Countess of Chester Hospital NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS (PART 1, PUBLISHED ITEMS) TUESDAY, 13TH JULY 2021, AT 9:30AM – 1:00PM HELD VIA VIDEO-CONFERENCE, DUE TO COVID-19 PANDEMIC RESTRICTIONS

A G E N D A

Apologies:

PART A				
FORMAL BUSINESS			Lead:	Decision Required/ purpose:
9:30am	1.	Welcome & Apologies	Trust Chair	
9:30am	2.	Declarations of Conflicts of Interest with agenda items	Trust Chair	
9:30am	3.	To receive a Staff Story	Director of HR & OD	To note
9:35am	4.	Minutes of the meeting held on 20th May 2021 (attached) Pages 4 - 15	Trust Chair	To approve
9:40am	5.	To consider any matters arising and action log (attached), including: Pages 16 - 17 (a) Further adjustment to NED portfolios (verbal)	Trust Chair	To note
9:45am	6.	Chief Executive Officer's Report (attached) Pages 18 - 24	Chief Executive Officer	To note
9:55am	7.	Board Assurance Framework (BAF) – Quarter 1 2021/22 (attached) Pages 25 - 45	Interim Governance Consultant/ Executive Directors	To note
SAFE				
10:05am	8.	Quality & Safety Committee Chair's Report - 22 June 2021 (attached) Pages 46 - 49	Quality & Safety Committee Chair	For assurance
10:15am	9.	Infection Prevention & Control BAF (attached) Pages 50 - 69	Interim Director of Nursing	For assurance
10:25am	10.	(a) Mortality Indicators/Learning from Deaths Report (attached) Pages 70 - 84 (b) Mortality Update - review of HSMR (attached) Pages 85 - 90	Executive Medical Director	For assurance
10:40am	11.	Nursing & Midwifery Safe Staffing Report (attached) Pages 91 - 134	Interim Director of Nursing	For assurance
10:50am	12.	CNST Maternity Incentive Standards Submission (attached) Pages 135 - 162	Interim Director of Nursing	For assurance
11:00am - 11:10am		COMFORT BREAK		
EFFECTIVE				
11:10am	13.	Finance & Performance Committee Chair's Report – 25 May 2021(attached) Pages 163 - 166	Finance & Performance	For assurance

			Committee Chair	
11:20am	14.	Finance: (a) Finance Report – Month 02, May 2021/22 (attached) Pages 167 - 175 (b) Capital Plan (attached) Pages 176 - 183	Director of Finance	For assurance To approve
11:35am	15.	Electronic Patient Record update report (attached) Pages 184 - 193	Chief Digital Information Officer	For assurance
11:45am	16.	Integrated Performance Report – May 2021 (attached) Pages 194 - 248	Chief Operating Officer/ Executives	For assurance
12:05pm	17.	Audit Committee Effectiveness Review Report (attached) Pages 249 - 250	Audit Committee Chair	For assurance
CARING				
12:15pm	18.	WRES AND WDES Action Plan Update (attached) Pages 251 - 267	Director of HR and Organisation Development	To note
WELL LED				
12:25pm	19.	Freedom to Speak Up Guardian Report (attached) Pages 268 - 312	FTSU Guardian and Director of HR and Organisation Development	For assurance
12:35pm	20.	*In the Board's role as Corporate Trustee:* Charitable Funds Committee Chair's Report – June 2021(attached) Pages 313 - 314	Charitable Funds Committee Chair	For assurance
		PART B ***See separate Part B public papers***		
12:45pm	21.	a. Updated Board Business cycle 2021/22	Trust Chair	To note
		b. Council of Governors Report – June 2021		To note
		c. GMC National Trainee and Trainer Survey Results		For assurance
		d. Continuous Improvement Update Report		For assurance
		e. National Cost Collection Report		To note
12:50pm	22.	Minutes for noting and receipt:- ***Sent under separate cover*:** a) Approved minutes of the Quality & Safety Committee – 20 April 2021 b) Approved minutes of the Audit Committee – 26th April 2021 c) Draft Minutes of the Finance & Performance Committee – 25 May 2021	Trust Chair	To note

12:50pm	23.	Any Other Business	Trust Chair	To note
12:55pm	24.	Closing remarks and review of the meeting	Trust Chair	
1:00pm	25.	Date & Time of next meeting: The following public meeting of the Board of Directors is scheduled on **14 September 2021, to be held at 9:30am-12:00.** **Note: The Annual Members Meeting is scheduled at 5pm - 6:15pm on Thursday 30th September.**	Trust Chair	

NHS
Countess of Chester Hospital
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS (PART 1, PUBLISHED ITEMS)

THURSDAY, 20TH MAY 2021, AT 9:30AM – 12:45PM

HELD VIA VIDEO-CONFERENCE, DUE TO COVID-19 PANDEMIC RESTRICTIONS

Members	20/05/2021	13/07/2021	14/09/2021	09/11/2021	Jan/2022	Mar/2022
Trust Chair, Ms C Hannah	☑					
Chief Executive Officer, Dr S Gilby	☑					
Non-Executive Director, Mr A Higgins	☑					
Non-Executive Director, Mr D Williamson	☑					
Non-Executive Director, Mr M Adams	☑					
Non-Executive Director, Mrs R Fallon	☑					
Non-Executive Director, Ms B Fletcher	☑					
Non-Executive Director, Mr P Jones	☑					
Non-Executive Director, Mr K Gill	☑					
Executive Medical Director, Dr D Kilroy	☑					
Director of Finance, Mr S Holden	☑					
Interim Director of Nursing, Ms H Gwilliams	☑					
Director of Human Resources and Organisation Development, Mrs A Hall	☑					
Chief Digital Information Officer, Mrs C Williams	☑					
Chief Operating Officer, Mr D Coyle	☑					

In Attendance	20/05/2021	13/07/2021	14/09/2021	09/11/2021	Jan/2022	Mar/2022
Associate Non-Executive Director, Ms A Campbell	☑					
Interim Governance Consultant, Mr K Haynes	☑					
Lead for Governance Improvement, Mrs D Bryce	☑					
Emergency Department Matron, Ms J Jarvis, for (item B3)	☑					
Director of Transformation, Mr I Bett	☑					

FORMAL BUSINESS		
B1/ 05/21	**Welcome, Opening Remarks & Apologies** The Trust Chair welcomed everyone to the meeting, including the governors and public observers present. There were no apologies of absence. The Chair explained that Mrs Alison Kelly, Director of Nursing & Quality, had recently left the organisation and went on to thank Mrs Kelly, on behalf of the Board, for her eight years of service to the Trust. Ms Hilda Gwilliams, Interim Director of Nursing & Quality was welcomed to her first Board meeting.	
B2/ 05/21	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest in relation to conflicts with agenda items.	
B3/ 05/21	**To receive a patient story *(video shared with Board members only, in the absence of patient consent for wider circulation)*** The Chair expressed her concern at some of the messages within the patient story which	

	related to the patient's experience in the Emergency Department and noted the potential for the organisation to learn. The Emergency Department (ED) Matron remarked on her direct dealings and time taken with the complainant in November 2020 to listen to the concerns raised, and summarised the department's response to the concerns which included: • A revised ED handover process to be undertaken at the bottom of each bed, in relation to patient confidentiality and privacy issues raised. • Confirmation that regular drinks were in place, due to water having been taken away from each bedside due to infection prevention and control (IPC) issues. • An aim to place a blanket at the bottom of each bed, recognising that the department is busy. • Concerns shared with ED staff in relation to treating patients with dignity. • The challenges experienced in relation to staff making physical contact with other members of staff during difficult times. • The willingness to learn from the complaint, recognising that the ED received more compliments than complaints. It was acknowledged by the Interim Director of Nursing that there was agreement with the learning points on the whole, and that the learning points and IPC issues would be followed-up outside of the meeting. There was a discussion on sharing the learning from the patient story and taking proactive actions, prompted by Non-Executive Directors Ms Fallon and Ms Fletcher, with confirmation received from the ED Matron that the immediate learning had been shared with all ED staff in response to the complaint, with constant messaging provided on complaint issues received within ED. The zero tolerance approach required within the department to demonstrate correct behaviours to the public was commented on by Non-Executive Director, Mr Adams in response to IPC issues with staff making physical contact with other members of staff. . **The Board received and considered Jane's story and the learning points within it.**	
B4/ 05/21	**Minutes of the meeting held on 9th March 2021** The minutes of the Board of Directors meeting held on 9th March 2021 were approved.	
B5/ 05/21	**To consider any matters arising and action log** The Board considered the action log and noted that action 17/20-21 had now been resolved. There were no other matters arising discussed.	
B6/ 05/21	**Chief Executive Officer's Report** Since the time of writing the report, the Chief Executive Officer advised the meeting that at a regional level the Chair and Chief Officer of the Integrated Care System (ICS) had announced that they would not be continuing in their roles when the ICS becomes a statutory organisation and that she was grateful for the population focus they had brought to the region and for their support through the recent challenging times. In regard to local matters, the Chief Executive Officer's key points raised included the following:- • There had been no positive Covid-19 patients for at least the last 10 days. • The rate of decrease of Covid-19 infection in the older age groups was greater than	

	the decrease in the younger groups, indicating that the vaccine programme was working. • The Trust no longer had Covid- cohort wards in place, with any patients nursed in side rooms on wards, where required. • Visiting restrictions had been relaxed, with visiting permitted via a booking system. In response to a request for further information on integrated working and the provision of mutual aid, from Non-Executive Director, Mr Higgins, the Chief Executive Officer advised of the various groups across the region considering the challenges, with a focus on elective and cancer waiting lists and data gathering. The CEO explained that one of the regional programmes of work included the use of AI (Artificial Intelligence) to risk stratify waiting lists and that the Trust was the next site for implementation of this programme. In addition, work on clinical pathways, including discharge processes, was confirmed as being in place, with the Trust also sourcing its own support in relation to this work. The arrangements relating to the financial allocation also remained a challenge. The Chair referred to the current recovery challenge as a 'system' problem to address, and remarked on the strong representations in place via the Chair's Network. In support of this, the CEO referred to the work in place by the Trust with primary care on the issues, and the requirement for support by the regional team and the wider system in addition to this. **The Board noted the Chief Executive Officer's Report.**	
B7/ 05/21	**Proposed Changes to Non-Executive Director Portfolios and Appointment of Trust Vice Chair** The Board considered the paper, and Non-Executive Director, Mr Adams advised that he was also a member of the EPR advisory group, and it was agreed that this would be added to the portfolio of Mr Adams. The Chair thanked Mr Higgins for his contributions as the previous Vice Chair; congratulated Ms Fletcher as new Vice Chair; and remarked on the diligence and time required from the Non-Executive Directors to undertake the significant role, expressing her appreciation. **The Board:** • **Ratified the previous decision (request circulated electronically dated 7 April 2021) of the Board of Directors approving the changes to Non-Executive Director portfolios from 1 May 2021; noting that Mr Mark Adams was also a member of the EPR Advisory Group.** • **Noted the decision of the Council of Governors (taken on 22 April 2021) to the appointment of Ms Bridget Fletcher as Vice-Chair with effect from 1 June 2021, for an initial twelve month period.**	
SAFE		
B8/ 05/21	**Quality & Safety Committee Chair's Report - 20 April 2021** Referring to her report on the committee meeting of 20th April, Non-Executive Director, Ms Fallon highlighted the consideration of the following:- • Incident reporting, with an outcome awaited on the operational work in place and the agreement to report on duty of candour in future. • The work underway on discharge improvement processes. • Two presentations/reports on research and innovation and the clinical trials underway to enable better care with Covid-19. • The work on perinatal care, referring to the national imperatives that the service is required to cover, including the Ockenden Report, CNST and MBRACE. With	

	a development session planned for June 2021 for the Board to understand further the issues in relation to maternity and the neonatal department. The Executive Medical Director remarked on the excellent research work into Covid-19 and the impact of this, for which the Trust should be proud. Non-Executive Director, Mr Gill referred to paragraph 8 of the report and the reference to CQC reporting and hospital death statistics, enquiring as to any response from the CQC in this regard, and potential consequences. In response, the Executive Medical Director advised that the most recent HSMR data had been shared with the CQC, along with the sharing of the work underway to mitigate any issues in relation to the Trust's mortality metrics. Following a request from Non-Executive Director, Mr Higgins for an update on the increasing trend in HSMR data, the Executive Medical Director made the Board aware of the following points:- • All elements of the current metric are investigated with some pathways currently under scrutiny. • There is a frustrating lag on mortality metric reporting. • The current position in relation to mortality is of concern and an update will be provided to Quality & Safety Committee in June on the work underway. There was a discussion on the need to review and discuss in more detail the mortality indicators report which was in Part B of the papers. **<u>Action agreed:</u> To include the mortality indicators/learning from deaths report within Part A of the agenda at the next meeting and in future.** **The Board:-** • **Noted the content of the Chair's report** • **Noted the content of the Mortality Indicators and Learning from Deaths Report** • **Noted the content of the Guardian of Safe Working Report** • **Noted that the Committee received a new report at its April meeting, Research and Innovation Committee Chair's Report.**	**KH**
<u>EFFECTIVE</u>		
B9/ 05/21	**<u>Finance & Performance Committee Chair's Report – 23 March 2021</u>** An update on the meeting on 23 March 2021 was provided by Non-Executive Director, Mr Higgins who referred to the consideration of the Board Assurance Framework key risks, with the greatest risk identified in relation to access and waiting times, and a plan to cover this in more detail at the meeting of 25 May. It was noted that consideration had also been given to cyber and information governance risks and there was satisfaction on the flow of information on these. Three business cases in relation to property had also been considered and, in light of further developments, were planned to come to Board in due course. **The Board noted the contents of the report.**	
B10/ 05/21	**<u>Staff Survey Outcome 2020</u>** The staff survey which had been undertaken by Quality Health was considered and the Director of HR & OD highlighted the following points to the Board: • The work undertaken recently to improve staff engagement, with a 12% improvement in response rate, and an ambition to improve this further. • There had been additional responses from clinical staff in the 2020 survey.	

	• With regard to bullying and harassment, staff are encouraged not to stay silent and the numbers reported have increased. • There is a need to concentrate on staff health and wellbeing, especially in relation to the long-term impact of the pandemic on staff. • Supplementary surveys will be undertaken every quarter to enable 'pulse checks' and updates on this will be provided to Finance & Performance Committee. Non-Executive Director, Mr Adams commented that it was disappointing that 21 items had scored significantly worse than the sector and made enquires as to the comparative methodology and if it was now time to revisit establishing a separate workforce committee of the Board. In response, the Director of HR & OD advised that the results were compared with comparable size Trusts, and that further engagement with the workforce was required along with consideration of how that work would be supported. And with regard to establishing a workforce-based committee, this was a matter for further debate and consideration. **Action agreed: To consider in due course if a separate workforce committee of the Board is required, or to continue with current integration of workforce items with the Finance and Performance Committee.** There was a discussion on progress of the previous 2019 staff survey actions and the confidence on training for senior managers, prompted by Non-Executive Directors, Ms Fallon and Ms Fletcher, with the Director of HR and OD outlining the current limited capacity; the work to monitor previous action plans; the further work to do; the request to divisions to undertake action plans based on the survey findings; and the key deliverable within the People Strategy to deliver development to senior leaders. Following a remark from Non-Executive Director, Mr Jones as to the existence of a central corporate staff survey action plan and an engagement champion to work in an overall co-ordinated approach, the Director of HR & OD advised that work was underway with improvement teams with an aim to monitor through the delivery of the People Strategy. **The Board received the Staff Survey Outcome 2020, considered the findings and supported the next steps.**	**CH/ SG**
B11/ 05/21	**Electronic Patient Record (EPR) Update Report** The Board noted that there were nine weeks to go until the EPR system 'go live' and that there had been some developments since the report was written. The Chief Digital Information Officer remarked upon the huge change programme and training underway, with integration testing in place ahead of the launch, and that an experienced team is working with the Trust, with amber rating being a cautious view. In addition, concern remains regarding data quality as the current system is not Referral to Treatment (RTT) compliant, which is being worked through and going well, and consultancy support has been extended through August and September 2021 to support the EPR transition. With reference to the financial table in Appendix two, the Director of Finance referred to the £1.3m gap in funding which was artificially low as it relies on a £2m asset sale, and that the gap is realistically £3.3m, which is lower than the previously reported gap in funding. He went on to outline the £0.5m funding for the EPR within the financial plan; and that the gap was bridgeable, but would leave the Trust with a deficit, but that he remained optimistic on the finances. In response to an enquiry made by Non-Executive Director, Ms Fallon in relation to resourcing of the training programme, time allocated to staff and any operational impact, the Chief Digital Information Officer advised of the two forms of training, e-learning and	

	classroom based training, with e-learning predominantly for clinical staff, due to infection prevention and control requirements. With refresher training possible and support in place via floor walkers, local champions and service desk support to staff. The likely impact on productivity was noted, which had been accounted for in the Trust's activity forecast. There were further enquiries made by Non-Executive Directors, Ms Fletcher and Mr Williamson in relation to data quality concerns and risk to patients; the 35 integrations in the phase one EPR delivery; and assurances in relation to the out of scope items. In response, the Chief Digital Information Officer advised that 820,000 patient records were being transferred and there were some known demographic data difficulties which had been progressing. Furthermore, RTT had been considered separately and the Chief Operating Officer had been leading on this, and there was an overlap, with an aim to improve the data quality at go live in July. With regard to the integrations, it was reported that some are in relation to devices and some are for systems, and these are being worked through, and where they are not ready to go live, considerations are given to the mitigations at the Operational Readiness Board, with the integrations to be put in place post-go live, at the most appropriate time. **The Board noted:** • **The summary account of progress on the EPR programme.** • **The financial risk and estimated impact on the financial forecast due to the change in go live date, along with the requirement to ensure the organisation has the correct resources to safely manage the system post go live and that these issues will be considered as part of the Trust's annual planning processes for 2021/22.**	
B12/ 05/21	**<u>Finance:</u>** **(a) Finance Report – Month 12, 2020/21** The Director of Finance referred to the year-end £1.3m deficit posted, including prudent accruals. He remarked on a year of change during the pandemic, with associated expenditure and a cash balance at the end of the year of £32m, with higher than normal capital expenditure, linked to the pandemic. The Board's attention was drawn to page 9 of the report, and the table on activity by point of delivery which was £34m down on expected, mainly due to daycase activity, followed by non-elective activity and acute macular degeneration activity; with one of the areas, maternity, being above expected activity levels. **The Board noted the detail outlined within the recommendations of the paper.** **(b) Draft Financial Plan 2021/22 – including restoration and recovery** The Director of Finance raised the following points in relation to the plan: • There has been an assumption that the same Covid-19 funding as last year will be received in 2021/22, but this is yet to be clarified by the Integrated Care System (ICS). • The report covers the known cost pressures, with no assumption of Elective Recovery Funding (ERF) to reach the predicted £4.8m deficit position, and with a cost improvement requirement based on non-recurrent solutions. • Wales have agreed to follow the English rules, subject to confirmation, and subject to interpretation and performance thresholds. • Appendix one of the paper includes the sizeable Trust pressures which are yet to be prioritised.	

The Chair remarked on the recommendation to delegate authority to the Chief Executive Officer and Director of Finance on the final submission, subject to review of the draft plan at Finance & Performance Committee on 25 May, noting the submission date of the plan of 24 May. Non-Executive Director, Mr Higgins noted that consideration of the plan by Board gave an awareness of the outline of the plan and that Finance & Performance Committee scrutiny was more likely to concentrate on any updates from the Director of Finance to ensure from an internal perspective that the plan joins up activity with finances. It was agreed that there would be a comment submitted with the plan on 24 May 2021 that Finance & Performance Committee would give further consideration to it on the subsequent day with regard to the timetable placed upon the Trust.

The moral imperative to treat as many patients as possible, versus the uncertainty within the finances was raised by Non-Executive Director, Mr Gill, who went on to query the changing allocation in relation to capital funding; where the Trust was positioned in relation to this; and if capital projects could begin sooner. In his response, the Director of Finance referred to a capital allocation received during the year which had been less than requested; prioritisation of capital underway; and that capital funding could not be spent unless it had been allocated. It was clarified that the Trust would draw down a capital loan to progress the capital programme, and that anything deemed 'urgent and necessary' would be dealt with.

Non-Executive Director, Mr Higgins noted the Appendix 3 letter and that it was helpful for the Board to acknowledge the sentiments expressed in the letter regarding the organisation being left with a residual cost improvement requirement, as outlined within Appendix 2 of 3.2%, which is a considerable challenge; and to acknowledge the requirement as a partner in the integrated system as a whole, including bridging the financial gap. The Chair summarised on behalf of the Board that when submitting the operational and financial plan, those form of words should be included and checked with Mr Higgins, as the chair of the Finance & Performance Committee, which was agreed by the Board.

The Board:

- **Noted the content of the report, including the points highlighted and risks.**
- **Agreed *to* delegate approval of the final plan submission to the Chief Executive Officer and the Director of Finance, subject to review at the Finance & Performance Committee on 25 May 2021, and subject to inclusion of the acknowledgement of the sentiments expressed within the Appendix 3 letter of the report, which would be checked with Mr Higgins first.**

(c) Finance Month 1 (April), 2021-22, Overview Report *(report tabled)*

The Board acknowledged that, due to reporting timescales, the Month 1 report had only been circulated on the previous evening. The Director of Finance, referring to the expected deficit for the year, raised that the overspend in April should be in the region of £830,000, but the position was actually £950,000. However, the Trust had qualified for elective recovery funding to reduce the overspend figure. He drew attention to the Electronic Patient Record programme implementation which would impact on activity numbers, referring to the activity within the last page of Appendix 2 which indicated how the tariff works and clarified the current activity position.

The Board noted the contents of the report including the risks outlined, and that further detail would be provided to the Finance & Performance Committee for consideration.

B13/ 05/21	**Integrated Performance Report – March 2021** The Board considered the raised Hospital Standardised Mortality Ratio (HSMR) and the effect of Covid-19 on the data. The Executive Medical Director advised that the Trust had been hit extremely hard by Covid-19, and that there was a lag in the data of several months when the Trust was in the depths of the pandemic. He explained that the depth of clinical coding was impacted during the pandemic. In addition, there were other significant elements within the mortality data that were being addressed such as the significant spike in mortality due to long lengths of stay, with work being undertaken via clinical teams with external support from Dr Ian Sturgess. Other highlights from the Chief Operating Officer on the report included; a slight increase in falls with harm, Sepsis treatment performance, Emergency Department (ED) standard not met, but had performed the best regionally; Referral to Treatment (RTT) incomplete pathways had reduced based on work undertaken; and the 62 day and 14 day cancer targets were of concern, with attempts to get them back on track. The Chair remarked that the midwifery continuity of carer exception report had not provided a full explanation of the issues. In discussion, the Chief Executive Officer advised that the standard that had previously been reported had not included the actual labour period and the Trust's staffing model did not allow it to meet the continuity of carer for that period, which was being addressed, as the standard had changed. The Chair concluded that it would be helpful for the explanation to be contained within the exception report. Non-Executive Director, Ms Fletcher commented on antibiotic treatment within the Sepsis pathway; and the patients on the patient tracking list (PTL) of over 100 days, including the 12 patients within skin/plastics, seeking assurance that these patients were not disadvantaged when transferred to another local organisation to be seen. In discussion, the Executive Medical Director acknowledged the improvement work in place for Sepsis and the monitoring in place for skin/plastics patients to ensure they were not being disadvantaged, with some patients being 'watched' clinically and others not wishing to travel to other providers, but these being in the minority. The nursing agency spend increase in March was raised by Non-Executive Director, Mr Higgins who enquired if there was an issue with the nurse establishment as Covid-19 numbers had declined. In response, the Director of HR & OD confirmed that the issue had been considered by the Strategic Workforce Group and it was considered that the taking of outstanding annual leave had contributed. **Action: It was agreed that the better identification of improvement timescales would be considered within the Integrated Performance Report by the Chief Operating Officer and Interim Director of Nursing & Quality.** There was consideration of achievement of mandatory training compliance and appraisal performance, prompted by Non-Executive Director, Ms Fallon, along with congratulations on the ED position within the region, with an enquiry as to the confidence of sustained ED performance. In discussion, the Chief Operating Officer outlined his uncertainty within ED due to a huge upsurge in attendances, however, raising confidence on maintaining safety whilst performance drops. In relation to appraisal performance and mandatory training, the Director of HR & OD outlined the approach taken to reduce the burden with the process during the pandemic. In addition, she referred to the benchmarking undertaken on absence management figures and the intention to redress the absence target via Finance & Performance Committee as the Trust was performing best regionally despite not achieving its internal target. This was supported.	**DC & HG**

	The Board: • **Noted the content of the Integrated Performance Report.** • **Requested better identification of improvement timescales within the Integrated Performance Report in future.** • **Supported Finance & Performance Committee's consideration of redressing the Trust's absence target.**	
B14/ 05/21	**Audit Committee Chair's Report – 26 April 2021** The newly appointed Chair of the Audit Committee, Non-Executive Director, Mr Gill emphasised the good progress made on the 2020/21 Annual Report and Accounts and that external auditors, KPMG, had provided a level of assurance on their methodology. There had been detailed consideration of accounting policies and judgements at the April meeting, with an intention for the Committee to meet in early June to consider the final year-end documents, with subsequent consideration at an extraordinary Board of Directors meeting. It was reported that the *Moderate* Head of Internal Audit Opinion received was disappointing and provided an opportunity for consideration of the internal audit recommendations and their implementation across the organisation. Finally, it was reported that the Committee had considered cyber security risks and had met separately to consider its effectiveness, concluding that there were opportunities for improvement. **The Board:** • **Noted the contents of the Audit Chair's report** • **Noted the progress being made to bring the various strands of the Annual Report and Accounts 2020-21 together and that a special Board meeting would be convened to consider the final Audit Committee agreed version.** • **Accepted the *Moderate* assurance opinion of the Head of Internal Audit, noting that consideration would be given to how this outcome could be improved upon and that an action plan for internal audit to this end would be developed via the Audit Committee.**	
WELL LED		
B15/ 05/21	**Five Year Strategy** The Chief Executive Officer introduced the Five Year Strategy which outlined the five year intentions of the organisation, remarking on the additional enabling strategies and her ambition to develop and finalise the strategy since discussing this with the CQC early on in taking up her role. It was noted that the pandemic had delayed the production of the strategy following a stakeholder event held in February 2020, but that a workshop had been held with the Board earlier in May 2021 and the strategy now makes clear what the organisation needs to do for its population, along with its position in the wider health system. Thanks were raised to the Board, staff, stakeholder organisations, patient groups, local authority partners, and Director of Transformation who had helped to develop it. The Board was advised of the proposed new vision and four key pillars within the strategy by the Director of Transformation, and that the Trust's existing values and behaviours had been incorporated into it. He drew attention to the 'strategy on a page' and the intention to socialise the strategy with staff for them to understand how they can be involved in the delivery. The intention to develop the supporting strategies further was outlined along with the intention to continually engage with stakeholders on its progress. In response to an enquiry made by Non-Executive Director, Mr Jones, as to the deployment plan for the strategy, the Director of Transformation informed that a	

	continuous improvement methodology would drive this. The intention to align staff objectives to the strategy was also highlighted by the Chief Executive Officer. The partnership working within the strategy and opportunity to link with the ICS and wider health system was noted by Associate Non-Executive Director and Chair of Cheshire West ICP, Ms Campbell, who raised her intention to consider the strategy alongside other partner strategies at the June ICP Board meeting and consider synergies for the population health model. Non-Executive Director, Ms Fletcher, commented on the positive document, inclusion of the reference to health inequalities and that the Board would be required to consider what this meant in developing and evolving to understand its role in the wider system; addressing inequalities and understanding the broader aspect of health and social care; being outward facing; and would possibly need to consider a session with Public Health in its partner role. The Chair thanked all contributors to the Strategy and summarised a key point in relation to the importance of the supporting strategies and internal coherence with the overarching strategy, and deployment, welcoming the emphasis on partnership working, and noted that the document should be live and be adapted, and sit in the context and align with the Place strategy which was currently being refreshed by the local authority. With the Board being required to consider how it becomes more aware of health and inequalities locally via its Board workshop programme. **The Board approved the Five Year Strategy, supported its link to the developing Integrated Care System and agreed to review and monitor its implementation at least annually.**	
B16/ 05/21	**(a) People Strategy 2021- 26** It was acknowledged that the enabling People Strategy had been developed in discussion with stakeholder groups, including partnership groups, and a Board workshop held in May 2021, and reflected the requirement to contribute to the national priorities and the national People Plan. The Director of HR and OD raised the key items reflected within the strategy and referred to the incorporation of a 'plan on a page' and how the plan would be delivered, including engagement. There was a discussion on Trust values and staff being engaged with the strategy in a year's time, and also the success measures and aspirational targets within the document and whether both should be in place, prompted by Non-Executive Directors, Ms Fletcher and Mr Jones. In response, the Director of HR and OD advised of the further opportunity to better describe the Trust's values in future along with an opportunity to review the measures with stretch targets, but that they currently stood at a point in time. Non-Executive Director, Mr Williamson remarked that the Five Year Strategy referred to the Trust aspiring to be a teaching hospital and this was not reflected in the People Strategy, he also raised the capability required to deliver the strategy, and possible digital enhancement required to support delivery. In response, the Chief Executive Officer advised that the aspiration to become a teaching hospital would be outlined in a supporting Education and Research Strategy and the Director of HR and OD advised that the people target operating model was due for further consideration in relation to capability and resource, and that she would engage with the Chief Digital Information Officer on engaging the workforce digitally. The Chair summarised the importance of engagement with the workforce, the aspirational targets included within the strategy and that it would be dynamic in future,	

	reflecting local and national influences. **The Board approved the Trusts' People Strategy 2021-2026** **(b) Wellbeing Guardian** The Board considered the rationale outlined within the paper and noted the synergy with the Freedom To Speak Up Champion role, and that Non-Executive Director, Mr Jones had agreed to incorporate this into his portfolio. **The Board:** • **Noted the contents of the paper confirmed the appointment of Non-Executive Director, Mr Paul Jones to the role of Wellbeing Guardian.**	
B17/ 05/21	**In the Board's role as Corporate Trustee** **Charitable Funds Committee Chair's Report – March 2021** Non-Executive Director, Mr Jones made the Board aware of the three points of escalation within the report. Non-Executive Director, Ms Fallon enquired as to what the reduction in staff referenced within the report meant for the team and the individuals. In response, the Director of Finance referred to the existing vacancy within the team and the undertaking that there would be no redundancies; that the team had been redeployed during the pandemic; and that with charitable giving currently being low that the charitable funds would reduce if expenditure was not reduced. **The Board noted the contents of the report, including the specific areas of escalation.**	
PART B		
B18/ 05/21	The Board noted the following: a. Updated Board Business cycle 2021/22 b. Council of Governors Report – March 2021 c. Mortality Indicators Report – March 2021 d. 2020 Annual Report on Safe Working Hours: Doctors and Dentists in Training.	
B19/ 05/21	**Minutes for noting and receipt:-** The Board noted the following: a. The approved minutes of the Quality & Safety Committee – 10 February 2021 b. The approved minutes of the Audit Committee – 16 February 2021 c. The draft minutes of the Finance & Performance Committee – 23 March 2021.	
B20/ 05/21	**Any Other Business** There was no other business raised.	
B21/ 05/21	**Closing remarks and review of the meeting** The Chair remarked on the good balance of items within the agenda, including retrospective items along with the prospective new strategies.	

B22/ 05/21	**Date and Time of Next Meeting** The public meeting of the Board of Directors is scheduled on **13 July 2021, at 9:30am-1:00pm.**	

NHS
Countess of Chester Hospital
NHS Foundation Trust

Board of Directors Public Action Log 2021-22 (13 July 2021)

Action no.	Board date	Allocated to	Action detail	Action update/outcome	Due date	Status
14/20	01.12.20	Non-Executive Director, Ms Fallon	CQC temperature monitoring progress – to be progressed off-line with the Chief Digital Information Officer.	Updated 09.03.21: IT infrastructure is now ready and deployment planning is underway. Updated 12.05.21 - IM&T infrastructure now in place. Workshop held on 11.05.2021 to determine how the devices are to be configured and deployed with representatives from Pharmacy, Estates, EBME and IM&T teams. Deployment will involve a pilot as part of a continuous improvement approach. Update at Quality & Safety Committee 22.06.21: proposal for operating out of hours is now confirmed; allocation of devices planned in conjunction with EPR roll out.	~~20.05.21~~ 31.08.21	Ongoing
16/20-21	19.01.21	Director of Nursing & Quality & Trust Chair	There will be further consideration of the Ockenden report in a separate Board session relating to the Trust's progress in implementing the report's recommendations and the submissions which it had made in response to NHSE/I requirements.	Planning meeting held on 23.04.21. Updated 12.05.21 – currently liaising with Clinical Leads to agree a date for workshop in June; Thursday being a preferable day. Maternity services Board workshop held 24.06.21	30.06.21	Closed
17/20-21	09.03.21	Director of Finance	Clarify with Non-Executive Director, Ms Fallon if the January nurse management overspend includes annual leave accrual apportionment or other factors.	Clarified. Action closed	20.05.21	Closed

Action no.	Board date	Allocated to	Action detail	Action update/outcome	Due date	Status
01/21-22	20.05.21	Interim Governance Consultant	To include the mortality indicators/learning from deaths report within Part A of the agenda at the next meeting and in future.	Included within Part A agenda, 13 July 2021		Closed
02/21-22	20.05.21	Chair and Chief Executive Officer	To consider in due course if a separate workforce committee of the Board is required, or if continue with current integration of workforce items with the Finance and Performance Committee.		30.11.21	Ongoing
03/21-22	20.05.21	Chief Operating Officer and Interim Director of Nursing & Quality	It was agreed that the better identification of improvement timescales would be considered within the Integrated Performance Report.		31.07.21	Ongoing

Meeting	**13 July 2021**		**Board of Directors**					
Report	**Agenda item 6.**		**Chief Executive Officer's Report**					
Purpose of the Report	Decision		Ratification		Assurance		Information	x
Accountable Executive	Susan Gilby				Chief Executive Officer			
Author(s)	Susan Gilby				Chief Executive Officer			
Board Assurance Framework	Q1 Q3 E4	Quality & Safety Infection Prevention & Control Access, Waiting times, care pathways and Constitutional standards						
Strategic Aims	-							
CQC Domains	Well Led							
Previous Considerations	N/A							
Summary	The purpose of this report is to: • Provide an overview of relevant local regional and national matters which may have impact on the Trust's strategic objectives.							
Recommendation(s)	The Board is asked to**:-** • Note and consider the contents of this report.							
Corporate Impact Assessment								
Statutory Requirements								
Quality & Safety	Covered within the report							
NHS Constitution								
Patient Involvement								
Risk								
Financial impact								
Equality & Diversity								
Communication	Document to be published on Trust's website							

Chief Executive Officer's Report

National issues

1. In mid-June, the Government announced its decision to push back the lifting of all remaining COVID-19 restrictions from 21 June to 19 July, following the growth in the number of Delta-variant cases in the UK and the desire to fully vaccinate as many over-50s as possible before removing the remaining social restrictions. Estimates from the Office for National Statistics on 25 June suggested that about 153,000 people in the UK would test positive for COVID-19 in the week ending 19 June, up from 119,000 people the previous week. This is 0.24% of the population – or approximately one in 420 people.

2. Rt Hon Sajid Javid MP was appointed as the new Secretary of State for Health and Social Care in late June, following the resignation of the former Secretary of State, Rt Hon Matt Hancock MP. Speaking to MPs in his first address to the House of Commons as Secretary of State, Mr Javid confirmed that COVID-19 restrictions in England would not be eased from 5 July despite prior speculation and pressure from some Conservative backbenchers, to enable more of the population to be fully vaccinated. He also noted that while COVID-19 cases are increasing rapidly, the number of patients being admitted to hospital is still relatively low, increasing confidence within Government that all remaining social restrictions can be lifted on 19 July.

3. The COVID-19 vaccine deployment has continued to make progress over June. As of 30 June, over 44.5 million people in the UK had received a first vaccination, while nearly 33 million had received full protection with a second dose. All adults have now been offered a first vaccination. Meanwhile, a study by Public Health England (PHE) found that Pfizer/BioNTech and AstraZeneca vaccines are highly effective against the Delta-variant identified after two doses. PHE's study showed that the Pfizer/BioNTech COVID-19 vaccine was 96% effective at preventing hospitalisation from the Delta-variant after two doses, while Oxford/AstraZeneca's vaccine offered 92% protection against hospitalisation by the Delta-variant.

4. Emergency Departments in hospitals across the UK are struggling to manage the significant increase in demand which has developed over recent months. A number of hospitals have been forced to declare major incidents in the last few weeks because of the increasing numbers of patients. Hospitals across the country have set new records for patient numbers in recent weeks, surpassing the worst days of the winter of 2019 – the most recent winter crisis in the NHS before the pandemic. In some units patients are waiting as long as nine hours to be seen, with overall numbers up by 50% compared with pre-pandemic levels.

5. In May, NHS data highlighted that up to 8,700 patients died after catching COVID-19 while in hospital being treated for another medical problem. The figures supplied by NHS trusts in England show that 32,307 people have probably or definitely contracted the disease while in hospital since March 2020 – and 8,747 of them died. That means that almost three in 10 (27.1%) of those infected that way lost their lives within 28 days. Creating a safe environment for treating and caring for our patients is the Trust's key priority, and we are continuing to enforce robust measures for infection prevention and control activity to protect both our patients and colleagues.

6. The NHS faces a significant backlog in elective care cases, despite the number of COVID-19 hospital admissions remaining relatively low. According to a recent study published by the British Journal of Anaesthesia, hospitals in England and Wales undertook almost 1.6m fewer operations last year because of the pandemic, including on people who needed emergency and urgent surgery. The authors of the study said their findings are the first to quantify the number of people whose surgery did not happen, and that a total of 1,568,664 operations fewer than expected went ahead in England and Wales during 2020. The study predicts that the total will increase to 2.4m by the end of this year. The research further illustrates how the widespread suspension of normal NHS care during the pandemic has affected patients who have not been able to access diagnostic tests or treatment.

7. Recent research from the University of Glasgow has highlighted how the pandemic has disrupted routine healthcare disproportionately across society with women, older people and minority ethnic groups most likely to report cancelled or delayed appointments, prescriptions and procedures. The study – which used data from nearly 70,000 people enrolled in 12 major UK studies – found evidence for widespread inequalities, with disadvantaged groups often facing the greatest disruption to their medical care.

Regional & local issues

1. The Trust is continuing to experience very high levels of demand for its Emergency Department services, and colleagues are working extremely hard to ensure that patients are seen in a timely manner and receive the necessary care and treatment. As part of our effort to manage this growing demand, we are continuing to focus on ensuring that those with the most urgent cases are seen first. Our experience is being mirrored at a regional and national level, with unprecedented levels of demand for both primary and secondary care.

2. The Trust is now only a few weeks away from introducing its new electronic patient record system, Connecting Care epr+. The Trust will stop using Meditech on Friday 23 July and over that weekend the new Cerner epr will be stood up so that by the morning of Monday 26 July the Trust will have moved to the new system. This transition to a new system is the culmination of meticulous work by staff across the Trust and is the realisation of an ambition set more than five years ago. It a source of immense pride to me that this has been achieved during the pressures of a pandemic, and is a testament to all those colleagues who have been involved in creating this positive step towards a more digitally mature hospital. Our expectation is that the new system will improve the ways in which we assess, admit, care for, and discharge our patients using enhanced digital processes, as well as other important benefits for both our patients and colleagues. I am pleased to note that there has already been a strong uptake for epr+ training ahead of the go live date at the end of July, showing a strong commitment among colleagues to make the transition between systems as smooth as possible.

3. Ahead of the introduction of the Connecting Care epr+ system, the Countess will be launching its Trust-wide *Perfect Week* initiative to improve flow through our hospitals, resetting our capacity and reducing delays for patients. It is timed to precede the epr+ go live so that we are at optimal operational readiness for what will be a period of significant adjustment for the Trust, albeit with great rewards to be realised. This initiative provides an opportunity for the whole Trust to focus on proactively improving patient care and experience.

4. In late May, I attended the Cheshire West Integrated Care Partnership (CWICP) Board Meeting. A variety of issues and policy areas were raised and discussed during the meeting, including the importance of providing holistic support for young people - for example, through a focus on young people's mental health and respiratory disease. One of the key takeaways from the meeting was the need to consider a system-wide communications approach to support the regional health service in responding to the significant demand for services.

5. In late June, we welcomed visitors back to the Trust, after what has been such a difficult year for both patients and their families. Managing this has been a huge undertaking for our Family Support Team and ward colleagues, so I want to take this opportunity to thank all colleagues for enabling us to restart visits safely. It is heartening to see normality returning to the hospital, but we remain alert to the possibility of future spikes in COVID hospital admissions.

6. In June, the Trust's Head of Facilities, Russ Morrow was invited to attend a COVID Thank You reception at 10 Downing Street with the Prime Minister, as one of 15 NHS colleagues from across the country to recognise their hard work during the pandemic. Russ was delighted to represent the Trust and told the Prime Minister how hard our facilities team work to keep the hospital running on a daily basis. This special recognition is a testament to the effort of the entire team and is well deserved.

7. On behalf of the Board, I also want to congratulate Paula Edwards, one of the Trust's matrons who leads our Family Support Team. Paula was selected from a list of nominations put forward by trusts across the country to attend a special service at St Paul's Cathedral to mark the 73rd birthday of the NHS on 3rd July. We are very proud of Paula and the entire Family Support Team who have worked tirelessly under difficult circumstances to help patients stay connected with their families while visiting has been limited or suspended because of the pandemic. Their compassion and commitment to supporting patients and families over the past year has been tremendous, and they deserve our immense gratitude.

Report

Cheshire West Integrated Care Partnership (CWICP) Board – May 20th 2021

Andrea opened the Board meeting by noting the resignation of Alan Yates and Jackie Bene from Cheshire and Mersey Health Care Partnership. Andrea wanted to put on record her thanks to them both for their commitment and support to develop integrated care.

Feedback from Health and Wellbeing Board Development Session

At its development session on April 21st 2021, Cheshire West Health and Wellbeing Board members discussed the priorities of the Board in light of impending changes triggered by the Government White Paper. Poverty, Mental Health & Wellbeing and Climate Change were chosen as the Board's key priorities. Subsequently, the Board received a presentation on Climate Change which energised individuals and organisations to consider positive steps they can take.

From recent discussions of the Board it is clear that a robust Joint Strategic Needs Assessment (JSNA) is required as part of a refresh of the Place Plan. The Board also agreed to establish a Place Executive, which is due to meet for the first time in May 27th 2021, to capture the work of all partners in one place and share best practice.

It was noted that the voice of General Practice must continue to be heard at Health and Wellbeing Board.

Partners agreed:

- To take the update from the Health and Wellbeing Board through the Board meetings of individual partner organisations and the Primary Care Network Director's Group.
- To ensure individual Boards are briefed about the role and remit of the Place Executive.

Care Community Steering Group Update

Nine Care Community Steering Groups are now established across Cheshire West, aligned with Ward Councillors and consisting of a wide range of individuals and organisations in each area.

Although one of the Care Community Steering Groups (Chester South) remains without a lead clinician, work to confirm a lead clinician is now at an advanced stage.

Emerging key themes are centred around supporting young people – for example young people's mental health and respiratory disease – with a golden thread of Population Health.

While the steering groups are all at different stages of development, there is a lot of enthusiasm and a desire to learn from the likes of Northwich and Winsford. Patience will be required to enable them to grow and mature organically.

Partners agreed:

- To update the Boards of individual partners and the Health and Wellbeing Board about the ongoing development of Care Community Steering Groups across Cheshire West.
- To receive a progress report at CWICP Board in six months' time.

Managing Director's Report

Partners have agreed six statements which set out our work for the year focused on developing as an alliance of providers, resetting our mission around reducing health inequalities, developing care communities, a focused set of transformation and service improvement priorities, clarifying investment in the ICP and reshaping as required in response to the changing NHS architecture.

To support this, a review of the Integration Agreement is underway.

The ICS has established a number of collaborative networks. Alongside Del Curtis, Alison Lee attended the second meeting of the Integrated Care Partnership network – at which Jackie Bene presented the ICS roadmap and a slide deck highlighting ICP "core features" was also presented.

Partners agreed:

- To consider a paper on the progress of ICP development framed around the core features set out by the ICS at the Board meeting in July 2021.
- A revised ICP integration agreement and Board terms of reference will be brought back to partners in July 2021.
- To separately invite CoCH representatives to sign off both recommendations in the paper.

Director Updates

Dr Chris Ritchieson reported on positive meetings with counterparts from Cheshire CCG and Cheshire East ICP to consider the future of clinical leadership, especially in terms of how clinical lead roles might integrate in the next 12 months. Discussions about potential options for closer working between PCNs and the development of a network of networks in Cheshire East are now being shared with Cheshire West.

The strength of feeling in General Practice following a national letter from Nikki Kanani about restoration of services was also discussed. The importance of supporting General Practice via a system-wide response was noted.

Partners agreed:

- To invite Cheshire CCG Medical Directors to monthly clinical leadership meetings.
- To consider a system-wide communications approach to support GPs in response to high post-pandemic demand.

Ali Wheeler reported that Transformation work is undergoing a reset and that CWICP is out to advert for both Programme and Project Managers. A Senior Responsible Officer for the Communications and Engagement programme remains a gap.

CWICP is currently in discussions with Cheshire CCG around the second tranche of Place monies.

Partners agreed:

- Directors Group to develop final versions of programme mandates to be ratified in July 2021.

Alison Swanton reported on the achievements of the High Intensity Users (HIU) project in the last six months. The introduction of a Band 6 employee to support 50 of the most frequent users of health and care services to access the right support first time, has led to reductions in attendances of between 23% and 91%.

Cheshire and Wirral Partnership have now agreed to permanently fund the post, however, across Cheshire West it is estimated that around 250 further HIUs could benefit from this approach – which would require a team of up to five people to achieve similar interventions.

It was noted that achieving value should not only be judged around direct cost-savings – better use of resources generates value too.

Partners agreed:

- To consider a full business case re expanding the HIU project at a future Board meeting.
- To start measuring progress via the proposed Community Services Outcomes Framework.

Next Meeting

The next meeting is a development session on population health. Each Partner is asked to present a summary of their strategy focused on population health with a view to agreeing an approach for the ICP.

Meeting	**13 July 2021**		**Board of Directors**					
Report	**Agenda item. 7.**		**Board Assurance Framework - Quarter 1, 2021/22**					
Purpose of the Report	Decision		Ratification		Assurance	X	Information	
Accountable Executive	Susan Gilby				Chief Executive Officer			
Author(s)	Keith Haynes				Interim Governance Consultant			
Board Assurance Framework		All areas of the Board Assurance Framework						
Strategic Aims	Includes all strategic areas							
CQC Domains	Well Led							
Previous Considerations	Quality & Safety Committee – 22 June 2021							
Summary and Key Points	The 2021/22 Quarter 1 Board Assurance Framework (BAF) further builds on the BAF content during 2020/21. Due to operational pressures, the quality and safety risks Q1-Q4 were not updated during Quarter 4 of 2020/21, however they have been subject to executive review in Quarter 1 2021/22. The following new risk has been added to the Quarter 1 BAF by the Senior Risk Owner (Director of Finance): E9 – Requirement for new Women's & Children's build; with an initial total risk score of 4x5=20 and a residual total risk score of 3x5=15. The following are the **Trust's top five risks**, following the implementation of mitigating actions, within the BAF/Strategic Risk Register, all with a residual total risk score of either 15 or 16: • E4 - Access, Waiting Times, Care Pathways and Constitutional Standards (4x4=16) • E5 – Business Continuity – Pandemic Flu/Virus (4x4=16) • E7 – Cyber security/Digital Strategy (5x3=15) • E9 – Requirement for new Women's & Children's build (3x5=15) • G2 – Failure to ensure appropriate Information Governance (3x5=15). It is intended that the BAF will remain subject to ongoing review and development during 2021/22 and that it will continue to be reviewed by each of the relevant Board Committees.								

Recommendation(s)	The Board is asked to; • Review the BAF/Strategic Risk Register and consider if the top risks reflect the current knowledge and understanding of strategic risks within the organisation. • Note the addition of the new risk, E9 – Requirement for new Women's & Children's build, with a residual risk score of 3x5=15; which will be subject to further review by Finance & Performance Committee
Corporate Impact Assessment	
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status
Quality & Safety	Improved patient safety
NHS Constitution	Improves overall assurance on key strategic objectives
Patient Involvement	
Risk	Alignment with corporate risk register
Financial impact	
Equality & Diversity	
Communication	

Countess of Chester Hospital NHS Foundation Trust

Board Assurance Framework (BAF) Quarter 1, 2021/22

BACKGROUND

1. A Board Assurance Framework (BAF) outlines the key risks to achievement of an organisation's strategic objectives.

2. Since the Quarter 4, 2020/21 BAF was considered at the Board of Directors meeting in March 2021, a number of updates have been made.

3. The Quarter 1 BAF has benefitted from further Executive Director input and updating of risks, with the addition of one new risk: E9 - Requirement for new Women's & Children's build, which will be subject to further review by Finance & Performance Committee.

PURPOSE

4. The purpose of this paper is to share the Quarter 1, 2021/22 BAF, making the Board aware of the top risks to achievement of the organisation's strategic objectives.

UPDATES TO THE Q1 BAF

5. The more specific recent updates to the BAF include:

- The inclusion of a new additional risk – E9: Requirement for new Women's & Children's build.
- The addition of action plans in relation to gaps in control for risks Q5 and Q6.
- Completely revised action plans for risks Q1-Q4.
- General updating to the BAF narrative, including gaps in controls and assurance, action plans and the inclusion of timeframes, along with the review of risk scores.
- Actions continue to be aligned (via relevant numbering) with gaps in controls/assurance, where available.

CHANGES TO BAF RISK SCORES (SINCE QUARTER 4 2020/21)

6. The following changes have been made to the BAF risk scores in Quarter 1 2021/22, since Quarter 4 2020/21:

BAF risk reference	Risk area	Initial total risk score Q1	Residual total risk score Q1	Target total risk score Q1	Movement since Q4
P3	Staff engagement	4x3= 12	3x3=9	3x3=9	↓ Decrease in initial total risk score from 16 to 12. ↓ Decrease in residual total risk score from 12 to 9.
P5	Workforce capacity	4x5=20	3x3 = 9	2x3=6	↓ Decrease in residual total risk score from 16 to 9.
Q2	Think Family - Safeguarding Adults & Children	-	4x2= 8	-	↓ Decrease in residual total risk score from 12 to 8.
Q3	Infection Prevention & Control	-	4x3= 12	-	↓ Decrease in residual total risk score from 16 to 12.
Q4	Nursing & Midwifery Workforce	-	4x3= 12	-	↓ Decrease in residual total risk score from 16 to 12.
Q5	Patient safety -failure to identify avoidable clinical harm and avoidable death	4x4=16	4x3=12	-	↑ Increase in total initial risk score from 12 to 16. ↑ Increase in total residual risk score from 8 to 12.
Q6	Failure to provide an adequately trained and skilled medical workforce to support the services we provide	4x3=12	4x2=8	-	↓Decrease in initial total risk score from 20 to 12. ↓ Decrease in residual total risk score from 12 to 8

E1	Underlying Long Term Trust Financial Sustainability	4X4= 16	4X3 = 12	3X2 = 6	↑ Increase in initial total risk score from 12 to 16. ↑ Increase in residual total risk score from 8 to 12.
E2	Uncertainty of financial funding	4X3 = 12	3X3 = 9	3X2 = 6	↑ Increase in residual total risk score from 6 to 9.
E5	Business continuity - pandemic	4x4=16	4x4=16	3x3=9	↓ Decrease in initial total risk score from 20 to 16.
E6	EU Exit transition	3X3 =9	3X2 = 6	2X3 = 6	↓ Decrease in initial total risk score from 12 to 9. ↓ Decrease in residual total risk score from 9 to 6.
E9	Requirement for new Women's & Children's build	4x5=20	3X5= 15	1x2= 2	**New risk**

TOP RISKS FOLLOWING MITIGATING ACTIONS

7. The following are the **Trust's top five risks**, following the implementation of mitigating actions, within the BAF/Strategic Risk Register, all with a residual total risk score of either 15 or 16:

- E4 - Access, Waiting Times, Care Pathways and Constitutional Standards (4x4=16)
- E5 – Business Continuity – Pandemic Flu/Virus (4x4=16)
- E7 – Cyber security/Digital Strategy (5x3=15)
- E9 – Requirement for new Women's & Children's build (3x5=15)
- G2 – Failure to ensure appropriate Information Governance (3x5=15)

8. The previous three top risks from Quarter 4, 2020/21BAF of: Q3 - Infection Prevention & Control, Q4 - Nursing & Midwifery Workforce and P5 – Workforce Capacity, now have reduced residual risk scores in Quarter 1 2021/22 which has taken them out of the Trust's Top 5 risks.

RECOMMENDATIONS:

The Board is asked to;

- Review the BAF/Strategic Risk Register and consider if the top risks reflect the current knowledge and understanding of strategic risks within the organisation.
- Note the addition of the new risk, E9 – Requirement for new Women's & Children's build, with a residual risk score of 3x5=15; which will be subject to further review by Finance & Performance Committee.

Board Assurance Framework & Strategic Risk Register 2021/22 - Quarter 1 Summary

NHS Countess of Chester Hospital NHS Foundation Trust

BAF Risk ID	Work Programme linked to Strategy	Initial total risk score (C x L)	Residual total risk score Q1 (C x L)	Action plan	Target total risk score (C x L) Q1	Change in risk score since previous quarter	
Strategic Aim: People - attract and retain talented people with the right skills and attitude to create a positive environment with a shared sense of pride and ambition for everyone Lead Executive Director: Alyson Hall, Director of Human Resources & Organisation Development / Lead Assurance Committee: Finance & Performance Committee							
P1	Recruitment	**4x4=16**	**4x2=8**	1. Capacity issues within Resourcing team identified and plans put in place to address these going forward - by Q2 2021/22. 2. Develop a brand strategy/recruitment offer/why come and work here - by Q3 2021/22. 3. Review the collaborative international recruitment campaign strategy - by Q2 2021/22.	**3x2=6**		
P2	Retention	**4x3=12**	**3x3=9**	1. Retention performance within the Trust falls within or above acceptable rates for comparable sized Trusts but more activity is required through the development and implementation of a comprehensive Employee Engagement Strategy. Work has commenced to address this identified need. (On-going) 2. Health and Wellbeing Strategy to be drafted and implemented (Q2) 3. Make the data count- review data collection methods and develop a package of proposals to increase and improve our analysis, understanding and reporting of retention information (Ongoing)	**2x3=6**		
P3	Staff Engagement	**4x3= 12**	**3x3=9**	1 & 2. Trust outcomes for the National Employee Survey have improved since 2020 but still requires further improvement. This is being addressed through the development and implementation of an Employee Engagement Strategy. This work has now commenced (On-going) 3. Introduction of quarterly staff survey 'people pulse' quarters 1,2 and 4, in addition to the national Staff Survey in quarter 3 - from July 2021.	**3x3=9**	Decrease in initial total risk score from 16 to 12. Decrease in residual total risk score from 12 to 9..	↓
P4	Education and Training	**4x3=12**	**4x3=12**	1. Whilst there is good provision of technical training and development programmes within the Trust to provide assurance in relation to clinical capability and competency, there is no similar provision to address supervisory, management and leadership capability. Management development programme to be developed and implemented (2020/21) 2. This requires extensive review of capacity to address long term under investment in the development of internal talent at all levels across the Trust. HR and OD Operating Model drafted for consideration by the Trust (considered at Board workshop May 2021 and paper to be developed for formal Board - July 2021) 3. Budget responsibility to move under the Head of Education, Development and Training. (Q1 21/22) 4. KPIS to be developed (Q4 2021/22)	**3x3=9**		
P5	Workforce capacity	**4x5=20**	**3x3 = 9**	1. Psychological first aiders to be put in place, as part of review of staff psychological provision and in conjunction with CWP to provide psychological interventions for health care workers at risk. £40k funding secured for psychological support appointment within OH. 2. Continue vaccination programme. 3. Focus on retention to support staff wellbeing. (Commenced and Ongoing)	**2x3=6**	Decrease in residual total risk score from 16 to 9.	↓

BAF Risk ID	Work Programme linked to Strategy	Initial total risk score (C x L)	Residual total risk score Q1 (C x L)	Action plan	Target total risk score (C x L) Q1	Change in risk score since previous quarter	
Strategic Aim: Quality & Safety - To deliver safe care and treatment Lead Executive Director: Darren Kilroy, Executive Medical Director & Alison Kelly, Director of Nursing & Quality/Deputy Chief Executive / Lead Assurance Committee: Quality & Safety Committee							
Q1	Quality & Safety	**5X4 = 20**	**4X3 = 12**	1.The Trust has commissioned a Quality Governance external review, scheduled in July 2021. The review Terms of Reference includes; Structure, systems and processes, culture and engagement, capability and capacity across the KLOE required for a fully integrated model. In addition, an internal and external Quality Governance review in Women's and Children's in response to concerns raised has been completed in Q1 and report pending. Early learning has been adopted and implemented across the Trust. Furthermore, a full time dedicated risk lead for W&C has been successfully recruited following a long term gap. 3. A review of the Serious Incident process has been undertaken and some changes in practice. 4. Oversight and assurance monitoring reduced during pandemic and agreed bi-annual reporting to CCG; internal monthly monitoring continues. 5. Regulatory standards included in Ward Accreditation system and quarterly peer assessment across all clinical areas. 6. The Trust has recruited to the national Patient Safety role; the post holder commences in Q2 and will prioritise the implementation of the strategy and review the new NHS Serious Incident Framework. 7. Some progress against strengthening the corporate quality governance team whilst awaiting the external review. 8. Mortality review undertaken in relation to the increasing HSMR trend, assurance report provided by MD and support from regional team provided. 9. The Trust has participated in a Quality Risk Profile review by the NW Regional team at NHSE, following concerns raised in relation to quality and risk data performance and safety. Outcome pending. The process involved submitting various assurance documents inclusive of Restoration and Recovery for long waiters, covering 52 week wait position (inpatient, day case and outpatient), diagnostics, and endoscopy. This paper also provides assurance in relation to clinical prioritisation and clinical harm review.	**3X3 = 9**		
Q2	Safety - 'Think Family' - Safeguarding Adults & Children	**4X4 = 16**	**4X2 = 8**	1. 'Think Family' Strategy now ratified. 2. Business case for 'Think Family' model presented at Senior Leadership Group and agreement made for current cost pressures and statutory roles to be funded recurrently. As a result, the Senior Leadership within the service has been strengthened. The residual structural elements require further review. This has enabled a successful appointment to the Children's Named Nurse role, with the remaining vacancy of Named Professional for Midwifery being actively recruited to. 2. Training compliance monitored regularly and is improving post - COVID. 3. Systems and processes strengthened with revised policy and easy to read tools to support clinical practice. These will be launched during Q2 2021/22. 4. Continued engagement with LA in relation to LPS, awaiting the new Code of Practice to design systems and processes internally. 5. The Trust received an unannounced visit from the LA and CCG in relation to the cluster of serious incidents on 14th June 2021. Received initial feedback, no areas of concern and positive outcome (awaiting formal feedback).	**3X3 = 9**	Decrease in residual total risk score from 12 to 8.	↓

BAF Risk ID	Work Programme linked to Strategy	Initial total risk score (C x L)	Residual total risk score Q1 (C x L)	Action plan	Target total risk score (C x L) Q1	Change in risk score since previous quarter	
Q3	Safety - Infection Prevention & Control	5X4 = 20	4X3 = 12	1. Natural ventilation plans in place for all clinical areas. Group established to look at options for technical ventilation solutions. Remedial work undertaken in high risk areas to improve the ventilation. Estates improvement works have been completed as part of the respiratory and cardiology reconfigurations. In addition, opened a newly commissioned ward as part of the elective recovery programme. 2. Additional cleaning support now recruited to and being implemented in line with new cleaning published cleaning requirements. 3. Additional isolation facilities provided in the respiratory reconfiguration and temporary isolation PODs purchased and available to use. 4. IPC Strategy finalised, currently in governance ratification process. 5. Following publication of National guidance, local RCA process aligned to requirements and outbreak exercises have been commenced. 6. Estate assessment of space between beds undertaken, achieving two meters, however when patients mobilising the distance is reduced. In order to mitigation this risk the Trust has invested in additional screens between bed spaces in high risk areas. 8. Temporary workforce remains in place; requirement reducing. 11. Currently zero nosocomial transmission of COVID. 12. Divisional IPC data packs provided, which are received at all Divisional Governance Groups. Risk has achieved its target score, however risk to remain open as North West community prevalence trend is increasing.	4X3 = 12	Decrease in residual total risk score from 16 to 12.	↓
Q4	Safety - Nursing & Midwifery Workforce	5X4= 20	4X3= 12	1. Centralised Nursing Workforce Team established as part of COVID response, team currently utilises redeployed staff. The model has provided effective robust management flexible/temporary workforce and has provided full visibility and strengthened oversight. Business case required to recurrently fund a sustained model. 5. The Trust has successfully recruited to six registered nurse apprenticeship training posts. The risk has now achieved its target score, however risk to remain open as business case yet to be agreed.	4X3 = 12	Decrease in residual total risk score from 16 to 12.	↓
Q5	Patient safety -failure to identify avoidable clinical harm and avoidable death	4X4= 16	4X3 = 12	1. Identify top 6 clinical pathways of concern within the HSMR data and each undergoing individual case note review to interrogate clinical care within those pathways; tracked via LFD Group and Executive Group - conclusion by August 2021. 2. Identify spike of potential avoidable mortality within long stay patients - work underway to drive down long length of stay via system piece of work supported by Dr Ian Sturgess to address that cohort of patients.	3X2 = 6	Increase in total initial risk score from 12 to 16. Increase in total residual risk score from 8 to 12.	↑
Q6	Failure to provide an adequately trained and skilled medical workforce to support the services we provide	4X3 = 12	4X2 = 8	1. Engagement meetings with the speciality training schools to track incoming medical staff numbers and to mitigate planned gaps in training - ongoing. 2. Revised and refreshed format and content of external adverts for medical staff to maximise uptake - complete and to re-visit as required. 3. Revised traditional face to face education programme and reprovided around 80% of content as virtual learning and supported attendance for established staff on virtual external CPD courses through the pandemic. The appraisal system accommodating guidance from the GMC and the regional revalidation office to reposition appraisals as a welfare conversation for staff - subject to GMC guidance. 4. Undertaken establishment reviews in hard to fill specialities to accommodate new roles and new models of care provision - undertaken on ad hoc basis.	3X2 = 6	Decrease in initial total risk score from 20 to 12. Decrease in residual total risk score from 12 to 8.	↓

BAF Risk ID	Work Programme linked to Strategy	Initial total risk score (C x L)	Residual total risk score Q1 (C x L)	Action plan	Target total risk score (C x L) Q1	Change in risk score since previous quarter	
Strategic Aim: Effectiveness - Providing efficient and financially sustainable services. Lead Executive Director: Simon Holden, Director of Finance/ David Coyle, Chief Operating Officer & Cara Williams, Chief Digital Information Officer / Lead Assurance Committee: Finance & Performance Committee							
E1	Underlying Long Term Trust Financial Sustainability	**4X4= 16**	**4X3 = 12**	1. Develop a robust financial savings plan (waste reduction plan) which underpins the organisation's recurrent sustainability - by 30 June 2021 1-3 & 7. Develop a financial plan that reflects activity and restoration plans - by June 2021. H1 submitted, re-submission scheduled. Longer term plans will continue to be developed . 1 & 7. Continued engagement with Healthcare partnership and Cheshire system to identify opportunities for waste reduction, along with internal engagement - June 2021 4. Continue to work with NHSE/I and Wales health boards to agree financial risk arrangements - by September 2021 5. Work with medical workforce team to further understand job plans in relation to recurrent budget setting - by 30 Sept 2021. 6. Review recruitment processes with HR and operational managers - by Sept 2021 1-3 & 7. Link with transformation team and EPR team regarding business planning cycle to ensure financial plans reflect transformation plans and are affordable - by June 2021 8. Develop long term financial plan and commence reporting of underlying financial position to the Board - by Dec 2021 9. Regularise workforce establishment reporting - by June 2021 10. Regularise Finance & Performance Working Group - by July 2021	**3X2 = 6**	Increase in initial total risk score from 12 to 16. Increase in residual total risk score from 8 to 12.	↑
E2	Uncertainty of financial funding and consequences of breaching control total under current Covid-19 financial regime	**4X3 = 12**	**3X3 = 9**	1, 3 & 4. Develop a financial plan that reflects activity and restoration plans - by June 2021. 1. Await national guidance to be published for H2 and then complete associated financial plans - by Sept 2021 1. Continue to work with NHSE/I to agree financial risk arrangements in integrated care system- by Sept 2021 4. Develop Board report to show health of the underlying deficit position - by Sept 2021 5. Explore alternative benchmarking opportunities - by Sept 2021	**3X2 = 6**	Increase in residual total risk score from 6 to 9.	↑
E3	Financial Ledger System stability	**4X3 = 12**	**3X3 = 9**	1. Pursue appetite with partners within HCP/ICS for collaborative procurement of new financial system - complete 1. Undertake options appraisal to remain with existing system or procure new system - by September 2021 - completed 2. Identification of resource requirements as part of the budget setting process - by September 2021 - complete 1. Undertake migration to the hosted solution - by Sept 2021	**2X3 = 6**		

BAF Risk ID	Work Programme linked to Strategy	Initial total risk score (C x L)	Residual total risk score Q1 (C x L)	Action plan	Target total risk score (C x L) Q1	Change in risk score since previous quarter	
E4	Access, Waiting Times, Care Pathways and Constitutional Standards	**4X5=20**	**4X4 = 16**	1 & 2. Implementation of key actions identified in action plan Increased clinical engagement & oversight - clear objectives for cancer manager. Relaunch cancer committee - relaunched. Cancer improvement consultant temporarily engaged. By Feb 2022. 1& 2. Development of actions to address 18 weeks and longest waiters, Validation of wait lists is ongoing. We are aiming to increase theatre productivity (by Oct 2021) . Validation and education programme has commenced as part of the RTT - Ongoing. 1-11. Covid-19 restoration programme based on national restoration programme requirements continues; trajectory-re-submission ongoing. Close working with Right Care and NHSI continues to identify available support and mutual aid within the North West system. In terms of controlling the effects of Covid-19 we have a dedicated swabbing unit. By March 2023. 4 & 5. Divisional support to develop workforce plans & alternative roles to be presented via medical staffing meeting & Nursing & midwifery workforce group - ongoing work which has been pause due to Covid-19 disruption has been reinstated. Successful bids made to HEE to appoint ACP and ANP training schedules. Ongoing medical and nursing workforce focus to ensure adequate cover at all levels to achieve constitutional standards. 6. EPR upgrade currently preparing for cross over in July 2021. 7. ED - Whole system approach to hospital avoidance and supported primary care function. Submission of capital plans for new Urgent Emergency Care service implementation. Specialised respiratory unit commissioned and aim to go live Nov 2021. T-Block conversion (complete), ED reconfiguration (complete) and Modular Ward continue with the majority of changes completed. Same Day Emergency Care Unit construction ongoing - predicted to be finalised Oct 2022. 8. Intensive focus on Endoscopy to increase activity is ongoing - we are almost achieving pre-Covid levels of activity but our aim is to increase this substantially to improve the backlog . New CT scanner for Ellesmere Port Hospital April 2021. Liaison with local CCG to ensure a robust triage filtration system for primary care referrals, particularly in certain specialities. 9. Increasing primary care/demand for diagnostics and hospital requires senior oversight, education & training - ongoing. 10. Temporary theatre rate agreed June 2021 - review on monthly review basis. 11. Clinical vision of flow being constructed by senior consultants with support from Dr Ian Sturgess. Perfect Week commencing 19th July 2021. Clinical vision of flow to be embedded by end August 2021. 12. Cerner report suite agreement required and swap from Qlikview to Power BI reporting platform - by August 2021.	**3X3=9**		
E5	Business Continuity - Pandemic Flu / Virus	**4x4=16**	**4x4=16**	1. Identification of paediatric assessment area and identification of paediatric high dependency area as part of our response plan - June 2021. 2. National instruction via local and Trust system commands - ongoing. 3. Some Local initiatives to reduce risk of Covid transmission remain including appointments only visiting access, one way system at entrance, increased security presence and target communications to staff: Hands, Face, Space - ongoing. 4. Further identification of staff break and wellness areas - by Sept 2021. 5. Maintain critical care surge readiness plan - ongoing.	**3x3=9**	Decrease in initial total risk score from 20 to 16.	↓
E6	EU Exit transition	**3X3 =9**	**3X2 = 6**	1. Reporting and escalation of supplier status through SRO & Silver control. 1. Operation of usual Medicines shortages procedures which include up to six weeks stock piling of key supplies and medications.	**2X3 = 6**	Decrease in initial total risk score from 12 to 9. Decrease in residual total risk score from 9 to 6.	↓
E7	Cyber security (Digital Strategy)	**5X4 = 20**	**5X3 = 15**	1-4. Developing the business plan for 2021-22 for IM&T including priority on cyber activity, although awaiting clarification of capital funding - by July 2021 2. Progressing the target operating model for IM&T including cyber security team - one position approved for 21/22 in place Sept 2021. 5. Complete annual DSPT review - June 2021 5 & 6. Progress action plans from previous cyber security audits - March 2022	**4X3 = 12**		

BAF Risk ID	Work Programme linked to Strategy	Initial total risk score (C x L)	Residual total risk score Q1 (C x L)	Action plan	Target total risk score (C x L) Q1	Change in risk score since previous quarter	
E8	EPR+ Programme	**4X4 = 16**	**4X3 = 12**	1. Further develop benefits identification and tracking, including benefits owners - by Sept 2021 2. Target operating model proposal discussed at Board in May 2021 - first phase approved and now needs implementing - by Sept 2021 3. Continued focus on benefits tracking, to be reported through Transformation Group - starting Sept 2021	**4X2 = 8**		
E9 (new)	Requirement for new Women's & Children's build	**4x5=20**	**3X5= 15**	1. Completion of outline business case - by Sept 2021 1. Installation of fail safes - by Nov 2021, as reported centrally, with procurement underway. 1. completion of full business case - by Dec 2022 1. Construction phase - 2024-2027 2. Link to existing EPRR plans 3 & 4. Progress on actions and sight of surveyors report to Finance & Performance Committee and Board	**1x2= 2**	**New**	
To collaboratively innovate and transform the Trusts Clinical Services Lead Executive Director: Darren Kilroy, Medical Director & Alison Kelly, Director of Nursing & Quality/Deputy Chief Executive / Lead Assurance Committee: Finance & Performance Committee							
C1	Failure to progress implementation plan of the clinical services strategy	**3X3 = 9**	**3x2 = 6**	1. Continue to work with and engage with the regional regulatory team and the regional Medical Director and COO network to ensure that the potential challenge of command and control is as mitigated as possible by necessary clinical reconfiguration - ongoing in 2021/22. 2. Ongoing dialogue with neighbouring providers, executed via the Transformation Team, to ensure we are aware of and are responsive to their own clinical strategies and that we work in collaboration to maximise success.	**2X2 = 4**		
Strategic Aim: Good Governance - To develop and improve corporate governance Lead Executive Director: Chief Executive Officer and Director of Corporate Affairs. Lead Assurance Committee: Finance & Performance Committee							
G1	Failure to progress implementation of the governance improvement plan	**3X4 = 12**	**3X3= 9**	1. Governance training to progress at a suitable time in 2021, post-pandemic 2. FPPT to be reviewed by end Sept 2021 3. BAF updated for Q1 and then further monitoring and review ongoing 5. Review of Board/Committee effectiveness to be scheduled by August 2021 (Audit Committee effectiveness review completed April 2021) 6. Charitable Funds investment strategy to be further developed by end Q2 (Sept)	**2X2 = 4**		
G2	Failure to ensure appropriate Information Governance	**4X5 = 20**	**3X5 = 15**	3 & 5. The Data Security and Protection toolkit review is undertaken/reviewed annually - June 2021 1, 3 & 6. Increased ask for resources within IM&T to support faster implementation of technical controls as part of DSPT - first phase approval for cyber security role for 21/22 - from Sept 2021. 4. Second iteration of IG annual report planned for submission to F&P Committee July 2021	**3X4= 12**		

BAF Risk ID	Work Programme linked to Strategy	Initial total risk score (C x L)	Residual total risk score Q1 (C x L)	Action plan	Target total risk score (C x L) Q1	Change in risk score since previous quarter

Risk Score Matrix

Risk Scoring Matrix	Likelihood Rating				
Consequence Rating	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	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 Negligible	1	2	3	4	5

	Risk description:
1 to 5	Very low
6 to 8	Low
9 to 14	Moderate
15 to 25	High

Board Assurance Framework & Strategic Risk Register 2021/22 - People

BAF Risk ID	Work Programme linked to Strategy (what the organisation aims to deliver, and Executive Lead)	Risk Description **Cause** - what has led up to the risk being possible **Impact** - immediate effect on services, service users, staff, projects **Consequence** - longer term concerns	Initial total risk score (C x L)	Controls (Actions taken to manage the risk).	Assurance (Where can the organisation gain evidence that its controls/ systems on which it places reliance are effective, e.g. internal audit, reviews, data).	Residual total risk score (C x L)	Gaps In Controls (Identified weaknesses in current management arrangements) **AND** **Gaps In Assurance** (identified weaknesses in how we gain evidence to assure ourselves - or lack of scrutiny)	Target total risk score (C x L)	Action plan
Strategic Aim: People - attract and retain talented people with the right skills and attitude to create a positive environment with a shared sense of pride and ambition for everyone **Lead Executive Director: Alyson Hall, Director of Human Resources & Organisation Development / Lead Assurance Committee: Finance & Performance**									
P1	Recruitment	**Cause:** If the Trust is unable to recruit sufficient numbers of clinical staff due to reduced availability and increased competition then this will impact the quality of patient care and safety. - Recruitment of Consultants and Registered Nurses is a national issue. **Impact:** - reduction in job satisfaction and staff morale - loss of workforce productivity arising from a reduction in discretionary effort amongst a substantial proportion of the workforce - workforce fatigue and increased absenteeism - loss of experienced staff **Consequence** Possibility of extended unplanned suspension of services Poor clinical outcomes and experience for large numbers of patients resulting in an increased risk of harm Potential for the Trust to fail to achieve its constitutional standards Potential for workloads to become unmanageable leading to increased costs to cover sickness absence, higher agency pay/overtime	**4x4=16** **(Jan 2021)**	**Strategic Level** Participation in National and STP Workforce Planning Joint collaborative working with other Trusts in Cheshire and Mersey including International Nurse Recruitment. Review of Nursing establishment carried out and implemented with Health Rostering system **Operational Level** Strategic Workforce and Nursing & Midwifery Workforce Groups established; Workforce Hub aligned with Staffing Solutions Recruitment strategy implemented to over recruit up to the Trusts 'attrition rate of 8% for RNs Senior management and Executive oversight of clinical rotas and gaps. Weekly meetings of Transformation and Resourcing Panel Staff escalation process in place to ensure minimum levels are met. Strong Out of Hours Clinical manager and Clinical Director process. Development of workforce plans at Directorate level Bank and Temporary workforce process in place Relaunching Retire and Return Policy Trust People Strategy in draft International recruitment commenced Framework Agreements with Recruitment Agencies secured	**Reported to Board (Date)** - Integrated Performance Report (monthly) **Reported Elsewhere (Date)** - Strategic Workforce Group (Monthly) - Finance and Performance Group - (Monthly) - Divisional Quality Performance Review meetings - Nursing, Midwifery & AHP workforce Group (monthly) - Finance & Performance Committee (bi-monthly)	**4x2=8** **(Mar 2021)**	**Gaps in control:** 1. Pressures on staffing have required the utilisation of agency staff off framework on occasion. 2. Delta variant impact on international nurse recruitment programme. **Gaps in assurance:** 3. Failure to be able to recruit in some key speciality areas	**3x2=6** **(Mar 2021)** **(target Q3 2021/22)**	1. Capacity issues within Resourcing team identified and plans put in place to address these going forward - by Q2 2021/22. 2. Develop a brand strategy/recruitment offer/why come and work here - by Q3 2021/22. 3. Review the collaborative international recruitment campaign strategy - by Q2 2021/22.
P2	Retention	**Cause:** The Trust is unable to retain sufficient numbers of clinical staff Retention of Consultants is a national issue. Retention of registered nurses is a national issue. Geographic location of Trust services. Limited agency cover available **Impact:** Trust-wide it will negatively affect the safety and quality of the services provided including the ability of the Trust to meet its targets around access, waiting times and care pathways. **Consequence** Possibility of extended unplanned suspension of services Poor clinical outcomes and experience for large numbers of patients resulting in an increased risk of harm Potential for the Trust to fail to achieve its constitutional standards Potential negative impact upon staff morale leading to further attrition and Potential for workloads to become unmanageable leading to increased costs to cover sickness absence, higher agency pay/overtime	**4x3=12** **(Jan 2021)**	**Strategic Level** Participation in National and HCP Workforce Planning. On-going discussions with Commissioners. Board, Executive and Board Committee review Safer Staffing Report. On-going work with Universities. **Operational Level** Senior management and Executive oversight of staff rotas. Bank and Temporary workforce process in place. Implementing appraisal and supervision training for all managers to ensure good quality employee experience across Trust. Transfer Window for Band 5 Clinicians agreed and implemented. Agreed and enhanced support for newly qualified staff (Band 5 Nurse Preceptors). Launching Admin Conference. Relaunching Flexible Retirement Policy. Development of a Trust Organisational Development Strategy and Employee Engagement Strategy Junior doctors forum, succession and talent planning, international recruitment commenced, Transformation and resource panel (weekly)	**Reported to Board (Date)** - Integrated Performance Report (Monthly) - Safer Staffing - Staff Survey (Mar 2021) - **Reported Elsewhere** - Finance and performance Committee (Workforce Assurance Report) - Divisional Quality Performance Reviews - Divisional Governance Meeting (Monthly HR Reports) - NHSI report - benchmarking information shows how Trust performs against national and regional trusts. Bank and temporary workforce audit. Annual GMC Survey	**3x3=9** **(Jan 2021)**	**Gaps in control:** 1. Retention Strategy to meet the 1% improvement target. 2. Health & Wellbeing Programme initiated to enable better retention of staff. **Gaps in assurance:** 3. Data quality requires improvement and training for staff in use of ESR	**2x3=6**	1. Retention performance within the Trust falls within or above acceptable rates for comparable sized Trusts but more activity is required through the development and implementation of a comprehensive Employee Engagement Strategy. Work has commenced to address this identified need. (On-going) 2. Health and Wellbeing Strategy to be drafted and implemented (Q2) 3. Make the data count- review data collection methods and develop a package of proposals to increase and improve our analysis, understanding and reporting of retention information (Ongoing)
P3	Staff Engagement	**Cause:** The Trust loses the engagement of a substantial proportion of its workforce due to ineffective leadership or inadequate management practice Lack of availability/equity of access to appropriate training and development Inability to attract / retain good quality staff **Impact:** - Reduction in staff morale - Less effective team work - Reduced compliance with policies - Increased levels of absence - Increased levels of turnover - Inability to attract high quality staff Poor reputation **Consequence:** Poor clinical outcomes and experience for large numbers of patients resulting in an creased risk of harm Potential for the Trust to fail to achieve its constitutional standards Increased risk of reputational damage for the Trust	**4x 3 = 12** **(June 2021)** **(was: 4x4=16)** **(Jan 2021)**	**Strategic Level** Organisational and Local Staff Engagement: - **People Strategy** - **Five Year Strategy** - Continuous Improvement Strategy - Employee Engagement Strategy - Chief Executive Briefings - Executive Back to the Floor sessions - Staff Side Partnership Forum / Joint Local Negotiation and Consultation - Freedom to Speak Up - Occupational Health and Wellbeing Service - Talent Management and Succession Planning processes - HR Policies which reflect best practice and relevant employment legislation - Workforce reviews, workforce metrics - Feedback from Quality and Safety Committee on workforce related matters - Staff Recognition and Achievement of Excellence Awards Improved comms (daily coved briefing, whole hospital meeting) **Operational Level** - **Wellbeing Guardian appointed** - Managers' briefing and newsletters - Staff Appraisal - Exit Interviews (query quality and effectiveness, and location of data)	**Reported to Board (Date)** - Integrated Performance Report (Monthly) - Staff Survey (Mar 2021) - **Wellbeing Guardian appointed at Board level (May 2021)** Reported Elsewhere - Strategic Workforce Group (Qrtly) - Finance and Performance Committee - Divisional Governance Meetings - Monthly HR Reports - **People action plan 2021/22**	**3X3= 9** **(June 21)** **(was: 3x4=12)** **(Jan 2021)**	**Gaps in control:** 1. Lack of Trust wide Employee Engagement Strategy **Gaps in assurance:** 2. Further improvement required in staff response rates to national Staff Survey	**3x3=9**	1 & 2. Trust outcomes for the National Employee Survey have improved since 2020 but still requires further improvement. This is being addressed through the development and implementation of an Employee Engagement Strategy. This work has now commenced (On-going) 3. **Introduction of quarterly staff survey 'people pulse' quarters 1,2 and 4, in addition to the national Staff Survey in quarter 3 - from July 2021.**
P4	Education and Training	**Cause:** Unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate resource, inadequate IT infrastructure and capacity leading to: - a lack of availability of appropriate supervisory, management and leadership skills at all levels across the Trust - reduced ability to release staff to attend mandatory training **Impact:** Declining standards of performance due to lack of management skill and capability - inability to attract / retain good quality staff - Staff feel there is a lack of development opportunities that provide a career pathway - Inability to provide sufficient capacity for undergraduate healthcare students due to re-design of services during pandemic. Poor learning experience for students; Students unable to meet curricula requirements; Delays in attainment of registration for students. - Managers within the Trust do not fully understand their responsibilities to their staff i.e. appraisals, talent management, succession planning **Consequence:** Potential of reputational damage to the Trust Increased indiscipline and grievance leading to increased risk of legal challenge/fee and costs, Reduced safety, reduced capability, Non-compliance with CQC standards and Statutory requirements e.g. compliance with mandatory training Multiple complaints and patient care and experience adversely affected,	**4x3=12** **(Jan 2021)**	**Strategic level:** Review of Education and Training structure as part of the broader HR Review Engagement with NHS Leadership Academy SLG Talent and Succession Mapping exercise Continuous Improvement Strategy Review of Trust workforce policies development of business case for the procurement of a learning Management system that is fit for purpose. **Operational Level:** Interview outcomes and performance of internal candidates suitability for promotion Staff appraisals Capability and Performance Management process monitoring Monitoring of grievances Freedom to Speak Up Exit Interviews Delivery of Matrons Development Programme linked to the Matrons Handbook Development of Leadership Development Programme, due for implementation. Provision of training through alternative methods e.g. eLearning, zoom. Development of a training directory. Closely working with universities across the region to look at pinch points; Working with regional group on placement expansion programme; capacity planning with Associate Directors of Nursing; Commencing a pilot of virtual reality simulation to improve learning and skills acquisition; Member of regional project - Place Based Tariff; Member of regional group for Enhancing Learning Environment project.	**Reported to Board; N,MW & AHP (monthly)** - Integrated Performance Report (Monthly) - Staff Survey (Mar 2021) **Reported Elsewhere** - Strategic Workforce Group (Workforce Assurance Report) - Finance and Performance Committee - Divisional Governance Boards - Monthly HR Reports - **GMC National Trainee and Trainer Survey Results (F&P May 2021)**	**4x3=12** **(Jan 2021)**	**Gaps in control:** 1. Lack of formal annual Training Needs Analysis (TNA) undertaken in the Trust 2. Lack of transparent tracking of income & expenditure against Learning and Development activities 3. Lack of governance framework within learning and development/education **Gaps in assurance:** 4. No formal Learning and Development KPIs	**3x3=9**	1. Whilst there is good provision of technical training and development programmes within the Trust to provide assurance in relation to clinical capability and competency, there is no similar provision to address supervisory, management and leadership capability. Management development programme to be developed and implemented (2020/21) 2. This requires extensive review of capacity to address long term under investment in the development of internal talent at all levels across the Trust. HR and OD Operating Model drafted for consideration by the Trust (considered at Board workshop May 2021 and paper to be developed for formal Board - July 2021) 3. Budget responsibility to move under the Head of Education, Development and Training. (Q1 21/22) 4. KPIS to be developed (Q4 2021/22)

BAF Risk ID	Work Programme linked to Strategy (what the organisation aims to deliver, and Executive Lead)	Risk Description **Cause** - what has led up to the risk being possible **Impact** - immediate effect on services, service users, staff, projects **Consequence** - longer term concerns	Initial total risk score (C x L)	Controls (Actions taken to manage the risk).	Assurance (Where can the organisation gain evidence that its controls/ systems on which it places reliance are effective, e.g. internal audit, reviews, data).	Residual total risk score (C x L)	Gaps In Controls (Identified weaknesses in current management arrangements) **AND** **Gaps In Assurance** (identified weaknesses in how we gain evidence to assure ourselves - or lack of scrutiny)	Target total risk score (C x L)	Action plan
P5	Workforce Capacity	**Cause:** Balancing the operational need for the delivery of safe patient care with the resilience and wellbeing of our workforce due to COVID-19. Covid-19 impact on staff capacity and availability and other non- illness related issues such as child care or other domestic issues. National constraints for managing ER issues **Impact:** short notice absences and sickness absence/non-attendance, self-isolation and shielding **Consequence:** staff burnout, long coved, PTSD, shortfalls in staffing below that considered to be safe or ensure the effective delivery of services both frontline and in support areas.	**4x5=20** **(Jan 2021)**	Routine testing. Staff track and trace. National guidance is implemented. Fast track recruitment & checks, increased bank and agency use, Lateral Flow implementation, vaccination programme (Both Flu and Covid-19), risk assessment inc BAME focus, central nursing workforce team siting staff, silver control and medical staffing Developing health and wellbeing framework. Occupational health resources supporting psychological support, part of Cheshire collaborative Recruitment and effective vacancy management (international nurses) Utilisation of students, tactical meeting, roster compliance, working time directive compliance	Daily sitreps on Covid absence STP and regional sitreps for staffing monitor via Strategic Workforce Group Monitored via Nursing & Midwifery workforce group which reports into F&P Committee **Vaccination uptake high within staff groups**	**3x3=9** **(June 2021)** **(was: 4X4 = 16)** **(Jan 2021)**	**Gaps in control:** 1.No mechanism for reporting for non-sickness absence, e.g. urgent annual leave or urgent domestic leave. 2. Always a lag in ESR in relation to sickness absence other than nursing reporting from e-roster. **Gaps in assurance:** **3. Vaccination uptake data reflects Cheshire based staff but not Welsh staff**	**2x3=6**	1. Psychological first aiders to be put in place, as part of review of staff psychological provision and in conjunction with CWP to provide psychological interventions for health care workers at risk. £40k funding secured for psychological support appointment within OH. 2. Continue vaccination programme. 3. Focus on retention to support staff wellbeing. (Commenced and Ongoing)

Board Assurance Framework & Strategic Risk Register 2021/22 - Quality & Safety

BAF Risk ID	Work Programme linked to Strategy (what the organisation aims to deliver, and Executive Lead)	Risk Description **Cause** - what has led up to the risk being possible **Impact** - immediate effect on services, service users, staff, projects **Consequence** - longer term concerns	Initial total risk score (C x L)	Controls (Actions taken to manage the risk)	Assurance (The mechanisms we know the controls are working - reports, scrutiny meetings, committees, internal & external audits and reviews)	Residual total risk score (C x L)	Gaps In Controls (Identified weaknesses in current management arrangements) **AND** **Gaps In Assurance** (identified weaknesses in how we assure ourselves - or not enough information or lack of scrutiny)	Target total risk score (C x L)	Action plan
Strategic Aim: Quality & Safety- To deliver safe care and treatment **Lead Executive Director: Darren Kilroy, Medical Director & Alison Kelly, Director of Nursing & Quality/Deputy Chief Executive / Lead Assurance Committee: Quality & Safety**									
	Safety (Director of Nursing & Quality & Executive Medical Director)								
Q1	Quality & Safety (Director of Nursing & Quality & Executive Medical Director)	**Cause:** - Failure to ensure the Trust has sufficient systems and processes and clinical policies in place - Failure of staff to comply with agreed systems and processes and clinical policies. - Failure to escalate non-compliance with systems and processes **Impact:** - Unsafe care leading to avoidable harm - Detrimental effect on safety culture **Consequence:** - Regulatory sanctions - Increased complaints and Reputational damage and increased external scrutiny - Poor staff survey and inpatient survey results	**5X4 = 20** **(Jan 2021)**	**Strategic Level** - Monthly CQC/Exec engagement meetings - Partnership working with safety – related external agencies - STEIS reporting of significant incidents; MIAA audits of key quality & safety measures. - Board and Sub-Board committee oversight -Assigned Director Portfolios, structures and teams -Implementation of External Governance Review (progress reduced due to Covid); **Operational Level** - Weekly executive led Serious Incident Panel - Safety Summits and targeted staff comms - Quality Governance Group and Learning from Deaths Group - Monthly Divisional Governance Group meetings. Divisional Performance Management meetings paused but to be recommenced in Q4 (20/21). -Ward to Board reporting, structures and teams; -7 day working for Matrons; -Patient Experience operational Group; -Safeguarding Children & Adults Team and processes; -Infection Prevention & Control Strategy Group meetings & sub groups; -Risk Management Strategy; -Incident reporting, SI/Never Event Reporting, Claims & Inquest reporting; -Annual Quality Priorities; CQUIN & Quality Contract monitoring, Deteriorating Patient Group; Medicines Safety Group; National Surveys; NICE, Clinical Audit & HSIB monitoring; Engagement with GIRFT Programme; Patient Experience Strategy (under review); Maternity CNST; MatNeo Safety Collaborative; Ward Accreditation Programme; Clinical Audit Strategy; Staff Mandatory Training; Internal Serious Escalation Plan in place; Reconfiguration of ED pathways, systems and processes completed in 2020. Regular MADE events in place to support patient discharge; regular review of 7, 14 and 21 LOS patients. **COVID:** *Daily Tactical/Command & Control Reporting and structures in place; Silver Control established*	**Reported to Board (Date)** - Trust monthly integrated performance report - Annual Infection Prevention & Control Report -National Survey reports; CQC Inspection/Review reports -Quarterly & Annual Mortality Report -Annual Quality Account; Patient Experience & Complaints Annual Report; Health & Safety Annual Report; Safeguarding Adults/Children's Annual Report (Think Family); CQC compliance updates **Reported Elsewhere (Date): Quality & Safety Committee & Quality Governance Group & Senior Leaders Group meetings** - Triangulation report (complaints, incidents, claims) - Annual Medicines Management report - Infection Prevention & Control Strategy Meeting - Divisional Governance Group Assurance Chairs reports 'Think Family' Strategy Group (safeguarding): Monthly Serious Incident Report; Safer Nurse Staffing Report; Mortality/Learning From Deaths Reports; Patient Safety reports as indicated; Maternity/Neonatal Reports; Clinical Audit Reports; CQC compliance update reports. QIA's signed off by Medical Director & Director of Nursing & Quality; Matrons Audits; Covid Operational Dashboard; Daily Covid Workforce dashboard; Daily Covid data shared; Daily Covid specific comms & weekly Trust comms; CEO weekly message; Weekly Trust Teams Meeting; Twice weekly Nursing & midwifery Teams briefing with DoN; Review of Constitutional targets and service risks (including financial impact).	**4X3 = 12** **(Jan 2021)**	1. Quality Governance at Divisional level requires further strengthening 2. Gaps in knowledge at ward & department level re risk management processes 3. Formal risk management group requires establishment 4. Lack of up to date risk management Strategy 5. Lack of trust wide audit programme to consistently audit CQC standards 6. Lack of Patient Safety Strategy (in line with national plans) 7. Lack of resource in Quality Governance team to be able to support overarching QG agenda - temp risk management resource in Women's & Children's - this requires substantive resource going forward	**3X3 = 9**	**1.The Trust has commissioned a Quality Governance external review, scheduled in July 2021. The review Terms of Reference includes; Structure, systems and processes, culture and engagement, capability and capacity across the KLOE required for a fully integrated model. In addition, an internal and external Quality Governance review in Women's and Children's in response to concerns raised has been completed in Q1 and report pending. Early learning has been adopted and implemented across the Trust. Furthermore, a full time dedicated risk lead for W&C has been successfully recruited following a long term gap.** **3. A review of the Serious Incident process has been undertaken and some changes in practice.** **4. Oversight and assurance monitoring reduced during pandemic and agreed bi-annual reporting to CCG; internal monthly monitoring continues.** **5. Regulatory standards included in Ward Accreditation system and quarterly peer assessment across all clinical areas.** **6. The Trust has recruited to the national Patient Safety role; the post holder commences in Q2 and will prioritise the implementation of the strategy and review the new NHS Serious Incident Framework.** **7. Some progress against strengthening the corporate quality governance team whilst awaiting the external review.** **8. Mortality review undertaken in relation to the increasing HSMR trend, assurance report provided by MD and support from regional team provided.** **9. The Trust has participated in a Quality Risk Profile review by the NW Regional team at NHSE, following concerns raised in relation to quality and risk data performance and safety. Outcome pending. The process involved submitting various assurance documents inclusive of Restoration and Recovery for long waiters, covering 52 week wait position (inpatient, day case and outpatient), diagnostics, and endoscopy. This paper also provides assurance in relation to clinical**
Q2	Safety - 'Think Family' - Safeguarding Adults & Children (Director of Nursing & Quality)	**Cause:** Failure to 'Think Family' i.e. not taking a holistic approach to safeguarding. Failure to ensure the Trust has sufficient systems and processes and policies in place to safeguard vulnerable adults and children. Failure of staff to comply with agreed systems and processes above. Failure to escalate non-compliance with systems and processes . **Impact:** Vulnerable adults or children may come to harm. There may be missed opportunities in avoiding harm to adults or children . **Consequence:** Regulatory sanctions . Increased complaints and reputational damage and increased external scrutiny . Legal Action: The Trust has a legal responsibility to safeguard children and adults in line with their human rights and the requirements are set out within the Health and Social Care Act (2008).	**4X4 = 16** **(Jan 2021)**	**Strategic Level** -Engagement in Local Adults Safeguarding Board & Children's Partnership Board - Attendance at local Safeguarding forums re: LD/Domestic abuse/child exploitation/Training & Development/Quality Assurance/Dementia/PREVENT. - Monthly reviews a submission of commissioning standards with CCG Safeguarding Lead -Attendance at national Strategic Safeguarding Training for Executives; -Engagement with CQC re ongoing improvements; Engagement with University of Chester; **Operational Level** - Ward Accreditation Programme in place incorporating safeguarding standards - Operational systems and processes in place to support referrals and management of safeguarding cases - Matron oversight of safeguarding cases within operational Divisions - Partially implemented new integrated model of 'Think Family 'and Complex Care Team in place led by an Interim Lead Nurse for Safeguarding - Plans to present the final elements of the model for financial support Q4 (2021/22). -Specific Dementia nurses integrated into Ward teams. -Multi-professional (including external agencies) table top review undertaken when themes/trends/concerns highlighted; Multi-professional training in place L1-L4; -Independent Domestic Abuse advocate (IDVA) employed in the Trust in partnership with LA;	**Reported to Board (Date)** - Think Family/Safeguarding Annual Report - Annual Quality Account **Reported Elsewhere (Date): Quality and Safety Committee & Quality Governance Group** - CCG Quality Contract Meeting (Monthly) - Think Family Strategy Group in place (with external partners attending); -6 operational sub groups in place; Minutes from Think Family Strategy Meeting received at QGG; -Safeguarding Improvement Plan shared with CCG and reviewed at each internal meeting (including previous MIAA audit actions); Safeguarding input into Pressure ulcer & falls reporting; -Local and national Serious case reviews reported through Trust meeting structure re learning. Safeguarding and Domestic Abuse Policies in place	**4X2 = 8** **(June 2021)** **(was: 4x3=12)**	1. 'Think Family' Strategy not finalised, incorporating Children's Safeguarding, Adult Safeguarding, PREVENT, DA, LD/Autism, Mental Health, Delirium & Dementia. Implement final elements of integrated model, for approval in Q4 2021/22; 2. Revised training programme not finalised (in line with Covid restrictions); 3. Revised audit programme to be finalised (in line with new meeting structure and improvement plan) - delayed due to Covid; 4. Implications of the pending implementation of the Liberty Protection Safeguards has not been shared across the Board and Trust. Systems and processes are not consistently implemented/followed (e.g. section 42 cases)	**3X3 = 9**	**1. 'Think Family' Strategy now ratified.** **2. Business case for 'Think Family' model presented at Senior Leadership Group and agreement made for current cost pressures and statutory roles to be funded recurrently. As a result, the Senior Leadership within the service has been strengthened. The residual structural elements require further review. This has enabled a successful appointment to the Children's Named Nurse role, with the remaining vacancy of Named Professional for Midwifery being actively recruited to.** **2. Training compliance monitored regularly and is improving post - COVID.** **3. Systems and processes strengthened with revised policy and easy to read tools to support clinical practice. These will be launched during Q2 2021/22.** **4. Continued engagement with LA in relation to LPS, awaiting the new Code of Practice to design systems and processes internally.** **5. The Trust received an unannounced visit from the LA and CCG in relation to the cluster of serious incidents on 14th June 2021. Received initial feedback, no areas of concern and positive outcome (awaiting formal feedback).**
Q3	Safety - Infection Prevention & Control (Director of Nursing & Quality)	**Cause:** - Failure to ensure the Trust has sufficient systems and processes and policies in place to Infection Prevention & Control - Failure of staff to comply with agreed systems and processes above - Failure to escalate non-compliance with systems and processes **Impact:** - Unsafe Care leading to avoidable harm/death - Detrimental effect on safety culture; Poor staff morale and culture **Consequence:** - Regulatory sanctions - Reputational damage and increased external regulatory scrutiny - Media attention	**5X4 = 20** **(Jan 2021)**	**Strategic** - Membership of North West Director of Infection & Control (DIPC) Forum - Membership of Cheshire Local Health Protection Board - Engagement with monthly CQC meetings & NHSE support and review meetings **Operational** - Matron oversight and leadership of IPC agenda at Ward level - IPC Link Practitioners in place on each clinical area with roles & responsibilities; Business case approved for additional IPC resource - all posts recruited to (not all have commenced in post) - IPC Audit Programme in place - Spot Matron Audits; Fit Testing Programme, systems and processes established; - IPC included in daily tactical calls - IPC policies, procedures and SOP's in place - COVID risk register in place; workplace risk assessments undertaken re social distancing and screens/facilities put in place to mitigate risks - Established coved swabbing service in place (with SOPs) for patients and staff - Established Vaccination service in place with relevant SOP/guidance	**Reported to Board (Date)** - Trust Integrated Board Report - Annual Infection Prevention & Control Report - Annual Quality Account (featuring IPC section re objectives) - IPC Board Assurance Framework - CQC review of COVID **Reported Elsewhere (Date):** IPC Strategy Group with sub groups reporting into this Group: Water Safety, Antibiotic Stewardship; Respiratory Support Group etc. Regular review of IPC data (including regional benchmarking); NHSE/I visit action plan COVID improvement plan to Q&S Committee Surgical Site Infection (SSI) surveillance & HCAI's incidence monitoring. Ward Accreditation Programme via Quality Governance Group Space Utilisation Group	**4X3 = 12** **(June 2021)**	1. Poor estate and infrastructure impacting on compliance with IPC guidance - Ward .environments require upgrading 2. Full implementation of additional cleaning not yet in place 3. Lack of isolation facilities 4. IPC Strategy not finalised (due to Covid) 5. Backlog of root cause analysis investigations (re Covid Outbreaks); 6. Lack of 2 metre spacing between patients due to infrastructure and increased occupancy; 7. Trust occupancy >98% impacting on IPC risk; 8. use of increased temporary/agency staff; 9. Lack of effective ventilation systems in place; 10. Cleaning data results not easily available to triangulate with IPC audits; 11. High rates of nosocomial infections requiring daily focus on compliance with IPC practices; 12. IPC discussions at Divisional Meetings variable; sharing Learning not always consistent.	**4X3 = 12**	**1. Natural ventilation plans in place for all clinical areas. Group established to look at options for technical ventilation solutions. Remedial work undertaken in high risk areas to improve the ventilation. Estates improvement works have been completed as part of the respiratory and cardiology reconfigurations. In addition, opened a newly commissioned ward as part of the elective recovery programme.** **2. Additional cleaning support now recruited to and being implemented in line with new cleaning published cleaning requirements.** **3. Additional isolation facilities provided in the respiratory reconfiguration and temporary isolation PODs purchased and available to use.** **4. IPC Strategy finalised, currently in governance ratification process.** **5. Following publication of National guidance, local RCA process aligned to requirements and outbreak exercises have been commenced.** **6. Estate assessment of space between beds undertaken, achieving two meters, however when patients mobilising the distance is reduced. In order to mitigation this risk the Trust has invested in additional screens between bed spaces in high risk areas.** **8. Temporary workforce remains in place; requirement reducing.** **11. Currently zero nosocomial transmission of COVID.** **12. Divisional IPC data packs provided, which are received at all Divisional Governance Groups. Risk has achieved its target score, however risk to remain open as North West community prevalence trend is increasing.**
Q4	Safety - Nursing & Midwifery Workforce (Director of Nursing & Quality)	**Cause:** - The Trust is unable to consistently deliver safe care due to the lack of available workforce (exacerbated by Covid pandemic) - Lack of training and education around the fundamentals of care - Failure to listen/engage with patients and their families/careers **Impact:** - Poor standards of care are delivered - Compromised staff morale -Friends and Family results deteriorate - Non-compliance with regular standards **Consequence** - Reputational damage - Increased external scrutiny +/- sanction - CCG contract sanctions - Poor recruitment and retention rates	**5X4= 20** **(Jan 2021)**	**Strategic Level** - Membership of Cheshire & Merseyside N&M Workforce Programme - NHSE/I Retention Collaborative - Membership of Director of Nursing/University of Chester forum - Part of Cheshire & Merseyside International recruitment collaborative **Operational Level** - Weekly Matron Quality and Safety checks - Ward accreditation monitoring of standards (facilitated by Quality Matron) - Centralised Nursing Workforce team in place, co-ordinating all workforce requests and monitoring risk producing shift by shift SitRep. - Safer Staffing Policy (currently under review) - Cheshire & Merseyside Revised Guidance on Staffing during Covid Pandemic in place - 7 day working for Matrons; - Daily Tactical ops meeting in place reviews staffing risks; Daily Nurse staffing Ops meeting chaired by Deputy Director of Nursing; -Successful international recruitment achieved, 40 nurses recruited to date - Electronic rostering in place with management information re fill rate data - Daily nursing & midwifery workforce dashboard re Covid absences - Workforce data produced monthly re vacancies, recruitment & retention rates - Nursing & midwifery workforce sub groups being established: Recruitment (including student placement and recruitment), Retention, wellbeing, education and workforce data; Practice Development Team in place facilitating international nurses and newly qualified nurse development.	**Reported to Board (Date)** - Trust Integrated Performance report (monthly) - Bi-Annual Safe Staffing Report (including midwifery) **Reported Elsewhere (Date)** - Quality and Safety Committee (bi-monthly) - Quality Governance Group (monthly) - Nursing, Midwifery & AHP Workforce Group reporting into Strategic Workforce Group - N&M Establishment review (Quality & Safety Committee) - N&M Workforce data presented at N/M/AHP Workforce Group - Nursing & Midwifery Resource Paper (SLG) - over-establishment agreed to N&M turnover	**4X3= 12** **(June 2021)**	1. Centralised Nursing Workforce Team (CNWT) not substantively established - currently staffed on redeployed staff 2. Workforce and HR nursing & midwifery data not fully aligned 3. Escalation areas not established 4. No established backfill for redeployed staff during Covid; 5. Plan regarding Nurse Apprentice not agreed; 6. E-Roster KPI's not agreed;	**4X3 = 12**	**1. Centralised Nursing Workforce Team established as part of COVID response, team currently utilises redeployed staff. The model has provided effective robust management flexible/temporary workforce and has provided full visibility and strengthened oversight. Business case required to recurrently fund a sustained model.** **5. The Trust has successfully recruited to six registered nurse apprenticeship training posts. The risk has now achieved its target score, however risk to remain open as business case yet to be agreed.**

BAF Risk ID	Work Programme linked to Strategy (what the organisation aims to deliver, and Executive Lead)	Risk Description **Cause -** what has led up to the risk being possible **Impact -** immediate effect on services, service users, staff, projects **Consequence -** longer term concerns	Initial total risk score (C x L)	Controls (Actions taken to manage the risk)	Assurance (The mechanisms we know the controls are working - reports, scrutiny meetings, committees, internal & external audits and reviews)	Residual total risk score (C x L)	Gaps In Controls (Identified weaknesses in current management arrangements) **AND** **Gaps In Assurance** (identified weaknesses in how we assure ourselves - or not enough information or lack of scrutiny)	Target total risk score (C x L)	Action plan
Q5	Patient safety -failure to identify avoidable clinical harm and avoidable death (Executive Medical Director)	**Cause:** - inaccurate or insufficient depth of coding at ward level - the extremely high denominator of Covid-19 patients within the Trust has exerted a depressant effect on the HSMR basket The HSMR calculation methodology was not and is not designed to accommodate mortality calculations for Covid-19 -clinical coding teams were unable to work at ward level in the usual sense due to restrictions due to Covid-19 safety - failure to adequately capture the initial diagnosis within the first three finished consultant episodes (FCE's) due to amended patient pathways put into place to accommodate Covid-19 **Impact:** - high HSMR rate impacted by the denominator effect **Consequence:** - failure to identify potential avoidable harm and or death	**4x4=16** **June 2021** **(was: 4X3 = 12)** **(Jan 2021)**	**Strategic level:** Dr Foster clinical benchmarking software system and early alert system with clinician level data Additional early warning score software separately procured to enable enhanced scrutiny of data quality and early alerts to clinical pathway concerns LFD Group oversight Quality & Safety Committee and Quality Governance Group oversight Board of Directors oversight Monthly Divisional morbidity and mortality (M&M) meetings where HSMR is discussed **operational level:** Controls - clinical staff coding training programme; specific assigned clinical coders to specialty teams who are now redeployed into the ward environment, post-Covid; ongoing clinical benchmarking engagement sessions; spot-check clinical note quality inspections; clinical staff memoranda and reminders concerning the importance of quality note-keeping; full Medical Examiner team now in place performing 100% of in-hospital death reviews (May 2021)	**Reported to Board (Date)** Integrated performance report (monthly) via Q& S Committee Chair's report (bi-monthly) mortality indicators report to Q&S and Board **Reported Elsewhere (Date)** **Weekly standing item at Executive Directors Group (from June 2021)** Learning from Deaths Group chair's report; Quality Governance Group; Quality and Safety Committee; Integrated Performance Report. Scheduled Mortality Reports and ad-hoc deep dive reports as indicated by emergent or anticipated trends in mortality date (e.g. Covid 19).	**4x3=12** **June 2021** **(was: 4X2= 8)** **(Jan 2021)**	**Gaps in Controls -** **1. Further scrutiny and deep dive of data quality and clinical patient pathway management within the mortality data to highlight specific areas of concern.** **2. Analysis of the implications of avoidable mortality within patients with the longest lengths of stay (over 21 days)**	**3X2 = 6**	**1. Identify top 6 clinical pathways of concern within the HSMR data and each undergoing individual case note review to interrogate clinical care within those pathways; tracked via LFD Group and Executive Group - conclusion by August 2021** **2. Identify spike of potential avoidable mortality within long stay patients - work underway to drive down long length of stay via system piece of work supported by Dr Ian Sturgess to address that cohort of patients.**
Q6	Failure to provide an adequately trained and skilled medical workforce to support the services we provide (Executive Medical Director)	**Cause:** Failure to recruit, train and retain sufficient numbers of medical staff to enable safe and effective care to be delivered at all times and with sufficient agility to accommodate sudden changes in demand. **Impact:** Inadequate or poor quality clinical care at a patient level; near-miss or actual clinical harm; poor patient or family experience. **Consequence:** Increased numbers of complaints and critical incidents; reputational damage; regulatory scrutiny or sanction; poor recruitment; poor retention.	**4x3=12** **(June 2021)** **(was: 5X4= 20)** **(Jan 2021)**	**Controls:** Full participation in HEE regional training programmes for all relevant specialties; collaborative partner with Universities of Liverpool and Chester for undergraduate teaching and training in order to maximise graduate workforce supply; pro-active ongoing medical staff vacancy advertisement programme; rolling medical staff educational programmes at all levels; staff education and development database; weekly deployment meetings within the medical staffing team; established educational line management programme; established appraisal and revalidation programme; dedicated clinical lead for appraisal; dedicated appraisal and revalidation manager.	**Reported to Board (Date)** GMC trainee survey (annual), at F&P Committee May 2021 Board and Committees via Integrated Performance Report (appraisal and vacancy rates) - monthly **Reported Elsewhere (Date)** Educational programme attendance database; appraisal and revalidation database; GMC revalidation external submission data; ; HEE engagement and performance meetings; Quality and Safety Committee via Integrated Performance Report (appraisal and vacancy rates); GMC engagement meetings (quarterly); Responsible Officer Network.	**4x2=8** **(June 2021)** **(was:4X3 = 12)** **(Jan 2021)**	**Gaps in Controls -** 1. Insufficient trainee supply from HEE regional specialty training schools; 2. poor uptake from external advertisements; 3. operational pressures leading to compromised staff training and continuing professional development; 4. resignation and retirement in hard-to-fill specialties.	**3X2 = 6**	1. Engagement meetings with the speciality training schools to track incoming medical staff numbers and to mitigate planned gaps in training - ongoing. 2. Revised and refreshed format and content of external adverts for medical staff to maximise uptake - complete and to re-visit as required. 3. Revised traditional face to face education programme and reprovided around 80% of content as virtual learning and supported attendance for established staff on virtual external CPD courses through the pandemic. The appraisal system accommodating guidance from the GMC and the regional revalidation office to reposition appraisals as a welfare conversation for staff - subject to GMC guidance. 4. Undertaken establishment reviews in hard to fill specialities to accommodate new roles and new models of care provision - undertaken on ad hoc basis.

Board Assurance Framework & Strategic Risk Register 2021/22 - Effectiveness

BAF Risk ID	Work Programme linked to Strategy (what the organisation aims to deliver, and Executive Lead)	Risk Description **Cause -** what has led up to the risk being possible **Impact** - immediate effect on services, service users, staff, projects **Consequence** - longer term concerns	Initial total risk score (C x L)	Controls (Actions taken to manage the risk)	Assurance (The mechanisms we know the controls are working - reports, scrutiny meetings, committees, internal & external audits and reviews)	Residual total risk score (C x L)	Gaps In Controls (Identified weaknesses in current management arrangements) **AND** **Gaps In Assurance** (identified weaknesses in how we assure ourselves - or not	Target total risk score (C x L)	Action Plan
Strategic Aim: Effectiveness - Providing efficient and financially sustainable services. **Lead Executive Director: Director of Finance/ Director of Clinical Operations & Chief Digital Information Officer / Lead Assurance Committee: Finance & Performance**									
E1	Underlying Long Term Trust Financial Sustainability (Director of Finance)	**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; - Reduction in activity and associated loss of PbR income (only applicable when PBR in operation) - High numbers of medically optimised and delayed transfers of care for which costs are not fully reimbursed; - Costs associated with medical and nurse agency usage; - Non compliant medical rotas; - Identification and delivery of Cost Reduction Savings (CRS); and - The need to continue to invest in safety. - Lack of internally generated Capital resource **Impact:** The Trust is unable to achieve a sustainable financial balance & achievement of recurrent efficiencies for 2020/21 and beyond & deliver its strategic objectives **Consequence:** - Current Trust strategy development will be threatened. - Continued deficit position will exacerbate the lack of cash already experienced by the Trust to fund the capital programme and create potential revenue liquidity issues. - Inability to maintain safe and effective local services. - Increased external scrutiny from NHSE/I. - Adversely effect the financial position of the Cheshire & Merseyside System.	**4x4=16** **(April 2021)** **(4X3 = 12)** **(Jan 2021)**	**Strategic Level:** Participation in National and Regional NHS I/E financial workshops Active member of the Cheshire and Mersey Health and Care Partnership Active member of the Cheshire Financial Recovery Programme Active member of Cheshire and Mersey collaboration at scale (i.e. pathology, pharmacy, estates etc.) Executive board committee review financial information including benchmarking Development of long term financial plan linked to strategic planning objectives **Operational Level** Senior management and executive oversight of performance Escalation processes in place to ensure minimal levels of performance are met Divisional Board Report Finance & Performance Working Group Monthly Robust contract monitoring information (reduced contract monitoring arrangement in place under Level 4 emergency response) Capital requirements prioritised through the ERPE process. Workforce planning and international recruitment. E-Roster. Internal audit reviews / assessments. Daily cash flow monitoring.	**Reported to Board** Trust board monthly information Finance Performance Working Group Audit Committee Council of Governors **Reported Elsewhere** Executive Director Group Senior Leadership Group Cheshire System Betsi Cadwaladr Health Board Transformation Group NHSI via monitoring returns and weekly telephone calls Divisional Boards (Monthly) Capital Steering Group (Monthly)	**4x3=12** **(June 2021)** **(was: 4X2 = 8)** **(Jan 2021)**	**Gaps in Controls:** 1. Gap and high risk nature of efficiency (waste reduction) Plans, and reliance on non-recurrent measures 2a. Inability to control volumes of medically optimised patients due to external factors **2b. Operational focus on activity delivery and patient safety with potential detriment on finance and defining operational budgets** **2c. Difficulty in establishing robust recurrent costs and activity, especially given the IPC constraints** 3. Failure to deliver agreed activity levels and associated loss of income to the Trust 4. Strategic Partnership with Wales and different financial regimes to NHS England 5. Lack of information on junior doctor rota gaps 6. Requirement to improve workforce recruitment processes 7. Retaining focus and management of risks with regards to delivery of large transformation programmes 8. Long term financial plan aligned to strategy **Gaps in assurance:** 9. Lack of regular workforce establishment reporting and benchmarking data 10. Lack of routine Finance & Performance Working Group underpinning financial sustainability	**3X2 = 6** **(by 31.03.23)**	1. Develop a robust financial savings plan (waste reduction plan) which underpins the organisation's recurrent sustainability - by 30 June 2021 1-3 & 7. Develop a financial plan that reflects activity and restoration plans - by June 2021. **H1 submitted, re-submission scheduled. Longer term plans will continue to be developed .** 1 & 7. Continued engagement with Healthcare partnership and Cheshire system to identify opportunities for waste reduction, along with internal engagement - June 2021 4. Continue to work with NHSE/I and Wales health boards to agree financial risk arrangements - by **September** 2021 5. Work with medical workforce team to further understand job plans in relation to recurrent budget setting - by **30 Sept 2021.** **6. Review recruitment processes with HR and operational managers - by Sept 2021** 1-3 & 7. Link with transformation team and EPR team regarding business planning cycle to ensure financial plans reflect transformation plans and are affordable - by June 2021 8. Develop long term financial plan and commence reporting of underlying financial position to the Board - by **Dec** 2021 9. Regularise workforce establishment reporting - by June 2021 10. Regularise Finance & Performance Working Group - by July 2021
E2	Uncertainty of financial funding and consequences of breaching control total under current Covid-19 financial regime **H1, including Elective Recovery Fund (ERF) and longer-term H2 regime** (H=half of year) (Director of Finance)	**Cause**: Emergent financial guidance and developing pandemic and policy response. Uncertainty regarding Cross-border arrangements **Impact**: financial uncertainty and impact of operationally led response. **Consequence**: year-end performance and the ability to plan ahead. Impact on Underlying Future years' financial performance due to decisions taken under Emergency response levels out of local control	**4X3 = 12** **(Jan 2021)**	**Strategic level:** Working within the HCP system and NHSI/E. Financial planning and control, e.g. budget setting Maintenance of current Governance arrangements **Operational level:** Financial controls and reporting Authorisation controls balancing financial risk with service delivery Procurement controls to ensure value for money	**Reported to Board** Trust board monthly information Finance Performance Committee Audit Committee Council of Governors **Reported Elsewhere** Executive Director Group Senior Leadership Group Cheshire System Betsi Cadwaladr Health Board Transformation Group NHSE/I via monitoring returns and frequent telephone calls Divisional Boards (Monthly)	**3x3=9** **(April 2021)** **(was: 3X2 = 6)** **(Mar 2021)**	**Gaps in controls:** 1a. Policy set nationally with limited influence on national direction. 1b. System level control totals and development of policies and processes to underpin 2. Speed of operational response in response to clinical demand. **Gaps in Assurance:** **3.** Recurrent activity and recurrent run rate 4. Implications of recurrent spend and productivity partly due to Infection Prevention and Control measures. 5. Lack of benchmarking data.	**3X2 = 6** **(by 31.03.22)**	1, 3 & 4. Develop a financial plan that reflects activity and restoration plans - by June 2021. 1. Await national guidance to be published for H2 and then complete associated financial plans - by **Sept 2021** 1. Continue to work with NHSE/I to agree financial risk arrangements in integrated care system- by **Sept 2021** 4. Develop Board report to show health of the underlying deficit position - by **Sept 2021** **5. Explore alternative benchmarking opportunities - by Sept 2021**
E3	Financial Ledger System stability (Director of Finance)	**Cause:** The finance and procurement system is practically reliant on a single local server supported by an individual. Should the hosting service cease unexpectedly the IMT department do not believe they have the capability to step in and maintain the key elements of the system hosting in order to facilitate a managed transfer to an alternative provider. **Impact:** The finance and procurement systems will be unavailable for an extended period of time and manual procedures will need to be implemented. **Consequence** During this time there will be a decreased level of service to the organisation, and the risk of stock-outs, fraud and error will increase.	**4X3 = 12** **(Jan 2021)**	**Operational level:** The management of the database is now carried out by the software provider supported by dedicated in-house resource.	External audit review reported to Audit Committee 2020 and action plan in place, with follow up audit planned. Procurement completed for hosted solution.	**3X3 = 9** **(Jan 2021)**	Gaps in controls: 1. Potential single point of failure 2. Identification of resource	**2X3 = 6** **(by 31.03.22)**	1. Pursue appetite with partners within HCP/ICS for collaborative procurement of new financial system - **complete** 1. Undertake options appraisal to remain with existing system or procure new system - by September 2021 - **completed** 2. Identification of resource requirements as part of the budget setting process - by September 2021 - **complete** **1. Undertake migration to the hosted solution - by Sept 2021**
E4	Access, Waiting Times, Care Pathways and Constitutional Standards (Chief Operating Officer)	**Cause:** Unable to meet the demand for services within available resources Impact of continuing Covid-19 pressures and IPC requirements **Increasing ED attendances** **Known loss of productivity due to Cerner migration impact** **Impact:** Increasing patient waits for access to services. Failure to meet key targets Failure to meet regulation requirements **Consequence** Sub-optimal service provision Potential extrapolated harm to patients due to slowing down of service provision Potential risk of an increase in complaints from family, friends and carers. Potential reputational damage to the Trust.	**4X5=20** **(Mar 2021)**	Insourcing for Endoscopy and general surgery Maximise use of independent providers Increased lists of challenged specialities such as ophthalmology, urology and colorectal Mutual aid for Plastic Surgery with Whiston ECIST support ongoing from NHSI for referral to treatment (RTT) Increased theatre and outpatient productivity focus; **Productive Partners commissioned on a six week diagnostic basis.** Patient Initiated follow up (PIFU) implementation remote clinical establishment using Attend Anywhere Accelerated IT equipment programme to facilitate remote working Capital acquisitions of equipment that increase productivity Increased recruitment in challenged areas, particularly endoscopy, radiology and anaesthesia RTT delivery specialist on an interim contract (with Cerner migration experience) Temporary validation team to mitigate Meditech legacy issues Improved reporting to demonstrate actual picture, along with regional scrutiny and monitoring **Strict trajectory setting for Divisions and performance management against these trajectories** **Endoscopy new scope room was appointed January 2021. Critical Care have now moved out of Endoscopy unit (mid-Feb 2021).** Cancer Alliance part-funding received for a recovery consultant- started 09.06.21 for diagnostic	**Reported to Board (Date)** Integrated Performance Report to Board (each meeting) Finance and Performance Committee - including Integrated Performance Report **Reported Elsewhere (Date)** Executive Directors Group Senior Leadership Group Cheshire System (HCP) National reporting of constitutional performance standards **Management Review meetings re-established with increased frequency - end Feb 2021** **Monthly Management review meetings in progress and weekly operational restoration group meeting** **Outpatient Restoration task and finish group (weekly)** **Divisional Performance Management Groups - Urgent and Planned Care (weekly)** **Weekly regional submissions against trajectory** **CQC Restoration Assurance document**	**4X4 = 16** **(Mar 2021)**	**Gaps in Controls:** 1. Gaps in managerial awareness of RTT and process compliance 2. Gaps in understanding appropriate business rules in the RTT arena 3. Meditech is not an RTT management platform **4. Clinician availability to perform lists** **5. Gaps in workforce planning to mitigate vacancies** **6. Predicted reduction in productivity due to EPR implementation** **7. historical poor understanding of flow and discharge requirements to enable whole hospital safety** **8. Endoscopy activity affected by critical care surge activity.** **9. Pandemic causing fluctuating levels of referral activity from primary care** **10. Individual theatre staff incentive rates** **11. Clinical vision of flow** **Gaps in assurance:** 12. Requires ongoing fixing of business information reports to identify an accurate picture	**3X3=9** **(Mar 2021)**	1 & 2. Implementation of key actions identified in action plan Increased clinical engagement & oversight - clear objectives for cancer manager. Relaunch cancer committee - relaunched. Cancer improvement consultant temporarily engaged. By Feb 2022 1& 2. Development of actions to address 18 weeks and longest waiters, Validation of wait lists is ongoing. We are aiming to increase theatre productivity (by Oct 2021) . Validation and education programme has commenced as part of the RTT - Ongoing 1-11. Covid-19 restoration programme based on national restoration programme requirements continues; trajectory-re-submission ongoing. Close working with Right Care and NHSI continues to identify available support and mutual aid within the North West system. In terms of controlling the effects of Covid-19 we have a dedicated swabbing unit. By March 2023. 4 & 5. Divisional support to develop workforce plans & alternative roles to be presented via medical staffing meeting & Nursing & midwifery workforce group - ongoing work which has been pause due to Covid-19 disruption has been reinstated. Successful bids made to HEE to appoint ACP and ANP training schedules. Ongoing medical and nursing workforce focus to ensure adequate cover at all levels to achieve constitutional standards. 6. EPR upgrade currently preparing for cross over in July 2021

BAF Risk ID	Work Programme linked to Strategy (what the organisation aims to deliver, and Executive Lead)	Risk Description **Cause** - what has led up to the risk being possible **Impact** - immediate effect on services, service users, staff, projects **Consequence** - longer term concerns	Initial total risk score (C x L)	Controls (Actions taken to manage the risk)	Assurance (The mechanisms we know the controls are working - reports, scrutiny meetings, committees, internal & external audits and reviews)	Residual total risk score (C x L)	Gaps in Controls (Identified weaknesses in current management arrangements) **AND** **Gaps in Assurance** (identified weaknesses in how we assure ourselves - or not	Target total risk score (C x L)	Action Plan
E5	Business Continuity - Pandemic Flu / Virus (Chief Operating Officer)	**Cause:** A serious epidemic of much greater severity than the usual seasonal flu when a novel flu (Coronavirus) virus emerges with sustained human to human transmission. **Impact:** Up to 50% of the population may experience symptoms, which could lead to thousands of fatalities in total in the UK. The Trust will be expected to change the way in which it provides services to those infected and how they are isolated and how staff are also protected. **Consequence** Each pandemic is different and the nature of the virus and its impacts cannot be known in detail in advance. Based on understanding from previous pandemics, a pandemic is likely to occur in one or more waves, possibly weeks and months apart, each wave may last between 12-15 weeks. Up to half the population could be affected. All ages may be affected, but until the virus emerges, we cannot know which groups will be most at risk. This type of incident has the potential of significantly affecting our service users and staff, which will impact on service provision and demand.	4x4=16 **(June 2021)** **(was:5X4= 20)** **(Jan 2021)**	**Strategic Level** Cascading information available from Public Health England in the event of a new pandemic strain being identified, and risk of cases in the UK. Silver Command remains active for Cerner cut over Whole hospital brief (weekly) Experienced Emergency Preparedness, Resilience & Response (EPRR) Officer Ongoing establishment of remote working Targeted family support team ongoing. Establishment of a surge operational plan, agreed at SLG. <u>Changes in senior governance</u> - Board meetings held virtually - Update meetings for Non-Executive Directors - Established structure for linking in to senior operational and clinical Gold command and regional operational cells. - Maintain visibility of vaccination related communications **Operational Level** - In response to the pandemic, the governance structure was amended to reflect the guidance received in the 'Reducing the Burden' correspondence received from NHS England. E9	Trust Pandemic flu/virus plan approved by Trust at November 2019 The Trust has access to and supported the review of the LHRP resilience plan. Monthly updates to Board from Executive Team Establishment of EPRR Committee Monthly attendance at the regional EPRR group meeting	4x4=16 **(Jan 2021)**	1. **Predicted paediatric bronchiolitic surge** 2. Staff knowledge and experience to look after patients if acutely unwell and no available beds in acute hospitals during a pandemic situation although new methods of care have been proved to reduce morbidity. (Control) 3. Staff and their families are as vulnerable to Pandemic infection as the patients. This may dramatically impact the availability of safe staffing. 4. Ongoing staff wellbeing impact. 5. **Ongoing increased levels of patients requiring critical care services, thus requiring additional staff from routine hospital operations.**	**3x3=9** **(Mar 2021)**	1. Identification of paediatric assessment area and identification of paediatric high dependency area as part of our response plan - June 2021 2. National instruction via local and Trust system commands - ongoing 3. Some Local initiatives to reduce risk of Covid transmission remain including appointments only visiting access, one way system at entrance, increased security presence and target communications to staff: Hands, Face, Space - ongoing 4. Further identification of staff break and wellness areas - by Sept 2021 5. Maintain critical care surge readiness plan - ongoing
E6	EU Exit transition (Chief Operating Officer)	**Cause:** Financial and operational sustainability post-Brexit/end of transition period 31st December 2021. **Impact:** Uncertainty of usual routes and cost of supplies & Pharmacy, EU staff to have EU settled status or to follow sponsorship route, different charging arrangements for EU patients **Consequence:** Lack of availability of drugs & supplies, increased cost of supplies, reduced ability to recruit & retain EU staff, possible loss of income for treating EU patients	**3x3=9** **(June 2021)** **(was:4X3 = 12)** **(Jan 2021)**	**Strategic Level:** - Review & action of all National/regional level plans - SRO and command & control structures in place - Contingency planning if data protection adequacy status is not granted **Operational Level:** - Adjust supply processes where predicted changes in lead time - Providing usage information to the Regional Procurement pharmacist - Follow established process for managing disruption in medicines supply including working with clinicians to agree suitable alternatives - Monitoring of EU workforce starters & leavers	**Reported to Board (Date)** Trust Board (December 2020) **Reported Elsewhere (Date)** **EPRR & Silver Control** Senior Leadership Group Sitreps & National Reporting (as required)	**3x2=6** **(June 2021)** **(was:3X3 =9)** **(Jan 2021)**	**Gaps in controls:** 1. Policy set nationally with limited influence (command and control Level 4 National Emergency). **Gaps in Assurance:**	**2X3 = 6**	1. Reporting and escalation of supplier status through SRO & Silver control. 1. Operation of usual Medicines shortages procedures which include up to six weeks stock piling of key supplies and medications.
E7	Cyber security (Digital Strategy) (Chief Digital Information Officer)	**Cause:** Failure to invest sufficiently in secure digital infrastructure, systems, service and data to enable safe, effective clinical patient care and business operations Failure to adequately train staff in cyber security awareness Failure to recruit a cyber security team **Impact:** Insecurities within the systems and infrastructure with vulnerabilities that could be exploited through a cyber attack. Compromised systems and infrastructure would result in business continuity measures being put in place for staff and patients. Staff unaware of cyber risk **Consequence** Regulatory sanctions if personal data is lost Reputational damage Poor clinical outcomes and experience for large numbers of patients resulting in an increased risk of harm Potential for the Trust to fail to achieve its constitutional standards Potential for workloads to become heavy through more manual processing	5X4 = 20 **(Jan 2021)**	**Strategic Level** Digital Strategy approved by Board in January 2021 to address medium to long term investment plans in IM&T architecture and service, including cyber Review the IM&T organisational structure in order to develop a target operating model that accommodates cyber skills - approved for phase 1 - implementation August 2021. Audit of cyber security and NHS Data Security and Protection toolkit to review annual progress; reporting into Audit Committee via CDIO Staff awareness of cyber security practices through training . Pshing exercise Sept 2020 as part of initial assessment. **Operational Level** Ensuring staff awareness of cyber security practices through online training - training mandatory annually. IM&T Enterprise Architecture review on an annual basis as a health check on cyber Ensuring progress on the Cyber Tracker Action List from the annual DSP toolkit review Updating Cyber-related policies	**Reported to Board** - Digital Strategy (Draft - Jan 2021) - Cyber Tracker action list update to Audit Committee quarterly (July & Nov 2020, April 2021) **Reported Elsewhere** - Finance and Performance Committee (Quarterly) - Informatics Steering Group (Quarterly) - SLG, as required - Executive Directors, as required	5X3 = 15 **(Jan 2021)**	**Gaps in Controls** **1.** Cyber Security to become an agenda item for regular review by Executive Directors and SLG 2. Development of the target operating model within IM&T (investment required) to include dedicated cyber security team - in discussion February 2021 3. Lack of detailed policies and lack of up to date review 4. Reporting on staff take up of mandatory training **Gaps in Assurance** 5. Further reporting required on progress being made against identified IM&T vulnerabilities to governance in the Trust 6. Greater visibility of incident management through reporting to Exec Directors and SLG	**4X3 = 12** **(by 31.03.22)**	1-4. Developing the business plan for 2021-22 for IM&T including priority on cyber activity, although awaiting clarification of capital funding - by July 2021 2. Progressing the target operating model for IM&T including cyber security team - one position approved for 21/22 in place Sept 2021. 5. Complete annual DSPT review - June 2021 5 & 6. Progress action plans from previous cyber security audits - March 2022
E8	EPR+ Programme (Chief Digital Information Officer)	**Cause:** - The Trust is unable to implement the new Electronic Patient Records System before November 2021 resulting in increased costs in system support and delayed benefits in terms of clinical and operational efficiencies. - The Trust is unable to implement the new EPR system by end July 2021 resulting in a delay of 12 months before the supplier has sufficient resource to deliver the implementation. This could have financial implications for the Trust of c£5million. - The success of the EPR implementation is dependent on good quality patient pathway data. - **The success of the EPR implementation is affected by increased patient demand/activity.** - Training for clinical staff through E-learning **Impact:** - Impact of COVID19 in terms of timing of implementation - Contract renewal date of November 2021 for Meditech EPR system if the replacement Cerner EPR system is not live - Additional funding pressures emerging through gateway checks challenging the agreed business case - Trust-wide it will negatively affect the safety and quality of the services provided including the ability of the Trust to meet its clinical objectives. - Efficacy of the new EPR will be determined by the quality of patient pathway data. - **E-Learning is not as effective in enabling staff to feel confident in using a new**	**4X4 = 16** **(Mar 2021)**	- EPR governance in place and audited by MIAA. MIAA also attends the EPR assurance group. **EPR governance will be revised after Go-Live as part of IM&T governance.** - EPR Programme placed in hibernation during June to Sept 2020 to accommodate the response to COVID19 pandemic. - Revised business case and financial forecasts approved by Board July 2020 . '- The Senior Responsible Officer for the programme is Darren Kilroy, Executive Medical Director '- **Productivity modelling has been adjusted for July and August to accommodate the impact of lower levels of productivity, which has been shared at regional level with the ICS** '- **additional resources secured over the early go-live support period (August/Sept 2021) to ease transition.** '**- increased communications and engagement with staff around EPR and monitoring and take up of training.**	**Reported to Board** - Revised business case and delivery plans (Sept 2020) - Board updates (Quarterly) **Reported Elsewhere (Date)** - Finance and Performance Committee (bi-monthly) - Finance and Performance Group (monthly) - Exec Directors (regular standing item) - Programme run through a series of gateways prior to 'go live', allowing checkpoints to assess data readiness. - SLG - EPR Steering Group (monthly) as part of whole EPR programme governance	**4X3 = 12**	Gaps in Control: 1.Strengthening mechanism for identification and tracking of benefits under implementation. 2. Data validation support provided through a framework until 30th July 2021, an in-house data quality team will be recruited, estimated start date August 2021. Gaps in Assurance 3. Recording benefits that have been realised - both cashable and non-cashable.	**4X2 = 8**	1. Further develop benefits identification and tracking, including benefits owners - by **Sept** 2021 2. **Target operating model proposal discussed at Board in May 2021 - first phase approved and now needs implementing - by Sept 20**21 3. **Continued focus on benefits tracking, to be reported through Transformation Group - starting Sept 2021**

Board Assurance Framework & Strategic Risk Register 2021/22 - Partnership

BAF Risk ID	Work Programme linked to Strategy (what the organisation aims to deliver, and Executive Lead)	Risk Description **Cause** - what has led up to the risk being possible **Impact** - immediate effect on services, service users, staff, projects **Consequence** - longer term concerns	Initial total risk score (C x L)	Controls (Actions taken to manage the risk)	Assurance (The mechanisms we know the controls are working - reports, scrutiny meetings, committees, internal & external audits and reviews)	Residual total risk score (C x L)	Gaps In Controls (Identified weaknesses in current management arrangements) **AND** **Gaps In Assurance** (identified weaknesses in how we assure ourselves - or not enough information or lack of scrutiny)	Target total risk score (C x L)	Action plan
To collaboratively innovate and transform the Trusts Clinical Services **Lead Executive Director: Darren Kilroy, Medical Director / Lead Assurance Committee: Quality & Safety**									
C1	Failure to Progress implementation plan of the clinical services strategy (Executive Medical Director)	**Cause:** - Underdeveloped partnership working arrangements - Lack of clinical engagement to the required changes to pathways - Lack of reciprocal engagement in the wider health system (including Integrated Care Partnerships) - Clinical Consultants and drivers leading to compromised implementation **Impact:** - The Trust cannot achieve its strategic goals - Suboptimal patient pathways of care - Trust reputation - Trust continues to provide clinically unsustainable services **Consequence** - Resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability - Poor patient outcomes - Issues with recruiting and retraining workforce	**3X3 = 9** **(Jan 2021)**	**Strategic Level** - Organisational implementation plan facilitated by the Transformation Team; - Commissioner discussions regarding future services; - Engagement with local Health care partnerships regarding services reconfiguration; - GIRFT programme engagement in relation to specialty-specific reconfigurations implicated in the clinical services strategy; - Liaison with external acute and community provider organisations in relation to services whose future provision predicates alternative provision of services; - Annual dialogue and reporting of progress to the Cheshire West Health and Wellbeing Board of the Local Authority; **Operational Level** - Divisional operational planning aligned to strategy (including national operational guidance) - QRM (quarterly review meetings with Divisions) oversight of the execution of the strategy; - Divisional operational planning occurs in the context of the clinical services strategy; - Outpatient activity approvals are sanctioned in terms of their propensity to use non face-to-face methodology; - IT/PC equipment is procured and distributed to teams as requested to support non face-to-face clinical management of patients.	**Reported to Board (Date)** - Clinical Services Strategy agreed at Board September 2019 , with periodic updates provided to Board **Reported Elsewhere (Date)** - Monthly reporting to Transformation Group and then up to Finance and Performance Committee - Compliance with GIRFT Programme	**3x2 = 6** **(Jan 2021)**	**Gaps in controls:** 1. Continued effect of national command-and-control means that the real-terms ability of the Trust to execute improvement and change is of necessity compromised at this time; 2. The emergent strategic aims and objectives of neighbouring providers may have consequences for our own clinical services strategy which we cannot control.	**2X2 = 4**	1. Continue to work with and engage with the regional regulatory team and the regional Medical Director and COO network to ensure that the potential challenge of command and control is as mitigated as possible by necessary clinical reconfiguration - ongoing in 2021/22 2. Ongoing dialogue with neighbouring providers, executed via the Transformation Team, to ensure we are aware of and are responsive to their own clinical strategies and that we work in collaboration to maximise success.

Board Assurance Framework & Strategic Risk Register 2021/22 - Governance

BAF Risk ID	Work Programme linked to Strategy (what the organisation aims to deliver, and Executive Lead)	Risk Description **Cause** - what has led up to the risk being possible **Impact** - immediate effect on services, service users, staff, projects **Consequence** - longer term concerns	Initial total risk score (C x L)	Controls (Actions taken to manage the risk)	Assurance (The mechanisms we know the controls are working - reports, scrutiny meetings, committees, internal & external audits and reviews)	Residual total risk score (C x L)	Gaps In Controls (Identified weaknesses in current management arrangements) **AND** **Gaps In Assurance** (identified weaknesses in how we assure ourselves - or not enough information or lack of scrutiny)	Target total risk score (C x L)	Action plan
Strategic Aim: To develop and improve corporate governance **Lead Executive Director: Chief Executive Officer / Director of Corporate Affairs / Lead Assurance Committee: Finance & Performance**									
G1	Failure to Progress implementation of governance improvement plan (Chief Executive Officer & Director of Corporate Affairs)	**Cause:** - External governance review - CQC Well Led review - Lack of governance systems and processes **Impact:** - The Trust cannot achieve its strategic goals - Trust reputation and impact on quality of patient care **Consequence** - CQC rating - Compliance with Foundation Trust Code of Governance - Potential intervention	**3X4 = 12** **(Jan 2021)**	**Strategic Level** - Reconstituted Committees of the Board and revised terms of reference agreed Governance improvement plan facilitated by external governance support and internal support - External training roll out across the Trust - Board development programme underway and ongoing - Governor training November 2020 - Stakeholder engagement event held for corporate strategy development in February 2020 **Operational Level** - Trust wide training - Ongoing engagement on development of Board Assurance Framework (BAF) - Positive engagement with Governors and enhanced communication via small group sessions with Non-Executive Directors	**Reported to Board (Date)** - Governance Handbook agreed by Board Nov 2019. - Improvement update to F&P Committee March 2020 - Remuneration & Nomination Committee work plan agreed Oct 2020 - Refreshed Finance & Performance Committee terms of reference approved by Board July 2020 - Refreshed Quality & Safety Committee terms of reference scheduled for January 2021 Board. - Refreshed Constitution agreed with Board and Council of Governors in December 2020 - Charitable Funds training on role of Corporate Trustee was undertaken on 18th January 2021 - Board BAF session held 11th January 2021 **Reported Elsewhere (Date)** - **Scheduled** reporting to Finance & Performance Committee - Compliance with FT Code of Governance within Annual Report - Head of Internal Audit Opinion to Audit Committee April 2021 - Annual Governance Statement agreed June 2021 - NHS Provider License Self-Assessment - June 2021 Board - Conflicts of Interest Policy updated and agreed by Audit Committee Feb 2021 - External Auditor's Annual Report - June 2021	**3X3 = 9** **(Jan 2021)**	1. Pause in governance training due to Covid 19 pandemic affecting Phase 2 of improvement plan. 2. Review of Fit and Proper Person Policy. 3. Continued review and further updating of the Board Assurance Framework 4. Need to improve quality assurance of Board papers which is dependent upon timely submission by authors. 5. Board committee effectiveness review delayed during Covid pause; need to reschedule. 6. Charitable Funds investment strategy review required.	**2X2 = 4**	1. Governance training to progress at a suitable time in 2021, post-pandemic 2. FPPT to be reviewed by end Sept 2021 3. BAF updated for Q1 and then further monitoring and review ongoing 5. Review of Board committee effectiveness to be scheduled by August 2021 (Audit Committee effectiveness review completed April 2021) 6. Charitable Funds investment strategy to be further developed by end Q2 (Sept)
G2	Failure to ensure appropriate Information Governance	**Cause:** Non-compliance with data security training and requirements of the data protection toolkit and other legislative/mandated requirements **Impact:** Staff unaware of IG and cyber security risks Lack of formal information asset ownership **Consequence:** Adverse impact on the Trust's reputation Regulatory sanctions if personal data is compromised Data breaches	**4X5 = 20** **(Mar 2021)**	**Strategic Level** - Information Governance and IT Security policies and procedures Identified and trained Caldicott Guardian and Senior Information Risk Owner Information Asset Ownership being sought by the IG across the Trust IG training for staff **Operational Level** - DPIAs and ISAs - IG training for staff - Data flow mapping - Information Asset Register - Information Asset Ownership	**Reported to Board** - Data protection toolkit audited and presented to Audit Committee 2020 (and due July 2021). - IG Annual Report to Finance & Performance Committee and Board (due July 2021) - Minutes from IG Committee are escalated to Committee/Board where appropriate **Reported elsewhere (date)** Information Governance Committee (bi-monthly)	**3X5 = 15** **(Mar 2021)**	**Gaps In Controls** 1. Improve compliance with Information Asset Management and Data Flow mapping requirements. 2. Improve compliance with Information Governance Training Trust wide 3. Lack of compliance with Toolkit requirements **Gaps In Assurance** 4. Further development of the IG Annual Report required in 2021 5. Improved compliance with DSP toolkit required reporting by June 2021 6. **Improved collaborative working with cyber security team**	**3X4= 12** **(Mar 2021)**	3 & 5. The Data Security and Protection toolkit review is undertaken/reviewed annually - June 2021 1, 3 & **6**. Increased ask for resources within IM&T to support faster implementation of technical controls as part of DSPT - first phase approval for cyber security role for 21/22 - from Sept 2021. 4. **Second iteration of IG annual report planned for submission to F&P Committee July 2021**

Meeting	**13th July 2021**		**Board of Directors**					
Report	**Agenda item: 8.**		**Quality & Safety Committee Chair's Report, June 2021**					
Purpose of the Report	Decision		Ratification		Assurance	**x**	Information	
Author(s)	Ros Fallon				Non-Executive Director			
Board Assurance Framework	Q1-Q6							
Strategic Aims	-							
CQC Domains	Well Led							
Previous Considerations	N/A							
Summary	The purpose of this report is to inform board members of matters discussed and approved by the Quality & Safety Committee at its meeting on 22 June 2021, and to provide assurance on these matters.							
Recommendation(s)	The Board is asked to**:** • Note the contents of the report • Note the movement of BAF risk Q7 (now E9 on the latest version of the BAF) to the Finance and Performance Committee • Note the contents of the IPC BAF • Note the Mortality Indicators/Learning from Deaths Report • Note the Nursing & Midwifery Safe Staffing report • Note the Maternity Incentive Standard Submission							
Corporate Impact Assessment								
Statutory requirements	The Quality & Safety Committee is a committee of the Board of Directors							
Quality & Safety	-							
NHS Constitution	-							
Patient Involvement	-							
Risk	Quality & safety risks are overseen by the Committee							
Financial impact	-							
Equality & Diversity	-							
Communication	-							

NHS
Countess of Chester Hospital
NHS Foundation Trust

Quality and Safety Committee Chairs Report

The Quality & Safety Committee met on 22 June 2021 and the following items of business were covered:

1. **Fridge temperature monitoring:** This has been an ongoing agenda item. Whilst good progress has been made there is still an outstanding issue in relation to reporting during out of hours. Resolution may be delayed due to implementation of the new EPR therefore the timescale has been moved to August 2021.

2. **Discharge process:** revised discharge processes will be built into the 'perfect week' scheduled for mid July.

3. **Emergency Preparedness Resilience and Response (EPRR):** The Emergency Preparedness Officer role is now firmly established and this was removed from the action log.

4. **Board Assurance Framework (BAF):** each risk relating to the committee was reviewed and a consensus was reached as to the residual risk rating and mitigation.
    - It was agreed that as community prevalence has reduced then the Infection Prevention Control (IPC) was reduced however this will remain under constant review.
    - The Nursing and Midwifery Workforce risk has also has reduced with the reduction in occupancy and critical care areas now back with their original footprint.
    - A new risk (Q7) was identified relating to the requirement for a new women's and children's build with an outline business case in preparation for September 2021 which the Board is sighted on. It was agreed that this risk should be under the remit of the Finance and Performance Committee.

5. **Quality Governance Group Report:** Infection Prevention Control (IPC), Emergency Department (ED) increased activity and elective recovery were highlighted as key operational issues and were discussed in detail further on the agenda.

6. **IPC BAF**: there are 112 IPC indicators and it was reported that there is good evidence for 77% of these indicators. Training has improved as has estates and investment in cleaning. Whilst the Trust compares well with other trusts there are still challenges with two metre distancing, isolation and side rooms although these do have mitigation in place.

7. **Mortality indicators:** Whilst there is a time lag with reporting the data analysis is highlighting specialties to focus on improvement work. Structured Judgement Reviews (SJR) are also highlighting areas for improvement such as depth of coding. No serious safety or clinical concerns have been reported. It was noted how the overall process of Learning from Deaths has improved over the last two years.

8. **Maternity items:** The Ockenden Position Statement identified no red areas of concern however there are some issues relation to workforce on Delivery Suite which is being

addressed. Work is ongoing to submit evidence onto the national portal. The maternity dashboard provided a helpful overview against key metrics.

9. **Bi annual Nursing and Midwifery Staffing Report:** good progress has been made on recruitment and there are zero vacancies in established budgets. Recruitment will continue to 8% above established budgets to manage turnover. It is also expected that this will reduce agency usage. Phase 2 and 3 establishment reviews are still outstanding due to the pandemic. Whilst good discussion took place in relation to Nursing and Midwifery it was noted that the same level of scrutiny does not take place for other staff groups. As workforce reporting comes under the remit of the Finance and Performance Committee is was agreed to escalate this issue to the Trust Board.

10. **Integrated Performance Report including elective recovery:** The report was reviewed in detail and although there are still challenges with ED and Cancer performance there has been san 40% reduction in patients waiting over 52 weeks over the last two months. Trajectories will be built into future reports. There was one 'never event' reported in April and learning has been shared. Compliance with Covid screen was below plan however it was noted the work underway to improve this. A trajectory towards compliance with Continuity of carer is to be included in future reports. The number of open complaints are still above plan however it is improving. Plans are in place to include Non Executive Directors in a review of complaint letters.

11. **Draft Quality Account:** this report was reviewed within the context of a difficult year during the pandemic. The committee recognised the amount of work that has gone into improving quality and safety and agreed the priorities for 2021/22. It was noted that there is greater potential to link the priorities with recently published strategy and will be built into the committee work plan for the remainder of the year.

12. **Continuous improvement update:** the committee received a verbal update on the leadership programme and a graduation event is to be held on 7 July

13. **Clinical Strategy:** the committee received a verbal update on the Clinical Strategy in relation to specific services and subsequent service changes will be reported through the appropriate committee. Dialogue is taking place with Primary Care Networks to manage flow in ED and facilitate discharge.

Major matters arising, key agreements or decisions made

14. It was agreed that the BAF risk Q7 should move to the Effective section of the Finance and Performance Committee.
15. The Quality Accounts were considered and agreed on behalf of the Board. The final version will be shared with the Board following receipt of Stakeholder comments.

Items for escalation to Board

16. There were no items for escalation to the Board.

Recommendation

17. The Board is asked to:
    - note the contents of this report
    - note the movement of BAF risk Q7 to the Finance and Performance Committee
    - note the contents of the IPC BAF
    - note the Mortality Indicators/Learning from Deaths Report
    - note the Nursing & Midwifery Safe Staffing report
    - note the Maternity Incentive Standard Submission

Meeting	**13th July 2021**		**Board of Directors**					
Report	**Agenda item. 9.**		**Infection Prevention & Control BAF – June 2021**					
Purpose of the Report	Decision		Ratification		Assurance	x	Information	
Accountable Executive	Hilda Gwilliams				Interim Director of Nursing & Quality			
Author(s)	Karen Jones				Associate Director of Nursing IP&C			
Board Assurance Framework	Q3	Safety – Infection Prevention & Control						
Strategic Aims								
CQC Domains	Well Led							
Previous Considerations	Quality and Safety Committee 22nd June 2021							
Summary	This report is intended to provide an update on progress with Infection Prevention and Control (IPC) COVID-19 Board Assurance Framework (BAF). The framework helps providers assess themselves against the IPC PHE and related guidance as a source of internal assurance that quality standards are being maintained. It also helps identify any areas of risk and show the corrective actions taken in response. The areas of 'strong' and 'moderate' evidence are outlined within the report.							
Recommendation(s)	The Board is asked to note the contents of the report.							
Corporate Impact Assessment								
Statutory Requirements								
Quality & Safety	Improved patient safety							
NHS Constitution								
Patient Involvement								
Risk								
Financial impact								
Equality & Diversity								
Communication								

Publications approval reference: 001559 and now joint togther Publications approval reference: 001559

Infection Prevention and Control COVID-19
Board Assurance Framework – Updated 20.05.2021

(National: 22 May 2020, Version 1.2 Reviewed: 19/10/20 in line with new National document: 22nd July 2020 Version 1.3 National updated version 15th October. Version 1.4 added in red along with new forward and introduction pages)

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in evidence- based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

IPC BOARD ASSURANCE FRAMEWORK

Effective infection prevention and control is fundamental to our efforts in the control of COVID-19. A Board Assurance COVID-19 Framework will aim to assess compliance against Public Health England and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

PRIORITIES FOR 2021-2022

1	Ensure we have appropriate governance & assurance in place in relation to Infection Prevention & Control through the development of an Assurance & Accountability Framework to meet its responsibilities and accountabilities in relation to infection prevention and control and the COVID-19 pandemic and its long term requirements.
2	Development of Infection Prevention & Control Strategy which will encompass: 1. High level Strategy- Identifying core objectives and priorities 2. Delivery Programme - Detailing actions and processes to deliver the strategy. The Strategy will be supported by the Board Assurance Framework and the IPC Improvement Plan
3	Improve reporting at Divisional Level ensuring appropriate scrutiny of IPC. Governance of IPC to be standardised at all Divisional meetings
4	Ensure robust review and scrutiny of the IPC / COVID Risk Registers strengthening and enhancing the governance processes. The register will be updated and received at the IPC Strategy Group (monthly) and oversight and scrutiny will be given at the Quality & Safety Committee, Finance & Performance Committee and Senior Leadership Group. There will be clearly identified leads and specific timeframes in place for each risk, this will enable progress to be monitored, challenged and scrutinised.
5	Monitor progress from Divisions in the implementation of the IPC Management Checklist through the ward accreditation programme and provide assurance to the Board in relation to COVID-19 arrangements.
6	Ensure structured review of all IPC policies, and develop a framework to measure compliance with policies through the IPC Delivery programme that underpins the IPC Strategy. .
7	The Training Needs Analysis should be formally ratified and distributed appropriately. Compliance against these training requirements should be monitored and evidenced as such to ensure compliance targets are met.

Total Key lines of enquiry	99	
Key		
Level of Assurance	Colour	
Strong Evidence	76	77%
Moderate Evidence	23	23%
Limited Evidence	0	0%

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Level of Assurance
Systems and processesses are in place to ensure:				
Infection risk is assessed at the front door and this is documented in patient notes	Clinical pathways in place following the PHE COVID-19 Care Pathways. Implementation of pathways across emergency (ED, SAU, AMAC, Paediatrics and Obstetrics) and elective admission (surgical, endoscopy, obstetrics) streams. June 2020 - IPC management checklist overall baseline compliance score of 89% with rapid triage systems	Compliance with screening compliance not achieved consistently.	Localised action for improvement within any ward/department with identified gaps in compliance. Implementation of lateral flow testing with the ED and screening of all visitors for COVID-19 symptoms	COVID-19 screening compliance continues to be monitored through established processes. Trend illustrates high level of compliance with day 1 screening and sustained improvement with day 3 and 5 compliance.
Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Local process for clinical teams to escalate any change in condition. Appropriate bed allocation managed through Co-ordination Centre (Teletracking - CATI-3 realtime tool). Monitoring and assurance in IPR - broad oversight. COVID-19 screening results managed through the Coordination Centre 24/7 – communicated to wards, documented on EPR and database of confirmed cases maintained by IPC. June 2020 - IPC management checklist overall baseline compliance score of 79% in limiting patient movement.	Patient movement - target for >95% of patients to have less than 3 bed moves.	Trust-wide action in progress to minimise the number of patient moves, both between wards and between beds within the same ward – this is inclusive of patients with possible or confirmed COVID-19, IPC stepdowns, contact bays, bay closures and outbreak management.	Reduced prevalence of COVID-19 together with a reduction in current operational pressures has enabled adherence to COVID-19 risk pathways and correct management of patient flow.
Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Discharge/transfer pathway developed, including patient screening programmes prior to discharge to a social care setting. Patient information developed specifically in relation to COVID-19 positive patients and identifed contacts. Care home guidance for transfers agreed and standardised across the regional network.	Evidence of compliance with the regional and national discharge/transfer for discharge/transfer of COVID-19 positive patients.	Consider audit of discharge/transfer pathways to incorporate key actions identified within 'Hospital Discharge service Requirements' - Recommendations dependant on audit outcomes.	Internal hospital discharge guidance introduced 16/4/20. No patients discharged to care homes without a negative screen
Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC champions to embed and encourage best practice	IPC practice monitored through the established IPC audit programme, supplemented by the Trust wide roll out of IPC Link Practitioner (Champions) audit programme in November 2020.	Ensuring identified IPC links (Champions) across all clinical areas.	95% of clinical areas with an identifed IPC link (champion)	IPC team has established a local dashboard to record IPC champions audits - dashboards to be shared with divisions as part of monthly IPC governance packs.
Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	Monitoring of compliance with PPE is embedded within both the IPC Link Practitioner audit programme and the IPC Ward/Departmental Audit Programme.	Compliance for donning & doffing competency	PPE donning & doffing training vailable via IPCT/ E-learning. PPE donning & doffing audits in place to assess competence & compiance monthly	IPC audit programme formally recommenced in October 2020. Audit data demonstates 83% compliance.
Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	7 day system and process for staff screening, Test and Trace established through a multi-disciplinary team collaboration. Programme of staff testing in place in high risk areas. Lateral flow testing implemented then succeeded with LAMP testing	Plans to integrate resource of staff contract tracing with patient contract tracing	Enhanced staff screening in declared outbreak areas	LAMP testing established for staff testing
All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	Staff PPE training, including reminders in practice originally led by the IPC Team with support from a deidcated Floorwalker Team, Fit Testing team, daily briefings, posters and screensavers. PPE supplies for individual areas are coordinated through Silver Control and the Supplies team. PPE meeting weekly to assess PPE sustainability, plus daily stock check. PPE training embedded with inducation and mandatory training elearning package. Included on IPC mandatory training programme (clinical and non-clinical staff) and Trust Induction	Compliance with training policy-monitored though the IPC strategy group and through divisional governance though monthly ESR training compliance reporting.	IPC management checklist incorporated into the ward accreditation programme mapping priority IPC requirements Monitoring of compliance with PPE is embedded within both the IPC Link Practitioner audit programme and the IPC Ward/Departmental Audit Programme.	Level 2 IPC training compliance-78% Level 1 IPC training compliance-87% PPE donning & doffing compliance-94% Hand hygiene compliance -94%
Training in IPC standard infection control and transmission-based precautions are provided to all staff				
IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training				

All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	Comms throughout the organisation in place across key area reinforcing the 'hands, face, space' messaging (signage and floor signage). Trust implemented early the recommnedation for patient's to wear face coverings. Established processes in place for monitoring of compliance with PPE and hand hygiene. Health and safety assessments undertaken Trustwide of non-clinical and rest areas undertaken to assess capacity in relation to making areas covid secure.	IPC management checklist incorporated into the ward accreditation programme mapping priority IPC requirements	IPC education and training (mandatory training and induction) programme continuing, bespoke face to face training limited due to education and training centre re-purposed for vaccination delivery. Regular reminders of key messages delivered though nursing forums. Rolling programme of Health and safety assessments in place to monitor non-clinical and rest areas capacity in relation to making areas covid secure.	Robust comms messaging of 'hands, face, space'. Established processes in place for monitoring of compliance with PPE and hand hygiene - require process to monitor compliance with physical distancing. Assurance provided by Divisions at IPCSG
National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Information received from various national teams through formal routes e.g. CAS alerts, CMO/CNO letters etc.; - dissemination of updates co-ordinated through Silver control. IPC Team receive automated PHE updates and have escalated to NHS England for a similar process to be enabled for NHSe/i updates – updates communicated via Silver Control and approved Comms routes depending on content/intended audience. June 2020 - IPC management checklist overall baseline compliance score of 100% for Floorwalker daily briefings being shared with staff - current actions to continue to support sustained compliance. Executive Team receive updates directly from national correspondence, or via Silver Control/IPC Team (see above)	Lack of scrutiny could result in out of date gudiance being followed.	Daily COVID-19 updates disseminated through Trust comms, daily tactical calls and weekly whole hospital briefings. Updated IPC guidance reviewed by IPC team and changes highlighted through governance (IPC Strategy Group).	Robust review co-ordinated through local and national updates and disseminated via Silver Control, EPRR and IPC.
Risks are reflected in risk registers and the Board Assurance Framework where appropriate	IPC Strategy Group to have oversight of IPC and COVID-19 risk registers and approvals sort prior to Quality Governance Group Submission.	Evidence of regular review and updates of COVID-19 risk register	IPC Strategy Group to have oversight of IPC and COVID-19 risk registers and approvals sort prior to Quality Governance Group Submission. 06.05.21 - EPRR lead to oversee monthly update of executive COVID-19 risk register. All risks from the register are embedded within the IPC BAF.	COVID-19 risk register reviewed/ monitored and scrtunised monthly at IPCSG/ Quality Governance Group
Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Established systems and processes remain in place for non-COVID-19 infections and pathogens, including mandatory reporting requirements	Limitations on single room capacity have resulted in a change to isolation risk assessments , to include COVID-19 criteria and other 'alert' organisms (e.g. VRE, MRSA, CPE, Clostridium difficile)	COVID-19 and other infections are risk assessed and prioritised for single rooms accordingly e.g. suspected COVID-19, C. difficile infection, diarrhoea etc. Confirmed COVID-19 cohort area utilised to full capacity to optimise use of single rooms. IPC team matin daily IPC sitrep with surveillance of all COVID-19 and other IPC risks	Established IPC risk assessment process remains in place
That Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	Established process in place via Silver Control for daily submission of nosocomial data sitrep. DIPC oversite of all submissions		Updated process (December 2020) for declaration and reporting of COVID-19 outbreaks via National Portal. Completion of IIMARCH and executive approvla prior to outbreak declaration and submisison.	Established process remains in place via Silver Control for daily submission of nosocomial data sitrep. DIPC over site of all submissions
Ensure Trust Board has oversight of ongoing outbreaks and action plans.	Robust surveillance system in place within the IPC service for the identification of outbreaks. Management of outbreaks led by the Associate Director for IPC /Matron Infection Prevention and Control and IPC Doctor utilising PHE COVID-19 IPC guidance.	Timely review of outbreaks with documented evidence of decision making	Due to exceptional operational and capacity pressures the outbreak management process has not been able to include the closure of wards to admissions. Admissions to any outbreak area have continued to be risk assessed on an individual basis. This element of the outbreak management process has been escalated and discussed with NHSE/I.	Outbreak management process strengthened through closure to admissions of declared outbreak wards (due to reduced operational pressures).

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Level of Assurance
1. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. Systems and processes are in place to ensure:				
Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Dedicated team identification - theatre (red and blue pathways), Haematology Ward and elective day surgery, critical care (ICU), respiratory support unit (RSU).	IPC management checklist incorporated into the ward accreditation programme mapping priority IPC requirements	Implementation of IPC guidelines to minimise the risk of transmission of all micro-organisms, including COVID-19.	With the reduced prevalence of COVID-19 there is now a dedicated COVID-19 cohort area in place on Ward 44 (RSU) with designated teams assigned to care for patients within this area.
Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	Domestic Teams cover all ward/department areas regardless of COVID status, in conjunction with appropriate mask fit testing to enable the service to be delivered in higher risk areas	IPC management checklist incorporated into the ward accreditation programme mapping priority IPC requirements	An investment in excess of 800K has been approved to support an additional 2nd ward service and will include provision for ward designated Domestic Services Assistants.	Significant investment into the Domestic Teams aims to improve cleaning and catering services across the Trust. Recruitment / training underway
Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other	Facilities support terminal cleaning requirements – advised by the Coordination Centre (Note: within limitations of patient remaining in situ if terminal cleaning required due to patient capacity and flow pressures. Terminal cleaning is completed by a separate team who specialise in this bespoke service	Lack of enhanced decontamination system available.	IPC management checklist overall baseline compliance score of 100% - current actions to continue to support sustained compliance. Terminal cleaning is completed by a separate team who specialise in this bespoke service	Established Rapid Response domestic service in place to ensure decontamination and terminal decontamination of isolation rooms is undertaken. Scoping and trial of enhanced decontamination systems underway
Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance. Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	National guidance updated to include patient isolation rooms/cohort areas, toilets and bathrooms to be cleaned twice daily (minimum) – currently cleaned on a daily basis with additional wipe downs of frequently touched surfaces.	Lack of enhanced decontamination system available.	Exec Director approval for additional investment in excess of 800K to support the recruitment of additional Domestic Services staff to undertake the 2nd ward service.	Established Rapid Response domestic service in place to ensure decontamination and terminal decontamination of isolation rooms is undertaken. Scoping and trial of enhanced decontamination systems underway
Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	All environmental and equipment cleaning/disinfection is being undertaken with a combined neutral detergent/chlorine-based disinfectant (1,000ppm available chlorine); 70% isopropyl alcohol wipes as standard disinfectant for more fragile equipment that is physically clean; approved disinfectants for specialist equipment/areas as per standard practice. June 2020 - IPC management checklist overall baseline compliance score of 100% - current actions to continue to support sustained compliance.			Established process in place for decontamination of all clinical areas with chlorine based disinfectant (1,000ppm). Assurance provided to IPCSG against National Cleanliness Standards
Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products	As per standard disinfectants in use within the Trust – no new products have needed to be introduced for COVID-19. June 2020 - IPC management checklist overall baseline compliance score of 97%.	Staff adherence to cleaning processes	Not always sufficient time to allow items to air dry within the Resuscitation area (Emergency Department). 21.11.20 – Roll out of additional patient monitoring equipment undertaken by EBME	Additional monitors put in place. Regular auditing of decontamination processes. Assdurance provided through decontamination group.
As per national guidance: - 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids - electronic equipment, e.g. mobile phones, desk phones, tablets, desktops, and keyboards should be cleaned at least twice daily	Facilities undertake touch point cleaning throughout the day e.g. door/toilet handles, hand rails, toilet door handles and lift call buttons in all public areas, with additional wipe downs of frequently touched surfaces in clinical areas Clinical teams – cleaning/ decontamination communication was shared and frequently updated via Floorwalker Team and daily briefing messages, plus other team meetings Checklist for Equipment/ Environment under review by Matron group – awaiting feedback then roll out across the organisation.	Staff adherence to cleaning processes	Checklist for equipment in place. Use of 'I am clean' stickers	Checklist for Equipment/Environment decontamination now rolled out and established across the clinical care areas. IPC team to continue to monitor compliance with utilisation of checklist.

Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	National guidance updated as above, to include rooms where PPE is removed	IPC management checklist overall baseline compliance score of 36%, due to resource requirement for full implementation of requirements	Facilities have undertaken an assessment of updated guidance and a draft paper has been developed to identify the resources required to meet this requirement – requires progression. This is currently with the Director of Infection Prevention & Control for review before progressing.	Significant investment into the Domestic Teams aims to improve cleaning and catering services across the Trust. Recruitment / training underway
Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	As per established linen handling policy	June 2020 - IPC management checklist overall baseline compliance score of 90% for the compliance monitoring section relating to linen	Localised action for improvement within any ward/department with identified gaps in compliance, with a particular focus on correctly labelling linen bags (55% overall compliance score achieved for correctly labelling linen bags). Management and disposal of line is monitored through IPC audit programme. Commes disseminated via Matron group to reinforce process of labelling of line bags). 28.04.21 - Where linen that was related to any patient confirmed or suspected of Covid-19, such linen was placed into a red alginate laundry bag, and then onward into a standard white laundry bag. this process at ward level continues.	IPC to continue to reinforce and promote education to ensure compliance with linen policy.
Single use items are used where possible and according to Single Use Policy	As per established decontamination of medical devices policy. June 2020 - IPC management checklist overall baseline compliance score of of 97%		Localised action for improvement within any ward/department with identified gaps in compliance. Monitoring of single use item use is maintained through IPC audit programme	Established decontamination and medical device policy in place.
Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	As per established decontamination of medical devices policy and supported by IPC Team and daily briefing messages	Spot check assurance programme identified an overall compliance score of 58%, with the gap in compliance identified as insufficient equipment being available in a number of areas to facilitate practice	A Trust-wide action is currently in progress to assess equipment deficits and provide the required quantity of equipment to identified areas. Monitoring of equipment cleanliness is maintained through IPC audit programme.	Repeat spot-check audit undertaken by IPC Team identified 100% compliance in the decontamination of equipment.
Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Air flow assessment undertaken within ICU and single rooms within the Trust (February 2020) with remedial works progressed in ICU to optimise air flow direction National guidance updated to recommend that local consideration is given to any enhancements that could be made to improve ventilation in healthcare premises	Poor ventilation across the environment	Await the outcome of Estates ventilation assessment and report any requirements for improvement within the BAF Capital monies requested through national process to include improvements n Trust wide ventilation systems.	Ventilation group now established inaugural meeting held 18.05.21 to provide oversight and assurance.
Ensure cleaning standards and frequencies are monitored in non- clinical areas with actions in place to resolve issues in maintaining a clean environment	Roll out of 2 in 1 cleaning and disinfection wipes across all non-clinical areas. Non-clinical area cleaning guidance and checklist developed and available via COVID-19 intranet hub	Cleaning schedules not fully embedded in all non-clinical areas	Cleaning guidance and checklist (for non-clinical areas) available via COVID-19 intranet hub.	Scoping of cleaning schedules being utilised underway within non-clinical areas. Areas for improvement will be shared with Divisions
There is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	Standardised decontamination process across all COVID-19 pathways (including low risk pathways) using combination of detergent and disinfectants - Sodium hypochlorite 1,000ppm and Sanicloth AF universal wipes.			Standardised decontamination process across all COVID-19 pathways (using combination of detergent and disinfectants) remains in place.

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Level of Assurance
2. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Systems and processes are in place to ensure:				
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Established systems and processes remain in place for operational antimicrobial stewardship, including point prevalence assessments as per local programme and mandatory reporting requirements; local COVID-19 antibiotic guidelines have also been developed. COVID-19 specific 'Start smart then focus' audit completed and results/learning are being shared through medical unit meetings 02.02.21 – ASC reports to the IPC strategy group on a monthly basis to provide assurance of mandatory reporting requirements to the board via the Trust Governance structure.	Antimicrobial Stewardship Committee (ASC) paused mid 2020 - re-established in September 2020	Antimicrobial stewardship is a standing agenda item for the IPC Strategy Group – gaps in assurance can be escalated through this route pending ASC being reconvened DIPC has discussed on going medical engagement in this agenda with the Medical Director NEED UPDATE ON ANY GAPS	ASC re-established in September 2020 and continues to feed into the IPC Strategy Group.

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Level of Assurance
3. Provide suitable information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion. Systems and processes are in place to ensure:				
Implementation of national guidance on visiting patients in a care setting	National guidance for visiting patients been implemented, with support systems developed to patients, families and friends. Hospital environment adaptations implemented in consultation with Health and Safety (enhanced social distancing signage, one way systems)	Potential variation in practice	Departments undertaking risk assessment & developing SOP for safe re-commencement of visiting	Divisional assessment and SOPs under development for safe re-commencement of visiting.
Areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access	Standardised red/amber/green zone signage in place across the Trust, maintained by clinical areas with support from IPC team.	Not all areas have restricted access so there is the potential for a suspected case of COVID-19 to be isolated within any single room in the Trust	Action has been taken since the time of this baseline assessment, with Trust-wide standardised signage introduced to indicate red/amber/green zones, plus the requirement for doors to be kept closed is consistently reinforced through ward visits and comms briefings. Adherence to pathways enhanced through oversight from co-ordination centre - ensuring patient's are placed within appropriate risk pathway.	Central access to signs available via Trust Shared drive. Requirement to keep doors closed continually reinforced by IPC during clinical visits
Information and guidance on COVID-19 is available on all Trust websites with easy read versions	Trust website (COVID-19 hub) has defined links to national resources, including easy read versions. Hub maintained and monitored by EPRR, IPC and Comms team. IPC team engage with the comms team to ensure links to PHE guidance is current.		Current actions to continue to support sustained compliance	Enhanced COVID-19 intranet hub developed.
Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Clinical handover routinely includes infection risk/status, including electronic and ED handover proforma; infection status is also included with e-discharge and transfer of care documentation	100% compliance with communicating infection status was identified for discharges or transfers to other healthcare or social care providers	Localised action for improvement within any ward/department with identified gaps in compliance Current actions to continue to support sustained compliance NEED UPDATE FROM ?WHO AS TO HOW THIS IS MONITORED (??WARD ACCREDITATION)	Established process includes Infection risk/status on handover, transfer documentation.
There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	Enhanced comms, posters and signage in place at key areas/entrances/rest areas across the Trust promoting compliance with 'hands, face and space' advice, oversight maintained by EPRR. Site assessment undertaken and maintained by Health and Safety.			Development of patient packs which include hand hygiene information, hand wipes and face makes to improve and enhance compliance.

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Level of Assurance
4. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people. Systems and processes are in place to ensure:				
Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	Clinical pathways in place following the PHE COVID-19 Care Pathways. Implementation of pathways across emergency (ED, SAU, AMAC, Paediatrics and Obstetrics) and elective admission (surgical, endoscopy, obstetrics) streams. June 2020 - IPC management checklist overall baseline compliance score of 89% with rapid triage systems. Triage process to assess for COVID-19 risk in place across assessment areas.	Compliance with screening compliance not achieved consistently.	Localised action for improvement within any ward/department with identified gaps in compliance. Implementation of lateral flow testing with the ED and screening of all visitors for COVID-19 symptoms	COVID-19 screening compliance continues to be monitored through established processes. Trend illustrates high level of compliance with day 1 screening and sustained improvement with day 3 and 5 compliance.
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non-COVID-19 cases to minimise the risk of cross-infection, as per national guidance				
Staff are aware of agreed template for triage questions to ask				
Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Competency assessed locally with ED to ensure staff are trained and competent to undertake patient triage. Manchester triage process implemented			Standardised triage process within the ED remains in place.
Face coverings are used by all outpatients and visitors Face masks are available for patients with respiratory symptoms	Face covering and Face masks available at all Trust entrances and distributed to all staff and visitors entering the Trust		07.05.21 - IPC team leading on development of 'patient packs' containing masks and hand wipes. To be provided to all patients on admission. Procurement have supported with provision of bags, mask and wipes. Medical illustration provided information in relation to hand hygiene. Volunteer co-ordinator providing support and resource to prepare the packs.	Face covering and Face masks continue to be available at all Trust entrances and distributed to all staff and visitors entering the Trust Spot checks by IPCT
Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	Posters and comms distributed on the correct use of facemasks. All patient's continue to be encouraged by staff to use facemasks where tolerated		07.05.21 - IPC team leading on development of 'patient packs' containing masks and hand wipes. To be provided to all patients on admission. Procurement have supported with provision of bags, mask and wipes. Medical illustration provided information in relation to hand hygiene. Volunteer co-ordinator providing support and resource to prepare the packs.	Development of patient packs which include hand hygiene information, hand wipes and face makes to improve and enhance compliance. Spot checks by IPCT
Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Trust wide assessment of key reception areas undertaken and led by estates. Areas of 'high traffic' identified and Perspex screens in place.		Perspex screens in place at all key reception areas identified as 'high traffic' areas	Complete
Mask usage is emphasised for suspected individuals	Local recommendation that all patients wear a surgical face mask, at all times, if tolerated.	AUDIT AND MONITORING PROCESS	Localised action for improvement within any ward/department with identified gaps in compliance and consistently reinforced through ward visits and Comms briefings. 07.05.21 - IPC team leading on development of 'patient packs' containing masks and hand wipes. To be provided to all patients on admission. Procurement have supported with provision of bags, mask and wipes. Medical illustration provided information in relation to hand hygiene. Volunteer co-ordinator providing support and resource to prepare the packs.	Development of patient packs which include hand hygiene information, hand wipes and face makes to improve and enhance compliance.

Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Some front door areas/departments have a screened reception desk - all reception desks, including outpatients require assessment for physical separation options e.g. screens	Availability of Perspex screens currently limited across inpatient areas	Perspex screens in place at all key reception areas identified as 'high traffic' areas. Scoping underway to implement screens within high risk inpatient areas	Perspex screen in use in reception areas across the Trust. High risk inpatients prioritised for next phase pf Perspex screen between bed areas.
For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Process developed to isolate/cohort patients who develop signs/symptoms of COVID-19 during their admission, or who screen positive for COVID-19 as part of any assessment.	IPC management checklist overall baseline compliance score of 38%, with the gap in assurance identified as limitations for enhanced contact tracing.	Interim action taken since this baseline assessment was undertaken, to introduce a method of enhanced contact tracing through Meditech and teletracking. This became unsustainable during the second wave due to the limited resource allocated for patient contact tracing. 15.03.21 - Continuous improvement mapping process on place, recommendation to align resource for contact tracing (staff and patients). This has been added to the corporate COVID-19 risk register and will be monitored monthly	Continuous improvement mapping process in place, recommendation to align resource for contact tracing (staff and patients). This has been added to the corporate COVID-19 risk register and will be monitored monthly
Patients with suspected COVID-19 are tested promptly	Laboratory capacity supports patient testing for COVID-19. Established process to monitor compliance with emergency admission COVID-19 screening, plus screening on day 3 and day 5 of admission. June 2020 - IPC management checklist overall baseline compliance score of 100% - current actions to continue to support sustained compliance	Compliance with day 3 and day 5 admission screening	Screening checklist introduced across clinical area & incorporated into meditech. Weekly compliance report compiled and disseminated to clinical leads. Areas with lower compliance highlighted and targeted for improvement. March 2021 - twice weekly screening introduced as method to improve day 3 and day 5 screening compliance (Ward 33, Ward 34 and Ward 53)	COVID-19 screening compliance continues to be monitored through established processes. Trend illustrates high level of compliance with day 1 screening and sustained improvement with day 3 and 5 compliance.
Patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re- tested and contacts traced	Clinical pathways in place following the PHE COVID-19 Care Pathways, incorporating isolation/cohort of patients who develop signs/symptoms of COVID-19 during their admission, or who screen positive for COVID-19 as part of any assessment. Established process to monitor compliance with emergency admission COVID-19 screening, plus screening on day 3 and day 5 of admission.	IPC management checklist overall baseline compliance score of 38%, with the gap in assurance identified as limitations for enhanced contact tracing.	Clinical pathways in place to ensure appropriate placement of patients	Continuous improvement mapping process in place, recommendation to align resource for contact tracing (staff and patients). This has been added to the corporate COVID-19 risk register and will be monitored monthly
Patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	Only urgent/essential elective/planned services are currently being delivered. Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance		Robust pathways in place to ensure appropriate placement of patients	Process for COVID-19 screening of all emergency and elective admissions in place. Temperature checking and symptom checking in place at key entrances to the Trust

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Level of Assurance
5. Systems to ensure that all care workers (including contractors nd volunteers) are aware of and discharge responsibilities in the process of preventing and controlling infections. Systems and processes are in place to ensure:				
Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Clinical pathways in place following the PHE COVID-19 Care Pathways. Implementation of pathways across emergency (ED, SAU, AMAC, Paediatrics and Obstetrics) and elective admission (surgical, endoscopy, obstetrics) streams. June 2020 - IPC management checklist overall baseline compliance score of 89% with rapid triage systems. Implementation of one way systems and dedicated entrance/exit across the patient pathways (ED, AMAC, Theatres, SAU).	Dedicated entrance/exits within care pathways (Red/Amber) areas (AMU).	Clear signage of zoned areas with the AMU identifying red, amber and green pathways. Dedicated nursing staff deployed to red/amber pathways.	Robust implementation of care pathways across emergency and elective admission care areas. Limitation with the infrastructure of the AMU to apply dedicated entrances/exits to red/amber pathways.
All staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other	Staff PPE/IPC training, including reminders in practice originally led by the IPC Team with support from a dedicated Floorwalker Team, Fit Testing team, daily briefings, posters and screensavers. PPE supplies for individual areas are coordinated through Silver Control and the Supplies team. PPE meeting weekly to assess PPE sustainability, plus daily stock check. PPE training embedded with indication and mandatory training elearning package. Included on IPC mandatory training programme (clinical and non-clinical staff) and Trust Induction. All staff induction and mandatory training records maintained centrally through electronic staff records (ESR).	Compliance with training policy- monitored though the IPC strategy group and through divisional governance though monthly ESR training compliance reporting.	June 2020 - IPC management checklist overall baseline compliance score of 100% - with current actions to continue to support sustained compliance. Monitoring of compliance with PPE is embedded within both the IPC Link Practitioner audit programme and the IPC Ward/Departmental Audit Programme.	17.05.2021: Level 2 IPC training compliance-78% Level 1 IPC training compliance-87% PPE donning & doffing compliance-94% Hand hygiene compliance -94%
All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it safely				
A record of staff training is maintained				
Appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed	Central decontamination processes developed for 3M Jupiter hoods and reusable eye protection. June 2020 - IPC management checklist overall baseline compliance score of 100% for staff access to the PPE they require - current actions to continue to support sustained compliance. PPE related incidents would be recorded via incident reporting system (Datix) and actioned accordingly	Gaps in assurance would be identified via Datix reports NEED TO ENSURE REPORTS IS SHARED WITH IPCSG	Development and implementation of a centralised service for the decontamination and reuse of eye protection and powered respirator hoods.	Established central process for decontamination of reusable eye protection and powered respirator hoods in place. Established incident reporting system (datix) in place.
Any incidents relating to the re-use of PPE are monitored and appropriate action taken				
Adherence to PHE national guidance on the use of PPE is regularly audited	Formal monitoring of compliance with PPE guidance is incorporated into the IPC departmental audit programme and the IPC Link Practitioner audit programme. June 2020 - IPC management checklist overall baseline compliance score of 100% with PPE use - current actions to continue to support sustained compliance			Established programme of IPC audit and compliance monitoring in place.
Staff regularly undertake hand hygiene and observe standard infection control precautions	Established trust wide hand hygiene compliance monitoring programme in place. Hand hygiene practice also audit as part of IPC departmental audit programme and the IPC Link Practitioner audit programme			Established trust wide hand hygiene compliance monitoring programme in place. Hand hygiene practice also audit as part of IPC departmental audit programme and the IPC Link Practitioner audit programme
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: 1. hand hygiene facilities including instructional posters 2. good respiratory hygiene measures 3. maintaining physical distancing of 2 meters wherever possible unless wearing PPE as part of direct care 4. frequent decontamination of equipment and environment in both clinical and non-clinical areas 5. clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	Hand hygiene facilities available to all patients/staff within clinical areas (hand wash basins, hand sanitizer). Roll out undertaken to ensure hand hygiene instructional posters are displayed in all toilet areas across the Trust. A review of the availability of hand sanitizer identified a requirement for additional wall mounted sanitizer dispensers. Works in progress to fit additional dispensers. Signage promoting physical 2 meter distancing in place across communal (corridors, stairwells). Provision of environmental cleaning materials (2in1) detergent/disinfectant wipes and hand sanitizer distributed to all non-clinical areas. Posters and comms distributed on the correct use of facemasks. All patient's continue to be encouraged by staff to use facemasks where tolerated. Checklist for Equipment/ Environment under review by Matron group – awaiting feedback then roll out across the organisation.	Ability to maintain social distance in clinical areas	Level of availability of hand sanitiser across all OPD areas increased utilising portable hand sanitiser. Number of hand hygiene dispensers increased throughout OPD, Compliance with hand hygiene, respiratory hygiene/mask/PPE use, equipment/environment decontamination monitored through IPC audit programme and IPC link practitioner audit programme. Clear messengering for Social Distancing	Systems, process and policies in place to ensure compliance/monitoring and adherence with all IPC measures. Assurance provided at IPCSG

Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	Use of disposable paper hand towels is standard practice within all clinical areas	Progress check required with Facilities on progress with removing the small number of hand dryers located within some public toilet areas		Complete
Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff area	Staff information, including reminders in practice supported through staff communication e.g. daily briefings. Guidance on hand hygiene available across all public toilets and staff areas (on soap/sanitiser dispensers) - gap in assurance relating to guidance not incorporating drying.	Audit & monitoring	Action required to purchase click frames to appropriately display the national hand hygiene guidance poster within all patient/public bathrooms/toilets – adjacent, or near to hand wash basins for ease of reference. 21.11.20 – Collaborative project between estates and IPC. Appropriate posters and click frames procured. Programme now established and works on-going to ensure hand hygiene instructional posters are displayed in all toilet areas across the Trust.02.02.21 - Repeat spot-check audit undertaken by IPC Team identified an increase in compliance to 74%.	Additional posters sourced and currently being rolled out across the Trust.
Staff understand the requirements for uniform laundering where this is not provided for on site	Staff information, including reminders in practice supported by Floorwalker Team and through staff communication e.g. daily briefings. June 2020 - IPC management checklist overall baseline compliance score of 94%	Audit & monitoring	Localised action for improvement within any ward/department with identified gaps in compliance. Provision of scrubs to all staff working on COVID-19 cohort areas.	Established uniform policy. Provision of scrubs to all staff working on COVID-19 cohort areas.
All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms	Staff information, including reminders in practice are supported by Occupational Health and IPC Team and through staff communication e.g. Intranet resources, daily briefings. June 2020 - IPC management checklist overall baseline compliance score of 100% - current actions to continue to support sustained compliance	Audit & monitoring	Established process/SOP for staff screening. If staff develop COVID-19 symptoms to inform their manager, arrange to be screened via Trust screening service and self-isolate pending screen result. Process supported by Centrla nursing workforce team, medical staffing, line managers and human resources.	Established process/SOP for staff screening. If staff develop COVID-19 symptoms to inform their manager, arrange to be screened via Trust screening service and self-isolate pending screen result.
A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals	COVID-19 surveillance processes established and maintained by a collaborative of the Business Intelligence and IPC Team. Surveillance process identifies community/hospital cases with escalation/incident reporting process for all hospital onset cases. COVID-19 screening dashboard maintained and incorporated into monthly integrated performance dashboard for executive oversight.	Audit & monitoring	Surveillance data also shared though daily tactical meetings, IPC sittrp and critical care sitrep	COVID-19 surveillance processes established and maintained by a collaborative of the Business Intelligence and IPC Team. Surveillance process identifies community/hospital cases with escalation/incident reporting process for all hospital onset cases. COVID-19 screening dashboard maintained and incorporated into monthly integrated performance dashboard for executive oversight.
Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Process established for SBAR investigation of all hospital onset COVID-19 cases. All cases linked to a declared outbreak reviewed as part of an enhanced outbreak investigation process.	Development of process for investigation of outbreaks, hospital onset COVID-19 cases and hospital onset COVID-19 related deaths	Risk recovery plan developed in conjunction with Risk and Safety Team and IPC. Designated project lead allocated (Steve Bridge) supported with redeployed and agency staff. IPC team collating detailed information of declared outbreaks to feed into the investigation process.	Clear process now established for the review of COVID-19 outbreaks (developed by risk and safety and IPC team). IPC team have completed process of outbreak data collection to support facilitation of outbreak table-top reviews
Robust policies and procedures are in place for the identification of and management of outbreaks of infection	Robust surveillance system in place within the IPC service for the identification of outbreaks. Management of outbreaks led by the IPC Matron/IPC tea, and IPC Doctor utilising PHE COVID-19 IPC guidance.	Operational pressure may influence decision making around ward closure during outbreak, leading to increased risk of prolonged outbreaks.	Outbreak management process escalated and discussed with NHSE/I. Outbreak management process strengthened through closure to admissions of declared outbreak wards (due to reduced operational pressures).	Management of outbreaks currently led by the (Acting) Lead Infection Prevention and Control Nurse and IPC Doctor utilising PHE COVID-19 IPC guidance.

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Level of Assurance
6. Provide or secure adequate isolation facilities. Systems and processes are in place to ensure:				
Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Clinical pathways in place following the PHE COVID-19 Care Pathways. Implementation of pathways across emergency (ED, SAU, AMAC, Paediatrics and Obstetrics) and elective admission (surgical, endoscopy, obstetrics) streams. June 2020 - IPC management checklist overall baseline compliance score of 89% with rapid triage systems. Implementation of one way systems and dedicated entrance/exit across the patient pathways (ED, AMAC, Theatres, SAU).	Dedicated entrance/exits within care pathways (Red/Amber) areas (AMU).	Clear signage of zoned areas with the AMU identifying red,amber and green pathways. Dedicated nursing staff deployed to red/amber pathways. Portable screens erected as a physical separation between pathways.	Structured implementation of care pathways across emergency and elective admission care areas. Limitation with the infrastructure of the AMU to apply dedicated entrances/exits to red/amber pathways. Prioritisation of Perspex screens for high risk areas for next phase of installation
Patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Process in place to triage patients who have confirmed COVID-19, are suspected to have COVID-19 (high suspicion or low suspicion), patients who are shielding or vulnerable and patients who have no COVID-19 risk factors, to support decision making for bed allocation. NEED TO EMBED TRIAGE TOOL. Development and implementation of COVID-19 Patient Risk Pathways (utilising the PHE IPC Guidance) - see column F.	IPC management checklist overall baseline compliance score of 52% for isolation in a single room with clinical wash hand basin and en-suite facilities (low compliance due to limited ensuite facilities in single rooms)	Challenges with resources (infrastructure) to achieve compliance – insufficient single rooms with required en-suite Development and implementation of cohort wards for confirmed COVID-19 cases - this impacted on reducing the risk of nosocomial transmission through reducing the distribution of COVID-19 positive cases across the organisation. Patients are cohorted by identified risk group, single rooms prioritised for immunosuppressed patients, clinically extremely vulnerable patients (shielding) or patients with another increased risk factor. Teletracking system to trace all patient flow, bed moves and provide centrla oversight of possible and confirmed COVID-19 cases. 19.01.21 - 5 isolation PODS received by the Trust Joint estates/facilities/ IPC plan to safely operationalize PODS. Implemented within the Modular Ward (CCU) to increase isolation capacity	Prioritisation of clinical risk assessments in place to ensure approiate isolation of patients with infection risk.
Areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE	Designated cohort areas for all confirmed COVID-19 cases. Designated areas within the Emergency Department and Theatres to separate suspected COVID-19 and non-suspected cases. Full compliance within critical care unit of patient segregation (100% single rooms within the Critical care unit).	The Trust does not currently have a standard 2m separation between patients within general ward areas	Action required to consider how the standard 2m separation may routinely be achieved, plus options for alternative screens that will not obscure visibility and will continue to support use of privacy curtains when required for care activity. Identified risk added to the COVID-19 Risk Register for monitoring and oversight at the IPC Strategy Group. Request for Capital monies through national process submitted to fund separation screens to support this action. 19.01.21 - Clear screens now in place within a limited number of clinical areas (Renal Dialysis, Ward 44).	Prioritisation of clinical risk assessments in place to ensure appropriate isolation of patients with infection risk. Prioritisation of Perspex screens for high risk areas for next phase of installation
Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Established systems and processes remain in place for patients with a resistant/alert organism, to ensure risk assessment for the most appropriate placement in conjunction with available resources. Patient infection risk assessed within nursing admission assessment.	IPC management checklist overall baseline compliance score of 80% - with the gap in compliance identified as the requirement for improved documentation of infection risk within patient medical records	A number of resistant/alert organisms are taking a lower priority for isolation in a single room than previously e.g. MRSA, VRE, due to limitations on single room capacity and patients with a higher priority for isolation e.g. COVID-19 or vulnerable patient groups. IPC team provide oversight of patients with resistant/alert organisms through daily update and dissemination of IPC surveillance sitrep. IPC risk assess on a case by case basis proving clinical support and advice on patient management.	Prioritisation of clinical risk assessments in place to ensure appropriate isolation of patients with infection risk.

COCH - COVID-19 Patient Risk Pathways

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Level of Assurance
7. Secure adequate access to laboratory support as appropriate. Systems and processes are in place to ensure:				
Ensure screens taken on admission given priority and reported within 24hrs	21.11.20 – Process for screening for COVID-19 for all emergency admissions in place, with rapid screening of suspected cases. Monitoring process of screening compliance established with overall Trust compliance for admission screening (w/c 09.11.20) reported as 84%. High level of compliance (98%) demonstrated from key admission pathway are (AMU). 10.02.21 –			Systems/ processes and policies in place to ensure compliance. Assurance reported through IPCSG
Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Turn-around times are monitored regularly for each separate PCR platforms. Results are reported daily to Medical Microbiology Consultants, Microbiology and Pathology Managers. These are shared with the Executive team on a regular basis. Monitoring focuses on the time taken from receiving the			
Testing is undertaken by competent and trained individuals	Microbiology Laboratory SOPs in place for COVID-19 testing. Staff training records all stored and maintained locally within the microbiology laboratory.			Microbiology Laboratory SOPs in place for COVID-19 testing. Staff training records all stored and maintained locally within the microbiology laboratory.
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Established process in place to monitor compliance with emergency admission COVID-19 screening, plus screening on day 3 and day 5 of admission and weekly thereafter. On-site staff screening process in place for identified staff groups and for symptomatic staff.	Compliance with day 3 and day 5 screening. Staff uptake with LAMP testing.	Implementation of asymptomatic staff screening (through later flow testing and then LAMP testing)	Established staff screening service and SOP in place. Compliance uptake reported through IPCSG
Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Protocols for testing and reporting of positive and negative results are developed in the laboratory and regularly reviewed with changing recommendations and guidelines. All methods used have undergone strict verification processes, SOPs created, using internal quality controls and performing regular environmental testing are included into the testing regimen. Cepheid testing is UKAS accredited, further platform are awaiting UKAS accreditation. All results including positive and negative results are reported nationally through SGSS.			Protocols for testing and reporting of positive and negative results are developed in the laboratory and regularly reviewed with changing recommendations and guidelines. All methods used have undergone strict verification processes, SOPs created, using internal quality controls and performing regular environmental testing are included into the testing regimen. Cepheid testing is UKAS accredited, further platform are awaiting UKAS accreditation. All results including positive and negative results are reported nationally through SGSS.
Screening for other potential infections takes place	Established processes for infection/colonisation screening remain in place for microbiology testing.		Compliance monitoring via established systems in place for MRSA screening	Established processes for infection/colonisation screening remain in place for microbiology testing.

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Level of Assurance
8. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections. Systems and processes are in place to ensure:				
Staff are supported in adhering to all IPC policies, including those for other alert organisms	Established IPC systems and processes remain in place, with these being strengthened by the COVID-19 response; supported by staff information, including reminders in practice by IPC Team and through staff communication e.g. daily briefings. Adherence to IPC policies is supported and reinforced through staff engagement by the ADONs, Matrons, Departmental Managers.	Potential variability in adherence to practice	Assurance monitoring supported through established systems (IPC audit programme, divisional governance boards) plus COVID-19 spot check assurance programme	Formal monitoring of compliance with IPC policies is incorporated into the IPC departmental audit programme and the IPC Link Practitioner audit programme.
Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Information received from various national teams through formal routes e.g. CAS alerts, CMO/CNO letters etc.; - dissemination of updates co-ordinated through Silver control. IPC Team receive automated PHE updates and have escalated to NHS England for a similar process to be enabled for NHSe/i updates – updates communicated via Silver Control and approved Comms routes depending on content/intended audience.		Daily COVID-19 updates disseminated through Trust comms, daily tactical calls and weekly whole hospital briefings. Updated IPC guidance reviewed by IPC team and changes highlighted through governance (IPC Strategy Group).	Local and national updates co-ordinated an disseminated via Silver Control, EPRR and IPC. January 2021 - updated guidance 'COVID-19; Guidance for maintaining services within health and social care setting - Infection prevention and control recommendations, gap analysis clarified use of valved respirators within a theatre environment. Reinforced messaging through comms and though engagement with Theatre leads and IPC.
All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	All COVID-19 related clinical waste is disposed of via 'orange' Category B waste stream. Waste is segregated at source and housed in clinical waste containers. Removed from Trust site by approved/licenced waste contractor. 100% - current actions to continue to support sustained compliance			Compliant
PPE stock is appropriately stored and accessible to staff who require it	PPE is appropriately stored and availability to all areas. Centralised system established for the provision of PPE to all clinical areas.	Audit & Monitoring		PPE is appropriately stored and availability to all areas. Centralised system established for the provision of PPE to all clinical areas.

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Level of Assurance
9. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection. Systems and processes are in place to ensure:				
Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Established local risk assessments for staff in place. Co-ordination/redeployment of 'At risk' staff led by Central Workforce Planning with staff allocated/redeployed to appropriate areas, guided by risk assessment outcomes.	Consistency of application of risk assessment and changes to risk assessment as more national guidance is provided requires regular updating and communication to staff and managers.	Regular briefings are provided to staff and work to develop an electronic RA tool will provide central oversight to identify gaps and allow for identification of emerging issues.	Established local risk assessments for staff in place. Co-ordination/redeployment of 'At risk' staff led by Central Workforce Planning with staff allocated/redeployed to appropriate areas, guided by risk assessment outcomes.
That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	Co-ordination by Workforce Planning in collaboration with Occupational Health to ensure appropriate staff risk assessment is undertaken with staff allocated/redeployed to appropriate areas, guided by risk assessment outcomes.	Risk Assessments are submitted and reported on-line, to generate monthly reports. Such reports are identified for each Division/Service Area and also separately show BAME Risk Assessment compliance data.	HR Business Partners review and discuss % compliance with the Divisions, usually at Finance & Performance meetings, and provide support on a case-by-case basis. The current Trust-wide average Risk Assessment compliance is reported as 87%, and the BAME average compliance is reported as 94%. The data enables analysis, to interpret trends and to address compliance as required.	Occupational Health support with clinical individual risk assessment of staff referred by managers. OH practitioners use the Society of Occupational Medicine and University of Glasgow's covid return to work risk assessment guidance; and the covid age medical assessment developed by the Association of Local Authority Medical Advisors, in consensus with the NHS North-West Consultants in Occupational Medicine group. Fifty eight (58) Covid-19 specific OH consultations have taken place so far in 2021.
Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Established fit testing programme (using reusable FFP3 respirators) led by Emergency Planning Lead. Oversight of process maintained through Respiratory Protective Equipment Group.	Robust central record log of staff fit tested (with a reusable respirator)	Emergency Planning Lead in process of developing database to record fit testing data. Processes in place for safe decontamination of re-useable FFP3.	Reusable respirators introduced and integrated within the Fit Testing strategy/programme – led by Emergency Planning Data collection for Respiratory Protective Equipment collated through ESR. Data cleanse underway to ensure validity.
Staff who carry out fit test training are trained and competent to do so	Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR and Silver Control. FFP3 Fit Testing delivered via quantitative process using a Portacount machine. All staff who provide fit testing have been trained in the use of the Portacount machine (Training provided by 'Full Support Healthcare')		Deployment of trained fit tester to trust via central NHS Funding.	All staff conducting qualitative (portacount) fit testing are trained by an accredited training provider (Full Support Healthcare) to meet the requirements of HSE INDG419. This includes a mix of substantive COCH Staff, Bank Staff and staff provided by Ashfield Healthcare under the DHSC Fit Test Framework.
All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Established fit testing programme (using an FFP3 respirator) led by Emergency Planning Lead. Oversight of process maintained through Respiratory Protective Equipment Group.	Robust central record log of staff fit tested (with all forms of FFP3 respirator)	Emergency Planning Lead in process of developing database to record fit testing data.	Data collection for Respiratory Protective Equipment collated through ESR. Data cleanse underway to ensure validity. Respiratory Protective Equipment (RPE) group (sub-committee of the IPC Strategy Group). The RPE group reports to the IPC Strategy Group monthly – providing assurance of the governance processes in place for fit testing.
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation				
For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods				
For members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm				
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health				
Following consideration of reasonable adjustments e.g. respiratory hoods, personal re- usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record				
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board				

Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	For nursing, Centralised Nursing Workforce Team in place. This 'hub' supports safe deployment of staff, tracks movements, staff absences and screening. Medical Staffing team in place to support medical staff deployment.	Daily monitoring and escalation	Planned/elective pathways and urgent/emergency pathways established in a number of areas – identified that staff are moved between areas of the Trust as staffing levels do not always support dedicated teams of staff for identified areas – this is risk assessed	For nursing, Centralised Nursing Workforce Team continue to support and facilitate safe deployment of staff, tracks movements, staff absences and screening. Medical Staffing team continue to support medical staff deployment.
All staff adhere to national guidance on social distancing (2metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	Staff information, including reminders in practice supported by IPC Team and through staff communication e.g. daily briefings Staff routinely wear a face mask in all areas of the Trust, both clinical and non-clinical areas, as per updated national guidance Health and Safety assessments of all workplace settings undertaken across the organisation by Health and Safety Team. Central record of these assessments that have been undertaken is maintained by Health and Safety. Space Utilisation group formed – with objective to evaluate the safe utilisation of work space across the organisation. Scoping exercise undertaken by the estates team to identify and ensure areas of increased traffic have appropriate Perspex screens in place at reception areas. All staff rest areas adjusted to be COVID-19 secure (to ensure 2 metre distancing, provision of wipes for environmental decontamination.	IPC management checklist overall baseline compliance score of 90% with social distancing	Health and Safety have co-ordinated 'covid secure' assessments of all non-clinical areas - maintaining a database of assessments	Systems. processes and policies in place and fully embedded across the Trust. Assurance provided by Divisions at IPCSG.
Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	Use of facemasks applies to all staff in all areas of the organisation. (Exclusions being if in a single occupancy office with the door closed or when eating/drinking when in a staff rest area).		Compliance reinforced through comms and staff engagement. Monitored through IPC audit programme	High level of compliance with PPE use evidenced through IPC audit programme.
Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	IPC management checklist overall baseline compliance score of 90% with social distancing. Reconfiguration of staff rest areas/staff restaurant to ensure 2m social distancing. Availability as accessibility to staff rest areas increased (near main entrance and within women's & children's building)		Staff restaurant hours (Lunch time) now extended to enable break times to cover a broader period.	
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Staff information on wellbeing and how to access testing is supported by managers, Occupational Health and through staff communication e.g. Intranet resources, daily briefings Staff absence is routinely monitored through eRoster/ESR	HR Business Partners, in partnership with Occupational Health (and Trade Unions where appropriate), continue to monitor and advise, in accordance with Trust Policies, including NHS Employers and National Guidance.	Partnership discussions are held with Managers, to identify and consider reasonable adjustments/re-deployment, to ensure continued support and that colleagues are regularly updated and provided with meaningful work.	Staff wellbeing and how to access testing continually supported by managers, Occupational Health, Workforce Planning and through staff communication e.g. Intranet COVID-19 hub, daily briefings Staff absence is routinely monitored through eRoster/ESR. 29.04.21 - OH supply daily data to Workforce on named staff who are isolating due to a positive test, to differentiate from other covid related absences. OH field calls daily/as necessary from all staff groups/managers and give advice on how/ when to test. OH & IPC liaise with the LAMP testing project as necessary to check consistency of messaging. Staff working on Track & Trace are briefed in support options for staff who are isolating either due to a positive test themselves, or as a cloe contact of a colleague who is positive.
Staff that test positive have adequate information and support to aid their recovery and return to work	Staff are routinely signposted to national resources and are supported by their manager, workforce hub and Occupational Health Track and trace team (facilitated by Occupational Health) contact individuals directly on receipt of test results and provide advice and guidance as required.		Occupational Health continue to contact individuals directly on receipt of test results (during office hours) and provide advice and guidance as required. Communication of positive result (out-of hours) is facilitated by the staff test and trace system. Occupational Health facilitate a staff Track & Trace system 7 days per week, contacting all positive PCR & LAMP tests and failed PCR tests results and provide advice and guidance as required. 7 day escalation to IPC is available. Any community tested positives notified to OH or IPC are traced in the same way; as are any national NHS Test and Trace	Staff continue to be guided to national PHE/NHS guidance and are supported by their manager and Occupational Health

Meeting	**13th July 2021**		**Board of Directors**					
Report	**Agenda item 10(a)**		**Mortality Indicators Report – May 2021**					
Purpose of the Report	Decision		Ratification		Assurance	X	Information	
Accountable Executive	Darren Kilroy				Executive Medical Director			
Author(s)	Michelle Greene Denise Wood				Divisional Medical Director Head of Information & Performance			
Board Assurance Framework								
	Q5	Patient safety -failure to identify avoidable clinical harm and avoidable death						
Strategic Aims	To provide assurance on the Learning from Deaths process							
CQC Domains	Safe							
Previous Considerations	Quality & Safety Committee – 22nd June 2021							
Summary	This report is intended to: • Summarise the key mortality indicators • Highlight areas of concern • Assure the Board of actions in place for improvement.							
Recommendation(s)	The Board is asked to note the overall performance against all areas and actions being taken to meet targets							
Corporate Impact Assessment								
Statutory Requirements	Meets the Trust compliance with Learning from Deaths mandated reporting							
Quality & Safety	Improve patient safety							
NHS Constitution	Demonstrate improvements to HSMR and SHMI rates							
Patient Involvement								
Risk								
Financial impact								
Equality & Diversity								
Communication								

Trust Mortality Indicator Report – May 2021

1. Executive Summary

Indicator	Result	Threshold	Date range	Previous Result
SHMI	**106.7**	100	Jan 20 to Dec 20	**106.5**
HSMR	**131.1**	100	Mar 20 to Feb 21	**125.9**
Elective HSMR Admissions: Crude Mortality Rate	0.2%	0.1%	Mar 20 to Feb 21	0.2%
Non-Elective HSMR Admissions: Crude Mortality Rate	7.6%	5.7%	Mar 20 to Feb 21	7.2%
Mortality Reviews Completed	12%		Apr-20 to Mar-21	12%

The Trust continues to be a statistical outlier for the HSMR rate. There are 18 conditions which are statistical outliers and 7 areas with a CUSUM alert which warrant further investigation.

Chart 1 – HSMR compared to Dr Foster Covid-19 peer group

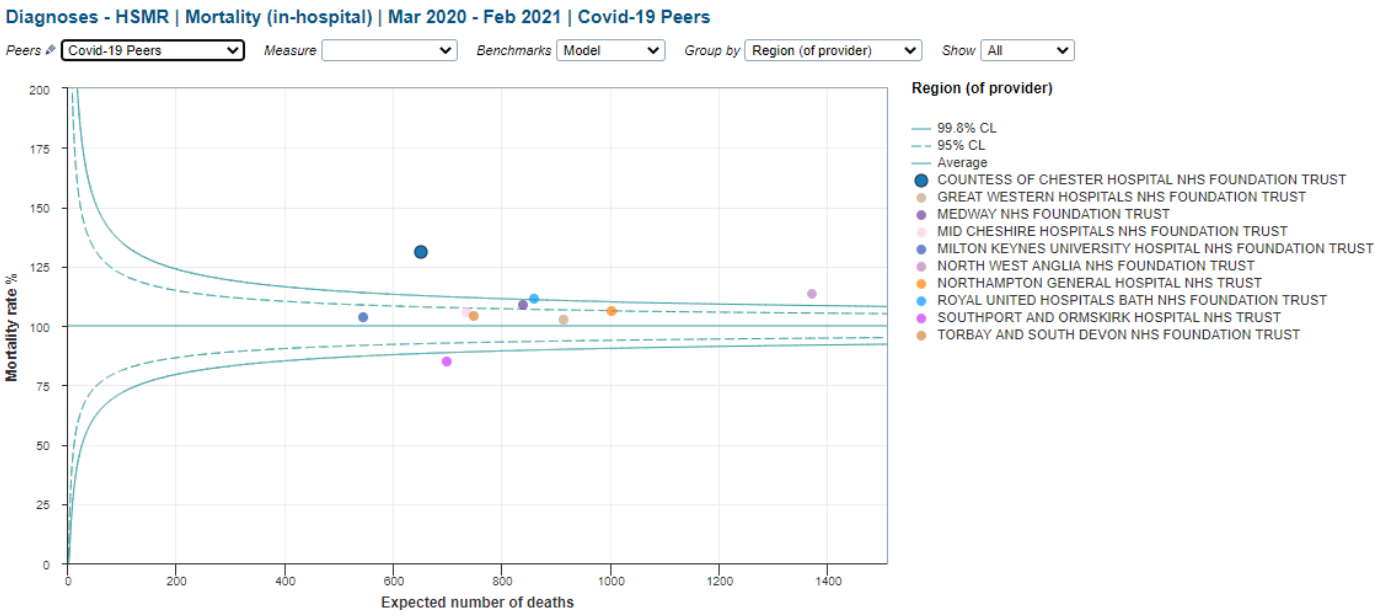
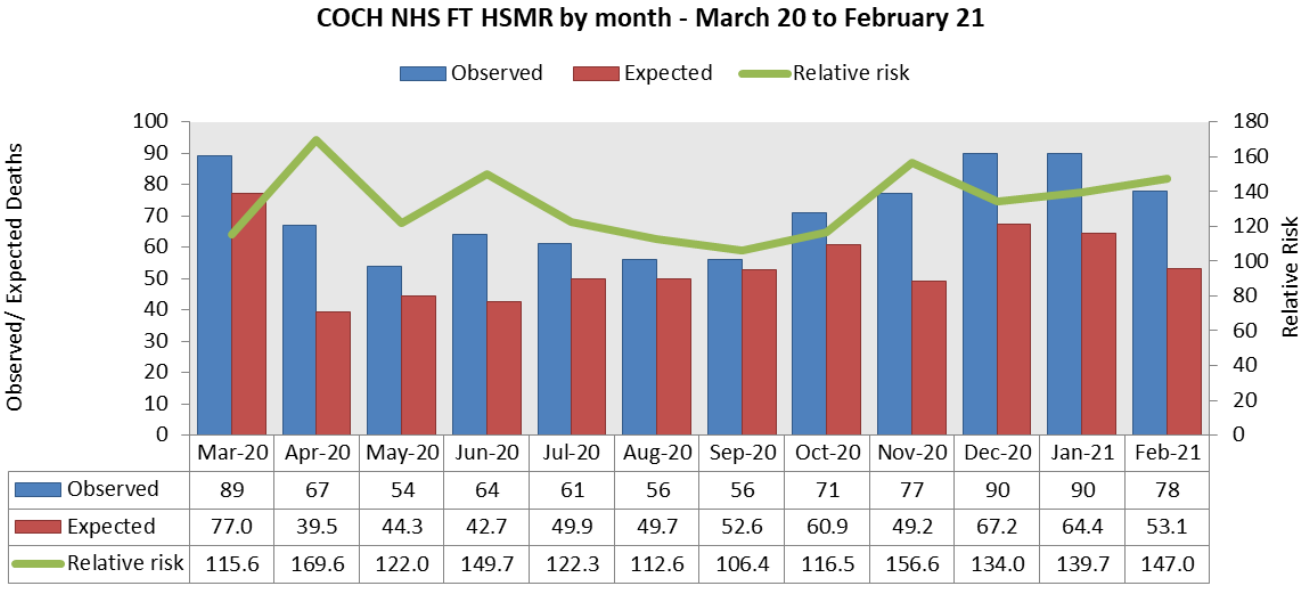


Chart 2 – HSMR by month



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Observed	89	67	54	64	61	56	56	71	77	90	90	78
Expected	77.0	39.5	44.3	42.7	49.9	49.7	52.6	60.9	49.2	67.2	64.4	53.1
Relative risk	115.6	169.6	122.0	149.7	122.3	112.6	106.4	116.5	156.6	134.0	139.7	147.0

2. Actions and learning by diagnosis group

After review of the excess deaths on the Early Warning System (observed-expected, conditions with an increased relative risk of dying were identified, and then prioritised based on the number of patients this affects. Independent analysis was then undertaken by our Dr Foster consultant Anna Roger, to confirm that this warrants an area for further investigation and highlight any relevant factors.

The process for reviewing these conditions consists of:

- Identifying the casemix
- Ratifying the clinical coding
- Reviewing the clinical pathway meets Regional and National recommendations
- Undertake SJRs of the identified patients (MDT review)
- Aligning where possible with the Quality Assurance (QA) data
- Writing a report and making recommendations about the associated learning for the pathway

1. Fracture of neck of femur (highlighted in April)

Observed and expected (12 months to Feb 2021) from Dr Foster:

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Fracture of neck of femur (hip)	314	**41**	19.6	**21.4**	13.1	6.2	209.1

- The Trust is the only statistical outlier in the North West for fracture of neck of femur. The diagnosis group features patients, who developed Covid-19 further in their pathway of care. Excluding Covid-19 patients, reduces the relative risk to within the expected.
- The Trust has the highest proportion of patients aged 85 plus, they are also an outlier for patients incurring the longest lengths of stay.
- There are more deaths than expected for patients who incurred a complication of care.

Actions taken and any associated learning:

The coding has been ratified for all cases and a multidisciplinary team has been put in place to review from a clinical perspective. 47 SJR's have now been completed and a further meeting is in place early June, with a draft report planned for early June to take to Quality Governance Group (QGG).

2. Acute cerebrovascular disease (highlighted in May)

Observed and expected (12 months to Feb 2021) from Dr Foster:

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Acute cerebrovascular disease	449	**85**	59.9	**25.1**	19.1	13.5	142.0

- The Trusts relative risk remains significantly high, even when excluding Covid-19 patients.
- The Trust had significantly more deaths than expected within the one to six day length of stay band. A higher percentage of patients who died, had no recorded comorbidity. Given the trusts more elderly patient profile, we need to review how robustly this information is being recorded.
- Fewer patients who died, received specialist palliative care input.

Actions taken and any associated learning:

This condition is at the data stage and review team is to be established in June.

3. Pneumonia (highlighted in December)

Observed and expected (12 months to Feb 2021) from Dr Foster:

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Pneumonia	851	**130**	105.8	**24.2**	15.3	12.4	122.9

The data for pneumonia was reviewed and again there was an increase in number of patients in the older age groups that were admitted and subsequently died of pneumonia. There is already some prospective data from Quality assurance regarding pneumonia and a piece of work around aspiration pneumonia. With a Community acquired pneumonia pathway and robust guidelines from NICE and British Thoracic Society it was agreed that community acquired pneumonia would be reviewed.

Actions taken and any associated learning:

The caseload has been identified and the coding ratified. The cases are being reviewed and 28 out of 87 cases have already been reviewed. Although the original finish date for reviews was intended to be by the end of May, the fracture neck of femur cases have taken priority. The prospective QA data has also been collated and when finished requires a report of a similar format.

4. Septicaemia (highlighted in May)

Observed and expected (12 months to Feb 2021) from Dr Foster:

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Septicemia (except in labour)	612	**119**	98.0	**21.0**	19.5	16.0	121.5

- The inclusion of Covid-19 patients, has a notable impact on the trusts relative risk. Excluding Covid-19 reduces the trusts relative risk for septicaemia to 103, which is within the expected range.

- The Trust had a higher percentage of patients who died who had a complication of care.
- There is a notable variance in outcomes, across the admitting days. Thursday stands out as giving rise to significantly higher than expected mortality.

Actions taken and any associated learning:

This condition is at the data stage and review team to be established in June.

5. Acute and unspecified renal failure (highlighted in May)

Observed and expected (12 months to Feb 2021) from Dr Foster:

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Acute and unspecified renal failure	239	**44**	23.8	**20.2**	18.6	10.0	184.8

- The Trust had a higher than average percentage of deaths, who incurred long lengths of stay.
- More patients who died had three or more previous emergency admissions; this may suggest that these patients require more intensive support and interventions, to prevent repeated emergency admissions.
- The Trust is an outlier for the percentage of patients who died who had multiple episodes of care.

- **Actions taken and any associated learning:**

This condition is at the data stage and review team to be established in July.

6. UTI (highlighted in March)

Observed and expected (12 months to Feb 2021) from Dr Foster:

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Urinary tract infections	731	**19**	9.9	**9.1**	2.6	1.4	192.0

- The diagnosis of Urinary tract infection has generated one CUSUM alert, and also has a significantly higher than expected relative risk of 185.3.
- UTI represents 4% of the trusts HSMR activity.
- Only 87% of patients remained under a diagnosis of UTI, compared to a peer average of 92%.
- Diagnosis on discharge suggests many patients are moving into much more complex diagnoses, such as septicaemia, pneumonia and senility related diagnoses. If these had been identified and diagnosed within the first FCE, the expected mortality associated with these patients, would have been much higher.
- There is a significantly high relative risk, within the 28 day length of stay band, reflecting the wider issue with super stranded patients and high crude mortality for long length of stay patients.
- Patients with three of more A&E attendances are statistical outliers, suggesting these frequent flyers may need more proactive management and support outside of hospital.

Actions taken and any associated learning:

The cases have been established and the clinical coding is currently under review. The review team is to be established in July

Although Other non- traumatic joint disorders was identified as statistical outliers this related to a small number of patients (6). For Viral infections the risk model cannot provide an accurate expected risk for Covid-19, due to a lack of historic data on the condition, and its impact on mortality. Covid related deaths are being reviewed through either the mortality review process or the mandated hospital acquired infection investigatory process.

3. Dr Foster Early Warning Mortality – HSMR

Use of Dr Foster's Early Warning Mortality Tool allows for more timely analysis of the HSMR position and the monthly data below shows a predicted decrease in relative risk for recent months of March and April 2021 (figures are subject to change once rebased along with all national data).

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Local Trend	128.21	154.7	126.72	113.5	108.6	116.22	153.66	132.79	141.31	150.13	99.52	103.55
HIP Trend	122	149.72	122.35	112.65	106.41	116.5	156.64	133.98	139.7	147.02		

Appendix 1 – Supporting information

1. Data to support the HSMR

Dr Foster HSMR - March 2020 to February 2021

Diagnosis group	Spells	Observed	Expected	Observed-expected	Crude rate (%)	Expected rate (%)	Relative risk
All	17188	**853**	650.5	**202.5**	5.0	3.8	131.1
Acute cerebrovascular disease	449	**85**	59.9	**25.1**	19.1	13.5	142.0
Pneumonia	851	**130**	105.8	**24.2**	15.3	12.4	122.9
Fracture of neck of femur (hip)	314	**41**	19.6	**21.4**	13.1	6.2	209.1
Septicemia (except in labour)	612	**119**	98.0	**21.0**	19.5	16.0	121.5
Acute and unspecified renal failure	239	**44**	23.8	**20.2**	18.6	10.0	184.8
Senility and organic mental disorders	199	**21**	9.6	**11.4**	10.6	4.8	219.7
Fluid and electrolyte disorders	238	**21**	9.9	**11.1**	8.8	4.2	211.8
Urinary tract infections	731	**19**	9.9	**9.1**	2.6	1.4	192.0
Intracranial injury	106	23	15.9	7.1	21.9	15.2	144.3
Chronic obstructive pulmonary disease and bronchiecta	383	19	12.9	6.1	5.0	3.4	147.6
Other gastrointestinal disorders	1061	14	7.9	6.1	1.3	0.7	177.6
Acute bronchitis	450	14	8.5	5.5	3.1	1.9	165.2
Pulmonary heart disease	182	10	5.6	4.4	5.5	3.1	178.0
Intestinal obstruction without hernia	196	14	9.7	4.3	7.2	5.0	143.9
Other circulatory disease	423	7	3.2	3.8	1.7	0.8	217.1
Skin and subcutaneous tissue infections	438	8	4.3	3.7	1.8	1.0	186.4
Biliary tract disease	658	9	5.6	3.4	1.4	0.9	160.8
Coronary atherosclerosis and other heart disease	422	7	3.9	3.1	1.7	0.9	179.6
Congestive heart failure nonhypertensive	568	41	38.0	3.0	7.2	6.7	107.8
Other liver diseases	184	7	4.1	2.9	3.8	2.3	169.0
Cancer of prostate	137	5	2.3	2.7	3.7	1.7	219.4
Cancer of pancreas	22	6	3.3	2.7	27.3	15.0	181.3
Cardiac arrest and ventricular fibrillation	23	12	9.7	2.3	52.2	42.1	124.0
Gastrointestinal haemorrhage	407	14	11.9	2.1	3.4	2.9	117.8
Peripheral and visceral atherosclerosis	135	10	8.0	2.0	7.4	5.9	125.4
Malignant neoplasm without specification of site	102	8	6.0	2.0	7.8	5.9	132.9
Secondary malignancies	137	7	5.0	2.0	5.1	3.7	139.2
Other fractures	200	8	6.1	1.9	4.0	3.1	132.1
Deficiency and other anaemia	861	6	4.3	1.7	0.7	0.5	140.2
Cancer of bronchus lung	129	8	6.6	1.4	6.2	5.1	120.5
Pleurisy pneumothorax pulmonary collapse	124	6	4.7	1.3	4.9	3.8	129.0
Liver disease alcohol-related	130	16	14.8	1.2	12.3	11.4	108.2
Complication of device implant or graft	392	3	1.9	1.1	0.8	0.5	156.8
Leukaemias	592	4	3.0	1.0	0.7	0.5	131.8
Cardiac dysrhythmias	748	6	5.1	0.9	0.8	0.7	118.7
Cancer of colon	138	4	3.2	0.8	2.9	2.3	124.7
Syncope	182	1	0.3	0.7	0.5	0.2	286.4
Abdominal pain	991	1	0.5	0.5	0.1	0.1	191.1
Cancer of bladder	452	1	0.5	0.5	0.2	0.1	190.1
Cancer of rectum and anus	118	3	2.9	0.1	2.5	2.4	103.9
Cancer of stomach	27	1	1.0	0.0	3.7	3.8	97.3
Noninfectious gastroenteritis	91	0	0.2	-0.2	0.0	0.2	0.0
Cancer of ovary	28	1	1.3	-0.3	3.6	4.5	79.1
Peritonitis and intestinal abscess	12	1	1.5	-0.5	8.3	12.4	67.4
Aspiration pneumonitis food/vomitus	103	26	26.8	-0.8	25.2	26.0	96.9
Chronic ulcer of skin	88	3	3.9	-0.9	3.4	4.5	76.1
Chronic renal failure	35	0	1.0	-1.0	0.0	3.0	0.0
Cancer of breast	182	3	4.1	-1.1	1.6	2.3	72.7
Other upper respiratory disease	342	0	1.1	-1.1	0.0	0.3	0.0
Non-Hodgkin's lymphoma	373	0	1.8	-1.8	0.0	0.5	0.0
Cancer of oesophagus	51	0	1.8	-1.8	0.0	3.6	0.0
Acute myocardial infarction	241	17	18.9	-1.9	7.1	7.9	89.7
Other lower respiratory disease	195	1	3.0	-2.0	0.5	1.5	33.8
Respiratory failure insufficiency arrest (adult)	29	4	6.1	-2.1	13.8	20.9	65.9
Aortic peripheral and visceral artery aneurysms	110	9	11.2	-2.2	8.2	10.2	80.5
Other perinatal conditions	557	5	10.5	-5.5	0.9	1.9	47.6

HSMR: 12 Month Rolling Score at Trust Level (Mar-20 to Feb-20)

The following summary provides an overview of the Trust HSMR compared to similar acute peer groups, for the HSMR Basket of 56 Diagnosis Groups. For the 12-month rolling period March 2020 to February 2021, the Trust's score is higher at **131.1,** when compared to the 12 month rolling period between February 2020 and January 2021, at 125.7, the **HSMR remains above the expected range**.

Table 3: HSMR for COCH sites compared to Peers Mar 20 – Feb 21

Covid-19 Peers	Observed	Expected	Relative risk
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	**853**	**650.5**	**131.1**
NORTH WEST ANGLIA NHS FOUNDATION TRUST	1,555	1370.7	113.4
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	955	859.1	111.2
MEDWAY NHS FOUNDATION TRUST	915	839.9	108.9
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	1,065	1001.1	106.4
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	775	733.8	105.6
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	780	747.4	104.4
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	565	544.8	103.7
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	935	913.6	102.3
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	595	698.6	85.2

Using Dr Foster to select a comparable peer group the above Trusts have a similar case mix.

HSMR breakdown by admission method March 2020 to February 2021

HSMR	Latest Result	Previous Result
All Admissions	131.1	125.9
Non-Elective Admissions	130.9	125.7
Elective Admissions	152.6	152.1

HSMR: Diagnosis groups of concern

Dr Foster provides CUSUM alerts (short for 'cumulative sum'). Alerts are designed to signal that a pattern of activity appears to have gone beyond a defined threshold and act as a smoke alarm, to inform users that something might be going wrong.

CUSUM alert	Observed deaths	Expected deaths	Relative Risk (RR)
Intestinal infection	15	5.4	275.2
Fracture of neck of femur (hip)	41	19.6	209.1
Residual codes, unclassified	27	12.5	216.4
Viral infection	327	213.7	153
Acute and unspecified renal failure	44	24	183.2
Urinary tract infections	19	9.9	192

Source: Dr Foster Mortality Summary for 12 months to February-2021

2. Clinical Coding Indicators

Indicator	COCH value	Previous COCH value	Peer value	National value
% Non-elective deaths with palliative care	24.3%	24.2%	35.7%	33.3%
% Non-elective spells with palliative care	3.3%	3.2%	5.3%	4.6%
% Spells in Symptoms & Signs chapter	4.7%	4.7%	7.0%	7.0%
% Non-elective Spells with Charlson comorbidity score = 0	44.5%	44.6%	41.9%	41.0%
% Non-elective Spells with Charlson comorbidity score = 20+	12.9%	13.0%	14.2%	14.7%

Source: Dr Foster Mortality Summary for 12 months to February-2021

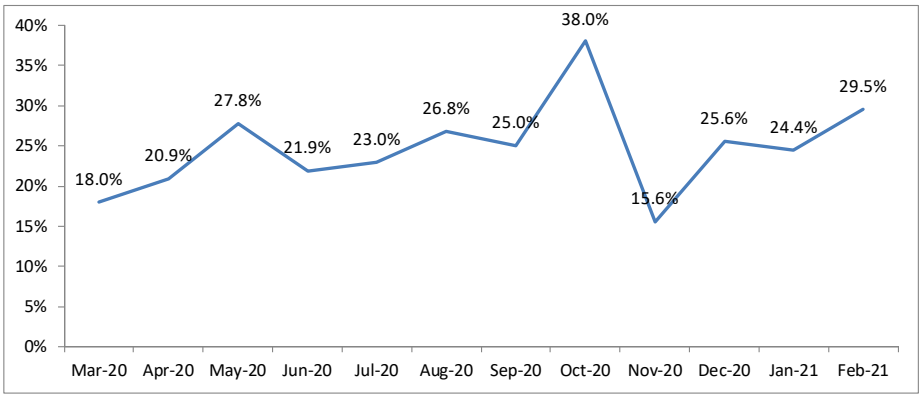
Coding depth

		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Planned	AvgCodingDepth	**2.2**	**2.2**	**2.3**	**2.4**	**2.3**	**2.5**	**2.6**	**2.5**	**2.5**	**2.4**	**2.6**	**2.5**	**2.6**
	Spells	1529	1936	2161	2604	2849	3357	3689	3478	3294	2418	2545	3746	3742
Urgent	AvgCodingDepth	**6.0**	**5.7**	**5.6**	**5.5**	**5.1**	**5.4**	**5.1**	**5.2**	**5.5**	**6.0**	**6.2**	**5.7**	**5.2**
	Spells	1221	1523	1747	1753	1648	1936	1940	1766	1783	1901	1735	1890	2341
Total AvgCodingDepth		**3.9**	**3.8**	**3.8**	**3.6**	**3.3**	**3.5**	**3.4**	**3.4**	**3.6**	**4.0**	**4.0**	**3.6**	**3.6**

3. Palliative care

HSMR - Palliative Care

	Observed	With Palliative	Palliative%
All	**853**	**209**	**24.5%**
Mar-20	89	16	18.0%
Apr-20	67	14	20.9%
May-20	54	15	27.8%
Jun-20	64	14	21.9%
Jul-20	61	14	23.0%
Aug-20	56	15	26.8%
Sep-20	56	14	25.0%
Oct-20	71	27	38.0%
Nov-20	77	12	15.6%
Dec-20	90	23	25.6%
Jan-21	90	22	24.4%
Feb-21	78	23	29.5%



4. Summary Hospital-Level Mortality Indicator (SHMI)

The following summary provides an overview of the Trust SHMI score for the period December 2019 to November 2020 sourced from NHS Digital.

5.1 Trust SHMI Analysis

The COCH SHMI value for the most recent reporting period is 106.65 and remains within the expected range. Table 4 below provides an overview of the observed and expected deaths.

Table 4: COCH SHMI Score Jan-20 to Dec-20
Figures from NHS Digital (filtered to COCH Covid-19 Peer Group)

Provider name	SHMI value	SHMI banding	Number of spells	Observed deaths
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	1.1440	1	33580	1100
NORTH WEST ANGLIA NHS FOUNDATION TRUST	1.1359	1	70295	2620
MEDWAY NHS FOUNDATION TRUST	1.0683	2	49795	1605
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	**1.0665**	**2**	**38055**	**1200**
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1.0520	2	30195	1135
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	1.0423	2	54000	1730
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	1.0048	2	39955	1540
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	0.9966	2	60985	1725
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	0.9870	2	49975	1630
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	0.9501	2	44880	1230

Trust SHMI Diagnosis Groups of Concern (January-20 to December-20)

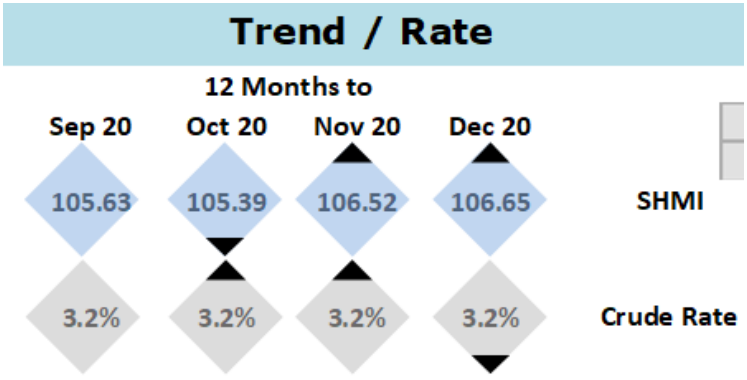
Analysis of the Trust SHMI at diagnosis level indicates the diagnosis groups in which the observed number of deaths rate was higher than the expected, but not statistically significantly high, using 95% confidence intervals.

Table 5: Trust SHMI Diagnosis Groups of Concern Jan-20 to Dec-20

SHMI Gro #	Obs	Exp	SHMI	Low / High
(124) Intracranial injury	20	10	200.00	122.11 308.90
(98) Other gastrointestinal disorders	20	10	200.00	122.11 308.90
(6) Hepatitis, Viral infection, Other infections; including parasitic, Sexually transmitted infections (not	20	10	200.00	122.11 308.90
(140) Allergic reactions, Rehabilitation care, fitting of prostheses, and adjustment of	35	20	175.00	121.88 243.39
(66) Acute cerebrovascular disease	85	65	130.77	104.45 161.70
(99) Acute and unspecified renal failure	45	35	128.57	93.77 172.04
(83) Intestinal infection	15	10	150.00	83.89 247.42
(68) Peripheral and visceral atherosclerosis	15	10	150.00	83.89 247.42

NOTE: There have been some methodological changes with the SHMI data nationally, which now follows a methodology employed by HES (Hospital Episodes Statistics). This disclosure control methodology has been updated to a methodology based on rounding, so the number of finished provider spells and observed deaths are now displayed to the nearest five.

Table 6: Trust SHMI Trend/Rate



Appendix 2 - SHMI & HSMR Methodologies

	Hospital Standardised Mortality Rate (HSMR)	Risk Adjusted Mortality Index (RAMI)	Summary Hospital-level Mortality Indicator (SHMI) **
Observed	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England*	Total number of observed in-hospital deaths	Number of observed in-hospital deaths plus deaths out of hospital within 30 days of discharge
Expected	Expected number of deaths	Expected number of deaths *Calculated using a 10 year data set (as of 2012) to get the risk estimate*	Expected number of deaths *Calculated using a 36 month data set to get the risk estimate*
Adjustments	▪ Sex ▪ Age in bands of five up to 90+ ▪ Admission method ▪ Source of admission ▪ History of previous emergency admissions in last 12 months ▪ Month of admission ▪ Socio economic deprivation quintile (using Carstairs) ▪ Primary diagnosis based on the clinical classification system ▪ Diagnosis sub-group ▪ Co-morbidities based on Charlson score ▪ Palliative care ▪ Year of discharge	▪ Sex ▪ Age ▪ Clinical grouping (HRG) ▪ Primary and secondary diagnosis ▪ Primary and secondary Procedures ▪ Hospital type ▪ Admission method Further detailed methodology information is included in CHKS products, or specific enquiries to CHKS www.chks.co.uk	▪ Sex ▪ Age group ▪ Admission method ▪ Co-morbidity ▪ Year of dataset ▪ Diagnosis group Details of the categories above can be referenced from the methodology specification document at http://www.ic.nhs.uk/services/summary-hospital-level-mortality-indicator-shmi
Exclusions	Excludes day cases and regular attendees	Excludes mental illness, obstetrics, babies born in or out of hospital, day cases, and patients admitted as emergencies with a zero length of stay discharged alive and spells coded as palliative care (Z515)	▪ Specialist, community, mental health and independent sector hospitals. ▪ Stillbirths ▪ Day cases, regular day and night attenders
Whose data is being compared and how much data is used for comparison e.g. all trusts or certain proportion etc.	All England provider trusts via SUS Data attributed to all Trusts within a 'super-spell' of activity that ends in death	UK database of Trust data and HES Data attributed to Trust in which patient died	All England non-specialist acute trusts except mental health, community and independent sector hospitals. Data attributed to Trust in which patient died or was discharged from

*HSMR does not exclude 20% of deaths, it looks for the diagnosis groups that account for the majority of deaths, and the figure of 80% is quite variable dependent on the case mix of the trust. HSMR could just as easily cover 100% of activity. It covers 80% of activity mostly for historical reasons and the fact that you get little extra value from the other 20%.

The Mortality indicators report provides information relating to mortality both in-hospital and during the 30 days following discharge from hospital. Whilst evidence suggests a mortality ratio as a single indicator of hospital quality is, at best, akin to a smoke alarm, it has been recognised nationally that regular examination and better understanding of mortality can potentially improve the way care is delivered, recorded and coded, and in turn help improve the quality of the data used.

The majority of indicators presented in the report pertain to Standardised Mortality Ratios (SMRs). SMRs are the ratio of the number of deaths in hospital within a given time period to the number that might be expected if the hospital had the same death rates as some reference population (in this case the hospitalised population of England). As well as standardising for age, the hospital mortality measures discussed in this report, the Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Indicator (SHMI), also make adjustments for patient differences which can influence deaths in a hospital, but are ultimately outside of its control (for example deprivation and sex) . An overview of the methodology applied to each of these mortality measures (HSMR & SHMI) can be found in Appendix 2.

The report standardised mortality measures with the presentation of contextual indicators that directly impact on the mortality rates discussed, namely, clinical coding measures including:

- Palliative Care
- Depth and accuracy of clinical coding (‘Signs and Symptoms’ coding)
- Co-morbidities (Charlson Comorbidity Index)

The coding of patient co-morbidities is one of the twelve weighting factors applied to the calculation of HSMR, and one of the six weighting factors applied to the calculation of SHMI. A high level of patient co-morbidities increases the ‘expected’ number of deaths in both methodologies, and thus reduces the relative risk rate. The Charlson Comorbidity Index is used to calculate comparative levels of co-morbidity, and consists of 17 conditions for which a ‘weighting’ is assigned. The higher the patient weighting, the higher the risk the co-morbidity is perceived to be as a contributing factor to a patient’s health outcome, and potential risk of death. In order to calculate a patient’s co-morbidity score, each spell is calculated as the sum of the weights for each of the conditions in all secondary diagnosis fields in the first episode of the spell.

Meeting	**13th July 2021**		**Board of Directors**					
Report	**Agenda item 10 (b)**		**Mortality Update**					
Purpose of the Report	Decision		Ratification		Assurance	X	Information	
Accountable Executive	Darren Kilroy				Executive Medical Director			
Author(s)	Michelle Greene Denise Wood				Divisional Medical Director, Planned Care Head of Information & Performance			
Board Assurance Framework	Q5	Patient safety - failure to identify avoidable clinical harm and avoidable death						
Strategic Aims								
CQC Domains	Safe, Effective, Well Led							
Previous Considerations	Quality & Safety Committee – 22nd June 2021 Learning from Deaths Group - May 2021 EDG - 7th June 2021							
Summary	The purpose of this report is to: • Summarise the key mortality indicators • Highlight areas of concern • Assure the Board of actions in place for improvement							
Recommendation(s)	The Board is asked to**: -** • Note the summary account of progress on the mortality improvement plan							
Corporate Impact Assessment								
Statutory Requirements	Meets the Trust compliance with Learning from Deaths mandated reporting							
Quality & Safety	Improve patient safety							
NHS Constitution	Demonstrate improvements to HSMR and SHMI rates							
Patient Involvement								
Risk								
Financial impact								
Equality & Diversity								
Communication								

BACKGROUND

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic by NHS Digital.

The SHMI is the ratio between the actual number of patients who die following hospitalization at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

The hospital standardised mortality ratio (HSMR) is calculated by using 56 primary diagnosis groups, these groups account for 80% of hospital mortality.

Currently the Trust SHIMI is within expected range but the HSMR is outside the expected range, and makes the Trust a statistical outlier.

Mortality data is monitored by the learning from deaths group with the executive medical director oversight.

PURPOSE

The purpose of the paper is to update on the current position and the action plan being undertaken to provide assurance around the care patients with certain conditions receive.

Any learning will inform any requirement of changes to patient pathways.

CURRENT POSITION

Chart 1 – Mortality data for the Trust

Indicator	Result	Threshold	Date range	Previous Result
SHMI	**106.7**	100	Jan 20 to Dec 20	**106.5**
HSMR	**131.1**	100	Mar 20 to Feb 21	**125.9**
Elective HSMR Admissions: Crude Mortality Rate	0.2%	0.1%	Mar 20 to Feb 21	0.2%
Non-Elective HSMR Admissions: Crude Mortality Rate	7.6%	5.7%	Mar 20 to Feb 21	7.2%
Mortality Reviews Completed	12%		Apr-20 to Mar-21	12%

The Trust continues to be a statistical outlier for the HSMR rate. There are 18 conditions which are statistical outliers and 7 areas with a CUSUM alert which warrant further investigation. (see chart 2 in appendix 1)

Chart 3 (in appendix one) demonstrates the observed versus the expected mortality seen at the Countess of Chester Trust. The HSMR is a rolling yearly trend.

The Trust has been using enhanced Doctor Foster analysis methodology to identify the priority areas for deep dives. The selected clinical conditions each have an observed and expected mortality rate; from this the excessive death rate has been calculated (observed minus expected) and whilst not suggestive of deaths cause it gives an indication of the number of patients potentially affected in a 12 month period. This is used with the relative risk to prioritise the deep dive conditions.

The process for reviewing these conditions consists of:

- Identifying the case mix
- Ratifying the clinical coding
- Reviewing the alignment of the clinical pathway to relevant regional and national recommendations
- Undertake SJRs of the identified patients (MDT review)
- Aligning where possible with the Quality Assurance (QA) data
- Writing a report and making recommendations about the associated learning for the pathway

Currently the deep dive areas are:-

1. Fracture of neck of femur (highlighted in April)

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Fracture of neck of femur (hip)	314	**41**	19.6	**21.4**	13.1	6.2	209.1

2. Acute cerebrovascular disease (highlighted in May)

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Acute cerebrovascular disease	449	**85**	59.9	**25.1**	19.1	13.5	142.0

3. Pneumonia (highlighted in December)

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Pneumonia	851	**130**	105.8	**24.2**	15.3	12.4	122.9

4. Septicaemia (highlighted in May)

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Septicemia (except in labour)	612	**119**	98.0	**21.0**	19.5	16.0	121.5

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5. Acute and unspecified renal failure (highlighted in May)

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Acute and unspecified renal failure	239	**44**	23.8	**20.2**	18.6	10.0	184.8

6. UTI (highlighted in March)

Diagnosis group	Spells	Observed	Expected	Observed - expected	Crude rate (%)	Expected rate (%)	Relative risk
Urinary tract infections	731	**19**	9.9	**9.1**	2.6	1.4	192.0

The compiled reports will be presented at Learning from Deaths and then to Quality Governance Group once completed and shared with relevant divisional governance groups.

Action tracker

The current action tracker as of Thursday 3 June is shown below. In real terms, work is occurring across multiple pathway reviews at the same time, with a target completion date for all review reports by August. Note that the completion of reports is different from their planned submission dates to QGG and on to Q and S. Every effort is being made to expedite the work involved as resources allow.

stage	fracture neck of femur	acute cerebrovascular disease	pneumonia	UTI	sepsis	acute unspecified renal failure
Identifying the case mix	May-21	May-21	Dec-20	Aug 02	Jul-21	Aug-02
Ratifying the clinical coding	May-21	7th June 21	Feb-21	Aug-02	Jul-21	Aug-02
Reviewing the clinical pathway meets Regional and National recommendations	Mid-June (QGG)	14th June	Feb-21	Aug-16	Jun-21	Aug-16
identify review group	May-21	7th June	14-Jun	Aug-16	Jul-05	Aug-16
Undertake SJRs of the identified patients (MDT review)	Jun-21	14th June	July	Aug-30	Jun-28	Aug-30
Aligning where possible with the Quality Assurance (QA) data	Mid-June (QGG)		Jul-05	Aug-30	Jun-28	Aug-30
Writing the report and making recommendations about the associated learning for the pathway	Mid-June (QGG)	QGG June	QGG July	Sept QGG	July QGG	Sept QGG

Dr Foster Early Warning Score

The Doctor Foster early warning system is being used to highlight areas of arising concern or apparent anomaly as a separate piece of work.

Medical Examiners

The medical examiner team are achieving 100% scrutiny of deaths for the last few months. They are feeding incidents into the Datix system and also requesting SJR when they feel care requires scrutiny.

Other Mortality review cases

Over the past year 146 cases have undergone a mortality review; these included deaths associated with Covid. The learning from this has been presented to the Learning from Deaths Group.

The stillbirths and inter-uterine deaths for Jan-July 2020 have also had a note review and this has been presented to the Learning from Deaths Group (9 deaths).

The LeDer Deaths were reviewed and compared to the national LeDeR report on deaths and this was presented to the Learning from Deaths Group.

RECOMMENDATION

The Committee is asked to:-

- Note the summary account of progress on the mortality improvement plan.

Appendix One

Chart 2 – HSMR compared to Dr Foster Covid-19 peer group

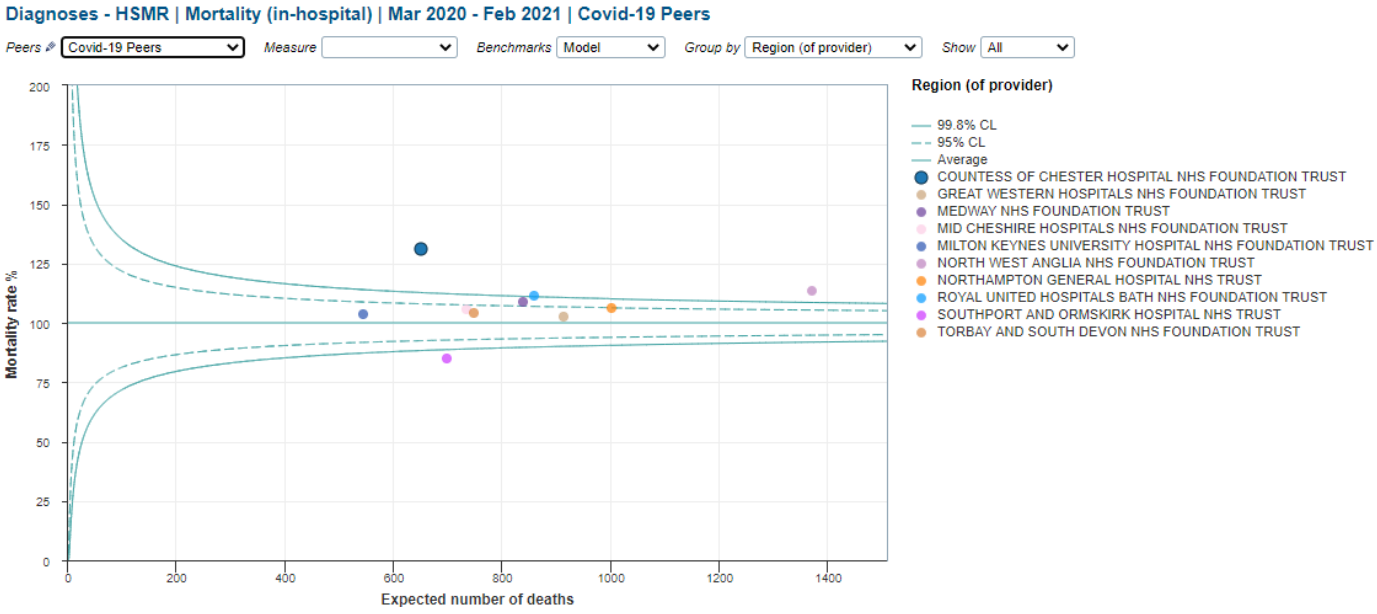
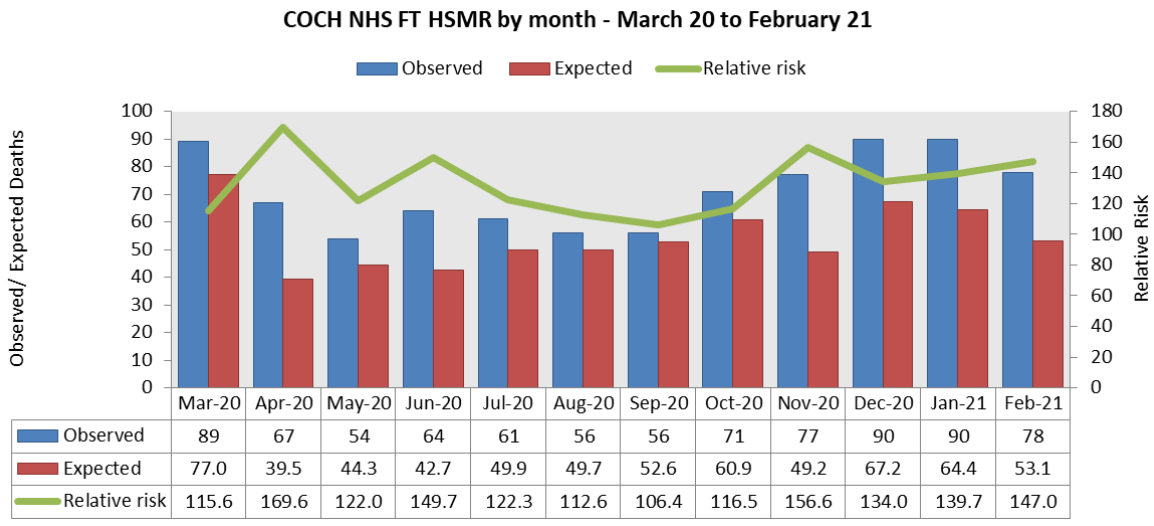


Chart 3 – Observed vs expected deaths



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Observed	89	67	54	64	61	56	56	71	77	90	90	78
Expected	77.0	39.5	44.3	42.7	49.9	49.7	52.6	60.9	49.2	67.2	64.4	53.1
Relative risk	115.6	169.6	122.0	149.7	122.3	112.6	106.4	116.5	156.6	134.0	139.7	147.0

Meeting	**13th July 2021**		**Board of Directors**					
Report	**Agenda item. 11.**		**Bi-annual Nursing & Midwifery Staffing Report (August 2020 to June 2021)**					
Purpose of the Report	Decision		Ratification		Assurance	x	Information	
Accountable Executive	Hilda Gwilliams				Interim Director of Nursing & Quality			
Author(s)	Melanie Kynaston				Deputy Director of Nursing			
Board Assurance Framework	Q4	Safety – Nursing & Midwifery Workforce						
Strategic Aims								
CQC Domains	Safe/Effective/Caring/Responsive/Well Led							
Previous Considerations	Quality and Safety Committee 22nd June 2021 Quality Governance Group on 26th May 2021							
Summary	This reporting period has seen significant pressure (operationally and financially) in response to the pandemic. However, the nursing & midwifery workforce have responded to support patients and service users by adopting new ways of working and deploying to unfamiliar areas to maintain safety, quality and operational performance. There has been a sustained improvement in vacancy against budgeted establishment, turnover, care hours per patient per day, registered and unregistered fill rates and the quality of care delivered. To achieve this there has been a reliance on temporary staff which has generated a significant spend (particularly agency costs). Work is now focused on returning to business-as-usual models and supporting the recovery and restoration programme.							
Recommendation(s)	The Board is asked to note the content for assurance.							
Corporate Impact Assessment								
Statutory Requirements								
Quality & Safety								
NHS Constitution								
Patient Involvement								
Risk								
Financial impact								
Equality & Diversity								
Communication								

Bi-annual Nursing and Midwifery Staffing report

(August 2020 – January 2021)

1.0 Purpose

1.1 This paper has been produced to provide assurance on the current nursing and midwifery provision at the Countess of Chester Hospital NHS Foundation Trust. It will provide an annual update on the position (at the end of January 2021), reflect any changes since August 2020 (previous assurance report) and evaluate the effectiveness of actions taken. The full bi-annual midwifery position is detailed in appendix 1.

2.0 Introduction

2.1 The bi-annual Nursing and Midwifery report is a national requirement to comply with the Care Quality Commission (CQC) fundamental standards across five domains of safe; Effective; Caring; Responsive and Well-led. The Trust's compliance is measured against a range of national standards to demonstrate the effectiveness of workforce planning, deployment and development. These standards include National Quality Board (NQB) recommendations for urgent and emergency care, adult in-patients, children and young people and maternity services. The information is presented using the NHS Improvement: Developing Workforce Safeguards framework[1] with a focus on evidence based tools and data, professional judgement and outcomes.

2.2 During the previous reporting period (January 2020 – July 2020) significant changes have been made to nurse establishments as a result of improvement work and later in response to the Covid-19 pandemic. As such, a quality impact assessment has been made to ensure the right staff, with the right skills are delivering care in the right place at the right time.

3.0 National Context

3.1 It is recognised that there is a shortfall in healthcare workforce numbers across the United Kingdom (UK) and this problem has a direct impact on peoples care and experience. NHS hospitals, mental health and community providers are reporting shortages of more than 100,000 FTE staff (representing one in eleven posts), with greater affect seen in some key workforce groups. One of the greatest challenges is seen in nursing, with 41,000 FTE vacancies reported (one in eight posts)[2]. This position has worsened from the reported 10% gap in adult nursing (shortfall of 22,000 FTE) in 2017 and has exceeded the more pessimistic prediction of 38,000 FTE by 2020[3]. It is now reported that there will be a shortfall of 108,000 FTE nurse by 2030[2] (prediction made prior to the publication of the NHS People Plan[4] and the work undertaken in response to the Covid – 19 pandemic).

To address the shortfall work is underway to increase the number of nurses joining the NHS for training, reduce the 'drop out' rate during training and encourage qualifying nurses to remain in the NHS[6]. 'Cost of living' grants are being offered to nursing students, training place numbers are being increased and clinical placements are being expanded and maximised to facilitate the practice element. In addition, Ruth May, Chief Nursing Officer for England in collaboration with regulators and Health Education England launched a renewed national recruitment drive in November 2020[5] following the publication of the We are the NHS People Plan[3], whilst capitalising on the interested seen to join the NHS following the Covid -19 pandemic. The campaign sets out to increase applications for degree courses further, implement apprenticeship routes to training and maximise support programmes for the recruitment and training of unregistered healthcare workers. The national team has also successfully lobbied Government to secure significant funding to progress overseas recruitment drives.

3.2 In nursing and midwifery the national pandemic has forced a number of changes to the way in which people work and how people are deployed to utilise the full range of skills and experience available. These changes have allowed for the rapid mobilisation of staff to meet the needs of patients hospitalised with covid-related disease. This has been achieved at pace and the support provided has been testament to the dedication and commitment of the skilled workforce offering training and supervision in the specialities most affected by the pandemic.

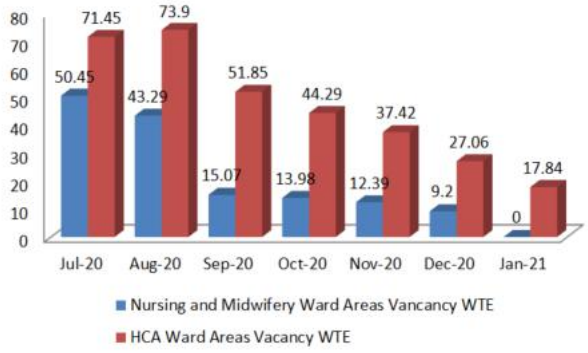
4.0 Local Context

4.1 Vacancy rates

Managing nursing and midwifery vacancies is very challenging for a number of multi-factorial reasons. The overall vacancy against budgeted establishment has been reduced significantly (as seen in graph 1) and this position is an over achievement against the improvement plan (zero vacancy achieved in January 2021). However, the complexity of Covid - 19 and the additional operational services in place has created a higher than expected 'actual' deficit for registered and unregistered nurses across the Trust. These services include (but are not limited to):

- Vaccination programme;
- Screening Village;
- Swab Tracking;
- Centralised Nursing workforce Team (CNWT);
- Family Support Team;
- Decontamination Service for Jupiter Hoods; and
- Fit Testing.

Graph 1: Registered and unregistered nursing and midwifery vacancy (FTE)



In addition, there have been up to 4 escalation wards open for emergency and urgent care patients during Q3 and Q4 2020/21, these nursing teams are not funded and continue to generate a pressure (operationally and financially). Furthermore, due to changing operational models, critical care, theatres and the respiratory unit have had to increase the nursing numbers on their safe staffing template to meet the Covid – 19 demands and consideration needs to be given to this when interpreting vacancies as they are not necessarily reflective of the 'actual' gap in practice.

4.2 Unavailability

During 2020 a total of 254.15 WTE hours were lost and required backfill in registered and unregistered nurse staffing grades. This operational and financial pressure is in addition to the services introduced in response to Covid – 19 and the vacancy position (present in section 4.1). When broken down by category (see charts 1 and 2) the same pattern is seen across both registered and unregistered staff. The largest amount of lost hours seen (total

186.38 WTE) is attributed to special leave (inclusive of Covid -19 isolation) and sickness. A further 50.77 WTE practice hours has been lost to parental leave.

Chart 1: Registered nurse hours lost to unavailability

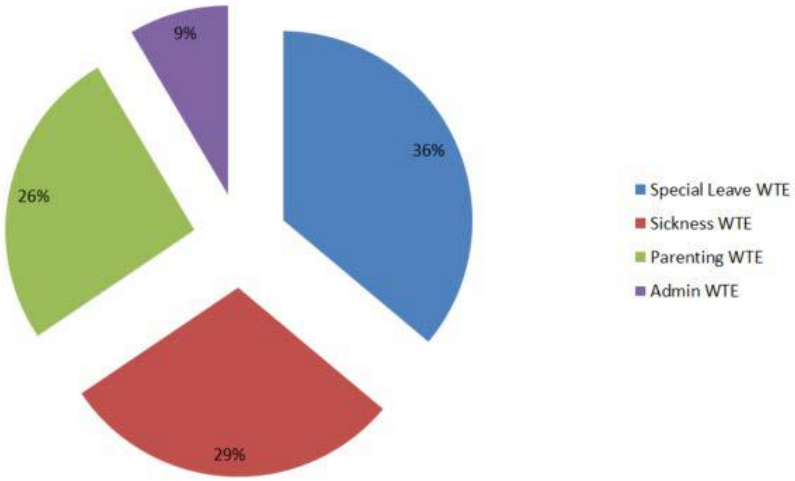
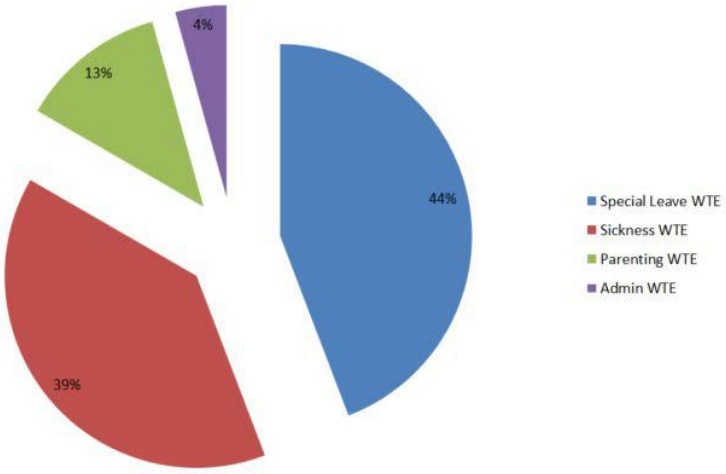


Chart 2: Unregistered nurse hours lost to unavailability



In addition, staff in high risk and extremely clinically vulnerable groups have been supported during this reporting period and redeployed to non-patient facing roles or have been shielding in line with Government advice. The number of staff supported at any given time has ranged between 26 – 57 (head count).

4.3 Recruitment Activity

Nurse recruitment initiatives have been progressed throughout the reporting period and in despite of the Covid – 19 challenges. This programme of work will continue 2021/22. The Trusts priorities align to the national requirements; these include (but are not limited to):

- **Undergraduate**
  - university engagement and early offers of employment
  - supporting paid placements (as part of national Covid – 19

response)
    - increasing placement capacity to support increase in pipeline
- **Local recruitment**
    - move to ward and department based recruitment (rather than corporate adverts)
    - rolling programme of adverts (continuous recruitment drives in difficult to recruit areas)
    - targeted recruitment drive for Respiratory and Cardiology specialties (as per reconfiguration plans and anticipated growth)
- **International recruitment**
    - continue international recruitment drives (supported by national funding)
- **Apprenticeship Training**
    - recruit to approved apprenticeship training posts (6 per year, on a rolling programme)

4.4 Anticipated growth

It is difficult to quantify the anticipated growth during the next reporting period due to a number of uncertain variables. These variables include (but are not limited to) operational changes in response to the ongoing pandemic, the elective recovery and restoration programme and the anticipated increase in turnover in certain specialities. This is a financial risk, particularly in light of the uncertain national funding arrangements. As such, the growth is presented with as a pessimistic and an optimistic forecast (as seen in table 1).

4.5 Turnover

The Trust continues to achieve a sustained improvement in registered nursing and midwifery turnover rates (as seen in graph 2 and table 2). This has been a result of work completed in collaboration with the NHS Improvement Retention Programme, which concluded prior to the Covid – 19 pandemic. However, it is clear that the turnover rate for unregistered staff has increased from a stable 7-8% to 16%. On further analysis (as seen in table 3) the top reported reason for leaving has been the end of a fix-term contract (N 62). This directly correlates with the student nurse paid placements scheme which saw 2nd and 3rd year students placed into support worker roles for a fix period during the pandemic.

Table 1: Predicted registered nursing demand 2021/22

	Option A (Pessimistic)	Option B (Optimistic)
ADDITIONAL NURSING POSTS REQUIRED	**WTE**	**WTE**
Ward 41 to Ward 40 & 56	9.72	9.72
Ward 34	2.47	2.47
Poppy Ward Ellesmere Port	2.78	2.78
RSU	16.44	16.44
ITU	5.00	5.00
GPU 7/7 Model	2.00	2.00
Renal	2.40	2.40
TOTAL ADDITIONAL NURSING POSTS (GROWTH)	**40.81**	**40.81**
LESS ADDITIONAL NURSING POSTS (GROWTH) ALREADY BEING RECRUITMENT TO (20% ASSUMED TBC)	**- 8.16**	
Anticipated turnover @ 8%	41.00	78.50
TOTAL ADDITIONAL NURSING POSTS - GROWTH + TURNOVER	**73.65**	**119.31**
PIPELINE		
Newly Qualified Student Nurses - expected during 2021	55.00	55.00
Overseas Nurses - COCH Cohort 3	7.00	7.00
First Collaborative Overseas Nurses Bid	72.00	72.00
Second Collaborative Overseas Nurses Bid - Strand B plus	60.00	60.00
Assume 2% attrition for International Nurse Recruitment	-2.78	-2.78
Current over establishments on the wards (includes unallocated International Nurses)	TBC	
Current number of maternity leaves, secondments, career breaks etc covered permanently	15.48	
TOTAL PIPELINE	**206.70**	**191.22**
TOTAL OVER SUPPLY	**133.05**	**71.91**
POTENTIAL FURTHER REQUIREMENTS FOR TRAINED NURSES (FURTHER GROWTH)		
SDEC		
Cardiology Reconfiguration		
Ward 42 (UC)		
Theatres ODP & Recovery Nurses On Call Arrangements		
Escalation Ward		
Restoration		
TOTAL POTENTIAL FURTHER REQUIREMENTS FOR TRAINED NURSES (FURTHER GROWTH)	**-**	**71.91**
REVISED OVER / UNDER SUPPLY	**133.05**	**-**

Graph 2: Nursing and Midwifery turnover and average headcount (monthly)

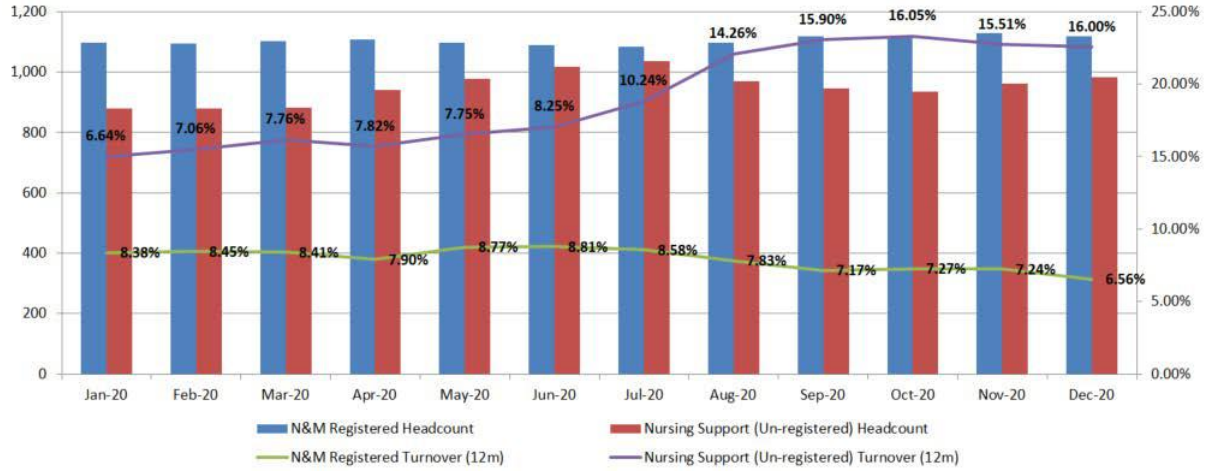


Table 2: Nursing and Midwifery turnover and average headcount (monthly)

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
N&M Registered Turnover (12m)	8.38%	8.45%	8.41%	7.90%	8.77%	8.81%	8.58%	7.83%	7.17%	7.27%	7.24%	6.56%
Nursing Support (Un-registered) Turnover (12m)	6.64%	7.06%	7.76%	7.82%	7.75%	8.25%	10.24%	14.26%	15.90%	16.05%	15.51%	16.00%
N&M Registered Headcount	1,098	1,095	1,102	1,107	1,096	1,088	1,083	1,096	1,117	1,119	1,128	1,117
Nursing Support (Un-registered) Headcount	878	878	881	939	977	1,018	1,035	969	945	934	962	982

Table 3: Unregistered nurse reasons for leaving

Leaving Reason	Leavers
End of Fixed Term Contract	62
Voluntary Resignation - Other/Not Known	20
Retirement Age	13
Voluntary Resignation - Work Life Balance	10

During 2021/22 there will continue to be a focus on the following retention initiatives:

- **Redesign of Practice Development Model**
  - preceptorship and beyond
  - competency based training programmes relevant to specialty (SDEC, respiratory and cardiology as priorities)
  - career development (pathways)
- **Leadership Development**
  - focus on matrons and ward managers programme
  - succession planning and talent management
- **Advanced Clinical Practitioner training**
  - assess requirement in line with the divisional priorities (Emergency Care, SDEC, Specialties)
  - review current roles and align to national requirements and models
  - establish funding for training numbers required and progress plan to support operational delivery

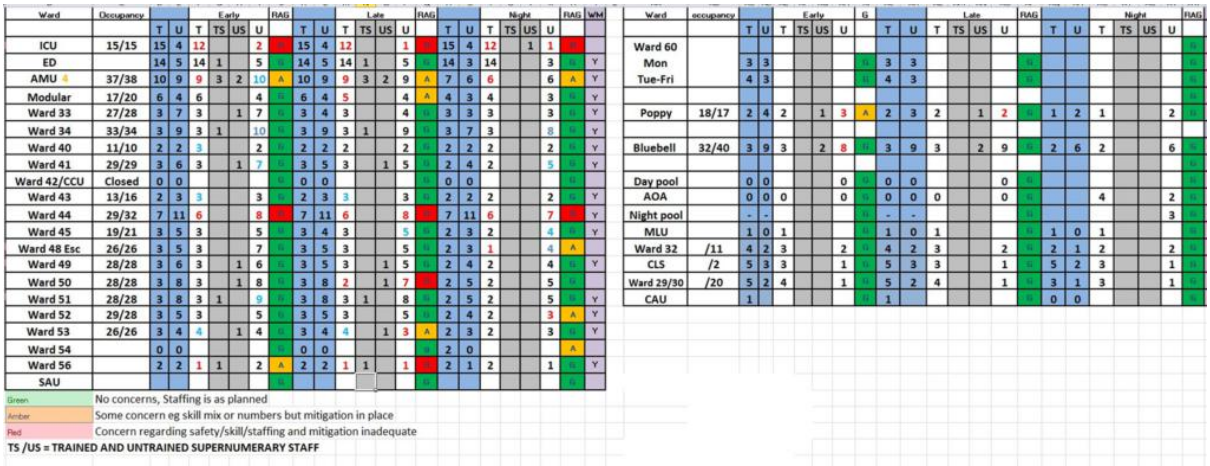
5.0 Assurance

5.1 Deploying staff effectively

The following data sets (1 – 3) evidence the Care Hours per Patient Day (CHPPD) that have been provided and the % fill rates for registered and unregistered nursing during the reporting period. There has been an overall improvement in the care hours delivered to patients, with the most significant and sustained improvement seen in the Urgent Care Division. This improvement has been a result of the earlier establishment review (2019/20) and the temporary changes made to roster templates in response to Covid – 19, to align the safe staffing levels to the activity and acuity seen in certain wards and departments. In addition, there has also been new investment agreed in some Urgent Care specialities in response to changes in operational models. Furthermore, the Covid-19 response has seen nursing staff redeployed on a temporary basis (from Planned Care to urgent Care) and student nurses have been deployed into paid placements.

All nursing rosters are currently being managed by the Centralised Nursing Workforce Team (CNWT), which was operationalised on the 6th April 2020 in response to the many challenges that arose as a result of the pandemic. This centralised function manages the ***'operational'*** day to day nursing and midwifery workforce planning and any associated deployment actions (7 days a week). The team has full visibility on 'required' staffing levels needed in each area and what 'actual' levels are available. The named matron of the day provides oversight for real-time decisions made in response to any emerging safety or operational challenges seen. The team attend the 3 ***'tactical'*** meetings each day and ***'strategic'*** assurance is provided twice daily to the senior leadership team in a 'safe staffing assurance sitrep' (as seen in diagram 1).

Diagram 1: Example of safe staffing assurance sitrep



Ward	Occupancy	Early					RAG	Late					RAG	Night				RAG	WM
		T	U	T	TS	US	U		T	U	T	TS	US	U		T	U	T	TS	US	U		
ICU	15/15	15	4	12			2	R	15	4	12			1	R	15	4	12		1	1	R	
ED		14	5	14	1		5	R	14	5	14	1		5	R	14	3	14			3	R	Y
AMU 4	37/38	10	9	9	3	2	10	A	10	9	9	3	2	9	A	7	6	6			6	A	Y
Modular	17/20	6	4	6			4	R	6	4	5			4	A	4	3	4			3	R	Y
Ward 33	27/28	3	7	3		1	7	R	3	4	3			4	R	3	3	3			3	R	Y
Ward 34	33/34	3	9	3	1		10	R	3	9	3	1		9	R	3	7	3			8	R	Y
Ward 40	11/10	2	2	3			2	R	2	2	2			2	R	2	2	2			2	R	Y
Ward 41	29/29	3	6	3		1	7	R	3	5	3		1	5	R	2	4	2			5	R	Y
Ward 42/CCU	Closed	0	0				R	0	0					R	0	0						R	
Ward 43	13/16	2	3	3			3	R	2	3	3			3	R	2	2	2			2	R	Y
Ward 44	29/32	7	11	6			8	R	7	11	6			8	R	7	11	6			7	R	Y
Ward 45	19/21	3	5	3			5	R	3	4	3			5	R	2	3	2			4	R	Y
Ward 48 Esc	26/26	3	5	3			7	R	3	5	3			5	R	2	3	1			4	A	
Ward 49	28/28	3	6	3		1	6	R	3	5	3		1	5	R	2	4	2			4	R	Y
Ward 50	28/28	3	8	3		1	8	R	3	8	2		1	7	R	2	5	2			5	R	
Ward 51	28/28	3	8	3	1		9	R	3	8	3	1		8	R	2	5	2			5	R	Y
Ward 52	29/28	3	5	3			5	R	3	5	3			5	R	2	4	2			3	A	Y
Ward 53	26/26	3	4	4		1	4	R	3	4	4		1	3	A	2	3	2			3	R	Y
Ward 54		0	0					R	0	0					R	2	0					A	
Ward 56		2	2	1	1		2	A	2	2	1	1		1	R	2	1	2			1	R	Y
SAU								R							R							R	

Green	No concerns, Staffing is as planned
Amber	Some concern eg skill mix or numbers but mitigation in place
Red	Concern regarding safety/skill/staffing and mitigation inadequate

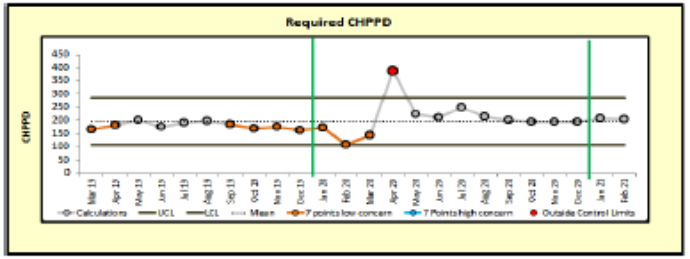
TS /US = TRAINED AND UNTRAINED SUPERNUMERARY STAFF

Ward	occupancy	Early					G	Late				RAG	Night			RAG
		T	U	T	TS	US	U		T	U	T	TS	US	U		T	U	T	TS	US	U		
Ward 60																							
Mon		3	3					R	3	3					R							R	
Tue-Fri		4	3					R	4	3					R							R	
Poppy	18/17	2	4	2		1	3	A	2	3	2		1	2	R	1	2	1			2	R	
Bluebell	32/40	3	9	3		2	8	R	3	9	3		2	9	R	2	6	2			6	R	
Day pool		0	0				0	R	0	0				0	R							R	
AOA		0	0	0			0	R	0	0	0			0	R			4			2	R	
Night pool		-	-					R	-	-					R						3	R	
MLU		1	0	1				R	1	0	1				R	1	0	1				R	
Ward 32	/11	4	2	3			2	R	4	2	3			2	R	2	1	2			2	R	
CLS	/2	5	3	3			1	R	5	3	3			1	R	5	2	3			1	R	
Ward 29/30	/20	5	2	4			1	R	5	2	4			1	R	3	1	3			1	R	
CAU		1						R	1						R	0	0					R	

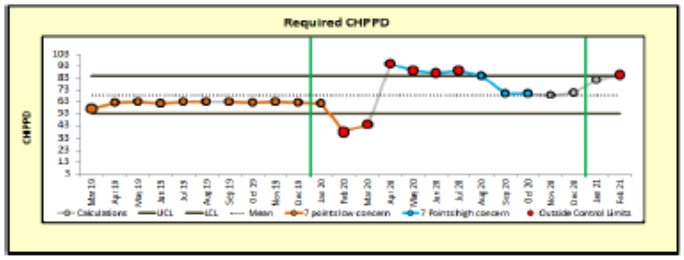
Data set 1: CHPPD required for activity and acuity

Required Care Hours Per Patient Per Day (CHPPD)		
Area	**2020 Average**	**Target**
Overall Position	208.2	Increase
Urgent Care	72.3	Increase
Planned Care	78.0	Increase
Integrated Care Partnership	13.6	Increase
Women's and Children's	44.4	Increase

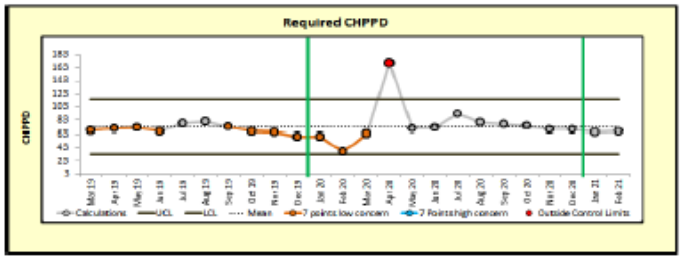
Overall Position



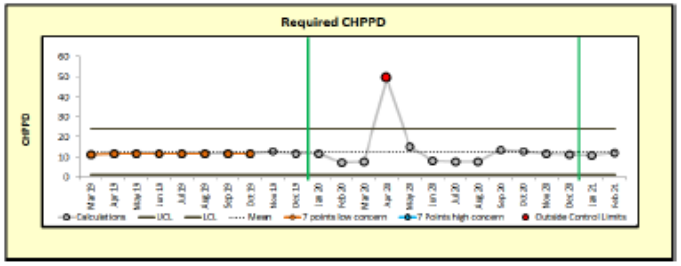
Urgent Care



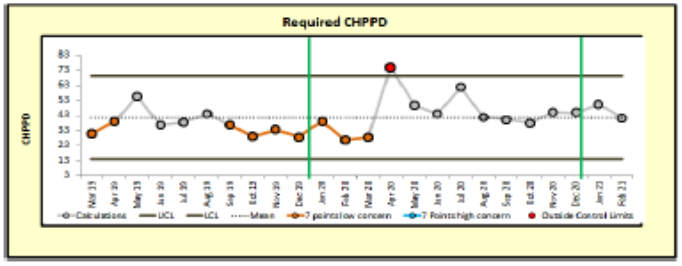
Planned Care



Integrated Care Partnership



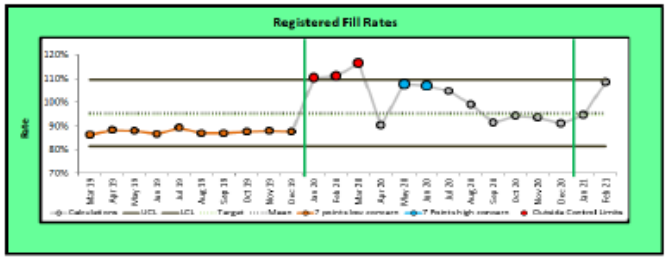
Women's and Children's



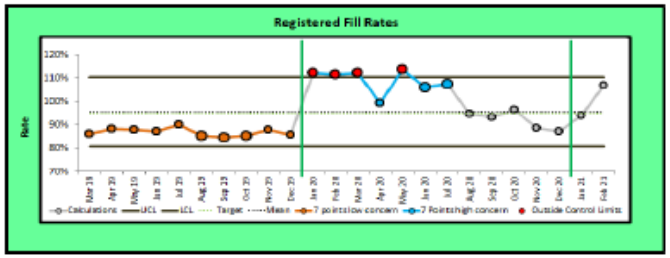
Data set 2: Registered nurse % fill rates

Registered Midwifery Fill Rates		
Area	**2020 Average**	**Target**
Overall Position	102%	95%
Urgent Care	102%	95%
Planned Care	103%	95%
Integrated Care Partnership	91%	95%
Women's and Children's	100%	95%

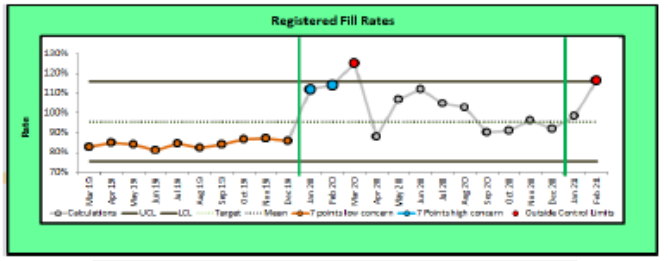
Overall Position



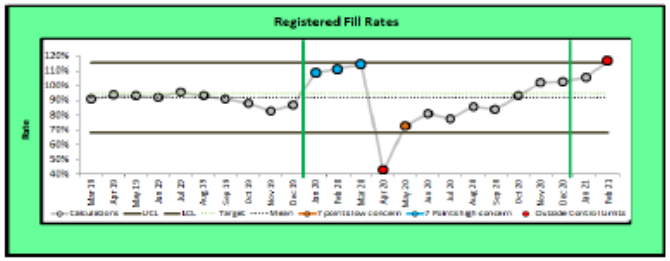
Urgent Care



Planned Care



Integrated Care Partnership

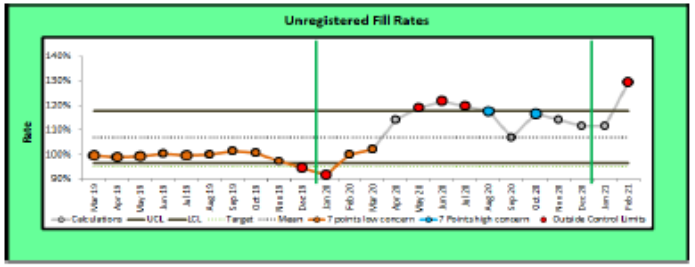


Women's and Children's

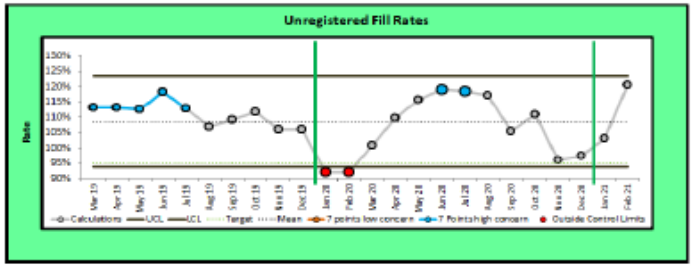
Data set 3: Unregistered nurse % fill rates

Unregistered Midwifery Fill Rates		
Area	**2020 Average**	**Target**
Overall Position	111%	95%
Urgent Care	106%	95%
Planned Care	119%	95%
Integrated Care Partnership	94%	95%
Women's and Children's	114%	95%

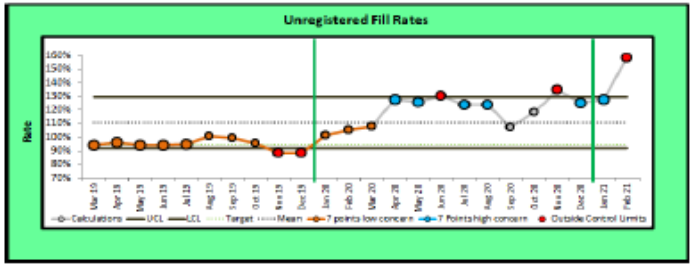
Overall Position



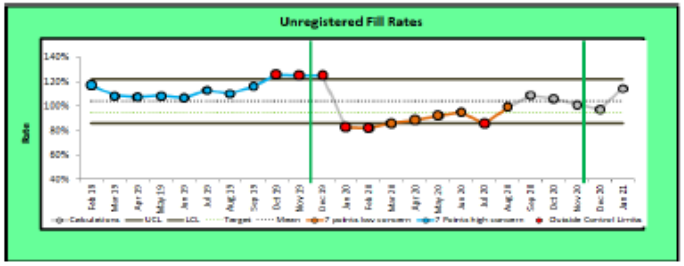
Urgent Care



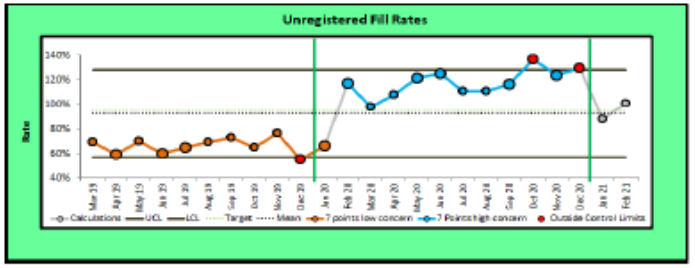
Planned Care



Integrated Care Partnership



Women's and Children's



5.2 Responding to unplanned workforce challenges

An advisory framework[7] was published in December 2020 to support hospitals in maintaining safe services during the pandemic. This focused on the additional supply of staff anticipated and taking a risk assessed approach to deployment to maintain the skills needed to provide safe care and treatment. Services were reconfigured at pace to release capacity to meet demand in key areas such as the Emergency Department, Critical Care, Respiratory Support Unit and adult Urgent Care wards. This required the nursing and midwifery workforce to adopt new ways of working, to be flexible and responsive to the needs of patients and this resulted in many staff working in areas outside of their usual place of work.

The skill mix in ward and department teams has been affected as a result of the surges seen during the pandemic. Teams adapted by moving to a task allocation model of care supported by a buddy system. Where possible; preparatory training was provided and practice development support was deployed to high risk areas to induct and train staff in respiratory skills and equipment competencies. Safety assessments continued in every ward and department throughout the period to provide insight into any impact seen to the quality of care delivered (please refer to section 5.4).

During 2020 there has been more reliance on temporary staff (bank and agency) to support the workforce numbers and compensate for the unavailability presented in section 4.2. A staggering 45,140 shifts have been filled by bank workers (57.65% fill rate) and a further 4,538 shifts filled by agency staff (5.8% fill rate) during the reporting period (as seen in table 4). This reliance on temporary staffing has been a significant cost pressure and the agency spend, particularly during wave 2 has increased substantially to maintain the staff staffing levels (as seen in graph 3).

Table 4: Temporary staffing duty (shift) requests and % fill rates

	Filled Duties						
	Bank Filled		Agency Filled		Overall Fill Rate	Unfilled	
Duties Requested	Duties	%	Duties	%		Duties	%
78,295	45,140	57.65%	4,538	5.80%	63.45%	28,617	36.55%

Graph 3: Nursing and Midwifery agency spend

5.3 Staff Well-being

A range of support has been offered and promoted to the nursing and midwifery workforce during the reporting period. These include (but are not limited to):

- Guidance giving staff pointers on self-care, perspectives on trusted sources of information, meditation and mindfulness
- Promotion of the established external Employee Assistance Programme (EAP) with Health Assured, available 24/7 free to all staff plus their household
- Promotion of Remploy mental health vocational rehabilitation service
- Regional resources made available from the Cheshire and Merseyside Resilience Hub and charitable counselling organisations such as Frontline19 and Healthbox CIC

The communications team daily Trust updates and weekly bulletins have been used to circulate this information. In February 2020 staff had the opportunity to join four free wellbeing webinars provided by EAP. Teams have made themselves available to staff, to talk by telephone or in person. The Occupational Health team have been responsive and reactive to staff calling for advice and support; and other teams have opened themselves with kindness and compassion to staff, in particular the Macmillan Cancer Support and Spiritual Care centres. Other colleagues have made use of the PACE (peer assessment after clinical exposure) facilitators, or the safeguarding team. To coincide with the 'Time to talk day', the Organisational Development team led a month long Listening Service, a simple non-therapeutic approach for staff to call to chat, share a thought, or just be signposted. In addition, 2 dedicated staff wellbeing rest areas have been created to enable somewhere quiet and away from the immediate work area for a rest or meal break.

5.4 Quality impact assessment

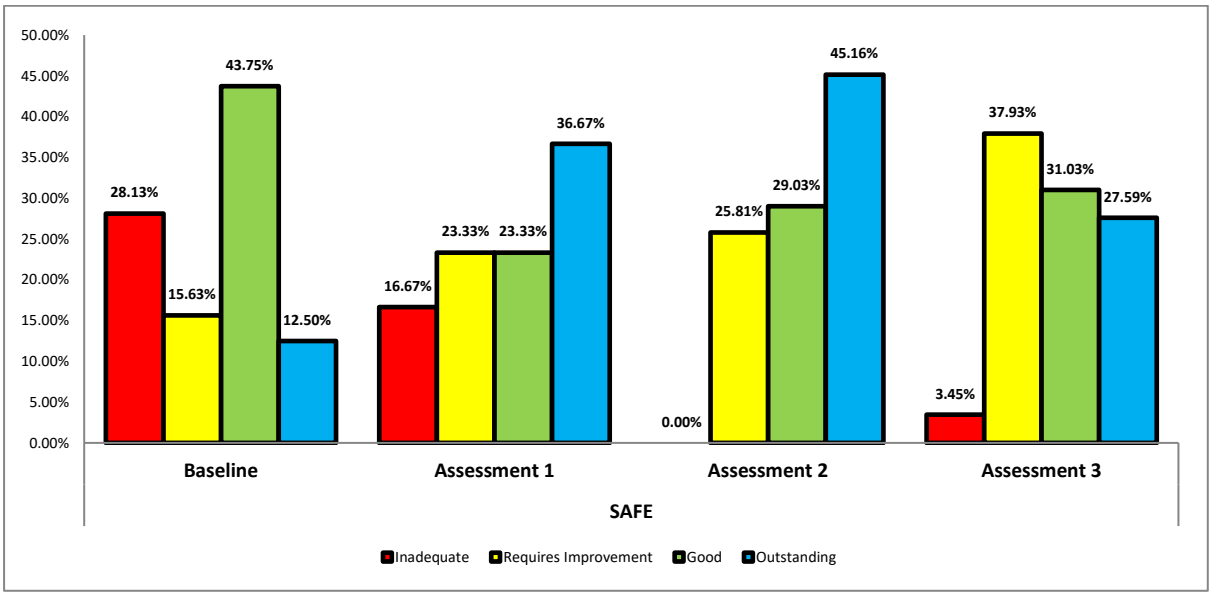
When considering safe staffing levels across wards and departments it is imperative that staffing data is triangulated with key safety, quality and experience metrics. With a particular focus on patient safety, the quality of care delivered and compliance to a range of regulatory and commissioning standards. This ensures not only are the right numbers of nurses available but they also have the right skills for the dependency and acuity of the patients they are caring for.

At the Countess of Chester NHS Foundation Trust we are committed to improving and sustaining the standard of care for all our patients to ensure that they are treated and cared for in a timely manner to support improved health outcomes and overall experience. Following the Care Quality Commission (CQC) Inspection (December 2018), internal and external audits and feedback from patients and their families the Trust took the decision to combine multiple audits into one comprehensive internal inspection system. The Care Assurance Framework (CAF) was developed during 2019 and each ward and department is now assessed against the agreed standards. There is a core set of standards that apply to all areas, with additional measures added for relevant services. Each CAF has been designed using the CQC key lines of enquiry (KLOE) and (where relevant) can be mapped to the 28 regulations set out in the Health and Social Care Act (2008), regulatory activities, Regulations (2010) and the Care Quality Commission (Registration) Regulations (2009).

Despite the challenges posed by the pandemic, quarterly assessments have continued throughout this reporting period, with a particular focus on the 'safe' domain. It is pleasing

to see (in graph 4) the improvement achieved within this domain since the baseline assessment in 2019. There has been a 15% increase in the number of areas achieving 'outstanding' and a 24.68% reduction in those scoring 'inadequate'.

Graph 4: Ratings and improvement in 'safe' domain during this reporting period



When considering 'overall' ratings, the majority of wards and departments have improved their rating or have improved compliance across a domain (as seen in data set 4). There remains work to do over the next reporting period to further improve and achieve an 'overall' rating of 'good' to 'outstanding' across the majority of areas.

Data set 4: Overall ratings by ward and department during reporting period

	2019	2020	2020	2020
PLANNED	B/L	1ST	2ND	3RD
40				
41	RI	O	O	RI
MODULAR	IA	RI	O	RI
45	RI	O	IA	RI
52	IA	RI	IA	RI
53	RI	RI	IA	IA
56				
60	IA	RI	RI	RI
GYNAE O/P	O	O	RI	O
GENERAL O/P	RI	RI	RI	RI
WESTMINSTER EYES	O	O	O	O
BREAST UNIT	O	O	IA	RI
JUBILEE/ESSU	IA	IA	RI	RI
THEATRES	IA	IA	RI	RI
RENAL UNIT	RI	O	O	O
UROLOGY	RI	RI	RI	
ICU	RI	O	RI	RI

	2019	2020	2020	2020
ICP	B/L	1ST	2ND	3RD
BLUEBELL	O	O	IA	RI
POPPY	RI		RI	IA

	2019	2020	2020	2020
URGENT	B/L	1ST	2ND	3RD
33	RI	IA	RI	RI
34	IA	IA	RI	RI
42	IA	RI	RI	RI
43	RI	RI	RI	O
46/47	IA	IA	RI	RI
48	RI	RI	RI	O
49	IA	RI	IA	O
50	O	IA	RI	O
51	IA	RI	RI	RI
ED	IA	RI	RI	

	2019	2020	2020	2020
WOMEN'S & CHILDREN'S	B/L	1ST	2ND	3RD
30	RI	O	O	O
32	O	RI	O	O
35	O	O	O	O
NNU	O	O	O	O

During this reporting period staff have continued to report incidents that directly relate to staffing levels and those where staffing may be a contributory factor (as seen in graph 5 and table 5). Urgent Care has been the highest reporter and the top 2 most reported issues have been inpatient falls and treatment.

Graph 5: Incidents relating to nursing and midwifery staffing (direct or contributory)

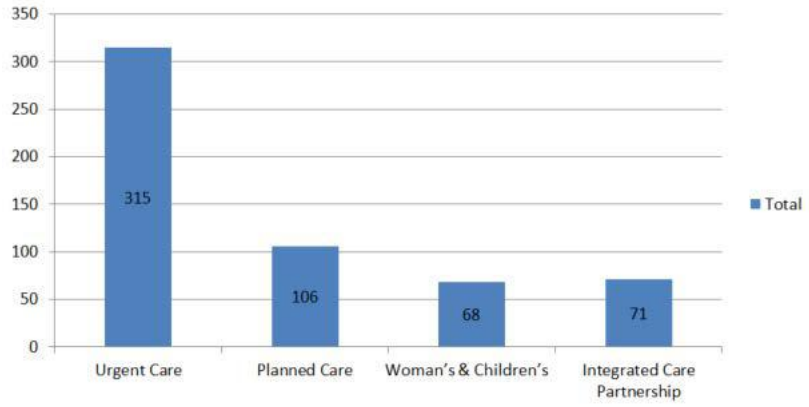


Table 5: Incidents relating directly to nurse staffing by Division

Incident Category	Urgent Care	Planned Care	Woman's & Children's	Integrated Care Partnership	Grand Total
Slip, Trip, Fall (In-Patient)	13	5		5	23
Treatment	11	3			14
Security - Abuse - Patient to Staff/3rd Party	4			1	5
Bed management	3	2			5
Medication	3	2			5
IT/Computer Related	1	1	1		3
Diagnosis	2				2
Recognising Risk in Deteriorating Patient	2				2
Health & Safety Incident	1	1			2
Administrative	1		1		2
Security - Abuse - Patient to Patient	1				1
Gynaecology (Pick List)			1		1
Manual Handling - Patient involved				1	1
Security - Other Incident				1	1
Resuscitation	1				1
Health Records	1				1
Catering	1				1
Discharge			1		1
Equipment	1				1
Theatre Services		1			1
Paediatric (Pick List)			1		1
Unexpected events		1			1
Pathology (Microbiology/Blood Sciences/Blood Transfusion/Cellular Pathology	1				1
Radiology		1			1
Grand Total	47	17	5	8	77

23 falls have occurred in wards and departments as a direct result of staffing levels, of these 9 resulted in harm (6 low harm and 3 moderate harm). Learning from these incidents has identified that these falls were (in the main) unwitnessed in a bays, single rooms or bathrooms. This correlates with the falls dashboard which tracks all falls (seen in charts 1 and 2). Improvement work supported by an on-going audit cycle has demonstrated:

- 85% completion with falls assessment within 6 hours of patient arriving at hospital
- 98% completion with falls assessment during the patients hospital stay (improvement of 5.5% since previous audit)

- 100% of patients identified as being 'at risk' following the initial assessment had standard falls prevention measures in place (demonstrated on care and comfort charts)

Compliance to 2 of the best practice bundle elements remain below the standard expected (as seen in graph 6). Improvement work in now targeted to include lying and standing blood pressure and visual assessments. However, the insight gained from the incident data has identified that observation of patients is a root cause of the unwitnessed falls. Covid -19 and the risk reduction measures put into place in clinical areas (closing down of bays), has reduced the visibility of patients and further work is now being undertaken to assess compliance with the 'enhanced supervision' policy.

Chart 1: Overall falls incidents by area

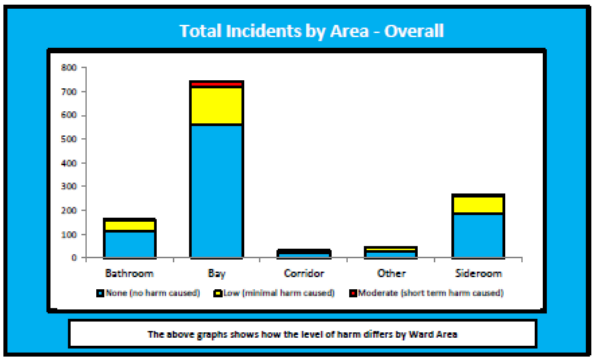
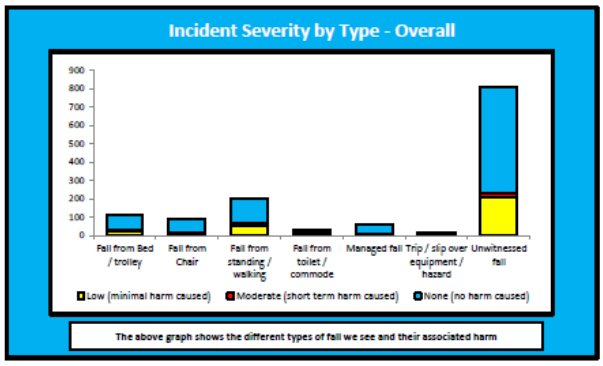
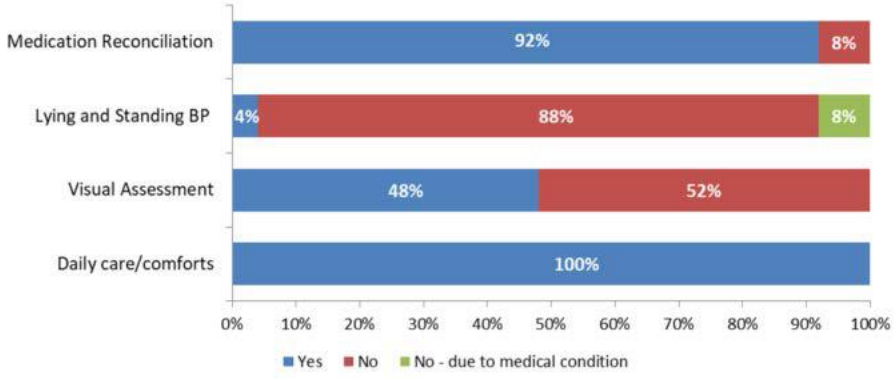


Chart 2: Overall incident severity by type



Graph 6: Compliance to falls best practice bundle



14 incidents that relate directly to staffing have been categorised under 'treatment' (3 low harm and 3 moderate harm). Incidents reporting under this fall into 3 sub-categories:

- Delay in performing a procedure or operation
- Delay in treatment
- Patient has no wrist band or identification band

On review of these incidents 2 relate to nurse staffing levels, one in relation to a delay in IV paracetamol administration for a patient with a temperature and the other in relation to a busy assessment area which could not provide the level of intervention needed to support a patient, which was actioned at the time appropriately and the patient was transferred to the Acute Medical Unit.

5.5 Compliance to National Requirements

Table 6 below outlines the Countess of Chester Hospitals compliance against the following regulatory and National Quality Board Standards:

- Emergency Department External Review (2019) using National Quality Board Urgent and Emergency Care Standards (2018) – please see appendix 2 for full details;
- National Quality Board (2018) An improved resource for adult inpatient wards in acute hospitals[8]–please see appendix 3 for full details;
- National Quality Board (2017) Safe, sustainable and productive staffing: An improvement resource for maternity services[9]-please see appendix 4 for full details;
- National Quality Board (2018) Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals[10]-please refer to appendix 5 for full details; and
- NHS Improvement (2019) Care Hours per Patient Day (CHPPD): Guidance for inpatient trusts (updated July 2019)[11]-please refer to appendix 6 for full details.

The National Quality Board (NQB) published these frameworks for provider organisations to use when assessing and reviewing nursing and midwifery safe staffing levels. They are designed to ensure transparency in reporting from 'ward to board' and to ensure the triangulation detailed in the previous section is undertaken consistently and using a standardised framework.

Table 6: Summary of compliance to NQB and NHS Improvement Staffing Standards

NQB/NHSI Framework	(N) Standards	Met (N)	Partially Met (N)	Not Met (N)	Excluded (N)	%
Emergency Department External Review	27	20	1	1	5	92.5%
NQB (2018) An improved resource for adult inpatient wards in acute hospitals	10	8	1	1	0	80%
NQB (2017) Safe, sustainable and productive staffing: An improvement resource for maternity services	13	13	0	0	0	100%
NQB (2018) Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals	12	11	1	0	0	91%
NHS Improvement (2019) Care Hours per Patient Day (CHPPD): Guidance for inpatient trusts	16	15	0	1	0	93.7%

In addition to the NQB standards there are core neonatal nurse staffing standards outlined by British Association of Perinatal Medicine and supported by Department of Health Neonatal Toolkit, NICE Quality Standards 4 (2010), Bliss and the North West Operational Delivery Network. These include:

- Intensive care babies require 1:1 nursing
- High Dependency 1:2
- Special care babies require 1:4

The Countess of Chester Hospital NHS Foundation Trust achieves these standards consistently (as seen in table XX).

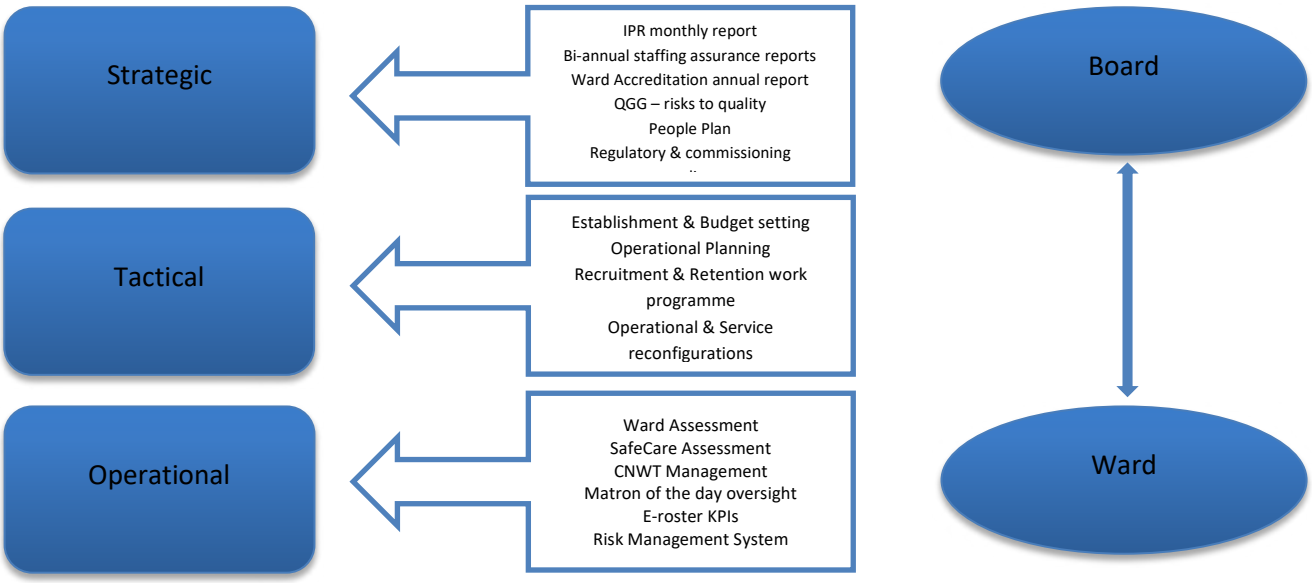
Table 7: Extract from Neonatal Safe Staffing Dashboard

						Overall
NURSE STAFFING - NUMERICALLY STAFFED	NWNODN	66%	82%	71%	77%	**74%**
	Cheshire & Merseyside	70%	84%	76%	78%	**77%**
	Countess of Chester	98%	99%	99%	99%	**99%**
NURSE STAFFING - PROPORTION OF QIS NURSES	NWNODN	61%	61%	60%	62%	**61%**
	Cheshire & Merseyside	69%	71%	69%	69%	**69%**
	Countess of Chester	52%	52%	51%	34%	**47%**
NURSE STAFFING – SHORTFALL	NWNODN	0.5	0.2	0.4	0.3	**0.4**
	Cheshire & Merseyside	0.3	0.2	0.2	0.2	**0.2**
	Countess of Chester	0.0	0.0	0.0	0.0	**0.0**
NURSE STAFFING – Completeness	NWNODN	99%	99%	99%	98%	**99%**
	Cheshire & Merseyside	98%	98%	98%	96%	**98%**
	Countess of Chester	100%	100%	100%	100%	**100%**

6.0 Oversight and Governance

The ward to board model for nursing and midwifery workforce safeguards is shown in figure below. This model demonstrates the operational response to safe staffing, from assurance provided to oversight given by Board.

Figure 1: Ward to Board Nursing and Midwifery Safeguards Model



Formal risk assessments have been undertaken during this reporting period in high risk areas, to monitor and respond to staffing numbers and skill mix. Providing assurance on the actions being taken to mitigate the risk and minimalise the impact.

7.0 Conclusion

This reporting period has seen significant pressure (operationally and financially) in response to the pandemic. However, the nursing and midwifery workforce have responded to support patients and service users by adopting new ways of working and deploying to unfamiliar areas to maintain safety, quality and operational performance. There has been a sustained improvement in vacancy against budgeted establishment, turnover, care hours per patient per day, registered and unregistered nurse fill rates and the quality of care delivered. To achieve this there has been a reliance on temporary staff which has generated a significant spend (particularly agency costs). Work is now focused on returning to business as usual models and supporting the recovery and restorations programme.

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5. NHS England (2020) NHS Launches renewed recruitment drive. Available at: https://www.england.nhs.uk/2020/11/nhs-launches-renewed-recruitment-drive/

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8. National Quality Board (2018) *An improved resource for adult inpatient wards in acute hospitals.* Edition 1. Available at: www.nhsimprovement.com

9. National Quality Board (2017) *Safe, sustainable and productive staffing: An improvement resource for maternity services.* Available at: https://improvement.nhs.uk/documents/1353/Safe_Staffing_Maternity_final_2.pdf

10. National Quality Board (2018) *Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals.* Available at: https://improvement.nhs.uk/documents/2980/Safe_Staffing_CYP_FINAL_PROOF_27_June_2018.pdf

11. NHS Improvement (2019) *Care hours per patient day (CHPPD): guidance for all inpatient trusts.* Available at: https://improvement.nhs.uk/documents/5604/Care_hours_per_patient_day_CHPPD_guidance_for_all_inpatient_trusts.pdf

Appendix 1: Midwifery Safe Staffing Report

Purpose: to provide an update to the Trust Board, of the 6 monthly safe staffing review for the maternity service. This report informs the board on the Midwifery staffing levels and whether they are adequately budgeted to meet the dependency and demand. For continuity, the same methodology of Birth Rate Plus has been used, as per the last staffing review.

Midwifery staffing

Safe Maternity Staffing is recognised in the following documents;

- Birth-rate Plus (the only calculating tool endorsed by NICE)
- NICE Safe Staffing (2016)
- NHS England NQB Safe Staffing documents (2017).

To ensure a safe service the following measures are in place;

- An escalation guideline which is enacted at times of high activity, including deployment of senior midwifery managers and specialist midwives to support the service as required.
- Rotation of staff to support service needs, ensuring a competent and skilled workforce.
- Established ERoster principles.
- Development of the workforce via the appraisal process to develop a staffing establishment that is competent for the activity/services to be delivered and identifying aspiring leaders.
- On-going review of midwifery indicators as per NICE safe staffing guidance for adverse incidents with an established governance framework.
- Introduction of Birthrate + acuity tool March 2019.

Principles applied to the development of the Midwifery/Nursing Establishment:

- Reviewed in line with activity, capacity and occupancy, both current and potential future service developments, for the financial year 2021/22.
- Professional judgement using National frameworks to inform the triangulation of evidence.
- Patient acuity and dependency.
- Supernumerary Shift Coordinator (Safer Childbirth guidance 2007).
- 19.65% uplift for sickness absence, annual leave and training and development.

Additional key requirements to support the Midwifery Establishment:

- Saving Babies Lives Lead Midwife (1.0wte) to lead and ensure compliance with SBLBv2 national directive

Midwifery

The calculations are based on the information collected for the period January to December 2018 Methodology; Birthrate Plus (Ball & Washbrook), RCM Staffing Standard Guidance (2009), Safer Childbirth (2007) and calculations for the implementation of continuity of carer model.

The rolling 12 months births for June 2019 –May 2020 was 2297

The table below demonstrates that we are currently non-compliant with safe staffing levels as per the Birthrate+ recommendations. However, it is noted that the 2018 Birthrate+ figures were based on 2779 births per year, which is approximately 400 more than our current forecast birth rate. The main reason behind this difference is the drop in Welsh births based on changes in their commissioning. Birthrate+ will be undertaking another review this year (May 2021) on the updated birth figures but in the interim, we have based this paper on similar methodology to give an estimate. This estimate also shows that our staffing levels are still below the recommended. Current staffing levels could result in unit closures if staffing levels are not at the recommendations of the Birthrate+ review.

Areas	Required (Using BR+ methodology for 2400 births)	Current budget	Birthrate+ Assessment 2018 (Based on 2779 births)
Delivery Suite 6 midwives required	35.48wte	35.53wte	35.48wte (deliveries/acuity of women, includes triage)
MLU	5.38wte	5.36wte	5.38wte
Postnatal/Antenatal Ward	25.35wte	16.08wte	29.35wte
DAU	3.07wte	2.60wte	3.07wte
ANC	2.0wte	2.0wte	6.02wte
Community	19.06wte	22.70wte	22.07wte
Band 8a	0.8wte	0.8wte	-
Band 7 manager	2.11wte	2.11wte	-
Non-Clinical including specialists	7.83wte	7.83wte	8.56wte
Total	101.08 wte (includes a trajectory target of over 60% continuity of carer by 2022)	95.01wte	109.93 wte clinical required

As part of the Better Births Report (2017), trusts are required to implement the Continuity of Carer model within their maternity service. The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period (NHS England 2017). Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures (Sandall et al 2016).

Trusts are expected to meet the following trajectories over the following years;

- 2020- 35% women **booked** onto a continuity of care pathway
- March 2021 - 21% women in **receipt** of continuity of care
- March 2022 - 51% of women in **receipt** of continuity of care

This trajectory is a minimum requirement and will increase year on year. The expectation is that continuity is the aim for all women where appropriate so it will not be sufficient to aim for the minimum target only, there must be progression seen. **Currently we have 0% women in receipt of continuity of care.**

Working towards continuity of care requires a different way of working for our midwifery teams so there are staffing and HR considerations that must be worked through. Some of this work has been delayed due to Covid. The table above shows that our required midwifery staffing should be 101.08wte. We have modelled continuity as well and, if we were funded to this level, we would be able to implement over 60% of continuity within that resource. However, if we were funded to 102.25wte, this would give us 74% continuity which would allow a much more future proofed service.

Issues considered within the review

- The trajectories required following implementation of the Continuity of Carer model.
- Ockenden immediate and essential actions compliance required.
- Ockenden report (2020) asks for trusts to be Birthrate plus compliant.
- Enhanced pay tariff of 4.5% for continuity of carer midwives instead of individual on call payments to reduce the trusts expenditure in on call rates. The impact upon finance levels of this are illustrated in appendix 3.
- Implementation of the training compliance mode as per the Ockenden (2020) review.
- Safeguarding continues to be an increasing challenge and significant use of midwifery resources.
- National guidance has impacted on pathways in particular the Saving Babies Lives care bundle which has increased attendance at triage with reduced fetal movements and increased the demand for serial scans which impacts on midwifery time.

Main areas of risk

- Neonatal unit is currently downgraded to a level 1+
- COVID 19 has increased our acuity of managing complex cases, and impacted upon midwifery staffing and skill mix available.
- Non-compliant with the RCM leadership manifesto (2019) of employing a Director of Midwifery and Consultant Midwife.
- National recommendation to review maternity triage areas. It is recommended that this is staffed by a Consultant Midwife/Band 7 midwife, and going forward staffing models for maternity triage have recommended this also staffed by two senior midwives. This is a significant difference and hasn't been included in the above calculations of additional staffing required until we receive further national guidance.
- The continued challenge of contributing towards the Trust Cost Improvement Programme.
- Introduction of Cerner will require an increase in resource requirements of an IT midwife to develop the external data set requirements within maternity, ensure existing electronic databases such as CTG K2 database co-exist with Cerner and to develop the community resource requirements. Current service provision it is anticipated will not provide adequate resource given the large scale roll out both within the hospital and community.

Proposed developments in next 4 months

- Roll out of 2 case loading team for mixed risk women
- Roll out of elective caesarean section continuity of carer team
- Review of the escalation capacity
- Review of the governance support role for succession planning and to assist with complying with National Safety drivers.
- Cerner EPR, and development of the community resources

Proposed developments in the next 12 months

- Development and roll out of 6 continuity of care teams
- Development of the safe maternity triage model
- Review and expand the bereavement service within maternity to comply with the National Bereavement Care Pathway
- Proposal for acquisition of a Consultant Midwife as per recommendations from RCM Leadership Manifesto (2019).

Ward Accreditation

Central Labour Ward Dec 2019- 2020– Outstanding
Cestrian Dec 2019-2020 – Outstanding

Care Metrics

Quarterly data is collated to create a baseline for audit and reporting to ensure a high quality service that is able to recognise trends in incidents; triangulate complaints, incidents & legal cases and demonstrate ongoing evaluation of areas that are consider to be high risk midwifery.

Last 2020 quarterly report data:

- ⇨ Objective 1- The aggregated audit tool demonstrates 30 maternity health records have been audited which meets the 10 sets a month
- ⇨ Objective 2 -There was some elements that failed to meet the 100% compliance of all sections of our guidelines to the minimum requirements specified the guideline.
- ⇨ Objective 3- The audit tool has demonstrated that 15 out of 15 guidelines meet the required standard of 75%:
- ⇨ Objective 4- As a result of the audit the action plan has been all elements met the overall 75% minimum requirement.

  The audit results have been reviewed monthly and actions taken to address non-compliance with specific individuals. Monthly reports are displayed on the ward quality boards.

Area of practice reviewed	Monthly Audit Results			Overall Average %	Overall Status
	Oct	Nov	Dec		
Maternity Health Records	78	100	93	90%	
Booking Appointment	100	100	98	99%	
Care of Women in Labour	71	96	92	86%	

Intermittent Auscultation	94.5	100	83	92.5%	
CEFM	89	93	95	92%	
OB review women having CEFM	95	100	100	98%	
Meows	100	100	99	99.5%	
Bladder Care	85	95	90	90%	
Fluid Balance	100	90	75	88%	
VTE Assessment 28 weeks	85	100	100	95%	
RFM	88	100	100	96%	
Smoking 36 weeks					
Accompanied Data	95	100	94	96%	
Pressure Area Care	100	100	85	95%	
Medicines Management	90	91	86	89%	
Sepsis	100	100	100	100%	
WHO checklist	-	100	-	100%	

Incidents

A DATIX trend report showed low staffing was the highest reported incident for 2020. There were 48 incidents related to inadequate staffing submitted between January 2020-December 2020. All incidents were in relation to staffing on the labour ward and Cestrian ward.

Month	Staffing Incidents	Serious Incidents
January 2020	0	
February 2020	1	1
March 2020	7	
April 2020	3	1
May 2020	0	1
June 2020	2	1
July 2020	2	
August 2020	11	2
September 2020	3	3
October 2020	6	
November 2020	3	
December 2020	6	

One to One Care in Labour

An increase in the induction of labour rates has affected the complexity of care women require. The local induction of labour rate is approximately 40% with the national being approximately 31.6% in 2017-2018 (NHS Digital 2018). A local audit is being planned to examine the data and create any action plan.

Conclusion

This paper has demonstrated that the Trust has complied with the requirements to review midwifery staffing levels and report to the Board on a 6 monthly basis. Following Ockenden (2020) recommendations that trusts are to be Birthrate+ compliant, an increase in midwifery staffing is required for us to achieve this. Using the Birthrate+ methodology based on 2019-2020 births and to implement Continuity of Carer it has been identified that 101.08 wte are required although 102.25wte would allow us to achieve 74% which would future proof our achievement. By increasing our maternity staffing to the recommended 101.08wte, we are able to comply with the Continuity of Care Model trajectory of 51% by March 2022. However, should the target be increased, we require additional which is why our preference would be to aim for 74%. This would be an increase of 7.24wte midwives.

The implementation of Continuity of Carer will decrease our inpatient stay, improve both maternal and neonatal outcomes, reduce the incidence of poor outcomes and reduce the number of midwives required within in the hospital.

Appendix 2: Emergency Department External Nursing Review (action plan updated July 2020)

Recommendation	Status	Expected date of completion	Comments
Right Staff			
Review the numbers and responsibilities of Band 7 and ENPs	Complete	NA	Roles and responsibilities revised and launched, meeting held with Director of Nursing & Quality to set out expectations and each team leader written to individually.
New roster template, effective from February 2020, should be reviewed and involve Finance to ensure this is aligned to the budget	Complete	NA	Included as part of phase 1 of establishment review.
Further review of staffing requirements is undertaken following completion of the refurbishment of the Department	Complete	NA	Included as part of phase 1 of establishment review.
To assist with the determination of staffing requirements using professional judgement and considering the areas to be staffed, a suggested spreadsheet is attached to this report to assist with this	Excluded	NA	**This is not an NQB recommendation.** This is a recommendation from the external reviewer to use an establishment calculation spread sheet to determine numbers needed. This is not supported by the Trust as there is already a Trust wide establishment setting methodology.
Consideration should be given to achieving compliance with guidance (NQB 2018b):			
• with an uplift of 25%	Not achieved	Revised date: March 2022	Will be included in phase 2 and 3 of establishment review.
• skill mix of 85% RN	Excluded		**Over achieve on HCA numbers.**

			Adequate RN numbers for safe staffing template. % not achieved as further investment made to expand the HCA numbers (over and above requirement). • Day shift: 77% RN to HCA ratio • Night shift: 82% RN to HCA ratio
• staffing requirement of 86.80 WTE is suggested – 72.80 WTE RN (at least 8.4 WTE of which should have ENP skills) and 14.0 WTE HCAs	Complete		Establishment review carried out and investment made to ensure adequate staffing numbers.
There should be a named practice education lead within the ED to ensure training requirements are identified and met (NQB 2018b)	Complete	NA	1.0 WTE PDN band 6 establishment identified and post recruited to, post holders now in place.
Trust should also consider the employment of housekeepers to provide support to nursing staff and improve the service to patients. It is suggested this service covers the core hours and 1 per 12-hour shift x 7 days (the current uplift would provide adequate cover for this service) would require an establishment of 2.68 WTE	Completed	NA	Housekeepers x2 in post from April 2020 covering 7 day service excluding holidays.
A review of RN and HCA support for the ENP service should be undertaken to maximise the efficiency and patient flow through this service	Complete	NA	Establishment review completed, HCA support allocated by shift to ENP in minors, skills development programme now in place to bring all HCAs to band 3 level with associated competencies.
Right Skill			
Ensure the risk assessment and action plan to mitigate the risks of non-compliance with the RCPCH recommendations is available	Complete	NA	Risk assessment and action plan in place. Mitigated by core ED staff trained in PILS and revised and enhanced pathways to paediatric unit. Recruitment drive continues to reach full

			compliance. 50% of shifts now fully compliant.
There is a need for role clarity around team leader/ENP function – consideration should be given to increasing the ENP numbers would increase the knowledge base, staff flexibility, job satisfaction and improve succession planning	Complete	NA	There is now clarity on how these roles differ. Matrix developed and implemented for what staff progression and career pathways are.
Clinical Educator should undertake training needs analysis and develop competency training programme to ensure adequate numbers of staff are available with required skill	Complete	NA	Training needs analysis completed, competency development programme in place.
Roster rules should reflect the number of staff with the required skills on each shift to ensure any shortfall is visible when the rosters are analysed prior to approval. An example of this would be: • take charge skills are assigned to appropriate staff and there should be one Band 6/7 nurse on duty with this skill on duty each shift and one member of staff with an ATLS skill on duty each shift	Complete	NA	Now visible in roster by shift.
Right Place Right Time			
Further review of the roster templates, rules and skill requirements for each shift/day of the week following completion of the refurbishment of the Department	Complete	NA	Completed.
Ensure staff are rostered to work in all areas of ED to maintain skills and competence	Complete	NA	Allocation sheet and been devised and clear path way of progression through department written.
When reviewing the roster policy, the governance	Excluded	NA	**This is not an NQB recommendation.**

arrangements and individual responsibilities of the roster creators/approvers should be clarified to ensure ownership and adequate oversight of the rosters			This is a recommendation from the external reviewer. The Trusts governance has more rigor than recommendation made.
Consideration should be given to retrain senior staff in the use and functionality of the eRoster system to ensure the efficient and effective deployment of staff in the Department	Excluded	NA	**This is not an NQB recommendation.** This is a recommendation from the external reviewer. The Trusts governance has more rigor than recommendation made.
Regular check and challenge meetings may be beneficial to monitor compliance with rostering key performance indicators, however if this may need investment to increase the size of the eRoster team	Partially completed	Revised date: September 2021	Business case for Centralised Nursing workforce Team in development. e-Roster capacity and capability needed to progress this action.
Measure & Improve			
Consideration should be given to the development of local quality dashboard specific to ED	Complete	NA	4 hour timeline KPI launched and Qlikview dashboard developed and visible in all areas, ED specific 'Care Assurance Framework' developed as part of the Ward accreditation System initial assessment undertaken as baseline, improvement work started.
Review the ED safety checklist to include the omission regarding notification of and communication with next-of-kin, safeguarding concerns etc. Compliance with the use of this should be audited regularly	Complete	NA	This is audited regularly and results demonstrate consistent compliance.
Regular reviews of the efficiency of roster and the inclusion of the staff metrics available from the eRoster system – this should include compliance with mandatory and job specific training	Complete	NA	Mandatory training is regularly monitored and staff reminded of compliance.

Culture & Leadership			
There appears to be a need to clarify the roles and responsibilities of the senior nursing staff within the ED	Complete	NA	Roles and responsibilities revised and launched, meeting held with Director of Nursing & Quality to set out expectations and each team leader written to individually.
Training in the process of roster approval and analysis is required	Excluded	NA	**This is not an NQB recommendation.** This is a recommendation from the external reviewer. The Trusts governance has more rigor than recommendation made. Approvals at ADoN level.
It is suggested that Department meetings – nursing as well as meetings of the wider team would improve communication	Complete	NA	Monthly meeting are held with staff.
Ensure that team leaders have sufficient management time allocated and any delegated responsibilities are appropriate	Complete	NA	As from August band 7s will be allocated some management time.
Improve recruitment and retention of staff within the ED it may be worth considering setting up a rotation between ED/Medical/Surgical Assessment Units/Critical Care	Complete	NA	Department now fully recruited and turnover has stabilised.

Appendix 3 National Quality Board (2018) An improved resource for adult inpatient wards in acute hospitals

Recommendation	Compliance	Date	Evidence and/or actions
A systematic approach should be adopted using an evidence-informed decision making tool triangulated with professional judgement and comparison with relevant peers.	Achieved	NA	SafeCare uses NICE recommended 'Shelford Safer nursing care' tool. Acuity census is taken twice daily to measure number of care hours needed. Data collected is used to inform staffing decisions in real-time alongside professional judgement.
A strategic staff review must be undertaken annually or sooner if changes to services are planned.	Achieved	NA	Annual staffing assurance report and 6 monthly progress/update Annex report presented to Board of Executive Directors. Nurse Establishment review undertaken during 2019/20.
Staffing decisions should be taken in the context of the wider registered multi-professional team.	Achieved	NA	Integrated multi-professional staffing models adopted and in place for integrated care partnership and EMU, pharmacy technicians integrated into a number of acute ward teams.
Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning.	Achieved	NA	This is being strengthened with a formal governance process to ensure operational plans are implemented with the required staffing model (+/- short, medium and long term plans). This now includes CNS/ANP job planning and training requirements to support delivery of the Trusts Clinical Strategy.
Action plans to address local recruitment and retention prioritises should be in place and subject to regular review.	Achieved	NA	Recruitment & Retention plans in place, supported by comprehensive work programme.
Flexible employment options and efficient deployment of staff should be maximised	Achieved	NA	Completed establishment review in 2019/20, roster templates updated to reflect numbers needed, uplift allocated into individual budgets. Centralised Nursing Workforce team established as part of COVID -19 operational response. Twice daily safe staffing SitRep

across the hospital to limit the use of temporary staff.			completed. Staff risk assessments determine offers for redeployment.
A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision making.	Achieved	NA	Safe staffing and Quality Measures dashboard developed & in use (Qlikview), visibility on key indicators presented at Transformation Group, CHPPD dashboard being developed to compliment the Board Report and People vs Spend dashboard for Nursing and Midwifery Workforce Group is in draft.
Organisations should ensure they have an appropriate escalation process in cases where staffing is not delivering the outcomes identified.	Partially achieved	September 2021	Safe Staffing Policy and Escalation Cards under review. Interim arrangements put into place as part of Covid-19 response. Staffing models and escalation routes in line with NHS England 'Advice on acute sector workforce models during COVID – 19'. Risk assessments in place for high acuity areas (critical care and respiratory).
All organisations should include a process to determine additional staff uplift requirements based on the needs of patients & staff.	Not achieved	March 2020	Current uplift is not reflective of patient and staff requirements and is not in line with national standard. This will be included in phase 2 and 3 of establishment review.
All organisations should investigate staffing-related incidents and their outcomes on patients and ensure action & feedback.	Achieved	NA	Risk Management system in use is Datix; this system incorporates all aspects of incident management. The online incident reporting form is simple to use and suitable for both clinical and non-clinical incident reporting. Staffing is a category and in addition every submission (regardless of category) has the section 'is this incident related to staffing'? The system allows the reporter to add detail that is specific to the incident. The Risk & Safety team send all low/no harm staffing incidents to the specific ward or departmental manager to review and action, this allows ownership, prompt action and feedback to staff. The Risk & Safety Leads monitor incidents that have caused moderate and above categories of harm, they then produce an SBAR's for the Serious Incident panel who then decide upon the level of action required. Any action plans that form part of a Level 1 or 2 Investigation are monitored by the Divisional Governance Board until completed and are signed off by the CCG.

Appendix 4: National Quality Board (2017) Safe, sustainable and productive staffing: An improvement resource for maternity services

Recommendation	Compliance	Date	Evidence and/or actions
Boards are accountable for assuring themselves that appropriate tools (such as the NICE-recommended Birthrate Plus (BR+) tool for midwifery staffing) are used to assess multi-professional staffing requirements.	Achieved	NA	Birthrate+ establishment review completed during 2018, acuity based tool now in use continuously. Formal re-assessment (Birthrate+) is being undertaken in May 2021.
Boards are accountable for assuring themselves that results from using workforce planning tools are cross-checked with professional judgement and benchmarking peers.	Achieved	NA	Annual staffing assurance report and 6 monthly progress/update Annex report presented to Board of Executive Directors. Midwifery Establishment review using Birthrate+ tool undertaken during 2018. Professional judgement using national frameworks to inform the triangulation of evidence provided. Workforce planning is undertaken in conjunction with the Trusts workforce team and local universities (supported by wider HEE work streams). Changes in skill mix may be required to support new models of care. Benchmarking with peer groups and national providers can be accessed through the NHSi Model Hospital portal and is received at the Nursing and Midwifery Workforce group for discussion/review.
Boards must review midwifery staffing annually, aligned to their operational and strategic planning processes and review of workforce productivity, as well as a midpoint review every six months in line with NICE guideline NG4.	Achieved	NA	Staffing reviewed conducted 6 monthly, this now uses an evidenced based nationally recognised tool (Birthrate+). Reviewed in line with activity, capacity and occupancy both current and potential future service developments. Focus for 2021 – Continuity of Carer Model which may require additional establishment to support full implementation.
Boards are accountable for assuring themselves that staffing reviews use the RCOG, RCoA and OAA guidelines on effective maternity staffing resources.	Achieved	NA	
Boards are accountable for assuring themselves that sufficient staff have	Achieved	NA	Midwifery staff undertake an annual appraisal where a detailed discussion takes place in relation to training required to maintain or advance development to support

attended required training and development, and are competent to deliver safe maternity care.			professional and service objectives, this includes all relevant mandatory training. Rotation of staff to support service needs, ensuring a competent and skilled workforce that is transferable across the maternity pathway. MDT training forms part of CNST requirements.
Organisations should have action plans to address local recruitment and retention priorities, which are subject to regular review.	Achieved	NA	Recruitment & Retention plans in place, supported by comprehensive work programme.
Flexible employment options and efficient deployment of trained staff should be maximised across the hospital to limit numbers of temporary staff.	Achieved	NA	Flexible model has been adopted across maternity services, with midwives working across the full range of the maternity pathway, spanning hospital and community, allowing for a flexible and transferable workforce. Flexible working arrangements are available and maternity currently operates an open rostering system allowing for greater staff choice in shift preferences. Only minimum (very occasional) temporary staffing required to support required fill rates (registered and unregistered).
Organisations should have a local dashboard to assure stakeholders about safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.	Achieved	NA	Safe staffing dashboard developed & in use.
Organisations should have clear escalation processes to enable them to respond to unpredicted service needs and concerns about staffing.	Achieved	NA	Escalation process for Midwifery is enacted at times of high activity including deployment of senior midwifery managers and specialist midwives to support the service as required. The policy is currently under review for adult inpatients but this will not affected the escalation process in Maternity Services.
Establishments should include an uplift to allow for the management of planned and unplanned leave to ensure that absences can be managed effectively.	Achieved	NA	Current uplift is not in line with national standard. However, operationally able to manage this effectively with resource available, annual leave rostered evenly throughout the year (in line with key performance indicators), established e-roster principles continue to be monitored and refined.
Organisations must have mandatory training, development and education programmes for the multidisciplinary	Achieved	NA	Robust induction, preceptorship and CPD training programme available, staff rostered to attend.

team, and establishments must allow for staff to be released for training and development.			
Organisations must take an evidence-based approach to supporting efficient and effective team working.	Achieved	NA	All training and guidelines are evidence based. Rotation of staff to support service needs, ensures a competent and skilled workforce, this also allows for integrated team working across the maternity pathway.
Services should regularly review red flag events and feedback from women, regarding them as an early warning system	Achieved	NA	Red flags are reported in line with national requirements, all safety, quality and experience metrics are monitored and actioned (as required) through the Women's and Children's Governance Committee.
Organisations should investigate staffing-related incidents, outcomes on staff and patients, and ensure action, learning and feedback	Achieved	NA	Risk Management system in use is Datix; this system incorporates all aspects of incident management. The online incident reporting form is simple to use and suitable for both clinical and non-clinical incident reporting. Staffing is a category and in addition every submission (regardless of category) has the section 'is this incident related to staffing'? The system allows the reporter to add detail that is specific to the incident. The Risk & Safety team send all low/no harm staffing incidents to the specific ward or departmental manager to review and action, this allows ownership, prompt action and feedback to staff. The Risk & Safety Leads monitor incidents that have caused moderate and above categories of harm, they then produce an SBAR's for the Serious Incident panel who then decide upon the level of action required. Any action plans that form part of a Level 1 or 2 Investigation are monitored by the Divisional Governance Board until completed and are signed off by the CCG.

Appendix 5: National Quality Board (2018) Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals

Recommendation	Compliance	Date	Evidence and/or actions
Adopt a systematic approach using an evidence-based decision tool, triangulated with professional judgement and comparison with peers.	Achieved	NA	Annual staffing assurance report and 6 monthly progress/update Annex report presented to Board of Executive Directors. Nurse Establishment review undertaken during 2019/20. SafeCare in use utilising the paediatric version of the 'Shelfold' tool to assess acuity in real-time to support decision making alongside professional judgement.
Undertake a strategic staffing review annually or more often if changes to service are planned.	Achieved	NA	Annual staffing assurance report and 6 monthly progress/update Annex report presented to Board of Executive Directors. Nurse Establishment review undertaken during 2019/20.
Staffing decisions should consider the impact of the role and carers.	Achieved	NA	A limitation of the paediatric SafeCare tool is that it does not account for the role of carers with regards to the child's requirements. Professional judgement is applied to staffing allocation on each shift to take this into consideration.
Factor into the establishment the requirement that all children and young people should have access to a registered children's Nurse 24 hours a day – particularly important in the NHS Acute Trusts and DGH's where the children's services are often a small department.	Achieved	NA	Minimum of 2 Registered Children's Nurses on any shift, evidence available on HealthRoster.
Take staffing decisions in the context of the wider registered multi-professional team.	Partially achieved	September 2021	Advanced practitioners are used to support the nursing numbers in the Children's Assessment Unit (currently under established), this leads to limitations in them delivering their usual duties (at an advanced level). A new model with supporting assistant practitioners is currently being explored, this will form part of phase 2 and 3 of the establishment review.
Safe Staffing requirements and workforce productivity should be	Achieved	NA	This is being strengthened with a formal governance process to ensure operational plans are implemented with the required staffing model (+/- short, medium and long

integral to operational planning.			term plans). This now includes CNS/ANP job planning and training requirements to support delivery of the Trusts Clinical Strategy.
Organisations should have plans to address local recruitment and retention priorities, and review them regularly.	Achieved	NA	Recruitment & Retention plan in place, supported by comprehensive work programme.
Hospitals should offer flexible employment and deploy staff efficiently to limit use of temporary staff, paying particular attention to the younger age profile of registered children's nurses.	Achieved	NA	Flexible working arrangements are available, with some agreements in place, these are reviewed annually. Staff deployment within our speciality area reducing the need for temporary staff (which is minimal).
Organisations should have a local dashboard to assure stakeholders about safe and sustainable staffing. It should include quality indicators to support decision-making.	Achieved	NA	Safe staffing and Quality Measures dashboard developed & in use (Qlikview), visibility on key indicators presented at Transformation Group, CHPPD dashboard being developed to compliment the Board Report and People vs Spend dashboard for Nursing and Midwifery Workforce Group is in draft.
All organisations should have a process to determine additional staffing uplift requirements based on the needs of patients and staff.	Achieved	NA	Currently 20% uplift, although not in line with national recommendation, with occupancy and acuity this can be managed within budgeted establishment.
All organisations should investigate staffing-related incidents and their effect on staff and patients, taking action and giving feedback.	Achieved	NA	Risk Management system in use is Datix; this system incorporates all aspects of incident management. The online incident reporting form is simple to use and suitable for both clinical and non-clinical incident reporting. Staffing is a category and in addition every submission (regardless of category) has the section 'is this incident related to staffing'? The system allows the reporter to add detail that is specific to the incident. The Risk & Safety team send all low/no harm staffing incidents to the specific ward or departmental manager to review and action, this allows ownership, prompt action and feedback to staff. The Risk & Safety Leads monitor incidents that have caused moderate and above categories of harm, they then produce an SBAR's for the Serious Incident panel who then decide upon the level of action required. Any action plans that form part of a Level 1 or 2 Investigation are monitored by the Divisional Governance Board until completed and are signed off by the CCG.

Feedback from children, and young people, families and carers, including complaints, should be an early warning to identify service quality concerns and variation.	Achieved	NA	Friends and Family, thank you cards, PALS, Social Media (for example twitter and Facebook), comments are reviewed and actioned appropriately.

Appendix 6: NHS Improvement (2018) Care Hours per Patient Day (CHPPD): Guidance for acute and acute specialist trusts

Recommendation	Compliance	Date	Evidence and/or actions
Do trusts have a clear process for Safe Staffing monthly returns to be quality assured as well as clinically validated within their organisation prior to submission? This will help ensure accuracy, completeness and robustness of reported CHPPD data.	Achieved	NA	Staff staffing data is pulled from the HealthRoster monthly. This is retrospective so all moves/shift changes are reflected in the information pulled. The data pulled is reflective of actual hours worked (day/night and registered/unregistered) by each ward/department. This information is validated by the Centralised Nursing Workforce Team and submitted through the Business Intelligence team to NHS Digital before the reporting window closes. ***NB. The CHPPD calculation used is the NHSi/NHSE definition in line with the Lord Cater metric not SafeCare which uses the Shelford tool.***
Are the ward and speciality names routinely checked for alignment across other national data returns?	Achieved	NA	This now forms part of the clinical validation and approval process undertaken by the Centralised Nursing Workforce Team.
Where there is a legitimate reason for a ward to be renamed, is there a Trust process for validating and updating the Model Hospital in accordance with the revised change form?	Not achieved	December 2020	Newly included standard (July 2019), internal process needed to address, action to be completed by December 2020. **Passes deadline: no progress made in relation to this standard as paused until EPR implementation complete.**
Is there a way of exploring the level of variation across the Trust for nationally reported CHPPD in the Model Hospital, and whether this is warranted or unwarranted?	Achieved	NA	Safe staffing and Quality Measures dashboard developed & in use (Qlikview), visibility on key indicators presented at Transformation Group, CHPPD dashboard being developed to compliment the Board Report and People vs Spend dashboard for Nursing and Midwifery Workforce Group is in draft. For CHPPD dashboard, information from the Model Hospital portal is used as a benchmark, any variation internally or against peer is identified.
Is there an understanding of reported CHPPD by ward or specialty compared to national averages and to similar	Achieved	NA	As above

wards at peer Trusts?			
Are ward establishments set using NICE endorsed evidenced based tools such as the Safer Nursing Care Tool (SNCT) and Birthrate Plus	Achieved	NA	Birthrate+ used for Maternity. SafeCare (Shelford tool) used in adults and paediatrics to support real-time decision making. National audit against Shelford tool (twice yearly) commenced in August 2020.
Are these in line with NQB and underpinned by auditable clinical judgement?	Achieved	NA	All reviews undertaken have been in line with the NQB expectations and validated by the Associate Directors of Nursing and Head of Midwifery and Paediatric Nursing.
Are such tools used consistently and exactly as instructed in the implementation guidance in an auditable manner?	Achieved	NA	Nationally validated tool used in SafeCare & fully embedded in line with guidance.
Is the set establishment as signed off at budget setting by finance, workforce, operational and clinical leads being expressed in terms of care hours (and could therefore be convertible to CHPPD) to enable comparisons and triangulation with nationally reported CHPPD?	Achieved	NA	Governance in place to ensure that establishments are now signed off annually at budget setting by finance, workforce, operational and clinical leads. Shelford tool is used to determine number of nurses needed (FTE using multipliers for acuity seen). There is no nationally validated tool that is available to convert CHPPD into establishments (FTE by band) but the Trust can translate establishments in this way to understand the care hours available on each shift (using the safe staffing templates) and historical data can be used to provide intelligence on the number of hours needed to meet demand/acuity.
Do trusts have systems and processes in place to capture the CHPPD that is planned on their daily roster?	Achieved	NA	SafeCare fully embedded and visibility available at ward, divisional and organisation level, with the establishment review and the 'tightening' of roster templates the data quality will improve moving forward.
Can this be reviewed on a shift to shift basis?	Achieved	NA	SafeCare fully embedded and visibility available at ward, divisional and organisation level.
Do trusts have systems and processes in place to capture the CHPPD that is actually delivered on their daily roster?	Achieved	NA	SafeCare fully embedded and visibility available at ward, divisional and organisation level.

Can this be reviewed on a shift to shift basis?	Achieved	NA	SafeCare fully embedded and visibility available at ward, divisional and organisation level.
Can this then be compared and tracked against establishment CHPPD?	Achieved	NA	Reports can be run out of the roster to track and compare CHPPD against establishment (required vs actual). This is visible in the Qlikview app.
Reviewing CHPPD on a daily and shift to shift basis can form a transparent and helpful basis for levelling and redeploying staff between wards.	Achieved	NA	This process takes place on a daily basis by the Centralised Nursing Workforce Team in real-time and in response to changes in staffing level and/or demand.
Daily and shift-to-shift comparisons, auditable, evidence-based methods that are clinically assured and clearly aligned with guidance are required to capture patient acuity and dependency.	Achieved	NA	SafeCare uses the validated Shelford tool; this has been rolled out to all adult and paediatric inpatient wards, using the nationally agreed multipliers to calculate required staffing. In critical care a regional dependency tool has been adopted until a national one is available and the ICS Standards for staffing are applied. In Maternity the Birthrate+ tool is used and in Neonates the BAPM standards are applied in relation to levels of care.

Meeting	**13th July 2021**		**Board of Directors**					
Report	**Agenda item: 12.**		**Maternity Incentive Standards Report**					
Purpose of the Report	Decision		Ratification		Assurance	**x**	Information	
Accountable Executive	Hilda Gwilliams		Interim Director of Nursing					
Author(s)	Jean Fisher Liz Hall		Associate Director of Paediatric Nursing & Head of Midwifery (Interim) Directorate Manager for Women & Children's (now left the Trust)					
Board Assurance Framework	Q1	Quality & Safety						
Strategic Aims	To support the delivery of safer maternity care							
CQC Domains	Safe/Effective/Caring/Responsive/Well Led							
Previous Considerations	Quality Governance Group – 26th May 2021 Quality and Safety Committee – 22nd June 2021							
Executive Summary	NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care by incentivising ten maternity safety actions. The maternity incentive scheme applies to all Acute trusts that deliver maternity services and are members of the CNST. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund (approximately £250k for CoCH) and will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.							
Recommendation(s)	The Board is requested to**: -** Review the attached detailed working document. The document demonstrates compliance to all ten safety actions. Submission of achievement of the Incentive Standards requires self-certification							

	from the Board. The Board is asked to review the supporting evidence and approve that we have sufficiently achieved all ten standards so that we can submit to NHS Resolution in time for the deadline of 15th July 2021. Dr Susan Gilby Chief Executive Officer, is asked to review, complete and sign the Board declaration at the end of the MIS Safety Action Final-V2 July 21 document. On Completion this will be submitted to NHS resolution by 15th July 2021
Corporate Impact Assessment -	
Statutory Requirements	Legal and regulatory Impact
Quality & Safety	
NHS Constitution	
Patient Involvement	
Risk	Risk & Performance Management
Financial impact	Financial impact
Equality & Diversity	
Communication	

In recognition of the current pressure on the NHS and maternity services in response to COVID-19, the majority of reporting requirements relating to the maternity incentive scheme 10 safety actions are paused until Monday 31 August 2020.
The scheme was officially relaunched on the 1st October 2020. SUBMISSION DATE IS NOW THURSDAY 15TH JULY 2021 12pm (DECLARATION FORM CAN BE SENT BETWEEN 12TH JULY AND 15TH)
Trusts will be notified by end of November 2021

Action No.	Maternity safety action	Required standard	Lead name	Role	Action met? (Y/N)	Update on response	Link to file for evidence
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	(a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started before 15th July 2021. iii. Removed	Lesley Tones	Interim Risk and Patient Safety Lead	Yes	(a) (i) COMPLETE (ii) COMPLETE All reported cases suitable for review using the PMRT tool were started. (However, some reports are not finalised due to: awaiting coroners court outcome and secondly time constraints in completion of reports.)	
		b) i. At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15th March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15th July 2021. ii. Removed	Lesley Tones	Interim Risk and Patient Safety Lead	Yes	As above (ii)	
		c) For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.	Lesley Tones	Interim Risk and Patient Safety Lead	Yes	There will have been a conversation with 100% of families before discharge and an appointment given for the postnatal risk clinic. Not all attend. A letter is sent to the GP and the family offering support and an 'open door policy' following all cases. Some will letters have been written (By DC) about the PMRT seeking their views. Again some families respond others do not. We have had 1 family alert us to the fact that the family had not received the report as promised. She had contacted the risk lead numerous times who was off sick therefore did not get a response and whilst a complicated case in terms of questions that the family required answering (not answered within the PMRT meeting) this elongated the process. I can confirm now that the report has been received and the family questions answered. Going forward the current interim is trialling a process whereby the Bereavement Team Midwives (BTM) as the link/advocate with the families. Any queries about their care etc. will be presented at the PMRT by the BTM. Once the PMRT report has been finalised then the BTM will present and go through the report with the family (if they so wish). This will provided a compassionate service to those families.	
		d) i. Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.	Lesley Tones	Interim Risk and Patient Safety Lead	Yes	All reports completed and submitted to relevant parties	Evidence\Standard 1 PMRT
2	Are you submitting data to the Maternity Services Data Set to the required standard?	See individual tab	Denise Wood	Head of Information	Yes	Confirmation received we are submitting the dataset monthly with all the required tables 4/9/20. The October relaunch says the majority of achievement for this standard will be based on the December 2020 submission made by 28th Feb 2021. Email received 17/02/21 to confirm we were on track to pass all criteria	Evidence\Standard 2 MSDS\Feb 21 email to confirm Dec submission.msg
3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	~~a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.~~	Dr Jo Dangerfield	Neonatal clinical lead	Yes	Removed Mar 21 update	Evidence\Standard 3 NNU\Transitional Care pathway.doc

		~~b) The pathway of care into transitional care has been fully implemented and is audited every other month. Audit findings are shared with the neonatal, maternity safety champion and Board level champion.~~	Dr Jo Dangerfield	Neonatal clinical lead	Yes	Removed Mar 21 update	Evidence\Standard 3 NNU\Copy of MASTER Term Admissions Database as at 04092020.xlsx
		~~c) A data recording process for capturing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc) has been embedded.~~	Dr Jo Dangerfield	Neonatal clinical lead	Yes	Removed Mar 21 update	
		d) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.	Dr Jo Dangerfield	Neonatal clinical lead	Yes		
		e) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding. Review of term admissions should be an ongoing process. The review of admissions during Covid-19 should be completed by the Friday 26 February 2021.	Yvonne Griffiths	Neonatal Unit Manager	Yes	Closures - no impact on TC but ensure TC beds are always available and staffing is supportive of keeping ¾ cots available. Parental access - Recent changes to hospital visiting has reduced Dads ability to have open access. Dads restricted to 3 hours of visiting 12 till 3 effective from 19/01/2021 prior to this open access. No staff redeployment. Jaundice etc - Sharon Jones completing audit for 2020 readmissions and has sent a short report, complete. Also, care for PN readmissions has improved with new guideline which means mums and babies are admitted to PN ward not CU. Guideline included as evidence.	Evidence\Standard 3 NNU
		f) An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion. Progress on Covid-19 related requirements are monitored monthly by the neonatal and board safety champions from January 2021.	Dr Jo Dangerfield	Neonatal clinical lead	Yes	Report complete and shared with safety champions, email confirmation received	
		g) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.	Dr Jo Dangerfield	Neonatal clinical lead	Yes		Evidence\Standard 3 NNU\Re ATAIN action report DK.msg
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	~~Obstetric medical workforce All boards should formally record in their minutes the proportion of obstetrics and gynaecology trainees in their trust who responded 'Disagreed or /Strongly disagreed' to the 2019 General Medical Council (GMC) National Trainees Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' Furthermore, there should be an agreed strategy and an action plan with deadlines produced by the Trust to address these lost educational opportunities due to rota gaps. The Royal College of Obstetricians and Gynaecologists (RCOG) has examples of trust level innovations that have successfully addressed rota gaps available to view at www.rcog.org.uk/workforce The action plan should be signed off by the trust Board and a copy (with evidence of Board approval) submitted to the RCOG at workforce@rcog.org.uk~~	Liz Kewin/Dr Sara Brigham	Directorate Manager/O&G Clinical Lead	Yes	LK 11/11/20 Report and action plan complete and ratified at the W&C Governance Committee for November. Submitted to Alison Kelly 08/1/21 for Trust Board approval. LK emailed action plan to RCOG as required 8/1/21. Removed Mar 21 update	Evidence\Standard 4 Workforce\GMC 2019 training action plan -2020.docx
		An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 (A copy of rotas and lists showing dedicated theatre lists with a named consultant, or SAS (Staff Grade, Associate Specialist and Specialty Doctors) doctor who is able to work without consultant supervision, with no other clinical commitment should be provided. A copy of the rota to demonstrate duty consultant anaesthetist or SAS (Staff Grade, Associate Specialist and Specialty Doctors) doctor who is able to work without consultant supervision availability at a time when labour ward rounds are taking place.)	Liz Whitelaw	Directorate Manager for Theatres, Anaesthetics and Critical Care	Yes	We meet all the standards now that all elective lists are taking place in main theatres and evidence of rotas downloaded from CLW rota system.	Evidence\Standard 4 Workforce\Anaesth Roster CNST standards (4) for 2021.msg
		Neonatal medical workforce The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level	Dr Jo Dangerfield	Neonatal clinical lead	Yes	Report completed and saved in the evidence folder	
		Neonatal nursing workforce The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at board level to meet these recommendations	Yvonne Griffiths	NNU Manager	Yes	Remain BAPM compliant and Yvonne has sent evidence	Evidence\Standard 4 Workforce\RE CNST standard 3 update re BAPM compliancy.msg
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	Jean Fisher	Head of Midwifery and Paediatric Nursing	Yes		
		b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service	Jean Fisher	Head of Midwifery and Paediatric Nursing	Yes		

		c) All women in active labour receive one-to-one midwifery care	Jean Fisher	Head of Midwifery and Paediatric Nursing	Yes		
		d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year, during the maternity incentive scheme year three reporting period (December 2019 – July 2021).	Jean Fisher	Head of Midwifery and Paediatric Nursing	Yes	Jan to Jun 2020 report completed and approved at W&C Governance Committee. July to Dec 2020 report completed and submitted to Deputy Director of Nursing 19/03/21	Evidence\Standard 5 midwifery workforce\Review of Midwifery Nursing style 2020 june 2020.docx
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	a) Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2019/20 standard contract.	Jean Fisher	Head of Midwifery and Paediatric Nursing	Yes	Minuted at monthly maternity safety champion meetings regarding progress with SBL and to be included in monthly report to Board from Feb 21. CO testing resumed Feb 15th	
		b) Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network	Jean Fisher	Head of Midwifery and Paediatric Nursing	Yes		
		c) The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The corroborating evidence is the SBLCBv2 survey and MSDS data, availability of this depends on the COVID-19 status.	Jean Fisher	Head of Midwifery and Paediatric Nursing	Yes	Submitted by RS Feb 21 (latest)	
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Evidence: Terms of Reference for your MVP A minimum of one set of minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback Evidence of service developments resulting from coproduction with service users Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data. A template pack has been developed by the safety action leads in order to support trusts with evidencing compliance with the requirements of safety action seven. The pack can be found here https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/	Jean Fisher	Head of Midwifery and Paediatric Nursing	Yes	H:\CNST\MVP evidence coproduction March 2019 to March 2021.pdf	Evidence\Standard 7 MVP
8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	a) Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Attendance should be 90% or above for the following staff groups. However, anaesthetic staff and critical care staff are not required to attend fetal monitoring and neonatal resuscitation training.	Cath Sales	PDM	Yes	As of 1/3/21 - ODPs are at 93% so compliant. Cath confirmed anaesthetists will be compliant by first week of June so will then be green. Compliant June 21	Evidence\Standard 8 training\Training Report June 21.docx
		b) Can you evidence that multiprofessional training occurs at least twice a year with anaesthetic/maternity/neonatal teams in the clinical area, and that risks/issues identified are addressed.	Cath Sales	PDM	Yes		
		c) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course in the last training year?	Cath Sales		Yes		
9	Can you demonstrate that the trust safety champions (obstetric, midwifery and neonatal) are meeting bimonthly with Board level champions to escalate locally identified issues?	a) A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and board safety champions, including the Executive Sponsor for the MatNeoSIP, share safety intelligence from floor to board and through the LMS and MatNeoSIP Patient Safety Networks.	Hilda Williams	Director of Nursing & Quality/Deputy Chief Executive	Yes		
		b) Board level safety champions are undertaking feedback sessions every other month for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to Covid-19 service changes and service user feedback and can demonstrate that progress with actioning named concerns are visible to staff.	Hilda Williams	Director of Nursing & Quality/Deputy Chief Executive	Yes		
		c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.	Jean Fisher	Head of Midwifery and Paediatric Nursing	Yes	Report received and to go on to the March/April safety champion meeting	

		d) Together with their frontline safety champions, the Board safety champion and MatNeoSIP Patient Safety Networks has reviewed local outcomes in relation to: I. Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes. II. The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK. III. The MBRRACE-UK SARS-Covid-19 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf IV. The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups And considered the recommendations and requirements of II, III and IV on I.	Hilda Williams	Director of Nursing & Quality/Deputy Chief Executive			Evidence\Standard 9 Safety Champions
		e) The Board Level Safety Champion is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas: • Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns • ~~The Patient Safety Networks of which each Trust will be a member~~ • Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with ~~• The Patient Safety Network clinical leaders group where Trust staff are members~~ Evidence of how the Board has supported staff involved in the four key areas outlined in part e) of the required standard and specifically to: •work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems •utilise SCORE safety culture survey results to inform the Trust quality improvement plan ~~•active participation in system level improvement through the Patient Safety Networks, aligned to the ambitions of MatNeoSIP~~ •~~Patient Safety Network and.~~ ~~U~~ndertaking of improvement work aligned to the MatNeoSIP national driver diagram and key enablers	Hilda Williams	Director of Nursing & Quality/Deputy Chief Executive	Yes		
10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?	a) Reporting of all outstanding qualifying cases for the year 2019/20 to NHS Resolution's EN scheme.	Lesley Tones	Interim Risk and Patient Safety Lead	Yes	From 1 April 2020, it is no longer necessary for trusts to report Early Notification (EN) cases to NHS Resolution. In September 2020 this was reviewed and the decision was taken to extend this to the end of March 2021. However, it is still important to report all cases that meet the EN criteria to HSIB during this time. HSIB will triage all cases and prioritise those where there is evidence of harm (brain injury) to the baby and will share these cases directly with NHS Resolution.	
		b) Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21.	Lesley Tones	Interim Risk and Patient Safety Lead	Yes		
		c) For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. 1. the family have received information on the role of HSIB and the EN scheme; and 2. 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Lesley Tones	Interim Risk and Patient Safety Lead	Yes	The families would have received verbal info. Evidence will be written in hospital records. All families that have engaged with HSIB will have signed consent.	Evidence in email proof for standard 1

Maternity incentive scheme - Guidance

Trust Name	**Countess of Chester Hospital NHS Foundation Trust**
Trust Code	**T422**

This document must be used to complete your trust self-certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. **Your trust name will populate each tab. If the trust name box is coloured pink please**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**

The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested.

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within the condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

Tab B - action plan summary sheet - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

Tab D - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the three allocated spaces within this document: one signature to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the maternity incentive scheme evidence have been discussed with commissioners and a third signature to declare that there are no external or internal reports covering either 2020/21 financial year or the previous financial year (2019/20) that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 15 July 2021.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**
Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on **Thursday 15 July 2021** to MIS@resolution.nhs.uk
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Were all perinatal deaths eligible notified to MBRRACE-UK from the 11 January 2021 onwards to MBRRACE-UK within 7 working days and the surveillance information where required completed within four months of each death?	Yes
2	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 20 December 2019 to 15 March 2021 been started before 15 July 2021?	Yes
3	Were at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 20 December 2019 to 15 March 2021 reviewed using the PMRT, by a multidisciplinary review team? Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.	Yes
4	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents told that a review of their baby's death will take place? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
5	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents' perspectives, questions and any concerns they have about their care and that of their baby sought? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
6	If delays in completing reviews were anticipated, were parents advised of this and were they given a timetable for likely completion?	Yes
7	Have you submitted quarterly reports to the Trust Board from 1 October 2020 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
8	Were the quarterly reports discussed with the Trust maternity safety champion from 1 October 2020 onwards?	Yes

Safety action No. 2
Are you submitting data to the Maternity Services Data Set to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Were your Trust compliant with all 13 criteria in either the December 2020 or the January 2021's submission?	YES
2	Has the Trust Board confirmed that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.	YES

Safety action No. 3
Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note standard a), b) and c) of safety action 3 have now been removed.		
Standard D) Commissioner returns on request for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.		
1	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC. Is this in place?	YES
Standard E) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.		
2	Has a review of term admissions to the neonatal unit and to TC during the COVID period (Sunday 1 March 2020 – Monday 31 August 2020) been undertaken and completed by 26 February 2021 to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding	Yes
An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.		
3	Do you have evidence of the following • An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. • Evidence of an action plan to address identified and modifiable factors for admission to transitional care. • Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. • Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion.	Yes
Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.		
4	Has the ATAIN action plan been revised in the light of learning from term admissions during Covid-19 and has it been shared and agreed with the neonatal, maternity and Board level champions, with progress on Covid-19 related requirements monitored monthly by the neonatal and board safety champions from January 2021?	Yes
5	Has the progress with the Covid-19 related requirements been shared and monitored monthly with the neonatal and maternity safety champion ?	Yes
6	Has the progress on Covid-19 related requirements been monitored monthly by the board safety champions from January 2021?	Yes

Safety action No. 4
Can you demonstrate an effective system of clinical workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note that the standards related to the obstetric workforce have been removed.		
1	**Anaesthetic medical workforce** Have your Trust Board minuted formally the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met?	YES
2	If your Trust did not meet these standards, has an action plan been produced (ratified by the Board) stating how the Trust is working to meet the standards?	YES
3	**Neonatal medical workforce** Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing?	YES
4	If your Trust did not meet the standards outlined in requirement no.3, has an action plan been produced (signed off by the Board) stating how the Trust is working to meet the standards?	N/A
5	**Neonatal nursing workforce** Does the neonatal unit meet the service specification for neonatal nursing standards?	YES
6	If your Trust did not meet the standards outlined in requirement no.5, has an action plan been produced (signed off by the Board) and shared with the RCN, stating how the Trust is working to meet the standards?	N/A

Safety action No. 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?	YES
2	Has your review included the percentage of specialist midwives employed and mitigation to cover any inconsistencies?	YES
3	Has an action plan been completed to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent been completed, where deficits in staffing levels have been identified?	YES
4	Do you have evidence that the Maternity Services detailed progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls?	YES
5	Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with **supernumerary labour ward co-ordinator** status in the scheme reporting period? This must include mitigations to cover shortfalls.	YES
6	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% supernumerary status for the **labour ward coordinator** which has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	N/A
7	Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with **1:1 care in labour** in the scheme reporting period? This must include mitigations to cover shortfalls.	Yes
8	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% compliance with **1:1 care in labour** has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	N/A
9	Do you have evidence that a review has been undertaken regarding COVID-19 and possible impact on staffing levels to include: - Was the staffing level affected by the changes to the organisation to deal with COVID? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?	YES
10	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board at least once every 12 months within the scheme reporting period?	YES

Safety action No. 6

Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of Trust Board level consideration of how the Trust is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019?	YES
2	Has each element of the SBLCBv2 been implemented? Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by the Clinical Network.	YES
3	The quarterly care bundle survey must be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net. Have you completed and submitted this?	YES
ELEMENT 1 - Reducing smoking in pregnancy		
Standard a) Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital. If CO monitoring remains paused due to Covid-19, the audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks.		
4	Has **standard a)** been successfully implemented (80% compliance or more)?	YES
5	If the process metric scores are less than 95% for Element 1 **standard A**, has an action plan for achieving >95% been completed?	N/A
Standard b) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.		
6	Has **standard b)** been successfully implemented (80% compliance or more)?	YES
7	If the process metric scores are less than 95% for element 1 **standard b)**, has an action plan for achieving >95% been completed?	N/A
Standard c) Percentage of women where CO measurement at 36 weeks is recorded.		
8	Has **standard c)** been successfully implemented (80% compliance or more)?	YES
9	If the process metric scores are less than 95% for element 1 **standard c)**, has an action plan for achieving >95% been completed?	YES
ELEMENT 2 - Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		
Standard a) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking.		
10	Has **standard a)** been successfully implemented (80% compliance or more)?	YES
11	If the process metric scores are less than 95% for element 2 **standard a)**, has an action plan for achieving >95% been completed?	N/A
Do you have evidence that the Trust Board has specifically confirm that all the following 3 standards are in place within their organisation:		
12	1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards	Yes
13	2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation	Yes
14	3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation	Yes
15	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board evidenced that they have followed the escalation guidance for the short term management of staff?	N/A
16	If the above is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	N/A
17	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board confirmed that the Maternity Services are following the modified pathway for women with a BMI>35 kg/m2?	N/A
18	If Trusts have elected to follow Appendix G due to staff shortages related to the Covid-19 pandemic Trust Boards should evidence they have followed the escalation guidance for the short term management of staff (https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-Covid-19-information/). They should also specifically confirm that they are following the modified pathway for women with a BMI>35 kg/m2. If this is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	N/A
ELEMENT 3 Raising awareness of reduced fetal movement		
Standard a) Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.		

19	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
20	If the process metric scores are less than 95% for element 3 **standard a)**, has an action plan for achieving >95% been completed?	N/A
Standard b) Percentage of women who attend with RFM who have a computerised CTG		
21	has **standard b)** been successfully implemented (80% compliance or more)?	Yes
22	If the process metric scores are less than 95% for element 3 **standard b)**, has an action plan for achieving >95% been completed?	N/A
ELEMENT 4 Effective fetal monitoring during labour		
Standard a) Percentage of staff who have received training on fetal monitoring in labour in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.		
23	Has the Trust Board minuted in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted?	Yes
24	If the process metric scores are less than 90% for Element 4 standard a), has the trust identify shorfall in reaching the 90% and commit to addressing those?	N/A
Standard b) Percentage of staff who have successfully completed mandatory annual competency assessment.		
25	Have training resources been made available to the multi-professional team members?	Yes
26	If the process metric scores are less than 90% for **Element 4 standard b)**, has the trust board identify shorfall in reaching the 90% and commit to addressing those when this is permitted?	N/A
ELEMENT 5 Reducing preterm births		
Standard a) Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth		
27	Has **standard a)** been audited? Completion of the audit for element 5 standards A should be used to confirm successful implementation.	Yes
28	If the process metric scores are less than 85% for Element 5 **standard a)**, has an action plan for achieving >85% been completed?	N/A
Standard b) Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.		
29	Has **standard b)** been audited? Completion of the audits for element 5 standards B should be used to confirm successful implementation.	Yes
30	If the process metric scores are less than 85% for Element 5 **standard b)**, has an action plan for achieving >85% been completed?	N/A
Standard c) Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).		
31	Has **standard c)** been audited? Completion of the audits for element 5 standards C should be used to confirm successful implementation.	YES
32	If the process metric scores are less than 85% for Element 5 **standard c)**, has an action plan for achieving >85% been completed?	N/A
33	Do you have evidence that the Trust Board has specifically confirmed that: • women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • an audit has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.	Yes

Safety action No. 7

Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have Terms of Reference for your Maternity Voices Partnership group meeting?	Yes
2	Are minutes of Maternity Voices Partnership meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback?	Yes
3	Do you have evidence of service developments resulting from coproduction with service users?	Yes
4	Do you have a written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses?	Yes
5	Do you have evidence that the MVP is prioritising the voice of woman from Black Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation as a result of UKOSS 2020 coronavirus data?	Yes

Safety action No. 8

Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
MULTI-PROFESSIONAL MATERNITY EMERGENCY TRAINING, including Covid-19 specific training, including maternal critical care training and mental health & safeguarding concerns training In the current year we have removed the threshold of 90% for this year. This applies to all safety action 8 requirements. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.		
Can you confirm that: Covid-19 specific e-learning training has been made available to the multi-professional team members listed below:		
1	Obstetric consultants	YES
2	All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota	YES
3	Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	YES
4	Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)	YES
5	Obstetric anaesthetic consultants	YES
6	All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota	YES
7	Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)	YES
8	Can you evidence that 90% of all staff groups in line 1-7 above have attended the the multi-professional training outlined in the technical guidance?	YES
9	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.8, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions when this is permitted?	N/A
NEONATAL RESUSCITATION TRAINING Can you evidence that the following staff groups involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since launch of MIS year three in December 2019:		
10	Neonatal Consultants or Paediatric consultants covering neonatal units	Yes
11	Neonatal junior doctors (who attend any deliveries)	Yes
12	Neonatal nurses (Band 5 and above)	Yes
13	Advanced Neonatal Nurse Practitioner (ANNP)	Yes
14	Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) Maternity theatre midwives who also work outside of theatres	Yes
15	Can you evidence that 90% of all staff groups in line 10-14 above have attended the the neonatal resuscitation training as outlined in the technical guidance?	Yes
16	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.15, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions once when this is permitted?	N/A

Safety action No. 9

Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a pathway been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions, share safety intelligence between each other, the Trust Board, the LMS and MatNeoSIP Patient Safety Networks?	YES
2	Do you have evidence that the written pathway is in place, visible to staff and meeting the requirements detailed in part a) and b) of the action is in place by Friday 28 February 2020?	YES
3	Do you have evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff?	YES
4	Are Board level safety champions undertaking monthly feedback sessions for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to COVID-19 service changes and service user feedback?	YES
5	Was a monthly feedback sessions for staff undertaken by the Board Level safety champions in January 2020 and February 2020?	YES
6	Were feedback sessions for staff undertaken by the Board Level safety champions every other month from 30 November 2020 going forward?	YES
7	Do you have a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users? This must include concerns relating to the Covid-19 pandemic.	YES
8	Is the progress with actioning named concerns from staff workarounds visible from no later than 26 February 2021?	YES
9	Has the CoC action plan been agreed by 26/02/2021 and progress in meeting the revised CoC action plan is overseen by the Trust Board on a minimum of a quarterly basis commencing January 2021?	YES
10	Has the Board level safety champion reviewed the continuity of carer action plan in the light of Covid-19, taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas? The revised action plan must describe how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.	YES
11	Do you have evidence of Board level oversight and discussion of progress in meeting the revised continuity of carer action plan?	YES
Together with their frontline safety champions, has the Board safety champion has reviewed local mortality and morbidity cases has been undertaken and an action plan, drawing on insights from the two named reports and the letter has been agreed		
12	I) Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of COVID-19, drawing on resources and guidance to understand and address factors which led to these outcomes by Monday 30 November 2020?	YES
13	II) The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK.	YES
14	III) The MBRRACE-UK SARS-COVID19 report	YES
15	IV) The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups	YES
16	Together with their frontline safety champions, has the Board safety champion considered the recommendations and requirements of II, III and IV on I by Monday 30 November 2020?	YES
Do you have evidence that the Board Level Safety Champions actively supporting capacity (and capability), building for all staff to be actively involved in the following areas:		
17	• work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems	YES
18	• utilise SCORE safety culture survey results to inform the Trust quality improvement plan	YES
19	Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event held in March 2020 by 30 June 2021	YES

Safety action No. 10

Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all outstanding qualifying cases for 2019/2020 been reported to NHS Resolution EN scheme?	YES
2	Have all qualifying cases for 2020/21 been reported to Healthcare Safety Investigation Branch (HSIB)?	YES
3	For cases which have occurred from 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and EN scheme: and 2. there has been compliance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	YES
4	Have the Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team?	YES

Section A : Maternity safety actions - Countess of Chester Hospital NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	8	0	0
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes	2	0	0
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes	6	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	4	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	8	0	0
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	Yes	33	0	0
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes	5	0	0
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?	Yes	14	0	0
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes	19	0	0
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21	Yes	4	0	0

Section B : Action plan details for Countess of Chester Hospital NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		

Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		

Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 5

Safety action | **To be met by**

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			