NHS
Countess of Chester Hospital
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS (PUBLISHED ITEMS)
Tuesday 24th September 2024, 8.30am – 11.50am
Boardroom, 1829 Building

A G E N D A

Chair: Mr I Haythornthwaite, Trust Chair
Apologies: Mr J Develing, Director of Strategic Partnerships

Time	Agenda Number	Agenda Item	Lead	Page Number	Decision Required
FORMAL BUSINESS					
8.30	1.	Welcome, apologies and Chair's opening remarks (verbal)	Trust Chair	/	For noting
8.30	2.	Declarations of Conflicts of Interest with agenda items (verbal)	Trust Chair	/	For noting
8.30	3.	Freedom to Speak up Champions (to be presented on the day)			
8.45	4.	Lung Cancer Service Showcase (to be presented on the day)			
9.00	5.	Minutes of the previous meeting held on 30th July 2024 (attached)	Trust Chair	5 - 21	For approval
9.05	6.	To consider any matters arising and action log (attached) Trust response to the independent infected blood inquiry (verbal)	Trust Chair Medical Director	22 /	For noting For noting
9.10	7.	Patient Story (to be presented on the day)	Director of Nursing & Quality / Deputy Chief Executive	/	For noting
9.15	8.	Chief Executive Officer's Report (attached)	Chief Executive Officer	23 - 36	For noting
9.25	9.	Board Assurance Framework 2024/25 (attached)	Director of Governance Risk & Improvement	37 - 51	For noting
QUALITY OF CARE					
9.30	10.	Midwifery and Maternity Safer Staffing Report – 1st January 2024 to 30th June 2024 (attached)	Director of Midwifery	52 - 68	For assurance
9.40	11.	Freedom to Speak Up Update Report (attached)	Chief Operating Officer / Freedom to Speak Up Guardian	69 - 75	For assurance
9.50	12.	Clinical Strategy (attached)	Medical Director	76 - 78	For information

9.55	13.	Care Quality Commission (CQC) Improvement Plan including Well Led (attached)	Director of Nursing & Quality / Deputy Chief Executive	79 - 132	For assurance
Comfort Break – 10.05 – 10.15					
10.15	14.	Integrated Incidents, Complaints and Claims Report – Quarter 1 (2024/25) (attached)	Director of Nursing & Quality / Deputy Chief Executive	133 -144	For assurance
10.25	15.	Care Quality Commission National Inpatient Survey 2023 - Results Update (attached)	Director of Nursing & Quality / Deputy Chief Executive	146-153	For assurance
10.35	16.	Quality & Safety Committee Chair's Report – 10th September 2024 (attached)	Non-Executive Director	154-156	For assurance
10.40	17.*	Infection Prevention and Control (Quarter 1 – 2024/25) Surveillance and Performance Report (attached)	Director of Nursing & Quality / Deputy Chief Executive	157-183	For assurance
OPERATIONAL PERFORMANCE					
10.40	18.	System Oversight Framework Report (to follow) Operational Performance Quality Safety Finance People & Organisation Development	 Chief Operating Officer Director of Nursing & Quality Medical Director Chief Finance Officer Interim Chief People Officer		For assurance

LEADERSHIP, IMPROVEMENT CAPABILITY, ORGANISATION DEVELOPMENT AND PEOPLE					
10.55	19.	Annual submission to NHS England North West: Medical Appraisal, Revalidation and Medical Governance (attached)	Medical Director	188-205	For assurance & for decision
11.00	20.	Research Update (to be presented on the day)	Clinical Director for Research	/	For noting
11.10	21.	People & Organisation Development Committee Chair's Report – 13th August 2024 (attached)	Non-Executive Director	206-207	For assurance
11.15	22.	People & Organisation Development Committee – Terms of Reference (to follow)	Interim Chief People Officer	/	For approval
GOVERNANCE					
11.25	23.	Updated Cheshire & Merseyside Acute Specialist Trust (CMAST) Joint Working Agreement and CMAST Leadership Board Committee in Common Terms of Reference (attached)	Director of Governance Risk & Improvement	208-253	For approval
ANNUAL REPORTS					
11.30	24.	Safeguarding and Complex Care Annual Report 2023/24 (attached)	Director of Nursing & Quality / Deputy Chief Executive	254-297	For assurance
ITEMS FOR NOTING					
11.40	25.	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 4th July 2024 b) Approved minutes of the People & Organisation Development Committee – 11th June 2024 c) Approved minutes of the Audit Committee – 16th April 2024 and 25th June 2024 (attached) d) Research and Innovation Committee Chair's Report - 9th September 2024 and Research Executive Meeting Minutes - 5th July 2024 (attached) **Other items:** e) Board of Directors Workplan 2024/25	Trust Chair	2 - 17 18 - 31 32 - 52 49 - 59 60 -65	For noting
OTHER ITEMS					
11.40	26.	Any Other Business (verbal)	Trust Chair	/	For noting

11.45	27.	Questions from Governors and members of the Public relating to items on the meeting agenda - ***Questions to be submitted in writing in advance of the meeting to:*** coch.membershipenquiriescoch@nhs.net ***by Friday 20th September 2024.***	Trust Chair	/	For noting
11.50	28.	Closing remarks (verbal)	Trust Chair	/	For noting
11.50	29.	**Date & Time of next meeting:** The next public meeting of the Board of Directors will be held on the Tuesday 26th November 2024. **Future Dates:** Tuesday 28th January 2025 Tuesday 25th March 2025			For noting

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

NHS
Countess of Chester Hospital
NHS Foundation Trust

MINUTES OF THE PUBLIC BOARD OF DIRECTORS

Tuesday 30th July 2024, 8.30am – 11.30am

Boardroom, 1829 Building

Members	04/06/ 2024	30/07/ 2024				
Trust Chair, Mr I Haythornthwaite	☑	☑				
Chief Executive Officer, Ms J Tomkinson OBE	☑	☑				
Non-Executive Director, Mr D Williamson	☑	☑				
Non-Executive Director, Mr P Jones	☒	☑				
Non-Executive Director, Mr M Guymer	☑	☑				
Non-Executive Director, Mrs P Williams	☑	☑				
Non-Executive Director, Professor A Hassell	☑	☑				
Non-Executive Director, Mrs W Williams	☑	☑				
Non-Executive Director, Mrs S Corcoran	☒	☑				
Chief Operating Officer, Ms C Chadwick	☑	☑				
Medical Director, Dr N Scawn	☑	☑				
Director of Nursing & Quality/Deputy Chief Executive , Ms S Pemberton	☑	☑				
Director of Strategic Partnerships, Mr J Develing	☑	☑				
Chief Digital & Data Officer, Mr J Bradley	☒	☑				
Interim Chief People Officer, Mrs D Herring	☒	☑				
Chief Finance Officer, Mrs K Edge	☑	☑				
Director of Governance, Risk & Improvement, Mrs K Wheatcroft	☑	☑				

In Attendance						
Deputy Director of Governance & Risk, Mrs L Leadsom *(Minutes)*	☑	☑				
Director of Midwifery, Ms N Macdonald	☑	☑ (items 6b & 10)				
National Maternity Improvement Advisor -NHS England, Mr S Mehigan	N/A	☑ (items 6b & 10)				
Deputy Director of Nursing & Quality, Ms M Kynaston	☑	☑ (item 3)				
Head of Nursing – Urgent Care, Mrs E Maxwell	N/A	☑ (item 3)				
Divisional Director – Urgent Care, Mrs K Townsend	N/A	☑ (item 3)				
Development Non-Executive Director, Mr M Smith	☑	☑				
Development Non-Executive Director, Mrs L Liang	☑	☑				
Pharmacy Clinical Services Manager, Mrs J Barlow	N/A	☑ (item 12)				
Pathology Service Manager, Mr J Banwell	N/A	☑ (item 14)				

FORMAL BUSINESS		
PB1/ 07/24	**Welcome, apologies and Chair's opening remarks** The Trust Chair, Mr Ian Haythornthwaite, welcomed members to the meeting. No apologies of absence were received.	
PB2/ 07/24	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest raised in relation to agenda items.	
PB3/ 07/24	**Maintaining Focus and Oversight to Quality and Care and Experience in Pressurised Services** The Deputy Director of Nursing & Quality, Ms M Kynaston, provided an outline of the letter received from NHS England dated 26th June 2024 highlighting the requirements for all Trusts to ensure they are maintaining focus and oversight to quality, care and experience in pressurised services. Ms M Kynaston provided an overview of the focus on key areas and including the continued partnership working, to relieve pressures across the Urgent & Emergency Care (UEC) pathway. The Divisional Director – Urgent Care, Mrs K Townsend, outlined the alternatives to the Emergency Department including: a community response, continued work with Cheshire & Merseyside collaborative and at PLACE to increase referrals from the North West Ambulance Service (NWAS), an expanded frailty offering and later working and 7-day service of the Same Day Emergency Care Centre (SDEC) and the robust streaming model at the front-door to enable usage of Emergency Department (ED) alternatives. The Head of Nursing – Urgent Care, Mrs E Maxwell, provided an overview of the quality & safety measures in place across the department and highlighted that the Patient Experience Strategy has now been launched across the Trust and that patient and family feedback is collated and analysed regularly. Mrs E Maxwell updated regarding the Emergency Department Improvement Framework, with comfort packs being provided for patients, and the continued focus on staff wellbeing. Mrs E Maxwell advised of further work being progressed relating to the care and management of mental health patients within ED, including wait times, and that a Collaborative Mental Health Steering Group has been established with representatives from the Trust, Cheshire & Wirral Partnership NHS Foundation Trust and Cheshire Constabulary. Ms M Kynaston provided an update relating to inpatient flow and quality assurance across the UEC pathway, noting this review is being completed internally to assist with flow within the department, with daily escalation processes n place including the Operational Pressures Escalation Policy. Ms M Kynaston outlined that the timeliness of discharge from the department requires further work and that monthly meetings are held with the Clinical Leadership teams to measure the quality, safety and patients experience at ward level, with the impact	

	of this initiative being monitored. Ms M Kynaston advised that the ward accreditation programme has been strengthened, which also includes self-assessment against the CQC framework and initiatives are in place to continue to drive improvement, with Governor and Non-Executive Director walkabouts also reinstated. Mrs K Townsend updated regarding out of hospital flow, noting that daily and weekly calls are held with Flintshire Health Board and Local Authority colleagues to discuss complex discharges. Mrs K Towsend highlighted that as at today there are 113 Non Criteria to Reside (NCTR) across the Trust Hospitals, and that this remains a significant issue as this has an impact on bed capacity. Mrs K Townsend advised that there is an aim to reduce this to 10% by April 2025, noting this is currently at 18%. Mrs K Towsend outlined that any additional finance to support patient discharge is being consolidated into the Better Care Fund (BCF) and there is system agreement on how that money is spent. As part of the Intermediate care capacity and demand model the ICB have commissioned Newton Europe and Prof John Bolton to support the system in reviewing the BCF spend and recommending areas for investment to provide maximum impact on patient flow out of the acute trust. The Chief Executive Officer, Ms J Tomkinson, referenced that this letter was issued from NHSE in response to a recent Dispatches Programme regarding Emergency Departments, and acknowledged credit to the leadership team in place to strive to drive these improvements and provide assurance to the Board. **The Board noted the update and expressed thanks to the team.**	
PB4 07/24	**Service Showcase** It was noted that this item would be covered as part of agenda item PB3/07/24.	
PB5/ 07/24	**Minutes of the previous meeting held on the 4th June 2024** The minutes of the previous meeting held on the 4th June 2024 were formally approved as a true and accurate record.	
PB6/ 07/24	**Matters arising and action log** The Board of Directors received the updated action log and noted that one action remains open with a due date of September 2024. The following updates were provided following the last meeting held on 4th June 2024: **a) Urology Patient Story update** The Chief Operating Officer, Ms C Chadwick, outlined that this update relates to the patient story presented to the previous Board of Directors held on 4th June 2024, noting that this had been formally managed and responded to as a formal complaint. Ms C Chadwick explained that 7 actions were identified from this investigation and provided an update against each of these areas, noting that the common themes primarily relate to issues identified with communications. Ms C Chadwick updated that a review has been undertaken of the model of Clinical Nurse Specialists (CNS) together with a review of job plans within the Urology service to explore opportunities to utilise skills. Ms C Chadwick explained that drop in sessions have been reinstated and catheter passports have also been	

	introduced. The Medical Director, Dr N Scawn, outlined that the aim of the catheter passports is to ensure a functional document is in place to assist within the department and that following work with Medical Directors, firm guidelines have been published & implemented in relation to specialist care. It was agreed for this action to be closed and that following a recent query at a previous Council of Governors (COG) that an update regarding this would also be provided to the next COG meeting to be held in October 2024. **b) Maternity Services – Update in relation to Postpartum haemorrhage** It was noted that this update would be provided as part of agenda item PB10/07/24 and it was agreed for this action to be closed. **c) Clinical Audit Annual Report 2023/24** Dr N Scawn outlined that the purpose of this report was to address any queries raised in relating to Clinical Audit from the last Board of Directors meeting, highlighting that in 2023/24 there were 309 audits registers and 25 abandoned, with the reasons outlined within the updated annual report. Dr N Scawn noted that there were 29 audits with limited /very limited assurance and that action plans are being implemented to address these areas, in line with National Institute for Health & Care Excellence (NICE) guidance. Non-Executive Director, Mrs P Williams, queried if this is linked to the ward accreditation programme and Dr N Scawn advised that this is not linked but a separate audit process. The Director of Nursing & Quality /Deputy Chief Executive, Ms S Pemberton, confirmed that they are two separate processes. Non-Executive Director, Mrs S Corcoran, acknowledged the good report noting that she would expect to see limited assurance in some areas. Mrs S Corcoran suggested that it would be beneficial for progress and improvements with audits to be included in future reports and Dr N Scawn agreed for future reports to include this information. Non-Executive Director, Mr D Williamson, highlighted the reference within the report to the substantive team decrease in size and queried how this is monitored. Dr N Scawn advised that it was a small team affected and updated that Senior Nurses are now in place to support the team, noting the team are now in a good position to deliver the requirements of the team. Ms S Pemberton explained that the requirements of clinical audit are being encompassed as part of the ongoing review of risk management across the Trust and it is recognised that if additional support is required this will be covered as part of the current resource available. Non-Executive Director, Professor A Hassell, highlighted that it was felt at the Quality & Safety Committee held on 4th July 2024 that there was moderate assurances in place, with clear understanding of the issues together and how these areas will be progressed further. It was agreed for this action to be closed.	
PB7/ 07/24	**<u>Chief Executive Officer's Report</u>** The Chief Executive Officer, Ms J Tomkinson, provided an overview of the relevant local, regional, and national issues:	

- Given the overall financial position of Cheshire and Merseyside Integrated Care System (ICS) as reported for month 2, NHS England has assessed the system as being at high risk of overspending against the plan submitted for the year and hence not meeting the system statutory requirement to breakeven. Therefore the system has agreed with NHS England that the Trust will engage external support to urgently review the financial position of the Countess of Chester Hospital NHS Foundation Trust and wider system. Ms J Tomkinson confirmed that interviews had been held with herself, the Trust Chair, Mr I Haythornthwaite, and the Chief Finance Officer, Mrs K Edge, and that the Trust are actively participating in this piece of work.
- The System Improvement Board (SIB) met on the 19th July 2024 and the Trust presented an update on the improvement journey and achievements against the SIB exit criteria, which will now be considered by NHS England. Ms J Tomkinson noted this was a positive meeting, with a deep dive of the exit criteria and the Trust are awaiting the final outcome of this.
- The North West Regional Black Asian and minority ethnic (BAME) Assembly was established in 2020 as a strategic advisory group for senior NHS leaders from black, Asian and minority ethnic backgrounds. The Assembly has recently published its 2023/24 annual report and the Trust is one of 27 in the Region to commit to the implementation of the anti-racist framework. Ms J Tomkinson acknowledged that this requires a significant level of focus which will be led by the Interim Chief People Officer, Mrs D Herring.
- The Trust was selected by the Fuller Inquiry Team to participate in the second stage of the Inquiry's work looking at the arrangements in place across the wider NHS. As part of this process, the Trust has submitted a range of documents, that support the procedures and practices for safeguarding the deceased together with interviews being held with a range of leads.
- The new Women and Children's build is on track and within budget, thanks to the leadership of the Chief Finance Officer, Mrs K Edge, with construction works due to be completed by 31st March 2024 and the Trust are on track to move into the new building in Summer 2025.
- A Staff Awards ceremony will take place on 20th September 2024 and the Trust will have full sponsorship for this event.
- In September 2024, the Trust will launch a new Medical Emergency Team (MET) which will be there to support our teams in responding to acutely unwell or deteriorating patients. This is an important development which will have a significant impact on patient safety, reducing harm and making sure we have the right medical support in place to support deteriorating patients.
- The Council of Governors met on 11th July 2024 and during this meeting the Council approved the second term of office for the Trust Chair, Ian Haythornthwaite, which will commence in September 2024. The process also included approval by NHS England and the Cheshire and Merseyside Integrated Care Board.

	The Medical Director, Dr N Scawn, acknowledged the huge step forward for the Trust with planned launch of the MET, noting this will provide further support across the Trust. **The Board of Directors noted the update report provided.**	
PB8/ 07/24	**Board Assurance Framework (BAF) and Risk Appetite Statement (2024/25)** The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, outlined that a full reset of the BAF has been undertaken, which has included a full Board development session held in May 2024. Mrs K Wheatcroft explained that the BAF now has a focus on 10 strategic risks, which are aligned to the Trust's strategic objectives, and a revised risk appetite statement has also been collated. Non-Executive Director, Mr M Guymer, queried the initial scores and measures identified to minimise risks, however, that the assurances remain rated as red in some areas. Mrs K Wheatcroft explained that assurances are not rated in the same way as actual risks, and that the partial assurance is taken into consideration is determining the residual risk score and the areas for action. The actions will assist the Trust in reaching the target risk scores for all areas. Non-Executive Director, Mrs S Corcoran, noted the phenomenal improvement with the BAF and recognised the input from the Board Development session held in May 2024. Non-Executive Director, Mr D Wiliamson, acknowledged the tremendous structure improvements to the BAF including the reference to the Trust's strategic objectives however, highlighted that the detail within the causes and consequences column required further work with regards to the wording included. Mrs K Wheatcroft suggested that the assurance committees should consider this further when they review the relevant extracts of the BAF. Non-Executive Director, Mr P Jones, acknowledged the level of clarity provided within the BAF and queried BAF areas 9 and 10 and the risk appetite to seek risk particularly in relation to research and innovation. Mrs K Wheatcroft clarified that the revised BAF will enable leads to take more innovate approaches to secure next steps, noting the real ambition in these areas for the Trust to get to where it needs to be and this will require a more innovative approach. The Chief Executive Officer, Ms J Tomkinson, clarified that the Director of Research, Dr P Bamford, provides quarterly updates regarding Research to the Board of Directors, is actively seeking funding opportunities as part of this role, and that this will require support for the Board of Directors to do things differently to support this. The Medical Director, Dr N Scawn, confirmed that the University of Chester are keen to be involved and discussions are in progress. The Trust Chair, Mr I Haythornthwaite, recognised the improvements to the BAF in a very short space of time and acknowledged the benefits of the Board of Directors in having a clear document to work with. Mr I Haythornthwaite expressed thanks to Mrs K Wheatcroft for leading this and progress to date. **The Board of Directors:**	

	• **Approved the baseline BAF for 2024/25** • **Noted the alignment and progress against the Trust's Strategic Objectives 2024/25** • **Approved the Board risk appetite statement for 2024/25.**	
PB9/ 07/24	**<u>High Risks Report</u>** The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, updated that there are currently 25 risks in total with a residual risk score of 15 or above on the Datix system, noting this is a decrease from the 36 reported in April 2024. It was noted that work is also ongoing to further strengthen and embed risk management across the Trust, together with the review of the current Risk Management policy. Mrs K Wheatcroft updated that this report will be progressed further with Executive Directors and will be triangulated with the BAF going forward, with the BAF being reviewed quarterly but also being a standing agenda item for each Board of Directors meeting. Non-Executive Director, Mr D Williamson, highlighted that the risks relating to finance & performance overlap with the BAF and Mrs K Wheatcroft clarified that the BAF sits separately to the risk register and whilst these will remain separate, further work is required to join up these areas. The Interim Chief People Officer, Mrs D Herring, updated that the people related risks are currently being reviewed further with an update to be provided to the next People & Organisation Development Committee meeting. Non-Executive Director, Mrs W Williams, acknowledged the need for people & organisation related risks to be reflective of concerns raised and to structure future deep dives being presented to the Committee. Non-Executive Director, Professor A Hassell, queried the ventilation issues referenced within the report and if Quality & Safety Committee is the correct Committee to monitor this risk and it was agreed this would be clarified following the meeting. **The Board of Directors:** • **Noted the contents of this report and note the risks with a residual risk score of 15 and above.** • **Noted the next steps as outlined above and how they will be progressed.**	
PB10/ 07/24	**<u>Maternity Safety Support Programme (MSSP Exit Recommendation</u>** The Director of Midwifery, Ms N Macdonald, introduced the National Maternity Improvement Advisor – NHS England, Mr S Mehigan to the Board of Directors. Ms N Macdonald outlined that the purpose of this report is to seek agreement of the Board of Directors with the recommendations of the National Maternity Improvement Advisor and the Regional Chief Midwife for the Northwest that the Countess of Chester Hospitals NHS Trust should formally exit the Maternity Safety Support Programme with the ongoing oversight and assurance of the maternity services being undertaken by the Local Maternity & Neonatal System (LMNS) and Integrated Care Board (ICB). Ms N Macdonald advised that during the Perinatal Assurance and Improvement Board a detailed presentation was	

	provided regarding the Quality Improvement work and next steps including regional working and regional Postpartum haemorrhage monitoring. Ms N Macdonald confirmed that following agreement at the Board of Directors, a letter of support is required to be sent to Claire Matthews confirming this paper has been discussed and to confirm that the Board of Directors are supportive of this exit. Mr S Mehigan advised that he also attended the Perinatal Assurance and Improvement Board and noted the only areas of challenge were in relation to the inactive Maternity and Neonatal Voices Partnership (MNVP) and reference to the sustainability plan, however, evidence was provided to demonstrate there is input from service users. It was agreed for Mr S Mehigan to update the paper provided to include these further 2 points and for this to be circulated to the Board of Directors. **Subject to the minor additions as outlined above, the Board of Directors:** • **Noted the progress made by the maternity service during its time on the MSSP** • **Agreed the recommendation that the Trust formally exit the MSSP** • **Agreed that the ongoing external assurance and oversight will be provide by the LMNS / ICB.**	
PB11/ 07/24	**<u>Care Quality Commission (CQC) Improvement Plan including Well Led</u>** The Director of Nursing & Quality / Deputy Chief Executive, Ms S Pemberton, provided an update on progress with the consolidated CQC Improvement Plan, including Well Led. Ms S Pemberton updated that progress has been noted, with completed actions, within the following areas: • Full review of Nurse staffing undertaken (in line with Safer Nursing Care Tool Guidance). • Launch of the Patient & Family Experience Strategy. • Approval of the Board sub-committees Terms of Reference and workplans • Wellbeing Hub has opened which is accessible to all staff. • Listening events held and civility statement agreed. • Fit and Proper Person Test Framework • Executive network champions identified. • Review of all storage across the Trust undertaken and spot checks being implemented. • Full review of NET2 access undertaken. • Patient Led Assessments of the Care Environment assessments • Civility Charter agreed and is being incorporated into all employee processes. • New welcome induction programme in place. • Emergency Department Improvement Plan in place • Workstreams established within Medicines Safety Group. • National mandated medicine audits have been reviewed • Increased visibility and Executive walkarounds	

- All Board positions substantively appointed with (with the exception of the Chief People Officer, which has a recruitment plan in place)
- Board development programme agreed for 2024/25
- The Trust Strategy has been approved at the Board of Directors
- The new Complaints Policy has been formally ratified.
- CQC registration Tarporley Hospital (awaiting CQC confirmation)
- Mental health and community services collaborative
- Board Assurance Framework refresh
- Quality priorities
- Clinical Standard Operating Procedure in place to identify and risk assess patients entering the Emergency Department that present a self-harming risk.
- Divisional Leadership teams have engagement and visibility plans in place for visiting all wards and departments.

It was noted that continued areas of focus include:

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

	• Freedom to Speak Up Board self-assessment to be held on 6th August 2024 • Work is progressing on the 4 Staff survey priorities The Trust Chair, Mr I Haythornthwaite, acknowledged the good progress of the consolidated CQC improvement plan. Non-Executive Director, Mrs P Williams, acknowledged the excellent update report, however, queried of the 'green' status with regards to health & safety audits not being completed, noting this has been flagged via the Finance & Performance Committee previously too. Ms S Pemberton advised that the 'green' status indicates that this is work in progress and it is the 'blue' status which confirms completion. The Chief Operating Officer, Ms C Chadwick, outlined that there are identified issues relating to Health & Safety resource, however that a new interim experienced staff member commenced at the Trust on 29th July 2024. Ms C Chadwick confirmed that a priority for this staff member is to review the Health & safety action plan to ensure it is fit for purpose, then priorities are to be included. Ms C Chadwick explained that health & safety usually sits with fire & security services, however, that they had been previously split at the Trust and the team now consists of one team member which is not a sustainable model. Ms C Chadwick provided assurance that by the end of August 2024 further work will be completed to pull all aforementioned areas together into estates and this will then be led by the Chief Finance Officer, Mrs K Edge. **The Board of Directors noted the assurance of the progress against the consolidated CQC action plan and noted that progress against this action plan will be tracked through the Executive Directors Group and reported to the Board of Directors, together with outcomes.**	
PB12/ 07/24	**Controlled Drugs (CD) Annual Report 2023/24** *To note, this item was presented following PB10/07/24.* The Pharmacy Clinical Services Manager, Mrs J Barlow, advised that she was presenting this report to the Board of Directors on behalf of the Director of Pharmacy, Mrs K Adams, noting this is the first separate Controlled Drugs (CD) report produced for the Trust following guidance from NHS England. Mrs J Barlow highlighted the positive areas of assurance as outlined within the report and confirmed that there are no concerns that the Director of Pharmacy had been required to raise with the Board of Directors. Mrs Barlow outlined that quarterly reports and audits are reported via NHS England and the Trust Medicines Safety Committee and that the Director of Pharmacy has completed a CQC self-assessment and no gaps were identified and no cases of concern were raised in relation to thematic reviews. Mrs J Barlow confirmed the Trusts 100% compliance with all statutory requirements and that following a recent Home Office Inspection, 3 minor actions were identified, 2 of which are now completed and the final one due to be completed by the end of Summer 2024. The Director of Nursing & Quality, Ms S Pemberton, acknowledged the positive assurance report. The Trust Chair, Mr I Haythornthwaite, expressed thanks to Mrs J Barlow for presenting this update to the Board of Directors.	

	The Board of Directors noted the assurance provided within the report.	
PB13/ 07/24	**System Oversight Framework Report** The Chief Operating Officer, Ms C Chadwick, introduced the item and provided a summary of the key performance indicators. Ms C Chadwick highlighted the following areas of positive assurance: • Hospital Standardised Morality Ratios (HSMR) • 0 reported STEiS and Never Events • Reduced number of falls • Sustained delivery of 28 day Cance Faster Diagnosis Standard (FDS). • Significantly higher performance than national average against 31 and 62 Cancer standard. • Reduction in 12 hour breaches • Improved compliance in both appraisals and mandatory training • Sustained reduction in Nurse agency spend • Sustained reduction in staff turnover. Ms C Chadwick highlighted the following areas requiring improvement: • Registered Nursing Fill Rates • Medical Agency Spend • Emergency Medicine Performance • Financial overspend. Ms C Chadwick continued highlighting the following: • Emergency Department (ED) attendances remain average in ED (240 per day) • There has been an increase to over 60 minutes for ambulance handover times • There has a been a reset within the Emergency Department, with a revised Urgent & Emergency Care (UEC) offer available from 3rd August 2024 • The Trust has received 7.5 million of capital to build a new front door for ED to assist with triage • There is a continued focus regarding the delivery of elective care by the end of September 2024 • Increased activity levels are assisting with the Cost Improvement Programme (CIP) in relation to diagnostics • The wait times for endoscopy have significantly reduced but some patients continue to take the decision to wait longer • There remains concerns relating to Echocardiograms, including the high demand noting that the Executive Directors have supported recruitment into the team and are continuing to work with Cheshire and Merseyside Acute Specialist Trust (CMAST) regarding mutual aid options • The Trust closed 2023/24 with over performance against activity targets, and is on track to deliver for this year too, to date The Director of Nursing & Quality/Deputy Chief Executive, Ms S Pemberton highlighted the following in relation to nursing and quality: • The incident reporting culture has improved and harm levels remain low	

- There were 0 new never events reported in June 2024 and an investigation is ongoing in relation to the never event (retained swab) reported in the previous period
- There has been 6 cases of Cdifficile, noting community rates are high currently
- There is an improvement plan in place for sepsis screening which is showing improvements to date
- There are 13 complaints currently open and the Trust is undertaking a deep dive regarding concerns raised, which will include working with specialities
- Regular Friends and Family Test (FFT) data is provided to the Trust with a 95% response rate for outpatients, 91% for inpatients and 71% for the Emergency Department.

The Medical Director, Dr N Scawn, confirmed he had nothing further to add relating to safety elements of the SOF.

The Chief Finance Officer, Mrs K Edge, highlighted the following in relation to financial performance:

- The Trust reported a £9.6m deficit as at Month 3 2024/25, noting the main drivers of the variance related to public inquiry costs to date and Junior Doctor industrial action held in June 2024.
- The risk regarding medical pay remains, noting the Trust is however underspend in the totality, and that this remains an area of focus linked to the Cost Improvement Programme.
- There is a lot of continued focus on supporting delivery of the CIP opportunities at pace.
- Further opportunities have been identified regarding income productivity and delivering activity.

Non-Executive Director, Professor A Hassell, queried if the Trust recruited to the full establishment, if there would still be the same amount of agency spend. Dr N Scawn clarified that £3m of the £13m relates to waiting list initiatives and overtime, noting this is currently being reviewed against substantive positions. Dr N Scawn continued that there has been a significant change in junior doctors working with more than 50% working less than Whole Time Equivalent (WTE), with a majority at 0.8WTE. Professor A Hassell requested if the Junior Doctor shortfall can be quantified and Dr N Scawn explained this is a disincentive for certain Doctors to get their Certificate of Eligibility of Specialist Registration (CESR), noting that the process is lengthy. Professor A Hassell queried if the Doctors would earn less they if they received their CESR and the Interim Chief People Officer, Mrs D Herring, clarified that they would not be paid less and that this can be provided in further detail at the People & Organisation Development Committee with regards to the with fixed term contracts and ad hoc cover arrangements.

Non-Executive Director, Mr M Guymer, acknowledged the positive steps being taken and expressed congratulations to all Executive Directors getting back on track so early on in the financial year across all areas notwithstanding the challenging cost improvement programme.

	Non-Executive Director, Mr P Jones, requested an update regarding the recently agreed Junior Doctors pay award and the Trusts funding for this and Mrs K Edge confirmed the Trust are awaiting clarification regarding this from NHS England. The Interim Chief People Officer, Mrs D Herring, highlighted the following in relation to people & organisation development: • Mandatory training compliance continues to improve and that this is almost at 90%. • Appraisal rates are improving. • Agency and bank spend remains below the target for the Nursing staff, however, medical cover remains an area of concern. • Progress has been made in various areas relating to health & wellbeing, with a new attendance management policy been agreed is ensuring cases are managed more proactively. Mr M Guymer highlighted that it had been raised at the Audit Committee held on 23rd July 2024 regarding counter fraud including the need to increase the training for some staff and requested an update regarding this. Mrs D Herring advised that all mandatory training areas are currently being reviewed to see if any areas can be streamlined, together with a review of capacity for staff to attend training. Mrs D Herring explained that during times of extreme pressure within the Trust that training is sometimes cancelled, and that the process for this is being reviewed with a suggestion that training can still go ahead during these times, but with a review of attendance. **The Board of Directors noted the positive areas of assurance and the updates provided.**	
PB14/ 07/24	**COCH response to the independent infected blood inquiry** The Pathology Service Manager, Mr J Banwell, shared a presentation with the Board of Directors regarding the Infected Blood Inquiry and the Trust's response to each of the recommendations together with progress to date. The Chief Executive Officer, Ms J Tomkinson, provided assurance that the Trust is proactive in reviewing recommendations from public and independent inquiries via internal governance mechanisms. Ms J Tomkinson expressed thanks to Mr J Banwell for leading this piece of work and for providing this update to the Board of Directors. Non-Executive Director, Professor A Hassell, queried one area relating to recording if a patient had received a transfusion previously and that it would be beneficial to understand this process and Mr J Banwell referenced this has been raised at the Quality & Safety Committee also and confirmed that the Trust has records for all patients receiving a transfusion and that data is available on legacy systems. Non-Executive Director, Mr M Guymer, queried the possibility to include a flag on patient records who had a transfusion pre 1996 and the Medical Director, Dr N Scawn, confirmed that this is possible, but highlighted that the national responsibilities of this were discussed at the Quality & Safety Committee and the	

	Trust are awaiting ICB / national guidance. Professor A Hassell suggested for the Trust to query with the ICB or nationally for further guidance regarding this and Mr J Banwell agreed to discuss this with peer colleagues to ensure consistency. The Trust Chair, Mr I Haythornthwaite, expressed thanks to Mr J Banwell for attending and providing the update. **The Board of Directors noted the assurance provided within the report and presentation provided, together with proposed actions which will be monitored via the Hospital Transfusion Committee (HTC).**	
PB15/ 07/24	**Council of Governors Update Report** The Board of Directors noted the update report.	
PB16/ 07/24	**Anchor Institution** The Director of Strategic Partnerships, Mr J Develing, outlined that in 2020 the Trust embarked on a commissioned project with the Purpose Coalition and that the coalition has developed a framework of 14 purpose goals to allow organisations to measure their activities and identify the gaps where they could provide more support where it is needed. Mr J Develing updated that the 14 measures have been used to develop this report, providing progress against the framework and cross referenced as evidence towards being accredited as an Anchor Institution. Mr J Develing updated that the Trust is working with Cheshire & Wirral Partnership NHS Foundation Trust (CWP) regarding broader social value, to enable the Trust to further understand this role and so how to influence with reaching services into the community. Mr J Develing highlighted that this progress confirmed the Trusts commitment to becoming anchor institution and establishment of group and Non-Executive Director (NED) oversight also. The Trust Chair, Mr I Haythornthwaite, queried if there is a trigger point when the Trust can refer to itself as an anchor institution and Mr J Develing confirmed that when areas are actioned, the Trust can then be measured as an anchor institute. The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, acknowledged the benefits of this being combined together into a progress update and suggested it would be beneficial for this to also include a structured workplan including timescales, responsibilities and measurable outcomes. The Chief Executive Officer, Ms J Tomkinson, acknowledged that this is a good example of the Trusts ambition a key player of the healthcare system and as a part of social requirements and influencing leadership opportunities across Chester, via education and fulfilment and social lens too. Ms J Tomkinson expressed thanks to Mr J Develing in collating this and suggested next steps should include how this can be communicated externally as to what we are doing to support population health. The Trust Chair, Mr I Haythornthwaite, acknowledged the good engagement and progress to date, recognising the positive initiative and that the Board of Directors will await further feedback regarding progress at a future meeting. **The Board of Directors noted the progress to date.**	

PB17/ 07/24	**People & Organisation Development Committee Chair's Report – 11th June 2024** Non-Executive Director, Mrs W Williams, presented the Chair's report and outlined one area to be highlighted to the Board of Directors regarding the high number of surveys issued across the Trust, however, with very poor response rates to some surveys issued. Mrs W Williams continued that this was discussed at length with the Committee and it was agreed for work to be undertaken to streamline and reduce surveys being sent and utilising alternative engagement mechanisms. **The Board of Directors noted the report.**	
PB18/ 07/24	**Quality & Safety Committee Chair's Report – 4th July 2024** Non-Executive Director, Professor A Hassell, presented the Chair's report and highlighted the Committee had noted the limited assurance in relation to the policy update provided, and it was agreed for a more detailed update to be shared back at a future meeting. The Director of Nursing & Quality / Deputy Chief Executive, Ms S Pemberton, updated that each Executive Director now has a list of their out of date policies to review and progress. The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, updated that a full list of out of date policies was also provided within a report to the Audit Committee held on 23rd July 2024 and that the process for this recovery programme is being prioritised via the Executive Directors and supporting teams. Professor A Hassell updated that the Committee had received an update regarding the response to the independent infected blood inquiry, noting the action plan in place in response to the findings, and the Committee suggested a system approach should be included, noting this is linked to the update provided to the Board of Directors earlier as part of agenda item PB14/07/24. **The Board of Directors noted the report.**	
PB19/ 07/24	**Finance & Performance Committee Chair's Report – 19th June 2024** Non-Executive Director, Mrs P Williams, presented the Chair's report and referenced the limited assurance from the health & safety report provided, noting that an update regarding this was provided earlier in the meeting by the Chief Operating Officer, Ms C Chadwick, as part of agenda item PB11/07/24. It was noted that it had been agreed for a full update report to be provided back to the next Committee to be held in September 2024. Mrs P Williams updated that the Committee had received a Month 2 Cost Improvement Programme (CIP) position, and concerns were raised regarding the recovery of the month 2 position and future impact of this. However, as per the update from the Chief Finance Officer, Mrs K Edge, earlier in the meeting as part of agenda item PB13/7/24, that the Committee will continue to monitor progress against this. **The Board of Directors noted the report.**	
PB20/ 07/24	**Audit Committee Chair's Report – 23rd July 2024** Non-Executive Director, Mr M Guymer, advised that an extraordinary meeting of the Audit Committee was held on 25th June 2024 whereby the Committee formally approved the Annual Report and Accounts for 2023/24 and expressed thanks to all involved in this process.	

	Mr M Guymer provided a verbal update following the Committee held on the 23rd July 2024 and highlighted the limited assurance received in relation to the current out of date policies. Mr M Guymer noted however that a thorough update report had been provided outlining the out of date policies and that the Committee were updated of the process in place to address outstanding documents. Mr M Guymer continued that this includes a revised focus across Executives and that the Audit Committee will be seeking to receive a pathway for recovery (including dates for prioritisation). **The Board of Directors noted the report.**	
PB21/ 07/24	**Code of Governance Compliance Checklist – June 2024** The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, outlined that the assessment against the new Code of Governance, which came into effect from 1st April 2023. The report was by exception as the Audit Committee had reviewed the full assessment. This provided assurance on compliance with the governance requirements placed on NHS Foundation Trusts, including: • Board leadership and purpose • Division of responsibilities • Composition, succession and evaluation • Audit, risk and internal control • Remuneration Mrs K Wheatcroft confirmed that of the 136 areas in total, the Trust has declared partial compliance in 7 areas and there are mitigations and actions in place. The code is assessed on the basis of comply or explain and that details relating to any actions required are included within this summary report. Mrs K Wheatcroft advised that this annual compliance report will be aligned to the Annual report timetable going forward, with full a full compliance report being provided via the Audit Committee. **The Board of Directors:** • **Noted the Trust's current compliance against each of the Code of Governance provisions, noting the actions required to ensure full compliance as outlined.**	
PB22/ 07/24	**Provider Licence Compliance 2023/24** The Director of Governance, Risk & Improvement, Mrs K Wheatcroft outlined that the paper provides assurance on compliance with the Provider Licence for 2023/24. Mrs K Wheatcroft explained that assurance is provided in the context that during 2023/24 the Trust has continued to manage the recovery of waiting lists, alongside the challenges of continued industrial action, staffing constraints and operational pressures. These areas continued to have strong oversight through the Executive Team, respective assurance committees and the Board of Directors. Mrs K Wheatcroft advised this annual compliance report will be aligned to the Annual Report timetable going forward, with a mid-year review being provided to the Audit Committee.	

	Non-Executive Director, Professor A Hassell, suggested it would be beneficial to highlight in the report of the number of areas of which the Trust is compliant with and it was agreed for this to be reflected in future reports. **The Board of Directors noted the review of the compliance with the provider licence for 2023/24.**	
PB23/ 07/24	**Items for noting and receipt** **The Board of Directors noted the following minutes which had been approved by the relevant Committees:** a) Approved minutes of the Quality & Safety Committee – 30th April 2024 b) Approved minutes of the People & Organisation Development Committee – 9th April 2024 c) Approved minutes of the Finance & Performance Committee – 17th April 2024 and 26th April 2024 d) Approved minutes of the Operational Management Board – 23rd May 2024 **The Board of Directors noted the following items:** e) Board of Directors Workplan 2024/25 f) Cheshire & Merseyside Acute Specialist Trust (CMAST) Leadership Board Update - July 2024	
PB24/ 07/24	**Any other business** There were no further items of business raised.	
PB25/ 07/24	**Questions from Governors and members of the Public relating to items on the meeting agenda** No questions were raised.	
PB26/ 07/24	**Closing remarks** The Trust Chair, Mr I Haythornthwaite, expressed thanks to all members for their input to the reports and discussions during the meeting. Mr I Haythornthwaite acknowledged the references to assurances being provided within the reports provided, noting the positive progress to date with improvements across all areas of the Trust and expressed thanks to all Executive Directors on behalf of himself and all Non-Executive Directors. *To note, the meeting was closed at 11.20am.*	
PB27/ 07/24	**Date & Time of next meeting** The next meeting will be held on Tuesday 24th September 2024 (timings to be confirmed).	

Board of Directors Action Log - Updated 17th September 2024

Action No.	Meeting Date	Allocated To	Agenda Item Number	Issue / Action Raised	Action Details	Action Update / Outcome	Due Date	Status
29	04/06/2024	Director of Nursing & Quality / Deputy Chief Executive	PB9/06/24	Integrated Incidents, Complaints, Claims and Inquests Quarter 4 2023/24 - Mr D Williamson suggested it would be beneficial to include Volumes of Complaints and Serious Incidents, for each of the previous 3 quarters, as is done in the report for Concerns.	It was agreed for this data to be included in future reports.	**Update 17th September 2024** - This will be reflected within the next quarterly report to be provided to the Board of Directors to be held in November 2024.	26/11/2024	**Open**
30	04/06/2024	Director of Nursing & Quality / Deputy Chief Executive and Director of Governance, Risk & Improvement	PB9/06/24	Integrated Incidents, Complaints, Claims and Inquests Quarter 4 2023/24 - The Trust Chair, Mr I Haythornthwaite, also acknowledged the improvements to date, however, queried how the figures reported compare to other Trusts.	Ms S Pemberton explained that the Trust needs to further understand the data being collated and provided to enable this to be benchmarked against other Trusts, noting this also links to the requirements for the targeted improvement for concerns. It was agreed this reporting would be discussed with the Director of Governance, Risk & Improvement, Mrs K Wheatcroft, for a future report.	**Update 17th September 2024** - This will be reflected within the next quarterly report to be provided to the Board of Directors to be held in November 2024.	26/11/2024	**Open**
35	30/07/2024	Medical Director & Pathology Service Manager	PB17/ 07/24	COCH response to the independent infected blood inquiry	Non-Executive Director, Mr M Guymer, queried the possibility to include a flag on patient records who had a transfusion pre 1996 and the Medical Director, Dr N Scawn, confirmed that this is possible, but highlighted that the national responsibilities of this were discussed at the Quality & Safety Committee and the Trust are awaiting ICB / national guidance. Professor A Hassell suggested for the Trust to query with the ICB or nationally for further guidance regarding this and Mr J Banwell agreed to discuss this with peer colleagues to ensure consistency.	**Update 9th August 2024** - Verbal update to be provided to the next Board of Directors to be held on 24th September 2024.	24/09/2024	**Open**
36	30/07/2024	Director of Strategic Partnerships	PB16/ 07/24	Anchor Institution	The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, acknowledged the benefits of this being combined together into a progress update and suggested it would be beneficial for this to also include a structured workplan including timescales, responsibilities and measurable outcomes. Ms J Tomkinson suggested next steps should include how this can be communicated externally as to what we are doing to support population health.	**Update 9th August 2024** - Update to be provided back to a future Board of Directors meeting - Date TBC.	TBC	**Open**

Meeting	**24th September 2024**		**Board of Directors**					
Report	**Agenda item 8.**		**Chief Executive Officer's Report**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Jane Tomkinson OBE				Chief Executive Officer			
Author(s)	Karan Wheatcroft Laura Leadsom				Director of Governance, Risk and Improvement Deputy Director of Governance & Risk			
Board Assurance Framework	ALL	Relevant across all BAF areas						
Strategic Aims	SG3 - Purposeful Leadership							
CQC Domains	Well-led.							
Previous Considerations	Not applicable.							
Executive Summary	The purpose of this report is to provide an overview of the relevant local, regional, and national issues for consideration alongside the strategic objectives and wider Board agenda.							
Highlights	Updates included in the report: • CMAST Leadership Board • Cheshire Review • Federated data platform • National NHS Leadership session (3rd September 2024) • Inpatient survey results • Financial Improvement Support update • Urgent Emergency Care Support • Targeted winter support • System Improvement Board (SIB) Exit • RSV, Flu and Covid vaccinations (national update) • Health and Care Overview and Scrutiny Panel • Clinical Strategy day • Women's and children's building update • Staff awards • Staff networks • MET team update • Martha's Rule • Thirlwall update							
Recommendation(s)	The Board of Directors is asked to note the contents of this report.							
Corporate Impact Assessment								
Statutory Requirements	Meets the Trust compliance with Foundation Trust status							

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

Chief Executive Officer's Report – September 2024

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

1. CMAST Leadership meeting

The CMAST Leadership Board met on the 6th September. The meeting focussed on:

- The CMAST Annual Plan (including Clinical Pathways Programme, Diagnostics, Efficiency at Scale, Elective Recovery and Transformation Programme)
- Finance update
- Virtual wards update
- The CMAST Joint Working Agreement (JWA) and Committee In Common (CIC) Terms of Reference (TOR) review and refresh

The CMAST Bulletin for August 2024 is included as an appendix to this paper.

2. Cheshire Health and Care Review

On 1st August 2024 the elected leaders and NHS Chief Executives and Chairs asked to form an Executive Steering Group to identify a proposed programme and scope for a review to be referred to as the Cheshire Health and Care review. It was agreed for workstream leads to coordinate and develop proposals for respective work streams and scope for each area, noting that the outcome of this work will then enable a final recommendation to be agreed on the programme scope. It was agreed for this proposal to be submitted to elected Leaders, Chairs and Chief Executive Officers by 31st October 2024.

3. Regional update – Cheshire and Merseyside Integrated Care Board (ICB)

With the formation of a new government, the Deputy Prime Minister and Secretary of State for Housing, Communities and Local Government wrote to Local Authority leaders in July 2024 to lay out the ambitions for devolution. Our colleagues in Cheshire and Warrington are submitting a proposal, and Liverpool City Region is hoping to build on its existing devolved responsibilities.

These proposals are being considered by the ICB in planning the future Cheshire & Merseyside operating model and the ICB will also engage with local systems and providers on the future operating model.

4. Federated Data Platform (FDP)

NHS England has procured and is deploying a Federated Data Platform (FPD) for local, regional and national uses. The FDP is software that will enable NHS organisations to bring together operational data – currently stored in separate systems – to support staff to access the information they need in one safe and secure environment. The Trust has deployed applications using FDP to support elective recovery for theatre scheduling, and care coordination in discharge management.

Cheshire and Merseyside are exploring options for FDP to support population health management.

5. National NHS Leadership session (3rd September 2024)

This session was held on 3rd September 2024. It was highlighted that the Government has indicated the intent to develop a new 10-year plan for Health informed by having honest conversations with patients, staff, stakeholders, and leaders. The plan will be informed by:

- Lord Darzi – A review of NHS performance and productivity which will be a frank appraisal of the scale and challenges facing the NHS. The Darzi review was published on 13th September 2024.
- Engagement – Through wide reaching dialogue with the public, NHS staff and leaders, and stakeholders.
- Policy development - The Plan will be supported by policy development.

The 10-year plan is expected to be the catalyst for building a health and care system for the future, with the aim of shortening the amount of time people spend in poor health. The plan will have three principal areas of focus:

- Hospital to Home - Change so that more people get care at home in their community.
- Analogue to Digital - Change so we have a workforce we need, with the technology to deliver the best care.
- Treatment to Prevention - Change so that we focus on prevention.

6. Inpatient Survey Results

The Trust's CQC Inpatient Survey 2023 results were published on 21st August 2024 and demonstrate improvement on the previous year's results in all sections apart from one where the score remained the same as the previous year. There are some areas where continued improvement is required, with the two main areas raised relating to the time waiting for a bed and understanding explanations given when changing wards during the night. Of 1,250 patients invited to take part, 457 responded (circa 40% c.f. the national response rate of 42%).

7. Financial Improvement Support

PricewaterhouseCoopers (PWC) were appointed by Cheshire & Mersey Integrated Care Board (ICB) to undertake a review of the opportunities for improvement for the Trust and system to mitigate delivery risk in 2024/25. The actions to date include:

- A phase 1 assessment has been undertaken by PWC (to assess the Trust arrangements for delivery of the financial plan and governance arrangements that provide support).
- A nominated lead has been appointed by NHS England (NHSE) whose role is to provide advice, challenge and experience to the system in relation to financial delivery. An initial

risk adjusted forecast has been provided with mitigations the Trust will pursue to ensure delivery of the agreed financial position (excluding costs of the inquiry).

There are further activities planned to improve grip and control and accelerate delivery of the agreed Cost Improvement Programme (CIP). The Trust has received the draft report from PWC, and has reviewed the recommendations for improvement and a management response developed.

8. UEC Support

Five Trusts in Cheshire and Merseyside have been placed into Tier 1 for their Urgent and Emergency Care (UEC) services and this includes our Trust. Intensive support for all organisations in Tier 1 has been allocated from the Emergency Care Intensive Support Team (ECIST) via NHS England (NHSE). The Trust has asked for targeted support with triage, new models of working and day to day clinical leadership of the Emergency Department. The Chief Operating Officer is working closely with the Integrated Care Board (ICB)/NHSE/ECIST to finalise the offer and also having an increased focus on breaches of the 4 hour target that are within the control of our Emergency Department.

9. Targeted winter support

We have started our winter planning but thus far have not received any communications from NHSE or the ICB on winter planning targets or any additional funding that may be available. As per last year the trust will be challenged as there will be no escalation beds we can open. To support winter planning and the everyday lack of G&A beds Chester West Place led a discharge summit on the 11th September, to review the work of Professor John Bolton (subject matter expert in complex discharge). The summit was well attended and was designed to focus all system partners on changes we need to make to enable the number of patients that no longer meet the criteria to reside (NCTR) to drastically reduce.

10. System Improvement Board (SIB) Exit

NHS England submitted their recommendation to the Northwest Regional Support Group based on the Trust's delivery against the SIB exit criteria as of July 2024. In view of the Trust meeting four of the five criteria, it was recommended that oversight arrangements be transferred to Cheshire and Merseyside ICB with the establishment of a System Oversight Group (SOG) to support the Trust's onward journey towards NHS Oversight Framework (NOF) segment 2. The Trust subsequently received formal notification of the discontinuation of the System Improvement Board (SIB) and is working with the SOG to agree the oversight criteria.

11. RSV, Flu and Covid vaccinations (national update)

Flu vaccinations for pregnant women, and all children's flu cohorts, commenced on 1st September 2024 and will be followed by the main flu and COVID-19 vaccination campaign, which will commence on Thursday 3rd October 2024.

The RSV vaccine is being routinely offered for the first time this year, from September 2024, to those turning 75 years of age and will also be offered to pregnant women from 28 weeks of pregnancy.

12. Health and Care Overview and Scrutiny Committee

The Trust presented the Quality Account to the Health Scrutiny Panel held in July 2024, and the quality priorities for the Trust were agreed with stakeholder involvement.

An update relating to the CQC Improvement Plan (including Well Led) was presented to the Committee held in September 2024, with further updates to be provided to the next Committee.

13. Clinical Strategy Day

We know that patients present in a quite different way to when the NHS was first created. Whilst we (the NHS) have adapted over time, and now in most cases operate in a multidisciplinary way, there is a need to consider future service design particularly given changing needs of the population, changes in workforce and the fragility and sustainability of some clinical services.

Our new clinical strategy will need to consider these changing dynamics alongside the wider Integrated Care Systems and the strategic approach to collaborate rather than compete with neighbouring organisations. To facilitate the development of our clinical strategy, a sponsored full days event has been arranged for 24th October 2024 ensuring that our approach is clinically led.

14. Women's and Children's Build update

The new Women and Children's building is continuing to progress at pace and on time. Site visits for our clinical and support services are ongoing with over 100 people having visited so far. Excitement is growing and we are on a 10 month count down. The teams have begun to prepare for their move, ensuring we are ready for a safe and effective transition by Summer 2025.

15. Staff awards

Our staff Celebration of Achievement Awards will be held on the 20th September 2024 and the finalists for this year have now been chosen. The quality of the award applications was excellent and made for tough judging by our panel, and we are looking forward to recognising the achievements of our colleagues at the event.

16. Staff Networks Update

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

- BAME
- Carers
- Disability and Wellness
- Faith and Belief
- LGBTQ+

- Neurodiversity
- Women's

Over 30 people from the LGBTQ+ staff network, friends and family represented the Trust in the Chester Pride parade held on 17th August 2024.

17. MET team update

From Monday 9th September 2024, the Trust has changed the way in how we respond to the acutely unwell or deteriorating inpatient. A Medical Emergency Team (MET) is now available to respond to adult inpatient areas that use the NEWS2 scoring system for the recognition and escalation of patients at risk of deterioration. The MET will provide a rapid response to the deteriorating inpatient, therefore helping to ensure that patients with the greatest need of urgent care are prioritised and promptly reviewed. This is an important part of the patient safety improvements we have made.

18. Martha's Rule

Following the implementation of the MET, we are now focussing on the 3 points of Martha's rule implementation working with national, regional and local teams. The 3 points of Martha's rule include:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition.
3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

19. Thirlwall Inquiry update

The Thirlwall Inquiry oral hearings commenced on Tuesday 10th September 2024. The Counsel to the Inquiry set out their opening statement over the course of the first two days, followed by the legal counsels for the families and other core participants delivering their opening statements.

The Trust is committed to continuing to support the Thirlwall Inquiry in the weeks and months ahead.

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Acute and Specialist Trust Provider Collaborative

CMAST BULLETIN

Welcome message

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

CMAST Leadership Board met on 6th September, including Trust Chairs, and discussed four substantive items as follows:

Ann Marr presented a summary of CMAST's Annual Plan, as she had presented to the ICB in July and which included highlights of a number of the main achievements for 23/24. Thereafter CMAST Programme Directors provided an outline of programme plans for 24/25, as well as updates on delivery progress year to date.

Claire Wilson, ICB Chief Finance Officer, provided an update on the system financial position, NHSE and partner scrutiny and the current areas of focus. Correspondence outlining initial recommendations from Simon Worthington, the NHSE partner placed with the ICB, had been circulated to CEOs recommending a number of measures to increase grip and control across organisations, highlighting the need for a rapid adjustment in trajectory and approach.

Tony Mayer, Director MHLDC Provider Collaborative updated on Virtual Wards, the variance in performance against planned occupancy rates was noted, as well as the increased challenge for Trusts with multiple community/Place partners.

A review of the CMAST Joint Working Agreement and committees in common terms of reference was presented to the Board with a request for review and support in commending this documentation to Trust Boards for adoption. The changes were summarised as mainly relating to updates to circumstantial commentary. The updated documentation will now be recommended to Trust Boards following CMAST Leadership Board support.

Elective Recovery

Senior Responsible Officer: Janelle Holmes
Programme Director: Jenny Briggs

NHS
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At end of August 2024

1,214

patients waiting over 65 weeks for treatment. With 5,100 breaches to clear before the end of September

We are currently reporting

0

78-week capacity breaches.

There were 55 breaches (choice and complex) at the end of July

We have organisations who are carrying some risks around 65-week delivery, we are working closely with them to ensure that all **mutual aid and operational and tactical measures** are taken to ensure that patients are seen and treated by end of September.

Outpatients

83%

of the Further Faster checklists are now complete across the providers and clinical networks for the C&M priority specialties.

We are achieving the national value for Remote Consultations, **Elective Recovery Fund (ERF) Activity** and **Patient Initiated Follow Up (PIFU)** Utilisation. Working with the ICB to support Primary Care to use these services.

New **Follow Up (FU) ratio** reviews have commenced with a pilot Trust and division.

Theatres

78% capped theatre utilisation, touch time within planned session vs planned session time

82% uncapped theatre utilisation, total touch time vs planned session time

https://www.liverpoolft.nhs.uk/about-us/our-stories/power-idea-how-two-staff-members-are-standardising-surgical-care-across-world

All sites currently have a self-assessment against the **Theatre Productivity Checklist**. Results will be shared in early September and action plans will be developed.

1-2-1s and Workshops scheduled with **Warrington and Halton**, **Mersey and West Lancs**, **Liverpool Womens, Alder Hey** and **Countess of Chester.**

https://www.mcht.nhs.uk/news-and-events/news/cheshire-and-merseyside-surgical-centre-victoria-infirmary-continues-take-shape

Clinical Pathways (CPP)

Programme Directors: Jenny Briggs / Helen Murphy

NHS Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

The CPP Programme continues to work with Dermatology, ENT, Gynaecology, Ophthalmology and Cardiology.

Gynaecology

Expressions of interest circulated for **Pelvic Pain Pilot**; utilising CDC 7/7 ultrasound capacity, to support faster diagnosis and improved patient experience

Menopause Pilot led by **Liverpool Womens Hospital** due to conclude end of September. Clinics due to continue within Liverpool Central PCN and discussions to scale this model in other areas are in progress.

Targeted Investment Fund (TIF) funded Ambulatory Programme clinical pathways group to present at **Gynaecology Network**, defining expected pathway changes as part of estate development

Topping out ceremony marks significant milestone for new Women and Children's Building at the Countess of Chester Hospital | Countess of Chester Hospital (coch.nhs.uk)

ENT (Ear nose and Throat)

ENT Community presentation planned for September to ensure network sighted on community provision

Referral Assessment Service (RAS) workstream aiming to achieve single approach for C&M ENT within this financial year

Exploring opportunities to pilot **nurse-led triage model** at single provider within C&M to evaluate effectiveness

Cardiology

A Cardiology Options Appraisal Workshop is scheduled for **September** – attendees will explore and score options to improve the patient pathway for Cardiac Diagnostic Services across Cheshire & Merseyside.

The strategic aim is to agree a **sustainable model** that delivers sufficient access to both invasive and non-invasive diagnostic facilities, ensuring that **Cardiac Catheterisation Laboratories** are both fully utilised and equipped/enabled to deliver timely treatments for patients.

Provider engagement remains a key theme. Updates were presented at the monthly CAMRIN management group and a site visit took place at **Liverpool Heart and Chest Hospital** on, 26th July, to view the setup of **PCI-enabled Cath labs**.

Ophthamology

SPoA

Single Point of Access

The SPoA pilot launched on 1st July in **East Cheshire, West Cheshire, Halton, St Helens and Knowsley**. All ophthalmology referrals from GPs and optometrists will go through the SPoA as part of a 6-month pilot

As part of the pathway improvement work, we visited **Wirral Universtiy Hospital** in July and **Warrington and Halton Hospital** in August to observe a local anaesthetic cataract only theatre list alongside GIRFT (Getting it Right the First Time) colleagues. A visit is scheduled with **East Cheshire Hospital** in September, and we are in the process of scheduling visits with remaining Trusts as well.

Dermatology

This reporting period centers on the potential implementation of Skin Analytics across the following trusts: **Mersey and West Lancashire Teaching Hospital, Countess of Chester Hospital, Wirral University Teaching Hospital, Mid Cheshire Hospitals**, and **Bridgewater**. The primary activities involve:

Clinical Pathway Development: Ongoing efforts are being made to develop and refine clinical pathways within each trust, ensuring that the integration of **Skin Analytics** aligns seamlessly with existing practices.

There is active collaboration with the **Clinical Diagnostic Centers (CDC) leads**. This partnership aims to leverage the CDC's capabilities for **dermatology diagnostic image capture**, which will support the broader adoption and effectiveness of **Skin Analytics** across the involved trusts.

Diagnostics

Senior Responsible Officer: Liz Bishop
Programme Director: Tracey Cole

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Remain one of only 2 ICSs to be delivering waiting time performance of 90% of patients receiving a diagnostic test within 6 weeks.

Date	Patients Waiting	Ranking	Seen within 6 weeks
June 2023	76,047	18th	79%
June 2024	66,452	2nd	90%

9000+ fewer patients waiting for tests this year vs last year.

110,633
overall activity for June, a 5.1% decrease from previous month

66,452
Total number of patients waiting, with 6,736 waiting over 6 weeks

#2
Ranked as 2nd out of 42 ICS at end of June 2024

89.9%
of DM01 patients being seen within 6 weeks or less, down 0.1% from previous month.

Endoscopy

9 out of 10
Trusts delivering >95% of core capacity

JAG Accreditation visit with **East Cheshire & Countess of Chester** complete with accreditation deferred for 6 months to be resolved remotely

Endoscopy Health Care Assistants fully funded **training and development opportunity** - Expression of Interest circulated to trusts

Pathology

LIMS
Programme moving to contract finalisation and signature by end August

Maturity Matrix - Network plan to achieve maturity by March 2025

TOM (3 Hub Target Operating Model)
Pathology Network wide workshop held on 10 July to support transformation prioritisation and delivery through workstreams – positive feedback and excellent engagement to support development of critical path

Histopathology
New Programme Manager has commenced role - focus will be on performance and delivery of the Histopathology review action plan

Diagnostics

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Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

Physiological Sciences

Neurophysiology and **Audiology** Community of Practice first meetings held

Enhanced GP Direct Access for COPD, Asthma and Heart Failure
Proposal presented through Diagnostic governance and endorsed. Meeting held with ICB to ensure identified as ICB strategic priority for Urgent and Emergency Care programme

Network year 1 work plan, project plan and timescales finalised

https://www.thewaltoncentre.nhs.uk/news/michael-received-early-diagnosis-thanks-to-our-rapid-access-clinic-seeing-neurological-emergencies-quickly/634970

Artificial Intelligence (AI) in Echocardiology Clinics
Pre-market engagement complete with 3 potential providers identified

Radiology/Imaging

AI for Chest X-Rays
Network continuing to outline clinical governance processes at all trusts

Interventional Radiology
Operational & Clinical leads appointed. Trust visits in progress. Data collection continuing.

Ologies
Business as usual, management of the Ologies system handed over to **Clatterbridge Cancer Centre.** Planned schedule of work with Philips and the local IT teams for expansion to all trusts completed and expected to commence as soon as MOU approved and trusts sign.

Community Diagnostic Centres (CDCs)

Trusts given extension on **International Recruitment** until **5 July** to express interest. Awaiting further updates from NHSE.

Re-profiling of activity to take place end of August/early September.

Sustainability Project
Draft report being pulled together and will be presented to September Diagnostic Steering Group

Contact us for more information regarding the latest news!

ccf-tr.candmdiagnosticprogramme@nhs.net

Efficiency at Scale (E@S)

Senior Responsible Officer: Ged Murphy
Programme Director: Nina Russell

NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

The E@S programme is working with PwC who are leading the Cheshire and Merseyside Information & Intelligence (I&I) review.

Medicines Optimisation

The QIPP 24/25 target is on plan to deliver

£19.5m

in primary care

£3.3m has been delivered in year to date

Finance/Legal

The **Liverpool Legal Services Collaborative** has been selected as an early implementer of the National Legal Services System (NLSS). This is currently in the design phase with NHSE and is due to go live in **October 2024.**

The new General Counsel will commence their position **19th September 2024**.

Procurement

The 24/25 procurement workplan is on track. A saving of

£5.1m

has already been delivered against the

£7.1m

workplan.

The **Estates and Digital** workplan has commenced. Category information has been shared as a part of the I&I review.

Meeting	**30th July 2024**		**Board of Directors**					
Report	**Agenda item 9.**		**Board Assurance Framework 2024/25**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft				Director of Governance, Risk and Improvement			
Author(s)	Karan Wheatcroft				Director of Governance, Risk and Improvement			
Board Assurance Framework	ALL	All areas of the Board Assurance Framework						
Strategic Aims	Includes all strategic goals							
CQC Domains	Well Led							
Previous Considerations	Board of Directors – 30th July 2024							
Summary and Key Points	The updated BAF was reviewed and approved by the Board in July 2024. This paper provides for continued triangulation with the Board agenda. The quarterly review and update of the BAF will be reported to the Board in November 2024. The BAF risks and residual risk scores are: • BAF1 - quality of care (16) • BAF2 - safety and harm (16) • BAF3 - operational planning standards (16) • BAF4 - workforce (15) • BAF5 - financial plan (16) • BAF6 - capital programme (15) • BAF7 - digital transformation and IT resilience (15) • BAF8 - corporate governance (12) • BAF9 - system working (12) • BAF10 - research and innovation (12)							
Recommendation(s)	The Board of Directors is asked to note the Board Assurance Framework 2024/25 as aligned to the Board agenda and papers received.							
Corporate Impact Assessment								
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status.							
Quality & Safety	Improved patient safety.							
NHS Constitution	Improves overall assurance on key strategic objectives.							
Patient Involvement	In line with Quality and Safety.							
Risk	Alignment with the Corporate Risk Register.							
Financial impact	Financial risk is considered as part of the Effectiveness areas of the BAF.							

Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics.
Communication	Document to be published on the Trust's website as part of the Board of Directors agenda.

Countess of Chester Hospital
NHS Foundation Trust

Board Assurance Framework 2024 - 25

Risk Theme: Quality & Patient Experience

RISK APPETITE: CAUTIOUS - Upper tolerance limit 9

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

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

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

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

Risk Theme: Finance & Capital

RISK APPETITE: OPEN - Upper tolerance limit 12

LINKS TO STRATEGIC GOALS: **SG4: Adding Value**

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

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

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

Risk Theme: System Working and Collaboration

RISK APPETITE: SEEK - Upper tolerance limit 16

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

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

Risk Theme: Research and Innovation

RISK APPETITE: SEEK - Upper tolerance limit 16

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

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

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

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

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

SG4 Adding Value		

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

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

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

Board Assurance Framework

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

5x5 risk scoring matrix:

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

Risk Appetite Levels

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

Meeting	**24th September 2024**		**Board of Directors**				
Report	**Agenda item 10.**		**Midwifery and Maternity Safer Staffing Report – 1st January 2024 to 30th June 2024**				
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information
Accountable Executive	Sue Pemberton				Director of Nursing and Quality / Deputy Chief Executive		
Author(s)	Claire Davies				Head of Midwifery		
Board Assurance Framework	BAF2 – Failure to maintain safety and prevent harm would result in poorer patient care and outcomes						
Strategic Aims	SG1 – Patients and Family						
CQC Domains	Safe, Effective, Caring, Responsive, Well Led						
Previous Considerations	People & Organisation Development Committee – 13th August 2024						
Executive Summary	The Midwifery and Maternity Safer Staffing Report outlines the Trust's commitment to ensuring safe and effective care within the maternity unit through rigorous workforce planning and monitoring. This report covers the period from 1st January 2024 to 30th June 2024 and aligns with NHS Resolution Maternity Incentive Scheme requirements and addresses the recommendations set forth in the Ockenden report (2022). This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist midwifery hours and compliance with a supernumerary labour ward coordinator, one to one care in labour and red flag incidents.						
Highlights	**Key Findings:** <u>Workforce Planning and Compliance</u>: The Trust has successfully implemented a systematic, evidence-based approach to midwifery staffing establishment. Compliance with the recommended Birth Rate Plus assessment ratios is maintained, reflecting alignment with patient acuity. <u>Supervision and Oversight:</u> The Trust has maintained the provision of a supernumerary labour ward coordinator for every shift, who ensures continuous oversight of birth activities, enhancing patient safety and staff support. <u>One-to-One Care:</u> The commitment to providing one-to-one midwifery care to women in established labour is unwavering. Compliance						

	remains at 100%, reflecting the dedication to enhancing patient outcomes. Red Flag Incidents: An effective monitoring system captures midwifery red flag events, aiding in timely response to potential staffing challenges. The Birthrate Plus Acuity tool recorded 106 red flag incidents reported from January to June 2024 underscore the importance of continued vigilance. Collaboration and Communication: The continuation of safety huddles and the Birthrate Plus Live Acuity Tool enhances collaboration and proactive risk management. Collaborative efforts within the Cheshire and Merseyside network promote effective intrapartum acuity oversight.
Recommendation(s)	The Board of Directors is asked to note the contents of this report and the assurance provided that the Trust is fully compliant with the Maternity incentive scheme year 6 safety action 5.
Corporate Impact Assessment	
Statutory Requirements	Ensure the Trust's alignment with Foundation Trust status, maintaining all regulatory obligations
Quality & Safety	Responsive service, focused on patient safety. Enhance adherence to the maternity incentive scheme year 6 recommendations, striving for continuous improvement in these areas
NHS Constitution	Monitors performance against key targets complies with maternity incentive scheme.
Patient Involvement	Actively incorporate patient feedback through consultation with the service users, reflecting patient perspectives in service development.
Risk	Define and assess potential risks to the organisation, implementing proactive measures to mitigate them
Financial impact	Balance staffing expenditure with service improvement to manage costs effectively while advancing care
Equality & Diversity	Foster an inclusive environment where all voices are heard
Communication	Ensure timely and transparent communication, including publishing key documents on the Trust's website to facilitate public access

Midwifery and Maternity Safer Staffing report
1st January 2024 to 30th June 2024

1. Purpose

The purpose of this report is to provide assurance to the Board Of Directors that the Trust has an effective system for midwifery workforce planning and monitoring of safe staffing levels from 1st January 2024 to 30th June 2024. To note, this meets the requirements of the NHS Resolution Maternity Incentive Scheme (MIS) for Safety Actions 5 and demonstrates compliance with the Ockenden Report (2022) recommendations for safe and effective staffing**.**

2. Background

The NHS Resolutions Maternity Incentive Scheme requires each trust to demonstrates that there is an effective system of midwifery workforce planning to the required standard. This report demonstrates that:

- A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.
- Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
- The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.
- All women in active labour receive one-to-one midwifery care.
- Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with National Institute for Health and Care Excellence (NICE) midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

3. Birthrate Plus® Workforce Planning

A formal Birthrate Plus assessment was completed in December 2021, which reviewed the acuity of women who used the maternity services. The review recommended a midwife to birth ratio of 1: 27. This ratio reflects the optimal allocation of midwives to births to ensure safe and effective care, however this fluctuates due to the complexity and acuity of the women. NICE (2015) recommend that an assessment is carried out every three years, and therefore to ensure that the current establishment is in keeping

with the ongoing activity and acuity. The Birthrate Plus assessment considers the acuity of women using maternity services, aligning staffing with patient complexity.

The Birthrate Plus report (December 2021) concludes that the Trust complies with recommended staffing establishment levels from the Birth Rate Plus assessment. This reflects the Trust's efforts to ensure safe midwifery staffing aligned with patient acuity. The comprehensive report, including detailed calculations and the Birthrate Plus assessment, has been previously shared with the Board of Directors.

4. Birthrate Rate Plus calculation December 2021

Birthrate Rate Plus calculation of staff compared to current funded establishment inclusive 20% uplift

	RMs	**MSWs**	**Bands 3 - 7**
Current Total Clinical	88.65	9.08	
Contribution from Specialist MWs	4.80		
Total Current Funded	**93.45**	**9.08**	**102.53**
BR+ Clinical wte			92.17
Skill Mix Adjustment (90/10)	82.95	9.22	
Variance +/-	10.50	-0.14	
TOTAL CLINICAL VARIANCE		**10.36**	
	BR+	Current	Variance
NON CLINICAL @ 9%	8.30	9.73	1.43
OVERALL TOTAL VARIANCE			11.79

Funded Establishment vs Birthrate Plus® recommendations Table 3

The presented table illustrates that the Trust maintains a workforce establishment of 102.53. When factoring in the Birthrate Rate, a suggested establishment of 92.17 is recommended, resulting in a variance of 11.79.

All Trust Boards of Directors must assure themselves of compliance with midwifery staffing recommendations, such as those outlined in the Ockenden report (2022). This assurance should be documented in Board minutes and demonstrate alignment between the funded staffing establishment and the results obtained from Birthrate Plus assessments or similar calculations.

The Trust is fully compliant with the Birthrate Plus recommendations.

	Birthrate plus WTE recommendation	Budget WTE	Actual WTE	Vacancy Rate
Midwives and Band 3	92.17	100.63	86.92	13.71

June 2024 Financial Position

CLINICAL MIDWIVES						NON-CLINICAL MIDWIVES				
Band	**Birth Rate + WTE based on births**	**Budget WTE**	**Actual WTE**	**Variance WTE**		**Band**	**Birth Rate + (Average Births per month 189**	**Budget WTE**	**Actual WTE**	**Variance WTE**
Band 8A				-		**Band 8A**		2.00	2.00	-
Band 7		9.47	10.04	0.57		**Band 7**		9.63	10.09	0.46
Band 6		66.09	51.43	(14.66)		**Band 6**		2.84	0.92	(1.92)
Band 5		11.70	12.96	1.26		**Band 5**				-
TOTAL QUALIFED MIDWIVES	92.17	**87.26**	**74.43**	**(12.83)**		**TOTAL QUALIFED MIDWIVES**	8.30	**14.47**	**13.01**	**(1.46)**
Band 4			1.19	1.19		**Band 4**				-
Band 3		13.37	12.49	(0.88)		**Band 3**		0.80	0.80	-
Band 2		16.94	15.01	(1.93)		**Band 2**				-
GRAND TOTAL	**0**	**117.57**	**103.12**	**(14.45)**		**GRAND TOTAL**	**8.30**	**15.27**	**13.81**	**(1.46)**

The team has actively addressed the midwifery vacancies actively through a multifaceted approach continuous rolling advertisement and a successful recruitment day, including recruiting our early career midwives. A significant recruitment day was held on 3rd July 2024, successfully filling 10.02 Whole Time Equivalent (WTE) vacancies, primarily with Band 5 Midwives. This leaves 3.28 WTE vacancies for Band 6 Midwives to be recruited, ensuring an appropriate skill mix.

5. Vacancy rate Whole Time Equivalent (WTE) Midwife

Months 2024	January	February	March	April	May	June
Vacancy WTE	8.08	8.08	9.35	10.18	10.57	12.83

Despite the vacancy rate shown above, the unit maintains safe staffing levels by efficiently utilising bank and agency staff. A significant portion of bank hours addresses maternity leave and various sickness absences. This aligns with increased use of bank and agency resources. The Director of Midwifery has approval from the Director of Nursing & Quality to use external agency support at times, when required.

6. Planned Versus Actual Midwifery Staffing Levels

Daily reviews assess unit acuity and activity, facilitating staff redeployment as needed. The table below illustrates required staffing for unit safety.

Planned Staffing	Central Labour Suite	Ward 33
Day	6	3
Night	6	2
Weekend	6	3

The table below displays monthly percentage fill rates for the inpatient area. Although an 85% rate is a favorable benchmark, it must be interpreted alongside acuity and activity levels for a comprehensive assessment.

7. Maternity Inpatients

2024	Day shift qualified %	Night shift qualified %
January	103%	102%
February	101%	101%
March	100%	97%

April	105%	94%
May	102%	99%
June	103%	96%

8. NEW: Community Midwifery

2024	Day shift qualified %	Night shift qualified %
January	98%	100%
February	89%	100%
March	91%	100%
April	96%	100%
May	90%	100%
June	88%	100%

The priority fill rate is allocated to out of hours shifts to ensure adequate safe cover, day shifts are supported where needed by staff who are rostered as non-clinical staff such a as specialist midwives and managers. The escalation process is deployed as below. When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Request midwifery staff undertaking specialist roles to work clinically
- Elective workload prioritised to maximise available staffing
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward coordinator roles is maintained
- Request Mutual aid for elective work from Cheshire and Mersey Local maternity and neonatal system Activate the on-call midwives from community to support labour ward
- Activation of the Northwest divert policy and unit closure.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies, it is preferable to have higher fill rates during the night shifts and weekends when there is less support available from specialist midwives and managers. Actions taken to support safe staffing are captured in the live Birthrate Plus acuity tool. The inability to meet actual staffing requirements is attributed to various factors, including, short-term sickness and absence, long-term sickness, including Long Covid.

9. Pipeline / Succession Planning

Pipeline planning has been utilised to welcome newer or more junior talent into the workforce team. Succession planning has applied to identify and develop new leaders who can take over their predecessor should they leave.

The below roles have been implemented during Quarter 4 2023/24 and Quarter 1 2024/25 to support the future of our workforce structure.

- Midwife: Band 7 Developmental Labour Ward Coordinator Post (pipeline)
- Community Midwife: Parent Education 15 hours (succession)
- Community Midwife: Perinatal Mental Health Support: 15 hours (succession)
- Community Midwife: Tobacco Dependency: 22.5 hours (pipeline)
- Community Midwife: Pelvic Health Lead:17.5 hours (15 hours community) (pipeline)
- Inpatient Midwife: Bereavement Support: 37.5 hours (succession)

Within the next Quarter, the Head of Midwifery aims to succession plan for the roles of Fetal Surveillance and Digital Midwives.

10.Growing the Midwifery Workforce

Through the Trust Appraisal process Midwives highlighted their future aspirations. Midwives have been supported to apply and will be supported with time to attend the below course.

- Fetal Medicine Midwife: Postgraduate Certificate (PGC) in Medical Ultrasound
- International Education Midwife: Reverse Mentoring Program
- Community Manager: BSc Masters Advanced Clinical Practice
- Digital Midwife: Digital Healthcare Leadership Postgraduate Diploma
- Community Midwife: Level 7 Perinatal Mental Health Module

11. Workforce Improvements

The Head of Midwifery is working collaboratively with the Matrons, Managers, and key stakeholders to develop the below workforce improvements:

- Workforce Improvement Plan – 12 key objectives
- Management of Change – Inpatient On-Call
- Manager of the Day - Standard Operating Procedure
- Senior Management On-Call Rota

12. Birth to Midwife Ratio

The birth to midwife ratio is determined monthly using the Birthrate Plus methodology and the actual delivery rate for that month. The table below displays the real-time monthly birth to midwife ratio. This report confirms that the Trust remains compliant with the Birthrate Plus recommendations for midwife to birth ratios of 1:27:

Month 2024	January	February	March	April	May	June
Birth to midwife ratio	1:27	1:27	1:27	1:27	1:27	1:27
Total Number of Births	160	163	164	146	161	153

13.Specialist Midwives

Birthrate Plus suggests excluding 8-11% of the total establishment from clinical figures, 11% is recommendation for multi-sited Trusts. This category encompasses management roles and specialist midwives. Currently, the specialist midwife percentage stands at 9%, within the recommended range of 8-11%. The specialist midwife roles, as outlined in the Birthrate Plus report (December 2021, Appendix A), encompass a range of responsibilities including audit, staff training, perinatal mental health, infant feeding, professional midwifery advocates role, screening, smoking cessation, fetal monitoring lead, 'Saving Babies Lives' lead (now retired), Better Birth Midwife (vacant) bereavement midwife, and guidelines and audit midwife. Collectively, these roles require 8.30 WTE, aligning with the 9% application based on the clinical total WTE.

14. Birthrate Plus Live Acuity Tool

The Birthrate Plus Live Acuity Tool was introduced in stages, with implementation in intrapartum areas in 2019 and subsequent adoption in other inpatient areas in 2020.

This tool serves as a means for midwives to assess their real-time workload, considering the number of women requiring care and their condition throughout the labor, delivery, and postnatal processes. It quantifies the level of 'acuity' and is developed based on clinical indicators adapted from the well-established Birthrate Plus workforce planning system.

Unlike the previous retrospective assessment of labour processes and outcomes, the Birthrate Plus classification system is a predictive/prospective tool. The labor ward coordinator completes the tool every four hours, utilising it to gauge the complexity of the clinical situation and estimate the required number of midwives.

Aligned with NICE Guidance NG4 (2015) and endorsed by NICE, this safe staffing toolkit encompasses most aspects necessary for determining maternity staffing requirements in established settings. It not only furnishes evidence of actions taken during high acuity periods but also facilitates the implementation of the escalation policy when needed.

The tables below provides data for January to March (Quarter 4 2023/24) and April to June (Quarter 1 2024/25):

Review of Staffing Factors/Actions/Red Flags 01/01/2024 to 30/06/2024 (Scheduled Data)

Scheduled Assessments	Assessment Periods	Confidence Factor
Actual scheduled assessment periods completed	Maximum number of scheduled assesment periods available in selected data period	
864	**1092**	**79.12%**

Download

Number & % of Staffing Factors Recorded

From 01/01/2024 to 30/06/2024

SF1	Unable to fill vacant shifts	235	58%
SF2	Unexpected staff absence	128	32%
SF3	Staff on transfer duties	8	2%
SF4	Midwife scrubbed in theatre	0	0%
SF5	Staff redeployed to another clinical area	31	8%
	Total	402	

Download

Number & % of Management Actions Taken

From 01/01/2024 to 30/06/2024

MA1	Redeployment of staff from ANC	6	7%
MA2	Redeployment of staff from ANDU	17	19%
MA3	Redeployment of staff from ward	24	27%
MA4	Redeployment of staff from community	16	18%
MA5	Staff working beyond rostered hours	2	2%
MA6	Management working clinically	7	8%
MA7	Additional staff sourced from bank	9	10%
MA8	Additional staff sourced from database to work	8	9%
MA9	Maternity unit on divert	0	0%
	Total	89	

Download

15.Supernumerary Labour Ward Coordinator

The presence of a supernumerary labour ward coordinator is endorsed as a best practice to ensure safety on the labor ward. This role entails an experienced midwife who offers advice, support, and guidance to clinical personnel. Moreover, they are equipped to manage activities and workloads across the labor ward.

The maternity incentive scheme year 6 The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift. The labour ward is fully compliant with the requirements of the Maternity Incentive Scheme Year 6, specifically concerning the supernumerary status of the midwifery coordinator in charge of the labour ward. The following measures have been implemented to ensure adherence to these requirements:

16.Supernumerary Coordinator Status

Rostered Planned Supernumerary Coordinator: Our labour ward consistently assigns a supernumerary coordinator for each shift. This ensures that the coordinator is not included in the direct care staffing numbers, allowing them to focus solely on overseeing all birth activities and maintaining high standards of care and safety.
Actual Supernumerary Coordinator at Shift Start: We have instituted a robust process to guarantee that an actual supernumerary coordinator is present at the start of every shift. This practice ensures continuous and effective oversight of the labour ward operations.
Escalation Plan:

An established escalation plan is in place to address situations where the designated coordinator is unavailable at the beginning of a shift. This plan includes clear procedures for providing a substitute coordinator to ensure uninterrupted oversight and management of the labour ward.
These measures are designed to maintain and enhance the quality of care provided within our labour ward, ensuring that all birth activities are closely monitored and managed. Our compliance with the Maternity Incentive Scheme Year 6 demonstrates our commitment to upholding the highest standards of maternal and neonatal care. These actions meet and exceed the expectations set by the scheme.

17.One to One in Established Labour

Women in established labour are required to have one to one care and support from and assigned midwife, which is associated with increased likelihood of normal vaginal birth and reduced interventions and operative deliveries. While care may not be consistently provided by the same midwife throughout labour, one-to-one care remains a priority.

If circumstances prevent one-to-one care, the labour ward coordinator will refer to the acuity tool for appropriate clinical or management actions.

Please refer to the provided table for compliance details by month:

Month	January	February	March	April	May	June
Compliance	100%	98%	100%	100%	100%	100%

Between 1st January 2024 to 30th June 2024, 5 red flags were reported in relation to the delivery suite coordinators being unable to maintain supernumerary status. On review of the datix system 3 cases were reported. Each incident was investigated, and appropriate escalation protocols were upheld, ensuring minimal impact on patient care and staff performance.

Between 1st January 2024 to 30th June 2024, 4 red flags were reported in relation to the delivery suite coordinators being unable to maintain supernumerary status and provide 1:1 care.

In February 2024, 2 red flags were reported in relation to any occasion when 1 midwife is not able to provide continuous one to one care and support to women in established labour.

Following a further review on these 2 cases the below was highlighted;

1. 7th February 2024, 19:30, acuity -2.05 red. No Datix submitted.
   Delivery shift co-ordinator entered onto Birthrate plus acuity tool – " x1 awaiting ARM since 10:00. SL working in triage with MW since 18:00, discharges planned for therefore not escalated to community, nil requiring immediate intensive care.

2. 8th February 2024, 15:30, acuity -1.05 amber. Datix submitted.
   Delivery shift co-ordinator entered onto Birthrate plus acuity tool – " shift leader covering in triage while Midwife supports Lavender Suite. DAU Midwife pulled to CLS and kindly staying for LD. Risk Midwife pulled to relieve shift leader in triage, shift leader returned to supernumerary. Digital Midwife now left as shift has ended delay in triage. Nil adverse effects, staffing to improve for the night shift. Nil further TCI in triage so should improve before Risk Midwife needs to leave.

On further review of the 2 cases, neither mentioned women not receiving 1:1 care in labour. As part of the actions, the below will be implemented;

1. Re-circulate the Escalation Policy to delivery shift leaders
2. Circulate the criteria for completing a Datix for red flags
3. Manager of the Day to have the oversight and helicopter view of the service needs

18.Red Flag Incidents

A midwifery red flag incident serves as an indicator that potential issues may exist with midwifery staffing (as outlined in NICE NG4 2015). When such an event occurs, the midwife overseeing the service is promptly informed. It becomes their responsibility to assess if midwifery staffing is the contributing factor and to decide on the appropriate course of action. The collection of red flags is facilitated through the live Birthrate Plus acuity tool. From January to June 2024 there was 106 midwifery red flags recorded.

In addition, there were 9 delays in the commencement of elective sections and 171 delay's in continuing the induction of labour process.

The tables below show data for January to March (Quarter 4 2023/24) and April to June (Quarter 1 2024/25):

Number & % of Red Flags Recorded

From 01/01/2024 to 30/06/2024

RF1	Delayed or cancelled time critical activity	84	79%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	1	1%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	10	9%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	2	2%
RF10	Delivery Suite Coordinator unable to maintain supernumerary status	5	5%
RF11	Coordinator unable to maintain supernumerary status & providing 1:1 care	4	4%
	Total	106	

Download

19.Staff Health and Wellbeing

Ensuring staff health and wellbeing is crucial for delivering a safe and effective service. We have an active team of Professional Midwifery Advocates (PMA) who support clinical

supervision following the nationally recognized A-EQUIP model (Advocating for Education and Quality Improvement). This model promotes continuous improvement, personal and professional resilience, enhanced quality of care, and preparedness for appraisal and revalidation. The restorative function of the A-EQUIP model positively impacts staff wellbeing, reducing stress and burnout, improving job satisfaction, retention, and team dynamics. This model is now being extended to the nursing profession in collaboration with the Trust's Organisational Development team.

In line with the Ockenden report (2022), the Trust are mandated to establish Freedom to Speak Up Guardians (FTSU) and the Division are collaborating with the Trust's FTSU

Champion to enhance awareness and encourage the role of FTSU champions within our Maternity service, fostering open communication and a culture of continuous improvement and patient-centered care.

20.Neonatal Nursing Workforce

Evidence supports a higher nurse: baby ratio, especially of nurses with a neonatal Qualified in Specialty (QIS) qualification, for the delivery of high-quality neonatal care. National safe neonatal nurse staffing requirements are clearly defined by British Association of Perinatal Medicine (BAPM) and Department of Health Toolkit for

Neonatal Services (2010) and state that nurse to baby staffing levels on neonatal units should equate to 1:1 or Intensive Care, 1:2 for High Dependency and 1:4 for Special Care. We have continued to maintain our BAPM compliance and currently have recruited/recruiting into current vacancies and have invested in nurse training to gain Qualification in Specialisms qualification. The unit remains committed to maintain BAPM compliance.

The neonatal unit utilises the Neonatal Nursing Workforce Tool below to illustrate compliance with the BPAM (British Association of Perinatal Medicine) standards.

Neonatal Clinical Reference Group (CRG) Nursing Workforce Calculator for August 2023, Neonatal Unit, COCH

Unit details		
Trust	Countess of Chester NHS Foundation Trust	
Unit	Chester	
Designation	LNU	
Completed by		
Date completed		
Activity period	01/04/2023 -31/03/2024	365 DAYS

Activity (HRG 2016)		
	Activity	Commissioned cots
HRG 1 (IC)	54	1
HRG 2 (HD)	278	2
HRG 3 - 5 (SC)	1,848	10
Total	**2,180**	**13**

Staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	20.92	16.95
Total Non QIS	7.39	3.69
Total Non Reg	6.30	5.97
Total	**34.61**	**26.61**

Activity calculations (HRG 2016)						
	Activity	*For calculations*	Commissioned cots			

		80% of daily activity	*WTE (6.07 / BAPM)*		Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
HRG 1	54	*0.2*	*6.07*	1	14.79%	1	0
HRG 2	278	*1.0*	*3.04*	2	38.08%	1	1
HRG 3	1,848	*6.3*	*1.52*	10	50.63%	6	4
Total	**2,180**		**13**		**45.94%**	**8**	**5**

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 33.39, of which 23.37 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occupancy	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	34.61	26.61	19.69	14.92	6.92
Total reg nurses	28.31	20.64	16.80	11.51	3.84
Total QIS	20.92	16.95	11.76	9.16	5.19
Total non-QIS	7.39	3.69	5.04	2.35	-1.35
Total non-reg	6.30	5.97	2.88	3.42	3.09
Reg nurses as % nursing staff	81.8%	77.6%	85.4%		
QIS as % reg nurses	73.9%	82.1%	70.0%		

21. Assumptions

For further details please refer to narrative sheet

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses providing direct patient care only. Exclude additional roles e.g. management, outreach, education.
- Numbers are for nurses providing direct patient care only. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependency care should be undertaken by registered nurses with QIS training
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

22.Conclusion

This report confirms the Trust's adherence to biannual midwifery staffing reviews, which are required for transparent reporting to the Board of Directors. Our alignment with NHS Resolution Maternity safety actions highlights our commitment to patient safety.

The evidence presented demonstrates the robustness of our workforce planning system, ensuring safe staffing levels within the Maternity unit. Through monitoring, we consistently match staffing levels with patient acuity, enabling interventions and the delivery of optimal care. Our continuous efforts in workforce planning and monitoring confirm the commitment to providing exceptional maternal care.

23.Recommendation

The Board of Directors is asked to note the contents of this report and the assurance provided that the Trust is fully compliant with the Maternity incentive scheme year 6 safety action 5.

Countess of Chester Hospital NHS Foundation Trust

Meeting	**24th September 2024**		**Board of Directors**				
Report	**Agenda Item: 11.**		**Freedom to Speak Up Update Report**				
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information
Accountable Lead	Cathy Chadwick			Chief Operating Officer			
Author(s)	Helen Ellis			Freedom to Speak Up Guardian			
Board Assurance Framework	ALL	Linked to all areas of the BAF.					
Strategic Aims	SG2 - People and Culture SG3 - Leadership						
CQC Domains	Safe, Effective, Caring, Responsive and Well Led						
Previous Considerations	Not applicable.						
Summary	This report is intended to provide: • Comparative data outlining on the number of concerns raised and by whom, themes and trends, status and learning. • An update on the development of a Freedom to Speak Up (FTSU) Champions Network • An outline of governance arrangements • An update of Mandatory Training compliance • Plans for FSTU Month • Service Development updates						
Recommendation(s)	The Board of Directors is asked to note the contents of the report and the assurance provided that local FTSU arrangements are in place and continue to meet best practice.						
Corporate Impact Assessment							
Statutory Requirements	To ensure everyone working within the NHS feels safe and confident to speak up.						
Quality & Safety	To aim to improve the quality of speaking up arrangements across the NHS.						
NHS Constitution	Promoting equality and addressing health inequalities.						
Patient Involvement	Not applicable.						
Risk	Not applicable.						
Financial impact	Not applicable.						
Equality & Diversity	Promoting equality and addressing health inequalities.						
Communication	Once approved, this Policy will be shared with all Trust staff.						

Freedom to Speak Up

NHS
Countess of Chester Hospital
NHS Foundation Trust

1. Executive Summary

The purpose of this paper is to provide the Board of Directors with an update of the work of the Freedom to Speak Up (FTSU) Guardian and Champions in supporting the safety culture within the Trust, reflect on the progress made by the FTSU Network in empowering staff to speak up freely and to encourage ongoing positive cultural change. The paper provides an overview of issues and concerns raised in Quarter 4 2023/24 and Quarter 1 2024/25 with comparison of figures for previous quarters. These will show that significant more concerns were raised last year with a similar trend continuing during Q1 and Q2 of the current year. Poor attitudes and behaviours continues to be cited in over half of all concerns raised whilst patient quality and safety features least.

Updates from the National Guardians Office for Freedom to Speak Up are provided, with the aim of providing assurance that the local arrangements in place continue to meet best practice and support staff to raise concerns. This is done in the context of an evolving and maturing national agenda, that is learning from the collective experiences of FTSU Guardians, their champion networks and those at the National Guardian Office. A recent film for non-executive FTSU leads to support greater understanding of their responsibilities has been released and the NGO has published its key strategic aims to improve services.

Updates on the continuing growth of the Champions Network, plans for ‘’ Speak Up month’ and the rise in mandatory training compliance will be shared.

2. Background

The Freedom to Speak Up (FTSU) policy continues to be integrated at the Countess of Chester Hospital. In line with the national guidelines, the Trust has appointed a Freedom to Speak Up Guardian, whose role is to provide of an alternative channel for workers to raise concerns, ensuring that concerns received are escalated, investigated, and followed up to enhance patient safety and worker experiences.

The FTSU Guardian continues to engage and communicate with the National Guardian’s Office (NGO) and the Northwest Regional Network of FTSU Guardians to remain current and support continued learning and development. The FTSUG continues to work closely with the FTSU Executive Director, champions, and senior leaders to enable effective escalation, review and triangulation of safety and welfare concerns. Through a personal speak-up safety pledge, the Trust’s Chief Executive encourages all staff to speak up and gives assurance that any concerns raised will be investigated, and the staff will be protected from detriment because of speaking up.

The FTSU network at the Trust comprises of the FTSU Executive Director, Non-Executive Director Leads, a Freedom to Speak Up Guardian and a network of multi-disciplinary FTSU Champions.

3. Assessment of FTSU Concerns Q4 (2023/24) and Q1 (2024/25)

The Trust has several safety reporting channels such as speaking directly to line managers, incident

reporting and team and trust safety huddles. Issues raised in other channels are not logged as FTSU unless referred to or raised directly to the FTSU Guardian or champions.

In Quarter 4 2023/24 a total of 37 concerns were raised compared to 16 the previous year.
In Quarter 1 2024/25 a total of 27 concerns were raised compared to 11 the previous year.

During the last six months although the number of concerns is significantly higher than previous years the rate at which these have increased has currently stabilised.

The themes of the FTSU concerns raised are categorised in line with the NGO guidelines and detailed in the table below with comparative data from the previous year.

Comparative Themes:

Themes of concerns	**Q4 (2022\23)**	**Q1 (2023/24)**	**Q2**	**Q3**	**Q4**	**Q1 (2024\25)**
Total Number of concerns raised.	**16**	**11**	**41**	**30**	**37**	**27**
Raised anonymously.	**1**	**0**	**0**	**2**	**0**	**0**
Patient safety or quality	**4**	**4**	**2**	**10**	**17**	**8**
Worker safety or wellbeing	**4**	**9**	**19**	**20**	**23**	**14**
Bullying or harassment	**6**	**5**	**19**	**10**	**18**	**6**
Poor attitudes and behaviours	**12**	**10**	**28**	**21**	**29**	**19**
Detriment from speaking up	**1**	**0**	**1**	**2**	**4**	**0**

Although most concerns are raised by colleagues with no managerial responsibility there has been a noticeable increase in managers raising concerns over this reporting period.

In Quarter 4 2023/24 a total of 12 managers raised concerns compared to 0 the previous year.
In Quarter 1 2024/25 a total of 5 concerns were raised compared to 1 the previous year.

The table below reflects comparative data of concerns raised by professional groups, as per the National Guardian Office guidelines.

Comparison of concerns raised by different professional groups:

Professional Group	**Q4**	**Q1 (2023/24)**	**Q2**	**Q3**	**Q4**	**Q1 (2024\25)**
Staff/Porters/Catering/Security/Maintenance	**1**	**1**	**5**	**1**	**5**	**1**
Registered Nurses/ Midwives/ ANP	**6**	**3**	**13**	**13**	**16**	**7**
Nursing Assistants & Support Staff	**2**	**0**	**7**	**5**	**1**	**4**
Corporate Service Staff	**3**	**0**	**1**	**1**	**4**	**1**
Administrative/ Clerical	**3**	**0**	**11**	**2**	**4**	**7**
Doctors/Dentists	**0**	**2**	**0**	**1**	**2**	**4**
Allied Health Practitioners	**0**	**2**	**4**	**7**	**5**	**2**
Other	**1**	**3**	**0**	**0**	**0**	**1**

4. Analysis of FTSU Concerns, Actions, Status and Learning:

All concerns for this reporting period have been concluded. The main opportunities for learning were:

- Improved communication between colleagues. This presents in the majority of cases.
- Civility and respect
- Improved approach by managers to listen without bias, to remain impartial and to investigated openly.
- Improve the understanding of the importance of providing feedback when concerns are raised and the appropriate approach to take.
- To better consider the impact of poor behaviours of colleagues on team members and the responsibilities managers have in providing support rather than just referring to other services.
- Zero tolerance of poor behaviours regardless of performance.
- Removing the perception that staff will suffer detriment because of speaking up.

5. Progress on Internal Assessments and Governance

Cathy Chadwick, Chief Operating Officer and Executive lead for FTSU, and Paul Jones, Non-Executive Director lead for FTSU, continue to have executive/non-executive leadership for FTSU. The Executive lead, Chief People Officer and the Guardian convene triangulation meetings when cases of concern involve HR services. Monthly support and service review meetings between the Executive lead and Guardian are held monthly as a minimum.

The Board of Directors completed its first FTSU Self-Assessment on 6th August 2024 and an action plan that improves the FTSU offer is currently being developed and will be prioritised over the coming months with progress being reported to the Board of Directors.

FTSU reports are also submitted to the People and Organisation Development Committee bi-annually and the Audit Committee and Quality and Safety Committee annually.

6. Updates from the National Guardian Office

The National Guardians Office has recently developed a film which brings together information for Non-Executives and Trustees understand their remit, promote their role and set up positive working relationships. This has been shared with both the Executive and Non-Executive Leads for FTSU at the Trust. In July 2024, the National Guardian's Office published its six new strategic goals to achieve the National Guardian's vision, improving existing services as well as making some step changes to drive further change across the system. These are:

- Continuing to improve resources and offer to Freedom to Speak Up guardians
- Developing additional support and guidance for organisational leaders
- Using the National Guardian's independent voice to champion Freedom to Speak Up and challenge the healthcare system by raising awareness of issues which affect workers' confidence to speak up
- Using the insight gathered by the National Guardian's Office to drive recommendations to improve speak up measures and culture, for example through Speak Up Reviews, and challenging organisations to do better.
- Improving partnership working with key organisations to deliver change
- Improve the organisational maturity and internal infrastructure of the National Guardian's Office to support these ambitions.

The Countess FTSU Strategy is due for review in 2025, however this will be undertaken earlier with the first draft to be presented to the Executive Directors Group (EDG) at the end of November 2024 and shared with the Board of Directors in March 2025.

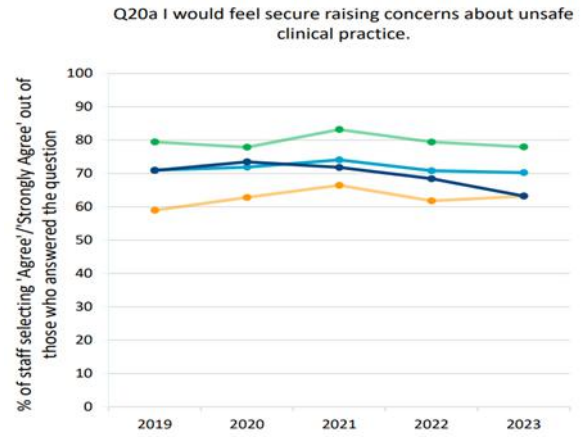
7. FTSU Mandatory Training

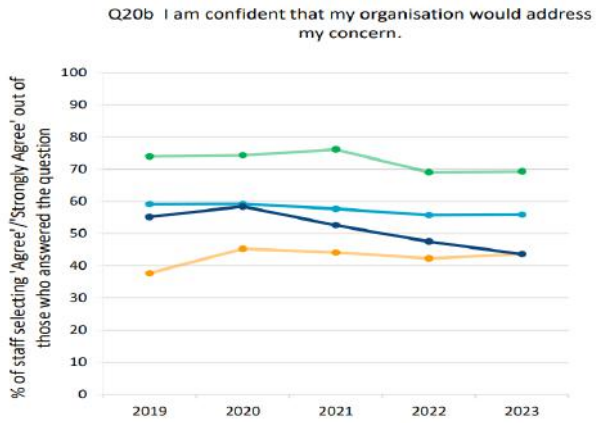
'Speak Up' staff compliance is now at 90.09% with the relatively new 'Listen Up' training compliance at 69.12%:

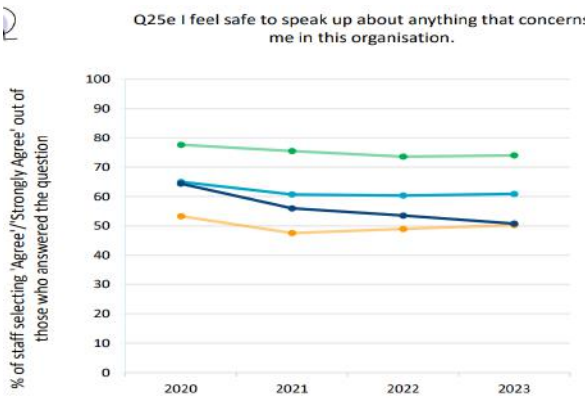
Staff Group	Speak Up Compliance %	Listen Up Compliance %
Add Prof Scientific and Technic	96.95%	77.10%
Additional Clinical Services	92.60%	70.82%
Administrative and Clerical	94.83%	76.16%
Allied Health Professionals	96.24%	77.12%
Estates and Ancillary	60.64%	36.67%
Healthcare Scientists	90.91%	58.59%
Medical and Dental	86.93%	51.15%
Nursing and Midwifery Registered	96.11%	76.60

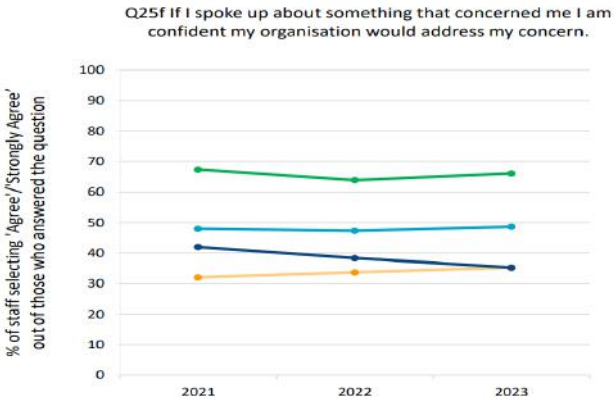
8. NHS Staff Survey

In March 2024. the NHS Survey results were published for 2023 and although the four questions within the survey do not specifically relate to Freedom to Speak Up, they do provide some insight into staff perception and therefore a valuable tool in which to consider how we might best improve our speak up culture.









Countess	Best Results	Average Results	Worse Results

In all four questions the score has not shown any significant change from the previous year indicating that we still have much to do to improve the confidence of our colleagues in speaking up. FTSU will actively contribute to the wider organisations plan to improve culture and embed speaking up as business as usual. The activities planned during October's FTSU month, continued regular staff updates and FTSU workshops for managers will be further enhance learning on how to raise concerns, the importance of meaningful feedback and increase the confidence of colleagues in the process.

9. Freedom to Speak Champions Network

This continues to grow with colleagues across many disciplines and grades now involved. Bi-monthly peer support network meetings , facilitated by the Guardian ensures all Champions have a voice that influences service planning and delivery and provides an opportunity for continued learning. A more robust method of collecting monthly data from champions about their FTSU activities was introduced in January 2024 and is working well. The annual Champions Activity Report will be shared at the next Board meeting. Currently there are 58 registered Champions listed on the FTSU intranet page.

10. FTSU Month

This October's Speak Up Month national theme is Listen Up, focusing on the power of listening, and the important part which listening plays in encouraging people to feel confident to speak up. Colleagues are being encouraged to complete their Listen Up training and make a 'Listen Up Pledge'. Throughout the month the FTSU Team will be out and about across the Trust providing an opportunity to meet as many of our colleagues as possible. Many of the Champions are planning to visit an area of the hospital that they are unfamiliar with, particularly those wards and departments that do not have an FTSU champion. Additionally, three Champions will be attending the Trust Board meeting in September to share the findings of the FTSU survey they have used within their own teams.
Information display stands will be circulated between Occupational Health and the Wellbeing Centre, Ellesmere Port Hospital, Outpatient Departments, Women and Children's, Mostyn Lodge, Emergency Dept, Staff Restaurant ,1829 Building and the Education Centre. Helene Donnelly (Culture Lead for Nuffield Health) will be co-facilitating two workshops for champions mid-October providing a further opportunity to share good practice and experiences.

11. Conclusion

The FTSU compliments existing policies and processes within the trust, providing an alternative channel for staff to speak confidentially or anonymously. The policy provides assurance that concerns will be escalated, and workers are supported during the process and investigations.

The FTSU Guardian, supported by the network of champions continue to maintain engagement with the staff to raise the FTSU profile, support staff who have raised concerns, record and follow-up cases raised and wherever possible identify and disseminate learning. Data is shared with the National Guardians quarterly. Monthly Guardian blogs continue to be posted to all staff.

The champion's network continues to grow, meaning more staff have greater knowledge of all that is FTSU and able to share with their colleagues in a way that is engaging and relevant to their area of work.

The FTSU Guardian will continue to provide quarterly and annual reports on the number of concerns raised through the FTSU Network and any common themes to the Board of Directors and the

National Guardian's Office. Learning from cases will continue to be reviewed and shared appropriately. The FTSU guardian will continue to maintain engagement with the National Office and regional networks to ensure that national updates are cascaded and implemented.

12. Recommendation

The Board of Directors is asked to note the contents of the report and the assurance provided that local FTSU arrangements are in place and continue to meet best practice.

Meeting	**24th September 2024**		**Board of Directors**				
Report	**Agenda item 12.**		**Clinical Strategy**				
Purpose of the Report	Decision		Ratification		Assurance	Information	**X**
Accountable Executive	Dr Nigel Scawn				Medical Director		
Author(s)	Jonathan Develing				Director of Strategy and Partnerships		
Board Assurance Framework	Linked to all areas of the BAF.						
Strategic Aims	SG3 - Purposeful Leadership SG4 - Adding Value SG5 – Seeking partnership opportunities SG6 - Populations						
CQC Domains	Safe, Effective, Caring, Responsive, Well Led						
Previous Considerations	Not applicable						
Executive Summary	The purpose of this report is to provide an update on the development of clinical strategies within the Trust. The report confirms the plans in place to develop a Clinical Strategy. Plans are in place to develop clinical strategies which will culminate in a facilitated workshop in October 2024. Prior to this, respective teams will complete an opportunities questionnaire which will be used pre and post the event to develop more service specific strategies. It is envisaged that an overarching Trust Clinical Strategy will then become available in quarter three of this fiscal year with all service specific strategies completed by the end of the fiscal year 2024/25.						
Recommendation(s)	The Board of Directors is asked to note the development of the Clinical Strategy.						
Corporate Impact Assessment:							
Statutory Requirements	It is a requirement that Trusts have up to date clinical strategy						
Quality & Safety	Not applicable						
NHS Constitution	Not applicable						
Patient Involvement	Not applicable						
Risk	Not applicable						
Financial impact	Not applicable						
Equality & Diversity	Not applicable						
Communication	Not applicable						

Countess of Chester Hospital NHS Foundation Trust

Clinical Strategy

1. INTRODUCTION

Since April 2024, the Trust has introduced new strategies as it seeks in its purpose to become an outstanding organisation. This includes Transforming Care Together – our corporate strategy and our Patient and family experience strategy / Women and Children's strategy.

Recognising the progress each of these strategies is now delivering there is now a need to translate our corporate objectives into an overarching clinical strategy.

2. BACKGROUND

Published in 2019, the Trust has an existing five-year clinical strategy which, given the changing context of the health and care system, our demographic growth and impact of health inequalities, now requires a fresh approach.

3. PURPOSE

The purpose of this report is to provide an update on the development of clinical strategies within the Trust.

4. CLINICAL STRATEGY DEVELOPMENT

We know that patients present in a quite different way to when the NHS was first created. Whilst we (the NHS) have adapted over time, and now in most cases operate in a multidisciplinary way, there is a need to consider future service design particularly given changing needs of the population, changes in workforce and the fragility and sustainability of some clinical services.

Our new clinical strategy will need to consider these changing dynamics alongside the wider Integrated Care Systems and the strategic approach to collaborate rather than compete with neighboring organisations.

To facilitate the development of our strategy a framework approach has been developed.

This approach is designed to be as flexible as possible whilst ensuring that each clinical strategy is not developed in isolation.

Clinical strategy will be led by clinical and operational teams, collaborating to explore, discuss, design, innovate and horizon scan future opportunities. In support, a full day's clinical summit has been sponsored and arranged for the 24th of October 2024.

At this important and future annual event teams will consider a six-step framework approach based upon:

1. Shared values – Safe, Kind and Effective
2. Guiding principles including
    a. Being driven by the needs of patients and families.
    b. Deliver services that are safe and effective aligned to the needs of the population
    c. Target areas of health inequality
    d. Take a holistic approach to health and care
    e. Take a Multidisciplinary approach
    f. Have due consideration for equality, diversity and inclusion
    g. Collaborate with partners

   h. Empower patient and families
   i. Empower staff to deliver change
   j. Be disruptive and challenge status quo
   k. Seek out innovations
   l. Continually learn and improve at every opportunity
   m. Offer value for money by aligning our population need with procedures and outcomes of value
3. Strategic Themes.
   a. Changing demographics
   b. Long Term Conditions
   c. Population health
   d. Health inequalities
   e. Prevention and early intervention
   f. Research and Innovation
   g. Partnership Opportunities
4. Clinical Priorities
   a. To be determined through the engagement and design process
5. Clinical Outcomes
   a. To be determined through the engagement and design process
6. Patient Experience – This section will consider why, what and how services will be delivered in the future including
   a. You can expect to be seen as close to home as possible?
   b. You can expect to be seen quickly
   c. You can expect to have optimal outcomes
   d. You can expect to have more seamless care

Prior to the workshop respective teams will be required to complete a template return to help develop the strategic thought process and get the most from the event.

5. CONCLUSION

Plans are in place to develop clinical strategies which will culminate in a facilitated workshop in October 2024. Prior to this respective teams will complete an opportunities questionnaire which will be used pre and post the event to develop more service specific strategies.

It is envisaged that an overarching Trust clinical strategy will then become available in quarter three of this fiscal year with all service specific strategies completed by the end of the fiscal year 24/25.

6. RECOMMENDATIONS

The Board of Directors are asked to note the development of the Clinical Strategy.

Meeting	**24th September 2024**		**Board of Directors**					
Report	**Agenda item 14.**		**Care Quality Commission (CQC) Improvement Plan including Well Led**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton		Director of Nursing & Quality / Deputy Chief Executive					
Author(s)	Sue Pemberton Laura Leadsom		Director of Nursing & Quality / Deputy Chief Executive Deputy Director of Governance & Risk					
Board Assurance Framework	BAF1	Failure to maintain quality of care would result in poorer patient & family experience						
Strategic Aims	SG1 – Patient and Family Experience SG3 - Leadership							
CQC Domains	Well Led, Safe, Effective, Responsive and Caring							
Previous Considerations	Not applicable							
Executive Summary	The purpose of this report is to provide assurance on progress with the Trusts Improvement Plan, including Well Led, in response to the regulatory breaches identified within the CQC's report and reflected within the subsequent CQC ratings. The consolidated Improvement Plan will be updated monthly to reflect reported progress, any changes to timescales and owners. This is reported via Executive Directors Group and to each Board of Directors meeting.							
Highlights	Progress has been noted, with completed actions, within the following areas: • Implementation of an effective system to ensure the assessment, prevention and management of infection prevention and control in the physical environment. • The number of mix sex breaches per month is now visible to each of the Board of Directors meetings on the Strategic Oversight Framework (SOF) report. • Review undertaken to ensure premises and environment are safe and secure. A review of all fire exits has also been undertaken. • Effective systems are in place for the safe management, storage, and monitoring of medicines including medicines administered covertly and the administration care plan is complete.							

	• Visibility and awareness of research increased including regular reporting mechanisms in place. • Discharge summit held with system partners invited to join. To note, this report includes the actions in progress only (as below) and the actions closed since the last Board of Directors held on 30th July 2024. The completed actions previously reported have been removed from this report for ease. Continued areas of focus progressing include: • Malnutrition Universal Screening Tool screening has been launched in the Emergency Department and compliance rates are under review • Review of all information available to patients (in various languages and formats) • To continue to embed the changes made to the post-operative care of women's & birthing people following obstetric surgery (initial review conducted in 2024 and outcome report is currently awaited) • Electronic Prescribing and Medicines Administration system review undertaken and training controls in place whilst stronger system controls are sought. • Electronic Patient Record optimisation and upgrade programme underway • Directorates and Divisions to develop enabling strategies. • Trial of out of hours stroke service provision extended until midnight as a pilot • Review of the Governance Handbook • A review of 7-day services • Coronial cases governance • Review of all equipment being undertaken to ascertain that it is fit for purpose. • Anti ligature Policy in development. • Review of Risk Management Strategy and processes • Out of date policy review • Employee engagement plan • Statutory and mandatory training compliance • Further audit of waiting lists (Referral to Treatment and Non-Referral to Treatment) • Review of Allied Health Professionals workforce and medical staffing • Review of medicines prescribing policy • Sepsis screening improvement plan in place • Work is progressing on the four Staff survey priorities.

	• CQC registration Tarporley Hospital (awaiting CQC confirmation) – CQC have now visited Tarporley and the Trust is awaiting feedback.
Recommendation(s)	The Board of Directors is asked to: • Note the assurance on the progress of the consolidated CQC Improvement Plan. • Note that progress against this action plan will continue to be tracked through the Executive Directors Group and reported to the Board of Directors, together with outcomes also being reported going forward.
Corporate Impact Assessment	
Statutory Requirements	Trust compliance with the CQC regulatory framework, Provider License and Code of Governance.
Quality & Safety	Improved compliance across the CQC Domains
NHS Constitution	Improve quality and safety by striving for the highest standards of excellence and professionalism, working together for patients, respect and dignity, commitment to quality of care and compassion.
Patient Involvement	Patient Experience and Staff Feedback is a key driver for change which has been linked to the delivery of specific milestones within the improvement plan which is now in progress.
Risk	Various risks included on Board Assurance Framework (BAF) and risk registers.
Financial impact	Not applicable.
Equality & Diversity	Meets Equality Act 2010 duties & Public Sector Equality Duty 2 aims and does not directly discriminate against protected characteristics.
Communication	This has been shared with the Executive Director Group.

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

Updated: 17th September 2024

Completed	On track	Behind schedule	Not achieved

Summary of actions progressing

Actions progressing

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

CQC 23/24 Reinspection: Improvement Areas Identified

Countess of Chester Hospital NHS Foundation Trust

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

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

Improvement Area 3 – Director of Nursing
- Infection Prevention

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

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

Improvement Area 5b – Medical Director
- Clinical Audit

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

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

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

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

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

Improvement Area 10 – Medical Director
- Safe Medications

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

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

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

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

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

Improvement Area 11f – Chief Digital Officer
- Information Governance

Action Plan:

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

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M1	Patient Experience & Staff Feedback	TW	The trust must assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service in line with the regulations.	SP	~~Sep-24~~ Review Oct 24	• Patient and Family Experience Strategy Launch Quality & Safety Strategy	• Improvement programme (Harms) demonstrating improvements • Quality and Safety strategy being developed • Monthly Harms Oversight Group commenced – quarterly reports and annual reports planned for QGG • Patient Experience Vision posters available on all ward areas, vision embedded. • Monitoring outlines previously • Patient Experience included in ward accreditation process • Two patient experience engagement undertaken where patients attended the hospital.	• Inpatient Survey Results • Patient Experience results • Complaints • Concerns • FTT • PFE launched • Patient and Family Experience Strategy launched • Quality Account published	• Q&S Committee	• Patient and Family Strategy • Quality & Safety Strategy • Quality Account • SOF dashboard
M6	Registration	TW	The trust must implement effective systems to comply with the requirements of CQC registration. The system must ensure services are provided from locations which have appropriately added to the trust's registration.	SP	~~Jun-24~~ Review Sept-24	• Update SRO and include registration of Tarporley Hospital. • Review if action has been complete.	• Identified lead for CQC – DON • Currently with CQC to action Visit from CQC undertaken at Tarporley Hospital in line with registration process on 11/09/2024 – Outcome is awaited.	Awaiting confirmation from CQC.	• Q&S Committee	• CQC Registration Documenta-tion

Action Plan:

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

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

Action Plan:

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

NHS Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M11	Risk & Complaints Manage-ment	TW	The trust must implement an effective system to identify, report and learn from incidents involving the use of restrictive interventions including restraint and rapid tranquilisation.	SP	~~Sep-24~~ Review Oct 24	• Refer to Section 29a Reg 17 Governance Action Plan. • Implement daily review of incidents per division supported by the Deputy Director of Nursing and Governance. • Review with the Director of Risk, Governance and Improvement the Organisational Learning Policy to ensure it is fit for purpose. • Review the incidents relating to restraint and rapid tranquilisation to ascertain themes. • Ensure the trust policies in relation to restraint and rapid tranquilisation are being followed. • Review in progress regarding commencement of Safety Surveillance and introduction of a Risk management committee.	• Daily review of incidents by DDoN and escalation route through Daily exec led Site meeting • Daily review of incidents by division • Weekly Patient Safety learning meeting • Weekly Patient Incident Oversight group. • Monthly Safety Surveillance steering group commenced in August 2024 which will replace the weekly patient safety incident group • Harms Improvement Oversight Group commenced in August 2024 – quarterly reports and annual reports planned for QGG. • Violence and aggression steering group had first meeting; new terms of reference written • Review of Risk Management meeting underway • Reduction in complaints – weekly monitoring .	• Patient Safety Learning Group • Patient Oversight Group • Learning & Sharing • Organisational Learning Policy • Incident Reporting • Security reports to Think Family Group • ICB engagement and attendance at incident oversight meeting	• Q&S Committee • Think Family Group	• Integrated Incident, Complaints & Claims Report

Action Plan:

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

NHS Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M12 M13 S8	Patient Assessment	TW UEC	The trust must ensure service user records are audited appropriately to evidence that reasonable adjustments are in place to meet the needs of patients living with complex needs such as dementia, learning disabilities and mental health and to identify missed opportunities to safeguard patients and ensure ongoing compliance (e.g. Mental Health Capacity Act).	SP	~~Aug-24~~ Review Oct-24	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Develop strategy for patient with additional needs - **In draft** • **Safeguarding EPR tool (admission screening tool) devised awaiting input into EPR** • **Relaunch Complex Care Passport.**	• **Reasonable Adjustment strategy in Draft awaiting approval.**	• Safeguarding Task & Finish Group • Incidents • Complaints • Inpatient Experience Results • Complex Care Assessments • Think Family Meetings • Learning Disability Standards • Mental Capacity Assessment Compliance	• Q&S Committee	• Safe-guarding Quarterly Assurance Reports to BoD • National Inpatient Survey Results
M21	Risk & Complaints Manage-ment	MED	The trust must ensure the risks presented by gaps in the out of hours stroke service are effectively assessed and mitigated.	SP	~~Sept-24~~ **Review** **Oct-24**	• Develop business case to mitigate risks and submit to EDG for review	• Business case to mitigate against risks has been collated. • **Trial of service till midnight 7 days** • **Collaborative venture re regional stroke service.**	**Service provision has been extended until midnight as a pilot**	• Q&S Committee	• **EDG for Decision-addressed internally by division**

Action Plan:

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

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M47 S11	Patient Assessment	CYP MED	The trust must ensure that appropriate nutritional risk assessments are completed for anyone with specific dietary requirements or anyone with social, religious, or cultural needs. That there is a nationally recognised screening tool to monitor patients at risk of malnutrition within clinical audit.	SP	Review Sep-24	• MUST screening to be launched in ED.	• Scales purchased for ED • Mealtime coordinators in place across all wards. • Nutritional risk assessments should be undertaken for all patients – this needs improvement as compliance is low. The compliance and outcomes for this are monitored at the Nutrition and Hydration Steering Group. • When assessing the current food provision against the British Dietetic Association standards the Trust recognised itself as partially compliant in this area. Work is underway to review the establishment within the dietetic team to address how these areas of non-compliance can be addressed. • The Trust has yet to fully demonstrate the BDA standard of "Existence of a menu planning working group, meeting minutes and/or project planner. Evidence must show involvement of Registered dietitian throughout the process. Patient satisfaction surveys and patient involvement.	• Nutrition Support Group • Senior Nurse Meetings • Must Assessment Compliance • Patient Survey Results • Patient Experience Strategy • Complaints	• Q&S Committee	• OMB • QGG • SOF • Nutrition Annual Report to BoD

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

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S3	Patient Experience & Staff Feedback	TW	The trust should implement effective patient engagement in the development of the trust's services.	SP	~~Aug-24~~ Review Oct 24	• Planned engagement sessions for 2024 • Launch Patient and Family Experience Strategy (Apr-24) • Launch Quality & Safety Strategy (Sep-24)	*Linked with M1.*	• Patent Survey Results • Patient Experience Six Steps Monitoring • Healthwatch Feedback • Complaints and concerns • Friends and Family Test	• Q&S Committee	• Patient and Family Strategy • Quality & Safety Strategy • National Inpatient Survey Results
S9 S20	Patient Experience & Staff Feedback	MED CYP	The trust should ensure that health promotion and information is available in all departments is available in languages other than English, in child friendly versions, and in alternative formats.	SP	Mar-25	• Review of all information available to patients and ensure that they are all available in all languages.	Review of translation services underway- update provided to the Quality & Safety Committee held in September 2024.	• Patient Experience Operational Group	• Q&S Committee	• Q&S Assurance Report to BoD

Action Plan:

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

Countess of Chester Hospital NHS Foundation Trust

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

Action Plan:

Owner: Cathy Chadwick – Chief Operating Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M19	Reporting	MED	The trust must seek to eliminate mixed sex accommodation breaches and must identify and report mixed sex accommodation breaches appropriately for all inpatient settings	CC	Review Sep-24	• See Patient Flow / UEC Improvement Plan • Mixed sex reporting to be included within the trusts SOF and monitored monthly.	The number of mix sex breaches per month is now visible to each of the Board of Directors meetings on the Strategic Oversight Framework (SOF) report. **Complete.**	• Wards Task & Finish Group • Patient Flow Working Group • KPIs / UEC Dashboard • Monthly SOF report provided to the Board of Directors and sub-committees.	• Q&S Committee	• EDG • OMB • SOF
M20 M54	Patient Flow & Perfor-mance	MED EPH	The trust must ensure that effective and timely care is provided; to improve patient access and flow through the hospital to safe discharge or transfer to other appropriate services.	CC	Review ~~Sep-24~~ Nov-24	• See Patient Flow / UEC Improvement Plan	The Trust is holding a discharge summit in September 2024 where system partners will be invited to join. The revised UEC improvement plan has a focus on improving ward processes, which the Deputy Director of nursing is leading on. ECIST, GIRFT and AQUA all gave improvement ideas which have been added to the plan. The Trust continues to try further engage with BCUHB and Flintshire LA, however meetings have not been attended.	• Complaints • Patient Flow Working Group • KPIs / UEC Dashboard • System Improvement Board • OPELG	• F&P Committee	• EDG • OMB • SOF • SIB Exit Criteria

Action Plan:

Owner: Jason Bradley – Chief Digital & Data Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M30	Medica-tions	UEC	The Trust must be assured that medicines are being stored securely and administered safely as per manufacturing guidance.	JB	Review Dec-24	• Refer to Section 29a Reg 17 Governance Action Plan. • Evaluate EPR and the potential risk for double dosing medications. • Develop EPR solution to ensure the safe administration of medications.	• EPMA system review undertaken to identify the cause of the potential double dosing risk identified. Cause identified as attributable to users recording late administration of doses against future doses rather than recording as 'drug not give' and then undoing this once the dose becomes available. Training control in place whilst stronger system controls sought.	• Medicine Safety Group • Digital Transformation Group • EPR Programme Board • Incident Reports	• Q&S Committee	• Annual Report for Medicine Safety

Action Plan:

Owner: Jason Bradley – Chief Digital & Data Officer

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NHS Foundation Trust

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

Action Plan:

Owner: Jon Develing – Director of Strategy & Partnerships

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M7	Strategy	TW	The trust must ensure strategies designed to support the delivery of the trust's new overall strategy are completed, implemented, and monitored to ensure their effectiveness.	JD	Mar-25	• Enabling strategies in support of the overall Trust strategy will be developed during 2024/25. These will align with the 6 strategic goals to provide a golden thread ensuring that all parts of the organisation are supporting the same direction of travel	The Trust strategy has been approved and prepared for wider consultation and launch. This included Team Brief (July 2024) and a series of events and bulletins, screensavers, intranet slider and pubic facing website content including social media. Publications are to be included within MP briefing stakeholder and Countess Matters In addition, new vinyl's are being developed to adorn strategic placement across the hospital. Following this launch, the work will continue to progress the further enabling strategies.	• Delivery of the strategic goals and objectives within the overall Trust are a core component of respective executive Director portfolios and will be reported to the Board of Directors on a quarterly basis. • Trust Strategy approved in June 2024. • Launch of the women & children's strategy in July 2024.	• BoD	• BoD • OMB • EDG
M10	Auditing	TW	The trust must ensure there is effective oversight of the quality and safety of care provided to patients with mental health needs.	JD	Dec-24	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Review and refresh the Mental Health Group. • Develop a Trust Wide Mental Health Strategy.	• The Director of Strategy & Partnerships is now part of the Mental Health and Community services collaborative. • The collaborative is currently looking at the provision of safe spaces within hospitals including the use of 136 designate services. • Mental health collaborative group (CWP and COCH) have now developed an action and work plan for 2024/25. • The Trust has agreed a secondment with CWP to commence a 4-week programme looking at the wider implications of mental health within the hospital and at Ellesmere Port hospital. This review will include mental health provision in ward areas as well as in the emergency department and focus on patient and staff safety.	• Mental Health Steering Group • Datix Reporting • Learning Outcomes from Complaints • ED Safety & Quality Update	• Safe-guarding Committee • Q&S Committee	• Safe-guarding Quarterly Assurance Reports to BoD • Q&S Assurance report to BoD

Action Plan:

Owner: Jon Develing – Director of Strategy & Partnerships

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S1	Strategy	TW	The trust should implement effective systems to identify and plan services to address health inequalities.	JD	Nov-24	• Health Inequalities is a specific objective within the Trust strategy and part of the Director of Strategic Partnerships portfolio. • A bespoke approach will be developed in the first quarter of this year – this will include use of CIPHA/PHE Fingertips/Trust PTL/JSNA and NHS Benchmarking tools.	• Outline approach to health inequalities to be reported to the Board of Directors to be held in Quarter 3 2024/25.	• Waiting list Performance Reporting • Cheshire West Partnerships Board	• F&P Committee • External Cheshire West Partnership Board	• BoD • OMB • EDG

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Out comes	Committee	Assurance
M17 M53	Environ-ment inc. Equipment	MED EPH	The trust must ensure that fire exits are clear from obstruction and well maintained.	KE	~~Aug-24~~ Review Oct-24	• Fire audits to be conducted trust wide. • Full review to be undertaken of all fire exits across the Trust and spot check to be implemented into the PLACE Lite and annual PLACE Review.	• As part of the annual Fire Risk Assessment (conducted by the Trust's Fire Safety Officer), the Fire Exit doors are checked to ensure that they are operable (see FRA Section 3 Fire protection Measures attached). Ward 45 is the last ward to be assessed this year and shall completed week commencing Monday 16th September. So far, the assessment has confirmed that all Fire Exits doors are in sound operable condition. Each month, the respective ward based Fire Warden completes a 'Fire Safety Audit' against a standard check-list. The completed form is retained on the ward in an evidence folder, and any issues requiring resolution are escalated to Estates. A monthly fire safety audit of their areas is completed, and a checklist is used as a reminder of what they should be reviewing. This includes Means of Escape, Fire Fighting Equipment etc. [Fire Warden Checklist (Proposed)]. As a continuous improvement, to better capture assurance and be able to assess compliance, Estates are proposing to move to an on-line reporting system (similar to the water flushing) that will be required from each ward on a monthly basis, and be compiled into a report. Initial conversations about how this would be achieved have been had with Business Intelligence and a new, simpler check-list has been created [Fire Warden Checklist (Proposed)]. The aspiration is to go live with the new system before the end of the year.	• Update to F&P • Fire Safety Reporting to F&P	• F&P Committee	• F&P Assurance Report to BoD • Fire Safety Compliance Report to BoD
M28 S19	Environ-ment inc. Equipment	UEC CYP	The trust must ensure that there is sufficient equipment that is maintained to keep patients safe including but not limited to resuscitation equipment.	KE	~~Sep-24~~ Review Oct-24	• Trust wide review of all equipment used to ascertain that it is fit for purpose and that there is satisfactory levels of equipment required across all areas and incorporate how medical equipment is checked and maintained.	• Assurances received at the Trust Medical Devices Group held in July 2024 for the medical devices maintained by the Clinical Engineering Dept (EBME) Risk Assessment and action plan agreed through Deputy Medical Director and Deputy Director or Nursing & Quality Governance around limited Medical Device assurances - This is to be presented at the Quality Governance Group to be held in October 2024.	• Asset register and report to F&P Oct-24 and then monitoring quarterly	• F&P Committee • Quality Governance Group	• Resuscitation Assurance Reports • F&P Assurance Report to BoD

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring	Committee	Assurance
M29 M45	Environ-ment inc. Equipment	UEC CYP	The trust must ensure premises and environment are safe and secure. This includes but is not limited to ensuring storeroom doors are not left open or unlocked and hazardous substances, COSHH cleaning chemicals and oxygen cylinders are safely stored and accessible only to staff.	KE	Sep-24	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Full review to be undertaken of all storage across the Trust and spot check to be implemented into the PLACE Lite and annual PLACE review	• Domestics Teams briefed on importance of securely closing DSR/ Cleaning Cupboards when exiting (recorded Tool-Box talk given). Also part of induction of new staff. • Domestics Shift-Supervisors undertake checks to confirm that Cleaning Cupboards and DSRs are securely closed. • Key-Code security locks fitted to cupboard doors to restrict unauthorised access. • The Trust Security Team also undertake a check of the same doors as part of their standard patrol. **Completed.**	• Matron Audits • Incidents	• F&P Committee	• F&P Assurance Report to BoD • PLACE Assurance Reports
M32	Environ-ment inc. Equipment	UEC	The trust must ensure that patients identified with a mental health condition are cared for in a safe ligature free environment and have appropriate risk assessments completed.	KE	~~Sep-24~~ Review Oct-24	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Trust wide review of ligature risks to be conducted to ensure the environment is safe for patient care • Development of an Estates Strategy	• Clinical SoP in-place to identify and risk assess patients entering ED that present a potential self-harming risk. • Anti-barricade door systems fitted to all WC doors in ED to enable rapid access should a patient be suspected of self-harming inside. • New and improved Anti-Ligature Policy now developed and ratified. Timing schedule for conducting Ligature Assessments in-place. Upon successful award of UEC ACTIF Funds - a new Mental Health Equalities Area to be created within the ED footprint to provide improve care and support to people with mental health issues (to be implemented before the end of the 2024-25 financial year).	• EDG • OMB	• Q&S Committee • F&P Committee	• Safe-guarding Assurance Report to BoD • Estates Strategy

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M39	Environ-ment inc. Equipment	MAT	The trust must ensure the maternity theatre, birthing rooms and room 15 are serviced, maintained, and fit for purpose in line with best practice guidance.	KE	~~Sep-24~~ Review Oct-24	• Full review to be undertaken of maternity theatre, birthing rooms and room 15 to ensure fit for purpose in line with best practice guidance. • AFPP review to commence.	• Critical plant verification (annually) to undertaken in accordance with HTM 03. • CLS, and Birthing rooms 5-15, annual critical plant verifications undertaken. • 6 Monthly Entonox environmental monitoring to ensure daily exposure limits are not exceeded. • Water safety temperature checks completed in accordance with HTM-04. • AFPP review conducted June 2024 – this involved reviewing maternity theatres – Draft report received and to be presented to EDG, OMB(to be held in October 2024) and the Board of Directors to be held in November 2024.	• AFPP Review Report • Matron Audits	• F&P Committee	• F&P Assurance Report to BoD
M40 M48 S4 S22	Environ-ment inc. Equipment	MAT CYP MED EPH	The trust must ensure that a robust system is in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and ensuring premises are safe and for their intended purpose.	KE	Review Oct-24	• UEC Improvement plan • Full review of the trust premises to ensure fit for purpose in line with best practice guidance.	• H&S audits not achievable with current resource levels. (This gap is identified on the H&S action plan). • The Trust have employed Knifes to undertake a • 6 Facet Survey of the acute estate and the final version of the survey has now been received.	• Health Safety Audits • Patient Flow Working Group • KPIs / UEC Dashboard • System Improvement Board • Outcomes?	• F&P Committee • Q&S Committee	• EDG • OMB • F&P and Q&S Assurance Reports to BoD

Action Plan:

Owner: Karen Edge – Chief Finance Officer

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

Action Plan:

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

Countess of Chester Hospital NHS Foundation Trust

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

Action Plan:

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

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M43	Policy Manage-ment	MAT	The trust must ensure that policies and procedures are reviewed and follow national guidance.	KW	Review Dec-24	• Review of all documents on SharePoint as policies. • Revise internal process for updating / removing / amending documents on SharePoint. • Further communications across the Trust to embed the processes.	• The Continuous Improvement Team have commenced the cleanse of policy documents on Sharepoint with an initial position statement reported via EDG. • A process has been established to monitor progress and escalate the position through EDG. • Further work is required to deliver these improvements. • Progress updates provided via the Audit Committee (last held in July 2024).	• Board of Directors • Sub-committees	• Via the relevant Committee dependant on the policy document	• EDG • Audit Committee

Action Plan:

Owner: Debbie Herring – Interim Chief People Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M8	Patient Experience & Staff Feedback	TW	The trust must ensure staff feedback is captured and responded to appropriately to identify risks and drive improvement in services.	DH	Dec-24	• To design a staff experience strategy/ cultural development programme that improves staff satisfaction and supports staff in the delivery of high-quality services. Its focus will be to: • Embed all elements of the NHS People Promise • Embed the Trust values & behaviours (Civility Charter) • Support all aspects of the employee lifecycle	Staff survey 2024 preparations are underway, including a review of developments in response to 2023 survey outcomes. Review developed with a communication plan to support promotion of all activities impacting staff improvement. People Strategy scoping to map staff experience /People Promise measures pending refresh (link to exemplar programme). Improvement in People Pulse participation rates and outcomes including wellbeing support and involvement. People Promise branding is being used across corporate communications and further staff communications are being developed for rollout in Quarter 3 2024/25. Action Plan for remainder of exemplar programme in development.	• Paper to EDG outlining actions and next steps including the development of a Civility Charter and training modules • Monitoring to take place at Divisional level, also at EEWG, OMB, POD according to meeting schedules • People Pulse	• POD	• EDG • OMB • Partnership Forum • EDG • Engagement as standing item at POD Reporting calendar established linked monitoring process Escalation of issues to EDG (on-going) • Staff Survey Results / Action Plan

Action Plan:

Owner: Debbie Herring – Interim Chief People Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M15 M35 M36 M51	Training	MED UEC EPH	The trust must implement an effective system to ensure that all staff have the skills, knowledge, experience, and appraisal to care for and meet the needs of patients within their service area.	DH	Dec-24	Review induction programme and content. Review local induction process and format. Develop minimum competencies for staff groups. Align competency set to ESR and staff groups. Review training provision and capacity. Appraisal paperwork under review.	• New Welcome induction event now in place. • New appraisal process developed and implemented. • Training Needs Analysis and minimum skills competencies to be reviewed October 2024. • Additional training dates have been provided to ensure capacity meets demand. DNA rates are monitored and managers informed of staff DNAs.	• New welcome induction event • Training capacity reviewed and increased • New appraisal paperwork launched	• POD	• SOF • OMB • Staff Survey Results / Action Plan

Action Plan:

Owner: Debbie Herring – Interim Chief People Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M22	Training	MED	The trust must ensure that staff receive conflict resolution training in a timely manner, as is necessary to enable them to carry out the duties they are employed to perform.	DH	~~Sep-24~~ Revised Dec 24	Undertake TNA with SME. Liaise with external trainer regarding training dates and capacity for F2F training. Link competency to relevant staff on ESR. Increase communication to divisions on compliance through OMB and HRBPs.	• TNA completed • Additional dates added on ESR to increase capacity. • Monthly alerts to divisions – **Current compliance is at 65.1% (as at 13/09/24) -** aim to reach Trust compliance target of 90% by end of Dec 24.	• Monthly compliance reports sent to all divisions and accessible on 'S' drive. • Current compliance is at 65.1% (as at 13/09/24)	• POD	• SOF • EDG • OMB
M44	Training	CYP	The trust must ensure that mandatory training (including safeguarding) compliance meets the trust target.	DH	~~Sep-24~~ **Revised Dec 24**	Review TNA for level 3 safeguarding Review capacity meets demand for all face-2-face sessions. Provide additional sessions for basic life support. Provide enablers for those staff with limited access to PCs to undertake eLearning. Increase communication to divisions on compliance through OMB and HRBPs.	• Face-2-face sessions. implemented for non-clinical staff. • Promoted access to PC's in the library and supported provided from library staff for accessing ESR and eLearning. • **Latest overall Trust compliance is 88.48% (as at 13/09/24). Aim to reach Trust compliance target of 90% by end of Dec 24.**	• Monthly compliance reports sent to all divisions and accessible on 'S' drive. • Latest overall Trust compliance is 88.48% (as at 13/09/24) • Divisions have been provided detailed reports on areas that need compliance improvement. • **Safeguarding level 1 &2 is at or above 90% target. We are now focusing on an improvement in trajectory for**	• POD	• SOF • EDG • OMB

Action Plan:

Owner: Nigel Scawn – Medical Director

NHS
Countess of Chester Hospital
NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M5	Patient Flow & Perform-ance	TW	The trust must ensure patients waiting to receive treatment after a referral are clinically reviewed and validated	NS	Review Jan-25	• Refer to Section 29a Reg 17 Governance Action Plan. • Representation at the Surgical Risk Programme Group. • Any patient seen in outpatients who appears to have come to harm due to their wait should be recorded within Datix and investigated. • Any patient who attends ED for harm consequently for the condition that they are awaiting treatment should be recorded within Datix and investigated. • Implement C2AI (prediction tool) to prioritise surgical patients.	• Datix reporting. • Regular submission of data to C2AI commenced and first cohort (orthopaedics) of patients of increased risk is now received. Process rolling out to further specialities across the Trust. • Quarterly waiting list harms audit (ED) in July 2024 presented to August 2024 QGG. • Data quality issues remain for patients particularly on the non RTT list and actions to address this is being explored.	• Daily Safety Huddles • Divisional Governance Groups • Incidence Report • Serious Incident Reports	• Q&S Committee • F&P Committee	• Integrated Incident, Complaints & Claims Report • Q&S and F&P Assurance Reports to BoD

Action Plan:

Owner: Nigel Scawn – Medical Director

NHS
Countess of Chester Hospital
NHS Foundation Trust

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

Action Plan:

Owner: Nigel Scawn – Medical Director

NHS
Countess of Chester Hospital
NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M26	Safe Staffing	UEC	The trust must ensure that medical staffing levels, with the right qualifications and competencies, are safe for the numbers of patients in the department.	NS	Oct-24	• See Patient Flow / UEC Improvement Plan (Nursing and Medical). • Case for expansion of medical staff numbers to be developed. • Review roles and responsibilities of allied professionals to support triage and UTC.	• Linked to Well Led 7.2 • Case presented and agreed to EDG and OMB. • Additional consultant appointments made and planned further vacancy to recruit to in April 2025. • Additional medical lead for UTC in post. • UTC & minors now moved to upstairs within SDEC to improve numbers and flow. • Review of AHP workforce and medical staffing currently being progressed.	• Patient Flow Working Group • Streaming Task & Finish Group • KPIs / UEC Dashboard • System Improvement Board	• F&P Committee • POD Committee	• EDG • OMB • SOF

Action Plan:

Owner: Nigel Scawn – Medical Director

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S6	Medica-tions	MED	The trust should review the prescribing of medicines that control distressed behaviour to ensure the policy is followed and monitoring is completed.	NS	**Review Oct-24**	• Review the policy and education for relevant teams	• The policy is under review and being expedited for approval imminently.	• Incident Reporting • Mental Health Steering Group	• Q&S Committee	• Q&S Assurance Report to BoD

Action Plan:

Owner: Nigel Scawn – Medical Director

NHS
Countess of Chester Hospital
NHS Foundation Trust

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

Well Led Action Plan – KLOE 1

KLOE 1	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
1.4	• Develop a quality and safety strategy	Director of Nursing & Quality /Medical Director	**October 2024**	This is on track and will be completed by October 2024 following the launch of the overall refreshed Trust Strategy.		High
1.8	• Continue to embed quarterly divisional performance meetings (FM Governance report 2019 REC 18) • Review format and timing for divisional performance meetings alongside the Operational Board agenda	Director of Governance, Risk & Improvement / Chief Operating Officer	~~September 2023~~ ~~Revised August 2024~~ **Revised December 2024**	Performance reporting has been established to each OMB. The COO is also developing an approach to reintroduce Quarterly Divisional Reviews. The proposed approach was agreed at EDG and the COO is establishing the plan for quarterly reviews to commence in Quarter 3 2024/25.		High

Action Plan – KLOE 2

KLOE 2	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
2.2	• All divisions to work towards the development of their respective strategies	Director of Strategic Partnerships	~~October 2023~~ ~~March 2024~~ ~~May 2024~~ **Revised October 2024**	Clinical Strategy Development Day is scheduled for 24th October 2024. Following this the work will continue to progress the further enabling strategies.	Trust Strategy was approved in June 2024. The Women's and Children's Division strategy was launched in June 2024.	Medium
2.3	• Develop a five year financial strategy	Director of Finance	June 2023 – first draft Draft in line with ICB requirements ~~Revised April 2024~~ ~~September 2024~~ **Revised October 2024**	Final 24/25 financial plan submitted in May 2024 in line with national deadlines. The financial plan has been co-ordinated with Cheshire & Merseyside ICB and national financial planning. Further work is to be undertaken on the 5-year financial plan to provide more detailed financial plan following completion of the Trust strategy and Clinical Services strategy.	Final 24/25 financial plan submitted in May 2024 in line with national deadlines.	High
2.5	• Review and rationalise the divisional governance arrangement to allow for a single operational approach to divisional governance to provide consistency and uniformity in the meeting and reporting arrangements • (FM Governance report 2019 REC 16)	Director of Governance, Risk & Improvement	~~September 2023~~ ~~Revised August 2024~~ **Revised October 2024** (The Governance training delivered to senior leaders by Facere Melius in 2022 was to embed 2019 FM Governance Improvement findings around governance arrangements, but think this needs revisiting for new OMB members/divisions)	A map of sub-committee groups is currently being developed which has been shared with EDG and is currently being finalised with a view for this to be reviewed and actions agreed in October 2024. Governance and assurance slides developed and shared with Executive Directors and Non-Executive Directors. Further sessions planned with Operational Teams and as part of the Leadership Programmes to be held in September / October 2024. New report template and guidance has been developed and to be circulated in September 2024.	Map of sub-committees and new report template & guidance to be rolled out Trust wide, with training to support.	Medium

Action Plan – KLOE 2

KLOE 2	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
2.6	• Develop supportive strategies mental health, E and I and estates and facilities, well being	Medical Director Chief Operating Officer Director of HR	June 2023 – well- being strategy Mental health – November 2024 EDI I - completed Estates and facilities – November 2024 ***Revised dates for all strategies to be confirmed following launch of overall Trust Strategy.***	Wellbeing Hub now open. Wellbeing annual report that reviewed activity against wellbeing strategy objectives, including mental health support was submitted to POD Committee April 2024. Further supportive strategies in progress.		Medium
2.9 (moved from KLOE 4 ref: 4.3)	• Develop and refresh a new Trust Strategy • Engagement and awareness of new strategy • Establish Annual objectives and priorities (FM Governance Report 2019 REC 8)	Director of Strategic Partnerships	~~July 2023~~ ~~Revised January 2024~~ **Revised March 2025**	**Refer M7.** The Trust strategy has been approved and prepared for launch. This included Team Brief (July 2024) and a series of events and bulletins, screensavers, intranet slider and pubic facing website content including social media. Publications are to be included within MP briefing stakeholder and Countess Matters In addition, new vinyl's are being developed to adorn strategic placement across the hospital . Annual objectives and priorities agreed and linked to the BAF and Executives objectives.	Launch of Trust strategy.	High

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
3.2	• Staff survey feedback needs full analysis and clarity required on the key changes that need to happen as a result. Trust wide engagement sessions need to be held within April/May to meet face to face with all staff to demonstrate that the Trust is listening and taking on board their feedback. • Delivery of staff survey action plans	Chief People Officer	~~May 2023~~ ~~November 2023~~ ~~April 2024~~ ~~Revised September 2024~~ **Revised November 2024**	Zero abuse promotional programme to commence Autumn 2024 (build on Civility Charter). Staff recognition – Team/Employee of the month awards commenced. Culture & Civility Handbooks developed and launched as both online flipping book and pocket handbook to be circulated to all staff. Training offered as drop in and team based sessions, with many teams requesting sessions. Sessions included on all internal leadership programmes. New appraisal documentation, guidance notes and training has been developed, launched and is in use within the Trust in all areas.	Staff awards now in place Launch of Culture & Civility handbooks Further training in place	High

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact Rating
3.3	Implement the recommendations from the recent risk management review March 2023	Director of Governance, Risk & Improvement	~~October 2023~~ ~~Revised to end of Quarter 2 2024/25~~ **Revised October 2024**	Monthly reports are now shared with EDG and then feedback provided to the Divisions in relation to their risks. Risk updates also continue to be updated via the Operational Management Board. A High Risks report is provided to the Board of Directors and sub-committees. The Trust's Risk Management Policy and Procedure is currently being reviewed together with a review of the Trust's approach to Risk Management training. A process is also being developed for regular reviews of the risk register and to develop assurance reports via the relevant governance structures. Workshop to be held to agree priorities for Datix development (within October 2024) with a view to establish a Risk Management Committee to provide clear oversight on the effectiveness of risk management within the Trust.		High
3.5	• Provide a trajectory plan trust wide (supported by divisions) for all areas to achieve trust targets for all of mandatory training. To be monitored through Operational Management Board. • Mandatory training performance to achieve target	Chief People Officer	~~June 2023~~ **Review December 2024**	Work completed with ESR within the Training department. Divisions to now monitor compliance at their level and release the staff to attend with a planned target to achieve 90% compliance by the end of December 2024. Mandatory training compliance improved to 88.48% and capacity increased.	Mandatory training compliance improved to 88.48%.	High

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
3.6 (moved from KLOE 8 Ref: 8.4)	A plan needs to be in place to ensure there is review of all out-of-date policies and procedures and that these are reviewed annually or as otherwise stated (FM Governance report 2019 REC 17)	Director of Governance, Risk & Improvement /Director of Nursing	Initial target timescale for phase 1 is the end of March 2024 given sheer number of out-of-date policies. **Revised December 2024**	A detailed update report on progress with policies was provided to the Audit Committee held in July 2024. Executive Directors are providing narrative against all out of date documents to support plans which is due to be presented to EDG at the end of September 2024 and with a further update to be provided back to the Audit Committee in October 2024. This will also include a forward look to policies that will become due for review in 2024/25.		High
3.7 (NEW)	Establish quality improvement priorities, learning and outcomes.	Director of Nursing	*To be completed in conjunction with the quality and safety strategy* ~~August 2024~~ Review October 2024	Quality priorities agreed and Quality account published with stakeholder involvement Scrutiny panel undertaken of part of Quality Account process in July 2024.	Quality priorities agreed and established as part of quality account . Monitored through QGG Linked with Quality Strategy.	High

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
3.10 (NEW)	EDI work	Chief People Officer	~~March 2024~~ **Revised October 2024**	Exec champions identified and new network meetings being publicised and taking place. • EDISG Effectiveness Review taken place and revised Steering Group convening to monitor action plans delivery commencing October 2024 • High Impact Action Plan activity supplemented by new corporate strategy which develops clarity around health inequalities agenda (Trust role as an anchor institution) • WRES/WDES action plans in development • Trust Board development session on cultural architecture delivered August 2024 • EDS - Services for review in 2024 identified Scope of Staff networks flexing to address priorities and support effective engagement including new co-chairs of BAME network identified and potential merge of neurodiversity and disability networks.	Executive Champion roles identified. Ongoing network meetings.	High

Action Plan – KLOE 4

KLOE 4	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
4.3	• Develop a meeting map to incorporate Board, operational and management meetings focusing on attendees, membership, terms of reference and roles and responsibilities • (FM Governance report 2019 REC 13)	Director of Governance, Risk & Improvement	October 2023 Following conclusion of Committee effectiveness review cited above – Linked to 4.2 above. ~~Revised August 2024~~ **Revised October 2024**	Work has commenced on the full committee organogram and collation of Terms of Reference and workplans to support this. Governance and assurance slides have been developed and are being used in different forums to increase understanding and expectations.		High

Action Plan – KLOE 4

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

Action Plan – KLOE 4

KLOE 4	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
4.11	• Review of Non-Executive Directors portfolio and development needs to ensure that there is a good understanding of their roles and responsibilities as a Non-Exec Director. • Review governor roles and expectations and understanding of roles. (FM Governance report 2019 REC 2)	Director of Governance, Risk & Improvement. Director of Governance, Risk & Improvement.	September 2023 **Revised December 2024** September 2023 **Revised December 2024**	NWLA run open programmes for NEDs which anyone can book on to by going onto via their website. NED inductions now in place and new NEDs invited to attend the NHS Employers events. Review of NED responsibilities undertaken and shared with Council of Governors. Board development programme finalised for 2024/25. A number of changes to Governors expected in September 24 AMM and session to be held subsequently regarding roles. Workshop also to be held with COG in October 2024 to reconfirm roles and reset the role of the COG going forward, with the support of the Trust Chair and Lead Governor.	COG workshop to be held in October 2024. NED inductions in place. Details of NWLA training shared with NEDs.	Medium

Action Plan- KLOE 5

KLOE 5	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
5.1	The process for reviewing and assessing risk needs to be strengthened to allow for transparency of risks to ensure the Board are fully sighted on risks to patients and services (to include embedding risk management and review of BAF)	Director of Governance, Risk & Improvement	~~Revised to end of Quarter 2 2024/25 in line with MIAA management response~~ **Revised November 2024**	This is linked to 3.3 also. Monthly reports are now shared with EDG and then feedback provided to the Divisions in relation to their risks. Risk updates also continue to be updated via the Operational Management Board. A High Risks report is provided to the Board of Directors and sub-committees. The Trust's Risk Management Policy and Procedure is currently being reviewed together with a review of the Trust's approach to Risk Management training. A process is also being developed for regular reviews of the risk register and to develop assurance reports via the relevant governance structures. Introduction of a Risk Management Committee.	Monthly reporting to EDG and OMB. High Risks report to the Board of Directors.	Medium

Action Plan- KLOE 5

KLOE 4	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
5.5	The Trust must implement quality improvement systems and processes such as regular audits of the services provided and must assess, monitor and improve the quality and safety of services. The Trust needs to develop an improvement strategy	Director of Governance, Risk & Improvement	April 2024 **Revised March 2025**	The Trust has a continuous improvement team in place, as well as a number of other teams that deliver improvement work. An improvement strategy is required for 2024 and beyond. A session has been held with the Continuous Improvement Team in May 2024 to align team priorities to strategic priorities. Wider picture across all improvement activity to be developed. For 2024/25, a set of agreed improvement priorities has been developed and is currently being reset to include the Cost Improvement Programme and a number of other strategic priorities. Impact Strategy to be launched by March 2025.		Medium
5.6	The governance of coronial cases needs to improve which will be underpinned by the improvement in governance of all incidents to ensure that patients families and carers are involved in investigations, communicated with frequently and have their questioned answered and receive investigatory reports at least 28 days prior to any inquest. The investigatory reports need to be shared with the coroner 28 days prior to hearings also.	Assistant Chief Executive	~~October 2023~~ ~~June 2024~~ **Revised October 2024**	Database of coronial inquest developed. Legal team included in Safety Surveillance and learning steering group. Plan to monitor 28-day compliance with investigation reports to coroner. Evidence of patient and family involvement in investigations documented.	Transparency of all coronial cases. Good communication with legal team Further work re oversight and improved timeframes for report submission.	High

Action Plan – KLOE 5

KLOE 5	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
5.13 (NEW)	Improved Board and Committee reporting: Quality of reports, report writing and presentations.	Director of Governance, Risk & Improvement	~~April 2024~~ ~~Revised September 2024~~ **Revised October 2024**	Further guidance to be provided for Leads and Authors. To also consider a report writing brief course to be provided. Revised Report & cover sheet template produced with guidance included also, to be launched across the Trust.	Revised Report & cover sheet template. Governance awareness sessions being provided as part of Clinical Leaders programme and team meetings.	Medium
5.14 (NEW)	Enhance visibility and awareness of research and its impact.	Medical Director	**September 2024**	Research Lead provides quarterly updates to Operational Management Board & Board of Directors. Work has commenced on the new Research Unit. Cheshire & Merseyside Research Bus planned to be onsite and COCH branded to increase visibility and awareness at Trust and across community. **Completed.**	Increased visibility Trust wide and across the Community Regular Research update reports to Operational Management Board and the Board of Directors.	Medium

Action Plan – KLOE 6

KLOE 6	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
6.4 (NEW)	Deliver plan to optimise Cerner Full optimisation	Chief Digital and Information Officer	**October 2024**	EPR Optimisation and Upgrade Programme underway. Upgrade on track for delivery September / October 2024. Programme manager appointed and in post. NHSE England readiness review completed and internal audit review of previous lessons completed, both providing positive assurance but further actions identified and in train. First phase optimisation completed prior to change freeze for upgrade, and phase 2 to commence post upgrade. Clinical prioritisation process for EPR changes to be instigated from October 2024.		Medium

Action Plan – KLOE 7

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

Action Plan – KLOE 7

KLOE 7	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
7.5 (NEW)	Continue to build upon system understanding and engagement with external partners, stakeholder mapping.	Director of Strategic Partnerships	~~July 2024~~ **Revised October 2024**	Update on Anchor Institutional status and the work of the purpose coalition presented to the Board of Directors held in July 2024. System engagement in place and to continue with external partners. Partnership working session to be provided as part of the Board of Directors Development Session to be held in October 2024.	System engagement in place.	Medium

Action Plan – KLOE 8

KLOE 8	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
8.1	The Trust need to establish a Board Lead for organisational learning. This will then allow a strategic review of where all learning takes place, who by and outcomes. This then needs to result in the development of an organisational learning policy which is inclusive of all disciplines and services. • Review policy to ensure comprehensive coverage of organisation learning. • Establish mechanisms (as required) and embed organisation learning across the Trust	Director of Governance, Risk & Improvement	~~June 2023 Revised August 2024~~ **Revised December 2024**	Organisational Learning Policy being progressed to reflect the mechanisms in place. Share the learning forums in place which are attended Trust wide. Head of Legal Services, Deputy Medical Director and Deputy Director of Nursing & Quality Governance also looking to work more closely to align organisational learning.		High

Action Plan – KLOE 8

KLOE 8	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
8.4 (NEW)	Continuous improvement • workstreams to be aligned to strategic priorities. • Consider opportunities to involve patients • Board development and NHS IMPACT assessment (including action plan) • Transformation programme priorities and approach to be confirmed and aligned to strategy	Director of Governance, Risk & Improvement	~~March 2024~~ **Revised October 2024**	The Trust has a continuous improvement team in place, as well as a number of other teams that deliver improvement work. An improvement strategy is required for 2024 and beyond. A session has been held with the Continuous Improvement Team in May 2024 to align team priorities to strategic priorities. Wider picture across all improvement activity to be developed. For 2024/25, a set of agreed improvement priorities has been developed and is currently being reset to include the Cost Improvement Programme and a number of other strategic priorities.		Medium

Action Plan – KLOE 8

	Development Areas	Responsibility	Timeframe	Progress	Impact rating
8.5	The emergency department needs a robust improvement plan across all domains, care, culture, operational polices and flow. The Trust needs to improve that patients receive care in a timely way and work to improve performance against national standards (from arrival to assessment in the emergency department) Improve data capture and process of 12 hour DTA breach data Improve time to initial assessment using Manchester Triage System Deteriorating Patients and Reduction in Incidents: • Full review of the nurse and health care support workers • Roles and responsibilities in across the nursing workforce have been re-affirmed • An accountability framework is being introduced • Matron does regular drop in sessions and a department news letter is produced. • Weekly audit in place via Tendable and additional PDN training. • Twice daily Consultant in-reach sessions supporting review of NEWS and an ED specific NEWS addendum developed for Trust policy Maximise SDEC • Aim for over 1000 attendances per month • Direct conveyance from NWAS • Open 12 hours per day 7 days per week Introduce an Urgent treatment Centre outside the ED footprint	Chief Operating Officer	~~End of March 2024~~ ~~End of May 2024~~ End of November 2024	Nurse staffing review completed. SDEC has been repurposed. Five Trusts in Cheshire and Merseyside have been placed into Tier 1 for their Urgent and Emergency Care (UEC) services and this includes our Trust. Intensive support for all organisations in Tier 1 has been allocated from the Emergency Care Intensive Support Team (ECIST) via NHS England (NHSE). The Trust has asked for targeted support with triage, new models of working and day to day clinical leadership of the Emergency Department. The Chief Operating Officer is working closely with the Integrated Care Board (ICB)/NHSE/ECIST to finalise the offer and also having an increased focus on breaches of the 4 hour target that are within the control of our Emergency Department.	High

Appendices

Summary of Improvement Outcomes

Countess of Chester Hospital NHS Foundation Trust

Urgent & Emergency care

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

Quality, Safety & Harms Improvement

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

Board Governance & assurance

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

People & OD

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

Summary of completed actions (to date)

Countess of Chester Hospital NHS Foundation Trust

Completed Actions

- Full review of Nurse staffing undertaken (in line with SNCT Guidance).
- Launch of the Patient & Family Experience Strategy.
- Approval of the Board sub-committee TOR's and workplans
- Wellbeing Hub has opened which is accessible to all staff.
- Listening events held and civility statement agreed.
- FPPT Framework
- Executive network champions identified.
- Review of all storage across the Trust undertaken and spot checks being implemented.
- Full review of NET2 access undertaken.
- PLACE assessments
- Civility Charter agreed and is being incorporated into all employee processes.
- New welcome induction programme in place.
- Emergency Department Improvement Plan in place
- FTSU Board self-assessment held on 6th August 2024
- Workstreams established within Medicines Safety Group.
- National mandated medicine audits have been reviewed
- Increased visibility and Executive walkarounds
- All Board positions substantively appointed with (with the exception of the Chief People Officer, which has a recruitment plan in place)
- Board development programme agreed for 2024/25
- The Trust Strategy has been approved at the Board of Directors
- The new Complaints Policy has been formally ratified.
- CQC registration Tarporley Hospital (awaiting CQC confirmation)
- Mental health and community services collaborative
- Board Assurance Framework refresh
- Quality priorities
- Clinical SOP in place to identify and risk assess patients entering ED that present a self-harming risk.
- Divisional Leadership teams have engagement and visibility plans in place for visiting all wards and departments.
- Discharge summit held with system partners invited to join
- Review of all fire exits undertaken.

Meeting	**24th September 2024**		**Board of Directors**					
Report	**Agenda item QS14/09/24**		**Integrated Incidents, Complaints and Claims Report – Quarter 1 (2024/25)**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton				Director of Nursing and Quality / Deputy Chief Executive			
Author(s)	Fiona Altintas Ana Sanderson Maureen Wolfe Bev Hunt Alison Wylie Liz Kanwar Sarah Harper Lea Samantha Lacey				Deputy Director of Nursing and Quality Governance Governance Business Partner Governance Business Partner Governance Business Partner Lead Nurse Therapies and Integrated Community Care Division Head of Quality Head of Legal Services Associate Director of Nursing			
Board Assurance Framework	BAF 1 – Failure to maintain quality of care would result in poorer patient & family experience							
Strategic Aims	SG1 – Patient and Family Experience							
CQC Domains	Well Led, Safe							
Previous Considerations	Quality and Safety Committee - 10th September 2024							
	This report is to assure the Board of Directors of effective identification, reporting, and management of patient safety incidents. The report also gives an overview of the improved governance of patient safety across the Trust, inclusive of the provision of opportunities to share the learning with colleagues.							
Highlights	• The number of reported patient safety incidents has reduced by 300 compared to previous quarter – June saw the lowest number of incidents reported, with April and May in line with previous months. This trend will be reviewed through the safety surveillance meeting to ensure a strong reporting culture continues. • An increased number of moderate to severe incidents noted in this quarter, themes will be monitored through the Safety surveillance monthly meeting and may be contributed to closer weekly scrutiny in the Patient safety Incident Oversight meeting							

	• Divisions continue to monitor trends and themes and undertake appropriate level investigations. • The Trust has recovered its position with regards to StEIS reportable serious incidents and all non-maternity Serious incidents have now been closed. • The top 5 themes of incidents are highlighted and there are improvement programmes in place to address these • The governance surrounding incident oversight and timeframes for completion of reviews has improved • A continued increasing trend in new concerns is noted in this period, in conjunction with a reduction in complaints • The top themes in relation to causation in claims is delay in treatment and inadequate nursing care, with subsequent actions such as the launch of the Patient Experience Vision, the Back-to-Basics programme and audits of quality indicators to drive improvements amongst many other improvement streams
Recommendation(s)	The Board of Directors is asked to note the assurance provided on the reporting and safety systems in place to provide oversight of patient safety incidents, learning and changes in practice to ensure a continuous improvement of care, treatment and experience for patients for this reporting period.
Corporate Impact Assessment	
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status
Quality & Safety	An effective organisational response following patient safety incidents
NHS Constitution	Not applicable
Patient Involvement	Patient feedback has been considered at Patient Experience Operational Group
Risk	Not applicable
Financial impact	Not applicable
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not applicable

1. Executive summary

This report provides the Board of Directors with an overview of the governance of patient safety Trust wide. The report relates to activity in quarter one 2024/5. Data is provided on patient safety incidents, complaints and concerns, patient experience feedback and legal claims made against the organisation and inquests. The report seeks to demonstrate that the Trust is learning and responding to this information to support improvements in services

and better patient outcomes and experience for future patients and their families. The report seeks to demonstrate that several approaches are utilised to disseminate immediate learning to care teams. Robust governance, learning and improving patient outcomes remains a priority for the Trust.

The Trust now holds a weekly patient safety incident oversight meeting where moderate and above incidents are reviewed, level of harm agreed, and actions and learning discussed and shared. This meeting is attended by Executives. In addition, there is now a monthly Safety Surveillance meeting which includes the review of trends of reporting and sharing of learning in addition to a newly formed monthly harms improvement oversight meeting to ensure trust oversight of the harm's improvement agenda, identifiable actions and measurable outcomes. Both are intended to have close oversight of how patient safety and learning is being managed trust wide. Attendance is from all divisions and relevant departments, such as the legal department and Patient and Family Liaison service and is led by the Deputy Medical Director and Deputy Director of Nursing and Quality Governance

The Committee is asked to note the report to receive assurance of the arrangements and systems in place for the management and learning from incidents, complaints, patient feedback, claims and inquests.

2. Incident reporting culture

During quarter 1 of 2024/25 a total of 3376 patient safety incidents were reported on the Trust's Datix system, between 1/4/24 and 30/6/24. This is a reduction compared to quarter four of 316 reported incidents. This in the main, is due to a reduction of incidents reported in June 24. This will be monitored going forward in the monthly Safety Surveillance meeting to ensure a strong positive reporting culture is maintained. There are 13 incidents that were reported where the incident occurred pre-April 2024.

The top five categories of incidents reported are:

1. Skin integrity (452)
2. Staffing (299)
3. Slips trips and Falls (275)
4. Medication (261)
5. Security response (202)

A fall steering group and a pressure ulcer steering group are now in place. The pressure ulcer steering group includes a weekly review of all pressure ulcer reviews, chaired by the Deputy Director of Nursing and the Tissue Viability Nurse Consultant. Both groups are improving governance and learning.

A violence prevention steering group has also reconvened to ensure support, prevention techniques and guidance for staff surrounding this category of incidents.

Staff incidents are reviewed daily and supported by at least twice daily staffing meetings. A safe staffing review has been undertaken and a 6-month review will be commencing shortly.

The Trust has now established new processes for managing patient safety incidents through the daily divisional patient incident review meetings. These occur each working weekday morning, Monday to Friday, to review reported incidents submitted within the previous 24

hours or weekend. Immediate allocation of a lead to review all harm incidents is completed and the level of harm is validated, and next steps are determined. Immediate learning or safety concerns are relayed into the Executive senior site briefing meeting and then the Trust-wide daily safety huddle at 9:30am every weekday, to share cross organisational learning or engage support for immediate actions to be commenced.

Table 1 shows patient safety incidents by month and level of harm for quarter 1 2024/25 with the previous quarters for comparison. Harm and month for quarter 3 and 4 of 2023/24 3 as a comparator. Tables 2 demonstrates the level of harm for all the incidents reported in quarter 1 2024/25. 96% of all incidents in this reporting period are either no or low harm.

Table 1

		No harm	Low harm	Moderate harm	Severe harm	Catastrophic harm	Total *(month)*
Q3 2023/24	**October**	1036	185	44	5	0	1270
	November	1060	160	55	7	1	1283
	December	902	152	56	2	1	1113
Q4 2023/24	**January**	1033	216	30	1	1	1307
	February	997	179	31	0	0	1207
	March	971	161	39	7	0	1178
Q 1 2024/24	**April**	942	181	32	11	1	1167
	May	943	147	34	4	1	1129
	June	878	164	29	7	2	1080

Urgent Care remain the highest reporting division, followed by Planned care, Women's and Children's and then Diagnostic and Infrastructure, which is consistent and relevant given the size of divisions and patient contacts. See Table 2 for a breakdown in departments of incidents reported.

Table 2

Row Labels	Count of ID
Corporate Services	78
Diagnostics and Clinical Support	66
Diagnostics and Infrastructure	334
Digital & Data Services	12
Human Resources (for Risk Register use only)	19
Other Provider/Trust (Not COCH)	210
Planned Care	703
Therapies and Integrated Community Care	172
Urgent Care	1386
Women and Children	396
Grand Total	3376

Table 3 demonstrates that of the 3376 incidents reported, 85% have been investigated and closed, 14% are being reviewed and 1% are awaiting review. Progress can be demonstrated that incidents area being managed in a timely fashion.

Table 3

Row Labels	Count of ID
Being reviewed	470
Finally approved	2854
In the holding area, awaiting review	52
Grand Total	3376

3. Severity of incidents

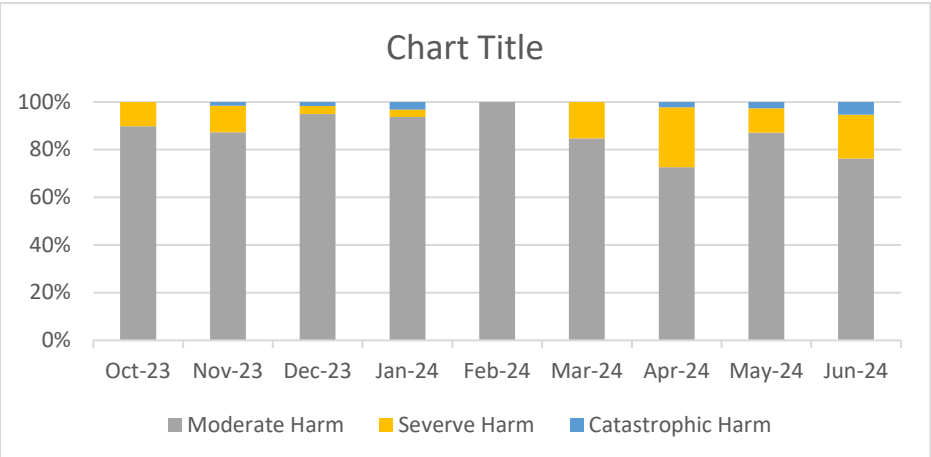
The greatest proportion of incidents result in low or no patient harm (96%) It is a priority to ensure levels of harm are validated via the daily review meetings and that data quality is maintained. The distribution of incidents across all levels of harm during quarter 1 is presented below in Table 5. **Table 5**. Incidents by severity of harm

	No Harm (near miss)	Low harm	Moderate Harm	Severe Harm	Catastrophic Harm
Q1 2023/24	2856	555	159	14	19*
Q2 2023/24	2932	561	185	11	2
Q3 2023/24	2998	497	155	14	2
Q4 2023/24	**3006**	**566**	**101**	**8**	**1**
Q1 2024/25	**2768**	**359**	**95**	**22**	**4**

*16 Catastrophic incidents relate to historic deaths from Covid-19.

Graph 2 demonstrates that while moderate incidents remain relatively static from the previous quarter, the number of severe and catastrophic incidents have increased in quarter 1, with number reported similar to the previous two quarters combined. This is being monitored and themes will be scrutinised through the new Safety surveillance monthly meeting and may be contributed to closer weekly scrutiny in the Patient safety Incident Oversight meeting

Graph 2



4. Serious Incidents and Transition to the Patient Safety Incident Response Framework

The Trust closed all non-maternity serious incidents on StEIS in the final Serious Incident Review Group (SIRG) with the ICB in June 2024.

The Women and Children's Division have submitted all their outstanding StEIS reports to the ICB and have presented at Cheshire and Mersey Maternity Panel in June 2024. There was some additional feedback and actions to be included in the action plans. This has been completed and the reports have been re submitted.

While we no longer report Serious Incidents since the transition to the Patient Safety Incident Response Framework (PSIRF) we still report to StEIS any incidents that have been agreed that a Patients Safety Incident Investigation (PSII) is to be undertaken. Duty of candour has been completed where a notifiable patient safety incident has occurred. We have reported five PSII to date.

- Thematic Review of Stroke Incidents (Urgent Care – PSII completed)
- Thematic Review of Glaucoma pathway incidents (Planned Care PSII completed)
- Incident where a baby fell from mothers' bed. (Women's and Children PSII ongoing)
- Never Event – a retained swab following a post-partum haemorrhage perineal repair following a forceps delivery. (Cross divisional Women's and Children/ Planned Care - ongoing)
- Missed Opportunity to diagnose complete visual loss right eye (Planned Care ongoing)

The Trust is also undertaking several thematic reviews that have arisen from themes of incidents that may not have resulted in moderate harm and above but have been identified as an opportunity for significant learning and service improvement for our patients. The thematic reviews that are currently being undertaken are:

Thematic Reviews

- Methotrexate administration
- Misidentification of patients – Radiology
- Recognising Deteriorating patient (ED)
- Sample management

5. Complaints and Concerns

In quarter 1, the Trust received 20 new formal complaints (1 less than the previous quarter). All new complaints have been acknowledged within the required policy standard of 3 working days. 29 complaints were closed in this period (18 more than the previous quarter). 7 of these 29 were withdrawn. The following key process-based learnings have been obtained and implemented.

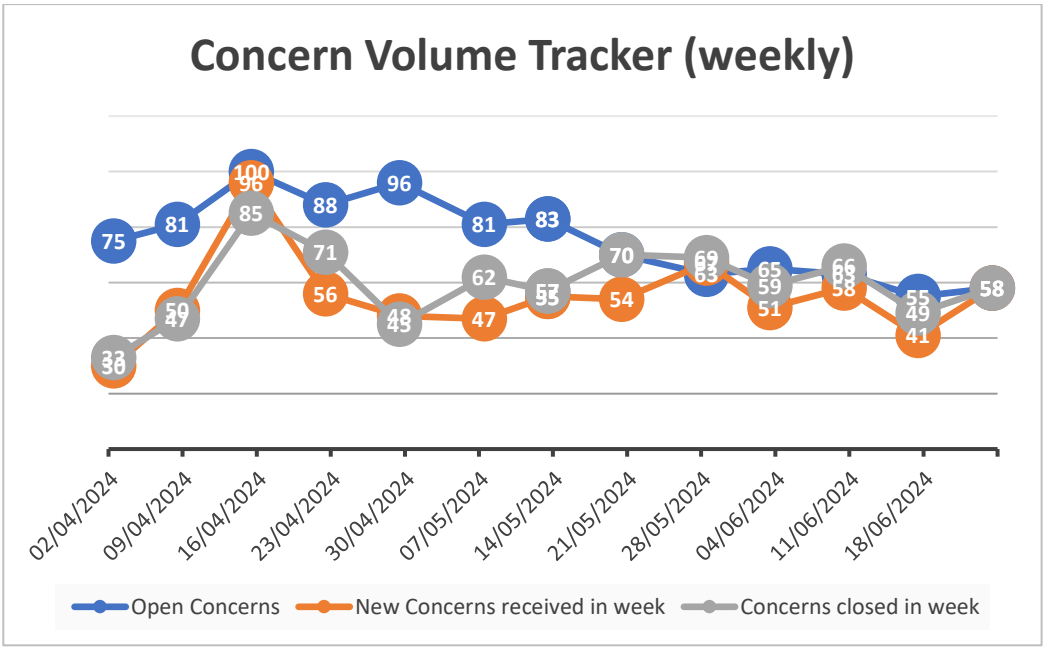
Speciality	Learning
Diabetes / Endocrinology	• Policy has been updated to amend discrepancy regarding contacting patients for appointments.

ED	• Increase staffing levels of health care support workers. • Introduction of medication cabinet within triage, allowing for more timely pain relief. • Allocation of nurse within the waiting room. • Introduction of a dedicated member of staff responsible for nurse rounding. • Introduction of tables that attach to trolleys to better facilitate mealtimes for patients. • Introduction of weekly environmental audits. • Relocation of Minor Injuries and the Urgent Treatment Centre too allow patients to be streamed into these areas.
Fertility	• Clarification of the recurrent miscarriage referral process.

In Quarter 1, 742 concerns were raised. This is 235 more than 2023/24 Q1.

Quarter	Q2	Q3	Q4	Q1	Total
Raised	598	601	727	742	2,668
Closed	566	550	707	767	2,590

The number of open concerns has decreased through the quarter, as opposed to Q4 where these increased. This is assurance that the concern process is busy but under control.



As concerns are becoming more complex, they are remaining open for longer whilst meetings with the service are arranged and the concern is resolved.

- 53.7% of concerns (435) are closed in 2 working days or less.
- 77.1% of concerns (591) are closed in 10 working days or less.

Informal resolution of concerns is the aim, however there were 14 instances whereby complaints have been raised due to being unable to resolve the issue during the PALS pathway. Complainants were not satisfied with the initial response from the service for reasons such as:

1. Complainant wants to progress with a claim and would like a written response.
2. Complainant contests information that was provided to them in the concerns process and wants investigation.
3. Patient wants the issue to be escalated and responded to by a senior member of staff, or CEO oversight.

The top three concern themes throughout the Trust are: communication, appointment issue, and general enquiry.

Division	Communication	Appointment Issue	General Enquiry
Corporate Services	13	1	39
* Diagnostics and Clinical Support	2	1	3
Diagnostics and Infrastructure	10	15	9
Digital and Data Services	2	2	3
Other Provider/Trust (Not COCH)	9	1	4
Planned Care	154	188	62
Therapies and Integrated Community Care	8	6	2
Urgent Care	119	60	43
Women and Children	49	46	7

** In June 2024, the division Diagnostics and Infrastructure was split on Datix. All facilities, security and estates concerns are to remain in this division, and Diagnostic and Clinical Support Services were moved into their own division.*

Within the theme of communication, the top three specialities involved are ED (48), ENT (42) and Gynaecology (28). The main sub-themes are as follows:

- **ED** - corridor care is inappropriate for patient and the patient /family do not feel listened to, not kept updated on the plan of care, poor staff attitude (all grades), and requests for discharge summary.
- **ENT** – patients make contact to chase: appointments, prescriptions, referrals, results, and to get advice on post-surgical complications. There are still ongoing issues with patients being able to contact ENT directly in this quarter.
- **Gynaecology** – patients are largely getting in touch due to the cancellation of appointments, staff attitude (all grades), and requesting post-procedure debriefs.

6. Clinical Negligence Claims Reported to NHS Resolution

There are a total of 150 open potential claims, where disclosure of medical records has taken place with litigation in mind, without formal allegations made to date. There are a total of 127 ongoing actual clinical negligence claims.

During quarter 1 2024/2025 a total of 9 new clinical negligence claims (Table 7) were reported to NHS Resolution (NHSR) - by comparison 11 claims were reported during quarter 1 2023/2024. The incident dates for these new claims range from August 2016 to September 2023.The Trust had undertaken an internal investigation in relation to 7 of the 9 new claims reported.

The top theme during quarter 1.in relation to causation was failure/delay in treatment (4) and learning from the claims is to ensure timely communication with patients and families

following any incident investigation which if lacking can be a driver for litigation. The Legal Team is working with the Risk, Complaints and PALS leads to consider cases that potentially fit with this theme.

The nine claims, include:

- Fracture following a fall
- Never Event (OMFU) and ongoing pain
- Two separate incidents where there was a delay in stroke diagnosis
- Delay in urodynamic studies
- Delay in appointment/follow up
- Complication following surgery
- Nickel allergy caused dermatitis
- Missed cancer

Coroner's Inquest Investigations

There are a total of 34 open coroner's inquest investigations. 11 of the open investigations relate to deaths that occurred over 12 months ago. There are 3 open inquest investigations that have been open since 2015/2016 which are on hold due to the Neonatal Investigation.

During quarter 1, the coroner notified the Trust of 9 new investigations. All 9 new inquest notified fall under Urgent Care, 3 of which also relate to care under Planned Care. The Trust had undertaken investigations in relation to 3 of those patients:

- deterioration in patient condition
- in hospital falls
- formal complaint re circumstances of death.

Inquest Hearings Held During

There were 17 inquest investigations closed by HM Coroner during quarter 1, of which 7 hearings were attended by Trust witnesses.

Post Inquest Learning:

The Trust endeavours to identify and address any learning prior to each inquest hearing engaging with patients their family and carers where possible. Inquest hearings are attended by Legal Services and any additional learning identified for the Trust is relayed to the Executive Team and Divisional Governance Leads. Completion of any residual learning is monitored via a weekly Divisional Report.

Of the 7 inquests attended their post inquest learning is to be taken forward in respect of the following:

- Further assurance required in relation to results sent to consultant's inboxes that can be missed due to large volumes of emails received or a change in consultant responsible for the patient.
- Consider an alternative pathway for MRSA results currently sent to consultants for all surgical patients adding to email traffic
- General Surgery Handover Standard Operating Procedure (SOP) – Audit planned for June 2024, results to be reviewed

- Feasibility of a function in Cerner to ensure patients are not discharged with unendorsed results was being explored by clinical leads and IM&T – do we now have assurance on this issue. For discussion at Planned Care Governance Committee 22 April 2024, Senior Clinical Team Meeting by the end of April 2024 and the Digital Transformation Group on 2 May 2024.
- Family meeting to be arranged re communication post meeting

HM Coroner issues 2 Prevention of Further Death Reports at inquests attended by the Trust, but to other organisations involved and not to the Countess of Chester.

7. Patient Experience

Feedback via the Trusts Friends and Family Test question shows that a large proportion of patients rate their care as good or very good.

The average FFT positive score for this quarter is 90%, reducing from 92% in the previous quarter from a similar 10,000 responses.

The FFT test results are grouped for ED, Inpatients, Outpatients, and Maternity as directed by NHS England. National NHS FFT data for the Emergency Department (ED) for April 2024 is 79%

Emergency Department FFT

April 24	77% positive	598 responses
May 24	70% positive	512 responses
June 24	71% positive	373 responses

Themes from positive feedback is that the care and treatment is provided by kind caring and friendly staff. Negative feedback is received about waiting times to be seen by an ED Doctor and by specialities, waiting for a bed on the ward, privacy and dignity when being cared for on the corridor, analgesia and pain control whilst waiting the waiting area.

Inpatient FFT

April 24	93% positive	1135 responses
May 24	93% positive	1066 responses
June 24	91.7% positive	738 responses

National NHS FFT data for the Inpatients for April 2024 is 94%.Themes from positive feedback is that the care and treatment is provided by kind, caring and friendly staff. Negative feedback is received in low numbers where care pathways have felt disorganised possibly due to miscommunication with the patients. In some areas patients have expressed concern about sleeping at night when the ward has been hot or interrupted by noise.

Outpatient FFT

April 24	93% positive	2135 responses
May 24	93% positive	2024 responses
June 24	95% positive	1333 responses

National NHS FFT data for the Outpatient for April 2024 is 94%.Themes from positive feedback is that the care and treatment is provided by kind, caring and friendly staff and efficiency whilst attending the service. Negative feedback is received low numbers where expectations for treatment or advice at the appointment has not been met. Negative feedback is received where patients wait beyond 30 minutes to be seen in the clinic, some waiting up to 3 hours. Some negative feedback is received regarding the consultation feeling the doctor is rude and or dismissive of the patient.

Maternity FFT

Responses to the maternity FFT are captured at four points: antenatal care, birth, postnatal ward and postnatal community. National NHS FFT data for the Maternity for April 2024 is between 92% and 93% respectively, showing the Trust is outperforming where data is sufficient to give a value. Themes from positive feedback is the care and treatment provided by kind, caring and friendly staff throughout the whole pregnancy.

April 24		
Antenatal	100% Positive	13 responses
Birth	96% Positive	8 responses
Postnatal ward	100% Positive	8 responses
Postnatal Community	No score	4 responses
May 24		
Antenatal	No score	2 responses
Birth	87% positive	30 responses
Postnatal ward	98% positive	62 responses
Postnatal Community	No score	3 responses
June 24		
Antenatal	No score	1 response
Birth	100% positive	34 responses
Postnatal ward	100% positive	27 responses
Postnatal Community	No score	1 response

The National Inpatient CQC survey undertaken in November 2023 has been completed its and results were received under embargo during quarter 1. 457 patients completed the survey. For overall positive score change the Trust achieved an improved ranking of 4th

(Picker). The Trust has improved in all sections of the survey apart from where the score was the same as the previous year.

The National Urgent and Emergency Care survey was undertaken in March and April 2024. Results are expected in the Trust in October of 2024/25

The National Children's and Young Peoples survey is currently underway. The survey period will close at the end of May 2024, and results will be available to the Trust in the Autumn of 2024.

Since the launch of the Trust Patient and Family Experience Strategy in April 2024, Specialities have been developing Patient and Family Experience Vision action sets to plan out how they are will develop and improve the patient and family experience within the speciality. Inpatient survey feedback has been used as insight by wards and departments in these plans. These action sets are on display in all areas and will be monitored within the Division. A patient survey was launched in June 2024 asking patients for feedback on their care experienced as set out in the six steps vision. The baselines results have been received and will be monitored for the rest of 2024/25. Following this, targets will be set across all services to ensure that the trust is striving for excellence for all patients across all services.

8. Organisational Learning

The Trust has established organisational learning events.

Patient Safety 9:30am Huddle

This daily meeting allows staff to raise immediate concerns relating to patient safety for immediate action. An overview of incidents reported in the previous 24 hours are discussed with associated actions shared.

Sharing & Learning Forum

The Sharing & Learned forum is delivered monthly to all nursing and multi-disciplinary teams via Microsoft teams. The agenda is derived from safety incidents, learning from differing forums and areas that staff wish to highlight and discuss. In the last quarter the forum has shared and discussed items around the importance of the completion of discharge checklists. Learning from the Coroners inquests and patient safety investigations have focused on the learning and required changes to practice.

Patient Safety Summits

The Patient Safety Summit is held monthly and covers a patient safety incident presentation followed by discussion and agreed learning, actions to be taken to reduce reoccurrence.

Weekly Safety & Learning Meeting

The Trust has aligned the Serious Incident Panel meeting to the newly implemented Patient Safety Incident Response Framework (PSIRF) to form the Patient Safety Learning Meeting that meets on a weekly basis. All identified learning from this meeting is collated with the Daily Safety Huddle learning to form the Trust ‘Weekly Learning’.

Weekly Patient Incident Oversight Group

To ensure the Trust has robust and demonstrable governance and decision-making processes with regards to patient safety incidents, a newly formed Patient Safety Oversight Meeting has been formed since April. Attended by Executive colleagues, all moderate and above incidents are reviewed from the previous week, with agreement achieved regarding the level of harm, the format of response (within PSIRF), timeframes for report and responsible persons. This is also the forum where decision making regarding any incident to be reported to StEIS and for completed reports to be approved. The Head of Quality & Safety Improvement at NHS Cheshire and Merseyside ICB - Cheshire West place, has also been invited when a PSII is scheduled for approval.

9. Learning from Patient Safety Events (LFPSE)

The Trust rolled out LFPSE as the replacement platform for the National Reporting and Learning System (NRLS) on 15th of February 2024. There have been some subtle changes to the Datix reporting system, which will affect staff reporting incidents. The most notable change is the definition of harm. These now include both physical and psychological harm. The definitions have been socialised through divisions – laminated copies should now be accessible near computers.

The LFPSE field is now a mandatory field to be completed, with several others so we can capture more meaningful data from our incidents. Levels of harm can be amended, and the national database will update. The CQC and the ICB regularly review the LFPSE platform and can request at any time, feedback and reviews from the Trust.

10. Recommendations:

The Board of Directors is asked to note the assurance provided on the reporting and safety systems in place to provide oversight of patient safety incidents, learning and changes in practice to ensure a continuous improvement of care, treatment and experience for patients for this reporting period.

Meeting	**24th September 2024**		**Board of Directors**					
Report	**Agenda Item: 15.**		**Care Quality Commission National Inpatient Survey 2023 – Results Update**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton				Director of Nursing & Quality / Deputy Chief Executive			
Author(s)	Sue Pemberton				Director of Nursing & Quality / Deputy Chief Executive			
Board Assurance Framework	BAF 1	Failure to maintain quality of care would result in poorer patient & family experience						
Strategic Aims	SG1 - Patients and Family							
CQC Domains	Care							
Previous Considerations	Executives Directors Group – August 2024							
Executive Summary	The Trust's Care Quality Commission (CQC) Inpatient Survey 2023 results demonstrate improvement on the previous year's results in all sections apart from one where the score remained the same as the previous year. The Trust was rated 7.9 for overall care experience compared to 7.7 in the 2022 results. There are also some areas where improvement is still required, with the two main areas raised relating to the time waiting for a bed and understanding explanations given when changing wards during the night. Of 1250 patients invited to take part, 457 responded (circa 40%): the national response rate was 42%. Patients aged 16 years or older and who had spent at least one night in hospital during November 2023 were eligible to participate in the survey. The published results can be accessed via the following link: Adult inpatient survey 2023 - Care Quality Commission (cqc.org.uk)							
Highlights	The responses to three questions in the survey were better than most Trusts. The response to one question in the survey was somewhat worse than most Trusts.							

	Trust performance improved; ranked 57 in 2022, it ranked 35 in 2023 (Picker). For 'overall positive score change', the Trust achieved an improved ranking of four (Picker). Picker has advised that it is reviewing some of the responses (relating to sleep at night), therefore the analysis does not contain the answers to this question.
Recommendation(s)	The Board of Directors is asked to note the assurance provided within the report highlighted by the CQC National Inpatient Survey Results.
Corporate Impact Assessment	
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status
Quality & Safety	Not applicable
NHS Constitution	Not applicable
Patient Involvement	Not applicable
Risk	Not applicable
Financial impact	Not applicable
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not applicable

1. Background

The CQC national inpatient survey results were published on 21st August 2024.

The questionnaire was divided into the following sections:

1. Admission to hospital
2. The hospital and ward
3. Doctors
4. Nurses
5. Your care and treatment
6. Virtual wards
7. Leaving hospital
8. Feedback on quality of care
9. Kindness and compassion
10. Respect and dignity
11. Overall care

In 2022 there were 10 sections, including 'operations and procedures'. That had been removed for 2023 and 'virtual wards' and 'kindness and compassion' included.

2. Outcomes – 2023 survey

Responses to five questions had significantly improved:

Most improved scores	Trust 2023	Trust 2022
Q50. Asked to give views on quality of care during stay	30%	6%
Q2. Did not mind waiting as long as did for admission	74%	62%
Q36. Staff involved family or carers in discussions about leaving the hospital	65%	56%
Q43. Staff told patient who to contact if worried after discharge	70%	61%
Q14. Got enough help from staff to eat meals	85%	78%

Responses to one question was significantly worse:

Most declined scores	Trust 2023	Trust 2022
Q5. Did not have to wait too long to get to a bed on a ward	52%	61%

The Trust improved from a ranking of 57 in 2022 to a ranking of 35 in 2023 (Picker). This was out of 67 Trusts. It's important to note that Picker benchmark the Trust both against its previous scores and scores from other participating Trusts (n=67).

For overall positive score change the Trust achieved an improved ranking of four (Picker).

Sections	2022	2023	Same Deterioration Improvement
Admission to hospital	6.5	7.5	Improvement
Hospital and ward	7.4	7.4	Same
Doctors	8.7	8.8	Improvement
Nurses	8.2	8.4	Improvement
Care and Treatment	8.1	8.3	Improvement
Virtual wards	N/A	7.5	New question
Operations and Procedures	8.5	N/A	Section removed
Leaving Hospital	6.5	7.1	Improvement
Feedback on care	0.7	3.2	Improvement
Kindness and compassion	N/A	9.1	New question
Respect and Dignity	9.0	9.2	Improvement
Overall Care	7.7	7.9	Improvement

3. Assessment

It's important to note that the CQC 'standardises' the data by applying a weighting to individual responses to account for differences in demographic profile between trusts. For each Trust, results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to reflect the 'national' age-sex-admission type distribution (based on all respondents to the survey). This helps to ensure that no Trust will appear better, or worse, than another because of its respondent profile.

The Trust's results were much worse than most trusts for zero questions.

The Trust's results were worse than most trusts for zero questions.

The Trust's results were somewhat worse than most trusts for one question.

Table 1: Admission to hospital

Question	Respondents	2023 Score	2023 Band	2022 Score	2022 Change
How did you feel about the length of time you were on the waiting list before your admission to hospital?	53	8.6	Much better	7.1	↑

The Trust's results were **better** than most trusts for one question.

To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	331	6.2	Better	4.9	↑

Your Trust's results were **somewhat better** than most Trusts for one question.

Table 5: Your care and treatment

Question	Respondents	2023 Score	2023 Band	2022 Score	2022 Change
Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	400	8.2	Somewhat better	8.0	
How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	440	5.7	Somewhat worse	5.8	

The Trust's results were about the same as other Trusts for 45 questions.

4. Actions and next steps

The Trust launched the Patient and Family Experience Vision in April 2024. This is set out in a six-step format across the patient experience journey. At the same time, the Emergency Department and Maternity Services have developed their six-step Vision for their patient groups. For each step there is an aspirational statement and an anticipated response statement that we aspire to achieve for our patients. Subsequently, the six step vision concept has been adapted by numerous areas Trust wide. These are owned by the respective teams, are visible in individual areas and have been developed by further individual departments.

Under each of the six steps all areas have identified the actions they will take to achieve the required standards. These have been set for 2024/25 and every area will review in April 2025.

As with any patient experience strategy, it is important to monitor how well the Trust is performing against the six steps set. The questions aligned to the six-step model has been tagged within the FFT SMS text service and therefore the results can be grouped for 'Inpatient', 'Outpatient', 'Maternity' and 'ED'.

In July 2024 a baseline for the six steps questions was reported as below and whilst the responses are low currently,(there is system review of the maternity results) we aim to drive this and encourage as many patients as possible to feedback on their experience:

Each step within the Visions is supported by a Patient Statement. In understanding progress of the Trust Visions, patients are surveyed after receiving care as to what extent they agree with the Patient Statements. This is accumulated into a positivity score.

Results for July 2024

Inpatients- Hospital Vision

Patient Statement	Number of responses	Positivity score
The Countess is my preferred hospital, everyone is kind and friendly and I received great care.	152	88.15 %
I felt welcomed at the trust, staff were expecting me	152	90.13 %
Me and my family knew what was happening throughout my care	151	85.43 %
Staff were kind, gentle and respectful to me	152	94.94 %
I felt safe and staff knew what they were doing	152	97.36 %
I felt I had the right support to get on with my life	152	87.5 %

Outpatients - Hospital Vision

Patient Statement	Number of responses	Positivity score
The Countess is my preferred hospital, everyone is kind and friendly and I received great care.	378	88.62%
I felt welcomed at the trust, staff were expecting me	377	91.51%
Me and my family knew what was happening throughout my care	377	88.59%
Staff were kind, gentle and respectful to me	376	94.68%
I felt safe and staff knew what they were doing	377	94.96%
I felt I had the right support to get on with my life	378	86.50%

Emergency Department Vision

Patient Statement	Number of responses	Positivity score
It was easy to understand where to go to be treated and accessing the service was simple.	82	95.12%
I was listened to, they understood my needs. I was assessed promptly, and was informed about what would happen next.	82	93.90%
I knew what was going on and was part of the decisions about my care and treatment.	82	92.68%
The department was welcoming, tidy and clean and I felt safe there.	82	81.70%
I knew who was caring for me. I was made to feel comfortable and had everything I needed	82	90.24%
I received excellent treatment from the care team	81	96.29%

Maternity Vision

Patient Statement	Number of responses	Positivity score
When I discovered I was pregnant I knew that the Countess is where I wanted to be cared for.	2	100%
I felt respected and treated as an individual.	2	100%
From the outset I was met by expert staff who went beyond their professional duty to make my experience exceptional.	2	100%
I had all the information I needed to make the right decisions for me and my baby at each step.	2	100%
I had trust in my maternity team and felt safe.	2	100%
I was supported to care for my baby my way.	2	100%

5. Summary and conclusions

The CQC Inpatient Survey 2023 results demonstrate that improvements have been made across all sections assessed by the survey apart from one, which has remained the same. The key areas for improvement relate to patient flow and waiting for a bed for our patients. It also highlights that communication to our patients when they are moved to other clinical areas needs to improve. There are significant improvements in workstreams under the Urgent Care Plan that relate to this, however all areas will be asked to include 'improving communication with patients when changing beds' in the six steps actions.

It is important that the Trust continues to monitor patient experience through all mechanisms available: the six steps questions, friends and family feedback, Healthwatch feedback and complaints/concerns and compliments. Triangulation of this feedback is important and identifying improvements to ensure that learning is acted upon.

6. Recommendation

The Board of Directors is asked to note the assurance provided within the report highlighted by the CQC National Inpatient Survey Results.

Committee Chair's Report

Committee:	Quality & Safety Committee
Date of meeting:	10th September 2024
Chair:	Professor Andrew Hassell, Non-Executive Director

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

ALERT
The Committee wanted to alert the Board to the following areas escalated from the Quality Governance Group (QGG): • Stroke Sentinel Audit Report – Limited assurance received. It was noted that there will be Stroke Nurse cover from 8am – 12am (midnight)with stroke cover available across Chester and the Wirral. The flow of stroke patients through the Countess of Chester Hospital site and Ellesmere Port Hospital site was noted as challenging. • Policy recovery Programme – Limited assurance received. It was noted that actions are in place to progress the out of date policies with the possibility of an exceptional QGG to ratify the policies. Challenges were noted with regards to the limited number of people with authority to add and remove policies to/from the intranet.
ASSURE
The Committee received updates against the following actions: • NatSSIPs and LocSSIPs position update - It was confirmed that there is good clinical engagement with update reports shared via the Quality Governance Group (QGG). Dr N Scawn, Medical Director has also been identified as the responsible Executive. • Bank Staff Mandatory Training compliance – Improving (markedly) trajectory It was agreed to receive a further compliance update at the Committee to be held in January 2025. • Translation Service position update - It was noted that a framework service with one provider is currently under review, with a contract specification and cost benefit analysis being developed. It was agreed for the Committee to receive an update at the next Committee to be held in November 2024. • Nutrition and Hydration service position update - Partial assurance was noted by the Committee with an agreement for a further update to be received at the Committee to be held in January 2025.

- Clinical Audit Update – It was noted that those audits receiving providing only partial assurance are being repeated post implementation of actions. Results of re-audits will be included in the relevant future report.
- Patient Led Assessments of the Care Environment (PLACE) – Cleaning standards across the Trust update - It was agreed for the Committee to receive a Cleaning Standards Trust position update at the Committee to be held in November 2024. It was noted that good PLACE progress has been made across the Trust with the Ward Accreditation model being followed and the first formal PLACE audit will take place in early October 2024.

The Committee received the Integrated Incidents, Complaints and Claims Report – Quarter 1 (2024/25). An increase in number of severe harms was noted. No themes identified. The number of unwitnessed falls was discussed together with the improvement actions being progressed. It was noted that the Trust has expressed an interest in taking part in a national research programme regarding enhanced provisions and the model workforce.

The Committee noted the following from the Key Risks and Assurance report from the Quality Governance Group (QGG) held in July 2024. Note, where partial assurance has been received the Committee has assurance about progress and the trajectory.

- Performance Dashboard (areas of risk) – Moderate assurance received.
- Radiology Discrepancy Report (6 monthly update) – Partial assurance received.
- Medicine Management Annual Report – Moderate assurance received.
- Mortality Improvement report including Learning from Deaths Quarter 1 2024/25 – Moderate assurance received.
- Equality, Diversity & Inclusion (EDI) (Patients) progress Assurance Report – Partial assurance received.
- Ligature Risk Assessment – Moderate assurance received.
- PLACE – Partial assurance received.
- Palliative Care and End of Life Service – Partial assurance received.
  It was noted that a Palliative Care and End of Life Steering Group has been established to drive forward improvements across the Trust.
- Unendorsed Results Progress – Moderate assurance received.
- Transfusion Competency – Moderate assurance received.
- Fridge Temperature Assurance Report – Partial assurance received.
  It was noted that a reset is to take place across the Trust with an options appraisal to be shared at a future Executive Directors Group (EDG).
- Integrated Quality Report – Significant assurance received.
- World Health Organisation (WHO) Surgical Safety Checklist and the Association for Perioperative Practice (AfPP) Update – Partial assurance received.
- Infection Prevention and Control report – Moderate assurance received.
- Resuscitation report – Partial assurance received.
- National Early Warning Score (NEWS) Compliance report – Partial assurance received.
- MY Kit Check Compliance Report- Moderate assurance received.
- Clinical Audit Report – Moderate assurance received.
- Consent to Treatment report – Partial assurance received.
- Complaints Annual report – Significant assurance received.
- Concerns Deep Dive – Moderate assurance received.

- Cheshire & Mersey Critical Care Network (CMCCN) Major Trauma report – Moderate assurance received.

The Committee received the Maternity Service Quarterly Update – Quarter 1 2024/25 - Significant assurance was noted. Post Partum Haemorrhage (PPH) figures were discussed, and the Committee received assurance the Trust is correctly monitoring, reporting, and dealing with (including escalating), PPH.

The Committee noted the Cancer Harm Reviews progress. Concerns regarding reviews from last year which are outstanding; trajectory for completion of these to be provided to the Committee.

The Committee noted the National Institute for Health Care Excellence (NICE) Guidance Reporting. It was agreed for the Committee to receive a verbal update on the Diabetes / Endocrinology - Type 1 diabetes in adults: diagnosis and management (2022) and Gastroenterology - Colorectal cancer prevention: colonoscopic surveillance in adults with ulcerative colitis, Crohn's disease, or adenomas (2022) guidance at the Committee to be held in November 2024.

The Committee noted the contents of the Strategic Oversight Framework / Dashboard with corrections to be made on future reports for data accuracy.

The Committee noted an Ionising Radiation Medical Exposure Regulations (IRMER) Update. It was agreed that IRMER updates would be provided by the Chief Operating Officer, Ms C Chadwick, in future and that an update will be received at the Committee to be held in November 2024. It was agreed for the Deputy Radiology Services Manager, Ms A Miller, to also attend this Committee to provide an update on 3 issues raised in the mock CQC visit.

ADVISE

The Committee noted the Quarter 2 2024/25 Board Assurance Framework (BAF) and High Risks Report. The Committee agreed with the risk ratings outlined within the report and the suggestion of a Risk Management Committee was discussed with a view for this to be in place within October/November 2024.

The Committee noted the Quality Impact Assessment (QIA) update provided and commended the well-established processes in place.

The Committee received a very positive patient story, and it was agreed to share the story with the Board of Directors .

The Committee noted the following items:

- Quality & Safey Committee Workplan 2024/25
- Quality Governance Group Minutes – 6th June 2024
- Cancer Services Group Chair's Report – 2nd July 2024
  Governor/Non-Executive Director Walkabout Feedback – Haematology and Urology 3rd July 2024 and CRV 7th August 2024.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

No new risks were identified.

Meeting	**24th September 2024**				**Board of Directors**			
Report	**Agenda item 17.***				**Infection Prevention and Control (Quarter 1 – 2024/25) Surveillance and Performance Report**			
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton				Director of Nursing & Quality / Deputy Chief Executive			
Author(s)	Michael Woodward				Head of Nursing – Infection Prevention and Control			
Board Assurance Framework	BAF 1 – Failure to maintain quality of care would result in poorer patient & family experience							
Strategic Aims	SG1 – Patient and family experience							
CQC Domains	Safe/Effective/Caring/Responsive/Well Led							
Previous Considerations	Infection Prevention and Control Assurance Committee – 24th July 2024 Quality Governance Group – 1st August 2024							

Executive Summary	The purpose of this report is to provide the Board of Directors with an update and provide assurance on the Trust's performance relating to Infection Prevention and Control during Quarter 1- 2024/25, across a range of key areas that support the delivery of Trust objectives.
	
	The NHS Standard Contract for 2024/25 that outlines the threshold objectives set for each acute care provider relating to *Clostridium difficile* and blood stream infections (*MRSA, MSSA* and Gram-negative organisms) were released by NHSE in August 2024. Reductions in cases numbers of 5% (across each category) have been set, with a reduction by 1 case where the count was less than 10.
	
	Prior to this in collaboration with the Integrated Care Board (ICB) agreed local thresholds were set for *Clostridium difficile* and *E. coli* blood stream infections.
	
	In line with the UKHSA national mandatory surveillance program this report contains surveillance information on all trust assigned cases of:
	• Methicillin resistant *Staphylococcus aureus* bacteraemia (*MRSA*)
	• *Staphylococcus aureus* bacteraemia (*MSSA*)
	• Gram-negative bloodstream infection
	  ○ *Escherichia coli* bacteraemia (*E. coli*)
	  ○ *Klebsiella species* bacteraemia
	• *Pseudomonas aeruginosa* bacteraemia
	• *Clostridium difficile*
	
	Snapshot Quarter 1 2024/25:								

Pathogen	NHSE Annual Threshold 2024-25 Total	Current year (Trust cases) Q1 2024-25	NHSE Threshold trajectory Q1 2024/25	Trust cases Q1 2024/25 v NHSE Q1 2024/25 Threshold
C.difficile	73	18	18	level
MRSA	N/A	0	N/A	N/A
E. coli	51	12	12	level
Klebsiella	21	11	6	+5
Pseudomonas aeruginosa	1	1	1	level
MSSA	N/A	9	N/A	N/A

HCAI performance for 2024-25 (Trust assigned cases): -
At the end of Quarter 1, the incidence of *C. difficile* infections were level with the threshold trajectory as set by NHSE (18 cases in Q1). This is in contrast with the wider picture across the locality with incidence of *C. difficile* infection having increased across the community and at other acute trusts within the Cheshire and Merseyside region. Cases of both *E. coli and P.aeruginosa* bloodstream infections were also level with the NHSE set threshold for Quarter 1.

Cases of *Klebsiella* blood stream infections were above the NHSE set threshold trajectory of 6 cases for Quarter 1, with 11 cases reported. This is in line with the wider picture across the locality with incidence across other acute trusts within the Cheshire and Merseyside region showing an increase of 59% in case numbers during 2024-25 Quarter 1 in comparison with 2023-24 Quarter 1.

- Enhanced surveillance illustrates source of infection to be 45% lower urinary tract infection (5 cases), 27% unknown origin (3 cases), 18% hepatobiliary (2 cases) and 10% related to a graft abscess.
- There was a wide distribution of cases with the 11 cases reported from 8 different areas. Ward 45 and ICU the only areas to report more than 1 case.
- An increased incidence of Klebsiella species blood stream infections correlate with the wider picture across the locality. Incidence across other acute trusts within the Cheshire and Merseyside region shows an increase of 59% in cases during 2024-25 Q1 in comparison with 2023-24 Q1.

The targeted improvement works to reduce cases of E. coli (UTI prevention and management) will also be relevant to reducing risks around Klebsiella. The hepatobiliary as a source is more difficult to

address as this may relate to gall bladder issues/gallstones and prevention may relate to lifestyle/diet/health promotion.
There are no set objectives for blood streams infections of either *MSSA* or *MRSA.* During Q1 there were 9 cases of *MSSA* and zero cases of *MRSA* blood stream infections.

HCAI data for 2024/25 (community assigned cases):

	Cheshire & Merseyside (Community cases)		
Pathogen	Q1 - Previous Year (2023-24)	Q1 - Current Year (2024-25)	Q1 - 2023/24 v Q1 – 2024/25 % change across C&M
C.difficile	63	113	+79%
MRSA	7	7	Nil change
E. coli	367	403	+9.8%
Klebsiella	99	99	Nil change
Pseudomonas aeruginosa	25	19	-24%
MSSA	128	113	-11.7%

Across the Cheshire and Merseyside region during Q1 there has been a significant rise (79%) in the prevalence of *C. difficile* community assigned cases in comparison with Q1 of the previous year. A rise in community assigned cases of *E. coli* blood stream infection has also been evident (9.8%). In contrast there has been a reduction in the prevalence of community assigned cases of *MSSA* and *Pseudomonas aeruginosa*. There has been no change in the prevalence of *MRSA* or *Klebsiella* bloodstream infections within the community.

Incident reviews continued to be undertaken for *C. difficile* cases, with the IPC team undertaking enhanced surveillance of *MSSA, E. coli, Klebsiella and Pseudomonas aeruginosa* to identify any emerging themes or trends. The main themes and trends emerging from the *C. difficile* case review continue to be: -

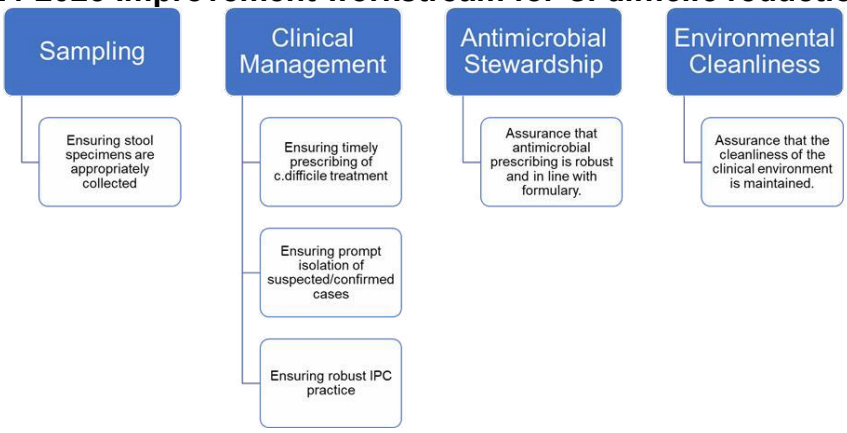
- Exposure to antimicrobials
- Repeat sampling of previously known cases

Enhanced surveillance of the cases of *E. coli* continues to demonstrate urinary tract infections to be the predominant source (91%).

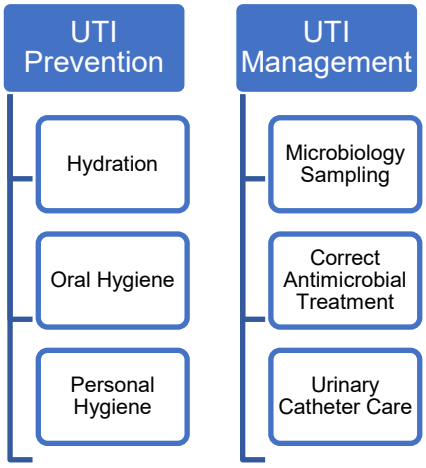
<u>HCAI Harms Improvement Program 2024/25</u>
Launched in March 2024, the HCAI Harms Improvement Program is a working group focusing on reducing the incidence of *C. difficile and E. coli* bloodstream infection. Meeting every month the group has

established primary drivers that are associated with the development of these infections, implementing targeted improvement work.

2024-2025 Improvement workstream for *C. difficile* reduction



2024-2025 Improvement workstream for *E. coli* blood stream infections



<u>Surgical Site Infection Surveillance (SSIS)</u>

During the previous quarter (Quarter 4 2023-24) the Trust participated in the Surgical site infection surveillance (SSIS) program within vascular surgery. The data for this was submitted by end of Quarter 1 (2024-25) and a summary released by UKHSA in July 2024. Across Quarter 4 (2023-24) there were 104 vascular procedures included in the surveillance with 2 incidences of SSI being identified. This maintained the rolling 5-year rate of SSIs within the vascular specialty (1.2%) which remains below the national rate (2.0%).

There was a spike in the prevalence of norovirus in June 2024 during which two outbreaks were reported on the Modular ward and Ward 50.

<u>Education, Training and Audit</u>

A comprehensive IPC education and audit program was maintained during Quarter 1 including annual ward audits, enhanced practice monitoring, divisional IPC audits and spot check audits of key aspects of care (iv-line care, urinary catheter care and commode cleanliness).

	A focused eLearning training package relating to Aseptic Non-Touch Technique (ANTT) was rolled out in June 2024. The training is mandatory for all medical, dental, nursing and additional clinical services staff. Within 6 weeks of roll out 63% of staff (designated as required to undertake ANTT training) had completed the eLearning module, equating to 1655 staff out of 2622. <u>Water Safety</u> The assurance process for reporting of underused water outlets (and their associated flushing) continued to be embedded during Quarter 1. Compliance with the reporting process continued to increase across Quarter 1 with 100% of areas reporting during week 2 of June 2024. Overall reporting compliance of >90% was achieved, providing assurance of the location of underused water outlets and their safe management. <u>IPC Board Assurance Framework</u> The IPC Board Assurance Framework is utilised by the Trust to demonstrate compliance with 10 criterion of the Health and Social Care Act 2008. Self-assessment against the 54 key lines of enquiry currently illustrates compliance with 49 of the 54 key lines, with partial compliance assessed in the remaining 5 key lines of enquiry.
Highlights	• Incidence of *C.difficile* infection dropped considerably during 2024/25 Q1 (18 cases) v the previous quarter (Jan-Mar 2024 - 28 cases) • Reducing cases of *C.difficile* infections is a key priority for 2024-25 and forms part of the Harms improvement programme. The targeted improvement work to strengthen processes relating to stool specimen collection, clinical patient management, antimicrobial stewardship and environmental cleanliness continued throughout Q1. • The NHSE set threshold for the incidence of *C.difficile* infections was achieved (no more than 18 cases). • The NHSE set threshold for the incidence of *E.coli* blood stream infections was achieved (no more than 12 cases). • Enhanced surveillance of cases of *E.coli* blood stream infections continued to illustrate the main source of infection to be urinary tract infections. • Reducing cases of *E.coli* continued to form a key part 2024-25 Harms Improvement Programme, with a focus on the prevention and robust management of urinary tract infections. • Zero cases of *MRSA* blood stream infection reported. • In Q1 there was an overall improvement in comparison with Q4 of 2023-24 in the care of IV-lines, urinary catheter care and commode cleanliness. Data is shared with divisions in real time and monthly through the IPC divisional governance packs. Care of IV-lines, urinary catheter care and commode cleanliness remains an integral part of IPC education and training.

<table>
<tr><td></td><td>
Mandatory Training compliance (Level 1) during Q1 has exceeded the 95% target, with 97% of non-clinical staff compliant with their IPC mandatory training.
HCAI Thresholds as set by NHSE (and released in August 2024) for 2024/25 –
<table>
<tr><th>Pathogen</th><th>NHSE Annual Threshold 2024-25 Total</th><th>Current year (Trust cases) Q1 2024-25</th><th>NHSE Threshold trajectory Q1 2024/25</th><th>Trust cases Q1 2024/25 v NHSE Q1 2024/25 Threshold</th></tr>
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</table>
</td></tr>
<tr><td>Recommendation(s)</td><td>The Board of Directors is asked to note the assurance provided within the report.</td></tr>
<tr><td colspan="2">Corporate Impact Assessment</td></tr>
<tr><td>Statutory Requirements</td><td>Meets NHSE/I and UKHSA guidance.
Supports compliance with the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance</td></tr>
<tr><td>Quality & Safety</td><td>Supports delivery of safe care, CQC and UKHSA requirements</td></tr>
<tr><td>NHS Constitution</td><td>Contributes to safety standards</td></tr>
<tr><td>Patient Involvement</td><td>Patient feedback not obtained for this report</td></tr>
<tr><td>Risk</td><td>Corporate IPC risk registers in place, with specific IPC risk escalated through Divisions</td></tr>
<tr><td>Financial impact</td><td>Financial impact of HCAI’s will be affected by prevalence (increases or decreases)</td></tr>
<tr><td>Equality & Diversity</td><td>Not applicable</td></tr>
<tr><td>Communication</td><td>Document to be circulated to all divisions</td></tr>
</table>

ACRONYMS	
	ANTT - Aseptic Non-Touch Technique BSI - Blood Stream Infection CDI - Clostridium difficile Infection CPE (NDM) – Carbapenemase producing Enterobacterales (New Delhi metallo-B-lactamase) CQUIN - Commissioning for Quality and Innovation D&CSS - Diagnostics and Clinical Support Services DCS - Data Capture Surveillance

	DIPC - Director Infection Prevention & Control DoH - Department of Health E. coli - Escherichia coli ICB – Integrated Care Board IPCAC- Infection Prevention and Control Assurance Committee HCAI - Healthcare Associated Infection IPCT - Infection Prevention and Control Team MRSA - Methicillin-resistant Staphylococcus aureus MSSA - Methicillin-sensitive Staphylococcus aureus NHSE – NHS England NOF - Neck of Femur PICC – Peripherally inserted central cannula. PIR - Post Infection Review PPE - Personal Protective Equipment UKHSA – United Kingdom Health and Security Agency VIP – Visual infusion phlebitis VRE - Vancomycin-resistant enterococci W&C - Women's and Children's

1. INTRODUCTION

The purpose of this paper is to provide Board of Directors with an update, and to provide assurance on the Trust's performance relating to healthcare associated infections and Infection Prevention and Control during Quarter 1 (2024-2025) across a range of key areas that support the delivery of Trust objectives. This report includes information on the following:

The national mandatory surveillance program requires reporting of all cases of:

- Methicillin resistant *Staphylococcus aureus* bacteraemia (MRSA)
- Gram-negative bloodstream infection
    - *Escherichia coli* bacteraemia (*E. coli*)
    - *Klebsiella species* bacteraemia
- *Pseudomonas aeruginosa* bacteraemia
- *Clostridioides difficile*
- *Staphylococcus aureus* bacteraemia (MSSA)

The NHS Standard Contract for 2024/25 details the threshold objectives set for each acute care provider relating to *Clostridium difficile* and blood stream infections (*MRSA, MSSA* and Gram-negative organisms) and was released by NHSE in August 2024. Utilising the case number data for 2023/24, targets have been set aimed at a 5% reduction in cases numbers (across each category), with a reduction by 1 case where count was less than 10.
Prior to this in collaboration with the Integrated Care Board (ICB) agreed local thresholds were set for *Clostridium difficile* and *E. coli* blood stream infections.

Quarter 1 Summary:
HCAI data for 2024-25 (Trust assigned cases) are:

Pathogen	NHSE Annual Threshold 2024-25 Total	Current year (Trust cases) Q1 2024-25	NHSE Threshold trajectory Q1 2024/25	Trust cases Q1 2024/25 v NHSE Q1 2024/25 Threshold
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At the end of Q1, the incidence of *C. difficile* infections were level with the threshold trajectory as set by NHSE (18 cases in Q1). This is in contrast with the wider picture across the locality with incidence of *C. difficile* infection having increased across the community and at other acute trusts within the Cheshire and Merseyside region.

Cases of both *E. coli* and *P. aeruginosa* bloodstream infections were also level with the NHSE set threshold for Q1.

Cases of *Klebsiella* blood stream infections were above the NHSE set threshold trajectory of 6 cases for Q1, with 11 cases reported. This is in line with the wider picture with incidence across other acute trusts within the Cheshire and Merseyside region showing an increase of 59% in cases during 2024-25 Q1 in comparison with 2023-24 Q1/

There are no set objectives for blood streams infections of either MSSA or MRSA. During Q1 there were 9 cases of MSSA and zero cases of MRSA blood stream infections.

HCAI data for 2024-25 (community assigned cases):

	Cheshire & Merseyside (Community cases)		
Pathogen	Q1 - Previous Year (2023-24)	Q1 - Current Year (2024-25)	Q1 - 2023/24 v Q1 – 2024/25 % change across C&M
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Across the Cheshire and Merseyside region during Q1 there has been a significant rise (79%) in the prevalence of *C. difficile* community assigned cases in comparison with Q1 of the previous

year. A rise in community assigned cases of *E. coli* blood stream infection has also been evident (9.8%). In contrast there has been a reduction in the prevalence of community assigned cases of *MSSA* and *Pseudomonas aeruginosa*. There has been no change in the prevalence of *MRSA* or *Klebsiella* bloodstream infections.

Incident reviews continued to be undertaken for trust assigned *C. difficile* cases, with the IPC team undertaking enhanced surveillance of *MSSA, E. coli, Klebsiella and Pseudomonas aeruginosa* to identify any emerging themes or trends. The main themes and trends emerging from the *C. difficile* case review continue to be:

- Exposure to antimicrobials
- Repeat sampling of previously known cases

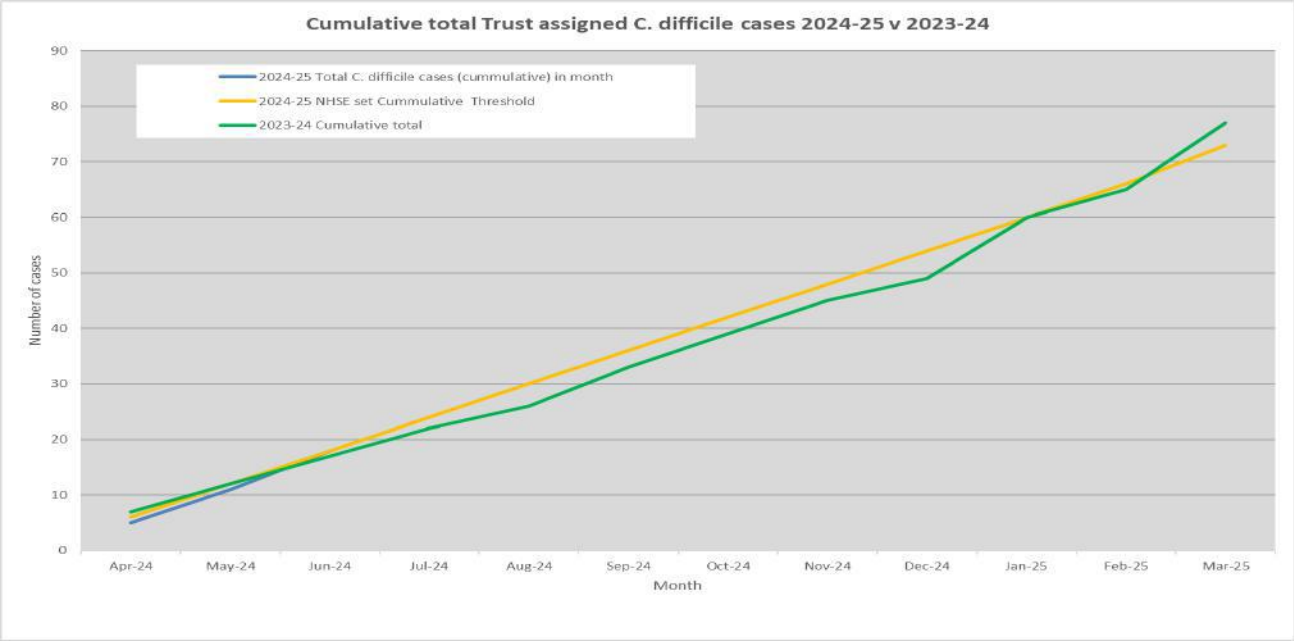
Enhanced surveillance of the cases of *E. coli* continues to demonstrate urinary tract infections to be the predominant source (91%).

2. ALERT ORGANSISM

2.1 Clostridium difficile

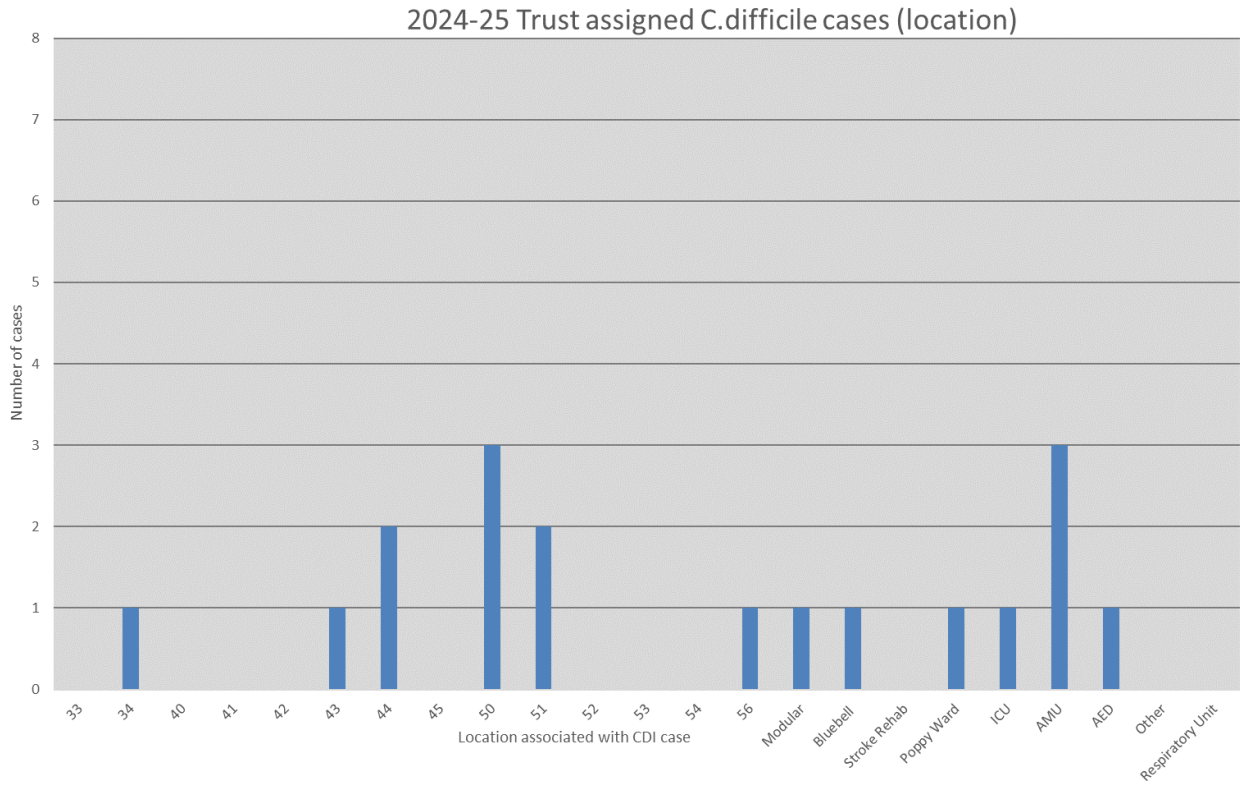
Trust-level thresholds include healthcare-associated cases only.The NHSE set threshold for *C. difficile* for 2024/2025 is no more than 73 cases. Figure 1 illustrates the current position at end of Q1 (v threshold trajectory and v previous year).

Figure 1: illustrates the number of Trust assigned *C. difficile* healthcare associated infections.



Quarter 1 end position was level with the threshold trajectory of 18 cases. In comparison with the previous year (2023-24) Quarter 1 there was +1 case reported in Quarter 1 of 2024-25.

Figure 2: 2023-2024 trust Assigned Cases (by location)



There was a wide distribution of being reported (18 cases from 12 different areas). AMU and Ward 50 being the areas with the highest number of reported cases. This is predominantly due on AMU to the patients recently being discharged and subsequently readmitted. On Ward 50 a period of increased incidence was declared in May 2024, with 2 cases linked by time, location and ribotype. At the end of Q1 the number of *C. difficile* cases stood at 18 cases. Enhanced IPC measures continue to be implemented in areas where cases have been identified combined with enhanced environmental cleaning/ education and spot check IPC audits. Rapid incident reviews continue to be undertaken (within 72 hours of case being reported) for each case.
Learning, themes & trends

- Exposure to antimicrobials (16 of the 18 cases)
- Average length of stay 30.4 days (admission to positive result)
- Prolonged admission episodes for 5 cases (147 days, 103 days, 97 days, 66 days, 31 days)
- Repeat specimens sent on four cases.

2.2 MRSA BACTERAEMIA:

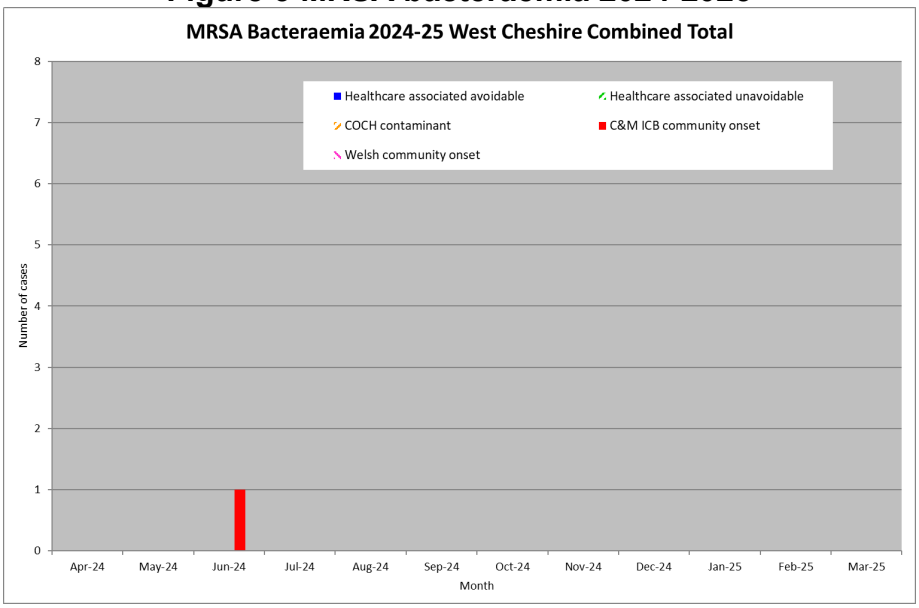
There were zero trust assigned healthcare associated cases of MRSA bacteraemia during Quarter 1 of 2024-25. There was a community onset case in June 2024 who presented to the Trust following direct transfer from another acute healthcare provider based in London.

The focus for continuous improvement and risk reduction continued to be aimed at maintaining established systems of infection prevention, evidenced based best practice and key clinical procedures, including:

- Compliance with MRSA screening policy

- Insertion and on-going management of invasive devices, including review and documentation.
- Comprehensive and inclusive admission assessment
- Standard communication between clinical teams
- Antimicrobial stewardship

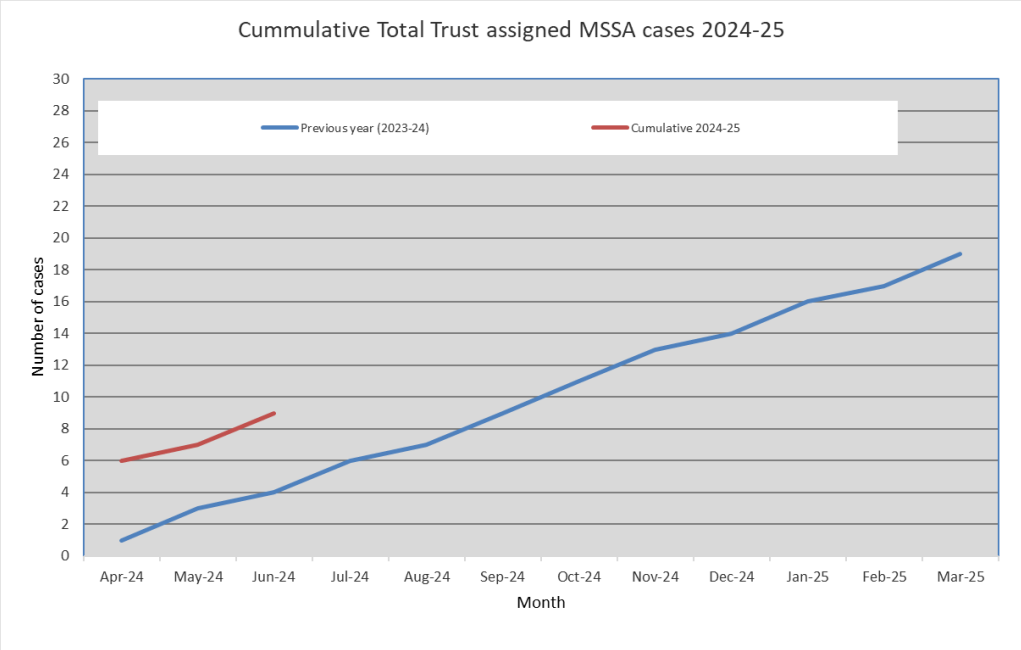
Figure 3 MRSA bacteraemia 2024-2025



2.3 MSSA BACTERAEMIA

Mandatory surveillance for MSSA bacteraemia has continued through Q1 as part of the national surveillance program. Data collection is via the national HCAI data capture system with robust surveillance systems in place. Objectives for the reduction of MSSA bacteraemia have not been set, with the Trust benchmarking against the incidence from the previous year (2023-24). In comparison with the previous year's (2023-24) Q1 (4 cases reported) there was an increased number of cases reported in Q1 of the current year (9 cases). Enhanced surveillance of the cases identified no emerging themes or trends with the 9 cases occurring across 8 different areas and the source of infection unknown for 5 of the cases.

Figure 4 Cumulative Total Trust assigned MSSA cases 2024-25.



2.4 GRAM-NEGATIVE BLOODSTREAM INFECTION (GNBSI)

As part of the UK's recently updated 5-year plan to tackle antimicrobial resistance '*Confronting antimicrobial resistance 2024 to 2029'* there is a sustained target relating to the challenge posed by gram-negative blood stream infections: -

'Target 1b: by 2029, we aim to prevent any increase in Gram-negative bloodstream infections in humans from the 2019 to 2020 financial year baseline.'

In line with the national plan and the NHSE set thresholds for *E. coli* bloodstream infections a target for 2024/25 is set at no more than 51 cases within year. Thresholds have also been set for both *Klebsiella species* (no more than 21 cases) and *P. aeruginosa* (no more than 1 case).

The GNBSI mandatory surveillance program includes:

- Gram-negative bacteraemia surveillance for *E. coli, Klebsiella* species and *Pseudomonas aeruginosa*.

This enhanced surveillance program for GNBSI involved surveillance data sourced from secondary care, with data entry responsibilities for community and hospital onset cases sitting with the acute organisation. Local surveillance data identifies that GNBSI predominantly develop within the community setting.

Figure 5 GNBSI bacteraemia 2024-2025

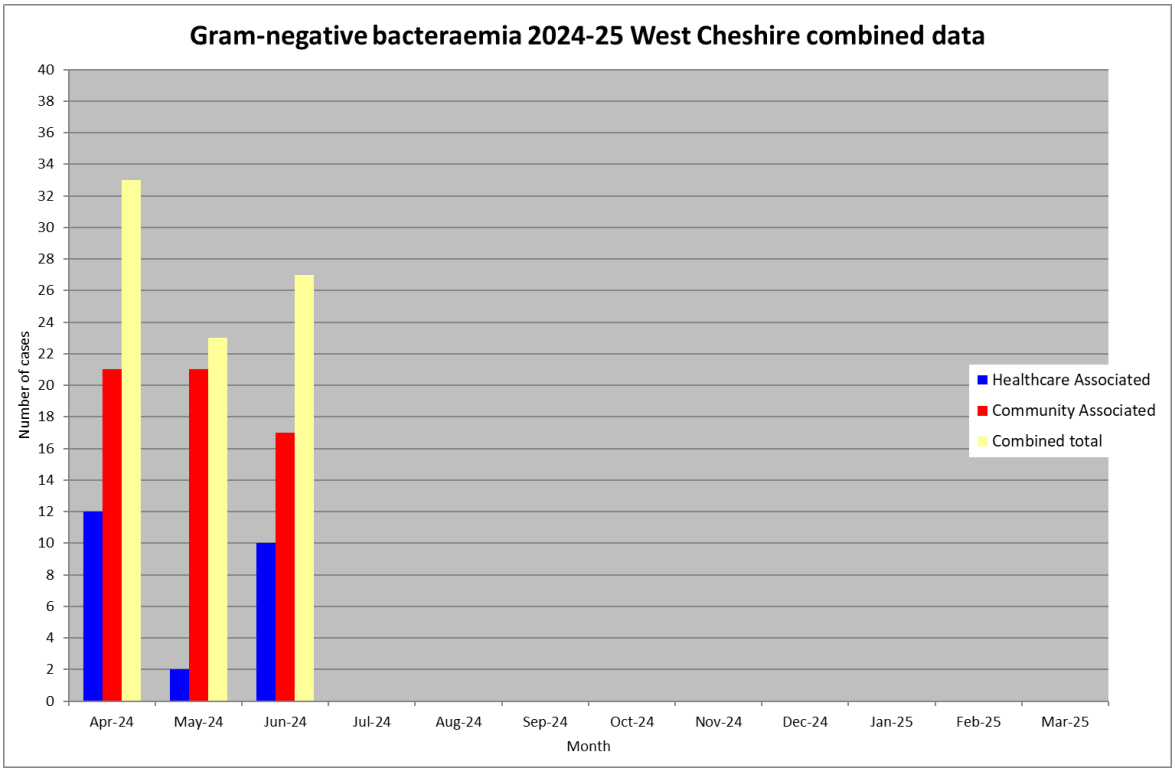
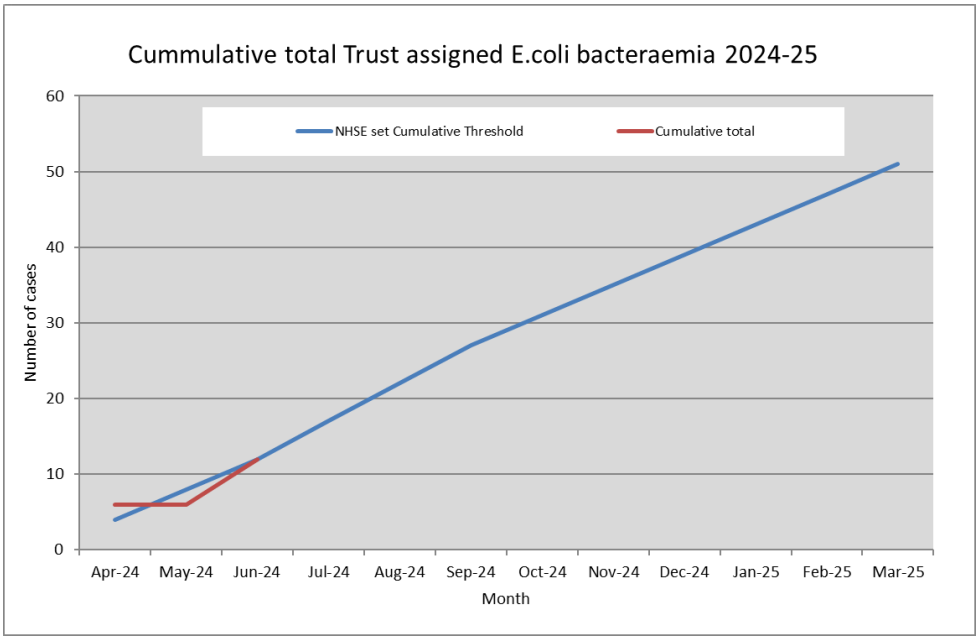


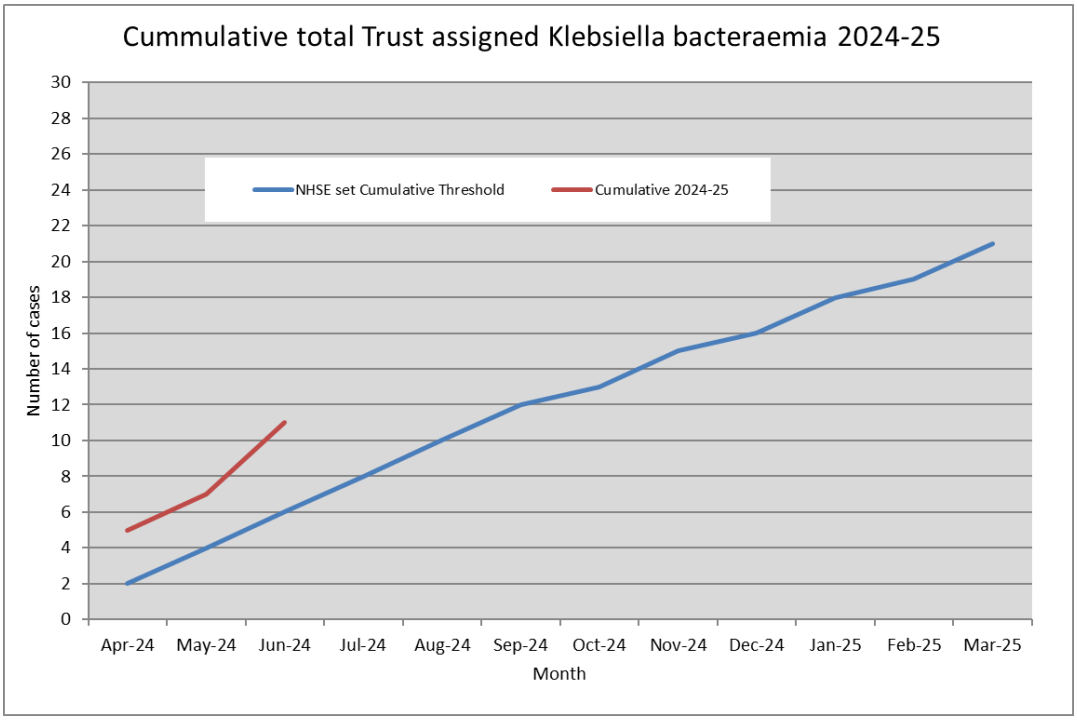
Figure 6 – Trust assigned E. coli bacteraemia cases v threshold.



There were 12 reported cases for *E. coli* by end of Q1 (level with the threshold trajectory). Enhanced surveillance of cases has identified the following trends –

- Urinary tract infection (main source of infection) identified in 91% (11 of the 12) cases.
- No emerging theme or trends by location. With the 12 cases occurring across 11 different areas.

Figure 7 – Trust assigned *Klebsiella* bacteraemia cases v threshold.

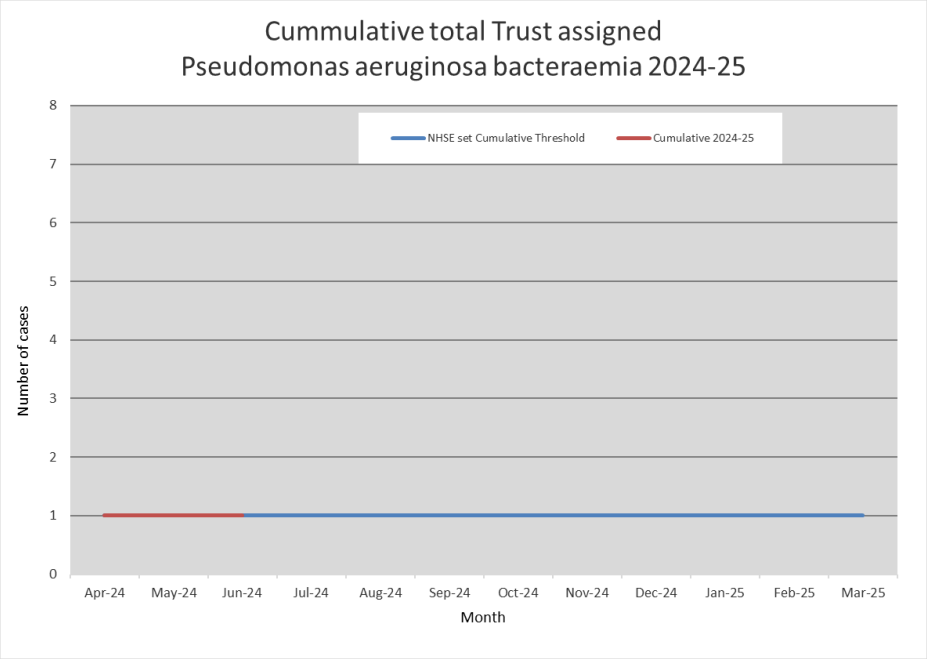


There were 11 cases reported by end of Q1 which is +5 cases more than the threshold trajectory for 2024/25.

Enhanced surveillance of cases has identified the following –

- Enhanced surveillance illustrates 45% lower urinary tract infection, 27% unknown origin, 18% hepatobiliary and 10% related to a graft abscess.
- There was a wide distribution of cases with the 11 cases reported from 8 different areas. Ward 45 and ICU the only areas to report more than 1 case.
- An increased incidence of *Klebsiella species* blood stream infections correlate with the wider picture across the locality. Incidence across other acute trusts within the Cheshire and Merseyside region shows an increase of 59% in cases during 2024-25 Q1 in comparison with 2023-24 Q1.

Figure 8 – Trust assigned *Pseudomonas aeruginosa* bacteraemia cases v threshold.



There was 1 case of *Pseudomonas aeruginosa* bacteraemia during Q1, which is the NHSE threshold set for 2024/25 year.

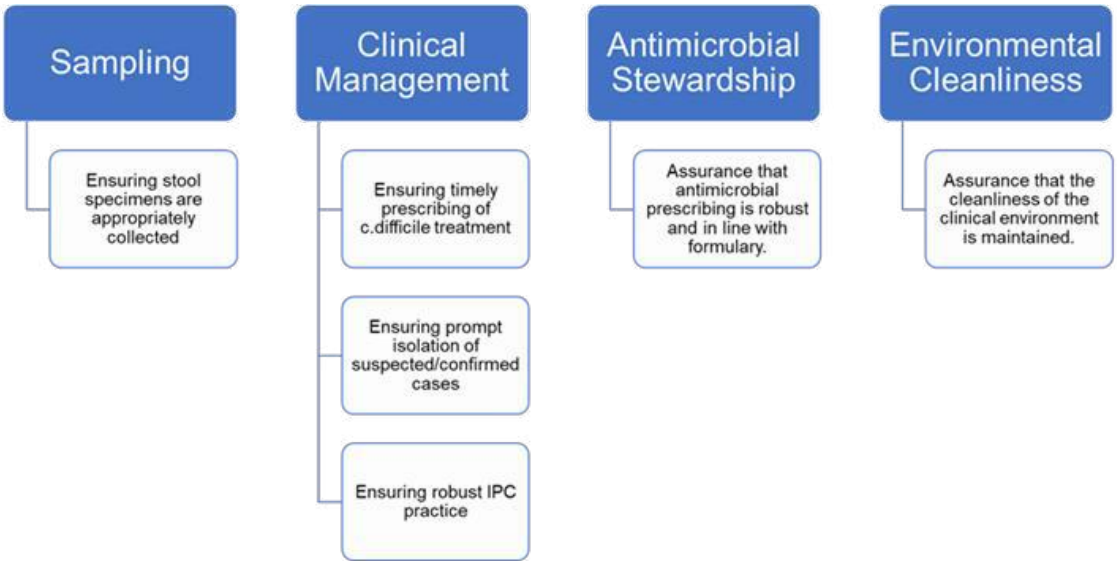
3. HCAI HARMS IMPROVEMENT PROGRAM 2024-25

For 2024-25 infection prevention and control has been incorporated into the trusts 'Harms Improvement Program'. Working in collaboration with the 'Continuous Improvement Team' a focused program of work has been established targeting the NHSE set thresholds to reduce cases of *C. difficile* infection and *E. coli* blood stream infections.

- *Clostridium difficile*

The program has 4 key work streams, derived from the learning taken from previous cases of *C. difficile* infection.

Figure 9 – HCAI Harms Improvement Program (C. difficile workstreams)



Appropriate stool sampling

- During 2023-24 there were incidences of repeat specimens being collected from patients with a known history of *C. difficile* infection (resulting in duplicate counting of cases)
- During 2023-24 there were incidences where collection of a stool specimen on admission was delayed, resulting in likely community onset cases being assigned as trust cases.

Clinical Management

- During 2023-24 there were incidences where following report of a *C. difficile* result there were delays in both patient isolation and the commencement of appropriate treatment

Antimicrobial Stewardship

- During 2023-24 exposure to antimicrobials was the single most common factor in patients developing *C. difficile* infections.

Environmental Cleanliness

- During 2023-24 there were two occasions where transmission of infection is likely to have occurred from one patient to another. A contaminated environment can be a contributing factor in the indirect transmission of *C. difficile* infection.

The improvement work aims to strengthen processes in relation to the 4 key workstreams. This will be achieved primarily by: -

1. Reinforcement of the acute diarrhoea management pathway. To provide a clear framework and assessment tool when managing patients with acute diarrhoea.
2. Working collaboratively with wards and clinical areas to ensure no patients with a *C. difficile* diagnosis experience any delays in transfer to a single room or any delays in appropriate treatment being commenced.
3. Strengthening the antimicrobial stewardship program
    a. Increased divisional engagement with the AMS committee.
    b. Review of the antibiotic formulary
    c. Monitoring of antimicrobial prescribing through the AMS audit program
    d. Scoping the potential for software (antibiotic app) to ease accessibility to antibiotic formulary.

4. Strengthening assurance of processes relating to environmental cleanliness.
    a. Facilities undertaking a review of both workforce establishment and equipment resource.
    b. Reviewing the audit program for environmental cleanliness and increasing the multidisciplinary team engagement.

2024-25 Q1 progress to date

Case numbers have stabilized across Q1 with 5, 6 and 7 cases reported respectively per month, Historically the monthly case numbers exceeded those of community assigned cases, during 2023-24 community case numbers (per month) only exceeded acute trust case numbers in 1 month (November 2023).
The community case numbers have exceeded case numbers for trust for both April & May. This demonstrated an increased prevalence of *C. difficile* infections in the wider community. During Q1 there were 17 community cases reported which is more than double the numbers of cases reported in Q1 of the previous year (2023-24) when 8 cases were reported.
In reinforcing the implementation of the acute diarrhoea pathway 5 cases of *C. difficile* infection have been identified on admission, with the cases being community assigned. Across the 18 trust assigned cases 4 have had a previous history of *C. difficile* infection.

Antibiotic usage continues to be monitored closely, with the quarterly point prevalence audit in March 2024 showing a drop (from January 2024) in the overall percentage of patient receiving an antibiotic 39% (down from 45% in January 2024). A further program of antimicrobial prescribing audits is scheduled in relation to both community and hospital acquired pneumonia, carbapenem usage and use of proton pump inhibitors.

The divisional triumvirate leads have been requested to ensure there is senior divisional representation on the AMS committee.

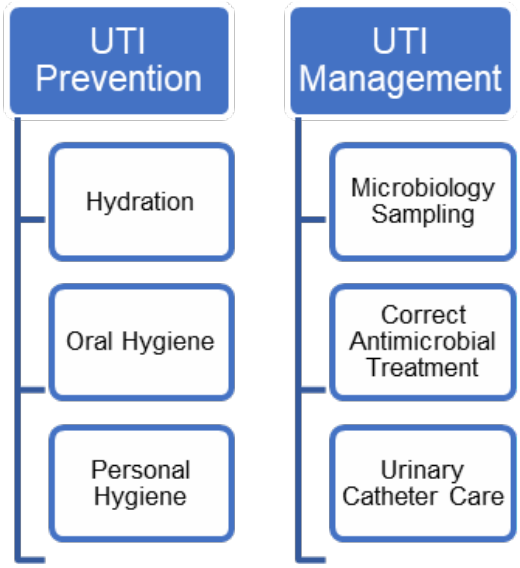
Due diligence is being undertaken in relation to the potential implementation of an app for access to the antibiotic formulary.

The schedule for the program of environmental cleanliness audits has been developed, with a focus in 2024-25 to widen participation and engagement of the multidisciplinary team to support and drive the audit program.

- *E. coli blood stream infections*

With enhanced surveillance of the cases of *E. coli* continues to demonstrate urinary tract infections to be the predominant source (91%) the focus of the improvements works to reduce *E. coli* blood stream infections is centered towards the prevention and treatment of urinary tract infections.

Figure 10 – HCAI Harms Improvement Program (E. coli workstreams)



UTI Prevention

Work to prevent urinary tract infections is focused on 3 key areas: -

- Hydration
  - Ensuring that hydration of our patients is a core component of the fundamental delivery of nursing care.
  - Promoting hydration through focused campaigns
  - Providing assurance that patient hydration is maintained through robust fluid balance management.
- Oral Hygiene
  - Ensuring that the oral hygiene of our patients is a core component of the fundamental delivery of nursing care.
  - Seeking assurance that oral hygiene is maintained through the mouthcare matters assessment and audit program.
- Personal Hygiene
  - Ensuring that the personal hygiene of our patients is a core component of the fundamental delivery of nursing care.
  - Seeking assurance that personal hygiene is maintained through the back-to-basics program.

UTI Management

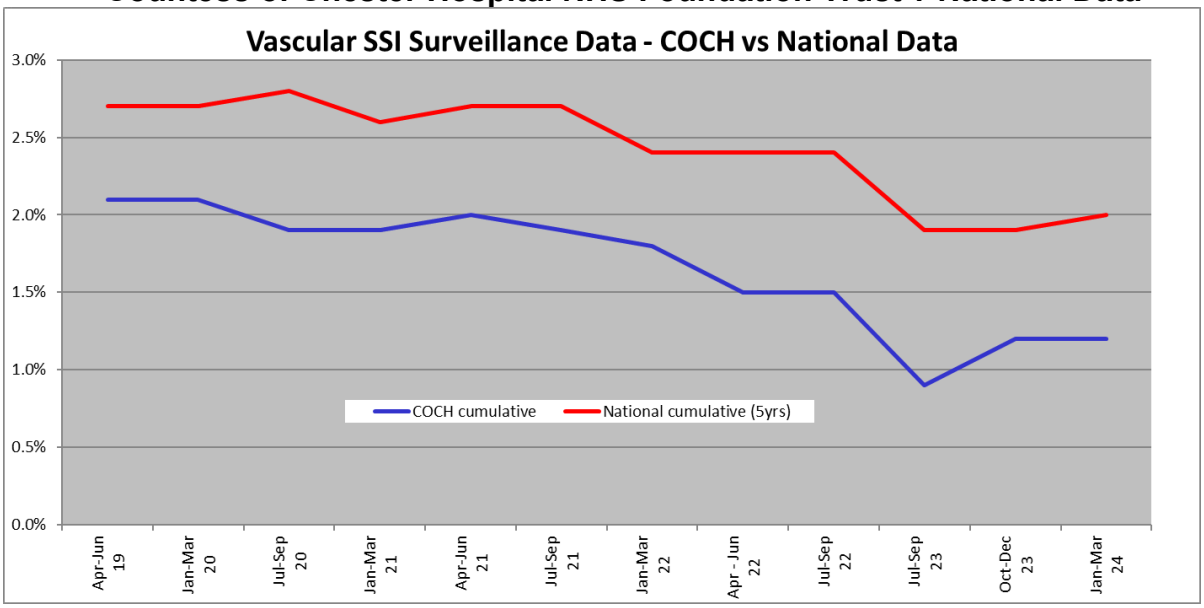
Work to strengthen the management of urinary tract infections is focused on 3 keys areas: -

- Microbiology Sampling
  - Ensuring and promoting the collection of a urine specimen for microbiological analysis when a UTI is suspected.
  - Reinforcing the appropriateness of ward testing (urine dipstick) of urine specimens
- Correct antimicrobial treatment.
  - Promoting robust antimicrobial stewardship in relation to UTI management
- Urinary catheter care
  - Promoting robust urinary catheter care
  - Seeking assurance though the audit process of the care and documentation of urinary catheters

4. SURGICAL SITE INFECTION SURVEILLANCE

During the previous quarter (Q4 – 2023-24) the Trust participated in the Surgical site infection surveillance (SSIS) program within vascular surgery. The data for this was submitted by end of Q1 (2024-25) and a summary released by UKHSA in July 2024. Across Q4 (2023-24) there were 104 vascular procedures included in the surveillance with 2 incidences of SSI being identified. This maintained the rolling 5-year rate of SSIs within the vascular specialty (1.2%) which remains below the national rate (2.0%).

Figure 11 – Vascular SSI Surveillance Date –
Countess of Chester Hospital NHS Foundation Trust v National Data



Surveillance of SSIs within vascular shows the Trust rolling average of SSI to be at 1.2% which is below the national average of 2.0%.

5. OUTBREAKS

5.1: Norovirus

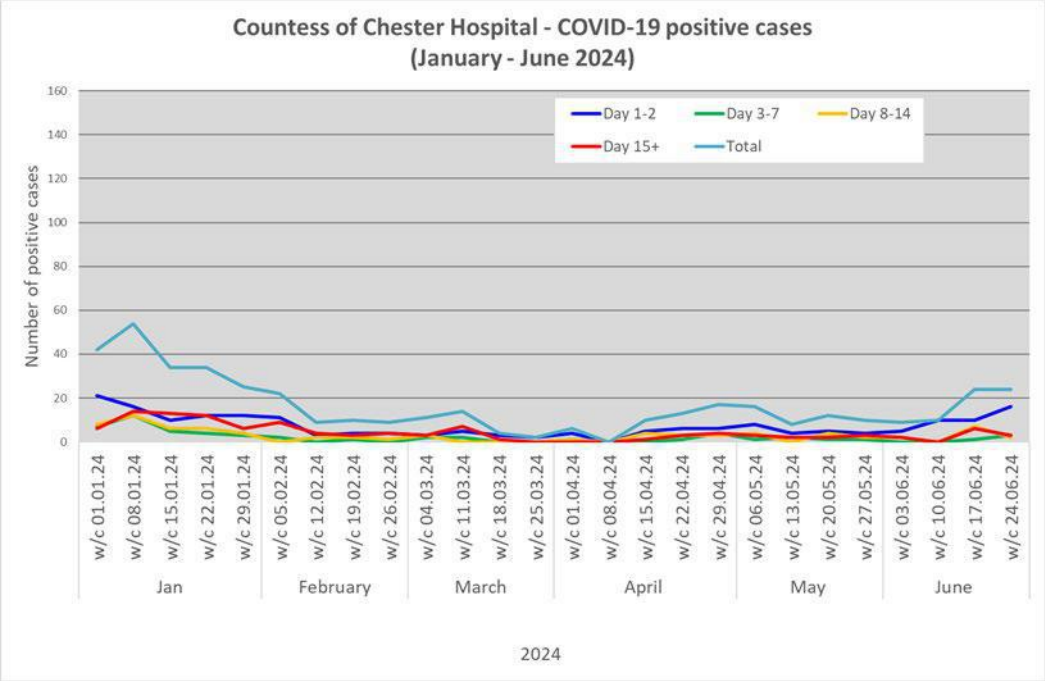
There was a spike in the prevalence of norovirus in June 2024 during which two outbreaks were reported on the Modular ward and Ward 50. Both outbreaks resulted in the wards being closed to admissions and visiting restrictions implemented.

- Ward 50 – outbreak duration 3 days (24.06.24 – 27.06.24)
- Modular Ward – outbreak duration 7 days (24.06.24 – 01.07.24)

6. COVID-19 / INFLUENZA

Across Q1 there was a sustained low prevalence of both COVID-19 and Influenza, with routine testing of influenza cases ceasing during Q1.

Figure 12 – COVID-19 positive cases (January-June 2024)
Countess of Chester Hospital NHS Foundation Trust



7. AUDIT PROGRAMME:

7.1 Infection Prevention and Control service audit programme 2024/25

The audit program focuses on key elements and aspects of infection prevention and control practice and is driven primarily by the Infection Prevention and Control Team.
The key components and structure of the audit program are: -

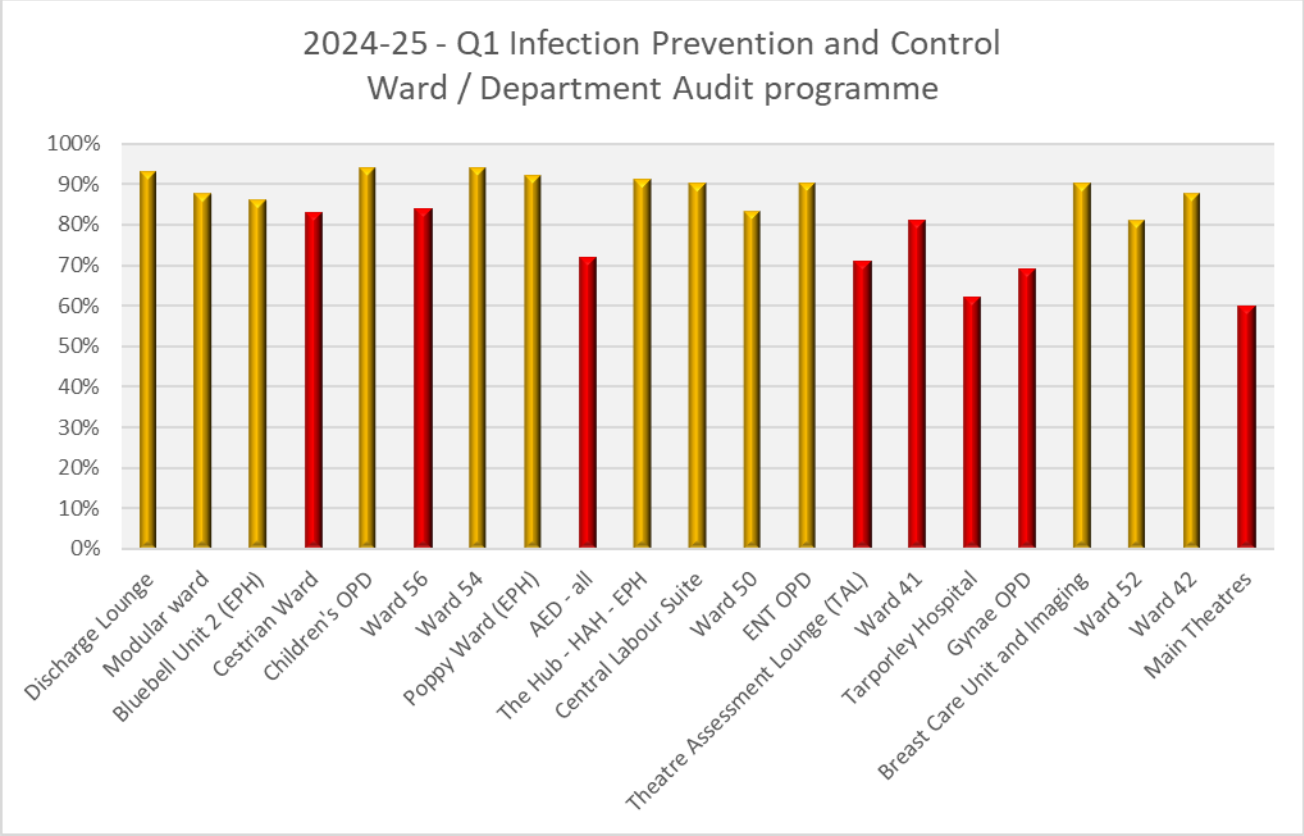
- Ward and Departmental annual audits (undertaken by the Infection Prevention and Control Team).
- Hand Hygiene Compliance Monitoring.
- MRSA screening surveillance.
- Infection Prevention and Control IPC Champions Audit.
- IPC spot checks (urinary catheter care, intravenous cannula care, commode cleanliness).
- Safe management, use disposal of sharps.
- Provision of hand hygiene dispensers.

There is a well-established audit program that is delivered by the Infection Prevention and Control team, utilising a nationally recognized, evidence-based audit tool developed by the Infection Prevention Society. The audit tool encompasses the full range of standard principles of infection prevention and control. From the audits, action plans are generated and circulated with ward/department managers to enable focused action on any aspects of non-compliance.

Ward / Departmental Audits (end of Q1)

- 21 areas completed.
- Target of 95% compliance with IPC standards
- Average compliance score of 83% (v 90% across 2023/2024)
- 8 of the 21 areas audited scored below 85% compliance.
- Main issues affecting compliance continues to be the fabric of the environment/ storage issues, clutter and cleanliness.
- Ward and departments are proactively formulating and returning action plans to identify where remedial work is being targeted. 15 of the 21 areas returned completed action plans with the 4-week time frame.

Figure 13: 2024-2025 (end of Q1) Infection Prevention & Control Ward/ Departmental Audit



7.2 IPC enhanced monitoring

The infection prevention and control team maintains a constant programme of HCAI surveillance. If any ward/department is identified to have had an increased prevalence of any transmissible pathogens then the IPC team implement a period of enhanced monitoring of IPC practices.

During Q1 the IPC team completed 184 separate enhanced monitoring audits across 24 different wards and departments.

The enhanced monitoring audits focus on 3 key aspects of IPC practice – Ward enviroment, personal protective equipment (PPE) and hand hygiene. Overall compliance across Q1 was 77.1%. The enhance monitoring audits evaluates 3 key aspects of IPC practice:-

- Ward Environment
    - Themes of non-compliance – clutter and general cleanliness

- Personal Protective Equipment
    - Themes of non-compliance – incorrect use of PPE (non-removal after each single use)
- Hand hygiene
    - Themes of non-compliance – clutter on clinical hand wash basins

Observations and learning is shared in real time (and via the monthly IPC divisional governance packs) with wards and departments.

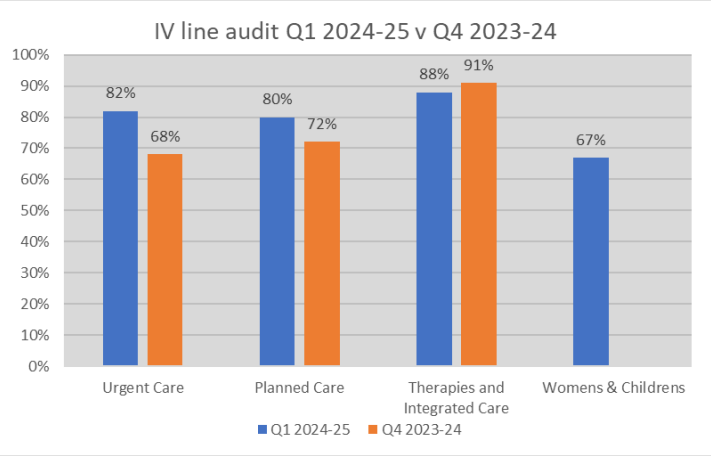
7.3 IPC spot checks

Embedded within the IPC audit programme is a series of spot check audits focusing on IV line care, urinary catheter care and commode cleanliness.

IV line care

During Q1 a total of 306 observations of IV line care were completed. Overall compliance was identified at 79%, this was an improvement from Q4 of 2023-24 (70%). The main aspect of non-compliance being lack of clear/correct documentation of IV cannula insertion and ongoing care (VIP score). Observations and learning is shared in real time (and via the monthly IPC divisional governance packs) with wards and departments.

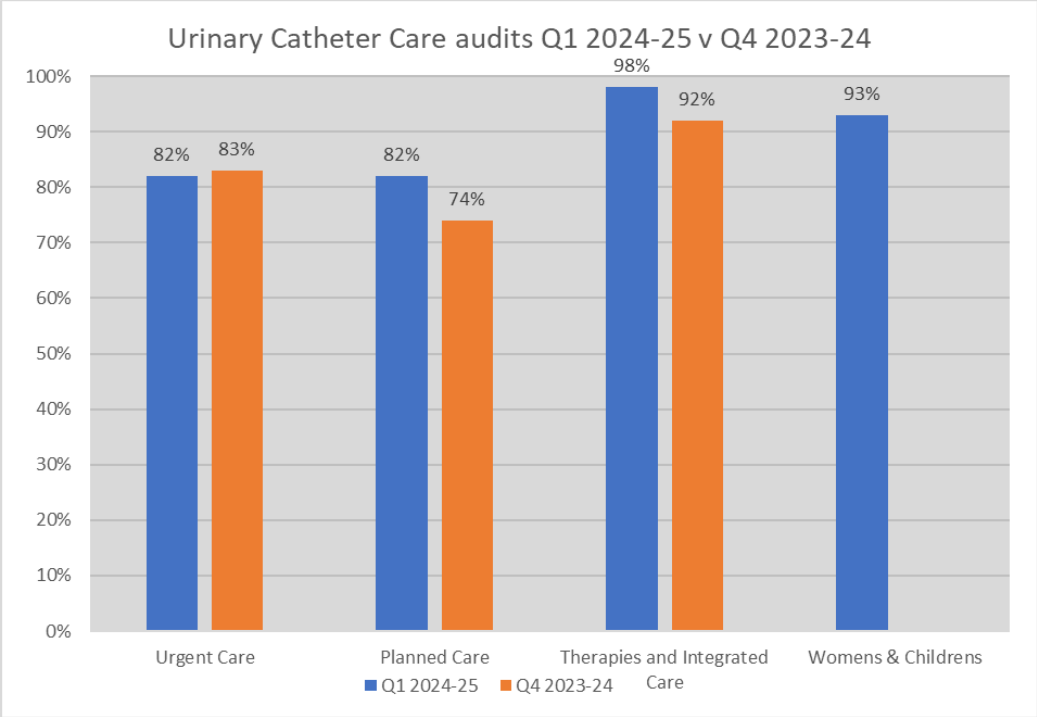
Figure 14: Q1 – IV line audit compliance (by division)



Urinary catheter care

During Q1 a total of 185 observations of urinary cather care were completed. Overall compliance was identified at 89%, this was an improvement on Q4 of 2023-24 (82%). The main aspect of non-compliance being lack of clear/correct documentation of urinary catheter insertion and ongoing care. Observations and learning is shared in real time (and via the monthly IPC divisional governance packs) with wards and departments.

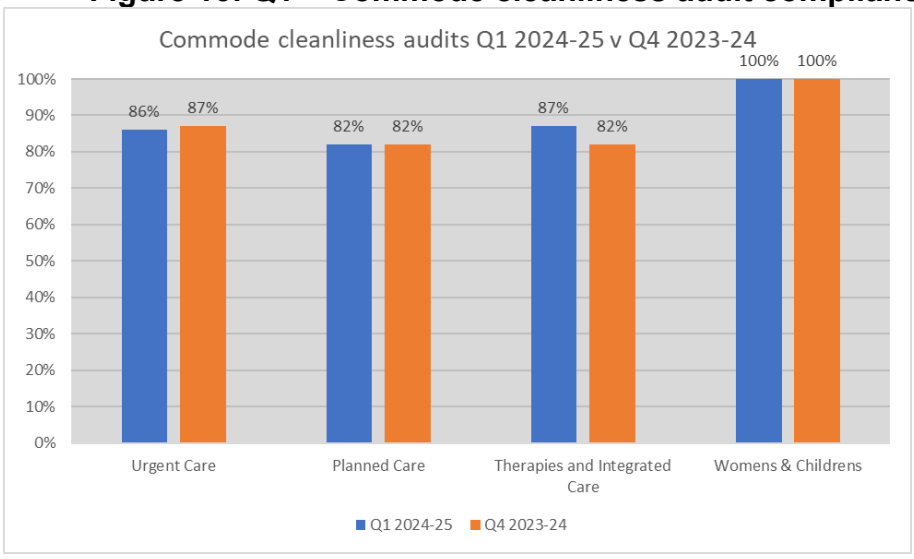
Figure 15: Q1 – Urinary catheter care audit compliance (by division)



Commode cleanliness

During Q1 a total of 373 observations of commode cleanliness were completed. Overall compliance was identified at 89%, this was an improvement on Q4 of 2023-24 (85%). The main aspect of non-compliance being non use of 'I am clean' tape to provide assurance that the commode has been decontaminated. Observations and learning is shared in real time (and via the monthly IPC divisional governance packs) with wards and departments.

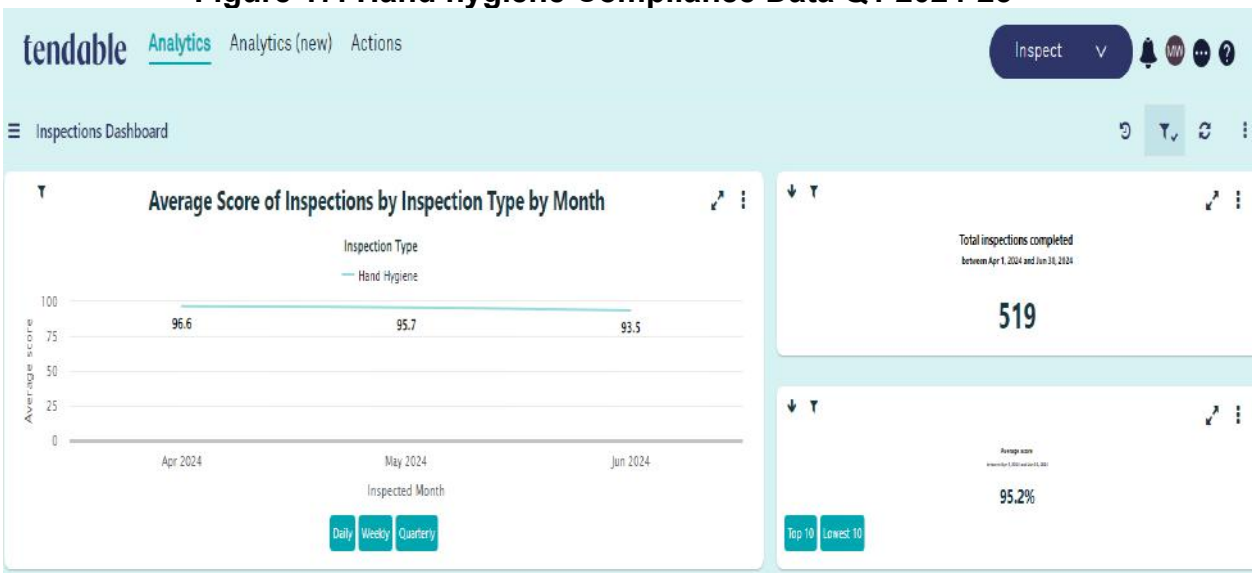
Figure 16: Q1 – Commode cleanliness audit compliance (by division)



7.4 Hand hygiene compliance monitoring

The chart below outlines Trust performance across Q1 of 2024-25 which consistently remained above the aim of 95% compliance. During Q1 the process for hand hygiene compliance continued to be monitored through the Tendable audit system (for the 26 areas include in the Tendable audit program). A total of 519 observations were recorded during the Q1 period with overall compliance reported at 95.2%. The majority of the audits were undertaken by ward staff (86%) with compliance from these audits reported as 96%. A proportion (14%) of hand hygiene audits were undertaken by the IPC team, with compliance from these audits reported as 83%.

Figure 17: Hand hygiene Compliance Data Q1 2024-25



8. TRAINING AND EDUCATION

A core function of the Infection Prevention and Control Team has been supporting the delivery of the established infection prevention and control training and education framework. All disciplines of staff within the organisation (including all staff in clinical or non-clinical roles) are mandated to receive training in infection prevention and control. The IPC educational framework is aligned with the national framework (from NHSE) with its core aims being to –

- support the design and delivery of education programs that meet the needs of the workforce.
- enable staff to understand and demonstrate the required expectations for effective and safe IPC practice.
- ensure infection prevention is a core component of all initial and induction training.
- inform the content of education and training provided by health and social care organisations, support agencies (e.g., UKHSA, NHS England, Health Education England [HEE], SfH and Skills for Care [SfC]) and commercial training providers.
- inform education programs to ensure evidence-based IPC is consistently built into, and delivered within, all health and social care related educational programs.
- support commissioning to promote all systems and providers of health and social care to commit to continuous learning and development in relation to IPC.
- enable audit of education programs against the identified standards and to assess capabilities of those in the workforce.

Within the IPC educational framework during Q1 the IPC team have delivered a range of education and training sessions including: -

- Clinical mandatory training
- Non-clinical mandatory training
- Trust welcome event
- Womens & Childrens mandatory training
- Nurse induction
- Healthcare support worker induction
- Core skills for nurse
- Preceptee essential skills
- Student nurse workshop
- Allied healthcare professionals IPC training
- PPE educational session at Ellesmere Port Hospital

Training compliance

During Q1 there has been a sustained high level of compliance for IPC mandatory training in level 1 (non-clinical) 97.35%. Compliance for level 2 (clinical) staff remains static at 86.2%.

8.1 ASEPTIC NON-TOUCH TECHNIQUE (ANTT) TRAINING

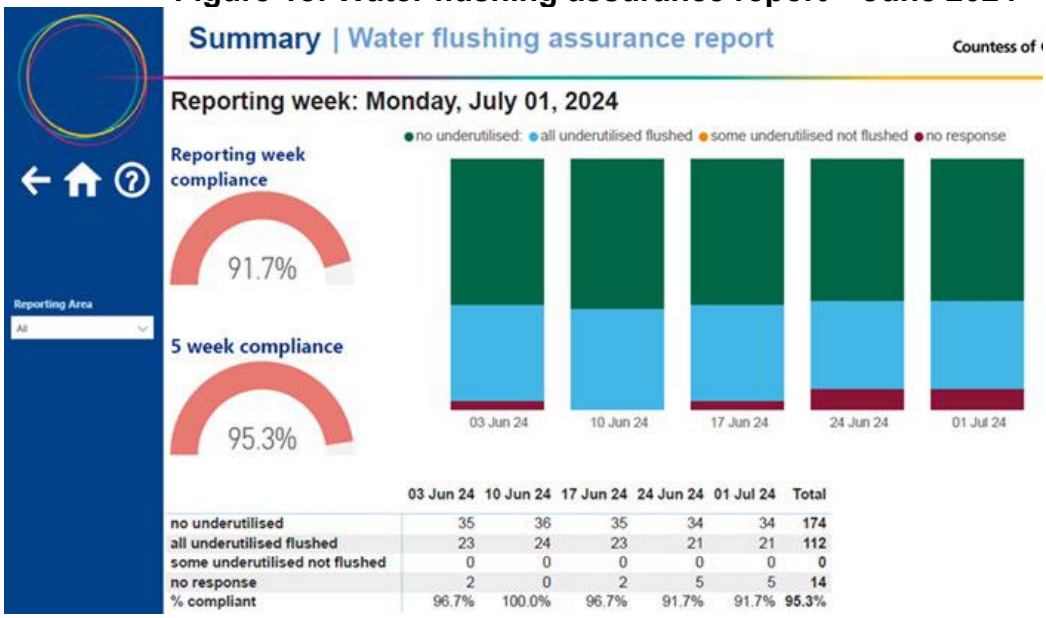
A focused eLearning training package relating to Aseptic Non-Touch Technique (ANTT) was rolled out in June 2024. The training is mandatory for all medical, dental, nursing and additional clinical services staff.

Compliance report illustrating the uptake in the eLearning module released in July 2024 showed a 63% uptake in completing the eLearning module equating to 1655 staff out of 2622.

9. WATER OUTLETS (UNDERUSED) REPORTING AND FLUSHING ASSURANCE

The assurance process for reporting of underused water outlets (and their associated flushing) continued to be embedded during Q1. Compliance with the reporting process continued to increase across Q1 with 100% of areas reporting during week 2 of June 2024. Overall reporting compliance of >90% was consistently achieved, providing assurance of the location of underused water outlets and their safe management.

Figure 18: Water flushing assurance report – June 2024



	03 Jun 24	10 Jun 24	17 Jun 24	24 Jun 24	01 Jul 24	Total
no underutilised	35	36	35	34	34	174
all underutilised flushed	23	24	23	21	21	112
some underutilised not flushed	0	0	0	0	0	0
no response	2	0	2	5	5	14
% compliant	96.7%	100.0%	96.7%	91.7%	91.7%	95.3%

10. IPC BOARD ASSURANCE FRAMEWORK (BAF)

The trust has adopted and implemented the NHSE National Infection Prevention and Control Board Assurance Framework as a tool to demonstrate compliance with the Health and Social Care Act 2008.

The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format.

The compliance rating column allows for the selection of a red, amber, green (RAG) rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant, compliant.

A full update of the IPC BAF is undertaken biannually with updates provided to the IPCAC. Updates of the IPC BAF will occur during the year as and when required to individual elements of the framework.

The 10 sections of the IPC BAF are broken down further into 54 key lines of enquiry. An update of the IPC BAF in July 2024 illustrates compliance with 49 of the 54 key lines of enquiry (91%). Partial compliance has been assessed in 5 of the key lines of enquiry which are: -

1. **All staff receive the required training commensurate with their duties to minimise the risks of infection transmission**. This relates to the compliance of level 2 (clinical) IPC mandatory training, currently at 86.2%. Compliance across the level 2 clinical mandatory training categories is <90%. The mandatory training group are exploring options for increasing capacity on face-to-face training sessions.
2. **There is evidence of compliance with National cleanliness standards including monitoring and mitigations (excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract these setting will have locally agreed processes in place).** This relates to challenges within the facilities workforce (vacant posts, high level absenteeism and lack of equipment). A broader piece of work is being undertaken by the Deputy Director of Nursing, IPC Head of Nursing and Facilities Manager to review the challenges within the service and plan how to address these.
3. **There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01.** This relates to dated air handling units within the main trust building and lack of working mechanical ventilation plant at Ellesmere Port Hospital. Estates have escalated and asked for capital funding this financial year to bring these systems to an operable condition.
4. **There is evidence of a program of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09.** This relates to fabric and integrity of the clinical environment and the challenges within the estates department in maintaining the integrity of the clinical environment. This has been logged on the corporate risk register (ID 2912) with remedial action to address the risk to be incorporated within the estate's strategy.
5. **That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.** This relates to the overall low compliance of staff who require an FFP3 mask fit test. Currently at 49% the target is to achieve 90% compliance. Work is ongoing to sustain a centralized fit testing service, supplemented by trained fit testers within clinical divisions. The prioritization of staff for fit testing has been aligned with the NHSE guidance. Clinical divisions have been tasked with developing local plans to improve compliance within their respective areas.

11. RECOMMENDATIONS

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

Meeting	**24th September 2024**		**Board of Directors**					
Report	**Agenda item 19.**		**Annual submission to NHS England North West: Medical Appraisal, Revalidation and Medical Governance**					
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Nigel Scawn				Medical Director & Responsible Officer			
Author(s)	Lesley Spruce Lyndsay Cheater				Appraisal & Revalidation Manager Appraisal Lead			
Board Assurance Framework	BAF1	Failure to maintain safety and prevent harm would result in poorer patient care and outcomes						
Strategic Aims	SG1 – Patient & family Experience							
CQC Domains	Safe							
Previous Considerations	People & Organisation Development Committee – 18th August 2024							
Executive Summary	The purpose of this report is to provide assurance regarding the medical appraisal and revalidation process together with medical governance activity.							
Highlights	Revalidation of the organisations medical staff is a core element of how we ensure safe care. This Framework for Quality Assurance provides evidence of how we assure such care.							
Recommendation(s)	The Board of Directors is asked to note the assurance provided within the report and to approve the Framework and the Statement of Compliance prior to submission. *To note, this was agreed at the People & Organisation Development Committee held on 13th August 2024.*							
Corporate Impact Assessment								
Statutory Requirements	Meets NHS England's Framework of Quality Assurance for all Responsible Officers							
Quality & Safety	Improved patient safety							
NHS Constitution	Not applicable							
Patient Involvement	Not applicable							
Risk	Not applicable							
Financial impact	Not applicable							
Equality & Diversity	Not applicable							
Communication	Not applicable							

Countess of Chester Hospital NHS Foundation Trust

Annual submission to NHS England North West: Medical Appraisal, Revalidation and Medical Governance

BACKGROUND

1. Each year the Trust completes this audit/report for NHS England to assure our compliance with the Responsible Officer Regulations and to show our commitment to continual quality improvement in the delivery of professional standards.

PURPOSE

2. The purpose of this report is to provide assurance to the Board of Directors and support future progress.

CURRENT POSITION

3. The completed annual submission is due to be submitted to the National Body by 31st October 2024. Prior to submission, the Board of Directors is required to review the content and the submission is required to be signed by the Chief Executive Officer or Chair, on behalf of the Trust.

RECOMMENDATIONS

4. The Board of Directors is asked to note the assurance provided within the report and to approve the Framework and the Statement of Compliance prior to submission.

   To note, this was agreed at the People & Organisation Development Committee held on 13th August 2024.

NHS England North West
Medical Directorate
Professional Standards Team

2023-2024 Annual Submission to NHS England North West:

Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2024**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2023-2024 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Countess of Chester Hospital NHS FT
What type of services does your organisation provide?	Secondary Care

	Name	**Contact Information**
Responsible Officer	Nigel Scawn	nigel.scawn@nhs.net
Medical Director	Nigel Scawn	nigel.scawn@nhs.net
Medical Appraisal Lead	Lyndsay Cheater	lyndsay.cheater@nhs.net
Appraisal and Revalidation Manager	Lesley Spruce	lesley.spruce@nhs.net
Additional Useful Contacts	Ian Benton	ibenton@nhs.net Deputy Medical Director

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

No

If yes, who is this with?

Organisation: n/a

Please describe arrangements for Responsible Officer to report to the Board: The RO is also the Executive Medical Director and therefore is a member of the Board. The MD produces and reports a monthly 'Medical Director's Update' to Board which includes any concerns regarding medical staff that need to be escalated to the Board.

Date of last RO report to the Board: The 2022/2023 Annual Submission was presented to the Trust Board in January 2024.

Action for next year: To continue to submit the AOA for NHS England to the Board for their approval.

Annex A

Illustrative designated body annual board report and statement of compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 – Summary and conclusion Section 4 – Statement of compliance

Section 1: Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of Countess of Chester Hospital NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	None.
Comments:	The RO is the Medical Director
Action for next year:	To continue to ensure that we have a trained licensed medical practitioner appointed as RO.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	None.
Comments:	The trust has a ROAG (Responsible Officer Advisory Group) which meets monthly. This group comprises of the RO (MD), the DMD, Medical Appraisal and Revalidation Lead, Appraisal Manager, Medical Staffing Lead, and in 2024-2025, Trust Board representation has been strengthened by the introduction of a Non-Executive Director to the group. The trust funds 1 PA for the Medical Appraisal and Revalidation Lead who is a consultant. A new software package (L2P) has been funded and rolled out in January 2024 to increase the efficiency and ease of the appraisal process
Action for next year:	To include a NED into ROAG in 2024-2025.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	None
Comments:	The Appraisal & Revalidation Manager (ARM) maintains a record of all doctors employed by the Trust, this is updated as and when a new doctor joins the Trust. If a doctor has not made their own ‘connection’ to the Trust the ARM will make the connection on their behalf. When doctors leave the Trust their connection to the Trust is removed by the ARM via the GMC Connect Website.
Action for next year:	To continue maintaining this process.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	None.

Comments:	Now that we have a new electronic platform for appraisal in place, we will be updating our Appraisal Policy to take reflect this.
Action for next year:	To review our Appraisal Policy in 2024-2025 to ensure it is up to date and effective.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	To plan a peer review once we have had the electronic appraisal system up and running for a 12-month period
Comments:	In January 2025 we will have had the L2P electronic appraisal system up and running for 12 months. We have made links with the appraisal team in a local trust (WUH) and have approached them to see if working with them on a peer review would be possible
Action for next year:	To progress with a peer review of our appraisal and revalidation processes in early 2025.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	None.
Comments:	All doctors for whom CoCH is their designated body and main employer are supported in their appraisal & revalidation should that fall due whilst they are working at COCH. When they join the Trust they are invited to an Appraisal Awareness Session run by the Appraisal Lead and the ARM. In this session they are introduced to the Trust's appraisal and revalidation processes and signposted to any help and guidance that they may need. They are also given an account on the L2P electronic appraisal platform.
Action for next year	To continue to support these doctors and run appraisal Awareness sessions at 2-3 appropriate points in the year to capture these doctors.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's

whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	None.
Comments:	As part of the appraisal process, doctors provide details about and discuss their scope of practice at CoCH and in any other organisations in which they work. A scope of practice form needs to be included in their appraisal evidence from any other organisations, which incorporates information on any claims, incidents or adverse events they have been involved in
Action for next year:	None

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	n/a
Comments:	n/a
Action for next year:	n/a

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	None
Comments:	There is a Medical Appraisal Policy in place but this hasn't been updated since 2015. It needs to be updated to reflect our current processes including the use of the new electronic platform.

Action for next year:	To update our Appraisal Policy in 2024-2025.

1B(iv) Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	None
Comments:	We plan to hold 1 or 2 Appraiser Training sessions per annum to recruit and train new appraisers, to ensure we have an adequate number of trained appraisers to each complete 5-8 appraisals a year in a timely manner and to a high standard.
Action for next year:	To update the appraiser training to include guidance on L2P and to continue running regular appraisal training.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	None
Comments:	We continue to hold bi-annual Appraiser Support Groups (ASG). At these meetings we are able to update our appraisers on any changes or developments that we receive from NHS England Revalidation Team Meetings and provide a forum for open discussion on appraisal matters or challenges arising. ARM and Medical Lead for Appraisal and Revalidation easily available for appraisal advice.
Action for next year:	Continue ASG and appraiser support.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	None
Comments:	The Appraisal manager quality assures appraisals submitted to the appraisal team, and if incomplete or of a substandard quality, will discuss these with the Medical Lead for Appraisal and Revalidation. These appraisals are returned the appraiser/ appraisee with feedback on what improvements are needed to reach the standard required. Appraisals reaching the standard are then submitted to the appropriate AMD's for review. The ASPAT tool (Appraisal Summary PDP Audit tool) will be used from 1st April 2024 to audit and quality assure the appraisal summary and PDP of doctors in the organisation. We will retrospectively review 20% of the appraisers summaries each year, so over a 5 year cycle, all the appraisers will have been audited and quality assured once, appraisers receiving feedback at the time. The findings will be reported to the ROAG group 6 monthly.
Action for next year:	Continue as above, support and educate appraisers as needed

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	None
Comments:	All revalidation recommendations are considered by the Responsible Officer Advisory Group (ROAG) at the monthly meeting. The evidence is circulated 2 weeks in advance for review. The ROAG review appraisal and 360 MSF (Multi-Source Feedback) evidence for doctors who are due for revalidation and the RO then makes his recommendation to the GMC.
Action for next year:	To continue.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	None
Comments:	Doctors are informed by the ARM once the RO has submitted a recommendation for them. If the recommendation is one of deferral or non-engagement this will have been fully discussed with the doctor before the recommendation is submitted.
Action for next year:	To continue

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	None
Comments:	Any concerns raised about a doctor would be discussed with them at the first available opportunity, including removing them from the clinical environment if considered necessary to ensure patient safety. Each clinical division within the organisation holds a monthly governance meeting, where feedback would be given about doctors if any concerns had arisen and what plans were in place going forward. The doctor would also have a duty to inform other organisations in which they work if they are excluded from clinical practice. The Appraisal & Revalidation Manager (ARM) provides reports on claims, complaints and incidents which are uploaded into appraisal documentation in advance of their appraisal, so that they have time to reflect and comment upon any claims, complaints and incidents that are recorded.
Action for next year:	To continue as above

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	None
Comments:	All doctors employed by the Trust including Lead Employer Trainee doctors are subject to the Trusts Disciplinary and Capability procedure (see later) and the MHPS document. All conduct and performance issues are discussed and logged with NHS Resolutions (Practitioners Performance Advisor) and their advice is shared with the doctor in difficulty and the Trust through a Designated Board Member.
Action for next year:	To continue

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	None
Comments:	Doctors are emailed any claims, complaints or incident reports one month in advance of their appraisal date. The doctor is expected to then reflect and make comment on these and they are available for the appraiser to view prior to the appraisal. They also receive their Mandatory Training Report in this way.
Action for next year:	To continue. A Doctor Foster report used to be included, but was considered inaccurate and of minimal use and so it will not be used in 2024-2025

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	None.
Comments:	The organisation has a policy on Sharepoint entitled: Disciplinary and Capability procedure for medical and dental staff maintaining high professional standards". This was written in 2017 by the Medical Director at that time, and last modified in 2020. The RO holds regular informal updates with both the GMC Employment Liaison Advisor and the Practitioners Performance Advisor.
Action for next year:	To update the above policy in 2024-2025, and continue to hold these updates with the GMC and PPA

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	None
Comments:	There would be regular informal updates with both the GMC Liaison Officer and the Practitioners Performance Advisor. Disciplinary matters concerning doctors is a standing agenda item for the Medical Director at every Trust Board Meeting and discussed at divisional governance meetings (see earlier). If a doctor is excluded from practice this is reported immediately to the Chief Executive and the Board and reported every 4 weeks until the exclusion is lifted, and the doctor is back in work.
Action for next year:	To continue.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about
a) doctors connected to our organisation and who also work in other places, and
b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	None
Comments:	We use the Transfer of Information Form (TOI) to request information from a doctors previous Trust. The information on this is cross checked with other evidence including their DBS check, GMC information and their references. We also complete TOI requests from other Trusts when a doctor has left our employment. The RO is made aware of any concerns that we may have surrounding any TOI forms received in from another Trust.
Action for next year:	To continue

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	None

Comments:	All MHPS/Disciplinary cases are 'overseen' by a Non-Executive Director. The RO is also advised by the Trust's Responsible Officer Advisory Group which has been strengthened by the addition of a Non-Executive Director and the Head of Medical Staffing. Equality and Diversity training is mandatory for all staff in the organization.
Action for next year:	To continue

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture (give example(s) where possible).

Action from last year:	
Comments:	The RO, ARM and Medical Appraisal and Revalidation Lead attend regional RO meetings each year where updates are highlighted and discussed. In between these times, the RO would bring information on any developments to the monthly ROAG meeting to discuss.
Action for next year:	Continue to remain up to date

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	
Comments:	All health care practitioners are reviewed annually as part of their professional appraisal process, by peers in their profession
Action for next year:	The RO and ROAG will be advised by the GMC regarding additional appraisals that will need to be carried out going forward for non-medical practitioners

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background

checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	None
Comments:	The following policies are in place to ensure the appropriate pre-employment background checks have been carried out: - Managers Guide to Recruitment - Policy for the Appointment of Consultant Medical & Dental Staff - Equal Opportunities Policy - Registration Authority Policy - Deployment of temporary staff operational policy - Recruitment and selection policy - Disclosure and barring service checks policy - Honorary contracts policy - Staff secondment policy - Managing retirement policy
Action for next year:	To continue to implement and update these policies as and when necessary.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	
Comments:	All doctors are given enough time to fully complete supported professional activities, and additional roles in education, research etc are supported
Action for next year:	A job plan review for all senior medical staff will ensure all improvement work is appropriately reflected.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	None
Comments:	The organisation has been working hard on developing a civility charter which was launched in May 2024 after a series of roadshows collecting ideas from staff groups, and short development sessions to raise awareness. A culture and civility handbook is being developed for all staff that will be available in both paper and electronic format. This will cover the importance of civility, our behavioural standards, key cultural drivers such as the Anti Racism and Sexual Safety charters and it will outline all the support mechanisms available to staff. There is also wellbeing hub that was opened in May 2024, which is a staff only space that is open 24/7. Its role is primarily a base for staff to sit away from the workplace, but is also a hub for accessing wellbeing support, staff network activities, for partner organisations to visit and for colleagues to access information as and when they need it.
Action for next year:	

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	None
Comments:	There has been a drive in the organisation to promote awareness and confidence in “freedom to speak up”. (FTSU) There is a leader for this initiative, and a dedicated page on the hospital intranet with contacts and resources. There is a FTSU Champions Network which continues to grow, with 50 colleagues currently trained, and further training dates for circulated. The training and role of a FTSU champion is open to all staff of all grades and all roles, who will need to have completed the two mandatory e-learning modules; ‘speak up’ and ‘listen up’ before attending the face-face training. There are monthly “safety summits” which have a different theme each month and act as a forum for all staff to explore, share and learn about all aspects of complex patient safety issues.

	There are also “weekly learning” reports circulated to all staff, where themes of learning from critical incidents are shared.
Action for next year:	Continue to promote and expand awareness of the FTSU initiative hoping the network is represented in all different clinical areas and staff groups, and other patient safety initiatives.

1F(iv) Mechanisms exist that support feedback about the organisation’ professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	None
Comments:	Representatives from the GMC have presented to senior medical staff at a whole hospital RHD regarding the 2024 updates on Good Medical Practice. There is a bullying and harassment policy on Sharepoint which includes a flowchart of how the process works. Doctors can give feedback about the organisation’ professional standards processes to their appraisers at their appraisal, or through the FTSU route or directly via the GMC Liaison team.
Action for next year:	

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	None
Comments:	All members of ROAG have completed Equality and Diversity mandatory training, compliance with which is reviewed at their annual appraisals. ROAG doesn’t formally assess the level of parity in terms of country of primary medical qualification and protected characteristics, however it is mixed group from different backgrounds that works hard to deal with all cases individually

Action for next year:	Consider an annual audit of country of primary medical qualification and protected characteristics for doctors discussed at ROAG from the previous 12 month period.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher- level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	None
Comments:	The RO, ARM and Medical Lead for Appraisal and Revalidation attend twice yearly regional RO meetings, and we are hoping to engage with APH in a peer review process.
Action for next year:	Continue to attend meetings

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 to 31 March 2024.

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	391

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	346
Total number of appraisals approved missed	43

Total number of unapproved missed	2

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	72
Total number of late recommendations	0
Total number of positive recommendations	61
Total number of deferrals made	11
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	11

2D – Governance

Total number of trained case investigators	15
Total number of trained case managers	15
Total number of new concerns registered	1

Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March	106 weeks

Median duration of concerns processes closed	Mean 90 weeks
Total number of doctors excluded/suspended	1
Total number of doctors referred to GMC	1

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	99
Number of new employment checks completed before commencement of employment	99

2F – Organisational culture

Total number claims made to employment tribunals by doctors	2
Number of these claims upheld	1 (1 on-going)
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
We now have the new electronic appraisal platform (L2P) up and running, this is going very well and doctors seem to be engaging sooner in their annual appraisal process. This year also saw the appointment of a new revalidation and appraisal lead which has further energized the process.
Actions still outstanding
See below
Current issues
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

Peer review Update appraisal policy Update disciplinary policy
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
This year has seen a strengthening of the Responsible Officers Advisory Committee to include a NED and a senior representative of medical staffing which, together with a new appraisal and revalidation lead has both improved and energized the whole Consultant appraisal process.

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body	

Name:	
Role:	
Signed:	
Date:	

Committee Chair's Report

Committee:	People & Organisation Development Committee
Date of meeting:	13th August 2024
Chair:	Ms Wendy Williams, Non-Executive Director

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

ALERT
There were no items to alert to the Board of Directors.
ASSURE
• The Committee received an updated Terms of Reference for the Committee and approved the suggested change of the Committee title to People Committee, update the committee membership and to dissolve some of the feeder groups and focus on a Workforce Governance Group. • The Committee agreed the framework for the Statement of Compliance for the 2023-2024 Annual Submission to NHS England Northwest: Framework for Quality Assurance and Improvement, ahead of the Board of Directors approval. • The Committee received the High Risk Report, noting there are currently 25 risks in total with a residual risk score of 15 on the Datix system. This is a decrease from the 27 reported in June 2024. The paper set out the key themes from the 3 high risks relating to People & Organisation Development. • The Committee received an annual update on the progress with the People Strategy, noting the contents of the report and approving the plan to develop a new 3 year People strategy. • The Committee noted the assurance provided from the Workforce Data Dashboard. • The Committee received an Appraisal Management Update noting the assurance that improvements have been made to the appraisal documentation with the aim of creating a more meaningful conversation, agreeing objectives linked to corporate, divisional and departmental goals and developing and retaining staff. • The Committee received a Leadership and Management Development Report noting the assurance provided within the report and the ongoing work to ensure leaders/managers are appropriately developed and supported to perform in their roles along with the consideration of how a system of collecting training needs may be chosen, funded and implemented. • The Committee received a Policy Development Update and ratified the Attendance Management, Transitioning in the Workplace and Bullying &

Harassment policies which had been reviewed and agreed by Partnership forum. The overall progress to date was noted and planned future actions in relation to the development and review of people policies.

- The Committee noted the contents of the Midwifery and Maternity Safer Staffing Report 1st January – 30th June 2024 and that the Trust is fully compliant with the Maternity incentive scheme year 6 safety action 5.

ADVISE

- The Committee noted the Interim Chief People Officers report and the key updates provided.
- The Committee received a staff story from Neuro Occupational Therapy Support Worker, Mr N Jones.
- The Committee note the Audit Tracker.
- The Committee noted a Restructuring of the People Services Update.
- The Committee received a deep dive presentation relating to Workforce Planning noting the contents of the report.
- The Committee received an Equality, Diversity & Inclusion Update noting the progress to date.
- The Committee noted an Apprenticeship & Levy Spend Report – June 2024. It was agreed that an Apprenticeship & Levy Spend Report will be brought back to next Committee for monitoring.
- The Committee noted the contents of the Violence and Aggression (V&A) Six Monthly Report, 1st January – 30th June 2024
- The Committee noted the following items:
  - Equality, Diversity & Inclusion Steering Group Chair's Report – 21st May 2024
  - Joint Local Negotiating & Consultation Committee (JLNC) Minutes - 8th February 2024.
  - People & Organisation Development Workplan 2024/25

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

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

Meeting	**24th September 2024**		**Board of Directors**					
Report	**Agenda item 23.**		**Updated Cheshire & Merseyside Acute Specialist Trust (CMAST) Joint Working Agreement and CMAST Leadership Board Committee in Common Terms of Reference**					
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Karan Wheatcroft				Director of Governance, Risk & Improvement			
Author(s)	Laura Leadsom				Deputy Director of Governance & Risk			
Board Assurance Framework	BAF8	Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation, and our reputation.						
Strategic Aims	SG3 - Leadership							
CQC Domains	Well Led							
Previous Considerations	CMAST Leadership Board – 6th September 2024							
Summary and Key Points	The Cheshire & Merseyside Acute Specialist Trust (CMAST) Joint Working Agreement (JWA) and CMAST Leadership Board Committee in Common (CiC) Terms of Reference (TOR) have been reviewed and updated by the CMAST Leadership Board. The key changes are outlined throughout both documents with the use of 'tracked changes' and include the following: The key updates to the JWA: • Removal of references to Southport and Ormskirk NHS Hospital Trust • References to St Helens & Knowsley Trust have been updated to Mersey & West Lancashire Teaching Hospitals NHS Trust • Vision statement has been amended • Additions to the priorities of CMAST • Lead arrangements for CMAST CiC TOR: • Removal of references to Southport and Ormskirk NHS Hospital Trust • References to St Helens & Knowsley Trust have been updated to Mersey & West Lancashire Teaching Hospitals NHS Trust.							
Recommendation(s)	The Board of Directors is asked to approve the update Cheshire & Merseyside Acute Specialist Trust (CMAST) Joint Working Agreement and CMAST Leadership Board Committee in Common (CiC) Terms of Reference, on the basis of the review and recommendation by the CMAST Leadership Board.							

Corporate Impact Assessment	
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status.
Quality & Safety	Not applicable.
NHS Constitution	Not applicable.
Patient Involvement	Not applicable.
Risk	Not applicable.
Financial impact	Not applicable.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics.
Communication	Not applicable.

Draft No: 1 ~~6~~
Date of Draft: ~~5~~ September 2024~~2~~

Dated 2024~~2~~

CHESHIRE & MERSEYSIDE ACUTE AND SPECIALIST TRUSTS PROVIDER COLLABORATIVE (CMAST) JOINT WORKING AGREEMENT

Between

(1) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

(2) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

~~**(3) SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**~~

~~(4)~~(3) WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST

~~(5)~~(4) WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

~~(6)~~(5) THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

~~(7)~~(6) LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST

~~(8)~~(7) THE WALTON CENTRE NHS FOUNDATION TRUST

~~(9)~~(8) LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

~~(10)~~(9) ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST

~~(11)~~(10) EAST CHESHIRE NHS TRUST

~~(12)~~(11) ~~ST HELENS AND KNOWSLEY~~MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST

~~(13)~~(12) MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST

and

~~(14)~~(13) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

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Date of Draft: ~~5~~ September 202~~4~~2

CONTENTS

CLAUSE **PAGE**

1 Introduction

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly.
CMAST Leadership Board	the CMAST CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMAST CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of a CMAST CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, ~~Southport And Ormskirk Hospital NHS Trust~~, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT,

	Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire ~~St Helens And Knowsley~~ Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMAST as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMAST but is not forming a CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 The CMAST Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMAST Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 Our vision did span a range of time horizons. However as we have become more confident and cohesive we have summarised it to: Our vision is to work collectively for a single healthcare system to provide high quality, timely, efficient and productive services to everyone in Cheshire and Merseyside.

~~2.1 CMAST has the immediate and short-term vision to ensure the coordination of an effective provider response to current system and NHS priorities including: ongoing pandemic response; NHS service restoration and elective recovery; support and mutual aid; sharing best practice, increasing standardisation and reducing variation. CMAST Trusts will work together to speak with one voice, enhancing our ability to lead on system wide programmes and workforce development, including harnessing clinical and professional leadership resources.~~

~~2.2 In the medium and longer term CMAST will develop an overview of existing services, locations and pathways to ensure they are patient-centred, productive, streamlined and of high quality. CMAST will work with the wider system and the ICB to ensure finances and organisational structures facilitate change and do not obstruct progress. The Trusts will work together, in places and with partners to ensure that those in greatest need have access to high quality services.~~

Key functions

~~2.3~~2.2 The key functions of CMAST are to:

~~2.3.1~~2.2.1 Deliver the CMAST vision;

~~2.3.2~~2.2.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

~~2.3.3~~2.2.3 Align priorities across the member Trusts,

~~2.3.4~~2.2.4 Support ~~establishment of~~delivery by ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

~~2.3.5~~2.2.5 Direct operational resources across Trust members to improve service provision;

~~2.3.6~~2.2.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

~~2.3.7~~2.2.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

~~2.4~~2.3 CMAST's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to deliver:~~:~~

2.3.1 Clinical Improvement and Transformation

2.3.2 Sustainability and Value

By achieving this we believe we will:

~~2.4.1~~2.3.3 Reduce health inequalities;

~~2.4.2~~2.3.4 Improve access to services and health outcomes;

~~2.4.3~~2.3.5 Stabilise fragile services;

~~2.4.4~~2.3.6 Improve pathways;

~~2.4.5~~2.3.7 Support the wellbeing of staff and develop more robust workforce plans; and

~~2.4.6~~2.3.8 Achieve financial sustainability.

~~2.5~~2.4 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMAST CiCs acting through the CMAST Leadership Board.

~~2.6~~2.5 More specifically the CMAST CiCs and the CMAST Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMAST development*:*

~~2.6.1~~2.5.1 Delivery and coordination of the C&M Elective Recovery Programme;

~~2.6.2~~2.5.2 Cancer Alliance delivery and enablement – subject to ~~the~~ requests of the Alliance;

~~2.6.3~~2.5.3 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

~~2.6.4~~2.5.4 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

~~2.6.5~~2.5.5 Coordinating and enabling CMAST members contribution and response to collective system wide workforce needs, pressures and the People agenda;

~~2.6.6~~2.5.6 Coordinating and enabling CMAST members contribution and response to system wide financial decision making, pressures and financial governance;

~~2.6.7~~2.5.7 Responding to and coordinating CMAST action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, reduction in ~~104~~ long ~~week~~ waiters ~~reduction delivery~~; and

~~2.6.8~~2.5.8 The CMAST Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMAST will provide both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMAST may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMAST Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMAST workplan.

~~2.7~~2.6 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMAST will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 Rules of working

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMAST CiCs as the **CMAST Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMAST openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.8 Recognising and respecting the collective view and keeping to any agreements made between the CMAST CiC's;

3.1.9 Maintain CMAST collective agreed position on shared decisions in all relevant communications;

3.1.10 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.11 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMAST CiCs shall meet together as the CMAST Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-14).

4.1.1 Meetings of the CMAST Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMAST Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMAST Leadership Board – Decisions to be made under the CMAST CiC delegations - CiC CEOs;

C. CMAST Leadership Board –CiC CEOs and Chairs discussion (or NED designate)

4.2 The CMAST CiCs shall work collaboratively with each other as the CMAST Leadership Board in relation to the committees in common model.

4.3 Each CMAST CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMAST CiC or its duty to act in the best interests of its Trust, each CMAST CiC shall seek to reach agreement with the other CMAST CiCs in the CMAST Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMAST CiCs meet in common, as the CMAST Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the ~~current~~ lead arrangements will be reviewed periodically reflecting the will of the membership. The next review point is expected to be no later than 2025.~~for the Meeting Lead will continue until 1 April 2024 [and thereafter rotate between the Trusts on a biannual basis with each Meeting Lead remaining in place for a period of 24 months].~~

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMAST Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution) in the following approach:

Scale of involvement/impact	Approach to decision
Matter under discussion has no involvement or impact on other CMAST Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMAST Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMAST Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMAST CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMAST Leadership Board.
Matter involves or impacts all CMAST Trusts and comes within the delegation under the	Matter to be dealt with through the CMAST CiCs at the CMAST Leadership Board in

[1] Chairs will be invited to CMAST Leadership Board meetings, at least quarterly.

CMAST CiCs (e.g. collaborative approach to non-clinical services or workforce)	accordance with this Agreement and the Terms of Reference.

4.6 Each CMAST Trust will report back to its own Board and the CMAST Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMAST Trust Board meetings. The CMAST Trust chairs will (as well as their quarterly CMAST meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMAST on an informal basis. In addition, the CMAST Leadership Board will seek to ensure that each CMAST programme has the opportunity for ~~should have~~ a Chair sponsor to be appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMAST CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMAST (or if relevant, section of the meeting), will be held in public except where a resolution is agreed by the CMAST Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of CMAST meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Within three (3) months of the date of this Agreement the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMAST CiC Chairs varying the Agreement under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this Agreement at Appendix 15 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMAST CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMAST Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 15) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMAST CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the CMAST Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The CMAST Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this Clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMAST is committed to clear, consistent and transparent communication across the CMAST Trusts and with system partners' where appropriate. It is specifically recognised that CMAST Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMAST and the CMAST Trusts may be asked to represent both their own organisations and CMAST in such local place-based discussions.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998) and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMAST Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMAST activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts commit to ~~will seek to~~ agreeing a protocol to manage the sharing of information to facilitate the futher operation or development of CMAST across the Trusts as envisaged if and when required.~~under this Agreement in accordance with competition law requirements, within three (3) months of the date of this Agreement~~. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be inserted into this Agreement at Appendix 16 and the

Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement[2].

9 Conflicts of Interest

9.1 Members of each of the CMAST CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMAST Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMAST's decision-making processes.

9.2 The CMAST Leadership Board will, where relevant, agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMAST website. It is proposed that such policies will either be CMAST developed or CMAST will support the adoption and application of the policy of the CMAST Chair and/or Meeting Lead.

9.3 All CMAST Leadership Board, committee and sub-committee members, and employees acting on behalf of CMAST, will comply with the CMAST policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by CMAST. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMAST Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMAST Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMAST Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMAST Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMAST CiCs at the CMAST Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMAST Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMAST Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

[2] To date (2022 – 2024) it has been considered unnecessary and unwarranted by virtue of ICS facilitated and governed ways of working

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMAST Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMAST Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMAST Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMAST Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMAST Leadership Board to work towards a consensus decision in respect of the Dispute;
- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMAST Leadership Board at such discussions;
- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and
- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMAST Leadership Board may decide to recommend their Trust's Board of Directors to:

10.6.1 terminate the Agreement;

10.6.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11 Variation

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 Counterparts

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression “counterpart” shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

~~**This Agreement is executed on the date stated above by**~~

~~……~~
~~For and on behalf of **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**~~

This Agreement is executed on the date stated above by

……
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of ~~**ST HELENS AND KNOWSLEY**~~**MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1 – TERMS OF REFERENCE FOR THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Countess of Chester Hospital NHS Foundation Trust CiC]

APPENDIX 2 – TERMS OF REFERENCE FOR THE LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool University Hospitals NHS Foundation Trust CiC]

~~Appendix 3 – TERMS OF REFERENCE FOR THE SOUTHPORT AND ORMSKIRK HOSPITAL NHS FOUNDATION TRUST CIC~~

~~[Insert Terms of Reference for the Southport and Ormskirk Hospital NHS Foundation Trust CiC]~~

~~Appendix 4~~APPENDIX 3 – TERMS OF REFERENCE FOR WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC]

~~Appendix 5~~APPENDIX 4 – TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral University Teaching Hospital NHS Foundation Trust CiC]

~~Appendix 6~~APPENDIX 5 – TERMS OF REFERENCE FOR THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Clatterbridge Cancer Centre NHS Foundation Trust CiC]

~~Appendix 7~~APPENDIX 6 – TERMS OF REFERENCE FOR THE LIVERPOOL HEART AND CHEST HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Heart and Chest Hospitals NHS Foundation Trust CiC]

~~Appendix 8~~APPENDIX 7 – TERMS OF REFERENCE FOR THE WALTON CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Walton Centre NHS Foundation Trust CiC]

~~Appendix 9~~APPENDIX 8 – TERMS OF REFERENCE FOR THE LIVERPOOL WOMEN'S NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Women's NHS Foundation Trust CiC]

~~Appendix 10~~APPENDIX 9 – TERMS OF REFERENCE FOR THE ALDER HEY CHILDREN'T HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Alder Hey Children's Hospital NHS Foundation Trust CiC]

~~Appendix 11~~APPENDIX 10 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST CIC

[Insert Terms of Reference for the East Cheshire NHS Trust CiC]

~~Appendix 12~~APPENDIX 11 – TERMS OF REFERENCE FOR THE ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Mersey and West Lancashire ~~St Helens and Knowsley~~ Teaching Hospitals NHS Foundation Trust CiC]

~~Appendix 13~~APPENDIX 12 – TERMS OF REFERENCE FOR THE MID CHESHIRE HOSPITALS NHS TRUST CIC

[Insert Terms of Reference for the Mid Cheshire Hospitals NHS Trust CiC]

~~Appendix 14~~APPENDIX 13 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE SERVICE NHS TRUST CIC

[Not applicable]

~~Appendix 15~~APPENDIX 14 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one thirteenth of any professional advisers' fees incurred by and on behalf of CMAST in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMAST Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no join assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMAST and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMAST CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMAST as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMAST CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

~~Appendix 16~~APPENDIX 15 - INFORMATION SHARING PROTOCOL

[to be inserted once deemed necessary and agreed]

CMAST LEADERSHIP BOARD TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMAST TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

Cheshire & Merseyside Acute and Specialist Trusts Provider Collaborative or CMAST	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This operates within the NHS Cheshire & Merseyside Integrated Care System.
CMAST Agreement	the joint working agreement signed by each of the Trusts in relation to their provider collaborative working and the operation of the **[TRUST]** CiC together with the other CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly;
CMAST Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
CMAST Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to CMAST;
CMAST Programme Support	Administrative infrastructure supporting CMAST;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of an CMAST CiC in accordance with their Trust's Terms of Reference, and Members shall be interpreted accordingly;
NHS Cheshire & Merseyside Integrated Care System or "C&M ICS"	the Integrated Care System (ICS) for Cheshire and Merseyside bringing together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up care for the population.
[TRUST] CiC	the committee established by **[TRUST]** NHS Foundation Trust, pursuant to these Terms of

	Reference, to work alongside the other CMAST CiCs in accordance with these Terms of Reference;
[TRUST] NHS Foundation Trust	**[TRUST]** NHS Foundation Trust of [Address];
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, ~~Southport And Ormskirk Hospital NHS Trust,~~ Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire ~~St Helens And Knowsley~~ Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

1.2 The [Trust] NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMAST to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMAST but is not forming its own CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 Each Trust has entered into the CMAST Agreement on **[DATE]** and agrees to operate its CMAST CiC in accordance with the CMAST Agreement.

2 Aims and Objectives of the [TRUST] CiC

2.1 The aims and objectives of the [Trust] CiC are to work with the other CMAST CiCs on system work or matters of significance as delegated to the [Trust] CiC under Appendix A to these Terms of Reference to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of CMAST and its workstreams;

2.1.2 set the strategic goals for CMAST, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.5 ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Professional (reference) Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts of CMAST;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review the CMAST Agreement and Terms of Reference for CMAST CiCs on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3 Establishment

3.1 The **[TRUST]** NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the **[TRUST]** CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the **[TRUST]** CiC.

3.2 The **[TRUST]** CiC shall work cooperatively with the other CMAST CiCs and in accordance with the terms of the CMAST Agreement.

3.3 The **[TRUST]** CiC is a committee of **[TRUST]** NHS Foundation Trust's board of directors and therefore can only make decisions binding **[TRUST]** NHS Foundation Trust. None of the Trusts other than **[TRUST]** NHS Foundation Trust can be bound by a decision taken by **[TRUST]** CiC.

3.4 The **[TRUST]** CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The **[TRUST]** CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in **[TRUST]** NHS Foundation Trust's Constitution.

4.2 **[TRUST]** CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the **[TRUST]** CiC in paragraph 4 of these Terms of Reference shall be retained by **[TRUST]** NHS Foundation Trust's Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of **[TRUST]** NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the **[TRUST]** CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to **[TRUST]** NHS Foundation Trust's Board for inclusion on the private agenda of **[TRUST]** NHS Foundation Trust's next Board meeting in order that **[TRUST]** NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The **[TRUST]** CiC shall send the minutes of **[TRUST]** CiC meetings to **[TRUST]** NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of **[TRUST]** NHS Foundation Trust's Board meeting.

6.3 **[TRUST]** CiC shall provide such reports and communications briefings as requested by **[TRUST]** NHS Foundation Trust's Board for inclusion on the agenda of **[TRUST]** NHS Foundation Trust's Board meeting.

7 Membership

7.1 The [TRUST] CiC shall be constituted of directors of [TRUST] NHS Foundation Trust. Namely the [TRUST] NHS Foundation Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each **[TRUST]** CiC Member shall nominate a deputy to attend **[TRUST]** CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for **[TRUST]** NHS Foundation Trust's Chief Executive shall be an Executive Director of **[TRUST]** NHS Foundation Trust.

7.4 In the absence of the **[TRUST]** CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend [TRUST] CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of [TRUST] CiC's; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a **[TRUST]** CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

7.5 The chair of the **[TRUST]** CiC shall be nominated by the **[TRUST]** CiC.

7.6 When the CMAST CiCs meet in common, one person nominated from the Members of the CMAST CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

8.1 The Members of the other CMAST CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of [TRUST] CiC. The **[TRUST]** 's Chair shall be invited to meetings of the CMAST CiCs on at least a quarterly basis (or where ~~where~~ the CiC feels it is appropriate – see CMAST JWA) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of **[TRUST]** CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMAST CiCs.

8.3 The CMAST Programme Lead shall have the right to attend the meetings of **[TRUST]** CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3 inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMAST CiCs' meetings, but for the avoidance of doubt, any such persons

in attendance at any meeting of the CMAST CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of **[TRUST]** CiC.

9 Meetings

9.1 Subject to paragraph 9.2 below, [TRUST] CiC meetings shall take place monthly.

9.2 The [TRUST] CiC shall meet with the other CMAST CiCs as the CMAST Leadership Board in accordance with the CMAST Agreement (as set out in clause 4 of the CMAST Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMAST CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMAST Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the [TRUST] CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMAST Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the [TRUST] CiC shall be confidential to the [TRUST] CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of [TRUST] Board.

10 Quorum and Voting

10.1 Members of the [TRUST] CiC have a responsibility for the operation of the [TRUST] CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the [TRUST] CiC shall have one vote. The [TRUST] CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the [TRUST] CiC shall comply with the provisions on conflicts of interest contained in [TRUST] NHS Foundation Trust Constitution/Standing Orders, the CMAST Agreement and NHS Conflicts of Interest guidance. For the avoidance of

doubt, reference to conflicts of interest in [TRUST] NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the [TRUST] CiC.

11.2 All Members of the [TRUST] CiC shall declare any new interest at the beginning of any [TRUST] CiC meeting and at any point during a [TRUST] CiC meeting if relevant.

12 Attendance at meetings

12.1 [TRUST] shall ensure that, except for urgent or unavoidable reasons, [TRUST] CiC Members (or their Nominated Deputy) shall attend [TRUST] CiC meetings (in person) and fully participate in all [TRUST] CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the [TRUST] CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the [TRUST] CiC will be provided by CMAST Programme Support (or such other route as the Trusts may agree in writing). The CMAST Programme Support will:

13.1.1 draw up an annual schedule of CMAST CiC meeting dates and circulate it to the CMAST CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMAST CiC meetings; and

13.1.3 take minutes of each [TRUST] CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant [TRUST] CiC meeting.

13.2 The agenda for the [TRUST] CiC meetings shall be determined by the CMAST Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMAST Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE [TRUST] CIC

The Board of each Trust within CMAST remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to [TRUST] NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the [TRUST] CiC to decide are set out in the table below.

If it is intended that the CMAST CiCs are to discuss a proposal or matter which is outside the decisions delegated to the [TRUST] CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the [TRUST] CiC meeting with a view to [TRUST] CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by [TRUST] NHS Foundation Trust's Board). Any proposals discussed at the [TRUST] CiC meeting outside of these parameters would come back before [TRUST] NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMAST Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMAST Agreement and which may be supplemented or further defined by an annual CMAST Work Programme) and may include both back office and clinical services.

	Decisions delegated to [TRUST] CiC
1.	Providing overall strategic oversight and direction to the development of the CMAST programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the [TRUST] CiC referred to it by the CMAST Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMAST Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of CMAST Programmes;
6.	In relation to services preparing business cases to support or describe delivery of agreed CMAST priorities or programmes (including as required by any agreed CMAST annual work programme);

	Decisions delegated to [TRUST] CiC
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.

	Decisions delegated to [TRUST] CiC
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMAST Joint Working Agreement on an annual basis.

APPROVED BY BOARD OF DIRECTORS: [DATE]

Meeting	**24th September 2024**		**Board of Directors**					
Report	**Agenda item 24.**		**Safeguarding and Complex Care Annual Report**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton				Director of Nursing & Quality / Deputy Chief Executive			
Author(s)	Jill Cooper				Interim Associate Director of Nursing (Safeguarding and Complex Care)			
Board Assurance Framework	BAF 1 – Failure to maintain quality of care would result in poorer patient & family experience							
Strategic Aims	SG1 - Patient and Family experience							
CQC Domains	Safe and Well Led							
Previous Considerations	Not applicable							
Executive Summary	The safeguarding and complex care annual report is an opportunity to provide an analysis of the achievements, developments and data around the Trust's safeguarding and complex care agenda in 23/24. The paper provides an overview of the Trust's: • Safeguarding leadership and organisational accountability • Safeguarding processes • Safeguarding policies • Safeguarding and complex care activity • Safeguarding training • Partnership working and multiagency reviews • Allegation management. This report provides an opportunity to assure the Board of Directors of the effective arrangements that are in place within the Trust to safeguard our patients and care for those with additional needs. This report is open and transparent and identifies areas where further development is required. This approach enables greater protection of our vulnerable patients as well as further supporting those patients with additional needs. To note the Trust has a named Doctor for children but not for adults currently. This is being addressed by the Medical Director.							
Highlights	The annual report provides assurance that the Trust continues to meet its statutory duties to the safeguarding and in place complex care agenda. • Evidence of an increase in activity within every area of the safeguarding and complex care agenda.							

	• This triangulates with an improvement in the compliance of safeguarding knowledge through training and increased visibility of the safeguarding team • Improved knowledge and skills are demonstrated by the frontline practitioners; in recognising and responding to safeguarding and complex care concerns • Strong compliance with Level 1 and 2 safeguarding adults and children training • During 23/24 Level 3 training was introduced for adults and children and compliance has improved but remains under the target of 90%. Targeted actions are in place and compliance is closely monitored. • Evidence that safeguarding our patients and staff remains a key priority for the organisation. • Robust governance- executive oversight, statutory named professionals in post and strong partnership working. • Compliant policies and procedures and audit evidenced of these standards being applied in practice • Evidence of safeguarding being made personal including evidence that the child and vulnerable adult's voice is captured. • Strong evidence in the management of staff allegations and multiagency working where necessary. • Referrals and incidents monitored and learning from these have been cascaded accordingly. • Safeguarding and complex care priorities have been agreed for 24/25 and these align to local and system objectives.
Recommendation(s)	The Board of Directors is asked to note the assurance provided within the report.
Corporate Impact Assessment	
Statutory Requirements	Meets the Trust's compliance with regulatory and professional requirement, with specific reference to the commissioned safeguarding assurance framework and commissioning standards
Quality & Safety	Improved compliance with NHS safeguarding commissioning standards
NHS Constitution	Improve quality and safety by ensuring effective safeguarding systems and processes are in place, working together for patients, respect and dignity, commitment to quality of care and compassion.
Patient Involvement	Not applicable
Risk	Failure to provide assurance around the Trust's ability to safeguard patients and support patients with additional needs could result in the Trust not being compliant with their statutory and regulatory duties and consequently failing to protect.

Financial impact	Not applicable
Equality & Diversity	Not applicable
Communication	Not applicable

NHS
Countess of Chester Hospital
NHS Foundation Trust

Safeguarding & Complex Care Annual Report 2023/24

Jill Cooper – Interim Associate Director Safeguarding & Complex Care

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Table of Content **Page**

1. Introduction

The purpose of this Safeguarding and Complex Care Annual Report is to provide assurance to the Board that necessary frameworks are in place and that appropriate action is taken to enable the Countess of Chester NHS Foundation Trust (the Trust) to fulfil its statutory responsibilities and requirements as a regulated provider; under Regulation 13 of the Health and Social Care Act 2008, Care Act 2014, Childrens Acts of 1989 and 2004, the statutory guidance Working Together to Safeguard Children 2018 and the Intercollegiate Document for Roles and Competencies for Health Care Staff 2018, pertaining to safeguarding training compliance.

The report presents an overview of activity, compliance and learning across the safeguarding and complex care agenda at the Trust between 1st April 2023 and 31st March 2024. It provides assurance of how the Trust has met its statutory and regulatory responsibilities.

2. Summary

The Trust is committed to meeting its safeguarding responsibilities and promotes a strong organisational commitment to ensuring there are high standards of safeguarding and complex care practices in place, where the workforce has a sound understanding of the importance of their practices in ensuring children, young people and adults at risk of harm, who access the Trust, are safe and free from harm.

During 2023/24, the Trust has continued to develop and strengthen its safeguarding and complex care arrangements to ensure they remain effective and meet local and national standards.

3. Leadership and Organisational Accountability

The Director of Nursing and Quality is the nominated executive lead for safeguarding and complex care and provides executive leadership across the organisation, ensuring the safeguarding and complex care agenda remains on the board agenda. The Deputy Director of Nursing and Quality and Associate Director of Nursing (Safeguarding and Complex Care) both support the Director of Nursing and Quality strategically and operationally with the delivery of the safeguarding and complex care agenda. They represent and participate in the respective safeguarding partnership arrangements; Safeguarding Children Partnership (SCPs), Local Safeguarding Adult Board (LSAB), Domestic Abuse Board and Learning Disability Board across Cheshire West and Chester. The Associate Director of Nursing and the Named Lead Professionals for the Trust represent and participate in the various subgroups of these boards.

The statutory named professionals are in post to ensure the provision of policies, processes, and safeguarding arrangements within the Trust remain in line with local and national guidance and legislation. They also provide the operational leadership to the team.

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

The Trust also has a Named Doctor for Safeguarding Children in place.

The team has a range of specialist nurses covering the agenda and are co-located, although these nurses are experts in their fields, they strive to develop a core skill set across the whole safeguarding and complex care agenda to ensure the service remains resilient and operative. The team also has a full time IDVA (Independent Domestic Abuse Advocate) working with them. In 23/24 the service has also developed a safeguarding and complex care practice links network to ensure the agenda is streamed to all clinical areas.

The safeguarding and complex care governance structure adopted by the Trust is outlined in Appendix 1.

The Safeguarding Assurance Committee is chaired by the Director of Nursing and Quality. The purpose of this committee is to provide assurance that safeguarding and complex care responsibilities are met through the activities of the Trust in line with the terms of reference (appendix 2). The committee provides a quarterly report to the Quality Governance Group and Quality and Safety Committee (a subcommittee of the Board).

The Safeguarding Assurance Committee in 23/24 took place quarterly and was attended by all clinical divisions across the Trust, it had membership attendance from partnership agencies including the Integrated Care Board (Cheshire West Place), Cheshire West Adult Social Care, Cheshire West Children's Social Care and Betsi Cadwaladr University Health Board.

There are several identified working groups within the safeguarding and complex care agenda, to ensure the delivery of identified priorities and provide challenge and assurance to the wider teams across the organisation. Some of the key functions include the monitoring of training compliance, benchmarking and internal / external standards.

The Trust continues to provide assurance to Cheshire and Merseyside Integrated Care board (ICB) through the completion of the Safeguarding Assurance Framework (SAF), this quarterly return includes data submissions for training, activity, audit, performance, and supervision alongside other metrics. In addition, the Trust submitted the biannual Safeguarding Commissioning Standards Self-Assessment for both adult and children's safeguarding in 23/24 and an action plan has been developed which is monitored via the safeguarding governance framework.

4. NHS Safeguarding Commissioning Standards

In 23/24 the Trust assessed themselves against the NHS Commissioning Standards via a self-assessment audit, the Trust has a duty to assure the Integrated Care Board (ICB) that they are compliant with the legislation and statutory guidance relating to safeguarding children, young people, and adults at risk as well as Children in Care. It is worth noting that the Trust is in a strong position following the completion of the commissioning standards, in total there are 64 domains the Trust measure themselves against and in most domains, there were only partial exceptions of noncompliance. Following the completion of the self-assessment audit an action plan was developed to measure progress against the outstanding areas of compliance. This is reviewed quarterly at the Trust's Safeguarding Assurance Committee.

5. Safeguarding Policies

The Trust has a suite of safeguarding and complex care policies that are regularly updated to reflect structural, departmental, and legal changes. The safeguarding policies are all uploaded onto share point for staff to access. The Safeguarding and Complex Care Team also have oversight of some other Trust policies to ensure that safeguarding standards are met.

- Safeguarding and Promoting the Welfare of the Child
- Safeguarding Adults at Risk Policy
- Prevent
- Domestic Abuse
- Female Genital Mutilation (FGM) Pathway
- Modern Slavery / Human Trafficking Statement
- Mental Capacity Act and Deprivation of Liberty Safeguards
- VIP and Celebrities Policy
- Safer Recruitment
- Freedom to Speak Up Policy
- Physical Intervention and Restraint Policy
- Enhanced Supervision Policy.
- Discharge Policy
- Chaperone Policy

6. Incidents

The Associate Director for Nursing (Safeguarding and Complex Care) attends the daily Senior Quality, Safety and Site Position Meeting where all significant incidents are discussed. In addition, the team attend the daily Trust Safety Huddle and feedback the Trust's current safeguarding and complex care position as well as respond to any safeguarding and complex care concerns other areas of the Trust may have.

The team have access to the DATIX system and respond to safeguarding and complex care incidents via this route. They work closely with the Heads of Nursing in responding to any significant incident where safeguarding and complex care maybe a factor and are present in the PSIRF (Patient Safety Incident Report Framework) processes. The team have also been responsible for completing 2 level 1 investigations in 23/24.

The Associate Director for Nursing (Safeguarding and Complex Care) completed the Trusts PSIRF training in 23/24 and attends the weekly Patient Safety Learning Meeting where learning from safeguarding and complex care incidents is shared and subsequently cascaded across the Trust.

7. Audits

The Safeguarding and Complex Care Team have engaged in audits throughout 23/24. The team have supported the Safeguarding Children Partnership with multiagency audits and relevant learning has been conveyed via communication bulletins across the Trust. Audits have been

completed in all areas of the safeguarding and complex care agenda and learning from these has been cascaded accordingly.

8. Safeguarding Activity

Safeguarding the Unborn, Children and Young People

Key Achievements in 23/24

- Bespoke Training provided to midwifery and obstetric staff on FGM.
- EPR+ templates developed for recording safeguarding supervision.
- ICON (safe sleep) training provided to all midwifery staff.
- Reasonable adjustments risk assessment now being used for pregnant woman where a learning disability or neurodivergent issue is identified.
- A child exploitation dashboard was developed to monitor data and identify emerging themes to improve clinical practice.
- Bespoke training on child exploitation and neglect was delivered to all paediatric and Emergency Department staff.
- A mandatory safeguarding assessment tool has been introduced into the Emergency Department Paediatric Assessment providing assurance that every child under 16 is screened for safeguarding concerns. More recently, following thematic learning, the tool was extended to ensure screening took place to identify Electively Home Educated children.
- A child exploitation screening tool was introduced into the Emergency Department to support staff with their safeguarding practices.
- Alerts are now placed on children's records from the CP-IS database received from Cheshire West and Chester Local Authority to ensure that all staff (not just those in the Emergency Department) are aware of those children who are subject to a child protection plan or who are looked after.
- A Children in Care and Care Leaver Pledge was created.
- The Safeguarding and Complex Care Team all have access to Cheshire West and Chester's electronic system (Liquid Logic). This will reduce the number of contacts made to the Local Authority.
- A daily report continues to be received by the team which identifies any under 18s who are on an adult clinical area and the team can then ensure their needs are met accordingly. In 23/24 there were 145 under 18 (excluding maternity) where records were reviewed to ensure the standards of care were met.
- The reporting of safeguarding children concerns continues in frequency and complexity, reinforcing that staff are aware of their duties to recognise, respond and report concerns. In 23/24 1465 safeguarding children referrals were received (excluding maternity). This is similar in numbers to the previous year.
- The quarterly reports including child exploitation and mental health figures continue to provide assurance to both the Trust and external partners in relation to safeguarding activity and training.
- The revision of key safeguarding documents including the safeguarding children's flowchart, chaperoning and consent for children.
- There has been an increase in the number of safeguarding supervision sessions provided to staff to discuss individual cases and the footprint of staff accessing these

sessions has expanded and includes midwives, specialist nurses, ward staff, dieticians, paediatric therapists.

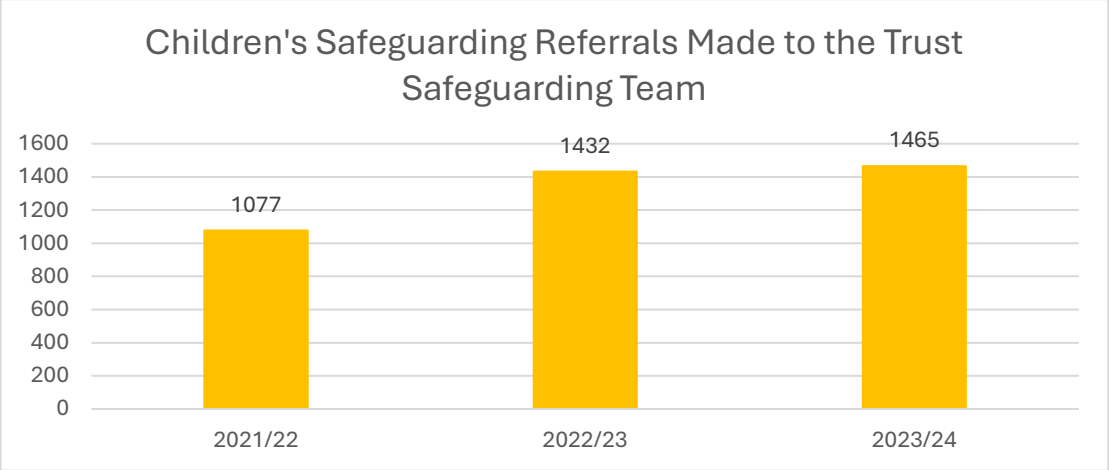
- There has been an increase in the number of Perplexing Presentation cases (Fabricated Induced Illness) that have been identified. These cases have been coordinated by the Named Nurse for Safeguarding Children and have been complex in nature and have included several staff groups in each case.

Annual Safeguarding Children Activity

At the Trust, Safeguarding referrals into the team are generally generated when a member of staff identifies a safeguarding concern or issue and formally notifies, informs, or escalates a concern via the referral form on a patient's electronic record (EPR+). If the concern is of an urgent nature the staff member can refer in via phone during office hours.

Safeguarding Referrals

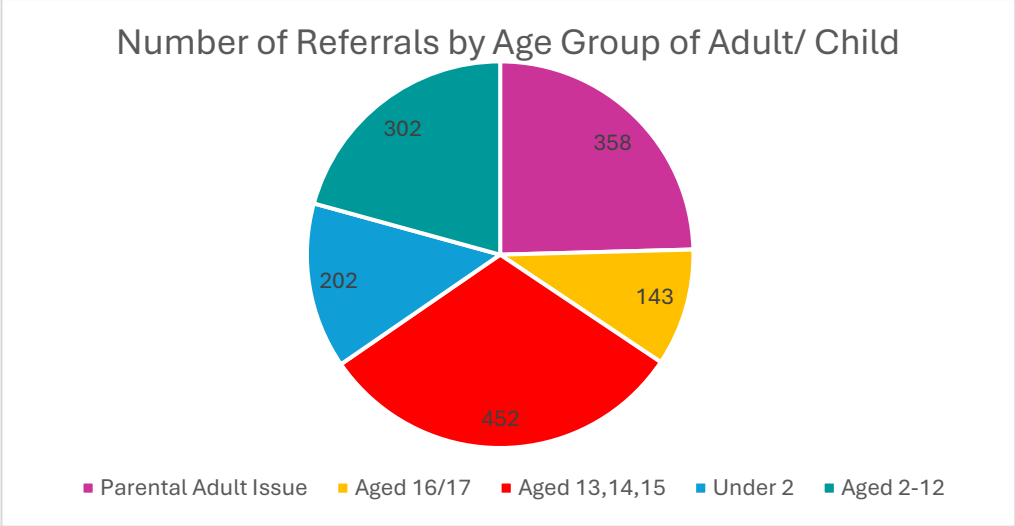
The level of referrals can be seen in the chart below, there is an increase in the level of safeguarding children activity year on year within the organisation, this is aligned to the visibility of the safeguarding team across the Trust and the increase in training compliance which has increased staff confidence and competence in effectively recognising and responding to safeguarding issues. In Q4 an audit was completed around the standards of the safeguarding children's referrals into the team, this referral is vital in determining the quality of the subsequent multi-agency response and support that the child and family receive. Assurance was gained from this audit that staff are competent in identifying and managing safeguarding children issues. A learning bulletin was developed to share with staff following the completion of the audit.



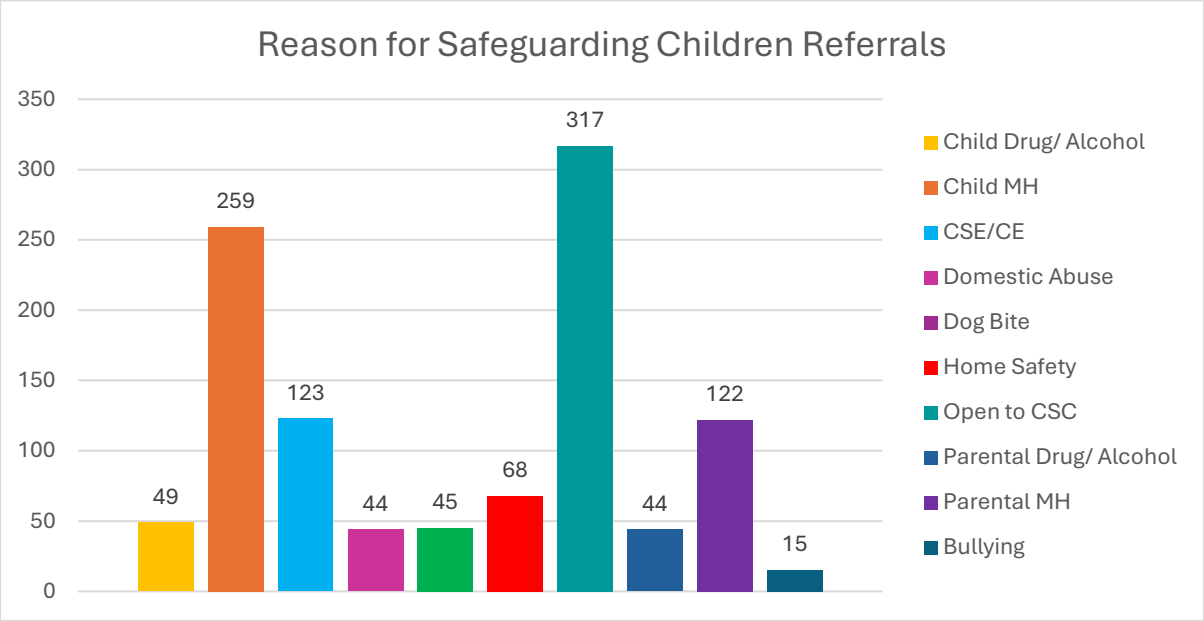
Nature of the Referrals received.

The Safeguarding team collate the data from referrals to support practice development as well as supporting the partnership with data requirements.

In 23/24 the age of the referred individual to the team was collated. The chart below demonstrates the proportion of the age groups broken down.



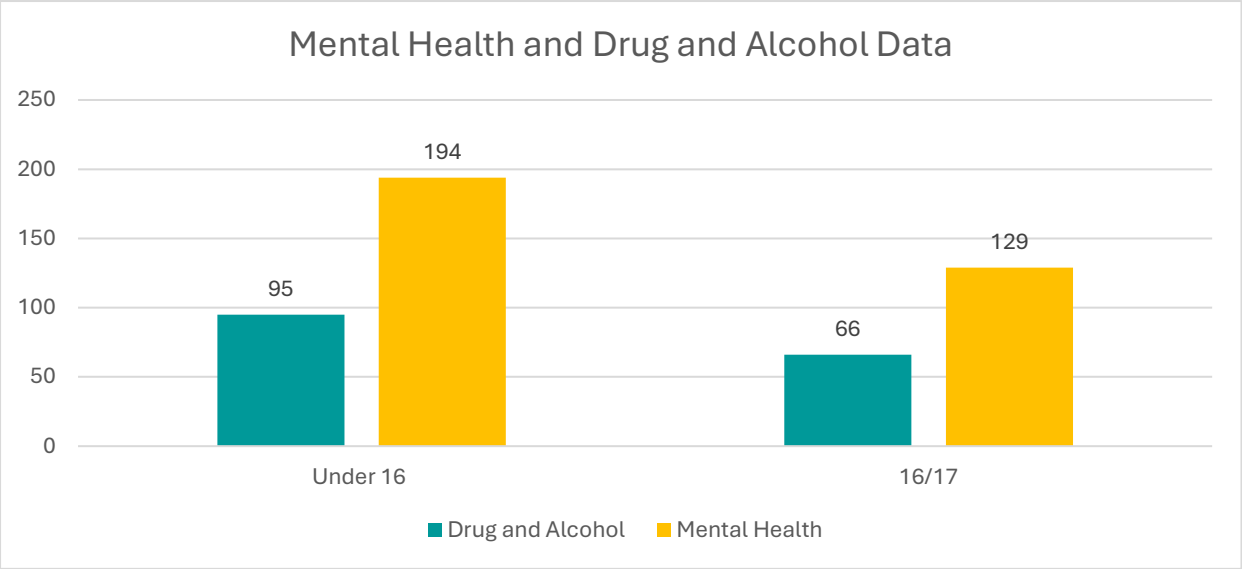
The chart provides strong evidence that the Trust staff consider the impact of parental issues on children with almost a quarter of referrals pertaining to the adult (this in the main will be due to domestic abuse, mental health, or substance misuse issues). This supports the 'Think Family' agenda that the Safeguarding and Complex Care Team have been promoting and embedding into practice for the last 3 years. In addition, it is reassuring that young people aged 16/17 who are treated in adult services are recognised as requiring safeguarding children support and are referred in appropriately by the Trust's adult facing staff. The other key areas who require safeguarding support are the under 2s and the teenagers. In response to the teenage data, this follows the national data that has seen an increase in teenagers presenting with mental health issues/ bullying/ behavioural issues due to neurodiversity and child exploitation. For children under 2, referrals in the main these are due to non-accidental issues, home safety and an increase in dog bites in the home. The chart below shows the key reasons for safeguarding children referrals made by hospital staff into the team.



Children and Mental Health Difficulties.

In 23/24 the Safeguarding Children Partnership requested data for all children who attended the Emergency Department with mental health or drug and alcohol issues. The Trust's Business

Intelligence team were able to run a report based on the codes and this information has been submitted on a quarterly basis to the partnership. The chart below shows the information submitted to the Partnership.



The number of child mental health, and drug and alcohol attendances in the Emergency Department has risen throughout the year. The Safeguarding Children Partnership has been provided with this data for further thematic analysis. The Cheshire West and Chester self-harm pathway has been reinforced to all Emergency Department staff via additional training as well as staff bulletins and there is minimal evidence from the DATIX (incident reporting system) that the Emergency Department staff do not follow this. The safeguarding team have a strong working relationship with the Child and Adolescent Mental Health Service (CAMHS) and joint working for the sharing of information and safe discharge plans is evidenced in records. In addition, the safeguarding team support CAMHS with a timely upload of their mental health assessments onto a child's EPR+ records to ensure continuity of care takes place.

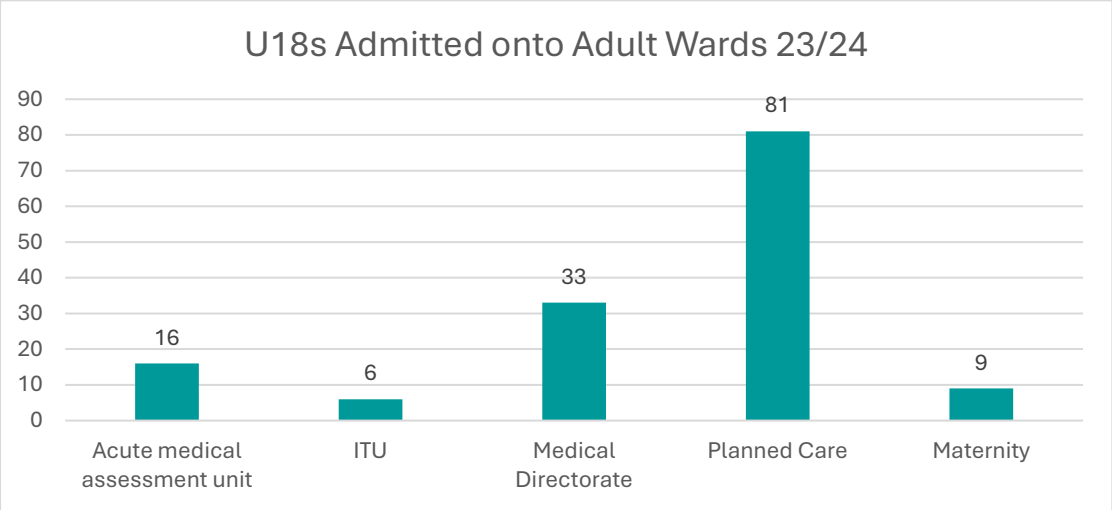
Emergency Department Safeguarding Referral

Safeguarding referral received from ED due to a 15yr old boy who presented with a school staff member following an intentional overdose of 30 paracetamol. The young person (YP) had extensively researched online how to end their life. The YP disclosed that he was carrying out care needs for two younger siblings including cooking, washing clothes, and taking them to school and didn't want to be here anymore. His caring responsibilities were due to his mother misusing alcohol so was asleep at home a lot.
Conversation had with social care who shared that the family were previously known. Consent gained with mother to submit a referral into social care. YP required hospital treatment and was in hospital for 7 days – 4 days after being deemed medically/mentally fit for discharge due to the significant concerns regarding his mothers' ability to keep him safe. Safeguarding team worked closely with the YPs school and CAMHS to ensure all information was made available to support all assessments. Safeguarding team requested a strategy meeting, which was held, and the outcome was for the case to be heard at an initial child protection case conference. YP was discharged to a family member who could meet his needs and keep hum safe.

Children on Adult Wards

The team are committed to ensuring high standards of care are maintained for those children (generally who are aged 16/17) who are admitted into adult clinical areas. The team receive a daily report of all children who are currently in an adult clinical area. The safeguarding team review each child to ensure their needs are met, for example, parents are able to stay with the young person, they are allocated a side room (where possible) and a safe discharge is coordinated.

The chart below shows the numbers of children admitted into adult clinical areas in 23/24. The number of young people attending planned care settings include those who have undergone surgery (generally appendicectomy, vascular and orthopaedic procedures). These young people are rarely in hospital for more than 48 hours. Those young people admitted to ITU are visited by the safeguarding children's team whilst on the unit. An audit in 22/23 provided assurance that young people on an adult ward had their needs addressed appropriately. It is anticipated that this audit will be completed quarterly moving forward.



Child on an Adult Ward

Safeguarding referral received from AMU for a 16-year-old girl who had been admitted following an overdose of her mum's insulin. The staff had identified that her CP-IS (child protection- information system) status was positive indicating she was subject to a child protection plan. The referral indicated that the young person had the following vulnerabilities.

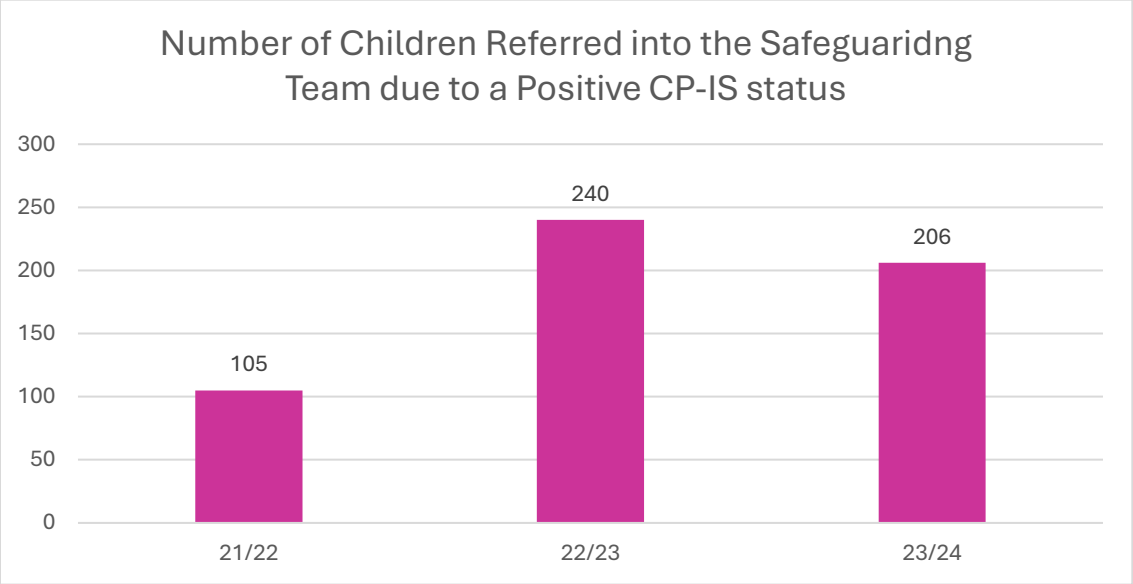
- Diagnosis of ADHD (currently can't access her medication) therefore increased risk of impulsivity.
- Subject to a Child Protection Plan
- Previous risk of Child Sexual Exploitation
- Concerns over risk of absconding from the ward when Mum leaves her.
- Previous attendances for mental health and accessing support from CAMHS

Safeguarding nurse went to visit the young person on the ward and promoted the standards of caring for a young person in an adult area to the wad staff. Liaison with Social Worker and advised them of admission. Advised staff that if mum is to leave the ward the YP is potentially a flight risk. All risk factors and a safety plan highlighted within the child's EPR+ records. The child was visited by the safeguarding team prior to discharge and liaison was had with social worker and mental health services prior to discharge.

CPIS in the Emergency Department

The Child Protection-Information Sharing (CP-IS) programme assists information sharing between the Local Authority and health. CP-IS identifies and safeguards unborn babies and children who are subject to a Local Authority Child Protection Plan or who are a Child in Care of the Local Authority when attending unscheduled healthcare settings across England. The chart below shows the numbers of cases where CP-IS has triggered a referral into the safeguarding team over the last 3 years. Although the number has slightly decreased in 23/24 there is still strong evidence that staff are aware of the process and onward referrals are being made. Unfortunately, CP-IS isn't available for Flintshire patients, this is a risk for those children as there are no flags available for the clinical staff to identify their vulnerabilities, however staff are aware of this.

Currently CP-IS is only available in unplanned care settings and is triggered via the NHS spine. The Trust's safeguarding team have used the CP-IS database provided by Cheshire West and Chester Local Authority to ensure an alert is placed (and subsequently removed) on their EPR+, so all staff are aware of the child's safeguarding status.



CP-IS Case Study Example

Safeguarding referral received from the Emergency Department for a 17-year-old boy with a cognitive age of 11. The staff had identified that his CP-IS (child protection- information system) status was positive indicating he was subject to a looked after child. The referral indicated that the young person had the following vulnerabilities:

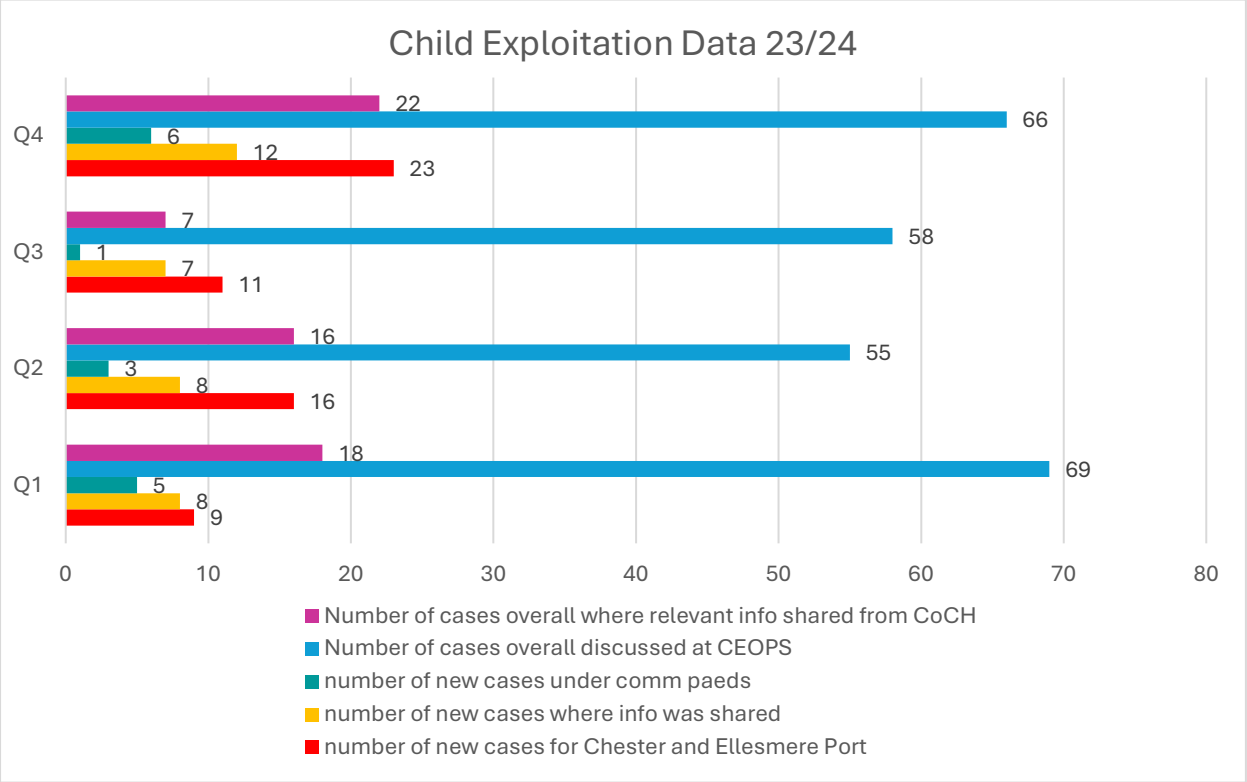
- Diagnosis of epilepsy (non-compliant with medication) therefore increased risk of seizure – this led to attendance.
- Child in care
- Current care home not fit for purpose
- Previous attendances for mental health and accessing support from CAMHS

Safeguarding nurse went to visit the young person on the ward and promoted the standards of caring for a young person in an adult area to the staff. Liaison with Social Worker, Epilepsy Specialist Nurse and Looked After Children's Nurse – all advised and kept up to date. All risk

factors and a safety plan highlighted within the child's EPR+ records. Safeguarding team attended multiple discharge planning meetings to ensure a safe discharge and to prevent re-admission.

Child Exploitation

The safeguarding team continues to attend the Operational Child Exploitation meeting held monthly in Cheshire West and Chester. This meeting is chaired by Cheshire Police and all children and young people who are assessed as being at high risk or medium risk of exploitation are discussed. The table below highlights the activity relevant to the Trust at these meetings. There is a notable increase across the year for relevant information the Trust shares at these meetings (in the best interest of the child). This can be a child that has attended the Emergency Department intoxicated, with mental health problems or substance misuse, or they are under the Community Paediatricians for neurodivergent issues (this is monitored due to a national spike in children and young people who have neurodiversity issues being at higher risk of child exploitation). For all children who are assessed as high and medium risk of exploitation as an outcome of the meeting, alerts are put in place on their EPR+ records.



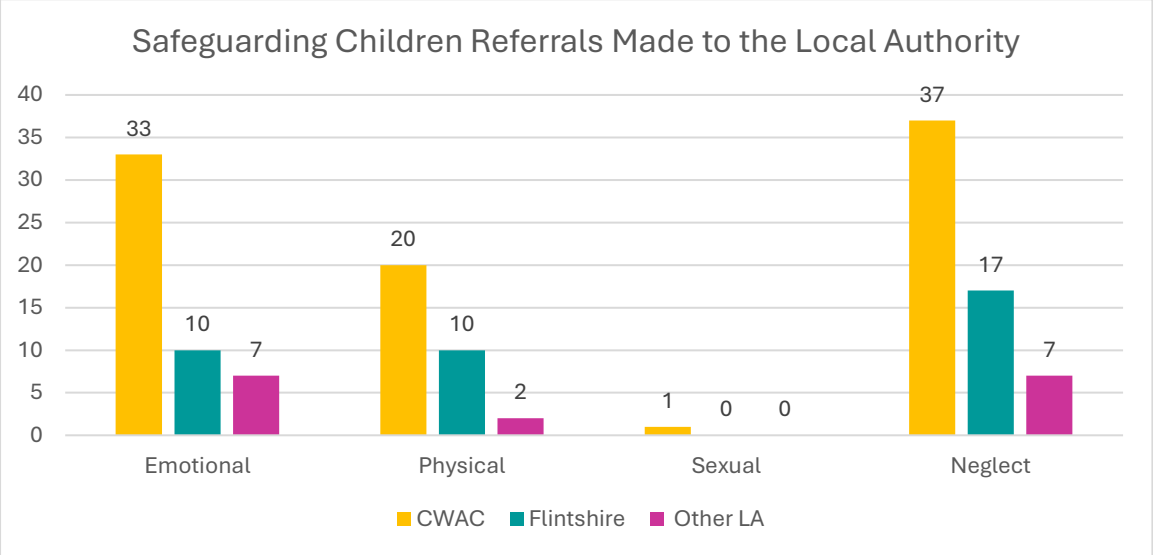
Referrals to Children's Social Care

The table below reflects the referrals that were made by the Trust into Children's Social Care. Referrals are required when a threshold is met that the child requires additional services (under S17 of the Children Act, 1989) or where the child is at significant risk of harm or who has been harmed (S47 of the Children Act, 1989). In the Trust, referrals are made for multiple reasons; non accidental injury, domestic abuse, drug and alcohol overdoses of parents/ child, mental

health of parent/child, neglect, perplexing presentation to name the common ones. As a result of the referrals made, themes suggest that:

- The safeguarding team use the consultation available with their social care colleagues to ensure appropriate referrals are made.
- Further information is often required to be provided by the team to support enquiries.

Statutory safeguarding guidance, such as Working Together; HM Government (2023) refers to the recognition of harm under 4 categories of abuse; emotional, physical, sexual and neglect. The Trust Safeguarding team categorises the referrals they make to the Local Authority.



In 23/24 the Trust referred 147 cases to Children's Social care. This is a decrease compared to the number made in 22/23 of 183 and in 21/22 of 157. However, of the referrals into the safeguarding team from the clinical areas, the team contacted the Local Authority 1223 times to ascertain further information, this is a steep rise compared to the 1067 times the Local Authority was contacted in 22/23. The reason for the lower referrals possibly is due to the information provided by the Local Authority which determines a decision of threshold for the child/ family and identifies that an early intervention package of care could support the child/ family.

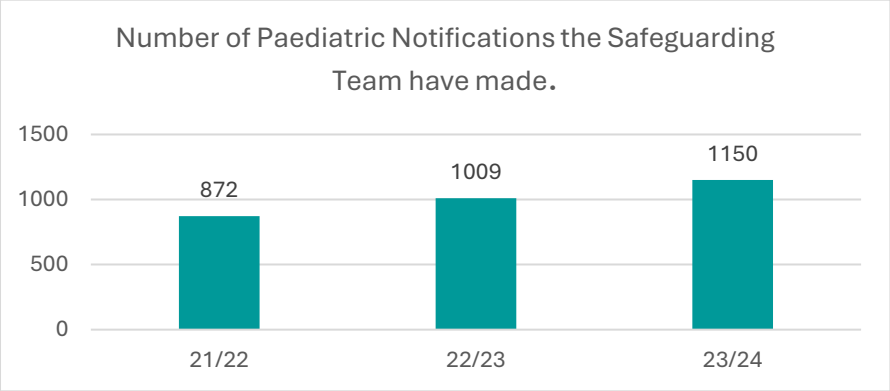
Liaison with Other Agencies

Currently the Paediatric Liaison Nurse works within Cheshire and Wirral Partnership Trust. This role is to ensure any concerns regarding children and young people in hospital settings are shared with the community services (generally Health Visitor and School Nurses) to ensure continuity of care. The safeguarding team provide written information to this service for any children and families they may have concerns about from a safeguarding perspective. This role is vital in supporting the communication pathways that operate between the community and acute health environments and enables the community practitioners to be informed of any vulnerabilities that may need following up in the community.

As well as the Paediatric Liaison Notification process, the team have developed strong relationships with the Safeguarding Children in Education Team (SCIE) where any concerns pertaining to a child's admission that relates to school is shared with them. This generally is

when children present with self-harming behaviours due to them being bullied in school. As already mentioned, liaison between CAMHS and the team for those complex mental health cases is evident as well as relationships between the team and Ancora House staff when children are detained under the Mental Health Act (5 in 23/24).

The table below shows the increase in Paediatric Liaison Notifications the team have made over the past 3 years



Social Care Referral and Liaison with Other Agencies Case Example

Safeguarding referral received from Ward 30 for a 15-year-old boy who was admitted to the children's ward via GP. The child presented with extensive psoriasis, covered from head to toe with extensive dry skin lesions. His skin was painful and excoriated – this was photographed by medical photography. It was evident that prescribed cream by GP had not been applied by parents. The child had not attended school for the last three months due to his condition.

- Safeguarding Team visited child on ward and obtained his voice, wishes and feelings.
- Safeguarding Team discussed concerns with parent and the reasons for wanting to submit a referral to social care which the mother agreed to.
- Safeguarding Team referred to social care and informed SCIE (Safeguarding Children in Education Team) and Starting Well service.
- Photographs shared by Safeguarding Team with social care due to concerns of parental neglect.
- Strategy meeting attended. Multiple concerns raised by several partnership agencies. Police have opened a criminal case for neglect.
- S47 threshold met – single agency assessment progressing and Child in Need Plan in place. If parents choose not to engage, case will progress to case conference.

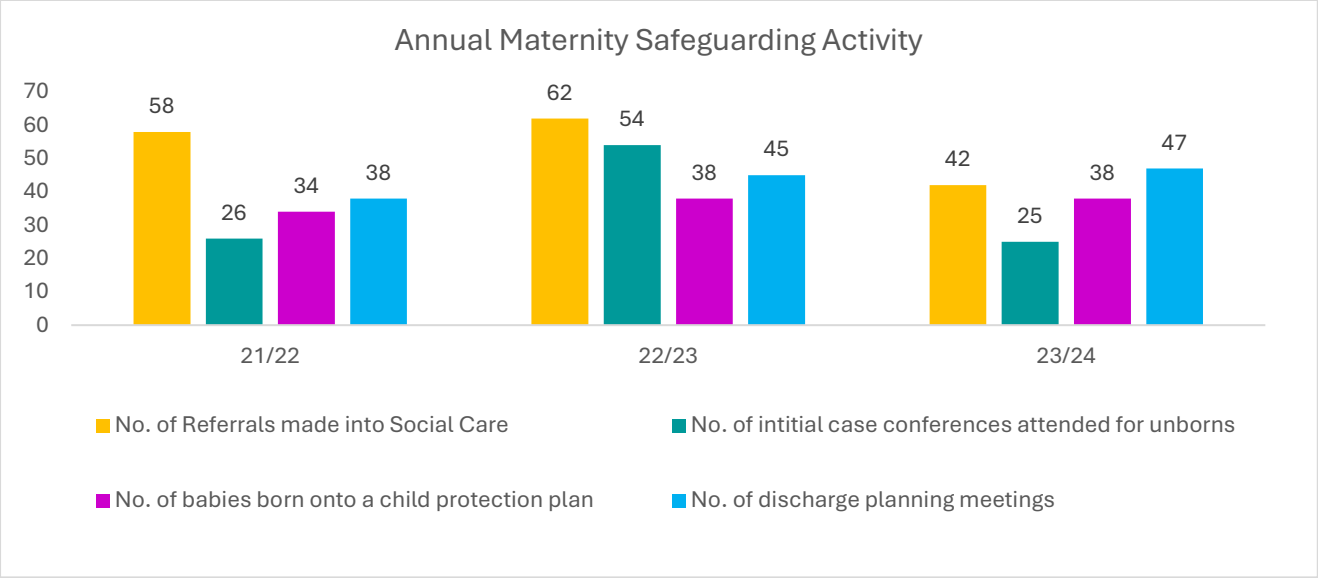
Maternity Safeguarding Activity

The governance arrangements for safeguarding maternity services is through the Safeguarding Assurance Committee and the Safeguarding Assurance Framework to the ICB.

When a complex pregnancy is identified and there are potential safeguarding concerns, a referral is received into the safeguarding team from the midwives. The Named Midwife for Safeguarding has a pivotal role in ensuring that our families and babies are safeguarded. They provide specialist knowledge, advice, and expertise to all staff within the maternity unit in all areas of children's safeguarding. The Named Midwife works collaboratively with the multi-

disciplinary team and partner agencies to ensure all babies and families who use the Trust's services are safeguarded and their welfare is promoted.

The table below shows the maternity safeguarding activity for the last 3 years. In 23/24 there were 231 antenatal referrals into the Trust's safeguarding team. Unfortunately, there is no comparable data for previous years. Of these referrals, only 42 of these converted into referrals into the Local Authority (18% conversion) and only 11% of the referrals progressed to an initial child protection case conference. The discharge planning meeting figures have risen year on year, this indicates that the learning from a Safeguarding Child Practice Review completed in 21/22 by Cheshire West and Chester Safeguarding Children Partnership that recommended the meetings has been embedded into practice. In addition, the team attended 33 multiagency strategy meetings in 23/24.



In 23/24 the team were involved in 7 babies that were taken into the care of the Local Authority. These cases are emotionally very challenging for both the midwifery team and the safeguarding team as they provide a significant amount of support to all the staff involved. Of these cases the Local Authority requested the team to provide 4 court reports to support further legal planning of these babies.

Case Study- ***Perinatal and Substance Misuse Process for Maria and Unborn X***

- 25-year-old lady , history includes; late booking of her pregnancy (20/40), previous history of domestic abuse, previous children in foster care, previous diagnosis of psychosis, and a history of substance misuse.
- Current situation on booking- actively engaging with various services and maintaining abstinence from substance use, positive engagement with mental health services, maintained separation from the unborn child's father, who was a perpetrator of domestic abuse
- At 25 weeks gestation, lady went missing from her temporary accommodation and was found in a psychotic state with her ex-partner. She admitted to using substances, she was detained by the police under the Mental Health Act and brought to the Emergency Department for her safety and the safety of her unborn child. She was admitted to a Mental Health unit.
- Safeguarding team coordinated antenatal care and liaison with several agencies and supported her in attending the obstetric unit. Comprehensive plan developed around her delivery especially considering

her mental health and potential mental capacity issues. Neonatal team briefed in anticipation of their support.

- Plans by the Local Authority to place an interim care order on the baby at birth- safeguarding team supported the lady with the court hearing , concerns were raised around her understanding of the process and this was escalated to senior management due to the potential risks of her 'removing' the baby after birth , further plans put in place.
- Case study highlights the importance of a multi-disciplinary and coordinated approach when dealing with complex perinatal and substance misuse cases. The safeguarding team played a crucial role in ensuring the safety and well-being of both lady and her unborn child, navigating the challenges and uncertainties that arose throughout the process. There was clear evidence that the Trust acted in the lady's best interests in facilitating a safe and smooth transition to the care of the local authority for baby.

In 23/24 the safeguarding team recognised the following trends in antenatal presentations

- An increase in women booking with a Learning Disability and neurodivergence. Reasonable adjustment risk assessments were completed on these women and a care plan developed following this.
- An increase in concealed pregnancies, late booking and free birthing, these emerging themes have been reported into the Safeguarding Children Partnership, these are recognised as a national trend and the team are working closely with the partnership to strengthen the Prebirth Risk Assessment to include these emerging themes.

Safeguarding Children Supervision

Both the Children Acts of 1989 and 2004 require safeguarding supervision to be available for all staff in direct contact with children and their families. The Trust has a safeguarding supervision policy which sets out the principles and expectations for effective supervision. Safeguarding supervision is a statutory and contractual responsibility. All staff that provide supervision have undergone additional recognised and accredited supervision training. The compliance with requirements for safeguarding supervision is closely monitored by the ICB.

A variety of approaches are used across the Trust including 1:1 supervision, group supervision, peer supervision and adhoc.

The cohort of staff accessing supervision in 23/24 has widened and now includes midwives, the community paediatric nursing team, dieticians, therapists, and ward-based nursing staff. All midwifery cases that require Children's Social Care intervention are supervised every 3 months as per the Safeguarding Assurance Framework standard.

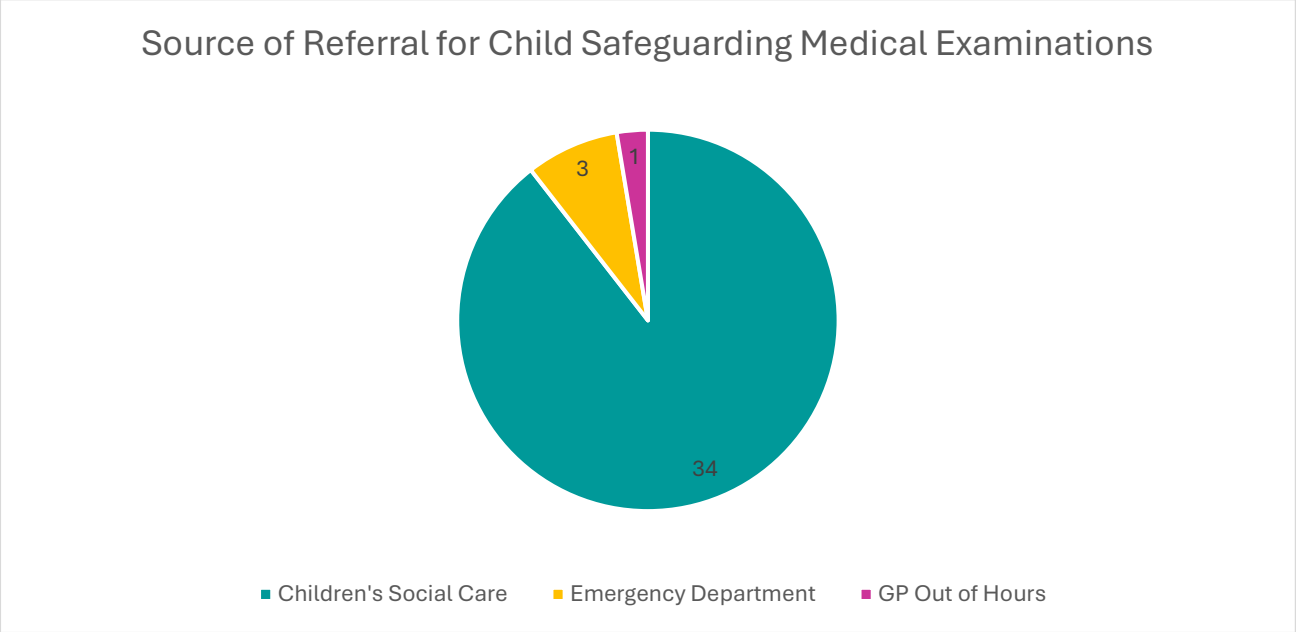
The Named Doctor for Safeguarding Children delivers a peer review each quarter. This is an opportunity for individual doctors to present a safeguarding case they have been involved in, to share the assessment and the outcomes with their peers. This session is well attended and more recently has included nursing colleagues.

Supervision is provided every 6 weeks to all the safeguarding and complex care team. The named professionals also receive supervision from the Designated Nurses in their respective specialities.

Child Protection Medical Examinations

The following is a summary of the clinical activity and performance figures for child safeguarding medical examinations undertaken by both hospital and community paediatricians in 23/24.

A total of 48 Child Protection medicals were completed in 23/24, this is a significant increase from the previous year's numbers of 27 in 21/22 and 31 in 22/23. The chart below shows where the referrals came from for the medicals. The increase in the number of child protection medicals requires monitoring and this information is shared with the Safeguarding Children Partnership. However, the numbers are still comparatively low compared with neighbouring hospitals. No reason has been identified for this but will continue to be monitored through the partnership.



The Types of Abuse Children were referred in for Child Safeguarding Medical Examinations were in large due to physical abuse. This was for all but 3 of the examinations, where one was for a sibling medical and 2 were for neglect.

Safeguarding the Vulnerable Adult

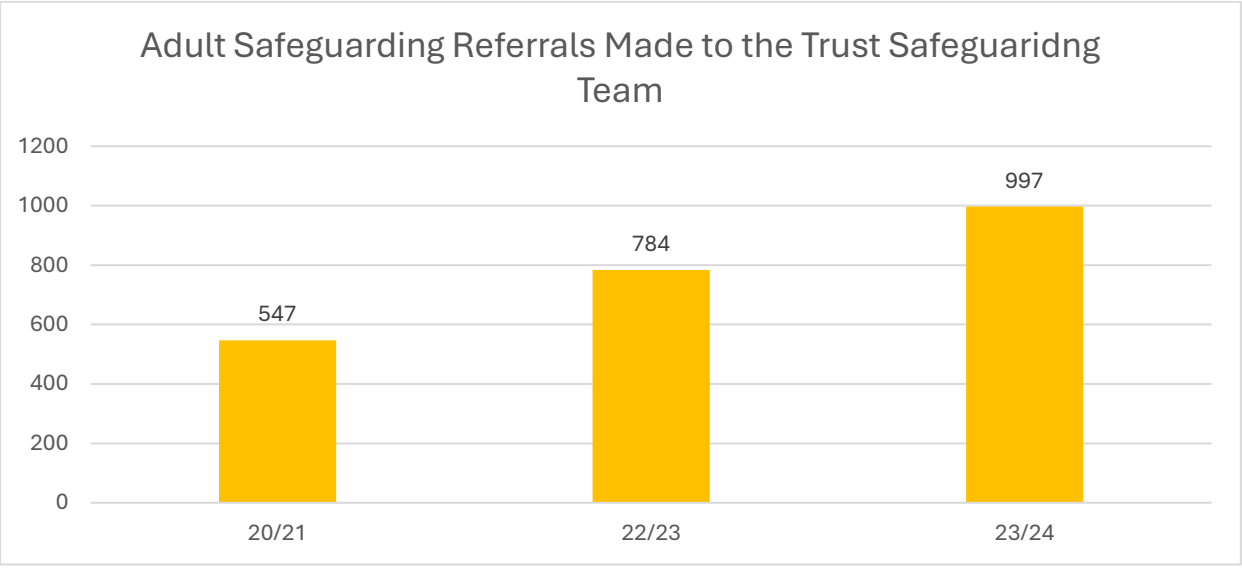
Key Achievements in 23/24

- Bespoke Training provided around Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS) for key groups of staff.
- Pressure Ulcer Review Template incorporates the Safeguarding Decision tool
- Pressure Ulcer on Arrival Notification form developed to support Local Authority notification process.
- Development of flowcharts for both *Present on Arrival* and *Hospital Acquired* pressure ulcers.
- Development of a safeguarding alert 'pop up' on the electronic record. This is a more visual alert for staff to ensure they are aware of the Safeguarding concerns associated with the patient.
- Safeguarding Practice Links Model developed.

- Consistent attendance at Prevent / Channel
- Monthly meetings embedded between Senior Social Care Manager and Lead professional for Safeguarding Adults to discuss cases and emerging safeguarding adult themes.
- Regular supervision with the Rapid Response Team leads following several S42 enquiries.
- Increased visibility across both the Countess of Chester and Ellesmere Port Hospital sites.
- Joint working between specialist practitioner for the homeless and the Safeguarding Team
- Processes developed between the safeguarding team and GPs to ensure safeguarding information is liaised to the GPs (and vice versa) to ensure continuity of care.
- Pressure Ulcer dashboard developed to track potential pressure ulcers that require safeguarding intervention.
- The Safeguarding and Complex care team all have access to Cheshire West and Chester's electronic system (Liquid Logic). This will reduce the number of contacts made to the Local Authority.

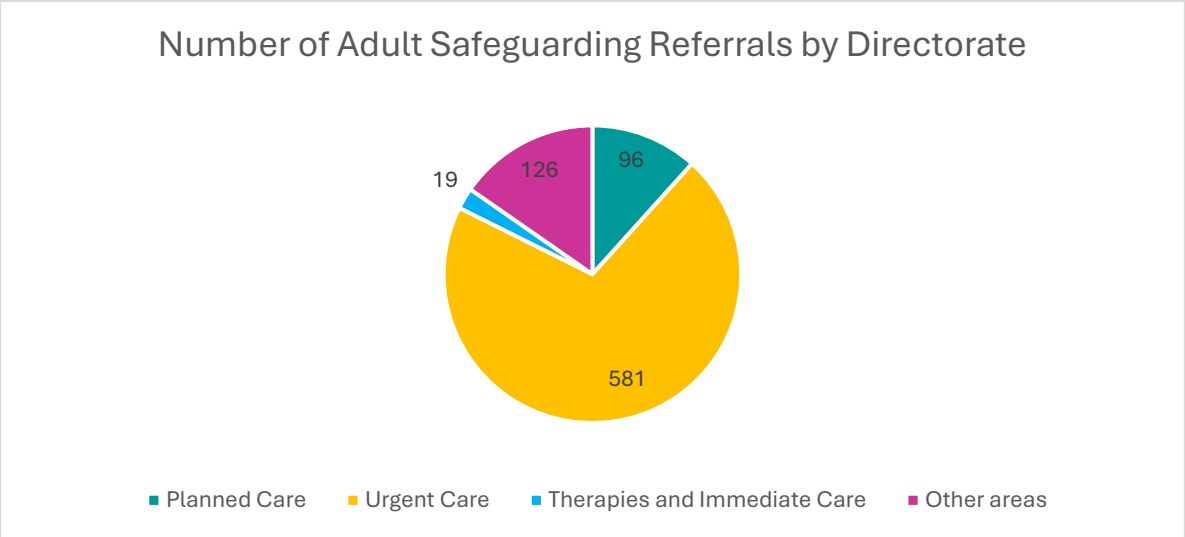
Safeguarding Adults Activity

The hospital safeguarding adult team continues to provide specialist advice and support for a wide range of issues relating to adults with care and support needs and those who have experienced or may be at risk of abuse or harm. The number of referrals made into the safeguarding adult team in 23/24 was 997, there is an increase in the level of safeguarding adult activity year on year within the organisation, this is aligned to the visibility of the safeguarding team across the Trust and the increase in training compliance which has increased staff confidence and competence in effectively recognising and responding to safeguarding adult issues. Referrals increased in numbers across each quarter throughout the year, however data suggests that of the 997 referrals received, 311 did not meet the threshold for a safeguarding adult response as 'no safeguarding concerns' were identified within the referral. Further training in 24/25 is required to respond to this evidence.

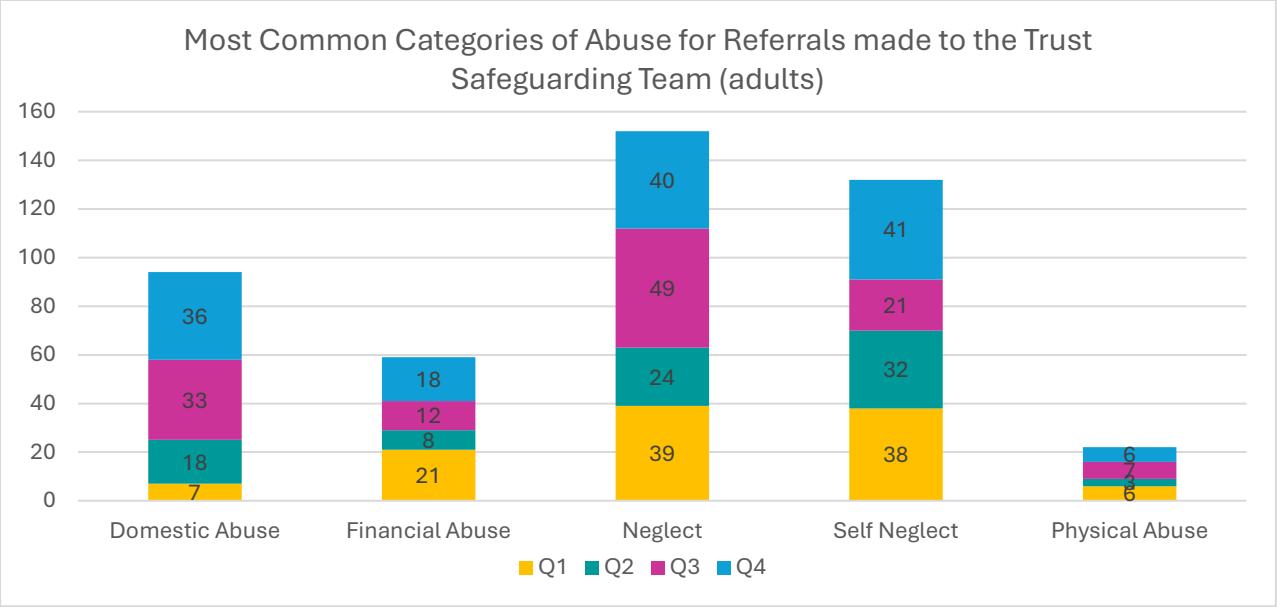


Nature of the Referrals received.

The safeguarding team collate the data from referrals to support practice development. The chart below demonstrates which directorate the referrals are made from in the hospital. The chart provides strong evidence that most referrals are received from Urgent Care. Within this directorate is both the Emergency Department and Acute Medical Assessment Unit. Both clinical areas are where initial assessments take place and where safeguarding concerns would be expected to be identified. In both these areas the team has increased their visibility to support staff with key safeguarding practices.



The table below reflects the nature of the referrals received into the team for adult safeguarding. The table demonstrates that the key reason for referrals are; for a disclosure of domestic abuse, financial abuse, neglect and self neglect. This supports the national and local trend of an increase in these areas. It is encouraging that staff also recogonise some less common types of abuse including modern slavery (4), radicalisation (4), sexual abuse (10), psychological abuse (9) and organisational abuse (10) and made approriate referrals to the team on recognition. This trend correlates with the Trust's commitment to improving their safeguarding training indicating the effectiveness of the training the staff receive.



Adult Safeguarding Case Study

Safeguarding referral received from the Emergency Department (ED) for a 61-year-old female patient. Concerns raised due to unstageable wound to Sacrum and nursing staff concerned that patient was unkempt with dirty clothing.

- On review of EPR+ documentation it was noted that patient had been discharged following review from Plastics team ,unstageable wound on sacrum was from recent surgery to remove a large cyst.
- Safeguarding and complex care team also noted that patient lives with elderly mother who has dementia, this was patient 2nd attendance to ED following the surgery 3 weeks earlier.
- Safeguarding team contacted GP practice and spoke with care co-ordinator, who gave assurance that she had recently visited both the patient and her mother and that they appear to be managing well. Care co-ordinator stated that both are usually well presented, and this would be out of character.
- Care co-Ordinator agreed to arrange to contact patient to check on welfare.
- Safeguarding and complex care team contacted DN who are visiting daily for wound care, District Nurses agreed to monitor and review
- Safeguarding and complex care team received a telephone call from care co-ordinator to report that patient was in ED with pain to surgical wound and is tearful
- Safeguarding and complex care team attended ED to review and support patient whilst in ED, patient reported that she has been feeling emotional and anxious following surgery this has contributed to several attendances to ED
- Patient was referred to Psychiatric liaison and GP follow up
- Telephone call to care co-ordinator to update

Working With Adult Social Care

In 23/24 the Trust made 127 referrals into Adult Social Care, unfortuantely there is no comparable data from previous years. Safeguarding referrals are made under the Care Act (2014) when an adult is at risk who:

- Has care and support needs
- Is expereincng, or is at risk of abuse or neglect
- As a result of their care and support needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

An increase in the recognition and subsequent onward referral of financial abuse may be that staff have a wider understanding and ability to recognise these areas or it could be due to the cost-of-living crisis and financial abuse is more prevalent due to this. In the other areas of abuse, one modern slavery case, 3 exploitation cases and 9 domestic abuse cases were referred into the Local Authority under the Care Act (2014). 77% of all referrals were made to Cheshire West and Chester Local Authority and 20% to Flintshire, this is in line with the proportion of patients that attend the hospital from the 2 areas.

Of these referrals, 9 progressed to provider led S42 enquiries, where the Trust led on an adult safeguarding enquiry to find out what, if anything happened to an adult who is believed to have experienced abuse or neglect. An Organisational Safeguarding Alert (OSA) was opened by the Local Authority in December 2023 due to concerns relating to the Trust's response to the enquiries, the Trust developed a robust action plan to address the issues that had been raised and the OSA was closed in March 2024. The Trust was able to provide strong assurance in relation to safeguarding systems, processes and practice.

Analysis of the findings from these enquiries identified the following learning themes.

- Missing or incomplete Mental Capacity Assessments
- Issues with restraint techniques
- Improper manual handling techniques
- Inadequate communication between staff and patients
- Inadequate documentation in EPR+
- Inadequate discharge multi-agency planning
- Inadequate pressure area care
- Slow response to allegations

The identified learning has been cascaded across the Trust via various mechanisms including the weekly learning bulletin and team brief. In addition processes have been changed in response to the learning and audits are scheduled in 24/25 to monitor the effectiveness of these changes.

In addition, the Trust received 55 requests from Adult Social Care to provide information to support other S42 enquiries on adults with care and support needs who were potentially at risk of abuse of abuse or neglect. This is an increase compared to the 42 requests received in 22/23 and possibly indicates the rise in cases of adult abuse that are being reported nationally.

Adult Safeguarding Case Study

Safeguarding referral received from the emergency Department for a 61-year-old female patient. Concerns raised by carers and ambulance crew in relation to patient's son.

- Carers were concerned that patient son is not giving her all the medication when appropriate and could be withholding some medication due to his beliefs that she doesn't need them.
- Son got quite irate at the fact of patient going into hospital. Son appears very agitated and restless whilst in the Emergency Department
- Safeguarding team made a referral into Adult Social Care –Community Safeguarding concerns raised by multiple teams in relation to son coercion and control over patient, including withholding medication not allowing health professionals into her home and installing cameras to monitor this.
- Safeguarding practitioners and Independent Domestic Abuse Advocate (IDVA) liaised closely with patient, ward staff, Social Care and police.
- Patient agreed to remain in hospital until Safeguards in place to support safe discharge
- Police arrested son, bail conditions to prohibit son going to her house, locks changed, and cameras removed, deterrent alarms put on doors.
- Patient discharged home with all care back in place, follow up strategy meeting planned and will remain open to Local Authority for ongoing care and support
- At risk of domestic abuse flag in place to alert hospital staff of community concerns if patient is re-admitted.

Pressure Ulcers and Safeguarding

Pressure ulcers may occur because of neglect. Neglect may involve the deliberate withholding or unintentional failure of a paid, or unpaid carer to provide appropriate and adequate care and support. In some instances, this is highly likely to result in significant preventable skin damage and the development of higher category pressure ulcers. In the Trust it is recognised there are 2 different types of pressure ulcers, Present on Arrival (POA) mainly via the Emergency

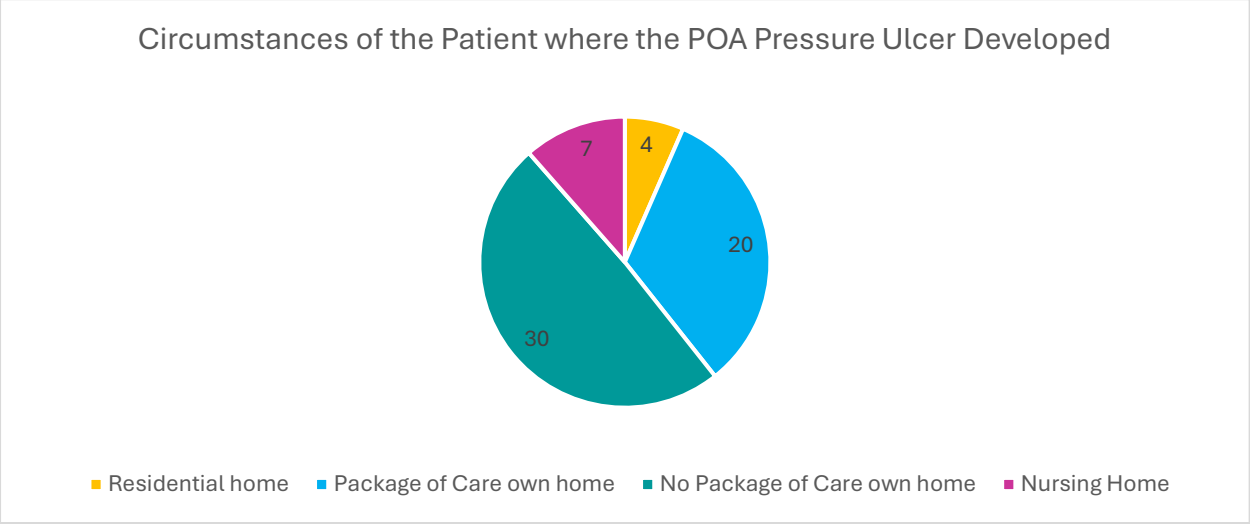
Department and Hospital Acquired Pressure Ulcers (HAPU). In 23/24 the Safeguarding and Complex Care team strengthened their processes for both types of pressure ulcers to support both the Trust's and Local Authority's response to the management of pressure ulcers. Data from a safeguarding perspective on pressure ulcers has only been collated since Q3 23/24.

Hospital Acquired Pressure Ulcers (HAPUs)

In Q3 and Q4 23/24 the safeguarding team were alerted via the DATIX system to 24 HAPUs which were multiple category 2 HAPUs or Category 3 or 4. The Team have worked with clinical staff to cascade the Government's *Adult Safeguarding Decision Tool* Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK (www.gov.uk) into clinical practice by embedding the tool into the Trust's existing Pressure Ulcer Review Template. This resulted in only 1 referral being made to Adult Social Care in these 2 quarters as well as providing assurance that an adult safeguarding response was not necessary for the other HAPUs.

Present on Arrival (POA) Pressure Ulcers

In Q3 and Q4 23/24 the safeguarding team were alerted via the DATIX system to 61 POA (multiple category 2s, Category 3 or 4). The breakdown of the circumstances where the POA pressure ulcer was developed is detailed in the chart below. Of these cases, 5 patients were referred into the Local Authority due to concerns being raised by the Trust regarding potential neglect from other care providers. A notification form has been developed to standardise this process. The Trust is working closely with the quality team from the Integrated Care Board to gain assurance that all care providers complete the *Adult Safeguarding Decision Tool* to standardise the response to pressure ulcers in both acute and community care settings.



Liaison with Other Agencies

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

Prevent

The Counter-Terrorism and Security Act (2015) contains a statutory duty on the health sector to have due regard to the need to prevent people from being drawn into terrorism. This is also known as the *Prevent Duty*

The Trust is required to provide assurance that the Statutory Prevent duty is met. To achieve this, the following arrangements are in place:

- An identified Prevent Lead (Lead Professional for Safeguarding Adults) who staff can contact for advice and support.
- An up-to-date Trust policy and strategy that provides guidance to staff to identify and respond to concerns
- A prevent training programme to raise awareness.
- Attendance by the Prevent Lead at multiagency meetings.
- Submission of Prevent data quarterly to the Integrated Care Board.

The Trust has made one referral into Channel Panel in 23/24 and has attended all meetings to share relevant information as requested to the Channel coordinator.

Modern Slavery

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

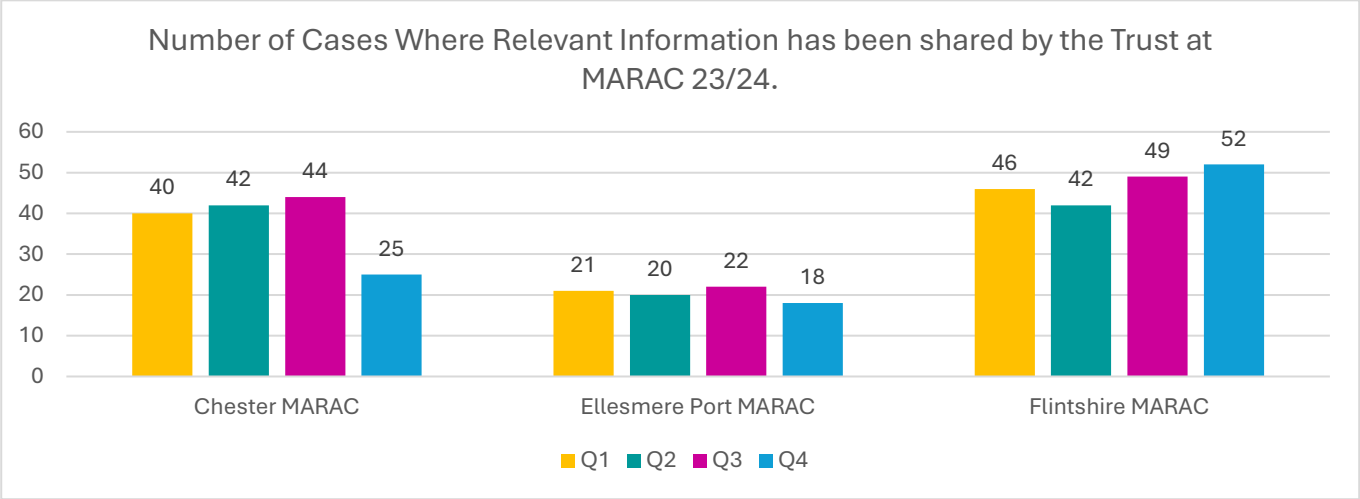
Domestic Abuse

A key priority for the Trust is to continue to raise awareness and understanding of the safeguards in relation to domestic abuse, ensuring that all staff have access to resources and support to enable them to effectively safeguard those experiencing, or at risk of domestic abuse**.** The Trust has a co-located Independent Domestic Abuse Advisor (IDVA) based within the Safeguarding and Complex Care team who support both patients and staff members who disclose domestic abuse**.**

In 23/24 the hospital IDVA received 246 referrals from hospital staff, these referrals are mainly received from the Emergency Department and the wards, the previous year there were 243 referrals received. Safe Lives (2020) a domestic abuse charity, suggests that victims of domestic abuse often seek medical support for sustained injuries from the abuse they have suffered or for other presenting concerns such as mental health or substance abuse associated with their domestic abuse. Therefore, victims need to be given a routine opportunity to disclose if they are suffering from domestic abuse and the IDVA presents as a positive opportunity to support these patients when a disclosure is made. The hospital IDVA provides an opportunity to see the patient prior to discharge and ensures safety planning can be completed and any onward referrals be made to safeguard the patient further.

The IDVA represents the Trust at the various Multi Agency Risk Assessment Conferences (MARAC) across the Trust footprint where relevant information is shared relating to the victim, perpetrator and any children that maybe involved. The table below shows the number of cases discussed at the MARAC meetings for 23/24 where relevant information was shared by the

hospital Independent Domestic Violence Advocate (IDVA). There are 4 MARAC meetings per month that the Trust commits to attending (Note- MARAC is only for high-risk cases of domestic abuse). The volume of preparatory work for these meetings is significant and places pressures on the IDVA (and safeguarding team in her absence). The Trust also ensures alerts are in place on both the perpetrator and victims records post MARAC to ensure patients are responded to and safeguarded as necessary. In total in 23/24, relevant information was shared on 421 different patients who were discussed at MARAC, this is a significant increase from the 286 cases where information was shared in 22/23. This reflects the national picture of an increase in domestic abuse prevalence.



Domestic Abuse Case Study

The safeguarding team received a call from Jubilee Ward to ask for some advice. They advised that a patient was at a pre operation assessment accompanied by her daughter, she had observed that her daughter looked upset. The member of staff had asked why her daughter was not in school today and was there something that they would like to talk about. The patient disclosed that this morning, her daughter and her husband got into an argument, her husband was particularly nasty and threw objects at her, she did not feel up to going into school as she was so upset. She said he is nasty most days. But today was a particularly bad day.

The staff was concerned due to these disclosures, the IDVA with the patient's consent went straight away to talk to her. Ongoing domestic abuse concerns were identified in the home and the child was at risk, mum consented to a local authority referral, the child was also spoken to.

Due to the nurse asking questions and demonstrating professional curiosity, this led to the patient getting the support she needed. She had never reached out for any support previously; she had never made any domestic abuse disclosures. If it hadn't been queried in the first instance, why her daughter wasn't in school, which lead to open conversations, they may well have been still in the same situation to this date.

Complex Care Activity

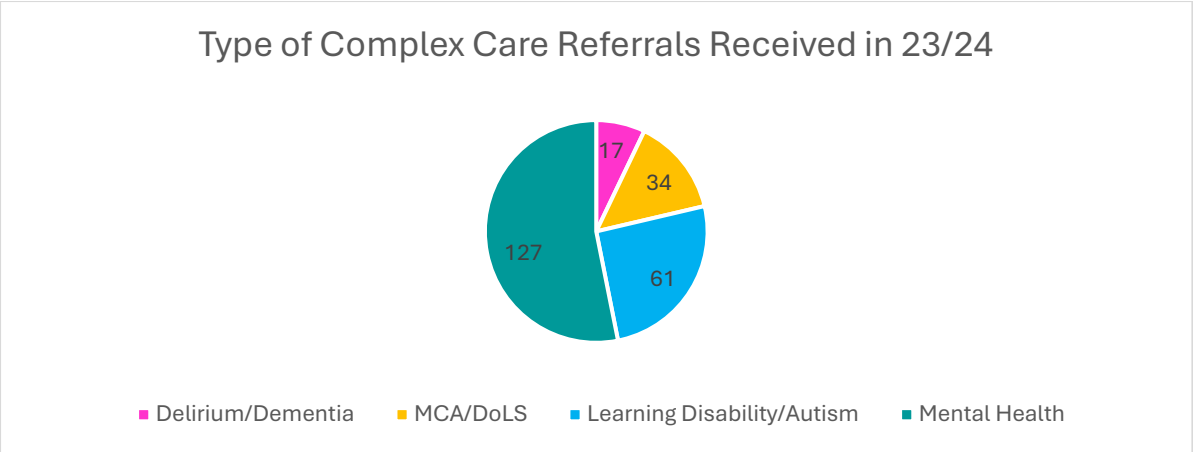
Key Achievements in 2023/24

- Bespoke Training provided around Mental Capacity Act (MCA)/ Deprivation of Liberty Safeguards (DoLS) for key groups of staff.
- Improved quality assurance processes for the application of a DoLS

- Reasonable adjustments flags added to all patients identified as having a learning disability and / or autism.
- Improved Trust compliance on the Oliver McGowan training course.
- Training for the acceptance of Mental Health Act Section papers to key staff.
- Development of *Supporting Patients with Additional Needs Strategy*
- Completion of the NHS Learning Disability Improvement Standards
- Strengthening of governance and reporting arrangements for *LeDeR (Learning from Lives and Deaths- People with a Learning Disability and Autistic People Review)*
- Development of STOMP (stopping over-medication of people with a learning disability, autism or both with psychotropic medicines) processes
- Learning disability passports more widely used and promoted
- Development of guidance and a training package to support the assessment and planning of reasonable adjustments
- Development of reasonable adjustment risk assessment on EPR+
- Development of ligature risk assessment on EPR+
- Strengthened governance arrangements to monitor trust performance.
- Appointment of a lead professional for complex care
- Development of pilot programmes to improve knowledge, confidence and competence in caring for patients with dementia and use of the Mental Capacity Act in discharge for hospital.

The Complex Care team provides specialist advice and support for a wide range of issues relating to the Complex Care agenda. This, in the main is for those patients where, there are challenges in accessing care or delivering care due to a cognitive impairment such as a Learning Disability, Autism and or dementia as well as those patients with mental health challenges. In 23/24 an additional needs strategy was developed and will be promoted in 24/25, this strategy sets out a three-year strategic plan, detailing how we will respond to the profile of our local population to deliver high quality, person-centred care for people with additional needs and their carers.

In 23/24 the team received 142 referrals via EPR+ for complex care cases. The majority of these were for mental health support and those patients with an identified Learning Disability. There is no comparable data from the previous years. The breakdown of reasons for referrals are shown below. This data does not include DoLS applications, nor the patients identified with a Learning Disability identified elsewhere.



Learning Disability

It is estimated that 1.5 million people in the UK live with a learning disability - this makes up approximately 2% of the population. It is estimated that more than one in ten people in the UK have a diagnosis of autism spectrum disorder.

The Countess of Chester Hospital has a responsibility to ensure reasonable adjustments are made to the care of anyone who comes into hospital whether this is unplanned or a planned visit. Reasonable Adjustments are a statutory duty under the Equality Act 2010.

The nature of an individual's learning disability or autistic spectrum disorder varies widely and can range from mild to significant. Being in hospital can be difficult for anybody, being in hospital with a learning disability and/or autistic spectrum disorder can be particularly challenging and frightening. We know that compared to the general population this group of patients are significantly more likely to require health services, we also know that this group of patients are more likely to have poorer health outcomes and experience poorer levels of care.

The complex care arm of the wider safeguarding and complex care team provides a service to patients with a learning disability and/ or autistic spectrum disorder. The service helps ensure that people with a learning disability and or autistic spectrum disorder get the care they need when they need it.

They support patients by:

- Creating and providing easy read information to help patients understand the treatment or their proposed care.
- They give advice and support to the patient's clinical team to ensure reasonable adjustments are made for the patient.
- They support the patients and their carers to prepare for a hospital visit.
- They help organise and attend appointments or best interest meetings.

The team are committed to ensuring standards of care are maintained for those patients with a learning disability and or autistic spectrum disorder. The team receive a daily report of all patients who are in the hospital who have a learning disability / autism alert on their records. In 23/24 there were 225 patients who were admitted with a flag. The team reviewed each patient to ensure reasonable adjustments were made for them.

Quarterly audits are completed on patients who have a clinical code for a Learning Disability and/ or Autism. The audit measures compliance against the following criteria

- Appropriate alerts/ flags are in pace
- Hospital passport is available to staff on the patients EPR+.
- A referral to the Safeguarding and Complex Care Team has been made
- Reasonable adjustments have been identified and acted upon.
-

Recommendations are developed following the completion of the audit, these are shared at the Trustwide Safeguarding Assurance Committee and learning is cascaded across various forums.

Case Study for an Autistic Person

A referral for support was received for P, a 37 yearr old woman with Autism, ADHD (Attention Deficit Hyperactive Disorder) who is registered as blind and was admitted to ward.

A reasonable adjustments risk assessment was completed with the patient, identifying triggers and known de-escalation techniques to reduce stress. P was provided with fidget adjuncts and moved to a low stimuli location on the ward, where the curtains could be drawn. P was given a radio and encouraged to use her headphones to block out external noise and call her partner to attend.

Following discussions with the clinical team, an early discharge was agreed. Feedback from P stated "The Complex Care Practitioner was a godsend for me. Being in hospital as an Autistic person is difficult. Staff did not explain medication to me and why I should take them. Neurodiverse people need to be listened to more. Listen to your patient. We are the experts at living with our neurodiversity."

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

In 23/24 the Trust also drove the STOMP initiative forward across the trust. It is a national project which is helping to stop the overuse of these medicines. The Safeguarding and Complex Care Team are represented on the Trust's Medicines Management Group and complex patients are reviewed by the team with STOMP in mind.

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

Research has shown that on average, people with a learning disability and autistic people die earlier than the general public, and do not receive the same quality of care as people without a learning disability or who are not autistic.

LeDeR reviews deaths to see where we can find areas of learning, opportunities to improve, and examples of excellent practice. This information is then used to improve services for people living with a learning disability and autistic people. A LeDeR review looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes. In 23/24 the Trust referred 2 cases into LeDeR where a patient had died who had a learning disability and or autism and they supported a further 2 cases where information was requested for a LeDeR review. No learning has been issued from the LEDER review as yet for these 2 cases.

Case Study for a Learning Disability Case

Referral received from Colorectal Consultant to support the process for management of rectal bleeding in the community. P was 38 yr old woman, diagnosed with a profound learning disability because of Ehlers Danlos syndrome and needle phobia. With support, she was established as lacking capacity to consent to the investigation and management of the rectal bleeding and subsequently, following consultation with her mother and the community learning disability team the least restrictive option was agreed for P to attend the Trust for a CT scan and flexi sigmoidoscopy under sedation, in her best interest.

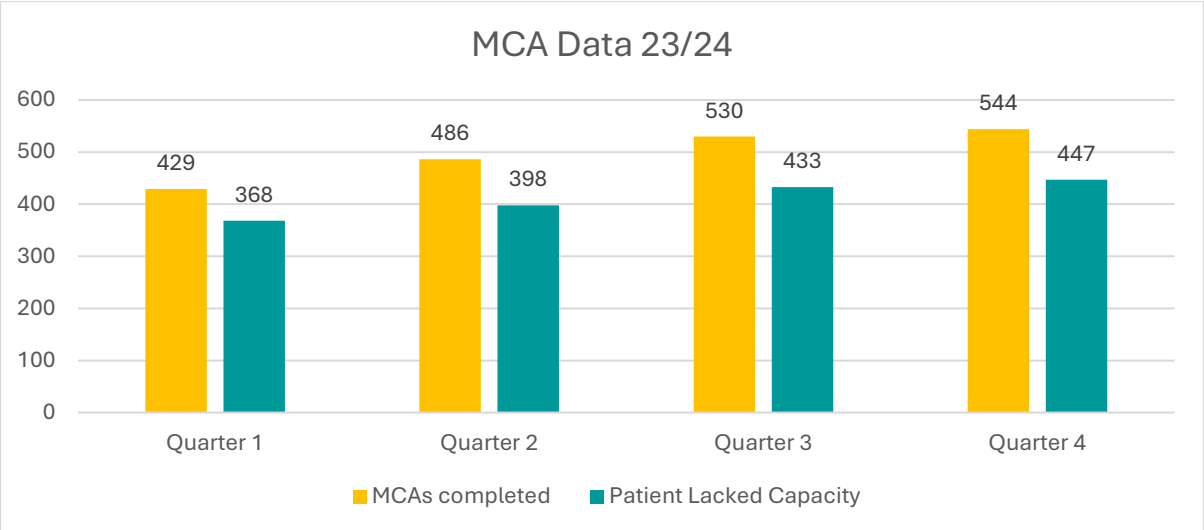
Acting as the single point of contact to co-ordinate the admission a reasonable adjustments risk assessment was completed by the Safeguarding & Complex Care team identifying the need for a quiet waiting area in the CT department, unrestricted access to her relative, known triggers were minimised and utilising de-escalation and distraction techniques P was successfully cannulated, and the procedure was completed without complication.

Feedback from P's relative stated *'All went to plan thanks to the Complex Care team. Everyone was briefed and she was seen very promptly thus reducing her anxiety. It meant that what could have been a very stressful experience was made a lot easier thanks to everyone working together on reasonable adjustments. I have to say the whole experience from meeting with the Consultant through to the procedures being completed have been made more bearable.*

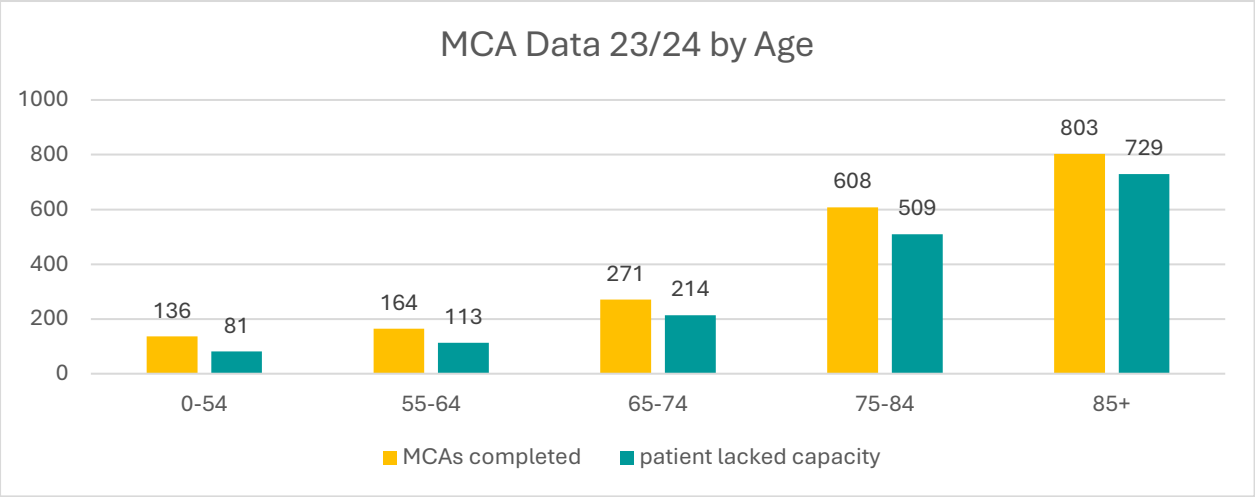
The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

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

There were 1989 mental capacity assessments completed across the Trust for patients in 23/24, this number has increased by 20% from the 1663 forms in 22/23. Of the 1989 forms completed in 23/24, 1646 indicated that the patient lacked capacity to make specific decisions around their care and treatment compared to only 1274 the year before. The break down per quarter for 23/24 is below.

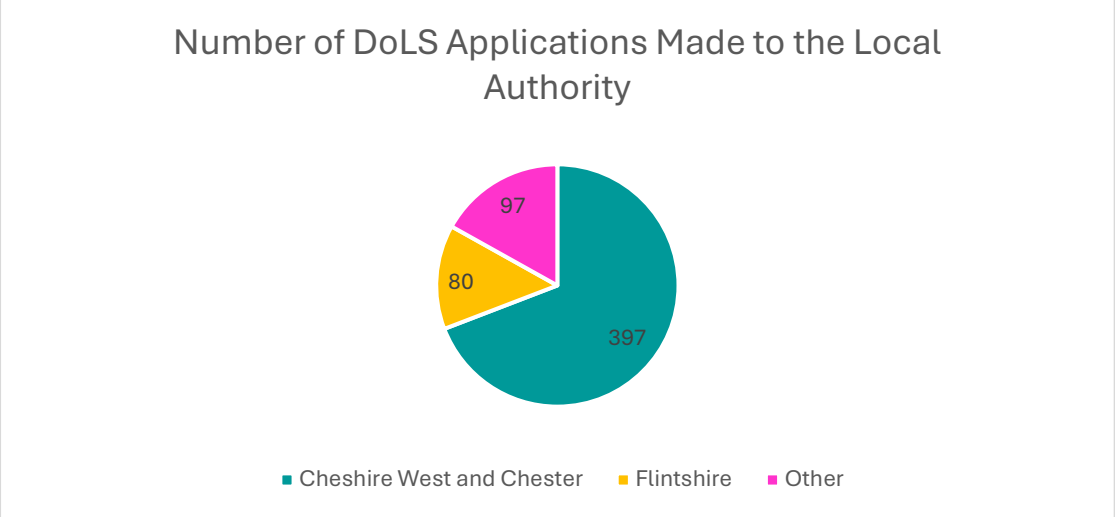


In 23/24 the Safeguarding and Complex Care team drove the MCA agenda forward. They provided bite size briefing sessions for staff to attend online and increased their visibility in the clinical areas to support staff in completing MCA assessments. In addition, they supported the security team in their understanding of mental capacity so they can intervene more effectively with those patients that lack capacity and ensure patients receive the *least restrictive option* of care. The chart below breaks down those patients who lacked capacity by age.

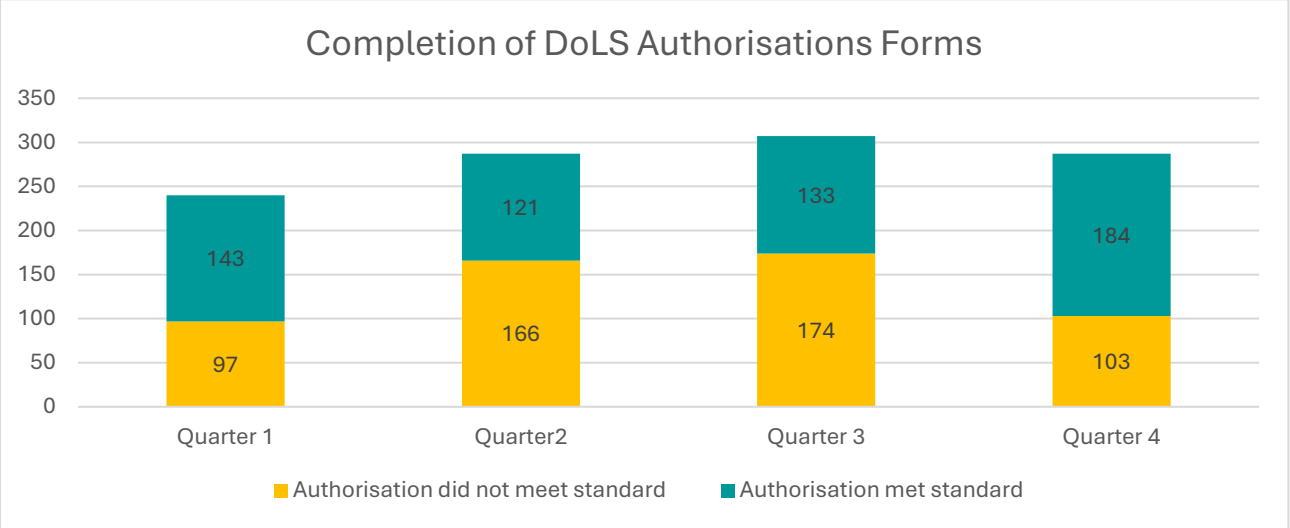


For the cohort of younger patients, the patients often have a learning disability, autism, delirium (often due to drug and alcohol misuse) or an acquired brain injury. The older cohort of patients can be for dementia, delirium, learning disability, brain injury as well as other conditions.

In all cases, the restrictions placed upon a person who lacks capacity may amount to a deprivation of their liberty. Where a deprivation of liberty is required, the hospital makes an application to the Local Authority for a DoLS (Deprivation of Liberty Safeguards). This is to ensure that the hospital act in the patient's best interests using the least restrictive care required. In 23/24 the CoCH applied to the Local Authority for a DoLS 484 times. In comparison, 449 applications were made in 22/23 and 437 in 21/22. The breakdown of Local Authority applications can be seen on the pie diagram below.



In 23/24, a quality assurance process was implemented to ensure the legal requirements of the DoLS application was met by the Trust prior to their submission to the Local Authority. This process highlighted that a considerable number of initial applications did not meet the threshold required and were returned to the staff who had completed the paperwork. In most of these cases it was because there were inaccuracies in the completed forms, a lack of a best interest decision taking place, or the lack of a completed MCA assessment. The table below demonstrates the annual figures of the completed DoLS applications by clinical staff. In Q3 due to the high numbers, the process for completing a DoLS application was changed, and the hospital matrons took on the role of quality assurance. As well as this, only electronic copies of the form were accepted so minor changes to ensure the legal requirements were met could be made. This has significantly improved the compliance.



In addition, a DoLS flowchart is available to staff on the intranet continues to be in place to provide staff with support and guidance around when a Deprivation of Liberty is required and what the process is for making a DoLS application.

Dementia

Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of brain functioning. There are many different causes of dementia, and many different types. Research shows there are more than 944,000 people in the UK who have dementia, 1 in 11 people over the age of 65 have dementia in the UK. At any one time 1 in 4 hospital beds are occupied by people living with dementia, and these patients often experience longer hospital stays, delays in leaving hospital and reduced independent living (Dementia UK, 2024). The symptoms of dementia usually become worse over time. In the late stage of dementia, people will not be able to take care of themselves and may lose their ability to communicate. Depending upon the stage of the person's dementia, they may require additional support including help with making decisions.

Hospital admission can trigger distress, confusion and delirium for someone with dementia. This can contribute to a decline in functioning and a reduced ability to return home to independent living. The Safeguarding and Complex Care Team provide specialist advice and education to staff across the Trust to support them in delivering high standards of care to patients living with dementia. A quarterly audit is completed to ensure the Trust's standards of

care for those patients living with dementia are met. The audits measures compliance against the following criteria

- The patient has the appropriate alerts on their EPR+
- A dementia/delirium diagnostic assessment has been completed on their EPR+
- Evidence of delirium is considered.
- A copy of 'this is me' is accessible via EPR+
- Any evidence of a failed discharge.

The audits have highlighted areas where practice could be improved, the assurance that 'this is me' documentation has been completed and utilised to its full advantage to support patient care is required as well as the appropriate assessments for patients with dementia / delirium are completed. This will be a trust priority in 24/25.

Management of a Patient Requiring Reasonable Adjustments and Who Lacked Capacity

The Safeguarding & Complex Care Team received a telephone enquiry from a patient's sister asking for support and reasonable adjustments for her brother who had been brought into the Emergency Department following a fall at home. P was a 71 year old male with a bi-polar disorder, dementia and a speech impairment.

Following triage, P had been waiting for 2 and a half hours in the main waiting room, which was extremely busy leading to P becoming very distressed. A Complex Care practitioner attended the department and following discussions P was transferred to a side room, where a reasonable adjustment risk assessment was completed.

P was assessed as requiring Intravenous hydration and antibiotic therapy and following P being established as lacking capacity and a decision to treat made in best interest, identifying the least restrictive option to enact the decision.

Supporting the clinical team, the complex care practitioner remained with the patient and used distraction and de-sensitisation techniques, mitigating the need for sedation or restraint which ensured appropriate care was delivered; leading to an optimised recovery and discharge back to supported living on the same day with support from the hospital at home service.

Mental Health Act (MHA)

In most cases when people are in hospital, and they have a mental health difficulty they have agreed or volunteered to be there. However, there are cases when a person is detained, also known as sectioned, under the Mental Health Act (1983) and treated without their agreement. In 23/24 the Trust detained 25 patients under the Mental Health Act (1983). The decision to detain under the Act is made (other than in an emergency) by two Doctors and an Approved Mental Health Professional (AMHP). People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

The Chief Executive Officer can formally delegate their duties to receive and scrutinise section papers (legal documents) to staff within the Trust who have received appropriate training in 'the receipt of Section papers.' In 23/24 all Heads of Nursing, Matrons and the Clinical Site Coordinators received the training of accepting section papers by the Safeguarding and

Complex Care Team. This training ensured that staff were competent to make such a judgement, and to identify any error in the documents, which may require rectification.

Mental Health Act administrators also undertake further scrutiny and rectification of documents. This is provided by Cheshire and Wirral Partnership Trust (CWP) who act on behalf of the Trust for all Mental Health Act administration under a Service Level Agreement (SLA). In 23/24 this SLA was reviewed by both Trusts.

9. Training

Safeguarding education is the foundation of safeguarding competence within the workforce. All safeguarding training delivered within the Trust is based on the requirements specified within the Intercollegiate Safeguarding documents.

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

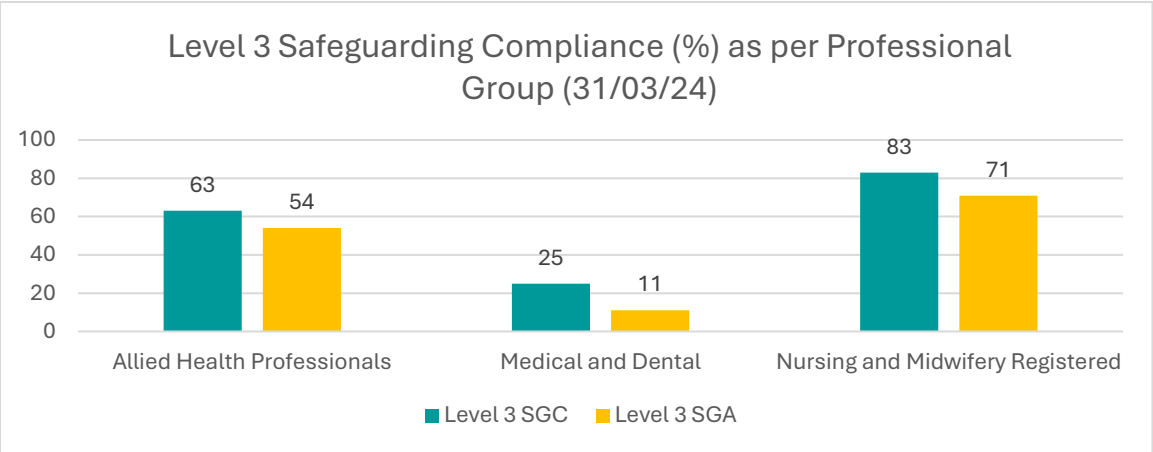
The key performance indicators (KPIs) for safeguarding training are agreed locally with the ICB and is set at 90% compliance. The training packages accommodate a variety of learning styles from eLearning packages to full day face to face learning. Training is inclusive of all staff members across the Trust.

All training packages are reviewed annually and updated in accordance with statutory guidance and legislation as well as learning from safeguarding reviews and incidents.

The table below shows the training compliance for the different mandatory training courses across the Trust for 31/03/2024.

Level 1 Safeguarding Adults	93%	Level 1 Safeguarding Children	90%
Level 2 Safeguarding Adults	90%	Level 2 Safeguarding Children	92%
Level 3 Safeguarding Adults	63%	Level 3 Safeguarding Children	67%
Level 4 Safeguarding Adults	100%	Level 4 Safeguarding Children	100%

The chart below shows the compliance of level 3 training per professional group at year end 31/03/2024.



Actions have been taken over the year to address the gap in Level 3 training:

- Breakdown of Trust compliance into clinical areas to target non-compliant areas.
- Review of the Training Needs analysis (TNA).
- Additional capacity created in the training sessions.
- Regular communication reminding staff of the importance of accessing the training.

The staff group requiring the most focus for Level 3 training is now the medical teams. The action plan was shared with the ICB, and a trajectory determined, however the trajectory wasn't met by the end of Q4. This is a standing agenda item at the Safeguarding Assurance Committee.

The children's workforce, namely maternity services, paediatrics, and the Emergency Department receive additional training at Level 3. This bespoke training focuses on local and national themes and learning. In 2023 the focus was contextual safeguarding and sexual harmful practices, in 2024 the training is on childhood neglect and corresponds to the Safeguarding Children Partnership's priorities.

In addition, the Safeguarding and Complex Care Team provide bespoke training packages around Dementia, MCA, and Domestic Abuse. These have been delivered as both lunch and learn online bite size sessions as well as face to face training.

The Oliver McGowan Mandatory Training on Learning Disability and Autism is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to receive training. The Health and Care Act 2022 introduced a statutory requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role. The compliance for the Trust at year end 23/24 was 79%, this is a staggering increase compared to 46% in June 2023 when reporting commenced. This demonstrates the commitment the Trust has made supporting patients with a learning disability and/ or autism.

Safeguarding Children training is also delivered to all new junior doctors who join the Emergency Department as part of their rotation by the named Doctor and Nurse for Safeguarding Children. Key subjects include the recognition and management of non-accidental injuries, child exploitation and child mental health.

The Trust uses the following measures to gauge the impact of training on staff behaviours and outcomes for patients.

- Compliance with the Safeguarding children and adult policy and procedures
- Number of appropriate referrals made to the Safeguarding team.

10. Multiagency Reviews

During 23/24 the Trust contributed to several external safeguarding reviews. Staff from the Safeguarding and Complex Care Team have contributed to the submission of patient chronologies as well as attending panel meetings, contributing to the development of both the final reports and recommendations working with the Trust's safeguarding partners.

A Child Safeguarding Practice Review (CSPR) or a Safeguarding Adult Review (SAR) will be commissioned where there has been abuse and neglect and the child or adult has died or has

been seriously harmed and there is concerns that agencies could have worked more effectively to protect that individual. A Domestic Homicide Review (DHR) will be considered where the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted in violence, abuse or neglect by a person whom they were relate or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

The table below shows the contributions the Trust has made to these reviews in 23/24.

	Chronologies Submitted	Panel Membership
Child Safeguarding Practice Reviews	2	1
Safeguarding Adult Reviews	5	2
Domestic Homicide Reviews	0	0

In 23/24 only one DHR was concluded. Learning was cascaded for this across the Trust using a 7-minute briefing. The learning is also incorporated into Safeguarding training.

11. Allegation Management

When safeguarding allegations are made against members of staff, the Trust follows either Cheshire West and Chester LADO processes (Local Authority Designated Officer) or PiPOT processes (Person in a Position of Trust). To ensure all staff adhere to these processes in 23/24 the Safeguarding and Complex Care Team worked closely with Human Resources to standardise the approach to the management of allegations against staff. The Associate Director of Nursing (Safeguarding and Complex Care) takes a lead role in the management of allegations against people in a position of trust and coordinates timely internal strategy meetings. Where indicated subsequent referrals to the Local Authority, LADO, Police, and professional bodies as well as the Trust's Controlled Drug Accountable Officer (CDAO) are made. There is executive oversight of all allegations, and a thematic analysis is produced of via a quarterly report to the Safeguarding Assurance Committee. In 23/24, 25 strategy meetings were held involving allegations against staff members, of these 9 were referred to the LADO, 13 involved the PIPOT process and the Police were involved in 9 (inclusive of LADO/PIPOT cases).

12. Partnership Working

The Trust is an established key provider across the multiagency safeguarding framework.

In 23/24 the Trust has contributed to child death reviews, multiagency practice reviews, multiagency audits as well as being a key delegate at multiagency steering groups. As a partner in the multiagency safeguarding arrangements, the Trust embed clinical practices which ensure that the welfare of both children and adults is paramount.

Collaboration and partnership working is prioritised by the Trust. The Director of Nursing and Quality (the Executive lead for Safeguarding) or deputy attends the Cheshire West and Chester Safeguarding Children Partnership Executive and Local Safeguarding Adult Board, whilst the Associate Director of Nursing for Safeguarding and Complex Care attends the Cheshire West and Chester Domestic Abuse Board. The Named Professionals within the Safeguarding and Complex Care Team prioritise their attendance at all the partnership subgroups.

13. Conclusion

The report demonstrates an increase in activity within every area of the safeguarding and complex care agenda. In part this is due to the improved knowledge and skills demonstrated by the frontline practitioners; in recognising and responding to safeguarding and complex care concerns, however it is also due to the increased number of patients with safeguarding and complex care needs that the hospital staff are caring for which is reflective of societal changes. Either way, this annual report demonstrates that safeguarding our patients and staff remains a key priority for the organisation. The report demonstrates the work streams that have been delivered in 23/24 has resulted in

- Robust governance- executive oversight, statutory named professionals in post and strong partnership working.
- Compliant policies and procedures
- Streamlined processes
- Referrals and incidents monitored and learning from these have been cascaded accordingly

The annual report provides assurance that the Trust continues to meet its statutory duties to the safeguarding and complex care agenda.

Key Priorities Moving Forward

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

14. References

Dementia UK (2024) Types of dementia - Dementia UK

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

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

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

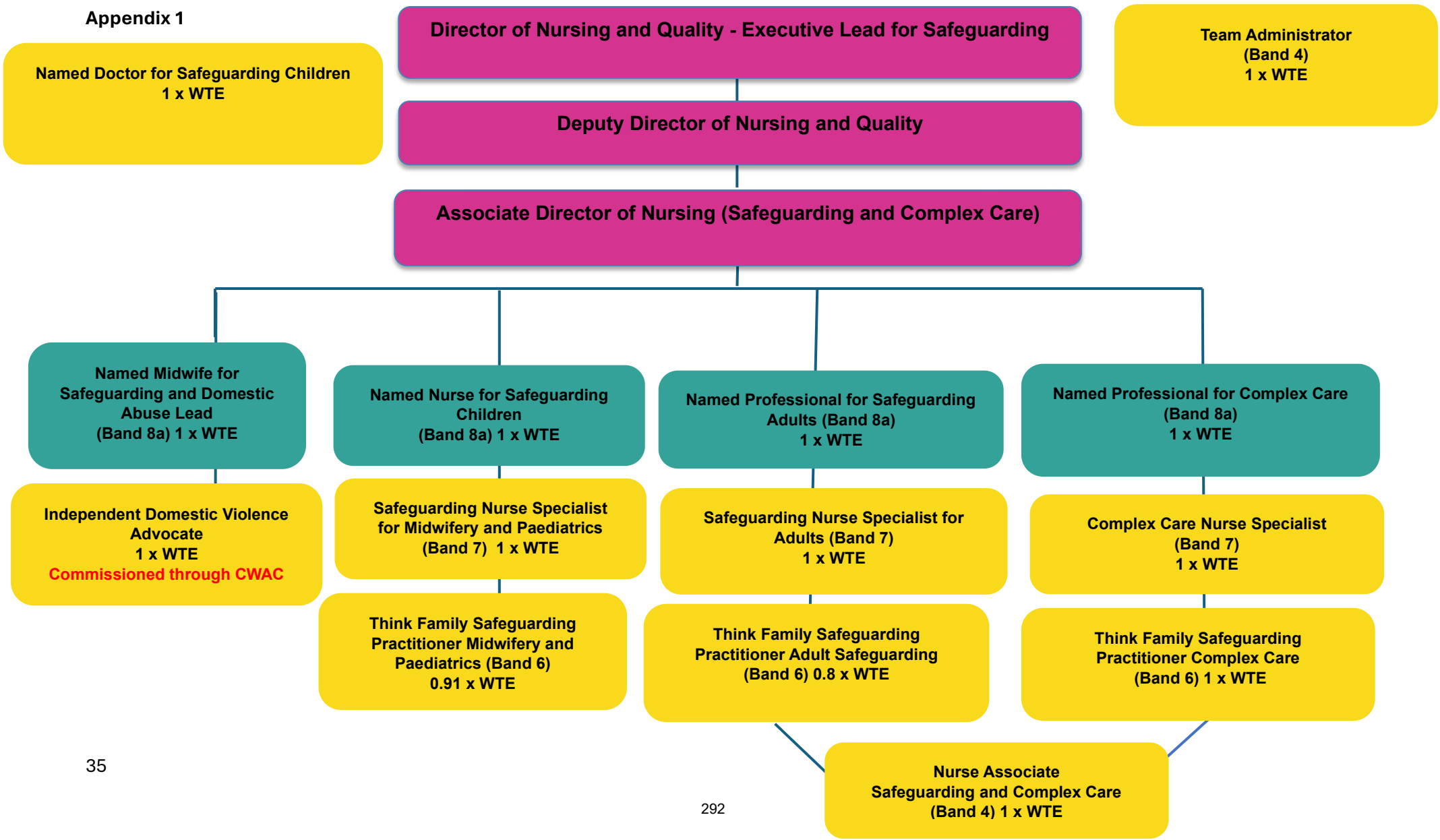
Royal College of Nursing (2020) *Looked After Children: Roles and Competencies of Healthcare Staff*

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

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

SAFEGUARDING AND COMPLEX CARE

Appendix 1



Appendix 2- TERMS OF REFERENCE

Safeguarding & Complex Care Assurance Committee

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

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

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

Appendix 3

Safeguarding & Complex Care Priorities Implementation Action Plan 24/25

Service Specific	Priority Action
Strategic	Develop a training strategy that identifies the training requirements of all staff in all areas of safeguarding and complex care.
	Develop an internal staff allegation process.
	Develop a safeguarding screening tool that is completed in all admission processes that includes all relevant information and that is data SMART
Complex Care	To provide assurance against the NHS Learning Disabilities Improvement Standards
	To provide assurance against the Dementia Hospital Standards
	To provide assurance that Reasonable Adjustments are implemented across the Trust
	To provide assurance that the Mental Capacity Act & DoLS are implemented across the Trust
	To provide assurance that detentions to the Trust under the MHA are implemented
Children	Develop an internal monitoring and response process for those children who attend the hospital due to being bullied at school.
	Develop a Children in Care action plan that assures the Trust that the needs of children in care are met.
	To provide assurance that the workforce are trained in recognising and responding to child neglect.
Adults	Develop external links with GP practices to improve communication and information sharing processes
	Develop external links for the process around Homelessness
	Develop an internal monitoring and response process for adults with care and support needs who are not brought for hospital appointements
Maternity	Drugs and Alcohol Substance misuse in pregnancy pathway to be strengthened.
	To support women who are likely to have their unborn removed with making memory boxes and creating keepsakes of their and their baby's journey**.**

	Staff to identify and appropriately refer and manage women who conceal pregnancy and those booking late for Antenatal care or who are free birthing by utilising the CWAC Concealed pregnancy guideline.
Domestic Abuse	Domestic Abuse Champions within COCH to be confident supporting other staff and service users who are experiencing DA.
	Staff to be able to access IDVA support in the new Wellbeing Building.
	Domestic Abuse risk assessment and MARAC referrals to be made digital.
Think Family	Training compliance is achieved at 90% in all domains of the safeguarding and complex care training programme
	To develop a Safeguarding and Complex care referral process that includes all relevant information and that is data SMART
	Review and embed the W*as not Brought* policy across the Trust for all vulnerable patients.