan Wheatcroft				Director of Governance, Risk and Improvement			
Board Assurance Framework	ALL	All areas of the Board Assurance Framework						
Strategic Aims	Includes all strategic goals							
CQC Domains	Well Led							
Previous Considerations	Board development session 21st May 2024.							
Summary and Key Points	Following the Board development session in May 2024, the Board Assurance Framework (BAF) has been fully reviewed and updated. A revised Board risk appetite statement has been developed for approval and the risk appetite levels applied to the BAF. The BAF risks and residual risk scores are: • BAF1 - quality of care (16) • BAF2 - safety and harm (16) • BAF3 - operational planning standards (16) • BAF4 - workforce (15) • BAF5 - financial plan (16) • BAF6 - capital programme (15) • BAF7 - digital transformation and IT resilience (15) • BAF8 - corporate governance (12) • BAF9 - system working (12) • BAF10 - research and innovation (12) The key control lines and actions have been aligned to the Trust strategic objectives, with progress to be reported alongside the BAF on a quarterly basis to the Board of Directors. The risk appetite statement has been drafted for consideration with risk appetite levels and maximum tolerance proposed for each domain.							
Recommendation(s)	The Board of Directors is asked to: • Approve the baseline BAF for 2024/25 • Note the alignment and progress against the Trust's Strategic Objectives 2024/25							

	• Approve the Board risk appetite statement for 2024/25
Corporate Impact Assessment	
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status.
Quality & Safety	Improved patient safety.
NHS Constitution	Improves overall assurance on key strategic objectives.
Patient Involvement	In line with Quality and Safety.
Risk	Alignment with the Corporate Risk Register.
Financial impact	Financial risk is considered as part of the Effectiveness areas of the BAF.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics.
Communication	Document to be published on the Trust's website as part of the Board of Directors agenda.

Countess of Chester Hospital NHS Foundation Trust

Board Assurance Framework (BAF) Quarter 3 (2023/24)

1. BACKGROUND

A Board Assurance Framework (BAF) outlines the key risks to achievement of an organisation's strategic objectives. The BAF is a key tool used by the Board to ensure a focus on strategic risk, including controls, assurances and actions to manage and mitigate the risks.

The 2024/25 BAF has been developed using the feedback from the Board development session, aligned to the new Trust strategic goals and objectives, and risk appetite statement.

2. BAF RISKS ALIGNED TO STRATEGIC GOALS AND OBJECTIVES

Alignment to strategic goals and objectives has been included within the BAF, with strategic objectives shaded within the key controls. The current risk exposure against the strategic goals is summarised below.

Principal Risk	Strategic Goals					
	Patient and family experience	People and Culture	Leadership	Adding Value	Partnership	Populations
BAF1. Failure to maintain **quality of care** would result in poorer patient & family experience						
BAF2. Failure to **maintain safety and prevent harm** would result in poorer patient care and outcomes						
BAF3. Inability to deliver **operational planning standards**, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust.						
BAF4. Challenges in ensuring a high quality, engaged, diverse and inclusive **workforce** would affect our ability to deliver patient care						
BAF5. Failure to deliver **financial plan** and underlying financial position could impact long term financial sustainability for the Trust and system partners						

BAF6. Inability to achieve the **capital programme** within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of our services						
BAF7. Failure to ensure strong **digital transformation and IT resilience** could impact the delivery of services for patient and our workforce						
BAF8. Failure to ensure effective **corporate governance** could impact our ability to comply with legislation and regulation, and our reputation.						
BAF9. **System working** and provider landscape changes may present challenges in ensuring COCH is positioned as a strong system partner, with priorities aligned to system partners across Cheshire & Merseyside.						
BAF10. Inability to deliver the **Research and Innovation** agenda to exploit future opportunities						
Risk exposure						

Appendix B sets out the progress against strategic objectives for 2024/25.

3. RISK APPETITE

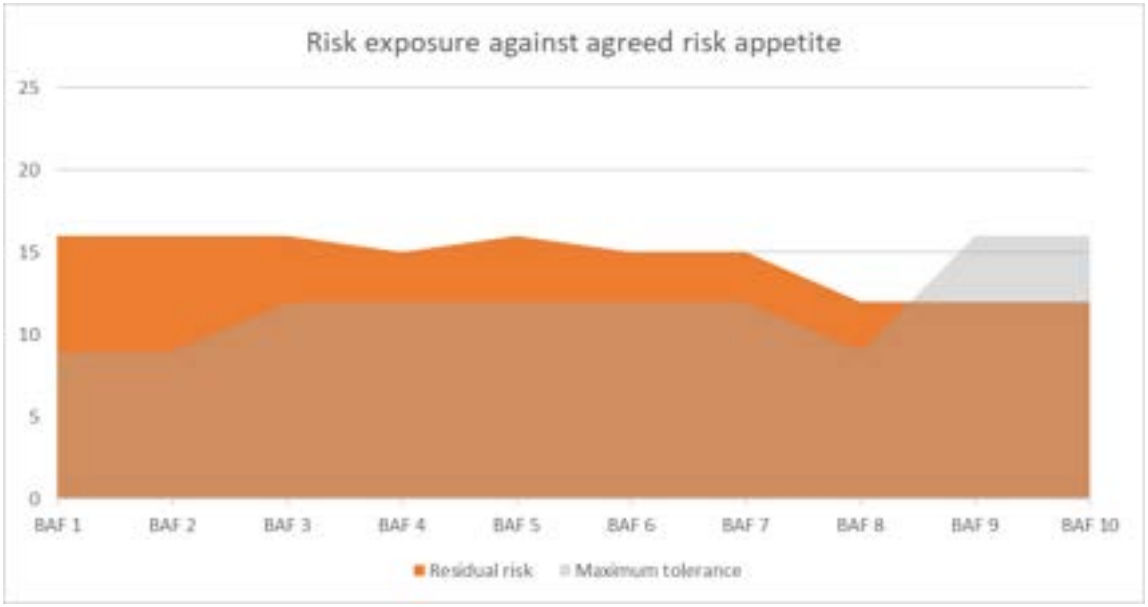
Risk appetite has been included within the BAF, along with target scores aligned to the upper tolerance limit for risk domains as follows:

Risk domain	Risk appetite level	Risk score upper tolerance limit
Quality, Safety, and Patient Experience	Cautious	9
Operational Effectiveness	Open	12
Workforce	Open	12
Finance	Open	12
Digital	Open	12
Governance	Cautious	9
Research and Innovation	Seek	16
System working and Strategic Partnerships	Seek	16

A full risk appetite statement is provided in Appendix A.

4. CURRENT RISK SCORE AGAINST TARGET SCORE

The following graph shows the current residual risk score against the target risk score. The graph enables a quick comparison of target versus actual residual risk. Actions to further mitigate and manage these risks are included within the BAF along with progress updates.



Key:

BAF1 - quality of care
BAF2 - safety and harm
BAF3 - operational planning standards
BAF4 - workforce
BAF5 - financial plan
BAF6 - capital programme
BAF7 - digital transformation and IT resilience
BAF8 - corporate governance
BAF9 - system working
BAF10 - research and innovation

5. RECOMMENDATIONS:

The Board of Directors is asked to:

i. Approve the baseline BAF for 2024/25
ii. Note the alignment and progress against the Trust's Strategic Objectives 2024/25
iii. Approve the Board risk appetite statement for 2024/25

Appendix A – Board Risk Appetite Statement 2024/25

We will continue to protect the Quality and Safety of Care, being cautious of risks that may have a detrimental effect on the Patient and Family Experience and outcomes.

We have an open attitude to risk in relation to Operational Effectiveness and Finance. We acknowledge that there are significant financial and operational challenges across our healthcare system, and we need to look at innovative ways to support delivery.

Transforming services to ensure sustainability and productivity will require changes in staffing models and an agile, resilient workforce. We have an open risk approach to our workforce challenges as we look at new and innovative ways to recruit, retain and support our people, whilst we maintain a strong focus on engagement and culture.

We need to have an open attitude to the digital agenda underpinning clinical innovation and optimization of our digital systems to become more efficient and effective. While we are prepared to accept some level of risk to implement changes for longer term benefit, we will ensure that information governance and data security remains a priority and risks are mitigated to appropriate levels.

Strong governance is crucial to delivering our services, and we will be cautious about risks relating to governance.

Recognising the need for new ways of working we have a risk-seeking approach to research, innovation, strategic partnerships and system working. In developing our clinical research and innovation ambitions we accept that these carry a higher level of inherent risk. We will seek opportunities to work collaboratively with partners, contribute to the delivery of priorities and develop new ways of working through a range of partnerships.

Risk appetite has been set as follows:

Risk domain	Risk appetite level	Risk score upper tolerance limit
Quality, Safety, and Patient Experience	Cautious	9
Operational Effectiveness	Open	12
Workforce	Open	12
Finance	Open	12
Digital	Open	12
Governance	Cautious	9
Research and Innovation	Seek	16
System working and Strategic Partnerships	Seek	16

Risk Appetite Descriptors

Appetite level	Averse	Minimalist	Cautious	Open	Seek
Description	Avoidance of risk and uncertainty	Preference for ultra-safe delivery options that have a low degree of inherent risk	Preference for safe delivery options that have a moderate degree of inherent risk and may have limited potential for reward	Willing to consider all potential delivery options and choose the ones most likely to result in successful delivery while also taking some risks providing an acceptable level of reward	Eager to be innovative and to choose options offering potentially higher rewards despite greater inherent risk
Tolerance	**Max score 3**	**Max score 6**	**Max score 9**	**Max score 12**	**Max score 16**

Appendix B – Progress against Strategic Objectives Q1

Strategic Objectives	Lead	Q1 Progress
SG1 Patients and Family		
Systematic approach to improving quality and safety and reducing harm	SP	Work commenced on overarching Quality and Safety Strategy refresh. Patient and family experience strategy being implemented with local consideration of actions needed to embed.
Delivery of NHS planning standards	CC	The Trust continues to meet the long waiting RTT targets and the reduction in suspected long waiting cancer patients. Access to UEC services remains as above and is challenged due to high ED attendances and lack of progress with the reduction of patients that no longer have the criteria to reside. There is a full UEC improvement programme in progress with improved metrics of 12 hour DTA and time to triage. The Trust continue to work with the wider systems and local authorities to enable an improved number of complex discharges. The Trust continues to explore options to extend SDEC opening hours.
Development of a patient and family care model	SP	Work commenced on overarching Quality and Safety Strategy refresh. Patient and family experience strategy being implemented with local consideration of actions needed to embed.
Adoption of continual improvement and learning	KW	The Trust has developed a range of organisational learning through PSIRF, learning from deaths, national inquiries, clinical audit, patient safety summits etc. The policy is being developed to capture all these opportunities, and consider how sharing of learning can continue to be maximised.
SG2 People and Culture		
United shared values, goals, mindset and behaviours	DH	Civility statement developed through wide engagement, and approved by the Board (May 24). Launch and roll out commenced.
Develop an approach for recruitment, development and retention	DH	Onboarding processes being reviewed and new framework for corporate induction being implemented from July 2024.
Improve the health and wellbeing of our staff	DH	Staff hub opened (Q1) and wellbeing offer developing to include physical, mental and financial. Exploring salary sacrifice schemes.
SG3 Leadership		
Development of clinical strategy	NS	Discussions with the Clinical Directors and Divisional leads has taken place. Development day planned with Clinical Leads for October 2024 to drive forward the development of the Clinical Strategy.
Take a leadership role within Cheshire West	JD	Representation and engagement continues across a range of forums.

		Director of Strategy facilitated, arranged and chaired the first of a series of prevention conference across Place focussed on CVD Prevention.
Develop our leadership teams	DH	Leadership framework established and programmes rolled out for clinical leaders, and aspiring leaders (band 2-4). Lead managers programme being rolled out in Q2. Training needs analysis to be developed in the Autumn.
Ensuring governance is in place across the organisation	KW	Significant progress made against well led action plan including assurance committee effectiveness, BAF and risk appetite reset for 2024/25. Work progressing on risk management arrangements and sub committee structures.

SG4 Adding Value		
Development of a new financial plan and strategy	KE	Conclusion of 2024/25 annual planning process (June 2024). Development of deficit drivers underway. Revisit of PWC action plan and HfMA financial control checklist being undertaken.
Advance digital solutions in support of transforming care	JB	NHS Providers led Board session planned on Digital Maturity (August 2024).
Achieve anchor institution status. (green / social value / prevention)	JD	New Anchor Institution oversight group established (June which will meet bi monthly). New reporting framework adopted. Revised terms of reference. Board report presented in July 2024.

SG5 Partnership		
Develop a bespoke research, education and innovation strategy	NS	Early discussions to establish research ambitions to support strategy development.
Explore new models of care for In reach, Out Reach and Networked services.	CC	Continued discussions with WUHFT following Board to Board.
Increase academic appointments	NS	Communication strategy developed to support awareness for partner organisations. Current focus on building relationships and developing collaboration opportunities.

SG6 Populations		
Develop a Trust approach to health inequalities and prevention	JD	To be undertaken in Q3
Purposeful shift from traditional provision to a population health approach	JD	Clinical Framework socialised with AMDs and approved by executives. Framework to be shared in August 2024 for pre clinical summit completion.
Further development our integrated care approach	CC	MOU in place. Discussions underway and paper being developed for COCH/CWP Community Services collaboration vision and future operating model.

Countess of Chester Hospital
NHS Foundation Trust

Board Assurance Framework 2024 - 25

Risk Theme: Quality & Patient Experience

RISK APPETITE: CAUTIOUS - Upper tolerance limit 9

LINKS TO STRATEGIC GOALS: SG1: Patient and Family Experience; SG:3 Leadership;

Risk description & information	Causes & consequences	Inherent risk score (C x L)	Key controls (Actions taken to manage the risk)	Board Assurance (The mechanisms we know the controls are working - reports, scrutiny meetings, committees, internal & external audits and reviews)			Residual risk score (C x L)	Within risk tolerance?	Gaps in Control / Assurance (Identified weaknesses in current management arrangements/ how we assure ourselves - or not enough information or lack of scrutiny	Actions		Target risk score (C x L)	Estimated date of achievement of target score
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update		
BAF1 Failure to maintain quality of care would result in poorer patient & family experience **Executive Risk Lead:** Director of Nursing and Quality **Assurance Committee**: Quality and Safety Committee **Last Update:** July 2024	- Longer patient waiting lists resulting in patients presenting more sick. - Patient Flow challenges due to longer length of staff due to no criteria to reside, patient harm. - Emergency Department capacity not supportive of the high volume of patients presenting to the Emergency Department. - Consultant vacancies and failure to recruit. - Poor national patient survey results. - Failure to implement the National Safety Strategy. - Maternity Services Survey. - Emergency Care Survey. - Underdeveloped partnership working arrangements to support clinical strategy delivery. - Lack of clinical engagement to the required changes to pathways. - Lack of reciprocal engagement in the wider health system (including ICB, and Place).	***4 x 5 = 20***	C1) Quality and Safety Strategy priorities. **Control Owner:** Director of Nursing and Quality	- Integrated Complaints, Claims and Incidents Quarterly report - Quality and Safety Committee reports - Quality Governance Group via Q&S Committee - Patient Experience Operational Group via Q&S Committee - Operational Management Board	National inpatient survey results. Healthwatch reports. Internal audit reviews. NHS Staff survey results. CQC Inspection Outcomes. Family and friends test results.	*Partial*	***4 x 4 = 16***	**NO**	Quality & Safety Strategy refresh.	Quality and Safety Strategy to be refreshed in 2024/25. Patient and Family experience startegy to be embedded. **Action Owner**: Director of Nursing and Quality **Due date:** Q3	Work commenced on overarching Quality and Safety Strategy refresh. Patient and family experience strategy being implemented with local consideration of actions needed to embed.	***3 x 3 = 9***	***Mar-25***
			C2) Quality Governance Structures **Control Owner:** Director of Nursing and Quality	- Consolidated CQC and Well Led Action Plan reported to each Board of Directors - Quality and Safety Committee - Quality Governance Group via Q&S Committee	Commissioner reviews of quality (quarterly). CQC reports.	*Partial*			Review of work plans of reporting sub committees/ groups to strengthen assurance coverage.	To review sub committee/ group reporting structures and workplans for Q&S Committee. **Action owner**: Director of Nursing and Quality **Due Date:** Q3	Deputy Director of Nursing & Governance commenced in post on the 1st February 2024. Full review of Quality Governance Structures completed. Comprehensive Well Led action plan is in place and progressing with updates provided to Executive Directors Group monthly and to each Board of Directors. Sub committee/ group workplans to be reviewed.		
			C3) Infection Prevention and Control. **Control Owner:** Director of Nursing and Quality	- SOF - Infection, Prevention & Control Quarterly Report via Q&S Committee - Quality Governance Group via Q&S Committee - Annual Quality Account (featuring IPC section re objectives)	CQC reports	*Partial*			Assurance gap re cleaning standards. IPC compliance assurance and improvements.	To improve compliance assurance through harms improvement (ecoli and cdiff), and campaigns (e.g. Gloves off). To establish assurance reporting on cleaning standards. **Action Owner:** Director of Nursing and Quality **Due date:** Quarterly updates	Harms improvement priorities agreed for 2024/25 and programmes progressing. Gloves off campaign established.		
			C4) CQC regulatory compliance **Control Owner:** Director of Nursing and Quality	- Consolidated CQC and Well Led Action Plan reported to each Board of Directors - Quality and Safety Committee - Quality Governance Group via Q&S Committee - Ward accreditation reporting via Q&S	Commissioner reviews of quality (quarterly). CQC reports.	*Partial*			Roll out of the new ward accreditation process across all areas.	To deliver the programme of ward accreditation across the Trust. **Action owner:** Director of Nursing and Quality **Due date:** Quarterly updates	Ward accreditation programme in place and being rolled out.		
BAF2 Failure to maintain safety and prevent harm would result in poorer patient care and outcomes **Executive Risk Lead:** Medical Director **Assurance Committee**: Quality and Safety Committee **Last Update:** July 2024	- Longer patient waiting lists resulting in patients presenting more sick. - Patient Flow challenges due to longer length of staff due to no criteria to reside, patient harm. - Emergency Department capacity not supportive of the high volume of patients presenting to the Emergency Department. - Consultant vacancies and failure to recruit. - Poor national patient survey results. - Failure to implement the National Safety Strategy. - Maternity Services Survey. - Emergency Care Survey. - Underdeveloped partnership working arrangements to support clinical strategy delivery. - Lack of clinical engagement to the required changes to pathways. - Lack of reciprocal engagement in the wider health system (including ICB, Place). - Review of mental health service provision in A&E and across all Trust sites	***5 x 4 = 20***	C1) Safety priorities. **Control Owner:** Medical Director	- SOF - Quality Governance Group via Quality and Safety Committee	CQC Inspection Outcomes	*Partial*	***4 x 4 = 16***	**NO**	Delivery of quality improvement outcomes.	To deliver harms improvement programme outcomes. **Action owner:** Medical Director **Due date:** Quarterly updates	Reviewed 23/24 acheivements, and revised programme for 24/25. Continued presentation of A3s to EDG and updates to Qualtiy Governance Group.	***3 x 3 = 9***	***Mar-25***
			C3) Organisational learning **Control Owner:** Medical Director/ Director of Governance Risk and Improvement	- Integrated Complaints, Claims and Incidents Quarterly report - Quarterly learning from deaths report via Q&S Committee - Quality Governance Group via Q&S Committee		*Partial*			Organisational Learning Policy and embedding of approach.	The production of an Organisational Learning Policy, including range of activity, forums and reporting. **Action Owner:** Director of Governance, Risk and Improvement **Due date:** Q2	The Trust has developed a range of organisational learning through PSIRF, learning from deaths, national inquiries, clinical audit, patient safety summits etc. The policy is being developed to capture all these opportunities, and consider how sharing of learning can continue to be maximised.		
			C4) Review of deaths **Control Owner:** Medical Director	- Quarterly Learning from Deaths report and annual mortality report via Q&S Committee - Quality and Safety Committee - Quality Governance Group via Q&S Committee	Telstra Health (Dr Foster) benchmarking	*Acceptable*							
			C5) Development and implementation of Clinical Strategy **Control Owner:** Medical Director			*Partial*			Refresh of the Clinical Strategy aligned to the Trust Strategy.	The Medical Director will work closely with the Director of Strategic Partnerships and Clinical leaders to ensure the Clinical Strategy is aligned to the Trust Strategy and reflective of the new clinically led divisional infrastructure. **Action owner:** Medical Director **Due Date:** Q4	Discussions with the Clinical Directors and Divisional leads has taken place. Development day planned with Clinical Leads for October 2024 to drive forward the development of the Clinical Strategy.		
			C6) Mental Health review **Control Owner:** Director of Strategy and Partnerships	CEO Report to Board.	Mental Health, Learning Disability and Communuty collaborative updates	*Partial*			Education and training in mental health awareness and mental health first aid training. An understanding of the roles and resposnibilites of a 136 place of safety and continuity of care when handing over between acute and mental services.	Action Plan developed including reintroducing the mental health collaboative between CWP and the Trust for liasion psychiatry services, with an aim to reduce delays in the process for people with MH crisis in ED, and supporting Children and Young People with Mental Health needs in an Acute Paediatric Setting. **Action owner:** Director of Strategy and Partnerships **Due Date:** Quarterly updates	Ligature risk well embedded in A&E and being rolled out across ward areas. Plan in place for every patient to have a safegaurding risk assement. Workplan for 2024/25 developed.		

Risk Theme: Operational Effectiveness													
RISK APPETITE: OPEN - Upper tolerance limit 12													
LINKS TO STRATEGIC GOALS:	**SG4: Adding Value**												
Risk description & information	**Causes & consequences**	**Inherent risk score (C x L)**	**Key controls**	**Board Assurance**			**Residual risk score (C x L)**	**Within risk tolerance?**	**Gaps in Control / Assurance**	**Actions**		**Target risk score (C x L)**	**Estimated date of achievement of target score**
				Internal sources of assurance	**External sources of assurance**	**Overall assurance level**				**Planned action**	**Progress update**		
BAF3 Inability to deliver operational planning standards, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust. **Executive Risk Lead:** Chief Operating Officer **Assurance Committee**: Finance and Performance Committee **Last Update:** July 2024	**Cause:** - Unable to meet the demand for services within available resources - Increased demand in suspected cancer referrals and ED attendances - Known loss of productivity due to Cerner migration impact **Impact:** - Increasing patient waits for access to services. - Increasing potential risks to patient safety as a result of delays of access to services. - Failure to meet key targets - Failure to meet regulation requirements - Significant raised numbers of 52 and 65 week waiters. **Consequence;** - Sub-optimal service provision - Potential harm to patients due to slowing down of service provision - Potential risk of an increase in complaints from family, friends and carers. - Potential reputational damage to the Trust.	***4 x 5 = 20***	C1) Annual plan with clear activity and performance reporting against trajectories. **Control Owner:** Chief Operating Officer	- System Oversight Framework to Board (each meeting), including enhanced reporting on RTT. - Finance and Performance Committee - Divisional Performance via Operational Management Board - Operations and Performance Executive Led Group via OMB	North West performance report overseen by ICB. Contract review meetings.	*Partial*	***4 x 4 = 16***	**NO**	Management of flow, consistent application of discharge requirements and significant NC2R patients requiring wider system response. UTC/ SDEC restricted opening hours.	(i) ED - Whole system approach to hospital avoidance and supported primary care function. Continued focus at SIB. (ii). ED - Continued MADE multidisciplinary discharge events, and perfect weeks. (iii). Explore options to extend Same Day Emergency Care Unit opening hours. **Action Owner:** Chief Operating Officer **Due date:** Quarterly updates	The Trust continues to meet the long waiting RTT targets and the reduction in suspected long waiting cancer patients. Access to UEC services remains as above and is challenged due to high ED attendances and lack of progress with the reduction of patients that no longer have the criteria to reside. There is a full UEC improvement programme in progress with improved metrics of 12 hour DTA and time to triage. The Trust continue to work with the wider systems and local authorities to enable an improved number of complex discharges. The Trust continues to explore options to extend SDEC operning hours.	***4 x 3 = 12***	***Mar-25***
			C2 Performance management framework and Governance Structure Control Owner: Chief Operating Officer	- System Oversight Framework to Board (each meeting), including enhanced reporting on RTT. - Finance and Performance Committee - including System Oversight Framework - Divisional Performance via Operational Management Board - Operations and Performance Executive Led Group via Finance and Performance Committee		*Acceptable*			Some gaps in validation (non RTT) and data quality issues remain	Increased focus on Non RTT follow up data quality, clinical validation and delivery **Action Owner:** Chief Operating Officer **Due date:** Quarterly updates	CMAST resources secured to support validation (end Q2).		

Risk Theme: Workforce												
RISK APPETITE: OPEN - Upper tolerance limit 12												
LINKS TO STRATEGIC GOALS:	**SG3: People and Culture**											
Risk description & information	**Causes & consequences**	**Inherent risk score (I x L)**	**Key controls**	**Board Assurance**			**Residual risk score (I x L)**	**Within risk tolerance?**	**Gaps in Control / Assurance**	**Actions**		**Target risk score (I x L)**	**Estimated date of achievement of target score**
				Internal sources of assurance	**External sources of assurance**	**Overall assurance level**				**Planned action**	**Progress update**		
BAF4 Challenges in ensuring a high quality, engaged, diverse and inclusive workforce would affect our ability to deliver patient care. **Executive Risk Lead:** Chief People Officer **Assurance Committee:** People and Organisation Development Committee **Last Update:** July 2024	**Causes** - Poor staff morale - Staff burn-out - Increase in mental health issues - Lack of health and wellbeing support - Further surges / new variants - Staff burn-out - Industrial action - Perceptions of the NHS as a place to work - Competition for talent - Expectations of Millennials entering the labour pool - Failure to listen and act with 2 way communication **Consequences** - A deterioration in the physical and mental wellbeing of our workforce - Loss of goodwill and staff engagement - Fluctuating capacity - Increase in long-term sickness absence - Increased staff turnover - Staff vacancy gaps exacerbated - Increased bank/ temp staff hours - Lack of leadership stability - Erosion of skills and knowledge - Delays in onboarding - Reduced leadership capacity and capability - Lack of confidence in leadership teams - Reduced staff engagement - Increased staff turnover	***5 x 4 = 20***	C1) Workforce Plan **Control Owner**: Chief People Officer	- System Oversight Framework Report (bi-monthly) - Staffing monitored via Strategic Workforce Group and chair's report to People and Organisation Development Committee	Annual plan submitted to ICS.	*Partial*	***5 x 3 = 15***	**YES**	Enhanced workforce controls required, including vacancy control measures, and pay controls aligned to system oversight expectations.	Establish and embed enhanced vacancy control measures aligned to ICS headcount expectations. **Action owner:** Chief People Officer **Due date:** Q2 2024	Executive led vacancy control group including variable pay measures established in Q1. Corporate Services Review progressing.	***4 x 3 = 12***	***Mar-25***
									Workforce plan underpinned by professional group workforce reviews and plans.	Professional group workforce plans to be developed and reviewed. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	Review of nurse staffing complete and actions agreed. Workforce plan template being rolled out for completion in Q2.		
			C2) Staff experience, engagement, morale and culture **Control Owner**: Chief People Officer	- SOF - Workforce dashboard/ SOF via POD - GMC Survey via POD - Preceptorship survey via POD - Staff survey action plan updates and Pulse surveys via POD - FTSU Bi-annual update and via POD - Quarterly employer relations report via POD	NHS Staff Survey results	*Partial*			Staff survey action plan delivery and assurance on delivery of Divisional action plans.	Delivery of staff survey action plan including listening channels, respect and civility work, and engagement strategy. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	Civility statement developed through wide engagement, and approved by the Board (May 24). Launch and roll out commenced.		
									Clear and comprehensive wellbeing offer.	Improving the Trust wellbeing offer. **Action Owner:** Chief People Officer **Due date:** Q2 2024	Staff hub opened (Q1) and wellbeing offer developing to include physical, mental and financial. Exploring salary sacrifice schemes.		
			C3) Equality, Diversity and Inclusion **Control Owner:** Chief People Officer	- Staff survey - WRES/WDES Reports via POD	NHS staff survey results. WRES/ WDES.	*Partial*			Well established staff networks and feedback.	Establish and develop staff networks. **Action Owner:** Chief People Officer **Due date**: Q2 2024	Executive leads identified for staff networks and initial meetings taking place.		
			C4) Recruitment and Retention **Control Owner:** Chief People Officer	- SOF - Workforce dashboard/ SOF via POD		*Acceptable*			Delivery of talent and succession planning including scope for growth.	Delivery of talent and succession planning including roll out of Scope for Growth. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	New appraisal framework developed and being used for appraisals.		
									Enhanced onboarding process and experience.	Redesign of onboarding processes. **Action Owner:** Chief People Officer **Due date:** Q3 2024	Onboarding processes being reviewed and new framework for corporate induction being implemented from July 2024.		
			C5) Education and Development, including leadership capabilities **Control Owner:** Chief People Officer	- L&D Reports via POD - Guardian of Safe Working reports - GMC survey via POD - Preceptorship survey via POD	NHS Staff survey results. GMC Survey results Preceptorship survey results	*Acceptable*			Training needs analysis. Delivery of leadership programmes.	Leadership programmes to be rolled out at all levels. Training needs analysis to be developed following appraisals. **Action Owner:** Chief People Officer **Due date:** Q3 2024	Leadership framework established and programmes rolled out for clinical leaders, and aspiring leaders (band 2-4). Lead managers programme being rolled out in Q2. Training needs analysis to be developed in the Autumn.		

Risk Theme: Finance & Capital

RISK APPETITE: OPEN - Upper tolerance limit 12

LINKS TO STRATEGIC GOALS: SG4: Adding Value

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score (I x L)	Estimated date of achievement of target score
BAF5 Failure to deliver financial plan and underlying financial position could impact long term financial sustainability for the Trust and system partners. **Executive Risk Lead:** Chief Finance Officer **Board Committee**: Finance and Performance Committee **Last Update:** July 2024	**Cause:** The Trust operates in an increasingly challenging financial environment in line with the national position for acute providers. This is driven by: - Increase in non elective activity delivered at premium costs; High numbers of medically optimised and delayed transfers of care for which costs are not fully reimbursed; - Costs associated with medical and nurse agency usage; - The Trust, as part of the Cheshire & Merseyside system has agreed a planned deficit for 2024/25. This is dependant on the Trust delivering efficiency savings of 5% whilst not investing in any further developments. - Identification and delivery of recurrent Cost Improvement Plan (CIP) - Return to Payment by Results (PbR) for elective and outpatient activity and block funding for non-elective activity alongside activity target requirements and potential clawback of income through Elective Recovery Fund (ERF) if activity targets are not delivered - Lack of internally generated Capital resource **Impact:** - The Trust is unable to achieve a sustainable financial balance & achievement of recurrent efficiencies & deliver its strategic objectives. This will result in the requirement to borrow cash from DHSSC (with a cost associated with borrowing cash) - Inability to maintain safe and effective local services. - Increased external scrutiny from NHSE and Integrated Care Board (ICB) - The Trust's inability to deliver financially would also impact on the financial position of the Cheshire & Merseyside System.	*4 x 4 = 16*	C1) Finance Strategy and underlying sustainability **Control Owner**: Chief Finance Officer	- Trust board report (monthly) - Finance & Performance Committee - Divisional Boards via Operational Management Board (Monthly) - Capital Steering Group via F&P Committee (Monthly) - Operational Performance Executive Led Group reporting to OMB	System Financial Plan ICB submissions ICB monthly expenditure controls group NHSE monitoring returns and weekly telephone calls	*Partial*	*4 x 4 = 16*	**NO**	Long term financial plan aligned to strategy	A more detailed 5 year financial plan is in the process of being prepared. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Conclusion of 2024/25 annual planning process (June 2024). Development of deficit drivers underway. Revisit of PWC action plan and HfMA financial control checklist being undertaken.	*4 x 3 = 12*	***Mar-25***
			C2) Annual Budget and systems of budgetary control **Control Owner**: Chief Finance Officer	- Financial Plan (approved) - Finance Report to Board - F&P Committee	Financial Plan ICB submissions Internal Audit reviews	*Partial*			Uncertainty of impact of emerging system expenditure controls, expectations and productivity ask on local plans, budget pressures and investments.	Continue to work with the ICB and C&M CFOs to understand and manage the implications. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Ongoing discussions with the ICB and C&M CFOs.External support to be convened July/ August 2024 to assure and development improvement.		
			C3) Cost Improvement Programme including Quality Impact Assessments **Control Owner**: Chief Finance Officer	CIP delivery group reporting to F&P. F&P Committee	Financial Plan NHSE Template	*Partial*			Delivery phase of CIP Programme, low levels of maturity and to be underpinned by productivity expectations.	Development of schemes and further movement of opportunities into identified schemes which can be transacted. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Workstreams identified and Executive Leads assigned. Workshop held in April 2024 to engage teams and agree next steps. CIP Delivery Group established with CEO as Chair, and reporting into F&P Committee. Workstreams reporting into CDG, with scheme maturity levels moving positively.		
BAF6 Inability to achieve the capital programme within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of our services **Executive Risk Lead:** Chief Finance Officer **Board Committee:** Finance and Performance Committee **Last Update:** July 2024	**Causes** - Implications of ICS capital envelope with undetermined ICB estates strategy and capital prioritisation process - Ageing estate and challenging backlog maintenance risks - Womens and Childrens building major capital scheme - limited development opportunities due to space constraints **Consequences** - Impact on delivery of capital plan - insufficient progress on backlog maintenance - Inability to invest in innovations not currently identified in the Trust's five year financial plan - Having to re-prioritise the programme if an unidentified need arises - Disruption to operational services during a complex capital programme	*5 x 4 = 20*	C1) Robust governance arrangements for Capital Management. **Control Owner**: Chief Finance Officer	- Finance and Performance Committee reporting to Board. - Capital Management Group via F&P Committee		*Partial*	*5 x 3 = 15*	**NO**	Uncertainty of the ICS approach to capital, estates strategy and capital prioritisation process.	Engagement in ICS Estates Strategy development. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Member of efficiency at scale wokrstream overseeing system estates work.	*4 x 3 = 12*	***Jul-25***
			C2) Management of new Women's and Children's Build **Control Owner**: Chief Finance Officer	W&C Project board governance - monthly risk review undertaken and assurance report provided to Project Board with escalations to Board of Directors via Finance and Performance Committee.		*Acceptable*							
			C3) Capital planning and prioritisation **Control Owner**: Chief Finance Officer	Quarterly update to the Finance and Performance Committee. Estates Strategy.		*Partial*			Exploring opportunities for contingency and system capital funding,	Continue to explore opportunities for system capital **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Capital allocation confirmed and prioritised plan in place for 2024/25.		
			C4) Estates strategy **Control Owner**: Chief Finance Officer	- Health and Safety Committee reports via Finance and Performance Committee. - Capital Management Group via F&P Committee	Six Facet Survey. Regulatory and statutory assurance received ad hoc (e.g. fire safety, H&S etc).	*Acceptable*			RAAC remediation plan .Risk and management of RAAC is guided by the most up to date professional guidance as issued by NHSE	RAAC failsafe works to continue with expected completion end Q3. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	At end of January 2024 Regional RAAC Board agreed additional funds to support the remaining failsafe works to the existing building, with advance of £2m to support the developmentoptions to re-provide bed capacity. New contractor has commenced failsafe works in July 2024.		

Risk Theme: Digital													
RISK APPETITE: OPEN - Upper tolerance limit 12													
LINKS TO STRATEGIC GOALS:	**SG4: Adding Value**												
Risk description & information	**Causes & consequences**	**Inherent risk score (I x L)**	**Key controls**	**Board Assurance**			**Residual risk score (I x L)**	**Within risk tolerance?**	**Gaps in Control / Assurance**	**Actions**		**Target risk score (I x L)**	**Estimated date of achievement of target score**
				Internal sources of assurance	**External sources of assurance**	**Overall assurance level**				**Planned action**	**Progress update**		
BAF7 Failure to ensure strong digital transformation and IT resilience could impact the delivery of services for patient and our workforce **Executive Risk Lead:** Chief Digital & Data Officer **Assurance Committee**: Finance and Performance **Last Update:** July 2024	**Cause:** - Failure to invest sufficiently in secure digital infrastructure, systems, service and data to enable safe, effective clinical patient care and business operations - Failure to adequately train staff in cyber security awareness - Failure to recruit a cyber security team - Increasing risk profile with more attacks evident, including Ransomware and Phishing. **Impact:** - Insecurities within the systems and infrastructure with vulnerabilities that could be exploited through a cyber attack. - Compromised systems and infrastructure would result in business continuity measures being put in place for staff and patients. - Staff unaware of cyber risk - Data loss **Consequence** - Regulatory sanctions if personal data is lost - Reputational damage - Poor clinical outcomes and experience for large numbers of patients resulting in an increased risk of harm - Potential for the Trust to fail to achieve its constitutional standards - Potential for workloads to become heavy through more manual processing during	***5 x 4 = 20***	C1) Delivery of Digital Strategy **Control Owner:** Chief Digital & Data Officer			*Partial*	***5 x 3 = 15***	**NO**	Strategy refresh required with regular consolidated reporting to F&P Committee.	Refresh Digital Strategy informed by National digital maturity assessment. **Action Owner:** Chief Digital and Data Officer **Due date:** Q3	NHS Providers led Board session planned on Digital Maturity (August 2024).	***4 x 3 = 12***	***Mar-25***
			C2) Cyber security and Digital Infrastructure **Control Owner**: Chief Digital & Data Officer	- DSPT via Audit Committee	- Annual MIAA assurance audit on DSPT submission	*Partial*			SIRO report for F&P Committee. Information Asset Owner responsibilities. Completion of capital infrastructure investment including data centres. New DSPT toolkit for completion in 2024/25.	To develop regular SIRO report to cover range of cyber and information governance assurances. **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update			
			C3) EPR Upgrade and Optimisation **Control Owner**: Chief Digital & Data Officer	- EPR update reported to Finance & Performance Committee	- MIAA lessons learned review (reported to Audit Committee and F&P Committee) - NHSE Readiness review (reported via F&P Committee)	*Partial*			Completion of upgrade.	Complete EPR upgrade **Action Owner:** Chief Digital and Data Officer **Due date:** Q3	EPR upgrade progressing to plan. Independent assurances received from lessons learned report (MIAA) and Readiness assessment report (NHS England).		
									EPR optimisation structures, engagement and assurance reporting.	New prioritisation process for EPR to be introduced, including clinically led group to drive EPR optimisation programme. **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update			
			C4) Data Quality and Analytics **Control Owner**: Chief Digital & Data Officer	- Annual report to F&P Committee		*Partial*			Clear data quality framework and assurance reporting.	Develop and deply data quality framework with enhanced assurance reporting. **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update			
			C5) Professional digital and data workforce capacity,capability, and sustainability **Control Owner**: Chief Digital & Data Officer		- National digital workforce survey (reported via F&P Committee)	*Partial*			Fit for the future workforce plan.	Workforce plan review, including data scientist capabilities. **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	Awaiting national digital workforce strategy findings to inform workforce plan, along with Digital Strategy refresh.		

Risk Theme: Governance													
RISK APPETITE: CAUTIOUS - Upper tolerance limit 9													
LINKS TO STRATEGIC GOALS:	**SG3: Leadership**												
Risk description & information	**Causes & consequences**	**Inherent risk score (I x L)**	**Key controls**	**Board Assurance**			**Residual risk score (I x L)**	**Within risk tolerance?**	**Gaps in Control / Assurance**	**Actions**		**Target risk score (I x L)**	**Estimated date of achievement of target score**
				Internal sources of assurance	**External sources of assurance**	**Overall assurance level**				**Planned action**	**Progress update**		
BAF8 Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation, and our reputation. **Executive Risk Lead:** Director of Governance, Risk and Improvement **Board Committee**: Audit Committee **Last Update:** July 2024	**Causes** - - new partnership arrangements developing **Consequences** - reputation and public confidence in the Trust - legal challenges	***4 x 3 = 12***	C1) Effective Governance Structures **Control Owner:** Director of Governance, Risk and Improvement	- Well led action plan. - Annual report. - Committee effectiveness annual reports via Audit Committee.	Head of Internal Audit Opinion (via Audit Committee). VFM opinion (via Audit Committee). CQC Reports.	*Partial*	***4 x 3 = 12***	**YES**	Well led action plan delivery.	Continued delivery of actions within the Well Led action plan including strengthened reporting and Sub Committee/ Group organogram. **Action Owner**: Director of Governance, Risk and Improvement **Due date**: Q3	Significant progress made against well led action plan including assurance committee effectiveness, BAF and risk appetite reset for 2024/25. Work progressing on risk management arrangements and sub committee structures.	***3 x 3 = 9***	***Q4 24/25***
			C2) Compliance with relevant codes of governance and legislative requirements **Control Owner:** Director of Governance, Risk and Improvement	- Annual report - code of governance compliance (via Audit Committee) - Provider licence compliance (via Audit Committee)		*Acceptable*			Comprehensive map of regulatory compliance and assurance reporting.	Regulatory compliance and asurance map to be developed. **Action Owner:** Director of Governance, Risk and Improvement **Due date:** Q4	Regulatory compliance map being developed to be populated by Divisions and teams. Compliance with NHS Constitution to be reported in Q4.		
			C3) Partnership Governance **Control Owner:** Director of Governance, Risk and Improvement	- CEO report	- CMAST CiC updates - Mental health and learning disabilities collaboration updates	*Partial*			Clairity of governance for emerging partnerships and collaborations.	To take stock of current partnerships and support emerging partnerships with effective governance. **Action Owner:** Director of Governance, Risk and Improvement **Due date:** Quarterly updates	Some early discussions progressing around collaborative community services governance.		
			C4) Public Inquiry **Control Owner:** Director of Governance, Risk and Improvement	- Thirlwall Inquiry Updates - Legal cost updates (via F&P Committee)		*Acceptable*			Corporate records management lessons learned.	Decision log and corporate records management lessons learned being developed. **Action Owner**: Director of Governance, Risk and Improvement **Due date:** Quarterly updates	Assurance on disclosure approach provided to Director of Governance, Risk and Improvement, and Director of Digital and Data. Decision log established. Corporate records management added to Information security and information governance group, with terms of reference for a review to be confirmed.		

Risk Theme: System Working and Collaboration

RISK APPETITE: SEEK - Upper tolerance limit 16

LINKS TO STRATEGIC GOALS: SG1: Patient and Family Experience, SG5: Seeking Partnership Opportunities, SG6: Populations

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score (I x L)	Estimated date of achievement of target score
BAF9 System working and provider landscape changes may present challenges in ensuring COCH is positioned as a strong system partner, with priorities aligned to system partners across Cheshire & Merseyside. **Executive Risk Lead:** Director of Strategy & Partnerships **Board Committee**: Board of Directors **Last Update:** July 2024	**Causes** - Primary Legislative Changes as per the Health and Care Act 2022 - Maturity of the ICS and Place - Further development of Provider Collaboratives - Changes in commissioning process - Unclear clinical priorities - Newly defined system strategy/ plans **Consequences** - Conflicting priorities between COCH and ICS - Diversion of COCH leadership capacity - Loss of autonomy - Disruption to established clinical networks	***4 x 4 = 16***	C1) Take a Leadership role in Cheshire West **Control Owner:** Director of Strategy & Partnerships	Chief Executive reports to Board.	Regular reporting from CMAST CiC Regular reporting from Mental Health, Learning Disabilities and Community Servcies CiC Cheshire West Health and Well Being Board Cheshire West Partnership Group	*Acceptable*	***4 x 3 = 12***	**YES**	Uncertainty regarding delegation and decision making.	Ensure the Trust has appropriate representation at the ICS, CMAST, MHLDC and other Provider collaboratives, specialised commissioning and local place based forums. **Action Owner**: Director of Strategy & Partnerships **Due date**: Quarterly updates	Representation and engagement continues across a range of forums. Director of Strategy facilitated arranged and chaired the first of a series of prevention conference across Place focussed on CVD Prevention.	***4 x 4 = 16***	***Achieved***
			C2) Develop a Trust approach to health inequalities and prevention **Control Owner:** Director of Strategy & Partnerships	Reports to People and Organisation Development Committee (bi-monthly)	Cheshire West Partnership Group	*Partial*			Internal and external availbility of data and the intelligence to join up data sets in order to better infom our approach and target popultions in greatest need.	Embark on a dedicated data collection. Attendance at the ICB Population Health Board. Enroll in the ICB Population Health Academy. **Action Owner:** Director of Strategy & Partnerships **Due date:** Quarterly updates	To be undertaken in Q3		
			C3) Purposeful shift from traditional provision to a population health approach **Control Owner:** Director of Strategy & Partnerships	Reports to People and Organisation Development Committee (bi-monthly)	Cheshire West Partnership Group	*Partial*			CInical strategy	Develop a framework by which clinical strtaegies can be developed. Seek sponsorships to fund dedicated clinical startegy development day. Program manage Clinical summit, 24th October 2024. **Action Owner:** Director of Strategy & Partnerships **Due date**: Q4	Clinical Framework socialised with AMDs and approved by executives. Framework to be shared in August 2024 for pre clinical summit completion.		
			C4) Achieve anchor institution status. (green / social value / prevention) **Control Owner:** Director of Strategy & Partnerships	People and Organisation Development Committee (bi-monthly) Finance & Performance Committee	ICB Net zero Group ICB Prevention Pledge Group Population Health Board National quarterly data collection via Foundary platfrom	*Partial*			Aligned assurance.	Align the three former workstreams into one overight function : NHS Prevention Pledge Social Value Progress against the Trust green net zero plan **Action Owner:** Director of Strategy & Partnerships **Due date:** Quarterly update	New Anchor Instution oversight group established (June which will meet bi monthly). New reporting framework adopted. Revised terms of reference. Board report presented in July 2024.		
			C5) Commerical Partnerships **Control Owner**: Director of Strategy & Partnerships	Operational Board Finance & Performance Committee Weekly Executive Group Theatre redevelopment Group (bi-weekly)	NHS Supply Chain Hill Dickson - legal advice	*Partial*			Developed approach for commercial partnerships.	Development of a MDT stakeholder Group Development of scope and specification for a hybrid theatre Develop a long term vision for main theatres **Action Owner:** Director of Strategy & Partnerships **Due date:** Q3	MDT Project Group established. Scope and specification development. OBC to be developed for July Board consideration. Market testing via Capability framework in August.		
			C6) Integrated Care approach **Control Owner**: Chief Operating Officer/ Director of Strategy & Partnerships	COCH/CWP Community Services updates through OMB.		*Partial*			Future vision and defined operating model.	To build on the work to date to develop the Community Services Collaboration, to agreed a clear vision and future operating model. **Action Owner:** Chief Operaitng Officer/ Director of Strategy & Partnerships **Due date:** Q4	MOU in place. Discussions underway and paper being developed for COCH/CWP Community Services collaboration vision and future operting model.		
			C7) Models of care for in reach, out reach and networked services **Control Owner:** Chief Operating Officer/ Director of Strategy & Partnerships			*Partial*			Development of partnership models.	Continued discussions with WUHFT and other partners to develop models of care. **Action Owner:** Chief Operating Officer/ Director of Strategy & Partnerships **Due date:** Quarterly updates	Continued discussions with WUHFT following Board to Board.		

Risk Theme: Research and Innovation

RISK APPETITE: SEEK - Upper tolerance limit 16

LINKS TO STRATEGIC OBJECTIVES: **SG5: Partnerships**

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score (I x L)	Estimated date of achievement of target score
BAF10 Inability to deliver the Research and Innovation agenda to exploit future opportunities **Executive Risk Lead:** Medical Director **Board Committee**: - **Last Update:** July 2024	**Causes** - Leadership capacity - Funding sources - Early stages of partnerships **Consequences** - Ability to maintain R&I function - Aligment of R&I activity	***4 x 3 = 12***	C1) Research Strategy **Control Owner**: Medical Director	Quarterly Board reports Updates via OMB	Annual report to CRN	*Partial*	***4 x 3 = 12***	**YES**	Strategy needs to be updated to reflect our ambition.	Refresh our Research Strategy to align to new Trust Strategy. **Action Owner:** Medical Director **Due date**: Q4	Early discussions to establish research ambitions to support strategy development.	***4 x 3 = 12***	***Target Score Achieved***
			C2) Team structure, SOPs and expertise **Control Owner:** Medical Director		MHRA inspections GPC inspections HTA inspections	*Partial*			Staff development and retention.	To agree and communicate the development offer for research staff. **Action Owner:** Medical Director **Due date**: Q4			
									Strengthening of governance and SOPs.	Review governance and SOPs (including CRF and Trust vehicle). **Action Owner:** Medical Director **Due date:** Q4			
			C3) CRN Arrangements **Control Owner**: Medical Director			*Partial*			Funding levels and income streams. Changes to CRN anticipated in 24/25.	Continued focus on funding streams, including securing grants and commercial funding. **Action Owner :** Medical Director **Due date:** Quarterly updates	Maturing relationships and engagement alongside submitting bids for funding.		
			C4) Partnership Arrangements (including academic appts) **Control Owner:** Medical Director	Updates through OMB		*Partial*			Increasing academic appointments. Partnership agreements and governance.	To continue to develop our partnership arrangements, inlcuding education institutes and commercial. **Action Owner:** Medical Director **Due date:** Quarterly updates	Communication strategy developed to support awareness for partner organisations. Current focus on building relationships and developing collaboration opportunities.		
			C5) Innovation Strategy **Control Owner**: Medical Director			*Partial*			Innovation strategy.	Partnership with University of Chester to be explored to support Innovation ambitions. **Action Owner:** Medical Director **Due date**: Quarterly updates			

Strategic Objectives	Lead	Q1 Progress
SG1 Patients and Family		
Systematic approach to improving quality and safety and reducing harm	SP	Work commenced on overarching Quality and Safety Strategy refresh. Patient and family experience strategy being implemented with local consideration of actions needed to embed.
Delivery of NHS planning standards	CC	The Trust continues to meet the long waiting RTT targets and the reduction in suspected long waiting cancer patients. Access to UEC services remains as above and is challenged due to high ED attendances and lack of progress with the reduction of patients that no longer have the criteria to reside. There is a full UEC improvement programme in progress with improved metrics of 12 hour DTA and time to triage. The Trust continue to work with the wider systems and local authorities to enable an improved number of complex discharges. The Trust continues to explore options to extend SDEC opening hours.
Development of a patient and family care model	SP	Work commenced on overarching Quality and Safety Strategy refresh. Patient and family experience strategy being implemented with local consideration of actions needed to embed.
Adoption of continual improvement and learning	KW	The Trust has developed a range of organisational learning through PSIRF, learning from deaths, national inquiries, clinical audit, patient safety summits etc. The policy is being developed to capture all these opportunities, and consider how sharing of learning can continue to be maximised.

SG2 People and Culture		
United shared values, goals, mindset and behaviours	DH	Civility statement developed through wide engagement, and approved by the Board (May 24). Launch and roll out commenced.
Develop an approach for recruitment, development and retention	DH	Onboarding processes being reviewed and new framework for corporate induction being implemented from July 2024.
Improve the health and well being of our staff	DH	Staff hub opened (Q1) and wellbeing offer developing to include physical, mental and financial. Exploring salary sacrifice schemes.

SG3 Leadership		
Development of clinical strategy	NS	Discussions with the Clinical Directors and Divisional leads has taken place. Development day planned with Clinical Leads for October 2024 to drive forward the development of the Clinical Strategy.
Take a leadership role within Cheshire West	JD	Representation and engagement continues across a range of forums. Director of Strategy facilitated arranged and chaired the first of a series of prevention conference across Place focussed on CVD Prevention.
Develop our leadership teams	DH	Leadership framework established and programmes rolled out for clinical leaders, and aspiring leaders (band 2-4). Lead managers programme being rolled out in Q2. Training needs analysis to be developed in the Autumn.
Ensuring governance is in place across the organisation	KW	Significant progress made against well led action plan including assurance committee effectiveness, BAF and risk appetite reset for 2024/25. Work progressing on risk management arrangements and sub committee structures.

SG4 Adding Value		

Development of a new financial plan and strategy	KE	Conclusion of 2024/25 annual planning process (June 2024). Development of deficit drivers underway. Revisit of PWC action plan and HfMA financial control checklist being undertaken.
Advance digital solutions in support of transforming care	JB	NHS Providers led Board session planned on Digital Maturity (August 2024).
Achieve anchor institution status. (green / social value / prevention)	JD	New Anchor Instution oversight group established (June which will meet bi monthy). New reporting framework adopted. Revised terms of reference. Board report presented in July 2024.

SG5 Partnership		
Develop a bespoke research, education and innovation strategy	NS	Early discussions to establish research ambitions to support strategy development.
Explore new models of care for In reach, Out Reach and Networked services.	CC	Continued discussions with WUHFT following Board to Board.
Increase academic appointments	NS	Communication strategy developed to support awareness for partner organisations. Current focus on building relationships and developing collaboration opportunities.

SG6 Populations		
Develop a Trust approach to health inequalities and prevention	JD	To be undertaken in Q3
Purposeful shift from traditional provision to a population health approach	JD	Clinical Framework socialised with AMDs and approved by executives. Framework to be shared in August 2024 for pre clinical summit completion.
Further development our integrated care approach	CC	MOU in place. Discussions underway and paper being developed for COCH/CWP Community Services collaboration vision and future operting model.

Board Assurance Framework

i) The BAF is presented thematically to show the different types of strategic risk that have been identified by the Board in relation to the delivery of the Trust's Strategic Plan
ii) A quarterly report on progress of the strategic objectives is provided separately to the Board
iii) The Board's risk appetite in relation to each risk theme is noted - this is based upon the Board's defined apppetite for risk
iv) Each risk is assigned an inherent risk score to estimate the uncontrolled risk - when compared with the residual (current) score it allows the Board to understand how effective the risk response is
v) Each risk is also allocated a target risk score which indicates the expected level of risk - this must be below the upper tolerance limit set for the risk theme and be forecast based on planned actions

5x5 risk scoring matrix:

X	LIKELIHOOD					
IMPACT / CONSEQUENCE		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligable	1	2	3	4	5

Risk Appetite Levels

Appetite level	Averse	Minimalist	Cautious	Open	Seek
Description	Avoidance of risk and uncertainty	Preference for ultra-safe delivery options that have a low degree of inherent risk and only have potential for limited reward	Preference for safe delivery options that have a moderate degree of inherent risk and may have limited potential for reward	Willing to consider all potential delivery options and choose the ones most likely to result in successful delivery while also taking some risks whilst providing an acceptable level of reward	Eager to be innovative and to choose options offering potentially higher rewards despite greater inherent risk
Tolerance	Max score 3	Max score 6	Max score 9	Max score 12	Max score 16

Meeting	**30th July 2024**		**Board of Directors**					
Report	**Agenda item 9.**		**High Risks – Update report**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft				Director of Governance, Risk & Improvement			
Author(s)	Laura Leadsom				Deputy Director of Governance & Risk			
Board Assurance Framework		All areas of the Board Assurance Framework						
Strategic Aims	Purposeful Leadership							
CQC Domains	Well Led							
Previous Considerations	Audit Committee – 23rd July 2024 Operational Management Board – 25th July 2024							
Summary and Key Points	There are currently 25 risks in total with a residual risk score of 15 or above on the Datix system. This is a decrease from the 36 reported in April 2024. The paper sets out the key themes from the high risks including quality and safety, people and finance and performance. Work is also ongoing to further strengthen and embed risk management across the Trust, together with the review of the current Risk Management policy.							
Recommendation(s)	The Board of Directors is requested to: • Note the contents of this report and note the risks with a residual risk score of 15 and above. • Note the next steps as outlined above and how they will be progressed.							
Corporate Impact Assessment								
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status.							
Quality & Safety	Improved patient safety.							
NHS Constitution	Improves overall assurance on key corporate objectives.							
Patient Involvement	Some risks may involve patients.							
Risk	In line with the Trust's Risk Strategy and Risk Policy.							
Financial impact	Financial risks are captured in the Risk Register.							
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics.							
Communication	Not applicable							

HIGH RISKS – UPDATE REPORT (July 2024)

BACKGROUND

1. The Corporate Risk Register contains significant risks identified as having potential impact on the Trust's corporate objectives, including risks identified and escalated by Divisions and Corporate departments. Risks are reviewed monthly at each Divisional Governance meeting and also by the Executive Directors' Group which has adopted the role of the former Executive Risk Group. A report of high risks is also provided bi-monthly to the Board of Directors and relevant extracts are also provided to each of the sub-committees.

HIGHIGHTS

2. On the Corporate Risk Register, there are currently 25 risks in total with a residual risk score of 15 and above that have been entered on to the Datix system. To note, this is a decrease of 9 risks scored at 15 and above, from 36 in April 2024. Risks scored 15 and over are scored in the following way:

Score	Count
15	8
16	17
20	0
Grand Total	**25**

Area	Count
Corporate Services	3
Diagnostics and Infrastructure	6
Finance	1
Human Resources	1
Digital & data services	2
Planned Care	7
Women's and Children's	1
Therapies and Integrated Community Care	0
Urgent Care	4
Grand Total	**25**

3. The key themes from the 25 risks with a residual score of 15 and 16 include:

   - Quality & Safety related including:
     - Backlog of and failure to follow up appointments
     - Ventilation issues across a small number of areas
     - Failure to follow up appointments
     - Inability to deliver timely care and treatment delays
     - Lack of second theatre on central Labour Suite
     - Medication storage
     - Potential delays in delivering Echocardiography testing
     - Lack of adherence to NHS England 4 hour Emergency Department target

   - People & Organisation related including:
     - Lack of Medical Devices Safety Officer (MDSO) role in the Trust
     - Population adequacy of the Spiritual Care Centre
     - Transparency of educational funding

   - Finance & Performance related (including cyber & digital) including:
     - Fire door rectifications required to ensure compliance
     - Potential loss of digital services
     - Risk in ability to deliver the Cost Improve recurrently for 2024/25
     - Storage of combustible items
     - Use of Siporex RAAC planks in current Women & Children's building roof

4. To ensure grip and consistency, all risks scored 15 and over are reviewed at both the Executive Directors' Group (EDG) and the Operational Management Board (OMB) on a monthly basis. A High Level Risk Report is also provided to the Board of Directors on a bi-monthly basis. Relevant extracts are also reported to each of the sub-committees of the Board of Directors for noting and each sub-committee to consider if the top risks reflect the current knowledge and understanding for the relevant risk areas across the Trust. Divisions and Departments also attend the Executive Directors' Group on a rotating basis to undertake a 'deep dive' into their key risks.

5. Whilst there are columns to record controls and comments the Datix system is currently being reviewed with a view to new fields being utilised to record action plans, mitigations and milestones and this will also be linked to the Board Assurance Framework and strategic objectives.

6. Work will be undertaken to develop a robust action plan to ensure that risk management processes are effective. This will include the review of the Trust's Risk Management Policy and Procedures and the Trust's approach to Risk Management training by the end of Quarter

2 2024/25. A process will also be developed and implemented for regular reviews of the risk register and to develop assurance reports via the relevant governance structures.

NEXT STEPS

7. Work will continue with the Divisions and Departments to ensure:
   - All risks are still appropriate and scored correctly and consistently.
   - All risks have a control in place or a plan to address any gaps in controls.
   - All risks have a target risk score and a narrative/timeline of how this will be achieved.
   - All open risks have a future review date.

8. To progress risk management systems and processes further as outlined above.

9. To further develop the regular reviews of the risk register and to develop assurance reports via effective governance structures and holding Divisions and Departments to account.

10. To note, the current focus on risks with a residual risk score of 15 and above is an interim approach to ensure the Board of Directors and sub-committees are cited on these areas. The robust action plan will include timescales for the review of risks with a residual score below 15.

RECOMMENDATIONS

11. The Board of Directors is asked to:
    - Note the contents of this report and note the risks with a residual risk score of 15 and above.
    - Note the next steps as outlined above and how they will be progressed.

Meeting	**30th July 2024**				**Board of Directors**			
Report	**Agenda item 10.**				**Maternity Safety Support Programme (MSSP) Exit Recommendation**			
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	**X**
Accountable Executive	Sue Pemberton				Director of Nursing & Quality / Deputy Chief Executive			
Author(s)	Simon Mehigan Natasha Macdonald				National Maternity Improvement Advisor Director of Midwifery			
Board Assurance Framework	BAF 14	Failure to deliver Quality & Safety agenda						
Strategic Aims	To deliver safe care and treatment							
CQC Domains	Well Led Safe							
Previous Considerations	Information presented at MSSP Exit meeting – 2nd July 2024 Paper presented at Perinatal Assurance and Improvement Board (PAIB) – 25th July							
Executive Summary	The purpose of this report is to seek agreement of the Board of Directors with the recommendations of the National Maternity Improvement Advisor and the Regional Chief Midwife for the Northwest that the Countess of Chester Hospitals NHS Trust should formally exit the Maternity Safety Support Programme with the ongoing oversight and assurance of the maternity services being undertaken by the Local Maternity & Neonatal System (LMNS) and Integrated Care Board (ICB). Following agreement at the Board of Directors, a letter of support is required to be sent to Claire Matthews confirming this paper has been discussed and that the Board of Directors are supportive of this exit.							
Highlights	• The maternity service has made continuous and sustained progress in relation to the areas highlighted within the MSSP diagnostic (August 2022) • The maternity service has addressed all the exit criteria agreed within the diagnostic phase • The maternity service has seen its Care Quality Commission (CQC) rating improve from 'Inadequate' in June 2022 to 'Requires Improvement' in February 2024 • Evidence of this progress was presented at the MSSP exit meeting on the 2nd of July and attendance included the Trusts Chief Executive Officer, Jane Tomkinson.							

Recommendation(s)	The Board of Directors is asked to: • Note the progress made by the maternity service during its time on the MSSP • Agree the recommendation that the Trust formally exit the MSSP • Agree that the ongoing external assurance and oversight will be provide by the LMNS / ICB.
Corporate Impact Assessment	
Statutory Requirements	Ensure the Trust's alignment with Foundation Trust status, maintaining all regulatory obligations.
Quality & Safety	Enhance adherence to the Ockenden report recommendations, striving for continuous improvement in these areas.
NHS Constitution	Comply with NHSI – Planning Guidance and CQC Essential Standards to align with broader NHS objectives.
Patient Involvement	Actively incorporate patient feedback through consultation with the MVP group, reflecting patient perspectives in service development.
Risk	Define and assess potential risks to the organization, implementing proactive measures to mitigate them.
Financial impact	Balance staffing expenditure with service improvement to manage costs effectively while advancing care.
Equality & Diversity	Foster an inclusive environment where all voices are heard, promoting a diverse and equal representation in all aspects.
Communication	Ensure timely and transparent communication, including publishing key documents on the Trust's website to facilitate public access.

Maternity Safety Support Programme (MSSP) Exit recommendation

BACKGROUND

1. The maternity service at Countess of Chester Hospitals joined the MSSP in July 2022 following the publication of the Care Quality Commission (CQC) report which reflected their assessment visits undertaken in February 2022.

The NHSE Maternity Support Programme

The overall objective of the MSSP is to deliver a maternity safety support initiative, led by NHS England. The CQC supports this through the provision of intelligence to identify priorities for improvement and assurance that required changes have been made. NHSE then provide a programme of support that is designed to be flexible and adaptive to meet the individual needs of the Trust's improvement journey.

Criteria for entry to the MSSP in 2021 were maternity services which have:

- An overall rating of inadequate
- An overall rating of requires improvement with an inadequate rating for either Safe and Well-Led or a third domain*
- Been issued with a CQC warning notice

- Dropped their rating from a previously outstanding or good rating to requires improvement in the Safety or Well Led domains
- DHSC or NHS England /Improvement request for a review of services or inquiry
- Been identified to CQC with concerns by HSIB

*This is what triggered CoCH to join the MSSP

The trust was allocated a dedicated Maternity Improvement Advisor who has been providing ongoing support to the trust whilst on its improvement journey.

The key areas of focus of the MIA have been-

- Professional support and guidance for the senior leadership team via 121s and joining key meetings
- Undertaking site walk-rounds, meeting staff and giving feedback to the senior team.
- Providing externality as part of the trusts review of evidence for compliance with the Maternity Incentive Scheme
- Participation in the Ockenden and regional oversight visits
- Sharing best practice from other services

PURPOSE

2. The purpose of this paper is to seek agreement on the recommendation that the maternity service should formally exit the MSSP and that the ongoing external assurance and oversight of the service should be undertaken by the LMNS / ICB

CURRENT POSITION

3. It is the view of the Maternity Improvement Advisor and the Regional Chief Midwife that the criteria for exiting the MSSP has been met and that the ongoing oversight of the maintenance of the improvements that have been made can be undertaken by the ICB and the Regional Teams

MSSP exit criteria

Overarching heading	Actions	Status	RAG Rating
Governance	Maternity governance structure in place with core roles implemented and robust governance framework embedded in maternity services linked with wider Trust governance and assurance processes Evidence of ward to board reporting and clear evidence of MIS / CNST compliance	In place and evidence seen In place and evidence seen of process	

Governance	Maternity risk management strategy is signed off and embedded into practice	In place and evidence that processes are being followed	
Effectiveness	Culture of continuous improvement is visible throughout the service. Can be evidenced in service redesign and improvement projects in practice	Multiple examples of quality improvement processes and methodology being used including triage and PPH	
Workforce	Clear workforce plan with clarity around roles and responsibilities to include succession planning	In place, next stage reviewing staffing model for new build	
CQC	Process in place to address CQC “must” and “should” do’s with board oversight	In place with regular reporting	

Attached in appendix 1 is the sustainability plan

RECOMMENDATIONS

5. The Board of Directors is asked to:

- Note the progress made by the maternity service during its time on the MSSP.
- Agree the recommendation that the Trust formally exit the MSSP.
- Agree that the ongoing external assurance and oversight will be provide by the LMNS / ICB and Regional Teams.

Meeting	**30th July 2024**		**Board of Directors**					
Report	**Agenda item 11.**		**Care Quality Commission (CQC) Improvement Plan including Well Led**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton		Director of Nursing & Quality / Deputy Chief Executive					
Author(s)	Sue Pemberton Laura Leadsom		Director of Nursing & Quality / Deputy Chief Executive Deputy Director of Governance & Risk					
Board Assurance Framework	BAF14	Failure to deliver Quality & Safety agenda						
Strategic Aims	Create a positive Patient and Family Experience							
CQC Domains	Well Led, Safe, Effective, Responsive and Caring							
Previous Considerations	Executive Directors Group – 17th July 2024							
Executive Summary	The purpose of this report is to provide assurance on progress with the Trusts Improvement Plan, including Well Led, in response to the regulatory breaches identified within the CQC's report and reflected within the subsequent CQC ratings. The consolidated Improvement Plan will be updated monthly to reflect reported progress, any changes to timescales and owners. This is reported via Executive Directors Group monthly and to each Board of Directors meeting.							
Highlights	Progress has been noted, with completed actions, within the following areas: • Full review of Nurse staffing undertaken (in line with Safer Nursing Care Tool Guidance). • Launch of the Patient & Family Experience Strategy. • Approval of the Board sub-committees Terms of Reference and workplans • Wellbeing Hub has opened which is accessible to all staff. • Listening events held and civility statement agreed. • Fit and Proper Person Test Framework • Executive network champions identified. • Review of all storage across the Trust undertaken and spot checks being implemented. • Full review of NET2 access undertaken. • Patient Led Assessments of the Care Environment assessments • Civility Charter agreed and is being incorporated into all employee processes. • New welcome induction programme in place.							

	• Emergency Department Improvement Plan in place • Workstreams established within Medicines Safety Group. • National mandated medicine audits have been reviewed • Increased visibility and Executive walkarounds • All Board positions substantively appointed with (with the exception of the Chief People Officer, which has a recruitment plan in place) • Board development programme agreed for 2024/25 • The Trust Strategy has been approved at the Board of Directors • The new Complaints Policy has been formally ratified. • CQC registration Tarporley Hospital (awaiting CQC confirmation) • Mental health and community services collaborative • Board Assurance Framework refresh • Quality priorities • Clinical Standard Operating Procedure in place to identify and risk assess patients entering the Emergency Department that present a self-harming risk. • Divisional Leadership teams have engagement and visibility plans in place for visiting all wards and departments. Continued areas of focus progressing include: • Malnutrition Universal Screening Tool screening to be launched in the Emergency Department • Review of all information available to patients (in various languages and formats) • To continue to embed the changes made to the post-operative care of women's & birthing people following obstetric surgery (initial review conducted in 2024 and outcome report is currently awaited) • Discharge summit to be held throughout July 2024, with system partners invited to join • Electronic Prescribing and Medicines Administration system review undertaken and training controls in place whilst stronger system controls are sought. • Electronic Patient Record optimisation and upgrade programme underway • Directorates and Divisions to develop enabling strategies. • Trial of out of hours stroke service provision extended until midnight as a pilot • Review of the Governance Handbook • A review of 7 day services • Coronial cases governance • Review of all fire exits being undertaken.

	• Review of all equipment being undertaken to ascertain that it is fit for purpose. • Anti ligature Policy in development. • Full review of maternity theatres and birthing rooms to be undertaken. • Review of Risk Management Strategy and processes • Out of date policy review • Employee engagement plan • Statutory and mandatory training compliance • Further audit of waiting lists (Referral to Treatment and Non Referral to Treatment) • Review of Allied Health Professionals workforce and medical staffing • Review of medicines prescribing policy • Sepsis screening • Freedom to Speak Up Board self-assessment to be held on 6th August 2024 • Work is progressing on the 4 Staff survey priorities.
Recommendation(s)	The Board of Directors is asked to: • Note the assurance on the progress of the consolidated CQC Improvement Plan. • Note that progress against this action plan will continue to be tracked through the Executive Directors Group and reported to the Board of Directors, together with outcomes also being reported going forward.
Corporate Impact Assessment	
Statutory Requirements	Trust compliance with the CQC regulatory framework, Provider License and Code of Governance.
Quality & Safety	Improved compliance across the CQC Domains
NHS Constitution	Improve quality and safety by striving for the highest standards of excellence and professionalism, working together for patients, respect and dignity, commitment to quality of care and compassion.
Patient Involvement	Patient Experience and Staff Feedback is a key driver for change which has been linked to the delivery of specific milestones within the improvement plan which is now in progress.
Risk	Various risks included on Board Assurance Framework (BAF) and risk registers.
Financial impact	Not applicable.
Equality & Diversity	Meets Equality Act 2010 duties & Public Sector Equality Duty 2 aims and does not directly discriminate against protected characteristics.
Communication	This has been shared with the Executive Director Group.

NHS
Countess of Chester Hospital
NHS Foundation Trust

Care Quality Commission (CQC) Improvement Plan (incl. Well Led)

Updated: 17th July 2024

Completed	On track	Behind schedule	Not achieved

Summary of Improvement Outcomes

Countess of Chester Hospital NHS Foundation Trust

Urgent & Emergency care

1. Improved performance in type 3 performance
2. Increased use of Same Day Emergency Care (SDEC)

Quality, Safety & Harms Improvement

1. Closure of serious incident backlog
2. Oversight and action regarding incidents through a range of daily and weekly meetings including the embedding of daily incident review meetings and a patient safety oversight meeting with Executive attendance.
3. Development of the 6 steps patient and family experience across all clinical areas
4. Safe nurse staffing reviews completed across all wards and the emergency department
5. Improved timeliness in response to complaints
6. Implementation of the triage process in Maternity

Board Governance & assurance

1. Fully established Executive Team with clear visibility and a schedule for visits trust wide implemented.
2. Committee effectiveness improvements and compliance with Code of Governance
3. Clear Board development plan, appraisals and objectives

People & OD

1. A wide range of engagement activities covering inclusivity, behaviours, wellbeing and appraisal and career conversations, and visibility of FTSU.

Summary of completed actions

Completed Actions

- Full review of Nurse staffing undertaken (in line with SNCT Guidance).
- Launch of the Patient & Family Experience Strategy.
- Approval of the Board sub-committee TOR's and workplans
- Wellbeing Hub has opened which is accessible to all staff.
- Listening events held and civility statement agreed.
- FPPT Framework
- Executive network champions identified.
- Review of all storage across the Trust undertaken and spot checks being implemented.
- Full review of NET2 access undertaken.
- PLACE assessments
- Civility Charter agreed and is being incorporated into all employee processes.
- New welcome induction programme in place.
- Emergency Department Improvement Plan in place
- Workstreams established within Medicines Safety Group.
- National mandated medicine audits have been reviewed
- Increased visibility and Executive walkarounds
- All Board positions substantively appointed with (with the exception of the Chief People Officer, which has a recruitment plan in place)
- Board development programme agreed for 2024/25
- The Trust Strategy has been approved at the Board of Directors
- The new Complaints Policy has been formally ratified.
- CQC registration Tarporley Hospital (awaiting CQC confirmation)
- Mental health and community services collaborative
- Board Assurance Framework refresh
- Quality priorities
- Clinical SOP in place to identify and risk assess patients entering ED that present a self-harming risk.
- Divisional Leadership teams have engagement and visibility plans in place for visiting all wards and departments.

Summary of actions progressing

Actions progressing

- MUST screening to be launched in the Emergency Department
- Review of all information available to patients (in various languages and formats)
- To continue to embed the changes made to the post-operative care of women's & birthing people following obstetric surgery (initial review conducted in 2024 and outcome report is currently awaited)
- Discharge summit to be held throughout July 2024, with system partners invited to join
- EPMA system review undertaken and training controls in place whilst stronger system controls are sought.
- EPR optimisation and upgrade programme underway
- Directorates and Divisions to develop enabling strategies.
- Trial of out of hours stroke service provision extended until midnight as a pilot
- Review of the Governance Handbook
- A review of 7 day services
- Coronial cases governance
- Review of all fire exits being undertaken.
- Review of all equipment being undertaken to ascertain that it is fit for purpose.
- Anti ligature Policy in development.
- Full review of maternity theatres and birthing rooms to be undertaken.
- Review of Risk Management Strategy and processes
- Out of date policy review
- Employee engagement plan
- Statutory and mandatory training compliance
- Further audit of waiting lists (RTT and Non RTT)
- Review of AHP workforce and medical staffing
- Review of medicines prescribing policy
- Sepsis screening
- FTSU Board self-assessment to be held on 6th August 2024
- Work progressing on the 4 Staff survey priorities

CQC 23/24 Reinspection: Improvement Areas Identified

Countess of Chester Hospital NHS Foundation Trust

Improvement Area 1 – Chief Operating Officer
- Emergency Department Improvement Plan

Improvement Area 2 – Chief People Officer
- Appraisal
- Training
- Mandatory Training
- Conflict Resolution
- Resuscitation
- Safeguarding

Improvement Area 3 – Director of Nursing
- Infection Prevention

Improvement Area 4 – Director of Governance, Risk and Improvement
- Governance

Improvement Area 5a – Director of Governance, Risk and Improvement
- Risk Management

Improvement Area 5b – Medical Director
- Clinical Audit

Improvement Area 5c – Chief Finance Officer
- Environment
- Estates
- Health & Safety

Improvement Area 6 – Chief Operating Officer
- Performance
- RTT
- Patient Flow

Improvement Area 7 – Chief People Officer
- Staff Experience
- Staff Engagement

Improvement Area 8 – Director of Nursing
- Learning from Incidents
- Restraint
- Safeguarding
- Patient Safety

Improvement Area 9 – Medical Director & Director of Nursing
- Safe Staffing Nursing & Medical ED

Improvement Area 10 – Medical Director
- Safe Medications

Improvement Area 11a – Director of Nursing
- Stroke Practitioners
- Reporting of Mix Sex Breaches
- Dignity & Respect
- Maternity Theatres
- Nutrition Assessments
- Patient Engagement
- Patient Information – Health Promotion & Children
- Complaints

Improvement Area 11b – Medical Director
- O2 Prescribing
- Sepsis

Improvement Area 11c – Chief Digital Officer
- Record Keeping & EPR

Improvement Area 11d – Director of Governance, Risk and Improvement
- Policies

Improvement Area 11e – Board Lead & Lead for Strategy
- Mental Health & Learning Disabilities

Improvement Area 11f – Chief Digital Officer
- Information Governance

Action Plan:

Owner: Sue Pemberton – Deputy Chief Executive Officer and Director of Nursing

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M1	Patient Experience & Staff Feedback	TW	The trust must assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service in line with the regulations.	SP	Sep-24	• Launch Patient and Family Experience Strategy (Apr-24) • Launch Quality & Safety Strategy (Sep-24)	• Improvement programme (Harms) demonstrating improvements • Patient and Family experience strategy launched • Quality and Safety strategy being developed • Quality Account published	• Inpatient Survey Results • Patient Experience results • Complaints • Concerns • FTT • PFE launched	• Q&S Committee	• Patient and Family Strategy • Quality & Safety Strategy • Quality Account • SOF dashboard
M6	Registration	TW	The trust must implement effective systems to comply with the requirements of CQC registration. The system must ensure services are provided from locations which have appropriately added to the trust's registration.	SP	Jun-24	• Update SRO and include registration of Tarporley Hospital. • Review if action has been complete.	• Identified lead for CQC – DON • Currently with CQC to action (awaiting confirmation)	Awaiting confirmation from CQC.	• Q&S Committee	• CQC Registration Documenta-tion

Action Plan:

Owner: Sue Pemberton – Deputy Chief Executive Officer and Director of Nursing

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M9 M16 M27 M38	Infection Prevention Control	TW UEC MAT	The trust must implement an effective system to ensure the assessment, prevention and management of infection prevention and control in the physical environment, this is recorded, monitored, and audited with actions taken to improve compliance. The trust must ensure that staff adhere to the standards.	SP	Mar-25	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Implementation of National cleaning standards MDT focused (Apr-24) • C Diff improvement programme (Harms) (Apr-24)	• C Diff improvement programme (Harms) participating within the Harms Showcase (Mar-24) • IPC programme in place including audits, compliance and action • Divisional LED IPC assurance committee • Developed teams • Reviewed audit programme • TOR and Membership • Harms reduction Programme re HCAI • Antimicrobial stewardship programme	• IPC Assurance Committee • Matron audits • Observational practice • Visibility of IPC team • National cleaning standards • National IPC targets / compliance	• Q&S Committee	• PLACE Assessments • National Cleaning Standard Compliance • Board Assurance IPC Reports

Action Plan:

Owner: Sue Pemberton – Deputy Chief Executive Officer and Director of Nursing

NHS Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M11	Risk & Complaints Manage-ment	TW	The trust must implement an effective system to identify, report and learn from incidents involving the use of restrictive interventions including restraint and rapid tranquilisation.	SP	Sep-24	• Refer to Section 29a Reg 17 Governance Action Plan. • Implement daily review of incidents per division supported by the Deputy Director of Nursing and Governance. • Review with the Director of Risk, Governance and Improvement the Organisational Learning Policy to ensure it is fit for purpose. • Review the incidents relating to restraint and rapid tranquilisation to ascertain themes. • Ensure the trust policies in relation to restraint and rapid tranquilisation are being followed. • Review in progress regarding commencement of Safety Surveillance and Risk management committee.	• Daily review of incidents by DDoN and escalation route through Daily exec led Site meeting • Daily review of incidents by division • Weekly Patient Safety learning meeting • Weekly Patient Incident Oversight group.	• Patient Safety Learning Group • Patient Oversight Group • Learning & Sharing • Organisational Learning Policy • Incident Reporting • Security reports to Think Family Group • ICB engagement and attendance at incident oversight meeting	• Q&S Committee • Think Family Group	• Integrated Incident, Complaints & Claims Report

Action Plan:

Owner: Sue Pemberton – Deputy Chief Executive Officer and Director of Nursing

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M12 M13 S8	Patient Assessment	TW UEC	The trust must ensure service user records are audited appropriately to evidence that reasonable adjustments are in place to meet the needs of patients living with complex needs such as dementia, learning disabilities and mental health and to identify missed opportunities to safeguard patients and ensure ongoing compliance (e.g. Mental Health Capacity Act).	SP	Aug-24	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Develop strategy for patient with additional needs - **In draft** • **Safeguarding EPR tool (admission screening tool) devised awaiting input into EPR** • **Relaunch Complex Care Passport.**	• **Reasonable Adjustment strategy in Draft awaiting approval.**	• Safeguarding Task & Finish Group • Incidents • Complaints • Inpatient Experience Results • Complex Care Assessments • Think Family Meetings • Learning Disability Standards • Mental Capacity Assessment Compliance	• Q&S Committee	• Safe-guarding Quarterly Assurance Reports to BoD • National Inpatient Survey Results
M21	Risk & Complaints Manage-ment	MED	The trust must ensure the risks presented by gaps in the out of hours stroke service are effectively assessed and mitigated.	SP	Sept-24	• Develop business case to mitigate risks and submit to EDG for review	• Business case to mitigate against risks has been collated. • **Trial of service till midnight 7 days** • **Collaborative venture re regional stroke service.**	**Service provision has been extended until midnight as a pilot**	• Q&S Committee	• **EDG for Decision-addressed internally by division**
M25 S5 S23	Safe Staffing	UEC MED EPH	The trust must ensure that nurse staffing levels, are safe for the numbers of patients and they meet peoples care, treatment needs and keep them from avoidable harm.	SP	**July-24**	• Annual review of nurse staffing using SNCT	• **Full review of Nurse staffing levels undertaken and presented to the Board held on 26th March 2024. Implementation of the amendments now being implemented. Completed.**	• Incidents • Staff Experience Survey • People Pulse • **Establishments have been reviewed in lie with SNCT guidance and recruitment in progress to align to the recommended levels across all areas**	• Q&S Committee	• Annual Safe Staffing Assurance Report to BoD

Action Plan:

Owner: Sue Pemberton – Deputy Chief Executive Officer and Director of Nursing

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M33	Auditing	UEC	The trust must ensure that there is effective oversight of checks to maintain patient safety.	SP	Review Jul-24	• Refer to UEC Improvement Plan • Conduct ED daily checks	• Priorities identified • Incremental progress • Trajectories outlined • Emergency department improvement plan in place and assurance on patient safety checks presented to quality and safety committee. **Completed.**	• Patient Flow Working Group • KPIs / UEC Dashboard • ED safety checklist compliance • Matron audits • ED Safety & Quality Update • Compliance with audits for patient safety checks is improving	• Q&S Committee	• SIB Exit Criteria • Integrated Complaints Incidents & Claims Report to BoD • Q&S Assurance Report to BoD
M47 S11	Patient Assessment	CYP MED	The trust must ensure that appropriate nutritional risk assessments are completed for anyone with specific dietary requirements or anyone with social, religious, or cultural needs. That there is a nationally recognised screening tool to monitor patients at risk of malnutrition within clinical audit.	SP	Review Sep-24	• MUST screening to be launched in July 24 in ED.	• Scales purchased for ED • Mealtime coordinators in place across all wards. • Nutritional risk assessments should be undertaken for all patients – this needs improvement as compliance is low. The compliance and outcomes for this are monitored at the Nutrition and Hydration Steering Group. • When assessing the current food provision against the British Dietetic Association standards the Trust recognised itself as partially compliant in this area. Work is underway to review the establishment within the dietetic team to address how these areas of non-compliance can be addressed. • The Trust has yet to fully demonstrate the BDA standard of "Existence of a menu planning working group, meeting minutes and/or project planner. Evidence must show involvement of Registered dietitian throughout the process. Patient satisfaction surveys and patient involvement.	• Nutrition Support Group • Senior Nurse Meetings • Must Assessment Compliance • Patient Survey Results • Patient Experience Strategy • Complaints	• Q&S Committee	• OMB • QGG • SOF • Nutrition Annual Report to BoD

Action Plan:
Owner: Sue Pemberton – Deputy Chief Executive Officer and Director of Nursing

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S3	Patient Experience & Staff Feedback	TW	The trust should implement effective patient engagement in the development of the trust's services.	SP	Aug-24	• Planned engagement sessions for 2024 • Launch Patient and Family Experience Strategy (Apr-24) • Launch Quality & Safety Strategy (Sep-24)	*Linked with M1.*	• Patent Survey Results • Patient Experience Six Steps Monitoring • Healthwatch Feedback • Complaints and concerns • Friends and Family Test	• Q&S Committee	• Patient and Family Strategy • Quality & Safety Strategy • National Inpatient Survey Results
S9 S20	Patient Experience & Staff Feedback	MED CYP	The trust should ensure that health promotion and information is available in all departments is available in languages other than English, in child friendly versions, and in alternative formats.	SP	Mar-25	• Review of all information available to patients and ensure that they are all available in all languages.	Health promotion/well being information is produced by service specialities and is available in a range of formats including written or by using QR codes. Using a digital platform, the service user is able to use software for translation and other accessibility purposes. Where the service user is a child, the information is produced for the appropriate reading age. Where translation from English to another language is required, the Trust uses a Translation service provider. Services also use patient information provided by reputable parties such as Diabetes UK, The Stroke Association to sign post patents to appropriate/relevant information. The Clinical Divisions each monitor the use and relevance of this information. The EIDO reference library contains patient information specific to clinical procedures to support the patient's understanding of their procedure. The information in this library is managed by the supplier. Use of this service is monitored by Nurse Management.	• Patient Experience Operational Group	• Q&S Committee	• Q&S Assurance Report to BoD
S12	Risk & Complaints Manage-ment	MED	The trust should ensure it maintains local oversight of the quality of responses to complaints.	SP	Review Sep-24	• Refer to Section 29a Reg 17 Governance Action Plan. • Inpatient surveys • Matron audits • Complaints	• **Oversight process Robust signed off by DDON and Director of Nursing and CEO. Completed.**	• Complaints Operational Group Meeting • Sign-off by DON & CEO	• Q&S Committee	• Integrated Complaints Incidents and Claims Report Quarterly to BoD

Action Plan:

Owner: Sue Pemberton – Deputy Chief Executive Officer and Director of Nursing

NHS Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S13	Environment inc. Equipment	MED	The service should ensure that patients' privacy, dignity and confidentiality is maintained in the reception area.	SP	Mar-25	• Staff need to ensure that the privacy and dignity for patients is maintained within the reception area at all times.	• Nurse allocated to waiting room in ED in all shifts to oversee the care of patients • Interim national inpatient survey results are improved in relation to privacy and dignity of care for patients .	• Complaints • Friends and Family Test • Inpatient Survey Results • Concerns • Matron Audits	• Q&S Committee	• Patient and Family Experience Assurance Report to BoD • National Inpatient Survey Results
S16	Patient Assessment	MAT	The trust should continue to embed the changes made to the post-operative care of women and birthing people following obstetric surgery.	SP	Mar-25	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan	• AFPP review conducted June 2024 – this involved reviewing maternity theatres – report awaited.	• Report expected August/September 2024.	• Q&S Committee	• Quarterly Maternity Assurance Reports to BoD
S17	Patient Assessment	MAT	The trust should continue to embed the changes made to the triage systems and processes.	SP	Mar-25	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan	• Triage process in maternity embedded – **Completed.**	• All patients triaged as per the process	• Q&S Committee	• Quarterly Maternity Assurance Reports to BoD

Action Plan:

Owner: Cathy Chadwick – Chief Operating Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M19	Reporting	MED	The trust must seek to eliminate mixed sex accommodation breaches and must identify and report mixed sex accommodation breaches appropriately for all inpatient settings	CC	Review Sep-24	• See Patient Flow / UEC Improvement Plan • Mixed sex reporting to be included within the trusts SOF and monitored monthly.	Further detail & information to be included in future SOF reports, next due to be presented to the Board of Directors to be held on 30th July 2024. This will include the data on the actual number of breaches and a narrative on how many patients were involved.	• Wards Task & Finish Group • Patient Flow Working Group • KPIs / UEC Dashboard • Monthly SOF report provided to the Board of Directors and sub-committees.	• Q&S Committee	• EDG • OMB • SOF
M20 M54	Patient Flow & Perfor-mance	MED EPH	The trust must ensure that effective and timely care is provided; to improve patient access and flow through the hospital to safe discharge or transfer to other appropriate services.	CC	**Review Sep-24**	• See Patient Flow / UEC Improvement Plan	The Trust is holding a discharge summit in July 2024 where system partners will be invited to join. The revised UEC improvement plan has a focus on improving ward processes, which the Deputy Director of nursing is leading on. ECIST, GIRFT and AQUA all gave improvement ideas which have been added to the plan. The trust has tried to further engage with BCUHB and Flintshire LA, however meetings have not been attended.	• Complaints • Patient Flow Working Group • KPIs / UEC Dashboard • System Improvement Board • OPELG	• F&P Committee	• EDG • OMB • SOF • SIB Exit Criteria

Action Plan:

Owner: Cathy Chadwick – Chief Operating Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S2	Safe Staffing	TW	The trust should improve the visibility of senior leadership in all services and particularly in urgent and emergency care services.	CC	July-24	• See Patient Flow / UEC Improvement Plan (Streaming); full review of nurse staffing in ED department using RCEM standards. • Divisional Leadership team to hold drop-in sessions. • Divisional Leadership team to have a plan for visiting all wards and departments.	Linked to Well Led AP area 8.5. W&C – Visibility plan produced & in use and monthly newsletter in use which includes details of tea with the team listening event. UC - Staff Engagement Programme in place. PC – Drop in sessions introduced, which form last item of weekly tri meetings from May 24. Divisional Tri monthly walk arounds introduced and Quarterly Speciality reviews. Diagnostics – Log is being set up of areas visited. Drop in sessions to also be arranged as part of the staff survey work which will also be documented on the divisional engagement plan. Therapies – Rolling programme of monthly senior team drop ins and visits at EPH for wards and Community teams based there and a separate monthly rolling programme in place for attendance at various therapy forums and services. Meetings also held with the lead therapists and matrons every two weeks. ED Nurse staffing review undertaken, using nationally endorsed “Safer Nursing Care Tool” . This was approved in Q1 by the Board of Directors and there has been significant investment within the ED Nurse Staffing budget, ensuring there are the right number of nurses in the department to meet demand and acuity in all areas including the front door triage and streaming, resus and paediatric ED. Recruitment is underway with a trajectory to be “fully recruited” by the end of September 2024. There is a stable Nurse Leadership team within ED and across the Urgent Care division, with additional Nurse Manager and Matron resource aligned to the ED team to allow improved oversight and improvement of quality, safety and performance metrics. A safer nurse staffing review is being completed for the Same Day Emergency Care service, to ensure the staffing ratios reflect the increased demand following improvement in streaming from the ED. A robust career development pathway has been completed for the Emergency Department, with a trajectory to “grow our own” experienced Urgent and Emergency Care nurses who will have the ability to work across all services in the Emergency Care, Same Day Emergency Care and Urgent Treatment footprint, also having an impact on staff satisfaction, retention and reputation. **Completed.**	• Patient Flow Working Group • Streaming Task & Finish Group • KPIs / UEC Dashboard • System Improvement Board • Visibility plans in place • Engagement programmes in place	• F&P Committee • POD Committee	• EDG • OMB • SOF

Action Plan:

Owner: Jason Bradley – Chief Digital & Data Services

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M30	Medica-tions	UEC	The Trust must be assured that medicines are being stored securely and administered safely as per manufacturing guidance.	JB	Review Dec-24	• Refer to Section 29a Reg 17 Governance Action Plan. • Evaluate EPR and the potential risk for double dosing medications. • Develop EPR solution to ensure the safe administration of medications.	• EPMA system review undertaken to identify the cause of the potential double dosing risk identified. Cause identified as attributable to users recording late administration of doses against future doses rather than recording as 'drug not give' and then undoing this once the dose becomes available. Training control in place whilst stronger system controls sought.	• Medicine Safety Group • Digital Transformation Group • EPR Programme Board • Incident Reports	• Q&S Committee	• Annual Report for Medicine Safety
M41 S14	Training	MAT MED	The trust must ensure patient records are complete, contemporaneous, securely stored kept confidential when displayed or stored in public areas.	JB	Review Sept-24	• Continued monitoring of information governance compliance. • See Patient Flow / UEC Improvement Plan; Wards • Drive compliance to deliver trust target	• All electronic records are stored contemporaneously and hold an electronic date & time stamp. All wards have secure lockable cabinets for notes that are in public areas but not in immediate use. Ward audits are completed regularly by ward managers and matrons in line with ward frameworks and Information Governance do unannounced spot-checks which are fed back to senior nursing managers as well as the Caldicott Guardian team - these are also documented in the DSPT as evidence. In clinic areas, there are racks behind the reception desks for holding that day's notes and these are given out to clinical staff as and when patients book in. They are then stored in a separate area overlooked by a member of the clinical team until the patient goes in to see the Consultant team - after that they are again, stored securely until picked up by portering staff in the green boxes and taken to the secretarial areas.	• Information Governance Training Compliance • Matron Audits; Wards Task & Finish Group • Patient Flow Working Group • KPIs / UEC Dashboard • Review of the latest audit to be undertaken to confirm controls are working.	• POD	• SOF • Information Governance Report POD • EDG • OMB

Action Plan:

Owner: Jason Bradley – Chief Digital & Data Services

NHS Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring	Committee	Assurance
M50	Risk and Complaints Manage-ment	CYP	The trust must assess and manage the risks relating to the electronic patient record system and transcription services. The trust must improve the quality of the services provided and ensure this did not impact on delays to patients care and treatment.	JB	Review Sept-24	• Develop eDischarge Summary Task & Finish Group. • Review the eDischarge process and develop an optimum pathway and SOP to support the newly revised discharge process. • Review current transcription services and monitoring of typing timeframes. • Review current monitoring arrangements and revise where appropriate. • Meet the National Access Standards.	• EPR risk include the Digital and Data strategic risk as part of the Board Assurance Framework. EPR Programme Board in place monitoring EPR developments and identified risks and issues. EPR PB report to Finance and Performance Committee and up to Trust Board. eDischarge task and finish group in place and addressing backlog of discharge summaries. This includes process reviews which have identified greater challenges for short stay units and extra support being provided for those areas. Progress monitored via Operations and Performance Executive Led Group and Operational Management Board.	• eDischarge Summary Task & Finish Group • Divisional Governance Meetings • Divisional Typing Figures / KPIs • **Progress monitored via Operations and Performance Executive Led Group and Operational Management Board.**	• Q&S Committee • F&P Committee	• Q&S plus F&P Assurance Report to BoD

Action Plan:

Owner: Jon Develing – Director of Strategy & Partnerships

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M7	Strategy	TW	The trust must ensure strategies designed to support the delivery of the trust's new overall strategy are completed, implemented, and monitored to ensure their effectiveness.	JD	Mar-25	• Enabling strategies in support of the overall Trust strategy will be developed during 2024/25. These will align with the 6 strategic goals to provide a golden thread ensuring that all parts of the organisation are supporting the same direction of travel	The Trust strategy has been widely consulted on with staff, patient, public workshops an stakeholders. Trust Board has received (in private) the final draft strategy and approved it publication once the purdah period has concluded. No other changes to monitoring / or reporting. Directors are now developing enabling strategies to provide cohesion between the corporate and operational approaches. This includes: • People and organisational development • EDI Strategy • Leadership strategy • Research and development. • Digital strategy. • Patient and family experience. • Risk reduction, harms, and continual learning. • End of Life strategy • Patient engagement • Anchor institution.	• Delivery of the strategic goals and objectives within the overall Trust are a core component of respective executive Director portfolios and will be reported to the Board of Directors on a quarterly basis. • Trust Strategy approved in June 2024. • Launch of the women & children's strategy in July 2024.	• BoD	• BoD • OMB • EDG
M10	Auditing	TW	The trust must ensure there is effective oversight of the quality and safety of care provided to patients with mental health needs.	JD	Dec-24	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Review and refresh the Mental Health Group. • Develop a Trust Wide Mental Health Strategy.	• The Mental Health Group has been reestablished (Mar-24). • The Director of Strategy & Partnerships is now part of the Mental Health and Community services collaborative. • The collaborative is currently looking at the provision of safe spaces within hospitals including the use of 136 designate services. • Mental health collaborative group (CWP and COCH) have now developed an action and work plan for 2024/25.	• Mental Health Steering Group • Datix Reporting • Learning Outcomes from Complaints • ED Safety & Quality Update	• Safe-guarding Committee • Q&S Committee	• Safe-guarding Quarterly Assurance Reports to BoD • Q&S Assurance report to BoD

Action Plan:

Owner: Jon Develing – Director of Strategy & Partnerships

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S1	Strategy	TW	The trust should implement effective systems to identify and plan services to address health inequalities.	JD	Nov-24	• Health Inequalities is a specific objective within the Trust strategy and part of the Director of Strategic Partnerships portfolio. • A bespoke approach will be developed in the first quarter of this year – this will include use of CIPHA/PHE Fingertips/Trust PTL/JSNA and NHS Benchmarking tools.	• The Cheshire West JSNA is being relaunched in March 2024 from which a forward plan will be developed. The Trust is already using C2AI as a method of targeting HI on the waiting list and working with Place partnership groups to target community services in those areas of higher inequality. • Outline approach to health inequalities to be reported to Board in July 2024 (following election).	• Waiting list Performance Reporting • Cheshire West Partnerships Board	• F&P Committee • External Cheshire West Partnership Board	• BoD • OMB • EDG

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M17 M53	Environ-ment inc. Equipment	MED EPH	The trust must ensure that fire exits are clear from obstruction and well maintained.	KE	Aug-24	• Fire audits to be conducted trust wide. • Full review to be undertaken of all fire exits across the Trust and spot check to be implemented into the PLACE Lite and annual PLACE Review.	• Local Fire Wardens undertake a monthly assessment against a standard check-list. • Any issues identified are escalated to Estates. • The Trust's Fire Safety Officer undertakes annual fire risk assessments across the Trust. • As part of the risk assessment Section 3.1 focuses on the 'Means of Escape from Fire'. • Awaiting confirmation re completion of review of all fire exits.	• Update to F&P • Fire Safety Reporting to F&P	• F&P Committee	• F&P Assurance Report to BoD • Fire Safety Compliance Report to BoD
M28 S19	Environ-ment inc. Equipment	UEC CYP	The trust must ensure that there is sufficient equipment that is maintained to keep patients safe including but not limited to resuscitation equipment.	KE	Sep-24	• Trust wide review of all equipment used to ascertain that it is fit for purpose and that there is satisfactory levels of equipment required across all areas and incorporate how medical equipment is checked and maintained.	• The Clinical Engineering Department (EBME) maintain an asset register of the medical devices they maintain. • Assurances of Clinical Engineering maintenance compliance are currently provided to the E&F Group Mtg, and will subsequently transfer to the Medical Devices Group for onward escalation to the F&P Committee. • High-Risk Resuscitation Equipment (Defibs, Suction and Resus Trolley) is checked/audited daily, and compliance reported to the Resus Team.	• Asset register and report to F&P Oct-24 and then monitoring quarterly	• F&P Committee	• Resuscitation Assurance Reports • F&P Assurance Report to BoD

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring	Committee	Assurance
M29 M45	Environ-ment inc. Equipment	UEC CYP	The trust must ensure premises and environment are safe and secure. This includes but is not limited to ensuring storeroom doors are not left open or unlocked and hazardous substances, COSHH cleaning chemicals and oxygen cylinders are safely stored and accessible only to staff.	KE	Sep-24	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Full review to be undertaken of all storage across the Trust and spot check to be implemented into the PLACE Lite and annual PLACE review	• Domestics Teams briefed on importance of securely closing DSR/ Cleaning Cupboards when exiting (recorded Tool-Box talk given). Also part of induction of new staff. • Domestics Shift-Supervisors undertake checks to confirm that Cleaning Cupboards and DSRs are securely closed. • Key-Code security locks fitted to cupboard doors to restrict unauthorised access. • The Trust Security Team also undertake a check of the same doors as part of their standard patrol.	• Matron Audits • Incidents	• F&P Committee	• F&P Assurance Report to BoD • PLACE Assurance Reports
M32	Environ-ment inc. Equipment	UEC	The trust must ensure that patients identified with a mental health condition are cared for in a safe ligature free environment and have appropriate risk assessments completed.	KE	Sep-24	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Trust wide review of ligature risks to be conducted to ensure the environment is safe for patient care • Development of an Estates Strategy	• **Clinical SoP in-place to identify and risk assess patients entering ED that present a potential self-harming risk.** • **New Anti-Ligature Policy in development.** • **Anti-baracade door systems fitted to all WC doors in ED to enable rapid access should a patient be suspected of self-harming inside.**	• EDG • OMB	• Q&S Committee • F&P Committee	• Safe-guarding Assurance Report to BoD • Estates Strategy

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M37 S10	Environ-ment inc. Equipment	MAT MED	The trust must ensure doors are not left unlocked and accessible to patients or members of the public including all doors leading to the children's areas.	KE	Jun-24	• Review of NET2 access and ongoing monitoring of employee access	• Access review undertaken and of high risk areas including Pharmacy, Mortuary and Children's areas. • NET2 access reviewed and removed from non-essential staff. **Completed.**	• NET2 access list • Matron Audits • Incidents	• Operational Management Board	• EDG • Security Action Plan Report to BoD
M39	Environ-ment inc. Equipment	MAT	The trust must ensure the maternity theatre, birthing rooms and room 15 are serviced, maintained, and fit for purpose in line with best practice guidance.	KE	Sep-24	• Full review to be undertaken of maternity theatre, birthing rooms and room 15 to ensure fit for purpose in line with best practice guidance. • AFPP review to commence.	• Critical plant verification (annually) to undertaken in accordance with HTM 03. • CLS, and Birthing rooms 5-15, annual critical plant verifications undertaken. • 6 Monthly Entonox environmental monitoring to ensure daily exposure limits are not exceeded. • Water safety temperature checks completed in accordance with HTM-04.	• AFPP Review Report • Matron Audits	• F&P Committee	• F&P Assurance Report to BoD
M40 M48 S4 S22	Environ-ment inc. Equipment	MAT CYP MED EPH	The trust must ensure that a robust system is in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and ensuring premises are safe and for their intended purpose.	KE	Review Oct-24	• UEC Improvement plan • Full review of the trust premises to ensure fit for purpose in line with best practice guidance.	• H&S audits not achievable with current resource levels. (This gap is identified on the H&S action plan). • The Trust have employed Nifes to undertake a • 6 Facet Survey of the acute estate • (draft document received for comment June '24 - awaiting final copy).	• Health Safety Audits • Patient Flow Working Group • KPIs / UEC Dashboard • System Improvement Board • Outcomes?	• F&P Committee • Q&S Committee	• EDG • OMB • F&P and Q&S Assurance Reports to BoD

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M46	Infection Prevention Control	CYP	The trust must ensure the premises and environment are clean and maintained to prevent the spread of infection. This includes but is not limited to repairs to flooring, walls and door frames, plumbing / drainage, and food storage within patient's fridges.	KE	Dec-24	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Development of an Estates Strategy	• The adoption of the NHS National Cleaning Standards assessment has been extended to include a multi-disciplinary team (MDT) approach, that includes stakeholders from outside of the Domestic Services organisation to provide an honest and independent assessment for assurance purposes. • (Items identified as failing to meet the required standards are logged and escalated to the appropriate 'resolution owner' (Nursing, Estates, Facilities etc. • PLACE (Full) and PLACE (Lite) assessments also utilise an MDT approach in addition to feedback from patient representatives to provide observations of where standards require improvement. • The Catering Department receive external compliance audits by the independent Environmental Health Officer (EHO), and is subsequently awarded a food standards rating accordingly. The CoCH Catering Service has maintained its 5-Star rating. • A draft Estates Strategy was shared with the Trust's Operational Management Board (OMB) in October 2023. As the Clinical Strategy approaches finalisation, the Estates strategy will be refined to accommodate the needs defined within, and then be subsequently ratified. • Estates issues raised through IPC audits are fed-back to Estates via the Limble helpdesk system. The closure of items is tracked by both Estates and the area inspected (Ward/ department).	• PLACE Assessments • Incidents • National Cleaning Standards	• F&P Committee • Q&S Committee	• Estates Strategy • PLACE Annual Assurance Assessment Report to BoD • F&P and Q&S Assurance Reports to BoD

Action Plan:

Owner: Karan Wheatcroft – Director of Governance, Risk & Improvement

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M2 M4	Risk & Complaints Manage-ment	TW	The trust must ensure risks in services are appropriately recorded, assessed, escalated to the trust's board where required, and regularly reviewed.	KW	Sep-24	• Review and update risk management strategy • Review structures, roles and responsibilities to ensure robust risk management across the Trust. • Confirm escalation processes • Provide high risk reports to OMB, Board and Committees	• All risks are reviewed monthly at each Divisional Governance meeting and also by the Executive Directors' Group. • A report of high risks is also provided bi-monthly to the Board of Directors, monthly to OMB and relevant extracts are also provided to each of the sub-committees. Risk Management Strategy under review.	• EDG • OMB • BoD • Sub-committees • Divisional Governance Meetings	• Audit Committee	
M3	Risk & Complaints Manage-ment	TW	The trust must ensure effective action is taken to address risks in services including areas of low compliance highlighted through internal governance systems.	KW	Sep-24	• Review and update risk management strategy • Review structures, roles and responsibilities to ensure robust risk management across the Trust. • Confirm escalation processes • Provide high risk reports to OMB, Board and Committees	• All risks are reviewed monthly at each Divisional Governance meeting and also by the Executive Directors' Group. • A report of high risks is also provided bi-monthly to the Board of Directors, monthly to OMB and relevant extracts are also provided to each of the sub-committees. **Risk Management Strategy under review.**	• EDG • OMB • BoD • Sub-committees • Divisional Governance Meetings	• Audit Committee	

Action Plan:

Owner: Karan Wheatcroft – Director of Governance, Risk & Improvement

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M43	Policy Manage-ment	MAT	The trust must ensure that policies and procedures are reviewed and follow national guidance.	KW	Dec-24	• Review of all documents on SharePoint as policies. • Revise internal process for updating / removing / amending documents on SharePoint. • Further communications across the Trust to embed the processes.	• The Continuous Improvement Team have commenced the cleanse of policy documents on Sharepoint with an initial position statement reported via EDG. • A process has been established to monitor progress and escalate the position through EDG. • Further work is required to deliver these improvements.	• Board of Directors • Sub-committees	• Via the relevant Committee dependant on the policy document	• EDG

Action Plan:

Owner: Debbie Herring – Interim Chief People Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M8	Patient Experience & Staff Feedback	TW	The trust must ensure staff feedback is captured and responded to appropriately to identify risks and drive improvement in services.	DH	Dec-24	• To design a staff experience strategy/ cultural development programme that improves staff satisfaction and supports staff in the delivery of high-quality services. Its focus will be to: • Embed all elements of the NHS People Promise • Embed the Trust values & behaviours (Civility Charter) • Support all aspects of the employee lifecycle	Employee Engagement Plan • Identifies key methods of gathering staff feedback, shared with Trust Board and EDG (includes 2023 Staff Survey outcomes, Staff Networks and Wellbeing Service Feb 2024) • First draft of comms plan developed • Engagement with divisional leads about 2023 staff survey outcomes and local themes for action • Four corporate Staff Survey priorities identified for action Actively working on the 4 Staff Survey Priorities – executive visibility and visits programme in place, enhanced team brief, new appraisal process in place car parking group establishes to review how charging is applied, new exec led induction process in place from July, Civility charter statement chosen and being incorporated into all employee processes.	• Paper to EDG outlining actions and next steps including the development of a Civility Charter and training modules • Monitoring to take place at Divisional level, also at EEWG, OMB, POD according to meeting schedules • Process to be devised; will involve identifying Trust drivers for action that are linked to 2023 survey recommendations for action (w/c 04.03.24) • People Pulse	• POD	• EDG • OMB • Partnership Forum • EDG • Engagement as standing item at POD (completed) • Reporting calendar to be established linked to monitoring process (31.03.24) • Escalation of issues to EDG (on-going) • Staff Survey Results / Action Plan

Action Plan:

Owner: Debbie Herring – Interim Chief People Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M14	Training	TW	The trust must implement an effective system to ensure that medical, nursing and midwifery staff have the skills, knowledge, experience (qualifications and competencies) and appraisal to care for and meet the needs of patients within their service area.	DH	Dec-24	Review induction programme and content Review local induction process and format. Develop minimum competencies for staff groups. Align competency set to ESR and staff groups. Review training provision and capacity. Leadership Development Framework and associated programmes signed off.	• **New Welcome induction event developed and in use from July. Comprehensive Leadership Programme in place. Medical leadership, first line leaders (B2 – 4) and nurse leaders programmes already in delivery. Other cohorts commencing July/August. Completed.**	• Monitoring through Assurance processes. • Framework has been to EDG, OMB, Partnership forum and POD. • People Pulse. • New welcome induction event. • Leadership development programmes in place.	• POD	• EDG • OMB • Partnership Forum • Staff Survey Results / Action Plan
M15 M35 M36 M51	Training	MED UEC EPH	The trust must implement an effective system to ensure that all staff have the skills, knowledge, experience, and appraisal to care for and meet the needs of patients within their service area.	DH	Dec-24	Review induction programme and content. Review local induction process and format. Develop minimum competencies for staff groups. Align competency set to ESR and staff groups. Review training provision and capacity. Appraisal paperwork under review.	• **New Welcome induction event signed off and in use from July. New appraisal process developed and implemented. Training Needs Analysis and minimum skills competencies to be reviewed October 2024. Additional training dates have been provided to ensure capacity meets demand. DNA rates are monitored and managers informed of staff DNAs**	• New welcome induction event • Training capacity reviewed and increased • New appraisal paperwork launched	• POD	• SOF • OMB • Staff Survey Results / Action Plan

Action Plan:

Owner: Debbie Herring – Interim Chief People Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M22	Training	MED	The trust must ensure that staff receive conflict resolution training in a timely manner, as is necessary to enable them to carry out the duties they are employed to perform.	DH	Sep-24	Undertake TNA with SME. Liaise with external trainer regarding training dates and capacity for F2F training. Link competency to relevant staff on ESR. Increase communication to divisions on compliance through OMB and HRBPs.	• TNA completed • Additional dates added on ESR to increase capacity. • Monthly alerts to divisions – aim to reach Trust compliance target of 90% by Sep-24.	• Monthly compliance reports sent to all divisions and accessible on 'S' drive. • Current compliance is at 62%.	• POD	• SOF • EDG • OMB
M44	Training	CYP	The trust must ensure that mandatory training (including safeguarding) compliance meets the trust target.	DH	Sep-24	Review TNA for level 3 safeguarding Review capacity meets demand for all face-2-face sessions. Provide additional sessions for basic life support. Provide enablers for those staff with limited access to PCs to undertake eLearning. Increase communication to divisions on compliance through OMB and HRBPs.	• Face-2-face sessions. implemented for non-clinical staff. • Promoted access to PC's in the library and supported provided from library staff for accessing ESR and eLearning.	• Monthly compliance reports sent to all divisions and accessible on 'S' drive. • Latest overall Trust compliance is 87.34%. Divisions have been provided detailed reports on areas that need compliance improvement. • Safeguarding level 1 &2 is at or above 90% target. We are now focusing on an improvement in trajectory for level 3.	• POD	• SOF • EDG • OMB

Action Plan:

Owner: Nigel Scawn – Medical Director

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M5	Patient Flow & Perform-ance	TW	The trust must ensure patients waiting to receive treatment after a referral are clinically reviewed and validated	NS	Review Jan-25	• Refer to Section 29a Reg 17 Governance Action Plan. • Representation at the Surgical Risk Programme Group. • Any patient seen in outpatients who appears to have come to harm due to their wait should be recorded within Datix and investigated. • Any patient who attends ED for harm consequently for the condition that they are awaiting treatment should be recorded within Datix and investigated. • Implement C2AI (prediction tool) to prioritise surgical patients.	• Nominated representative attend Surgical Risk Programme Group. • Clinical validation completed for mixed specialties in Nov-23. • Datix reporting established. • Regular submission of data to C2AI commenced and outcomes awaited. • Quarterly waiting list harms audit (ED) in July 2024 to be presented to the next QGG. • Data quality issues remain for patients particularly on the non RTT list.	• Daily Safety Huddles • Divisional Governance Groups • Incidence Report • Serious Incidence Reports	• Q&S Committee • F&P Committee	• Integrated Incident, Complaints & Claims Report • Q&S and F&P Assurance Reports to BoD

Action Plan:

Owner: Nigel Scawn – Medical Director

NHS Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M18 M52 S7 S15 S18	Medica-tions	MED EPH MAT CYP	The trust must ensure there are effective systems in place for the safe management, storage, and monitoring of medicines including medicines administered covertly and the administration care plan is complete. The system in place must ensure the safe administration of medicines.	NS	Sep-24	• Assign Chair to Medicine Safety Group. • Establish workstreams within the Medicines Safety Group.	• Medicines Safety Group now Chaired by the Deputy Medical Director (identified lead for patient safety). • Established workstreams include: O2, Insulin, VTE, Cytotoxic, Anticoagulants, Administration, storage, prescribing. • Established workplan and reporting process. **Completed.**	• Medicine Safety Group (reports to Q&S Committee and via Chair's report to the Board of Directors) • Drugs & Treatment Group • Incident Reports • Workplans established. • Systems in place for safe management, monitoring and storage of medicines.	• Q&S Committee	• Annual Report for Medicine Safety
M23 M55 M56	Auditing	MED EPH	The trust must ensure there is effective data collection, analysis and action to address low compliance and areas for improvement in quality and safety identified through internal audits to drive improvement in patient care.	NS	Sep-24	• Review divisional / specialty data submissions to National Registries and Specialist Commissioned services.	• Linked to well led 5.11 5.11 – All national mandated audits have been reviewed and registration, data collection and validation agreed with Divisions. Monthly review of open/ overdue audits and actions undertaken with communication with clinical teams to review and close as appropriate. **Completed.**	• Divisional Governance Meetings	• OMB	• EDG

Action Plan:

Owner: Nigel Scawn – Medical Director

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M26	Safe Staffing	UEC	The trust must ensure that medical staffing levels, with the right qualifications and competencies, are safe for the numbers of patients in the department.	NS	Oct-24	• See Patient Flow / UEC Improvement Plan (Nursing and Medical). • Case for expansion of medical staff numbers to be developed. • Review roles and responsibilities of allied professionals to support triage and UTC.	• Linked to Well Led 7.2 • Case presented and agreed to EDG and OMB. • Additional consultant appointments made and further vacancy to recruit to in April 2025. • Additional medical lead for UTC now in post. • UTC & minors now moved to upstairs within SDEC to improve numbers and flow. • Review of AHP workforce and medical staffing currently being progressed.	• Patient Flow Working Group • Streaming Task & Finish Group • KPIs / UEC Dashboard • System Improvement Board	• F&P Committee • POD Committee	• EDG • OMB • SOF
M31	Medica-tions	UEC	The trust must ensure that oxygen is prescribed as required by national guidelines.	NS	Oct-24	• Improved position on oxygen prescribing.	• **90% compliance consistently across the Trust.** • **Cerner prompt now added to support this. Completed.**	• O2 Prescribing Audits • **90% compliance consistently across the Trust.** • **Report provided to QGG and Q&S in May & June 2024 to provide further assurance.**	• Q&S Committee	• Monthly O2 Prescribing Report

Action Plan:

Owner: Nigel Scawn – Medical Director

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M34	Risk & Complaints Manage-ment	UEC	The trust must ensure there is effective action taken and evidenced in response to risks, issues and low compliance with audits.	NS	Review Sep-24	• Identify lead for Clinical Audit. • Review of nationally mandated audits and identify corporate audits. • Set divisional KPIs	• Head of Quality assigned as lead for Clinical Audit (Jan-24) • Progress limited due to staffing issues within the Audit Department. • Identified corporate audits within Health Records and Consent. • KPIs set to 10% monthly incremental improvement. • **Linked to well led 5.11 – All national mandated audits have been reviewed and registration, data collection and validation agreed with Divisions. Monthly review of open/ overdue audits and actions undertaken with communication with clinical teams to review and close as appropriate. Completed.**	• KPI Monitoring • Quality Governance Group	• Q&S Commit tee	• Q&S Assuranc e Report to BoD
S6	Medica-tions	MED	The trust should review the prescribing of medicines that control distressed behaviour to ensure the policy is followed and monitoring is completed.	NS	**Review Sep-24**	• Review the policy and education for relevant teams	• The policy is under review and being expedited.	• Incident Reporting • Mental Health Steering Group	• Q&S Commit tee	• Q&S Assuranc e Report to BoD

Action Plan:

Owner: Nigel Scawn – Medical Director

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring	Committee	Assurance
S21	Patient Assessment	CYP	The trust should ensure staff improve the compliance of completing the sepsis screening tool on the electronic patient record.	NS	Review Sep-24	• Harms • Acquire new blood gas analyser to measure lactate within ED • Focus on compliance of prescribing antibiotics within 1 hour of diagnosis of Sepsis.	• Blood gas anaylser now in situ.. • Regular monitoring through the Sepsis Improvement Group. • Sepsis care plans have been devised to be recorded within EPR, these are in draft form and work is underway with pharmacy/ microbiology re treatment options. Monitoring of sepsis screening collated monthly and discussed at monthly sepsis improvement group.	• Sepsis improvement programme (Harms) participating within the Harms Showcase (Mar-24) • AQ Compliance • Sepsis Screening Audits	• Q&S Committee	• Sepsis Assurance Report to BoD

Well Led Action Plan – KLOE 1

KLOE 1	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
1.1	• Formalise improving visibility for the exec team and senior leaders with a robust method for feedback • Refresh executive buddy system and NED walkabouts (including feedback loop)	Director of Nursing	~~April 2024~~ **Revised June 2024**	The walkaround schedule has been agreed with them to be held throughout May and feedback to then be provided back to EDG in June 2024. NED & Governor walkabouts plan has also been agreed until December 2025. **Completed.**	Walkabout schedules and feedback mechanisms in place.	High
1.4	• Develop a quality and safety strategy	Director of Nursing/Medical Director	**August 2024**	This is on track and will be completed by August 2024 following the launch of the overall refreshed Trust Strategy.		High
1.8	• Continue to embed quarterly divisional performance meetings (FM Governance report 2019 REC 18) • Review format and timing for divisional performance meetings alongside the Operational Board agenda	Director of Governance, Risk & Improvement	~~September 2023~~ **Revised August 2024**	Performance reporting has been established to each OMB. The COO is also developing an approach to reintroduce Quarterly Divisional Reviews.		High
1.10	• Consider undertaking a cultural and behaviour organisation review to ensure the organisation and its people align with the aspirations of the Board • (FM Governance report 2019 REC 20)	Chief People Officer	~~June 2023 Revised April 2024~~ **Revised June 2024**	Civility statement now chosen by staff. Civility booklet produced and going on line also cards for all staff. Used at new induction from mid July 2024. **Completed.**	Civility Training implemented. Embedded into all new leadership programmes	High

Action Plan – KLOE 1

KLOE 1	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
1.13 (NEW)	• Clear Board succession plan and appointments • Board Induction programme • Senior Leadership development and succession plan • Delivery of Leadership Strategy	Chief Executive Chief People Officer	**June 2024**	All Board Positions substantively appointed to (with the exception of the interim CPO and there is a succession plan in place) and objectives set. Board development plan in place. Consultant leadership programme and aspiring leaders (Band2 – 4) up and running. Nurse leaders programme in place. Board succession plan is place (reviewed by Remuneration Committee in 23/24), new Executive Directors reviewing existing succession plan and any updates will go to Remuneration Committee to be held in September 2024). **Completed.**	Strategic Plan in place across the Trust and in delivery. Succession plan in place. Board appointments. Induction programme in place.	High
1.14 (NEW)	• Board development programme. • Exec team development	Chair Chief Executive Director of Governance, Risk & Improvement	~~April 2024~~ **Revised June 2024**	The Board Development session programme has been revised for 2024/25 to incorporate relevant topics relating to strategy, governance and organisation / team development. The updated programme was approved at the Board development session held on 21st May 2024. **Completed.**	Board Development Programme in place.	High

Action Plan – KLOE 2

KLOE 2	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
2.2	• All divisions to work towards the development of their respective strategies	Director of Strategic Partnerships	~~October 2023~~ ~~March 2024~~ ~~May 2024~~ **Revised August 2024**	The development of strategies at Divisional level remains in progress to final completion dates to be confirmed. The draft overall Trust Strategy was presented and approved at the Private Board of Directors held on 4th June 2024. Directors are now developing enabling strategies to provide cohesion between the corporate and operational approaches. This includes: People and organisational development EDI Strategy Leadership strategy Research and development. Digital strategy. Patient and family experience. Risk reduction, harms, and continual learning. End of Life strategy Patient engagement Anchor institution.	Trust Strategy was approved in June 2024. The Women's and Children's Division strategy was launched in June 2024.	Medium
2.3	• Develop a five year financial strategy	Director of Finance	June 2023 – first draft Draft in line with ICB requirements ~~Revised April 2024~~ **Revised September 2024**	Final 24/25 financial plan submitted in May 2024 in line with national deadlines. The financial plan has been co-ordinated with Cheshire & Merseyside ICB and national financial planning. Work will commence on further developing the draft financial strategy to deliver financial sustainability over the medium term and to support the clinical services strategy.		High
2.5	• Review and rationalise the divisional governance arrangement to allow for a single operational approach to divisional governance to provide consistency and uniformity in the meeting and reporting arrangements • (FM Governance report 2019 REC 16)	Director of Governance, Risk & Improvement	~~September 2023~~ **Revised August 2024** (The Governance training delivered to senior leaders by Facere Melius in 2022 was to embed 2019 FM Governance Improvement findings around governance arrangements, but think this needs revisiting for new OMB members/divisions)	**Linked to 1.8** - Performance reporting has been established to each OMB . A session was held on accountability and we will continue to support divisional governance developments as these are enhanced. A map of sub-committee groups is currently being developed.		Medium

Action Plan – KLOE 2

KLOE 2	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
2.6	• Develop supportive strategies mental health, E and I and estates and facilities, well being	Medical Director Chief Operating Officer Director of HR	June 2023 – well- being strategy Mental health – July 2024 E and I - completed Estates and facilities – July 2024 ***Revised dates for all strategies to be confirmed following launch of overall Trust Strategy.***	**February 2024** - Wellbeing Hub due to open end of March 2024 / beginning of April 2024. Staff networks up and running. **May 2024** - Wellbeing Hub scheduled for opening and launch w/c 13th May 2024. Wellbeing annual report that reviewed activity against wellbeing strategy objectives, including mental health support was submitted to POD Committee April 2024		Medium
2.7 (NEW)	• Review effectiveness of FTSU actions	Chief Operating Officer	~~March 2024~~ May 2024 **Revised August 2024**	• FTSU Board self-assessment deferred and will be held as part of the Board development Session on 6th August 2024.		Medium
2.8 (NEW)	• Develop Board business cycle / strategy days	Director of Governance, Risk & Improvement	~~April 2024~~ **Revised June 2024**	• The Board Development session programme has been revised for 2024/25 to incorporate relevant topics relating to strategy, governance and organisation / team development. The updated programme was presented to the next session to be held on 21st May 2024 and was formally approved. **Completed.**	Board development programme in place.	Medium
2.9 (moved from KLOE 4 ref: 4.3)	• Develop and refresh a new Trust Strategy • Engagement and awareness of new strategy • Establish Annual objectives and priorities (FM Governance Report 2019 REC 8)	Director of Strategic Partnerships	~~July 2023~~ ~~Revised January 2024~~ **Revised September 2024**	**Refer M7.** The Trust Strategy has been approved by the Board of Directors and a Trust wide launch is planned for August / September 2024.		High

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
3.2	• Staff survey feedback needs full analysis and clarity required on the key changes that need to happen as a result. Trust wide engagement sessions need to be held within April/May to meet face to face with all staff to demonstrate that the Trust is listening and taking on board their feedback. • Delivery of staff survey action plans	Chief People Officer	~~May 2023~~ ~~November 2023~~ ~~April 2024~~ **Revised September 2024** **Local divisional plans to be identified by end May 2024, with plans for delivery by end September 2024.** **Corporate plans will require implementation at divisional level, actions required to be identified by end May 2024 with plans for delivery by end September 2024.**	Actively working on the 4 Staff Survey Priorities – executive visibility and visits programme in place, enhanced team brief, new appraisal process in place car parking group establishes to review how charging is applied, new exec led induction process in place from July, Civility charter statement chosen and being incorporated into all employee processes.		High

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact Rating
3.3	Implement the recommendations from the recent risk management review March 2023	Director of Governance, Risk & Improvement	~~October 2023~~ **Revised to end of Quarter 2 2024/25 in line with MIAA management response timescales**	Monthly reports are now shared with EDG and then feedback provided to the Divisions in relation to their risks. Risk updates also continue to be updated via the Operational Management Board. A High Risks report is provided to the Board of Directors and sub-committees. The Trust's Risk Management Policy and Procedure is currently being reviewed together with a review of the Trust's approach to Risk Management training. A process is also being developed for regular reviews of the risk register and to develop assurance reports via the relevant governance structures.		High
3.5	• Provide a trajectory plan trust wide (supported by divisions) for all areas to achieve trust targets for all of mandatory training. To be monitored through Operational Management Board. • Mandatory training performance to achieve target	Chief People Officer	~~June 2023~~ **Revised September 2024**	Work completed with ESR within the Training department. Divisions to now monitor compliance at their level and release the staff to attend with a planned target to achieve 90% compliance by September 2024.	Mandatory training compliance improved to 87.34%. Capacity increased.	High

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
3.6 (moved from KLOE 8 Ref: 8.4)	A plan needs to be in place to ensure there is review of all out-of-date policies and procedures and that these are reviewed annually or as otherwise stated (FM Governance report 2019 REC 17)	Director of Governance, Risk & Improvement /Director of Nursing	Initial target timescale for phase 1 is the end of March 2024 given sheer number of out-of-date policies. **Revised December 2024**	The Continuous Improvement Team have commenced the cleanse of policy documents on Sharepoint with an initial position statement reported via EDG. A process has been established to monitor progress and escalate the position through EDG. Further work is required to deliver these improvements.		High
3.7 (NEW)	Establish quality improvement priorities, learning and outcomes.	Director of Nursing	*To be completed in conjunction with the quality and safety strategy* **August 2024**	Scoping exercise completed, example strategies have been reviewed and outline for the CoCH strategy has been agreed with key stakeholders. Wider engagement and socialisation will take place in June 2024.	Quality priorities agreed and established as part of quality account . Monitored through QGG Linked with Quality Strategy.	High
3.8 (NEW)	Review and embed range of listening channels including FTSU work . Run Culture and Civility Roadshows. FTSU drop in sessions Reintroduce Coffee with the COO	Chief People Officer / COO	**Revised July 2024** **Complete**	FTSU process updated. COO executive lead. FTSU champions in place. Communications and Visibility improved and feedback loop for those raising concerns. COO and CPO monthly review of themes and related HR cases to ensure timely completion and closure. **Completed.**	FTSU process updated & relaunched. Champions in place with quarterly feedback to EDG. Monthly reviews of themes.	High

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
3.10 (NEW)	EDI work	Chief People Officer	~~March 2024~~ **Revised October 2024**	Exec champions identified and new network meetings being publicised and taking place.	Executive Champion roles identified. Ongoing network meetings.	High

Action Plan – KLOE 4

KLOE 4	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
4.2	Following review terms of reference needs to be updated and agreed by the Board of Directors. This will allow for clear accountability for leadership and membership of the committees	Director of Governance, Risk & Improvement	~~Revised March 2024~~ **Revised June 2024**	Findings from the external review were shared with all Executive Leads and Non-Executive Directors, for the relevant Committees. The Terms of Reference have been updated together with the workplans and were formally approved by the Board of Directors held in June 2024. **Completed.**	Refreshed TOR for all sub-committees. Annual review process in place.	High
4.3	• Develop a meeting map to incorporate Board, operational and management meetings focusing on attendees, membership, terms of reference and roles and responsibilities • (FM Governance report 2019 REC 13)	Director of Governance, Risk & Improvement	October 2023 Following conclusion of Committee effectiveness review cited above – Linked to 4.2 above. **Revised August 2024**	Linked to 4.2 as above and map is currently being developed.		High

Action Plan – KLOE 4

KLOE 4	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
4.5	• Develop a governance handbook and accountability framework so that individual roles and committee responsibilities and accountabilities are clearly documented. • Raise awareness and embed governance framework and expectations (FM Governance report 2019 REC 14)	Director of Governance, Risk & Improvement	**Revised September 2024**	Governance Handbook to be reviewed, updated & presented to the Board of Directors to be held in September 2024.		Medium
4.6	• Develop a ward to Board framework so that the Board receives assurance of its quality and safety to allow for clear and effective flows of information from ward to Board. • Subcommittee structure and workplans to be devised (FM Governance report 2019 REC 15)	Director of Nursing & Quality Director of Governance, Risk & Improvement	Harms/Q&S report to Board/Incidents is in place – the new SOF will support/replace this from August 2023 **Revised August 2024**	Integrated reports are provided quarterly to the Quality & Safety Committee and Board of Directors- **Completed.** This is being actioned as part of 4.2 & 4.3.	Ward accreditation plan in progress following piloting of the farmwork IICC report presented to Board Risk and Issues report from QGG to quality and safety committee	High
4.7	A review of 7 day services needs to be undertaken to understand any risks and gaps in care delivery and support for patients and staff	Executive Medical Director	~~October 2023~~ ~~April 2024~~ **Revised December 2024**	Several surgical specialities provide 7 day services at Consultant level. Further discussions are being held at Executive level with regards to job planning within Urgent Care.		Medium

Action Plan – KLOE 4

KLOE 4	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
4.8	• The BAF needs to be a dynamic and live document that informs the Board of risks to progress in meetings its strategic objectives • Review effectiveness of use of the BAF (FM Governance report 2019 REC 6)	Director of Governance, Risk & Improvement	August 2023. April 2024 **Revised June 2024**	The Trust's current Risk Appetite statement was approved by the Board of Directors held in May 2023, and the BAF realigned to the Trust's refreshed strategic objectives. The content & format of the BAF for 2024/25 has been further reviewed by the Director of Governance, Risk & Improvement and other executive leads and will be presented to the Board of Directors to be held in July 2024. A BAF and risk appetite session was also held with the Board of Directors during a development session on 21st May 2024. **Completed.**	Refreshed BAF in place, aligned to strategic objectives. Effectiveness of the BAF reviewed as part of this process.	High

Action Plan – KLOE 4

KLOE 4	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
4.10	• Implement a development programme for Board members and senior operational leaders (FM Governance report 2019 REC 5)	Chief People Officer/ Director of Governance Risk and Improvement	~~Revised April 2024~~ **Revised June 2024**	• All Board Positions substantively appointed to (with the exception of the interim CPO and there is a succession plan in place) and objectives set. Board development plan in place. Consultant leadership programme and aspiring leaders (Band2 – 4) up and running. Nurse leaders programme in place. Board succession plan is place (reviewed by Remuneration Committee in 23/24), new Executive Directors reviewing existing succession plan and any updates will go to Remuneration Committee to be held in September 2024). **Completed.**	Succession plan in place. Board appointments. Induction programme in place.	Medium
4.11	• Review of Non-Executive Directors portfolio and development needs to ensure that there is a good understanding of their roles and responsibilities as a Non-Exec Director. • Review governor roles and expectations and understanding of roles. (FM Governance report 2019 REC 2)	Director of Governance, Risk & Improvement.	September 2023 **Revised December 2024**	NWLA run open programmes for NEDs which anyone can book on to by going onto via their website. NED inductions now in place and new NEDs invited to attend the NHS Employers events. Review of NED responsibilities undertaken and shared with Council of Governors. Board development programme finalised for 2024/25. A number of changes to Governors expected in September 24 AMM and session to be held subsequently regarding roles.		Medium

Action Plan- KLOE 5

KLOE 5	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
5.1	The process for reviewing and assessing risk needs to be strengthened to allow for transparency of risks to ensure the Board are fully sighted on risks to patients and services (to include embedding risk management and review of BAF)	Director of Governance, Risk & Improvement	**Revised to end of Quarter 2 2024/25 in line with MIAA management response**	This is linked to 3.3 also. Monthly reports are now shared with EDG and then feedback provided to the Divisions in relation to their risks. Risk updates also continue to be updated via the Operational Management Board. A High Risks report is provided to the Board of Directors and sub-committees. The Trust's Risk Management Policy and Procedure is currently being reviewed together with a review of the Trust's approach to Risk Management training. A process is also being developed for regular reviews of the risk register and to develop assurance reports via the relevant governance structures.		Medium
5.3	The backlog of serious incidents needs to have a robust plan to review and complete and extract learning	Director of Nursing & Quality	~~April 2024~~ **Revised June 2024**	Continued significant improvements with the closure of the backlog of serious incidents. It is planned that all non-maternity serious incidents, will all be closed with the ICB by May 2024. Maternity serious incidents have also made good progress with reducing numbers remaining open. PSIRF continues to be embedded within the organisation with a strengthened focus on learning. There are several forums in place for sharing learning including Patient safety Summit, Patient Safety Learning Meeting, Trust Wide Weekly Learning Page, and Sharing and Learning. **Completed.**	All historical SI now closed with Steis and ICB. All historical maternity SI all presented and updated actions plans sent. PSIRF process now in place with oversight and engagement with ICB.	Medium

Action Plan- KLOE 5

KLOE 4	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
5.5	The Trust must implement quality improvement systems and processes such as regular audits of the services provided and must assess, monitor and improve the quality and safety of services. The Trust needs to develop an improvement strategy	Director of Governance, Risk & Improvement	April 2024 **Revised September 2024**	The Trust has a continuous improvement team in place, as well as a number of other teams that deliver improvement work. An improvement strategy is required for 2024 and beyond. A session has been held with the Continuous Improvement Team in May 2024 to align team priorities to strategic priorities. Wider picture across all improvement activity to be developed.		Medium
5.6	The governance of coronial cases needs to improve which will be underpinned by the improvement in governance of all incidents to ensure that patients families and carers are involved in investigations, communicated with frequently and have their questioned answered and receive investigatory reports at least 28 days prior to any inquest. The investigatory reports need to be shared with the coroner 28 days prior to hearings also.	Assistant Chief Executive	~~October 2023~~ ~~June 2024~~ **Revised September 2024**	Discussions taking place to enhance processes.	Transparency of all coronial cases. Good communication with legal team Further work re oversight and improved timeframes for report submission.	High

Action Plan – KLOE 5

KLOE 5	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
5.8	The Trust must review all training needs across all disciplines and prioritise mandatory training, EPR training and education regarding investigation reports, complaints responses, coroner cases and risk management.	Chief People Officer	~~September 2023~~ ~~April 2024~~ **Revised October 2024**	New appraisal process and leadership development programme implemented. Revised Training Needs Analysis to take place September/October once 2024 appraisals have taken place.	Launch of new appraisal process & paperwork.	High
5.12	There needs to be a process for receipt and monitoring of all NICE guidance and robust governance of ensuring that actions are in place to ensure adherence	Medical Director	~~September 2023~~ ~~April 2024~~ **Revised September 2024**	All NICE guidance received by the Trust is currently logged by the Head of Quality within Datix and ongoing work with clinicians to provide appropriate assurance is ongoing. All guidance is shared with leads. Work continues with Divisions Business Partners requires strengthening to ensure timely review of guidance.		High
5.13 (NEW)	Improved Board and Committee reporting: Quality of reports, report writing and presentations.	Director of Governance, Risk & Improvement	~~April 2024~~ **Revised September 2024**	Further guidance to be provided for Leads and Authors. To also consider a report writing brief course to be provided.		Medium
5.14 (NEW)	Enhance visibility and awareness of research and its impact.	Medical Director	**September 2024**	Research Lead provides quarterly updates to Operational Management Board & Board of Directors.		Medium

Action Plan – KLOE 6

KLOE 6	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
6.4 (NEW)	Deliver plan to optimise Cerner Full optimisation	Chief Digital and Information Officer	**October 2024**	EPR Optimisation and Upgrade Programme underway. Upgrade on track for delivery September / October 2024. Programme manager appointed and in post. NHSE England readiness review completed and internal audit review of previous lessons completed, both providing positive assurance but further actions identified and in train. First phase optimisation completed prior to change freeze for upgrade, and phase 2 to commence post upgrade. Clinical prioritisation process for EPR changes to be instigated from October 2024.		Medium
6.5 (NEW) Linked to 4.2	Deliver Board and Committee effectiveness review actions including TOR and workplan updates for Quality Committee; POD, F&P, and Audit Committee.	Director of Governance, Risk & Improvement	**June 2024**	Findings from the external review were shared with all Executive Leads and Non-Executive Directors, for the relevant Committees. The Terms of Reference have been updated together with the workplans and were formally approved by the Board of Directors held in June 2024. **Completed.**	Refreshed TOR for all sub-committees. Annual review process in place.	High

Action Plan – KLOE 7

KLOE 7	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
7.1	A review of all engagement with staff and patients needs to be undertaken to understand what is working well, what needs to improve, what else is required? From this priorities for engagement need to be discussed at exec group initially and then trust wide. Patient engagement events, well being events (well-being group), carers forums, quality events, patient expert groups?	Director of HR/ Director of Nursing	~~June 2023~~ ~~April 2024~~ **Revised September 2024**	Building on the Engagement Plan, to design a staff experience strategy/ cultural development programme that improves staff satisfaction and supports staff in the delivery of high-quality services.	Programme of patient engagement events commenced and a plan for the year ahead.	High
7.2	The Trust must be assured that they have the right numbers of staff with the right skills across all disciplines – focus on medical. Nursing and therapy staff Workforce plan submitted to NHSE May 2023 **Actions outstanding – review of AHP workforce** **Review of medical staffing**	Director of HR/Director of Nursing/Medical Director Assistant CEO Medical Director	June 2023 - **Completed** **August 2024**	Nurse staffing review completed using the safer nursing tool. Review of maternity staffing also. **Completed.** Medical staffing review remains ongoing.		High

Action Plan – KLOE 7

KLOE 7	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
7.4 (NEW)	Continue to increase visibility, access, awareness and work of PALS	Director of Nursing	~~April 2024~~ **Revised July 2024**	The PALS team meet weekly with each division to support timely closure of complaints and concerns. The team are included in the Patient Safety Learning Meeting to enable sharing of themes, learning and actions from complaints and concerns. **Completed.**	Weekly meetings in place with Divisions. Patient Safety Learning meeting in place.	Medium
7.5 (NEW)	Continue to build upon system understanding and engagement with external partners, stakeholder mapping.	Director of Strategic Partnerships	~~July 2024~~ **Revised August 2024**	We have a new anchor institution group which meets for the first time July. This group will also take into consideration the new CQC framework impact of net zero. The Board paper was also deferred due to purdah to July 2024 Board.		Medium

Action Plan – KLOE 8

KLOE 8	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
8.1	The Trust need to establish a Board Lead for organisational learning. This will then allow a strategic review of where all learning takes place, who by and outcomes. This then needs to result in the development of an organisational learning policy which is inclusive of all disciplines and services. • Review policy to ensure comprehensive coverage of organisation learning. • Establish mechanisms (as required) and embed organisation learning across the Trust	Director of Governance, Risk & Improvement	~~June 2023~~ **Revised August 2024**	Organisational Learning Policy being progressed to reflect the mechanisms in place.		High
8.2	The Trust must reduce the number and severity of clinical incidents relating in harm to patients. The recent harms summit signalled a number of improvements that are required. These areas need strong leadership to ensure that outcomes for patients are improved at pace. The quality and strategy needs to set clear objectives for the reduction of harm	Director of Nursing/Medical Director	**August 2024**	The Trust can demonstrate a reducing number of patient safety incidents that result in moderate and above levels of harm. Improved governance surrounding patient safety incidents with a focus on identifying themes, learning and actions as detailed in item 5.4. **Completed.**	Improved processes in place, completed.	High

Action Plan – KLOE 8

KLOE 8	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
8.3	The complaints policy needs to be fully embedded Trust wide with greater family involvement The learning from complaints needs to be strengthened The management of concerns needs to be strengthened	Director of Nursing	~~July 2023~~ ~~April 2024~~ **Revised June 2024**	The new complaints policy has been written and formally ratified.. This includes a reduction in the timeframes for the closure of concerns. Weekly divisional engagement will drive improvements with oversight from the deputy director of nursing and governance. Several family meetings have been undertaken and the learning from these shared at a variety of forums within the trust. Inclusion of the PALS team in the patient safety learning meeting supports the learning from complaints agenda. **Completed.**	New policy in place with revised timeframes.	High
8.4 (NEW)	Continuous improvement • workstreams to be aligned to strategic priorities. • Consider opportunities to involve patients • Board development and NHS IMPACT assessment (including action plan) • Transformation programme priorities and approach to be confirmed and aligned to strategy	Director of Finance	~~March 2024~~ **Revised August 2024**	- On track & will be further reviewed once the Director of Governance, Risk & Improvement commences in post in June 2024.		Medium

Action Plan – KLOE 8

	Development Areas	Responsibility	Timeframe	Progress	Impact rating
8.5	The emergency department needs a robust improvement plan across all domains, care, culture, operational polices and flow. The Trust needs to improve that patients receive care in a timely way and work to improve performance against national standards (from arrival to assessment in the emergency department) Improve data capture and process of 12 hour DTA breach data Improve time to initial assessment using Manchester Triage System Deteriorating Patients and Reduction in Incidents: • Full review of the nurse and health care support workers • Roles and responsibilities in across the nursing workforce have been re-affirmed • An accountability framework is being introduced • Matron does regular drop in sessions and a department news letter is produced. • Weekly audit in place via Tendable and additional PDN training. • Twice daily Consultant in-reach sessions supporting review of NEWS and an ED specific NEWS addendum developed for Trust policy Maximise SDEC • Aim for over 1000 attendances per month • Direct conveyance from NWAS • Open 12 hours per day 7 days per week Introduce an Urgent treatment Centre outside the ED footprint	Chief Operating Officer	~~End of March 2024~~ ~~End of May 2024~~ Complete Complete Complete Complete Complete Complete and On-going Complete and On-going Complete and On-going Complete Complete Complete Complete	Nurse staffing review completed.	High

Countess of Chester Hospital NHS Foundation Trust

Meeting:	**30th July 2024**		**Board of Directors**					
Report:	**Agenda item 12.**		**2023/24 Controlled Drugs (CD) Annual Report**					
Purpose of the Report:	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive:	Dr Nigel Scawn				Medical Director			
Author(s):	Karen Adams				Director of Pharmacy and Medicines Management Controlled Drugs Accountable Officer (CDAO)			
Board Assurance Framework:	BAF 14	Failure to Deliver Quality and safety Agenda						
Strategic Aims:	SG 2 - Create a positive Patient and Family Experience							
CQC Domains:	Safe Effective Responsive Well Led							
Previous Considerations:	Quality Governance Gorup – 6th June 2024 Quality & Safety Committee – 4th July 2024							
Executive Summary:	The purpose of this report is to provide assurance through an overview of controlled drugs activity during 23/24							
Highlights:	• Improvements have been identified and implemented to further strengthen governance and assurance of the use of controlled drugs within the organisation. • The trust is fully compliant with all statutory external reporting requirements							
Recommendation(s):	The Board of Directors is requested to: • Note the assurance provided within the report.							
Corporate Impact Assessment								
Statutory Requirements:	Meets the Trust compliance with Foundation Trust Status including regulatory and legislative compliance							
Quality & Safety:	Improves safety of patients and protects health and safety of staff							
NHS Constitution:	Provides assurance on provision of high standards of excellence and a commitment to quality of care							
Patient Involvement:	Not applicable							
Risk:	Alignment with risk register							
Financial impact:	No impact identified							
Equality & Diversity:	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics							
Communication:	No impact identified							

2023/24 Controlled Drugs (CD) Annual Report
BACKGROUND

1. The statutory requirements for the safe management of controlled drugs for designated bodies are outlined in the Controlled Drugs (Supervision of Management and use) Regulations 2013. One of the requirements is the appointment of an accountable officer who has responsibility for all aspects of controlled drugs management within their organisations. The controlled drugs accountable officer (CDAO) quality assures processes for managing controlled drugs in line with legislation. They also provide reports to the board and NHS England to provide assurance that controlled drugs are used and handled appropriately, to inform them of the likelihood that patients, staff and the organisation are safe. They also advise of gaps in systems and behaviours and the consequences of these. At the Countess of Chester Hospital FT, the CDAO is the Director of Pharmacy ad Medicines Management.

PURPOSE

2. The purpose of this CDAO report is provide assurance through an overview of controlled drugs activity during 23/24.

REPORT

3. Governance and assurance reporting

Prior to Q2 23/24, CD assurance to the trust board was provided through the medicines management annual report to the trust quality and safety committee. From Q2 23/24 onwards a CDAO quarterly report is reviewed by the Medicines Safety group allowing timely routes of escalation to Quality Governance Group (QGG) and the Quality and Safety committee respectively. This annual report continues to be submitted to QGG directly. Additionally the CDAO submits a designated body occurrence report to NHS England regional CD team on a quarterly basis and participates in the designated body improvement framework.

In Q2 due to a change in CDAO, the CQC CD self-assessment tool was undertaken and a review and gap analysis of the CQC annual report conducted and reported to Medication Safety Group. No major gaps in systems or behaviours were identified however the following improvements were introduced to improve oversight:

- Deputy CDAOs nominated and trained to improve oversight and resilience.
- Review and analysis of lower schedule CD use included in quarterly CDAO report.

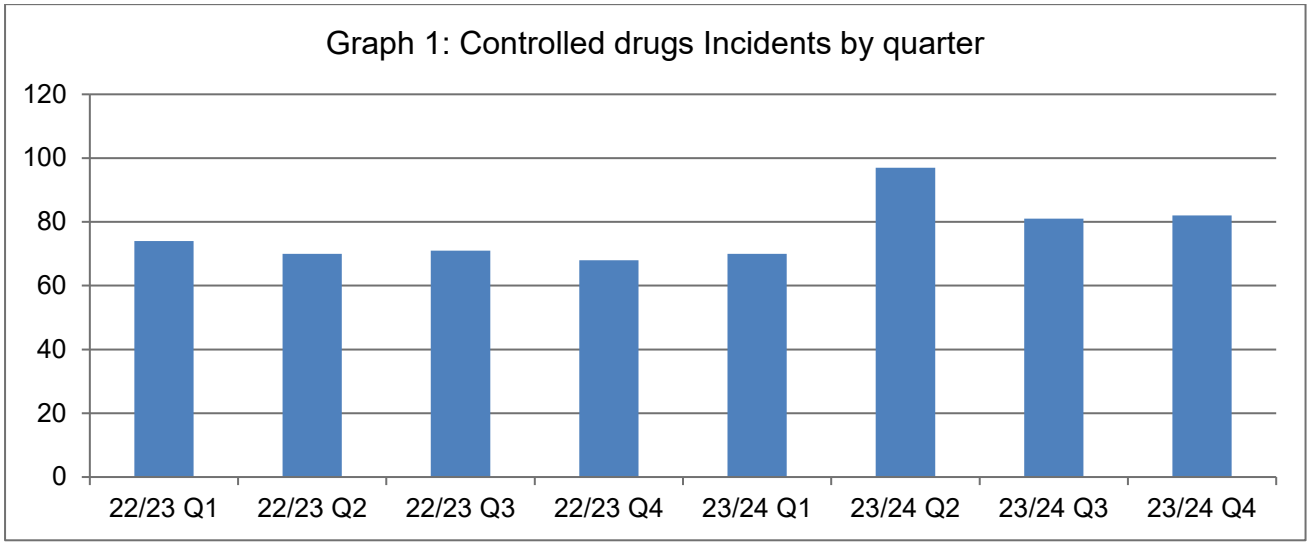
Processes related to controlled drugs are primarily managed through the following documents:

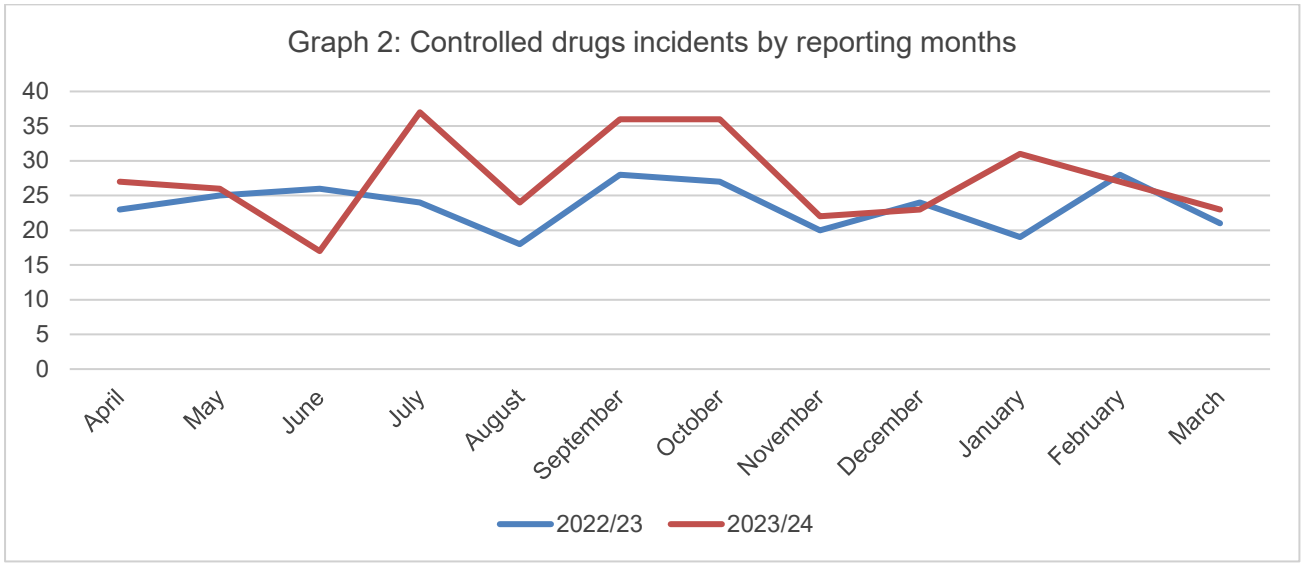
- Safe Management of controlled drugs policy
- Ward controlled drugs SOPs
- Theatre and Radiology controlled drugs SOPs
- Endoscopy controlled drugs SOPs
- Pharmacy controlled drugs SOPs

4. Incidents

Internal reporting

Trends related to reporting activity can be seen in graphs 1 and 2 with a sustained increase in reporting numbers from Q2 23/24 onwards.





Thematic reviews are undertaken quarterly in terms of drug, area and category with further analysis of trends in unaccounted for losses. This analysis has not detected any specific causes of concern during 23/24.

External reporting

2 incidents were reported to NHS England that met the criteria of direct timely reporting outside of quarterly occurrence reports

- Patient given 48 Buprenorphine tablets on discharge (not prescribed, stock supplied). Patient re-admitted.
- Employee of Concern, illicit use- Drug dealing

5. Compliance

Pharmacy quarterly assurance audits

Pharmacy CD assurance quarterly audit 23/24	Positive response	Q1	Q2	Q3	Q4
Are the CD keys kept as a separate bunch, that is, not combined with other keys, e.g. for medicines cupboards?	Yes	84.2%	66.7%	66.7%	81.3%
Was the CD cupboard securely locked?	Yes	100.0%	100.0%	100.0%	100%
Was the CD register locked away?	Yes	87.7%	94.0%	92.6%	95.8%
Was the CD order book locked away?	Yes	77.2%	96.0%	98.0%	95.6%
Was the grade of staff in possession of the CD keys appropriate (qualified staff)?	Yes	87.7%	98.0%	98.2%	100%
Is there a spare key for the CD cupboard in Pharmacy?	Yes	70.2%	70.4%	77.7%	79.2%
Was all medication in date and fit for use?	Yes	68.4%	76.0%	74.0%	72.9%
Was the stock check correct and free from any discrepancies?	Yes	82.5%	83.0%	96.3%	83.3%
Was the CD cupboard free from other items other than CDs?	Yes	84.2%	94.0%	92.6%	93.8%
Were all 'received requisitions' signed?	Yes	61.4%	41.0%	48.0%	50%
Are requisitions checked and confirmed as being present in the CD register? (sample of 5 per area)	Yes	93.0%	91.0%	98.0%	97.9%
Is the list of authorised signatories in the CD order book 'live' and up to date?	Yes	84.2%	89.0%	96.3%	85.4%
Are the registers legible, free from crossing out or alterations and in line with SOPs?	Yes	59.6%	50.0%	57.4%	75.0%
Is naloxone a ward stock item available and in date on the day of inspection?	Yes	87.7%	98.0%	92.60%	97.9%
If midazolam is stocked on the ward, is flumazenil available and in date on the day of inspection?	Yes	82.5%	98.0%	98.2%	100%
Where breakages or spillages have been recorded in the register, is the same individual's name repeatedly involved in the breakages or spillages?	No/NA	91.0%	88.0%	94.4%	95.8%
Are CD cupboards appropriate in size for the amount of stock used?	Yes	94.7%	93.0%	98.2%	100%
Is the CD cupboard made of metal?	Yes	100.0%	100.0%	98.2%	100%
Are all the entries in the Patients' Own CD Register up to date and correct?	Yes	91.0%	85.0%	88.9%	93.8%

Areas of improvements identified and actioned:

- *Were all 'received requisitions' signed?*
  Added to tenable audit to reinforce expected standards and drive improvement
- *Is the list of authorised signatories in the CD order book 'live' and up to date?*
  Current process cumbersome and under review with a view to holding centralised lists in pharmacy
- *Are the registers legible, free from crossing out or alterations and in line with SOPs?*
  Exploration of additional register labelling to highlight documentation standards

Local intelligence network (LIN)

A legal duty of collaboration between specific organisations (responsible bodies) is outlined in the Health Act 2006, which is described in detail in the Controlled Drugs (supervision of management and use) regulations 2013. 'Local intelligence networks' are formed from these organisations and there is a legal duty for members to share information and intelligence relating to concerns in connection with the management and use of controlled drugs.

The trust is fully compliant with all requirements of LIN participation including:

- 100% attendance at network meetings
- 100% occurrence reports submitted
- All alerts related to 'Relevant Individuals' actioned as required
- All incidents meeting the criteria for direct reporting, reported to NHS England

Home office licence

The Trust holds a Home Office controlled drugs licence to allow it to supply controlled drugs to external legal entities (primarily the hospice of the Good Shepherd). The current licence renewal is pending a compliance inspection by the Home Office which is scheduled for the 16th May 2024.

2 risks have been identified in relation to the licence.

1. Lack of Home Office approved authorised witnesses
2. Pharmacy storage non -compliance with BS2881 Level 2 -will be resolved by Omnicell installation due May 2024 but subject to delays related to works by external provider

Authorised witnesses for CD destruction

The trust is required to have nominated authorised witnesses in place to witness destruction of specific schedules of controlled drugs. These persons may or may not be the same individuals as those approved for this role by the home office.

In light of the above risk around a lack of home office approved staff, for 24/25 the trust will have both CDAO nominated and home office approved witnesses, with senior nurses undertaking the home office approval process and divisional risk leads assuming the CDAO nominated roles.

RECOMMENDATIONS

6. The Board of Directors is asked to:

- Note the positive assurance provided within the report.

Meeting	**30th July 2024**		**Board of Directors**					
Report	**Agenda item 14.**		**COCH response to the independent infected blood inquiry**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Dr Nigel Scawn				Medical Director			
Author(s)	Joseph Banwell – Pathology Services manager Clare Barnard – Transfusion operational manager							
Board Assurance Framework	BAF14 - Failure to deliver Quality & Safety agenda							
Strategic Aims	SG 2 - Create a positive Patient and Family Experience							
CQC Domains	Well Led Safe							
Previous Considerations	Quality and Safety Committee – 4th July 2024							
Executive Summary	The Report provides assurance on the actions taken by the Trust in response to the learning from the Blood Inquiry Report (published May 2024). A clear action plan is in place to progress the remaining actions and this will be monitored through the Hospital Transfusion Committee (HTC). A report and summary presentation was received by the Quality and Safety Committee.							
Highlights	The Trust has confirmed arrangements in place for: • Capturing of patient concerns and ensuring duty of candour as required. • Mechanisms for implementing SHOT reports. • Traceability of all blood components. • Satisfaction survey of clinicians, patients and staff. • Use of online yellow card system. Further actions are required for: • Monitoring liver damage for those infected with Hepatitis C • Communication and audit of use of Tranexamic Acid within the Trust • Staffing review • Prioritisation of the implementation of BRIDGE once the EPR upgrade is complete							

	• Offering patients a test for Hepatitis C to support finding the undiagnosed.
Recommendation(s)	The Board of Directors is asked to note the assurance provided in the report, along with the proposed actions which will be monitored through Hospital Transfusion Committee (HTC).
Corporate Impact Assessment	
Statutory Requirements	Any new guidance released as a result of this Inquiry will also be considered.
Quality & Safety	As above
NHS Constitution	Demonstrates our commitment to patient safety
Patient Involvement	Not applicable
Risk	None identified
Financial impact	Not applicable
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published on website

1.0 Executive Summary

The report of the National Blood Inquiry was published in May 2024. The Countess of Chester Hospital NHS Foundation Trust is not referenced within the report.

The overall findings of the National Blood Inquiry highlight that individuals' patient safety was ultimately compromised as a result of being failed by their Doctors, the NHS and the government. These patients were refused compensation or an open public inquiry over decades.

The report sets out a range of recommendations including national Government led actions.

The Trust has reviewed the recommendations within the report to ensure learning, and this paper sets out the response to those recommendations relevant to the Trust.

The majority of the recommendations raised by this report are satisfied by the processes already in place at the Trust or require Government led intervention. The recommendations requiring further action include:

- Monitoring liver damage for those infected with Hepatitis C.
- Communication and audit of use of Tranexamic Acid within the Trust.
- Staffing review.
- Prioritisation of the implementation of BRIDGE once the EPR upgrade is complete.
- Offering patients a test for Hepatitis C to support finding the undiagnosed.

2.0 Findings

The report on the National Blood Inquiry identified a number of lessons to be learned. Whilst the Trust is not referenced in the report, there is an opportunity to learn from these findings.

A summary of the areas for action are provided below by exception, with A full assessment against the report recommendations is provided in Appendix A.

Ref.	Action required	Detail/ Action	Status
4	av) Individuals in leadership positions should be required by the terms of their appointment and by secondary legislation to record, consider and respond to any concern about the healthcare being provided, or the way it is being provided, where there reasonably appears to be a risk that a patient might suffer harm, or has done so. Any person in authority to whom such a report is made should be	This is already taking place in various forms throughout the trust but an internal review would be prudent. A review to be conducted – Review to look at the number of 'near miss incidents reported with the aim of seeing a reduction in actual incidents. A baseline review to be completed and then monitored – To be reviewed at HTC meetings.	

Ref.	Action required	Detail/ Action	Status
	personally accountable for a failure to consider it adequately. Success in implementation will be measured by the extent to which there is an increase in the number of reports made of near miss incidents to the designated data collector; and a decline in the number of widespread or significant healthcare failures.	**Responsible officer:** Fiona Altintas **Date:** Commence in August 2024	
6	**Monitoring liver damage for people who were infected with Hepatitis C** (a) All patients who have contracted hepatitis via a blood transfusion or blood products should receive the following care: (i) those who have been diagnosed with cirrhosis at any point should receive lifetime monitoring by way of six-monthly fibroscans and annual clinical review, either nurse-led, consultant-led or, where appropriate, by a GP with a specialist interest in hepatitis (ii) those who have fibrosis should receive the same care (iii) where there is any uncertainty about whether a patient has fibrosis they should receive the same care (iv) fibroscan technology should be used for liver imaging, rather than alternatives (v) those who have had Hepatitis C which is attributable to infected blood or blood products should be seen by a consultant hepatologist, rather than a more junior member of staff, wherever practicable (vi) those bodies responsible for commissioning hepatology services	All these points require clinical input and action. These will be discussed at Hospital Transfusion Committee (HTC) on 24.6.24. JB to ask the chair to ensure the required stakeholders are invited. 24.6.24 - Discussed at HTC and Gastro. team informed of expectations. Clinical teams agreed actions were achievable (Dr Tina Maheswaran). It is also recommended that a communication is sent to GPs by the hospital to make them aware of their expectations. **Responsible officer:** Dr Arvind Pillai/Dr Nigel Scawn **Date:** TBC	

Ref.	Action required	Detail/ Action	Status
	in each of the home nations should publish the steps they have taken to satisfy themselves that the services they are commissioning meet the particular needs of the group of people harmed by NHS treatment		
7	**Patient Safety: Blood transfusions** **(a) Tranexamic acid** (i) In England Hospital Transfusion Committees and transfusion practitioners take steps to ensure that consideration of tranexamic acid be on every hospital surgical checklist; that hospital medical directors be required to report to their boards and the chief executive of their Trust as to the extent of its use; and that the board report annually to NHS England as to the percentage of eligible operations which have involved its use. If the percentage is below 80% or has dropped since the previous year, this report should be accompanied with an explanation for the failure to use more tranexamic acid and thereby reduce the risk to patient safety that comes with using a transfusion of blood or red blood cells.	To discuss at next HTC (24/06/2024) Hospital Medical Director is likely to be asked to send communication to all surgical teams regarding Tranexamic Acid. Its use in the trust should then be implemented and audited. Information presented to Medical director at Quality and governance Board meeting (4.7.24) **Responsible officer:** Dr Nigel Scawn **Date:** TBC	
7	**Patient Safety: Blood transfusions** c) Transfusion laboratories should be staffed (and resourced) adequately to meet the requirements of their functions.	No current vacancies but staffing review required due to cost pressures of additional post (B2 20hrs p/w) required to sustain the service and the workload pressures. **Responsible officer:** J Banwell/C Barnard **Date:** July 2024	

Ref.	Action required	Detail/ Action	Status
7	**(f) Establishing the outcome of every transfusion** (i) That a framework be established for recording outcomes for recipients of blood components. That those records be used by NHS bodies to improve transfusion practice (including by providing such information to haemovigilance bodies). Success in achieving this will be measured by the extent to which the SHOT reports for the previous three years show a progressive reduction in incidents of incorrect blood component transfusions measured as a proportion of the number of transfusions given.	Prioritise the implementation of BRIDGE once EPR upgrade completed. **Responsible officer:** C Barnard/J Banwell/Helen Brislen **Date:** December 2024	
8	**Finding the undiagnosed** (a) When doctors become aware that a patient has had a blood transfusion prior to 1996, that patient should be offered a blood test for Hepatitis C.	Trustwide communication should be sent to all staff to offer patients a test for Hepatitis C if we become aware that they have had a transfusion pre 1996. Discussed at HTC (24.6.24). Information presented to Medical director at Quality and governance Board meeting (4.7.24) **Responsible officer:** Dr Arvind Pillai/Dr Nigel Scawn **Date:** TBC	

3.0 Conclusion

The report itself is an uncomfortable read and the vast majority of recommendations require Government intervention. There are however some areas where we will need to take action, but these are all within our ability to deliver and should all be acted upon in a timely manner to prevent any further harm.

4.0 Recommendation

The Board is asked to note the contents of this update and consider the recommendations and the proposed actions.

Appendix A – Full Report Recommendations and COCH Response

Ref	Recommendation	COCH response	Action required
1.	**Compensation**	N/A – Government led	N/A
2.	**Recognising and remembering what happened to people.** a) A permanent memorial be established in the UK and consideration be given to memorials in each of Northern Ireland, Wales and Scotland. The nature of the memorial(s), their design and location should be determined by a memorial committee consisting of people infected and affected and representatives of the governments. It should be funded by the UK government. (b) A memorial be established at public expense, dedicated specifically to the children infected at Treloar's school. The memorial should be such as is agreed with those who were pupils at Treloar's. (c) There should be at least three events, approximately six months apart, drawing together those infected and affected, the nature and timing of which should be determined by a working party as described above, facilitated by some central funding.	a) N/A – Government led b) N/A – Government led c) N/A – Government led	N/A N/A N/A
3.	**Learning from the Inquiry** (a) The General Medical Council, and NHS Education for Scotland, Health Education and Improvement Wales, Northern Ireland Medical and Dental Training Agency and NHS England, should take steps to ensure that those "lessons to be learned" which relate to clinical practice should be incorporated in every doctor's training. (b) They should look favourably upon putting together a package of training materials, with excerpts from oral and written testimony, to underpin what can happen in healthcare, and must be avoided in future. (c) The Inquiry website is maintained online.	a) N/A – Government led/NHS Education for England. b) N/A – Government led/NHS Education for England.	N/A N/A N/A

		c) N/A – Government led/NHS Education for England.	
4.	**Preventing future harm to patients: achieving a safety culture** **(a) Duty of candour** (i) A statutory duty of candour in healthcare should be introduced in Northern Ireland. (ii) The operation of the duties of candour in healthcare in Scotland and in Wales should be reviewed, as it is being in England, to assess how effective its operation has been in practice. Since the duty was introduced in 2023 in Wales, the review there need not be immediate, but should be no later than the end of 2026. (iii) The review of the duty of candour currently under way in England should be completed as soon as practicable. (iv) The statutory duties of candour in England, Scotland, Wales (and Northern Ireland, when introduced) should be extended to cover those individuals in leadership positions in the National Health Service, in particular in executive positions and board members. (v) Individuals in leadership positions should be required by the terms of their appointment and by secondary legislation to record, consider and respond to any concern about the healthcare being provided, or the way it is being provided, where there reasonably appears to be a risk that a patient might suffer harm, or has done so. Any person in authority to whom such a report is made should be personally accountable for a failure to consider it adequately. Success in implementation will be measured by the extent to which there is an increase in the number of reports made of near miss incidents to the designated data collector; and a decline in the number of widespread or significant healthcare failures. **(b) Cultural change**	ai) - N/A – Government led aii) - N/A – Government led aiii) - N/A – Government led aiv) - N/A – Government led av) The Completion of an internal review would be appropriate.	N/A N/A N/A N/A Complete an internal review. N/A

	(i) That a culture of defensiveness, lack of openness, failure to be forthcoming, and being dismissive of concerns about patient safety be addressed both by taking the steps set out in (a) above, and also by making leaders accountable for how the culture operates in their part of the system, and for the way in which it involves patients.	bi) – Patient concerns raised are captured via PALS/DATIX/CAPA and reviewed internally. Duty of candor would always be considered as part of this process.	
	(c) Regulation (i) That external regulation of safety in healthcare be simplified. As a first step towards this, there should be a UK wide review by the four health departments of the systems of external regulation, with the aim of addressing all the points made earlier in this Report and in other reports since 2000.	ci) - N/A – Government led	N/A
	(ii) That the national healthcare administrations in England, Northern Ireland, Scotland and Wales explore, and if appropriate, support the development and implementation of safety management systems ("SMS"s) through SMS coordination groups (as recommended by the HSSIB), and do so as a matter of priority. *Success in implementation will be measured by the percentage of patients who know to whom they can express any concerns they may have about safety, who will take up their cause, and what they can expect from them. At the same time, it will be measured by the extent to which those who are busy working within the system, especially those in leadership roles, have clarity as to what, precisely, is expected of them, from whom. It should also be measured by a reduction in avoidable harm from both errors and systemic issues.*	cii) - N/A – Government led	N/A
	(d) Patient records (i) Before the end of 2027 there should be a formal audit, publicly reported, of the extent of success of digitisation of patient records in each of the four health jurisdictions of the UK, measuring at least the levels of patient access to their personal records, their ability to identify and correct apparent errors in them, their interoperability, and the confidence of health professionals in the detail, accuracy and	di) - N/A – Government led	N/A

	timeliness of any record they enter, and that little material which should be recorded has been omitted. Next steps should be identified. (e) Consideration should be given by the national healthcare administrations in England, Scotland, Wales and Northern Ireland, to further coordination of their approaches particularly to ensure that patterns of harm, or trends, are identified and any response which for the sake of patient safety would be better coordinated than left to each individual administration can collaboratively be agreed and implemented.	ei) - N/A – Government led	N/A
5.	**Ending a defensive culture in the Civil Service and government** (a) The Government should reconsider whether, in the light of the facts revealed by this Inquiry, it is sufficient to continue to rely on the current non-statutory duties in the Civil Service and Ministerial Codes, coupled with those legal duties which occur on the occasions when civil servants and ministers interact with courts, inquests and inquiries, as securing candour. (b) If, on review, the Government considers that it is sufficient to rely on the current non-statutory duties in the Civil Service Code, it should nonetheless introduce a statutory duty of accountability on senior civil servants for the candour and completeness of advice given to Permanent Secretaries and Ministers, and the candour and completeness of their response to concerns raised by members of the public and staff. (c) The Government should consider the extent to which Ministers should be subject to a duty beyond their current duty to Parliament under the Ministerial Code.	ai) - N/A – Government led Bi) - N/A – Government led ci) - N/A – Government led	N/A N/A N/A
6.	**Monitoring liver damage for people who were infected with Hepatitis C** (a) All patients who have contracted hepatitis via a blood transfusion or blood products should receive the following care: (i) those who have been diagnosed with cirrhosis at any point should receive lifetime monitoring by way of six-monthly fibroscans and	Requires clinical input. Will be discussed at Hospital Transfusion Committee (HTC) ai) – Requires clinical input. Will be discussed	Communication to be sent to GPs by hospital. Will be discussed at HTC and relayed to

	annual clinical review, either nurse-led, consultant-led or, where appropriate, by a GP with a specialist interest in hepatitis (ii) those who have fibrosis should receive the same care (iii) where there is any uncertainty about whether a patient has fibrosis they should receive the same care (iv) fibroscan technology should be used for liver imaging, rather than alternatives (v) those who have had Hepatitis C which is attributable to infected blood or blood products should be seen by a consultant hepatologist, rather than a more junior member of staff, wherever practicable (vi) those bodies responsible for commissioning hepatology services in each of the home nations should publish the steps they have taken to satisfy themselves that the services they are commissioning meet the particular needs of the group of people harmed by NHS treatment	at Hospital Transfusion Committee (HTC) aii) - Requires clinical input. Will be discussed at HTC aiii) - Requires clinical input. Will be discussed at HTC aiv) - Requires clinical input. Will be discussed at HTC av) - Requires clinical input. Will be discussed at HTC avi) - Requires clinical input. Will be discussed at HTC	Gastroenterology Team (24/06/24).
7.	**Patient Safety: Blood transfusions** **(a) Tranexamic acid** (i) In England Hospital Transfusion Committees and transfusion practitioners take steps to ensure that consideration of tranexamic acid be on every hospital surgical checklist; that hospital medical directors be required to report to their boards and the chief executive of their Trust as to the extent of its use; and that the board report annually to NHS England as to the percentage of eligible operations which have involved its use. If the percentage is below 80% or has dropped since the previous year, this report should be accompanied with an explanation for the failure to use more tranexamic acid and thereby reduce the risk to patient safety that comes with using a transfusion of blood or red blood cells. (ii) In Scotland, Wales and Northern Ireland offering the use of tranexamic acid should be	To discuss at next HTC (24/06/2024) N/A	To discuss at next HTC (24/06/2024) – Discuss with members and meeting to be minuted. Hospital Medical Director to send communication to all surgical teams regarding Tranexamic Acid. To be implemented and audited in Trust. N/A

	considered a treatment of preference in respect of all eligible surgery.		
	(iii) Consideration be given to standardising and benchmarking transfusion performance between hospitals in order to deliver better patient blood management.	On-going and led by HTC	N/A
	b) Progress in implementation of the Transfusion 2024 recommendations be reviewed, and next steps be determined and promulgated; and that in Scotland the 5 year plan is reviewed in or before 2027 with a view to determining next steps. The responsibility for this in England is that of NHS England, shared with the National Blood Transfusion Committee, the Royal Colleges (as appropriate), and NHSBT	Government led	N/A
	c) Transfusion laboratories should be staffed (and resourced) adequately to meet the requirements of their functions.	No current vacancies in laboratory. Secondment in place for Transfusion Practitioner currently a cost pressure.	No current vacancies but staffing review required.
	d) That those bodies concerned with undergraduate and postgraduate training across the UK of those people who are, or intend to be, working in the NHS ensure that they are adequately trained in transfusion, that the standards by which sufficiency of training is measured are defined, and accountability for training in transfusion be defined.	Government led.	N/A
	e) That all NHS organisations across the UK have a mechanism in place for implementing recommendations of SHOT reports, which should be professionally mandated, and for monitoring such implementation	Already in place – this is done through HTC.	N/A
	(f) Establishing the outcome of every transfusion (i) That a framework be established for recording outcomes for recipients of blood components. That those records be used by NHS bodies to improve transfusion practice (including by providing such information to haemovigilance bodies). Success in achieving this will be measured by the extent to which the SHOT reports for the previous three years show	Currently there is 100% traceability of all blood components at CoCH. This is reliant on a B2 MLA (Cost pressure) but should be managed electronically -Requires additional functionality of	Prioritise the implementation of BRIDGE once EPR upgrade completed.

	a progressive reduction in incidents of incorrect blood component transfusions measured as a proportion of the number of transfusions given. (ii) To the extent that the funding for digital transformation does not already cover the setting up and operation of this framework, bespoke funding should be provided. (iii) That funding for the provision of enhanced electronic clinical systems in relation to blood transfusion be regarded as a priority across the UK.	EPR/BRIDGE – Not yet available. EPR functionality expected through BRIDGE once available. Acknowledged.	 N/A N/A
8.	**Finding the undiagnosed** (a) When doctors become aware that a patient has had a blood transfusion prior to 1996, that patient should be offered a blood test for Hepatitis C. (b) As a matter of routine, new patients registering at a practice should be asked if they have had such a transfusion.	Trustwide communication should be sent to all staff to offer patients a test for Hepatitis C. N/A	To be discussed at HTC (24/06/2024). N/A
9.	**Protecting the safety of haemophilia care** (a) That peer review of haemophilia care should continue to occur as presently practiced, with any necessary support being provided by NHS Trusts and Health Boards; and (b) That NHS Trusts and Health Boards should be required to deliberate on peer review findings and give favourable consideration to implementing the changes identified with a view to ensuring comprehensive, safe, care. (c) A peer review of each centre should take place not less than once every five years. d) The necessary administrative and clinical resources should be provided by hospital trusts and boards, integrated care boards, and service commissioners to facilitate multi-disciplinary regional networks to discuss policy and practice in haemophilia and other inherited bleeding disorders care, provided they involve patients in their discussions. (e) recombinant coagulation factor products should be offered in place of plasma-derived	N/A N/A N/A N/A	N/A N/A N/A N/A

	ones where clinically appropriate. Service commissioners should ensure that such treatment decisions are funded accordingly f) that the National Haemophilia Database, run by the UKHCDO, merits the support of additional central funding.	N/A	N/A
10.	**Giving patients a voice** (a) That the patient voice be enabled and empowered by the following measures: (i) clinical audit should as a matter of routine include measures of patient satisfaction or concern, and these should be reported to the board of the body concerned. Success in this will be measured by comparing the measure of satisfaction from one year to the next, such that the reports to the board concerned demonstrate a trend of improvement by comparing this year's outcomes with the similar outcomes from at least the two previous years.	Satisfaction survey of clinicians, patients and staff to be completed on 3 year rotational basis, as per UKAS 2024 assessment. To feed back into continuous improvement for department.	Continue with current process.
	(ii) that the following charities receive funding specifically for patient advocacy: the UK Haemophilia Society; the Hepatitis C Trust; Haemophilia Scotland; the Scottish Infected Blood Forum; Haemophilia Wales; Haemophilia Northern Ireland; and the UK Thalassaemia Society.	Government led.	N/A
	(iii) that favourable consideration be given to other charities and organisations supporting people infected and affected that were granted core participant status (as listed on the Inquiry website) to continue to provide support for at least the next 18 months. Further support should be reviewed at that stage with a view to it continuing as appropriate.	Government led.	N/A
	(iv) particular consideration be given, together with the UK Thalassaemia Society and the Sickle Cell Society, to how the needs of patients with thalassaemia or sickle cell disease can best holistically be addressed.	N/A	N/A
	(v) steps be taken to give greater prominence to the online Yellow Card system to those receiving drugs or biological products, or who are being transfused with blood components.	Blood component issues being reported to SHOT and SABRE. Drugs and biological product issues	Continue with current practices.

		reported online using Yellow Card system by Pharmacy Dept.	
11.	**Responding to calls for a public inquiry** (a) that a minister should retain the power to call an inquiry as the minister sees fit, in accordance with the Inquiries Act 2005 – but where a minister does not choose to do so, then: (b) if there is sufficient support from within Parliament for there to be an inquiry, the question whether there should be one should be referred to PACAC for it to consider the question. (c) If it appears to PACAC that there is sufficient concern to justify a public inquiry, either because what happened and why has caused concern (as the committee sees it) or there are likely to be lessons learned which may prevent similar concerns arising in future, the committee may recommend to an appropriate minister that there be an inquiry. (d) If the minister disagrees with the recommendation, they must set out in detail and publish reasons for this disagreement which are sufficient to satisfy PACAC that the matter has been carefully and properly considered.	Government led. Government led. Government led.	N/A N/A N/A
12.	**Giving effect to Recommendations of this Inquiry** (a) Within the next 12 months, the Government should consider and either commit to implementing the recommendations which I make, or give sufficient reason, in sufficient detail for others to understand, why it is not considered appropriate to implement any one or more of them. (b) During that period, and before the end of this year – the Government should report back to Parliament as to the progress made on considering and implementing the recommendations. (c) This timetable should not interfere with earlier consideration and response to the Recommendations of the Second Interim Report of the Inquiry	Government led. Government led. Government led.	N/A N/A N/A

	(d) The Public Administration and Constitutional Affairs Committee ("PACAC") should review both the progress towards responding to the Inquiry's recommendations and, to the extent that they are accepted, implementing those recommendations	Government led.	N/A
	(e) PACAC should accept the role in respect of any future statutory inquiry of reviewing government's timetable for consideration of recommendations, and of its progress towards implementation of that inquiry's recommendations	Government led.	N/A

Meeting	**30th July 2024**		**Board of Directors**					
Report	**Agenda item 15.***		**Council of Governors Report**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft				Director of Governance, Risk & Improvement			
Author(s)	Laura Leadsom				Deputy Director of Governance & Risk			
Board Assurance Framework	BAF20	Governance Improvement						
Strategic Aims	Purposeful Leadership							
CQC Domains	Well Led							
Previous Considerations	Not applicable.							
Summary and Key Points	This report is intended to provide a summary update of recent activity related to the Council of Governors. The general duties of the Council of Governors include: • To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and • To represent the interests of the members of the Trust as a whole and the interests of the public.							
Recommendation(s)	The Board of Directors is asked to note the recent activity related to the Council of Governors.							
Corporate Impact Assessment								
Statutory Requirements	This report supports compliance with the duties related to Governors.							
Quality & Safety	No issues identified.							
NHS Constitution	No issues identified.							
Patient Involvement	No issues identified.							
Risk	No issues identified.							
Financial impact	No issues identified.							
Equality & Diversity	No issues identified.							
Communication	Council of Governors and Governor Development sessions support communication with Governors, Non-Executive Directors, Executive Directors and the wider Trust.							

Countess of Chester Hospital NHS Foundation Trust

Council of Governors Report

1. PURPOSE

1.1 This report is intended to provide a summary update of recent activity related to the Council of Governors.

2. BACKGROUND

2.1 The Council of Governors meetings are held on a quarterly basis. In between, a less formal Governor Development Session is held, which features guest speakers from specific areas of the Trust.

3. CURRENT POSITION

3.1 The Council of Governors met on the 11th July 2024 and key items included the following:

- A patient story was presented
- An update from each of the Executive Directors was provided in relation to the key areas from the NHS Oversight Framework Report including; Operational Performance, Quality, Safety, Finance and Human Resources & People.
- An update was provided from the Chair and the Chief Executive Officer on key matters.
- Chair's reports were received from the People & Organisation Development Committee, Quality & Safety Committee, Audit Committee and the Finance & Performance Committee.
- The Patient and Family Experience Strategy was presented.
- An update of the Thirlwall Inquiry was provided.

3.2 Governors also provided updates and feedback in relation to their attendance at the Board of Directors, Sub-Committees and other Trust meetings / groups. Governors are invited to Public Board meetings and have an opportunity to ask questions at the end of the meeting on any matters on the agenda.

3.3 Following the Council of Governors meeting held in public, a private meeting was held to note the completed appraisals for the Chair and Non-Executive Directors and the Council of Governors formally approved a second term of office for the Trust Chair, Ian Haythornthwaite, which will commence in September 2024.

4. RECOMMENDATIONS

4.1 The Board of Directors is asked to note the report and the activity during this period.

Meeting	**30th July 2024**		**Board of Directors**					
Report	**Agenda Item 16.**		**Anchor Institution**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Jonathan Develing				Director of Strategic Partnerships			
Author(s)	Jonathan Develing				Director of Strategic Partnerships			
Board Assurance Framework	BAF 1-5	Anchor Institution included within all areas of BAF 1-5						
Strategic Aims	ALL. With specific references to SG4 Adding Value.							
CQC Domains	Well Led, Effective, Responsive							
Previous Considerations	Not applicable							
Executive Summary	The purpose of this paper is to provide an update on progress towards the development of an Anchor Institution.							
Highlights	In 2020 the Trust embarked on a commissioned project with the Purpose Coalition. The coalition has developed a framework of 14 purpose goals to allow organisations to measure their activities and identify the gaps where they could provide more support where it is needed. The 14 measures have been used to develop the following report, providing evidence of progress against the framework and cross referenced for our own purposes as evidence toward being accredited as an Anchor Institution.							
Recommendation(s)	The Board of Directors is requested to note progress to date.							
Corporate Impact Assessment								
Statutory Requirements	Yes							
Quality & Safety	Yes							
NHS Constitution	Yes							
Patient Involvement	Yes							
Risk	Yes							
Financial impact	No							
Equality & Diversity	Yes							
Communication	On publication the document will be in the public domain							

Anchor Institution

1. PURPOSE

The purpose of this paper is to provide an update on progress toward the development of an Anchor Institution.

2. BACKGROUND

In 2020 the Trust embarked on a commissioned project with the Purpose Coalition. Chaired by Rt Hon Justine Greening the coalition is made up of organisations who are working to break down barriers to opportunity. It includes some of Britain's biggest employers including businesses, universities, the NHS, and local authorities.

The coalition has developed a framework of 14 purpose goals to allow organisations to measure their activities and identify the gaps where they could provide more support where it is needed.

These goals have been used to develop the following report, providing evidence of progress against the framework and cross referenced for our own purposes as evidence toward being accredited as an Anchor Institution.

Typically, an anchor institution has three component parts:

- Collaborate closely with local partners on targeted interventions to reduce health inequalities, promote earlier intervention and prevention. This is evidenced by our work to deliver the NHS Prevention Pledge
- Purchasing more locally for social benefit. This is evidenced by our work to deliver improved Social Value in the local economy.
- Reducing our environmental impact. This is evidenced by our work to deliver our Green Plan.

3. CURRENT POSITION

Goal 1. Strong foundations in Early Years

In our catchment area almost one in 15 babies are born to mothers under the age of 20. These women are often at higher risk of experiencing mental health issues and living in poverty.

The trust aims to provide safe, effective maternity and neonatal services. As part of its clinical strategy, we are developing a care model that supports a community-focused approach to patient management, this being a key feature in the new women and children's strategy.

Specialist inpatient paediatric services support community and primary clinicians to provide paediatric care as close to home as possible for families, including via family community hubs, spoke units, or where necessary on-site.

From 2025 services will be provided within a new purpose-built Women and Children's building designed by our clinical teams specifically to meet the needs of our patients

Goal 2. Successful school years (Early Intervention)

There is a significant educational achievement gap between those children in the area, who are eligible for free school meals, those in care and those who receive special educational needs support, and their peers who do not.

It is also estimated that 23 per cent of 4-5 years olds are overweight or obese, increasing to 34 per cent in 10–11-year-olds, leaving these children at risk of adult obesity. The trust recognises that it has a significant role to play in helping to tackle this.

We advocate for a care model which allows children to receive inpatient treatment, or care as close to home as possible, to make the experience as easy as possible for the family.

Goal 3. Positive destinations post 16+

Partnerships
The Trust has a key partnership with the University of Chester and other education providers, and we have established new career development pathways for young people at the beginning of their journey as healthcare professionals.

We also have strong links with the University of Liverpool and a robust ethos of post graduate medical education.

Placements
The Trust continues to support, through the provision of placements, undergraduate students in all health-related programmes with significant numbers of nursing students from the University of Chester being supported.

Apprenticeships
The Trust has an apprenticeship strategy and provides more than 30 apprenticeship opportunities across the organisation to anyone over the age of 16. There is no upper age limit.

Goal 4. Right advice and experiences

Volunteering, work experience and apprenticeships
The trust is committed to developing new volunteering, work experience and apprenticeship opportunities. Around 150 volunteers currently work for the trust.

Goal 5. Open recruitment

People strategy
Our people strategy has a focus on sustaining safe levels of staff availability, improving staff capability, and creating a positive staff experience. The Trust aspires to be the best place to work as well as being the best place to receive treatment. For this to be achieved we need everyone working at the Trust to take an active role in the culture, inclusivity, civility, and success of the organisation.

As a catalyst for improvement, we have developed a new civility statement.

`We will always treat everyone with respect and kindness, be polite and professional, listen and help each other whenever we can`

With our teams input this statement has now been adopted as the Trust civility statement and will become central to our work and a way of embedding civility into all that we do.

Nurse recruitment
Post pandemic, we embarked on a successful programme of overseas nurse recruitment, and we have close links with local universities and training programmes to attract new employees.

Goal 6. Fair career progression

The trust sees itself as a “teaching and learning” organisation and is in the process of developing future leaders and talent.

Staff are invested in developing their skills and professional development through effective learning and development programmes and facilities.

The trust works to a continuous improvement model, which aims to empower staff to identify and lead improvements in their own area of work, providing the necessary support, skills, and training to help them do so.

Trust Leadership programmes
A new Leadership Framework has been developed to help, challenge, and support our leaders across four domains:

1. Leading with compassion and Inclusion
2. Working together and collaboration
3. Learning and improvement and
4. Delivery & performance.

The framework will support the development needs of our organisation and its people as well as supporting delivery of our wider transformation plans and the NHS People Promise.

As part of our new Talent and Succession Planning strategy we are developing leadership programmes at four levels:

- Level 1: Aspiring leaders
- Level 2: First line leaders
- Level 3: Senior and clinical leaders
- Level 4: Strategic Leaders

The leadership offers will be a combination of internal and external offers such as via Northwest Leadership Academy (NWLA) and the National Leadership Academy as well as our own bespoke programmes.

Lean for Leaders

The Lean for Leaders programme is designed to provide leaders with an introduction to lean methodology and an in depth look at the various concepts, tools, and techniques which they practice whilst implementing an organisational relevant improvement project.

Goal 7. Widening access to savings and credit

Staff can access financial and legal advice through a contracted Employee Assistance Programme.

All staff are entitled to the NHS Pension Scheme, and control measures are in place to meet all employer obligations contained within the scheme regulations.

Goal 8. Good health and well-being

One of the six strategic goals of the Trust is that of improving the health of local population. That is promoting prevention and early intervention, good health and wellbeing of the local population and communities it serves. This recognises the leadership role the Trust can play in tackling public health burdens in the wider community, including smoking, alcohol, and obesity, promoting, and supporting primary care with heart failure management and coronary vascular and respiratory outreach services.

Staff health and well-being
Our new wellbeing opened in Spring 2024 and provides a dedicated space for staff to rest and relax in a non-clinical environment open 24/7. The hub also provides a dedicated space for accessing wellbeing support from our staff wellbeing team.

The hub also provides a central space for:

- Running wellbeing activities and events aimed at supporting staff.
- Delivering wellbeing drop-in sessions in collaboration with our community partners.
- Delivering a programme of wellbeing focussed workshops designed to support staff and drive a positive wellbeing culture at the Trust.
- Space for our wellbeing community, including our nursing and midwifery advocates to provide restorative support.
- A central point to easily access evidence-based resources and information to support personal wellbeing.

Mental health signposting in A&E
The Trust works closely with Cheshire and Wirral Partnership Trust (CWP) a provider for mental health services. This partnership supports patients in the Accident and Emergency Department and a Framework for the Management of mental health patients has been developed.

Mental Health support
The Trust has also established engagement with the Cheshire West Voluntary Services Mental Health Alliance. Helping us to build our partnerships with local mental health support services in the community and establish better referral/signposting links for staff to access additional low level mental health support.

Making Every Contact Count
The Trust has signed up to the NHS Prevention Pledge including `Making Every Contact Count` (MECC) - an approach to behaviour change.

MECC focuses on the lifestyle issues that, when addressed, can make the greatest improvement to an individual's health:

- Stopping smoking
- Drinking alcohol only within the recommended limits
- Healthy eating
- Being physically active
- Keeping to a healthy weight
- Improving mental health and wellbeing.

High Intensity Use Programme (HIU)
The HIU programme offers a robust way of supporting people who make high intensity use of health services, in particular A&E, non-elective admissions, primary care, and mental health services.

Through the Cheshire West Integrated Care Partnership, the trust assists with the HIU Programme, along providing advice and support.

Goal 9. Extending enterprise

The trust actively seeks to establish commercial relationships with businesses in the local area, and to use its resources responsibly. A commercial strategy is being developed to support local procurement and supply chains.

Local procurement is also an important part of the Trust's Green plan.

Countess volunteers
Volunteers provide a reliable source of support for the staff and patients in the Trust. We currently have 115 active volunteers who deliver 500 hours each month. Where volunteers support is ever changing as we forge new relationships with departments and identify new roles.

Volunteers are supported throughout their time volunteering with us with events and celebrations planned throughout the year to thank them for their vital and kind support.

NHS Prevention Pledge
The NHS Prevention Pledge is a key workstream within the Cheshire and Merseyside Integrated Care Board's Population Health Programme. The Countess of Chester Hospital is one of ten phase 3 Trusts who started adoption and the Trust has received a plaque to celebrate 'intermediate adoption' of the NHS Prevention Pledge.

Goal 10. Closing the digital divide

Digital strategy

As healthcare becomes increasingly digital, we are focused on providing tools that make it easy for people to access information and services to improve their own health.

The trust aims to ensure that all members of the community have access to the health and care services that they need regardless of their personal access to technology.

Cheshire care record

The trust is signed up to the Cheshire Care Record, which is an overview of a patient's health and social care information in one digital record. The shared health and social care information includes test results, medications, allergies and social or mental health information. By sharing a summary of the information included in the records, patients enable the trust to provide better care.

Electronic patient records

The trust continues to develop our electronic patient records system provided by Cerner Millennium. The system means a patient's full record is available electronically for healthcare professionals in one place, at any time.

Goal 11. Infrastructure for Opportunity

In 2021 the trust installed secure bike parking facilities for staff, as well as 'dock less' parking bays for electric scooter rental which is available on site.

The trust actively promotes alternative modes of transport through a cycle to work scheme and encourages the use of Cheshire West and Chester Council's Park and Ride service. It has collaborated closely with the council in securing a stop and pick up and concessionary rates for the bus service to and from the Countess of Chester Hospital.

Community diagnostic centre

A community diagnostic centre has been developed at Ellesmere Port Hospital to enable patients to receive life-saving checks, scans, and tests closer to their homes.

Tarporley War Memorial Hospital

The trust is working in partnership with Tarporley War Memorial Hospital to renovate and develop the facility. The hospital will become an integrated rural hub for services provided to the local community by several NHS providers and other local service providers.

Chester Health Park Travel Plan

The Trust works collaboratively with CWP on all aspects of Travel as part of both Trust using the same Health Park.

As a collaborative, we have already introduced 'shared' use between the two Health Park Trusts of our staff cycle storage & changing facility, with uptake and use of the facility improving each day as part of our 'Active Travel' work stream. We have improved the 'NHS' staff offer for those staff who elect to take up 'Alternative Travel' by securing attractive discount rates for all Health Park staff with Stagecoach and Arriva Travel bus company's which includes provision for Park & Ride facility in Upton besides the Chester Zoo.

Green plan update (Ozone Waste intent)

Within the Trust's Green Plan (GP), as part of the Trust's Waste & Environmental Management, we outlined a substantial project committing to investigate all advancements in waste management technology to identify what is possible for a Trust of our size and how we can improve in this key area. The project has identified a solution, which if successful, would see our site become the first Trust in the UK, to manage its health care associated waste through the process of Ozoning.

This innovative proposal would be a first for the NHS and would further support our Trust in working toward the mandated Net Zero targets by 2028 to 2032. It would also mitigate financial and operational risks associated with a fluctuating waste provider market.

Goal 12. Building homes and sustainable communities

The trust collaborated with local partners, including the Land Trust to transform a derelict brownfield site into the 29-hectare Countess of Chester Country Park for the use of the public.

It continues to collaborate with these partners in sustaining the public space with appropriate maintenance, while also offering opportunities for community engagement through a range of health and wellbeing, educational and environmental initiatives.

Primary Care Collaborations
The Trust has an Integrated Care Division within which we have developed a strong working relationship with primary care, through supportive working with colleagues, enhancing community services and even staff deployed within Primary Care Networks (PCNs).

Goal 13. Harness the energy transition

The trust's Green Plan 2022-2025 sets out an in-depth strategy for how it plans to become a more sustainable business for future generations to take forward.

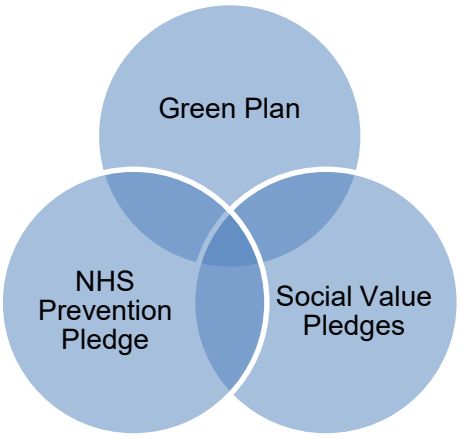
Goal 14. Achieve equality through diversity and inclusion.

The trust aims to create a diverse and inclusive place of work, with around 10 per cent of Trust employees currently belonging to Black, Asian, or ethnic minority backgrounds.

It is focused on reducing incidences of bullying, harassment, and discrimination and its 'Freedom to speak up' and 'Your Voice Matters' initiatives encourage staff to raise concerns safely and ensure action is taken quickly and effectively.

The trust undertakes a substantial number of inclusion and engagement activities with protected groups and has an awareness day calendar for equality, diversity and inclusion that includes Black History Month, LGBT History Month, Pride, Disability Awareness Day, Carers Week, and more.

Strategic delivery
To oversee the full range of workstreams within the Trust we have now established a strategic delivery oversight group for our Anchor Institution work. Bringing together the following interdependent workstreams provides cohesion and coordination of our combined efforts to become an Anchor Institution.



An oversight dashboard has been developed with clinical and operational leads identified for each workstream. In summary these workstreams and key lines of inquiry include.

Green Plan – Summary of indicators used.

1. Governance
    a. Board updates and reporting.
2. Workforce
    a. staff awareness and training
3. Clinical leadership
    a. considerations of carbon impact of care delivery through a clinical lens
4. Digital transformation
    a. Use of cloud solutions and repurposing of hardware
5. Digital strategy
    a. Commitment to meeting net zero ambitions as per National digital strategy.
6. Travel and Transport
    a. Move to Electric Vehicles (EV) within Trust fleet, travel incentive schemes, transport partnership and active travel.
7. Estates and facilities
    a. Move to 100% renewable Rego, certified electricity.
    b. Energy meterage
    c. LED lighting replacement
    d. Use of building management systems to monitor and manage energy use.
    e. Local energy management solutions.
    f. Off-site renewables.
    g. Proportion of decarbonization of heating across all sites.
    h. Waste segregation.
8. Medicines Management
    a. Audit of waste generated from piped nitrous oxide and decommissioning as required.
    b. Move toward the use of dry powder inhalers.
    c. Removal of harmful anesthetic gases (Desflurane)
    d. Reduction in medicine management waste.

    e. Net zero impact on supply chain management
9. Supply chain.
    a. Inclusion of a carbon reduction weighting in all procurement.
10. Food and nutrition
    a. Meal ordering systems
    b. Seasonal products
    c. Monitoring of waste produced.
    d. Proportion of fruit and vegetables, pulses, and other low carbon ingredients
11. Climate changes adaptions

NHS Prevention Pledge – Summary of indicators used.

1. Embedding prevention within our governance structures
2. Quality improvement for prevention
3. Using Marmot principles in service design
4. Lifestyle approaches to CVD and stroke prevention and rehabilitation
5. Establish key anchor practices.
6. Systematically adopting and embedding a ‘Making Every Contact Count approach
7. Work with primary care, local authorities and VCSO’s to systematically refer to sources of non-clinical support through social prescribing.
8. Support workforce development, providing training and/or resources to frontline staff to offer brief advice and/or referral in supporting patients to eat well, be physically active, reduce harm from tobacco and alcohol and promote mental well-being.
9. Ensure a smoke-free environment, linked to support to stop smoking for patients and staff who need it.
10. Foster an organisational culture that promotes workplace resilience and creates opportunities for staff to eat well, be active, reduce harm from tobacco and alcohol and promote mental well-being.
11. Review food and drink provision across all our NHS buildings.
12. Increase public access to fresh drinking water on NHS sites.
13. Support the sub-regional physical activity strategy.
14. Sign up to the ‘Prevention Concordat for Better Mental Health for All
15. Monitor the progress of the pledge against all commitments.

Social Value Pledges – Summary of indicators used.

1. Health and Wellbeing
2. Education and Skills
3. Employment and Volunteering
4. Environmental (Cross over with Green Plan)
5. Economic Social and Community
6. Crime and Justice
7. Housing
8. Leadership

5. CONCLUSION

Countess of Chester Hospital NHS Foundation Trust is an example of an organisation that recognises the wider role that it can play in the communities that it serves.

The Trust will use its systems leadership role to deliver those pledges within our direct control and to facilitate those pledges which require new ways of working in partnership with other NHS Providers, Place, Local authorities, and the voluntary and charitable sector.

The development of our Strategic Delivery Oversight Group provides a comprehensive and cohesive response to key interdependent workstreams and provides vital evidence of action and progress for the new single CQC assessment framework, which now includes substantiality as a line of enquiry.

6. RECOMMENDATIONS

The Board of Directors is asked to note progress to date.

Committee Chair's Report

Committee:	People & Organisation Development Committee
Date of meeting:	11th June 2024
Chair:	Ms Wendy Williams, Non-Executive Director

Key discussion points and matters to be escalated from the discussion at the meeting:

ALERT

- The Committee discussed the multiple surveys issued to staff and the increasingly poor response rates. Quarterly People Pulse and the annual National Staff Survey are mandated however delays in understanding the outcomes and then responding to them do not encourage ongoing staff participation in surveys. Whilst our focus must remain on these mandated surveys and increasing staff engagement with them, other opportunities to gather and respond more quickly to staff feedback are being explored e.g. via a Staff app, Executive sponsorship and developing the EDI networks to improve staff voice and gain insight and feedback, improving communication routes providing speedier response times to survey results.

ASSURE

- The Committee noted the High Risk Report and also a verbal update regarding the Board Assurance Framework (BAF). It was noted that the report details all current risks scored at 15 and above relating to people & organisation development, and that this reporting will be updated further going forward in line with the current review of the BAF, which is due to be presented back to the Board of Directors to be held in July 2024.
- The Committee noted the assurance provided from the Workforce Dashboard and Workforce KPI Benchmarking Dashboard C&M Trusts. It was agreed the report to be developed further going forward to include a further narrative focusing on the risks.
- The Committee received an update with regards to the Leadership Development Programmes and it was agreed for the Committee to receive a summary of effectiveness of programmes to date, together with details of any impact on the work places from those involved in the programmes.
- A verbal Conflicts of Interest (COI) compliance update was provided noting the Trust is currently at 71% and that outstanding compliance with Medical Staff is now mandatory as part of the appraisal process.

ADVISE

- The Committee noted the Interim Chief People Officers report and the key updates provided. It was noted that a Variable Pay Group has been established and it was agreed that Workforce Planning will be the Deep Dive item to be received at the August 2024 Committee meeting. It was also agreed for a communications update to be received at a future meeting regarding the most effective ways in which to communicate messages/updates across the organisation to reach all members of staff.
- The Committee received a staff story from Consultant in Intensive Care and Anaesthesia & Director of Clinical Research, Mr P Bamford, and following the story it was agreed that the psychological support offer throughout the Trust should be reviewed.
- The Committee received a benefits and outcomes presentation following the Intensive Care Unit Team Away Days from the Consultant in Intensive Care and Anaesthesia & Director of Clinical Research, Mr P Bamford. The benefits of sharing the learning with other departments across the Trust was noted.
- The Committee received a deep dive presentation relating to Equality, Diversity & Inclusion (ED&I). It was noted that more assurance was required by the Committee with key priorities to be established that linked through the seven networks. An update on progress was requested for the next Committee.
- The Committee received an Apprenticeship Levy update. It was agreed for the Committee to receive 2023/24 Levy report via e-mail and then for the Committee to receive quarterly updates moving forward.
- The Committee received an Appraisal Management Update. The Committee emphasised their role to monitor the trajectory against the target of 80% given the importance of Appraisal as a key management tool.
- The importance of defining a communication plan to highlight the Trusts' people initiatives and achievements over the last 12 months was highlighted as important to remind staff in advance of the staff survey commencing.
- The Committee noted the System Improvement Board (SIB) - Exit Criteria (April 2024) and the positive position against the agreed exit criteria. It was agreed to share the progress made across the Trust.
- The Committee received a Freedom to Speak Up (FTSU) update.
- The Committee received a Medical Staffing Annual Update.
- The Committee noted the following items:
    - Strategic Workforce Group Chair's Report & Minutes – 23rd April 2024
    - Joint Local Negotiating & Consultation Committee (JLNC) Minutes – 8th February 2024
    - Partnership Forum Minutes – 6th February 2024
    - Equality, Diversity & Inclusion Steering Group Chair's Report – 19th March 2024
    - People & Organisation Development Workplan 2024/25

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- There were no new risks discussed or identified by the Committee.

Committee Chair's Report

Committee:	Quality & Safety Committee
Date of meeting:	4th July 2024
Chair:	Professor Andrew Hassell, Non-Executive Director

Key discussion points and matters to be escalated from the discussion at the meeting:

ALERT
The Committee noted the contents of the Key Risks and Assurance report from the Quality Governance Group (QGG) held on the 6th June 2024. Limited assurance was noted in relation to the Policy update provided, and it was agreed for a more detailed update to be shared back with the group. The Committee received an update regarding the response to the independent infected blood inquiry, noting the action plan in place in response to the findings, and the Committee suggested a system approach should be included. It was noted that this would also be shared at the Board of Directors to be held in July 2024.
ASSURE
The Committee received an update regarding the Maternity Safety and Support Programme (MSSP) Exit Criteria Update. Significant assurance was received with confirmation that the Trust will be exiting the programme and that this would also be presented to the Board of Directors to be held in July 2024. The Committee noted the progress with regards to Fasting Compliance, with moderate assurance received and it was agreed for a further update to be received at the November 2024 Committee. The Committee received an update against the progress and actions for performance and triage improvements along with improvements for NEWS2, with moderate assurance received. It was noted that there is a clear action plan for moving forward with no further update required to the Committee. The Committee received an update relating to the Unendorsed Results with moderate assurance noted. The Committee noted the following from the Key Risks and Assurance report from the QGG held on the 6th June 2024:

- Performance Dashboard (areas of risk) – Moderate Assurance received. A new Consultant Tissue Viability Nurse is now in post and will support improvement work with an update report to go back to QGG.
- End of Life Care Annual Report – Limited Assurance received. It was noted that the Associate Director of Nursing, Urgent Care, is leading this work, and this will be tracked monthly through QGG.
- Resuscitation Training – Limited Assurance received. It was noted that the Associate Director of Nursing, Planned Care, is tracking progress with a high focus at Divisional level.
- NEWS2 Compliance Report – Limited Assurance received. It was noted that the QGG members are confident future reports will highlight moderate assurance.
- MyKit Check Compliance Report – Limited Assurance received. Assurance is noted to move to moderate following MyKit software upgrades to support compliance.
- VTE Compliance Audit Report – Significant Assurance received.
- Trust Improvement Priorities – Significant Assurance received.
- Complaints and Concerns Quarter 4 2023/24 Report – Moderate Assurance received. It was noted that further work is required to align this to the policy review timeframes.
- Infection Prevention and Control Quarter 4 2023/24 Report – Moderate Assurance received. It was noted that C-difficile and E. coli improvement programmes are in place with the aim to reduce rates and recover position.
- Nutrition and Hydration update – Limited Assurance received. A Food Specialist Dietician is being reviewed within the team to provide further support within this area.
- Integrated Complaints, Concerns, and Incidents Report – Moderate Assurance received. It was noted that the Deputy Director of Nursing & Quality Governance is progressing the improvement of governance structures.
- PSIRF – Moderate Assurance received. It was noted that QGG members are confident this will move to significant assurance at the next meeting showing sustainability.
- National Inpatient Survey – Moderate Assurance received. It was noted that further work is required to continue to move towards a significant assurance position.
- Friend and Family (FFT) – Moderate Assurance received. To move to significant assurance following further Emergency Department experience improvements.
- Mortality Improvement Report – Significant Assurance received.
- Safeguarding Quarter 4 2023/24 Report – Moderate Assurance received. It was noted that training improvements are in place and Divisions are driving compliance, noting however, the requirement for the pace of this piece of work is to be improved.
- Ligature Risk Assessment – Limited Assurance received. It was noted that QGG members are confident this will move to moderate assurance at the next QGG meeting.
- Consent Audit – Limited Assurance received. It was noted that an action plan is in place to address the identified gaps with a further update to be received at the next QGG.
- PLACE – Limited Assurance received. The Committee is to receive an update paper at the September 2024 Committee meeting.
- Transfusion training – Limited Assurance received. It was agreed for updates to continue to be provided to the QGG.
- Ward Accreditation – Moderate Assurance received. It was noted that QGG members are confident this will move to significant assurance following the next report.
- e-Discharge – Moderate Assurance received. The significant improvements to date were noted as progressing.
- Oxygen Prescribing – Significant Assurance received.

- Medication Safety Annual Report – Moderate Assurance received. It was noted that QGG members received reassurance that outstanding issues will be addressed for the next report.
- Controlled Drugs Annual Report – Significant Assurance received.
- Care Quality Committee (CQC) Action Plan – Significant Assurance received.

The Committee received an E-Discharge update noting the progress made with the backlog pre-2024, recognising there is more work to do towards compliance with the target, noting moderate assurance.

The Committee received a Surgical Site Infection Surveillance (SSIS) update noting significant assurance. The Committee noted moderate assurance against the C.difficile Improvement Report received.

The Committee noted moderate assurance against the Caner Harm Review Report, with the Committee to receive quarterly updates.

The Committee noted moderate assurance provided in the Clinical Audit Annual Report, apart from against four audits which require further audit.

The Committee noted moderate assurance against the Mortality Annual Report 2023/24 with the suggestion to include Structures Judgement Review (SJR) data to move to significant assurance.

ADVISE

The Committee noted the updates taking place to the Board Assurance Framework (BAF), to be received at the Board of Directors to be held in July 2024.

The Committee noted the contents of the High Risks Update Report and the risks with a residual risk score of 15 and above and the next steps to progress the report.

The Committee received a Deteriorating Patient Training Compliance Report, noting the assurance and recognising the commitment to ensure capacity exists for clinical colleagues through multiple modalities of education approaches.

The Committee received a patient story.

The Committee noted the contents of the System Oversight Framework / Dashboard.

The Committee noted the Maternity and Neonatal Safety Champions Update.

The Committee noted the following items:

- Quality & Safey Committee Workplan
- Quality Governance Group Minutes – 4th April 2024
- Cancer Services Group Chair's Report – 7th May 2024
  Governor/Non-Executive Director Walkabout Feedback – Emergency Department - 5th June 2024

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

No new risks were identified.

Committee Chair's Report

Committee:	Finance and Performance Committee
Date of meeting:	19th June 2024
Chair:	Non-Executive Director, Pam Williams

Key discussion points and matters to be escalated from the discussion at the meeting:

ALERT
• The Committee received a Health & Safety Assurance Report and agreed that further assurance is required. It was noted that actions are progressing within the Executive Team and an update will be provided to the September 2024 Committee meeting. • The Committee received a Month 2 Cost Improvement Programme (CIP) position, and concerns were raised regarding the recovery of the month 2 CIP position future impact of this.
ASSURE
• The Committee noted the April 2024 System Improvement Board (SIB) and Revised Exit Criteria CoCH / ICB Assurance Update. • The Committee received a report on performance relating to relevant elements of the Strategic Oversight Framework Report for the period of April 2024. • The Committee noted the progress being made with regards to the Electronic Patient Record (EPR) Programme with some further risk assessment detail from the next EPR Programme Board to be shared at the September 2024 Committee meeting. • The Committee received an update relating to the Cyber Security and the Data Security and Protection Toolkit action plan 2022/23 noting assurance against the intention to submit a "standards met" for DSPT submission by the end of June 2024, the mandated use of Multi Factor Authentication by NHS England and it was noted that further action is required to provide assurance for the two items for business continuity and supplier management. • The Committee noted the assurance provided within the Trust and Commercial Procurement Services Year End Reports for 2023/24.
ADVISE
• The Committee received a verbal update relating to the Board Assurance Framework (BAF) noting a further reset of the BAF is taking place with Executive Directors and will be shared at the July 2024 Board of Directors. • The Committee noted the High Risks Update Report, the risks with a residual risk score of 15 and the next steps to be progressed with the Director of Governance, Risk, and Improvement.

- The committee noted the Emergency Preparedness, Resilience and Response (EPRR) update and acknowledged the hard work in situ to progress this.
- The Committee noted the progress update against the Digital and Data Strategy noting that further detail will be shared at the August 2024 Board of Directors Development session.
- The Committee noted the Month 1 financial position – April 2024/23 report, and a verbal update on the Month 2 position.
- The Committee received a verbal update with regards to the increased control and escalation processes across all financial areas.
- The Committee noted the LIMS Risk & Gain Share document.
- The Committee noted the 2024 National Cost Collection (NCC) Pre-submission Board Assurance Report.
- The Committee noted the Waiver Report – Quarters 3 & 4 2023/24 and noting that Waiver Standing Financial Instructions (SFIs) will be monitored via the Audit Committee.
- The Committee noted the Month 2 2024/25 Thirlwall Inquiry financial position.

The Committee noted the following items:

- Commercial Procurement Income Group Chair's Reports – 30th April 2024 and 29th May 2024.
- Information Governance and Information Security Committee Chair's Report – 13th May 2024.
- Operations & Performance Executive Led Group (OPELG) Chairs Report – 18th April 2024 .
- Digital Transformation Group Chairs Report – 6th June 2024.
- EPR Programme Board Chair's Report – 30th May 2024.
- Finance & Performance Committee Workplan 2024/25.
- MIAA Insight – Cost Improvement Programmes – How do processes compare?

The Committee requested additional assurance for the following items, and it was agreed this would be requested following the meeting:

- Women's and Children's New Building Project Chair's Reports – 30th April 2024 and 6th June 2024
- Estates and Facilities Divisional Group Chair's Report – 4th June 2024
- Health & Safety Committee Chair's Report – 19th June 2024

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

No new risks were identified.

Meeting	**30th July 2024**		**Board of Directors**					
Report	**Agenda item 21.**		**Code of Governance Compliance Checklist – June 2024**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Karan Wheatcroft				Director of Governance, Risk & Improvement			
Author(s)	Laura Leadsom				Deputy Director of Governance & Risk			
Board Assurance Framework	BAF20	Failure to Progress implementation of Corporate Governance improvement plan						
Strategic Aims	Purposeful leadership							
CQC Domains	Well Led							
Previous Considerations	Audit Committee – 23rd July 2024							
Summary and Key Points	The assessment against the new Code of Governance, which came into effect from 1st April 2023, sets out compliance with the governance requirements placed on NHS Foundation Trusts, including: • Board leadership and purpose • Division of responsibilities • Composition, succession and evaluation • Audit, risk and internal control • Remuneration Of the 136 areas in total, the Trust has declared partial compliance in 7 areas and there are mitigations and actions in place. The code is assessed on the basis of comply or explain. Details relating to any actions required are included within this summary report.							
Recommendation(s)	The Board of Directors is asked to: • Note the Trust's current compliance against each of the Code of Governance provisions, noting the actions required to ensure full compliance as outlined above.							
Corporate Impact Assessment								
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status.							
Quality & Safety	To highlight areas of concern and actions taken to improve safety, where required.							
NHS Constitution	To aid improvement in line with performance standards.							
Patient Involvement	Not applicable.							
Risk	A risk to the Trust of non-compliance against any code provisions.							
Financial impact	Not applicable.							
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics.							
Communication	Not applicable.							

1. Executive Summary

The purpose of this paper is to provide assurance on areas of compliance with the Code of Governance checklist. The Board of Directors is asked to note the reported compliance for 2023/24, noting that the remaining actions will be taken forward in 2024/25 (as outlined further below).

2. Background

The assessment against the new Code of Governance, which came into effect from 1st April 2023, sets out compliance with the governance requirements placed on NHS Foundation Trusts, including:

- Board leadership and purpose
- Division of responsibilities
- Composition, succession and evaluation
- Audit, risk and internal control
- Remuneration

3. Compliance 2023/24

Of the 136 areas in total, the Trust has declared partial compliance in 7 areas and there are mitigations and actions in place. The code is assessed on the basis of comply or explain. A detailed report was provided to the Audit Committee held on 23rd July 2024, in line with the Committees responsibilities, and the actions required include the following:

Action	Responsibility	Timeframe
1. (A.2.1) Formal Board Session to be arranged for 2024/25 to assess the basis on which the Trust ensures its effectiveness, efficiency, economy, as well as quality of its healthcare delivery over long term, and contribution to the objectives of the ICP and ICB.	Director of Governance, Risk & Improvement and Director of Strategic Partnerships	By the end of 2024/25
2. (A.2.2) New Trust Strategy to be launched in September 2024.	Director of Strategic Partnerships	By the end of September 2024
3. (A.2.5) Work to be undertaken to explore the opportunity to include ethnicity and deprivation data for relevant metrics within future reports.	Director of Strategic Partnerships / Chief Operating Officer/ Interim Chief People Offices	By the end of December 2024
4. (A.2.9) FTSU Board self-assessment to be held.	Chief Operating Officer	August 2024 (planned for Board on 06/08/24).

Two of the areas of partial compliance relate to the recommendation that Chair of the Audit Committee, ideally, should not be the Vice chair or Senior Independent Director and it has been noted that the Senior Independent Director (SID) is currently the Chair of the Audit Committee. However, the Vice Chair does not sit on the Audit Committee and there are 2 other independent Non-Executive Directors on the Committee. No action is planned.

The final area of partial compliance relates to the recommendation for the Council of Governors to establish a policy for engagement with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners. It is noted that the duties of the Council of Governors include to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors (as detailed within the Constitution), this includes liaising with NHS England to escalate any matters relating to performance, if required.

4. Recommendation

The Board of Directors is asked to note the Trust's current compliance against each of the Code of Governance provisions, noting the actions required to ensure full compliance as outlined above.

Meeting	**30th July 2024**		**Board of Directors**					
Report	**Agenda item 22.**		**Provider Licence Compliance 2023/24**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Karan Wheatcroft				Director of Governance Risk & Improvement			
Author(s)	Laura Leadsom				Deputy Director of Governance & Risk			
Board Assurance Framework	All - The paper provides assurance that the Trust has controls in place, including executive accountabilities, to ensure ongoing compliance with the provider licence.							
Strategic Aims	Purposeful leadership.							
CQC Domains	Effective; Responsive; Well Led							
Previous Considerations	Audit Committee – 23rd July 2024							
Executive Summary	The paper provides assurance on compliance with the Provider Licence for 2023/24. Assurance is provided in the context that during 2023/24 the Trust has continued to manage the recovery of waiting lists, alongside the challenges of continued industrial action, staffing constraints and operational pressures. These areas continue to have strong oversight through the Executive Team, respective assurance committees and the Board of Directors. To note, the full Provider Licence Compliance Assessment 2023/24 was presented to the Audit Committee held on 23rd July 2024.							
Highlights	Further actions to be progressed in 2024/25 include: • Health inequalities and population health approach • Well led action plan delivery, governance and risk management • Strategic objective delivery aligned to BAF • Continued focus on CIP approach • Introduction of quarterly provider licence checklist review • Annual assessment against the NHS Constitution pledges							
Recommendation(s)	The Board of Directors is asked to note the review of compliance with the provider licence for 2023/24.							
Corporate Impact Assessment								
Statutory Requirements	Regulatory compliance.							
Quality & Safety	Includes compliance with operational standards.							
NHS Constitution	Contributes to compliance with NHS constitution principles and pledges.							
Patient Involvement	Indirectly through patient feedback.							
Risk	Regulatory compliance.							
Financial impact	Not applicable							
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics							
Communication	Document to be published on website							

Provider Licence Compliance 2023/24

1. Executive Summary

The purpose of this paper is to provide assurance on compliance with the Provider Licence for 2023/24. The Board of Directors is asked to note the reported compliance with the new Provider Licence for 2023/24. The remaining actions will be taken forward in 2024/25 (as outlined further below).

2. Background

The Provider Licence sets out the obligations for providers of NHS services that will allow NHS England (NHSE) to fulfill its regulatory duties.

The licence has served as the main tool by which NHS England (NHSE) regulates providers of NHS services. The SOF is used to identify potential risk of a provider failing to comply with its licence.

A new licence was implemented from 2023/24 to take account of the establishment of Integrated Care Systems and the new obligations for Foundation Trusts (FT) linked to system reform, collaboration and partnership working. These reforms change the emphasis of FT regulation.

The 'Single Oversight Framework' (SOF) replaced the Risk Assessment Framework. The Trust is currently in SOF level 3 with a System Improvement Board (SIB) in operation. NHS England are currently consulting on a new National Oversight Framework. The Trust is working closely with Cheshire and Merseyside ICB to agree a set of exit criteria which supports the Trust moving from a National Oversight Framework (NOF) 3 to a NOF 2 Trust.

3. Compliance 2023/24

This paper provides a detailed review of each condition within the licence and identifies, where relevant, the current controls that are in place to ensure compliance. Each licence condition is assigned to an accountable Executive Director (refer Appendix 1).

The baseline assessment has identified a number of actions to be progressed.

Action	Responsibility	Timeframe
1. A bespoke exercise is needed to further understand health inequalities of patients on the waiting list and to correlate this with the wider population health data.	Director of Strategic Partnerships	By the end of Quarter 3 2024/25
2. Deliver the residual actions identified in the Well Led action plan to further enhance corporate governance aligned to best practice.	Director of Strategic Partnerships / Director of Governance, Risk & Improvement	By the end of Quarter 3 2024/25
3. Trust Strategy goals - Each goal is supported by Director led objectives for 2024/25 – Progress against objectives is aligned with the BAF and reported to the Board on a quarterly basis.	All Executive Directors	Quarterly reviews

Action	Responsibility	Timeframe
4. Introduction of a quarterly checklist to provide in year assurance on compliance with key aspects of the licence to the Audit Committee.	Director of Governance, Risk & Improvement	Quarterly reviews to be included within workplans for Audit Committee
5. Consider an annual review against the NHS constitution.	Director of Governance, Risk and Improvement	To be included in workplan for Board of Directors, Quarter 4
6. To further enhance the Trust's risk management framework.	Director of Nursing & Quality / Director of Governance, Risk & Improvement	By end of Quarter 3, 2024/25
7. Registration of Tarporley Hospital with the CQC for approval.	Director of Nursing & Quality	Awaiting confirmation from the CQC
8. Continue to enhance the operation of the Board and Committees, including review of sub committee/ group structures in 2024/25.	Director of Governance, Risk & Improvement	By the end of Quarter 3 2024/25
9. Continued focus on enhanced financial control environment within the Trust including a revised approach to CIP for 2024/25.	Chief Finance Officer	By the end of Quarter 4 2024/25
10. Continued focus on improving the Trust's SOF rating and exiting SIB in 2024/25.	Chief Finance Officer/ Chief Operating Officer/ Director of Nursing, Quality and Safety	By end of Quarter 2 2024/25

During 2023/24 the Trust has continued to manage the recovery of waiting lists, alongside the challenges of continued industrial action, staffing constraints and operational pressures. These areas continue to have strong oversight through the Executive Team, respective assurance committees and the Board of Directors.

The assessment confirms ongoing compliance with the Provider Licence in 2023/24.

For 2024/25 the proposal is to introduce a quarterly checklist to be completed by the relevant accountable Executive Directors and reported to the Audit Committee to provide assurance that the Trust is compliant with key licence conditions and / or to highlight emerging risks to regulatory compliance. Regulatory risks will also be highlighted to the Board for consideration via the Board Assurance Framework (BAF) and regular cycle of Board assurance documents.

4. Recommendation

The Board of Directors is asked to note the review of compliance with the provider licence for 2023/24.