Countess of Chester Hospital NHS Foundation Trust

Public meeting of the Board of Directors Agenda
(published items)
Tuesday 30th September 2025, 08.30 – 12.30
Boardroom, 1829 Building

Chair	Mr N Large, Trust Chair
Apologies	Mr M Guymer, Non-Executive Director, Ms C Chadwick, Chief Operating Officer
In attendance	Mr S Brown, Deputy Chief Operating Officer

Time	Agenda No.	Agenda item	Lead	Page No.	Decision Required
8.30	1.	Welcome, apologies and Chair's opening remarks (verbal)	Trust Chair		For noting
8.33	2.	Declarations of Conflicts of Interest with agenda items (verbal)	Trust Chair		For noting
8.35	3.	Patient Story (to be presented on the day)			
8.45	4.	a) Organ Donation Service Showcase (to be presented on the day) b) Organ donation Annual Report (attached)	Consultant in Intensive Care & Clinical Lead for Organ Donation	5-21	For noting
9.05	5.	Minutes of the previous meeting held on 29th July 2025 (attached)	Trust Chair	22-43	For approval
9.09	6.	To consider any matters arising and action log (attached)	Trust Chair	44-45	For noting
9.12	7.	Chief Executive Officer's Report (attached)	Chief Executive Officer	46-63	For noting
9.22	8.	Chair's Update (verbal)	Trust Chair		For noting
9.32	9.	a) Board Assurance Framework 2025/26 (attached) b) High Risks Report (attached)	Director of Governance, Risk & Improvement Director of Governance, Risk & Improvement	64-75 76-88	For noting
Quality of Care					
9.37	10.	Safeguarding Annual Report (attached)	Director of Nursing & Quality / Deputy Chief Executive	89-131	For assurance

9.47	11.	Perinatal Services Quarterly Update Quarter 1 (attached)		132-143	For assurance
9.55	12.	Care Quality Commission (CQC) Improvement Plan including Well Led (attached)	Director of Nursing & Quality / Deputy Chief Executive	144-173	For assurance
10.00	13.	Freedom to Speak Up (FTSU) Guardian Report (attached)	Deputy Chief Operating Officer / FTSU Guardian	174-181	For assurance and noting
10.10	14.	Quality & Safety Committee Chair's Report – 8th September 2025 (attached) –	Chair Quality & Safety Committee	182	For assurance
10.15	15.	National Inpatient Survey Results (attached)	Director of Nursing & Quality / Deputy Chief Executive	182-216	For noting
Comfort Break (10.25 – 10.35)					
Operational Performance					
10.35	16.	Integrated Performance Report (IPR) – August 2025 (attached) Operational Performance Quality Safety People Finance	 Deputy Chief Operating Officer Director of Nursing & Quality Medical Director Chief People Officer Chief Finance Officer	217-263	For assurance
10.55	17.	Operational Management Board Chair's Report – 24th July 2025 (attached)	Chief Executive Officer	264-265	For assurance
11.00	18.	National Oversight Framework (to follow)	Chief Digital and Data Officer		For information
11.10	19.	Winter Planning and Board Assurance Statement (attached)	Deputy Chief Operating Officer	266-290	For approval
Finance, Use of Resource and Performance					

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11.20	20.	Finance & Performance Committee Chair's a) 27th August 2025 (attached) b) 23rd September 2025 (attached)	Chair Finance & Performance Committee	291 292	For assurance
Strategic Change					
11.25	21.	Research Update a) Draft research strategy (to follow)	Director of Clinical Research		For information
11.40	22.	Green Plan (attached)	Director of Strategic Partnerships	293-334	For ratification
11.47	23.	Communities and Partnerships	Director of Strategic Partnerships	335-345	For assurance
Leadership, Improvement Capability, Organisation Development and People					
11.55	24.	People Committee Chair's Report – 12th August 2025 (attached)	Chair People Committee	346-347	For assurance
12.00	25.	Annual submission to NHS England North West: Medical Appraisal, Revalidation and Medical Governance (attached)	Medical Director	348-371	For approval
Governance					
12.05	26.	Application of Trust Seal (attached)	Director of Governance, Risk, and Improvement	372-373	For ratification
12.08	27.	Fit & Proper Persons Policy (attached)	Director of Governance, Risk, and Improvement	374-397	For approval
12.15	28.	Operational Management Board Terms Reference (attached)	Director of Governance, Risk, and Improvement	398-403	For approval
12.18	29.	Proposal to amend the Trust's Constitution (attached)	Director of Governance, Risk, and Improvement	404-516	For approval
Items for noting					
12.23	30.*	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 3rd July 2025 (attached)	Trust Chair		For noting

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		b) Approved minutes of the People Committee – 10th June 2025 (attached) c) Approved minutes of the Finance & Performance Committee – 25th June 2025 (attached) d) Approved minutes of the Operational Management Board – 22nd May 2025 (attached) e) Research and Innovation Committee Chair's report – 5th September 2025 and Approved minutes - 16th July 2025 (attached) **Other items:** f) Board of Directors Workplan 2025/26 (attached)			
Other items					
12.25	31.	Any Other Business (verbal)	Trust Chair		For noting
12.28	32.	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 Thursday 25th September 2025*** **Future Dates:** 25th November 2025 27th January 2026 31st March 2026	Trust Chair		For noting
12.30	33.	Closing remarks (verbal)	Trust Chair		For noting

Next Meeting: Tuesday 25th November 2025

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

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Board of Directors meeting
Date of meeting: 30/9/2025

Report	**Agenda Item 4b.**	**Annual organ donation plan 2025-2026**						
Purpose of the Report	Decision		Ratification		Assurance	X	Information	
Accountable Executive	Dr. Nigel Scawn			Medical director				
Author(s)	Name Dr. Darius Zeinali			Clinical lead for organ donation				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			x x	Provides assurance against aspects of quality and safety.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							x x
CQC Domains	Safe Effective Caring Responsive Well led							x x x
Previous considerations	Annual report 2024-2025							
Executive summary	The purpose of this report is to give assurance about the conduct of organ donation by displaying the data form the previous tax year, updating on progress with targets from last year. Finally there is a summary of the objectives for the coming year 2025-2026. This report confirms compliance with national standards and comments on the reduction in organ donation overall, with our local targets to help achieve this.							
Recommendations	The Board/Committee is asked to continue their support for organ and tissue donation in the trust.							

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	N/A
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 / confidential etc.

Countess of Chester NHS Foundation Trust

Annual Organ Donation Plan ***2025-2026***

Contents

1. Executive Summary

As a Trust we strive to offer the opportunity to donate to ALL those who may be able to. We benchmark well alongside similar trusts and larger trusts for early referral to the Specialist Nurse for Organ Donation team, identification and testing of patients who meet criteria for neurological death and donation consent rates. We aim to create an efficient and supportive process for the patient and their family when donation is part of end-of-life wishes and have had good feedback from teams involved and patient's families to support this.

In the last published data, from 2024/25, 381 people benefited from a solid organ transplant in the North West. However sadly, 79 people died on the transplant waiting list during this time.

Between 1 April 2024 and 31 March 2025, Countess of Chester Hospital NHS Foundation Trust facilitated 2 deceased solid organ donors, resulting in 6 lifesaving or life-changing transplantations. Additionally, this year 10 corneas were received by NHSBT Eye Banks from our Trust following tissue donation.

The focus of the Countess of Chester Organ Donation Committee is to implement the relevant recommendations from the Department of Health Organ Donation Taskforce. Alongside NICE guidance on Organ Donation for Transplantation and GMC recommendations for end-of-life care we aim to apply this to facilitate best practice within our Trust.

Organ donation activity is audited nationally and locally through the NHS Blood and Transplant (NHSBT) Potential Donor Audit (PDA) in all critical care units and emergency departments, by the regional Specialist Nurses-Organ Donation (SN-OD). A comprehensive breakdown of the Trust's performance during 2024/25 is included in this report.

The logistical process of Organ Donation is often challenging, but the outcome is truly amazing and this, for all involved, can often provide a glimmer of positivity during a desolate time.

Summary of Organ Donation Activity at the Countess of Chester NHS Foundation Trust for April 2024- March 2025:

- 2 proceeding organ donors from the Trust, resulting in 6 organ transplants.
- There was also a further 1 consented but non-proceeding potential organ donor, for clinical reasons (a prolonged time to cardiac arrest).
- 55% approach rate to families of all potential donors with 71% SNOD presence.
- 94% referral rate to organ donation team for potential donors.
- There were 2 occasions when potential donors were not referred.
- 10 corneas from tissue donors at the Trust.
- Active recruitment of DBD consented donors for the SIGNET trial.

1. Hospital Organ Donation Team Structure

TRUST

TRUST BOARD

HOSPITAL MANAGEMENT TEAM

ITU Consultants
Dr Darius Zeinali (CL-OD)
Dr Kate Tizard
Dr Santokh Singh
Dr Pete Bamford
Dr Eoin Young
Dr Nicole Robin
Dr Lyndsay Cheater
Dr Mary Cardwell
Dr Rebecca Gale
Dr Simon Ridler
Dr David Whitmore
Dr Richard Hay

REGIONAL CLINICAL LEADS

Dr ALISON INGHAM
Dr CHRIS BOOTH

NHS BLOOD AND TRANSPLANT

DIRECTOR

Anthony Clarkson

North West REGIONAL HEAD OF NURSING-ORGAN DONATION

Sue Duncalf

North West LEAD NURSE-ORGAN DONATIO

Lisa Francis

ORGAN DONATION COMMITTEE CHAIR

CAROLINE STEIN

CLINICAL LEAD - ORGAN DONATION (CLOD)

Dr DARIUS ZEINALI

SPECIALIST NURSE-ORGAN DONATION (SNOD)

REBECCA GALLAGHER

COUNTESS OF CHESTER NHS FOUNDATION TRUST

DONATION COMMITTEE

CRITICAL CARE

Dr Darius Zeinali, Consultant Anaesthetist & ICM

Ashley Timms, ICU Matron/RGN

Emily Carrick, RGN

Deborah Pye, RGN

Terri Jackson, RGN

EMERGENCY DEPARTMENT

Jackie Milliken, Trauma co-ordinator

THEATRES

Susie Davies, RGN
Nicola Beswick, RGN
Tracy Pugh, RGN
Claire Ling, HCSW

EXECUTIVE LEAD

Dr Nigel Scawn (Medical Director)

TISSUE DONATION REPRESENTATIVE

Not fulfilled by NHS Blood and Transplant

PALLIATIVE CARE

Dr Jenny Smith, Consultant Palliative Care

Bethany Oakes RGN Palliative Care Nurse Educator.

PASTORAL CARE

Hollie Tor, Chaplain

MORTUARY REPRESENTATIVE

Jamie Cunningham, Mortuary manager

2. Report from the Organ Donation Committee Chair

Every acute Trust in the UK should have a Clinical Lead for Organ Donation (CL-OD), a Specialist Nurse for Organ Donation (SN-OD) and an Organ Donation Committee (ODC). The ODC is responsible for ensuring that donation is integrated into the core business of the hospital and reports to the Trust Board on a regular basis. At the Countess of Chester, this is done through the Quality, Safety and Patient Experience Committee. Committee membership reflects local needs.

The Clinical Lead for Organ Donation and the Specialist Nurse for Organ Donation are key members. Other members include representatives from Critical Care, Emergency Medicine, Theatres, Palliative/End of Life Care, Chaplaincy, Pathology, the Trust HTA Designated Inspector and the Mortuary. The ODC plans to meet every 3 months and its keys roles are:

- To influence policy and practice in order to ensure that organ and tissue donation is considered in all appropriate situations.

- To identify and resolve any obstacles to this.

- To ensure that a discussion about donation features in all end of life care, wherever located and wherever appropriate, recognising and respecting the wishes of individuals. Whenever possible, following recognised best practice by enabling a collaborative approach to support donors and/or their families.

- To maximise the overall number and quality of organs and tissue donated.

The terms of reference for the ODC also describe the objectives of the committee as:

- To lead on donation policy and practice across the hospital/Trust, to raise awareness, and to ensure that donation is accepted and viewed as usual, not unusual.

- To ensure local policies and all operational aspects of donation are reviewed, developed and implemented in line with current and future national guidelines and policies.

- To monitor organ donation activity from Critical Care areas, including Emergency Medicine. Rates of donor identification, referral, approach to the family and consent to donation will be collected through the UK Potential Donor Audit (PDA).

- To report to the Medical Director not less than quarterly, and to the Board not less than six monthly, on comparative donation activity and any remedial action required.

- To support the Specialist Nurse for Organ Donation and the Clinical Lead for Organ Donation.

- To identify and ensure delivery of educational programmes to meet recognised training needs.

Chair update

This year marks the 30th anniversary of the Organ Donation Register, founded by Christine Cox. Her pioneering initiative has enabled thousands of patients to receive life-saving and life-enhancing transplants. As the Organ Donation Committee working in collaboration with the ICU and ED departments, our shared goal remains to ensure no opportunity for donation is missed.

The past 12 months have presented notable challenges both within our Trust and across the wider North West and national networks. We have seen a significant reduction in the number of successful donors, reflective of a broader trend. However, early signs in 2025 show a positive increase in activity, providing much-needed encouragement as the number of patients on transplant waiting lists continues to rise.

The Organ Donation Committee convenes quarterly to review donation data, discuss lessons learned, and share teaching points relevant to our Trust. Over the reporting period, two donors have resulted in six life-saving transplant procedures. We extend our deepest gratitude to all involved for their empathy, professionalism, and compassionate guidance offered to bereaved families during these incredibly difficult moments.

It remains profoundly inspiring to hear clinical teams reflect on the complex yet rewarding journey that leads to successful organ and tissue donations. A special note of thanks must go to our Organ Donation Link Theatre Staff, whose recent commitment has been extraordinary. Their willingness to come in on their days off to support retrieval operations is a testament to their dedication and spirit of teamwork.

We bid a heartfelt farewell to our long-serving Clinical Lead for Organ Donation (CL-OD), Kate Tizard. Kate has been a wonderful leader, and her dedication, encouragement, and passion for organ donation have left a lasting impact on the team. While she steps back from the role, she will continue to support from the ICU and provide guidance to our new CL-OD, Darius Zeinali. We warmly welcome Darius to his new role and look forward to working together to further our mission.

This year, I had the privilege of joining Darius and our Specialist Nurse in Organ Donation (SN-OD), Rebecca, at the St. John's Ceremony. This moving event honours the incredible generosity of donor families, who were sensitively acknowledged by the Lord Lieutenant and the Mayor of Chester in the Town Hall. It serves as a poignant reminder of the profound impact of donation.

In addition to organ donation, we continue to advocate for increased awareness and uptake of tissue donation. While this is typically addressed in ICU settings, we are expanding education and training to ward staff to ensure that opportunities for tissue donation are not overlooked—particularly for patients registered as donors where tissue donation may be the only viable route to honouring their wishes. A recent visit to the tissue bank at Speke reinforced just how many lives are improved through tissue donation.

On behalf of the Organ Donation Committee, I extend sincere thanks to every individual involved in supporting organ and tissue donation at the Countess of Chester Hospital. Your ongoing

commitment ensures that we continue to deliver this vital work with integrity, compassion, and excellence.

Caroline Stein

Chair Organ Donation Committee CoCH

3. Strategic update from the Clinical Lead for Organ Donation (CL-OD)

As the incoming Clinical Lead for Organ Donation, I am excited and privileged to be responsible for maintaining our good standards in promoting and facilitating organ donation for patients in our hospital.

As clinicians it is our duty of care to honour every patient's end of life wishes. As less than 1% of patients die in circumstances where organ donation is possible, in an intensive care setting, it is essential that we strive to get it right 100% of the time. This includes timely referral to organ donation specialist nurses, collaborative approaches to families, maximising potential for donation and transplantation as well as continuing to be part of innovation and research in the field. The culture in our Trust is very supportive of this ethos, having been cultivated by my predecessor Dr. Tizard, and our benchmarking data reflects the dedication of the teams involved.

The past year has seen a reduction in the number of proceeding donations as well as the number of eligible patients referred, which reflects national trends. Nonetheless, we have had two proceeding donors resulting in six transplants that have saved and transformed the lives of their recipients. Additionally, this year ten corneas were received by NHSBT Eye Banks from our Trust.

As previously discussed with Ms. Tomkinson and Dr. Scawn, our metrics from the previous year, while still acceptable when compared with national metrics, suggest a decline in performance. For example, the approach rate for patients eligible for donation after brainstem death (DBD) is recorded as 50%, a decrease from last year's 57%, and currently categorised as bronze level performance. Of the eight patients who may have been considered for DBD, two had absolute contraindications to organ donation. Of the remaining six, only three (50%) were approached regarding donation. The other three were not approached due to relative contraindications such as active infection, medical unsuitability, or the absence of viable transplantable organs. These non-absolute contraindications are not always captured in headline figures, which can result in referral rates appearing lower than expected.

It is also important to note that nationally, the number of proceeding organ donations has declined, for reasons that remain unclear. This is reflected in our own hospital's data. As the denominator shrinks, small numbers of exclusions have a greater proportional impact on performance metrics.

Our performance as a trust has been praised in a letter from our regional Clinical Lead for Organ Donation, Dr. Ingham, who has remarked on the good performance of our trust in promoting organ donation. This is something all those involved in Organ and Tissue Donation at the Trust can be proud of.

The "*Organ donation and transplantation 2030- meeting the need*" document sets out national strategic aims for deceased donation in order to help revolutionise the support for organ donation and maximise donation potential, with the vision that "*Deceased donation will become an expected part of care, where clinically appropriate, for all in society*".

This year our Trust strategic response to this has included:

"Public information campaigns, raising awareness, encouraging people to make an organ donation and tissue donation decision and share it with their families":

- Race4Recipients- In 2024, the Countess of Chester Hospital NHS FT once again recruited a large number of participants who travelled thousands of kilometres in honour of our organ donors, transplant recipients and everybody waiting for a life-saving transplant. The message had further reach with participants sharing links about organ donation with their family, friends and followers on social media across the UK.

- Organ Donation week- The trust flew the flag (literally) for organ donation, whilst running local awareness campaigns both about individual's choice regarding organ donation decisions, as well as promoting trust policies and role in facilitating donation within our hospital. Promotion hampers were hand delivered to all ward areas to promote organ and tissue donation as well as provide education to staff onsite at both Countess and Ellesmere Port sites.

- University Freshers' fair – Since starting my term as CL-OD we have made plans to engage with the student community in Chester, starting with our presence at a medical schools welcome event in September 2025. We are also aiming to attend the wider Chester student freshers' fair event to promote awareness of organ donation and encourage all to register a decision regarding donation and hope this will an exciting opportunity to promote understanding in a key demographic.

"Promote organ donation through NHSBT's Donor Ambassador programme leading to increased diverse community advocates for the benefit of organ donation":

- We also welcomed Helen Gleave to our committee meetings this year. Helen shared her experience of organ donation when her husband Peter became a donor following his death. Her insight helped provide a relative's perspective of both the process of donation but also the follow-up and care received following donation from the hospital and NHSBT.

"Further train staff involved in the donation process so that families can expect to receive the care and support they need during the donation process":

- We continue to have an established junior doctor education programme with sessions covering neurological death testing, organ donor stabilisation and organ & tissue donation. This is delivered to all junior doctors rotating through ICU, including foundation doctors, ACCS trainees, IMTs and anaesthetic & ICM trainees.

- Attendance of our senior nursing staff and ICM trainees at the national Organ Donation Simulation Training.

- Tissue donation advocates- facilitating awareness and training across ICU/ED and extending to medical wards starting with MAU, as well as ongoing audits and Quality Improvement Projects to increase tissue donation referrals across the trust. This work has been shared with the Organ Donation committee as well as at foundation doctor teaching to share learning, gain additional perspectives of potential barrier to tissue donation in the trust, and to raise awareness of tissue donation policies and procedures.

"Recognise donors and donor families"

- St John Award for Organ Donation was hosted at Chester Town Hall again this year, which was my first attendance at the ceremony. The award honours the gift donors and their families make by donating their organs to save and improve the lives of others. It is an emotional but inspiring ceremony and a chance to reflect on the positive effect donation can have on the donor's family and loved ones.

We aim to maintain our high levels of engagement with organ donation in the hospital as well as raise awareness of tissue donation across the whole Trust, making best practice the path of least resistance.

Dr Darius Zeinali

Clinical Lead - Organ Donation

4. Organ Donation Rates/PDA Benchmarking 2024/2025

Donation after Brain Death (DBD)

2024/2025	DBD
Patients with suspected death by neurological criteria	10
Neurological death tests performed	9
Confirmed neurological death	9
Referred	9
Medically suitable to donate	3
Families approached	3
Number of eligible donors whose last known decision was opt out	0
Consent given	2
Donation proceeded	2
Organs transplanted	6
MISSED POTENTIAL DBD DONOR	NIL
Identification of neurological death %	100%
Neurological death testing %	90%
Referral rate of patients confirmed BSD %	100%
Approach rate %	100%
Consent rate %	67%

Review of PDA 2024/2025. The trust will have received NHSBT reports that have been validated, which report on patients 80 **years old and under only**, as the above figures includes patients of all ages (including those >80 years) the data above **is inconsistent with these reports**. However, it is an accurate representation of the total organ donation potential at COCH.

Donation after circulatory death (DCD)

2024/2025	DCD
No. of patients for whom were ventilated & death was anticipated after withdrawal of life sustaining treatment (WLST)	35
No. Referred to the SNOD	32
No. of medically potential DCD donors (medically suitable)	5
Families approached	3
Number of eligible donors whose last known decision was opt out	2
Consent to donation	1
Donation proceeded	0
Organs transplanted	0
Missed potential DCD donors (medically suitable)	2
Referral rate of patients	91%
Approach rate % - medically suitable	60%
Consent rate % -of those referred	33%

Review of PDA 2024/2025. The trust will have received NHSBT reports that have been validated, which report on patients 80 **years old and under only**, as the above figures includes patients of all ages (including those >80 years) the data above **is inconsistent with these reports**. However, it is an accurate representation of the total organ donation potential at COCH.

Referrals to the Specialist Nurse for Organ Donation (SN-OD) are required for ALL patients who are potential DCD donors age <85 years. That is all patients in whom there is a plan to withdraw life sustaining treatment, where imminent death is then anticipated. **This is in accordance with COCH Trust policy & NICE clinical guideline 135.**

ANNUAL SUMMARY REPORT Countess of Chester NHS Trust
ORGAN DONATION POTENTIAL AUDIT 2024–202

AUDIT COMPLETED BY: Rebecca Gallagher, North West Regional Specialist Nurse –Organ Donation
AREA AUDITED: Critical Care Unit & Emergency Department

NUMBER OF VENTILATED PATIENT DEATHS:	64
NUMBER OF PATIENTS CONFIRMED WITH NEUROLOGICAL DEATH: (DBD)	9
NUMBER OF PATIENTS WHO HAD LIFE SUSTAINING TREATMENT WITHDRAWN: (DCD)	35
Number of patients referred (DBD & DCD)	**41**
NUMBER OF MEDICALLY SUITABLE ELIGIBLE DONORS:	**8**
NUMBER OF OPT OUTS ON ORGAN DONOR REGISTER	**2**
NUMBER OF FAMILIES APPROACHED ABOUT ORGAN DONATION:	6
NUMBER OF FAMILIES WHO CONSENTED:	**3**
NUMBER OF ACTUAL ORGAN DONORS:	**2**
NUMBER OF NON-PROCEEDING CONSENTED DCD DONORS:	**1**
NUMBER OF ORGANS TRANSPLANTED:	**6**

TOTAL REFERRAL RATE TO Specialist Nurse-Organ Donation Team: 93% (41 out of 44)
TIMELY REFERRALS: 97.5% (39 out of 40)
MISSED REFERRALS: 7% (3 out of 44)
MISSED POTENTIAL DONORS (of which were medically suitable): 4.5% (actual number= 2 patients)
APPROACH RATE: 75% (6 out of 8)
COLLABORATIVE APPROACH RATE: 83% (5 out of 6)
CONSENT RATE (of those patients referred): 50% (3 out of 6)

PDA Benchmarking Rates for Trust

Summary and comparison of National and Local key percentages: the Trust numbers presented are very small in comparison to national figures. Caution should therefore be applied to any comparisons with national percentages.
The Countess of Chester NHS Foundation Trust has been categorised as a **level 2 Trust** to reflect the average number of donors on an annual basis and to facilitate benchmarking against similar Trusts.

KEY RATES COMPARED	DBD	DCD	Combined
• National Organ Donation NEUROLOGICAL CRITERIA FOR DEATH TESTING RATES	72%	NA	NA
National goal set by NHSBT NEUROLOGICAL CRITERIA FOR DEATH TESTING RATES	100%	NA	NA
• North West Regional NEUROLOGICAL CRITERIA FOR DEATH TESTING RATES	70%	NA	NA
• Local COCH Organ donation NEUROLOGICAL CRITERIA FOR DEATH TESTING RATES	**90%**	NA	NA

KEY RATES COMPARED	DBD	DCD	Combined
• National Organ Donation REFERRAL RATES	99%	93%	94%
National goal set by NHSBT REFERRAL RATES	100%	100%	100%
• North West Regional REFERRAL RATES	99%	95%	95%
• Local COCH Organ Donation REFERRAL RATES	**100%**	**91%**	**93%**

KEY RATES COMPARED	DBD	DCD	Combined
• National organ donation APPROACH RATES	87%	87%	87%
National goal set by NHSBT APPROACH RATES	100%	100%	100%
• North West Regional APPROACH RATES	79%	88%	85%
• Local COCH Organ Donation APPROACH RATES	**100%**	**60%**	**75%**

KEY RATES COMPARED	DBD	DCD	Combined
• National Organ Donation SNOD PRESENT RATES	97%	89%	92%
National goal set by NHSBT SNOD PRESENT RATES	100%	100%	100%
• North West Regional SNOD PRESENT RATES	98%	91%	94%
• Local COCH Organ Donation SNOD PRESENT RATES	**100%**	**67%**	**83%**

KEY RATES COMPARED	DBD	DCD	Combined
• National organ donation CONSENT RATES	69%	53%	59%
National goal set by NHSBT CONSENT RATES	-	-	80%
• North West Regional CONSENT RATES	67%	57%	61%
• Local COCH Organ Donation CONSENT RATES	**67%**	**33%**	**50%**

5. 2024-2025 Objectives and achievements

- To maintain at least a 90-100% referral rate of all patients in Countess of Chester Hospital ICU to the NW SNOD team for assessment of DBD/DCD potential by March 2023 – achieved 94%

- To maintain the number of approaches made to a family at COCH regarding organ donation at 100% - not achieved (55%), this was because the patient was not medically suitable for donation (due to non-absolute contraindications that are not captured in the audit). As such it was felt that family approach was inappropriate.

- To achieve consent rates of greater than 80% in line with the national aspiration- did not achieve (43%), however national consent rate also fell to 59% and it is felt that this reflects a very low denominator (in this case 2 patients did not consent out of 5 eligible).

- To maintain a SNOD presence in any approach to families in COCH about organ donation at 100% - did not achieve (71%), since one donor was approached by a consultant. This is one area to focus efforts on as the incoming CLOD.

- To maintain current education strategies across the trust about organ donation, with key areas targeted toward ICU, Theatre and ED – achieved.

- To improve tissue donation referral rates across ICU and the wider-trust, building on recent quality improvement strategies- 10 corneas donated this year, but ongoing work required to promote tissue donation.

6. Aims & Objectives for 2025-2026

- To maintain at least a 95-100% referral rate of all patients in Countess of Chester Hospital ICU to the NW SNOD team for assessment of DBD/DCD potential by March 2025.

- To improve the number of approaches made to a family at COCH regarding organ donation and aim for 100% approach rate.

- To achieve consent rates of greater than 80% in line with the national aspiration.

- To maintain a SNOD presence in any approach to families in COCH about organ donation at 100%.

- To maintain current education strategies across the trust about organ donation, with key areas targeted toward ICU, Theatre and ED.

- To continue to improve tissue donation referral rates across ICU and the wider trust, building on recent quality improvement strategies.

- To promote organ and tissue donation across the wider community, including new demographics such as the student and younger population.

MINUTES OF THE PUBLIC BOARD OF DIRECTORS

Tuesday 29th July 2025, 8.30 – 12.30, Boardroom -1829 Building

Members	20/05/25	29/07/25				
Trust Chair, Mr N Large	☑	☑				
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, Mrs S Pemberton	☑	☑				
Director of Strategy and Partnerships, Mr J Develing	☑	☑				
Chief Digital & Data Officer, Mr J Bradley	☑	☑				
Chief Finance Officer, Mrs K Edge	☑	☑				
Director of Governance, Risk & Improvement, Mrs K Wheatcroft	☑	☑				
Chief People Officer, Ms V Wilson	☑	☒				

In attendance	20/05/25	29/07/25				
Head of Corporate Governance, Mrs N Cleuvenot	☑	☑				
Consultant Dermatologist/Skin Cancer Lead, Dr E Domanne	☑ (item 3)	n/a				
Healthcare Assistant, Ms M Facer	☑ (item 3)	n/a				
Director of Midwifery, Ms N Macdonald	☑ (item 11 and 12a)	☑ (item 4)				
Director of Clinical Research, Mr P Bamford	☑ (item 23)	n/a				
Deputy Medical Director, Dr I Benton	n/a	☑				
Maternity and Neonatal Voices Partnership Lead, Ms R El Boukili	n/a	☑ (item 4)				
Director of Pharmacy and Medicines Optimisation and Controlled Drugs Accountable Officer (CDAO), Ms K Adams	n/a	☑ (item 15)				

Time	Agenda No.	Agenda item	Action
8.30	1.	**Welcome, apologies and Chair's opening remarks** The Chair opened the meeting and members of the Board introduced themselves. Apologies were noted from Dr N Scawn, Medical Director, Ms V Wilson, Chief People Officer, Mr M Guymer, Non-Executive Director and Mr D Williamson, Non-Executive Director. Dr I Benton, Deputy Medical Director was deputising for Dr N Scawn, Medical Director.	
8.33	2.	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest raised in relation to agenda items.	
8.35	3.	**Patient Story** Gillian and Anthony Edwards attended the meeting to share the story of their daughter, Katie, who sadly passed away under the care of the Countess of Chester Hospital.	

		Ms L Kanwar (LK), Head of Quality introduced Mr and Mrs Edwards and acknowledged their significant contribution to learning and improvement within the Trust. Following Katie's death, the Edwards family worked with the Trust to help ensure lessons were learned. They produced a video sharing their experience, which has been shown at the Patient Safety Summit and other learning forums. The video was shared with the Board of Directors during the meeting. The Edwards were asked about their experience of being involved in the investigation process. They confirmed that they had received full transparency and consistent communication throughout. They emphasised the importance of asking for help and raising concerns and shared the profound impact Katie had on those around her. Ms S Pemberton (SP), Director of Nursing and Quality/Deputy CEO thanked Mr and Mrs Edwards for attending and acknowledged how difficult it must have been to share their story. She reiterated the Trust's commitment to learning and improvement and hoped the family felt their concerns had been taken seriously. Ms J Tomkinson (JT), Chief Executive Officer reflected on the power of the story in highlighting both positive and negative aspects of care. She noted the importance of the message around asking for help, which aligns with the principles of Martha's Rule. She acknowledged that what began as the Edwards' personal reflections had now informed Trust policy, and that asking for help should be seen as a strength, not something hindered by hierarchy. SP added that the Trust has implemented the HALT initiative, which empowers staff to pause care processes if something does not feel right, further supporting a culture of speaking up. The Board reiterated their thanks and appreciation to Mr and Mrs Edwards for attending and sharing their experience. The Board **noted** the patient story. *Mrs L Kanwar, and Mr and Mrs Edwards exited the meeting.*	
9.05	4.	**<u>Service Showcase</u>** Ms R El Boukili (REL), Maternity and Neonatal Voices Partnership Lead (MNVP), and Ms N Macdonald (NM), Directory of Midwifery attended the meeting to present an update on the work of the Maternity and Neonatal Voices Partnership**.** REL outlined the role of the MNVP as a collaborative group of service users, birth partners, healthcare professionals, and commissioners working together to improve maternity and neonatal services. The MNVP collects and analyses feedback from service users and co-produces improvements with the Trust.	

		Key areas of focus included: • Service User Feedback: Concerns raised included communication issues, challenges with breastfeeding post-C-section, food provision for coeliac patients, pressure around induction decisions, and transitions between postnatal and neonatal care. • Practice Improvements: Actions taken include redesigning appointment letters, enabling overnight stays for support persons, improved food options, and enhanced ward communication tools. • Parent Education: Themes identified included lack of preparation for neonatal admissions and emergencies, the need for accessible and inclusive classes, and broader educational content beyond labour and birth. • Health Inequalities: REL shared data highlighting disparities and outlined targeted actions such as cultural competence training, interpreter support, outreach to low-income and traveller families, and improved access to healthcare. • Future Plans: These include community listening events, support for bereavement midwives, neonatal communication tools, and increasing feedback from under-represented groups. Mrs W Williams (WW), Non-Executive Director thanked REL and was surprised at some of the statistics. She asked whether prenatal sessions include education on induction to help reduce pressure felt by parents. REL confirmed this is being reviewed and emphasised that induction should be an opt-in rather than opt-out process. Ms S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO commended the MNVP for exploring areas not previously investigated by the Trust, noting the value of the insights shared. Prof A Hassell (AH), Non-Executive Director asked about REL's background. REL shared that she is a mother of three, a former midwife, and previously a professional dancer. Her experiences across different healthcare systems have fuelled her passion for equitable access. AH noted that feedback about pressure to induce labour had also been raised at the Quality and Safety Committee and suggested potential collaboration with the university to research lived experiences more widely. Mrs S Corcoran (SC), Non-Executive Director highlighted REL's impactful contributions as a member of the Safety Champions Group and the importance of hearing service user voices within the organisation. Mr N Large (NL), Chair commended the work of the MNVP and thanked REL for her dedication, describing the presentation as "eye-opening."	

		The Board **noted** the service showcase. *Ms R El Boukili and Ms N McDonald exited the meeting.*	
9.35	5.	**Minutes of the previous meeting held on 20th May 2025** The minutes of the previous meeting held on the 20th May 2025 were **approved** as a true and accurate record of the meeting.	
9.40	6.	**To consider any matters arising and action log** Updates against the following actions had been added to the action log and proposed for closure: **3. Finance and Performance Committee to consider how the delivery of medium-term financial stability is reflected on the BAF** This has been considered in the BAF (July 2025). **5. KW to check if out of date policies is on the risk register and if it should be considered a high risk.** Out of date policies have been added to datix as a moderate risk. **6. Board to discuss risk appetite alongside BAF (including medium term financial plan) at a Board Development Day.** This was discussed at the 24th June Board development day. **7. SP to provide update on maternity services neonatal partnership (MNVP) work on addressing health inequalities in maternity services.** Update included on the agenda as part of Service Showcase. **8. JB to compare depth of coding (SHMI) data with other organisations.** Using data from Dr Foster (Telstra Health) for comparison, our coding depth matches the national average of 4.5 codes per record and is below the national average for records with no comorbidity recorded (34.7% for CoCH, compared with 43.2% nationally). The coding depth has shown an improvement from 4.2 average codes per record in 2023/24 to 4.5 in 24/25. The Dr Foster data is used to identify specialties where there is variation from national figures and work then undertaken with the specialty to review recording of comorbidities. It was confirmed that the above actions were closed and the remaining actions on the action log were due in September. The Board **noted** the updates.	
9.43	7.	**Chief Executive Officer's Report**	

		Ms J Tomkinson (JT), Chief Executive Officer, presented the CEO report and highlighted the following key updates: • The Trust's five-year strategy, *Transforming Care Together*, aligns well with the Government's new 10-Year Health Plan. Annual objectives will be adjusted accordingly rather than revising the overall strategy. • JT emphasised the Trust's ongoing work with the Cheshire and Merseyside system to address population health needs and health inequalities within the overall financial envelope. • JT, Mr N Large (NL), Chair and Mrs K Edge (KE) Chief Finance Officer had attended a system meeting to discuss the strategic blueprint for Cheshire and Merseyside. There is recognition that District General Hospitals (DGHs) across Cheshire must consider service sustainability and financial delivery. Mr J Develing (JD), Director of Strategy and Partnerships is leading this work with Mandy Nagra. • JT noted the need to strengthen collaboration with Cheshire and Wirral Partnership NHS Foundation Trust (CWP), while existing links with Wirral partners are strong and expanding. • The Trust's aseptic unit recently received accreditation, and there is potential to explore commercial opportunities aligned with the 10-Year Plan and subsidiary working. • The Trust saw improved results in the Children and Young People's CQC Survey, ranking 9th nationally in the 2024 Survey. • Open days for the new Women and Children's Building are underway, and Board members were encouraged to attend. • Employee of the Month and Team of the Month awards were highlighted, with a formal celebration of achievement event scheduled for September. • JT confirmed that the Trust has maintained safe staffing levels during the recent resident doctor strikes. Dr I Benton (IB), Deputy Medical Director reported that no cancer surgeries were cancelled during the strikes, and only one clinic was rescheduled. Locum cover was used, and consultants were redeployed to support services. Ms C Chadwick (CC), Chief Operating Officer added that emergency and front-of-house services were well covered, with consultants stepping into junior roles. Less activity was stood down compared to previous strikes, and lessons from earlier industrial action were applied. Attendance data for resident doctors is being manually collated to assess the financial impact. NL asked how many resident doctors were on strike. IB confirmed there are 289 resident doctors, with an average of 20 attending during the strike. Not all absences were due to strike action; some were on	

		leave or non-rostered days. CC noted that a Sunday night call led by consultants ensured safe overnight coverage. Prof A Hassell (AH), Non-Executive Director queried whether locums employed by the Trust could be striking elsewhere. IB acknowledged this was possible. The Board expressed appreciation for the consultants and all staff involved in planning and delivering safe services during the strike. NL asked about the nursing position. Ms S Pemberton (SP), Director of Nursing and Quality/Deputy CEO reported that just over 60% of nurses had expressed a desire to strike, though confirmation was pending. She acknowledged the significant challenge this would pose. The Board **noted** the CEO report.	
9.50	8.	**<u>Chair's Update</u>** Mr N Large (NL), Trust Chair, presented the Chair's update. • NL reported time spent attending system-wide meetings, reflecting on the challenges faced in delivering safe care and achieving turnaround across the region. • He emphasised the importance of securing tangible successes this year, particularly in areas such as Referral to Treatment (RTT) and the delivery of Cost Improvement Plans (CIP) as well as UEC improvements. • The Trust is actively working with system partners to identify and implement solutions. • A medium-term financial strategy is in development and will be reviewed in October. • NL attended a recent FTSU meeting, which was well-attended with over twenty FTSU Champions. • He shared reflections on the impact of organisational challenges and acknowledged the importance of continuing to manage these effectively. • NL stressed the need to develop and communicate a clear vision and future direction to staff. • Nominations for Governor elections closed on Friday, with the ballot stage of elections to commence from 18th August 2025. NL shared details on the composition of the Council of Governors, noting that 23 out of 26 seats will potentially be filled. • NL commented on the recently published 10-Year Health Plan, describing it as an exciting opportunity for the NHS. He acknowledged that there is still much to understand about the plan's implications but expressed optimism about the future.	

		NL thanked colleagues across the Trust for their continued support and commitment during a challenging period. The Board **noted** the Chair's report.	
9.55	9.	**<u>a) Board Assurance Framework 2025/26 including Risk Appetite Statement</u>** Mrs K Wheatcroft (KW), Director of Governance, Risk, and Improvement presented the refreshed Board Assurance Framework (BAF) and revised Risk Appetite Statement, noting: • A full refresh of the BAF was undertaken following discussions at the Board development day. • There are ten strategic risks, with minor amendments made to the wording. • Eight out of ten risks remain above the risk appetite. • Progress is being made against actions, and scores may reduce by the next quarter, but only once improvements are fully embedded. • The Risk Appetite Statement now includes specific reference to system and cyber. • The report also includes progress against strategic objectives, with updates to objectives for 2025/26 due in Q2. Mrs S Corcoran (SC), Non-Executive Director queried whether the target risk score of nine for patient safety was too high. KW explained that due to the high impact nature of safety risks, a higher score is often seen albeit the context of minimising risks to quality is important. Ms S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO confirmed this was a collective agreement at the Board development day and aligns with current context. SC asked whether the current target is where the Board wants to be long-term and suggested an ambition to work towards a lower target score. Mr N Large (NL), Chair clarified that the this was the target score for 2025/26 and not reflective of the long-term goal but would require annual re-evaluation. Mrs P Williams (PW), Non-Executive Director asked if the risk appetite could be changed mid-year. KW confirmed that in-year revisions can be done, and SP added that it is important that committees regularly refer to the BAF and make necessary updates. Mr P Jones (PJ), Non-Executive Director supported the current target of nine for quality and safety as realistic but stressed the importance of aiming for longer-term improvement. Prof A Hassell (AH), Non-Executive Director agreed, noting that achieving nine this year would be a significant accomplishment.	

		The Board: • **approved** the 2025/26 Board Assurance Framework • **noted** the update on progress in delivering strategic objectives • **approved** the revised Board Risk Appetite Statement 2025/26 **b) High Risks Report** KW provided an overview of the High Risks Report, highlighting: • The report includes risks recorded on Datix with a residual score of fifteen or above. • A total of fifteen high risks are identified, covering areas such as RAAC, waiting lists, equipment, radiology capacity, staffing, cyber security, infrastructure, and cash management. • The Risk Management Improvement Plan is progressing, with a focus on strengthening awareness and embedding risk management across all levels of the organisation. • Improvements are underway in Datix reporting capabilities, including alert functions and automated updates. • The report should be read in the context of the Board Assurance Framework (BAF), with ongoing work to improve consistency in scoring, mitigations, and actions. • The high risks register is manually updated to ensure visibility at Board and Committees. • Training is being further developed, with awareness in a number of the leadership development sessions and risk is increasingly being discussed across the organisation. The Board **noted** the high risk report recognising further work is progressing to improve and embed risk management across the Trust.	
10.05	10.	**Quality, Safety & Experience Strategy** Mrs S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO introduced the Quality, Safety and Experience Strategy, noting that the strategy had been reviewed by the Quality Governance Group (QGG). It was developed with input from staff and some patients and reflects known areas for improvement. SP noted whilst some elements may appear basic, they are foundational and critical to delivering safe, kind, and effective care. Key areas include complaint's themes, harms, sepsis, infections, falls, pressure ulcers, and care for deteriorating patients. Improvement programmes and structures are in place to support these areas. A quarterly feedback session led by Fiona Altintas, Deputy Director of	

		Nursing and Quality Governance will be introduced to monitor progress and ensure accountability. SP also highlighted progress on the violence and aggression policy and implementation of NatSSIPs; a new ward-based group has been established to focus on patient and family experience; and staff survey results will be used to evaluate cultural development and impact. Ms J Tomkinson (JT), Chief Executive Officer thanked SP for the comprehensive report and endorsed the priorities outlined in the strategy as appropriate and well-considered. A key theme emerged around the tension between driving the quality and safety agenda and meeting financial delivery targets. JT raised the question of how this balance would be achieved. SP confirmed that this issue had been discussed in a meeting the previous day, acknowledging the difficulty and complexity of aligning both agendas. Dr I Benton (IB), Deputy Medical Director praised the simplicity of the strategy, noting that it enhances clarity and makes monitoring easier. Mr N Large (NL), Chair affirmed that the strategy reflects what the Trust should be doing. Mrs W Williams (WW), Non-Executive Director shared feedback from a walkabout in Endoscopy, where staff expressed concern about Cost Improvement Programmes (CIP) and reiterated that patient safety came first. WW felt that the strategy can support the connection of financial savings with quality and safety delivery. WW questioned why staff often don't see the link between financial and quality goals. SP responded that leadership has historically lacked adequate support and that in some areas, the status quo is accepted rather than challenged. She emphasised the importance of setting standards and leading by example to demonstrate what good looks like. Mrs S Corcoran (SC), Non-Executive Director initially felt there were gaps in the risk register but acknowledged that the strategy and accompanying papers do capture the relevant risks. She appreciated the evaluation section and suggested that the Chief Executive Officer's FTSU pledge be visually highlighted more clearly within the strategy to re-emphasise the encouragement for staff to speak up and ensure they are heard. SP credited her team for their work in developing the strategy. NL asked how the Trust would know the strategy is making a difference. SP confirmed that updates would be brought to the Board as implementation progresses. NL noted that while evaluation will take time, improvements should hopefully be reflected in staff and patient surveys. The Board **approved** the Quality, Safety and Experience Strategy.	

10.15	11.	**Safety Surveillance and Learning Report – Quarter 4** Mrs S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO introduced the report, highlighting the Safety Surveillance and Learning Forum as a key platform for organisational learning. The forum includes attendance from divisional teams, claims and legal team, and reviews incidents, complaints, and coronial inquests. Attendance and engagement were noted as strong. In Quarter 4, the Trust reported 3,215 incidents, with 95% categorised as low or no harm, 14 severe, and 2 catastrophic incidents. The top five categories of moderate harm were: 1. Skin integrity 2. Obstetrics 3. Healthcare Associated Infections (HCAI) 4. Treatment 5. Falls Violence and aggression incidents were discussed, with 70% linked to confused patients. Enhanced therapeutic observation training is scheduled to begin in A&E next month to address this. Complaints and concerns were primarily related to communications in respect of appointments and waiting lists. The Trust is reviewing communication strategies to reduce reliance on PALs and improve patient access to information. Reports are now reviewed weekly and progress monitored to ensure we are meeting coroner requirements. The importance of duty of candour was emphasised, as demonstrated by the patient story earlier in the meeting. Prof A Hassell (AH), Non-Executive Director confirmed the report had been presented to the Quality & Safety Committee and noted it as evidence of a strong learning culture. He highlighted the high proportion of low and no harm incidents as indicative of a healthy reporting culture. Mr N Large (NL), Chair raised the issue of security response to incidents. SP responded that enhanced therapeutic observation training would help reduce the need for security involvement and that the Security Team also have a role in safeguarding incidents. The Board: • **Noted** the contents of the paper. • **Received assurance** that the Trust is continuing to promote a learning culture with evident and measurable actions to improve patient safety.	

		• **Noted** the improvements in governance and oversight workstreams within the Trust.	
10.25	12.	**<u>Quarter 1 2025-2026 Mortality Surveillance Report (learning from deaths)</u>** Dr I Benton (IB), Deputy Medical Director presented the Quarter 1 Mortality Surveillance Report, confirming that mortality indicators—SHMI (91.0), HSMR (93.5), and SMR (94.4)—remain within the "as expected" range. The Trust's depth of coding is slightly below the national average (5.9 vs. 6.4). IB explained that a higher depth of coding typically correlates with more accurate predicted mortality. Mortality rates are lower in more deprived areas, which is a positive outlier for the Trust. Mr N Large (NL), Chair raised concerns about the impact of long length of stay on mortality figures. Dr Benton confirmed this is being monitored through Non Criteria to Reside (NC2R) metrics. NL queried whether coding quality supports income recovery. Mrs K Edge (KE), Chief Finance Officer responded that coding is reasonably good but constrained by contract limits. Mr J Bradley (JB), Chief Digital and Data Officer added that external audits have shown positive results for coding for admitted patient care, and future improvements may come from automation and AI tools. Prof A Hassell (AH), Non-Executive Director praised the health inequality data and stressed the importance of maintaining coding standards. He asked whether feedback from families is received during medical examiner reviews. IB confirmed that feedback is shared with both the mortality surveillance group and clinical teams. AH suggested including family feedback in public Board papers. SP asked whether the list of good care examples came from medical examiners. IB clarified that these were identified through Mortality and Morbidity (M&M) reviews, which also highlight gaps in care. The Board **noted** the report and **received assurance** that learning from mortality and morbidity is improving across the organisation within the learning and safety meeting structures / groups reaching multiprofessional audiences.	
10.30	13.	**<u>Care Quality Commission (CQC) Improvement Plan including Well Led</u>** Mrs S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO presented the latest progress update against the consolidated CQC Improvement Plan, including the Well Led domain. She noted that several actions have been completed and are transitioning to business-as-usual (BAU), with updates and examples shared. Mrs K Wheatcroft (KW), Director of Risk and Improvement has contributed to the development of the updates and monitoring framework.	

		Prof A Hassell (AH), Non-Executive Director queried whether any areas remain amber despite the predominance of blue and green indicators. SP acknowledged that out-of-hours stroke service remains amber due to funding limitations beyond midnight. KW clarified that while many recommendations have moved to BAU, consistency of application is still being embedded. Monitoring and triangulation with the Board Assurance Framework (BAF) is important. Ms J Tomkinson (JT), Chief Executive Officer emphasised the distinction between assurance and reassurance, cautioning against sweeping statements. She acknowledged the work of SP and KW and stressed the need for continued executive-level conversations to ensure progress is sustained and embedded. Mr P Jones (PJ), Non-Executive Director asked about the timeline for a formal improvement strategy. KW responded that while elements exist across the Cost Improvement Programme (CIP) and Quality Strategy, a consolidated strategy is still needed but is being managed within competing priorities. JT highlighted the importance of managing expectations internally and externally, especially given reductions in corporate teams. She noted that resources are focused on safety, and improvement efforts must be realistic. The Board **noted** the assurance provided on progress against the CQC Improvement Plan.	
10.35	14.	**Quality & Safety Committee Chair's Report – 21st May 2025 and 3rd July 2025** Prof A Hassell (AH), Non-Executive Director/ Chair of Quality & Safety Committee presented the Quality and Safety Chair's report which included areas to Alert the Board to, areas where Assurance had been received, areas to Advise to Board and any new risks discussed. The Committee had convened an extraordinary meeting on 21st May to review the Trust's response to the Care Quality Commission (CQC) Section 29a notice concerning Urgent and Emergency Care. AH commended the Executive Team and colleagues for their swift and thorough response. Each area of concern was discussed in detail, with actions and progress reviewed. Agreement was reached on the nature of future assurance reporting to the Committee. On the 3rd of July, the Committee reviewed ongoing progress against the CQC Section 29a notice. While improvements were noted, several areas remain under scrutiny:	

		• Sepsis performance in ED: Worsening metrics prompted a request for further information and continued agenda presence. • Resuscitation capacity: Plans to expand by one adult and one paediatric bay were discussed. Despite expansion, the Trust will remain below national recommendations. Mr N Large (NL), Chair queried the source of guidance for resuscitation capacity, and Ms Chadwick (CC), Chief Operating Officer confirmed it was from the Royal College, based on attendance and clinical need. A clinically led risk assessment had taken place to determine the number of bays required but was not articulated in the paper and will be updated to reflect this in the next report. NL asked whether the CQC had flagged this as an area of concern; CC clarified it was not mandated but noted the absence of a separate paediatric area, which the Trust had already planned to address. AH stressed the importance of Committee assurance on this matter. Mr P Jones (PJ), Non-Executive Director highlighted concerns about data aggregation masking outliers. AH confirmed this had also been discussed in depth at the Committee. The Board **noted** the Quality and Safety Committee Chair's report.	
10.40	15.	**2024/25 Controlled Drugs (CDs) Annual Report** Ms K Adams, Director of Pharmacy and Medicines Optimisation and Controlled Drugs Accountable Officer (CDAO) presented the Controlled Drugs Annual Report, confirming that the Trust is compliant with the Controlled Drugs Regulations. Systems and processes are governed by established policies and procedures, with compliance monitored through quarterly audits. Incident reporting showed a reduction compared to the previous year (265 incidents, down 20%), though this was noted as an observation rather than an indicator of improvement. Thematic reviews are conducted quarterly, with particular attention to unaccounted-for losses, especially in the Emergency Department (ED), which has higher oversight due to increased reporting. There have been no themes identified in ED losses. Mr N Large (NL), Chair raised concerns about unsigned medication receipt forms. Karen Adams clarified that this relates to signatures upon receipt, and while porters wait for signatures, medication is never left unattended. Process improvements are being explored to ease this burden. The Trust achieved 100% compliance in its participation in the Local Intelligence Network (LIN), including attendance, reporting, and	

		actioning alerts. A Home Office inspection in May 2024 provided positive assurance, though the Trust has yet to receive its renewed licence. The delay has been escalated to NHS England, and the Trust continues to operate under existing permissions. Positive developments include portal-based ordering for lower scheduled drugs, enabling wards to track administration and supply trends, which helps identify red flags. Mrs S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO queried key security compliance. KA explained that non-compliance was due to controlled drugs (CD) keys being stored with medicines keys. Measures have been implemented to address this, including education and secure storage protocols. Mrs W Williams (WW), Non-Executive Director asked about disposal of partially used drugs. KA confirmed that quarterly audits would flag any issues, and no concerns have been raised. While diversion of CDs is a national issue, the theatre scenario poses lower risk than open shelf access. Prof A Hassell (AH), Non-Executive Director asked about underperforming areas in the report and whether it had been shared with the Quality Governance Group (QGG). KA confirmed that reporting flows through relevant channels and the Chair's report is submitted to QGG. NL queried whether all medication was in date and fit for use. KA noted that 80% compliance does not mean expired medication was used, but that its' presence poses a risk. The aim is to remove such items within 72 hours. Some medicines expire within six weeks of opening, and no high-cost medicines were wasted. The Board acknowledged and thanked the Pharmacy Team for their role and support during the industrial action. The Board of Directors **noted the assurance** provided within the report with regards to the safe management of controlled drugs within the organisation. *Ms K Adams exited the meeting.*	
11.00	16.	**<u>Integrated Performance Report (IPR) – June 2025</u>** Mr N Large (NL), Chair shared reflections on the IPR format and proposed a more forward-looking approach. He suggested including outturns and strategic indicators to focus on future performance rather than solely on retrospective data. **ACTION:** Mr J Bradley (JB), Chief Digital and Data Officer will develop mock-ups and consult with the Executive Team and committees, aiming for implementation by September 2025.	**JB**

		Operational Performance Ms C Chadwick (CC), Chief Operating Officer highlighted the following with regards to Operational Performance: • ED 4-hour performance reached a two-year high at 63.7%, with a significant reduction in patients waiting over 12 hours. • Ambulance handovers improved, with sustained reductions in 60+ minute delays. • Corridor care usage dropped dramatically. • Escalation policy revised with a focus to reduce ED stays from 72 to 18 hours. • Clinical triage at the front door being prioritised. • Elective care: Cancer 31-day and 62-day standards sustained; 28-day FDS performance declined due to skin tumour backlog. • RTT: Forecasted 15% improvement by October 2025. Mr N Large (NL), Chair asked whether NC2R delays were due to funding or care home availability; CC confirmed funding was the main issue. Prof A Hassell (AH), Non-Executive Director queried the corridor care success; CC attributed it to extended use of escalation spaces since January/ February 2025, noting the financial implications of this. Mrs S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO and Mrs W Williams (WW), Non-Executive Director raised concerns about Same Day Emergency Care (SDEC) delays and patient experience. Healthwatch feedback was positive on corridor care but flagged long SDEC stays. WW commented on the lack of correlation between operational mandates and health outcomes. Mrs S Corcoran (SC), Non-Executive Director asked about NC2R winter projections; CC confirmed no significant improvements can currently be expected. Mr P Jones (PJ), Non-Executive Director asked about benchmarking NC2R with other outlier hospitals; CC noted national work may address this but no themes have currently been identified. **Quality** Mrs S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO shared the highlights related to Nursing Quality of Care indicators: • Improved compliance in Braden, MUST, and falls risk assessments. • Zero STEIS incidents and never events in June 2025. • Reduction in falls and falls with harm. • Ward accreditation and deconditioning initiatives progressing.	

		NL raised concerns about sepsis performance in ED. SP confirmed this would be discussed further as part of the private Board papers. **Safety** Dr I Benton (IB). Deputy Medical Director shared the following in respect of the Safety indicators: • E-discharge compliance improving via task and finish group. • Standardisation of discharge checklists underway. • Mortality indicators (SHMI and HSMR) remain "as expected". SC queried Family and Friends Test (FFT) data accuracy; SP confirmed data errors due to mixed responses and Healthcare Comms are currently investigating this. NL asked if there was a declining birth trend. SP noted there had been a decline in births but a trend had not been identified. It was recognised that there was work to be done around advertising the maternity services at the New Women & Children's Building. There was discussion about the reputational issues the Trust has recently faced and the importance of publicising positive outcomes more effectively. The Board also discussed how the Quality Strategy could be used in external communications. The Board recognised the importance of utilising social media and developing communications with primary care. **Finance** Mrs K Edge (KE), Chief Finance Officer presented the key Finance updates: • Month 3 deficit of £8.2m in line with plan. • CIP under-delivery of £1.6m mitigated by non-recurrent benefits. • Cash position healthy at £21.2m but this will erode in coming months. • Better Payment Practice Code compliance: 95.3% (value), 91.5% (volume). NL noted that overall, we are on plan but CIP remains the key risk. **People** Ms C Chadwick (CC), Chief Operating Officer, presented the People and Organisational Development highlights on behalf of the Chief People Officer: • Turnover below target at 9.82%. • Sickness absence rose to 5.05%, driven by stress and anxiety.	

		• HR Business Partners are engaging with managers to ensure that Trust policies are appropriately implemented for employees on sick leave and to facilitate their effective return to work. • Mandatory training compliance reached target at 90.91% for the first time since 2019. • Appraisal compliance met target at 81.64%. • Agency spend reduced year-on-year; nursing agency spend at 0.8% of pay bill. The Board **noted** the Integrated Performance Report.	
11.20	17.	**Operational Management Board Chair's Report – 22nd May 2025** Ms J Tomkinson (JT), Chief Executive Officer presented the Operational Management Board (OMB) Chair's report including areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed. JT highlighted that the updated accountability framework had been approved at OMB for cascade across Divisions. The Board **noted** the OMB Chair's report.	
11.25	18.	**Audit Committee Chair's Report – 15th July 2025** The Board received the Audit Committee Chair's report which included areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed. The Board **noted** the Audit Committee Chair's report.	
11.30	19.	**Finance & Performance Committee Chair's – 20th May 2025 and 25th June 2025** Ms P Williams, Non-Executive Director presented the Finance and Performance Committee Chair's report which included areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed. On 20th May 2025 the Committee reviewed the Outline Business Case (OBC) for the Theatres Redevelopment Project. Issues were identified that required escalation to the Board. The Committee noted that a Full Business Case (FBC) would provide more detail and would require a dedicated session for thorough review. A verbal update was provided at the Board meeting on the 20th May 2025. On 25th June 2025 the Committee discussed the Emergency Department (ED), focusing on the sustainability of recent	

		improvements and the need to ensure they are embedded. The 2025–2026 Annual Plan was reviewed. At Month 2, performance was behind plan, and this trend continued into Month 3. Concerns were raised regarding the non-approval of deficit funding, which is expected to impact the Trust's cash position going forward. A paper is included on the Private Board agenda. The Board **noted** the Finance and Performance Committee Chair's report.	
11.35	20.	**<u>Annual Health & Safety Report 2024/25</u>** Mr K Edge (KE), Chief Finance Offer confirmed that the report had been reviewed at the Finance & Performance Committee. She acknowledged that the Health & Safety function has experienced instability in leadership over the past few years, but the appointment of Liam Telford as Health & Safety Manager in January 2025 has helped stabilise the function and initiate a robust improvement plan. The report highlighted one hundred and eighty-four health and safety incidents, with one hundred and eighty categorised as no-harm or low-harm and four as moderate harm. Two RIDDOR-reportable incidents were logged. Key objectives for 2025/26 include a Trust-wide audit, reintroduction of a Control of Substances Hazardous to Health (COSHH)system, policy reviews, accredited training for high-risk areas, and improvements in contractor safety and evacuation planning. Mr P Jones (PJ), Non-Executive Director raised concerns about the ageing infrastructure, fire safety and COSHH management, asking for assurance that mitigation plans are in place. KE responded that these risks are recorded on the risk register and actions progressing. Fire alarm replacements are underway, and while the risk is not yet eradicated, it is diminishing daily. The Trust is aiming for resolution by Q3. Prof A Hassell (AH), Non-Executive Director asked for clarification on the fire risk. KE explained that the Trust currently operates two fire alarm systems, which can cause confusion during activations. Although incidents have been isolated, the dual-system setup poses a risk that is being actively addressed The Board **noted** the annual health and safety report 2024/25 and the priorities for 2025/26.	
11.40	21*.	**<u>Digital and Data Strategy Update</u>** Mr J Bradley (JB), Chief Digital and Data Officer presented an update on the development of the Trust's revised Digital and Data Strategy. It builds on the 2021 "Digital Directions" strategy and aligns with the NHS "What Good Looks Like" framework and the Trust's strategic goals. The new strategy is structured around eight components:	

		People, Process, Infrastructure and Security, Applications, Data, Innovation, Green, and Partnerships. Key developments include: • A roadmap of digital projects through 2028, including Electronic Patient Record (EPR) upgrades, Artificial Intelligence (AI) pilots, and infrastructure improvements. • External assurance mechanisms such as the Digital Maturity Assessment, Healthcare Information and Management Systems Society (HIMSS) Electronic Medical Record Adoption Moderl (EMRAM), and Skills Development Network accreditation. • A prioritisation process embedded via divisional steering groups and the Clinical Digital Design Authority. • Risks identified across funding, resource, and cybersecurity, with mitigations in place The Board **noted** the update and received assurance on the development of a revised Digital and Data Strategy.	
11.43	22.	**<u>People Committee Chair's Report – 10th June 2025</u>** Ms W Williams (WW), Non-Executive Director/ Chair of the People Committee presented the People Committee Chair's report which included areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed. WW confirmed that many items had already been covered in the Integrated Performance Report (IPR) update but emphasised that the People Committee had conducted deep dives into sickness absence, the workforce plan, and financial plan targets, recognising these as critical areas. Additional work is planned to support the development and delivery of the People strategy. The Board **noted** the People Committee Chair's report.	
11.48	23*.	**<u>Council of Governors Summary Report – 17th July 2025</u>** The report summarised the key topics presented and discussed at the last Council of Governors meetings in July 2025. The Board **noted** the Council of Governors Summary Report.	
11.50	24.	**<u>People Strategy – 2025 – 2028</u>** This item was deferred to September 2025 to enable the Chief People Officer to present the paper**.**	

12.00	25.	**Terms of Reference Updates – Assurance Committees** **a) Audit Committee** **b) Finance & Performance Committee** **c) Quality & Safety Committee** **d) People Committee** All assurance committee Terms of Reference had been updated following the effectiveness reviews and approved through their respective committee meetings. The Board **ratified** the revised Terms of References for the following assurance committees: • Audit Committee • Finance & Performance Committee • Quality & Safety Committee • People Committee	
12.10	26.	**Use of Trust Seal: Women & Children's Build – Sub-Contractor Collateral Warranties** The Board were asked to approve the application of the Trust seal in retrospect for the Women and Children's build sub-contractor collateral warranties. The Board **approved** the use of the Trust Seal in retrospect.	
12.15	27.*	Items for noting and receipt: **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 1st May 2025 and Extraordinary 21st May 2025 (attached) b) Approved minutes of the People Committee – 8th April 2025 (attached) c) Approved minutes of the Finance & Performance Committee – 30th April and 20th May 2025 (attached) d) Approved minutes of the Operational Management Board – 24th April 2025 (attached) e) Approved minutes of the Audit Committee – 22nd April 2025 and Extraordinary 24th June 2025 (attached) f) Research and Innovation Committee Chair's report 16th July 2025 and approved Minutes 9th May 2025 (attached) **Other items:** g) Board of Directors Workplan 2025/26 (attached)	
12.18	29.	**Any Other Business** There was no other business to note.	
12.20	30.	**Questions from Governors and members of the Public relating to items on the meeting agenda**	

		Governors commented positively on the incentive to improve communications about the new Women's and Children's building.	
12.30	31.	**Closing remarks** The Chair asked if everyone was happy with the conduct of the meeting. No issues were raised and the Chair thanked everyone for their attendance and contribution.	

Next Meeting: Tuesday 30th September 2025

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

Countess of Chester Hospital NHS Foundation Trust

Public Board of Directors Action Log

Updated September 2025

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
1	4th June 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.	The Trust reports national data yearly to NHS England (KO41) the data of number of requests. This data is currently being uploaded with a submission date of June 25. The report will then be available publicly in August 25 and the results will be included in the Safety Surveillance Committee Paper. Previous years the Countess of Chester have been in the middle of the national tables. In 2023/24 the Countess were flagged as the trust that had seen the biggest reduction in complaints. This was due to a variety of reasons – mainly the Trusts Improvement plan, which included the utilisation the PALS and concerns process more. This is turn did show an increase in the number of	Sept-25	**Open**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
						concerns raised and a deep dive of concerns has been completed and presented.		
2	26th Nov 2024	Director of Strategic Partnerships	PB7/ 11/24	Chief Executive Officer's (CEO) Report	The Director of Strategic Partnerships, Mr J Develing, is representing the Trust on the reset of a new collaborative and a paper will be provided to a future Board of Directors meeting to detail the new governance arrangements.	**Update 19th August -** CMPC Joint Leadership Agreement and Terms of Reference have been added to the Private Board agenda.	Sept-25	**Closed**
3	25th March 2025	Director of Nursing & Quality / Deputy Chief Executive	PB12/ 03/25	Care Quality Commission (CQC) Improvement Journey	SP to chase up CQC for feedback on value for money assessment		Sept -25	**Open**
4	29th July 2025	Chief Digital and Data Officer	16.	Integrated Performance Report (IPR) – June 2025	Mr J Bradley, will develop mock-ups and consult with the executive team and committees, aiming for implementation by September.		Sept -25	**Open**

PUBLIC - Board of Directors
30th September 2025

Report	**Agenda Item 7.**		**Chief Executive Officer's Report**				
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Jane Tomkinson OBE			Chief Executive Officer			
Author(s)	Karan Wheatcroft			Director of Governance, Risk & Improvement			
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Relevant across all BAF areas.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led						**X** **X** **X** **X** **X**
Previous considerations	Not applicable						
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.						
Recommendations	The Board of Directors is asked to **note** the contents of this report.						

Corporate Impact Assessment	
Statutory/regulatory requirements	Contributes to the Trust compliance with Foundation Trust status.
Risk	Alignment with the Board Assurance Framework and Corporate Risk Register.
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 agenda pack.

Chief Executive Officer's Report

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

1. National

NHS England has published the Model Region blueprint which sets out the future role that regions will play as part of a new NHS operating model, as described in the 10 Year Health Plan. The implementation of the blueprint is a starting point to inform further work to develop the NHS operating model and the design of a new integrated centre.

In summary the document describes the role, purpose and core responsibilities of the new seven regions including

- Strategic leadership and planning
- Reform, innovation and development
- People leadership and workforce
- Digital transformation
- Performance management and oversight
- Improvement support and intervention
- Professional leadership and regional enabling functions
- Future developments and transition
- Enablers and capabilities for success

2. Cheshire & Merseyside Provider Collaborative (CMPC) Leadership Board meeting

August 2025

The CMPC Leadership Board met on Friday 1st August and discussed a number of system wide issues currently in focus. Trust Chairs were provided with an open invitation given some of the system stretch areas under discussion.

A large part of the meeting was used to explore commercial approaches and opportunities within the system drawing upon experience and lessons from within C&M, the region and progress to date through the CMPC Efficiency at Scale programme. Discussions were led by Bill Gregory, NHSE and James Thomson, UHLG Chief Commercial Officer and sought to provide a framework for response to the system's efficiency requirements but also the recent policy push from NHSE. Following discussions Trust representatives were asked to confirm their organisation's intention to participate in the next phase of the commercial opportunities programme covering the prioritised system opportunities - Pharmacy, Procurement, Estates & Facilities, and Digital - requirements for additional resource in areas including legal, tax, procurement, and PMO, will be subject to a further proposal for specific resourcing as the work develops.

Next the Leadership Board received an update on the work of the Community Services Programme which has been reviewed and reframed since becoming a CMPC programme. Its focus remains on schemes which reduce hospital admissions or enhance rates of discharge including virtual wards and urgent community response schemes. The programme's in year focus is on reducing variation and maximising consistency across C&M. Consideration was

also given the an ICB request for review of virtual ward services with a view to a circa 25% funding reduction £3m of £13m. while it is clear that a commissioning decision is required by the ICB views were put forward and explored on the least disruptive options that could be explored as a result of any such reduced funding envelope.

Finally, the Board were provided with a briefing on the work being progressed at the request of the ICB and the region to collate and prioritise schemes for Regional Transformation Bids. While no decisions had yet been made discussions were taking place on deliverability and in year benefit realisation covering NHS priorities: Analogue to Digital; Hospital to Community; Neighbourhood Healthy and other.

Update papers were also provided on the following areas:

- Update in implementation of Federated Data Platform (FDP) – this included a deployment update, consideration of enhanced governance and to build toward a system decision on use of a single PTL
- System financial report
- System performance update

<u>September 2025</u>

The CMPC Leadership Board met on Friday 5th September and discussed a number of system wide issues.

The Board noted Ann Marr's resignation from the ICB Board and her contribution to provider collaboration within C&M and took the opportunity to consider the next steps for provider collaboration within C&M while CMPC leadership choices were considered by Trusts during the early part of September. These discussions took two parts a Provider Collaborative reset and the development of a provider strategy – an NHS provider Trust blueprint.

The opportunity for a CMPC reset discussions focussed upon:

- Leadership and alignment with our Trust execs
- Alignment with the ICB and establishment of a recovery cell with the ICB
- Reset of our priorities focussing on:
    - Planned care including elective and diagnostics
    - Community services standardisation and patient flow
    - Clinical pathways and fragile services
    - Efficiency at scale including corporate services opportunities

In respect of the draft and in development NHS provider Trust blueprint opportunities discussed included:

- Fragility of clinical services – exploring creation of service chains for specialist services
- Number and scale of NHS Trust providers – development of provider groups and sub regional partnerships
- Variation in service integration across the ICS – alignment of community services with Places

- Multiple corporate and clinical support services – consolidation

Finally, the Board were provided with a brief over of the 65 week wait position and the need for individual Trust clarity in relation to these positions and expected reductions.

Update papers were also provided on the following areas:

- System financial report
- System performance update

The latest CMPC bulletin is appended to this report.

3. Cheshire, Warrington and Wirral

The NHS Trusts in Cheshire, Warrington and Wirral continue to meet to explore collaboration opportunities within Cheshire and Merseyside. These discussions centre on key principles of collaborative working including:

Key principles

Quality of care and equity of access:
Ensure the Strategy maintains and improves the quality of care and equity of access for patients and local populations

Fragility of clinical services:
Reduce the fragility of clinical services through the consolidation and joint working

Financial stability:
Reduce the operating costs of provider Trusts to support medium term financial stability of provider Trusts

Hosting and/or networking arrangements:
Promote the hosting and/or networking of identified clinical services, where there is clinical expertise and capacity

Organisational Forms:
Determine future organisational forms for Provider Trusts, aligning to patient flows and geographical locations

Place and Neighbourhoods:
The role and functions of Places and neighbourhoods will be initially excluded from the Provider and Clinical Strategy, with consideration for inclusion, at a later date

4. Cheshire West - Integrated Neighbourhood Teams

Although there was a lot of successful input from partners into the collation of an application for the national Integrated Neighbourhood Programmer, Cheshire West were unable to secure sign up from all Primary Care Networks in the available time period. PCNs voiced concern regarding having sufficient opportunity to discuss the commitments required and there level of readiness. Although this is disappointing, it has provided valuable learning to review our collective approach to Integrated Neighbourhoods within Cheshire West Place.

Further work is being done to review and revise the proposed governance for the Integrated Neighbourhood Programme and additional workshops will be held both with GP practices/PCNs in Sept and more broadly with Health and Wellbeing Board partners in October to develop a shared plan for the next 2 years.

5. Employee and Team of the Month

July

Our Employee of the Month for July was Kirsty Marie Smith, Urgent Treatment Centre**.** "Kirsty is a Emergency Nurse and consistently brings a positive attitude to every shift, showing empathy and care that patients truly appreciate. Her efficiency and dedication – including staying beyond her contracted hours and proactively managing patient flow – have played a key role in the success of the UTC. She leads by example and embodies excellence in everything she does."

Our Team of the Month for July was Ward 43. "Ward 43 secured the Macmillan Quality Cancer Environment Award for the third consecutive time – with their highest score to date. The award recognises the environment and experience of patients undergoing cancer treatment, and the assessors praised the team's kindness, dedication, and the welcoming, clean ward environment. Patient feedback highlighted the team's compassion and exceptional care, making this achievement a true reflection of their commitment to excellence".

August

Our Employee of the Month for August was Sandra Beato-Juarez, Service Manager, UC "Sandra is consistently a positive presence in the SDEC department. She is efficient in all tasks that she takes on despite pressures within the NHS. She always makes the team feel heard and supported. She has a lovely, warm and welcoming attitude that is a pleasure to work alongside. She truly cares for her colleagues and the service. She has a can-do attitude and will help support in any tasks even if they do not come under her job role but are for the benefit of the patients, team and service".

Our Team of the Month for August was the Cardio-Respiratory and Vascular (CRV) team. "The CRV team deserve recognition for their hard work, dedication and innovation during a challenging time. They show a commitment to service delivery and development and provide sometimes unseen support to multiple specialties within the Trust. They are commended for their openness to innovation and appetite for change and delivering the highest quality patient care"

6. NHS National Staff Survey launched in September

The 2025 national NHS Staff Survey launched in mid-September. The NHS Staff Survey is one of the most important ways we can hear directly from colleagues about their experiences at work. The feedback helps us understand what is working well and where we need to improve, shaping how we support our people now and in the future. Every response gives us valuable insight that drives real change – from improving workplace culture and staff wellbeing to enhancing the care we deliver for patients.

7. National recognition for Obstetrics and Gynaecology

We have been Highly Commended by the Royal College of Obstetricians and Gynaecologists, for being one of the most improved training environments for resident doctors in obstetrics and gynaecology.

This achievement reflects a significant turnaround, driven by a focused action plan, strong leadership, and a renewed commitment to structured learning, supervision, and staff development. The improvements were also reflected in the General Medical Council trainee survey.

8. Investing in lifesaving skills – and the people who use them

We are proud to announce the arrival of Sim Man, a state-of-the-art CPR training manikin funded through generous donations from The Ursula Keyes Trust Fund and the Countess of Chester Charity. This investment of nearly £100,000 enables our Resuscitation Team to deliver even more immersive and realistic training, helping staff build confidence and competence in responding to cardiac emergencies - wherever they may occur.

9. Women and Children's Building Opening

In July we got the keys to the new Women and Children's Building and in early September, after a month of final preparations, we opened to our patients.

The building has been years in the planning and is the result of hard work, clinically focused design and community collaboration which has helped to shape it into a modern healthcare facility to better meet the needs of our local community and that brings together maternity, neonatal, paediatrics and gynaecology services under one roof. It is brighter, bigger and better with more space, comfort, privacy, and support for families and staff. Pedestrian routes have been improved to ensure the accessibility of the building.

Clinical teams planned, tested and rehearsed for months ahead of the opening to ensure patients were moved seamlessly into the new facility.

Demolition of the old building, which was constructed in the 1970s, will begin in the coming weeks and be completed by the end of the current financial year.

10. Latest CQC rating for Urgent and Emergency Care Services

In August, the Care Quality Commission (CQC) published their latest report and rating for our Urgent and Emergency Care services (UEC), following their inspection in February. The CQC rated UEC as *'inadequate'.* Meaningful progress has been made but it is clear that the actions taken have not yet had the impact needed to consistently deliver the care and experience patients deserve.

The CQC recognised improvements made but also highlighted the need for consistency – getting standards right for every patient. The rating is for UEC but the service and performance is connected to every division and service across the Trust. All staff were encouraged to remain focused on strengthening the collective approach so that long-standing issues that have impacted standards can be addressed.

11. NOF

The NHS has published the latest national oversight framework (NOF) performance data for Trusts across the country. This data offers an overview of how each organisation is performing against a range of key measures, supporting the shared goal of high-quality care for patients and communities.

We recognise that our Trust currently faces significant challenges, and the published data reflects the scale of improvement needed. The Countess of Chester Hospitals NHS Foundation Trust is positioned at 133 out of 134 Trusts. While this is a disappointing outcome, we are absolutely committed to improving our performance and ensuring that our services meet the standards our patients, partners, and stakeholders expect.

The data does not capture the full dedication, professionalism, and compassion our staff demonstrate every day. We continue to take action to improve long-standing challenges and are already seeing early, positive signs of progress.

I want to reassure you that:

- Patient safety and quality of care remain our highest priorities.
- We are investing in areas that need improvement, including enhancing urgent and emergency care capacity.
- We are collaborating closely with our local Integrated Care Board, local authority, and all system partners to ensure we work together to deliver effective and sustainable change.

12. Industrial Action: Resident Doctors Strikes

The resident doctors' strike took place from 7am on 25th July until 7am on 30th July 2025. Robust plans were in place to minimise the impact on services, ensuring staff were supported and services remained safe during this period. The BMA has a six-month mandate for industrial action, covering the period from 21st July 2025 to 7th January 2026.

13. Flu Plan

The Flu Plan has been established with the Occupational Health team delivering a staff flu vaccination campaign launching 1st October 2025 and a strong focus on this campaign for the first 8 weeks. As in previous years this will be delivered with regular Trust wide communications and encouragement through the leadership structures.

14. Country Park wins two awards

In July, the Countess of Chester Country Park, received its eighth consecutive Green Flag award as well as the Land Trust's Health Park of the Year Award.

At a special celebration, representatives from COCH, CWP, Chester Zoo, the Wildlife Trust and Friends of the Country Park volunteers came together - a reminder of the wellbeing space we are fortunate to have on our doorstep.

It also highlighted our joint commitment to community health and wellbeing.

15. Celebration of Achievement Awards 2025

Our Celebration of Achievement event too place on the 19th September 2025, recognising a wide range of teams and individuals for their contributions. The winners of the awards were:

- **Inspirational Leadership Award:** Mark Smallwood - Lead Reporting Radiographer
- **Commitment to Learning Award:** Wiktoria Mysera – Apprentice in Outpatients Reception

- **Volunteer of the Year Award:** Pam Evans
- **Quality/Safety Improvement of the Year:** Critical Care Outreach Team
- **Countess Cornerstone Award:** PALS (Complaints and PALS Team)
- **Unsung Hero Award:** Ewelina Romanowicz - Maternity Assistant
- **Living the Values Award:** Dr Scott Williams - Consultant in Diabetes and Endocrinology
- **Digital Innovation of the Year:** Acute Take Project Team (including Adam Smith) in Digital Services
- **People's Choice Award for Outstanding Care:** Xavia Kelly – Midwife
- **Outstanding Individual Achievement of the Year:** Baki Kose, Domestic Services
- **Outstanding Team Achievement of the Year:** EPH Stroke Rehabilitation Team
- **Chief Executive's Award:** Hospital Sterilisation Decontamination Unit (HSDU)

16. Annual Members' Meeting

Our Annual Members' Meeting (AMM) will take place on Wednesday 1 October, 3pm – 5pm in the Trust Boardroom. The AMM is a chance to reflect on our annual report, the progress we have made in the past year and our priorities for the coming year.

17. 'Failure to Prevent Fraud'

On 1st September 2025 a new fraud offence came into force. This is a corporate offence of 'failure to prevent fraud', which is part of the Economic Crime and Corporate Transparency Act 2023. We have published a statement on our Trust website outlining our commitment and expectations in preventing fraud.

The failure to prevent fraud statement is appended to this report.

18. Board Leadership update

Dan Nash, formerly our Director of Performance and Operational Improvement, has refocused his role and has taken up the position of Director of Delivery with immediate effect. Dan will be instrumental in supporting the significant task ahead – delivering against our financial targets - which demands targeted leadership and expertise.

Dan will lead the Continuous Improvement team and support the development of a Project Delivery Office to help us drive forward our improvement work.

This change is not an additional post but a strategic refocus to ensure our efforts are directed where they are most needed.

CMPC BULLETIN

Welcome message

Linda Buckley Managing Director, CMPC, for and on behalf of our members

The CMPC Leadership Board met on Friday 4th July and 1st August, and discussed a number of system wide issues currently in focus.

In July, a significant portion of the meeting was handed over to a shared discussion with the ICB and NHSE colleagues and Trust Chairs for the Cheshire and Merseyside system to receive a summary of the outputs from the system wide rapid diagnostic review, led by Stephen Hay and supported by a team from PwC. At that time, individual Trust specific reports were expected to follow in month and have since been delivered. Discussions have continued about how the system responds to the recommendations arising from the review. Trusts have been notified of further in-depth discussions and exploration of monthly financial positions.

The Leadership Board received an update on the Efficiency at Scale Programme, specifically with relation to corporate back office and at scale opportunities. Support was provided to the more detailed work up of system wide opportunities covering: digital, procurement, occupational health and recruitment. Work will focus on exploring single solutions for C&M, where feasible, to ensure maximum benefit realisation. This update was built upon through a further discussion in August where commercial approaches and opportunities, within the system, were further explored drawing upon experience and lessons from within C&M, the region and progress to date through the CMPC Efficiency at Scale programme. Discussions were led by Bill Gregory, NHSE and James Thomson, UHLG Chief Commercial Officer and sought to provide a framework for response to the system's efficiency requirements, but also the recent policy push from NHSE. Following discussions, Trust representatives were asked to confirm their organisation's intention to participate in the next phase of the commercial opportunities programme covering the prioritised system opportunities - Pharmacy, Procurement, Estates & Facilities, and Digital - requirements for additional resource in areas including legal, tax, procurement, and PMO, will be subject to a further proposal for specific resourcing as the work develops.

Other items discussed at the August meeting included an update on the work of the Community Services Programme which has been reviewed and reframed since becoming a CMPC programme. Its focus remains on schemes which reduce hospital admissions or enhance rates of discharge including virtual wards and urgent community response schemes. The programme's in year focus is on reducing variation and maximising consistency across C&M. Consideration was also given to an ICB request for review of virtual ward services with a view to a circa 25% funding reduction £3m of £13m. While it is clear that a commissioning decision is required by the ICB, views were put forward and explored on the least disruptive options that could be explored as a result of any such reduced funding envelope.

Finally, the Board were provided with a briefing on the work being progressed at the request of the ICB and the region to collate and prioritise schemes for Regional Transformation Bids. While no decisions had yet been made, discussions were taking place on deliverability and in year benefit realisation covering NHS priorities: Analogue to Digital; Hospital to Community; Neighbourhood Healthy and other.

Update papers were also provided across both meetings on the following areas:

- Implementation of Federated Data Platform (FDP) – this included a deployment update, consideration of enhanced governance and to build toward a system decision on use of a single PTL
- System financial reports
- System performance updates

Efficiency at Scale (E@S)

Senior Responsible Officer: Ged Murphy
Programme Director: Nina Russell

NHS
Cheshire and Merseyside
Provider Collaborative

An update was provided to CMPC Leadership Board on **corporate collaboration models** across the Northwest and potential, at pace, opportunities for C&M. The Leadership Board agreed to progress with the assessment of collaboration opportunities in digital, procurement, recruitment and occupational health.

Medicines Optimisation

The medicines optimisation programme has received approval for £700k investment to support the delivery of **£6m savings** for oral nutritional supplements (ONS).

The Medicines Optimisation Programme has been shortlisted for the 2025 HSJ Awards for the 'Medicines, Pharmacy and Prescribing Initiative of the Year' category.

On 17th July 2025, over 340 colleagues from both primary and secondary care, attended a Valproate webinar, marking the official launch of the C&M Valproate Prescribing Guidance.

Month 4 – **£5.79m delivery** against a plan of £5.90m – on track to deliver £29.36m against £29.79m.

Procurement

31% of the procurement workplan has been delivered. The procurement programme is forecast to deliver **£18m** IYE against at £20m target, with £5.6m delivered YTD.

Commercial

C&M Commercial review was presented to the August CMPC Leadership Board and included an initial high-level financial assessment and proposed next steps. This was well received, and next steps are in progress.

Risk, Governance and Legal Services

The C&M IPC 'CPE Management: Toolkit & System Guidance' was presented to the Directors of Nursing in August which was well received; this marks the start of the formal launch of the toolkit.

E@S are working with the existing **Legal Collaboration** to explore wider system opportunities with a plan to present back to relevant professional leads.

Elective Recovery and Transformation

Senior Responsible Officer: Janelle Holmes
Programme Director: Steve Barnard

NHS
Cheshire and Merseyside
Provider Collaborative

End of July 2025:

1,282 65-week patients
(1,030 were capacity, 120 choice, 111 complex/unit and 21 corneal grafts).

The 52-week wait total cohort position (up to March 2025) has reduced from
177,377
in July 2024 to
15,093
in July 2025.

Validation improvement plans and trajectories continue to be tracked, in which, the actual position is reporting positive increases of 64.93% improvement for 12-weeks,71.64% for 26-weeks and 77.85% for 52-weeks.

C&M are achieving 77.85% for validation for 52-week validation performance; this has decreased compared to the previous month due to the implementation of a new EPR system at ECHT & MCHT which has impacted on trust submissions. 8 providers are now achieving the national target of 90%.

Theatres

New NHS surgical centre in Northwich officially opened :: Mid Cheshire Hospitals NHS Foundation Trust

Gynaecology

Clinical validation of the WUTH General Gynaecology waiting list has been completed. Over 1400 patients have been reviewed. As part of the outcomes, circa 10% of patients were found to be suitable for the GP with Special Interest (GPwSI) led Menopause clinics. Planning continues to launch these in Autumn 2025.

Group consultations onboarding session is taking place on 20th August with attendance from LWH and wider providers. The first pilot will be within LWH and the initial outcomes of this will be shared end of September 2025.

Commissioning for IUD fit and removal for non-contraceptive reasons for patients over 55 years old was approved in August 2025 on the Wirral. This will support less patients requiring onward secondary care referral.

Opening date for new Women and Children's Building revealed | Countess of Chester Hospital

Dermatology

Following approval from NHS England (NHSE) for NHS trusts to use the **Skin Analytics** system autonomously, the Dermatology Alliance will be carefully considering the data, timeline, and approach for transitioning to an autonomous service model, which includes the removal of the current second-read process.

Trusts are also discussing and developing plans around the possible implementation of **virtual clinics** into the pathway and the benefits this could bring for both trusts and patients. ICB finance leads have agreed which tariff can be utilised, enabling correct job planning of the virtual clinics.

ENT

As part of the **90 Day Accelerator** plans, work is progressing at pace with University Hospitals of Liverpool Group (UHLG) to support ENT improvement plans.

Installation of new OPD modular moves to fit-out phase :: Mid Cheshire Hospitals NHS Foundation Trust

Providers have been agreeing which pathways they wish to lead on to support the design and implementation of the **Single Point of Access (SPOA)**.
C&M pathway harmonisation continues. All provider on-site meetings are now arranged and are taking place by mid-Sept 2025.

Current ENT community provision has been mapped and shared with the C&M ENT Alliance.

Ophthalmology

Following the success of the initial 12-month pilot, approval has been received to implement a Single Point of Access across Cheshire and Merseyside. A steering group will be established to agree next steps with regards to procurement and commissioning.

Work continues on the **e-referral service (eRS) endpoint model** implementation. The final design has been approved by the eyecare network, and we are now looking for expressions of interest from Trusts to test the implementation of the model. This will support referral management and ensure appropriate and correct patient choice is offered.

In order to support the wider Elective Reform and Transformation objectives, the Eyecare network has been restructured. The full network, which includes Place and Primary Care representation, will now meet bi-monthly. On alternate months, a focussed meeting will take place with Trusts to focus on outpatient opportunities and GIRFT improvement plans

Diagnostics

Senior Responsible Officer: Rob Cooper
Programme Director: Tracey Cole-Wetherill

NHS
Cheshire and Merseyside
Provider Collaborative

88.6%

of patients waited 6 weeks or less in June (decrease from the previous month).

ICS ranking

#3

for 6 week waits

Endoscopy

List utilisation remains high:
103%
of lists taking are place.

In September, we will implement a pilot at 2 Trusts to move surveillance endoscopy patients to the Halton hub, improving waiting times and efficiently using available capacity

Pathology

We have had 2 cases fully approved by NHSE bringing a total of £4.75 million in capital into C&M to automate 2 Trusts' histopathology services further and enable the unified LIMS programme to continue to progress towards implementation in 2027.

In July there was excellent histopathology data submitted for Cheshire and Merseyside:
85.6%
of cancer cases are reported in 10 days (against a target of 80% and 71.2% of all cases are reported within 10 days against a target of 70%.

Physiological Sciences (PS)

We now have 2 new members of the team who will be concentrating on Cardiac and Respiratory Physiology workforce and education requirements across Cheshire and Merseyside.
Welcome to Angela Key and James Hardy-Pickering.

Single C&M WatchPAT procurement rate has been agreed with Zoll for Sleep Services. This will have an in year financial saving of £33k cost avoidance and £19k direct cost savings.

Alder Hey has launched the first vestibular screening programme for children in the UK - Alder Hey Children's Hospital Trust

Radiology/Imaging

The Cloud based Picture Archiving and Communication System (PACS) implementation is progressing well with 5 Trusts implemented (6 clinical sites). Lots of lessons learned from early implementations are ensuring that current implementations are moving more smoothly.

A business case has been approved to re-procure or extend the current C&M Radiology Information System for the Trusts involved.

Cheshire and Merseyside Radiology Imaging Network introduces transformational AI diagnostic technology - NHS Cheshire and Merseyside

Community Diagnostic Centres (CDCs)

We have now had 4 pilot pathways approved across 3 of our CDCs which will see a more efficient pathway for patients. If the pilots prove successful we would look to roll them out across all of our CDCs.

CDCs continue to provide significant mutual aid to Trusts across C&M where there are waiting times issues in specific diagnostic tests.

Community Services

Senior Responsible Officer: Ian Moston
Programme Director: Tony Mayer

NHS
Cheshire and Merseyside
Provider Collaborative

Virtual Wards

The target utilisation rate of 80% is still consistently achieved across C&M beds in total, and the programme is now focussing more on length of stay and throughput in order to maximise the impact of the VW service.

The mean LOS on VW is now at 7.5 days, a reduction from a mean of 9 days in 2024/25 that releases hospital bed capacity with an associated cost reduction of 97K year to date.

Urgent Community Response (UCR)

The latest month's data demonstrates the highest number of accepted referrals into UCR services since the service began with 4670 patients benefitting from the service during the month.

As a comparator with neighbouring ICBs C&M are consistently the best performing ICB within the northwest when comparing referrals per 100K population.

A target standard specification has now been developed and shared with providers with a gap analysis completed against target specification that will inform plans to standardise service delivery and outcomes.

Integrated Care Coordination

The North Mersey Integrated Care Coordination Hub went live on the 28th July, 3 months from its inception, as phase one of a C&M wide plan. The hub brings together the experts from acute and community providers to provide a single point of contact for ambulance staff and community based practitioners. The service has significantly increased referrals into services as an alternative to an ED attendance and/or hospital admission. The approach will now be extended to the remaining areas of C&M on the 8th September with initial talks to include mental health professionals line for phase 3, starting in early October.

Wheelchair Review

The review of wheelchair services across C&M has now commenced with an expectation to reduce overall cost through joint procurement and service standardisation.

Frailty

The inaugural C&M frailty group is set for the 24th September to progress system wide actions described within the recently documented frailty Improvement plan. The role of the provider collaborative has now been agreed to include review of frailty offer across providers, including impact and opportunities for standardisation.

CHIEF EXECUTIVE STATEMENT

on the new 'Failure to Prevent Fraud' offence and other financial crimes against the NHS

On 1st September 2025 a new fraud offence came into force. This is a corporate offence of *'failure to prevent fraud'*, which is part of the Economic Crime and Corporate Transparency Act 2023.

This new type of fraud occurs where **someone connected with the organisation (what the Act calls an 'associated person') commits a fraud offence that intentionally benefits the Trust , or a related body, rather than just the individual, and where the Trust should have had reasonable procedures in place to prevent this from happening.**

In these circumstances the legislation holds large organisations (including NHS organisations) criminally liable.

An 'associated person' can be any employee of the Trust, including volunteers, as well as contractors, subsidiaries, agents and other service providers or partner organisations.

Any breach of this new law could mean this Trust is criminally prosecuted and subject to an unlimited fine unless it has put reasonable anti-fraud measures in place even if these were intentionally ignored or by-passed.

I can assure everyone that this organisation takes its responsibilities very seriously and we have been working with our anti-fraud provider (MIAA) to ensure all 'associated persons' know their responsibilities in this area and that robust arrangements to prevent all forms of fraud, bribery or corruption are in place.

[Should you wish to read about the new legislation in more detail, the NHS Counter Fraud Authority has provided specific guidance, failure to prevent fraud offence | NHS Counter Fraud Authority, or you can speak to our dedicated Anti-Fraud Specialist whose contact details can be found below and in our Anti-Fraud Policy.

Tackling financial crime against the NHS

In addition to the new 'failure to prevent fraud' offence, there are other existing fraud, bribery and corruption offences in place, and now is a good time to re-affirm that this Trust takes a vigorous, zero tolerance, approach to those who commit any of these offences against the NHS.

Anyone who commits fraud against the Trust could be subject to any, and all, sanctions available (criminal, civil, disciplinary, and regulatory body). The Trust employs MIAA to undertake anti-fraud, bribery and corruption work and we will provide the necessary resources to enable our Anti-Fraud Specialists to conduct criminal enquiries against any alleged perpetrators of such offences.

In addition, this Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor do we, nor will we, accept bribes or improper inducements. This

approach applies to **everyone** who works for us, or with us. To use a third party as a conduit to channel bribes to others is a criminal offence. We do not, and will not, engage indirectly in, or otherwise encourage, bribery.

Counter Measures

The Trust is committed to the prevention, deterrence and detection of fraud, bribery, and corruption. To this end, everyone associated with the Trust is expected to play their part and act in accordance with both the law and all our policies and procedures.

The Trust adopts and implements the 'reasonable procedures' approach suggested by the new *'failure to prevent fraud'* offence (and which are similar to the 'adequate procedures' introduced in relation to the Bribery Act 2010).

The approach will, amongst other steps, involve:

- Top-level commitment: Active involvement and leadership from senior management, with a clear culture established and embedded from the top to ensure a 'no tolerance' approach towards fraud, bribery, and corruption.
- Risk Assessment: Regular identification and evaluation of fraud and corruption risks across all levels of the organisation, including third-party and supply chain risks.
- Proportionate risk-based prevention procedures: Tailored fraud controls that are suitable for the organisation's specific fraud risk exposure and complexity.
- Due diligence: Assessing the background, integrity, and reliability of individuals or entities performing services for or on behalf of the organisation.
- Communication (including training): Ensuring staff, contractors, and associates understand fraud policies and risks through regular awareness training.
- Monitoring and review: Continual evaluation of the effectiveness of fraud, bribery, and corruption prevention measures, with regular updates based on new risks or incidents.

Reporting Concerns

If you have any concerns or suspicions regarding bribery, corruption, or fraud, please contact:

- Your **Anti-Fraud Specialist – Karen McArdle**
  Tel – 07774 332881/ 0151 285 4500
  Email – karen.mcardle@miaa.nhs.uk
- NHS Fraud & Corruption Reporting Line
  Tel – 0800 028 4060
- NHS Fraud & Corruption Reporting Form (online)
  https://cfa.nhs.uk/report-fraud

Jane Tomkinson OBE

Chief Executive Officer

PUBLIC - Board of Directors
30th September 2025

Report	**Agenda Item 9a.**	**Board Assurance Framework 2025/26**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk & Improvement				
Author(s)	Nusaiba Cleuvenot			Head of Corporate Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Linked to all BAF areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Not applicable							
Executive summary	The BAF was reviewed and approved by the Board in July 2025. This paper provides for continued triangulation with the Board agenda. The full quarterly review and update of the BAF will be reported to the Board in November 2025. 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) To note the Digital BAF risk has been updated seperately and this will be reflected in the full report in November 2025.
Recommendations	The Board of Directors is asked to note the Board Assurance Framework as aligned to the Board agenda and papers received.

Corporate Impact Assessment	
Statutory/regulatory requirements	Trust compliance with the CQC regulatory framework, Provider Licence and Code of Governance.
Risk	Various risks included on Board Assurance Framework (BAF) and risk registers.
Equality & Diversity	Meets Equality Act 2010 duties & Public Sector Equality Duty 2 aims and does not directly discriminate against protected characteristics.
Communication	To be issued as part of the agenda pack.

Countess of Chester Hospital
NHS Foundation Trust

Board Assurance Framework 2025 - 26

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	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 2025	**Causes:** - Longer patient waiting lists - Inconsistent compliance with standards - Hospital capacity not supportive of the high volume of patients presenting to the Emergency Department. - Lack of clinical engagement.. **Consequences:** - Quality of care - Unintended harm - Poor patient experience - Regulatory compliance	***4 x 5 = 20***	C1) Quality and Safety Strategy priorities. **Control Owner:** Director of Nursing and Quality	- Safety Surveillance 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 - Quality and Safety Strategy and reporting	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**	Consistency of application of standards.			***9***	***Mar-26***
			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.	*Acceptable*							
			C3) Infection Prevention and Control. **Control Owner:** Director of Nursing and Quality	- IPR - Infection, Prevention & Control Quarterly Report via Q&S Committee - Quality Governance Group via Q&S Committee - Annual Quality Account (featuring IPC section re objectives) - PLACE inspection reports	CQC reports	*Partial*			Consistency of cleaning standards. IPC compliance assurance and improvements.				
			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.	*Acceptable*			UEC CQC inspection findings and response.	(i) To deliver the warning notice action plan. **Action owner:** Director of Nursing and Quality **Due date:** Q2 (ii) To respond to the findings of the CQC report. **Action owner:** Director of Nursing and Quality Due date: Quarterly updates	Comprehensive action plan developed and progress monitored weekly. Deep dive through the Q&S Committee. Bi-monthly progress report to Q&S Committee and update to Board of Directors (July 2025).	
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 2025	**Causes:** - Longer patient waiting lists. - Underdeveloped partnership working arrangements to support clinical strategy delivery. - Lack of reciprocal engagement in the wider health system. - Mental health service provision in A&E and across all Trust sites **Consequences:** - Unintended harm - Extended length of stay - De-conditioning of patients	***4x 5 = 20***	C1) Safety priorities. **Control Owner:** Medical Director	- IPR - 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 (falls, pressure ulcers). **Action owner:** Medical Director **Due date:** Quarterly updates	Continued updates to Quality Governance Group and presentations through Harms Improvement Oversight meeting.	***9***	***Mar-26***
									Consistent application of standards,	To deliver improvements in Sepsis complicance. **Action owner:** Medical Director **Due date:** Quarterly updates	New cerner processes implemented. Work ongoing to embed consistency of compliance with screening process and actions. Audit data being collated and reviewed. Updates provided to Q&S Committee.		
			C2) Organisational learning **Control Owner:** Medical Director/ Director of Governance Risk and Improvement	- Safety Surveillance Quarterly report to Q&S Committee and Board - Quarterly Mortality 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:** Q3	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. Early draft being updated by the Deputy Director of Nursing and Quality Governance.		
			C3) Review of deaths **Control Owner:** Medical Director	- Quarterly Learning from Deaths report and annual mortality report via Q&S Committee and Board - Quality and Safety Committee	Telstra Health (Dr Foster) benchmarking	*Acceptable*							
			C4) Delivery of the Clinical Strategy **Control Owner:** Medical Director			*Partial*			Delivery of the Clinical Strategy and assurance reporting.	Develop approach to providing assurance on the progress of delivery of the Clinical Strategy through OMB. **Action owner:** Medical Director **Due Date:** Q4	Clinical Strategy approved and launched. External engagement events to be led by the Director of Strategy and Partnerships (July 2025).		
			C5) Mental Health service provision **Control Owner:** Director of Strategy and Partnerships	Exec to exec meetings with CWP.		*Partial*			Response to CQC Warning notice. Delivery of mental healtjh review action plan. Clear governance for collaboration and partnership working.	Ensuring improvements in setting expectations, clarity of accountability, and consistent application. **Action owner:** Director of Strategy and Partnerships **Due Date:** Quarterly updates	Actions included in the CQC action plan. Ongoing monitoring of standards. Exec to exec planned to discuss position and agree action. Further work progressed on TOR for a Joint Executive led Committee.		

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: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (C x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
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 2025	**Cause:** - Unable to meet the demand for services within available resources - Increased demand in suspected cancer referrals and ED attendances - Increased number of patients that do not meet the criteria to reside **Consequences:** - Increased patient waits for access to services impacting on patient safety, potential harm and patient experience. - Failure to meet key targets and regulatory requirements in some areas - Sub-optimal service provision - Increased ambulance handover delays - Potential increase in complaints from family, friends and carers.	*4 x 5 = 20*	C1) Annual plan with clear activity and performance reporting against trajectories and focussed improvement plans as required. **Control Owner:** Chief Operating Officer	- IPR 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 - Quarterly Divisional Performance Reviews - Bi-weekly patient flow meetings.	North West performance report overseen by ICB. Contract review meetings. System Oversight Group.	*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 SOG. (ii) ED - Continued MADE (weekly) super MADE (bi-monthly) multidisciplinary discharge events. (iii) Explore options to extend Same Day Emergency Care Unit opening hours. (iv) Flow improvement plan integrated with UEC imporvement plan to drive forward clear priority actions and assess the impact. **Action Owner:** Chief Operating Officer **Due date:** Quarterly updates	The Trust continues to meet the elective long waiting targets, the reduction in suspected long waiting cancer patients, however compliance to the operational standards relating to RTT remain challenged. There is a plan for a significant improvement in RTT compliance by the end of September 2025 . 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 hours, ambulance handover delays 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 has an option to extend UTC opening hours however revenue funding would be required. Flow improvement plan being aligned with UEC improvement plan to ensure clear priorities and a focus on assessing the impact of the actions taken.	*12*	*Mar-26*
			C2 Performance management framework and Governance Structure **Control Owner:** Chief Operating Officer	- IPR 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 - Quarterly Divisional Performance Reviews		*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 and have supported validation. Continue to focus on non RTT follow up and report through OPELG. The AI validation tool is now at the point of being procured and will be implemented by Q4.		

Risk Theme: Workforce

RISK APPETITE: OPEN - Upper tolerance limit 12

LINKS TO STRATEGIC GOALS: SG2: People and Culture

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	Estimated date of achievement of target score
BAF4 Challenges in ensuring a high quality, engaged, diverse and inclusive workforce and culture would affect our ability to deliver patient care. **Executive Risk Lead:** Chief People Officer **Assurance Committee:** People Committee **Last Update:** July 2025	**Causes** - Poor staff morale and culture - Staff burn-out - Lack of health and wellbeing support - Increased pressures in the hospital - External scrutiny - Failure to engage staff, listen to feedback and act - lack of effective systems and processes - Lack of accountability **Consequences** - Loss of goodwill and staff engagement - Short term sickness absence - Turnover hotspots - A deterioration in the physical and mental wellbeing of our workforce - Increased bank/ temp staff hours - Erosion of skills and knowledge - Reduced leadership capacity and capability - Poor behaviours - Silo working, lack of collaboration and innovation, ownership of performance and delivery	*5 x 4 = 20*	C1) Workforce Plan **Control Owner**: Chief People Officer	- IPR (to every Board) - Staffing monitored via Strategic Workforce Group and chair's report to People Committee - Vacancy Control Panel reporting to EDG	Annual plan submitted to ICB. Monthly monitoring at ICB level	*Partial*	*5 x 3 = 15*	**NO**	Lack of digital workforce systems, processes and reporting. Greater scrutiny at system level and review of controls.	(i) Continue to ensure vacancy control measures are aligned to ICS headcount expectations and reporting. (ii) Continue to explore and progress digital systems **Action owner:** Chief People Officer **Due date:** Quarterly updates	Executive led Vacancy Control Group including variable pay measures and Pay Control Group in place. Plan being developed to roll out e'rostering for AfC staff to commence feb 2025. Medical e'rostering procurement underway with phased implementation from Q2 25/26.	*12*	*Mar-26*
									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 planning session at People Committee and Board development day in October 2024. Workforce planning aligned to 2025/26 operational planning as well as the Clinical Strategy. Band 2/3 and apprenticeships work continuing to progress.		
			C2) Staff experience, engagement, morale and culture **Control Owner**: Chief People Officer	- IPR - Workforce dashboard/ SOF via People Committee - GMC Survey via People Committee - Preceptorship survey via People Committee - Staff survey action plan updates via People Committee - FTSU Bi-annual update and via People Committee - Employer relations report via People Committee - People promise report via People Committee	NHS Staff Survey results Pulse 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, approved by the Board (May 24) and rolled out. Current focus includes zero tolerance and tackling poor behaviours. High level staff survey results 2024 received and development of action plans (March 2025). Progress being reviewed at sub committee level.		
									Consistency of wellbeing support.	Improving the consistency of the Trust wellbeing offer. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	Staff hub opened (2024/25) and wellbeing offer includes physical, mental and financial. Continuing to understand the wellbeing needs within the Trust and improve specific wellbeing support. Focus is also on the underlying challenges and improving working arrangements as well as consistency of offer across the Trust.		
			C3) Equality, Diversity and Inclusion **Control Owner:** Chief People Officer	- Staff survey - WRES/ WDES and gender pay gap reports via People Committee - CPO report to People Committee - integrated EDI action plan updates to People Committee - EDI annual report to People Committee - Equality Delivery System 2 reports.	NHS staff survey results. WRES/ WDES. Gender pay gap results. Equality Delivery System 2 stakeholder engagement.	*Partial*		Poor experience. Diversity of workforce at all levels.	(i) Delivery of the EDI action plan **Action Owner:** Chief People Officer **Due date**: Quarterly updates	Integrated EDI action plan and priorities in place.		
			C4) Recruitment and Retention **Control Owner:** Chief People Officer	- IPR - Workforce dashboard/ SOF via People Committee - assurances on staff experience (as above)		*Acceptable*			Delivery of talent and succession planning.	Delivery of talent and succession planning. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	New appraisal framework developed and being used for appraisals. Reviewing use of talent conversations. Board level succession plan being further developed in 2025/26.		
			C5) Education and Development, including leadership and management capabilities **Control Owner:** Chief People Officer	- L&D Reports via People Committee - Guardian of Safe Working reports - GMC survey via People Committee - Preceptorship survey via People Committee - Apprenticeship Report to People Committee - Workforce dashbord to People Committee	NHS Staff survey results. GMC Survey results Preceptorship survey results National Education and Training Survey	*Acceptable*		Training needs analysis. Development and delivery of action plan in respect of NETS	(i) Training needs analysis to be developed aligned to national work. (ii) Action plan to be developed and delivered in respect of the National Education and Training Survey results. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	Leadership framework established and programmes rolled out for clinical leaders, aspiring leaders (band 2-4) and lead managers. Basic skills for manager training developed for all managers and launched in Q1 2025/26. Training needs analysis to be progressed (Q2 25/26).		

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	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 2025	**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 bank and agency usage; - The Trust, as part of the Cheshire & Merseyside system has agreed a planned deficit for 2025/26. This is dependant on the Trust delivering efficiency savings of c7% whilst not investing in any further developments. - Identification and delivery of recurrent Cost Improvement Plan (CIP) - Block funding for non-elective, caps on elective income alongside challenging targets to deliver RTT improvement through additional activity - 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) - Low cash balances and need for cash preservation actions impacting on operational effectiveness - 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 Bi-Weekly ICB FCOG meeting ICB monthly expenditure controls group NHSE monitoring returns	*Partial*	*4 x 4 = 16*	**NO**	Long term financial plan aligned to strategy. Sustainable plan for C&M under development.	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 2025/26 annual planning process (May 2025). Development of deficit drivers underway. Closed PWC action plan and HfMA financial control checklist, reported to F&P Committee. and prioritised action plan will continue to be reported. Financial strategy will need to align with the clinical strategy and people strategy. Consideration of financial strategy approach Board strategy day (Jun 25).	**12**	***Mar-26***
			C2) Annual Budget and systems of budgetary control including additional grip and control actions comprising pay and non-pay controls **Control Owner**: Chief Finance Officer	- Financial Plan (approved) - Finance Report to Board - F&P Committee - Forecast processes and reporting within finance reports	Financial Plan ICB submissions Internal Audit reviews Bi-Weekly FCOG meeting and returns to the ICB (via System Improvement Director) including forecasting	*Partial*			Uncertainty of impact and funding for the pay award. Inquiry costs awaiting confirmation of national funding Unfunded escalation costs to maintain patients safety in light of increased levels of NC2R patient numbers	Continue to work with the C&M ICB. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Ongoing discussions with the ICB and NHSE CFOs re Inquiry funding. Pay award funding and impact assessment underway. System work continues on levels of NC2R and subsequent impact on escalation costs.		
			C3) Cost Improvement Programme including Quality Impact Assessments **Control Owner**: Chief Finance Officer	Weekly CIP delivery group reporting to F&P. F&P Committee	Financial Plan NHSE Template Weekly returns to ICB and NHSE and provider benchmarking of progress	*Partial*			Delivery phase of CIP Programme, low levels of maturity and to be underpinned by productivity expectations. Slippage and risk in converting CIP opportunities to identified schemes.	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 February 2025 to engage teams and agree next steps. Programme structure and targets agreed. CIP Delivery Group continues with CEO as Chair, and reporting into F&P Committee. Workstreams reporting into EDG, with scheme maturity levels moving positively. Consideration of acceleration of CIP opportunities supported by the Continuous Improvement Team. Additional financial control measures implemented and EDG working with Divisions to implement these.		
			C4) Cash Management **Control Owner**: Chief Finance Officer	F&P Committee	Financial Plan NHSE Template Weekly returns to ICB and NHSE	*Partial*			Approach needed to mitigate the new challenges regarding cash and deficit support.	Cash management mechanisms to be embedded, working with system to understand implications and action Cash Committee ToR being developed **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Cash risk associated with Q2 DSF withdrawal established Distressed Cash Funding applciation underway Cash preservation plan developed		
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:** Jul 2025	**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	ICB returns	*Acceptable*	*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 workstream overseeing system estates work.	**12**	***Mar-26***
			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 2025/26. Successful bid for £7.5m national capital to support ED/ UEC improvements with completion expected late 25/26.. TIF bid submitted to support elective capacity (Dec 24) and outcome awaited but preparatory work underway. 25/26 capital planning complete and majority of business cases drawn up and approved following prioritisation meeting held Feb 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).	*Partial*			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 complete and inspection programme in place. Ac**tion Owner**: Chief Finance Officer **Due date**: Quarterly updates	Annual assessment completed Jan 2025. No further exceptional work required, with failsafe and inspections to continue until decant.		

Risk Theme: Digital & Data

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	Estimated date of achievement of target score
BAF7 Failure to deliver transformative digital and data solutions and performant, secure and resilient infrastructure could impact on patient and staff experience and organisational productivity **Executive Risk Lead:** Chief Digital & Data Officer **Assurance Committee**: Finance and Performance **Last Update:** July 2025	**Cause:** - Failure to review and adopt innovative solutions to deliver value added digital transformation - impacting ability to support CoCH, ICB and NHSE strategies (Consequence C1) - Failure to invest sufficiently in secure, modern, sustainable digital infrastructure, systems, services and data to enable safe, effective clinical patient care and business operations (Consequence C1, C2) - Increasing cyber risk profile with more attacks evident, including ransomware and phishing. (Consequence C3) - Failure to identify, develop and maintain the required Digital & Data Services people capability (internal plus partnerships/third parties) (Consequence C4) - Failure to adequately train Trust wide staff in cyber security awareness (Consequence C5) - Failure to adequately assess and take action regarding the quality of data within the Trust digital clinical systems (Consequence C6) - Increasing support and licence costs for key systems (Consequence C7) Consequence: C1-Trust will be reliant on systems that are not fit for purpose, impacting productivity and consequently service quality/patient experience. C2- Insecurities within the systems and infrastructure with vulnerabilities that could be exploited through a cyber-attack.C8 C3 - Data loss and regulatory sanctions if personal data is lost, financial consequences of losng access to systems and data. C4 - Reduced level of skills in workforce due to inability to develop or recruit staff to required level C5 - Compromised systems and infrastructure would result in business continuity measures being put in place for staff and patients. C6 -Poor data quality could lead to Trust staff making ill-informed decisions and inaccurate external reporting C7 - Increasing license costs will impact on Trust financial position and may prevent the Trust renewing contracts and lead to removal of digital solutions	*5 x 4 = 20*	KC1) Digital and Data Strategy which aligns with internal, partner, ICS / ICB and National expectations **Control Owner:** Chief Digital & Data Officer	Updates into F&PC via Digital Strategic Programme Update Strategy update to Trust Board development session	MIAA Digital strategy audit (Jan-Mar 25)	*Partial*	*5 x 3 = 15*	**NO**	Strategy refresh required with regular consolidated programme / progress reporting to F&P Committee. Green policy is being updated in 2025 - Digital & Data Services are represented at the Anchor Institution Steering Group	(i) Refresh Digital and Data Strategy informed by National digital maturity assessment (DMA). **Action Owner:** Chief Digital and Data Officer **Due date:** September 2025 (ii) MIAA to conduct audit of Digital and Data Strategy. **Action Owner:** Chief Digital and Data Officer **Due date:** Q1 25/26	Strategy presented at Board Development day in June. MIAA strategy audit follow up to take place in Q2 Draft strategy to be aligned with objectives of 10 year plan DMA 2025 was submitted in June 2025 following peer review	*12*	***Mar-26***
			KC2) Annual plans that deliver effective management of Cyber security threats and Digital Infrastructure health **Control Owner**: Chief Digital & Data Officer	- DSPT 24/25 presented to Finance and Performance Committee (F&PC) - SIRO report into F&PC	- Annual MIAA assurance audit on DSPT submission	*Partial*			Information Asset Owner responsibilities for "essential services". Completion of capital infrastructure investment including data centres. .	(i) Completion of action plan relating to DSPT and Cyber Assurance Framework (CAF) **Action Owner:** Chief Digital and Data Officer **Due date:** March 26	DSPT submission was completed on 30th June - action plan has been developed to address gaps and mitigate risks		
										(ii) Deliver plan to maintain infrastructure health **Action Owner:** Chief Digital and Data Officer **Due date:** Sep 2025 Phase 1 Mar 2026 Phase 2	SAN is now operational with full migration to be completed in August 25. New aircon system is in place DC2 is now online and is supporting critical network infrastructure.		
										(iii) Deliver Cyber Security protection plan **Action Owner:** Chief Digital and Data Officer **Due date:** March 2026	New SIEM is now operational Cyber action plan is being worked through and monitored at IG&IS committee		
			KC3) Annual plan for investment, upgrade and optimisation of digital applications (including EPR) **Control Owner**: Chief Digital & Data Officer	- clinical digital systems progress (including EPR) reported to Finance & Performance Committee - Contract in place with EPR supplier, for upgrades over the next 5 years	- MIAA EPR lessons learned review (reported to Audit Committee and F&P Committee) - NHSE EPR Readiness review (reported via F&P Committee)	*Acceptable*			Application (including EPR) optimisation structures, engagement and assurance reporting.	Undertake Optimisation programme. Participate in national EPR usability survey and develop action plan based on results. **Action Owner:** Chief Digital and Data Officer **Due date**: EPR Optimisation Phase 1 August 2025 EPR Upgrade September 2025 EPR Optimisation phase 2 Mar 2026 Ophthalmology EPR Mar 2026	EPR upgrade will take place in Sept 2025 eRS integration will be live in July. Business case being developed for procurement of new Ophthalmology system - Q2 25/26.		
			KC4) Continuous improvement plan for Data Quality and Analytics **Control Owner**: Chief Digital & Data Officer	- Annual report to F&P Committee	Clinical coding audit	*Acceptable*			Clear data quality framework and assurance reporting.	Develop and deploy data quality framework with enhanced assurance reporting. **Action Owner:** Chief Digital and Data Officer **Due date:** Phase 1 October 2025, Phase 2 March 2026	Further development of key DQAM metrics has taken place. A review of the IPR has taken place with key leads and several updates have been made.		
										Adopt NCF Framework for internal reporting **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	National Competency Framework (NCF) workstreams in progress to support recruitment, retention and professional development within Analytics team		
			KC5) Digital and Data workforce plan ensuring, professionalisation, capacity, capability, and sustainability **Control Owner**: Chief Digital & Data Officer	National staff survey	- National digital workforce survey (reported via F&P Committee)	*Partial*			Fit for the future workforce plan.	Workforce plan review, including data scientist capabilities. Target achievement of DSDN Level 3 accreditation. (April 2025) **Action Owner:** Chief Digital and Data Officer **Due date:** Workforce plan September 2025	Regional digital workforce plan in development, DSDN Level 3 was achieved in April 2025 National workforce survey was completed in June 2025		

Risk Theme: Governance													
RISK APPETITE: CAUTIOUS - Upper tolerance limit 9													
LINKS TO STRATEGIC GOALS:	**SG3: Leadership, SG4: Adding Value, SG5: Partnerships**												
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**	**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. **Executive Risk Lead:** Director of Governance, Risk and Improvement **Board Committee**: Audit Committee **Last Update:** July 2025	**Causes** - implementation of changes in legislation - effectiveness of governance structures - clarity of accountability, decision making and assurance reporting - new partnership arrangements developing - organisational learning and sharing **Consequences** - legal and regulatory action - Board effectiveness	***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***	**NO**	Clarity of sub committee level and Divisional Governance. Deliver the risk management improvement plan.	(i) To further develop the Sub Committee/ Group and Divisional governance organogram and assess effectiveness and embedding of the Accountability Framework. (ii) To further develop and embed risk management. **Action Owner**: Director of Governance, Risk and Improvement **Due date**: Quarterly updates	Committee organagram developed and further review of sub committee structures including Divisions underway. Governance presentations continue to be delivered in various forums. Risk management improvement plan actions progressing, risk management policy approved and Risk Management Committee in place. Datix developments being implemented.	***9***	***Q3 25/26***
			C2) Compliance with relevant codes of governance, regulation 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. Likely to be developed into 2025/26.		
			C3) Partnership Governance **Control Owner:** Director of Governance, Risk and Improvement	- CEO report	- CMPC updates	*Partial*			Clairity of governance for emerging partnerships and collaborations. New CMPC governance to be confirmed. Governance to support local collaboaration.	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	Continued development of governance for CWP/COCH collaborative community services with Joint Committee TOR beign reviewed. Support provided on discreet projects/ developments (e.g. Pathology South Hub). Further work to identify and engage as partnerships develop.		
			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. Inquiry Report to be published (Jan 2026).	(i) Corporate records management policy to be updated and work to support embedding and improvement. (ii) Response to the Inquiry report. **Action Owner**: Director of Governance, Risk and Improvement **Due date:** Quarterly updates	Corporate records management added to Information security and information governance committee, with corporate records management policy re-draft in progress. We continue to understand, share and embed learning from the Inquiry.		

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	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 2025	**Causes** - Clarity of system leadership and management roles - Maturity of the ICS and Place - Further development of Provider Collaborative - Changes in commissioning process - Unclear system clinical priorities - 10 year health plan implications **Consequences** - Potential conflicting priorities between organisations and systems - 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 Officer 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 CVD events	*Acceptable*	*4 x 3 = 12*	YES	Clarity of assurance reporting to Board (including cheshire work, CVD prevention and wider partnership work).	Director of Strategy and Partnerships report to be developed. **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 focused on CVD Prevention. A second conference aimed at admission avoidance / specifically CVD-R (respiratory) was held in October with circa 55 primary care colleagues present. A third leadership event took place in April focussing on CVD and the management of diabetes.	*16*	***Target Score Achieved***
			C2) Develop a Trust approach to health inequalities and prevention, and population health **Control Owner:** Director of Strategy & Partnerships		Cheshire West Partnership Group	*Partial*			C2AI and Cipha into action reporting.	Develop a population health and health inequalities strategy. **Action Owner:** Director of Strategy & Partnerships **Due date:** Q3	Board development session held in October - raising education and training awareness of health inequalities at a national, Core20plus5, regional (Marmot) and local level using CIPHA data. Roles and responsibilities of Board members discussed and self assessment undertaken. An outline approach to Health Inequalities was discussed and has also been shared with local stakeholders who have endorsed the approach.		
			C3) Anchor institution workstreams (green / social value / prevention) **Control Owner:** Director of Strategy & Partnerships	Anchor Institute Group Chairs report to Finance & Performance Committee	ICB Net zero Group ICB Prevention Pledge Group Population Health Board National quarterly data collection via Foundary platform Anchor Institute Accreditation	*Partial*			Revised green plan to reflect National guidance.	Review and revise the Trust's Green Plan to reflect new National guidance. **Action Owner:** Director of Strategy & Partnerships **Due date:** Q2	Anchor Institution Accreditation received July 2025. National guidance published in February 2025 will require Trust to refresh Green strategy. This has been overseen by the Anchor Institution Group and will be reported to Board in Q2.		
			C4) 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. FBC development for Hybrid theatres.	FBC to be developed for Hybrid theatres. Approach to incldiue cabinet office approval, and tender documents. **Action Owner:** Director of Strategy & Partnerships **Due date:** Quarterly update	OBC approved by Finance and Performance Committee and Board (June 2025). Work progress with pipeline submission to Cabinet Office. Paper to be discussed at EDG including PMO support.		
			C5) Collaborative models **Control Owner**: Chief Operating Officer/ Director of Strategy & Partnerships	CEO Report to Board. COCH/CWP Community Services updates through OMB.	CMPC reporting.	*Partial*			Future vision and defined operating model.	To develop a joint COCH/CWP committee. **Action Owner:** Director of Strategy & Partnerships **Due date:** Q3	An exec to exec group has meet to discuss the formation of a joint committee with CWP to help with the strategic direction of developing community services and the neighbourhood model as well as wider collaboration opportunities.		
									Clarity of assurance reporting on collaborative work (level 1: local, level 2: pan providers, and level 3: C&M).	Director of Strategy and Partnerships report to be developed. **Action Owner**: Director of Strategy & Partnerships **Due date**: Quarterly updates	Director of Strategy and Partnerships leading work with Cheshire, Warrington and Wirral to explore opportunities. Continued discussions with WUHFT following Board to Board. There are several pieces of work with Wirral including the Pathology and Renal reviews.		

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	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**: Board of Directors **Last Update:** July 2025	**Causes** - Lack of leadership capacity and succession planning - Funding sources - Early stages of partnerships and strategic focus - Lack of capacity and focus on Innovation opportunities - Capacity and capability to deliver commercial research activity in the CRU **Consequences** - Ability to maintain R&I function - Aligment of R&I activity - Ability to secure funds - Future leadership plans	***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**: Q2	Research ambitions to support strategy development being aligned to the clinical strategy. Research Strategy being drafted for Board in Sept. A research nurse attends Divisional Boards to increase visibility of research studies and opportunities as well as provide feedback. Research sandpit being planned with the University.	***16***	***Target Score Achieved***
			C2) Team structure, SOPs and expertise **Control Owner:** Medical Director		MHRA inspections GPC inspections HTA inspections	*Partial*			Staff development and retention. Leadership resource.	To agree and communicate the development offer for research staff. **Action Owner:** Medical Director **Due date**: Quarterly update	Team charter developed with the team. Appraisals and development discussions have taken place, and individual objectives clearly aligned. The team continue to explore apprenticeships, career paths and progression opportunites. Stronger culture within the team and development discussions happening with individuals.		
									Strengthening of governance and SOPs.	Review governance and SOPs (including CRF and Trust vehicle). **Action Owner:** Medical Director **Due date:** Q3	An agreed structure for research governance and processes developed for expression of interest, feasilibility and approval. This ensures formal structures, processes and documentation are in place to support timely mobilisation of research studies. List of Standard Oprating Procedures (SOPs) in place and team engaged in further review and development. 5 new SOPS ratified at Research Board in July 2025. Priorities are now to update consent SOP, and manuals for Mobile Research Unit and Clinical Research Unit.		
									Lack of financial expertise embedded in the team.	To discuss financial support needs and resolve gap. **Action Owner:** Medical Director **Due date:** Q3	Meeting to take place with Finance Business Partner.		
			C3) Funding including RRDN (Regional Research delivery network) Arrangements **Control Owner**: Medical Director			*Partial*			Funding levels and income streams.	Continued focus on funding streams, including securing grants and commercial funding. **Action Owner :** Medical Director **Due date:** Quarterly updates	Assurance received that funding for 2025/26 will remain. Future year funding yet to be confirmed but likely to be built focussing on opening studies, recruitment, time and target which are areas the team are strengthening in preparation. Work ongoing with the Universities on grant opportunities. Clinical Research unit opened (Dec 24 but operationalised for clinical use from May 2025) and research bus received. Income remains similar and continued focus on opportunities. 2025/26 funding confirmed. Commercial Delivery network invovlement live from April 2025.		
			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. Framework agreed between COCH and the University of Chester (UoC) to progress partnership arrangements. Also building relationships with Primary Care Networks (PCNs) to develop a primary care research network. Trust Consultant (and Dir. of Medical Education) appointed as Acting Clinical Dean at the University of Chester. Steps to Teaching and University Hospital status explored with the Board (February 2025). Increase in academic appointments mostly teaching through UoC medical school. Research appts to continue to be explored. Discussions ongoing to develop teaching programmes with UoC.		
			C5) Innovation Strategy **Control Owner**: Medical Director			*Partial*			Innovation strategy. Capacity and leadership to drive innovation.	Partnership with University of Chester to be explored to support Innovation ambitions. **Action Owner:** Medical Director **Due date**: Quarterly updates	Current focus on building relationships and developing partnership opportunities. This will require leadership and resource to drive forward. Exploring innovation funds through grant applications.		

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**

PUBLIC – Board of Directors
30th September 2025

Report	**Agenda Item 9b.**	**High Risks Report**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft		Director of Governance, Risk & Improvement				
Author(s)	Nusaiba Cleuvenot		Head of Corporate Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research		**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Potential to link to all BAF risk areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led						**X** **X** **X** **X** **X**
Previous considerations	Not applicable						
Executive summary	Work is ongoing to further strengthen and embed risk management across the Trust, together with a refreshed Risk Management Policy. The Risk Management Committee is now established and is working to drive risk management improvement plan actions. The current focus is on Datix reporting and alerts and reviewing Risk Management Training for roll out across the Trust. Whilst the improvement plan is progressing, the reporting of high risks continues as per the Datix system with review and update by Executive Directors. This paper sets out the risks with a residual score of 15 or over and these risks include: • RAAC • Waiting lists and overdue follow ups • Equipment and assets • Radiology capacity and demand						

	• Staffing levels and gaps in resources • Cyber Security • Estates and infrastructure • Cash management
Recommendations	The Board of Directors is asked to consider and **note** the current high risks and the work that continues to strengthen risk management across the Trust to ensure risk registers reflect the risks faced, mitigations and actions.

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the requirements of the Health and Social Care Act 2008 and in line with the Trust's Constitution, Code of Governance and regulatory requirements.
Risk	As outlined within the risk management policy document.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential.

High Risks Report

1. BACKGROUND

The High Risk Report contains significant risks identified as having potential impact on the Trust's corporate objectives, including risks identified and escalated by Divisions and Corporate departments.

2. DATIX RISK REGISTER

On the High Risk Register, there are currently 15 risks in total with a residual risk score of 15 and above that have been entered on to the Datix system. Risks scored 15 and over are scored in the following way:

Score	Count
15	7
16	8
Grand Total	**15**

The details of the high risks along with mitigations and actions are provided in appendix A. The risks have been manually updated whilst work is ongoing to improve our risk management processes. The risk themes include:

- RAAC
- Waiting lists and overdue follow ups
- Equipment and assets
- Radiology capacity and demand
- Staffing levels and gaps in resources
- Cyber Security
- Estates and infrastructure
- Finance

Work is ongoing to further strengthen and embed risk management across the Trust, together with a refreshed Risk Management Policy. A Risk Improvement Plan is being progressed with Datix development priorities and reviewing Risk Management Training for roll out across the Trust. The Risk Management Committee continues to meet on a quarterly basis and has a key role in ensuring risk management is embedded.

3. RECOMMENDATIONS

The Board of Directors is asked to consider and **note** the current high-level risks and the work that continues to strengthen risk management across the Trust to ensure risk registers reflect the risks faced, mitigations and actions.

Appendix 1 – High Risks (as at 1st September 2025)

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
01/09/2022	2857	Backlog of overdue follow up appointments in: • Ophthalmology	Planned Care	4x4	16	Waiting lists being validated and monitored through the Divisions and through OPELG. AI validation software has been agreed and we have started the procurement process. The patient engagement portal will be used to contact patients as of May 2025. Investment in Ophthalmology diagnostics will facilitate more frequent measurement and virtual approach to follow ups. In addition failsafe officer employed to track most acute pathways.	March 2026	Cathy Chadwick	Finance & Performance Committee
24/01/2025	3398	Multiple factors that could result in a Cyber Attack- several separate areas of risk that could contribute to a Cyber attack. Separate risks have been raised for these areas	Digital and Data Services	5x3	15	Data Security Protection Toolkit submission was completed at the end of June 2025. The Trust did not meet the minimum compliance criteria for 4 out of the 49 outcomes – action plans have been developed to address these areas. Risk score remains at 15 whilst these are addressed.	March 2026 (in line with DSPT action plan)	Jason Bradley	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
		and this risk is to hold the overarching risk of a Cyber attack.				Controls are in place covering MFA, patch management and national cyber alert responses. Oversight is provided by IG & IS committee with SIRO report into F&P Committee at each meeting A bid for national cyber funding has been submitted to address a defined area of cyber risk - data exfiltration. Capital funding has been awarded as part of 25/26 capital plan to reduce another area of cyber risk – legacy equipment.			
10/06/2024	3260	Risk to patient safety due to lack of adherence to NHSE 4 hour Emergency Department standard	Urgent Care	3x5	15	Continued focus on flow and UEC improvement plan, which had been reviewed and is now a full system improvement plan. Long waiting times in the Emergency Department have significantly improved during February 2025 and this has remained consistent. Work continues to reduce the waiting times for a bed to under 12 hours.	October 2025	Cathy Chadwick	Quality & Safety Committee
19/07/2019	2550	Risk to provision of Microbiology service due to	Diagnostics and Clinical Support	4x4	16	Job planning exercise completed which supports the need for extra resource Paper presented to EDG	Q1 26/27 2025	Nigel Scawn	Quality & Safety Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
		insufficient resource in consultant microbiologist team				on 2nd July and approval given to recruit to a specialist doctor. Asked to delay recruitment of the backfill until new financial year as need to agree funding for the backfill. The risk score can be reduced if post is recruited to but this won't be until 26/27.			
19/01/2024	3159	Risk to service provision and staff burnout due to reduction in Obstetric and Gynaecology Consultant workforce	Women's and Children's	5x3	15	Long term agency locum in place, distribution of role across service to ensure focus on maternity services. Executive discussion on recruitment plans. One new appointment made at recent interview. SARD job planning exercise combined with capacity/demand modelling almost complete to guide future service needs.	January 2026	Nigel Scawn	People Committee
30/04/2024	3234	Inability to provide adequate IR service due to only having 1 IR theatre and no recovery ward	Diagnostics and Clinical Support	4x4	16	The current mitigation is to use the old IR suite for less complex procedures when staff are available. The long term solution is capital monies to convert the old IR suite and build a recovery space. Re-assessed & updated risk however score remains 16.	March 2026	Cathy Chadwick	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
						Old suite has been serviced July 25 and no major issues. A year long service plan was agreed by the CFO although this doesn't cover all potential failures. However, it should give us a year of an additional suite if all continues working. This will reduce the risk slightly. External bids for funding continue to be completed, supported by GIRFT report. . DD and clinical teams met 12/9/25 to discuss other mitigations. Risk score to be reassessed. Further complication of WUTH replacing their IR suite in Q3 so may need to send more work to COCH. This will put more pressure on COCH but needs more information before scoring is affected. Requested confirmation from WUTH.			
06/04/2020	2385	Use of Siporex RAAC Planks in W&C's Building Roof	Corporate	3x5	15	Risk and mitigations being managed through Women & Children's Project Board. National RAAC board sign-off of current risk rating (reduced from 20).	September 2025	Karen Edge	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
						Move to new build in Summer 2025 will significantly reduce risk rating.			
24/10/2024	3346	Trust Fire Alarm System - Non-Compliance	Corporate	4x4	16	Prioritised for capital investment in 2025/26 capital programme. Business case approved and phased approach to replacement of high risk areas first commenced. Expected completion date Q3 25/26.	Q3 25/26	Karen Edge	Finance & Performance Committee
09/02/2023	2964	High numbers of Non-criteria to reside (NCTR) patients across both Trust sites	Therapies and ICC	4x4	16	Agreed to increase to a red risk of 16 at OMB due to affect of the high percentage of (NCTR) patients across the 3 adult bed owning divisions. Failing to reduce NCTR percentage of the acute bed base to 15% creates subsequent risk in patient flow resulting in delayed ambulance handover and increased number of patients being held in ED who should be transferred to ward areas. The number of NCTR patients also requires the Trust to maintain a high level of escalation capacity at additional cost.	Q3 25/26	Cathy Chadwick	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
						For individual NCTR Patients that are ready for discharge they risk higher chances of deconditioning and developing hospital acquired infections that could result in poorer outcomes. Reduction in NCTR has been achieved through September to 20% against a 15% target by end of March 2026. Challenge is now being supported from C&M ICB Additional P1 and P2 community capacity funded through ICB discharge monies. Recruitment underway. Implementing actions form national discharge team assessment in September			
17/07/2024	3284	Non Achievement of Planned Care CIP Target 25/26 (£3.4million)	Planned Care	3x5	15	Additional weekly support regarding identification of cross divisional input into Surgery opportunities in place, with Exec led contributions. Secondment of band 9 into Director of Delivery role and standing up of PDO function to lead delivery and accelerate implementation of CIP	March 2026	Karen Edge	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
05/06/2025	3477	High number of medical patients being managed outside of the Urgent Care bed base.	Urgent Care	4x4	16	Additional funding to support the management of Day2 patients across ED, SDEC and corridor. This includes junior and senior input 7-days a week. Expanded bed base on respiratory. Planned cohorting of NC2R patients from September 2025 in the medical bed base along with expanded medical bed base to reduce the number of medical patients outlying into surgical beds. Medical Take List moved to Cerner in July 2025 to reduce the administration and concerns with managing from an MS Teams list. Risk continues to remain not fully mitigated and poses significant concern with patients outside of the core bed base between 30-90x patients daily. Potential for worsening position due to closure of beds in September 2025. Highly reliant on reduction in NC2R position.	October 2025	Cathy Chadwick	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
21/07/2025	1869	Treasury Management	Corporate	3x5	15	The Trust is maximising debt collection, ensuring CIP plans are cash releasing and delaying payments to intra-system providers. There are Trust wide pay/non pay controls. Cash balance is reported to DoF daily and high level cash forecast is reported to DoF weekly. The Trust needs to extend its payment terms from 30 to 45 days, prioritise payroll and non pay spend critical to service delivery and delay/cease non PDC or grant funded capital spend. Trust is also participating in ICB cash working group to look at cash preservation within the system and actions that will be required when cash distress funding is required	March 2026	Karen Edge	Finance & Performance Committee
20/01/2025	3395	CERNER ordering/reports - The telepath (I.T) systems in place at CWMS are obsolete and due to be replaced by the new Network	Diagnostics and Clinical Support	4x4	16	Risk reviewed with Pathology and mitigation options available but possibly with a cost of circa £1k. The mitigation would be to develop integration between the Microbiology Telepath system and the Cerner EPR. Division to consider the cost pressure. There	December 2025	Jason Bradley	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
		wide LIMS implementation, due 2027. There is currently a risk around microbiology results whereby Telepath result reporting cannot file back to CERNER under certain circumstances.				is an underlying issue with technical support for Microbiology which is being reviewed with WUTH.			
01/01/2024	3255	Dialysis machine past the recommended life span resulting in more frequent repairs.	Urgent Care	3x5	15	Dialysis machines were included in the 2025/26 Divisional capital bids, though no funding was awarded. A new bid will be submitted for 2026/27, pending prioritisation by the Division and Trust. Discussions are ongoing with Deputy COO to explore a MSC model, similar to the WUTH hub, which leases machines and avoids asset ownership risk. The Trust is reviewing the Renal/Dialysis service positioning within its broader strategy, especially in light		Cathy Chadwick/ Karen Edge	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
						of national discussions on home dialysis.			

PUBLIC – Board of Directors
30th September 2025

Report	**Agenda Item 10.**	**Safeguarding and Complex Care Annual Report**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Jill Cooper			Associate Director of Nursing (Safeguarding and Complex Care)				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X**	Provides assurance within the quality and safety BAF areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	N/A							
Executive summary	The 2024/25 Safeguarding and Complex Care Annual Report provides assurance that the Countess of Chester Hospital NHS Foundation Trust continues to meet its statutory responsibilities under the Care Act 2014, Children Acts 1989 and 2004, and associated national guidance. The report evidences a significant increase in safeguarding and complex care activity across the Trust, reflecting both the growing complexity of patient needs and the strengthened safeguarding culture embedded throughout the organisation. Key highlights include: • All areas of the safeguarding and complex care agenda have seen a rise in referrals, incidents, and multiagency engagement, supported by improved data collection and analysis. • The Trust achieved strong compliance in Level 1 and 2 safeguarding training for adults and children. Level 3 compliance improved significantly following targeted interventions, reaching 90% by year-end.							

- Executive oversight remains robust, with statutory named professionals in post and active participation in strategic safeguarding partnerships.
- Safeguarding policies are compliant and regularly reviewed. Audits confirm their effective application in clinical practice.
- The Trust continues to embed a person-centred approach, ensuring the voice of children and vulnerable adults is captured and acted upon.
- Internal strategy meetings increased by 184%, demonstrating improved confidence in reporting and managing allegations. External referrals decreased, indicating appropriate threshold application.
- Referrals to the Complex Care Team rose by 246%, with significant improvements in reasonable adjustments, MCA/DoLS compliance, and support for patients with learning disabilities, autism, and dementia.
- The Trust remains a key contributor to multiagency reviews, safeguarding boards, and strategic initiatives, ensuring system-wide learning and partnership working.
- Referrals to the Independent Domestic Violence Advisor (IDVA) nearly doubled, with enhanced support for patients and staff, and increased MARAC engagement.
- Clear objectives for 2025/26 have been identified, aligned with local and system-wide safeguarding strategies.

Throughout 2024/25, the Trust experienced a notable increase in safeguarding and complex care activity, with referrals rising across all domains. Complex Care referrals surged by 246%, and adult safeguarding referrals increased by over 11%, reflecting both the growing complexity of patient needs and improved staff awareness.

Training compliance remained strong, with Level 1 and 2 safeguarding training for adults and children exceeding 90%, and Level 3 compliance improving significantly from 67% to 90% following targeted interventions. The Trust also achieved 88% compliance with the Oliver McGowan online mandatory training programme, demonstrating its commitment to supporting patients with learning disabilities and autism.

Governance and leadership remained robust, with quarterly Safeguarding Assurance Committee meetings attended by all clinical divisions and key multiagency partners. Statutory named professionals continued to provide strategic and operational oversight, ensuring safeguarding remained a priority across the organisation. Policy compliance was maintained through regular reviews and audits, which confirmed effective application in practice.

The Trust strengthened its personalised approach to safeguarding, with increased use of hospital passports and “This is Me” documents and expanded safeguarding supervision across maternity and paediatrics. Allegation management saw a 184% increase in internal strategy meetings, while external referrals decreased, indicating improved internal resolution and understanding of thresholds.

Domestic abuse support was significantly enhanced, with 475 referrals to the Independent Domestic Violence Advisor (IDVA)—almost double the

	previous year—and a 154% increase in MARAC cases discussed over two years. Staff disclosures also rose, with 22 individuals supported internally. The Complex Care Team delivered substantial improvements, including a 550% increase in reasonable adjustment risk assessments and 600 DoLS applications submitted, each supported by personalised care planning. The Trust also referred seven cases to the LeDeR programme and completed five Structured Judgement Reviews, reinforcing its commitment to learning and improvement for patients with a learning disability and / or autism. Multiagency engagement remained strong, with contributions to 11 external reviews and active representation on strategic boards and subgroups. These highlights collectively demonstrate the Trust's continued dedication to safeguarding and complex care, ensuring safe, person-centred care for its most vulnerable patients.
Recommendations	The Board is requested to **Note** the assurance provided within the report

Corporate Impact Assessment	
Statutory/regulatory requirements	This report provides assurance that the Trust continues to meet its statutory safeguarding responsibilities, in line with regulatory and professional standards. It specifically supports compliance with the NHS Safeguarding Assurance Framework and commissioning standards, reinforcing the Trust's commitment to safe, high-quality care.
Risk	Failure to maintain effective safeguarding arrangements poses a significant risk to the Trust. Without robust systems, the organisation could fall short of its statutory and regulatory duties, potentially compromising patient safety and public confidence. This report provides assurance that the Trust is actively mitigating these risks through strong leadership, continuous improvement, and system-wide collaboration.
Equality & Diversity	Meets Equality Act 2010 duties & Public Sector Equality Duty 2 aims and does not directly discriminate against protected characteristics.
Communication	To be published through Board papers.

Safeguarding & Complex Care Annual Report 2024/25

Jill Cooper – Associate Director Safeguarding & Complex Care

Submission Date to Board: 30th September 2025

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1. Introduction

This Safeguarding and Complex Care Annual Report aims to assure the Board that the Countess of Chester NHS Foundation Trust (the Trust) has established the necessary frameworks and taken appropriate actions to meet its statutory responsibilities. These responsibilities are outlined under Regulation 13 of the Health and Social Care Act 2008, the Care Act 2014, the Children's Acts of 1989 and 2004, the statutory guidance "Working Together to Safeguard Children" (2023), and the Intercollegiate Document for Roles and Competencies for Health Care Staff (2018), particularly regarding safeguarding training compliance.

The report provides an overview of the Trust's activities, compliance, and learning in the safeguarding and complex care domains from 1st April 2024 to 31st March 2025, demonstrating how the Trust has fulfilled its statutory and regulatory obligations

2. Summary

The Trust is dedicated to fulfilling its safeguarding responsibilities and fosters a robust organisational commitment to maintaining high standards in safeguarding and complex care practices. The workforce is well-versed in the significance of their roles in ensuring the safety and protection of children, young people, and adults at risk of harm who access the Trust's services.

Throughout 2024/25, the Trust has consistently enhanced and reinforced its safeguarding and complex care arrangements to ensure they remain effective and comply with both local and national standards.

3. Leadership and Organisational Accountability

The Director of Nursing and Quality serves as the executive lead for safeguarding and complex care, providing leadership across the organisation to ensure these agendas remain a priority for the board. Supporting the Director are the Deputy Director of Nursing and Quality and the Associate Director of Nursing (Safeguarding and Complex Care), who assist both strategically and operationally. They actively participate in safeguarding partnership arrangements, including the Safeguarding Children Partnership (SCPs), Local Safeguarding Adult Board (LSAB), Domestic Abuse Board, and Learning Disability Board across Cheshire West and Chester. The Associate Director of Nursing and the Named Lead Professionals also engage in various subgroups of these boards.

Statutory named professionals ensure that the Trust's policies, processes, and safeguarding arrangements align with local and national guidance and legislation. They provide operational leadership to the team, which includes:

- Named Nurse for Safeguarding Children
- Named Doctor for Safeguarding Children
- Named Midwife for Safeguarding and Trust Domestic Abuse Lead
- Lead Professional for Safeguarding Adults
- Lead Professional for Complex Care

The Safeguarding and Complex Care Team comprises specialist nurses who, despite their expertise, strive to develop a core skill set across the safeguarding and complex care agenda to maintain service

resilience and operability. The team also includes a full-time Independent Domestic Abuse Advocate (IDVA).

The Trust's safeguarding and complex care governance structure is detailed in Appendix 1. The Safeguarding Assurance Committee, chaired by the Director of Nursing and Quality, ensures that safeguarding and complex care responsibilities are met in line with the terms of reference (Appendix 2). This committee provides quarterly reports to the Quality Governance Group and the Quality and Safety Committee, a subcommittee of the Board.

In 2024/25, the Safeguarding Assurance Committee met quarterly, with attendance from all clinical divisions and partnership agencies, including the Integrated Care Board (Cheshire West Place), Cheshire West Adult Social Care, Cheshire West Children's Social Care, and Betsi Cadwaladr University Health Board.

Several working groups within the safeguarding and complex care agenda focus on delivering identified priorities and providing challenge and assurance to the wider teams. Key functions include monitoring training compliance, benchmarking, and internal/external standards.

The Trust continues to assure the Cheshire and Merseyside Integrated Care Board (ICB) through the Safeguarding Assurance Framework (SAF), which includes quarterly data submissions on training, activity, audit, performance, and supervision. Additionally, the Trust submitted the biennial Safeguarding Commissioning Standards Self-Assessment for both adult and children's safeguarding in 2023/24, with an action plan monitored via the safeguarding governance framework.

NHS Safeguarding Commissioning Standards

In 2023/24, the Trust undertook a bi-ennial self-assessment audit against the NHS Commissioning Standards to evaluate its compliance with legislation and statutory guidance related to safeguarding children, young people, adults at risk, and Children in Care. This audit supports the Trust's duty to provide assurance to the Integrated Care Board (ICB). The assessment covered 64 domains, and the Trust demonstrated a strong position overall, with only partial exceptions of noncompliance in a few areas.

Following the audit, an action plan was developed to address these outstanding areas and monitor progress. This plan was reviewed quarterly by the Trust's Safeguarding Assurance Committee and was fully completed by 31 March 2025, reflecting the Trust's commitment to maintaining high safeguarding standards and continuous improvement

4. *Safeguarding Policies*

The Trust maintains a comprehensive suite of safeguarding and complex care policies, which are regularly updated to reflect changes in structure, departments, and legal requirements. These policies are accessible to staff via SharePoint. The Safeguarding and Complex Care Team also oversees several other Trust policies to ensure compliance with safeguarding standards.
Key policies include:

- Safeguarding and Promoting the Welfare of the Child
- Safeguarding Adults at Risk Policy

- Prevent
- Domestic Abuse
- Female Genital Mutilation (FGM) Pathway
- Modern Slavery / Human Trafficking Statement
- Mental Capacity Act and Deprivation of Liberty Safeguards
- VIP and Celebrities Policy
- Safer Recruitment
- Freedom to Speak Up Policy
- Physical Intervention and Restraint Policy
- Enhanced Supervision Policy
- Discharge Policy
- Chaperone Policy
- Was Not Brought Policy

5. Incidents

The Associate Director of Nursing for Safeguarding and Complex Care takes part in the daily Senior Quality, Safety, and Site Position Meeting, where significant incidents are reviewed. The team also attends the daily Trust Safety Huddle to provide updates on safeguarding and complex care activity and to respond to any concerns raised by other departments. Safeguarding and complex care incidents are managed through the DATIX system, with close collaboration between the team and Heads of Nursing to address any serious issues. The team is also actively involved in the Patient Safety Incident Response Framework (PSIRF) and participated in After Action Reviews during 2024/25 where safeguarding or complex care featured in the incident.

6. Audits

Throughout 2024/25, the Safeguarding and Complex Care Team actively engaged in a wide range of audits, both internally and in collaboration with external partners. This includes participation in multiagency audits with the Safeguarding Children Partnership and Local Safeguarding Adult Board, ensuring a joined-up approach to safeguarding across the system.

Key learnings from these audits have been disseminated through Trust-wide communication bulletins, supporting continuous improvement and shared understanding. Audits span the full safeguarding and complex care agenda, with findings used to inform practice development and meet the data requirements of strategic partners.

Overview of Safeguarding and Complex Care Audits

Corporate Audits	Encompasses audits on safeguarding training compliance, adherence to commissioning standards, and participation in national audits such as LeDeR and the National Audit of Dementia. These audits ensure organisational alignment with national safeguarding expectations.
Safeguarding Adults	Evaluates the quality and appropriateness of adult safeguarding referrals, checks compliance with Section 42 thresholds, and monitors the implementation of learning from safeguarding reviews and incidents.

Complex Care	Reviews compliance with statutory frameworks including the Mental Health Act (MHA), the Mental Capacity Act (MCA), and Deprivation of Liberty Safeguards (DoLS), ensuring lawful and ethical care for individuals with complex needs.
Maternity Safeguarding	Assesses safeguarding practices in maternity care, including routine enquiry for domestic abuse, delivery of ICON and Safe Sleep messages, safeguarding supervision, and involvement in pre-birth assessments.
Domestic Abuse	Audits compliance with the Trust's Domestic Abuse Policy through case reviews, ensuring appropriate identification, response, and support for individuals at risk.
Safeguarding Children	Covers a range of audits including notification quality, care of children nursed on adult wards, initial health assessments for children in care, and participation in multiagency safeguarding audits.

7. Safeguarding Activity

Corporate Activity: Enhancing Safeguarding and Complex Care Pathways

In 2024/25, the Trust advanced its safeguarding and complex care processes through the launch of a revised referral pathway within EPR+, supported by a data SMART framework. This enables structured data collection and analysis via a new PowerBI dashboard, helping to identify trends and inform service improvements.

A safeguarding screening tool was introduced in January 2025 as a mandatory part of the Adult Assessment History, ensuring early identification of safeguarding and complex care needs, including mental capacity, ligature risk, domestic abuse, social care involvement, and reasonable adjustments.

Further developments included the integration of safeguarding flags into GP discharge letters, the rebuild of pop-up alerts for reliability, and the ongoing development of a DoLS application form, expected to go live in 2025/26. The safeguarding intranet page was also refreshed with updated training materials and resources.

Following two safeguarding incidents, the chaperone process was relaunched with revised training, now part of mandatory sessions and supported by patient-facing materials. Additionally, ICB-funded virtual hospital tours are in development to support autistic patients and those with learning disabilities, with launch planned for 2025/26

Safeguarding the Unborn, Children and Young People

Key Achievements in 24/25

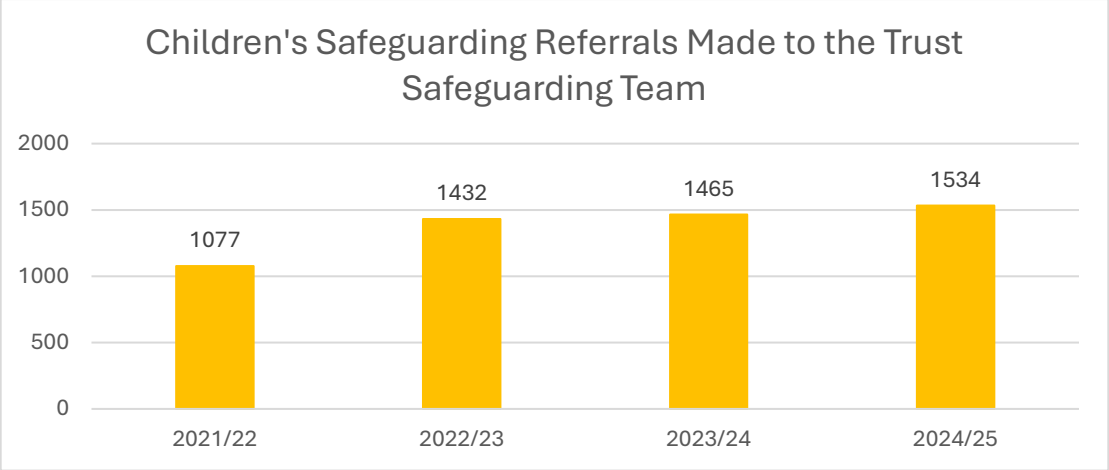
- Strong partnership with Children in Care (CIC) services and completion of the Children in Care Action Plan, aligning with ICB commissioning standards.
- Mobilisation of the Paediatric Liaison Nurse post (April 2025), enhancing continuity of care between acute and community services.
- As part of the Children in Care pledge, all key staff working with children in care have received face-to-face training to enhance their understanding and support for this group
- Introduction of monthly drop-in safeguarding supervision on children's units, alongside ongoing quarterly sessions for a wide range of clinicians.
- Established an internal monitoring and response process for children attending hospital due to bullying, enhancing early identification and support.

- Delivered targeted training to ensure the workforce is equipped to recognise and respond effectively to signs of child neglect
- Increased use of CP-IS flags, particularly in ED, supporting improved identification and management of safeguarding concerns.
- Collaborative Working in developing the Children in Care pledge and action plan through joint working between the Named Nurse for Safeguarding Children at Countess of Chester Hospital (CoCH) and the Named Nurse for Children in Care at Cheshire and Wirral Partnership
- Notifications for children entering care, changing placements, or no longer looked after are now sent to the Safeguarding and Complex Care Team to review their records. This ensures accurate contact details, helps prevent missed appointments, and supports continuity of care.
- The Safeguarding and Complex Care Team now has access to Cheshire West and Chester's electronic system, Liquid Logic. This access has reduced the need to contact the local authority directly, allowing the team to triage cases more efficiently and saving time in managing safeguarding concerns.
- Quarterly reports, which include data on child exploitation and mental health, continue to offer valuable assurance to both the Trust and external partners regarding safeguarding activities and staff training.
- There has been an increase in Perplexing Presentation cases, including Fabricated or Induced Illness, which are complex and require coordination across multiple staff groups. This rise is partly due to improved awareness through training and supervision. In response, a new referral proforma has been introduced to support clarity and consistency when submitting referrals for these cases into the Local Authority.
- Safeguarding supervision for all paediatricians has been enhanced through regular participation in peer safeguarding review meetings.

Safeguarding Children Activity Analysis – 2024/25

The chart below illustrates a continued year-on-year increase in safeguarding children's referrals within the organisation. This upward trend reflects the growing visibility and proactive engagement of the Safeguarding Team across the Trust. Contributing factors include:

- Enhanced Training Compliance: A sustained rise in safeguarding training compliance has significantly improved staff confidence and competence in identifying and responding to safeguarding concerns.
- Increased Staff Awareness: Ongoing visibility and communication from the Safeguarding Team have reinforced a culture of vigilance and responsibility.



Nature of the Referrals received.

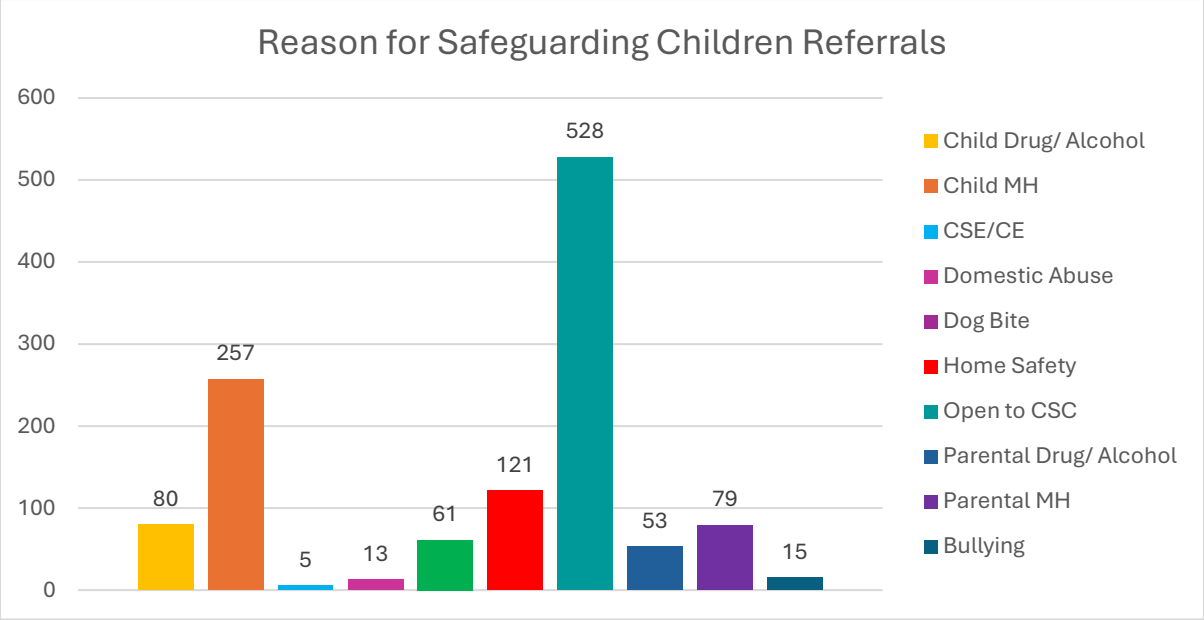
The Safeguarding Team collates referral data to inform practice development and support multi-agency partnerships with relevant data insights.

The chart below illustrates that children who are open to social care represent the most common reason for referral to the safeguarding team, accounting for 43.56% of all cases. This reflects a well-established and effective process for identifying safeguarding concerns at the point of entry, underpinned by strong familiarity with the CP-IS system and consistent use of the mandatory safeguarding screening tool for all children attending the department.

In contrast, Child Sexual Exploitation/Criminal Exploitation (CSE/CE) is the least reported category, comprising just 0.41% of referrals. This may be because children at risk of exploitation are often already known to social care under broader safeguarding concerns. Nonetheless, it remains essential to continue monitoring this category to ensure early identification and intervention.

Other significant areas include referrals related to child mental health and home safety, both of which account for notable proportions of the dataset. The prominence of mental health concerns highlights the ongoing need for collaborative working with mental health and social care partners to ensure children receive timely, holistic support that addresses both their immediate and underlying needs.

The data also shows that Parental Drug/Alcohol use and Parental Mental Health account for 4.37% and 6.52% of referrals, respectively. While not the most prevalent categories, their presence is significant and reflects the staff's ability to recognise safeguarding risks that stem from parental behaviours and circumstances. This demonstrates a strong awareness among frontline staff of the broader family context and the impact it can have on a child's safety and wellbeing. It also underscores the value of maintaining a whole-family approach in safeguarding assessments and interventions



Children and Mental Health Difficulties.

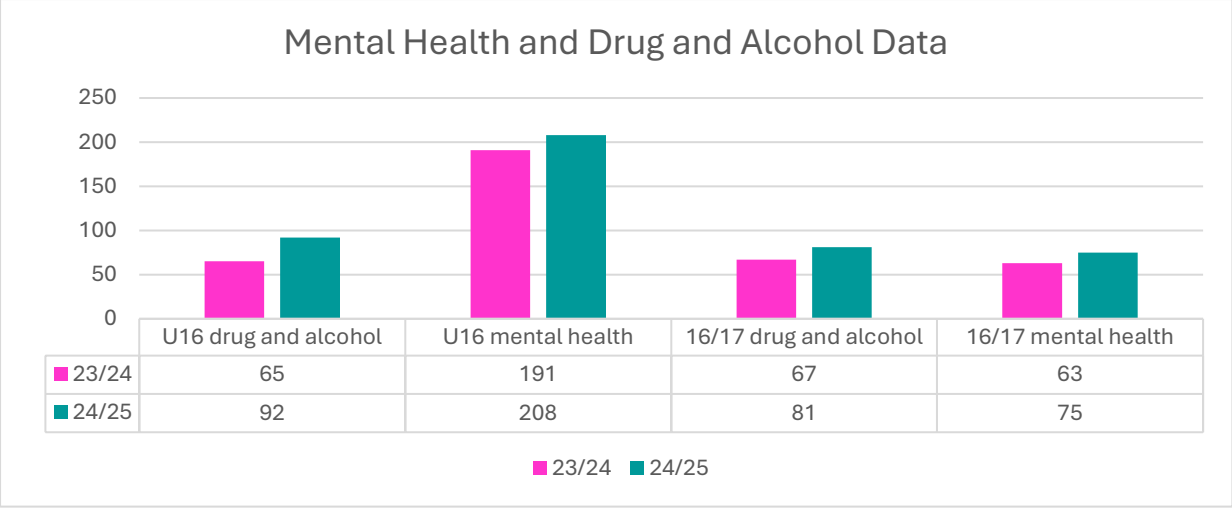
In 2024/25, the Safeguarding Children Partnership requested data on all children attending the Emergency Department (ED) with mental health concerns or drug and alcohol-related issues. The Trust's Business Intelligence team supported this request by generating reports based on relevant clinical coding. This data has been submitted to the Partnership on a quarterly basis.

The chart below presents the data shared with the Partnership.

Throughout the year, there has been a noticeable increase in ED attendances by children presenting with mental health difficulties and drug or alcohol-related issues. This trend has been highlighted to the Safeguarding Children Partnership for further thematic analysis.

To support frontline staff, the Cheshire West and Chester self-harm pathway has been re-emphasised through targeted training sessions and regular staff bulletins. Incident reporting via DATIX shows minimal evidence of non-compliance with the pathway, indicating strong adherence among ED staff.

The Safeguarding Team continues to maintain a close working relationship with the Child and Adolescent Mental Health Service (CAMHS). This collaboration ensures effective information sharing and the development of safe discharge plans, as evidenced in patient records. Additionally, the Safeguarding Team supports CAMHS by facilitating the timely upload of mental health assessments to children's EPR+ records, helping to ensure continuity of care.



Children on Adult Wards

The Safeguarding Team remains committed to ensuring that high standards of care are upheld for children—typically aged 16 or 17—who are admitted to adult clinical areas. To support this, the team receives a daily report identifying all children currently placed in adult settings.

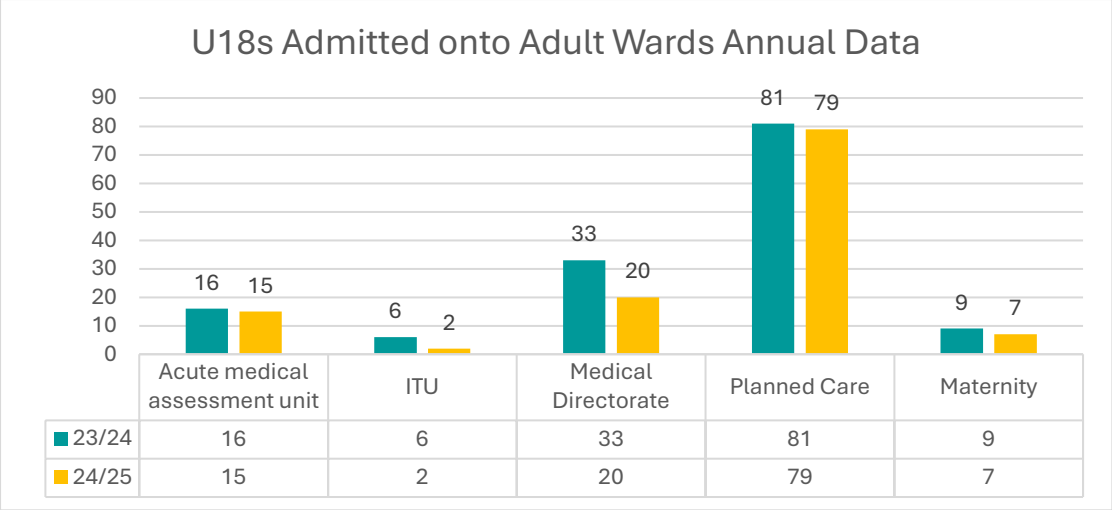
Each case is reviewed to ensure the young person's needs are being met. This includes considerations such as:

- Allowing a parent or carer to stay with the young person where appropriate
- Allocating a side room when available
- Coordinating a safe and timely discharge plan

The chart below illustrates the number of children admitted to adult clinical areas during 2024/25 compared to 2023/24

Young people attending planned care settings often include those undergoing surgical procedures such as appendicectomy, vascular, or orthopaedic interventions. These admissions are typically short, with most discharges occurring within 48 hours.

For those admitted to the Intensive Therapy Unit (ITU), the Safeguarding Children Team ensures direct contact is made during their stay to support their care and wellbeing.



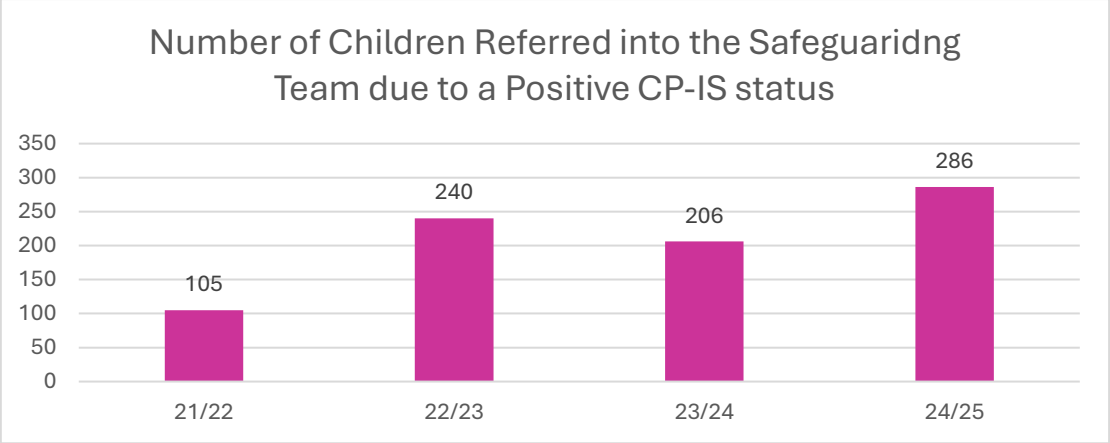
CPIS in the Emergency Department

The Child Protection-Information Sharing (CP-IS) programme continues to play a vital role in safeguarding children by enabling information sharing between Local Authorities and healthcare providers. It identifies children subject to a Child Protection Plan or who are in the care of the Local Authority when they attend unscheduled healthcare settings.

The data shows a notable increase in 2024/25, suggesting that staff are increasingly confident in recognising CP-IS alerts and making appropriate referrals. This reflects positively on staff training and awareness of safeguarding protocols.

Key Considerations:

- Flintshire Patients: CP-IS is not currently available for children from Flintshire, which presents a risk as clinical staff cannot access safeguarding flags for these patients. This concern was formally raised with the Wales Safeguarding Board in 2024/25 as part of a child practice review.
- System Integration: CP-IS is currently limited to unplanned care settings and is triggered via the NHS Spine. To enhance visibility, the Trust's safeguarding team uses the Cheshire West and Chester Local Authority CP-IS database to manually place and remove alerts on the EPR+ system, ensuring all staff are informed of a child's safeguarding status.



Child Exploitation

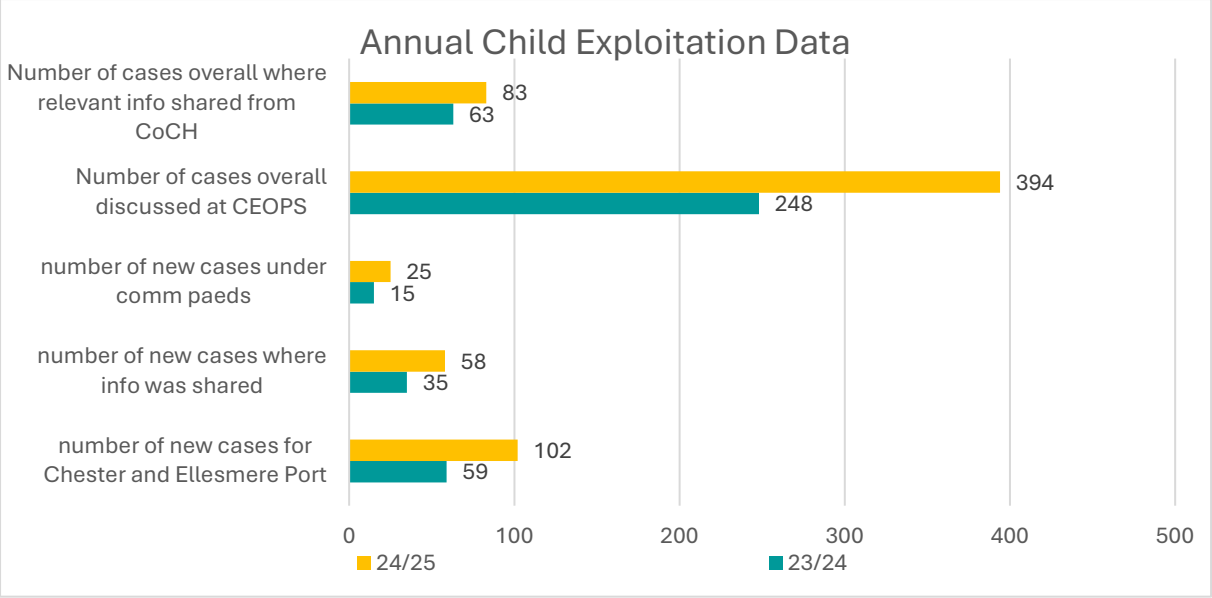
The Safeguarding Team continues to play an active role in addressing child exploitation by attending the monthly Child Exploitation Operational Group (CE-Ops) in Cheshire West and Chester. These meetings, chaired by Cheshire Police, bring together multi-agency partners to review and support children and young people identified as being at medium or high risk of exploitation.

Throughout 2024/25, there has been a notable increase in the volume of relevant information shared by the Trust at these meetings. This reflects both improved internal identification processes and a strong commitment to multi-agency safeguarding.

Children discussed at these meetings often include those who have:

- Attended the Emergency Department with intoxication, mental health concerns, or substance misuse
- Been referred to Community Paediatrics for neurodivergent conditions, which is a growing area of concern nationally due to the increased vulnerability of neurodiverse children to exploitation

For all children assessed as being at medium or high risk of exploitation, the Safeguarding Team ensures that appropriate alerts are placed on their EPR+ records. This enables all clinical staff to be aware of the child's risk status and respond accordingly to ensure their safety and wellbeing



The Safeguarding Team continues to actively contribute to the monthly Child Exploitational Operational Group (CE-OPs in Cheshire West and Chester, chaired by Cheshire Police. These multi-agency meetings focus on children and young people assessed as being at medium or high risk of exploitation.

Throughout 2024/25, the Trust has maintained a strong presence at these meetings, sharing relevant safeguarding information in the best interest of the child. This includes cases involving:

- Emergency Department attendances due to intoxication, mental health issues, or substance misuse
- Children under Community Paediatrics for neurodivergent conditions, reflecting national concerns about the increased vulnerability of neurodiverse young people to exploitation

There has been a marked increase in several key areas of child exploitation activity between 2023/24 and 2024/25.

The number of cases where relevant information was shared by the Trust rose from 63 to 83, and the number of cases discussed at the Child Exploitation Operational Panel (CEOPS) increased significantly from 248 to 394. These rises reflect both improved identification of Child Exploitation and a growing demand for multi-agency working.

The number of new cases under Community Paediatrics increased from 15 to 25, aligning with national concerns about the vulnerability of neurodiverse children to exploitation. Similarly, new cases where safeguarding information was shared rose from 35 to 58, indicating enhanced vigilance and responsiveness.

This overall rise in activity has had a significant impact on the workload and resources of the Safeguarding Team. Increased case volumes, more frequent information sharing, and the complexity of multi-agency working have placed additional pressure on the team's capacity.

Referrals to Children's Social Care

The table below outlines the number of referrals made by the Trust to Children's Social Care. These referrals are made when a child is assessed as requiring additional support under Section 17 of the

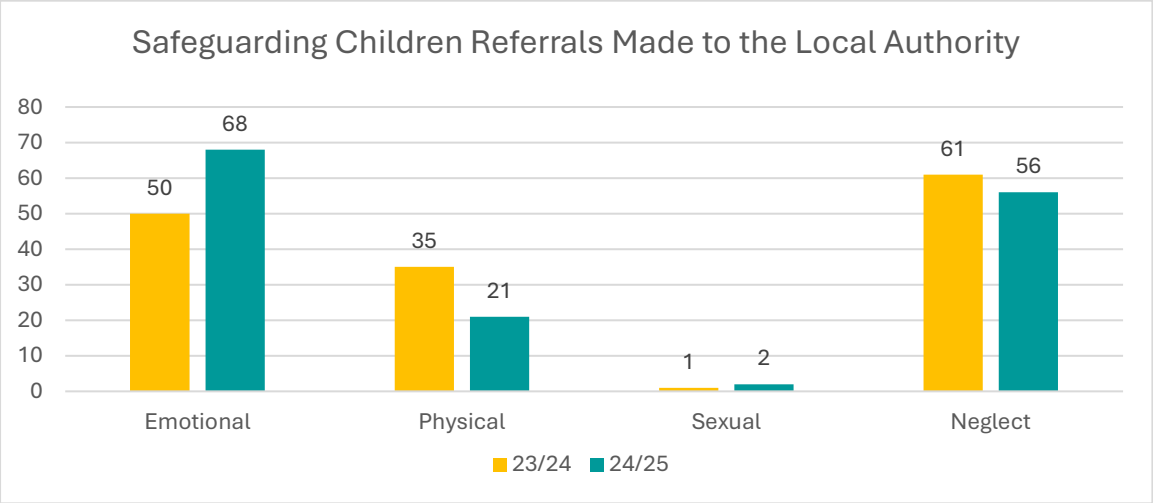
Children Act 1989, or when there are concerns that a child is at risk of, or has experienced, significant harm under Section 47 of the same Act.

Within the Trust, referrals are made for a range of safeguarding concerns. Common reasons include:

- Non-accidental injuries
- Domestic abuse
- Drug or alcohol overdoses involving either the child or their parent
- Mental health concerns affecting the child or parent
- Neglect
- Perplexing presentation

The Safeguarding Team works closely with social care colleagues, using consultation opportunities to ensure that referrals are appropriate and well-informed. In many cases, the team is required to provide additional information to support ongoing enquiries and assessments.

In line with statutory safeguarding guidance, such as *Working Together to Safeguard Children* (HM Government, 2023), harm is recognised under four categories: emotional, physical, sexual, and neglect. The Trust's Safeguarding Team categorises each referral accordingly when submitting to the Local Authority, ensuring consistency with national frameworks and enabling thematic analysis of referral trends



In 2024/25, the Trust made 147 referrals to Children's Social Care—the same number as in 2023/24. This figure represents a continued decrease when compared to previous years, with 183 referrals in 2022/23 and 157 in 2021/22.

One contributing factor to this sustained reduction may be the increased confidence and understanding among staff regarding safeguarding thresholds. Additionally, the Safeguarding Team's access to Liquid Logic, the Local Authority's electronic case management system, allows them to triage concerns more effectively. In some cases, this enables the team to take appropriate action without the need to submit a formal referral, ensuring that only cases meeting the statutory threshold are escalated.

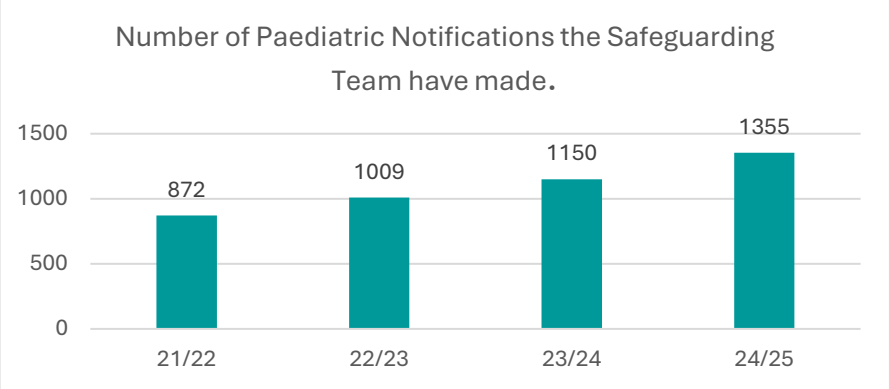
Liaison with Other Agencies

The Paediatric Liaison Nurse, currently based within Cheshire and Wirral Partnership Trust, is expected to transfer to the Trust in April 2025. This role ensures that concerns about children and young people seen in hospital are shared with community services—typically Health Visitors and School Nurses—to support continuity of care.

The Safeguarding Team provides written updates to the liaison service for any children or families where safeguarding concerns are identified. This role is key in maintaining effective communication between acute and community services, ensuring that vulnerabilities are followed up appropriately.

In addition, the team works closely with the Safeguarding Children in Education (SCIE) Team, particularly when admissions relate to school-based issues such as bullying and self-harm. Strong links also exist with CAMHS for complex mental health cases and with Ancora House for children detained under the Mental Health Act—with 4 such cases recorded in 2024/25.

The table below shows the increase in Paediatric Liaison Notifications the team have made over the past 4 years. This upward trend reflects the growing demand on the Safeguarding Team's capacity and highlights the increasing complexity and volume of safeguarding concerns requiring communication with community services. It also reinforces the importance of the Paediatric Liaison Nurse role, particularly as it transitions into the Trust in April 2025.



Perplexing Presentations

Children presenting with perplexing or medically unexplained symptoms continue to be a complex area of safeguarding practice. In 24/25 the team worked 10 cases where perplexing presentation of children was an issue. These cases often involve subtle or unclear concerns that require careful, multi-disciplinary exploration. Through increased supervision sessions with a wide range of hospital professionals, the Safeguarding Team has been able to identify emerging issues more effectively. These sessions have provided valuable insight into clinical observations and concerns, enabling the team to recognise safeguarding risks that may not have been immediately apparent. While this proactive approach has strengthened early identification and intervention, it has also significantly increased the team's workload and demand for specialist input from a wide range of hospital clinicians.

Safeguarding Children Supervision

Under the Children Acts of 1989 and 2004, safeguarding supervision must be available to all staff who work directly with children and their families. The Trust adheres to this statutory and contractual obligation through its Safeguarding Supervision Policy, which outlines the principles and expectations for effective supervision. All staff providing supervision have completed accredited and recognised training.

Compliance with safeguarding supervision requirements is closely monitored by the Integrated Care Board (ICB). A range of supervision methods is used across the Trust, including one-to-one, group, peer, and ad hoc supervision sessions.

In 2024/25 the range of staff accessing supervision expanded to include midwives, community paediatric nurses, dietitians, therapists, and ward-based nursing staff. All midwifery cases involving Children's Social Care are reviewed through supervision every three months, in line with the Safeguarding Assurance Framework.

The Named Doctor for Safeguarding Children facilitates monthly peer review sessions, where doctors present and discuss safeguarding cases they've managed. This is inclusive of both community and hospital paediatricians These sessions are well attended and have recently been extended to include safeguarding nursing colleagues.

Additionally, the Safeguarding and Complex Care Team receives supervision every six weeks. Named professionals also receive supervision from Designated Nurses within their respective specialties.

Child Protection Medical Examinations

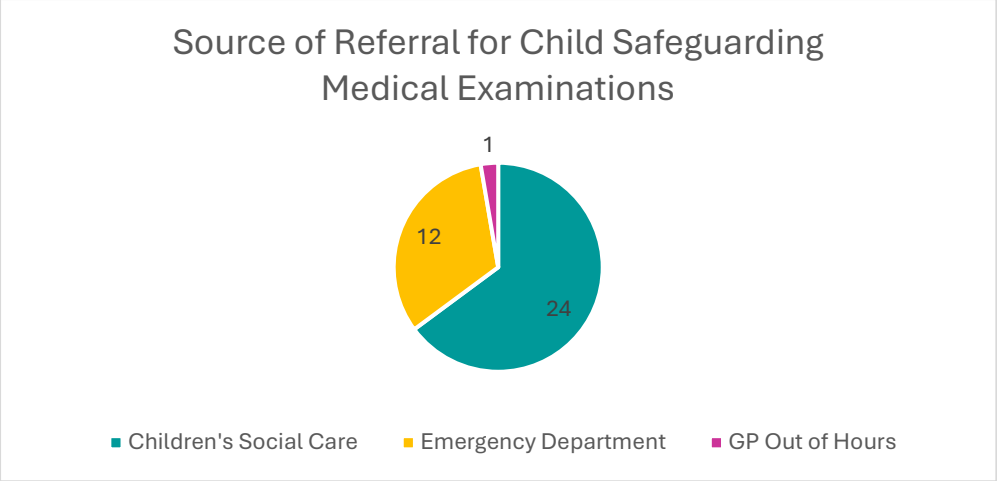
This section summarises the clinical activity and performance data for child safeguarding medical examinations conducted by both hospital and community paediatricians during 2024/25.

A total of 37 child protection medicals were completed in 2024/25. While this represents a decrease from 48 in 2023/24, it remains higher than previous years—31 in 2022/23 and 27 in 2021/22. The chart below illustrates the sources of referral for these medicals.

Although the number of examinations has declined from the previous year, the overall upward trend over recent years warrants continued monitoring. This data is regularly shared with the Safeguarding Children Partnership. Despite the increase, the number of medicals remains relatively low compared to neighbouring hospitals. No specific reason has been identified for this discrepancy, but it will continue to be reviewed through partnership oversight.

Notably, there was a significant rise in referrals from the Emergency Department (ED), increasing from 5 in 2023/24 to 12 in 2024/25. This may reflect both resource challenges in community settings and growing confidence among ED staff in recognising signs of abuse and initiating appropriate referrals.

All children referred for safeguarding medicals during this period were assessed due to concerns of physical abuse.



Maternity Safeguarding Activity

- The Trust is participating in the *Giving HOPE* project to support mothers separated from their babies at birth. Pilot phase is anticipated to begin in early 2025/26. The project promotes multi-agency collaboration and compassionate care.
- A consistent pre-birth assessment process is nearing completion. The pathway aims to ensure robust planning for unborn babies by 34 weeks' gestation.
- New safeguarding supervisors have been assigned to Community Midwives. Supervision is now geographically aligned, with group sessions planned where possible. Focus is placed on supporting cases involving learning disabilities and neurodivergence. Midwives are supported to complete reasonable adjustments and hospital passports.
- Bespoke safeguarding training is delivered to all new starters.
- Strong links are maintained with VIA (Drug & Alcohol Services), Homeless GP Practice, and Children's Social Care. These partnerships ensure joint planning to safeguard unborn babies.
- Routine enquiry regarding domestic abuse risk was conducted at booking for 73% of women.
- There has been an increase in DASH/RIC completion, linked to Level 3 training and supervision.
- The Safeguarding Team is involved early in planning the Continuity of Carer Enhanced Team. Safeguarding policies and pathways have been shared to support coordinated care.

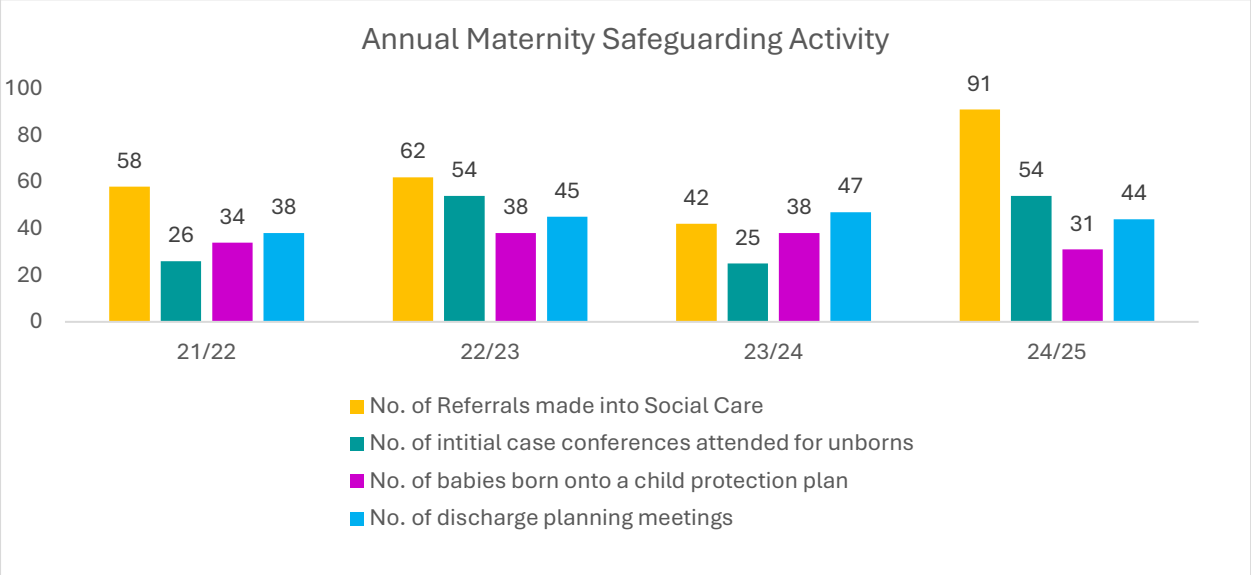
Safeguarding within maternity services is overseen by the Safeguarding Assurance Committee and aligned with the Safeguarding Assurance Framework under the Integrated Care Board (ICB). When safeguarding concerns arise during complex pregnancies, midwives refer cases to the Trust's Safeguarding Team. The Named Midwife for Safeguarding plays a pivotal role, providing specialist guidance and support to maternity staff on all aspects of child safeguarding.

Safeguarding Activity in Maternity Services

The Named Midwife for Safeguarding, alongside the safeguarding nursing team, works in close

The table below presents maternity safeguarding activity over the past four years. In 2024/25, the Trust received 185 safeguarding referrals—a reduction from 231 in 2023/24. Of these, 91 were escalated to the Local Authority, representing a 51% conversion rate compared to just 18% the previous year. This increase suggests a stronger understanding among midwives of safeguarding thresholds and appropriate referral processes.

Discharge planning meeting figures have remained relatively consistent, indicating that learning from the 2021/22 Safeguarding Child Practice Review by the Cheshire West and Chester Safeguarding Children Partnership has been effectively embedded into practice. Additionally, the team participated in 33 multi-agency strategy meetings in 2024/25, mirroring the previous year's engagement



In 2024/25, the team was involved in the care of nine babies who were taken into the care of the Local Authority—an increase of two cases compared to 2023/24. These situations are emotionally complex and demanding for both the midwifery and safeguarding teams, who provide extensive support to all staff involved. The introduction of the Hope Box project aims to offer additional support throughout this process.
In four of these cases, the Local Authority requested formal court reports from the team to assist with ongoing legal planning for the babies' futures

Safeguarding the Vulnerable Adult

Key Achievements 2024/25

- **Strengthened Strategic Collaboration**: Monthly meetings established between the Senior Social Care Manager and the Lead Professional for Safeguarding Adults to review cases and identify emerging themes.
- **Increased Visibility**: Enhanced safeguarding presence across both Countess of Chester and Ellesmere Port Hospital sites.

- **Policy Development**: Safeguarding Adults Policy updated, incorporating an internal process for monitoring and responding to adults with care and support needs who are not brought to hospital appointments.
- **Integrated Discharge Planning**: Daily triage meetings attended by the safeguarding team, discharge team, and hospital social workers to support safe and effective discharge planning.
- **Pressure Ulcer Oversight**: Weekly attendance at pressure ulcer review meetings, now managed electronically via Datix with the safeguarding decision tool embedded. Close collaboration with Tissue Viability Nurses (TVN) and quality teams supports ongoing Trust-wide improvement.
- **Support for Homeless Patients**: Strengthened partnerships with agencies supporting homeless individuals presenting to ED, including engagement with the GP practice serving this population in Chester.
- **Housing and Rough Sleeping Initiatives**: Established working relationships with CWAC complex housing officers and MARS, with regular attendance at MARS meetings and participation in a multi-agency rough sleeping development event.
- **Improved Information Sharing**: A new template developed to support information sharing with GPs, alongside regular updates to GP contact details.
- **Audit and Learning**: Participation in a CWAC multi-agency audit and learning event to review findings and implement practice improvements.
- **Learning from Reviews**: Attendance at external learning events related to published Safeguarding Adult Reviews (SARs), with key findings disseminated across the organisation.
- **Engagement in Safeguarding Adult Reviews**: Active involvement in three SARs, including the development of action plans to support organisational learning.
- **Prevent and Channel Panel Involvement**: Ongoing representation at Prevent and Channel panels, and participation in the North West Prevent Partnership Group to share training and best practices.
- **Specialist Working Groups**: Representation at the Chester West and Chester Hoarding Alliance and a newly formed CWAC working group focused on individuals with alcohol dependency.
- **Operational Development**: Introduction of Safeguarding Complex Care Operational Meetings to align strategic priorities and operational developments.
- **Reduction in Provider-Led Section 42 Enquiries:** Notable decrease in provider-initiated safeguarding enquiries.
- **Focus on Self-Neglect:** Self-neglect identified as a key priority for 2025/26. An action plan has been developed to establish a consistent approach to identifying, assessing, and managing self-neglect across all departments

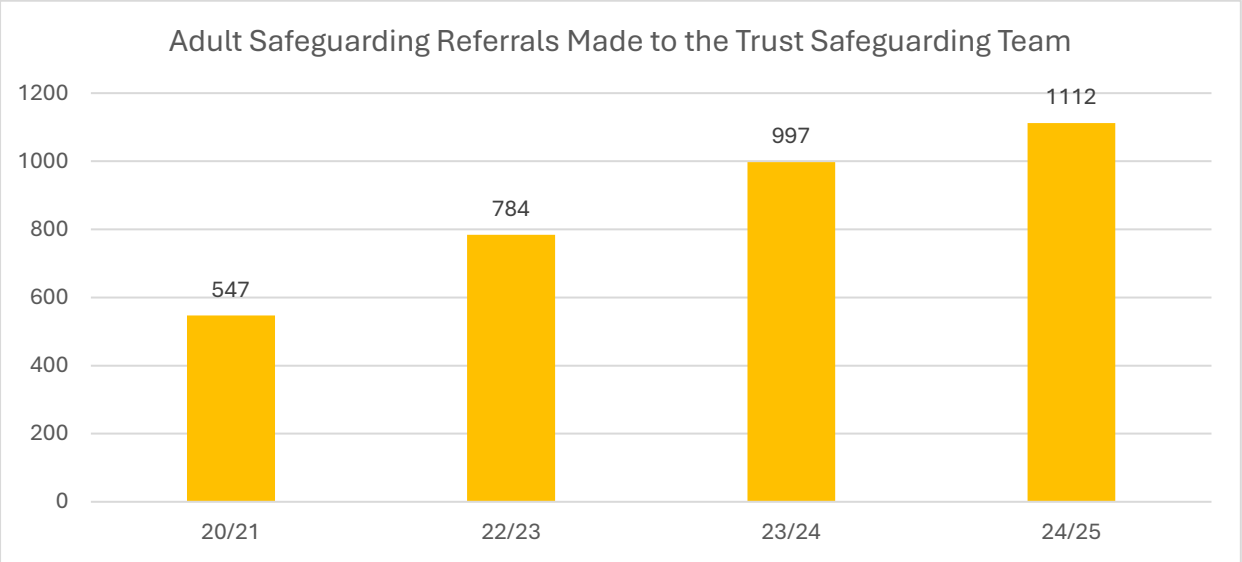
Safeguarding Adults Activity

The hospital's Safeguarding Adults Team continues to provide expert advice and support on a wide range of issues affecting adults with care and support needs, including those at risk of or experiencing abuse or harm.

In 2024/25, the team received 1,112 referrals—an increase from 997 in 2023/24—reflecting a year-on-year rise in safeguarding activity. This growth is attributed to the team's increased visibility across the Trust and improved staff confidence and competence, supported by higher compliance with safeguarding training.

Referral numbers rose steadily across each quarter. However, of the 1,112 referrals received, 373 were assessed as not meeting the threshold for a safeguarding response, with no safeguarding concerns identified. This figure is consistent with the previous year and highlights an ongoing challenge: while training compliance has improved, there remains a gap in staff understanding of safeguarding thresholds.

To address this, further targeted training is planned for 2025/26 to enhance staff awareness and ensure more accurate and appropriate referrals.



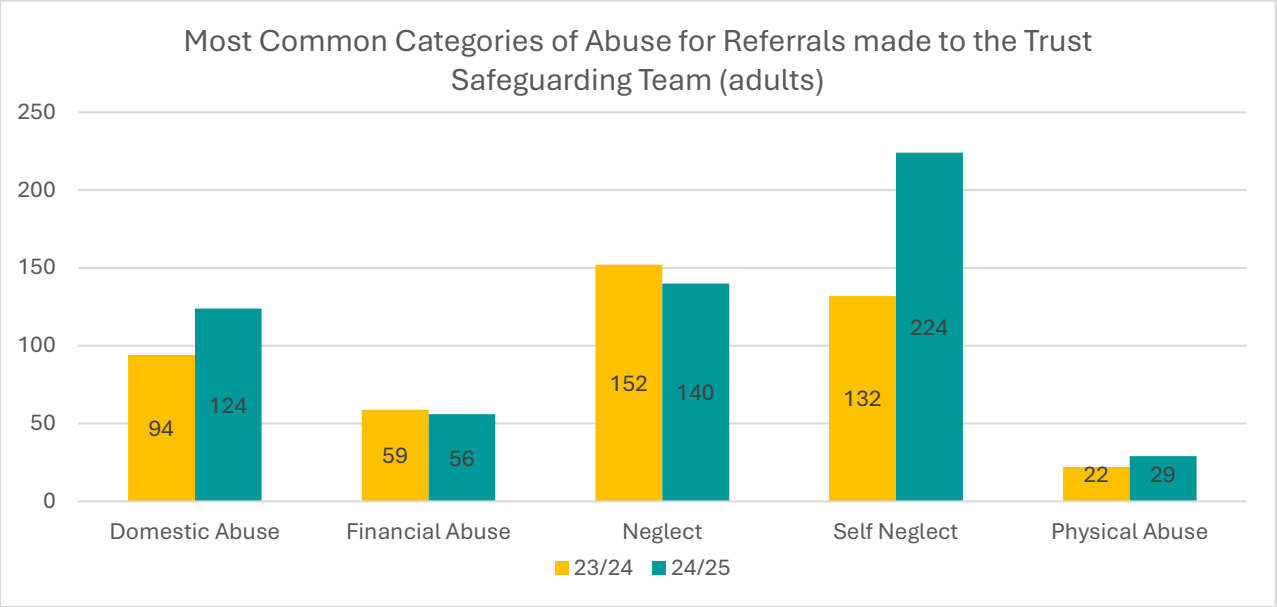
Nature of the Referrals received.

The table below reflects the nature of the referrals received into the team for adult safeguarding. The table demonstrates that the key reason for referrals are; for a disclosure of domestic abuse, financial abuse, neglect and self neglect. This supports the national and local trend of an increase in these areas. It is encouraging that staff also recogonise some less common types of abuse including cuckooing (1), radicalisation (1), sexual abuse (15), psychological abuse (6) and organisational abuse (16) and made approriate referrals to the team on recognition. This trend correlates with the Trust's commitment to improving their safeguarding training indicating the effectiveness of the training the staff receive.

The data highlights several key trends:

- Domestic Abuse referrals increased significantly, reflecting improved staff awareness and confidence in identifying and reporting abuse, supported by improved compliance in safeguarding training.
- Financial Abuse remained relatively stable, suggesting consistent recognition and reporting practices.
- Neglect saw a slight decrease, which may indicate more effective early intervention and support strategies from a community response.
- Self-Neglect showed a sharp rise—from 132 to 224 referrals. This increase is particularly notable and aligns with national trends, as well as the Trust's involvement in three Safeguarding Adult Reviews (SARs) where self-neglect was a key theme. In response, a dedicated action plan has been developed to improve identification, assessment, and management of self-neglect across all departments.
- Physical Abuse referrals also rose, likely due to increased staff training and vigilance.

These trends reflect the Trust's ongoing commitment to safeguarding training and the positive impact it has had on staff's ability to recognise and respond to a wide range of safeguarding concerns.



Working with Adult Social Care

In 2024/25, the Trust made 161 referrals to Adult Social Care, up from 127 in 2023/24. These referrals are made under the Care Act 2014 when an adult:

- Has care and support needs,
- Is experiencing or at risk of abuse or neglect,
- And, due to those needs, is unable to protect themselves.

Referral Breakdown:

- 79% were made to Cheshire West and Chester Local Authority
- 17% to Flintshire This distribution reflects the patient population served by the Trust.

Safeguarding Enquiries:

- 18 referrals progressed to a provider-led Section 42 enquiry, double the number from 2023/24

- The Trust also received 88 information requests from Adult Social Care to support external Section 42 enquiries—up from 55 in 2023/24 and 42 in 2022/23. This increase may reflect a broader national rise in reported adult abuse cases.

Pressure Ulcers and Safeguarding

Pressure ulcers remain a key area of safeguarding concern, as they can indicate potential neglect—whether through deliberate omission or unintentional failure by a carer to provide adequate care. Within the Trust, pressure ulcers are categorised as either Present on Arrival (POA), typically identified at admission, or Hospital Acquired Pressure Ulcers (HAPUs), which develop during a patient's hospital stay.

In 2024/25, the Safeguarding and Complex Care Team continued to embed and strengthen processes for managing both POA and HAPU cases. These efforts have supported the Trust's safeguarding responsibilities and aligned with the Local Authority's protocols, ensuring a more consistent and proactive approach to prevention, identification, and response.

The team was alerted to 78 HAPUs via the DATIX system, all involving either multiple category 2 ulcers or category 3 and 4 ulcers. The Government's Adult Safeguarding Decision Tool was fully integrated into the Trust's DATIX template in 24/25, enabling clinical teams to assess each case systematically. As a result, only two cases required referral to Adult Social Care, while the remaining cases were appropriately managed without triggering a formal safeguarding response.

For POA pressure ulcers, 149 cases were recorded in 2024/25. Of these, five were referred to the Local Authority due to concerns about potential neglect by external care providers. A standardised notification form was introduced to support this process. The Trust is also working closely with the Integrated Care Board's quality team to ensure consistent use of the Adult Safeguarding Decision Tool across both acute and community settings

Liaison with Other Agencies

The Safeguarding and Complex Care Team have set up a liaison service between each local GP surgery (both Cheshire West and Flintshire) and themselves to ensure key safeguarding information is liaised out to the GP surgery following a patient's admission. This liaison process has worked both ways and the team have been used by GPs to liaise their safeguarding concerns into the hospital to safeguard their patients during an inpatient admission. Data is not available on this process yet.

Prevent Duty

Under the Counter-Terrorism and Security Act 2015, the health sector has a statutory duty to have due regard to the need to prevent individuals from being drawn into terrorism—this is known as the Prevent Duty.

To ensure compliance with this duty, the Trust has implemented the following arrangements:

- An identified Prevent Lead (Lead Professional for Safeguarding Adults) is available to provide staff with advice and support.
- A current Trust Prevent Policy and Strategy offers clear guidance to staff on how to identify and respond to concerns.

- A Prevent training programme is in place to raise awareness and build staff confidence in recognising and reporting potential risks.
- The Prevent Lead actively participates in multi-agency meetings to support collaborative safeguarding efforts.
- The Trust submits quarterly Prevent data to the Integrated Care Board (ICB) to provide assurance and oversight.

In 2024/25, the Trust made one referral to the Channel Panel and has fully engaged in all related meetings, sharing relevant information with the Channel Coordinator as required

Modern Slavery

As a Trust, we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or supply chain. In accordance with the requirements of the UK Modern Slavery Act (2015) our Slavery and Human Trafficking Policy Statement sets out the actions taken by the Trust to understand all potential modern slavery risks and to implement effective systems and controls.

Domestic Abuse

Key Achievements in 24/25

The Trust has strengthened its domestic abuse awareness efforts through high-visibility campaigns such as:

- White Ribbon Day
- 16 Days of Activism
- Valentine's Day Campaigns

Additionally, "Well-being Wednesday" was introduced to provide staff with a supportive space to address domestic abuse concerns.

- Mandatory screening questions are now asked during all inpatient admissions.
- Safeguarding flags are added to patient records for individuals identified as victims or perpetrators, including all those discussed at MARAC (Multi-Agency Risk Assessment Conference).
- The DASH risk assessment tool is now integrated into the EPR+ system.
- A snapshot audit revealed that 93% of postnatal women were asked about domestic abuse during pregnancy.
- Domestic abuse training is readily accessible via the Trust's Safeguarding intranet

The Trust is committed to enhancing awareness and understanding of domestic abuse (DA) safeguards, ensuring all staff are equipped with the necessary resources and support. A key component of this effort is the presence of an Independent Domestic Abuse Advisor (IDVA) within the Safeguarding and Complex Care team, who supports both patients and staff disclosing abuse.

In 2024/25, the IDVA received 475 referrals—almost double the 246 received in 2023/24 and significantly higher than the 243 in 2022/23. This increase reflects improved routine enquiry

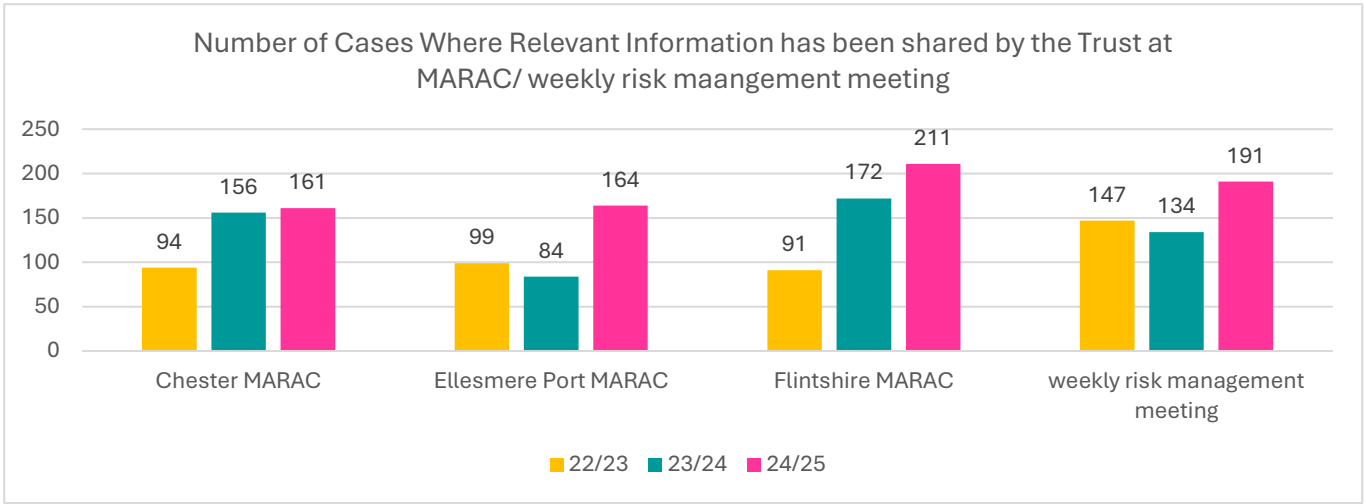
practices, particularly in the Emergency Department and hospital wards, where most referrals originate. The rise also aligns with national findings that victims often seek medical help for injuries or related issues such as mental health or substance use.

In the 2024/2025 reporting period, of the 475 domestic abuse (DA) referrals, with the majority—339—being adult cases. There were also 85 referrals involving children in the household, highlighting the broader impact of domestic abuse on families. Maternity-related referrals accounted for 29 cases, indicating that routine enquiry during pregnancy is identifying at-risk individuals. Additionally, 22 staff members disclosed experiences of domestic abuse, underscoring the importance of internal support mechanisms. Notably, 58 patients had drug or alcohol dependencies, reflecting the complex interplay between substance use and domestic abuse. These figures emphasise the need for continued vigilance, comprehensive screening, and integrated support services across all patient and staff groups.

The Independent Domestic Violence Advisor (IDVA) continues to play a central role in representing the Trust at Multi-Agency Risk Assessment Conferences (MARAC), which are held four times per month across the Trust's footprint as well as the Weekly Risk Meeting. These meetings focus exclusively on high-risk domestic abuse cases and involve the sharing of vital information about victims, perpetrators, and any children involved.

Between 2022/23 and 2024/25, the Trust experienced a significant rise in the number of high-risk domestic abuse cases discussed at Multi-Agency Risk Assessment Conferences (MARAC). In 2022/23, 286 cases were reviewed, increasing to 421 in 2023/24, and surging to 727 in 2024/25. This represents a 154% increase over two years, reflecting both a national rise in domestic abuse prevalence and the Trust's strengthened approach to identifying and referring high-risk cases.

The growing caseload highlights the critical role of the Independent Domestic Violence Advisor (IDVA), whose contributions to MARAC involve extensive preparation and coordination. While this increase demonstrates the effectiveness of routine screening and multi-agency collaboration, it also places considerable pressure on the IDVA and safeguarding teams. This trend underscores the need for ongoing investment in resources and capacity to ensure the Trust can continue to provide timely and effective support to those at risk



Complex Care Activity

Key Achievements in 2024/25

- The Trust can provide assurance that all patients, known as having a learning disability or autism are clearly identified to Trust staff and are assessed for reasonable adjustments both for elective care and ward admissions.
- All patients identified as having a learning disability and/or autism will have a Reasonable Adjustments flag added to their electronic patient record (EPR+). This flag is accompanied by a pop-up alert that provides staff with tailored guidance and key information to support the delivery of person-centred care.
- The Trust is actively progressing the rollout of the Oliver McGowan Mandatory Training in line with national requirements, 2 staff members are now registered trainers, qualified to deliver the programme
- Successful delivery of the NHSE e-learning pilot programme in Dementia Care to most nursing staff caring for patients with dementia.
- Successful implementation of an online patient/carer feedback questionnaire in an easy read format.
- Participation in the Annual NHSE benchmarking, learning disability improvement standards for NHS trusts assessment and the National Dementia Audit.
- The Trust can provide assurance that the STOMP (stopping over-medication of people with a learning disability, autism or both with psychotropic medicines) agenda has been fully embedded across the Trust.
- Improved uptake and use of Hospital passports for patients with a learning disability and/or autism
- Promoting the need for reasonable adjustment risk assessments via the implementation of the Safeguarding screening tool.
- Established a strong and skilled Complex Care Team to enhance support for patients with complex needs.
- Strong governance and reporting systems in place to support the LeDeR programme. Learning from reviews is shared across the Trust to drive improvements in care for people with learning disabilities and autistic people

The Complex Care team provides specialist advice and support for a wide range of issues relating to the Complex Care agenda. This, in the main is for those patients where, there are challenges in accessing care or delivering care due to a cognitive impairment such as a Learning Disability, Autism and or dementia as well as those patients with mental health challenges.

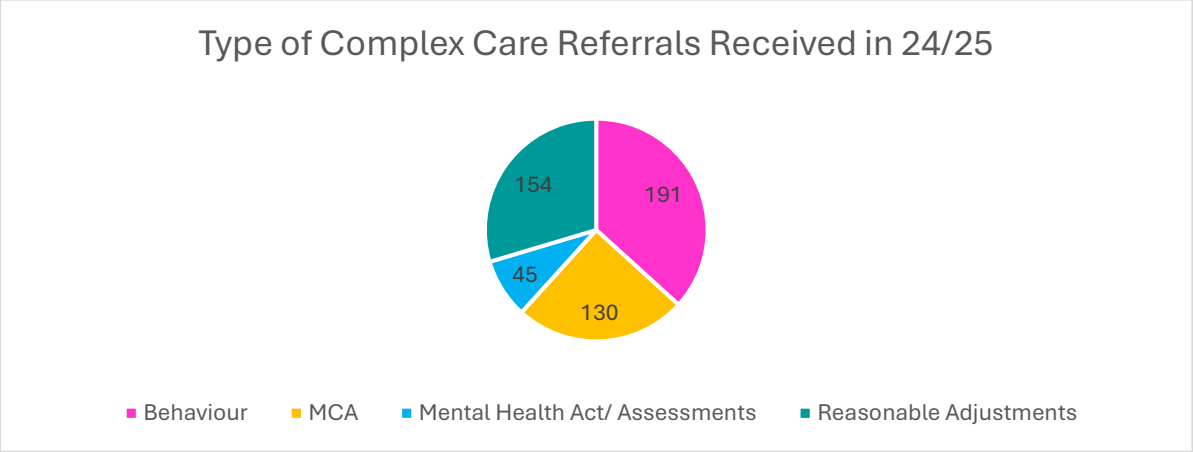
In 2024/25, the team received 492 referrals from staff—representing a significant increase of approximately 246% compared to the 142 referrals received in 2023/24.

The referral data into the Complex Care Team highlights key areas of patient complexity and support needs. The highest number of referrals (191) were related to behavioural issues, indicating a significant demand for specialist input in managing behaviours that challenge, often linked to neurodevelopmental, mental capacity or mental health conditions. This suggests a need for enhanced behavioural support, staff training, and multi-agency collaboration.

In 2024/25, the Trust recorded 200 reasonable adjustment risk assessments—a 550% increase compared to the previous year. This significant rise reflects a growing awareness of the need to personalise care for individuals with additional needs, such as those with learning disabilities or autism, and demonstrates the Trust's proactive commitment to inclusive care and compliance with the Equality Act.

Of the 154 referrals made for reasonable adjustments, many resulted in tailored care plans. A notable proportion involved patients attending for outpatient or same-day procedures, requiring detailed planning and coordination. Adjustments included home visits to assess capacity, extended appointment times, tailored scheduling, identification of low-stimulus environments, unrestricted access for carers or relatives, amalgamation of treatments, and the use of sedation within a Best Interest framework.

There were 130 referrals under the Mental Capacity Act (MCA), showing frequent need for support with complex decision-making and best interest processes, particularly in safeguarding contexts. Meanwhile, 45 referrals under the Mental Health Act (MHA) indicate a smaller but important group of patients requiring legal frameworks for treatment or detention. Overall, the data reflects a complex patient population and a responsive, legally informed care culture within the Trust.



Learning Disability and or Autism

An estimated 1.5 million people in the UK live with a learning disability, and over 10% are diagnosed with autism spectrum disorder. These individuals often need more frequent healthcare and face a higher risk of poor outcomes and unequal treatment. Under the Equality Act 2010, the Trust is legally required to make reasonable adjustments for patients with learning disabilities and/or autism, regardless of whether their hospital visit is planned or unplanned. To meet these needs, the Complex Care Team—part of the Safeguarding and Complex Care service—provides tailored support, including easy-read materials, guidance for clinical teams, help with hospital visit preparation, and coordination of appointments or best interest meetings.

In 2024/25, the Complex Care Team enhanced governance processes by making more effective use of the electronic patient record system. Patients with a recorded diagnosis of learning disability and/or autism were automatically identified through existing diagnostic codes. Based on this information, the team received daily reports highlighting individuals accessing the Trust. This enabled the team to review current admissions and, where appropriate, provide support to patients still in hospital. Throughout the year, 446 patients with a learning disability and 599 with autism attended the Trust. Some of these individuals had multiple attendances, resulting in 642 attendances for patients with a learning disability and 854 for those with autism. For all identified

patients, the Complex Care Team ensured that a reasonable adjustment flag was added to their electronic record. This flag triggers a pop-up alert whenever a staff member accesses the record, prompting them to consider and apply appropriate reasonable adjustments in the delivery of care.

Quarterly audits are carried out for patients with a clinical code indicating a learning disability and/or autism. These audits assess compliance against key criteria, including:

- Whether appropriate alerts and flags are in place.
- Availability of a hospital passport on the patient's EPR+.
- Whether a referral has been made to the Safeguarding and Complex Care Team.
- Identification and implementation of reasonable adjustments.

Following each audit, recommendations are developed and shared with the Safeguarding Assurance Committee. Key learning points are then cascaded across relevant forums to support continuous improvement in care delivery

Patients who have received support from the Complex Care Team, as well as those who have accessed wider hospital services, are invited to share their feedback via a form accessible through a QR code. Although response rates remain limited, the feedback received so far has included several positive reflections, highlighting both individual care experiences and broader aspects of hospital support.

Feedback from patients who have additional needs

By daughter had her own room to wait in and everyone was kind and helped her get through the day. It has been stressful, and we have been planning this day for 3 months. Very thankful to everyone on the day in the Jubilee Day Centre.

Everything has been great; all the planning was worth it. All staff friendly and helpful.

The separate room helped a lot and there was a long queue for bloods in a busy environment however one of the phlebotomists saw us straight away which was great.

Thank you for all your support and care to get my disabled son through his operation and prep, absolute angels.

We just wanted to say we can't thank you enough for the help and support you gave my son, in A&E, you provided information and smoothed navigation through A&E on what was a very stressful day for us. Thank you again. You are absolute stars.

My daughter has complex needs, and her care support was to leave my daughter if she was to be admitted to the ward. My daughter has fully funded care and this funding should not stop when she is in hospital. We are having trouble with the care Agency. The complex care team contacted the care agency and challenged them on behalf of us. This was reassuring and helpful. Thank you.

Reasonable Adjustments

This quarter has seen minimal change in the number of Reasonable Adjustments being applied to care pathways when compared to the previous quarter however, there has been a 550% increase in 2024/25.

Of the 52 patients where reasonable adjustments were made to established care pathways, 17% (9) involved patients attending the Trust as either an outpatient or same day procedure which required significant adjustments being made and co-ordination with external/internal professionals.

In these cases, the adjustments involved home visits to assess capacity, longer appointment times, timing of the appointment, identification of a low stimulus environment for care, unrestricted access to relative/carer, amalgamation of treatments and use of sedation within a Best Interest framework.

STOMP (*Stopping over-medication of people with a learning disability, autism or both with psychotropic medicines)*

Building on the strong foundations established in 2023/24, the Trust continued to drive forward the STOMP (Stopping Over-Medication of People with a Learning Disability, Autism or Both) initiative in 2024/25. To support this, STOMP awareness training was delivered twice during the year as part of the Trust's F1 induction programme, and all pharmacy technicians received dedicated training. In addition, STOMP principles are being embedded into ward-based pharmacy care plans to ensure ongoing awareness and application in daily practice.

As part of the Learning Disability and Autism Audit in Q4 2024/25, pharmacy teams reviewed all patients with a diagnosis of learning disability and/or autism. Reassuringly, no cases of inappropriate over-medication were identified, providing assurance that prescribing practices remain aligned with national STOMP objectives.

Learning from Lives and Deaths- People with a Learning Disability and Autistic People (LeDeR)

The Trust has implemented robust governance and reporting structures to support the Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) programme. These ensure that reviews are completed in a timely, transparent, and person-centred manner, with clear accountability. Oversight is embedded within the Trust's Learning from Deaths framework, with monthly reports capturing key learning and informing service improvements.

In 2024/25, the Trust referred seven cases to the LeDeR programme, up from two in 2023/24. Five Structured Judgement Reviews (SJRs) were also received. Outcomes and themes from LeDeR reviews are shared with relevant clinical and operational teams to support continuous improvement in care for people with learning disabilities and autistic people.

Case Study Summary – Supporting a Young Person with a Learning Disability
W, a 1young lady with a learning disability, non-verbal communication, unstable epilepsy, and mobility challenges, required multiple health checks. Due to her high sensitivity to stimuli and difficulty communicating, the Complex Care Team worked closely with her mother and multiple services to develop a personalised, least restrictive care plan. A Hospital Passport and Reasonable Adjustments were established, and all procedures were coordinated to take place under sedation in one location. The visit was completed in under three hours, and W's mother expressed deep appreciation for the compassionate, well-coordinated care

The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

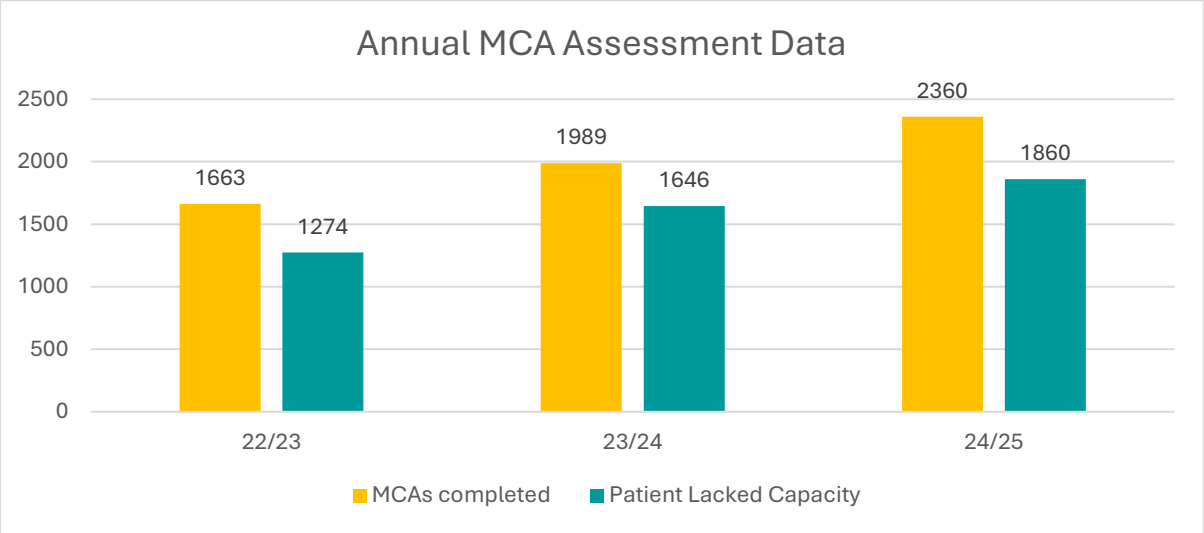
The Mental Capacity Act (MCA) protects and empowers people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged sixteen and over. It covers decisions about whether a patient has the capacity to decide about their care and treatment and their discharge destination. Examples of people who may lack capacity include those in hospital with dementia, delirium, a learning disability, and a brain injury (as well as other conditions).

Over the past three years, the Trust has seen a consistent and notable increase in the number of mental capacity assessments conducted. In 2022/23, there were 1,663 assessments, which rose to 1,989 in 2023/24, and further to 2,360 in 2024/25—a 42% increase over the period.

This upward trend reflects a growing emphasis on ensuring that patients are appropriately assessed for their ability to make informed decisions about their care and treatment. It may also indicate increasing complexity in patient needs or improved awareness and compliance with legal and ethical obligations under the Mental Capacity Act.

However, the more telling trend lies in the conversion rate—the proportion of assessments that concluded the patient lacked capacity to make specific decisions about their care and treatment:

This data shows that not only are more assessments being conducted, but a consistently high proportion are resulting in findings of incapacity. The chart below visually illustrates both the volume of assessments and the conversion to findings of incapacity, reinforcing the importance of these assessments in clinical decision-making.



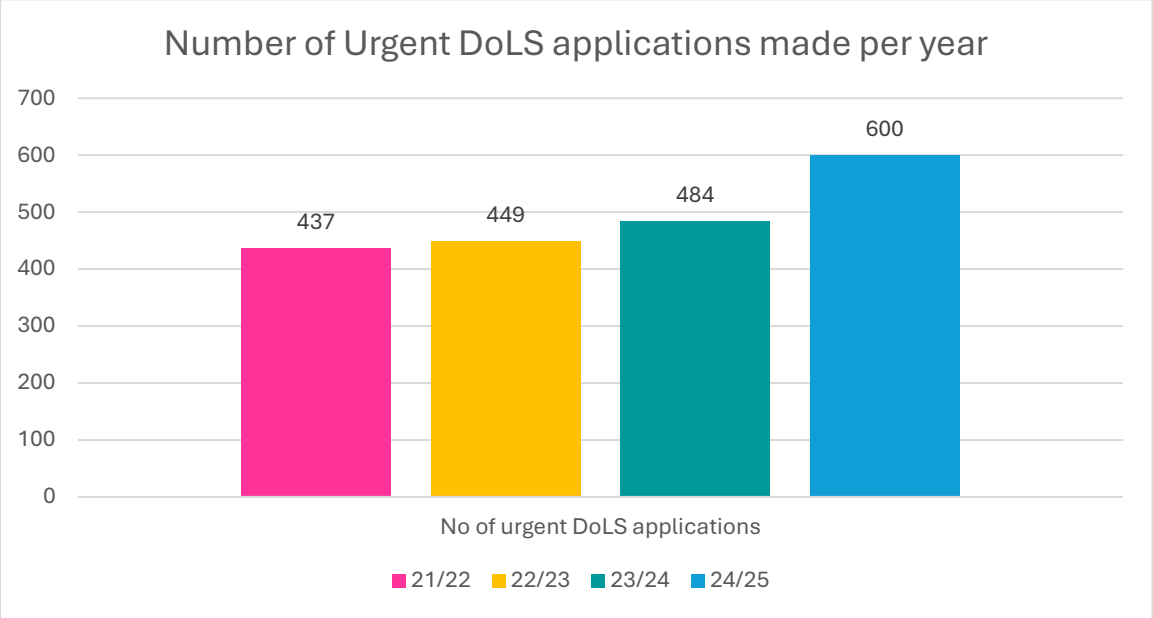
In 2024/25, the Safeguarding and Complex Care Team made significant progress in promoting the Mental Capacity Act (MCA) agenda. By increasing their visibility within clinical areas, they provided hands-on support to staff in completing MCA assessments. In addition to this, there was a notable improvement in Level 3 safeguarding compliance, which closely correlates with the rise in completed MCA assessments

When individuals lack mental capacity, they may be subject to restrictions that constitute a deprivation of liberty. In such cases, hospitals must apply for a Deprivation of Liberty Safeguards (DoLS) authorisation to ensure care is provided in the patient's best interests and in the least restrictive manner. The Countess of Chester Hospital submitted 600 urgent DoLS applications in

2024/25—up from 484 in 2023/24, 449 in 2022/23, and 437 in 2021/22. To support this process, a mandatory screening tool has been introduced for all inpatients where the MCA is applicable.

The Complex Care Team plays a crucial role in maintaining high standards of care. During the urgent DoLS authorisation period, in 24/25 they visited each patient three times to review and personalise care plans. Most patients subject to DoLS now have a "This is Me" document or patient passport, and all have alerts on their records. These tools are essential for providing personalised care, offering insights into each patient's preferences, communication needs, and daily routines.

To further enhance this process, the team has collaborated with the hospital's volunteer service to support the completion of "This is Me" and patient passports. This partnership not only improves the quality of documentation but also fosters a more inclusive and responsive environment for patients who lack capacity.



In 2024/25, the Trust made 7 referrals to Independent Mental Capacity Advocates (IMCAs) for patients who lacked the capacity to make key decisions about serious medical treatment or changes in accommodation, and who had no appropriate family or friends to consult. IMCAs play a vital role in safeguarding the rights of these individuals and ensuring that decisions made on their behalf are in their best interests

Dementia

Dementia is a progressive syndrome caused by various underlying conditions, leading to a decline in brain function and decision-making ability. Nearly one million people in the UK are living with dementia, and at any given time, one in four hospital beds is occupied by someone with the condition, who may require additional support depending on the stage of their illness, including help with making decisions

The Complex Care Team supports patients living with dementia who lack the mental capacity to make decisions about their care, treatment, or serious medical interventions, and who may require a Deprivation of Liberty Safeguards (DoLS) authorisation. In 2024/25, the team actively promoted the use of the *This Is Me* booklet for all patients with dementia. This resource plays a vital role in delivering person-centred care by capturing key information about the individual's preferences, routines, and communication needs—particularly important when the patient is unable to express

these themselves. Its use helps reduce distress, enhances care planning, and supports better outcomes during hospital stays.

Mental Health Act (MHA)

While most individuals admitted to acute hospital settings with mental health needs do so voluntarily, some require detention under the Mental Health Act (1983) when urgent treatment is necessary and there is a risk of harm to themselves or others. In 2024/25, 33 patients were detained under the Act, an increase from 25 in 2023/24.

To ensure legal compliance and oversight, the Chief Executive Officer may delegate the responsibility for receiving and scrutinising section papers to appropriately trained staff. During 2024/25, all Heads of Nursing, Matrons, and Clinical Site Coordinators received training from the Safeguarding and Complex Care Team to develop competence in reviewing section documentation and identifying any errors requiring correction. This training is also accessible via the Trust intranet.

Further scrutiny of Mental Health Act documentation is provided by Mental Health Act administrators from Cheshire and Wirral Partnership NHS Foundation Trust (CWP), under a Service Level Agreement (SLA). This agreement was jointly reviewed by both Trusts during 2024/25 to ensure continued quality and compliance.

8. Training

Safeguarding education forms the foundation of safeguarding competence across the workforce. All safeguarding training delivered within the Trust aligns with the standards outlined in the Intercollegiate Safeguarding documents:

- *Adult Safeguarding: Roles and Responsibilities for Healthcare Staff* (RCN, Aug 2018)
- *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff* (RCN, Jan 2019)
- *Prevent Training and Competencies Framework* (DHSC, 2022)
- *Looked After Children: Roles and Competencies of Healthcare Staff* (2020)

The Trust's safeguarding training Key Performance Indicators (KPIs), agreed locally with the Integrated Care Board (ICB), are set at 90% compliance. Training is inclusive of all staff and delivered through a range of formats to suit different learning styles, including eLearning modules and full-day face-to-face sessions.

All safeguarding training packages are reviewed annually to ensure alignment with current legislation, statutory guidance, and learning from safeguarding reviews and incidents. In 2024/25, the Trust developed a comprehensive safeguarding training strategy, underpinned by a detailed Training Needs Analysis (TNA), to support its strategic objectives.

To assess the impact of training on staff behaviour and patient outcomes, the Trust monitors:

- Compliance with safeguarding children and adult policies and procedures
- The number of appropriate referrals made to the Safeguarding Team

Training Compliance as of 31 March 2025:

Level 1 Safeguarding Adults	93%	Level 1 Safeguarding Children	88%

Level 2 Safeguarding Adults	92%	Level 2 Safeguarding Children	92%
Level 3 Safeguarding Adults	90%	Level 3 Safeguarding Children	91%
Level 4 Safeguarding Adults	100%	Level 4 Safeguarding Children	100%

To address the low Level 3 compliance rate of 67% recorded on 31 March 2024, the following actions were implemented across the year:

- Compliance data was analysed by clinical area to target underperforming teams
- The TNA was reviewed and updated
- Additional training capacity was introduced
- Regular communications were issued to reinforce the importance of training

As a result of these targeted efforts, Level 3 training compliance improved significantly, reaching 90% by the end of the reporting year. This remained a standing agenda item at the Safeguarding Assurance Committee throughout the year.

Specialist and Bespoke Training

Staff working in maternity, paediatrics, and the Emergency Department receive enhanced Level 3 safeguarding training tailored to local and national priorities. In 2024, the focus was on childhood neglect, aligned with the Safeguarding Children Partnership's priorities. In 2025, the emphasis shifted to Children in Care, in response to a series of related incidents.

Safeguarding Children training is also delivered to all new junior doctors rotating through the Emergency Department by the Named Doctor and Nurse for Safeguarding Children. Key topics include non-accidental injuries, child exploitation, and child mental health.

Additionally, the Safeguarding and Complex Care Team has delivered bespoke training on dementia, the Mental Capacity Act (MCA), and domestic abuse. These sessions have been offered both as online "lunch and learn" bite-sized modules and in-person training

A bespoke OSCE-based training programme was successfully delivered and evaluated, specifically designed to enhance the application of the Mental Capacity Act (MCA) within the discharge process

Dementia Training

Following a successful pilot, the Dementia E-Learning Programme was rolled out to additional wards in Q3 2024/25. Staff from other departments also completed the training independently.

Training Feedback & Outcomes

- Overall feedback was positive, with staff reporting improved confidence and praising the content's clarity and relevance.
- Challenges included difficulty completing modules during work hours and the time-intensive nature of the gold level.
- Bronze level: Staff valued modules on communication, behaviour, nutrition, and mobility.
- Silver level: The pharmacology module was particularly well received.
- Gold level: Found to be comprehensive but time-consuming.

Although the programme follows the NHS England Dementia Training Framework (2018), it's difficult to measure its direct impact on care delivery because the Friends and Family Test (FFT) results can't be isolated to just the pilot wards where the training was implemented.

The Oliver McGowan Mandatory Training programme

The Trust has begun implementing a structured action plan to roll out the Oliver McGowan Mandatory Training Programme across the organisation. A dedicated steering group is in place, and two staff members are now qualified to deliver train-the-trainer sessions. Our goal for 2025/26 is to expand delivery by recruiting and training in-house lead trainers and experts by experience to ensure sustainable, organisation-wide implementation.

The compliance for the Trust at year end 24/25 is 88% across the Trust for the online Oliver McGowan online mandatory training. This demonstrates the commitment the Trust has made supporting patients with a learning disability and/ or autism.

9. Multiagency Reviews

During 2024/25, the Trust actively contributed to several external safeguarding reviews. Members of the Safeguarding and Complex Care Team supported these processes by submitting detailed patient chronologies, attending multi-agency panel meetings, and working collaboratively with safeguarding partners to shape final reports and recommendations.

A Child Safeguarding Practice Review (CSPR) or Safeguarding Adult Review (SAR) is commissioned when a child or adult has died or been seriously harmed due to abuse or neglect, and there are concerns that agencies could have worked more effectively to protect them. A Domestic Homicide Review (DHR) is undertaken when the death of a person aged 16 or over appears to have resulted from violence, abuse, or neglect by a relative, intimate partner, or household member.

The table below outlines the Trust's contributions to these reviews during 2024/25.

	Chronologies Submitted	Panel Membership
Child Safeguarding Practice Reviews	2	1
Safeguarding Adult Reviews	7	1
Domestic Homicide Reviews	2	1

In 2024/25, one Safeguarding Adult Review (SAR) was concluded that identified significant learning for the Trust, specifically in relation to self-neglect. In addition, the Trust submitted two further referrals for SAR consideration, both involving self-neglect as a key factor.

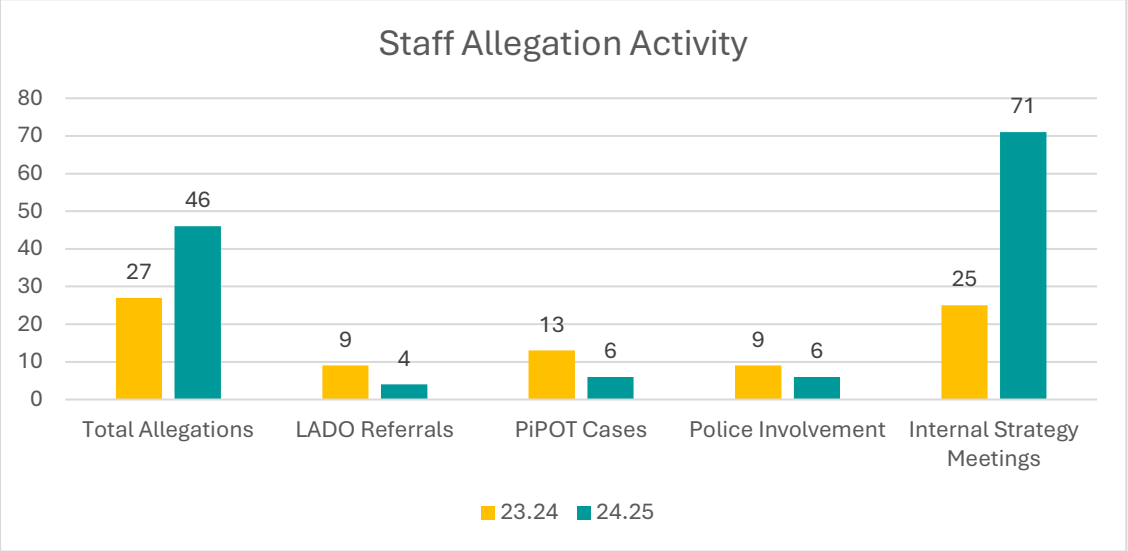
In response, the Trust developed a dedicated self-neglect action plan to ensure that learning from the review is embedded into clinical practice throughout 2024/25. Immediate learning was shared Trust-wide through a 7-minute briefing, helping to raise awareness and support improvements in the recognition and management of self-neglect

10.Allegation Management

In cases where safeguarding allegations are raised against staff, the Trust adheres to established procedures, including those outlined by Cheshire West and Chester's LADO and the PiPOT

framework. The Associate Director of Nursing (Safeguarding and Complex Care) leads the coordination of internal strategy meetings and ensures appropriate escalation to external agencies when necessary, including the Local Authority, Police, professional regulators, and the Controlled Drug Accountable Officer (CDAO). Executive oversight is maintained throughout, and a quarterly thematic report is submitted to the Safeguarding Assurance Committee.

In 2024/25, the Trust recorded a significant increase in safeguarding activity, with 71 internal strategy meetings held—an increase of 184% from the previous year. Allegations rose from 27 to 46, reflecting improved awareness and confidence in reporting mechanisms. Despite this rise, referrals to external bodies such as the LADO and through the PiPOT process decreased, indicating that thresholds for external escalation are well understood and appropriately applied. This shift highlights the Trust's growing capacity to manage concerns internally, supported by strong collaboration between Safeguarding, HR, and operational teams, and a culture of early intervention and transparency.



11.Partnership Working

The Trust is a well-established and active partner within the multiagency safeguarding framework, playing a central role in promoting the safety and wellbeing of both children and adults. In 2024/25, the Trust contributed to a wide range of multiagency safeguarding activities, including child death reviews, multiagency practice reviews, and thematic audits. These contributions not only demonstrate the Trust's commitment to safeguarding but also ensure that learning from complex cases is shared and embedded across the wider health and care system.

The Trust continues to be a key voice in strategic safeguarding discussions, with representation on several high-level boards and partnerships. The Director of Nursing and Quality (Executive Lead for Safeguarding), or their deputy, attends the Cheshire West and Chester Safeguarding Children Partnership Executive and the Local Safeguarding Adult Board. The Associate Director of Nursing for Safeguarding and Complex Care also represents the Trust on the Cheshire West and Chester Domestic Abuse Board and the Learning Disability Partnership Board.

Named Professionals within the Safeguarding and Complex Care Team ensure consistent representation across all relevant partnership subgroups. Their involvement is not only strategic but also operational, enabling timely escalation of specific patient concerns where safeguarding risks are

identified. In all such cases, the patient remains at the centre of decision-making, ensuring that safeguarding actions are proportionate, person-centred, and aligned with multiagency protocols.

12.Conclusion

The 2024/25 Safeguarding and Complex Care Annual Report evidences a significant increase in activity across all areas of the agenda, reflecting both the growing complexity of patient needs and the Trust's strengthened safeguarding culture. This rise is underpinned by improved staff knowledge, confidence, and visibility of the Safeguarding and Complex Care Team, alongside a broader societal shift in the volume and nature of safeguarding concerns presenting in acute care.

The report highlights the delivery of key workstreams that have resulted in:

- Strengthened governance and executive oversight
- Statutory compliance through named professionals and robust partnership engagement
- Clear, accessible policies and procedures
- Streamlined referral and escalation processes
- A proactive approach to learning, with incidents and reviews informing continuous improvement

The Trust's active participation in multiagency reviews, audits, and strategic boards demonstrates its commitment to collaborative safeguarding and system-wide learning. The increase in internal strategy meetings, alongside a reduction in external escalations, reflects a maturing safeguarding infrastructure with well-understood thresholds and timely, proportionate responses.

This report provides assurance that the Trust continues to meet its statutory safeguarding responsibilities and remains committed to delivering safe, person-centred care for all patients, particularly those who are most vulnerable. The priorities identified for 2025/26 will build on this foundation, ensuring that safeguarding and complex care remain embedded in clinical practice and aligned with both local and national expectations.

Key Priorities Moving Forward

The service has identified areas for further strengthening and improvement, with clear objectives for 24/25 (Appendix 3). These priorities are reviewed quarterly at the safeguarding and complex care assurance committee and reflect the strategic objectives of both the Trust and external bodies (mainly the Local Safeguarding Adult Board and Safeguarding Children Partnership).

13.References

HM Government (2023) Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk)

Royal College of Nursing (2018) *Adult Safeguarding: Roles and Competencies for Health Care Staff*

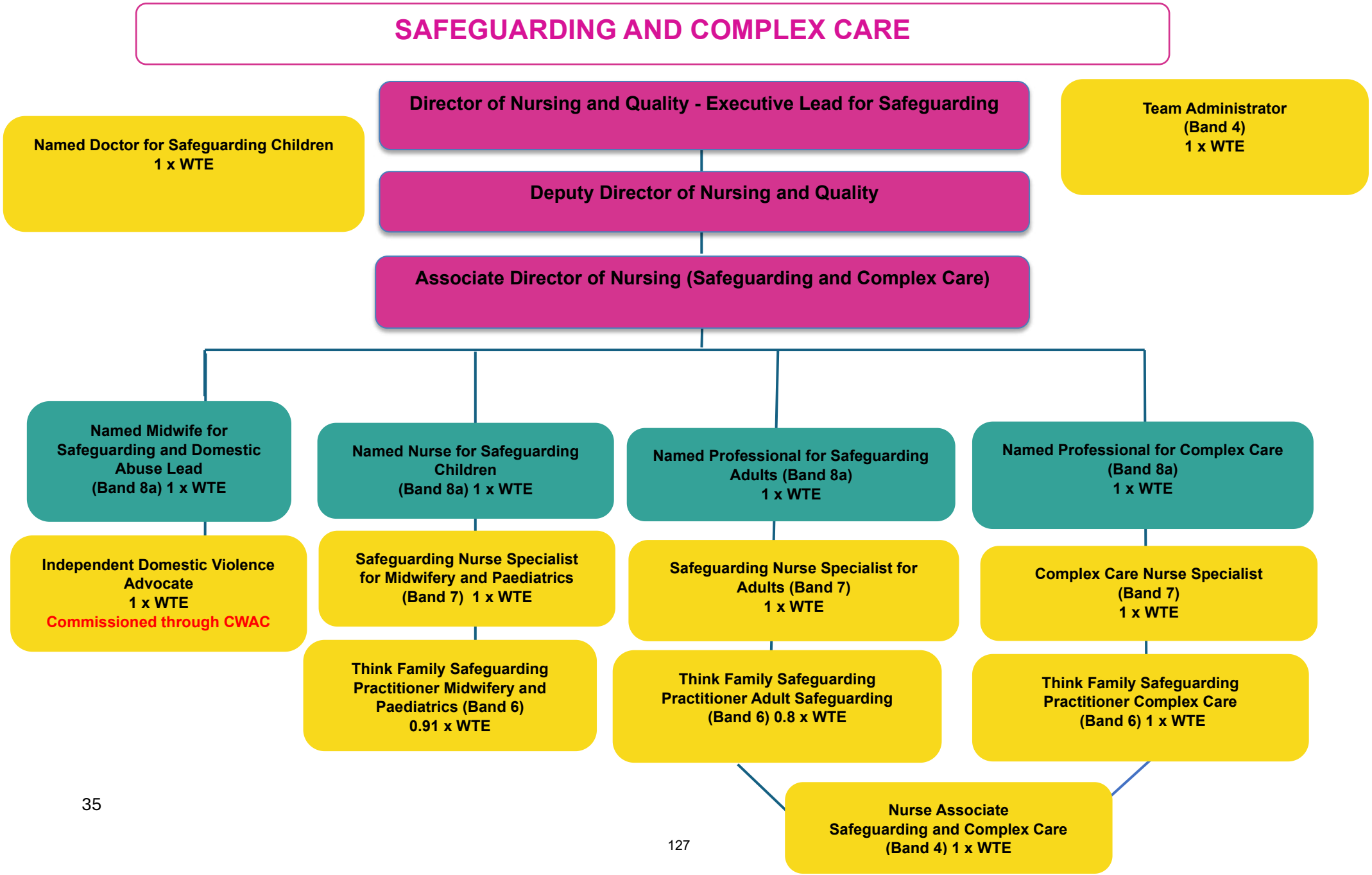
Royal College of Nursing (2019) *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff*

Royal College of Nursing (2020) *Looked After Children: Roles and Competencies of Healthcare Staff*

Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK (www.gov.uk)

Safe Lives, https://safelives.org.uk/health-pathfinder (2020) a domestic abuse charity.

Appendix 1 – Safeguarding and Complex Care Team



Appendix 2- TERMS OF REFERENCE

Safeguarding & Complex Care Assurance Committee

Constitution	The Trust Board hereby resolves to establish a Safeguarding & Complex Care Assurance Committee (formerly the Think Family Safeguarding Steering Group), which has no executive powers other than those specifically delegated in these Terms of Reference.
Purpose	The Safeguarding & Complex Care Assurance Committee reports to the Quality Governance Group and is responsible for ensuring that Safeguarding is a strategic objective within the Trust providing strong leadership and divisional accountability by making Safeguarding integral to care.
Membership	The following member are required to attend: Director of Nursing & Quality (Executive Lead and Chair) Associate Director of Nursing, Safeguarding & Complex Care (Vice Chair) Named Nurse for Safeguarding Children & Operational Service Lead Named Midwife & Lead for Domestic Abuse Named Professional Safeguarding Adults Named Dr. Safeguarding CoCH Medical Lead for Adult Safeguarding Divisional Director of Nursing – Planned Care Divisional Director of Nursing – Urgent Care Divisional Director of Midwifery – Women and Children's Independent Domestic Violence Advocate Safeguarding and Complex Care Team members Head of Quality Head of Nursing – Planned Care Head of Nursing – Urgent Care (ED) Head of Nursing – Urgent Care Head of Nursing- Ellesmere Port Head of Nursing- Paediatrics Inpatient Lead Therapist Designated Doctor for Safeguarding Cheshire West Representative from Betsi Cadwaladr health Security Manager & Local Security Management Specialist Senior Manager, Adult Safeguarding, Cheshire West & Chester Council Senior Manager, Children's Safeguarding, Cheshire West & Chester Council

Appendix 2

	CWP – Operational Lead Urgent Care First Response Service NHS Cheshire CCG
Attendance	The minutes of the meeting will record the names of the members attending and apologies given.
Quorum requirements	A quorum shall consist of a minimum of 7 members, 1 of which must be the Director of Nursing & Quality or the Associate Director of Nursing, Safeguarding & Complex care, in order to Chair the meeting. There must also be at least 1 Senior representative from the Safeguarding & Complex Care Team, 1 representative from each key area (Women & Children's, Planned Care, Urgent Care, ED) and 1 external partner member from either the CCG or LA. Other members unable to attend should endeavour to send a representative able to contribute to the business of the meeting.
Frequency of meetings	The committee will meet quarterly, although additional ad-hoc meetings may be arranged where necessary to deal with any issue which requires an early response. Emergency meetings are subject to: • Consent of the Chairperson. • When a written request from a group member is received.
Responsibilities & Objectives	• To ensure that safeguarding standards are monitored, and reporting mechanisms are properly established and working throughout the Trust so assurance can be given to the Board . • To ensure that the Trust has an effective and robust safeguarding and complex care strategy. • To provide an annual assurance report to the Board of Directors on all issues relating to Safeguarding (Adult & Children) and Complex Care. • To ensure systems and processes are in place to detect, prevent and respond to concerns about abuse or neglect and ensure that lessons learnt from incidents are disseminated across the Trust. • To approve policies and procedures relating to safeguarding issues and ensure that these are impact assessed to meet the requirements of specific at-risk groups. • To ensure that statutory requirements are met and responding to external enquiry/ recommendations in relation to safeguarding. • To ensure that the Trust is reporting effectively to external agencies when we have safeguarding concerns. • To review all high-level reports/recommendations and national documents relating to safeguarding and provide a response to the Quality Governance Group. • Monitor action plans to support implementation of these within Divisions and the improvements made through a standing agenda item. • To share progress against identified Safeguarding & Complex Care priorities.

Appendix 2

	• To receive update reports from Safeguarding & Complex care working groups. • To review patient experience feedback from a variety of sources to inform future direction and ensure that the patients and family voice is heard. • Ensure that improved communication occurs from team to team through incident discussion and monitoring so that the Trust is more responsive to safeguarding issues that may be linked across the Trust and/or require Trust-wide action and shared learning. • To receive details of safeguarding DATIX Incidents, SCP & LSAB Serious Case Reviews, Safeguarding Children Partnership (SCP) multi-agency case reviews, Practice Learning Reviews (PLR), Domestic Abuse Homicide reviews and incidents reported to the Strategic Executive Incident System (StEIS) and the National Patient Safety Agency (NPSA) and ensure that there is Trust-wide shared learning to improve practice and prevent events such as these reoccurring. • To receive relevant updates from the SCP and LSAB main Boards and relevant subgroups as appropriate. • To ensure that a robust 'Transition' process from Children's to Adults services is in place throughout the Trust. • Discuss and resolve issues relating to adults at risk and children so improving their care pathway and ensuring improved outcomes. • Lead a corporate approach to any required change. • To ensure that the safeguarding of children, young people and adults at risk are recognised as a corporate issue.
Administration	The PA to the Deputy Director of Nursing & Quality shall act as administration for the committee to include papers and minuting arrangements.
Accountability & Reporting arrangements	The committee reports to the Quality Governance Group. A Chairs report will be produced after each meeting, and this will be received at QGG. The Safeguarding & Complex Care Assurance Committee Annual Report will be received by the Board of Directors.
Review arrangements	The Terms of Reference shall be reviewed on an annual basis and/or if there are any changes in legislation or direction which affect the purpose of the group.
Document owner	Director of Nursing & Quality/Executive Lead for Safeguarding.

Appendix 3

Appendix 3 - Safeguarding & Complex Care Priorities Implementation Action Plan 24/25

Service Specific	Priority Action
Strategic	Integrate the Oliver McGowan strategy into the Trust's training schedule to enhance compliance
	Formalise the Safeguarding and Complex Care Team's flagging system
	Establish a safeguarding screening process in the Emergency Department to strengthen safeguarding procedures
	Develop information-sharing agreements with agencies to support the Trust in conducting thorough risk assessments of patients
	Gain assurance around the management of restraint in the Trust.
Complex Care	Establish an admission process for complex care at the Jubilee Centre
	Implement the digitisation of MHA detainment using the Thalamos platform to minimise errors associated with paper-based processes
	To create training webinars on the application of the MCA tailored for Trust staff
	Streamline the DoLS process to make it entirely electronic
Children	Ensure adherence to the Pan Cheshire Bruising in Non-Mobile Baby Policy in the Urgent Care department
	Create comprehensive materials on perplexing presentations, including a thematic review, a 7-minute briefing, and staff training sessions.
	Create a standardised "was not brought" letter to ensure consistent management of cases involving children across all Directorates.
Adults	Ensure the self-neglect action plan is fully completed by the end of 25/26.
	Implement systems to identify patterns in discharges and safeguarding issues, allowing the Trust to learn from incidents.
	To obtain assurance that all staff are sufficiently trained, confident, and competent in the use of the electronic Domestic Abuse Risk Assessment tool, and that it is being completed accurately in a timely manner
Maternity	Developing clear pathways and protocols for midwives to follow when a safeguarding concern is identified.
	Develop a resource kit for midwives on both local resources and safeguarding processes
	Establish a peer review process for midwives to learn from significant safeguarding cases

Public Board of Directors
30th September 2025

Report	**Agenda Item 11.**	**Perinatal Services Quarterly Update Quarter 1.**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Natasha Macdonald Sara Brigham Pippa Scott-Heale			Director of Midwifery Associate Medical director Divisional Director				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X**	BAF 1 – Failure to maintain quality may negatively impact patient and family experience BAF2 - Gaps in safety and harm prevention can compromise patient outcomes. BAF 3 – Failure to meet operational planning standards or address patient backlogs may lead to poorer outcomes and financial risk for the Trust.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Quality and safety committee 8th of September 2025							
Executive summary	• The Trust continues to meet national standards for maternity and neonatal safety, with all MIS safety actions on track • Patient Safety and Learning: All serious incidents are reviewed, with lessons learned translated into targeted actions to enhance patient safety and prevent recurrence. • Silver accreditation achieved for Wards 32 and 35; improvement plans in place for identified gaps. • Service User Engagement: Collboration with the Maternity and Neonatal Voices Partnership (MNVP) has been strengthened,							

	ensuring service users' feedback directly informs service improvements and decision-making.
Recommendations	The Board has been asked to note the assurance provide

Corporate Impact Assessment	
Statutory/regulatory requirements	Ensure the Trust's alignment with Foundation Trust status, maintaining all regulatory obligations.
Risk	Define and assess potential risks to the organization, implementing proactive measures to mitigate them.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics 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,

Perinatal Services Quarterly Update Quarter 1

1. Introduction

Maternity and neonatal quality and safety remain a priority for the Trust, in line with national standards and the Ockenden Report (2020). This report summarises key performance, safety concerns, serious incidents, and progress on the Maternity Incentive Scheme (MIS), using local and national measures from NHSEI's Perinatal Quality Surveillance Model. It provides ward-to-board insight and highlights current or emerging safety issues to support effective Board oversight.

2. Background

Maternity and neonatal services remain under close scrutiny, with the Ockenden Report (2020) highlighting the need for robust oversight. Now in its seventh year, the Maternity Incentive Scheme (MIS) continues to drive safety improvements linked to CNST standards. This report summarises Year 7 MIS progress, key initiatives such as the Saving Babies' Lives Care Bundle v3, compliance with the Maternity Services Data Set (MSDS), and learning from serious incidents and perinatal reviews.

3. Purpose

This report provides assurance to the committee on the safety, quality, and compliance of Maternity and Neonatal services with the Maternity Incentive Scheme (MIS).

4. MIS Progress Update

The Trust has embedded the ten MIS safety actions into routine practice, making them part of business as usual.

Safety Action		Assurance	
1	**Safety action 1:** Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?	Q1 2025/26 update within this paper	On track
2	**Safety action 2:** Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Ongoing interaction with the scorecard	On track
3	**Safety action 3:** Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	Term admissions have reduced by 2% this quarter, below the 5% target. Our QI project continues, with evidence of shorter admission durations. From now on, ethnicity data will be collected for all term admissions, recognising inequalities	On track

Safety Action		Assurance	
		in perinatal assessments (e.g. cyanosis, jaundice) that were developed using White European babies and may not be appropriate for diverse skin tones (NHS Race and Health Observatory, July 2023).	
4	**Safety action 4:** Can you demonstrate an effective system of clinical workforce planning to the required standard?	Six monthly report complete) all evidence complete and full compliance achieved	On track
5	**Safety action 5:** Can you demonstrate an effective system of midwifery workforce planning to the required standard?	The service confirms that midwifery staffing levels are compliant with BirthRate Plus recommendations, providing assurance that workforce capacity meets recognised national standards.	On track
6	**Safety action 6:** Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Saving Babies Lives, noting the Trust achieved compliance against the 6 elements based.	On track
7	**Safety action 7:** Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Under MIS Year 7, the Trust is working with the LMNS to provide training and support for MNVP representatives to attend PMRT meetings, recognising the need for preparation due to the sensitive and potentially traumatic nature of the discussions.	On track
8	**Safety action 8:** Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Training is ongoing, and we remain on track to sustain compliance with this standard.	On track
9	**Safety action 9:** Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	We have established a clear oversight mechanism to provide assurance to the Board on maternity and neonatal safety and quality issues. Bi-monthly oversight meetings were held in June, July, and September to monitor progress, address emerging risks, and provide assurance on compliance with national standards	On track

	Safety Action	Assurance	
10	**Safety action 10:** Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025	Q1 2025/26 report No cases referred to MNSI or Early notification.	On track

5. Dashboard

Maternity performance in July remained stable, with birth activity at a low level. There were no maternal deaths, stillbirths, or neonatal deaths, and no immediate risks requiring escalation. Strategic priorities remain focused on:

- Reducing avoidable neonatal term admission
- Sustaining reductions in third-degree perineal tears
- Managing postpartum haemorrhage (PPH) rates, particularly in line with new guidance implementation

6. Perinatal Mortality Rate

The national average for stillbirth rate is 3.22 per 1,000 births and 1.63 per 1,000 births for neonatal death (2023). These rates are presented and adjusted by MBRRACE-UK according to the number of births per maternity service and whether the service has a Neonatal Intensive

Care Unit (NICU). The rolling 12-month stillbirth rate at COCH is 2.1 per 1,000 births, The Neonatal Death rate for births ≥24 weeks gestation is 0.5 per 1000.

7. Cases Meeting Inclusion Criteria for Reporting to MBRRACE-UK (Q1 2025/26)

Surveillance case status	Review status	Date review opened	Parents perspectives	Factual ques	Factual questions	Review in standard	Standard b parents informed	Standard b parents input sought	Standard c review started	Standard c report publishec	Standard c published	External member present
Surveillance complete	Reviewing	03/06/2025	Parents informed of review:	100%	03/06/2025	Yes	Met	Not yet met	Met	Not yet met	02/12/2025	Not yet met
Surveillance complete	Reviewing	28/05/2025	Parents views sought:	100%	28/05/2025	Yes	Met	Met	Met	Not yet met	28/11/2025	Met
Surveillance complete	Writing report	02/04/2025	Parents views sought:	100%	02/04/2025	Yes	Met	Met	Met	Not yet met	01/10/2025	Met
Surveillance complete	Reviewing	27/12/2024	Parents views sought:	100%	09/01/2025	Yes	Met	Met	Met	Not met	26/06/2025	Met

Two cases met the inclusion criteria for reporting to MBRRACE-UK in Quarter 1 2025/26, both investigations remain ongoing.

8. Maternity and Newborn Safety Investigations (MNSI) Update

There are two ongoing cases. For one case, the final report has been received, the action plan completed, and we are awaiting confirmation from the Integrated Care Board to close the investigation. For the second case, the draft report has been returned to Maternity and Newborn Safety Investigations following the factual accuracy review, and the action plan has been completed.

9. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

	Midwives (Inpatient, Outpatient and Bank)	**Obstetricians (Consultant and resident doctors)**
Saving Babies Lives Care Bundle (elearning)	**99%**	**87%**
Foetal monitoring and surveillance	**99%**	**87%**
Maternity Emergencies and multi professional training	**97%**	**91%**
Equality / equity and personalised care *(featured on 2024's programme therefore 2024 figures)*	**97%**	**93%**
Care during labour and immediate post-natal period	(features on 2026's programme)	(features on 2026's programme)
Neonatal basic life support	**98%**	**75%**

10. Saving Babies' Lives Care Bundle (SBLv3)

The Saving Babies' Lives Care Bundle v3 (SBLv3), launched in May 2023, aims to reduce perinatal mortality by improving smoking cessation, fetal growth surveillance, fetal movement awareness, fetal monitoring, and preterm birth optimisation. As part of MIS Safety Action 6, compliance requires at least two quarterly quality improvement discussions with the ICB, focusing on progress, metrics, sustained improvement, harm reviews, and shared learning.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	96%	CNST Met

11. Saving Babies' Lives Care Bundle (SBLCBv3) – Quarter 1 Update (2025/26)

The Trust has maintained full implementation of SBLCBv3, with 4 of 5 elements fully embedded in Quarter 1 and all five compliant with MIS Year 7, achieving 'CNST Met' status. Priorities include improving training on very brief smoking cessation advice, increasing carbon monoxide (CO) monitoring is undertaken in pregnancy to identify smoking or harmful exposure early, enabling timely support and reducing risks to mother and baby.CO monitoring and delivering face-to-face symphysis-fundal height measurement training. Monthly compliance reports, targeted reminders and focused engagement are in place to address these. Full compliance expected Q2.

12. Safety Action 4 – Clinical Workforce Planning

The service confirms compliance with all elements of Safety Action 4. Effective systems are in place for clinical workforce planning across obstetrics, anaesthetics, and neonatal services. Obstetric staffing arrangements follow RCOG guidance, including safe engagement of locums and consultant attendance in acute situations, with progress towards compensatory rest standards. Anaesthetic cover meets ACSA Standard 1.7.2.1, with a duty anaesthetist available at all times and clear consultant escalation. Neonatal medical and nursing establishments are aligned to BAPM standards, with any action plans monitored via the risk register and reported through the LMNS and ODN.

13. Maternity Incentive Scheme (MIS) – Year 7: MNVP Involvement in PMRT

A key area for development under MIS Year 7 is the requirement for Maternity and Neonatal Voices Partnership (MNVP) representatives to be present during Perinatal Mortality Review Tool (PMRT) discussions.
The Trust is working collaboratively with the Local Maternity and Neonatal System (LMNS) to explore how best to provide appropriate training and support for MNVP members. This is particularly important given the exposure to sensitive and potentially traumatic content during PMRT meetings.
Ensuring MNVP representatives are well-prepared and supported will help maintain a compassionate and trauma-informed approach to family engagement and service improvement

14. Maternity Incidents (Q1)

Serious Incidents Reports

- Intrauterine deaths Reported: 3 (all subject to PMRT)

Swarm: 1 4.3 litre PPH following an elective section and return to theatre, learning shared around identification of deteriorating patient and escalation.

Number of moderate and above incidents: 30 (total was 34 but 4 have been downgraded)

Total reported: 30
Open currently of Q1: 17
Closed: 13

CQC escalations There were no CQC escalations received in this quarter
There was no regulation 28 received for maternity services during this quarter.

Maternity Risk Register Update – Q1
A high-risk remains:

- Impact of reduced O and G medical workforce – reduction in elective gynae activity

15. Inpatient Ward Culture and Quality Improvement Action Plan

- Following moderate incidents and complaints, a comprehensive action plan was developed by the Inpatient Midwifery Matron, informed by staff engagement across all inpatient areas.
- The plan includes 24 recommendations and 58 actions focused on:
    - Protected handovers
    - Timely medication and analgesia
    - Communication standards
    - Escalation protocols
    - Discharge processes
    - Documentation compliance

Progress (as of September 2025):

- Completed: 30 actions – practice strengthened, positive change embedded
- In Progress: 11 actions – progressing well, no delivery risks
- On Track: 15 actions – require continued focus
- Delayed: 2 actions (EPR SBAR optimisation, postnatal discharges) – mitigations in place (interim paper SBARs)

Completion Trajectory**:**

- All actions scheduled for closure by end of September 2025, except EPR SBAR (completion by November 2025).

As part of our focus on maternity and neonatal culture improvement, the **service** attended the Perinatal Culture and Leadership Programme – MOMENTS training in June 2025. This interactive programme, delivered by Health Innovation NWC, the aim is it will support staff to reflect on everyday practices and cultural values, providing a framework to strengthen leadership behaviors and team culture in line with national recommendations.

16. Learning from Concerns and Complaints– Q1 2025/26

There were no new formal complaints received by the service during Q1.
However, a total of 19 concerns were raised. A key emerging theme was a notable increase in requests for birth debriefs, alongside contact from patients expressing distress following traumatic birth experiences.
This trend highlights the emotional impact of some birth experiences and reinforces the importance of accessible, compassionate postnatal support and timely opportunities for debriefing**.**

17. Ward accreditation Striving for Excellence Programme

Ward accreditation continues to be delivered through the Striving for Excellence programme, providing structured assessment of care quality, patient safety, and staff engagement. The process aligns with CQC preparation and internal governance priorities, with outcomes rated against agreed standards.

<u>Recent Assessments (May–July 2025)</u>

Ward 32 maternity inpatient ward: Calm, clean environment with positive patient feedback and strong staff knowledge. Awarded Silver accreditation.

Ward 35 (Central Labour Suite & Day Unit): Patients described care as “exemplary.” Staff demonstrated strong safeguarding and consent practice. Awarded Silver accreditation.

Strengths identified:

- Positive patient experience, with families reporting feeling safe and well informed.
- Calm, well-managed ward environments.
- Staff demonstrated sound knowledge in safeguarding, capacity, and referral pathways.

Areas for improvement:

- Mandatory training and appraisal compliance remain below required levels for Gold status.
- Infection prevention audit reliability (hand hygiene, IV line checks) requires sustained improvement.
- Incident management: a number of Datix reports remain open, including a small number of severe/catastrophic cases due to the ongoing reviews.
- Staff on Ward 35 requested clearer communication of long-term plans and increased senior visibility.

Next steps:
Improvement plans have been developed for each ward, with progress monitored through divisional governance.

18. Maternity Outcomes Signal System (MOSS)

- National tool to identify early safety concerns in maternity services (launching Nov 2025).
- Detects statistically significant increases in term stillbirths, neonatal deaths, and soon term brain injuries.
- Passive data collection – no additional reporting burden on trusts.
- Countess already monitors aligned indicators (stillbirth, mortality, emergency CS, OASI, APGAR, term neonatal admissions).
- Regular governance review ensures trend analysis, early intervention, and readiness for rollout.

19. Recommendations

The board is asked to note the assurance provided within the report.

Appendix: Glossary of Terms and Acronyms

BAPM - British Association of Perinatal Medicine: A professional body providing standards for perinatal care in the UK, including neonatal and maternity services.

CNST - Clinical Negligence Scheme for Trusts: An NHS scheme providing financial incentives for trusts that meet specific safety standards to reduce clinical negligence costs.

CQC - Care Quality Commission: The regulatory body for health and social care in England, responsible for monitoring and inspecting services to ensure they meet safety and quality standards.

EN - Early Notification: A scheme by NHS Resolution to notify incidents of potential severe brain injury in newborns for rapid investigation and learning.

EBME - Electro-Biomedical Engineering: A department responsible for the maintenance and safety checks of medical equipment.

FASP - Fetal Anomaly Screening Programme: A national programme offering screening to identify specific fetal anomalies during pregnancy.

FFT - Friends and Family Test: A feedback tool allowing patients to share their experience of NHS services, used to improve quality of care.

FGR - Fetal Growth Restriction: A condition where a fetus is smaller than expected for gestational age, often requiring monitoring and intervention.

ICB - Integrated Care Board: Part of Integrated Care Systems (ICS) in the NHS, responsible for planning and coordinating local health services.

LMNS - Local Maternity and Neonatal Systems: Regional networks in England working to improve safety and quality in maternity and neonatal care.

MIS - Maternity Incentive Scheme: An NHS programme designed to encourage trusts to meet specific safety actions in maternity care to receive financial incentives.

MNVP - Maternity and Neonatal Voices Partnership: A group of service users, service providers, and commissioners working together to improve maternity and neonatal services.

MNSI - Maternity and Newborn Safety Investigations: A programme that investigates incidents involving potential harm to mothers and newborns to promote learning and improve safety.

MSDS - Maternity Services Data Set: A data set collected by NHS Digital that provides information on the maternity journey for women and babies in NHS-funded care.

NHSR - NHS Resolution: The body responsible for handling negligence claims, offering schemes like CNST and EN to improve patient safety.

PMRT - Perinatal Mortality Review Tool: A national tool for reviewing and learning from perinatal deaths, supporting standardised reviews and involving parents in the process.

PSII - Patient Safety Incident Investigation: Investigations conducted to understand and learn from incidents that could affect patient safety.

SBLv3 - Saving Babies' Lives Care Bundle Version 3: A set of evidence-based interventions aimed at reducing perinatal mortality in England.

SB - Stillbirth: The birth of a baby who has died after 24 completed weeks of pregnancy.

StEIS - Strategic Executive Information System: A system used by NHS organisations to report serious incidents, supporting transparency and learning.

PUBLIC – Board of Directors
30th September 2025

Report	**Agenda Item 12.**	**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 and Quality / Deputy Chief Executive				
Author(s)	Nusaiba Cleuvenot			Head of Corporate Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Linked to all BAF areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Executive Directors Group – 17th September 2025							
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. Areas identified as complete to transition to 'business as usual' are: • Quality and Safety Strategy approved. • Risk Management Improvement actions complete as planned, notwithstanding further training and embedding continues as part of BAU. • Staff survey action plans developed, in process of being developed and being monitored through People & Culture Sub-Committee. • Safe nurse staffing. • Trust Strategy and enabling strategies in place (including People and Clinical Strategies).							

	• Partnerships and Anchor Institute work.
Recommendations	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.

Corporate Impact Assessment	
Statutory/regulatory requirements	Trust compliance with the CQC regulatory framework, Provider Licence and Code of Governance.
Risk	Various risks included on Board Assurance Framework (BAF) and risk registers.
Equality & Diversity	Meets Equality Act 2010 duties & Public Sector Equality Duty 2 aims and does not directly discriminate against protected characteristics.
Communication	Not confidential.

NHS
Countess of Chester Hospital
NHS Foundation Trust

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

Updated: September 2025

Completed	On track	Behind schedule	Not achieved

Summary of actions complete (since last update)

Actions complete (proposal to move to BAU)

- Quality and Safety Strategy approved.
- Risk Management Improvement actions complete as planned, notwithstanding further training and embedding continues as part of BAU.
- Grant application with proposal to use predictive tools on RTT was rejected.
- Staff survey action plans developed, in process of being developed and being monitored through People & Culture Sub-Committee.
- Safe nurse staffing.
- Trust Strategy and enabling strategies in place (including People and Clinical Strategies).
- Partnerships and Anchor Institute work.
- Mental health action plan in place
- Environment improvements completed

Summary of actions progressing

Countess of Chester Hospital NHS Foundation Trust

Actions progressing

- New combined UEC action plan continues to be progressed.
- SARD capacity and demand review to support job planning is progressing with consistency panels now held. Mrs Herring (previous CPO) working as temporary project manager to get final sign off of job plan.
- Policy recovery programme continues to progress via Executive Directors and leads.
- 2024 staff survey action plans being delivered and 2025 survey open.
- EPR upgrade taking place on 16th September 2025 - this will introduce new functionality and align with SPINE security update.
- Digital and Data Strategy being refreshed in line with corporate and clinical strategies and 10 year plan. Refreshed strategy is currently being reviewed by MIAA.
- Procurement exercise to take place in Oct 25 to evaluate and purchase a Voice Recognition/Ambient Voice Technology solution to support letter turnaround time.
- New Sepsis screening action plan developed and reported to Q&S Committee. A further update on Sepsis audit metrics is being reported to Board in September 2025.
- 5 year financial plan progressing following finalisation of Trust and Clinical Services Strategies

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 and Data 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 and Data Officer

- Information Governance

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
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	Further update Dec - 25	• 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. • The urgent care division has confirmed that the out of hours stroke service has been extended to midnight and is funded. The division are currently reviewing if they are able to extend the service to cover 24/7. • The service has been recurrently funded until midnight.	Service provision has been extended until midnight as a pilot	• Q&S Committee	• EDG for Decision-addressed internally by division
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	Dec-25	• Review of all information available to patients and ensure that they are all available in all languages.	• Review of translation services underway- update provided to the Quality & Safety Committee held in September 2024. Further update provided to the Quality & Safety Committee held in November 2024, action plan is in place and is progressing. • The specification for the spoken and non-spoken languages has been completed as is with the budget holders for agreement . The intention is to award spoken language interpretation and translation via the NHS Cheshire & Merseyside framework agreement. For non-spoken languages, the intention is to make a direct award via the NHS SBS Framework for Interpretation & Translation Services (ITS). This will result in one supplier. Once the contract is agreed, an implementation plan with the supplier will be completed • Paper presented to QGG in June 25 – new leads identified – regional review of services being undertaken and COCH are part of regional review • Translation and Interpretation reviewed, renewed and ratified. Awaiting update re regional review of service providers	• Patient Experience Operational Group	• Q&S Committe e	• Q&S Assurance Report to BoD

Action Plan:

Owner: Cathy Chadwick – Chief Operating Officer

NHS Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
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	**Next Review JDec25**	• See Patient Flow / UEC Improvement Plan	A revised System Improvement Plan for UEC has been agreed and progress is monitored at Patient Flow Steering Group and System Oversight Group. One of the main areas of focus is 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 is being supported by NHSE National colleagues to further engage with BCUHB and Flintshire LA, and we have started to see additional discharges. The number of days NCTR patients are delayed is reducing however the total number of patients delayed still needs further work.	• Complaints • Patient Flow Working Group • KPIs / UEC Dashboard • System Improvement Board • OPELG	• F&P Committee	• EDG • OMB • SOF • SOG Exit Criteria

Action Plan:

Owner: Jason Bradley – Chief Digital & Data Officer

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	Next Review Dec 25	• 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.	• A process review of the eDischarge process has taken place. A further review is underway led by our CCIO to see if any additional enhancements to the EPR process can be deployed. Enhanced reporting is in place to aid with operational monitoring. • Progress monitored via Operations and Performance Executive Led Group and Operational Management Board. • An automated reminder process has been put in place – with daily emails going to clinicians. • The Trust will be going out to market in Oct 25 to procure a Voice Recognition solution this will assist with the automated creation of discharge summaries. • A review of EPR discharge process will take place following EPR upgrade (Sept 25). The aim will be to further streamline the process and improve discharge summary content inline with feedback from primary care.	• 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	Next review – Dec 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 approved and prepared for wider consultation and launch. The Trust strategy has been socialised with dedicated Team Brief sessions for Day and Night Staff. The strategy has also been an integral part of developing the Trust clinical strategy and has been shared with internal and external stakeholders. • Clinical strategy, leadership and learning events held in October 2024, December2024 and February 2025. • Part of a culture and strategy reset these sponsored events have helped develop the Trust corporate and clinical strategy both now produced and embedded within the organisation.	• 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. • The strategic themes within the strategy are part of all staff appraisals • The delivery goals and objectives within the Trust strategy are aligned with the Board Assurance Framework and reported as a single integrated report. • Clinical Strategy has been approved and public engagements events planned I July 20025 to coincide with the launch of the ten-year plan.	• 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	Next review – Dec 25	• 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.	• Mental Health review completed by a member of the psychiatric liaison service on secondment from CWP for 6 weeks. An interim report was reviewed at EDG in December 2024 with recommendations to be presented (Jan 2025). Recommendations arising from the review have been taken to Joint executive committee with CWP. • Progress being monitored though the Mental health group. • New action plan developed as result of CQC visits	• Mental Health Steering Group • Datix Reporting • Learning Outcomes from Complaints • ED Safety & Quality Update • New action plan • Raised at executive joint board level to ensure oversight of action plan	• 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

Countess of Chester Hospital NHS Foundation Trust

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	Next review – Dec 25	• 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.	• A health inequality framework and awareness raising / training workshop was held for Board Directors 29/10/2024. • Draft framework has been developed and co-produced with local authority public health colleagues. • Health inequalities has been built into the clinical strategy. • Trust is leading on CVD Prevention across the local system and has arranged 4 clinical symposium s on CVD and cardiometabolic disease.	• 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/ Out comes	Committee	Assurance
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	Next review Dec 2025	• 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.	• Monthly reports continue to be supported through both division and MDG (Medical devices group), High and Medium Risk assurances in line, and a plan to improve low risk compliance through inhouse team. Improved reporting shows trend and broken down to divisional level. Gaps still in total asset management, featured on action plan. • Action plan has been formulated and presented to the MDG, Dedicated meeting took place to assign responsible to individual/groups with time frames. It has been agreed for this to monitored via QGG quarterly. • Medical Devices Safety Officer (MDSO) commenced in post and completed a full gap analysis of equipment to provide full oversight of control and potential areas for improvement. Action plan developed. Capital and minor equipment bids in progress for high risk items. Equipment management being aligned across the trust, Identifying responsibility through updated policy. • AED have seen additional equipment in the form of a central station for continuous monitoring, 4th resus bay and dedicated Paed resus bay, equipment identified and purchased through a dedicated scheme. • First Medical Device Purchase group held, well attended and roles and responsibilities discussed. Led by MDSO.	• Asset register and report to F&P Oct-24 and then monitoring quarterly	• F&P Committee • Quality Governance Group	• Resuscitation Assurance Reports • F&P Assurance Report to BoD • Action plan following completion of gap analysis to track improvement for assurance. • Medical Device Purchasing Group

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
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	Next review Sept 2025	• UEC Improvement plan • Full review of the trust premises to ensure fit for purpose in line with best practice guidance.	• Substantive H&S manager in post and improvements made in processes and systems across the organisation • Positive progress has been made in restructuring the H&S committee's monitoring and reporting processes, ensuring efficiency and clarity in board notifications. This streamlined approach enhances communication and oversight. • Significant progress has been made in updating the Trust's Health & Safety policy suite, ensuring alignment with current legislation and best practice. This strengthens governance and supports a safer working environment. • Significant improvements have been made to fire safety with substantial investment in upgrading the fire alarm system, ensuring faster detection and enhanced reliability. • Slips, trips, and falls site safety improvements, the H&S team collaborating with facilities and capital projects to target risk reduction based on data-driven insights. Investments are being made in key areas to improve safety and minimise risks. • RIDDOR reporting improvements ensure the Trust meets statutory HSE requirements while leveraging data to prevent incident recurrence.	• Health Safety Audits • Patient Flow Working Group • KPIs / UEC Dashboard • System Improvement Board	• 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	Next review Sept 2025	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Development of an Estates Strategy • Carry out environment improvements in ED to improve patient experience, staff morale and IPC standards.	• 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. The process is being well managed. • (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. • As the Clinical Strategy approaches finalisation, the Estates strategy will be developed 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). • Regular dept reviews in place (every 2 weeks) between clinical and estates leads to review issues for action within key areas. • Estates lead ensuring continual review and improvement of key areas with Estates Team. • Environment improvements completed in Edin July 2025 (painting, fire door replacement, ceiling grid and tile replacement etc.) to improve. • Focused improvement on dealing with issues as identified to improve overall compliance across trust. • Increased auditing to provide assurance on service delivery	• 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

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M2 M4	Risk & Complaints Management	TW	The trust must ensure risks in services are appropriately recorded, assessed, escalated to the trust's board where required, and regularly reviewed.	KW	**Proposal to move to BAU Sept 25**	• 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 Policy revised and approved. • Risk Management Committee in place. • Datix developments progressed. • Reports, notifications and training developed. • Embedding of risk management continues as BAU.	• EDG • OMB • BoD • Sub-committees • Divisional Governance Meetings	• Audit Committee	• Risk reports • Risk Management Improvement Plan progress
M43	Policy Management	MAT	The Trust must ensure that policies and procedures are reviewed and follow national guidance.	KW	Next Review Sept-25	• 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.	• A process has been established to monitor progress and escalate the position through EDG. • Further work is required to deliver these improvements. • Progress updates provided via the Audit Committee. • Progress continues to be made but action to remain open until significant reduction in out of date policies is evident and work on other documents is progressing.	• Board of Directors • Sub-committees	• Via the relevant Committee dependant on the policy document	• EDG • Audit Committee

Action Plan:
Owner: Vicki Wilson– 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.	VW	Next review Dec 2025	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 • Revised aim to reach Trust compliance target of 90% - **trajectory for 90% at Sep 25.**	• Monthly compliance reports sent to all divisions and accessible on 'S' drive. • Current compliance is **steadily increasing and has increased (from 65% in sept 24, 75% in Dec, 80% in March 25), 83% in June and slipped to 82% in August 25.**	• POD	• SOF • EDG • OMB
M44	Training	CYP	The trust must ensure that mandatory training (including safeguarding) compliance meets the trust target.	VW	**Next review Dec 2025**	• 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.	Level 3 compliance still an issue across medical workforce. Date in place CPO, Chief Nurse and MD to review mandatory training competencies and denominators to ensure correctly applied and review delivery methods. Additional capacity provided to ensure enough places Staff provided with face to face training option where PC access limited and use of library and additional support to complete online as needed.	• Monthly compliance reports sent to all divisions and accessible on 'S' drive. • Latest overall Trust compliance is 89% (as at 13/09/24) • Divisions have been provided detailed reports on areas that need compliance improvement. • **Safeguarding level 1 &2 is at or above 90% target. Level 3 is continuing to improve and reached 89% in March 25%, and 90%** **August.**	• POD	• SOF • EDG • OMB

Action Plan:

Owner: Nigel Scawn – Medical Director

Countess of Chester Hospital NHS Foundation Trust

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	Further update Jan 26	• 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.	• Datix reporting. • Regular submission of data to C2AI commenced and first cohort (orthopaedics) of patients of increased risk is now received. Process rolling out to further specialities across the Trust. • The quality team are reviewing 100 patients per month who are on wating list to see if it corresponds with the reason for ED attendance. Where there could be a link, they are contacting the clinician to request review and if potential harm – requesting a Datix be submitted. • Data quality issues remain for patients particularly on the non RTT list and actions to address this is being explored.	• Daily Safety Huddles • Divisional Governance Groups • Incidence Report • Serious Incident 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

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	**Next Review Jan-26**	• 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 appointment made and further vacancy recruited to in June 2025. • New medical lead for ED and a medical lead for UTC in post. Weekly ED leadership team meeting. • UTC & minors now moved to upstairs within SDEC to improve numbers and flow. • SARD work commenced on capacity demand modelling for medical staff. Job plan consistency panels taken place. Mrs Herring (previous CPO) working as temporary project manager to get final sign off of job plan.	• Patient Flow Working Group • Streaming Task & Finish Group • KPIs / UEC Dashboard • System Improvement Board	• F&P Committee • POD Committee	• EDG • OMB • SOF

Action Plan:

Owner: Nigel Scawn – Medical Director

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
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	Complete	• Review the policy and education for relevant teams	The non-urgent and rapid tranquilisation policy was approved at June 2025 D&T meeting pending 2 points, firstly that it is made clear in the document that a record needs to be made following rapid tranquilisation on Cerner/Datix and secondly that there is an update to the monitoring section to indicate pharmacy will complete the audit to monitor compliance. The policy has been updated as per the above points and is in the process of being uploaded to Sharepoint.	• Incident Reporting • Mental Health Steering Group	• Q&S Committee	• Q&S Assurance Report to BoD
S21	Patient Assessment	CYP	The trust should ensure staff improve the compliance of completing the sepsis screening tool on the electronic patient record.	NS	Next Review Jan-26	• Harms • Acquire new blood gas analyser to measure lactate within ED • Focus on compliance of prescribing antibiotics within 1 hour of diagnosis of Sepsis.	• Regular monitoring through the Sepsis Improvement Group. • A new sepsis screening tool has been introduced onto Cerner. This is now linked to sepsis care plans that have been devised within EPR. • Monitoring of sepsis screening collated monthly and discussed at monthly sepsis improvement group. • Update from Sepsis paper for Board shows improved compliance.	• Sepsis improvement programme (Harms) participating within the Harms Showcase (Mar-24) • AQ Compliance • Sepsis Screening Audits	• Q&S Committee	• Sepsis Assurance Report to BoD

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	**Further update Sept 2025**	Discussions with the Clinical Directors and Divisional leads has taken place. Strategy day took place with Clinical Leads for October 2024 to drive forward the development of the Clinical Strategy. Specialty proposals were developed to support this and quarterly clinical leads strategy days planned to drive this forward. Further Trust wide workshop and discussion held in December and now built as BAU every quarter. Board report to be presented in January by way of progress. Final draft clinical strategy for Board approval in May. Bespoke support provide to respective divisions in developing service specific strategies that align with that of the organisation. Divisional priorities developed within Clinical Strategy.	Trust Strategy was approved in June 2024. Women's and Children's Division strategy was launched in June 2024.	Medium
2.3	• Develop a five year financial strategy	Chief Finance Officer	**Dec 2025**	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. Further work is to be undertaken on the 5-year financial plan to provide more detailed financial plan following completion of the Trust strategy and Clinical Services strategy. Work is commencing to develop the strategy with engagement with F&P in January with national guidance on medium term planning to be issue over summer 2025. Initial guidance has been received in relation to 2025/26 financial and operational planning with the requirement to prepare 3-5 financial plans. This work will be undertaken as part of the national planning work and will form the basis of the 5-year financial strategy.	Final 24/25 financial plan submitted in May 2024 in line with national deadlines.	High
2.6	• Develop supportive strategies mental health, E and I and estates and facilities, well being	Chief Finance Officer	**Estates and facilities – March 2026**	Estates strategy to be developed by end of 2025/26, engagement with F&P and alignment with Clinical Service Strategy underway.		Medium

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
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	**Next review Dec 2025**	• Level 3 compliance still an issue across medical workforce. • Date in place CPO, Chief Nurse and MD to review mandatory training competencies and denominators to ensure correctly applied and review delivery methods. • Requirements for training aligned to national programme. • Development of local oversight group in Jan 24 to optimise national and locally mandated learning. • Additional capacity provided to ensure enough places. • Continued focus on conflict resolution and resus which remain lower – although predominantly in A&C / E&F workforce. Revised trajectory plans requested from any non-compliant areas to ensure compliance by Sept 25.	Mandatory training target achieved - 91% against 90% target (as at Sep 25).	High
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	**Next update Dec 2025**	• A process has been established to monitor progress and escalate the position through EDG. • Further work is required to deliver these improvements. • Progress updates provided via the Audit Committee. • Progress continues to be made but action to remain open until significant reduction in out of date policies is evident and work on other documents is progressing.	Up to date policies accessible to all	High

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	**Proposal to move to BAU Sept 25**	• BAF in place. • 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 Policy revised and approved. • Risk Management Committee in place. • Datix developments progressed. • Reports, notifications and training being developed. Some delays in progressing.	Monthly reporting to EDG and OMB. High Risks report to the Board of Directors. Effective BAF in place.	Medium
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	**Further update – Dec 2025**	• The Trust has a continuous improvement team in place, as well as a number of other teams that deliver improvement work. • A session was held with the Continuous Improvement Team in May 2024 to align team priorities to strategic priorities. • For 2024/25, a set of agreed improvement priorities has been developed and has been reset for 25/26 to include the Cost Improvement Programme and a number of other strategic priorities. • Wider picture across all improvement activity to be developed • An improvement strategy is required for 2025/26. • Q&S strategy also defines the quality improvement priorities. • Further review of clinical audit activity planned. • Work to do to bring this all together.	Clear improvement Strategy/ Plan.	Medium

Action Plan – KLOE 7

KLOE 7	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
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 and review of medical staffing***	Chief People Officer/ Director of Nursing/ Medical Director	**Nursing- Completed**	Nurse staffing review completed using the safer nursing tool. Review of maternity staffing also. **Completed.**		High
			Medical – Next Review Jan- 26 **AHP – Nov 2025**	Medical staffing - currently being progressed. SARD undertaken a capacity demand modelling for medical staff in 16 biggest specialities. Revised job plans drafted and subject to consistency panels. Current review of job plans matched to capacity/demand work by specialities being co-ordinated by Debbie Herring. Review of AHP workforce - A review of the AHP workforce has been completed by the TICC division. AHP review remains outstanding and is been led by Lead for therapies.		
7.5 (NEW)	Continue to build upon system understanding and engagement with external partners, stakeholder mapping.	Director of Strategic Partnerships	**Next update Sept 2025**	New Anchor Institution oversight group established (June) which will meet bimonthly. New reporting framework adopted. Revised terms of reference. Board report presented in July 2024. Anchor Institute Oversight Group has now expanded membership to CWP and Chester University sustainability department. The group has now also engaged with the Country Park. The Trust has now been recognised by the ICB as an Anchor Institution	System engagement in place.	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	**Next update December 25**	Organisational Learning Policy being progressed to reflect the mechanisms and learning forums in place which are attended Trust wide. Head of Legal Services, Deputy Medical Director and Deputy Director of Nursing & Quality Governance also working more closely to align organisational learning. Early draft shared with Deputy Director of Nursing, Quality and Governance and Deputy Medical Director (Dec 2024). Further review required.	Clear arrangements in place to demonstrate systematic learning	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 Governance, Risk & Improvement	**Next update Sept 25**	• The Trust has a continuous improvement team in place, as well as a number of other teams that deliver improvement work. • A session was held with the Continuous Improvement Team in May 2024 to align team priorities to strategic priorities. • For 2024/25, a set of agreed improvement priorities has been developed and has been reset for 25/26 to include the Cost Improvement Programme and a number of other strategic priorities. • Wider picture across all improvement activity to be developed • An improvement strategy is required for 2025/26.	Measurable improvements.	Medium

Action Plan – KLOE 8

KLOE 8	Development Areas	Responsibility	Timeframe	Progress	Outcomes	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	**Next review – Dec 2025**	A revised System Improvement Plan for UEC has been agreed and progress is monitored at Patient Flow Steering Group and System Oversight Group. Additional support from the ICB to address the high number of patients that do not meet the criteria to reside (NCTR) has meant the trust has seen a reduction in delay days, but we are yet to see movement on the total number of patients The Trust has had a leadership away day hosted by NHSE. This will focus the team on roles/responsibilities, SOP's and Inter professional Standards and the leadership teem meet each week with the MD. We have introduced an SOP to reduce the length of time patients spend in the department which has successfully started to reduce long waits to under 24 hours and improved 12-hour wating times and has significantly reduced ambulance turnaround times. All original actions are now completed. Including: UTC fully open and taking 30-25% take each day SDEC taking well over 1200 patients per month and direct conveyance from NWAS Call before convey for all non-resus ambulances for over 18 years old also in place.	Improved performance against KPIs Improved patient experience	High

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Appendices

Summary of Improvement Outcomes

Urgent & Emergency care

1. Improved performance in type 3 performance
2. Increased use of Same Day Emergency Care (SDEC)
3. Reduction in long waiting patient and significantly improved ambulance turnaround times

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
7. Changes made to the post-operative care of women's & birthing people following obstetric surgery
8. Reasonable adjustments strategy completed and due to be launched Q4 2024/25
9. Transparency of all coronial cases, good communication with legal team and oversight through safety surveillance
10. Safeguarding arrangements strengthened

Summary of Improvement Outcomes

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
4. Awareness raising in respect of developing a strong culture of Governance and Risk Management
5. Visibility and reporting of BAF and Risk Registers
6. Clear accountability framework

People & OD

1. A wide range of engagement activities covering inclusivity, behaviours, wellbeing and appraisal and career conversations, and visibility of FTSU.
2. Improvements have been made following the 2023 staff survey
3. Clear EDI priorities and oversight of progress
4. Induction, appraisal and leadership programmes embedded to support People development
5. Improved compliance for mandatory training

Digital

1. Successful EPR upgrade
2. EPR optimisation prioritisation process in place

Summary of completed actions (to date)

Countess of Chester Hospital NHS Foundation Trust

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
- FTSU Board self-assessment held on 6th August 2024
- Governance and assurance slides have been developed and are being used in different forums to increase understanding and expectations.
- Plan has been developed, revised risk management policy and a new risk management committee has been introduced
- 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.
- Discharge summit held with system partners invited to join
- Review of all fire exits undertaken.
- Fire audits undertaken
- Anchor Steering Group now operational

Summary of completed actions (to date)

Countess of Chester Hospital NHS Foundation Trust

Completed Actions

- Daily review of incidents implemented, risk management committee established and Organisational Learning Policy reviewed.
- Complex Care passport relaunched. Safeguarding EPR tool.
- People Promise measure incorporated into People Strategic Plan
- Performance reporting has been established to each OMB.
- Trust wide engagement sessions and local Listening events held in response to staff feedback.
- Integrated reports are provided quarterly to the Quality & Safety Committee and Board of Directors.
- NED responsibilities reviewed and NED inductions now in place.
- Governor workshop held to reconfirm roles and reset the role of the CoG. Action plan in place to support governors in fulfilling their roles and further workshops scheduled.
- Database of coronial inquest developed.
- Revised reporting and cover sheet template in place.
- EPR upgrade has taken place and part of 4 year programme to ensure latest version is installed when released.
- Clinical Digital Design Authority process embedded.
- Feedback from staff survey 2023 has been collated and highlighted areas of action and high-level data from 2024 survey being reviewed to support and develop action plans.
- Harms improvement programme in place and embedded.
- MUST assessment implementation and monitoring.
- Risk management policy revised, Risk Management Committee established and regular review of risk registers. Divisional risk maturity self assessments complete.
- Induction and appraisal processes embedded.
- Leadership development programmes implemented.
- Committee organogram developed.
- New accountability framework in place.
- EDI workstreams and priorities and developed and governance in place to assure progress.
- Previous UEC action plan complete and superseded by new combined UEC action plan.
- The trust has notified the CQC that Tarporley Hospital no longer needs to be registered separately.
- AfPP revisit in June 2025 – accreditation received and positive feedback from AfPP
- Maternity theatre staffing plan agreed
- Clinical strategy approved and embedded within organisation
- New Mental Health Equalities area completed in April 2025 and live in clinical occupation
- Staff with limited access to PCs provided with face to face options and library access to support completion of mandatory training
- Datix developments progressed and reports, notifications and training being developed.
- Committee organogram developed, new Accountability Framework in place and planned work on Divisional governance 2025/26.
- New People Strategy which includes EDI, HWB (current people strategy, EDI & HWB strategies run to 2026) approved at People Committee.
- Staff networks developed to support equality and inclusion.