NHS
Countess of Chester Hospital
NHS Foundation Trust

Public meeting of the Board of Directors Agenda
(published items)
Tuesday 26th November 2024, 8.30 – 12.00
Boardroom, 1829 Building

Chair	Mr I Haythornthwaite, Trust Chair
Apologies	
In attendance	Ms K Cottrell, Specialist Neurological Occupational Therapist, Ms S Edwards, Associate Director of Nursing, Corporate Nursing

Time	Agenda No.	Agenda item	Lead	Page No.	Decision Required
8.30	1.	Welcome, apologies and Chair's opening remarks (verbal)	Trust Chair		For noting
8.30	2.	Declarations of Conflicts of Interest with agenda items (verbal)	Trust Chair		For noting
8.30	3.	Service Showcase (to be presented on the day)			
9.00	4.	Minutes of the previous meeting held on 24th September 2024 (attached)	Trust Chair	5 - 25	For approval
9.05	5.	To consider any matters arising and action log (attached)	Trust Chair	26 - 31	For noting
9.10	6.	Staff Story (to be presented on the day)	Specialist Neurological Occupational Therapist		For noting
9.20	7.	Chief Executive Officer's Report (attached)	Chief Executive Officer	32 - 41	For noting
9.30	8.	Chairs update • Council of Governors (verbal)	Trust Chair		For noting
9.35	9.	a) Board Assurance Framework 2024/25 – Quarter 2 2024/25 (attached) b) High Risks Report – November 2024 (to follow)	Director of Governance Risk & Improvement Director of Governance, Risk & Improvement	42 - 65	For noting For noting
Quality of Care					
9.45	10.	Maternity Service Quarterly Update (attached)	Director of Midwifery	66 - 125	For assurance
9.55	11.	Urgent and Emergency Care Patient Experience Survey Results 2024 (to follow)	Associate Director of Nursing,		For noting

			Corporate Nursing		
10.05	12.	Safety Surveillance Report – Quarter 2 2024/25 (attached)	Director of Nursing & Quality / Deputy Chief Executive	126 - 134	For assurance & noting
10.15	13.	Care Quality Commission (CQC) Improvement Plan including Well Led (attached)	Director of Nursing & Quality / Deputy Chief Executive	135 - 185	For assurance
Comfort Break (10.25 – 10.35)					
10.35	14.*	Bi-annual Safer Nurse Staffing Report – August 2024 (attached)	Director of Nursing & Quality / Deputy Chief Executive	186 - 212	For assurance
10.35	15.	Quality & Safety Committee Chair's Report – 7th November 2024 (attached)	Non-Executive Director	213 - 214	For assurance
10.40	16.	General Medical Council (GMC) National Trainee Survey Report 2024 (attached)	Medical Director	215 - 262	For noting
Operational Performance					
10.50	17.	System Oversight Framework Report (to follow) Operational Performance Quality Safety Finance People	 Chief Operating Officer Director of Nursing & Quality Medical Director Chief Finance Officer Interim Chief People Officer		For assurance
11.00	18.	Winter Planning (attached)	Chief Operating Officer	263 - 279	For noting

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11.10	19.*	Core Standards Compliance (including EPRR update) (attached)	Chief Operating Officer	280 - 291	For assurance
Finance, Use of Resource and Performance					
11.10	20.	Finance & Performance Committee Chair's Report – 25th September 2024 (attached) and 20th November 2024 (verbal)	Non-Executive Director	292 - 293	For assurance
11.15	21.	Audit Committee Chair's Report – 15th October 2024 (attached)	Non-Executive Director	294	For assurance
Leadership, Improvement Capability, Organisation Development and People					
11.20	22.	People Committee Chair's Report – 8th October 2024 (attached)	Non-Executive Director	295	For assurance
11.25	23.	People Strategy 2021 – 2026 Progress Update (attached)	Interim Chief People Officer	296 - 302	For assurance & noting
11.35	24.	a) Workforce Disability Equality Standard (WDES) Action Plan (attached) b) Workforce Race Equality Standard (WRES) Action Plan (attached)	Interim Chief People Officer	303 - 309 310 - 317	For decision & for noting For decision & for noting
Annual Reports					
11.50	25.*	Estates & Facilities Annual Report 2023/24 (attached)	Chief Finance Officer	318 - 324	For assurance
Items for noting					
11.50	26.	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 10th September 2024 (attached) b) Approved minutes of the People Committee – 10th August 2024 (attached) c) Approved minutes of the Audit Committee – 23rd July 2024 (attached) **Other items:** d) Board of Directors Workplan 2024/25 (attached)	Trust Chair		For noting
Other items					
11.50	27.	Any Other Business (verbal)	Trust Chair		For noting
11.55	28.	Questions from Governors and members of the Public relating to items on the	Trust Chair		For noting

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		meeting agenda - ***Questions to be submitted in writing in advance of the meeting to:*** coch.membershipenquiriescoch@nhs.net ***by Thursday 21st November 2024*** **Future Dates:** Tuesday 28th January 2025 Tuesday 25th March 2025			
12.00	29.	Closing remarks (verbal)	Trust Chair		For noting

Next Meeting: Tuesday 28th January 2025

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

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MINUTES OF THE PUBLIC BOARD OF DIRECTORS

Tuesday 24th September 2024, 8.30am – 11.50am, Boardroom – 1829 Building

Members	04/06/ 2024	30/07/ 2024	24/09/ 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	04/06/ 2024	30/07/ 2024	24/09/ 2024			
Deputy Director of Governance & Risk, Mrs L Leadsom *(Minutes)*	☑	☑	☑			
Director of Midwifery, Ms N Macdonald	☑	☑ (items 6b & 10)	☑ (item 10)			
Development Non-Executive Director, Mr M Smith	☑	☑	☒			
Development Non-Executive Director, Mrs L Liang	☑	☑	☑			

Radiology Consultant & Freedom to Speak Up Champion, Dr J Redfern	N/A	N/A	☑ (item 3)			
Practice Development Therapist & Freedom to Speak Up Champion, Ms M Fox	N/A	N/A	☑ (item 3)			
Freedom to Speak Up Guardian, Mrs H Ellis	N/A	N/A	☑ (items 3 & 11)			
Deputy Medical Director, Dr I Benton	N/A	N/A	☑ (item 4)			
Lung Cancer Support Nurse, Ms R Halliday	N/A	N/A	☑ (item 4)			
Clinical Director of Research Lead, Dr P Bamford	N/A	N/A	☑ (item 20)			
Interim Associate Director Safeguarding & Complex Care, Mrs J Cooper	N/A	N/A	☑ (item 24			

Formal Business		
Agenda Item Number	Item	Lead
PB1/ 09/24	**Welcome, apologies and Chair's opening remarks** The Trust Chair, Mr Ian Haythornthwaite, welcomed members to the meeting. Apologies were noted from the Director of Strategic Partnerships, Mr J Develing.	
PB2/ 09/24	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest raised in relation to agenda items.	
PB3/ 09/24	**Freedom to Speak Up (FTSU) Champions** *To note, this item was taken after agenda item PB4/09/24.* The Trust Chair, Mr I Haythornthwaite, welcomed Radiology Consultant & Freedom to Speak Up Champion, Dr J Redfern and Practice Development Therapist & Freedom to Speak Up Champion, Ms M Fox, to the Board of Directors and introductions were made. Dr J Redfern and Ms M Fox provided an overview of their roles as FTSU Champions and provided an overview of the feedback from the FTSU Digital & Data Services, Cardiology, Therapies & Integrated Community Care and Theatres Staff Survey recently issued. It was noted that results of this included perceptions about speaking up, what works well, suggested improvements and next steps. The Chief Operating Officer, Ms C Chadwick, expressed thanks to Dr J Redfern and Ms M Fox for their work in progressing this and for attending to present the outcomes to the Board of Directors.	

	The Interim Chief People Officer, Mrs D Herring, highlighted the importance of staff being able to raise issues with managers in the first instance and for this to be linked into other improvements currently being implemented as part of the Trusts culture work. Non-Executive Director, Mrs S Corcoran, thanked Dr J Redfern and Ms M Fox for being FTSU Champions and for the presentation provided. Mrs S Corcoran highlighted the importance of the language for feedback and ensuring this is built into management training programmes to ensure meaningful feedback is provided. The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, expressed thanks to Dr J Redfern and Ms M Fox for attending and acknowledged it is positive to see how the FTSU network of champions has grown and that it would be good to find opportunities to share outcomes from the FTSU speak ups as part of the work. Non-Executive Director, Professor A Hassell, acknowledged it is great Dr J Redfern and Ms M Fox have given their time to support with the FTSU agenda. Non-Executive Director, Mr P Jones, expressed thanks to Dr J Redfern and Ms M Fox and queried if there was one key ask for the Board of Directors what this would be. Ms M Fox acknowledged there has been a lot of changes across the Trust, recognising that the positive improvements are being made and there is a need to continue to advocate for FTSU and to be consistent across the Board. Mr I Haythornthwaite expressed thanks to Dr M Redfern and Ms M Fox for attending and sharing this update. The Board of Directors **noted** the update.	
PB4 09/24	**<u>Lung Cancer Service Showcase</u>** *To note, this item was taken after agenda item PB2/09/24.* The Trust Chair, Mr I Haythornthwaite, welcomed the Deputy Medical Director, Dr I Benton and Lung Cancer Support Nurse, Ms R Halliday, to the Board of Directors and introductions were made. Dr I Benton provided an overview of Lung Cancer service and outlined the significant improvements to the patients pathway since 2017. This also included the performance, with the service striving to provide the best care possible, together with patient feedback received and the members of the team. Ms R Halliday provided a patient story about the experience of the service which highlighted the support the service provides to both patients and family members and the great working relationships established with other organisations to support our patients. Non-Executive Director, Mrs W Williams, acknowledged the examples of patient feedback received and noted this is testament to the team.	

	The Chief Executive Officer, Ms J Tomkinson, highlighted this is a phenomenal service which should be celebrated and experiences shared across the Trust with the clear focus on continuous improvements in place. The Director of Nursing & Quality, Ms S Pemberton, highlighted that Ms R Haliday was presented with the Inaugural Carol Kutzner award for excellence in care and compassion in May 2024, following a nomination received from a Patient wife. The Board of Directors acknowledged this exceptional achievement. Mr I Haythornthwaite expressed thanks to Dr I Benton and Ms R Halliday for attending and sharing this service overview. The Board of Directors **noted** the update.	
PB5/ 09/24	**Minutes of the previous meeting held on the 30th July 2024** The minutes of the previous meeting held on the 30th July 2024 were formally approved as a true and accurate record.	
PB6/ 09/24	**Matters arising and action log** The Board of Directors received the updated action log. In terms of specific actions: **Trust response to the independent infected blood inquiry** – The Medical Director, Dr N Scawn, updated that he has explored with a number of other Trusts with regards to their approach, none of whom are actively following up with pre 1996 patients. Dr N Scawn updated that an Infected Blood Inquiry Group has now been established, and a suggestion from this is for this to be recorded as part of the pre operative checklist for effected patients, noting however, that this would only capture a small cohort of patients. It was agreed for this to be discussed further via the Quality & Safety Committee to agree the next steps. The Board of Directors **noted** the update and the remaining actions on the log.	
PB7/ 09/24	**Patient Story** It was noted that this item would be covered as part of agenda item PB15/ 09/24.	
PB8/ 09/24	**Chief Executive Officer's Report** The Chief Executive Officer, Ms J Tomkinson, provided an overview of the relevant local, regional, and national issues and highlighted the following: • On 1st August 2024 the elected leaders and NHS Chief Executives and Chairs were 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. It was noted this would be discussed further at the Board development session on 29th October 2024. • PricewaterhouseCoopers (PWC) had been 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. 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 with a management response developed. • NHS England submitted their recommendation to the Northwest Regional Support Group based on the Trust's delivery against the System Improvement Board (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 SIB and is working with the SOG to agree the oversight criteria. Non-Executive Director, Professor A Hassell, referenced the Urgent & Emergency Care (UEC) support as outlined within the report noting that the Trust has been placed into Tier 1 for their UEC services and this includes our Trust and queried the level of support being provided from ECIST. The Chief Operating Officer, Ms C Chadwick, noted that a review is being undertaken of all Emergency Departments, with the majority in tier 1 with the offer of support from ECIST. Ms C Chadwick advised that the support to date is 1 day per week on site from their Improvement Lead and also support on site from a Clinical Lead, as required. Ms C Chadwick explained that herself, Ms J Tomkinson and the Director of Nursing & Quality, Ms S Pemberton, met with Place colleagues on 23rd September 2024 and have continued to highlight the need for joined up working in relation to streaming, The Trust is also focussing on clinical support work and working with Emergency Department (ED) Clinicians to continue to work on the culture within the department. Development Non-Executive Director, Mrs L Liang, referenced the federated GP data platform within the report and queried if there is a timeframe for this. The Chief Digital & Data Officer, Mr J Bradley, explained that this remains in development with one for discharge co-ordination and one for theatres scheduled, which are complimentary to the EPR system.	

	The Board of Directors **noted** the update provided.	
PB9/ 09/24	**Board Assurance Framework (BAF) 2024/25** The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, outlined that the updated BAF was reviewed and approved by the Board of Directors in July 2024 and that this update paper is provided for continued triangulation with the Board agenda. The quarterly review and update of the BAF will be reported to the next Board of Directors to be held in November 2024. Non-Executive Director, Mr M Guymer, acknowledged the positive developments of the BAF noting the link to the Trust strategy and that it is evident to see where the initial risk and target progress towards is identified which is positive. The Trust Chair, Mr I Haythornthwaite, recognised the improvements to the BAF and acknowledged the benefits of the Board of Directors in having a clear document to work with and expressed thanks to Mrs K Wheatcroft for leading this. The Board of Directors **noted** the Board Assurance Framework 2024/25.	
PB10/ 09/24	**Midwifery and Maternity Safer Staffing Report – 1st January 2024 to 30th June 2024** The Director of Midwifery, Ms N Macdonald, advised that 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. It was noted that this report covers the period of 1st January 2024 to 30th June 2024, aligns with NHS Resolution Maternity Incentive Scheme requirements and addresses the recommendations set forth in the Ockenden report (2022). Ms N Macdonald explained that this report provides 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. The following key areas were highlighted: • Workforce Planning and Compliance - 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. • Supervision and Oversight - 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.	

	• One-to-One Care - 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. Non-Executive Director, Ms S Corcoran, acknowledged the assurance provided within the report and queried with regards to the 'red flags' and if there is any contextual information which could be provided including how the Trust compares with peers. Ms N Macdonald advised that a sitrep could be provided to include further details, however, that this would be explored via the Maternity & Neonatal Champions system and then any issues flagged to the Board of Directors. Non-Executive Director, Mr D Williamson, queried if the establishment is in line with the budget and Ms N Macdonald confirmed that it is, noting however, that the fill rate can be higher due to the usage of agency and bank staff, as required. Non-Executive Director, Mrs W Williams, acknowledged the level of publicity relating to national issues with maternity and queried how the Trust will monitor this and to be seen as an exemplar. Ms N Macdonald acknowledged the hard work required, as reflected in the last CQC report, noting that the Trust maintains good standards and compares favourably and that this will continue to be improved when the service moves into the Women & Children's new build in 2025. The Chief Finance Officer, Mrs K Edge, acknowledged the good standards of care being provided and highlighted that the number of women choosing to receive childcare at the Trust have now increased back to what they were in May 2023 and the Trust is confident that this will rise further when there is an official opening date for the Women & Children's new build. Non-Executive Director, Mrs S Corcoran, referenced the focus on maternity and neonatal care both locally and nationally in the public domain, highlighting the importance to showcase the improvements to date. Mrs S Corcoran referenced the walkabouts she has undertaken as part of her role as Maternity Safety Champion and that the feedback to date has been impressive which can continue to be built on.	

	The Board of Directors **noted** the contents of the report and the assurance provided that the Trust is fully compliant with the Maternity incentive scheme year 6 safety action 5.	
PB11/ 09/24	**Freedom to Speak Up Update Report** The Freedom to Speak Up Guardian, Mrs H Ellis, outlined that 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. It was noted that the paper provides an overview of issues and concerns raised in Quarter 4 2023/24 and Quarter 1 2024/25. Mrs H Ellis highlighted that bullying and harassment continues to be a top theme for concerns being raised, noting that the Staff Survey is due to be issued later this week, and flagged the importance of linking with messages relating to FTSU across the Trust. The Trust Chair, Mr I Haythornthwaite, referenced the increase in managers raising concerns as detailed within the report and queried the reasons for this and Mrs H Ellis explained that this could be due to the fact there are now more managers identified as FTSU Champions and alongside this suggested there is more work to do to ensure managers feel listened to. Non-Executive Director, Mr M Guymer, referenced the table detailing comparative themes and how this information is categorised and Mrs H Ellis advised that this is how the National Guardians Officer specify information should be reported. The Chief Executive Officer, Ms J Tomkinson, requested further detail on one of the comments made and advised that she would discuss this with the FTSU Guardian further. that she had not received the feedback regarding the Trust being target driven, noting the clear aim of patient care being paramount and that her role is key to managing, referencing the personal pledges as part of her which are reiterated across the Trust via Team Brief and other methods of communication. Ms J Tomkinson was keen for a further conversation following this meeting with Mrs H Ellis to discuss this and support any further actions going forward. The Interim Chief People Officer, Mrs D Herring, highlighted the importance of triangulating the information with staff survey results and how staff can be encouraged to complete the staff survey over the coming month. Non-Executive Director, Mrs W Williams, queried if a report relating to this would be provided to the next People & Organisation Development Committee and	

	it was agreed it would be for the Board of Directors to pursue particular themes regarding feedback and escalation, however, that this suggestion would be reviewed further following the meeting. The Board of Directors **noted** the contents of the report and the assurance provided that local FTSU arrangements are in place and continue to meet best practice.	
PB12/ 09/24	**<u>Clinical Strategy</u>** The Medical Director, Dr N Scawn, outlined that the purpose of this report was to provide an update on the development of the Clinical Strategy and confirmed that plans are in place to develop this which will culminate in a facilitated workshop in October 2024. Dr N Scawn advised that the Director of Strategic Partnerships, Mr J Develing, has been successful in securing sponsorship for a Clinical Strategy day to be held off site with the Clinical Team and following this the information collated from the day will be used to form the new Clinical Strategy. It was noted that an overarching summary would be available at end of December / beginning of 2025 and that this strategy will incorporate plans for all specialities. It was noted that prior to the day, respective teams will complete an opportunities questionnaire which will be used pre and post the event to develop more service specific strategies. Non-Executive Director, Mr M Guymer, welcomed the introduction of a Clinical Strategy noting this can then be aligned to ensure clarity for the Chief Finance Officer and for this to be fed into a longer term financial plan. The Interim Chief People Officer, Mrs D Herring, highlighted the importance of this linking into the workforce plan and model across the Trust. Non-Executive Director, Mrs P Wiliams, recognised that this is an enabler for other strategies across the Trust and acknowledged the progress to date. Non-Executive Director, Mr D Williamson, welcomed the bottom up approach and acknowledged the link to this together with support, capability, people, estates & digital and enabling plans to be collated and also to be deliverable across all areas. Dr N Scawn advised that members of the Operational Management Board (OMB) are also joining on the Clinical Strategy Day along with the Executive Directors. Non-Executive Director, Ms W Williams, acknowledged this is fundamental for the Trust moving forward, noting the improvements across each area is paramount and queried as a Board if there is an overarching theme. The Chief Executive Officer, Ms J Tomkinson, advised this will cover multiple areas to ensure this links to health inequalities as well as the Trusts six strategic objectives.	

	Mrs P Williams queried if the Trust is looking at any areas to disinvest from. Dr N Scawn advised that the Trust is exploring collaboration opportunities and options as part of this. Ms J Tomkinson outlined that it may be how the Trust partners with Trusts to share services and to explore different ways of working. Dr N Scawn expressed thanks to Mr J Develing who has been paramount in this work and also for gaining sponsorship for the day. The Board of Directors **noted** the progress and approach to the development of the Clinical Strategy. *To note, a comfort break was held from 10.10am – 10.20am.*	
PB13/ 09/24	**<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 against the consolidated CQC Improvement Plan, including Well Led. Ms S Pemberton updated that progress has been noted, with completed actions since the last Board of Directors held on 30th July 2024, including: • 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, including a review of all fire exits. • 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. Continued areas of focus included: • 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. Ms S Pemberton explained that these updates will also be presented to the CQC Engagement Meeting to be held on 2nd October 2024. The Chief Executive Officer, Ms J Tomkinson, updated that CQC registration legislation has now changed and that it has been agreed with the CQC that Tarporley War Memorial Hospital will be listed as a satellite site of the Trust and the application for this has been submitted and the Trust are awaiting confirmation from the CQC that this has been actioned. The Chief Digital & Data Officer, Mr J Bradley, updated that the EPR upgrade is scheduled to take place later today and an update following this will be provided to the Finance & Performance Committee to be held tomorrow, together with an outline of plans for further optimisation. Non-Executive Director, Mrs W Williams, queried the sepsis screening improvement plan noting the performance on screening is lower than preferred and queried the barriers for achieving this. The Medical Director, Dr N Scawn, outlined that one issue is timeliness and then completing screening, noting that the biggest issue with screening for sepsis is linked to the number of patients who present to ED with possible sepsis, noting that not all patients have a high MEWS. Non-Executive Director, Mr D Wiliamson, queried if the CQC are content with the revised timescales for some areas within the improvement plan and Ms S Pemberton confirmed that she meets with the CQC relationship team	

	fortnightly and no concerns have been raised, however, the focus will be at the CQC engagement meeting to be held the following week. Non-Executive Director, Mrs P Williams, referenced the changes to the CQC framework for Well Led and queried how the Trust will manage the transition to this. The Director of Governance, Risk and Improvement, Mrs K Wheatcroft, noted that the well led peer review the previous year had purposefully ensured coverage of the areas. Future work would include mapping out the self-assessment position against the framework, with a focus on each of the new requirements. Non-Executive Director, Professor A Hassell, highlighted the patient flow meeting referenced and that Flintshire did not attend and the Chief Operating Officer, Ms C Chadwick, advised there have been no further developments with this to date, with no senior engagement with Flintshire Local Authority. Professor A Hassell highlighted that this implies that they do not recognise the risk. Professor A Hassell also queried of the Health & Safety audits not being achievable with the current resource levels and Ms C Chadwick agreed to discuss this further following the meeting. The Board of Directors: • **Noted** the assurance on the progress of the consolidated CQC Improvement Plan. • **Noted** 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.	
PB14/ 09/24	**Integrated Incidents, Complaints and Claims Report – Quarter 1 (2024/25)** The Director of Nursing & Quality / Deputy Chief Executive, Ms S Pemberton, outlined that this report was previously presented to the Quality & Safety Committee held on 10th September 2024 and the purpose of this report is to provide assurance to the Board of Directors regarding the management of patient safety incidents, complaints and claims, including learning. Ms S Pemberton provided the following key highlights from the report: • The backlog of serious incidents has now been cleared with the exception of a small number of remaining maternity related incidents • 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 • There has been a reduction in complaints received but increase in concerns, a lot relating to appointments	

	• The themes outlined from claims relate to delays in treatment and inadequate nursing care • Further work is progressing following incidents and support being provided to staff, particularly in relation to violence and aggression related incidents • Nursing sickness levels have increased significantly, however, there is a lot of investment into the Emergency Department which will assist in the department being fully established. Non-Executive Director, Mr M Guymer, acknowledged the really good evidence of improved assurance within the report but referenced the increase in Quarter 1 of severe / catastrophic incidents and queried if there is any update regarding this. Ms S Pemberton provided assurance that all incidents are reviewed in depth, are presented to the weekly oversight meeting and that no themes have been identified within individual areas and that this will continue to be monitored. Non-Executive Director, Mrs W Williams, queried if any of the FTSU incidents highlight patient safety and Ms S Pemberton explained that the majority are incidents reported via the Datix system, referencing the excellent reporting culture within the Trust. The Chief Operating Officer, Ms C Chadwick, provided further assurance that if any patient safety related issues are raised via the FTSU route, they are investigated immediately Non-Executive Director, Ms S Corcoran, queried if there is any correlation between serious incidents and staff sickness levels and Ms S Pemberton confirmed there are no issues in a particular area as such, with the exception of the identified connection between sickness absence levels when staff are redeployed into the Emergency Department. Ms S Corcoran acknowledged the level of assurance provided within the report and recognised the benefits of the comparative data being included. The Board of Directors **noted** 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.	
PB15/ 09/24	**<u>Care Quality Commission National Inpatient Survey 2023 - Results Update</u>** The Director of Nursing & Quality / Deputy Chief Executive, Ms S Pemberton, highlighted that 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. Ms S Pemberton advised that the Trust was rated 7.9 for overall care experience compared to 7.7 in the 2022 results and that 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. It was noted that of 1250 patients invited to take part, 457 responded (circa 40%) and the national response rate was 42%. Ms S Pemberton outlined that the Trust is continually working on the basics of care as agreed and as per the six steps to patient safety, noting the Patient Family & Experience Strategy has now been launched and that the Trust will continue to build on the results, with a particular focus on waiting times. Ms S Pemberton presented a patient story to the Board of Directors from a mother regarding her daughter's experience within the Emergency Department (ED), Ward 47, Acute Medical Unit (AMU) and Respiratory Support Unit (RSU). Ms S Pemberton confirmed that the positive story/feedback has been shared via the Patient Advice and Liaison Service (PALs) and with the teams involved, with the patient's consent. The Chief Executive Officer, Ms J Tomkinson, reiterated that the Trust is the fourth most improved Trust across the Country in the survey results which is an achievement in itself and that colleagues should be proud of the improvements to date, in particular those staff who provide direct patient care. Non-Executive Director, Professor A Hassell, applauded the improvements and highlighted that the emphasis is in the right place and linked to patients feedback regarding the ED. Non-Executive Director, Mrs W Williams, referenced the focussed Team Briefs held to communicate the results Trust wide which were very well received. The Board of Directors **noted** the assurance provided within the report highlighted by the CQC National Inpatient Survey Results.	
PB16/ 09/24	**<u>Quality & Safety Committee Chair's Report - 10th September 2024</u>** Non-Executive Director, Professor A Hassell, presented the Chair's report and highlighted the Committee had noted the limited assurance in the following areas: • Stroke Sentinel Audit Report –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 – It was noted that actions are in place to progress the out of date policies with the possibility of an exceptional	

	Quality Governance Group (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. Professor A Hassell highlighted the excellent progress across a number of areas including NatSSIP and LocSSIPs and with bank staff mandatory training compliance. The Trust Chair, Mr I Haythornthwaite, queried how the AAA Chair's report are managed and how assurance levels are being determined. The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, acknowledged the breadth of the areas covered by the Committees and the aim of this report is to enable the Committee to prioritise the areas where it is felt further assurance is required. Mrs K Wheatcroft advised that guidance is being developed to assist the completion of the Chair's AAA reports and to ensure the consistency across the Committees going forward and how they are monitored. Professor A Hassell noted that the 'alert' section of the report are deemed as not having satisfactory assurance at the Committee with other areas being monitored but progressing. Non-Executive Director, Mrs S Corcoran, highlighted the importance of the difference between audit and clinical audit. It was agreed for the contents of the AAA Chair's reports to be discussed further following the meeting. The Director of Nursing & Quality /Deputy Chief Executive, Ms S Pemberton, highlighted the challenges with the breadth of the workplan covered by this Committee. Mr I Haythornthwaite acknowledged the volume of work being reported via the Committee, recognising the improvements to date and expressed thanks to Ms S Pemberton for driving these improvements forward. The Board of Directors **noted** the Committee Chair's report.	
PB17/ 09/24	**Infection Prevention and Control - (Quarter 1 – 2024/25) Surveillance and Performance Report** The Board of Directors **noted** the Infection Prevention and Control (Quarter 1 2024/25) Surveillance and Performance Report.	
PB18/ 09/24	**System Oversight Framework Report** The Chief Operating Officer, Ms C Chadwick, provided a summary of the key performance indicators and highlighted the following areas of positive assurance: • Hospital Standardised Morality Ratios (HSMR) • Sustained reduction in open complaints • 0 Never Events • Sustained low level of Hospital Acquired Pressure Ulcers • Sustained low level in the number of open complaints. • Reduction in long waiting elective patients. • Sustained reduction in Nurse agency spend.	

	• Sustained reduction in staff turnover Ms C Chadwick explained that the following areas requiring improvement: • Sepsis Treatment • Sepsis Screening • Sustained reduction in the number of women giving birth. • Emergency Medicine Performance • Sickness Absence Compliance • Financial Overspend Ms C Chadwick highlighted: • Emergency Department (ED) attendances remain average and there has also been a noted increase in patients attending via ambulance but no significant increase in acute attendance. • Ambulance handover delay over 60 minutes increased in August 2024 and this correlated with the number of NCTR patients in the Trust, which remains an issue due to the high number. • The Urgent Treatment Centre (UTC) is open 7 days a week 8am – 8pm and is meeting the performance target of 90%, however, there remains an ongoing struggle with meeting the performance target for type 1 attendances and a review is undertaken daily of all patients who breach the 4 hour target. • A Discharge Summit has been held which was led by the ICB and Place and a representative also attended from Betsi Cadwaladr Health Board and actions from this are being progressed with partner organisations. • The Trust is on track to overperform in relation to activity for cancer diagnostics. Non-Executive Director, Mrs W Williams, queried the gradual decrease of colonoscopies undertaken to 165 per month and Ms C Chadwick advised that the Trust has received a lot of support externally and also received monies to pay an insourcing company to drive the productivity throughout the Endoscopy Department. The Director of Nursing & Quality/Deputy Chief Executive, Ms S Pemberton highlighted that C Difficile cases are higher than trajectory, and there is an improvement plan in place to address this. Non-Executive Director, Mr D Williamson, queried of the registered staffing number and levels of vacancies and sickness and Ms S Pemberton confirmed this is 9.8% for nursing and 20% in Same Day Emergency Centre (SDEC), noting the main cause is stress and anxiety related absence caused by staff being redeployed to the Emergency Department and SDEC to cover gaps. 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 is currently off plan by £4.5m and £2.8m of this is associated with the Thirlwall Inquiry of which the Trust is still awaiting agreement of how this will be funded. This is also attributed to by £1m following the Junior Doctors strikes earlier this year. • The Trust is committed to deliver against the planned position and is working to out further resources and to accelerate the CIP plan. • The Trust has received central cash support and forecast is provided in relation to this on a regular basis. The Interim Chief People Officer, Mrs D Herring, highlighted the team are continuing to work to align the SOF to the workforce dashboard. Mrs D Herring updated that the team are continuing to review processes for absence management to ensure this is being managed appropriately. The Board of Directors **noted** the SOF and areas for action.	
PB19/ 09/24	**Annual submission to NHS England North West: Medical Appraisal, Revalidation and Medical Governance** The Medical Director, Dr N Scawn, outlined that the purpose of this report being to provide assurance regarding the medical appraisal and revalidation process together with medical governance activity. Dr N Scawn advised that 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. It was noted that this was agreed at the People & Organisation Development Committee held on 13th August 2024. The Board of Directors **noted** the assurance provided within the report and **approved** the Framework and the Statement of Compliance for submission.	
PB20/ 09/24	**Research Update** *To note, this item was taken after agenda item PB15/09/24.* The Clinical Director of Research Lead, Dr P Bamford, provided an update relating to research and innovation including details of successful capital bids, successful infrastructure bids, collaborative primary care research hubs, partnerships and successes to date. The Chief Executive Officer, Ms J Tomkinson, acknowledged Dr P Bamford's proactive leadership to get Chester on the map and in securing both capital and infrastructure bids and expressed thanks to Dr P Bamford for his drive on this. The Interim Chief People Officer, Mrs D Herring, queried if as a Trust we do enough to promote research in terms of encouraging to partake in research and if there are options to look to promote our research activity further particularly when trying to attract consultants. Dr P Bamford provided	

	assurance that it is an expectation that all Consultants are involved in delivering research and to create the continuation of the good work. The Medical Director, Dr N Scawn, also acknowledged Dr P Bamford's enthusiasm, his success in securing capital and partnership working established with the University of Chester The Board of Directors **noted** the research update.	
PB21/ 09/24	**<u>People & Organisation Development Committee Chair's Report – 13th August 2024</u>** Non-Executive Director, Mrs W Williams, presented the Chair's report and confirmed there were no items to alert to the Board of Directors and that there was a significant level assurance received via the reports provided, noting there are a number of actions moving at pace. The Board of Directors **noted** the report.	
PB22/ 09/24	**<u>People Committee –Terms of Reference (TOR)</u>** The Interim Chief People Officer, Mrs D Herring, presented the updated Terms of Reference and outlined the proposed key changes: • Changes to title of the Committee from "People & Organisational Development Committee" to "People Committee." • Changes to committee members/job titles. • Change to dissolve some of the feeder groups and focusing on a Workforce Governance Group The Chief Executive Officer, Ms J Tomkinson, highlighted the role of the sub-board committees as assurance committees with membership being focussed on Non-Executive Directors and other key leads in attendance. The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, referenced the committee effectiveness review work undertaken in 2023 and outlined that the committee focus should be on assurance reporting, with operational discussion taking place in advance of providing assurance. Executive Directors should provide a clear focus on assurance and actions for the committees to fulfil their Terms of Reference. It was agreed for the membership of the committee to be discussed following the meeting and for an updated version of the People Committee TOR to be circulated once agreed.	**DH**
PB23/ 09/24	**<u>Updated Cheshire & Merseyside Acute Specialist Trust (CMAST) Joint Working Agreement and CMAST Leadership Board Committee in Common Terms of Reference</u>** The Director of Governance, Risk & Improvement, Ms K Wheatcroft, outlined that 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 include: • 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 The key updates to the TOR include: • 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. The Trust Chair, Mr I Haythornthwaite, highlighted that these documents will link into wider discussions with the Director of Strategic Partnerships, Mr J Develing. The Board of Directors **approved** the updated 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.	
PB24/ 09/24	**Safeguarding and Complex Care Annual Report 2023/24** The Interim Associate Director of Nursing (Safeguarding and Complex Care), Mrs J Cooper, presented the report to the Board of Directors and provided the following key highlights: • There is 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. • There is 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. • It is evident that safeguarding patients and staff remains a key priority for the organisation. • Robust governance and 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	

	• There is evidence of safeguarding being made personal including evidence that the child and vulnerable adult's voice is captured. • There is strong evidence in the management of staff allegations and multiagency working where necessary. • Referrals and incidents are monitored and learning from these have been cascaded accordingly, noting there has been a significant increase in referrals relating to both adults and children. • The safeguarding and complex care priorities have been agreed for 24/25 and these align to local and system objectives some of which includes the aim for all inpatients to have had safeguarding screening, achievement of 90% compliance across all areas of safeguarding training, further development of Safeguarding strategies and to continue to develop a strong culture of learning from safeguarding related incidents. The Chief Executive Officer, Ms J Tomkinson, thanked Mrs J Cooper for the quality of the report and advised that she had shadowed the team recently and commended Mrs J Cooper for her drive across the team in relation to safety priorities for patients and staff. Ms J Tomkinson acknowledged the struggle with safeguarding training compliance particularly with medical staff and highlighted that the Trust is under scrutiny for this and that plans to address this have been requested from each of the Divisions by the end of September 2024. Mrs J Cooper agreed that training compliance for medical staff remains a challenge, noting that 2 full days of training are offered per month whereby 80 delegates can be accommodated and that these sessions are communicated across the Trust using various methods to reach all staff groups. The Medical Director, Dr N Scawn, acknowledged this ongoing issue and agreed for this to be discussed further following the meeting. The Interim Chief People Officer, Mrs D Herring, explained that training compliance with medical staff is an issue across many Trusts and suggested that this could be linked in with validation or appraisals to strengthen the process and agreed for this to be discussed following the meeting. The Board of Directors **noted** the assurance provided within the report.	**NS**
PB25/ 09/24	**<u>Items for noting and receipt</u>** **The Board of Directors noted the following minutes which had been approved by the relevant Committees:** 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 d) Research and Innovation Committee Chair's Report - 9th September 2024 and Research Executive Meeting Minutes - 5th July 2024 **The Board of Directors noted the following items:** e) Board of Directors Workplan 2024/25	

PB26/ 09/24	**Any other business** There were no further items of business raised.	
PB27/ 09/24	**Questions from Governors and members of the Public relating to items on the meeting agenda** No questions were raised.	
PB28/ 09/24	**Closing remarks** The Trust Chair, Mr I Haythornthwaite, expressed thanks to all members for their input to the reports and discussions during the meeting. *To note, the meeting was closed at 12.20pm.*	
PB29/ 09/24	**Date & Time of next meeting** The next meeting will be held on Tuesday 26th November 2024 (timings to be confirmed).	
	Closing remarks and review of the meeting	

NHS
Countess of Chester Hospital
NHS Foundation Trust

Public Board of Directors Action Log

2024/25 - Updated 19th November 2024

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
29	4th June 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, as part of the quarterly Safety Surveillance Report.	Nov-24	**Closed**
30	4th June 2024	Director of Nursing & Quality / Deputy Chief Executive and Director of Governance, Risk & Improvement	PB9/06/24	Integrated Incidents, Complaints, Claims and Inquests Quarter 4 2023/24 - The Trust Chair, Mr I Haythornthwaite, also acknowledged the improvements to date, however, queried how the figures reported compare to other Trusts.	Ms S Pemberton explained that the Trust needs to further understand the data being collated and provided to enable this to be benchmarked against other Trusts, noting this also links to the requirements for the targeted improvement for concerns. It was agreed this reporting would be	**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, as part of the quarterly Safety Surveillance Report.	Nov-24	**Closed**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
					discussed with the Director of Governance, Risk & Improvement, Mrs K Wheatcroft, for a future report.			
35	30th July 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. **Update 24th September 2024** - The Medical Director, Dr N Scawn, updated that he has explored with a number of other Trusts with regards to their approach, none of whom are actively following up with pre 1996 patients. Dr N Scawn updated that an Infected Blood Inquiry Group has now been	Sept-24	**Closed**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
						established, and a suggestion from this is for this to be recorded as part of the pre operative checklist for effected patients, noting however, that this would only capture a small cohort of patients. It was agreed for this to be discussed further via the Quality & Safety Committee to agree the next steps.		
36	30th July 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,	**Update 9th August 2024** - Update to be provided back to a future Board of Directors meeting - Date TBC. **Update 13th November 2024** - Partnership and System Update was provided as part of the Board of	TBC	**Closed**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
					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.	Directors Development Session held on 29th October 2024.		
37	24th September 2024	Interim Chief People Officer / Freedom to Speak Up Guardian	PB11/09/24	Freedom to Speak Up Update Report	The Interim Chief People Officer, Mrs D Herring, highlighted the importance of triangulating the information with staff survey results and how staff can be encouraged to complete the staff survey over the coming month. Non-Executive Director, Mrs W Williams, queried if a report relating to this would be provided to the next People Committee and it was agreed it would be for the Board of Directors to pursue particular themes	It was agreed that this suggestion would be reviewed further following the meeting. **Update 19th November 2024 -** Regular meetings are now taking place to triangulate FTSU data, complaints data and datix data to ensure items are reported via the People Committee ahead of the Board of Directors.	Nov-24	**Closed**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
					regarding feedback and escalation.			
38	24th September 2024	Chief Operating Officer	PB13/09/24	Care Quality Commission (CQC) Improvement Plan including Well Led	Professor A Hassell also queried of the Health & Safety audits not being achievable with the current resource levels.	**Update 19th November 2024** - This has been updated and reviewed as part of the bi-monthly review of the action plan.	Nov-24	**Closed**
39	24th September 2024	Director of Governance, Risk & Improvement	PB16/09/24	Quality & Safety Committee Chair's Report - 10th September 2024	Issues raised with regards to the content of the AAA Chair's reports and being used consistently across Committees. It was agreed for the contents of the AAA Chair's reports to be discussed further following the meeting.	**Update 30th September 2024-** The AAA Chair's Report template has been further updated to aid completion.	Sept-24	**Closed**
40	4th September 2024	Interim Chief People Officer	PB22/09/24	People Committee –Terms of Reference (TOR)	It was agreed for the membership of the committee to be discussed following the meeting and for an updated version of the People Committee TOR to be circulated once agreed.	**Update 19th November 2024 –** Discussions are ongoing to confirm the three executives to be members of the Committee.	Dec-24	**Open**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
41	4th September 2024	Medical Director	PB24/09/24	Safeguarding and Complex Care Annual Report 2023/24	Training compliance for medical staff remains a challenge The Medical Director, Dr N Scawn, acknowledged this ongoing issue and agreed for this to be discussed further following the meeting.	**Update 19th November 2024 –** The Medical Director has requested the latest compliance figures to review the number of bookings on planned sessions and implement improvements.	Nov-24	**Open**

PUBLIC - Board of Directors

Date of meeting: 26th November 2024

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

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the Trust compliance with Foundation Trust status.
Risk	Alignment with the Board Assurance Framework and Corporate Risk Register.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published on the Trust's website as part of the agenda pack.

Chief Executive Officer's Report – November 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 1st November 2024 and the meeting focussed on:

- The Leadership Board was provided with an analysis of the aggregate Cheshire & Merseyside (C&M) position in respect of NHS corporate services benchmarking (previously referred to as Model Hospital data) for 23/4 following recently released data.
- An update on the development of a Liverpool Adult Acute and Specialist (LAASP) Trusts programme of work and the direction of travel toward a group model.
- An update on progress in delivery of the C&M Pathology target operating model and Laboratory Information Management System (LIMS) as a key enabler of this area of work.
- Discussions concluded by sharing Urgent & Emergency Care (UEC) experiences from across each locality, summarising the initiatives that are seen to have had most impact.
- Update papers were also provided in relation to system financial updates and system performance updates.

2. Cheshire Health and Care Review

At the 1st August meeting elected leaders, chief executives and chairs considered the basis for a Cheshire Health and Care Sustainability Review. This reflected the commonality related to short, and longer term, health and care outcomes and system financial challenges including Increasing older population and rising levels of disease with greater need/demand for health and care services and inequalities in life expectancy and health and wellbeing outcomes across respective Places.

It was recognised that each organisation and Places have developed strategic and financial recovery/improvement plans already so the Cheshire Review recommendations need to offer additional benefits and may have a longer- term focus,

The review is considering the following programs

- Multimorbidity – As means of case finding patients with high risks of hospital admission
- Shifting care from hospital community – developing a community service specification and clarity of offer
- Cardiovascular and cardiometabolic disease – unified approach to prevention for this area of highest mortality
- Children and Young people with special educational needs and disabilities
- Dementia
- Ensuing the impact and benefits of recovery programmes.

3. Financial Improvement and Cost Improvement Programme

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 and activities are planned as part of this to improve grip and control and accelerate the delivery of the agreed Cost Improvement Programme (CIP). All staff are encouraged to submit ideas which can help us to deliver better value whilst contributing to meeting the Trust's CIP target. There have been some great initiatives implemented to date across the Trust which have included a reduction in postal costs, improvements in value for money for medication and the removal of waste from processes and sampling.

4. 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

We have met with the ICB and Regional NHSE colleagues to discuss challenges and to agree system action to support reduction in ambulance handover times and long length of stay in the Emergency department. In addition to system actions the trust has reviewed its action plane to streamline into three main actions per area of the UEC footprint to ensure focus on actions that will make the biggest difference before winter.

On the 2nd December Sarah-Jane Marsh UEC lead for the NHSE national team will be visiting UEC services where we will be walking her through our pathways, challenges and also what estates work we are undertaking with the national capital monies we have been allocated.

5. Strategy launch – Transforming Care Together

Our strategy provides a clear direction for how we will provide care for our patients and families, and how we take a leadership role that promotes a positive culture in how we look after and care for our patients, our population, and each other. At the heart of our approach is our population. We want everyone who requires support from us, in whatever setting, to receive the best possible care, experience and outcomes from the services they receive. Working in this more holistic way affords opportunity for earlier intervention, prevention and in focusing our joint efforts in areas of greatest inequality. For these reasons we have chosen to attach an all-encompassing title to our strategy indicating an intent to do things differently in the future. We held a range of Extra-ordinary Team Briefs as an opportunity for staff to learn more about our future plans and to be involved in shaping our services and approach to patient care. Come and hear more about our future plans and how you can play a part in shaping our services and approach to patient care.

6. Anchor Institution work underway

Reported to the Finance & Performance Committee, the Trust has now developed an Anchor Institution Group and the Terms of Reference and Non-Executive support is now identified. The group will focus its work on developing a refresh of the Rust Green plan and scope for opportunities to reduce carbon emissions and progress toward net zero. The group will also develop a roadmap to become accredited as an Anchor institution focusing on the NHS prevention pledge, social value and net zero. The group now also has representative from Cheshire & Wirral Partnership NHS Foundation Trust (CWP) to ensure we collectively develop the whole health park and more recently we have connected with Chester University as there is an active department for sustainability.

7. Patient portal launched

Patients can now access their health information anytime from anywhere with the launch of the new online Patient Portal - DrDoctor. The portal aims to support a smoother hospital experience for patients, giving them an easily accessible place to view their appointments and letters, request alterations to their appointments and access helpful health information.

8. Urgent Care Showcase event

After great success last year, the second Urgent Care showcase event was held on 11th November 2024 and highlighted the outstanding work undertaken by our teams within Urgent Care and gave the opportunity to present their projects. This was an opportunity to celebrate the tireless efforts of our teams who continue to provide excellent care despite the challenges they face.

9. Blue Skies Balcony topping out

We recently 'broke ground' on the Blue Skies balcony, an outdoor space in the Intensive Care Unit (ICU). The balcony will provide patients and their families with much-needed access to fresh air and outdoor space, without disrupting this complex care delivery. This exciting work has been made possible by funds raised by the Countess Charity as well as IHP, who are currently working on the construction of the Women and Children's Building, and are providing labour and materials at a subsidised rate. Members of the ICU clinical team had the opportunity to visit the site and hear about plans for the space.

10. Obstetric Ultrasound team

Our Obstetric Ultrasound team have been recognised in the top 10 Trusts in the country by the Perinatal Institute's Growth Assessment Protocol (GAP) for detecting small gestational age (SGA) babies. This is important as accurate detection of smaller babies is vital to ensure they receive the right care at the right time.

11. Respiratory Syncytial Virus (RSV) vaccine delivered to service users in maternity

From the 1st September 2024, all pregnant women have access to a vaccine during each pregnancy to protect their babies against respiratory syncytial virus (RSV). RSV is a common virus that can lead to bronchiolitis, a lung infection which can make breathing and feeding difficult for infants. To facilitate access to the vaccine, service users can utilise an online self-referral form. The vaccine will also be offered to all pregnant women during routine appointments at our Antenatal Clinic. This initiative aims to protect the health of newborns by providing essential immunisation against RSV at a critical time.

12. Safeguarding Adults Week

Safeguarding Adults Week is taking place 18th to 22nd November 2024 and to mark the week there will be a stand in the main reception of the Countess of Chester Hospital from 12pm – 2pm on Monday 18 November. There will be a safeguarding quiz for colleagues to take part in with prizes. The safeguarding team will also be out and about all week supporting staff and promoting the importance of safeguarding.

13. Mental Health Learning Disabilities and Community Services Collaborative (MHLDC)

With the intent of the Government to `shift left` activity into community services the MHLDC, with ICB support, are seeking to define the role of community services and develop a standardised approach that would support the case for investment and commissioning intentions in the future.

Community services are a vital part of the health and care system supporting people to stay well and independent longer. These services also support hospital discharge and flow across the system, as such MHLDC and CMAST (Acute provider collaborative) are discussing the integration of respective work plans and how these may be delivered more effectively by closer working.

14. Restart a heart – resus team event

Our Resuscitation team had a great day at Chester Cathedral in October 2024 teaching basic life support skills to the public for 'Restart a Heart' day. This annual event brings together community organisations to raise awareness of cardiac arrests and provides training in CPR and defibrillation. Thanks to our team, 156 adults and six children who attended the workshop at the Cathedral now have the skills and confidence to potentially save a life.

15. World Patient Safety Day

We celebrated World Patient Safety day in September 2024 with the focus on raising awareness of our harms programmes and driving forward improvement across key areas of patient care. Improvement initiatives were showcased including: pressure ulcers, falls, medication safety, deterioration, acute kidney injury, sepsis and healthcare associated infections. The events were well received with good attendance across all groups of staff.

16. Right Care Right Person (RCRP)

Earlier this year, I shared that Cheshire Police implemented some changes that affect how and when they respond to calls for support from health care partners. The policy is called *Right Care, Right Person*. Part of this policy focuses on patients who abscond. An absconder is someone who is not detained by law and who leaves a ward or the Emergency Department unexpectedly, without clinical staff knowing and for whom there is a concern about the potential risk of harm to themself or others. Since RCRP was introduced, 17% of calls to Cheshire police made by our Trust in relation to this policy were unnecessary. All colleagues are regularly reminded of the importance of the processes to follow and in what situations the police do and do not need to be called when a patient absconds.

17. Countess of Chester Hospital: hygiene rating

I would like to congratulate our catering team who have once again been awarded a five star hygiene rating by the Environmental Health Officer. The kitchen has twice yearly inspections and for the 15th consecutive year, they have retained a five star status, which is a great achievement for the team.

18. Freedom to Speak Up month

Our Freedom to Speak Up Guardian Helen Ellis and the FTSU champions ran events throughout October 2024 to raise awareness of Speak Up month. Speaking up remains an important part of developing a safe and supportive culture and I personally encourage everyone to raise issues if you have concerns.

19. Celebration of Achievement Awards

During our successful Annual Awards event on 20th September we recognised the excellence and achievements from across the Trust, with the focus on the people and teams who have gone above and beyond to improve care, safety and culture. This was also a fantastic opportunity to showcase the excellent work and to highlight the good practice of individuals and teams.

20. National Staff Survey

The Staff Survey 2024 is underway, with 41% of substantive staff and 18% of bank staff having completed the survey at the time of writing this report. All staff are being actively encouraged to complete the survey with prize draw incentives to encourage completion. The survey closes at the end of November 2024 and when the results are available they will be analysed to measure improvements and areas requiring additional focus.

21. Zero tolerance campaign launched

We launched our zero tolerance campaign in November 2024, with a reminder that as a Trust we are committed to fostering a safe, inclusive and supportive workplace where everyone is treated with dignity and respect and abuse of our staff will not be tolerated.

22. Staff vaccinations – Flu and COVID

Flu and COVID-19 vaccines continue to be offered to all staff who have contact with patients as part of your work benefit package. To date, the Occupational Health team have visited 38 locations over 18 dates to administer vaccinations and protect staff; 1,116 flu vaccines have been administrated, 791 COVID-19 boosters administered, 1,153 staff vaccinated (with one or both) and therefore 24% of the workforce are protected, all eligible staff are encouraged to get the vaccine.

23. Staff Networks – BAME relaunched

November was another exciting milestone for our staff networks and our commitment to a positive culture for everyone in the workplace. Our colleagues got the chance to meet the new co-chairs of the BAME network, Rami Ashour and Ola Olanrewaju. This was the first event since they came into post. Our staff networks are important in providing support for colleagues, as well as creating a space to seek advice and connect with others.

24. ELEVATE programme

The Elevate Leadership programme was specifically designed to support colleagues from Black, Asian and Minority Ethnic Backgrounds in exploring their leadership aspirations as we seek to encourage greater diversity within leadership positions across the NHS andenrich decision making and problem solving in all levels in our organisation. Following the success of last year's Elevate Programme, the Trust signed up to another programme which commenced in November 2024. Applications have now closed and we received more applications than the previous year and we will be linking in with the successful candidates.

25. Employment Rights Bill 2024

On 10th October 2024 the Government presented to Parliament the Employment Rights Bill 2024. Running to over 150 pages and containing 28 individual reforms, it proposes transformative employment law changes. Published alongside the draft Bill was the Next Steps to Make Work Pay policy paper which provides some context and explains the vision and objectives driving the proposed changes. The Bill does not specify a commencement date when it's provisions will come into force, and it is likely that implementation will be staggered with various aspects being brought into effect at different times. The majority of the proposals will be subject to parliamentary debate and various public consultations and whilst some of these are expected to start this year, the majority will follow throughout 2025 and into 2026. Highlights include a day 1 right to claim unfair dismissal, default flexible working, increasing protection from sexual harassment, a Fair Pay Agreement in adult social care, modernising Trade Union laws and establishing the Fair Work Agency. It is inevitable that the regulatory load on employers, and the risk of exposure to litigation, will increase and there will undoubtedly be an impact on ACAS and the employment tribunal service. We are engaged with the ongoing discussions that are taking place in the Chief People Officers (CPO) network and Healthcare People Management Association (HMPA) who are facilitating a legal session provided by Weightmans, to ensure that we are prepared for future changes.

26. MP Engagement

We continue to engage regularly with our local MPs and CEO meetings are scheduled, together with visits to our new Women's and Children's building, over the coming weeks.

27. Lucy Letby appeal rejected

On 24th October 2024, a panel of judges at the Court of Appeal in London refused Lucy Letby's application for leave to appeal against her conviction of the attempted murder of a baby girl in July 2024.

28. Thirlwall Inquiry update

The Thirlwall Inquiry oral hearings, which started in September 2024, are continuing at Liverpool Town Hall. The Inquiry has heard oral evidence including from families, experts in specific matters A wide range of individuals including some current and former staff and other NHS organisations. Oral hearings are currently scheduled to continue through to January 2025.

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

CMAST Leadership Board
Update to Boards October

CMAST Leadership Board met on 4th October discussing a number of system issues as follows:

Ann Marr briefly outlined for the Board the business considered and progressed by the ICB at its September meeting and the scheduling of an extraordinary Board meeting on 9th October to consider matters related to women's health.

A discussion took place proposed by the ICB Medical Director on system UEC capacity and its impact on ambulance handovers and associated congestion. Alternative approaches were explored with both NWAS and Trust CEOs open to different thinking but with a shared commitment to patient safety and minimising unintended consequences. Dr Rowan Pritchard – Jones was asked to continue exploring solutions and to impress upon Place the need to for consistent and supported hospital discharge and admission avoidance in each of C&M's localities.

The Board received updates on ICB commissioned organisational integration projects from the relevant acute Trusts involved in those activities and from Janelle Holmes on a regionally based peer improvement role focussed on elective recovery.

The Board was oriented and reminded on the milestones for delivery of a C&M Pathology operating model and associated design making with the LIMs system. A fuller update will be provided to the November meeting of the Leadership Board.

Finally the Leadership Board received a briefing from Ged Murphy, its identified CEO lead, on progress made with the Data into Action Programme and the potential benefits of this programme.

Updates were also received on the following areas:

- System financial report
- System performance update

CMAST Leadership Board
Update to Boards November

CMAST Leadership Board met on 1st November discussing a number of system issues as follows:

The Leadership Board was provided with an analysis of the aggregate C&M position in respect of NHS corporate services benchmarking (previously referred to as Model Hospital data) for 23/4 following recently released data.

Model Hospital data highlights variation across the system using a variety of benchmarking tools, the review presented used the national median as a comparison, but did not take organisational differences into account, for example demographics, organisation type.

The Board was then provided with an update on the development of a Liverpool Adult Acute and Specialist (LAASP) Trusts programme of work and the direction of travel toward a group model.

The Board received an update on progress in delivery of the C&M Pathology target operating model and LIMS as a key enabler of this area of work.

Discussions concluded by sharing UEC experiences from across each locality, summarising the initiatives that are seen to have had most impact.

Update papers were also provided on the following areas:

- System financial report
- System performance update

PUBLIC - Board of Directors
26th November 2024

Report	**Agenda Item 9.**	**Board Assurance Framework – Quarter 2 2024/25**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk & Improvement				
Author(s)	Karan Wheatcroft			Director of Governance, Risk & Improvement				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Linked to all BAF areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Not applicable							
Executive summary	The Board Assurance Framework (BAF) has been fully reviewed with Executive Leads at Quarter 2 2024/25 and this paper provides an update to the Board of Directors along with the full BAF. The BAF risks and residual risk scores are: • BAF1 - quality of care (16) • BAF2 - safety and harm (16) • BAF3 - operational planning standards (16) • BAF4 - workforce (15) • BAF5 - financial plan (16) • BAF6 - capital programme (15) • BAF7 - digital transformation and IT resilience (15) • BAF8 - corporate governance (12) • BAF9 - system working (12) • BAF10 - research and innovation (12)							

	8 of the 10 risks on the BAF remain above risk appetite level. Actions are progressing, but given the strategic nature of these risk it is recognised that it will take time to fully implement and embed the improvements needed, along with ensuring clear evidence of assurance that the risks are being mitigated. The report demonstrates the progress being made against key actions aligned to BAF risks and strategic objectives including • Embedding the patient and family experience strategy • UEC and flow action plans • Trust behaviours, civility and zero tolerance • Developing the Clinical Strategy • Leadership in the wider system and exploring partnerships • Strengthening governance and risk management • Assessing our digital maturity • Coordinating and expanding our anchor institute activities • Research developments including partnership with the University of Chester and primary care networks • Developing our approach to health inequalities and population health
Recommendations	The Board of Directors is asked to (i) **approve** the updates to the Board Assurance Framework at Q2 (ii) **note** the progress in delivering the 2024/25 strategic objectives

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

Board Assurance Framework (BAF) Quarter 2 2024/25

1. BACKGROUND

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

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

The Board of Directors receives the BAF each month with a full update completed on a quarterly basis. The purpose of this paper is to provide an overview of the BAF Q2 update, including actions to mitigate and manage strategic risks, and delivery of 2024/25 strategic objectives.

2. BAF RISKS ALIGNED TO STRATEGIC GOALS AND OBJECTIVES

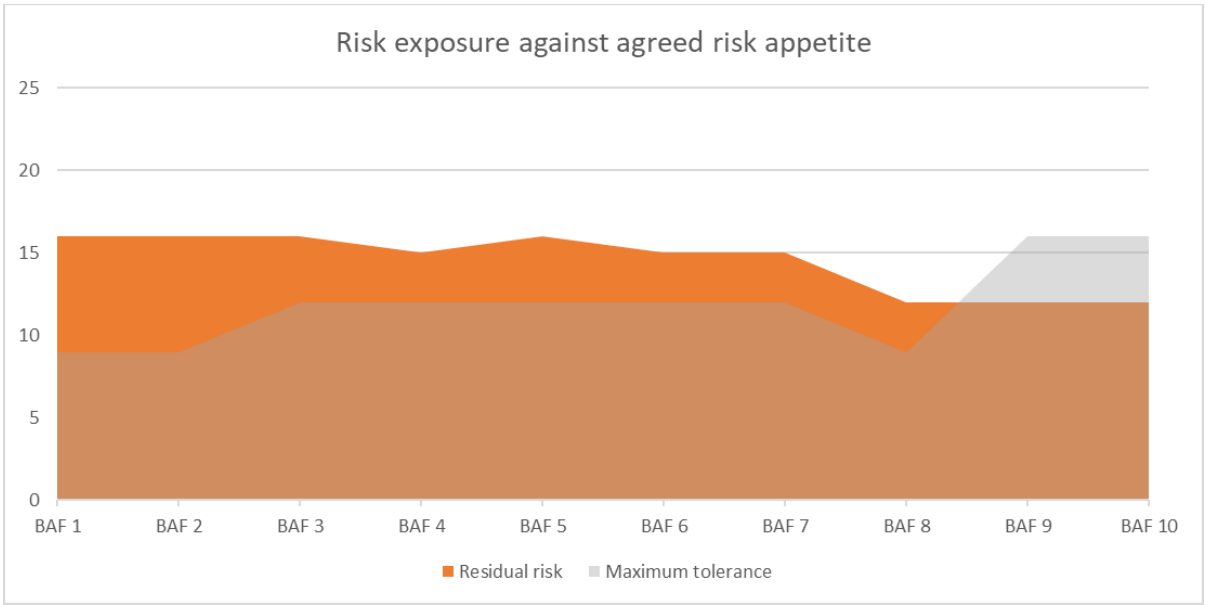
Alignment to strategic goals and objectives has been included within the BAF, with strategic objectives shaded within the key controls. The current risk exposure against the strategic goals is summarised below.

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

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

3. CURRENT RISK SCORE AGAINST TARGET SCORE

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



Key:

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

8 of the 10 risks on the BAF remain above risk appetite level. Actions are progressing, but given the strategic nature of these risk it is recognised that it will take time to fully implement and embed the improvements needed, along with ensuring clear evidence of assurance that the risks are being mitigated.

Appendix A provides a summary of the risks above risk appetite along with actions and progress.

4. PROGRESS AGAINST STRATEGIC OBJECTIVES AT Q2

Progress against strategic objectives has been aligned to the BAF. Key updates at Q2 include:

- Embedding the patient and family experience strategy
- UEC and flow action plans
- Trust behaviours, civility and zero tolerance
- Developing the Clinical Strategy
- Leadership in the wider system and exploring partnerships
- Strengthening governance and risk management
- Assessing our digital maturity
- Coordinating and expanding our anchor institute activities
- Research developments including partnership with the University of Chester and primary care networks
- Developing our approach to health inequalities and population health

Appendix B provides the full update on progress against strategic objectives.

5. RECOMMENDATIONS:

The Board of Directors is asked to:

(i) **approve** the updates to the Board Assurance Framework at Q2

(ii) **note** the progress in delivering the 2024/25 strategic objectives

Appendix A – Summary of strategic risks above risk appetite

8 of the 10 risks on the BAF remain above risk appetite level. Actions are progressing, but given the strategic nature of these risk it is recognised that it will take time to fully implement and embed the improvements needed, along with ensuring clear evidence of assurance that the risks are being mitigated.

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing
BAF1. Failure to maintain **quality of care** would result in poorer patient & family experience	**16**	**9**	Partial	- Developing new Quality and Safety Strategy - Embedding quality governance structures - Embedding patient and family experience strategy - IPC improvement plan - Ward accreditations
BAF2. Failure to **maintain safety and prevent harm** would result in poorer patient care and outcomes	**16**	**9**	Partial	- Harms improvement programme outcomes - Organisation learning policy - Clinical Strategy development
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.	**16**	**12**	Partial	- UEC action plan outcomes - Integrated flow and UEC improvement plans - Non RTT validation
BAF4. Challenges in ensuring a high quality, engaged, diverse and inclusive **workforce** would affect our ability to deliver patient care	**15**	**12**	Partial	- Pay control group established and external FICC reporting - Workforce planning - Staff survey launched - Improving the wellbeing offer - Data analysis and targets for EDI improvement - Talent and succession planning - Leadership and management development
BAF5. Failure to deliver **financial plan** and underlying financial position could impact long term financial sustainability for the Trust and system partners	**16**	**12**	Partial	- Financial Strategy - Acceleration of CIP opportunities supported by Continuous Improvement Team - Additional financial controls
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	**15**	**12**	Partial	- Engagement in system estates work - Capital plan delivery
BAF7. Failure to ensure strong **digital transformation and IT resilience** could impact the	**15**	**12**	Partial	- Digital maturity assessment - Infrastructure developments - EPR optimisation programme - Data quality assurance

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing
delivery of services for patient and our workforce				- Team workforce plan and skills development accreditation planned
BAF8. Failure to ensure effective **corporate governance** could impact our ability to comply with legislation and regulation.	**12**	**9**	Partial	- Well led action plan including risk management improvement plan and governance organogram - Regulatory compliance and assurance map - CWP/COCH collaboration governance - Corporate Records Management review

(Note: graphs showing the movement in risk scores over time will be added to this report in Q3)

Appendix B – Progress against Strategic Objectives Q2

The progress against strategic objectives at Q2 is set out in the tables below.

Strategic Objectives	Lead	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. All areas have now implemented 6 steps for patient and family experience, and we are developing an approach to seek feedback on these steps through the family and friends test.
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 DTAs, ambulance handover delays and time to triage. The Trust continue to work with the wider systems and local authorities to enable an improved number of complex discharges. The Trust continues to explore options to extend SDEC opening hours. Flow improvement plan being aligned with UEC improvement plan to ensure clear priorities and a focus on assessing the impact of the actions taken.
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. All areas have now implemented 6 steps for patient and family experience, and we are developing an approach to seek feedback on these steps through the family and friends test.
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, approved by the Board (May 24). And rolled out. New staff survey launched along with a you said we did timeline. Current focus includes zero tolerance and tackling poor behaviours.
Develop an approach for recruitment, development and retention	DH	Onboarding welcome event improved for all staff groups.
Improve the health and wellbeing of our staff	DH	Staff hub opened (Q1) and wellbeing offer developing to include physical, mental and financial. Continuing to

		understand the wellbeing needs within the Trust and improve specific wellbeing support. Focus is also on the underlying challenges and improving working arrangements.

SG3 Leadership		
Development of clinical strategy	NS	Discussions with the Clinical Directors and Divisional leads has taken place. Strategy day took place with Clinical Leads for October 2024 to drive forward the development of the Clinical Strategy. Specialty proposals were developed to support this and quarterly clinical leads strategy days planned to drive this forward.
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 focused on CVD Prevention. A second conference aimed at admission avoidance / specifically CVD-R (respiratory) was held in October with circa 55 primary care colleagues present. Director of Strategy has been approached to undertake this leadership work across Cheshire.
Develop our leadership teams	DH	Leadership framework established and programmes rolled out for clinical leaders, aspiring leaders (band 2-4) and lead managers. Basic skills for manager training being developed for all managers. Training needs analysis to be progressed (Q4).
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. Risk management improvement plan established, risk management policy approved and shadow risk management committee meeting held. Committee organagram developed and further review of sub-committee structures including Divisions underway. Governance presentations being delivered in various forums.

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 completed. Financial strategy will need to align with the emerging clinical strategy and people strategy.
Advance digital solutions in support of transforming care	JB	NHS Providers led Board session planned on Digital Maturity (August 2024). Digital presentation at clinical strategy day (Oct 2024). MIAA ToR agreed for digital strategy audit. Digital maturity assessment process completed results pending completion. Artificial Intelligence (AI) trials being planned with Microsoft and other suppliers

Achieve anchor institution status. (green / social value / prevention)	JD	New Anchor Institution oversight group established (June which will meet bi monthly). New reporting framework adopted. Revised terms of reference. Board report presented in July 2024. Anchor Institute Oversight Group has now expanded membership to CWP and Chester University sustainability department. The group has now also engaged with the Country Park.

SG5 Partnership		
Develop a bespoke research, education and innovation strategy	NS	Early discussions to establish research ambitions to support strategy development. This will be aligned to the clinical strategy approach. A research nurse will attend Divisional Boards to increase visibility of research studies and opportunities as well as provide feedback.
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. Framework agreed between COCH and the University of Chester to progress partnership arrangements. Also building relationships with Primary Care Networks (PCNs) to develop a primary care research network.

SG6 Populations		
Develop a Trust approach to health inequalities and prevention	JD	Board development session held in October - raising education and training awareness of health inequalities at a national, Core20plus5, regional (Marmot) and local level using CIPHA data. Roles and responsibilities of Board members discussed and self assessment undertaken. An outline approach to Health Inequalities was discussed and has also been shared with local stakeholders who have endorsed the approach.
Purposeful shift from traditional provision to a population health approach	JD	Clinical Strategy day was held as planned in October with over 60 colleagues in attendance. Videos of the event are now in SharePoint. The event was highly productive with colleagues asking for more events of this nature. Series of Operational and clinical leads strategy sessions to be undertaken on a Quarterly basis.
Further develop our integrated care approach	CC	MOU in place. Discussions underway and paper being developed for COCH/CWP Community Services collaboration vision and future operating model. Update provided at the Board strategy day (October 2024).

NHS
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	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:** Nov 2024	**Causes:** - Longer patient waiting lists - Inconsistent compliance with standards - Emergency Department capacity not supportive of the high volume of patients presenting to the Emergency Department. - Lack of clinical engagement.. **Consequences:** - Quality of care - Unintended harm - Poor patient experience - Regulatory compliance	*4 x 5 = 20*	C1) Quality and Safety Strategy priorities. **Control Owner:** Director of Nursing and Quality	- 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:** Q4	Work commenced on overarching Quality and Safety Strategy refresh. Patient and family experience strategy being implemented with local consideration of actions needed to embed. All areas have now implemented 6 steps for patient and family experience, and we are developing an approach to seek feedback on these steps through the family and friends test.	*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	Full review of Quality Governance Structures completed. Comprehensive combined CQC action plan in place and progressing with updates provided to Executive Directors Group monthly and to each Board of Directors. Sub committee reporting to Quality and Safety Committee is now embedded from Quality Governance Group.		
			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. Infection rates are exceeding the expected targets.	(i) To improve compliance assurance through harms improvement (ecoli and cdiff), and campaigns (e.g. Gloves off). (ii) 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. Concerns regarding C Difficile sampling processes and practices, with an improvement plan in place. Good progess on joint working with the Facilities Team regarding cleaning standards with an update reported to Quality and Safety Committee in November 2024.		
			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	Good progress with new ward accreditation programme roll out, with all wards planned to be completed in 2024/25 and a full report to the Board of Directors at the end of Q4.		
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:** Nov 2024	**Causes:** - Longer patient waiting lists. - Underdeveloped partnership working arrangements to support clinical strategy delivery. - Lack of reciprocal engagement in the wider health system (including ICB, Place). - Need to review of mental health service provision in A&E and across all Trust sites **Consequences:** - unintended harm - Extended length of stay - De-conditioning of patients	*4x 5 = 20*	C1) Safety priorities. **Control Owner:** Medical Director	- 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 updates to Quality Governance Group and presentations through new Harms Improvement Oversight meeting.	*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:** Q4	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. Strategy day took place with Clinical Leads for October 2024 to drive forward the development of the Clinical Strategy. Specialty proposals were developed to support this and quarterly clinical leads strategy days planned to drive this forward.		
			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. Mental Health review has begun and is supported by a member of the psychiatrict liaison service on secondment from CWP for 6 weeks. An interim report is to be taken to execlecutives in the first week in December.		

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**	**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:** Nov 2024	**Cause:** - Unable to meet the demand for services within available resources - Increased demand in suspected cancer referrals and ED attendances - Increased number of patients that do not meet the criteria to reside **Consequences:** - Increased patient waits for access to services impacting on patient safety, potential harm and patient experience. - Failure to meet key targets and regulatory requirements in some areas - Sub-optimal service provision - Increased ambulance handover delays - Potential increase in complaints from family, friends and carers.	***4 x 5 = 20***	C1) Annual plan with clear activity and performance reporting against trajectories and focussed improvement plans as required. **Control Owner:** Chief Operating Officer	- 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 - Quarterly Divisional Performance Reviews - Bi-weekly patient flow meetings.	North West performance report overseen by ICB. Contract review meetings. System Oversight Group.	*Partial*	***4 x 4 = 16***	**NO**	Management of flow, consistent application of discharge requirements and significant NC2R patients requiring wider system response. UTC/ SDEC restricted opening hours.	(i) ED - Whole system approach to hospital avoidance and supported primary care function. Continued focus at SOG. (ii) ED - Continued MADE (weekly) super MADE (bi-monthly) multidisciplinary discharge events. (iii) Explore options to extend Same Day Emergency Care Unit opening hours. (iv) Flow improvement plan integrated with UEC imporvement plan to drive forward clear priority actions and assess the impact. **Action Owner:** Chief Operating Officer **Due date:** Quarterly updates	The Trust continues to meet the 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 DTAs, ambulance handover delays and time to triage. The Trust continue to work with the wider systems and local authorities to enable an improved number of complex discharges. The Trust continues to explore options to extend SDEC opening hours. Flow improvement plan being aligned with UEC improvement plan to ensure clear priorities and a focus on assessing the impact of the actions taken.	***12***	***Mar-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 - Quarterly Divisional Performance Reviews		*Acceptable*			Some gaps in validation (non RTT) and data quality issues remain.	Increased focus on Non RTT follow up data quality, clinical validation and delivery **Action Owner:** Chief Operating Officer **Due date:** Quarterly updates	CMAST resources secured to support validation (end Q3)		

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: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF4 Challenges in ensuring a high quality, engaged, diverse and inclusive workforce would affect our ability to deliver patient care. **Executive Risk Lead:** Chief People Officer **Assurance Committee:** People and Organisation Development Committee **Last Update:** Nov 2024	**Causes** - Poor staff morale - Staff burn-out - Lack of health and wellbeing support - Increased pressures in the hospital - External scrutiny - Failure to engage staff, listen to feedback and act - lack of effective systems and processes **Consequences** - Loss of goodwill and staff engagement - Short term sickness absence - Turnover hotspots - A deterioration in the physical and mental wellbeing of our workforce - Increased bank/ temp staff hours - Erosion of skills and knowledge - Reduced leadership capacity and capability	*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*	**NO**	Enhanced workforce controls required, including vacancy control measures, and pay controls aligned to system oversight expectations. Lack of digital workforce systems, processes and reporting.	(i) Establish and embed enhanced vacancy control measures aligned to ICS headcount expectations. (ii) Continue to explore and progress digital systems **Action owner:** Chief People Officer **Due date:** Quarterly updates	Executive led vacancy control group including variable pay measures established in Q1. Pay Control Goup now in place. External assurance through weekly FICC returns to PWC on behalf of ICB/NHSE. Revised plan submitted to ICB.	*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 planning session at People Committee and Board development day in October 2024. Workforce planning will need to be aligned to 2025/26 operational planning as well as the Clinical Strategy. Band 2/3 and apprenticeships work continuing to progress.		
			C2) Staff experience, engagement, morale and culture **Control Owner**: Chief People Officer	- 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, approved by the Board (May 24). And rolled out. New staff survey launched along with a you said we did timeline. Current focus includes zero tolerance and tackling poor behaviours.		
									Clear and comprehensive wellbeing offer.	Improving the Trust wellbeing offer. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	Staff hub opened (Q1) and wellbeing offer developing to include physical, mental and financial. Continuing to understand the wellbeing needs within the Trust and improve specific wellbeing support. Focus is also on the underlying challenges and improving working arrangements.		
			C3) Equality, Diversity and Inclusion **Control Owner:** Chief People Officer	- Staff survey - WRES/WDES Reports via POD - CPO report to People Committee	NHS staff survey results. WRES/ WDES.	*Partial*			Well established staff networks and feedback. Poor experience. Diversity of workforce at all levels. Lack of clear metrics for improvement.	(i) Establish and develop staff networks. **Action Owner:** Chief People Officer **Due date**: Quarterly updates (ii) Data analysis to understand postion and set improvement targets. **Action Owner:** Chief People Officer **Due date:** Q4 2024/25	Executive leads identified for staff networks and initial meetings taking place.New EDI lead appointed and active work being done across the networks. EDI also a key part of the strategy, staff survey, wellbeing, and development plans. Data analysis being undertaken to understand position and set future improvement targets.		
			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. Reviewing use of talent conversations. Board level succession plan being further developed and return to NHS Leadership Academy due Q3.		
									Enhanced onboarding process and experience.	Redesign of onboarding processes. **Action Owner:** Chief People Officer **Due date:** Complete	Onboarding welcome event improved for all staff groups.		
			C5) Education and Development, including leadership and management 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 and management development.	Leadership and management programmes to be rolled out at all levels. Training needs analysis to be developed following appraisals. **Action Owner:** Chief People Officer **Due date:** Q4 2024/25	Leadership framework established and programmes rolled out for clinical leaders, aspiring leaders (band 2-4) and lead managers. Basic skills for manager training being developed for all managers. Training needs analysis to be progressed (Q4).		

Risk Theme: Finance & Capital

RISK APPETITE: OPEN - Upper tolerance limit 12

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

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF5 Failure to deliver financial plan and underlying financial position could impact long term financial sustainability for the Trust and system partners. **Executive Risk Lead:** Chief Finance Officer **Board Committee**: Finance and Performance Committee **Last Update:** Nov 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	*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 HIMA financial control checklist being completed. Financial strategy will need to align with the emerging clinical strategy and people strategy.	***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 - Forecast processes and reporting within finance reports	Financial Plan ICB submissions Internal Audit reviews Weekly FICC returns to the ICB (via FICC) including forecasting	*Partial*			Uncertainty of impact and funding for the pay award. Formal confirmation of Inquiry funding.	Continue to work with the C&M ICB to access support for the Inquiry. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Ongoing discussions with the ICB and C&M CFOs.		
			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 FICC returns to the ICB (via PWC)	*Partial*			Delivery phase of CIP Programme, low levels of maturity and to be underpinned by productivity expectations. Slippage and risk in converting CIP opportunities to identified schemes.	Development of schemes and further movement of opportunities into identified schemes which can be transacted. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Workstreams identified and Executive Leads assigned. Workshop held in 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. Consideration of acceleration of CIP opportunities supported by the Continuous Improvement Team. Additional financial control measures being implemented and EDG working with Divisions to implement these.		
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:** Nov 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	ICB returns	*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.	***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. Successful bid for £7.5m national capital to support ED/ UEC improvements.		
			C4) Estates strategy **Control Owner**: Chief Finance Officer	- Health and Safety Committee reports via Finance and Performance Committee. - Capital Management Group via F&P Committee	Six Facet Survey. Regulatory and statutory assurance received ad hoc (e.g. fire safety, H&S etc).	*Partial*			RAAC remediation plan .Risk and management of RAAC is guided by the most up to date professional guidance as issued by NHSE	RAAC failsafe works to continue with expected completion now at the end January 2025. **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. Additional fundign agreed to support increased costs.		

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**	**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:** Nov 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 into key roles when staff leave the service - Increasing support and licence costs for key systems - Increasing risk profile with more attacks evident, including Ransomware and Phishing. **Consequence** - Insecurities within the systems and infrastructure with vulnerabilities that could be exploited through a cyber attack. - Data loss and regulatory sanctions if personal data is lost - Reduced level of skills in workforce due to inability to recruit staff at required level - Compromised systems and infrastructure would result in business continuity measures being put in place for staff and patients.	*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.	(i) Refresh Digital Strategy informed by National digital maturity assessment. (ii) MIAA to conduct audit of Digital Strategy. **Action Owner:** Chief Digital and Data Officer **Due date:** Q4	NHS Providers led Board session planned on Digital Maturity (August 2024). Digital presentation at clinical strategy day (Oct 2024). MIAA ToR agreed for digital strategy audit. Digital maturity assessment process completed results pending completion. Artificial Intelligence (AI) trials being planned with Microsoft and other suppliers	***12***	***Mar-25***
			C2) Cyber security and Digital Infrastructure **Control Owner**: Chief Digital & Data Officer	- DSPT annual audit via Audit Committee - DSPT 23/24 presented to F&P commitee	- 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.	(i) SIRO Report to be developed **Action Owner:** Chief Digital and Data Officer **Due date:** Complete (ii) DSPT and Cyber Assurance Framework (CAF) initial audit evidence to be submitted December 2024 **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	SIRO report developed and submitted to F&P Committee (November 2024). Creation of new AI steering group – regular meetings now taking place. CAF review commenced. Progress made on new Data Centre, SAN procurement and Air con replacement		
			C3) EPR Upgrade and Optimisation **Control Owner**: Chief Digital & Data Officer	- EPR update reported to Finance & Performance Committee - Contract in place with EPR supplier, for upgrades over the next 5 years	- 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:** Complete	EPR Upgrade completed 25th Sept 2024 - closure report to F&P Committee (Nov 2024) HIMSS assessment planned for Q4.		
									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:** Complete Undertake Optimisation programme and encourage participation in National EPR usability survey **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	Prioritisation governance structure in place and digital priorities have been agreed. Report to F&P Committee (Nov 2024).		
			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 deploy data quality framework with enhanced assurance reporting. **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	Annual report to F&P Committee (Nov 2024). Data Quality Assurance Mark (DQAM) documentation to be produced for metrics and added to reports as an assurance symbol.		
			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	Regional digital workforce plan in development, Data science development plan in place. C&M EPR resourcing plan in development. National Competency Framework (NCF) workstreams in progress to support recruitment, retention and professional development within Analytics team Digital SDN (Skills Development Nrtwork) level 3 accreditation planned for Q4		

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: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF8 Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation. **Executive Risk Lead:** Director of Governance, Risk and Improvement **Board Committee**: Audit Committee **Last Update:** Nov 2024	**Causes** - implementation of changes in legislation - effectiveness of governance structures - clarity of accountability and assurance reporting - new partnership arrangements developing **Consequences** - legal and regulatory action	***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. Risk management improvement plan established, risk management policy approved and shadow risk management committee meeting held. Committee organagram developed and further review of sub committee structures including Divisions underway. Governance presentations being delivered in various forums.	***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	Continued development of governance for CWP/COCH collaborative community services with an update to the Board strategy day and proposal for Joint Committee to be established. Further work to identify and engage as partnerships develop.		
			C4) Public Inquiry **Control Owner:** Director of Governance, Risk and Improvement	- Thirlwall Inquiry Updates - Legal cost updates (via F&P Committee)		*Acceptable*			Corporate records management lessons learned.	Decision log and corporate records management lessons learned being developed for action. **Action Owner**: Director of Governance, Risk and Improvement **Due date:** Quarterly updates	Continue to understand and share learning including Board development session (October 2024). Decision log in place. Corporate records management added to Information security and information governance group, with terms of reference for a review being developed.		

Risk Theme: System Working and Collaboration

RISK APPETITE: SEEK - Upper tolerance limit 16

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

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF9 System working and provider landscape changes may present challenges in ensuring COCH is positioned as a strong system partner, with priorities aligned to system partners across Cheshire & Merseyside. **Executive Risk Lead:** Director of Strategy & Partnerships **Board Committee**: Board of Directors **Last Update:** Nov 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 focused on CVD Prevention. A second conference aimed at admission avoidance / specifically CVD-R (respiratory) was held in October with circa 55 primary care colleagues present. Director of Strategy has been approached to undertake this leadership work across Cheshire	***16***	***Target Score 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	Board development session held in October - raising education and training awareness of health inequalities at a national, Core20plus5, regional (Marmot) and local level using CIPHA data. Roles and responsibilities of Board members discussed and self assessment undertaken. An outline approach to Health Inequalities was discussed and has also been shared with local stakeholders who have endorsed the approach.		
			C3) 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*			Clnical strategy	Develop a framework by which clinical strategies 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 Strategy day was held as planned in October with over 60 colleagues in attendance. Videos of the event are now in SharePoint. The event was highly productive with colleagues asking for more events of this nature. Series of Operational and clinical leads strategy sessions to be undertaken on a Quarterly basis.		
			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 Institution oversight group established (June which will meet bi monthly). New reporting framework adopted. Revised terms of reference. Board report presented in July 2024. Anchor Institute Oversight Group has now expanded membership to CWP and Chester University sustainability department. The group has now also engaged with the Country Park		
			C5) Commerical Partnerships **Control Owner**: Director of Strategy & Partnerships	Operational Board Finance & Performance Committee Weekly Executive Group Theatre redevelopment Group (bi-weekly)	NHS Supply Chain Hill Dickson - legal advice	*Partial*			Developed approach for commercial partnerships.	Development of a MDT stakeholder Group Development of scope and specification for a hybrid theatre Develop a long term vision for main theatres **Action Owner:** Director of Strategy & Partnerships **Due date:** Q3	MDT Project Group established.Scope and specification development. Outline Business Case for hybrid theatres developed for July Board consideration.Market testing via Capability framework commenced with 3 potential suppliers identified, hence a mini competition is now indicated.		
			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 operating model. Update provided at the Board strategy day (October 2024).		
			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	Estimated date of achievement of target score
BAF10 Inability to deliver the Research and Innovation agenda to exploit future opportunities **Executive Risk Lead:** Medical Director **Board Committee**: Board of Directors **Last Update:** Nov 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. This will be aligned to the clinical strategy approach. A research nurse will attend Divisional Boards to increase visibility of research studies and opportunities as well as provide feedback.	***16***	***Target Score Achieved***
			C2) Team structure, SOPs and expertise **Control Owner:** Medical Director		MHRA inspections GPC inspections HTA inspections	*Partial*			Staff development and retention.	To agree and communicate the development offer for research staff. **Action Owner:** Medical Director **Due date**: Q4	Team charter being developed with the team. Appraisals and development discussions have taken place, and individual objectives clearly aligned. The team are also exploring apprenticeships, career paths and progression opportunites.		
									Strengthening of governance and SOPs.	Review governance and SOPs (including CRF and Trust vehicle). **Action Owner:** Medical Director **Due date:** Q4	An agreed structure for research governance and processes to include expression of interest, feasilibility and approval. This will ensure formal structures, processes and documentation are in place to support timely mobilisation of research studies. List of Standard Oprating Procedures (SOPs) in place and team engaged in further review and development in 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	Assurance received that funding for 2024/25 will remain. Future year funding yet to be confirmed but likely to be built focussing on opening studies, recruitment, time and target which are areas the team are strengthening in preparation. COCH are involved in the Cheshire and Merseyside ICB bid to create a commercial delivery network, with the outcome of the bid yet to be confirmed. Work ongoing with the University of Chester on grant opportunities.		
			C4) Partnership Arrangements (including academic appts) **Control Owner:** Medical Director	Updates through OMB		*Partial*			Increasing academic appointments. Partnership agreements and governance.	To continue to develop our partnership arrangements, inlcuding education institutes and commercial. **Action Owner:** Medical Director **Due date:** Quarterly updates	Communication strategy developed to support awareness for partner organisations. Current focus on building relationships and developing collaboration opportunities. Framework agreed between COCH and the University of Chester to progress partnership arrangements. Also building relationships with Primary Care Networks (PCNs) to develop a primary care research network.		
			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	Current focus on building relationships and developing partnership opportunities. This will require leadership and resource to drive forward.		

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. All areas have now implemented 6 steps for patient and family experience, and we are developing an approach to seek feedback on these steps through the family and friends test.
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 DTAs, ambulance handover delays and time to triage. The Trust continue to work with the wider systems and local authorities to enable an improved number of complex discharges. The Trust continues to explore options to extend SDEC opening hours. Flow improvement plan being aligned with UEC improvement plan to ensure clear priorities and a focus on assessing the impact of the actions taken.
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. All areas have now implemented 6 steps for patient and family experience, and we are developing an approach to seek feedback on these steps through the family and friends test.
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, approved by the Board (May 24). And rolled out. New staff survey launched along with a you said we did timeline. Current focus includes zero tolerance and tackling poor behaviours.
Develop an approach for recruitment, development and retention	DH	Onboarding welcome event improved for all staff groups.
Improve the health and well being of our staff	DH	Staff hub opened (Q1) and wellbeing offer developing to include physical, mental and financial. Continuing to understand the wellbeing needs within the Trust and improve specific wellbeing support. Focus is also on the underlying challenges and improving working arrangements.

SG3 Leadership		
Development of clinical strategy	NS	Discussions with the Clinical Directors and Divisional leads has taken place. Strategy day took place with Clinical Leads for October 2024 to drive forward the development of the Clinical Strategy. Specialty proposals were developed to support this and quarterly clinical leads strategy days planned to drive this forward.
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 focused on CVD Prevention. A second conference aimed at admission avoidance / specifically CVD-R (respiratory) was held in October with circa 55 primary care colleagues present. Director of Strategy has been approached to undertake this leadership work across Cheshire.
Develop our leadership teams	DH	Leadership framework established and programmes rolled out for clinical leaders, aspiring leaders (band 2-4) and lead managers. Basic skills for manager training being developed for all managers. Training needs analysis to be progressed (Q4).

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. Risk management improvement plan established, risk management policy approved and shadow risk management committee meeting held. Committee organagram developed and further review of sub committee structures including Divisions underway. Governance presentations being delivered in various forums.

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 completed. Financial strategy will need to align with the emerging clinical strategy and people strategy.
Advance digital solutions in support of transforming care	JB	NHS Providers led Board session planned on Digital Maturity (August 2024). Digital presentation at clinical strategy day (Oct 2024). MIAA ToR agreed for digital strategy audit. Digital maturity assessment process completed results pending completion. Artificial Intelligence (AI) trials being planned with Microsoft and other suppliers
Achieve anchor institution status. (green / social value / prevention)	JD	New Anchor Institution oversight group established (June which will meet bi monthly). New reporting framework adopted. Revised terms of reference. Board report presented in July 2024. Anchor Institute Oversight Group has now expanded membership to CWP and Chester University sustainability department. The group has now also engaged with the Country Park

SG5 Partnership		

Develop a bespoke research, education and innovation strategy	NS	Early discussions to establish research ambitions to support strategy development. This will be aligned to the clinical strategy approach. A research nurse will attend Divisional Boards to increase visibility of research studies and opportunities as well as provide feedback.
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. Framework agreed between COCH and the University of Chester to progress partnership arrangements. Also building relationships with Primary Care Networks (PCNs) to develop a primary care research network.

SG6 Populations		
Develop a Trust approach to health inequalities and prevention	JD	Board development session held in October - raising education and training awareness of health inequalities at a national, Core20plus5, regional (Marmot) and local level using CIPHA data. Roles and responsibilities of Board members discussed and self assessment undertaken. An outline approach to Health Inequalities was discussed and has also been shared with local stakeholders who have endorsed the approach.
Purposeful shift from traditional provision to a population health approach	JD	Clinical Strategy day was held as planned in October with over 60 colleagues in attendance. Videos of the event are now in SharePoint. The event was highly productive with colleagues asking for more events of this nature. Series of Operational and clinical leads strategy sessions to be undertaken on a Quarterly basis.
Further develop our integrated care approach	CC	MOU in place. Discussions underway and paper being developed for COCH/CWP Community Services collaboration vision and future operating model. Update provided at the Board strategy day (October 2024).

Board Assurance Framework

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

5x5 risk scoring matrix:

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

Risk Appetite Levels

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

PUBLIC – Board of Directors
26th November 2024

Report	**Agenda Item 10.**	**Maternity Service Quarterly Update**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Natasha Macdonald Sara Brigham Pippa Scott-Heale			Director of Midwifery Associate Medical Director Divisional Director				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X**	BAF 1 – Failure to maintain quality of care would result in poorer patient & family experience. BAF2 - Failure to maintain safety and prevent harm would result in poorer patient care and outcomes. BAF 3 – 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.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Women and Children's Governance committee – 31st October 2024 Quality & Safety Committee Date of meeting – 7th November 2024							
Executive summary	This report informs the Committee of the current status of Maternity and Neonatal (Perinatal) services at The Countess of Chester Hospital NHS Foundation Trust. It aims to update the Committee on key performance metrics, emerging safety concerns, cultural challenges, and compliance with the Maternity (and perinatal) Incentive Scheme (MIS). Key highlights include: • Maternity (and perinatal) Incentive Scheme Year 6 Update: Compliance with requirements. • Perinatal Surveillance Tool: Regular monitoring of safety metrics. • Saving Babies' Lives Care Bundle Version 3: Progress towards Safety Action 6 compliance.							

	• Quarterly Serious Incidents Overview: Details provided for Q2 findings. • Evidence to the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.
Recommendations	The Board of Directors is asked to note the assurance provided within the report.

Corporate Impact Assessment	
Statutory/regulatory requirements	Ensure the Trust's alignment with Foundation Trust status, maintaining all regulatory obligations.
Risk	Define and assess potential risks to the organization, implementing proactive measures to mitigate them.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics Foster an inclusive environment where all voices are heard, promoting a diverse and equal representation in all aspects.
Communication	Ensure timely and transparent communication, including publishing key documents on the Trust's website to facilitate public access,

Maternity Service Quarterly Update

1. Introduction

The quality and safety of maternity and neonatal (perinatal) services remain a key priority for the Trust, in line with national expectations and the findings of recent reviews, such as the Ockenden Report (2020). This report aims to provide the committee and Trust Board with a comprehensive update on the current position of these services, ensuring full oversight of performance, emerging safety concerns, and necessary improvements.

Guided by the Maternity (and Perinatal) Incentive Scheme (MIS) Year 6 technical requirements, this report highlights significant progress made in meeting the ten safety actions, including the compliance and evidence submissions required for the Clinical Negligence Scheme for Trusts (CNST). Additionally, the report reflects on serious incidents, cultural challenges, and service developments, allowing the Board to make informed decisions and ensure continued excellence in care for mothers, babies, and families.

This quarterly update ensures that the Board remains well-informed and is in a position to fulfil its governance responsibilities regarding the Trust's maternity and neonatal services.

2. Background

Maternity and neonatal services have faced increasing scrutiny following national reviews, including the Ockenden Report (2020), which identified the need for enhanced oversight and improvement in maternity care across the NHS. The Maternity (and Perinatal) Incentive Scheme (MIS), now in its sixth year, is a key driver of these improvements, encouraging Trusts to meet specific safety actions in return for financial incentives through the Clinical Negligence Scheme for Trusts (CNST).

This report responds to the requirements of the MIS Year 6, incorporating updates from key safety and quality initiatives, such as the Saving Babies' Lives Care Bundle Version 3. Additionally, it reflects the Trust's ongoing compliance with the Maternity Services Data Set (MSDS) and provides an overview of serious incidents and lessons learned from perinatal reviews. Previous updates have been shared with the Women and Children's Board, ensuring continuity and transparency.

3. Purpose

This report seeks to provide assurance to the Committee regarding the current position of Maternity and Neonatal services, specifically in relation to safety, quality, and compliance with the Maternity (and Perinatal) Incentive Scheme (MIS) Year 6.

Maternity (and Perinatal) Incentive Scheme (MIS) Year 6

An update on the Maternity (and Perinatal) Incentive Scheme (MIS) is provided as part Maternity Services report. This update is crucial in informing the Trust's progress towards compliance, with the final submission deadline set for 12 noon on 3rd March 2025.

Now in its sixth year, the MIS plays a critical role in enhancing maternity safety across the NHS by offering financial incentives. Trusts that successfully meet all ten key safety actions benefit from reduced contributions to the Clinical Negligence Scheme for Trusts (CNST).

These safety actions are specifically designed to drive best practices and improve outcomes in both maternity and neonatal care.

Compliance with MIS Year 6 is being closely monitored through the monthly Divisional Perinatal Assurance and Improvement Board. The Division are reviewing and gathering evidence against the MIS Year 6 Technical Guidance to ensure all requirements are met.

MIS Year 6 Progress Update

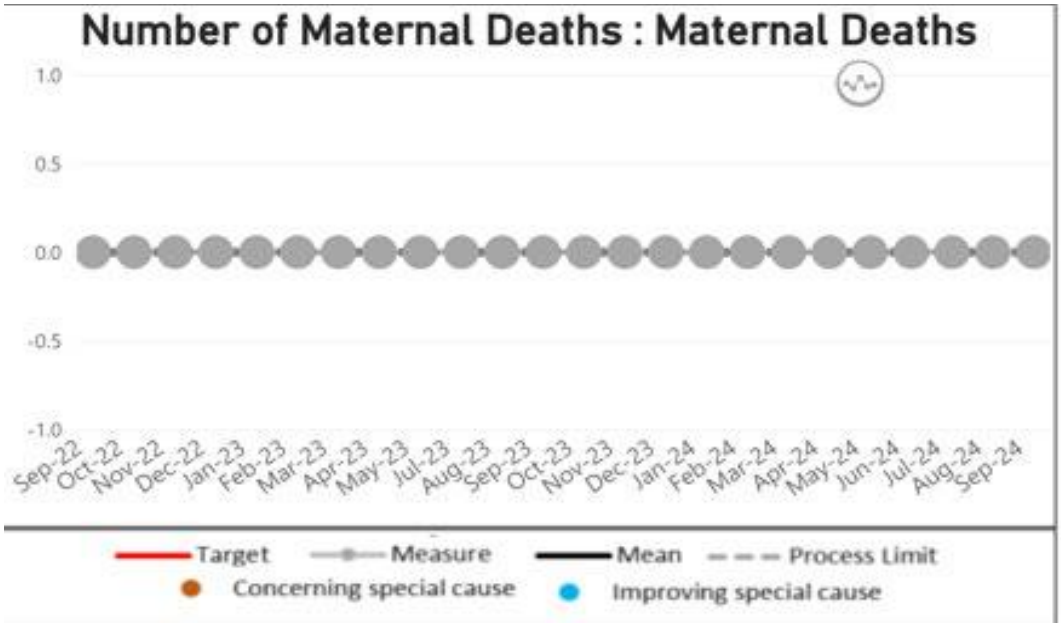
The Trust continues to make strong progress toward meeting the ten safety actions required for MIS Year 6 compliance. Regular reviews of evidence are being conducted, and the Trust remains on track to meet the 3rd March 2025 submission deadline. Monthly assessments ensure that any gaps in compliance are promptly identified and addressed.

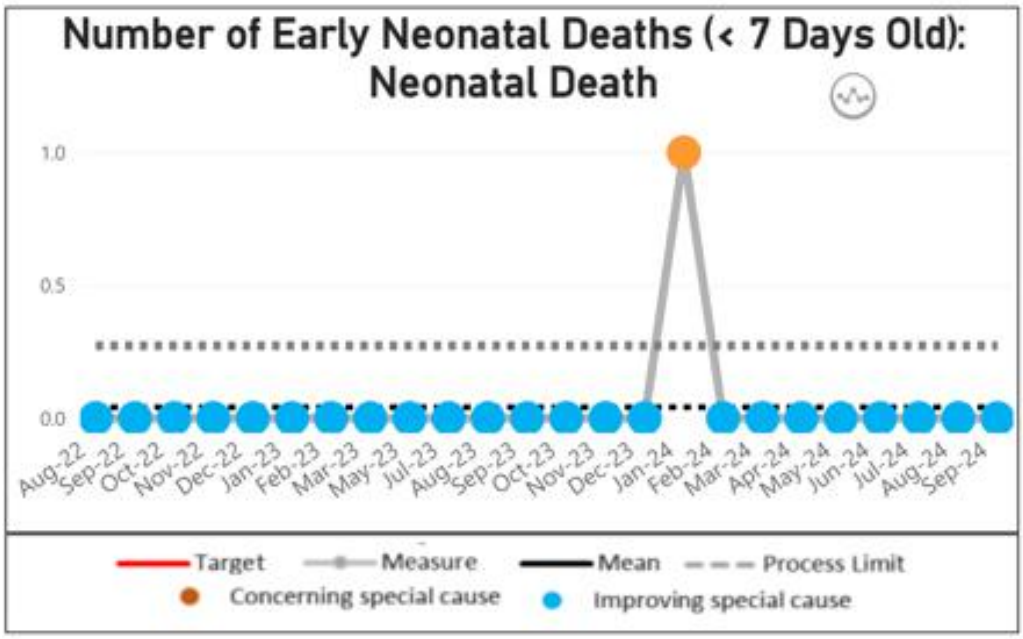
	Safety Action	Assurance
1	**Safety action 1:** Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard? deaths to the required standard?	The Perinatal Mortality Reviews Summary Report (PMRT) is included in **Appendix 1**
2	**Safety action 2:** Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	July 2024 Scorecard passed submission. This safety action is now complete.
3	**Safety action 3:** Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimize separation of parents and their babies?	Quality improvement project launched to further the attain work overseen by safety champions. Transitional care is provided in full alignment with the comprehensive specifications outlined in BAPM (British Association of Perinatal Medicine) guidance.
4	**Safety action 4:** Can you demonstrate an effective system of clinical workforce planning to the required standard?	Included at **Appendix 2** is the Obstetric and Anaesthetic workforce report along with the neonatal medical and nursing workforce paper reported in line with British Association of Perinatal Medicine (BAPM) providing an update on the Trust's position. The report confirms full adherence to this standard.
5	**Safety action 5:** Can you demonstrate an effective system of midwifery workforce planning to the required standard?	The biannual staffing report, covering the period from January to June 2024, received September 2024
6	**Safety action 6:** Can you demonstrate that you are on track to achieve compliance with all elements of the Saving	Saving Babies Lives, noting the Trust achieved compliance against the 6 elements based on evidence submitted in September 2024.

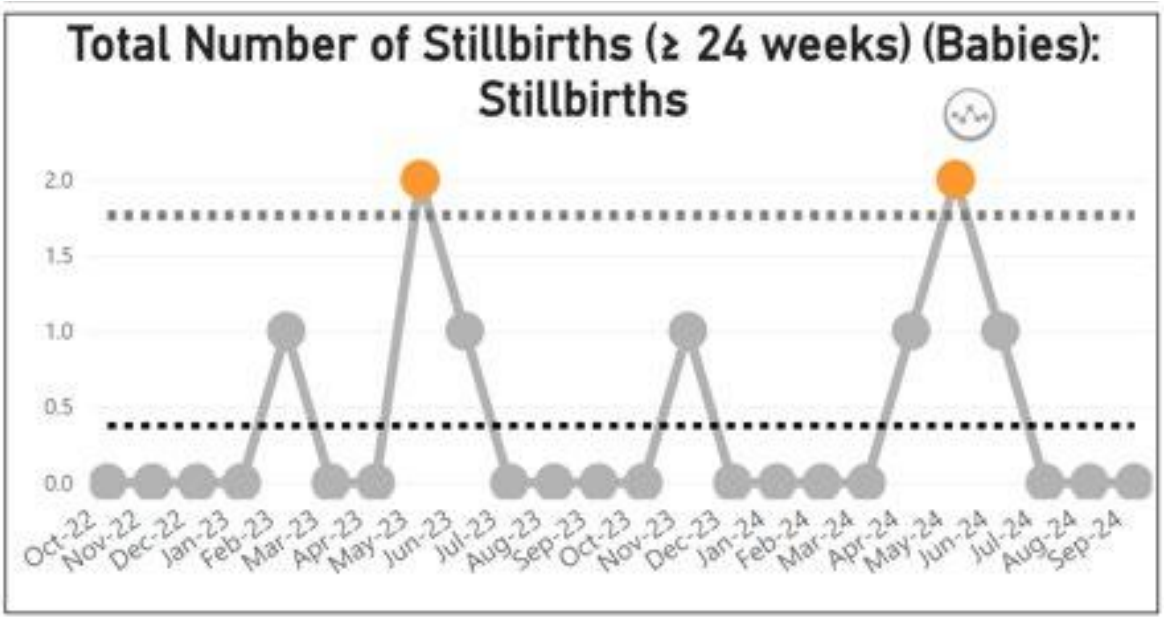
	Safety Action	Assurance
	Babies' Lives Care Bundle Version Three?	
7	**Safety action 7:** Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	The Maternity and Neonatal Voices Partnership MNVP lead has been successfully appointed has and begun working within our services. Listening to families continues to be high priority using the Trusts six steps model.
8	**Safety action 8:** Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	On track to full compliance Level 2 Safeguarding compliance as of the end of September 100%. Level 3 Children's Safeguarding compliance as of the end of September 96.1%. Area of focus is junior Doctor training since August changeover maintaining an MDT focus.
9	**Safety action 9:** Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	We have established a clear oversight mechanism to provide assurance to the Board on maternity and neonatal safety and quality issues. This is evidenced by a robust bi-monthly meeting schedule, with the latest meeting conducted in September. These meetings ensure continuous monitoring, evaluation, and improvement of safety and quality standards within our maternity and neonatal services. Strategic oversight framework presented by chief operating officer
10	**Safety action 10:** Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	There were no cases that met the requirement for referral to MNSI or early notification in this quarter.

Learning from deaths

Appendix 3 includes the full report of Cheshire and Merseyside Maternity Provider standardized Quarterly Perinatal Board report







Learning Extract: July 2024 to September 2024

This Maternity extract covers the period from July to September 2024, focusing on case reviews using the National Perinatal Mortality Review Tool (PMRT), the Maternity and Newborn Safety Investigations programme (MNSI), and NHS Resolution's Early Notification (EN) Scheme.

Key Findings:

- Cancelled Appointments: Ensure rescheduled appointments fall within the appropriate gestation timeframe.
- Counselling and Directives: Excellent counselling for Jehovah's Witnesses, with antenatal clinic review, advanced directive completion, and anaesthetic review.
- Preconception Counselling: Emphasised to better prepare individuals for pregnancy
- Saving babies lives Diabetes Criteria: Continue audit on Saving Babies Lives diabetes criteria.
- Multidisciplinary Reviews: continue Monthly reviews with Obstetrics and Diabetic teams
- Guideline Updates: Include specific surveillance for elevated HbA1c.
- Potassium: Improved medicines management in relation to the selection and handling of potassium
- Diabetes Study Day: Include diabetes updates in the Saving Babies Lives study day.
- Stillbirth Certificates: Enhance wording to ensure compassionate and sensitive language.
- New Equipment: New camera with enhanced safety features with two sim cards in case one is corrupt.

- Family Involvement: Families are invited to the PMRT outcome review, and answers to questions submitted by them are provided.

Conclusion: The findings from PMRT Q2 demonstrate a strong commitment to timely reviews, achieving the required standards in maternity services, involving parents in the review process, and ensuring ongoing quality improvement.

Neonatal Cases: Although not reportable for transparency there has been two Neonatal Deaths: **Twins less than 20 weeks gestation**.
Reviewed at the perinatal meeting (too young for PMRT); Child Death Overview Process (CDOP) forms are in progress.

- No significant clinical learning from the cases.
- Significant learning around the 'child death' process, with awareness sessions held during an Obstetrics & Gynaecology lunchtime teaching session and discussions at the perinatal meeting. The child death guideline update is forthcoming, and bereavement Midwifery team is increasing awareness of this process.

Saving Babies' Lives Care Bundle Version 3 (SBLv3) – Safety Action 6 of the MIS Year 5 Scheme

Launched in July 2023, the Saving Babies' Lives Care Bundle (SBLCBv3) provides evidence-based practices to reduce perinatal mortality across England. The national maternity safety ambition aims to halve perinatal mortality rates from 2010 to 2025, with a 20% reduction achieved by 2020. However, recent data highlight the need for continued efforts to meet the 2025 goal, especially with the onset of the COVID-19 pandemic in 2021. SBLCBv3 introduces a new focus on managing pre-existing diabetes in pregnancy, based on data from the National Pregnancy in Diabetes (NPID) Audit.

Key Progress:

Key Progress:

- Elements for *Smoking in Pregnancy*, *Reduced Fetal Movements*, and *Fetal Monitoring in Labour* are fully implemented (100%) and validated through both self-assessment and Local Maternity and Neonatal Systems (LMNS). These achievements align with
- The *Diabetes* element is fully implemented in our self-assessment, with partial validation from LMNS. Additional audit evidence is pending to achieve full validation.

Areas for Improvement:

- *Fetal Growth Restriction*: Currently at 85% implementation in both self-assessments and LMNS validation, this intervention requires targeted efforts to reach full implementation. Reintroduction of digital blood pressure monitoring following a review by the Electro-Biomedical Engineering (EBME) department.
- *Preterm Birth*: Achieved 93% implementation in our self-assessment and 96% validation from LMNS. A designated consultant will be assigned to this service following the completion of medical job planning

Next Steps:

- Strengthen efforts to fully implement *Fetal Growth Restriction* and close the validation gap for the *Diabetes* intervention.
- Continue refining the *Preterm Birth* intervention through multidisciplinary collaboration.

Summary:

Overall, we have achieved a 93% self-assessed implementation and 94% LMNS validation, positioning us on track to meet Maternity Incentive Scheme (MIS) requirements by the end of the reporting year.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	85%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	96%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	93%	Partially implemented	94%	CNST Met

Maternity (and Perinatal) Incentive Scheme Safety Action 1: Perinatal Mortality Reviews

During Quarter 2 of Year 6 (1st July to 30th September 2024), two cases met the criteria for review under Safety Action 1.

1. intrauterine death at 22+3 weeks gestation on 16th July 2024.
2. intrauterine death at 23+6 weeks gestation on 16th September 2024.

For both cases, the Trust achieved full compliance with all stages of the review process, including the use of the National Perinatal Mortality Review Tool (PMRT) and meeting the required timelines for notification and review. **Appendix 1 contains the full report.**

Lessons Learned

- Following a 29-week intrauterine death, symphysis-fundal height measurements are now offered to patients at every antenatal appointment from 24 weeks gestation. Growth surveillance commences based on risk, as per policy.
- After the death of a 36-week baby whose mother had Type 1 diabetes, it was identified that preconceptual counselling must be extended to all women of child-bearing age with Type 1 diabetes, even if they are not planning a pregnancy. This is now addressed through education in both primary and secondary care.
- All pregnant patients with pre-existing diabetes now benefit from joint multidisciplinary clinics, fully embedded as part of the "Saving Babies' Lives" care bundle (Version 6). This initiative was not fully in place at the start of the patients pregnancy, and its absence impacted the care of the patient in this case. We continue to monitor and review our multidisciplinary clinics to ensure effectiveness of them in line with SBLv3

Maternity (and Perinatal) Incentive Scheme Safety Action 10: Early Notification Scheme Compliance

In Quarter 2, there were no cases that required notification under the Early Notification (EN) Scheme. This indicates that there were no incidents involving term deliveries (≥37+0 weeks gestation) that resulted in severe brain injury during this period.

The Trust continues to demonstrate compliance with the reporting criteria, ensuring that all eligible cases are promptly notified to NHS Resolution's Early Notification Scheme, as well as adherence to the statutory duty of candour when required.

The Trust has met the required standards for both Safety Action 1 and Safety Action 10 for Q2 2024/2025, ensuring continued compliance with the Maternity(and Perinatal) Incentive Scheme.

The full detailed report is included in Appendix 2 for further reference.

Maternity neonatal voice partnership

The Maternity Service continues its active collaboration with the Chester Maternity Voices Partnership (MVP) on various projects. In alignment with the ambitions outlined in the Three-Year Delivery Plan, the MVP has rebranded as the Maternity and Neonatal Voices Partnership (MNVP) to better reflect its broader focus.

We are pleased to have recruited a new Maternity and Neonatal Voices Partnership MNVP lead, who has already actively participated in key engagements, including the Local Maternity and Neonatal Systems (LMNS) annual review and Women and Children's governance meetings.

Maternity Incidents

Q2 numbers as follows:

Serious Incidents Reports – 1

- 1 unit closure 12hrs September no service users diverted

PSII in progress 3 awaiting Integrated care board (ICB) sign off.

- never event (retained swab);
- PPH 4.9L, hysterectomy,
- ITU admission; baby fall)

AAR: 26

Rapid Review: **0**

Swarm: **0**

Thematic review: **1**

- Post Partum haemorrhage >1,500ml – data being analysed.

Number of moderate and above incidents

Total reported: **29** (x2 incidents are linked to 2 requiring only 1 learning response each, 1 managed outside division – facilities; interface incident), of these 4 severe, no fatal.

Open currently of Q2: **11** (4 severe)

Closed: **18** (1 severe)

CQC escalations There were no CQC escalations received in this quarter

There was no regulation 28 received for maternity services during this quarter.

Maternity and neonatal culture improvement plan

Our cultural improvement plan is based on the below strategic aims.

- Improvement
- Sustainability
- Leadership/Inclusion

Improvement

Our improvement journey is led through our Five-Year Strategy which was launched in June 2024 following inclusive collaboration with our teams. The service recognises the link between the strategic direction of the service and the behaviours that will get us there. The strategy consists of 6 priorities linked with national, regional and local priorities.

- Quality and safety for our patients
- A building fit for the future
- Investing in our workforce
- Listening and responding to service users
- Continuously improving and streamlining our services
- Purposeful leadership

Our strategy achievements are noted monthly within our W&C Divisional newsletter which provides us with the evidence that we are working towards our 6 priorities.

Sustainability

Sustainability is noted through our perinatal metrics and patient and family feedback. We are constantly adapting based on our safety performance and feedback. A recent example of this is noted within our GMC Training survey and the need for an action plan/change. As a specialty in general, O&G performs poorly in rates of burnout and negative workplace behaviors, with 82% of trainees at moderate or high risk of burnout nationally and a 1/3 of trainers and trainees alike reporting high/very high levels of work place frustration. The survey has shown a reduction in satisfaction of the trainees in a number of areas – improvement in these areas has been prioritized with the action plan in place for Women and Children's Governance Committee in October **Appendix 4 contains full report**

Leadership/Inclusion

Our leadership plans remain in place and sustained from 2023 staff survey. Actions included

- Monthly newsletter (example in appendix)
- Monthly senior leadership group (SLG) mirroring the Trust Operational Management Board (OMB) to ensure a direct cascade of information

- Tea with the team is maintained monthly providing informal opportunity to get to know each other. This has been expanded to weekends
- RCM leadership awards

Inclusion
- Visits and assemblies at local schools
- Head Teacher new build walk rounds
- Kids Bank Chester collaboration
- New Build transitional away days

Risk register

Three new risks were added in quarter 2 relating to Obstetric workforce, condemned cot mattress and Fetal Anomaly Screening (FASP) Standard. One high risk remains Lack of second theatre on Central Labour Suite.

Learning from Concerns and Complaints

0 New Complaints received in Q2.

New Concerns received Q2.
The service has received 8 concerns, 6 have been closed. Themes identified are around requests for debrief appointments to discuss care and communication.

The service monitors complaints and concerns weekly within their SLG meeting to ensure there is local resolution where possible and an opportunity to learn from themes.

Friends and Family Test (FFT)

1. Antenatal Services:
    - Response Rate: 13.1%
    - Satisfaction Rate: 76.92% positive, with 15.38% giving a neutral or negative response.
2. Labour Ward:
    - Response Rate: 10%
    - Satisfaction Rate: 100% positive.
3. NHS Obstetric Unit (Including Theatre):
    - Response Rate: 8.8%
    - Satisfaction Rate: 88.89% positive.

These figures reflect relatively high satisfaction rates, with the Labour Ward receiving the highest levels of positive feedback, though response rates vary, particularly with the Obstetric Unit having a lower response rate.

Summary of the Friends and Family Test (FFT) results for maternity services:

1. Antenatal Services:
    - Positive feedback on staff friendliness and clarity, though some noted long wait times and inconsistent information.
2. Labour Ward:
    - Highly praised for attentive, professional care. Patients felt supported and safe throughout the birthing process.
3. Postnatal Period:
    - Mixed feedback. While care was generally praised, concerns were raised about early discharge, particularly after C-sections.

An action plan has been developed to improve response rate and address areas of negative feedback.

Maternity & Neonatal Safety Champions Walkaround Feedback
Date: 15th October 2024

Summary of Findings:

No Immediate Safety Concerns: Staff reported a strong sense of teamwork and support, with a clean, family-focused unit environment.
Positive Feedback: Staff highlighted psychological support and a collaborative culture. Student nurses expressed enthusiasm for the unit, with one wishing to return post-qualification.
Improvement Areas: Staff suggested reinstating Level 2 care to avoid patient transfers.
Key Actions:
Review junior medical staff involvement in learning and team-building.
Increase visibility of Safety Champions' role.
Consider alternative formats for future walkarounds.
The visit provided assurance of a safe, high-quality environment, with recommendations to enhance staff engagement and interdisciplinary collaboration.

Conclusion
The Maternity Service is performing in line with key safety and quality standards, with active improvements being made through the MIS and other safety initiatives. The Committee is assured of continued high standards of care, and efforts to meet regional and national benchmarks are ongoing

Recommendations

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

Appendix: Glossary of Terms and Acronyms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1

The Perinatal Mortality Reviews Summary Report (PMRT)

Executive Summary	The purpose of this report is to provide the Committee with oversight of the cases that have met the criteria for review using the National Perinatal Mortality Review Tool (PMRT) and qualifying cases to The Maternity and Newborn Safety Investigations programme (MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 1 July 2024 to 30 September 2024 to the required standard.
Highlights	Maternity (and perinatal) incentive scheme Safety Action 1 • In Q2 24/25 2 cases met the inclusion criteria for Safety Action 1. 1 patient sadly experienced an Intrauterine death at 22+3 weeks gestation on 16/07/2024. There is full compliance with each stage of review development to date. See table 2 below. The 2nd patient also sadly experienced an Intrauterine death at 23+6 weeks gestation on 16/09/2024. There is full compliance with each stage of review development to date. See table 2 below. Maternity (and Perinatal) Incentive Scheme (MIS) Safety Action 10 • There were no cases that met the requirement for early notification in this quarter.

Perinatal Mortality Review Tool (PMRT)
Safety Action 1 and 10 Maternity Incentive Scheme (MIS)

Summary Report for the Countess of Chester NHS Foundation Trust

1st July – 30th September 2024 (Q2 24/25)

Authors: Lorna McNulty, Risk Midwife for Women's & Children's Services
& Lesley Roe, Bereavement Midwife.

October 2024

1.Background

This assurance report builds on previous quarterly reports submitted to board. A collaboration led by MBRRACE-UK was appointed by the Healthcare Quality Improvement

Partnership (HQIP) to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the DH/SANDS Perinatal Mortality Review 'Task and Finish Group'. The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

There are four aspects of the programme:

- The PMRT Tool
- Implementation support
- Involvement of parents
- National reporting

Each aspect is vital to ensuring that the lessons learned, the emerging themes and trends from local reviews are disseminated as widely as possible for the benefit of future babies, parents and families. National reports of the findings from the collected local reviews are produced by MBRRACE; a parent and public friendly version of these report are also made available.

The most recent PMRT Report was the 5th Annual Report (December 2023) Learning from Standardised Reviews when Babies Die. Since the launch of the national Perinatal Mortality Tool (PMRT) in early 2018 over 18,000 reviews have been started. This fifth annual report presents the findings for reviews completed from March 2022 to February 2023.

2. Eligible cases

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6 gestation
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth at 22+0 to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22+0 gestation but dies after 28 weeks gestation following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

Safety action 1:

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

Notify all deaths: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.

Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.

Review the death and complete the review: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.

Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.

A report should be received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Relevant Time period From 8 December 2023 to 30 November 2024

Table 2. Summary of cases reviewed/to be reviewed using the PMRT tool between 1st July – 30th September 2024

The below table gives a summary of cases. The titles now reflect the new standards required for Maternity (and Perinatal) Incentive Scheme (MIS) Year 6.

Patient	Date of Death	Trust review date	*Standard A Notification (Within 7 working days)*	Standard A *Surveillance Commenced (Within one calendar month)*	*Parents informed of review*	Standard B *(Parents input sought twice)*	Standard C Review started *(FQ completed within 2 months)*	Standard C *Published PMRT report (within 6 months)*	Standard D *Quarterly report*	Grading of care (1) up to the point of birth of the baby, (2) from birth up to the death of the baby, and (3) following the death of the baby.
A	29/01/24	07/03/24	12/02/24	29/02/24	30/01/24	01/02/24 & 15/02/24	25/03/24	29/07/24	20/06/24	D, B & B
B	15/02/24	02/05/24	22/02/24	15/03/24	08/03/24	08/03/24 & 15/03/2024	15/04/24	15/08/24	20/06/24	B & B
C	26/04/24	04/07/24	26/04/24	26/04/24	25/04/24	25/04/24, 30/04/24 & 18/06/24	26/06/24	26/10/24	07/11/24	B & A
D	24/05/24	01/08/24	28/05/24	04/06/24	24/05/24	31/05/24 & 05/06/24	24/07/24	24/09/24	07/11/24	C & C

E	**30/05/24**	**03/10/24**	**06/06/24**	**04/06/24**	**04/06/24**	**04/06/24 & 02/10/24**	**30/07/24**	**29/11/24**	**07/11/24**	**B & C**
F	**15/07/24**	**07/11/24**	**17/07/24**	**22/07/24**	**17/07/24**	**22/07/24**	**16/09/24**	**16/01/25**		
G	**16/09/24**	**02/01/25**	**19/09/24**	**19/09/24**	**16/09/24**	**16/09/24**	**16/11/24**	**16/03/25**		

4.Lessons learnt from PMRT.

Following PMRT meetings, any lessons learnt are disseminated in house (if they haven't been already following the 72-hour review) via communication from the Trusts Bereavement Midwife and Practice Development Midwife, discussed at rolling half day training, Perinatal Mortality and Morbidity meetings, and the 'Safety Huddle' and shared with the North -West Coast Network Special Interest Groups to enable wider learning across the network. All presentations, discussions and learning opportunities are always well received and evaluated.

- Following a 29-week Intrauterine death, symphysis fundal height measurements are offered to patients at every scheduled antenatal appointment from 24 weeks gestation and serial growth surveillance will then commence dependent on allocated risk as per policy.

- Following a 36-week Intrauterine death whose mother had type 1 diabetes it was identified that preconceptual counselling needs to be extended to encapsulate all women of child-bearing age who may not be necessarily planning a pregnancy. This can be achieved by education in both the primary and secondary care settings.

- All pregnant patients with pre-existing diabetes now benefit from the joint multi-disciplinary clinics that have been embedded as per the saving babies lives care bundle version 6. This had not been fully embedded and therefore did not benefit the above patient.

Safety action 10 of the Maternity (and Perinatal) Incentive Scheme (MIS).

Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

What are qualifying incidents that need to be reported to MNSI?

Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [or]
- Was therapeutically cooled (active cooling only) [or]
- Had decreased central tone AND was comatose AND had seizures of any kind.
- Once MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.

The definition of labour used by MNSI includes:

- Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation.
- When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking).
- Induction of labour (when labour is started artificially).
- When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.

Table 3

Standards required	Update on status	Evidence
Reporting of all qualifying cases to MNSI from 1st July 2024 until 30th September 2024.	No eligible cases	
Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 1st July 2024 until 30th September 2024.	No eligible cases	
For all qualifying cases which have occurred during the period 1st July 2024 until 30th September 2024 the Trust Board are assured that: the family have received information on the role of MNSI and NHS Resolution's EN scheme; and	No eligible cases	
There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008	No eligible cases	

(Regulated Activities) Regulations 2014 in respect of the duty of candour.		

The minimum essential requirement is that:

The Trust Board has sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolutions

The Trust Board has sight of evidence that the families have received information on the role of HSIB and the EN scheme.

The Trust Board has sight of evidence of compliance with the statutory duty of candour.

Appendix 2

Maternity (and Perinatal) Incentive Scheme (MIS) year 6
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Obstetric medical workforce

	Compliance
1) NHS Trusts/organisations should ensure that they meet the criteria for employing short-term locums	
2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums	
3) Trusts/organisations should implement RCOG guidance on compensatory rest	
4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document	

Dr Sara Brigham
July 2024
Associate Medical Director Women and Children's Division

Obstetric medical workforce

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota or

b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or

c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

Minimum Evidence required

Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses

Results

	Compliance/Evidence
During the period January 2024 – June 2024 inclusive, 52 shifts were covered by locum doctors on the tier 2/ 3 rota. 47 shifts were covered by Drs who are currently working at CoCH, 4 shifts were covered by a Dr who had worked in the unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP). 1 shift was covered by a Dr who had previously worked in the unit, having satisfactory ARCP, having worked in the unit within the last 5 years, but also does hold the certificate of eligibility to undertake short term locums	

Actions

1.Continue

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

Minimum Evidence required

Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS

Results

	Compliance/ Evidence
During the period January 2024 – June 2024 1 long term locum was employed who holds the Certificate of eligibility of locum and received induction and appropriate supervision as per RCOG	

Actions
1.Continue

3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

Minimum Evidence required
Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
Time period for audit 30 May 2023 - 7 December 2023

Results

	Compliance/ Evidence
All job plans in O&G at COCH do not have clinical activity following the day after on call. The Directorate manager and Clinical Director/ AMD have had no situations escalated where compensatory rest has not been taken	

Actions

1. Continue

4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non- attendancce
Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS
Time period for audit

Results

	Compliance/ Evidence
January – June 2024 audit showed 100% Consultant attendance for all scenarios as listed in the RCOG workforce document	

Actions

1. Continue with 6 monthly audit of consultant attendance

Action plan

Area for Review	**Recommendation/Action**	**Action Lead**	**Target date**	**Date of completion**
Monitoring of compliance for all short and long term locums	O&G rota co-ordinator to ensure that for every locum, the RCOG Compliance table is completed to provide on going evidence	Rota Co-ordinator/ Clinical lead	Ongoing	Ongoing
Compensatory rest	Continue to monitor clinical incidents for situations where consultants do not feel that they have been able to take appropriate compensatory rest	Clinical Director	Ongoing	Ongoing
Consultant attendance for all scenarios as listed in the RCOG workforce document	Continue with 6 monthly audit of attendance	Labour ward Lead	Ongoing	Ongoing

Monitoring of compliance	This report and action plan to be signed off by the Trust Board, Trust Board level safety champions and LMNS	Associate Medical Director	September 2024	

Maternity and Perinatal Incentive Scheme year 6
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Anaesthetic Medical workforce

	Compliance
A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1	

Dr Jo Fawkner Corbett
July 2024
Clinical Lead for Obstetric Anaesthesia

Anaesthetic medical workforce

Standard
A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)
Evidence required
The rota should be used to evidence compliance with ACSA standard 1.7.2.1. This can be a representative month of the rota
From 2 April 2024 to 30 November 2024
Methods
CoCH have a dedicated Anaesthetist covering the maternity Unit 24 hours per day 7 days per week
A review was undertaken of the anaesthetic rota – January 2024 to June 2024 inclusive
Results

	Compliance/ Evidence
CoCH has a dedicated Anaesthetist covering the maternity Unit 24 hours per day 7 days per week on the rota. In cases of sickness as described below, another Anaesthetist is identified to ensure that the maternity unit has dedicated cover	

January 100%
February 100%
March 100%
April 100%
May 100%
June 100%
We are able to demonstrate through audit of the anaesthetic staffing rota, that there is always a dedicated Anaesthetist covering the maternity unit 24 hours per day, 7 days a week. There have been no exceptions in this rota period.

In summary, COCH was 100% compliant with the staffing standard as set by the Royal College of Anaesthetists for immediate anaesthetist availability for the obstetric unit between January 2024 - June 2024. There are clear lines of communication to the oncall or supervising consultant at all times.
ACTION
Continue to audit the anaesthetic rotas to ensure a dedicated Anaesthetist is covering the maternity Unit 24 hours per day 7 days per week

Maternity Incentive Scheme year 6
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Neonatal Nursing staff

	Compliance
The neonatal unit meets the BAPM neonatal nursing standards	

Anne McGlade
Head of Neonatal and Paediatric nursing
July 2024

Neonatal nursing workforce
The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN

Results
Neonatal Nursing Workforce July 2024
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 QIS qualification. The unit remains committed to maintain BAPM compliance.

Action
Continue

Maternity Incentive Scheme year 6
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Neonatal Medical workforce

	Compliance
The neonatal unit meets the relevant BAPM national standards of medical staffing.	

Dr Victoria Guratsky
Neonatal and paediatric Clinical Director
July 2024

Neonatal medical workforce

The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce.

If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.

A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN)

Review of Medical Staffing Neonatal Unit Countess of Chester Hospital NHS Foundation Trust

Background:

The British Association of Perinatal Medicine (BAPM) issued a framework for practice in November 2018 : **Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing**

The framework included definitions of a 'Local Neonatal Unit' (LNU) and a 'Special Care Unit' (SCU) based on the definitions of level 2 and level 1 international classification.

Since June 2016 COCH the Neonatal Unit at CoCH has functioned between an LNU and SCU. COCH data for 2023 shows 25 infants admitted with admission weight < 1500 grams and 335 RCDs (Respiratory care days) were recorded. These figures are in keeping with a SCU rather than an LNU.

Nationally, there is a Neonatal Critical Care review being undertaken. This will determine the future status of COCH NNU.

Currently our unit has 12 cots including 2 HDU cots. There is an additional ICU level cot to stabilise a baby with a view to transfer. Limit of gestation is 32 weeks and over.

When we discuss 'Medical staffing' this comprises all roles traditionally undertaken by Medical Practitioners which are now also undertaken by appropriately trained and experienced Advanced Neonatal Nurse Practitioners (ANNPs) and augmented by Extended Nurse Practitioners (ENP).

As described above the unit is currently working somewhere between an LNU and SCU and figures for 2023 are in keeping with a SCU. However, the unit is referred to by the North West Neonatal Operational Network as an LNU and it is the vision for our perinatal services that the unit will return to level 2. We therefore include staff planning based on getting back to LNU workload as this is the long-term vision for our services.

N.B CoCH is compliant with BAPM standards for the current workload and the action plan is for internal use to ensure plans are in place to maintain BAPM compliance if the unit returns to a level 2 LNU.

BAPM Recommendations for Medical Staffing of LNUs and SCUs:

Tier One (F2/ST1/2 equivalent)

Local Neonatal Units

Units designated as LNUs should have immediately available at least one resident Tier 1 practitioner dedicated to providing emergency care for the neonatal service 24/7; the provision of newborn infant physical examination should not be the sole responsibility of this individual and midwives should be trained to deliver this aspect of care.

Special Care Units

SCUs should provide a resident Tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident Tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours if this does not reduce quality of care delivery and safety to the neonatal unit assessed using national standards.

SCUs delivering higher than recommended activity levels should provide a dedicated Tier 1 practitioner as required for LNUs

In stand-alone SCUs without co-located paediatric services this resident Tier 1 practitioner would be dedicated to the neonatal service alone

Tier Two (ST3+ or equivalent)

Local Neonatal Units

LNUs should provide an immediately available resident Tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00-22.00, seven days a week

LNUs undertaking either >1500 RCDs or >600 IC days annually should have immediately available a dedicated resident Tier 2 practitioner separate from paediatrics 24/7

LNUs undertaking either >1000 RCDs or >400 IC days annually should strongly consider providing a 24/7 resident Tier 2 dedicated to the neonatal unit and entirely separate from paediatrics; a risk analysis should be performed to demonstrate the safety, timeliness and quality of care delivery to both paediatrics, delivery suite, maternity unit and neonatal services if the Tier 2 is shared at any point 24/7 in these units. Considerations should include the level of activity of any Paediatric Unit including peak activity times and the geography of the site including the location of A&E and the Paediatric wards.

The Tier 2 should be immediately available at all times to the neonatal unit and the labour ward. If the site of the paediatric unit makes this immediate response impossible separate Tier 2 rotas are required.

Special Care Units

SCUs should provide a resident Tier 2 to support the Tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit

SCUs delivering higher than recommended activity levels should provide a Tier 2 practitioner as required for similar activity levels in LNUs

Tier Three (consultant level)

Local Neonatal Units

Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit

LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs.

All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake <4 'consultant of the week' service weeks annually.

No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training

Special Care Units

In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology)

Current Medical Staffing COCH NNU:
CoCH meet all requirements of a SCU and will continue to strive to meet all requirements of and LNU.

Tier 1

Tier 1 rota consists of 9 doctors. This includes paediatric ST1&2, GP ST1&2 and F2. There is an additional 'trust grade' doctor who contributes to the rota.

Two ANNP's are each working 3 long days a week. This equates to 08:30-21:00 6 days a week. Some weeks this will be across Monday-Friday and two weeks a month will include Saturday-Sunday.

A mixture of normal working days (08.30 – 16.30h); long days (08.30 – 21.00h); twilight shifts (16.00 – 00.00h) gives dedicated tier one cover to the neonatal unit during these hours:
Monday – Friday 08.30 – 00.00h
Saturday and Sunday 08.30 – 21.00h

Tier 2

Tier 2 rota consists of 7x ST3+ paediatric trainees. There is a dedicated tier 2 medical cover Monday –Friday 08.30 – 16.30h.

Tier 3

There are 12 consultants in total covering a 1in 10 rota. There is dedicated neonatal consultant cover Monday-Friday 08.30-16.30h. There is consultant presence in the hospital Monday-Friday 08.30-19.00; weekends 08.30 – 13.00 with the consultant returning for a ward round of new patients at around 17.00-19.00h. This is the minimum hours that consultants are expected to be resident in the hospital. Consultants are often in the hospital a lot more during their on call shifts. It should be noted that if there is an ICU level patient in the NNU, a consultant will be present until the baby is transferred by the transport team.

Consultants working the 1 in 10 rota work more than 4 "hot weeks" a year.

Changes implemented so far since publication of framework November 2018

COCH paediatric and neonatal team have implemented many changes since the publication of the BAPM framework in 2018. These include:

- Over-establishment of the Tier 1 level staffing – initially by employing 2x trust grade level doctors. Currently we have funding for 1x trust grade level doctor. This ensures better cover for sickness/annual leave/study leave, improves staffing in normal working hours and allowed implementation of the twilight shift.
- Introduction of the twilight shift Monday – Friday at Tier 1 level. This extended the dedicated tier 1 NNU cover from 21.00 to 00.00h.
- Two qualified ANNP now contribute to the Tier 1 neonatal rota (covering weekday and weekend long day shifts)
- Substantive staff grade Tier 2 level created and in post from March 2021.
- Two new consultants now in post
- Increase in enhanced neonatal nurse practitioner roles – two senior neonatal nurses are on the non-medical prescribers register. Along with enhanced skills, such has cannulation, this allows supplementation to tier one rota in managing infants requiring eg septic screens.
- FY1 on rotation to paediatrics now provides out-of-hours cover as part of their rota. Currently this practitioner is supernumerary to tier 1 rota and only covers paediatrics.
- APNP now established in covering seven days a week, 08:30-21:00

It should be noted by the trust, the neonatal network and Clinical Negligence Scheme for Trusts (CNST) that COCH dedicated neonatal medical staffing both in and out of normal working hours is more plentiful than that of other LNUs in the North West i.e a dedicated Neonatologist of the Week; tier 1 twilight shifts; consultant presence for any ICU level patient (including active cooling).

Recommendations to increase dedicated medical staffing for NNU

The number of tier 1 & 2 level doctors is limited by the number of paediatric and GP trainees. In 2022, national recruitment in paediatrics has improved. However, vacancy rates across paediatric rotas are increasing due to increased dropout and increased less-than full time working.

Whilst a case can be made to improve out of hours staffing with more trust grade doctors at tier 1 and tier 2 level, it should be noted that training opportunities will be diluted and careful consideration should be taken as to whether it is appropriate for there to be dedicated tier 1 level cover overnight at current capacity and workload.

Taking NIPE examinations out of routine workload would allow five 8 hour shifts on the tier 1 rota to be re-distributed to improve out of hours staffing.

ANNPs and APNPs further contributing to the out of hours rota should be strongly considered. These practitioners could only contribute to either paediatrics or neonates. ANNP posts are already established and part of their job plan is to cover the tier 1 rota. A precedent has been set.

APNPs have been in place on the paediatric ward for >10 years. They cover the tier 1 rota ad hoc in case of illness or unexpected under staffing.

Most of the tier 1 rota is covered by medical staffing monies. Funding for the advanced nurse practitioners has been varied; one ANNP was financed by corporate and one from medical staffing, our APNPs are financed within nurse staffing.

Action plan

N.B. this action plan would be progressed to become BAPM compliant for a level 2 NNU

Action	Person(s) responsible	Due	Update
Staffing options appraisal Review of workforce to ensure additional tier one rota. Options appraisal to be developed which includes review of APNP and ANNP workforce.	Paediatric and Neonatal Directorate Manager		Discussions ongoing at regional and national level to decide level of units within NW region
Review of APNP job plan & roles	Head of Paediatrics	Jan 2025	Progress has been made with agreement that ANNP's will be responsible for set out-of-hours evening work to allow further flexibility within the tier one rota.
Review midwifery ways of working to look at NIPE examinations becoming part of normal postnatal care.	Director of Midwifery	Jan 2025	Further training of midwives ongoing
Consultants are to maintain minimum of 8 hours neonatal CPD	Neonatal lead	September 2023	Complete and demonstrating through appraisal

References:

1. **Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018): A BAPM Framework for Practice**
2. **Toolkit for High-Quality Neonatal Services. NHS & Department for Health (2009)**
3. **Neonatal Service Specification from Neonatal Clinical Reference Group of the National Commissioning Board, DH England 2013**
4. **Review of Medical Staffing Neonatal Unit Countess of Chester Hospital NHS Foundation Trust June 2021, J Dangerfield**

Appendix 3

C&M Maternity Provider standardized Quarterly Perinatal Board report.

The Perinatal Clinical Surveillance Quality Tool dashboard provides an overview of the latest key quality and safety metrics.

The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services.

The dashboard is provided for information and whilst there is no indication to escalate any of the metrics to the Board of Directors.

Reported deaths in each quarter (**not** the reviews completed in that quarter).

NHS
Countess of Chester Hospital
NHS Foundation Trust

NHS
Countess of Chester Hospital
NHS Foundation Trust

Cheshire and Mersey Maternity Provider Quarterly Perinatal Board Report

Jul - Sep 2024

Report all deaths in each quarter **NOT** the reviews completed in that quarter.

EXECUTIVE SUMMARY:

	Q1 JAN – MAR 24	Q2 APR – JUN 24	Q3 JULY – SEP 24	Q 4 OCT – DEC 24
SB > 24 WEEKS	Rate 0 /1000	Rate 8.56/1000	Rate is 0/1000	Rate is 0/1000
NN mortality rate	Rate 2/1000	Rate 0/1000	Rate 2.01/1000	Rate is 0/1000
Add any other key findings progress on action plans, PMRT highlight themes, no. of StEIS reports	Coroner Informed no action			

DASHBOARD AND BENCHMARKING

Table. 1 Stillbirths and neonatal death dashboard

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	TOT ALL
Total stillbirths	0	0	0	1	2	1	0	0	0				4
Stillbirths (excluding terminations)	0	0	0	1	2	0	0	0	0				3
Births	162	166	165	149	163	155	182	147	168				1457
SB Rate	0	0	0	6.7 /1000	12.2 /1000	6.45 /1000	0	0	0				2.74 / 1000

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	TOTAL
Total Neonatal Mortality	0	1	0	0	0	0	1	0	0				2
Deliveries	162	166	165	149	163	155	182	147	168				1457

Neonatal Mortality Rate/1000 deliveries	0	6/1000	0	0	0	0	5.5 /1000	0	0				1.37 /1000

Table 2: Stillbirth (excluding terminations) & Neonatal death rate per quarter.

Quarter	Stillbirth Rate	NMR
Q1 Jan – Mar 24	0	6/1000
Q2 Apr – Jun 24	8.56/1000	0/1000
Q3 Jul – Sep 24	0	2.01/1000
Q4 Oct – Dec 24	0	0

Table 3: Stillbirth and NN Mortality by cause

	Q1 Jan – March 24		Q2 Apr – Jun 24		Q3 Jul – Sep 24		Q4 Oct – Dec 24	
Reported cause of death (based on CESDI 2018)	No.	In-utero transfers	No.	In-utero transfers	No.	In-utero transfers	No.	In-utero transfers
Stillbirth								
Termination of pregnancy for fetal abnormality	0	0	1	0	0	0		
Fetal abnormality	0	0	0	0	0	0		
Pre-eclampsia	0	0	0	0	0	0		
Antepartum haemorrhage	0	0	0	0	0	0		
Medical disorder	0	0	1	0	0	0		
Multiple pregnancy	0	0	1	0	0	0		
IUGR	0	0	0	0	0	0		
Mechanical	0	0	0	0	0	0		
Infection	0	0	0	0	0	0		
Specific placental condition	0	0	0	0	0	0		
Unclassified	0	0	0	0	0	0		
Neonatal death								
Prematurity	1 (23 Wks)		0		1 22+3 wks			
Infection	0		0		0			
HIE	0		0		0			
Congenital malformation	0		0		0			
Respiratory	0		0		0			
Abdominal	0		0		0			

Other	0		0		0			

MORTALITY REVIEWS AND KEY THEMES Quarter 1 (JAN - MAR 24)

Table 4. PMRT review panel grading of care provided.

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A		
PMRT grade B		**1**
PMRT grade C		
PMRT grade D	**1**	
Total cases	**1**	**1**

MORTALITY REVIEWS AND KEY THEMES Quarter 2 (APR – JUN 24)

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A		
PMRT grade B	**1**	**1**
PMRT grade C		
PMRT grade D		
Total cases	**1**	**1**

MORTALITY REVIEWS AND KEY THEMES Quarter 3 (JUL - SEP 24)

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A	1	
PMRT grade B		1
PMRT grade C	1	1
PMRT grade D		
Total cases	2	2

MORTALITY REVIEWS AND KEY THEMES Quarter 4 (OCT - DEC 24)

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A		
PMRT grade B		
PMRT grade C		
PMRT grade D		
Total cases		

Table 5. Reasons for review panel grading C&D

MORTALITY REVIEWS AND KEY THEMES Quarter 1 (JAN - MAR 24)

Review panel grading	Reason for grading	Level of investigation (StEIS/Level 2/Level 1	MNSI (yes/no)	Learning	QI plan aligned to theme	*Inform forward audit plan/implement QI project
D	Inappropriate assessment for preterm Birth when attended Wrexham maternity with signs of preterm labour	PMRT review	NO	All areas of learning applicable to Wrexham they have been informed. Element 5 SBL not adhered to by Wrexham maternity		

MORTALITY REVIEWS AND KEY THEMES Quarter 2 (APR – JUN 24)

Review panel grading	Reason for grading	Level of investigation (StEIS/Level 2/Level 1	MNSI (yes/no)	Learning	QI plan aligned to theme	*Inform forward audit plan/implement QI project
B	NA as B grading	PMRT REVIEW	NO			

MORTALITY REVIEWS AND KEY THEMES Quarter 3 (JUL – SEP 24)

Review panel grading	Reason for grading	Level of investigation (StEIS/Level 2/Level 1	MNSI (yes/no)	Learning	QI plan aligned to theme	*Inform forward audit plan/implement QI project
C	Suboptimal care up to 20/40 and not in line with SBL v3 joint MDT clinics and HbA1C testing No pre conception counselling Drug error with potassium Loss of photos due to camera malfunction	PMRT REVIEW	NO	Consider the benefits to introducing a preconceptual 'school' for all type 1 diabetics (to facilitate women who go on to have unplanned pregnancies). This will consist of sharing information and counselling to ensure women are fully informed of the risks of poor diabetic control. Review and update the management of perinatal diabetes guideline, to include elevated HbA1c and time out of range management Complete the learning response for the linked		

				incident – wrong dose potassium post-delivery		

6. INTRAPARTUM & TERM STILLBIRTHS

	Q1 Jan – Mar24	Q2 Apr – Jun 24	Q3 Jul – Sep 24	Q4 Oct – Dec 24
INTRAPARTUM SB	0	0	0	
TERM SB	0	0	0	

7. TERM NEONATAL DEATHS (*in-hospital deaths – for Level 3 units add deaths in Alder Hey*)

	Q1 Jan – Mar 24	Q2 Apr – Jun 24	Q3 Jul – Sep 24	Q4 Oct – Dec 24
NEONATAL DEATHS	1 (23 wks BBA booked at Wrexham)	0	0	

8. SAFEGUARDING/UNBOOKED AND LATE BOOKERS

	Q1 Jan – Mar24	Q2 Apr – Jun 24	Q3 Jul – Sep 24	Q4 Oct – Dec 24
NND – LATE BOOKING/ SAFEGUARDING ISSUES	BBA BOOKED AT WREXHAM	NO	NO	

9. LANGUAGE BARRIERS

	Q1 Jan – Mar 24	Q2 Apr – Jun 24	Q3 Jul – Sep 24	Q4 Oct – Dec 24
Women who experienced language barriers	NO	NO	NO	

10. LEARNING FROM DEATHS

	Learning from deaths	Progress on previous actions
Q1 Jan – Mar 24	All learning applicable to Wrexham maternity – They have been informed	Completed
Q2 Apr – Jun 24	**SB 29 weeks.** SFH measurements for Low-risk patients at every scheduled antenatal appointment from 24/40. High risk patients with a normal UAD to have SFH measurements at every scheduled appointment from 24/40 until USS commences at 32/40. May – 36/40 IUD. Not seen in medical disorders clinic following anatomy scan and growth ultrasound scans not	Completed

	commenced until 32/40 (although would not have changed the outcome) – work in progress for the streamlining of appointments.	
Q3 Jul – Sep 24	Consider the benefits to introducing a preconceptual 'school' for all type 1 diabetics (to facilitate women who go on to have unplanned pregnancies). This will consist of sharing information and counselling to ensure women are fully informed of the risks of poor diabetic control. Review and update the management of perinatal diabetes guideline, to include elevated HbA1c and time out of range management Complete the learning response for the linked incident – wrong dose potassium post-delivery	
Q4 Oct – Dec 24		

11. SMALL FOR GESTATIONAL AGE

	Q1 Jan – Mar 24	**Q2 Apr – Jun 24**	**Q3 Jul – Sep 24**	**Q4 Oct – Dec 24**
Was small for gestational age a contributing factor	NO	NO	NO	

12. HORIZON SCANNING

	COMMENTS
Q1 Jan – Mar 24	As part of intelligence gathering the following sources were used for horizon scanning: CQC, NCEPOD, NHS Digital, NHSE/I (includes LMNS), NHSR, PHE, RCOG, RCM, MBRRACE-UK, HSIB, Ockenden, Clinical Negligence Scheme for Trusts Clinical Negligence Scheme for Trusts CNST Maternity Incentive Scheme
Q2 Apr – Jun 24	As part of intelligence gathering the following sources were used for horizon scanning: CQC, NCEPOD, NHS Digital, NHSE/I (includes LMNS), NHSR, PHE, RCOG, RCM, MBRRACE-UK, MNSI, Ockenden, CNST Maternity Incentive Scheme
Q3 Jul – Sep 24	As part of intelligence gathering the following sources were used for horizon scanning: CQC, NCEPOD, NHS Digital, NHSE/I (includes LMNS), NHSR, PHE, RCOG, RCM, MBRRACE-UK, MNSI, Ockenden, CNST Maternity Incentive Scheme
Q4 Oct – Dec 24	

Appendix 4. GMC National Training Survey 2024 for O&G

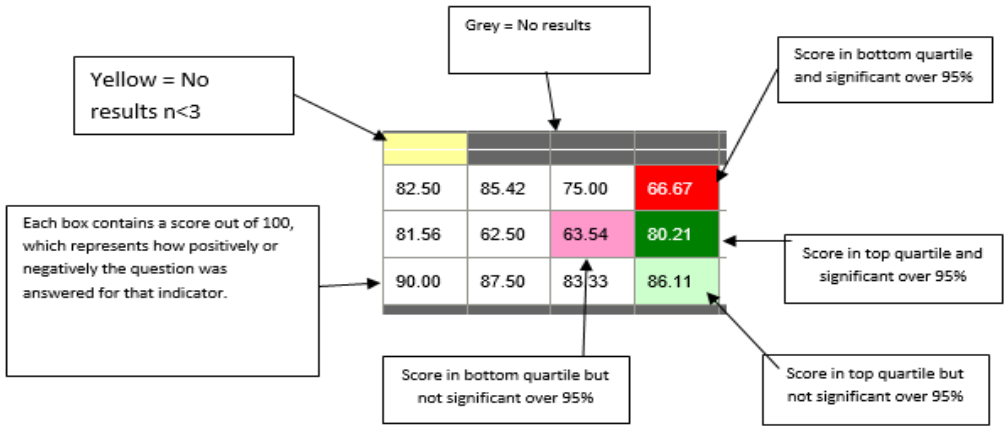
Executive summary

As a speciality in general, O&G performs poorly in rates of burnout and negative workplace behaviours, with 82% of trainees at moderate or high risk of burnout nationally and a 1/3 of trainers and trainees alike reporting high/very high levels of work place frustration. Nationally 35% of O&G trainees have experienced negative workplace behaviour, microaggressions or bullying. There have been no concerns raised locally and no free text comments related to workplace behaviours within the GMC survey but we need to be mindful that it is a problem nationally within the specialty and trainees rotating to us my have experienced this elsewhere and still be affected. During the time period of this survey there were significant gaps across all grades of the rota with frequent episodes of consultant having to step down and the use of agency locum consultants and registrars. There was also a time without any RCOG college tutor due to unexpected sickness then a temporary appointment to this role. Since this time a permanent RCOG college tutor has been appointed and we have managed to appoint a substantive consultant with ongoing active recruitment. However, we are deeply concerned with these results and had already begun implementing changes in the interval between the survey and the results being released.

Guide for interpreting results

Each box contains a score out of 100, which represents how positively or negatively trainee or trainers answered the questions for that indicator. If the score is significantly negative or positive compared to the national average, the box is highlighted red or green. Where it is negative or positive but shares a confidence interval with the national average, the box is highlighted pink or light green.

Key for interpreting results:



Results from 2020 are excluded as during this year there was only an abbreviated GMC Survey during the Covid-19 pandemic.

The “Post Specialty” includes all the programmes that have placement in that specialty e.g. foundation, core, ST3+, GP registrar etc.

The “Programme” includes all the programmes that have placement in that specialty a specific group e.g. all anaesthetic trainees, all F1’s in medicine etc.

Supervision, teamwork and experience

Unfortunately, over the past 12 months we have faced significant staffing challenges at consultant, registrar and SHO level. This is due to unexpected long term sickness absence and maternity leave at consultant level at a time that 2 consultants resigned to work closer to home. Despite ongoing attempts at active recruitment, we were unable to secure locum cover for the maternity leave or appoint substantively until recently. There have also been significant rota gaps at the registrar level due to maternity leave and sickness plus one registrar being moved to another unit that had worse staffing levels than we did. We also had further gaps and long term sickness at the SHO level. It presented difficulties with maintaining a safe service while allow appropriate training opportunities and release of doctors to attend regional teaching. Consultants were frequently required to step down and cover these gaps which then led to elective work being cancelled again reducing training opportunities and at a time when focus should have been on elective recovery. One of the most frequent sessions to be converted from a consultant perspective was the Emergency Gynaecology sessions, which specifically impacted on training opportunities and additional supervision over and above the on call consultant. We had to rely on agency locum consultants and registrars who did not provide the same level of education and commitment to training and supervision that we as a department strive towards which is reflected in the decrease in overall satisfaction and supervision scores. The remaining resident doctors on the registrar and SHO level also got demoralised with the continual rota gaps and last minute requests to cover further unexpected absence.

We have continued to try and improve our handover processes and have now embedded an electronic real time document on Teams. Following feedback from the wider multidisciplinary team regarding best timing of the neonatal 'huddle' this has been moved several times and is now at 0845-0900 just after the O&G handover. We now have an active document outlining resident doctor current competencies, special interests and training needs available on the S drive for all consultants to review along with the current list of educational supervisors. These documents are reviewed and updated by the RCOG college tutor at each rotation period.

As a department there is an ongoing rolling audit of consultant out of hours attendance that is led by the Labour Ward lead consultant and is line with the RCOG recommendations regarding when a consultant should attend. This document also details a list of cases that would require consultant attendance unless the trainee can demonstrate competence in the procedure. All specialty trainees are asked directly about their competence with relation to this on joining the department and after 6 months. This list is present on the S drive for consultants to review when needed.

Induction

In August 2022, the O&G doctors handbook was re-introduced which has been given to all doctors starting a post in O&G. This booklet has all the essential information needed by the trainees while they are with us and is edited regularly. Unfortunately, induction was impacted by sudden unexpected absence and the time taken to appoint a temporary college tutor. Work is ongoing to improve the induction process and we will engage with resident doctors – both specialty and GP trainees – to ensure the correct information is relayed during this process and that the doctors handbook contains everything needed to aid our team.

Education and teaching

Due to significant rota gaps and many LTFT doctors requesting the same non-working days it was difficult to release resident doctors to attend regional teaching. Whilst every effort was made to allow this, once annual leave was factored into the rota there were days when a safe service could not be maintained when teaching occurred. When possible consultants did cover additional services to allow release of trainees, including the use of locum staff, but this was not always possible. The consultant that oversaw local teaching was also on maternity leave and the consultant covering, who has since left the trust, did not have the same enthusiasm to keep this going. Due to consultants having to more non-clinical duties because of rota gaps this was

unfortunately not picked up. However, this has since been addressed and the weekly local teaching is fully established again.

Rota design

For portions of the year we have not had any rota coordinator with the majority of the rota management being performed by the consultant rota lead, along with the operations team and secretarial team leader in addition to their normal workload. Without this clear oversight from a person whose main role is to manage the rota it has been difficult to ensure resident doctors are getting a good breadth of experience within the department. We did manage to recruit to this position but have struggle with retention due to the complexities of managing the rota of what is essentially two distinct specialities and ensuring adequate cover arrangements are in place with the significant gaps we have had. Also, maternity services cannot be easily stood down or delayed due to the specific time frames needed for review/treatment of the pregnant population. There is ongoing active recruitment to this role and the job advert and banding is under review. We also had frequent rota changes within each week as many doctors have caring responsibilities and there would often be last minute carers leave plus the usual sickness absence.
The current day to day working hours and pattern were discussed with the resident doctors to see if they could be altered in any way and the feeling from them was to leave the hours as they were and they would prefer to exception report late finishes and receive TOIL.

Trainee Survey Results

Obstetrics and Gynaecology – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	76.25	76.33	74.58	44.23
Clinical Supervision	95	89.67	88.33	71.92
Clinical Supervision out of hours	96.09	89.73	96.02	80.29
Reporting Systems	76.25	78.67	79.09	52.31
Work Load	55.47	52.5	47.74	44.71
Teamwork	76.04	81.67	77.78	72.44
Handover	60.16	72.92	69.97	58.01
Supportive Environment	67.5	75.67	72.92	45
Induction	81.56	67	80.83	58.46
Adequate Experience	62.5	70.83	81.25	41.35
Curriculum Coverage	63.54			
Educational Governance	80.21	67.78	68.75	45.51
Educational Supervision	82.81	86.67	85.94	71.15
Feedback	83.33	70.83	75.83	50.38
Local Teaching	66.46	56.43	62	27.31
Regional Teaching	66.15	62.2	48.33	39.74
Study Leave	58.93	55.21	56.08	27.88
Rota Design	53.13	42.5	54.17	29.33
Facilities	81.25	56.56	66.53	51.25

Obstetrics and Gynaecology – Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	75.83	77.5	72.5	41.67
Clinical Supervision	95	96.5	95.63	76.11
Clinical Supervision out of hours	96.88	95	96.88	79.17
Reporting Systems	75.83	82.5	80.63	52.22
Work Load	56.25	50.63	49.22	48.61
Teamwork	76.39	83.33	77.09	70.37
Handover	57.29	76.25	67.19	55.56
Supportive Environment	65	75.5	71.25	45

Induction	82.08	73	81.88	63.89
Adequate Experience	58.33	66.25	78.13	30.56
Curriculum Coverage	62.5			
Educational Governance	81.95	68.33	67.71	43.52
Educational Supervision	86.46	90.63	85.94	73.61
Feedback	83.33	73.75	73.96	60.42
Local Teaching	68.06	56.5	64.79	28.52
Regional Teaching	76.39	65	48.44	52.78
Study Leave	62.5	59.49	60.42	23.61
Rota Design	53.13	41.88	48.44	32.64
Facilities		55.5	68.13	55.18

GP Programme – Obstetrics and Gynaecology Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction		71.25		50
Clinical Supervision		82.5		62.5
Clinical Supervision out of hours		83.33		82.81
Reporting Systems		72.5		52.5
Work Load		59.38		35.94
Teamwork		75		77.09
Handover		60.94		63.54
Supportive Environment		77.5		45
Induction		55		46.25
Adequate Experience		78.13		65.63
Curriculum Coverage				
Educational Governance		64.59		50
Educational Supervision		73.44		65.63
Feedback		55.56		23.61
Local Teaching		56.25		24.58
Regional Teaching		55.21		10.42
Study Leave		57.29		37.5
Rota Design		53.13		21.88
Facilities		58.33		

Changes implemented since GMC survey

As we were already aware of the difficulties faced by the previous cohort of resident doctors we had started to put changes in place. The RCOG college tutor has now been appointed on a permanent basis rather than a temporary cover arrangement and job plan changes have been made to allow for this with PA allowance for this.

There is now a robust Wednesday lunchtime teaching rota with assigned consultant facilitation and resident doctors appointed to lead the teaching. They are encouraged to submit portfolio assessments to consultants present to improve the educational experience. The CTG lead midwife regularly presents interesting cases and leads discussion around this followed by a resident doctor led topic. This teaching is now also on Teams to improve attendance, although there has been difficulty in securing a regular teaching space and the teaching laptop was removed from the department.

A resident doctors communication board has also been placed next to the handover room on the central labour suite to allow dissemination of learning, keep an up to date teaching rota and provide relevant information/updates. It also has information on the library service and how to access this, including literature review for aiding in QiP such as guideline reviews, audits and publications/posters.

All incoming speciality doctors have completed and educational needs assessment to allow allocation of an appropriate educational supervisor based on their specific needs and interests were possible. They have also been allocated a guideline to review with their educational supervisor and a suggested audit topic relevant to there expressed interests and training aims.

There were incidences of the clinical governance team directly approaching resident doctors for information and statements relating to clinical incidents which caused some distress and uncertainty. As a consultant body we were unaware of this initially and as the clinical governance team were only newly formed they did not realise the impact this could have on resident doctors. It was quickly rectified by the college tutor and now they have a list of educational supervisors and any requests for further information must go through the resident doctors named educational supervisor first so that they can discuss this directly with the doctor and provide any support required. If the educational supervisor is not available for whatever reason then the college tutor or clinical director can be asked for assistance.

We now have a newly appointed substantive consultant and the return of others from long term absence with active recruitment ongoing. This should reduce the dependence on agency locums, which should improve the experience, educational opportunities and supervision of our current resident doctors.

Action plan for 2024-2025:

Area for Review	Recommendation/Action	Action Lead	Target date	Date of completion
Local teaching	Ensure ongoing rolling teaching rota with appropriate educational content and	Dr Melisa Thomas	Ongoing	Ongoing
Local teaching facilities	Difficulty securing a regular room for local teaching and no laptop for teaching	Sophie Barker	Nov 24	Regular teaching location secured, teaching laptop requested
Resident Doctor's forum	Increase frequency of resident doctors forum to 2 monthly to ensure ongoing improvement in experience	Dr Lisa Canavan	Ongoing	Ongoing Last Sept 24, planned Nov 24
No current rota administrative support	Need to recruit to this post – banding is under review Currently looking at trust wide digital solution	Sophie Barker	Nov 2024	

Resident doctors handbook	Annual review of resident doctors handbook – This hand book will be e-mailed to resident doctors 2 weeks prior to starting, it has all the information the trainee will require for starting in O+G	Dr Lisa Canavan/Sophie Barker	July 2025	Reviewed July 24, to review again July 25
Regional Teaching	Liaise with rota coordinator and service manager to ensure appropriate clinical activity reduced to allow attendance.	Dr Lisa Canavan/rota team	Nov 24	Regional teaching timetables already emailed to rota team
College tutor new to role	To attend RCOG course – How to be an effective college tutor	Dr Lisa Canavan	Oct 2024	Course attended 10/10/24
Workplace behavior and trainee experience	Workplace behavior champion to be appointed Civility workshop to be held on rolling half day	Dr Lisa Canavan/Dr Sara Brigham	Nov 24 (champion) Whole hospital RHD Nov 24	
Clinical supervision	On call team job titles revised to emphasise team working as a whole department – agreed at resident doctors forum	Dr Lisa Canavan/rota team	Sept 24	Already implemented
Improve induction programme	Ensure adequate notice from medical staffing around trust induction, identify current resident doctors to ensure programme is relevant	Dr Lisa Canavan/Sophie Barker/rota coordinator	Dec 24 for GP induction July 25 for specialty doctor induction	
Current resident doctor experience	Mini GMC style survey to current trainees to ensure early intervention and improvement if needed	Dr Lisa Canavan/Dr Victoria Finney/Sophie Barker	Dec 24	
GP resident doctor educational needs	Meeting with GP TPD to ensure training needs fully understood	Dr Lisa Canavan/Rota team	Oct 24 – emails sent to GP TPD (Sept 24) with no response	
Resident doctors feeling unsupported during on call shifts, especially when covering the on call gynae bleep	Introduce a 1300 team huddle on weekdays to review current workload, assess clinical concerns	Dr Lisa Canavan	Nov 2024	

	and redirect workforce as needed			
Rota	Currently weekly rota is released on a Friday afternoon – will move this to earlier in the week	Sophie Barker/rota team	Dec 24	

Dr Lisa Canavan
O+G Consultant and RCOG College Tutor
October 2024

PUBLIC – Board of Directors
26th November 2024

Report	**Agenda Item 12.**	**Safety Surveillance Report – Quarter 2 2024/25**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	**X**
Accountable Executive	Sue Pemberton			Director of Nursing & Quality / Deputy Chief Executive				
Author(s)	Fiona Altintas			Deputy Director of Nursing, Quality & Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X**	This assurance paper has a positive impact on BAF 1.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Quality Governance Group – 3rd October 2024 Quality and Safety Committee – 7th November 2024							
Executive summary	The purpose of this report is to: • Provide an update on the transition from weekly Patient Safety Learning meeting to monthly Safety Surveillance and Learning meeting • Provide an update on themes and learnings from incidents, complaints, concerns and coroners inquest.							
Recommendations	The Board of Directors is asked to • Note the contents of the paper. • Note the assurance that the Trust is continuing to promote a learning culture with evident and measurable actions to improve patient safety. • Note the improvements in governance and oversight workstreams within the Countess of Chester Hospital							

	• Note the approval of the Quality & Safety Committee of the recommendation that a quarterly Harms Improvement Paper is presented, and a Safety Surveillance Paper is presented at each Quality Governance Group (QGG) meeting (i.e. 6 a year, that will replace the quarterly Integrated Incidents Complaints and Concerns paper but increased frequency of reporting).

Corporate Impact Assessment	
Statutory/regulatory requirements	Respective codes of governance, statutory and regulatory quality requirements.
Risk	Failure to maintain quality of care would result in poorer patient & family experience.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of agenda pack.

Safety Surveillance Report – Quarter 2 2024/25

1. BACKGROUND

To ensure learning from incidents, complaints and concerns, the trust previously held a weekly Patient Safety Learning Meeting, that included a review of previous moderate and above incidents. As the Trust progresses and develops the Patient Safety Incident Response Framework (PSIRF), improved governance and assurances frameworks have been developed, with one being the development of a monthly Safety Surveillance and Learning Meeting. The aim of this meeting is to articulate themes of incidents, complaints and concerns, learning from deaths and coroners' inquests. Subsequent learning responses are shared which guide and provide direction to changes in practice that will promote patient, families and carers and staff safety and overall experience and in turn, reduce patient and staff safety risk. It also provides a trust wide forum for learning to be shared.

Previously the Quality and Safety Committee and the Quality Governance Group received an Integrated Incidents, Complaints and Concerns report and it is proposed that this paper supersedes the previous papers to allow for Trust level oversight of incident management, learning and the triangulation of themes.

2. PURPOSE

The purpose of this paper is to inform and provide assurance that the trust is a learning organisation and has robust governance and assurance structures in place to identify and highlight risk, identify themes and present changes in practice whose progress can be monitored and a forum for escalation of any concerns.

3. CURRENT POSITION

The Safety Surveillance meetings commenced in August 2024, with membership from all divisions and relevant departments e.g. Tissue viability, PALs, Legal. It also included learning from the regional quality team when they shared learning from another trust with respect a Regulation 28, Prevention of Future Deaths notice. This good practice ensures system learning and awareness is shared both internally and externally. The overall trends for incident reporting in Quarter 2 2024/25 can be seen in table 1

<u>Incidents Reporting Quarter 2 2024/25</u>

The Trust reports between 230-300 incidents per week and this remains consistent. The majority of all incidents are no and low harm, with moderate and above harm incidents making up on average 5% of total incidents reported. There is a daily focus on no and low harms at the daily senior site meeting, to ensure near misses and themes are also reviewed and any themes identified.

The Top 10 themes of incidents can be seen in Table 1, they can fluctuate in ranking but are a consistent theme. Actions to mitigate the incidents are also included in the table.

Table 1:

Themes	Actions
Security	Violence and Aggression Steering group re-established with refreshed terms of reference and membership. Communications regarding zero tolerance
Skin integrity	Weekly review of all pressure ulcers. Harms Improvement Program and Oversight. Working with partners regarding Present on Admission pressure ulcers. Deconditioning workstreams

Themes	Actions
	Quarterly Report to Quality Governance Group
Slips Trips and Falls	Safer Mobility. Steering Group. Deconditioning workstreams. Education and use of Ramble guard Quarterly Report to Quality Governance Group
Staffing	Safer Staffing Review undertaken, further review being undertaken in November 23, three times daily staffing meetings, establishment logs
Bed Management	These incidents occur when the Trust is experiencing extreme pressure and are in OPEL 4, where areas outside of the norm are used for patient flow
Treatment	Delays in diagnosis, treatment, patient pathways
Medication	Harms Improvement program and oversight Safe Medications Group
Disruption of Services	These incidents occur when the Trust is experiencing extreme pressure and are in OPEL 4, where areas outside of the norm are used for patient flow
Unexpected Events	Cardiac arrest, return to theatre, bleeding
Obstetric	These incidents consist in the main of Post Partum Hemorrhages, 3rd and 4th degree tears and are mandated to be classed as moderate incidents.

An analysis of all moderate and above incidents in Quarter 2 2024/25 can be seen in table 2 and table 3.

Table 2 Moderate and above incidents reported in Quarter 2 2024/25:

	Moderate	Severe	Catastrophic	Total Incidents
July 24	60	10	0	1098
August 24	41	5	1	1163
September 24	46	7	4	1081

Table 3 Thematic Review:

	July 24	August 24	September 24
Skin Integrity (Trust)	14	6	6
Infection Prevention	11	9	12
% of all Moderate	41%	36%	40%
Other provider Skin Integrity	11 (18%)	8 (19%)	14 (30%)
All of above % of total moderate incidents	59%	55%	70%

Analysis

Skin integrity and Infection Prevention Incidents constitute around 40% of all Moderate incidents with Post Partum Haemorrhage (PPH) and 3rd or 4th degree tears make up (10-13%).

On average a further 22 % are incidents reported for another provider/patient's home. Therefore, it can be concluded that skin integrity, Infection Prevention and PPH/tears contribute to on average 73% of all moderate incidents. Falls contribute to on average 4% of all moderate incidents.

The remaining 27% (which equates to approx. 34 incidents) is the focus of the Patient safety Oversight Group, which are ultimately After-Action reviews are instigated. The themes are delays in diagnoses, unexpected events and treatment.

Skin Integrity and Infection Prevention are two of the Trusts Harms Improvement Projects and are monitored through specific steering groups. To ensure oversight of all Harms Improvement workstreams, a Harms Improvement oversight meeting has been established in which three projects present each month, with a quarterly report being submitted to the Quality Governance Committee, the first due to be submitted in December 2024.

4. Patient Safety Incident Response (PSII)

The Trust have reported twelve PSII's and one Never Event to StEIS to date, the detail can be seen in Table 4. The investigations are monitored through the Patient Safety Oversight Meeting. To date:

6 completed
2 expected in next 2 weeks
3 new
1 due November
1 overdue

Table 4 PSII (StEIS reportable Incidents):

Incident	Lead Division	Completion Date/Due date	Status
Thematic Review of Stroke Incidents	Urgent Care	July 24	Completed
Thematic Review of Glaucoma Pathway Incidents	Planned Care	12/6/24	Completed
Incident where baby fell from mothers' bed	Women's and Children	27/9/24	Completed
Never Event – retained swab following delivery	Women's and Children	4/10/24	Completed
Missed opportunity to diagnose ophthalmic condition in ED	Urgent Care	25/10/24	Oversight meeting for approval 25/10/24
Delay in Treatment - Stroke	Planned Care	13/9/24	Overdue
Missed diagnosis of base of skull malignancy	Planned Care	25/10/24	Multi organisational review in progress
Missed colon cancer	Urgent Care	27/9/24	Completed
Post partum hemorrhage and unplanned hysterectomy	Women's and Children	15/11/24	AAR completed and PSII underway – on target

Incident	Lead Division	Completion Date/Due date	Status
Maternity Unit being placed on Divert	Women's and Children	27/10/24	Opened and closed on StEIS – no patients diverted
Delay in treatment/diagnosis - ED	Urgent Care	8/11/24	Tabletop completed
Baby death	Women's and Children	1/11/24	SWARM completed/SUDIC 22/10/24
Baby transferred for cooling	Women's and Children	25/10/24	

A process has been agreed with the Integrated Care Board (ICB) to approve any PSII and close on StEIS. They are invited to the Friday Patient Safety Oversight Group if there is a PSII to approve, or an extraordinary meeting is held to allow for scrutiny and due diligence for each PSII. A meeting of this nature is scheduled for the 8th of November 2024.

5. Complaints and Concerns

In the last 9 months, the volume of incoming complaints has remained steady, with an average of 20 complaints per quarter being raised. 24% of complaints closed within this period were upheld. The average length of closure of complaints was 87 working days as compared with 114 working days for the previous year.

The status of complaints is tracked and managed via weekly divisional meetings, and overall performance and learnings are cascaded in the monthly divisional meetings and Safety Surveillance.

Around 700 concerns are raised per quarter. The top three concern themes are appointment issue, communication, and general enquiry. 35% of concerns are linked to appointment issues. ENT has experienced the highest volume of concerns, with a notable increase in 2024. Of the appointment related concerns, the three commonalities are evident: long waits, appointment cancelled and quality of the consultation. Improvement actions are in place such as the ENT service are completing an internal review to improve the service including communication and the Patient Experience Portal and website information.

6. Legal – Coroners and Claims

There are a total of 35 open coroner's inquest investigations.

During the period 1st July 2024 to 31 August 2024 the coroner notified the Trust of 6 new investigations, 5 were for Urgent Care Care and 1 for Planned Care

Table 5:

Reason for Inquest	**Urgent Care**	**Planned Care**	**Women & Children's**	**Diagnostics & Infrastructure**
Unnatural death	1			
Delay in treatment (NWAS)	1 interface incident			
Accident - In Hospital Fall	1			
Industrial disease	1			
Adverse reaction to prescribed medication	1			

Reason for Inquest	Urgent Care	Planned Care	Women & Children's	Diagnostics & Infrastructure
Accident – out of hospital fall		1		
Totals	**5**	**1**		

There were 5 inquest investigations attended/closed by HM Coroner during the period July 2024 to 31 August 2024**.**

The Trust was required to address concerns raised by the coroner at the inquest hearing in relation to urgent referrals made to the South Mersey Arterial Revascularisation Team (SMART), hosted by the Countess of Chester Hospital.

- *Whilst there is a triage process for the urgent referrals to the vascular team the urgent referrals cannot be processed as urgently as I would like and there is a risk of deaths occurring as some urgent referrals are not seen early enough."*
- *there is a risk of deaths occurring in the future due to there being insufficient staff to treat those who have correctly been referred urgently to the vascular team at the Countess of Chester Hospital.*

The Trust was required to respond to the coroner's concerns within 56 days to provide assurance, and response as below:

- Appointment of a Specialist Grade doctor in vascular surgery which has enabled COCH to increase outpatient appointment slots by 384 new slots per annum.
- Additional capacity has been enabled within our Same Day Emergency Care Centre (SDEC) which has enabled the vascular on call team to see urgent patients who cannot wait until a clinic slot is obtained. A further advantage of the SDEC is that it has immediate access to imaging if it is needed.

There are a total of 175 open potential claims, this is where disclosure of medical records has taken place with litigation in mind, but no formal allegations made to date.
During the period 1 July 2024 to 31 August 2024 a total of 6 new clinical negligence claims were reported to NHS Resolution (NHSR). There are a total of 98 ongoing actual claims investigations.

A new process is in evolution, to enable robust preparation, timely reports and investigations and providing support for coroner inquests is being established with the development of an inquest log supported with a weekly review of all coroner inquests and oversight from the Deputy Director of Nursing and the Legal team.

7. Incident and Learning Oversight

With the introduction of the Patient Safety Incident Response Framework (PSIRF), and in conjunction with the Harms Improvement Workstreams, the trust has been developing steering groups to reduce silo working, duplication and reporting mechanisms, new oversight meetings have been introduced. The forums for these are as follows:

Weekly Patient Safety Incident Oversight meeting – every Friday, attended by executives, this forum reviews moderate and above incidents from the previous week, has an action log to ensure timeframes for incident responses are maintained and learning outcomes monitored and measured.

Weekly Learning presentation shared Trust wide – Appendix 1

Monthly Safety Surveillance and Learning Group – themes and trends presented, learning outcomes shared, this will include going forward, learning from deaths and coroner inquests

Monthly Harms Oversight Steering Group – Every month three of the eight harms improvement projects present an update with the recommendation that a quarterly report will be presented at the Quality Governance Group (QGG).

Harms Improvement Projects are as follows:

- Pressure ulcer prevention
- Falls management
- Sepsis identification and management
- Acute kidney injury (AKI)
- The Trust Emergency Department (ED) improvement strategies and plans
- Medication incidents
- The deteriorating patient
- CDIff and E coli

Examples of learning for this reporting period are:

Clinical Support Worker (CSW) clinic in the Emergency Department (ED) to allow for weighing of patients on arrival and completion of risk assessments – drive improvements in 6-hour risk assessments

CDIFF reviews: New Electronic Patient Record template to be utilised and circulated to ward managers and raised at safety brief: Improved use of acute diarrhea chart and Infection, Prevention & Control to be contacted prior to any samples being sent.

Completion and documentation at triage of GCS (Glasgow Coma Scale) for any patient with a head injury

.

Triangulation of pressure ulcer reviews – highlighting themes – weekly meeting in place
Further Improvements

To continue the improvements, to be included in future papers, is

- Learning from deaths/coroners/Medical Examiners
- Thematic Review of all After Action Reviews (AAR)
- Duty of Candour compliance

8. RECOMMENDATIONS

The Board of Directors is asked to:

- Note the contents of the paper.
- Note the assurance that the Trust is continuing to promote a learning culture with evident and measurable actions to improve patient safety.
- Note the improvements in governance and oversight workstreams within the Countess of Chester Hospital
- Note the approval of the Quality & Safety Committee of the recommendation that a quarterly Harms Improvement Paper is presented, and a Safety Surveillance Paper is presented at each QGG (i.e. 6 a year, that will replace the quarterly Integrated Incidents Complaints and Concerns paper but increased frequency of reporting).

Appendix 1

Weekly Learning at COCH

Skin Integrity

Please ensure there is documented record of conversations held with patients when they decline treatment.

Staff to use reflective communication to ascertain the patients level of understanding in their decision making.

Safeguarding

All patients who are on a Deprivation of Liberty Safeguard (DoLS) must have a 'This is Me' or a patient passport in place.

All DoLS applications must be completed on a non-mobile computer that has a full Microsoft word package in place.

If a patient is already known to the Safeguarding Team and further safeguarding concerns come to light, please ensure that the team are made aware of the new information.

Sepsis Screen

The sepsis screening 'pop up' will appear on EPR for any patient with a NEWS of five or more, or score of three in one parameter.

Please ensure that this screen is completed for all patients where this 'pop up ' appears. All staff must screen for sepsis where appropriate.

Oxygen Therapy

Please ensure that patients on oxygen being transferred onto a ward have oxygen therapy connected to the mains supply at earliest possible time.

Long Acting Insulin and Variable Rate Insulin Infusions (VRII)

Please ensure long acting insulins are given alongside VRIII when they are prescribed.

Datix: Medication Categories

The medication categories on Datix have been improved to make the data more meaningful and help us to identify medication safety issues more easily.

Themes to Focus on for 'Striving for Excellence'

- Understanding of the Patient Safety Incident Reporting Framework (PSIRF)
- Personal Protective Equipment (PPE) usage
- Segregation of clinical and domestic waste
- Care planning and assessment completion

Controlled Drug Checks

Please ensure that all controlled drugs are checked once during every 24 hour period and records clearly reflect a check each calendar day.

Improvement Hub

The Improvement Hub is where you can view, log and share improvements that are being made across the Trust. Click on the icon on the intranet for more information.

WEEK ENDING 25 th October 2024

Be Kind *Be Safe* *Be Respectful*

PUBLIC – Board of Directors
26th November 2024

Report	**Agenda Item 13.**	**Care Quality Commission (CQC) Improvement Plan including Well Led**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Laura Leadsom			Deputy Director of Governance & Risk				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Linked to all BAF areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Executive Directors Group – 13th November 2024							
Executive summary	The purpose of this report is to provide assurance on progress with the Trusts Improvement Plan, including Well Led, in response to the regulatory breaches identified within the CQC's report and reflected within the subsequent CQC ratings. Key areas of progress include: • Successful EPR upgrade and the focus is now on optimisation. • Development of the clinical strategy has commenced. • Governance Handbook has been reviewed and options are currently being explored. • Coronial care governance continues to be strengthened. • Risk management improvements. • Policy recovery programme and process improvements. • Improvements have been made following the 2023 staff survey and there is a strong campaign to support engagement with the 2024 staff survey.							

	• Development session held and further workshops planned with the Council of Governors. • Governance, assurance and report writing awareness raising and development sessions in progress. The consolidated Improvement Plan progress will continue to 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. Evidence to the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.
Recommendations	The Board of Directors is asked to: • **Note** the assurance on the progress of the consolidated CQC Improvement Plan. • **Note** that progress against this action plan will continue to be tracked through the Executive Directors Group and reported to the Board of Directors, together with outcomes also being reported going forward.

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

NHS
Countess of Chester Hospital
NHS Foundation Trust

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

Updated: 13th November 2024

Completed	On track	Behind schedule	Not achieved

Summary of actions progressing

NHS
Countess of Chester Hospital
NHS Foundation Trust

Actions progressing

- The EPR upgrade was successful, and the focus is now on optimisation, which includes a prioritised approach. The Trust is also encouraging participation in the national EPR survey to support further opportunity for feedback and assurance.
- The development of the clinical strategy has commenced which will support divisional strategies.
- The Governance Handbook has been reviewed and 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 Terms of Reference 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.
- Coronial care governance continues to be strengthened with closer working between the legal team and risk and governance.
- A risk management improvement plan has been developed, revised risk management policy and a new risk management committee has been introduced. The Trust is also working to improve the Datix system and reporting for risk management.
- Processes continue to be developed to support the future reviews of policies and the policy recovery programme is being progressed via the Executive Directors and leads.
- Improvements have been made following the 2023 staff survey and there is a strong campaign to support engagement with the 2024 staff survey.
- Development session held and further workshops planned with the Council of Governors.
- Governance, assurance and report writing awareness raising and development sessions in progress.

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

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 Dec 24	• Patient and Family Experience Strategy Launch Quality & Safety Strategy	• Improvement programme (Harms) demonstrating improvements • Quality and Safety strategy being developed and planned for completion in December 2024. • Monthly Harms Oversight Group commenced – quarterly reports and annual reports planned for QGG. In August 2024, 3 progress projects were presented at each meeting. • 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. • Achieving 6 out of 9 Quality priorities for the year to date, actions for 3 areas remain underway.	• 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	• Update SRO and include registration of Tarporley Hospital. • Review if action has been complete.	• Identified lead for CQC – DON • Change to the statement of purpose submitted to the CQC confirming that Tarporley War Memorial Hospital is a satellite of the Countess of Chester Hospital NHS Foundation Trust for the provision of Outpatients and a Community base.	Awaiting confirmation from CQC.	• Q&S Committee	• CQC Registration Documenta-tion

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
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 Dec-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 • First Risk Management Committee to be held on 12th November 2024. • 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 Dec 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 (date TBC)** • **Introduction of 'This is me', using volunteers to support family to complete documentation.** • **All patients subjected to DoLS are reviewed by adult complex care team to ensure personalised care plans are in place, in line with the KPI of 72 hours.**	• 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 Dec-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 Nov-24	• MUST screening to be launched in July 24 in ED.	• Scales purchased for ED • Mealtime coordinators in place across all wards. • Nutritional risk assessments should be undertaken for all patients – this needs improvement as compliance is low. The compliance and outcomes for this are monitored at the Nutrition and Hydration Steering Group. • When assessing the current food provision against the British Dietetic Association standards the Trust recognised itself as partially compliant in this area. Work is underway to review the establishment within the dietetic team to address how these areas of non-compliance can be addressed. • The Trust has yet to fully demonstrate the BDA standard of "Existence of a menu planning working group, meeting minutes and/or project planner. Evidence must show involvement of Registered dietitian throughout the process. Patient satisfaction surveys and patient involvement.	• Nutrition Support Group • Senior Nurse Meetings • Must Assessment Compliance • Patient Survey Results • Patient Experience Strategy • Complaints	• Q&S Committee	• OMB • QGG • SOF • Nutrition Annual Report to BoD

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

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S3	Patient Experience & Staff Feedback	TW	The trust should implement effective patient engagement in the development of the trust's services.	SP	~~Aug-24~~ Review Dec 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. Further update provided to the Quality & Safety Committee held in November 2024, action plan is in place and is progressing.	• 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

NHS Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S13	Environment inc. Equipment	MED	The service should ensure that patients' privacy, dignity and confidentiality is maintained in the reception area.	SP	Mar-25	• Staff need to ensure that the privacy and dignity for patients is maintained within the reception area at all times.	• Nurse allocated to waiting room in ED in all shifts to oversee the care of patients • Interim national inpatient survey results are improved in relation to privacy and dignity of care for patients . • Capital funding has been allocated to extend the ED footprint; one initiative will be to provide designated spaces in the wait area for personal conversations. • Improving privacy and dignity.	• 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
S17	Patient Assessment	MAT	The trust should continue to embed the changes made to the triage systems and processes.	SP	Mar-25	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan	• Triage process in maternity embedded – **Completed.**	• All patients triaged as per the process	• Q&S Committee	• Quarterly Maternity Assurance Reports to BoD

Action Plan:

Owner: Cathy Chadwick – Chief Operating Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
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	A system discharge summit was held in September 2024 where system partners came together and agreed a set of actions. The main one being where we assess patients and the need for additional P2 capacity whilst longer terms plans are worked through. ICB and LA colleagues have been asked to identify a further 20 P2 beds. 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. Further work to be co-ordinated internally to link to wider improvements to patient flow.	• 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. Following identification the CNIO and pharmacy colleagues helped provide further training. As a result, no further incidents of this issue have been recorded. A request has been made to the EPR system supplier develop further system controls. **Completed.**	• 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

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring	Committee	Assurance
M50	Risk and Complaints Manage-ment	CYP	The trust must assess and manage the risks relating to the electronic patient record system and transcription services. The trust must improve the quality of the services provided and ensure this did not impact on delays to patients care and treatment.	JB	Review Dec-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.	• A process review of the eDischarge process has taken place. The review found no system based delays. Users have been retrained on the process where necessary. Enhanced reporting is being developed to aid with operational monitoring. • 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. The Trust strategy has been socialised with dedicated Team Brief sessions for Day and Night Staff. The strategy has also been an integral part of developing the Trust clinical strategy and has been shared with internal and external stakeholders. Clinical strategy day was held on 24th October 2024. Some 50 operational and clinical leaders from across the Trust were in attendance. A thematic is now being prepared for refinement by Associate Medical Directors to help shape a draft strategy by December 2024.	• Delivery of the strategic goals and objectives within the overall Trust are a core component of respective executive Director portfolios and will be reported to the Board of Directors on a quarterly basis. • Trust Strategy approved in June 2024. • Launch of the women & children's strategy in July 2024. • **The strategic themes within the strategy are integrated into the Board Assurance Framework to monitor progress and are now part of all staff appraisals**	• 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 Trust has agreed a secondment from psychiatric liaison services to undertake a dedicated review of mental health provision, inclusive of Ed and all ward areas. A specification has been agreed which includes Mental Health, Learning disabilities, Autism and dementia services. The review is expected to report in two months with progress being monitored though the Mental health group	• 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.	• A health inequality framework and awareness raising / training workshop was held for Board Directors 29/10/2024. • Draft framework has been developed and co-produced with local authority public health colleagues	• 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

NHS Countess of Chester Hospital NHS Foundation Trust

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). All Wards have now been assessed and 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. PLACE review held w/c 28th October 2024 at site and EPH and Tarporley held w/c 4th November 2024 which includes spot checks as identified within the actions required. **Completed.**	• 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 Dec-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 . • Position statement regarding the management and assurance regarding medical devices and equipment, including an action plan with responsible persons and timeframes, presented to the Quality Governance Group held in October 2024. It has been agreed for this to monitored via QGG quarterly. • Medical Devices Officer appointed and due to commence at the Trust in December 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
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 January 2025	• 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-baracade 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. First two assessments (ED and AMU) were conducted on 05/11/2024 and were led by the Deputy Director of Nursing & Quality Governance, Health & Safety and Estates representation. It has been agreed that the champion for this Policy to be enacted across the Trust will be the newly appointed Health & Safety Manager (start date currently awaited). • 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. **Completed**.	• 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 January 2025	• UEC Improvement plan • Full review of the trust premises to ensure fit for purpose in line with best practice guidance.	• H&S action plan to be progressed further by the newly appointed Health & Safety Manager (start date currently awaited). • The Trust have employed Nifes to undertake a • 6 Facet Survey of the acute estate and the final version of the survey has now been received. • H&S monitoring to be reported via the Risk Management Committee.	• 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 Dec-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 Policy revised. • Introduction of a Risk Management Committee with the first meeting held in shadow format on 12/11/24.	• 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 Dec-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 Policy reviewed.** • **Introduction of a Risk Management Committee with the first meeting held in shadow format on 12/11/24.**	• 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 October 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	Changes implemented since 2023 staff survey have been extensively communicated ahead of the launch of the 2024 survey which is open until end of November 2024. Zero tolerance campaign and posters showing our staff now produced and displayed across the trust. Comms re action taken when patients/staff abuse staff underway to build confidence in raising concerns. Bystander training in place setting out what is expected from staff and managers to actively support any colleagues suffering abuse. People Promise measures incorporated into People Strategic Plan.	• 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 induction process now BAU • New appraisal implemented fully backed by high levels of training and support • TNA for 2025/26 underway • Sub board level succession planning exercise underway. Return to region end of November.	• 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.	Level 3 compliance still an issue across medical workforce. Date in place CPO, Chief Nurse and MD to review mandatory training competencies and denominators to ensure correctly applied and review delivery methods. Additional capacity provided to ensure enough places	• 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 level 3.**	• POD	• SOF • EDG • OMB

Action Plan:

Owner: Nigel Scawn – Medical Director

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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

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~~ Review Jan-25	• 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. • SARD commissioned to undertake a capacity demand modelling for medical staff in 15 biggest specialities. Aim for revised job plans by the end of March 2025.	• Patient Flow Working Group • Streaming Task & Finish Group • KPIs / UEC Dashboard • System Improvement Board	• F&P Committee • POD Committee	• EDG • OMB • SOF
M31	Medica-tions	UEC	The trust must ensure that oxygen is prescribed as required by national guidelines.	NS	Oct-24	• Improved position on oxygen prescribing.	• **90% compliance consistently across the Trust.** • **Cerner prompt now added to support this. Completed.**	• O2 Prescribing Audits • **90% compliance consistently across the Trust.** • **Report provided to QGG and Q&S in May & June 2024 to provide further assurance.**	• Q&S Committee	• Monthly O2 Prescribing Report

Action Plan:

Owner: Nigel Scawn – Medical Director

NHS Countess of Chester Hospital NHS Foundation Trust

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	~~Nov-24~~ Review Jan 25	• Review the policy and education for relevant teams	• The non-urgent and rapid tranquilisation policy was approved at D&T pending 2 points, firstly that safeguarding were consulted on its contents and secondly that reporting and monitoring requirements were reviewed, clarified and strengthened. Education for relevant teams to be delivered by January 2025.	• 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 anaylser in situ.. • Regular monitoring through the Sepsis Improvement Group. • Sepsis care plans have been devised to be recorded within EPR, these are in draft form and work is underway with pharmacy/ microbiology re treatment options. Monitoring of sepsis screening collated monthly and discussed at monthly sepsis improvement group.	• Sepsis improvement programme (Harms) participating within the Harms Showcase (Mar-24) • AQ Compliance • Sepsis Screening Audits	• Q&S Committee	• Sepsis Assurance Report to BoD

Well Led Action Plan – KLOE 1

KLOE 1	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
1.4	• Develop a quality and safety strategy	Director of Nursing & Quality /Medical Director	~~October 2024~~ **Revised December 2024**	This is on track and will be completed by December 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 quarterly reviews have now commenced with Divisions.		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~~ ~~October 2024~~ **Revised December 2024**	Clinical strategy day was held on 24th October 2024. Some 50 operational and clinical leaders from across the Trust were in attendance. A thematic is now being prepared for refinement by Associate Medical Directors to help shape a draft strategy by December 2024,	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 January 2025**	Final 24/25 financial plan submitted in May 2024 in line with national deadlines. The financial plan has been co-ordinated with Cheshire & Merseyside ICB and national financial planning. Further work is to be undertaken on the 5-year financial plan to provide more detailed financial plan following completion of the Trust strategy and Clinical Services strategy.	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~~ **Revised December 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. 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 which were held in September / October 2024. New report template and guidance has been developed and to circulated Trust Wide. Work continues to focus on improving report writing.	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. The Trust strategy has been socialised with dedicated Team Brief sessions for Day and Night Staff. The strategy has also been an integral part of developing the Trust clinical strategy and has been shared with internal and external stakeholders.		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 socialised with dedicated Team Brief sessions for Day and Night Staff. The strategy has also been an integral part of developing the Trust clinical strategy and has been shared with internal and external stakeholders. The annual objectives are established and progress updates are embedded in the BAF reporting to Board. **Completed.**	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 December 2024**	• Zero abuse promotional programme commenced Autumn 2024. • Civility handbook produced and rolled out across trust. All new starters are provided with a copy. • Employee of the Month, Team of the month now fully implemented with high engagement levels. • Improvements have been made following the 2023 staff survey and there is a strong campaign to support engagement with the 2024 staff survey.	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~~ **Revised December 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 has been 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. Initial workshop held to agree priorities for Datix development (within October 2024) and Introduction of a Risk Management Committee with the first meeting held in shadow format on 12/11/24.		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**	• Level 3 compliance still an issue across medical workforce. • Date in place CPO, Chief Nurse and MD to review mandatory training competencies and denominators to ensure correctly applied and review delivery methods. • Additional capacity provided to ensure enough places.	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**	Update provided to the Audit Committee in October 2024 which included a forward look to policies that will become due for review in 2024/25. Processes continue to be developed to support the future reviews of policies and the policy recovery programme is being progressed via the Executive Directors and leads.		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 December 2024**	Quality priorities agreed and Quality account published with stakeholder involvement Scrutiny panel undertaken of part of Quality Account process in July 2024. The Trust is achieving 6 out of 9 quality priorities as at the end of Quarter 2 2024/25. Actions are in place for the delivery of the remaining 3 priorities and an update was presented to the Quality Governance Group held in October 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 December 2024**	• WRES and WDES published with one consolidated improvement plan. • New EDI coordinator started. • Each network has active exec champion • Focus each month at Team brief on work of one network and feedback. • Neuro diversity and disability networks now brought together for additional coverage. Renamed Enabled Network • Sexual Misconduct education sessions organised for COCH senior leaders to ensure meeting new framework requirements. • Dual new medical and nursing Chairs for BAME network group.	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~~ **Revised December 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~~ **Revised December 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~~ **Revised December 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**	Review of 7 day services undertaken. Current risk remains that weekend discharge ward rounds covered on a voluntary overtime basis.		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. Workshop held with the Council of Governors 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. Following this, there is a clear action plan in place to support Governors to fulfil their roles and further workshop sessions are planned.	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 December 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 has been revised 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 with the first meeting held in shadow format on 12/11/24.	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.		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~~ **Revised December 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
5.8	The Trust must review all training needs across all disciplines and prioritise mandatory training, EPR training and education regarding investigation reports, complaints responses, coroner cases and risk management.	Chief People Officer	~~September 2023~~ ~~April 2024~~ ~~Revised October 2024~~ **Revised November 2024**	New appraisal process and leadership development programme implemented. Revised Training Needs Analysis to take place September/October once 2024 appraisals have taken place.	Launch of new appraisal process & paperwork.	High
5.13 (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~~ **Revised December 2024**	Revised Report & cover sheet template produced with guidance included also which has been launched across the Trust. Governance and assurance slides have been developed and are being used in different forums to increase understanding and expectations.	Revised Report & cover sheet template. Governance awareness sessions being provided as part of Clinical Leaders programme and team meetings.	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	**Review December 2024**	EPR upgrade took place in Sept 2024, without any significant issues. The digital team have worked with trust colleagues to agree a list of EPR optimisations. A programme of work is now under way to deliver the optimisations. Monthly Clinical Digital Design Authority meetings take place (chaired by CCIO) to review optimisation list and agree new work packages.	Trust EPR was upgraded on 25th Sept 2024 Prioritised EPR optimisation list agreed in Oct 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 December 2024**	Awaiting 2024 staff survey results to measure improvements and areas requiring additional focus.	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 January 2025**	Nurse staffing review completed using the safer nursing tool. Review of maternity staffing also. **Completed.** Medical staffing - Review of AHP workforce and medical staffing currently being progressed. SARD commissioned to undertake a capacity demand modelling for medical staff in 15 biggest specialities. Aim for revised job plans by the end of March 2025.		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 November 2024**	An anchor institution steering group is now operational.	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 working 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~~ **Revised November 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. Further work to be co-ordinated internally to link to wider improvements to patient flow. UEC actions completed and new actions to be captured on the plan.	High

NHS
Countess of Chester Hospital
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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
7. Changes made to the post-operative care of women's & birthing people following obstetric surgery
8. Full review of maternity theatres and birthing rooms undertaken.

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.
- Fire audits undertaken
- Anchor Steering Group now operational

PUBLIC – Board of Directors
26th November 2024

Report	**Agenda Item 14***	**Bi-annual Safer Nurse Staffing Report – August 2024**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing & Quality / Deputy Chief Executive				
Author(s)	Melanie Kynaston			Deputy Director of Nursing & Quality				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X**	This assurance paper has a positive impact on BAF 1 and BAF 3.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	People Committee – 8th October 2024							
Executive summary	This paper has been produced to provide assurance that nurse establishments across wards and departments are sufficient to meet the needs of patients commonly seen within the area. The data presented relates to a 6-month period, between 1st January 2024 and 30th June 2024. The mid-year establishment review has demonstrated that most wards and departments have a budgeted nurse establishment that correlates with the last 2 SNCT data collections. There are 2 recommendations (in planned care) to change establishments in response to the findings of this review. A financial impact assessment has been undertaken and both changes can be achieved by moving resource, there is no additional funding required. The Trust continues to use temporary staffing to respond to short notice workforce gaps, vacancy and escalation during OPEL 4. Reliance on							

	temporary staffing has reduced again this reporting period.
Recommendations	The Committee is requested to note the assurance provided within the report.

Corporate Impact Assessment	
Statutory/regulatory requirements	Not applicable.
Risk	Failure to maintain quality of care would result in poorer patient & family experience.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of agenda pack.

BI-ANNUAL SAFER NURSE STAFFING REPORT – August 2024 (mid-year establishment review)

BACKGROUND

1.0 The bi-annual safer nurse staffing report is a national requirement to comply with the Care Quality Commission (CQC) fundamental standards across five domains of Safe; Effective; Caring; Responsive and Well Led. The Trust has used the NHS Improvement: Developing Workforce Safeguards framework to make a comprehensive assessment, using an evidence-based tool, professional judgement, and nurse sensitive outcomes.

PURPOSE

2.0 This paper has been produced to provide assurance that budgeted nurse establishments across wards and departments are sufficient to meet the needs of patients commonly seen within the area. The data presented relates to a 6-month period, between 1 January 2024 and 30 June 2024.

METHODOLOGY

3.0 Nursing establishments must be set using a nationally endorsed methodology, to comply with regulatory, commissioning, and professional standards. NHS England (2018) Developing Workforce Safeguards clearly sets out the framework for acute provider organisations to follow when evaluating the effectiveness of nursing establishments.

Establishments must be set using an **evidence-based acuity and dependency tool**.

Nurse sensitive outcomes must be triangulated with the data collected.

Professional judgement must be applied to the triangulated data and outcomes to ensure that specialty and environment knowledge is used to confirm the establishment is correct.

The Countess of Chester Hospital NHS Foundation Trust has implemented in full a nationally endorsed evidence-based tool to measure acuity and dependency, the Safer Nursing Care Tool (SNCT). Data is collected twice yearly over a four-week period by trained auditors (ward managers, practice development nurses, and senior nursing staff), in all adult and paediatric inpatient areas across both hospital sites.

Analysis from the data collected in this reporting period is presented in section 5.0, alongside nurse sensitive outcomes and professional judgement, with recommendations on any establishment changes needed to meet the needs of patients.

Critical Care (ITU / HDU) and Theatres are exempt from SNCT monitoring, as there is specified nurse staffing standards outlined by the relevant royal

colleges or societies. The Emergency Department (ED) establishment review was undertaken in April 2024 using the ED SNCT and the professional standards set out by the Royal College of Emergency Medicine (RCEM) and the Royal College of Paediatric and Child Health (RCPCH) in the Emergency Department. This review has been presented separately.

Maternity Services and the Neonatal Unit are outside of the scope of this mid-year establishment review and are presented separately in the Midwifery Safer Staffing Report.

SUMMARY OF FINDINGS

4.0 The mid-year safer staffing review has confirmed in most areas that the budgeted establishment is adequate to meet the needs of patients commonly seen in that ward or department. There are 2 recommended changes to establishments within the planned care division, these can be achieved by moving resource, there is no request or requirement for additional funding.

4.1 Urgent Care

The urgent care division has not made any recommendations to change nurse establishments. The SNCT data collected in September 2023 and April 2024 has in most wards correlated with the budgeted establishment. There are 4 wards (AMU, cardiology, stroke and respiratory) where the data has highlighted a possible over establishment. However, when triangulated with nurse sensitive outcomes, professional judgement and royal college or society standards it has been agreed the safe staffing template needs to remain in place and unchanged. In addition, the division are reviewing establishments outside of the ward reviews and has work ongoing in relation to the Emergency Department, Same Day Emergency Care, and Haematology Oncology Suite. These separate pieces of work will be presented to the Executive Directors Group in Q3.

4.2 Planned Care

The planned care division have put forward 2 recommendations to change nurse establishments. The SNCT data collected in September 2023 and April 2024 has in most wards correlated with the budgeted establishment. In ward 54, the review recommends a change in template, from 4/4, 4/4, 3/2 to 4/4, 4/3, 3/2. This is a reduction of 1 HCSW on a late shift. In ICU, the review recommends a change in template from 1 band 7, 3 band 6s and 9 band 5s per shift to 1 band 7, 4 band 6s and 8 band 5s. This is a skill mix change to address the challenges in senior support. In addition, an increase in band 7 hours is recommended to allow for 3 x 7.5 hours service improvement (SILs) days per month. These changes can be achieved by moving resource (please see financial impact assessment in section 7.0). In addition, the division are reviewing establishments outside of the ward reviews and has work ongoing in relation to theatres, OMFU, urology and Westminster Eye Centre. These separate pieces of work will be presented to the Executive Directors Group in Q3.

4.3 Therapies and Integrated Community Care

The therapies and integrated community care division has not made any recommendations to change nurse establishments. The SNCT data collected in September 2023 and April 2024 has in all wards correlated with the budgeted establishment.

4.4 Children's Unit

The children's unit has not made a recommendation to change the nurse establishment. The SNCT data collected in September 2023 and April 2024 has correlated with the budgeted establishment

RESULTS

5.0 The results of each ward and department are presented in divisional sections below.

5.1 **Wards in the Urgent Care Division**

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
AMU (Acute Medical Unit)	49 beds 14 monitored beds	11/7 11/7 10/7	65%	56	41	12	3	RNs 58.7 / HCSWs 25.2 **Total 83.9**	RNs 50.4 / HCSWs 27.1 **Total 77.5**	RNs 63.8 / HCSWs 36.29 **Total 100.1**
Professional Judgment During this data collection period and due to ongoing recruitment and redeployment, AMU has only achieved the new staffing template on 4 occasions. The ward spans over two ward areas, which includes 7 bays and a total of 10 single rooms, with 14 of the beds providing continuous monitoring. The current template (when achieved) enables an RN to patient ratio of 1 to 5, to deliver enhanced care in the monitored bays. This is in line with the Society of Acute Care standards. The unit has seen an increased number of mental health patients and an increased number of patients requiring 121 supervision which is not captured in the SNCT assessment. On the current establishment the unit can manage this complexity without the need for additional staff (bank or agency). **Recommendation – no change to establishment**										
Ward 34 (Care of the Elderly)	33 beds	5/6 5/6 4/6	43%	6	39	14	1	RNs 26.9 / HCSWs 40.3 **Total 67.2**	RNs 22.3 / HCSWs 29.5 **Total 51.8**	RNs 24.3 / HCSW 32.2 **Total 56.4**
Professional Judgment Ward 34 has found the increase in RNs and reduction of HCSWs by 1 per shift difficult, largely due to the layout of the ward, and enhanced supervision requirement, as visibility of all patients is a challenge to achieve. The data for this period shows the ward is providing 121 supervision to 2.11 (6%) patients every day, and zoned supervision to 5.88 (17%) patients. This places additional pressure on the HCSW workforce which is evident from the additional resource required from temporary staffing (bank and agency) for this period (but not always achieved). The ward was judged best to be managed with 5/7 due to the layout of the ward (7 smaller bays). However, the pending ward move (planned for November 2024) to a slightly smaller bed base and different layout would address the requirement for additional staff. **Recommendation – no change to establishment, continue in the short term to manage additional requirements through temporary staffing**										

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
Ward 42 (Hyperacute and acute stroke)	16 beds	3/5 3/4 3/3	45%	6	13	3	2	RNs 10.9 / HCSWs 10.9 **Total 21.9**	RNs 10.7 / HCSWs 13.1 **Total 23.8**	RNs 17.08 / HCSW 20.40 **Total 37.4**
Professional Judgement The ward was judged to be adequately and safely staffed on current staffing template, however during this data collection period the requirement to provide 121 supervision has increased to 1 (5%) patient/s per day. Due to the nature of the specialty, the acuity is high, particularly in the first few days of admission. Dependency can remain high throughout the patient's admission for those with ongoing care and rehabilitation needs, and most patients require support from a minimum of two staff to safely meet their care needs. Patients often have complex needs including naso-gastric feeding. There is also the addition of the stroke trolley space to focus on the 4 hours target for admission to the ward, SNCT data is not routinely collected on this space. Patients are often transferred to the ward immediately post thrombolysis and require 15-minute observations initially and then hourly for 24-hours, resulting in a high RN requirement. **Recommendation – no change to establishment**										
Ward 43 (Haematology)	16 beds	3/3 3/3 3/1	59%	12	16	2	2	RNs 13.3 / HCSWs 7.0 **Total 20.3**	RNs 15.1 / HCSWs 10.5 **Total 25.7**	RNs 16.08 / HCSW 11.03 **Total 27.1**
Professional Judgement The ward was judged to be adequately and safely managed on current numbers. Although there is a mix of haematology and endocrine patients, there has been an increase in the number of haematology patients admitted which has been consistent over the last 6 – 12 months. This impacts on acuity due to complex chemotherapy and other intra-venous regimes and the management of neutropenic septic patients. Nice Guidance (2019) indicates this complex care is comparable to the care delivered in a Level 2 (HDU) facility. The delivery of chemotherapy requires hourly observations and the administration of blood products. Chemotherapy regimes are often complex and range from 1 to 7 hours to deliver. In addition, ward 43 holds the Haematology Helpline telephone out of hours including weekend days (this is not captured in the SNCT data). **Recommendation – no change to establishment**										

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
Ward 44 (General Medicine)	28 beds	4/6 4/6 4/6	47%	24	22	4	4	RNs 19.7 / HCSWs 29.6 **Total 49.3**	RNs 19.2 / HCSWs 21.6 **Total 40.8**	RNs 21.4 / HCSW 24.3 **Total 45.7**
Professional Judgement The ward was judged to be adequately and safely managed on the current staffing template. However, in the previous review it was identified that the skill mix needed to be improved, with the provision of a band 6 team leader 24/7. This is actively being recruited to but in not yet in place consistently. As the only general medicine ward within the division the ward treats and cares for a range of conditions and complexities, including patients with mental health as well as physical health needs. The average number of patients requiring 121 support is 0.4 (1%), and the average patients requiring zoned supervision is 1.7 per day (6%). **Recommendation – no change to establishment, continue to work toward band 6 24/7 provision**										
Ward 45 (Gastroenterology)	28 beds	4/4 4/4 3/3	50%	6	38	6	1	RNs 25.7 / HCAs 11.0 **Total 36.7**	RNs 18.1 / HCAs 18.1 **Total 36.1**	RNs 18.9 / HCSW 18.9 **Total 37.8**
Professional Judgement The ward was judged to be adequately and safely managed on the current staffing template. Acuity of patients in gastroenterology differs from other acute wards, as they are often single organ failure with the potential to deteriorate quickly. In addition, Level 0 patients can often be unpredictable. **Recommendation – no change to establishment**										
Ward 48 and 49 (Respiratory and Unit and RSU)	27 ward beds 11 RSU beds	9/6 9/6 9/6	60%	24	28	6	2	RNs 42.0 / HCSWs 14.0 **Total 56.0**	RNs 31.8 / HCSWs 21.2 **Total 53.0**	RNs 49.3 / HCSW 32.7 **Total 81.4**
Professional Judgement The ward was judged to be adequately and safely managed on the current staffing template. This is a large 38 bedded unit which provides enhanced care in the 11 bedded RSU to patient needing non-invasive ventilation (NIV). Therefore, in addition to the SNCT data collected, the standards outlined within the British Thoracic Society need to be considered. The current model ensures that a nurse-to-patient ratio of 1 to 2 is achieved consistently for 8 out of 11 RSU beds (average NIV patients at any one time seldom exceeds 8). The remaining staffing establishment is then deployed across the area to care for ward patients. The unit commonly has patients with complex needs with a proportion of these having tracheostomies and chest drains. The average patients requiring 121 supervision equates to 0.5 (1%) for this data period and 2.7 (7%) require zoned supervision. **Recommendation – no change to establishment**										

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
Ward 50 (Care of the Elderly)	28 beds	4/6 4/6 3/5	39%	12	33	6	4	RNs 21.1 / HCSWs 31.6 **Total 52.7**	RNs 18.6 / HCSWs 29.1 **Total 47.7**	RNs 18.9 / HCSW 29.6 **Total 48.5**
Professional Judgement The ward was judged to be adequately and safely managed on the current staffing template and the April 2024 data supports this. The average patents requiring zoned supervision is 13.35 (48%) and the average 121 supervision equates to 0.5 (2%) of patients for this data collection period. Current staffing model enables an RN to patient ratio of 1 to 7. **Recommendation – no change to establishment**										
Ward 51 (Care of the Elderly)	28 beds	4/6 4/6 3/5	39%	6	50	7	3	RNs 21.2 / HCSWs 31.8 **Total 53.0**	RNs 16.0 / HCSWs 29.5 **Total 45.5**	RNs 18.9 / HCSW 30.6 **Total 49.5**
Professional Judgement The ward was judged to be adequately and safely managed on the current staffing template. The average patients requiring 121 supervision during this period was 0.83 (3%), with 3.91 (14%) requiring zoned supervision. Current staffing model enables an RN to patient ratio of 1 to 7. **Recommendation – no change to establishment**										
Modular Ward (Acute Frailty)	20 beds	4/3 4/3 3/3	58%	0	18	6	5	RNs 14.5 / HCSWs 21.8 **Total 36.3**	RNs 15.9 / HCSWs 11.5 **Total 27.4**	RNs 18.9 / HCSW 13.6 **Total 32.5**
Professional Judgement Since the last establishment review the ward has changed specialty from general medicine to acute frailty. This has changed the case mix of patients commonly seen as well as the dependency on nursing support for maintaining activities of daily living, with a higher proportion of patients needing assistance with eating and drinking, toileting and mobilisation. 121 and enhanced supervision requirements have also increased. For this data period 0.45 (2%) of patients required 121 supervision and 6.5 (31%) of patients required zoned supervision. There are 3 escalation beds that are regularly opened when the trust is in opel 4, this has resulted in the use of additional temporary staffing. **Recommendation – no change to establishment**										

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
Cardiology Unit	10 ward beds 6 CCU beds	5/2 5/2 5/2	72%	3	15	3	1	RNs 16.4 / HCSWs 5.5 **Total 21.9**	RNs 18.8 / HCSWs 7.3 **Total 26.1**	RNs 27.8 / HCSW 10.7 **Total 38.5**
The ward was judged to be adequately and safely managed on the current staffing template. This unit has 6 cardiac monitored beds, 10 ward beds and 4 telemetry beds. It provides enhanced care in the 6 bedded CCU to patient needing continuous monitoring and invasive and non-invasive interventions to maintain cardiovascular stability. Therefore, in addition to the SNCT data collected, the standards outlined within the British Cardiovascular Society need to be considered. The society suggests that the nurse patient ratio should not fall below 1 RN to 2 patients plus team leader. However, the current model provides an RN ratio of 1 to 3 for the 6 monitored beds and 1 to 5 for the non-monitored cardiology beds, with a supervisory team leader 24/7. **Recommendation – no change to establishment**										

5.2 **Wards in the Planned Care Division**

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
Ward 40 (Welsh medically fit cohorted patients)	11 beds	2/2 2/2 2/1	57%	0	13	1	0	RNs 9.0/ HCSWs 4.9/ **Total 13.9**	RNs 8.7/ HCSWs 6.6/ **Total 15.3**	RNs 10.72/ HCSWs 8.20/ **Total 18.92**
Professional Judgment Since the last establishment review the ward has changed specialty from general medicine (outlier ward) to medically optimised patients awaiting placement. The ward was judged to be adequately and safely managed on the current staffing template. This has changed the case mix of patients commonly seen as well as the dependency on nursing support for maintaining activities of daily living, with a higher proportion of patients needing assistance with eating and drinking, toileting and mobilisation. This change has not increased harm, however, there have been some delays in basic care being delivered. As a result, temporary staff have been utilised on the night shifts to increase the template to 2/2. **Recommendation – no change to establishment, a decision has been made to not change the budget at this time, this will be reviewed following September's data collection**										

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
Ward 41 (Trauma and orthopaedics)	29 beds	4/6 4/6 3/4	40%	12	13	8	0	RNs 29.4 / HCSWs 15.8 **Total 45.3**	RNs 19 / HCSWs 28.6 **Total 47.6**	RNs18.92 / HCSWs 28.12 **Total 47.04**
Professional Judgment The ward was judged to be adequately and safely managed on the current staffing template; no further change is needed to the existing model. There has been a significant reduction in harms in 2024 when compared to 2023 data. **Recommendation – no change to establishment**										
Ward 52 (Emergency General Surgery)	28 beds	4/3 4/3 4/3	51%	18	24	2	3	RNs 22.7 / HCSWs 12.2 **Total 35.0**	RNs 18.6 / HCSWs 17.9 **Total 36.4**	RNs18.92 / HCSW 17.88 **Total 36.8**
Professional Judgment The ward was judged to be adequately and safely managed on the current staffing template; no further change is needed to the existing model as this was uplifted previously. There is an increase of HCSWs in the agreed model and 77% has been recruited and appointed to. The ward is managing the challenge of now onboarding and deploying the new staff. There has been a significant reduction in pressure ulcers in 2024 compared to 2023 (by 86%), although an increase in falls has been noted (by 11%). The acuity of patients has been a challenge, the ward is the only emergency general surgical area in the trust, which means there is a high proportion of acutely unwell and critical care step-downs cared for in this area. Once the ward is fully recruited to it will become the tracheostomy cohort ward within the division. **Recommendation – no change to establishment**										
Ward 53 (Vascular)	26 beds	4/4 4/4 3/3	49%	12	34	10	0	RNs 23.0 / HCSWs 12.4 **Total 35.3**	RNs 19.8 / HCSWs 20.6 **Total 40.4**	RNs 18.92 / HCSWs 19.92 **Total 38.84**
Professional Judgment The ward was judged to be adequately and safely managed on the current staffing template; no further change is needed to the existing model. There has been a reduction in falls (by 12%) in 2024 when compared to that same period in 2023, with learning outcomes being embedded. **Recommendation – no change to establishment**										

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
Ward 54 (Elective Surgery)	27 beds	4/4 4/4 3/2	54%	12	15	2	2	Data collected excluded open escalation beds and does not reflect ward acuity or demand	RNs 16.3 / HCSWs 13.9 **Total 30.1**	RNs 18.92 / HCSWs 16.39 **Total 35.31**
Professional Judgment Following the spring review there has been a change in the staffing model to incorporate the increase of beds from 15 to 27, in addition, the staffing models for ward 54/56 has been separated so that they are now two stand-alone wards. The ward leadership was also split, and all vacancies created following this are actively being recruited to (46% achieved to date). There has been an increase in falls and C-Diff in comparison to 2023, this related to the increase in bed base and the change in patient case mix. The ward was judged to be slightly over established on HCSWs and professional consensus was to reduce the template by 1 HCSW on a late shift and continue to actively recurrent to the remaining vacancies. **Recommendation – change template to 4/4, 4/3, 3/2**										
Ward 56 (Urology and ENT)	11 beds (escalates to 14)	2/2 2/2 2/1	57%	0	8	0	1	Data collected excluded open escalation beds and does not reflect ward acuity or demand	RNs 7.6 / HCSWs 5.8 **Total 13.4**	RNs 10.72 / HCSWs 8.2 **Total 18.92**
Professional Judgment The ward was judged to be adequately and safely managed on the current staffing template; no further change is needed to the existing model. Following the spring review the staffing models for ward 54/56 has been separated so that they are now two stand-alone wards. There are 3 escalation beds that are regularly opened when the trust is in opel 4, this is absorbed within the current staffing model. **Recommendation – no change to establishment**										

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
JAU (Joint Arthroplasty Unit – Jubilee Day Centre)	9 ward beds	2/0 2/0 2/0	100%	-	-	-	-	NA as unit was not fully operational at the time of previous data collection	Budget is incorporated into Jubilee Day Centre. 2 RNs per shift 24/7 for 9 patients.	
Professional Judgment The ward was judged to be adequately and safely managed on the current staffing template; no further change is needed to the existing model. This ward does have a change of functionality based on service needs, therefore the staffing model needs to be responsive to meet demand. When there are no joints scheduled the elective programme is maximised using the JAU beds, this sometimes requires an additional HCSW at a weekend, which is managed using temporary staffing. **Recommendation – no change to establishment**										

5.3 **Wards in the Therapies and Integrated Community Care Division**

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
Bluebell	24 beds	3/5 3/5 2/3	38%	10	17	7	1	RNs 13.0 / HCSWs 21.3 **Total 34.3**	RNs 13.6 / HCSWs 22.2 **Total 35.8**	RNs 13.56 / HCSWs 21.75 **Total 35.31**
Professional Judgment Since the previous SNCT establishment review the staffing levels on Bluebell were increased. These posts are being actively recruited to, however, not all staff are currently in post. Therefore, there are occasions where the staffing numbers per shift are below to recommended template. All posts will be filled by late Autumn 2024. Bluebell ward provides general rehabilitation, medical and nursing care to 24 mixed sex elderly care patients with an expected LOS of 21 days. The ward layout requires staff to be present in the bays at all times as there is no clear line of sight from anywhere else in the ward. Patients are actively encouraged to be independent which places them at an increased risk of falls/ mobility incidents. Over recent years the medical acuity of patients transferring to EPH for rehabilitation has risen; with patients requiring higher levels of nursing and medical care. The new establishment figures are inclusive of the provision of one enhanced supervision bay on the ward. Medical responsibility is currently provided by the Divisional Associate Medical Director whilst a replacement for the previous consultant is sourced and a ward round is undertaken on a weekly basis. Day to day medical management (Monday – Friday office hours) of the patients on Bluebell Unit is provided by an Advanced Clinical Practitioner. Out of hours (overnight and at weekends) medical support is through the on-call registrar based on										

the main Countess site, this is an initial telephone call via the hospital bleep system which then may require the patient to be transferred back to the Countess main site. Critical outreach or resus team are not available at EPH.

Recommendation – no change to establishment

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
Poppy	19 beds	2/5 2/5 2/2	36%	3	15	7	1	RNs 10.0 / HCSWs 17.9 **Total 27.9**	RNs 11.7 / HCSWs 20.7 **Total 32.4**	RNs 10.72 / HCSWs 19.23 **Total 29.95**

Professional Judgment

Since the previous SNCT establishment review the staffing levels on Poppy were increased. These posts are being actively recruited to, however, not all staff are currently in post. Therefore, there are occasions where the staffing numbers per shift are below to recommended template. All posts will be filled by late Autumn 2024. Poppy ward provides general rehabilitation, medical and nursing care to 19 mixed sex elderly care patients with an expected LOS of 21 days. The ward layout requires staff to be present in the bays at all times as there is no clear line of sight from anywhere else in the ward. Patients are actively encouraged to be independent which places them at an increased risk of falls/ mobility incidents. Over recent years the medical acuity of patients transferring to EPH for rehabilitation has risen with patients requiring higher levels of nursing and medical care. The new establishment figures are inclusive of the provision of one enhanced supervision bay on the ward. Medical responsibility is provided by a care of the elderly physician from the Countess site and a ward round is undertaken on a weekly basis. Day to day medical management (Monday – Friday office hours) of the patients on Poppy Unit is currently provided by a senior house officer through temporary staffing, ordinarily this is provided by an Advanced Clinical Practitioner however following the previous post holder leaving this is currently out to recruitment. Out of hours (overnight and at weekends) medical support is through the on-call registrar based on the main Countess site, this is an initial telephone call via the hospital bleep system which then may require the patient to be transferred back to the main site. Critical outreach or resus team are not available at EPH.

Recommendation – no change to establishment

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
Stroke Rehab	17 beds	2/5 2/5 2/3	38%	2	14	3	1	RNs 10.4 / HCSWs 16.9 **Total 27.3**	RNs 10.1 / HCSWs 16.4 **Total 26.5**	RNs 13.56 / HCSWs 21.75 **Total 35.31**

Professional Judgment
Since the previous SNCT establishment review the staffing levels on Stroke Rehab were increased. These posts are being actively recruited to, however, not all staff are currently in post. Therefore, there are occasions where the staffing numbers per shift are below to recommended template. All posts will be filled by late Autumn 2024. Stroke Rehabilitation provides specialise rehabilitation, medical and nursing care to 17 mixed sex stroke patients. The ward layout requires staff to be present in the bays at all times as there is no clear line of sight from anywhere else in the ward. Patients are actively encouraged to be independent which places them at an increased risk of falls/ mobility incidents. Over recent years the medical acuity of patients transferring to EPH for rehabilitation has risen with patients requiring higher levels of nursing and medical care. Medical responsibility is provided by stroke / care of the elderly consultant from the main Countess site and a ward round is undertaken on a weekly basis. Day to day medical management (Monday – Friday office hours) of the patients on Stroke Rehab is provided by an Advanced Clinical Practitioner (Nurse Consultant frailty). Out of hours (overnight and at weekends) medical support is through the on-call registrar based on the main site, this is an initial telephone call via the hospital bleep system which then may require the patient to be transferred back to the Countess site. Critical outreach or resus team are not available at EPH.
Recommendation – no change to establishment

5.4 Children's Unit

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of mod or above incident	Number of HDU bed days	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
Children's Unit	22 beds	5/1 5/1 4/1	82%	1	1	32	0	RNs 20.39 / HCSWs 6.25 **Total 26.64**	RNs 23.75 / HCSWs 9.20 **Total 32.95**	RNs 21.99 / HCSWs 8.57 **Total 30.56**

Professional Judgment
Since the previous SNCT establishment review there has been an increase in band 5 RNs to comply with regulatory standards and there is now a supernumerary band 6 team leader on all day shifts (early and late). The team are actively recruiting to the increase in band 5's and new starters are joining the team in September 2024 and following any supernumerary period the team will be fully established. There are occasions where staffing numbers per shift are below the recommended template and the team leader in this case steps into the numbers and is not supernumerary. The establishment is also mapped against the RCN staffing guidance regarding the number of nurses to the correct age ranges. The children's inpatient unit cares for HDU patients, has adolescent facilities, isolation cubicles and a mixed bay. This staffing review has demonstrated that the current establishment is adequate and where acuity increases, temporary staff are sources in real-time to respond. However, in 2025 the children's unit will move to a new purpose-built unit and the environment and layout will be significantly different. Therefore, a nursing workforce plan will need to be completed by the division and presented to Executive Directors outside of the bi-annual safe staffing review.
Recommendation – no change to establishment

5.5 Adult Intensive Care Unit (ICU)

Area	Number of funded beds	Current staffing template	RN to HCSW %	Number Admin Drug Errors	Number of Falls	Number of HAPUs	Number of C-Diff Infections	SNCT Data September 2023	SNCT Data April 2024	Current Budgeted Establishment
ICU (Intensive Care Unit)	15 beds 7 Level 3 8 Level 2	13/1 13/1 13/1	93%	7	1	1	5	Excluded from data collection.	Excluded from data collection.	RNs 69.69 / HCSWs 5.36 **Total 75.05**

Professional Judgment
ICU is excluded from SNCT data collection as staffing levels are determined by the Intensive Care Society (ICS) Levels of Care as outlined in the General Provision for Intensive Care (GPICs) standards. The establishment has been set using this methodology which allows for a nurse-to-patient ratio of 1 to 1 for level 3 patients and 1 to 2 for level 2 patients. In addition, there is a supernumerary float nurse as the unit is 100% single rooms and supernumerary team leader. Following the spring review there was a change in the staffing model, taking the skill mix per shift to 1 band 7, 3 band 6s and 9 band 5s. However, this has resulted

in a diluted skill mix and has limited the senior nurse support available on shift. To mitigate this there is more than 50% of nursing staff trained in the ICU post graduate qualification and 83% of the nursing workforce have completed step 1 competencies (predicted to improve further to 97% December 2024). However, the skill mix remains challenging, with the additional managerial responsibilities being undertaken by the band 7 team leader. In addition, the Cheshire and Mersey Critical Care Network (CMCCN) have withdrawn funding for the 7.5 hours per week for the Service Improvement Lead (SILs), which has resulted in limited capacity at band 7 level to progress service development.
Recommendation – to increase skill mix per shift to 1 band 7, 4 band 6s and 8 band 5s, to increase band 7 establishment to allow for 3 x 7.5 hours SILs days per month.

5.6 Theatres

The theatres department consists of 17 theatres inclusive of local anaesthetic (LA)
and minor operations. In addition, the department provides a 24-hour service 7 days a week to radiology, endoscopy and maternity. Theatres are excluded from SNCT data collection as staffing levels are determined by the models needed to comply with the Association for Perioperative Practice (AfPP) standards. During weekday hours, 4 of these theatres run core emergency activity. This includes a general emergency theatre, vascular emergency theatre, plastics emergency theatre and orthopaedic trauma theatre. The department provides the following provision out of hours from 8pm to 8am 7 days a week:

- 1 general emergency theatre (2 theatre practitioners, 2 ODP/anaesthetic practitioner and 2 HCSWs on-site)
- Maternity theatre (1 theatre practitioner and 1 HCSW on-site)

In addition, other services are supported by the onsite ODP/anaesthetic practitioner, these are maternity emergency theatre, cardiac arrest team, endoscopy, interventional radiology and MRI.

Furthermore, to enable an additional emergency theatre to be opened at any time out of hours, there is an additional on-call provision 7 days a week between 8pm and 8am. This consists of 1 theatre practitioner, 1 anaesthetic practitioner and 1 HCSW.

It has been acknowledged that the theatre department staffing establishment does not meet the current demand nor provide the correct level of senior provision required. This is due to incremental increases in activity, in addition to a short notice requirement to support maternity theatres following the Care Quality Commission (CQC) Inspection in 2022. Although some investment was received into the theatre budget following the previous establishment review, the current theatre establishment still does not comply in full to the AfPP standards. The current staffing template to support a safe model across all areas, is being achieved using temporary staff (bank, agency and overtime) at cost pressure.

During this reporting period the Director of Nursing and Quality commissioned a review by AfPP to measure compliance against a range of national standards, including workforce. The AfPP report has been received by the trust in August 2024 and it includes recommendations to ensure a safe staffing model.

The recommendations are currently under consideration and include:

- Increasing the total establishment from 231.0 to 243.0 WTE
- Taking over maternity theatres staffing in full (hybrid cover arrangement currently in place)
- Increasing the ratio of the number of band 6 to band 5 staff to enhance skill set across specialty theatres
- Releasing time for band 7 staff to undertake leadership role

- Increasing practice development hours by 1.0 WTE to support education and training

Recommendation – undertake a detailed establishment review addressing the AfPP recommendations and present it to the Executive Directors Group (EDG) during Quarter 3.

The outcome of this review will be present in the next reporting period.

5.7 Emergency Department (ED)

The ED establishment review was undertaken in April 2024 using the ED SNCT and the professional standards set out by the Royal College of Emergency Medicine (RCEM) and the Royal College of Paediatric and Child Health (RCPCH) in the Emergency Department. This review has been presented separately. And it was agreed to uplift the band 2 to band 6 workforce to the required numbers. This has resulted in the following changes:

- Increased number of registered paediatric nurses on shift
- Increased number of registered nurses in resus
- Increased number of registered nurses streaming and triaging
- Improved nurse to patient ratio in majors
- Increased number of unregistered nurses to maintain fundamental care standards

The new establishment is currently being recruited to and it is anticipated that all staff will be in place by October 2024. When fully established, the model allows for the daily safe staffing template required to meet the needs of patients attending the emergency department. Enabling full compliance in nursing with the RCPCH standards and improved compliance to the RCEM standards. The remaining RCEM standards have been risk assessed and mitigations are in place.

Recommendation – no change to agreed establishment

5.8 Haematology Oncology Suite (Ward 60)

The clinical haematology team is accommodated in a purpose-built Haematology-Oncology Suite (Ward 60). The haematology activity occupies 70% of the ward capacity and the remaining space is used by other specialties, like, gastroenterology, rheumatology, and endocrinology.

Ward 60 is a nurse led day-case facility for chemotherapy treatments and a range of intravenous transfusions, including blood product, iron, immunoglobulins, and bisphosphonate. In addition, the team leader covers the ‘Haematology Helpline’ from 8:30am to 6.30pm, Monday to

Friday, and the out of hours the helpline is covered by the haematology inpatient ward (ward 43).

The team treat on average 25 patients per day through planned activity, however, they also provide unplanned treatment through referrals from other sources, like, haematology clinic, on advice from the helpline, or from other specialties, including but not limited to, Same Day Emergency Care (SDEC). The time to complete treatments is varied and can range from 1 to 7 hours, depending on the specific treatment and the patient response to treatment.

A substantial nurse establishment review has been undertaken over the last 2 months. It was not possible to use the nationally endorsed evidence based SNCT to undertake this review. Ward 60 is a day-case ward, and the tool is not designed for this purpose. Therefore, a thorough review of clinical activity has been undertaken, this included the number of nurses needed to undertake the range of nursing tasks and interventions required to maintain a safe and effective service. In addition, the review addresses the issues within the service of consultants undertaking nurse activities, as the establishment is currently not adequate to cover nurse related clinic activity. The assessment was also triangulated with professional judgement and has considered risks to income and opportunities to increase income.

Recommendation – the review is due to be presented to EDG during Quarter 3.

The outcome of this review will be present in the next reporting period.

5.9 **Same Day Emergency Care (SDEC)**

The Same Day Emergency Care unit (SDEC) opened in December 2022. The nursing establishment was moved from the Acute Medical Assessment Centre (AMAC) and Surgical Assessment Unit (SAU) to a new purpose-built combined unit. The nursing models did not initially change, however, some small modifications to the models have been put in place since, using staff deployed from other areas.

A full establishment review has now been undertaken (in August 2024) in response to an increase in SDEC attendances, which have grown by 56% (data from July 2023 – July 2024). There has been a significant expansion of pathways to SDEC to support the wider Urgent and Emergency Care (UEC) improvement programme. The new pathway means that most GP referrals are now seen in SDEC (90% of surgical referrals and 70% of medical referrals).

The establishment review has been undertaken using nationally endorsed evidence-based tools, the SCNT methodology and the ECIST nursing SDEC workforce tool. The outcome of the review has been benchmarked against the NHS England “Same Day Strategy”,

which outlines best practice in relation to staffing allocation across SDEC services.

Recommendation – the review is due to be presented to EDG during Quarter 3.

The outcome of this review will be present in the next reporting period.

5.10 **Oral Maxillofacial Unit (OMFU) - including orthodontics**

The dental nursing team provides specialised and dedicated support to facilitate the running of all outpatient clinics, minor ops and local anaesthetic (LA) lists in OMFU. An establishment review has been undertaken due to staffing shortfalls and loss of clinical capacity, resulting in delays. The review has demonstrated a gap in dental nursing of 3.42 WTE. This service has struggled to recruit and retain dental nurses in the past, as neighboring organisations employ dental nurses on a higher AfC band. In 2023/24 the turnover rate in dental nursing was 47%. The review makes recommendations to address the following:

- 3.42 WTE gap
- AfC banding difference
- Leadership model
- Blended workforce models, like using orthodontic therapist roles

Recommendation – the review is due to be presented to EDG during Quarter 3.

The outcome of this review will be present in the next reporting period.

5.11 **Urology Unit**

The urology unit is made up of two treatment/examination rooms and one recovery bay which is sizeable for up to 6 trollies. Cystoscopies currently take place in endoscopy with 6 sessions running per week. Activities that take place on the unit are prostate health clinics, prostate biopsies, lithotripsy, additional cystoscopy lists, urolift, administration of chemotherapy, catheter management, stent removals, diagnostic urodyamics, functional urinary investigations and self-catheterisation techniques, teach and follow up appointments. The urology unit nursing team provides specialised and dedicated nursing support to facilitate the daily running of the urology unit. The unit provides day case care and carries out minor procedures, including minor procedures under LA (this includes patients on urological cancer pathways). The urology unit also provides care for patients requiring emergency appointments.

A urology unit nurse staffing review has been undertaken during this reporting period. The review was triggered due to the increase in demand and the number of additional hours needed to maintain the service, which has been driving a financial overspend. The review evidenced a variance of 4.55 WTE.

Funded Establishment	8.98 WTE
Required Establishment	13.53 WTE

Additional funding has been sourced within the division to increase the establishment from June 2024 from 8.98WTE to 10.98 WTE to mitigate risk. Additional temporary posts have also been funded by the Cancer Alliance to support cancer pathways and surveillance. Although this has addressed some challenges, there remains a deficit of 2.55 WTE to address the risks in full and support quality improvement within the service.

Recommendation – the review is due to be presented to EDG during Quarter 3.

The outcome of this review will be present in the next reporting period.

5.12 **Westminster Eye Centre**

The Westminster Eye Centre is an ophthalmology unit that comprises of a large outpatient clinic and an ambulatory surgical day-case ward. The centre covers a large demographic, representative of the local population and treats all ages from newborn to older people. On average the centre supports 30,000 outpatients per year and performs around 4,000 operations. The department offers general ophthalmic services treating all common conditions. The centre also provides a 24-hour emergency eye casualty service 7 days per week.

A capacity and demand review has been undertaken within the service during this reporting period, to inform the workforce model needed. This highlighted additional nursing resource is required to; meet national quality and safety standards, meet service demand and flexibly support additional activity in response to risk associated with wait lists and operational priorities.

The centre is currently over established by 2.0 WTE band 5 nurses. Based on the establishment review, there is a requirement to increase the registered nurse establishment by 4.0 WTE.

Funded Establishment	31.33 WTE
Required Establishment	35.33 WTE

Recommendation – the review is due to be presented to EDG during Quarter 3 - The outcome of this review will be present in the next reporting period.

RISKS & CHALLENGES

6.0 Other considerations

6.1 Escalation

The Trust continues to operate unfunded beds in response to the pressure on UEC pathways. These beds are activated as part of the Trusts full capacity protocol, when the OPEL 4 triggers are met.

Escalation area	Number of beds
Pleural Unit	5
Cath Lab	4
Modular	3
Ward 56	3
Total	**15**

These areas are currently reliant on bank and agency staff to fill the roster. Assumption – pleural unit is only open for night shifts 5 days per week and has 5 bed spaces and cath lab is only open Friday to Tuesday 24/7 and has 6 bed spaces.

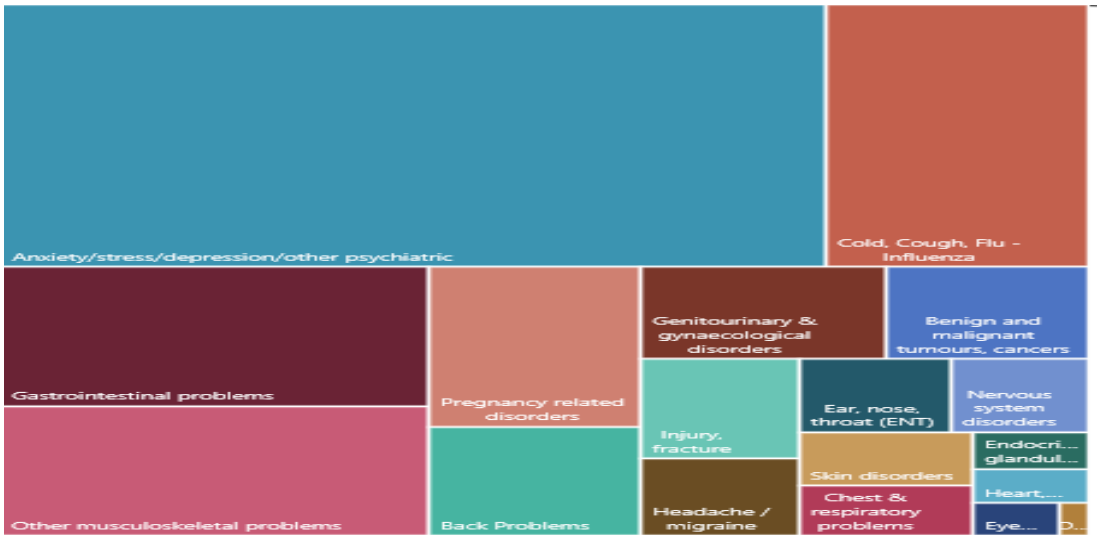
6.2 Vacancy (in WTE)

The table below provides details of the WTE vacancy in the registered and unregistered nurse staff groups. It represents the main wards and departments but excludes maternity (outside the scope of this review) and theatres due to data quality issues.

Budgeted	Actual	Vacancy	*Unavailability	Temporary staff usage	Actual working gap
Registered nursing					
850.31	810.01	**-40.30**	-133.64	60.11	-93.83
Unregistered nursing					
658.40	550.31	**-107.59**	-72.96	105.42	-75.13

**Unavailability – WTE data represents any unavailability over and above the 23% uplift*

The vacancy and unavailability of staff over 23% uplift is driving the use of temporary staff (bank and agency). The unavailability is being driven by a 9.64% absence rate across the registered and unregistered staff group. The main reasons for absence include stress and anxiety, gastrointestinal, musculoskeletal and cold/flu.


Anxiety/stress/depression/other psychiatric
Cold, Cough, Flu - Influenza
Gastrointestinal problems
Pregnancy related disorders
Genitourinary & gynaecological disorders
Benign and malignant tumours, cancers
Injury, fracture
Ear, nose, throat (ENT)
Nervous system disorders
Endocri... glandul...
Skin disorders
Heart,...
Other musculoskeletal problems
Back Problems
Headache / migraine
Chest & respiratory problems
Eye...

6.3 Use of temporary nursing staff

The use of temporary staff during this reporting period has been driven by:

- Vacancy gap following correction of nurse staffing templates in April 2024 (inclusive of ED)
- 9.6% sickness and absence rate
- Unfunded escalation beds

There has been a significant reduction in temporary staffing spend during this reporting period.

NURSE AGENCY	2023/24													2024/25					Monthly Average	Monthly Average	Straight Line Projection
Division	1	2	3	4	5	6	7	8	9	10	11	12	TOTAL	1	2	3	4	TOTAL	2023/24	2024/25	2024/25
Diagnostic & Clinical Support	£ 2,505	£ 3,402	£ 4,285	£ 10,097	-£ 6,084	£ 12,098	-£ 7,407	£ 3,976	£ -	£ 1,712	£ 3,276	£ 7,782	£ 35,642	£ 5,048	£ 1,653	-£ 4,539	£ 3,460	£ 5,622	£ 2,970	£ 1,405	£ 16,865
Nurse Management		-£ 1,420	£ -	-£ 180	£ -	£ 180	-£ 180	£ -	£ -	£ -	-£ 0	£ -	-£ 1,600					£ -	-£ 133	£ -	£ -
Planned Care Division	£ 60,341	-£ 12,732	£ 9,315	£ 986	£ 9,200	£ 14,423	£ 8,837	£ 21,858	£ 7,296	£ 8,407	£ 4,585	£ 303	£ 132,818	-£ 1,306	£ 1,062	£ 2,314	-£ 2,376	-£ 305	£ 11,068	-£ 76	-£ 916
Therapy And Int Community Care	£ 1,705	£ 1,109	£ 1,180	-£ 273	£ 484	£ 293	-£ 81	£ 2,175	£ 890	£ -	£ -	£ -	£ 7,482					£ -	£ 623	£ -	£ -
Trust Central Services	£ 3,637	£ -	£ -	-£ 5,079	£ -	£ 5,619	-£ 5,079	£ 1,442	-£ 1,199	£ 1,199	-£ 1,277	£ -	-£ 737					£ -	-£ 61	£ -	£ -
Urgent Care Division	£ 218,653	£ 280,016	£ 250,487	£ 194,654	£ 193,046	£ 161,503	£ 126,649	£ 144,608	£ 97,860	£ 88,418	£ 105,208	£ 96,497	£ 1,957,600	£ 82,337	£ 41,196	£ 47,213	£ 26,723	£ 197,469	£ 163,133	£ 49,367	£ 592,406
Women And Children Directorate	£ 76,831	£ 44,690	£ 69,059	£ 44,428	£ 56,921	£ 40,093	£ 39,517	£ 4,857	£ 11,472	£ 4,317	£ 6,097	£ 8,235	£ 406,518	£ 26,508	£ 8,656	£ 5,288	£ 5,598	£ 46,051	£ 33,876	£ 11,513	£ 138,152
Grand Total	£ 363,673	£ 315,064	£ 334,326	£ 244,633	£ 253,567	£ 234,209	£ 162,255	£ 178,916	£ 116,319	£ 104,053	£ 117,889	£ 112,817	£ 2,537,722	£ 112,587	£ 52,568	£ 50,276	£ 33,405	£ 248,836	£ 211,477	£ 62,209	£ 746,507

Agency spend during 2023/24 reached £2,5m, with an average monthly spend of £211k. During this reporting period the average monthly spend has reduced to £62k, with a forecast position for 2024/25 of £750k on nurse agency by year end.

NURSE BANK	2023/24													2024/25					Monthly Average	Monthly Average	Straight Line Projection
Division	1	2	3	4	5	6	7	8	9	10	11	12	TOTAL	1	2	3	4	TOTAL	2023/24	2024/25	2024/25
Corporate Clinical	£ -	£ -	£ -	£ -	£ -	£ 26	£ -	£ -	£ -	£ -	£ -	£ -	£ 26					£ -	£ 2	£ -	£ -
Corporate Non Clinical	£ 174	£ 0	£ 168	£ -	£ 341	£ 952	£ 7,100	£ 9,985	£ 14,777	£ 2,235	£ 1,082	£ 1,009	£ 37,822	£ 643	£ 216	£ -	£ -	£ 859	£ 3,152	£ 215	£ 2,577
Diagnostic & Clinical Support	£ 6,565	£ 5,813	£ 11,124	£ 10,844	£ 12,750	£ 7,090	£ 5,186	£ 5,536	£ 8,017	£ 5,442	£ 8,048	£ 13,772	£ 100,187	£ 9,996	£ 9,919	£ 12,630	£ 12,377	£ 44,922	£ 8,349	£ 11,231	£ 134,767
Estates And Facilities							£ 241	£ 1,599	£ 13	-£ 13	£ 3,986	£ 737	£ 6,563	£ 179	-£ 179			£ -	£ 547	£ -	£ -
Nurse Management	£ 4,734	£ 4,346	£ 609	£ 6,920	£ 10,359	£ 7,130	£ 9,130	£ 4,574	-£ 3,614	£ 2,187	-£ 14,829	£ 3,358	£ 34,904	£ 15,049	£ 9,795	£ 7,663	£ 9,887	£ 42,394	£ 2,909	£ 10,599	£ 127,182
Planned Care Division	£ 215,334	£ 169,632	£ 217,844	£ 217,822	£ 178,200	£ 214,791	£ 181,642	£ 171,473	£ 197,171	£ 190,863	£ 224,839	£ 303,535	£ 2,483,146	£ 166,812	£ 165,838	£ 197,206	£ 180,198	£ 710,054	£ 206,929	£ 177,513	£ 2,130,161
Therapy And Int Community Care	£ 110,185	£ 67,972	£ 115,846	£ 99,113	£ 67,697	£ 70,111	£ 61,547	£ 66,320	£ 68,127	£ 54,218	£ 75,553	£ 91,417	£ 948,106	£ 52,066	£ 36,077	£ 49,563	£ 45,290	£ 182,997	£ 79,009	£ 45,749	£ 548,990
Trust Central Services	-£ 139	£ 9,081	-£ 183,370	£ 6,325	£ 12,565	£ 17,559	-£ 2,951	£ 5,990	£ 1,256	£ 21,166	£ 10,760	£ 117,267	£ 15,507	£ 1,312	-£ 345	-£ 230	£ 19,250	£ 19,987	£ 1,292	£ 4,997	£ 59,961
Urgent Care Division	£ 635,770	£ 419,959	£ 697,733	£ 618,373	£ 430,870	£ 391,948	£ 310,312	£ 348,368	£ 394,541	£ 328,192	£ 504,629	£ 639,783	£ 5,720,479	£ 405,030	£ 321,103	£ 434,851	£ 388,677	£ 1,549,662	£ 476,707	£ 387,415	£ 4,648,986
Women And Children Directorate	£ 38,143	£ 31,224	£ 39,713	£ 40,634	£ 37,655	£ 32,878	£ 26,453	£ 25,214	£ 30,411	£ 27,151	£ 37,082	£ 40,359	£ 406,917	£ 28,751	£ 30,474	£ 28,349	£ 34,383	£ 121,956	£ 33,910	£ 30,489	£ 365,869
Grand Total	£ 1,010,766	£ 708,027	£ 899,666	£ 1,000,032	£ 750,437	£ 742,486	£ 598,660	£ 639,059	£ 710,699	£ 631,441	£ 851,150	£ 1,211,238	£ 9,753,658	£ 679,838	£ 572,899	£ 730,032	£ 690,061	£ 2,672,831	£ 812,805	£ 668,208	£ 8,018,493

Bank spend during 2023/24 reached £9,7m, with an average monthly spend of £812k. During this reporting period the average monthly spend has reduced to £668k, with a forecast position for 2024/25 of £8m on nurse bank by year end.

FINANCIAL IMPACT ASSESSMENT FOR RECOMMENDED CHANGES

7.0 The SNCT establishment review makes 2 recommended changes to safe staffing templates, both changes are within the Planned Care Division.

Ward 54

The review recommends a change in template, from 4/4, 4/4, 3/2 to 4/4, 4/3, 3/2. This is a reduction of 1 HCSW on a late shift.

ICU

The review recommends a change in template from 1 band 7, 3 band 6s and 9 band 5s per shift to 1 band 7, 4 band 6s and 8 band 5s. This is a skill mix change to address the challenges in+ senior support on shift. In addition, an increase in band 7 hours is recommended to allow for 3 x 7.5 hours SILs days per month.

The cost analysis below demonstrates this can be achieved within the division:

	Band 2		Band 5		Band 6		Band 7		Total	
	WTE	£	WTE	£	WTE	£	WTE	£	WTE	£
Ward 54	(1.34)	(£40,201)							**(1.34)**	**(£40,201)**
ICU			(5.36)	(£254,955)	5.36	£284,276			**-**	**£29,320**
ICU SILs							0.15	£9,436	**0.15**	**£9,436**
Total									**(1.19)**	**(£1,445)**

This change results in a slight reduction of head count and recurrent cost.

CONCLUSION

8.0 The mid-year establishment review has demonstrated that most wards and departments have a budgeted nurse establishments that correlates with the last 2 SNCT data collections. There are 2 recommendations (in planned care) to change establishments in response to the findings of this review. A financial impact assessment has been undertaken and both changes can be achieved by moving resource, there is no additional funding required.

The trust continues to use temporary staffing to respond to short notice workforce gaps, vacancy and escalation during OPEL 4. Reliance on temporary staffing has reduced again this reporting period.

RECOMMENDATION

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

Committee Chair's Report

7th November 2024, 2.15pm – 4.30pm, Boardroom – 1829 Building

Committee	Quality & Safety Committee
Chair	Professor Andrew Hassell, Non-Executive Director

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

Alert
(matters that the Committee wishes to bring to the Board's attention)

- Reducing Corridor Care – Limited Assurance. Remains an area of challenge. Lots of work continues on improving flow and on ensuring safety of patients placed in the corridor.
- Medical Device Management Report – Limited Assurance. Concerns with regards to a consolidated asset register and evidence of action plans. It was agreed that this register would be collated by the newly appointed Medical Device Safety Officer (start date to be confirmed).
- Resuscitation Report News 2 compliance My Kit check – Limited Assurance in relation to the NEWS 2 Limited Assurance and Moderate Assurance in relation to the My Kit check. The third time QGG has detailed limited assurance against NEWS2 with training compliance; performance has reached a plateau (81%). Improvement plans due to be presented to the Operational Management Board (OMB) in December 2024.
- Committee received the Association for Perioperative Practice Review Briefing Paper. Concerns in a number of areas, including issues with regards to WHO surgical checklist completion. Paper and action plan escalated to Board.
- GMC postgraduate trainee survey in Obstetrics.

Assure
(matters in relation to which the Committee received assurance)

- Maternity Service Quarterly Update - significant assurance overall. However, GMC trainee survey results of concern. The key issue appears to be rotas, an issue exacerbated by the number of trainees working less than full time hours.

Advise
(items presented for the Board's information)

The Committee noted the following from the Key Risks and Assurance report from the QGG on the 3rd October 2024 with dates for actions to be completed to be included in future updates to the Committee.

- Performance Dashboard – Moderate Assurance
- NatSSIP and LocSSIP Audit Report – Moderate Assurance
- NICE – Clinical Effectiveness assurance Report (6 months) – Limited Assurance
- Pressure Ulcer Update Report (Q1&Q2) – Moderate Assurance

- Safer Mobility and Falls Update Report (Q1 and Q2 – Moderate Assurance
- ED Improvement Framework – Limited Assurance
- Quality Accounts – Moderate Assurance
- Palliative Care and End of Life Service Review – Limited Assurance.
- Safety Surveillance and Learning – Moderate Assurance
- Safeguarding Annual Report – Moderate Assurance
- Cancer patient Experience Survey Results – Moderate Assurance
- CQC National Inpatient Survey 2023 – Moderate Assurance

The Committee received the Safety Surveillance and Learning Report – Quarter 2 2024/25 and it was noted that Mersey Internal Audit Agency (MIAA) are auditing the learning and how learning is implemented in Quarter 3 2024/25 which will be shared with the Committee.

The Committee received the Provision of Surgical Tracheostomy Care update and noted the moderate assurance provided.

Risks discussed and new risks identified

No new risks were identified.

PUBLIC – Board of Directors
26th November 2024

Report	**Agenda Item 16***	**General Medical Council (GMC) National Trainee Survey Report 2024**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Dr Nigel Scawn			Medical Director				
Author(s)	Dr Nicola Eardley			Director of Medical Education				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X**	BAF 2 – Failure to maintain safety and prevent harm would result in poorer patient care and outcomes BAF 4 – Challenges in ensuring a high quality, engaged, diverse and inclusive workforce would affect our ability to deliver patient care.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X**
Previous considerations	People Committee – 8th October 2024							
Executive summary	The purpose of this report is to provide the outcomes of the GMC National Training Survey 2024. There has been excellent engagement from trainees and trainers at the Trust with a response rate of 90.68% response rate from trainees (compared to the national average of 76%) and a response rate of 68.63% from trainers (compared to a national average of 38%). The overall trainee's results are comparable with the North West with a variable picture across the Trust, and the Trust has seen improvements in some specialties. Although the quality of postgraduate medical training across the UK remains high, the data also highlights how sustained pressures on our health services are continuing to impact doctors' wellbeing and							

	experiences at work and how service pressures can often conflict with education and training. The intensity of workloads and risk of burnout levels reported by both trainees and trainers remain very high, and while most trainees said they work in supportive environments, this wasn't reported as the case for everyone. 25% of the Trust's trainees are working less than full time hours, and by their final year half are working less than full time which is a clear change in working pattens for trainees and impacting on rotas and service provision. The top two areas of concern are rota issues and having the time to train. The new UK government is committed to supporting the Long-Term Workforce Plan in England with similar expansions in the workforce in Scotland, Wales and Northern Ireland. With national plans to increase medical school student numbers it is essential that this is mirrored by a significant expansion of educators to account for this workforce expansion. The Trust will need to balance the important need to support training, by protecting training time and providing resources and adequate support, alongside the continuing service pressures. The Trust also needs to provide support and development opportunities and make a clear commitment to protect and prioritise educators' time. The actions taken by the Trust include: • Interventions have taken place for some issues raised during the year to hopefully improve the experience going forward. • There is a new Guardian of Safe Working in post and resident doctor forums are now in place. • With regards to Consultant time to train, job planning work is taking place across the Trust and there is an updated job planning policy defining the job plan for time to train. The most striking deterioration in survey results is within Obstetrics and Gynaecology. A specific Obstetrics and Gynaecology action plan is attached as an appendix to the report.
Recommendations	The Board of Directors is asked to note the contents of the report.

Corporate Impact Assessment	
Statutory/regulatory requirements	In line with the annual process
Risk	Failure to maintain safety and prevent harm would result in poorer patient care and outcomes
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of the agenda pack

Countess of Chester Hospital NHS Foundation Trust
GMC National Training Survey 2024 Report

Nicola Eardley
Director of Medical Education
September 2024

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- Demographic of trainees across Health Education North West Deanery working less than full time training
- Trainees' risk of burnout across the Health Education North West Deanery
- Trainers' risk of burnout across the Health Education North West Deanery

1. Introduction

The annual GMC national training survey is the largest annual survey of doctors across the UK. This year over 74,000 doctors in training and trainers completed the survey. 76% of all trainees responded, slightly higher than in 2023 (74%), and 38% (as in 2023) of all trainers took part.

It is designed to gather the views of trainees about the quality of their training and the environments where they work and it asks trainers about their experience as a clinical and/or educational supervisor. The questions test compliance with the GMC's standards for medical education and training, and are organised around the following themes:

- Learning environment and culture
- Educational governance and leadership
- Supporting learners
- Supporting educators
- Developing and implementing curricula and assessments

This year for the first time the survey included analysis of some of the national training survey data by personal characteristics with the aim to support work to tackle inequalities that exist in medical education and help create supportive, inclusive, and fair environments for all doctors. A full list of questions and responses can be found at Current NTS briefing notes - GMC (gmc-uk.org) .

The survey data supports the quality assurance of postgraduate medical education. The GMC publication *Promoting excellence* sets out the standards expected of organisations responsible for educating and training medical students and doctors in the UK. The responses from the survey are used to check how these standards are being delivered, and to make sure that training across the UK is being provided in safe, effective, and appropriately supportive environments.

Doctors in training can also use the survey to report concerns relating to patient safety, bullying, or undermining that haven't been resolved locally. This information is shared with the relevant postgraduate dean, who must tell the GMC what action has been taken to address the issue.

By sharing these data, attention is called to the issues that currently affect doctors delivering and receiving training and by working with others across the healthcare system on policies or initiatives, the GMC can help to drive the necessary improvements to retain the vital skills and experience of the workforce needed for the future.

The 2024 national report can be found at https://www.gmc-uk.org/-/media/documents/national-training-survey-summary-report-2024_pdf-107834344.pdf

The report for the Countess of Chester Hospital NHS Foundation Trust has been prepared by reviewing the comprehensive data available in the GMC training survey education data tool which is freely accessible via the GMC website via the following

link: https://edt.gmc-uk.org/. The data for the Countess of Chester Hospital NHS Foundation Trust has been collated and summarised in sections to facilitate the review of results by staff and an overview reported in the following executive summary. I would encourage everyone to review and reflect on their own specialty results and consider how training could be improved further. Individuals are able to review the results at a more granular level by accessing the education data tool as above.

2. Executive Summary

The first thing to note is that there was fantastic engagement from both trainees and trainers at the Trust, with a 90.68% survey response rate from trainees (national 76%) and a 68.63% response rate from trainers (38% national).

2.1 Doctors in Training

Quality of training

Despite the many pressures on the health services, the quality of training across the UK remains high. As in 2023, 86% of UK trainees were positive about their clinical supervision and 83% said the quality of experience in their post was good or very good.

On reviewing the trainee results, it is reassuring to see that overall the Trust compared similarly to other acute Trusts although disappointingly did score in the bottom quartile for Adequate Experience and Local Teaching. These are areas which each specialty in the Trust should reflect upon and consider what improvements could be made to improve training.

Nationally, since 2022, there's been a decline of six percentage points (69% to 63%) in the proportion of trainees agreeing that their posts gave them opportunities to develop their leadership skills. Given the many systemic pressures affecting the health services, it's likely this vital aspect of training isn't being given the necessary focus and attention.

Looking in depth at each of the specialties in the Trust revealed some concerning changes from previous years with many more results in the bottom quartile across the Trust. Whilst some specialties have maintained or increased scores, there was deterioration in scores across the medical specialties and obstetrics and gynaecology. There are likely to be various reasons for this and each specialty is asked to review their own results and consider ways to improve trainee experiences. Indeed, throughout the course of the year and since the GMC National Training Survey 2023, there have been communications with various departments/specialties within the Trust based upon trainee feedback. There has been a regular Trust Junior Doctor Forum where trainees have highlighted areas for improvement and several improvements have already been made as a result e.g. review of medical cover over night.

As in previous years, trainees responding to this year's GMC National Training Survey were asked to assign free text comments to either of two dedicated categories: patient safety or bullying and undermining. There were two safety concerns raised by the Trust's trainees which were highlighted immediately to the relevant specialties and the Trust's Medical Director and formal responses were provided to the Postgraduate Dean. The were no reports of bullying or undermining. The Trust has recently published its own Culture and Civility Charter and also promotes Freedom to Speak Up processes which will hopefully continue to support the safety and culture at the Trust.

Rota design

Nationally, over a quarter (26% ↓3pp) of trainees in secondary care posts said their training is adversely affected because rota gaps aren't dealt with appropriately. Responses to questions about rota design varied between the different specialties, consistent with previous years. 42% (↓1pp) of obstetrics and gynaecology trainees said their training is adversely affected because rota gaps aren't dealt with appropriately compared to 11% (as 2023) of anaesthetics. 26% (↓3pp) of all trainees in secondary care posts felt this way. Secondary care trainers voiced similar concerns, with nearly a third (31% ↓2pp) saying that their trainees' education and training is adversely affected because rota gaps aren't always dealt with appropriately. As in 2023, trainers in obstetrics and gynaecology (46% ↓1pp) and surgery (41% as 2023) gave the highest proportion of negative responses.

There is no doubt that at a Trust level that in some departments there have been challenges affecting the workforce with gaps at consultant level and increasing gaps at trainee level. The number of less than full time (LTFT) trainees continues to increase with the percentage of trainees working LTFT more than doubling to 25.4% in 2024 as compared to 12.4% in 2019. This clearly poses challenges in covering elective and emergency work for LTFT trainees, but also for full time trainees, using traditional rotas.

There is no doubt the "rota gaps" created within traditional rotas can be hard to fill and this has compounded some of the clinical pressures already felt in some specialties. It has also resulted in the increased incidence of consultants "acting down" and taking on the duties of trainees where rota gaps have been unable to be filled. Clearly this is not ideal as this then takes consultants away from their regular practice, affecting service provision whilst also affecting morale.

It is promising that the Trust have committed to a Trust wide electronic rostering system which may help support rostering in the future but specialties and trainees may want to consider novel training and service models. The Trust may need to look at expanding its workforce with locally employed doctors and other health professionals to support service provision.

The reasons behind trainees wanting to work LTFT are varied but the majority are choosing to work less than full time to achieve a better work life balance.

Wellbeing and Burnout

Although there was a slight national improvement in the responses to questions about wellbeing, the survey results remain very concerning. Over a fifth (21% ↓2pp compared to 2023) of trainees measured to be at high risk of burnout and over half (52% ↓3pp) described their work as emotionally exhausting to a very high or high degree.

As in previous years there was a variation between the different specialties. Trainees in emergency medicine posts once again gave the highest proportion of negative responses to most of the seven questions. Over two thirds (69% ↓3pp) said their work is emotionally exhausting and 45% (↓4pp) told us their work frustrates them to a high or very high degree. While most specialties witnessed similar small decreases in the proportions of negative responses, there were some exceptions. For example, half of obstetrics and gynaecology trainees (49% ↑2pp) said they were exhausted in the morning at the thought of another day at work. And two thirds of GP trainees (66% ↑1pp) said they were always or often worn out at the end of the working day.

Discriminatory behaviours

Nationally, the majority of trainees continue to say that they work in supportive workplaces. However, findings from the demographic breakdowns of our questions about discriminatory behaviours provide insight into the extent to which unprofessional behaviours are taking place in some healthcare environments. The analysis shows that factors, including gender, ethnicity, religion, sexual orientation, and disability status affect a trainee's experience. As a Trust we need to ensure that we all have up to date Equality, Diversity and Inclusivity training and each of us need to be aware of our own behaviour, the harm of microaggressions and how to avoid being a bystander when others display discriminatory behaviour.

2.2 Trainers

Trainers are under no obligation to complete the survey and such a high response rate from Trust trainers (68.63% vs 38% national) is reflective of a motivated cohort of trainers. Completion of the GMC Training Survey and reflection is able to be used as evidence towards several domains for accreditation as a GMC recognised clinical or educational supervisor and trainers are supported to do this.

Quality of training

The Trust's trainers' overall results are comparable to Trusts of a similar acute nature and size, with no negative outlying results. When broken down into specialties however, the results are variable across the Trust, with trainers in some specialties reporting issues which need to be addressed. Challenges are similar across specialties with areas in the lowest quartile being Rota Issues and Time to Train in 3

specialties, Support for Training and Professional Development in a further 2 and Educational Governance being highlighted in 1. There will be a degree of overlap between these areas with the foundations for good training being fully staffed rotas and comprehensive job planning.

A stronger, better supported, and appropriately valued trainer workforce is a critical enabler of the national ambitious workforce expansion plans as it is dependent upon it for the development of the future senior medical workforce with the clinical leadership capability rightly expected of UK public healthcare provision.

Wellbeing and Burnout

Nationally, half of trainers are at moderate or high risk of burnout, and twenty-nine percent reported that they struggle to use time allocated for training for that purpose. As in 2023, trainers in emergency medicine gave the most negative set of responses. Despite there being a slight improvement in the responses to questions about wellbeing, the survey results remain very concerning. For the third year running, a quarter of trainers and a third of trainees in emergency medicine posts measured to be at high risk of burnout, suggesting unsustainable workplace pressures have become the norm in this specialty.

Workplace stress in healthcare organisations affects quality of care for patients as well as doctors' own health, with studies demonstrating clear links between patient safety and doctors' wellbeing.

Rota design

Nearly a third (31% ↓2pp) of secondary care trainers reported that their trainees' education and training are adversely affected because rota gaps aren't always dealt with appropriately.

It is the responsibility of employers to make sure that trainers are appropriately supported as they fulfil their responsibilities, and that training time is not eroded. Although challenges inevitably arise when the system is under extreme pressure, training must be seen as a priority - protecting training time is essential if standards are to be maintained.

It is important at the that trainers and trainees have time to train, and it can been seen that across the Trust that there are some specialties who are struggling with this, with a mismatch between training and service provision compounded by inadequately staffed rotas. It is going to become even more important to ring fence time for training as the new University of Chester Medical School commence their MB ChB programme and the Trust sees an increase in undergraduate numbers, also requiring training time, over subsequent years.

Previously there has been variation across the Trust with respect to job planning for educational time but this will hopefully become standardized with the imminent introduction of an updated job planning policy along with electronic job planning and a Trust wide review of job plans.

3. Conclusion

It is testament to the hard work and commitment demonstrated by trainees, trainers, postgraduate deans, and training providers, that the quality of postgraduate medical training across the UK remains high.

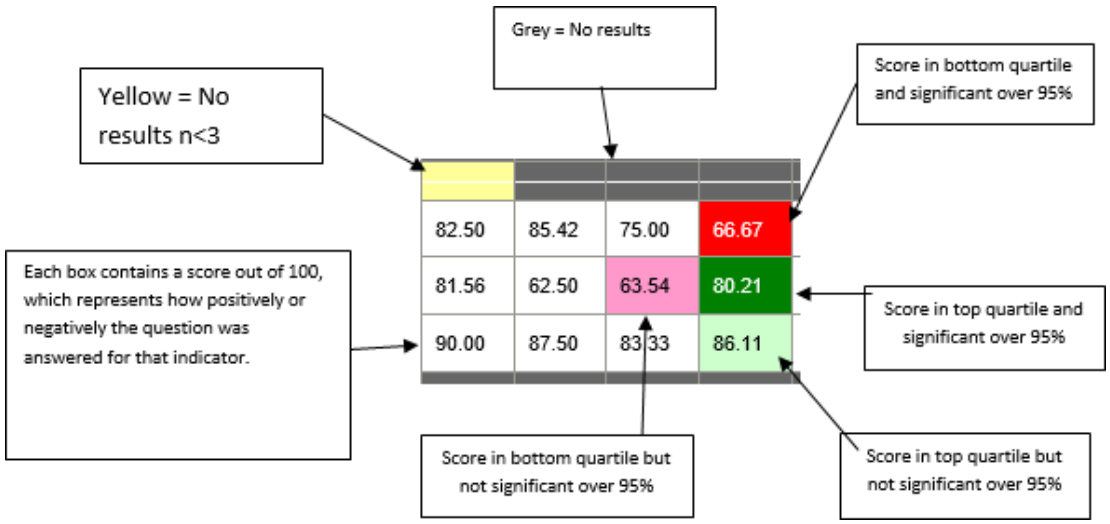
However, the data also highlight how sustained pressures on our health services are continuing to impact doctors' wellbeing and experiences at work and how service pressures can often conflict with education and training. The intensity of workloads and risk of burnout levels reported by both trainees and trainers remain very high, and while most trainees said they work in supportive environments, the demographic breakdowns to questions about discriminatory behaviours show that this isn't the case for everyone. Although the report primarily focuses on training, the rates of burnout are important as there is a relationship with high levels of burnout and worsening patient safety.

The new UK government is committed to supporting the Long Term Workforce Plan in England with similar expansions in the workforce in Scotland, Wales and Northern Ireland. With national plans to increase medical school student numbers it is essential that this is mirrored by a significant expansion of educators to account for this workforce expansion. Employers such as the Countess of Chester Hospital NHS Trust will need to balance the important need to support training, by protecting training time and providing resources and adequate support, alongside the continuing service pressures. The Trust needs to provide support and development opportunities and make a clear commitment to protect and prioritise educators' time.

4. Guide for interpreting results

Each box contains a score out of 100, which represents how positively or negatively trainee or trainers answered the questions for that indicator. If the score is significantly negative or positive compared to the national average, the box is highlighted red or green. Where it is negative or positive but shares a confidence interval with the national average, the box is highlighted pink or light green.

Key for interpreting results:



The following tables include available results for each specialty and programme in the GMC Training Survey 2024.

The “Post Specialty” includes all the programmes that have a placement in that specialty e.g. foundation, core, ST3+, GP registrar etc.

The “Programme” includes all the programmes that have a placement in that specialty specific group e.g. all anaesthetic trainees, all F1’s in medicine etc.

Where no specialty listed, less than 3 trainee responses for that specialty so data not available.

5. Overall Trainee Results for Countess of Chester Hospital NHS Foundation Trust 2024

Indicator / Year Score	2021	2022	2023	2024
Overall Satisfaction	79.35	73.68	77.38	72.6
Clinical Supervision	90.95	87.19	87.91	85.74
Clinical Supervision out of hours	89.4	84.15	84.71	83.71
Reporting Systems	73.53	70.82	73.14	67.83
Work Load	51.22	46.64	46.48	48.17
Teamwork	72.62	72.22	73.74	74.02
Handover	65.26	64.15	64.78	66.89
Supportive Environment	71.15	72.88	75.43	74.14
Induction	79.51	75.82	77.58	76.11
Adequate Experience	76.83	72.66	79.08	71.32
Curriculum Coverage	74.29			
Educational Governance	72.69	67.07	70.21	69.38
Educational Supervision	85.91	83.85	86.17	86.3
Feedback	71.94	62.54	72.2	68.37
Local Teaching	70.71	62.08	64.5	60.55
Regional Teaching	68.73	62.9	63.24	64.24
Study Leave	63.14	60.12	63.21	64.67
Rota Design	59.77	45.99	55.06	50.47
Facilities	62.36	61.74	64.78	64.31

6. Overall Trainee Results - Regional Trust Comparison Results 2024

	Alder Hey Children's NHS Foundation Trust	Countess of Chester Hospital NHS Foundation Trust	Liverpool Heart and Chest Hospital NHS Foundation Trust	Liverpool Women's NHS Foundation Trust	Liverpool University Hospitals NHS Foundation Trust	Mid Cheshire Hospitals NHS Foundation Trust	Mersey and West Lancashire Teaching Hospitals NHS Trust	The Clatterbridge Cancer Centre NHS Foundation Trust	The Walton Centre NHS Foundation Trust	Warrington and Halton Teaching Hospitals NHS Foundation Trust	Wirral University Teaching Hospital NHS Foundation Trust
Overall Satisfaction	77.13	72.6	82.72	78.55	78.55	75.87	73.29	78.68	75.2	69.55	76.75
Clinical Supervision	90.31	85.74	94.89	90.11	90.11	88.15	87.15	90	89.87	82.75	89.01
Clinical Supervision out of hours	88.53	83.71	89.77	87.61	87.61	87.52	82.11	87.81	89.58	80.43	87.35
Reporting Systems	73.85	67.83	76.67	72.87	72.87	71.34	68.02	73.09	67.09	69.17	70.24
Work Load	48.48	48.17	59.15	48.57	48.57	46.99	47.08	55.54	56.16	42.84	44.36
Teamwork	76.58	74.02	83.51	74.17	74.17	71.68	72.69	79.5	76.36	68.2	73.89
Handover	65.84	66.89	69.66	71.07	71.07	70.65	66.02	65.97	60.15	65.83	72.15
Supportive Environment	73.79	74.14	79.78	73.68	73.68	74.13	71.49	76.84	72.24	70.86	73.33
Induction	77.16	76.11	88.26	80.02	80.02	77.91	77.53	80.59	81.58	77.32	80.16
Adequate Experience	76.15	71.32	81.79	75.95	75.95	77.17	73.08	74.34	72.45	72.24	75.19
Educational Governance	67.76	69.38	78.8	70.24	70.24	69.58	67.62	72.37	72.79	66.01	67
Educational Supervision	81.96	86.3	89.54	85.72	85.72	85.85	82.85	83.22	86.1	84.01	86.27
Feedback	64.49	68.37	70.83	70.1	70.1	70.08	62.33	70.83	71.76	63.83	70.78
Local Teaching	66.02	60.55	72.83	69.79	69.79	67.91	63.48	75.13	72.55	55.43	63.39
Regional Teaching	64.32	64.24	66.85	70.57	70.57	64.96	64.53	68.31	66.49	71.27	65.23
Study Leave	72.39	64.67	82.07	72.97	72.97	61.4	62.26	68.09	77.04	64.93	63.69
Rota Design	58.11	50.47	77.03	63.36	63.36	53.35	53.37	58.33	58.69	47.48	52.09
Facilities	64.8	64.31	61.02	63.03	63.03	58.89	65.65	62.38	74.02	59.46	65.04

7. Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 Comparison Table

	Acute Internal Medicine	Anaesthetics	Cardiology	Clinical radiology	Emergency Medicine	Endocrinology and diabetes mellitus	Gastroenterology	General surgery	Geriatric medicine	Intensive care medicine	Obstetrics and gynaecology	Ophthalmology	Paediatrics	Plastic surgery	Respiratory Medicine	Trauma and orthopaedic surgery	Vascular surgery
Overall Satisfaction	70	87.78	60	78.75	65	49.17	64.29	83.08	74.5	94.17	44.23	95	82.65	60	54.38	78.33	90
Clinical Supervision	84.29	88.89	77.92	88.44	79.43	67.08	82.86	87.31	85.63	95.83	71.92	98.33	94.19	85.83	78.13	94.38	91
Clinical Supervision out of hours	80.65	86.72	60.42	87.5	71.21	73.75	72.32	91.67	80.09	94.79	80.29	95.83	94.14		73.44	93.75	85
Reporting Systems	48	65	55	77.86	72.5	68	63.57	77	65.63	76.67	52.31		76.54		57.5	65	85
Work Load	41.37	60.42	39.58	64.32	34.47	31.6	28.27	51.92	40.42	63.54	44.71	52.08	51.1	68.05	31.51	53.01	51.25
Teamwork	61.91	82.41	58.33	78.13	71.97	76.39	70.24	77.56	70	76.39	72.44		72.06	69.44	64.58	75	83.33
Handover	50	85.65	41.67		60.42	59.58	45.31	76.79	53.13	83.75	58.01		83.07	36.11	38.75	76.04	89.58
Supportive Environment	63.57	90	66.67	83.75	73.18	75	62.86	79.23	66	88.33	45	95	78.24	78.33	61.25	83.33	85
Induction	62.86	90	60	90.63	78.64	61.67	59.29	81.15	74.63	95	58.46	78.33	86.18	81.67	63.13	78.89	85.25
Adequate Experience	57.14	87.5	75	79.69	71.59	52.08	71.43	84.62	67.5	100	41.35	100	75	54.17	56.25	62.5	85
Educational Governance	60.72	83.33	61.11	76.04	70.45	54.17	53.57	75.64	73.33	76.39	45.51	100	68.14	72.22	69.27	75	80
Educational Supervision	87.5	95.14	68.75	95.31	85.23	80.21	86.61	91.35	91.25	85.42	71.15	91.67	84.93	85.42	74.22	90.28	92.5
Feedback	48.33	87.5		96.88	64.02	38.33	57.64	85.98	70.83	80.56	50.38		46.97	79.17	47.4	86.11	90.63
Local Teaching	48.33	72.59	63.89	74.79	67.92	31.25	37.08	60.48	72.5	83.33	27.31	92.22	63.78		45.83	70.83	72.22
Regional Teaching	63.09	75.93	50	57.29	64.58	44.79	45.83	90.48	76.39	60	39.74	91.67	55		80.56	73.61	97.22
Study Leave	51.79	88.89	33.33	87.5	61.11	47.5	25	78.13	91.67	93.75	27.88	95.83	57.81	70.83	27.5	67.86	100
Rota Design	32.14	72.92	27.08		41.25	14.58	29.46	56.77	61.88	91.67	29.33	91.67	58.59	54.17	29.69	47.92	78.75
Facilities	47.75	57.81		70	64.63	57.08	65.54	73.06	70.75		51.25		72.36		69.75	54.79	71.25

8.1 Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 – Anaesthetics / Intensive Care Medicine

Anaesthetics – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	86.15	86.15	93.64	87.78
Clinical Supervision	95.42	93.56	97.73	88.89
Clinical Supervision out of hours	96.02	93.18	96.59	86.72
Reporting Systems	76.25	67.88	89.5	65
Work Load	53.53	52.4	66.48	60.42
Teamwork	76.92	71.79	78.03	82.41
Handover	71.76	63.13	73.13	85.65
Supportive Environment	73.85	81.15	87.73	90
Induction	86.54	86.15	92.27	90
Adequate Experience	81.73	86.54	89.77	87.5
Curriculum Coverage	76.92			
Educational Governance	70.51	73.08	84.85	83.33
Educational Supervision	85.1	86.54	91.48	95.14
Feedback	70.37	67.13	81.95	87.5
Local Teaching	76.67	60.9	71.82	72.59
Regional Teaching	65.39	54.49	62.5	75.93
Study Leave	78.05	63.62	91.88	88.89
Rota Design	76.92	52.4	78.41	72.92
Facilities	62.25	71	77.08	57.81

Anaesthetics – Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	79.29	83.33	92.14	86
Clinical Supervision	96.67	92.5	97.86	88
Clinical Supervision out of hours	96.88	92.71	96.43	85
Reporting Systems	72.5	67.19	88.57	65
Work Load	54.46	52.08	66.96	60
Teamwork	70.24	62.5	78.57	93.33
Handover	69.1	62.5	65.28	82.5
Supportive Environment	63.57	73.33	88.57	93
Induction	83.57	89.17	93.57	92
Adequate Experience	73.21	83.33	91.07	82.5
Curriculum Coverage	72.62			
Educational Governance	66.67	70.83	86.9	81.67
Educational Supervision	79.46	82.29	91.07	95
Feedback	60.42	43.75	76.39	77.09
Local Teaching	73.33	58.89	67.14	64.33
Regional Teaching	58.33	59.03	75.6	80
Study Leave	66.37	69.79	88.89	82.5
Rota Design	75.89	48.96	75	77.5
Facilities				

Anaesthetics – Core Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	93	86.67	98.33	90
Clinical Supervision	93	93.54	96.67	90
Clinical Supervision out of hours	93.75	93.75	95.83	89.58
Reporting Systems	80	64	91.67	65
Work Load	55.42	53.13	64.58	60.94
Teamwork	83.33	76.39	77.78	68.75
Handover	77.08	64.06	82.64	89.58
Supportive Environment	89	85.83	90	86.25
Induction	88	83.33	86.67	87.5
Adequate Experience	92.5	87.5	100	93.75
Curriculum Coverage	85			
Educational Governance	75	73.61	88.89	85.42
Educational Supervision	90	88.54	97.92	95.31
Feedback	78.33	82.29	87.5	97.92
Local Teaching	81	56.39	78.33	82.92
Regional Teaching	73.33	45.14	52.78	70.83
Study Leave	91.67	57.64	95.14	96.88
Rota Design	77.5	51.04	79.17	67.19
Facilities	46.25			

Intensive Care Medicine – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	85.83	83.57	83.33	94.17
Clinical Supervision	91.67	92.86	95.83	95.83
Clinical Supervision out of hours	88.2	91.96	94.79	94.79
Reporting Systems	65	76.67	81.25	76.67
Work Load	65.63	62.5	60.42	63.54
Teamwork	72.22	86.9	77.78	76.39
Handover	82.29	86.9	78.82	83.75
Supportive Environment	72.5	80.71	76.67	88.33
Induction	82.5	91.79	85	95
Adequate Experience	85.42	82.14	81.25	100
Curriculum Coverage	75			
Educational Governance	66.67	65.48	61.11	76.39
Educational Supervision	84.38	82.14	89.58	85.42
Feedback	90.83	66.67	56.67	80.56
Local Teaching	71.67	58.34	65.33	83.33
Regional Teaching	53.13	48.33	67.5	60
Study Leave	59.38	68.45	80.21	93.75
Rota Design	72.92	74.11	72.92	91.67
Facilities	59.79	71.88	65.42	

8.2 Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 – Clinical Radiology

Clinical Radiology – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	80	71.67	70.83	78.75
Clinical Supervision	91.25	87.5	82.5	88.44
Clinical Supervision out of hours	81.25	78.33		87.5
Reporting Systems	81.25	71.25	76.67	77.86
Work Load	75.42	64.93	70.83	64.32
Teamwork	72.92	73.61	76.67	78.13
Supportive Environment	78	75.83	82.5	83.75
Induction	85	90	80.83	90.63
Adequate Experience	82.5	75	72.92	79.69
Curriculum Coverage	80			
Educational Governance	78.33	72.22	66.67	76.04
Educational Supervision	86.25	92.71	80.21	95.31
Feedback		56.25	65.63	96.88
Local Teaching	81.33	67.64	48.61	74.79
Regional Teaching	71.67	72.22	47.22	57.29
Study Leave	59.38	61.11	56.25	87.5
Facilities		63.75	55.42	70

Clinical Radiology – Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	80	71.67	70.83	78.75
Clinical Supervision	91.25	87.5	82.5	88.44
Clinical Supervision out of hours	81.25	78.33		87.5
Reporting Systems	81.25	71.25	76.67	77.86
Work Load	75.42	64.93	70.83	64.32
Teamwork	72.92	73.61	76.67	78.13
Supportive Environment	78	75.83	82.5	83.75
Induction	85	90	80.83	90.63
Adequate Experience	82.5	75	72.92	79.69
Curriculum Coverage	80			
Educational Governance	78.33	72.22	66.67	76.04
Educational Supervision	86.25	92.71	80.21	95.31
Feedback		56.25	65.63	96.88
Local Teaching	81.33	67.64	48.61	74.79
Regional Teaching	71.67	72.22	47.22	57.29
Study Leave	59.38	61.11	56.25	87.5
Facilities		63.75	55.42	70

8.3 Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 – Emergency Medicine

Emergency Medicine – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	81.36	63.33	63.08	65
Clinical Supervision	90	83.48	86.15	79.43
Clinical Supervision out of hours	89.02	79.33	79.97	71.21
Reporting Systems	81	62.81	58.33	72.5
Work Load	37.31	30.56	31.57	34.47
Teamwork	77.27	62.78	66.03	71.97
Handover	64.58	52.23	47.54	60.42
Supportive Environment	71.36	61	63.46	73.18
Induction	81.36	72.5	73.46	78.64
Adequate Experience	79.55	67.5	66.35	71.59
Curriculum Coverage	79.55			
Educational Governance	75	57.78	59.62	70.45
Educational Supervision	81.82	72.08	76.92	85.23
Feedback	68.23	49.68	73.75	64.02
Local Teaching	67.08	65.56	61.48	67.92
Regional Teaching	79.17	71.3	60.65	64.58
Study Leave	66.25	52.88	50.46	61.11
Rota Design	53.75	35	41.35	41.25
Facilities	62.71	57.81	53.47	64.63

Emergency Medicine – Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	78.57	62.22	63.33	73.33
Clinical Supervision	89.29	85.42	86.67	88.33
Clinical Supervision out of hours	87.2	81.25	82.18	81.94
Reporting Systems	76.67	71.67	62.86	
Work Load	40.77	35.42	34.72	50
Teamwork	75	68.52	70.37	77.78
Handover	63.39	50.78	45.83	62.5
Supportive Environment	73.57	66.11	67.78	83.33
Induction	78.57	77.78	76.11	75
Adequate Experience	75	62.5	65.28	79.17
Curriculum Coverage	77.38			
Educational Governance	71.43	58.33	61.11	72.22
Educational Supervision	85.71	71.53	75	89.58
Feedback	75.69	32.14	67.13	80.56
Local Teaching	66.67	61.67	65.37	76.67
Regional Teaching	80.95	79.63	63.43	70.83
Study Leave	67.86	60.68	50.52	83.33
Rota Design	52.08	44.44	45.83	52.08
Facilities	62.92	65	47.71	

Emergency Medicine – FY2 Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction		68	73.33	63
Clinical Supervision		83	88.33	72.75
Clinical Supervision out of hours		76.25	79.17	67.5
Reporting Systems		58.75		77.5
Work Load		27.5	31.25	30
Teamwork		63.33	61.11	65
Handover		56.25	66.67	58.33
Supportive Environment		57	61.67	70
Induction		65	76.67	83
Adequate Experience		80	75	67.5
Curriculum Coverage				
Educational Governance		51.67	58.33	68.33
Educational Supervision		78.75	85.42	85
Feedback		63.54		44.17
Study Leave		54.17		60
Rota Design		26.25	37.5	34.38
Facilities				62.5

8.4 Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 – General Surgery

General Surgery – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	80.45	71.5	81.25	83.08
Clinical Supervision	88.64	85	85.21	87.31
Clinical Supervision out of hours	85.63	87.5	78.96	91.67
Reporting Systems	71.7	76.11	71.36	77
Work Load	43.56	42.08	34.38	51.92
Teamwork	75.76	72.5	70.14	77.56
Handover	68.75	60.71	62.2	76.79
Supportive Environment	67.73	70.5	72.5	79.23
Induction	78.64	70.5	75.94	81.15
Adequate Experience	85.23	80	83.33	84.62
Curriculum Coverage	78.03			
Educational Governance	75.76	68.33	71.53	75.64
Educational Supervision	87.5	85.63	87.5	91.35
Feedback	68.75	75	81.25	85.98
Local Teaching	80.56	67.78	53.89	60.48
Regional Teaching	72.22	68.06	83.33	90.48
Study Leave	63.54	66.93	69.64	78.13
Rota Design	43.13	46.88	40.42	56.77
Facilities	50.28	60.42	59.82	73.06

Surgery FY2 Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction		60		71.67
Clinical Supervision		61.67		80.83
Clinical Supervision out of hours				
Reporting Systems		65		71.67
Work Load		39.58		73.61
Teamwork		52.78		80.55
Handover				73.61
Supportive Environment		45		86.67
Induction		45		78.33
Adequate Experience		83.33		75
Curriculum Coverage				
Educational Governance		41.67		72.22
Educational Supervision		81.25		89.58
Feedback		63.89		
Study Leave		56.25		70.83
Rota Design		39.58		68.75
Facilities				73.33

Core Surgical Training – Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	89	71	83.33	77.5
Clinical Supervision	93	89	90	88.75
Clinical Supervision out of hours	90	87.5	85.42	89.06
Reporting Systems	72.75	69		75
Work Load	43.75	38.75	35.42	48.44
Teamwork	85	71.67	80.55	81.25
Handover	66.25	71.25	61.81	63.89
Supportive Environment	84	65	81.67	82.5
Induction	82	76	67.5	73.75
Adequate Experience	85	70	87.5	75
Curriculum Coverage	86.67			
Educational Governance	83.33	73.33	72.22	77.08
Educational Supervision	91.25	76.25	100	84.38
Feedback	93.75	81.25	88.89	76.39
Local Teaching	84.33	59.67	48.89	50.83
Regional Teaching	78.33	64.17	72.22	66.67
Study Leave	60.42	62.92	64.58	59.38
Rota Design	60	38.75		48.44
Facilities	60.63	69.25	57.92	64.58

General Surgery - Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction		72.5	96.25	95
Clinical Supervision		88.75	97.5	97
Clinical Supervision out of hours		93.75	90.28	100
Reporting Systems		78.33	66.25	83.33
Work Load		50	39.58	53.75
Teamwork		79.17	64.59	81.67
Handover		60.94	65.63	82.29
Supportive Environment		80	82.5	95
Induction		68.75	85	87
Adequate Experience		75	96.88	95
Curriculum Coverage				
Educational Governance		72.92	72.92	83.33
Educational Supervision		85.94	93.75	93.75
Feedback			97.22	97.22
Local Teaching		66.67	59.58	69
Regional Teaching		64.59	85.42	88.33
Study Leave		57.29	79.69	90
Rota Design		56.25	50	78.13
Facilities		60.83		77.08

8.5 Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 - Medicine

Acute Internal Medicine – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	74.29	66.67	78.75	70
Clinical Supervision	81.67	85	92.5	84.29
Clinical Supervision out of hours	87.2	75	87.5	80.65
Reporting Systems	63.57		83.75	48
Work Load	49.11	48.61	52.61	41.37
Teamwork	64.29	72.22	83.33	61.91
Handover	50.89	54.17	64.58	50
Supportive Environment	64.29	80	92.5	63.57
Induction	76.61	56.67	77.5	62.86
Adequate Experience	62.5	83.33	90.63	57.14
Curriculum Coverage	65.48			
Educational Governance	67.86	66.67	72.92	60.72
Educational Supervision	87.5	77.08	98.44	87.5
Feedback	68.75	59.72	91.67	48.33
Local Teaching	67.86	55	65.42	48.33
Regional Teaching	56.55	62.5	70.83	63.09
Study Leave	49.41		63.54	51.79
Rota Design	44.64	41.67	62.5	32.14
Facilities			80.83	47.75

Cardiology – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	83.75	74.17	77.86	60
Clinical Supervision	91.25	86.67	89.29	77.92
Clinical Supervision out of hours	87.5	75	72.32	60.42
Reporting Systems	62.5	64.17	62.5	55
Work Load	53.13	42.01	31.25	39.58
Teamwork	62.5	69.45	70.24	58.33
Handover	37.5	60	52.08	41.67
Supportive Environment	71.25	71.67	67.14	66.67
Induction	66.25	63.33	62.86	60
Adequate Experience	84.38	60.42	78.57	75
Curriculum Coverage	75			
Educational Governance	70.83	59.72	69.05	61.11
Educational Supervision	90.63	89.58	85.71	68.75
Feedback	75	65.63	54.17	
Local Teaching	76.11	44.17	52	63.89
Regional Teaching	83.33	46.88	60.83	50
Study Leave	68.06	78.33	37.15	33.33
Rota Design	56.25	43.75	35.71	27.08
Facilities	61.25	58.5	51.5	

Endocrinology and Diabetes Mellitus – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	66.25	76.67	61.67	49.17
Clinical Supervision	93.33	91.67	72	67.08
Clinical Supervision out of hours	93.75	83.33	73.75	73.75
Reporting Systems		65	62.5	68
Work Load	45.31	25	40.97	31.6
Teamwork	70.83	72.22	61.11	76.39
Handover	54.17		72.5	59.58
Supportive Environment	66.25	70	66.67	75
Induction	72.5	78.33	67.5	61.67
Adequate Experience	71.88	70.83	68.75	52.08
Curriculum Coverage	70.83			
Educational Governance	62.5	58.33	70.84	54.17
Educational Supervision	79.69	87.5	79.17	80.21
Feedback		77.78	70.83	38.33
Local Teaching	68.89		68.75	31.25
Regional Teaching	77.78		67.71	44.79
Study Leave	63.19		61.25	47.5
Rota Design	56.25	45.83	40.97	14.58
Facilities	63.44		70.5	57.08

Gastroenterology – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	70	73.33	73.75	64.29
Clinical Supervision	84	80	79.38	82.86
Clinical Supervision out of hours	75	67.01	74.74	72.32
Reporting Systems	71	54	75	63.57
Work Load	49.58	33.68	29.95	28.27
Teamwork	61.67	59.72	73.96	70.24
Handover		57.81	59.38	45.31
Supportive Environment	67	65	78.75	62.86
Induction	70	64.17	80	59.29
Adequate Experience	67.5	62.5	81.25	71.43
Curriculum Coverage	70			
Educational Governance	63.33	50	69.79	53.57
Educational Supervision	73.75	63.54	85.16	86.61
Feedback	62.5	32.5	69.64	57.64
Local Teaching		40.42	70.42	37.08
Regional Teaching		33.34	67.71	45.83
Study Leave	57.64	26.56	56.25	25
Rota Design	52.5	28.13	35.16	29.46
Facilities	51.67	65.83	62.86	65.54

GP Programme – Medicine Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	71	68.75	68	
Clinical Supervision	82	76.88	82.5	
Clinical Supervision out of hours	75	70.14	84.38	
Reporting Systems	70	63.33	77.5	
Work Load	43.75	39.06	28.75	
Teamwork	66.67	72.92	85	
Handover	57.5	59.38	73.44	
Supportive Environment	69	62.5	75	
Induction	67	62.5	50.25	
Adequate Experience	67.5	71.88	75	
Curriculum Coverage	70			
Educational Governance	70	56.25	78.33	
Educational Supervision	93.75	70.31	87.5	
Feedback	51.04	55.56		
Local Teaching	64	57.5	69	
Regional Teaching	62.5	60.42	64.17	
Study Leave	21.53	64.06	38.75	
Rota Design	54.58	50	49.17	
Facilities	62.5	55	61.25	

Internal Medicine Programme - Stage One

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	77.5	66.88	70.71	61.25
Clinical Supervision	87.86	87.81	86.79	81.8
Clinical Supervision out of hours	89.88	80.6	81.7	80.21
Reporting Systems	65.42	63.75	65.42	59
Work Load	47.77	41.15	40.48	37.5
Teamwork	70.83	68.23	72.62	67.19
Handover	57.29	58.46	52.83	55.73
Supportive Environment	67.14	72.19	74.29	64.06
Induction	73.3	71.09	77.14	68.44
Adequate Experience	68.75	62.5	73.21	57.81
Curriculum Coverage	62.5			
Educational Governance	67.26	54.69	62.5	56.77
Educational Supervision	80.8	72.27	82.59	79.69
Feedback	73.15	44.23	43.4	48.89
Local Teaching	65.48	52.4	53.09	50.26
Regional Teaching	55.65	44.27	52.68	51.56
Study Leave	44.94	48.75	46.95	51.56
Rota Design	52.68	38.28	45.98	41.8
Facilities	56.96	61.04	65.25	61.46

Medicine FY1

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	77	83.33	79.17	70
Clinical Supervision	83.61	80.83	76.88	78.86
Clinical Supervision out of hours	82.03	68.75	66.15	75.57
Reporting Systems	72.86	67.29	70.56	73.33
Work Load	42.29	35.42	36.81	41.48
Teamwork	64.17	70.83	74.31	76.52
Supportive Environment	66.5	72.5	70.42	69.55
Induction	82.5	79.17	84.17	64.66
Adequate Experience	82.5	81.25	82.29	72.73
Curriculum Coverage	78.33			
Educational Governance	68.34	69.45	69.44	75.38
Educational Supervision	86.88	85.42	89.06	89.77
Feedback	70.37	52.08	77.5	65
Rota Design	61.88	53.13	43.23	47.73
Facilities	58.59	65.5	71.25	78.38

Medicine FY2

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction		58.33	63.33	75
Clinical Supervision		76.67	65	77.5
Clinical Supervision out of hours			60.42	64.58
Reporting Systems		63.33	65	71.67
Work Load		27.78	31.25	29.17
Teamwork		66.67	52.78	72.22
Handover		54.17	62.5	60.42
Supportive Environment		70	61.67	70
Induction		40	56.67	65
Adequate Experience		62.5	58.33	75
Curriculum Coverage				
Educational Governance		69.44	61.11	83.33
Educational Supervision		97.92	64.58	68.75
Feedback			77.78	
Study Leave		56.25	47.92	20.83
Rota Design		18.75	39.58	31.25
Facilities				

Geriatric Medicine – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	78.64	69.38	80.63	74.5
Clinical Supervision	85.68	84.22	82.66	85.63
Clinical Supervision out of hours	84.09	84.12	79.95	80.09
Reporting Systems	69.44	68.04	70.71	65.63
Work Load	41.48	38.02	42.97	40.42
Teamwork	68.94	76.04	78.13	70
Handover	57.14	67.26	57.81	53.13
Supportive Environment	65.91	71.88	74.38	66
Induction	76.36	75.94	78.28	74.63
Adequate Experience	77.27	59.38	78.13	67.5
Curriculum Coverage	71.21			
Educational Governance	71.97	65.63	75	73.33
Educational Supervision	86.93	77.34	89.84	91.25
Feedback	54.69	45.83	72.92	70.83
Local Teaching	67.14	72.38	70.42	72.5
Regional Teaching	54.76	65.48	60.42	76.39
Study Leave	43.33	63.39	55.73	91.67
Rota Design	54.55	35.94	66.41	61.88
Facilities	55.25	71.67	73.13	70.75

Respiratory Medicine – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	74	64.29	73.57	54.38
Clinical Supervision	87	78.93	81.61	78.13
Clinical Supervision out of hours	87.5	72.22	74.4	73.44
Reporting Systems	78	67.5	71.25	57.5
Work Load	37.08	23.21	28.57	31.51
Teamwork	73.33	70.24	78.57	64.58
Handover	70.83	53.13	57.81	38.75
Supportive Environment	72	70.71	70	61.25
Induction	72	69.29	78.57	63.13
Adequate Experience	75	71.43	78.57	56.25
Curriculum Coverage	70			
Educational Governance	68.33	71.43	67.86	69.27
Educational Supervision	90	86.61	85.71	74.22
Feedback	64.59	56.55	77.5	47.4
Local Teaching	34.45	53.33	64.58	45.83
Regional Teaching	80.55	63.33	72.92	80.56
Study Leave	41.67	43.75	45.31	27.5
Rota Design	69.58	23.21	41.07	29.69
Facilities	64.69	53.54	70.89	69.75

8.6 Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 – Obstetrics and Gynaecology

Obstetrics and Gynaecology – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	76.25	76.33	74.58	44.23
Clinical Supervision	95	89.67	88.33	71.92
Clinical Supervision out of hours	96.09	89.73	96.02	80.29
Reporting Systems	76.25	78.67	79.09	52.31
Work Load	55.47	52.5	47.74	44.71
Teamwork	76.04	81.67	77.78	72.44
Handover	60.16	72.92	69.97	58.01
Supportive Environment	67.5	75.67	72.92	45
Induction	81.56	67	80.83	58.46
Adequate Experience	62.5	70.83	81.25	41.35
Curriculum Coverage	63.54			
Educational Governance	80.21	67.78	68.75	45.51
Educational Supervision	82.81	86.67	85.94	71.15
Feedback	83.33	70.83	75.83	50.38
Local Teaching	66.46	56.43	62	27.31
Regional Teaching	66.15	62.2	48.33	39.74
Study Leave	58.93	55.21	56.08	27.88
Rota Design	53.13	42.5	54.17	29.33
Facilities	81.25	56.56	66.53	51.25

Obstetrics and Gynaecology – Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	75.83	77.5	72.5	41.67
Clinical Supervision	95	96.5	95.63	76.11
Clinical Supervision out of hours	96.88	95	96.88	79.17
Reporting Systems	75.83	82.5	80.63	52.22
Work Load	56.25	50.63	49.22	48.61
Teamwork	76.39	83.33	77.09	70.37
Handover	57.29	76.25	67.19	55.56
Supportive Environment	65	75.5	71.25	45
Induction	82.08	73	81.88	63.89
Adequate Experience	58.33	66.25	78.13	30.56
Curriculum Coverage	62.5			
Educational Governance	81.95	68.33	67.71	43.52
Educational Supervision	86.46	90.63	85.94	73.61
Feedback	83.33	73.75	73.96	60.42
Local Teaching	68.06	56.5	64.79	28.52
Regional Teaching	76.39	65	48.44	52.78
Study Leave	62.5	59.49	60.42	23.61
Rota Design	53.13	41.88	48.44	32.64
Facilities		55.5	68.13	55.18

GP Programme – Obstetrics and Gynaecology Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction		71.25		50
Clinical Supervision		82.5		62.5
Clinical Supervision out of hours		83.33		82.81
Reporting Systems		72.5		52.5
Work Load		59.38		35.94
Teamwork		75		77.09
Handover		60.94		63.54
Supportive Environment		77.5		45
Induction		55		46.25
Adequate Experience		78.13		65.63
Curriculum Coverage				
Educational Governance		64.59		50
Educational Supervision		73.44		65.63
Feedback		55.56		23.61
Local Teaching		56.25		24.58
Regional Teaching		55.21		10.42
Study Leave		57.29		37.5
Rota Design		53.13		21.88
Facilities		58.33		

8.7 Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 - Ophthalmology

Ophthalmology – Speciality/Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	93.33	88.33	86.67	95
Clinical Supervision	100	96.67	93.33	98.33
Clinical Supervision out of hours	95.83	90.97	93.75	95.83
Reporting Systems			70	
Work Load	60.42	64.58	60.42	52.08
Teamwork	75	80.56		
Handover			61.11	
Supportive Environment	86.67	81.67	88.33	95
Induction	90	65	70	78.33
Adequate Experience	87.5	70.83	75	100
Curriculum Coverage	83.33			
Educational Governance	86.11	83.33	72.22	100
Educational Supervision	100	95.83	91.67	91.67
Feedback	65.28			
Local Teaching	85	89.44	77.78	92.22
Regional Teaching	80.56	86.11	80.56	91.67
Study Leave	95.14	94.45		95.83
Rota Design	89.58	81.25	81.25	91.67
Facilities				

8.8 Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 - Paediatrics

Paediatrics – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	78.13	75	85	82.65
Clinical Supervision	93.44	94.33	92.87	94.19
Clinical Supervision out of hours	93.75	92.92	91.67	94.14
Reporting Systems	77.67	78.37	83.67	76.54
Work Load	55.86	51.67	57.35	51.1
Teamwork	73.18	73.89	72.55	72.06
Handover	75.45	74.4	76.3	83.07
Supportive Environment	72.5	75	77.94	78.24
Induction	78.91	83.33	75.88	86.18
Adequate Experience	70.31	70.83	80.88	75
Curriculum Coverage	70.83			
Educational Governance	68.75	70	72.55	68.14
Educational Supervision	84.38	82.92	84.19	84.93
Feedback	61.22	52.78	62.12	46.97
Local Teaching	67.29	61.31	71	63.78
Regional Teaching	57.03	53.27	57.78	55
Study Leave	59.11	56.53	69.05	57.81
Rota Design	62.5	53.75	62.5	58.59
Facilities	74.13	67.08	71.02	72.36

Paediatrics – Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	75.45	72.73	88.64	85.42
Clinical Supervision	91.82	92.5	93.98	94.27
Clinical Supervision out of hours	93.13	90.15	91.67	93.75
Reporting Systems	74.5	75.97	86.5	80.56
Work Load	53.98	51.7	55.68	45.83
Teamwork	69.32	70.46	68.94	79.17
Handover	72.22	70.21	75.38	83.85
Supportive Environment	70	73.18	79.09	83.33
Induction	75.23	80.91	83.18	87.08
Adequate Experience	67.05	65.91	81.82	79.17
Curriculum Coverage	67.42			
Educational Governance	63.64	62.88	76.52	71.53
Educational Supervision	82.39	82.39	88.64	88.02
Feedback	53.75	47.4	59.52	45.14
Local Teaching	60.61	59.7	73.03	67.78
Regional Teaching	53.41	47.35	66.67	71.53
Study Leave	60.23	58.52	71.76	67.71
Rota Design	59.38	53.98	63.07	63.64
Facilities	71.96	53.75	73.96	70.78

GP Programme – Paediatrics and Child Heath

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	84	80	72.5	80
Clinical Supervision	97	96.25	87.5	97.5
Clinical Supervision out of hours	95	98.44	87.5	95.31
Reporting Systems	84	83.75	75	65
Work Load	60	57.81	59.38	60.94
Teamwork	81.67	85.42	75	56.25
Handover	81.25	78.65	74.48	77.61
Supportive Environment	78	82.5	68.75	71.25
Induction	87	87.5	47.5	86.25
Adequate Experience	77.5	81.25	75	68.75
Curriculum Coverage	78.33			
Educational Governance	80	85.42	56.25	58.33
Educational Supervision	88.75	79.69	64.06	90.63
Feedback	86.11	61.46		46.88
Local Teaching	82	65.84	65.42	57.09
Regional Teaching	65	70.83	33.33	14.58
Study Leave	56.67	53.13	67.71	31.25
Rota Design	68.75	53.13	51.56	42.19
Facilities	79.17	75.83	50.83	

8.9 Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 – Plastic Surgery

Plastic Surgery – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction				60
Clinical Supervision				85.83
Clinical Supervision out of hours				
Reporting Systems				
Work Load				68.05
Teamwork				69.44
Handover				36.11
Supportive Environment				78.33
Induction				81.67
Adequate Experience				54.17
Curriculum Coverage				
Educational Governance				72.22
Educational Supervision				85.42
Feedback				79.17
Local Teaching				
Regional Teaching				
Study Leave				70.83
Rota Design				54.17
Facilities				

8.10 Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 – Trauma and Orthopaedic Surgery

Trauma and Orthopaedic Surgery – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	68.33	87.14	74	78.33
Clinical Supervision	88.75	82.14	93	94.38
Clinical Supervision out of hours	82.81	77.68	86.25	93.75
Reporting Systems	70.5	68	64	65
Work Load	55.56	43.45	44.17	53.01
Teamwork	68.33	66.67	75	75
Handover	68.75	69.17	69.79	76.04
Supportive Environment	62.5	79.29	81	83.33
Induction	73.33	77.14	72	78.89
Adequate Experience	64.58	85.71	62.5	62.5
Curriculum Coverage	73.33			
Educational Governance	73.61	67.86	56.67	75
Educational Supervision	87.5	89.29	87.5	90.28
Feedback	83.33	77.98		86.11
Local Teaching	76.67	69.17	68.75	70.83
Regional Teaching	74.17	82.29	64.58	73.61
Study Leave	64.06	41.25	61.46	67.86
Rota Design	47.5	44.45	53.75	47.92
Facilities	57.19	69.69	51.25	54.79

Trauma and orthopaedic surgery – Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	80	100	65	90
Clinical Supervision		96.67	93.33	98.75
Clinical Supervision out of hours		93.75	87.5	95.31
Reporting Systems			61.67	76.67
Work Load	61.11	52.08	35.42	37.5
Teamwork		72.22	69.45	75
Handover		73.61	63.89	77.61
Supportive Environment	71.67	90	76.67	85
Induction	85	83.33	61.67	77.5
Adequate Experience	66.67	100	50	78.13
Curriculum Coverage				
Educational Governance	83.33	72.22	50	75
Educational Supervision	87.5	100	83.33	95.31
Feedback		93.06		88.89
Local Teaching	85	74.44	71.11	75
Regional Teaching	91.67	97.22	66.67	91.67
Study Leave		37.5	56.94	59.38
Rota Design		57.64	66.67	62.5
Facilities				

2.5
8.11

Trainee Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024 – Vascular Surgery

Vascular Surgery – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	86.67	68	87.5	90
Clinical Supervision	96.67	91	95	91
Clinical Supervision out of hours	97.92	87.5	90.63	85
Reporting Systems	68.33	71.75	77.5	85
Work Load	43.06	61.25	48.96	51.25
Teamwork	72.22	66.67	79.17	83.33
Handover		71.88	88.89	89.58
Supportive Environment	80	71	72.5	85
Induction	86.67	75	75	85.25
Adequate Experience	95.83	65	90.63	85
Curriculum Coverage	91.67			
Educational Governance	80.56	81.67	81.25	80
Educational Supervision	91.67	90	84.38	92.5
Feedback	95.83	82.29		90.63
Local Teaching		60.84	82.78	72.22
Regional Teaching		77.08	91.67	97.22
Study Leave		67.19	84.03	100
Rota Design	91.67	60	75	78.75
Facilities	80.83	63.75	76.67	71.25

Vascular Surgery – Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction			93.33	93.33
Clinical Supervision			98.33	93.33
Clinical Supervision out of hours			97.92	100
Reporting Systems			85	
Work Load			54.17	43.75
Teamwork			91.67	86.11
Handover			88.89	89.58
Supportive Environment			85	85
Induction			86.67	91.67
Adequate Experience			91.67	87.5
Curriculum Coverage				
Educational Governance			91.67	88.89
Educational Supervision			95.83	89.58
Feedback				90.28
Local Teaching			82.78	72.22
Regional Teaching			91.67	97.22
Study Leave			84.03	100
Rota Design			83.33	79.17
Facilities				80

9. Overall Trainer Results - Regional Trust Comparison Results 2024

	Alder Hey Children's NHS Foundation Trust	Countess of Chester Hospital NHS Foundation Trust	Liverpool Heart and Chest Hospital NHS Foundation Trust	Liverpool Women's NHS Foundation Trust	Liverpool University Hospitals NHS Foundation Trust	Mid Cheshire Hospitals NHS Foundation Trust	Mersey and West Lancashire Teaching Hospitals NHS Trust	The Clatterbridge Cancer Centre NHS Foundation Trust	The Walton Centre NHS Foundation Trust	Warrington and Halton Teaching Hospitals NHS Foundation Trust	Wirral University Teaching Hospital NHS Foundation Trust
Supportive Environment	73.33	62.68	76.62	66.59	65.67	76.76	73.54	74.24	76.64	74.12	68.15
Educational Governance	65.78	56.44	67.67	62.04	62.40	66.40	67.58	65.46	67.14	73.80	61.98
Professional Development	72.69	65.36	70.22	69.83	69.22	69.75	73.72	68.34	71.52	68.73	65.85
Appraisal	59.71	55.54	57.18	70.91	57.55	56.87	62.09	57.39	61.27	71.05	40.97
Support for Training	71.02	64.05	71.68	73.99	69.01	72.48	74.41	69.19	72.75	62.60	67.10
Time to Train	55.73	49.46	60.26	62.64	62.41	54.81	58.26	54.36	57.24	72.07	59.95
Rota Issues	52.03	42.65	57.87	44.09	51.72	52.17	56.84	45.97	62.73	63.77	42.50
Handover	66.26	62.71	62.23	52.83	64.41	69.62	69.67	63.08	68.63	53.83	64.54
Resources to Train	66.96	62.14	72.22	74.14	66.01	73.24	71.90	59.85	74.59	74.12	67.58

10. Trainer Results per Specialty for Countess of Chester Hospital NHS Foundation Trust 2024

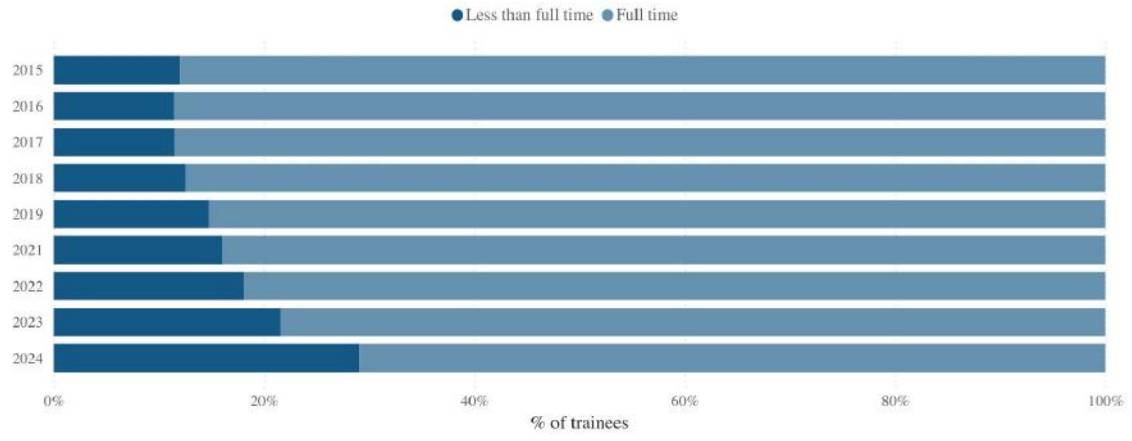
	Acute Internal Medicine	Anaesthetics	Cardiology	Clinical radiology	Dermatology	Emergency Medicine	Gastroenterology	General (internal) medicine	General surgery	Geriatric medicine	Haematology	Intensive care medicine	Obstetrics and gynaecology	Paediatrics	Plastic surgery	Respiratory Medicine	Trauma and orthopaedic surgery	Vascular surgery
Supportive Environment	52.5	65.74	68.75	68.06	75	47.5	62.5	41.67	68.75	65.28	75	77.5	50	64.77	62.5	65	48.44	54.69
Educational Governance	47.5	63.14	56.25	68.49	52.78	37.5	56.25	33.33	63.54	60.42	61.11	67.5	41.25	51.14	66.67	56.77	45.54	49.11
Professional Development	67.5	63.89	56.25	66.67	70.83	75	61.67	47.92	75	60.42	56.25	68.75	70	66.48	64.58	68.75	63.8	60.16
Appraisal	50	50.46	46.88	66.67	70.83	65	47.5	62.5	83.33	68.06	75	55	30	65.91	70.83	50	56.25	46.88
Support for Training	62.5	66.97	58.33	61.11	70.83	68.33	58.33	50	76.39	66.2	58.33	73.33	66.67	65.53	55.56	73.33	51.56	59.38
Time to Train	48.33	52.47	45.84	54.17	38.89	20	56.67	45.83	59.72	33.33	38.89	66.67	50	55.3	77.78	28.33	45.31	47.92
Rota Issues	35	48.15	50	61.11		15	40	33.33	37.5	44.44	58.33	60	20	22.5	50	35	28.13	34.38
Handover	60	60	50	65	58.33	70	50	33.33	70.83	50		65	70	72.5	75	50	78.13	59.38
Resources to Train	70	62.04	50	63.89	75	60	70	41.67	66.67	58.33	75	65	55	68.18	50	75	53.13	65.63

11. Less Than Full Time Training – Results for Health Education North West Deanery

Numbers and percentage of all trainees across Health Education North West Deanery working less than full time training

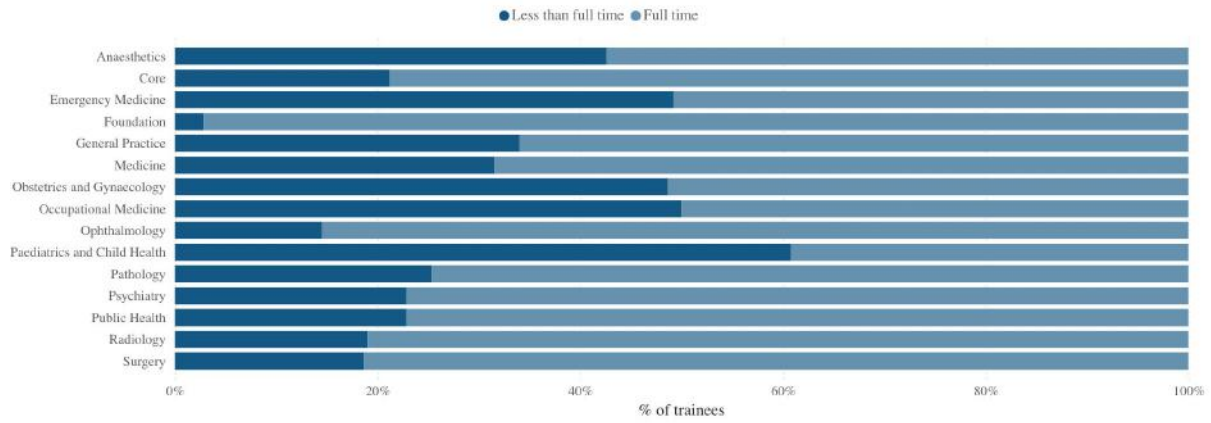
The following table and graph show the increasing numbers of trainees working less than full time across the North West Deanery. The proportion of less than full time trainees has more than doubled from 12.4% in 2019 to 25.4% in 2024.

Survey Year	Number of trainees	Less than full time	Full time
2015	6,067	11.5%	88.5%
2016	6,151	12.0%	88.0%
2017	6,004	10.8%	89.2%
2018	6,007	11.3%	88.7%
2019	6,147	12.4%	87.6%
2021	6,054	14.9%	85.1%
2022	5,932	19.0%	81.0%
2023	6,029	22.8%	77.2%
2024	6,509	25.4%	74.6%

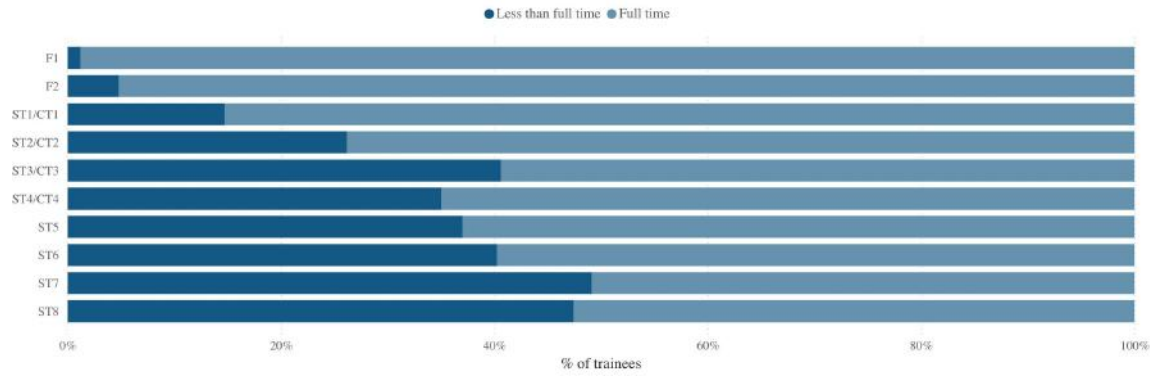


Demographic of trainees across Health Education North West Deanery working less than full time training

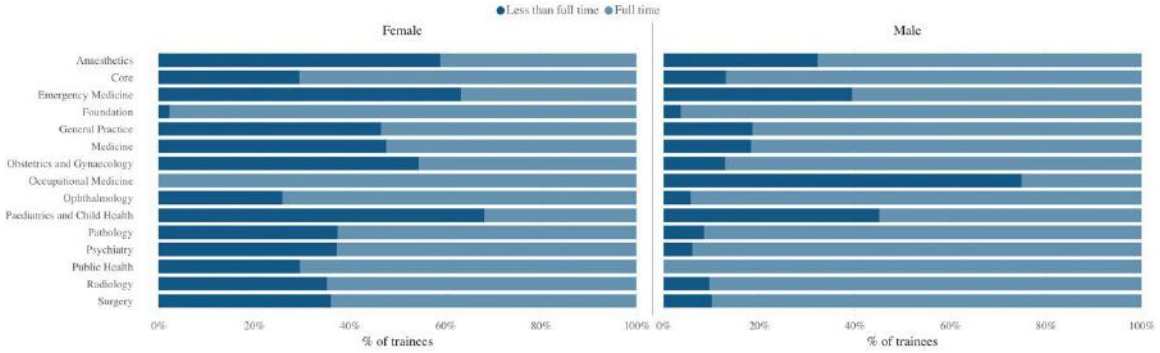
The following chart demonstrates the proportion of trainees working LTFT by Specialty across the Health Education North West Deanery and it can be seen that approximately 50% or more trainees now work LTFT.



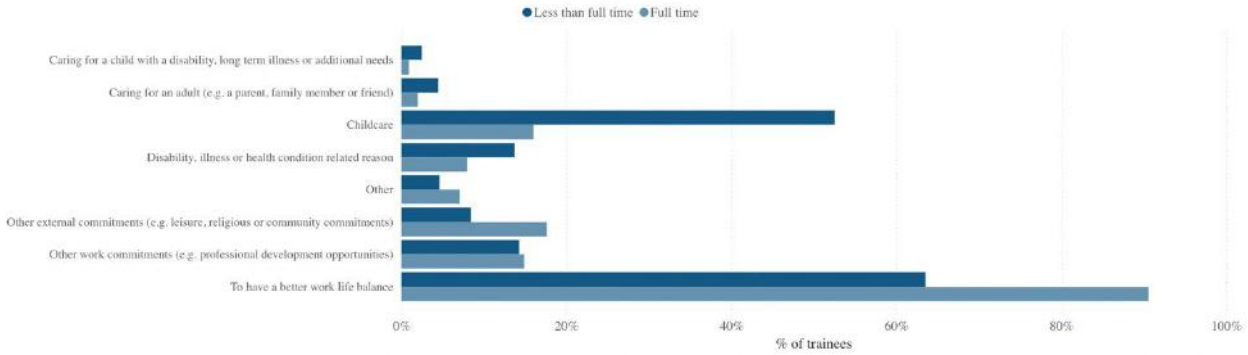
The following chart shows the proportion of trainees working LTFT by Grade across the Health Education North West Deanery. The proportion increases with seniority and almost half of ST8 trainees work LTFT. It is interesting to see that even at core training level (CT2) that over a quarter of CT2s are LTFT. This is clearly impacting on rota staffing at all levels and has implications for training as curriculum requirements may be difficult to achieve for not only the LTFT trainees but also the full time trainees who may be expected to cover more on call / emergency duties as a result of rota gaps.



The following chart shows the proportion of LTFT trainees by Gender across the Health Education North West Deanery. Whilst LTFT training was once seen as a path taken by female trainees, often for childcare reasons, it can now be seen that there are a significant proportion of male trainees who are also working LTFT.

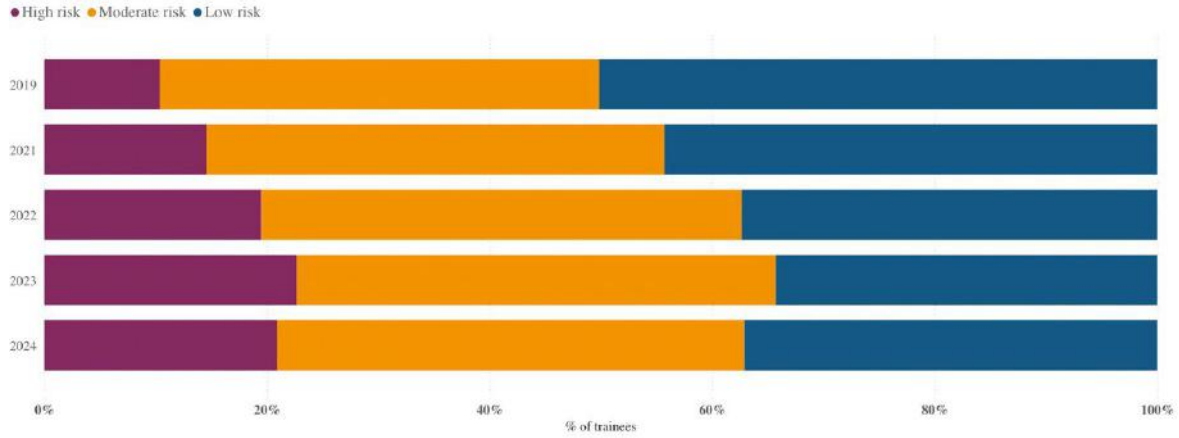


The following chart lists the reasons for trainees to work LTFT across the Health Education North West Deanery. It is perhaps surprising to see that the most common reason for LTFT working is to achieve a better work life balance. It may be that this increase in LTFT working has resulted in the stabilisation and slight reduction in trainees at risk of burnout nationally.

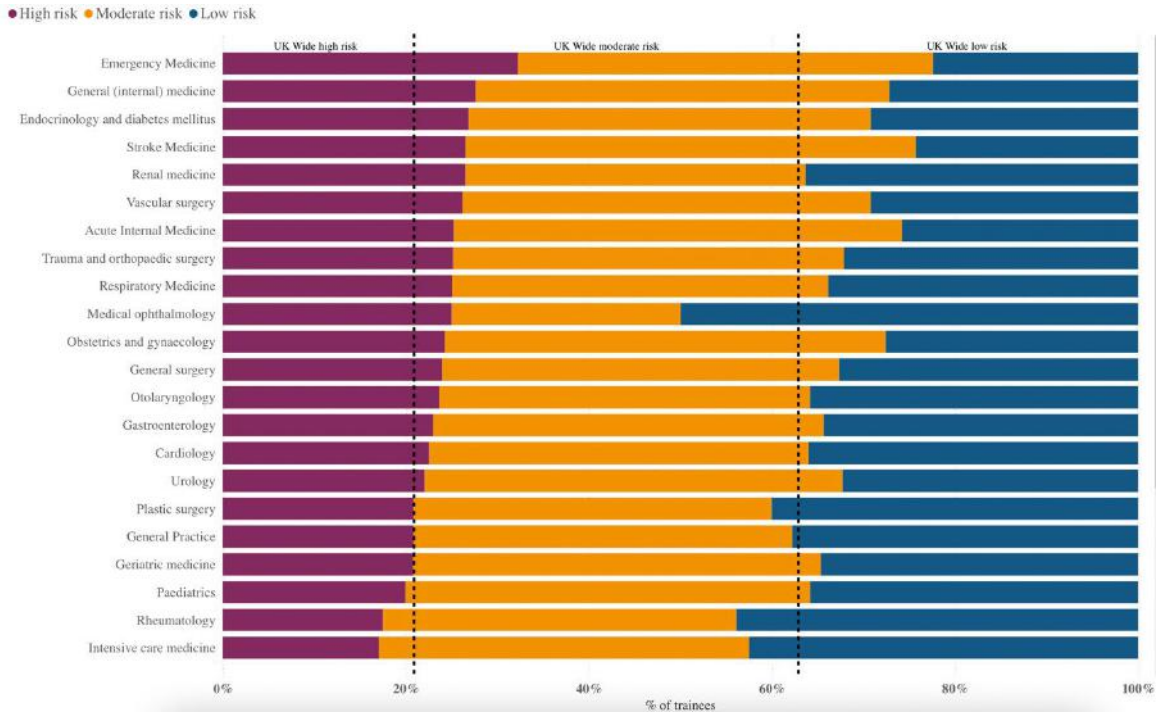


12. Trainees' risk of burnout across the Health Education North West Deanery

The following chart demonstrates the year on year risk of burnout for trainees across the North West Deanery. There was a steady increase from 2019 but the risk seems to have stabilised and the 2024 figures actually show a slight decrease. The reasons for this are unclear but the results are pleasing to see. It remains to be seen if these results will be sustained.



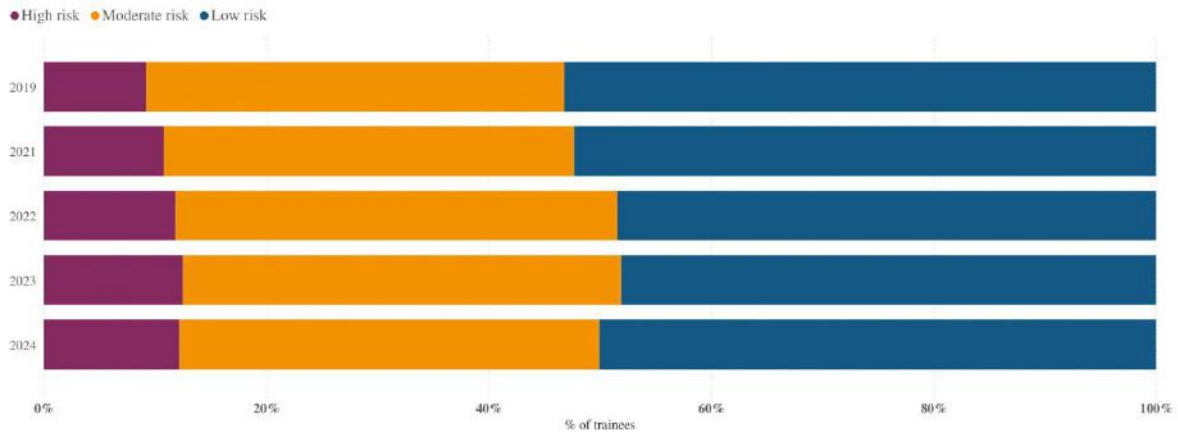
The following chart shows the of burnout for trainees nationally by specialty. There are differences across the specialties.



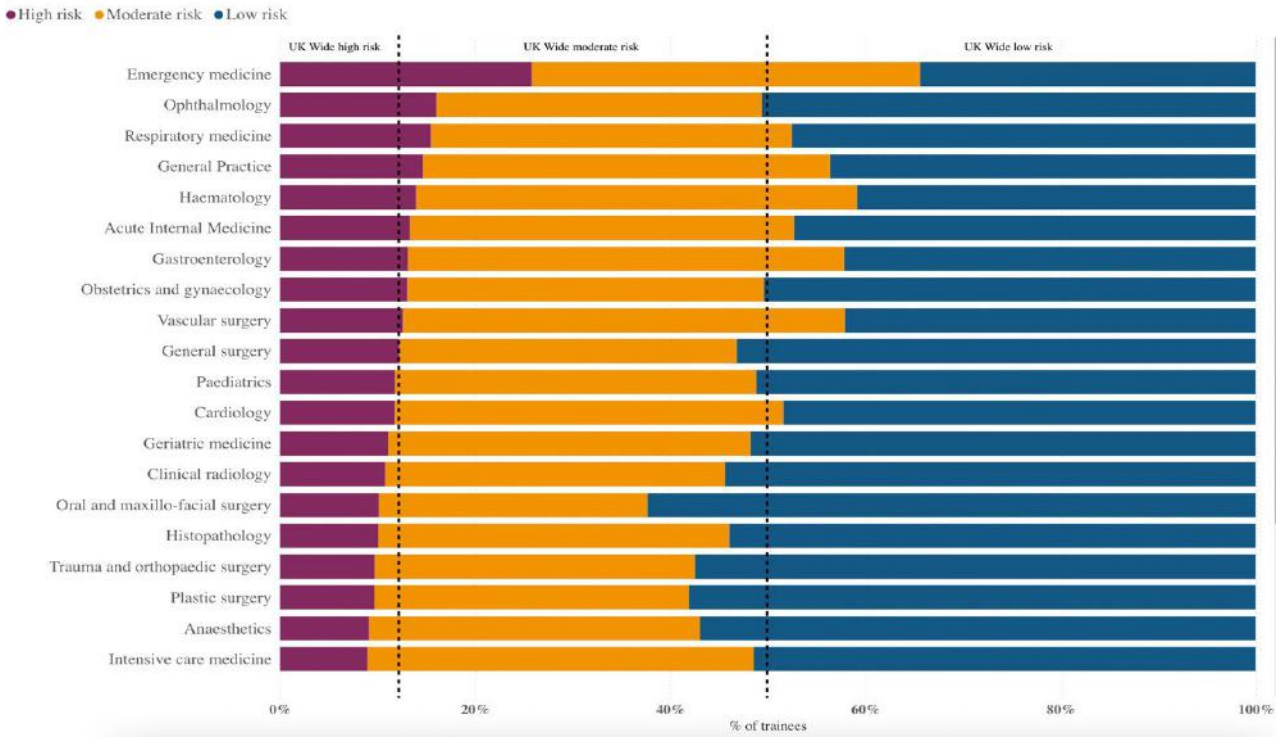
The burnout reports show the results of the NTS burnout for trainees and trainers. All reports split responses to the questions into high risk, moderate risk and low risk of burnout, and present the distribution for the selected group(s), alongside the UK average for comparison.

13. Trainers' risk of burnout across the Health Education North West Deanery

The following chart demonstrates the year on year risk of burnout for trainers across the North West Deanery. Similar to trainees, there was a steady increase from 2019 but the risk seems to have stabilised and the 2024 figures actually show a slight decrease. The reasons for this are unclear but the results are pleasing to see. It remains to be seen if these results will be sustained.



The following chart demonstrates the risk of burnout for trainers across the Health Education North West Deanery by specialty. Similar to trainees, there is variation across different specialties. These charts are a useful reminder as to the pressures our trainees and trainers are under.



Appendix 1: GMC National Training Survey 2024 for Obstetrics and Gynaecology (O&G)

Executive summary

As a speciality in general, O&G performs poorly in rates of burnout and negative workplace behaviours, with 82% of trainees at moderate or high risk of burnout nationally and a 1/3 of trainers and trainees alike reporting high/very high levels of workplace frustration.

Nationally 35% of O&G trainees have experienced negative workplace behaviour, microaggressions or bullying. There have been no concerns raised locally and no free text comments related to workplace behaviours within the GMC survey but we need to be mindful that it is a problem nationally within the specialty and trainees rotating to us may have experienced this elsewhere and still be affected.

During the time period of this survey there were significant gaps across all grades of the rota with frequent episodes of consultant having to step down and the use of agency locum consultants and registrars. There was also a time without any RCOG college tutor due to unexpected sickness then a temporary appointment to this role.

Since this time a permanent RCOG college tutor has been appointed and we have managed to appoint a substantive consultant with ongoing active recruitment. However, we are deeply concerned with these results and had already begun implementing changes in the interval between the survey and the results being released.

Supervision, teamwork and experience:

Unfortunately, over the past 12 months we have faced significant staffing challenges at consultant, registrar and SHO level. This is due to unexpected long term sickness absence and maternity leave at consultant level at a time that 2 consultants resigned to work closer to home. Despite ongoing attempts at active recruitment, we were unable to secure locum cover for the maternity leave or appoint substantively until recently.

There have also been significant rota gaps at the registrar level due to maternity leave and sickness plus one registrar being moved to another unit that had worse staffing levels than we did. We also had further gaps and long term sickness at the SHO level.

This presented difficulties with maintaining a safe service while allow appropriate training opportunities and the release of doctors to attend regional teaching. Consultants were frequently required to step down and cover these gaps which then led to elective work being cancelled again reducing training opportunities.

One of the most frequent sessions to be converted from a consultant perspective was the Emergency Gynaecology sessions, which specifically impacted on training opportunities and additional supervision over and above the on call consultant.

We also had to rely on agency locum consultants and registrars who did not provide the same level of education and commitment to training and supervision that we as a department strive towards which is reflected in the decrease in overall satisfaction and supervision scores. The remaining resident doctors on the registrar and SHO level also got demoralised with the continual rota gaps and last-minute requests to cover further unexpected absence.

We have continued to try and improve our handover processes and have now embedded an electronic real time document on Teams. Following feedback from the wider multidisciplinary team regarding best timing of the neonatal ‘huddle’ this has been moved several times and is now at 0845-0900 just after the O&G handover.

We now have an active document outlining resident doctor current competencies, special interests and training needs available on the S drive for all consultants to review along with the current list of

educational supervisors. These documents are reviewed and updated by the RCOG college tutor at each rotation period.

As a department there is an ongoing rolling audit of consultant out of hours attendance that is led by the Labour Ward lead consultant and is line with the RCOG recommendations regarding when a consultant should attend. This document also details a list of cases that would require consultant attendance unless the trainee can demonstrate competence in the procedure. All specialty trainees are asked directly about their competence with relation to this on joining the department and after 6 months. This list is present on the S drive for consultants to review when needed.

Induction:
In August 2022, the O&G doctors handbook was re-introduced which has been given to all doctors starting a post in O&G. This booklet has all the essential information needed by the trainees while they are with us and is edited regularly. Unfortunately, induction was impacted by sudden unexpected absence and the time taken to appoint a temporary college tutor.

Work is ongoing to improve the induction process, and we will engage with resident doctors – both specialty and GP trainees – to ensure the correct information is relayed during this process and that the doctors handbook contains everything needed to aid our team.

Education and teaching:
Due to significant rota gaps and many LTFT doctors requesting the same non-working days it was difficult to release resident doctors to attend regional teaching. Whilst every effort was made to allow this, once annual leave was factored into the rota there were days when a safe service could not be maintained when teaching occurred.

When possible consultants did cover additional services to allow release of trainees, including the use of locum staff, but this was not always possible. The consultant that oversaw local teaching was also on maternity leave and the consultant covering, who has since left the trust, did not have the same enthusiasm to keep this going.

Due to consultants having to more non-clinical duties because of rota gaps this was unfortunately not picked up. However, this has since been addressed and the weekly local teaching is fully established again.

Rota design:
For portions of the year we have not had any rota coordinator with the majority of the rota management being performed by the consultant rota lead, along with the operations team and secretarial team leader in addition to their normal workload. Without this clear oversight from a person whose main role is to manage the rota it has been difficult to ensure resident doctors are getting a good breadth of experience within the department.

We did manage to recruit to this position but have struggled with retention due to the complexities of managing the rota of what is essentially two distinct specialities and ensuring adequate cover arrangements are in place with the significant gaps we have had. Also, maternity services cannot be easily stood down or delayed due to the specific time frames needed for review/treatment of the pregnant population. There is ongoing active recruitment to this role and the job advert and banding is under review.

We also had frequent rota changes within each week as many doctors have caring responsibilities and there would often be last minute carers leave plus the usual sickness absence.
The current day to day working hours and pattern were discussed with the resident doctors to see if they could be altered in any way and the feeling from them was to leave the hours as they were and they would prefer to exception report late finishes and receive TOIL.

Trainee Survey Results:

Obstetrics and Gynaecology – Overall Specialty Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	76.25	76.33	74.58	44.23
Clinical Supervision	95	89.67	88.33	71.92
Clinical Supervision out of hours	96.09	89.73	96.02	80.29
Reporting Systems	76.25	78.67	79.09	52.31
Work Load	55.47	52.5	47.74	44.71
Teamwork	76.04	81.67	77.78	72.44
Handover	60.16	72.92	69.97	58.01
Supportive Environment	67.5	75.67	72.92	45
Induction	81.56	67	80.83	58.46
Adequate Experience	62.5	70.83	81.25	41.35
Curriculum Coverage	63.54			
Educational Governance	80.21	67.78	68.75	45.51
Educational Supervision	82.81	86.67	85.94	71.15
Feedback	83.33	70.83	75.83	50.38
Local Teaching	66.46	56.43	62	27.31
Regional Teaching	66.15	62.2	48.33	39.74
Study Leave	58.93	55.21	56.08	27.88
Rota Design	53.13	42.5	54.17	29.33
Facilities	81.25	56.56	66.53	51.25

Obstetrics and Gynaecology – Programme Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction	75.83	77.5	72.5	41.67
Clinical Supervision	95	96.5	95.63	76.11
Clinical Supervision out of hours	96.88	95	96.88	79.17
Reporting Systems	75.83	82.5	80.63	52.22
Work Load	56.25	50.63	49.22	48.61
Teamwork	76.39	83.33	77.09	70.37
Handover	57.29	76.25	67.19	55.56
Supportive Environment	65	75.5	71.25	45
Induction	82.08	73	81.88	63.89
Adequate Experience	58.33	66.25	78.13	30.56
Curriculum Coverage	62.5			
Educational Governance	81.95	68.33	67.71	43.52
Educational Supervision	86.46	90.63	85.94	73.61
Feedback	83.33	73.75	73.96	60.42
Local Teaching	68.06	56.5	64.79	28.52
Regional Teaching	76.39	65	48.44	52.78
Study Leave	62.5	59.49	60.42	23.61
Rota Design	53.13	41.88	48.44	32.64
Facilities		55.5	68.13	55.18

GP Programme – Obstetrics and Gynaecology Results

Indicator / Year score	2021	2022	2023	2024
Overall Satisfaction		71.25		50
Clinical Supervision		82.5		62.5
Clinical Supervision out of hours		83.33		82.81
Reporting Systems		72.5		52.5
Work Load		59.38		35.94
Teamwork		75		77.09
Handover		60.94		63.54
Supportive Environment		77.5		45
Induction		55		46.25
Adequate Experience		78.13		65.63
Curriculum Coverage				
Educational Governance		64.59		50
Educational Supervision		73.44		65.63
Feedback		55.56		23.61
Local Teaching		56.25		24.58
Regional Teaching		55.21		10.42
Study Leave		57.29		37.5
Rota Design		53.13		21.88
Facilities		58.33		

Changes implemented since GMC survey:

As we were already aware of the difficulties faced by the previous cohort of resident doctors we had started to put changes in place. The RCOG college tutor has now been appointed on a permanent basis rather than a temporary cover arrangement and job plan changes have been made to allow for this with PA allowance for this.

There is now a robust Wednesday lunchtime teaching rota with assigned consultant facilitation and resident doctors appointed to lead the teaching. They are encouraged to submit portfolio assessments to consultants present to improve the educational experience. The CTG lead midwife regularly presents interesting cases and leads discussion around this followed by a resident doctor led topic. This teaching is now also on Teams to improve attendance, although there has been difficulty in securing a regular teaching space and the teaching laptop was removed from the department.

A resident doctors communication board has also been placed next to the handover room on the central labour suite to allow dissemination of learning, keep an up-to-date teaching rota and provide relevant information/updates. It also has information on the library service and how to access this, including literature review for aiding in QiP such as guideline reviews, audits and publications/posters.

All incoming speciality doctors have completed and educational needs assessment to allow allocation of an appropriate educational supervisor based on their specific needs and interests were possible. They have also been allocated a guideline to review with their educational supervisor and a suggested audit topic relevant to their expressed interests and training aims.

There were incidences of the clinical governance team directly approaching resident doctors for

information and statements relating to clinical incidents which caused some distress and uncertainty. As a consultant body we were unaware of this initially and as the clinical governance team were only newly formed, they did not realise the impact this could have on resident doctors. It was quickly rectified by the college tutor and now they have a list of educational supervisors and any requests for further information must go through the resident doctors named educational supervisor first so that they can discuss this directly with the doctor and provide any support required. If the educational supervisor is not available for whatever reason, then the college tutor or clinical director can be asked for assistance.

We now have a newly appointed substantive consultant and the return of others from long term absence with active recruitment ongoing. This should reduce the dependence on agency locums, which should improve the experience, educational opportunities and supervision of our current resident doctors.

Action plan for 2024-2025:

Area for Review	**Recommendation/Action**	**Action Lead**	**Target date**	**Date of completion**
Local teaching	Ensure ongoing rolling teaching rota with appropriate educational content and	Dr Melisa Thomas	Ongoing	Ongoing
Local teaching facilities	Difficulty securing a regular room for local teaching and no laptop for teaching	Sophie Barker	Nov 24	Regular teaching location secured, teaching laptop requested
Resident Doctor's forum	Increase frequency of resident doctors forum to 2 monthly to ensure ongoing improvement in experience	Dr Lisa Canavan	Ongoing	Ongoing Last Sept 24, planned Nov 24
No current rota administrative support	Need to recruit to this post – banding is under review Currently looking at trust wide digital solution	Sophie Barker	Nov 2024	
Resident doctors handbook	Annual review of resident doctors handbook – This hand book will be e-mailed to resident doctors 2 weeks prior to starting, it has all the information the trainee will require for starting in O+G	Dr Lisa Canavan/Sophie Barker	July 2025	Reviewed July 24, to review again July 25
Regional Teaching	Liaise with rota coordinator and service manager to ensure appropriate clinical activity reduced to allow attendance.	Dr Lisa Canavan/rota team	Nov 24	Regional teaching timetables already emailed to rota team
College tutor new to role	To attend RCOG course – How to be an effective college tutor	Dr Lisa Canavan	Oct 2024	Course attended 10/10/24
Workplace behavior and trainee	Workplace behavior champion to be appointed	Dr Lisa Canavan/Dr	Nov 24 (champion)	

experience	Civility workshop to be held on rolling half day	Sara Brigham	Whole hospital RHD Nov 24	
Clinical supervision	On call team job titles revised to emphasise team working as a whole department – agreed at resident doctors forum	Dr Lisa Canavan/rota team	Sept 24	Already implemented
Improve induction programme	Ensure adequate notice from medical staffing around trust induction, identify current resident doctors to ensure programme is relevant	Dr Lisa Canavan/Sophie Barker/rota coordinator	Dec 24 for GP induction July 25 for specialty doctor induction	
Current resident doctor experience	Mini GMC style survey to current trainees to ensure early intervention and improvement if needed	Dr Lisa Canavan/Dr Victoria Finney/Sophie Barker	Dec 24	
GP resident doctor educational needs	Meeting with GP TPD to ensure training needs fully understood	Dr Lisa Canavan/Rota team	Oct 24 – emails sent to GP TPD (Sept 24) with no response	
Resident doctors feeling unsupported during on call shifts, especially when covering the on call gynae bleep	Introduce a 1300 team huddle on weekdays to review current workload, assess clinical concerns and redirect workforce as needed	Dr Lisa Canavan	Nov 2024	
Rota	Currently weekly rota is released on a Friday afternoon – will move this to earlier in the week	Sophie Barker/rota team	Dec 24	

Dr Lisa Canavan – October 2024
O+G Consultant and RCOG College Tutor

PUBLIC – Board of Directors
26th November 2024

Report	**Agenda Item 18.**	**Winter Planning**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Cathy Chadwick			Chief Operating Officer				
Author(s)	Shaun Brown			Deputy Chief Operating Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X**	BAF1 - Failure to maintain quality of care would result in poorer patient & family experience BAF2 - Failure to maintain safety and prevent harm would result in poorer patient care and outcomes BAF3 - Inability to deliver operational planning standards, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X**
Previous considerations	Finance & Performance Committee – 20th November 2024							
Executive summary	The purpose of this report is to highlight the COCH Winter Planning schemes being developed and implemented and how this interacts with the overall West Cheshire plan This report confirms: COCH currently have 509 general and acute (G&A) beds available and a further 23 beds for escalation purposes. A proposal has been developed to increase the core G&A bed base by a further 11 beds. Joint Arthroscopy inpatient activity will not transfer to WUTH Clatterbridge elective hub (as per 22/23 Winter Plan) but will remain in COCH.							

	The West Cheshire UEC Improvement Plan has a number of schemes to be implemented during Q3 and Q4 aiming to reduce unnecessary admissions, improve in hospital flow and facilitate timelier NCTR discharge.
Recommendations	The Board of Directors is asked to note the contents of this report and the next steps for implementation.

Corporate Impact Assessment	
Statutory/regulatory requirements	Constitution
Risk	No risk identified
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of the agenda pack.

Winter Planning

1. Introduction

Winter Planning is underway within COCH to mitigate against expected Winter surges in demand (November-April).

COCH currently have 509 general and acute (G&A) beds available and a further 23 beds for escalation purposes. A proposal has been developed to increase the core G&A bed base by a further 11 beds.

Whilst a large part of the additional nursing resource required to staff these areas have been sourced from existing rosters, there remains a non-recurrent cost of £253k associated with opening these beds. Nursing leaders are reviewing nursing budgetary underspends to determine where funding for this non recurrent cost pressure could be utilised.

The Elective Short Stay Unit (ESSU) will be utilised to provide a bed base for joint arthroscopy elective inpatient activity over Winter; cohort nursing, single sex lists and a ring-fenced footprint within ESSU will be prerequisites to delivering this.

A West Cheshire-wide Urgent Emergency Care Improvement programme is in place to support enhanced patient flow to mitigate the impact of increased demand for the Emergency Department and non-elective beds during Winter.

2. Background

Winter planning occurs annually across a healthcare system to prepare for predictable surges in non-elective demand. National guidance on Acute Trust's requirements for Winter planning was issued in September. CoCH have developed a Winter Plan based around these requirements to support the mobilisation of additional G&A beds. In conjunction with West Cheshire healthcare partners, an Urgent Emergency Care Improvement Plan has been developed. Numerous initiatives are planned to be implemented across the Winter period to support admission avoidance, flow within the hospital and timely discharge for NCTR patients.

3. Purpose

The purpose of this report is to highlight the plans being mobilised specifically with COCH and generally across West Cheshire Place to support patient flow and capacity during anticipated Winter surge pressures. The committee is asked to note the contents of this report.

4. National Guidance

The national guidance to support healthcare system 24/25 Winter Planning was issued on 16 September in a Winter and H2 Priorities letter (see appendix 1). Within this document, the operating assumptions for 24/25 H2 are outlined; this sets out the expectations of Acute Trusts in their preparations for Winter.

Specifically, Acute Trusts are required to:

- Review G&A core and escalation bed capacity plans.
- Review and test capacity plans in advance of Winter.
- Ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week and senior clinical decision-makers are able to make decisions in live time to manage flow.

This paper will demonstrate compliance with the above requirements.

4.2 G&A core and escalation bed capacity plans.

4.2.1 Current core and escalation bed capacity

Table 1 outlines the core and escalation bed capacity currently available. The Trust has a current core adult general and acute (G&A) bed capacity of 509 beds. This represents an increase from that available during Winter 23/24 as the Trust have, in 24/25, converted previously used escalation capacity e.g. ESSU, ward 56 additional beds, into funded beds.

Table 1: Core and escalation bed capacity

Adult G&A	COCH	EPH	Total
Core	449	60	509
ICU	15	0	15
OPEL3 escalation	6	0	6
OPEL4 escalation	15	2	17
Total	485	62	547

Twenty-three beds are currently available as temporary escalation as per the Trust's 'Operating Performance Escalation Levels (OPEL) Policy. These are detailed in Table 2.

Table 2: OPEL escalation beds

OPEL 3				
Order of consideration for use	**Ward**	**Beds**	**Additional G&A beds?**	**EL or NEL use?**
1st	Pleural Unit (overnight only)	5	5	NEL
2nd	45	1	1	NEL
	TOTAL	**6**	**6**	
OPEL 4				
Order of consideration for use	**Ward**	**Beds**	**Additional G&A beds?**	**EL or NEL use?**
1st	Modular	3	3	NEL
1st	W56	3	3	NEL/EL
2nd	ESSU (use for surgical elective outliers)	4	0	EL
2nd	Catheterisation Lab	4	4	NEL
3rd	B bay JDSC	5	5	EL
4th	EPH Stroke	2	2	NEL
5th	Pleural Suite (full use for NEL)	0	0	NEL
	TOTAL	**21**	**17**	

In addition, the Critical Care Unit funded (15 beds) and escalation (6 beds) bed capacity remains same as previous years- 21 beds.

Table 3: Critical Care Unit funded and escalation capacity

Baseline Commissioned bed base			Surge beds (Aligned and accessible within current footprint)	Additional capacity in the event of a 'super surge' (Outside ACC footprint)	Location of additional surge / escalation beds
Level 2	Level 3	Total			
8	7	15	6	10	Ward 40

4.2.2 Proposed Additional Winter G&A bed capacity

Unfortunately, given COCH's frequent heightened OPEL escalation status in Q2 and Q3, the Trust consistently runs at a high level of bed occupancy with all escalation beds detailed in table 2 often in use prior to traditional winter surge periods i.e. November- April. Despite this, ED remains congested with high numbers of patients with a decision to admit awaiting an inpatient bed. To improve this position over Winter (and to mitigate the risk of this position deteriorating) additional bed capacity (as well as the transformational improvement in flow detailed in section 4.5) will be required.

Table 4 highlights the proposed additional bed capacity that the Trust could make available to support anticipated winter surges/increases in demand. Table 5 demonstrates the proposed timeline for these additional beds to be made available.

In summary, an additional 12 beds on the Respiratory ward, could be opened as core bed capacity over Winter. Six of these beds would be provided in a bay currently converted into office space and a further 6 in the current Pleural Unit Bay on the Respiratory ward. The Pleural Unit is a clinical area which, in addition to performing respiratory day-case activity in the day, acts as an overnight 'fast flow' facility to alleviate congestion in ED overnight. Pleural Unit would relocate to SDEC and the 'fast flow' function would relocate to AMU, with the bay currently used as a training facility on AMU being converted into a 3 bedded bay and 2 side-rooms. These changes could be implemented by November/December.

In addition, as part of the RACC planking remedial work programme, ward 34 will relocate to ward 33 in January 2025 for the remainder of Q4. This will result in a loss of 1 G&A bed.

The net impact of this changes would be an increase of 11 G&A core beds over Winter.

Table 4: Proposed additional Winter bed base

	Bed change			
Ward/bay changes	Bay beds	Side-rooms	Total	Core or escalation capacity?
RSU office conversion to bay	5	1	6	Core
Pleural unit relocation to SDEC	5	1	6	Core
AMU 'education hub' conversion to bay	3	2	5	Escalation
ward 34-33	1	0	-1	Core

Each of the 3 additional spaces being proposed to being converted into G&A beds will require 1 *RN and 1 * CSW rostered during their hours of operation. Ward nursing establishments have been reviewed to ascertain opportunities for reconfiguring current ward rosters and realigning staffing

resource to the above areas to minimise additional nurse staffing costs. In summary, the additional overnight 'fast flow' beds on AMU will be staffed using existing funded AMU nursing resource. The Respiratory ward beds will provide an RN to partially staff the additional 12 beds on its ward. This will leave a residual requirement for 1 * RN and 2 * CSW 24/7. Costs and funding options are detailed in section 4.6.

Table 5: Timeline for G&A bed changes

Month	Core G&Abeds	Bed movement	Details of change
October	509	0	
November	521	12	Resp ward 2 bays, AMU 'education hub' conversion to bay *
December	521	0	
January	520	-1	Ward 34 (34 beds) moving to ward 33
February	520	0	
March	520	0	

* AMU 'education hub' will replace pleural unit in OPEL escalation bed capacity i.e. not core G&A bed capacity

Whilst these proposals will increase bed capacity within COCH, it needs to be noted that there will remain a significant community bed capacity gap. The NHSE Discharge Support Oversight Group commissioned Professor John Bolton to review West Cheshire NCTR flow in Summer 2024. The complete report highlighted a community bed capacity deficit of upto 20 beds for those patients requiring discharge on a P2 pathway i.e. requirement for bed based reablement or rehab. Whilst the onus on commissioning and mobilising additional P2 community beds lies with West Cheshire Place colleagues, COCH will continue to support the West Cheshire Place as a system partner in trying to realise a plan to mobilise these beds in time for anticipated Winter surges. Unfortunately, to date, a clear timeline for commissioning these beds has yet to be agreed.

4.3 Hospital at Home and Rapid Response

Hospital at Home (HaH) provides care that traditionally takes place in a hospital in a patient's own home. West Cheshire Place currently commissions 61 HaH beds; these are aimed at both admission avoidance and earlier medical stepdown from acute beds. These beds are managed by the COCH/CWP collaborative. Of these 61 beds, 4 have recently gone live in October to support Winter surge planning and will be utilised to support Heart Failure patients.

Additional HaH initiatives in place to support Winter surge planning include:

- A commitment to maintain 95%+ HaH bed occupancy.
- Recruitment of Community Geriatrician sessions to increase numbers of patients referred from wards.
- Continued daily presence in SDEC and AMU.
- Continuation with elastomeric home antibiotic infusions trial (equates to 3 beds).
- Co-locate SPA and HaH triage line in January- aims to reduces ED attendance by 5% daily.
- Trial of Consultant nurse in NWAS ambulance control to reduce conveyances.

COCH's Rapid Response service facilitates prompt and early supported discharges for patients not meeting the criteria to reside (NCTR) on a P1 pathway and also prevent unnecessary hospital admissions from the ED. The service is aiming to maintain 95% + occupancy over Winter to maximise use of the service.

All H@H and Rapid Response Winter initiatives are externally funded through the Better Care Fund.

4.4 Elective Planning

The Elective Short Stay Unit (ESSU) is an 11 bedded area within the Jubilee Day Surgery Centre currently used to deliver both inpatient Joint Arthroscopy and elective surgical activity. In 23/24 joint arthroscopy activity was transferred to Wirral University Teaching Hospital's (WUTH) Clatterbridge Elective Hub in Q4 to allow the whole of ESSU to be utilised for elective surgical activity (and enable elective surgical beds on Surgical wards to be used to either support surgical non-elective activity or medical outliers).

Whilst this arrangement safeguarded COCH's ability to continue with joint arthroscopy activity, it did result in a loss of activity (and therefore income) as a result of the activity being transferred to another provider. For 24/25, Q4 joint arthroscopy inpatient activity forms a core part of Trauma and Orthopeadic (T&O) annual activity plan with a planned delivery profile in Q4 of 68 joint arthroscopy operations at a value of £530k. As a result, the Planned Care Division and Trauma and Orthopeadic clinicians have planned to retain all joint arthroscopy activity in Q4 at COCH and, to facilitate this, will manage joint arthroscopy inpatients within a ring-fenced but smaller bed base on ESSU than previously.

This will be done through ringfencing a bay of 3 beds and upto 3 side-rooms on ESSU exclusively for joint arthroscopy activity and providing single sex only joint lists. The remaining 5 bedded bay of the bed base on ESSU will be used for surgical elective inpatients. Cohort nursing will be implemented to ensure the joint and surgical elective bays of ESSU are kept separate. The additional staffing associated with implementing cohort nursing will be borne from existing Planned care Division nursing rosters.

4.5 UEC Improvement Programme

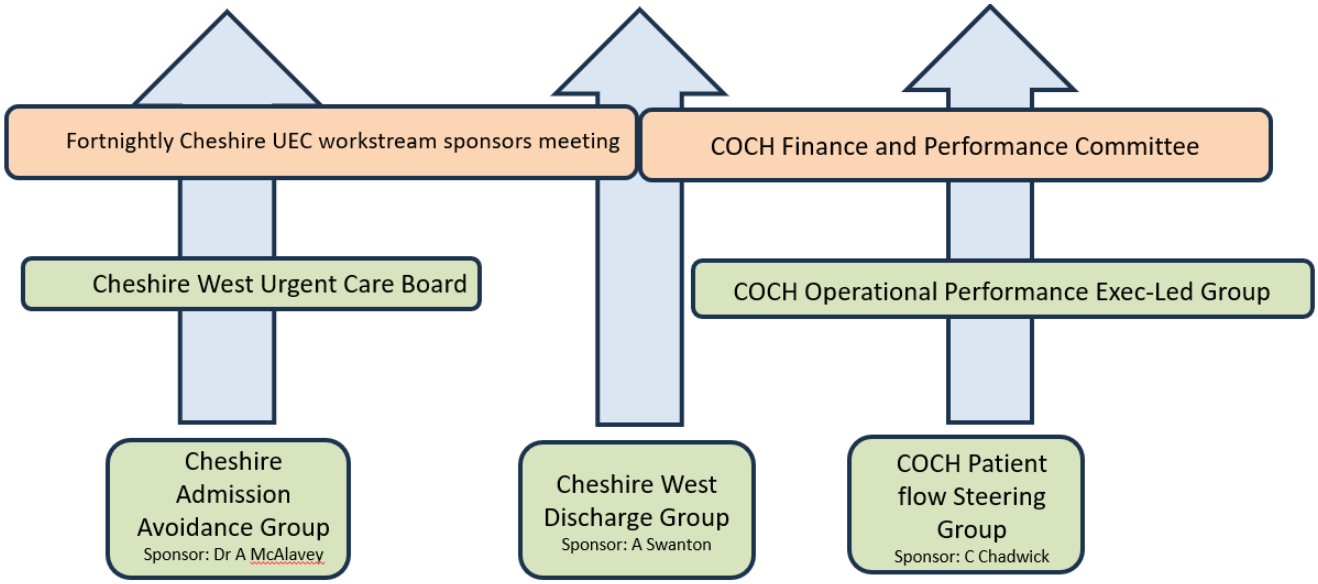
4.5.1 Summary

A system-wide Urgent and Emergency Care (UEC) Improvement Programme has been developed across three core improvement groups:

- Admission Avoidance Group
- Patient Flow Steering Group
- Discharge group

Picture 1 highlights the governance structure of the UEC Improvement Programme.

Picture 1: West Cheshire UEC Improvement Programme



COCH leads the Patient Flow Steering Group which manages the elements of UEC improvement related to Emergency Department (ED), Same Day Emergency Care (SDEC) and inpatient ward. In addition, progress reporting and assurance of delivery against the Winter Plan is provided within this group.

COCH provides senior management representation to the Admission Avoidance and Discharge Groups.

Each group has an improvement programme with numerous initiatives to be implemented over the Winter period to support capacity and service provision during Winter surge.

A summary of the key initiatives for each group are detailed below:

4.5.2 Admission Avoidance group

- Additional support to be provided by HaH service to care homes with higher admissions rates.
- Redesign of Single Point of Access service to provide more robust options for alternative to admissions.
- Implementation of risk stratification in three GP practices to target preventative admission actions.

4.5.3Patient Flow Steering Group

- Proactive breach management action plan: review of Progress Chaser role, use of CDU/SDEC, robust validation, clinical engagement.
- Daily ED performance breach meeting reviewing performance for the previous day in place.
- Embedding of clear roles for medical roles e.g. ACE, EPIC, SpR overnight.
- Refresh of medical handover- structure and outputs.
- Triage <15 mins improvement plan.
- Increased T3 attendances – extend UTC operating hours till 11pm.
- Tier 1 ECIST UEC support offer: ED-Intra professional standards, streaming/triage, front door frailty, call before convey.
- Optimisation SDEC – early ‘pull’ from ED daily, review of staffing and feasibility assessment of midnight closure.
- Estates capital work to be completed before 24/25-year end:

- Additional UTC clinical rooms/space for T3 attendances
- Mental Health/Learning Disability area- bespoke area which can be used flexibly.

- SDEC nurse staffing to be bolstered by additional 2 * bd 5 and 1 * bd 7 RN to support higher levels of activity in SDEC. Cost neutral-staffing pulled from AMU roster.
- Review of OPEL policy actions cards for key roles.
- Preventing Deconditioning Programme to be rolled out across all wards.
- Monthly oversight meetings with ward leadership teams to challenge discharge performance and KPI's in place.
- Revamped Manager of the Day role.
- Schedule of discharge events and MADEs.
- Discharge Lounge estate upgrade- creation of stretcher area and additional space.
- Redesign of Co-ordination Centre functions and processes

4.5.4Discharge Group

- Additional 6 residential 'Discharge to Recover' nursing home beds commissioned in October.
- Additional therapy staffing provided to all commissioned Discharge to Recover beds.
- Expansion of reablement service to support additional P1 discharges.

4.6 Financial Costs

As previously described in 4.2.2, current funded nursing rosters on AMU and Respiratory wards have been reviewed to realign some of the existing resource to support the additional staffing requirements for the proposed additional 12 beds on Respiratory ward and 5 additional 'fast flow' beds on AMU. There remains a residual staffing cost of 1 * RN and 2 * CSW 24/7:

Table 6: Costs to staff additional escalation beds:

Month	Monthly cost
Nov from 18/11/24	£24,712
Dec	£57,029
Jan	£57,029
Feb	£57,029
Mar	£57,029
Total	£252,828

Overall nursing budgets are £1.6m underspent at month 6. Senior nursing leaders are reviewing nursing cost centres to confirm a plan for funding the above costs from projected month 9-12 underspends within nurse staffing cost centres.

4.7 Next steps

- W/c 11/11/24: Funding plan for non-recurrent additional nursing costs utilising project future underspends from nurse staffing cost centres to be confirmed.
- W/c 11/11/24Executive Decision Group to confirm approval of proposed Winter Plan.
- W/c 18/11/24: Mobilisation plan for additional G&A beds to be implemented if approval given.
- Ongoing: Progress and delivery against UEC Improvement initiatives to be tracked and managed via agreed governance framework.

5. Conclusion

COCH Winter planning has been in line with national requirements and proposes a combination of the provision of additional G&A and H@H bed capacity and the implementation of UEC improvements plans to support admission avoidance, flow within the hospital and timely discharge for NCTR patients.

6. Recommendations

The Board of Directors is asked to note the contents of this report and the next steps for implementation.

Appendix 1: Winter and H2 Priorities Letter

To:
- Integrated care board:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
- Integrated care partnership chairs
- All NHS trust and foundation trust:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
- Regional directors

cc.
- Local authority:
  - chief executive officers

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

16 September 2024

Dear colleagues

Winter and H2 priorities

Further to the meeting with ICB and provider chief executives on 3 September, we are now confirming operating assumptions for the remainder of this financial year.

This letter outlines the steps NHS England is going to take, as well as those ICBs and providers are asked to take, to support the delivery of safe, dignified and high-quality care for patients this winter.

Planning and financial framework

You are all aware of the tight financial environment both across the NHS and for the government more widely; it remains essential in H2 that systems continue their work to return to their agreed 2024/25 plans.

Providing safe care over winter

As set out in our letter of 16 May, we are in the second year of the delivery plan for recovering urgent and emergency care (UECRP).

Colleagues across the country have worked incredibly hard to implement the priority interventions identified in the UECRP. This has delivered improvements in performance on the 4-hour emergency department (ED) and Category 2 ambulance response time ambitions, against an extremely challenging backdrop.

The delivery priorities for this winter remain unchanged from those agreed in system plans.

We all recognise, however, that despite these improvements, far too many patients will face longer waits at certain points in the pathway than are acceptable.

Given demand is running above expected levels across the UEC pathway, ahead of winter we collectively need to ensure all systems are re-confirming that the demand and capacity plans are appropriate and, importantly, are taking all possible steps to maintain and improve patient safety and experience as an overriding priority.

Supporting people to stay well

As a vital part of preventing illness and improving system resilience, it will be important to maximise the winter vaccination campaign.

As well as eligible population groups, it is imperative that employers make every possible effort to maximise uptake in patient-facing staff – for their own health and wellbeing, for the resilience of services, and crucially for the safety of the patients they are caring for.

More detail on eligible flu cohorts is on gov.uk:

- National flu immunisation programme 2024 to 2025
- COVID-19 autumn/winter eligible groups

We confirmed campaign timings for both vaccines in our system letter on 15 August.

This year for the first time, the NHS is offering the RSV vaccine to those aged 75 to 79 and pregnant women. This is a year-round offer but its promotion ahead of winter by health professionals is vital, particularly to those at highest risk.

To support vaccination efforts, NHS England will:

- ensure all relevant organisations receive information as quickly as possible for flu, COVID-19 and RSV
- maintain the National Booking Service, online and through the NHS 119 service for COVID and flu (in community pharmacy settings)
- continue to share communication materials to support local campaigns

ICBs are asked to work with:

- local partners to promote population uptake with a focus on underserved communities and pregnant women
- primary care providers to ensure good levels of access to vaccinations, ensuring that plans reflect the needs of all age groups, including services for children and young people and those who are immunocompromised
- primary care and other providers, including social care, to maximise uptake in eligible health and care staff

NHS trusts are asked to:

- ensure their eligible staff groups have easy access to relevant vaccinations from Thursday 3 October, and are actively encouraged to take them up, particularly by local clinical leaders
- record vaccination events in a timely and accurate way, as in previous campaigns
- monitor staff uptake rates and take action accordingly to improve access and confidence
- ensure staff likely to have contact with eligible members of the public are promoting vaccination uptake routinely

Maintaining patient safety and experience

We recognise this winter is likely to see UEC services come under significant strain, and many patients will face longer waits at certain points in the pathway than acceptable.

It is vital in this context to ensure basic standards are in place in all care settings and patients are treated with kindness, dignity and respect.

This means focusing on ensuring patients are cared for in the safest possible place for them, as quickly as possible, which requires a whole-system approach to managing winter demand and a shared understanding of risk across different health and care settings.

Evidence and experience shows the measures set out in the UECRP are the right ones, and systems and providers should continue to make progress on them in line with their local plans, with assurance by regional teams.

In addition, NHS England will continue to support patient safety and quality of care by:

- standing-up the winter operating function from 1 November:
  - providing capabilities 7 days a week, including situational reporting to respond to pressures in live time
  - this will be supported by a senior national clinical on-call rota to support local escalations
- completing a Getting It Right First Time (GIRFT) data-led review of support needs of all acute sites:
  - across all systems, and deploying improvement resources as appropriate, to support implementation of key actions within the UECRP, with a dedicated focus on ensuring patient safety
- convening risk-focused meetings with systems:
  - to bring together all system partners to share and discuss key risks and work together to agree how these can be mitigated
- expanding the Operational Pressures Escalation Levels (OPEL) framework:
  - to mental health, community and 111, and providing a more comprehensive, system-level understanding of pressures

NHS England will continue to support operational excellence by:

- co-ordinating an exercise to re-confirm capacity plans for this winter, which will be regularly monitored
- running an exercise in September to test the preparedness of system co-ordination centres (SCCs) and clinical oversight for winter, including issuing a new specification to support systems to assess and develop the maturity of SCCs

NHS England will continue to support transformation and improvement by:

- continuing the UEC tiering programme to support those systems struggling most to help them to enact their plans
- reviewing updated maturity scores for UEC high-impact interventions with regions and ICBs, to identify further areas for improvement
- as part of NHS IMPACT, launching a clinical and operational productivity improvement programme in September:
  - this will include materials and data for organisations to use, as well as a set of provider-led learning and improvement networks, to implement and embed a focused set of actions

ICBs are asked to:

- ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter:
  - primary care and community services should be working with these patients to actively avoid hospital admissions
- provide alternatives to hospital attendance and admission:
  - especially for people with complex needs, frail older people, children and young people and patients with mental health issues, who are better served with a community response outside of a hospital setting
  - this should include ensuring all mental health response vehicles available for use are staffed and on the road ahead of winter
- work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow
- assure at board level that a robust winter plan is in place:
  - the plan should include surge plans, and co-ordinate action across all system partners in real time, both in and out of hours
  - it should also ensure long patient delays and patient safety issues are reported, including to board level, and actions are taken appropriately, including involving senior clinical decision makers
- make arrangements through SCCs to ensure senior clinical leadership is available to support risk mitigation across the system
- review the 10 high-impact interventions for UEC published last year to ensure progress has been made:
  - systems have been asked to repeat the self-assessment exercise undertaken last year, review the output, consider any further actions required, and report these back through regions

NHS trusts are asked to:

- review general and acute core and escalation bed capacity plans:
  - with board assurance on delivery by the peak winter period
- review and test full capacity plans:
  - this should be in advance of winter
  - in line with our letter of 24 June 2024, this should include ensuring care outside of a normal cubical or ward environment is not normalised; it is only used in periods of elevated pressure; it is always escalated to an appropriate member

of the executive and at system level; and it is used for the minimum amount of time possible

- ensure the fundamental standards of care are in place in all settings at all times:
  - particularly in periods of full capacity when patients might be in the wrong place for their care
  - if caring for patients in temporary escalation spaces, do so in accordance with the principles for providing safe and good quality care in temporary escalation spaces
- ensure appropriate senior clinical decision-makers are able to make decisions in live time to manage flow:
  - including taking risk-based decisions to ensure ED crowding is minimised and ambulances are released in a timely way
- ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week:
  - with appropriate front door streaming, senior decision-making, regular board and ward rounds throughout the day, and timely discharge, regardless of the pathway through which a patient is leaving hospital or a community bedded facility

Next steps

In addition to existing guidance in the UECRP Year 2 letter and elsewhere, we have recently published further evidence-based guidance in the following areas to support further optimisation of winter plans:

- Same day emergency care service specification
- Single Point of Access hubs
- Virtual wards operational framework

As set out above, system risk discussions will follow during September.

We want to thank you and everyone across the NHS for your continued hard work this year.

Together, we are committed to doing everything we can to support the provision of safe and effective care for patients this winter, as well as continuing to improve services for the longer term.

Yours sincerely,

Sarah-Jane Marsh

National Director for Urgent and Emergency Care and Deputy Chief Operating Officer

Dr Emily Lawson DBE

Chief Operating Officer

Professor Sir Stephen Powis

National Medical Director

Duncan Burton

Chief Nursing Officer for England

PUBLIC – Board of Directors

26th November 2024

eport	**Agenda Item 19.***	**Core Standards Update – Emergency Preparedness, Resilience and Response (EPRR)**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Cathy Chadwick			Chief Operating Officer				
Author(s)	Emma Binns			Emergency Preparedness, Resilience and Response Manager				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X**	Paper contributes to the assurance on emergency preparedness, impacting quality, safety and operational risks.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Finance and Performance Committee – 25th September 2024 Finance and Performance Committee – 20th November 2024							
Executive summary	The purpose of this report is to provide an executive overview of Emergency Preparedness, Resilience and Response (EPRR) preparedness within the Trust and an update on the compliance with the NHS England EPRR Core Standards 2024/25.							
Recommendations	The Board of Directors is asked to: • Note the assurance with the improvements in compliance against the Core Standards. • Note the ongoing work to embed the Emergency Preparedness Resilience and Response agenda within the Trust.							

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the requirements of the Civil Contingencies Act 2004 and NHS Emergency Preparedness Resilience and Response.

Risk	EPRR risks are a standing agenda item on the EPRR Strategy Group
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of the agenda pack.

Core Standards Update – Emergency Preparedness, Resilience and Response (EPRR)

1. Introduction

1.1 The annual NHS England EPRR Core Standards Assurance is the minimum standard all providers and commissioners of NHS services are required to meet with regards to their Emergency Preparedness Resilience and Response (EPRR) portfolio. It forms the basis of assurance against NHS Resilience, seeking to understand whether those organisations will be capable of maintaining critical services whilst responding to or managing disruption. All findings ultimately report through to the Department of Health and Social Care (DHSC) and the Secretary of State for Health and Social Care.

1.2 There were 62 standards applicable to COCH this year as well as an 11 standard Deep Dive into Cyber Security arrangements. The Trust has assessed itself as **partially compliant** against the return, and this was submitted in draft to the Cheshire & Merseyside Integrated Care Board (ICB) EPRR Team on the 27th September. Details of the submission was presented verbally to the Finance & Performance Committee on the 25th September.

2.0 Legal and Regulatory requirements

2.1 The content of this report is directly applicable to requirements listed in:

- Civil Contingencies Act 2004.
- Emergency Preparedness Regulations 2005,
- Emergency Response and Recovery, 5th Edition, 2013, and
- associated Cabinet Office guidance.
- Expectations and indicators of good practice set for category 1 and 2 responders
- Section 46 of the NHS Act 2006, as amended by the Health & Social Care Act 2012.
- Health & Safety at Work Act 1974.
- Health and Care Act 2022.
- Equality and health inequalities legal duties.
- The National Risk Register.
- Skills of Justice NOS.
- Minimum Occupational Standards for NHS Emergency Preparedness, Resilience and Response (MOS).
- NHS England Business Continuity Management Framework (Service Resilience).
- NHS EPRR Framework, 2022.
- ISO 22301:2019 Security and resilience – Business continuity management
- NHS Constitution.
- NHS Standard Contract(s)
- NHS Core Standards for Emergency Preparedness, Resilience and Response.
- Other EPRR guidance available on the NHS England website.

2.2 Other applicable items include:

- The Counter Terrorism and Security Act 2015.
- Control of Major Accident Hazards Regulations 2015.
- Radiation Emergency Preparedness& Public Information Regulations 2001.

- Management of Health & Safety at Work Regulations 1999.
- Data Protection Act 2018.
- General Data Protection Regulations.
- Health Protection Legislation (England) Guidance 2010.
- Caldicott Principles.

3.0 Previous report

3.1 NHS England Emergency Preparedness, Resilience & Response (EPRR) Core Standards Assurance 2023, 27th September 2023.

4.0 EPRR Core Standards

4.1. Whilst there are a total of 73 standards and 11 domains, the applicability is dependent on the organisation's function and statutory requirements. COCH is rated against standards applicable to "Acute Providers". The overall assurance rating is reached via percentage of standards assessed as 'fully compliant'.

4.2. This year COCH was assessed against 62 standards, 48 of which were rated as 'fully compliant' and 14 were rated as 'partially compliant'. This provides an increased assurance rating from non-compliant to 'partial compliance'. No standards were assessed as non-compliant.

4.3. In 2023 the Trust achieved:

Full compliance against 5 standards.
Partial compliance against 57 standards

The criteria between full, partial and non-compliance of standards is as follows:

Individual Standard Compliance level	Compliance Definition (Main return)
FULLY COMPLIANT	**Fully compliant** with the core standard.
PARTIALLY COMPLIANT	**Not compliant** with the core standard. However, the organisation's EPRR work programme demonstrates **sufficient evidence of progress and an action plan** is in place to achieve full compliance within the next 12 months.
NOT COMPLIANT	**Not compliant** with the core standard. The organisation's EPRR work programme shows compliance will **not** be reached within the next 12 months.

4.4 A summary of compliance against the standards can be found appended to this report.

5.0 Process of assurance

5.1 The EPRR Manager completed the self-assessment and the spreadsheet, and all evidence was submitted via the NHS Cheshire & Merseyside ICB Resilience Direct depository on the 27th September.

5.2 Unlike the 2023 submission, the Trust have only been fully assessed against 6 of the 62 Standards as follows:

- Governance – EPRR Policy Statement
- Governance – EPRR Resource
- Governance – Continuous Improvement
- Duty to maintain plans – Protected Individuals
- Cooperation – LRF/BRF Engagement
- Hazmat/CBRN – Waste Disposal Arrangements

A number of areas of development were identified within the EPRR Policy and this will be added to the EPRR Work Programme.

Further evidence has been submitted to the ICB in support of the other standards reviewed.

5.3 The EPRR work programme will be updated to incorporate the recommendations from this process in addition to the gaps identified when completing the assurance process.

5.4 Progress against this workplan will be overseen by the Emergency Preparedness Resilience and Response (EPRR) Strategy Group, Operational Performance Executive Led Group (OPELG) and the Finance & Performance Committee (F&P).

6.0 ICB Feedback on assessed Core Standards

The following feedback was received from the ICB in relation to the six standards that were assessed. Following the initial feedback, the Trust were given 5 days to submit further evidence. Upon receipt of the final feedback, a decision was made to challenge the compliance rating in relation to the Policy and an updated draft EPRR Policy which included all of the recommendations was submitted to the ICB.

Core Standard	Initial feedback	COCH actions taken	ICB compliance rating suggestion following review
2 Governance EPRR Policy Statement	• The EPRR Policy needs to include security markings. • The EPRR Policy includes references to old terminology (i.e. NHSE as commissioning Board). • The EPRR Policy needs to include Strategic, Tactical and Operational commanders under roles and responsibilities. • The Policy needs to include terminology for Strategic/Tactical/Operational Commanders throughout to align with JESIP requirements. • The governance section needs to include the frequency that the oversight groups meet (EPRR Strategy Group / Quality and Safety Committee). X	Marked as Official Policy updated with new terminology. There is a paragraph that states who will undertake Strategic, Tactical and Operational roles however, this has been strengthened throughout the plan. The frequency of meetings has been included (this was included in the annex at the back of the Policy). Supplier information has been updated.	Disagree, partial COCH challenged and disagree.

	• Further information required on arrangements for key suppliers and contractors (who, how and when). • The policy needs to reference access to funds for EPRR. • The policy requires further information on continuous improvement - how are lessons identified documented, monitored, escalated and assured. • The policy needs to include the consultation process for EPRR policies and plans, both with internal and external stakeholders.	Finance information has been included within the update. This section has been updated and and reflects what has been included within the Incident Response Plan. A paragraph has been included.	
5 Governance EPRR Resource	• EPRR Manager job description, governance and reporting arrangements evidence items listed have not been submitted to allow us to review. • No organisational structure chart for EPRR included within the EPRR Policy to show the designated EPRR resource.	EPRR JD was included within initial update. Organisational structure drafted and included within plan. Governance structures also included.	Disagree, partial. COCH challenged and disagree

6 **Governance** **Continuous Improvement**	• The EPRR Policy requires further information on continuous improvement, including how are lessons identified, documented, monitored, escalated and assured. • The Incident Response Plan refers to lessons learned rather than lessons identified. Lessons are only learned once a change has been conducted and embedded. Be mindful of this terminology. • The definitions of hot and cold debriefs need updating to align with the EPRR Framework 2022. • Identification of who is trained to deliver debriefs required and documented. • There is no evidence of a lessons identified tracker, reporting of lessons, action plans with clear owners, or any debrief reports. This needs including.	Information regarding lessons identified has been expanded upon within the plan. The Trust already do this as business as usual. This is included within the IRP, this has now been included within the policy. The lessons identified tracker was submitted as additional evidence, however, the Exercise Roman Debrief Report was included with the original evidence but has not been acknowledged. The action plan from this debrief was used to develop the Incident Response Plan – the EPRR Manager has challenged why this has not been included as evidence.	Disagree, partial. Lessons identified action log provided, including lessons from the M53 incident only. Southport Incident briefing document.
18 **Duty to maintain plans** Protected Individuals	• VIP Action card within the Incident Response Plan is only in reference to a VIP requiring medical treatment. Information on VIPs as a visitor needs to be included. • VIP Policy not submitted – copy required.	Protected Individuals Policy provided.	Agree, full.

38 **Cooperation** LRF / BRF Engagement	• Evidence provided does not allow us to assess this core standard – please submit the relevant evidence for us to review.	Weekly roundup emails from NHS Cheshire and Merseyside. Invite from the LRF for Exercise Paddock.	Agree, full - noting there is a LHRP MoU for Cheshire and Merseyside.
62 **Hazmat / CBRN** Waste disposal arrangements	• The CBRN plan submitted as evidence is in draft and has not been signed off. Is there a live plan accessible to staff currently?	Live document provided is currently being reviewed (v2.1 March 2022)	Agree, full

General Comments:	• Statement of compliance signed; however, the Finance and Performance Committee date has been included instead of the Board date • The date to be published in the annual report is outstanding (this can be a later date) – please include

7.0 Next Steps

7.1 The updated EPRR Policy will be tabled at the EPRR Strategy Group on the 26th November, formal approval will then be requested from the Finance & Performance Committee.

7.2 The EPRR Manager will continue to undertake the EPRR work programme and focus on the following areas:

- CBRNe
- Business Continuity
- Training & Exercising
- Evacuation and Shelter
- Embedding of the EPRR agenda across the Trust

7.3 A detailed action plan is available at Annex 1.

Annex 1 - Core Standards Action Plan

Core Standard Title	Compliance Rating	Action required	Target Completion Date
New and emerging pandemics	Partial	The Pandemic Framework is currently being reviewed to take into consideration the new Emerging Panemdic Guidance. The COCH element has been drafted however, further guidance is required in relation to the multi agency arrangements.	March 2025
Evacuation and shelter	Partial	A review of the Trust evacuation plan has been undertaken however further work is required on a regional basis.	March 2025
Staff Awareness & Training	Partial	There is an on-call handbook and EPRR training has been delivered. Departmental EPRR sessions have been identified as a gap and is one of the actions from this process.	September 2025
LHRP Engagement	Partial	The Chief Operating Officer attends the LHRP as the Accountable Emergency Officer on behalf of the Trust.	December 2025
Business Impact Analysis/Assessment (BIA)	Partial	Business Impact Analysis have been undertaken across the majority of departments within the Trust. There is a BC monitoring report to track progress..	March 2025
Business Continuity Plans (BCP)	Partial	Business Impact Analysis have been undertaken and outstanding areas now need draft the plans in alignment with the BIAs.	June 2025
BC Training & Exercising	Partial	An exercise schedule has been developed to test each BC Plan. Debriefs will be undertaken and lessons learnt will be incorporated into plans. There will also be a forum within the BC Group to share good practice between divisions and departments.	September 2025
Hazmat/CBRN risk assessments are in place which are	Partial	A group has been established within ED to review the CBRN arrangements. The Risk Assessment will be developed as part of this group.	December 2024

appropriate to the organisation type			
	Partial		
Hazmat/CBRN planning arrangements	Partial	The plan is currently being reviewed. NWAS are attending ED on the 26/11/2024 and the updated plan will be available for this review. A Task & Finish Group has been established and meets bi-weekly.	December 2024
Decontamination capability availability 24 /7	Partial	The equipment is held within the department. However, there is a training deficit and members of the ED need to attend the NWAS training when available to ensure that there are enough trained staff available on a 24/7 basis. As soon as training has been undertaken, the rota will be updated to include a column that indicates those on shift that are Decon trained.	September 2024
Equipment and supplies	Partial	Equipment and supplies are being audited by NWAS on the 26/11/2024, any recommendations from this audit will be added to the CBRNe Action Log owned by the ED Management Team.	January 2025
Equipment - Preventative Programme of Maintenance	Partial	A CBRNe Champion is to be identified to undertake regular checks of the equipment.	November 2024
Hazmat/CBRN training resource	Partial	There are a number of staff who are trained within the department. However, due to the large turnover of staff it has been agreed that a training programme will be established and that every person in the department will attend this on a rolling basis.	September 2024
Staff training - recognition and decontamination	Partial	Updated training is required from NWAS, this will be discussed at the Audit on the 26/11/2024.	June 2025

Committee Chair's Report

Wednesday 25th September 2024, 2.00pm – 4.15pm, via Microsoft Teams

Committee	Finance & Performance Committee
Chair	Mrs P Williams, Non-Executive Director

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

Alert

(matters that the Committee wishes to bring to the Board's attention)

- The Committee received a Health & Safety Update for information The Committee noted that the update was for reassurance rather than assurance at this stage. As such, the Committee had only limited assurance and a more comprehensive, assurance based report was requested to be received at the next Committee meeting.

Assure

(matters in relation to which the Committee received assurance)

- The Committee received the Radiology Services Oversight Report noting the good level of assurance received.
- The Committee noted the assurance provided in the System Oversight Framework Report – August 2024.
- The Committee received a verbal Emergency Preparedness Response and Resilience (EPRR) and Compliance with Core Standards update noting the assurance provided and the significant progress made over the last twelve months.
- The Committee received the Information Governance Annual Report 2023/24 noting the progress being made and approved the annual report with the level of assurance contain within it.
- The Committee received an Electronic Patient Record (EPR) update noting the progress made on the EPR work programme, including optimisation and upgrade progress, with the assurance that gateways have been met and the first 'go' 'no go' decisions have been achieved.
- The Committee received the Cyber Security Update 2024/25 noting assurance and the:
  - planned October deployment of the Cynerio security tool to help to mitigate risks and increase patient safety.
  - provision of breached password software for computer access into key areas of the Trust (including Finance, Data and Digital).
  - changes to the Data Security and Protection Toolkit (DSPT) that will come into effect in 2025.
  - continued progress on actions from Mersey Internal Audit Agency (MIAA) infrastructure audit.
  - high compliance with Multi-Factor Authentication (MFA) and final actions in progress.
  - preparation has started for the 2024/25 DSPT completion and submission.
  - relevant cyber incidents are noted and continue to inform cyber security plans with a view to costing options for increase network segmentation.

- The Committee received the Month five (August 2024) finance position – 2024/25. A further update will be provided within the month six position paper to the Committee detailing the £14m allocation from the Integrated Care Board (ICB).

Advise

(items presented for the Board's information)

- The Committee received a Thirlwall Inquiry – Financial Spend Elements update as at the end of Month five 2024/25.
- The Committee received the Board Assurance Framework (BAF) – Quarter 2 2024/25 and High Risks Report and considered the current high level risks relating to Finance and Performance and the BAF extract in terms of triangulation with the work of the Committee. With a review of the report to be undertaken to ensure assurance is contained within it and an update to be shared with the Committee summarising the actions and timescales around the development of the report, in addition to an update from the responsible person for items one, five and six on the High Risk Register/BAF extract in advance of the next meeting.
- The Committee received the PricewaterhouseCoopers (PwC) Financial Improvement Support Action Plan noting its content
- The Committee received the Cost Improvement Plan (CIP) Progress update noting the month 5 status of the 2024/25 CIP delivery and the action being taken to accelerate the delivery of CIP in 2024/25.
- The Committee received the NHS England (NHSE) Grip and Control Checklist and agreed to consolidate this checklist with the Healthcare Financial Management Association (HFMA) financial sustainability checklist and the PwC action plan.
- The Committee received the 2024/25 Quarter 1 Waiver Report noting its contents and the work being undertaken to reduce the number of waivers raised within the Trust.
- The Committee received the 2024 National Cost Collection (NCC) Post-submission Board Assurance Report noting that the 2023/24 NCC was submitted (and accepted by NHS England) on the 18th July 2024 and that the delegated NCC sign-off by the Chief Finance Officer was provided.
- The Committee received a Productivity Benchmarking Update noting the current position and next steps

The Committee noted the following items:

- Commercial Procurement Income Group Chair's Reports – 26th June 2024 and 22nd July 2024
- Women's and Children's New Building Project Chair's Report – 5th September 2024
- Information Governance and Information Security Committee Chair's Report – 15th July 2024
- Operations & Performance Executive Led Group (OPELG) Chair's Report – 15th August 2024
- Digital Transformation Group Chair's Reports – 4th July 2024 and 1st August 204
- EPR Programme Board Chair's Report – 27th June 2024 and 25th July 2024

Risks discussed and new risks identified

- Health and Safety compliance limited assurance
- RAAC risk in Women and Children's building

Committee Chair's Report

15th October 2024, 2.00pm – 5.00pm, Boardroom – 1829 Building

Committee	Audit Committee
Chair	Mr M Guymer, Non-Executive Director

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

Alert

(matters that the Committee wishes to bring to the Board's attention)

- There were no items to alert to the Board of Directors.

Assure

(matters in relation to which the Committee received assurance)

- Committee organogram still being developed, governance being enhanced and approach to committee effectiveness review agreed.
- Risk management policy approved and improvement plan in place. Progress will be tracked through the Audit Committee.
- Out of date policy plan progressing, recognising there is a significant amount of work to do, and tracking system requested.
- Progress against internal audit plan and counter fraud plans on track.
- Legal services internal audit report provided only limited assurance, but clear action plan in place and system controls have been strengthened.
- Assurance also provided on FTSU, waivers and debt write off processes.

Advise

(items presented for the Board's information)

- MIAA Insight into "Bank and Agency Benchmarking" referred to P&OD Committee for consideration and review.
- Proposal to extend external auditors subject to COG approval, recognise this will extend beyond the 10 years but with benefits outweighing the risk to comply or explain.
- The Audit Committee received the BAF and discussed further refinement of causes and consequences. There were no new risks discussed or identified by the Committee.

Committee Chair's Report

Tuesday 8th October 2024, 1.00pm – 5.00pm, Boardroom – 1829 Building

Committee	People Committee
Chair	Ms W Williams, Non-Executive Director

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

Alert

(matters that the Committee wishes to bring to the Board's attention)

- Appraisal rates remain below expected target levels. Continuing to work on actions to improve appraisal compliance rates and Committee seeking further assurance.

Assure

(matters in relation to which the Committee received assurance)

- GMC survey results overall in line with previous years and national averages. Actions and progress for overall adequacy of experience and local teaching, as well as Divisions/ speciality specific action plans to be reported back to People Committee (December 2024).
- Safer nurse staffing establishments.
- Progress against people promise exemplar programme (NHS England visit to COCH planned November 2024).
- Leadership development programmes roll out progressing well.

Advise

(items presented for the Board's information)

- Terms of Reference membership resolved.
- New adult safer staffing tool being reviewed, and implementation commenced (likely to see data collection commenced from 2025).
- Workforce plan discussion and connection to Board session and need for strategic view to bring together detailed strands
- The CPO Report updated on a range of areas including our commitment to the NHS England sexual safety charter, implementation of the revised people services structure, communication and engagement for the NHS national staff survey, and band 2 to 3 healthcare support worker review.

Risks

(discussed and new risks identified)

- The high risk report was discussed and included risks and actions in relation to the Trust's payroll service, medical rostering, medical devices safety officer role, poor staff experience and medical workforce gaps.

PUBLIC – Board of Directors

Date of meeting: 26th November 2024

Report	**Agenda Item 23.**	**People Strategy 2021 – 2026 Progress Update**						
Purpose of the Report	Decision	**X**	Ratification		Assurance	**X**	Information	**X**
Accountable Executive	Debbie Herring			Interim Chief People Officer				
Author(s)	Debbie Herring			Interim Chief People Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X**	BAF impact is to develop a great workplace culture, staffed by effective and motivated staff to deliver the very best patient care.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X**
Previous considerations	Not applicable							
Executive summary	The purpose of this report is to provide an annual update on the Trust's 5-year People Strategy which was implemented in 2021. The fast pace of change, the Covid 19 pandemic, and the operational and financial pressures on the NHS services means that some areas of the strategy relating to leading and managing the Trust during and post pandemic are not now as relevant. Some significant progress is noted against the deliverables set out in 2021, but work on a new 3-year strategy, aligned to the Trust's corporate strategy "Transforming Care Together", will commence in 2025.							
Recommendations	The Board of Directors is asked to: • Note the update received and the assurance provided against the 2021 – 2026 People Strategy priorities. • Note the further priority actions set out in this paper with work commencing on the new People Strategy in 2025.							

	• Agree that progress against these priorities will be reported through the People Committee with an annual update to the Trust Board.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	To develop a great workplace culture, staffed by effective and motivated staff to deliver the very best patient care, risk included on strategic risk register
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

People Strategy 2021 – 2026 Progress

1. Background

The Trust employs circa 5000 people in a wide variety of roles, delivering acute, some specialist and community care and is the largest employer in Chester.

A 5-year People Strategy was implemented with effect from June 2021, with agreement that an update would be provided to the Board of Directors annually. A template document was used to outline the deliverables set out in this strategy and progress against these measures was most recently presented to the People Committee in August 2024.

The current strategy concludes in 2026, but it is recognised that the environment has changed significantly and that a new strategy will be required in 2025, aligned to the Trust's corporate strategy, 'Transforming Care Together'. Work to develop this strategy, including engagement with key stakeholders, will begin in the new calendar year. This will focus on the 4 Delivery Pillars of the 2030 National People Vision, underpinned by the 7 areas of the People Promise to improve staff experience, for which the Trust is an exemplar site. This is captured in the table below.

Our Ambitions	NHS People Promise	2030 Vision for HR & OD
Looking after our staff	We are compassionate and inclusive We are recognised and rewarded We are safe and healthy	Prioritising the health and wellbeing of all our people Creating a great employee experience
Culture and belonging	We each have a voice that counts We are a team	Ensuring inclusion and belonging for all
Growing and developing our workforce	We are always learning	Supporting and developing the people profession Harnessing the talents of all our people
New ways of working and delivering care	We work flexibly	Leading improvement, change and innovation Embedding digitally enabled solutions Enabling new ways of working and planning for the future

2. Current Position

A summary of the actions outlined in the 2021 People Strategy, together with progress to date and priorities for 2025 is attached as Appendix A. This summary sets out the priorities and groups them under the 4 People Vision pillars with a view to closing completed actions by the end of

Quarter 4 and incorporating on going pieces of work that are still valid into the new 3-year People Strategy which will be developed early in 2025.

Progress has been made across a number of areas, but it is recognised that there is still a considerable amount of work required to improve the culture at COCH, to embed the changes and improve staff experience. The Countess of Chester was one of the worst performers in the 2023 annual staff survey and a number of specific actions based on the feedback received have been implemented:

- Increased focus on staff wellbeing by extending the support resource available and the opening of the new Wellbeing Centre.
- A new appraisal process to support staff wellbeing and incorporate career conversations.
- Introduction of a suite of leadership development programmes to develop and embed inclusive leaders at all levels.
- Rollout of the team engagement and development (TED) tool, commencing in areas requiring support.
- Implementation of Employee and Team of the Month and long service recognition programmes, together with a relaunch of a bigger, more inclusive Annual Celebration of Achievement event
- Increased visibility of senior leaders and a revised internal communication process to engage staff and receive feedback.
- Development and rollout of a Trust Culture and Civility statement, handbook and training
- Launch of a Zero Tolerance campaign to combat violence and aggression towards staff by patients and colleagues.
- A new Welcome event for all new starters, led by the Chief Executive Officer and executive team
- Increased focus on encouraging staff to come forward to report incidents through embedding the Freedom to Speak Up (FTSU) Safely campaign and the large increase in the number and accessibility of FTSU Champions

In addition, the People Service directorate has been restructured to provide more expertise and accountability at middle and senior leadership levels.

The focus for 2025 will be on further embedding these changes and the additional improvement measures outlined in Appendix 1. There will also be a review and refocus of people governance to ensure this aligns with and supports delivery of the People Strategy. This will include ensuring that the lessons from the Thirlwall Inquiry are addressed to improve workforce governance and accountability.

The current performance against key performance measures is:

Measure:	Current Performance	Target Performance
Mandatory Training	88.33%	90.00%
Appraisal	80.74%	80.00%
Turnover (permanent roles)	8.89%	10.00%

Vacancy Rate	7.00%	No target set
Sickness absence (rolling 12 month)	5.95%	5.00%
Staff Survey (2023) Engagement Score	6.43	6.91 (national average)

The 2024 Annual Staff Survey is currently open to all Substantive staff and Bank workers. The survey closes at the end of November 2024 and early indicators will be available at the end of the calendar year. These results will be used to inform the new People Strategy priority measures.

3. Recommendations

The Board of Directors is asked to:

- Note the update received and the assurance provided against the 2021 – 2026 People Strategy priorities.
- Approve the further priority actions set out in this paper with work commencing on the new People Strategy in 2025.
- Agree that progress against these priorities will be reported through the People Committee with an annual update to the Trust Board.

Appendix A – People Strategy: 2021 - 2026

Delivery Pillar	Key Deliveries	Current Position	Draft Action Plan 2025
Looking after our people	• Review fundamental wellbeing needs across the Trust and address gaps.	• Opened the Well-being Hub in May 2024. • Trust wide programme of events promoted. • Health & Wellbeing Manager and Coordinator in place	• Review effectiveness of Employee Assistance Programme • Develop a Psychological support offer to all staff • Annual programme of wellbeing initiatives.
	• Measure the impact of our health and wellbeing offers on sickness absence, flexing and adapting as required.	• Reduced rolling sickness absence rate to <6% • New attendance policy implemented. • On-going training module for managers in place • Enhance admin support for managers to improve compliance with sickness policy Q4	• Focus on ensuring managers are equipped to support staff to combat work related stress. • Reduce variation in sickness rates across the Trust • Overall rolling absence target <5%
	• Trust wide approach to address violence and aggression from patients/public towards employees.	• Civility statement developed with staff and launched June 2024. Training in place. Incorporated into new Welcome event and Leadership and Management development programmes	• Bystander training developed and rolled out. • Continued push on Zero Tolerance of violence and aggression towards staff and action taken against offenders
Belonging in the NHS	• Develop and implement a staff survey action plan and improve feedback mechanisms	• Increased compliance with key employee feedback and improvement actions working with Divisions & Professional Groups. • Staff survey engagement score 6.43	• Culture Heat Map process in place Q2 2025 with high priority teams identified from 2024 staff survey and agreed support programmes in place • Improve staff engagement score to 7 (best 7.32)
	• Introduce new Leadership and Management Framework to develop compassionate and effective leaders	• Implemented leadership framework at all levels from first line supervisors to Band 8a leaders • Developing Core Management Skills programme for rollout Q4	• Embed leadership development programmes for senior leaders at Band 8a and above • Implement and embed Core Management Skills programme for managers at all levels
	• Introduce an employee Reward and Recognition programme.	• Annual Trust wide celebration events in Sep 24. • Process in place for recognising long service milestones • Employee & Team of month awards implemented July 24.	• Further embed recognition and reward programmes • Improve celebration of achievement event and introduce quarterly achievement awards
	• Increase our diversity and improve the experience of staff with protected characteristics	• Relaunched networks with new Exec leads & Chairs • New EDI Co-ordinator in post. • Zero representation of BME staff at Board level and very low numbers >Band 7 at 3.77%	• Deliver high impact actions in WRES & WDES plan • Increase BAME representation in roles >B7 to 7% in 2025 • Improve BME representation at Board level to >7% • Improve diversity at A4C >Band 7 to 7%

Delivery Pillar	Key Deliveries	Current Position	Draft Action Plan 2025
	• Develop an effective Mandatory and Statutory Training offer and achieve compliance	• Improved Mandatory Training compliance of circa 88% • Level 3 role specific training remains an issue with lower compliance rates (<70%) especially for medical staff	• Achieve a Mandatory Training completion rate of >90% • Review delivery of Core Skills training modules • Review role competencies to ensure appropriate for role
	• Implement revised appraisal documents to simplify process & support quality conversations.	• New appraisal process and training plan implemented June 2024 • Achieved Appraisal target rate of >80% in Oct 2024	• Further embed the appraisal process including Scope for Growth career conversations for managers at all levels. • Achieve Appraisal rate of >85%
	• Define the Trust Talent Management approach and implement	• Succession plan agreed for Executive positions • Talent Management programme for sub board level managers to be implemented by the end of Q4	• Implement Scope for Growth conversations for all managers at Band 8a and above
	• Increase apprenticeships, work experience, and recruitment events.	• <100 apprenticeships in post by the end of 2024 • 10% increase in work experience placements by end 24 • Programme of recruitment events with local schools	• Maximise number of clinical apprenticeships • Recruit 20 nursing basic entry apprenticeships by end Q2 • 40 nursing basic entry apprenticeships by end ofQ4
	• Develop and implement strategic workforce planning to ensure effective staffing models and numbers	• Vacancy rate below plan at 7%. • WTE 16.9WTE below plan October 2023 • Significant variation across professions • Substantive workforce below plan • Bank usage higher than plan • Revised workforce plan submitted to NHSE Sep 24	• Operational workforce plan developed & submitted Q1 • Trust wide and divisional strategic workforce plans developed, and implementation commenced Q2
	• Improve Workforce Efficiency to enable delivery of the Trust's Financial Plan	• Introduced Pay Control Framework and measures to reduce Pay • Pay expenditure currently circa £2m less than 2023 • Agency usage (off framework) 5.8% (target 0%) • Agency usage (under price cap) 35% (target 60%) • Agency use 1.8% achieved Q3 against target of 3.2%	• Implement agile working where possible • Remove agency off framework usage • Achieve agency target of 60% below price cap • Remove HCA agency usage • Agency use < 1% of pay bill with zero A&C staff • No locum bookings >12 months
	• Implement and optimise digital Workforce Systems ie. ESR, Health Roster, TRAC, Medical Roster and SARD Job Planning.	• Procuring an effective Medical Roster System • Procured and are implementing SARD Job Planning software • Restructured People Services to maximise effectiveness	• Successfully migrate payroll to Mersey and West Lancashire Trust hub in March 2025 • Roll out E-Rostering in all clinical & patient support areas • Optimise SARD Job Planning software and Job Plan all medical staff

PUBLIC – Board of Directors
26th November 2024

Report	**Agenda Item 24a.**	**Workforce Disability Equality Standard (WDES) Action Plan**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	**X**
Accountable Executive	Debbie Herring			Interim Chief People Officer				
Author(s)	Funbi Matthew			HR Business Partner, Equality, Diversity & Inclusion Lead				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X**	WDES Report Action Plan addresses the challenges in ensuring a high quality, engaged, diverse and inclusive workforce would affect our ability to deliver patient care. WDES Report and Plan provides assurance because it ensures effective corporate governance by complying with regulatory requirement to publish the WDES Plan. The impact goes beyond compliance with Equality Act 2010 and Public Sector Equality Duty.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Not Applicable.							
Executive summary	The report lists the ten Workforce Disability Equality Standard (WDES) metrics for 2023/24, which the Trust is required to report on annually under the NHS Standard Contract. Disability equality is the protection of people from discrimination based on their disability. The key purpose is to share current performance and the improvement actions and to provide assurance to the Board of Directors. **The WDES report summarises:** • The Trust has improved its performance against 6 of the 10 WDES metrics, and against parts of Metric, 4 which includes 4a, 4c and 4d.							

	• The actions taken to improve performance. • The actions planned, outlined in section 3, are part of the Trust's overarching Equality, Diversity and Inclusion Strategy 2023- 2026 as aligned to the NHS Improvement Plan 2023 with the aim of further improving the Trust's performance against the 10 statutory WDES indicators. The Trust's performance is also measured against the national average. The result shows that the Trust is: • Performing below the 2022/23 national average against 7 metrics out of 10 metrics. • Performing better against the national average against 3 indicators **RAG Action Decision Indicators:** Green / red in the right-hand column of the report indicates the Trust's direction since 2022/2023.
Recommendations	The Board of Directors is asked to: • Note the report and the actions to improve the Trust's position. • Agree that updates on progress will be provided though the People Committee. • Note that the planned actions align with the Trust's corporate strategy to improve the lives of our community and provide excellence in healthcare, through partnership and innovation and The Trust's values of Kind, Safe and Effective.

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the Trust's legal compliance.
Risk	Improved culture of inclusion, staff experience and patient safety.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

1 Introduction

The Workforce Disability Equality Standard (WDES) was introduced in 2019 to help NHS organisations, and other organisations providing NHS services, compare the workplace and career experiences of their disabled and non-disabled staff.

As an NHS organisation, the Trust reviews the ten statutory WDES metrics on an annual basis. The actions planned as a result are designed to help the Trust close the gaps in workplace experience between the Trust's disabled and non-disabled staff, and improve disabled staff representation at senior management and Board level.

The actions planned are part of the Trust's Equality, Diversity and Inclusion Improvement Plan 2023-25. The plan sets out the Trust's strategy, objectives and actions to tackle inequalities and improve human rights across our workplaces and services.

2 Considerations

2.1 2022/23 to 2023/24 data comparison

The table below shows the Trust's 2023/24 performance against each of the ten WDES metrics, compared to 2022/23 data at national and Trust level.

Green or red in the right-hand column indicates the Trust's performance since 2022/23. The Trust has improved its performance against 6 of the 10 WDES metrics, and against parts of Metric, 4 which includes 4a, 4c and 4d. However, the Trust is performing below the 2022/23 national average against 7 metrics out of 10 metrics.

2.2 Disability equity is the protection of people from discrimination based on their disability.

Metric	National average 2022/23	COCH 2022/23	COCH 2023/24	Progress indicator 2022/2023 2023/2024	External Equity Gap 2022/2023
1. Percentage of disabled staff	4.9	4.0	4.9	0.9	
2. Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants.	0.99	1.28	1.56	0.28	
3. Relative likelihood of disabled staff entering the formal	2.17	0	0		

Metric	National average 2022/23	COCH 2022/23	COCH 2023/24	Progress indicator 2022/2023 2023/2024	External Equity Gap 2022/2023
capability process compared to non-disabled staff.					
4. a) Percentage of disabled staff experiencing harassment, bullying or abuse(HBA) at work from the public in the last 12 months.	33.2	35.1	31.3	-3.8	
b) Percentage of disabled staff experiencing HBA from managers in the last 12 months.	16.1	17.7	17.8	0.1	
c) Percentage of disabled staff experiencing HBA from other colleagues in the last 12 months.	24.8	27.0	25.9	-1.1	
d) Percentage of disabled staff saying that the last time they experienced HBA they reported it.	51.3	46.0	53	7	
5. Percentage of disabled staff who believe that the Trust provides equal opportunities for career progression or promotion.	52.1	41.1	41.8	0.7	
6. Percentage of disabled staff who have felt pressure from their manager to come to work despite not feeling well enough.	27.7	32.8	30.5	-2.3	
7. Percentage of disabled staff who are satisfied with the extent that the Trust values their work.	35.2	25.3	20.8	4.5	
8. Percentage of disabled staff saying that the Trust has made reasonable adjustment(s) to enable them to carry out their work.	73.4	73.01	74.48	1.47	

Metric	National average 2022/23	COCH 2022/23	COCH 2023/24	Progress indicator 2022/2023 2023/2024	External Equity Gap 2022/2023
9. The staff engagement score for disabled staff.	6.4	6.0	5.98	-0.02	
10. Percentage disabled Board membership.	5.7	-4	2	6	

2.3 Action taken

The Trust's 2022/23 WDES report details actions to tackle disparities in workplace experience:

1. **The Trust continues to attract applicants with disabilities by maintaining Disability Confident membership and look to commit to the next level.** Re-accreditation application December 2023.

2. **Developed and launched Civility Charter alongside Equality Strategy and Wellbeing Via a Civility Roadshow**. Civility roadshow commenced in November 2023 and a cilivility pocket booklet has been provided to all staff in October 2024. Our Civility statement now read as follows:

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

3. **Board members were nominated as sponsors to Disability Staff Network, Neurodiversity Staff Network and Carers Staff Network.** Appointed December 2023

4. **Engage Managers in Reasonable Adjustment Training** Reasonable Adjustment was embedded into disciplinary and, sickness policy training**.** This is still ongoing. Resulting in evidence of improvement in metric 8.

5. **Commenced concerted effort to improve wellbeing through engagement and listening events via the wellbeing hub**. A dedicated wellbeing hub was opened in May 2024 and wellbeing materials and training sessions have been delivered via Workforce Wellbeing Lead.

3 Implications

The actions planned are part of the Trust's Equality, Diversity and Inclusion strategy 2023-2026. The table below sets out each action alongside its accountable and responsible lead and the WDES metrics it is designed to impact.

Action	Accountable	Responsible lead	Target WDES metrics									
			1	2	3	4	5	6	7	8	9	10
1. Launch of EDI Ally Network, to support disability equality work across the Trust	Chief People Officer	EDI Lead- Business Partner and EDI Coordinator							X	X	X	
2. Publish first Disability Pay Gap Report	Chief People Officer Workforce Lead Head of HR	EDI Lead- Business Partner and EDI Coordinator	X	X			X					X
3. Develop enhanced mandatory EDI training, to improve staff understanding of EDI principles, e.g. social model of disability	Chief People Officer, Deputy Chief People Officer	Head of HR Senior OD Practitioner , Education Director EDI Lead – Business Partner EDI Coordinator and Lead for Service Users and Carers			X	X		X		X		
4. Introduction of enhanced Staff Network Framework to improve the efficacy and reach of the Disability Staff Network, the Neurodivergent Staff Network, and the Mental Health Staff Network.	Chief People Officer and designated Board Sponsor	EDI Lead Business Partner and EDI Coordinator					X		X			X

Action	Accountable	Responsible lead	Target WDES metrics									
			1	2	3	4	5	6	7	8	9	10
5. Request quarterly update on health and wellbeing initiatives for marginalised staff	Chief People Officer Deputy Chief People Officer	Head of HR EDI Lead – Business Parrner			X				X			
6. Co-deliver staff survey on satisfaction with reporting harassment and discrimination	Chief People Officer	Senior OD Practitioner /Project Managers EDI – Business Partner				X					X	
7. Deliver tailored Active Bystander training		Senior OD Practitioner EDI Lead- Business Partnert and EDI Coordinator				X			X		X	

Planned completion dates for the above actions are due to be discussed and agreed at the People Committee to be held on 10th December 2024.

4 Conclusion

The Trust is dedicated to becoming an inclusive employer of choice for disabled candidates, and to improving the workplace experiences of its disabled staff.

The actions are part of the Trust's overarching Equality, Diversity and Inclusion Strategy 2023- 2026 as aligned to the NHS Improvement Plan 2023 with the aim of improving the Trust's performance against the 10 statutory WDES indicators.

Timelines against these actions will be agreed in December 2024 and progress monitored through the People Committee in 2025.

PUBLIC – Board of Directors
26th November 2024

Report	**Agenda Item 24b.**	**Workforce Race Equality Standard (WRES) Action Plan**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	**X**
Accountable Executive	Debbie Herring			Interim Chief People Officer				
Author(s)	Funbi Matthew			HR Business Partner, Equality, Diversity and Inclusion Lead				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X**	WRES Report Action Plan addresses the challenges in ensuring a high quality, engaged, diverse and inclusive workforce would affect the ability to deliver patient care. WRES Report and Plan provides assurance because it ensures effective corporate governance by complying with regulatory requirement to publish the WRES Plan. The impact goes beyond compliance with Equality Act 2010 and Public Sector Equality Duty, but also, impacts on our performance as an employer of choice.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Not applicable.							
Executive summary	The WRES report lists the nine Workforce Race Equality Standard (WRES) indicators for 2023/24, which the Trust is required to report on annually under the NHS Standard Contract. Research shows that unfair treatment of staff from Ethnic Minority Groups (BME according to WRES) can negatively impact patient care, patient satisfaction, and patient safety. The key purpose is to share the current performance and the improvement actions to provide assurance to the Board of Directors.							

	The WRES report summarises: • The Trust has improved its performance against 6 of the 9 WRES indicators between 2022/23 and 2023/24. These indicators are 1, 2, 3 ,4 , 6 and 7. The Trust's performance against 3 WRES indicators reduced. These indicators are: 5, 8 and 9. • The actions taken to improve performance. • The actions planned to address the gaps in race equality between white staff and staff from ethnic minority groups in the workplace and improve the experience of BME staff. The Trust's performance is also measured against the national average. The result shows that the Trust is: • Performing below the national average figure against 6 WRES indicators and • Performing better against the national average across 3 indicators. **RAG Action Decision Indicators:** Green / red in the right-hand column of the report indicates the Trust's progress since 2022/2023.
Recommendations	The Board of Directors is asked to: • Note the report and the actions to improve The Trust's position**.** • Agree that updates on progress will be provided though the People Committee. • Approve the focus on improving representation at senior levels as well as the creation of measurable EDI objectives for board members and senior leaders to enable EDI initiatives to be embedded. • To note that planned actions align with the Trust's corporate strategy to improve the lives of the community and provide excellence in healthcare, through partnership and innovation and the Trust's values of Kind, Safe and Effective.

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the Trust's legal compliance.
Risk	Improved culture of inclusion, staff experience and patient safety.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

1 Introduction

The Workforce Race Equality Standard (WRES) was introduced in 2015 to help NHS organisations, and other organisations providing NHS services, improve their workforce race equality performance. To support the advancement of EDI Agenda, NHS England published its first Equality, Diversity and Inclusion Improvement Plan On Thursday 8th June 2023. The plan includes six(6) high-impact action plans to address discrimination and prejudices in the NHS.

As an NHS organisation, the Trust is focused on continuous improvement and reviews the nine statutory WRES indicators on an annual basis and align's the plan with the six high-impact actions.The actions planned are designed to address the gaps in race equality between our white staff and our staff from ethnic minority groups in the workplace and improve the experience of our BME staff.

An essential element of the plan is focused on improving representation at Board level as well as the creation of measurable EDI objectives for senior management which will embed EDI initiatives from the top of the organisation.

The plan aligns with the Trust's strategy to improve the lives of our community and provide excellence in healthcare, through partnership and innovation and our values of Kind, Safe and Effective.

2 Considerations

2.1 Research shows that unfair treatment of staff from Ethnic Minority Group(BME according to WRES) can negatively impact patient care, patient satisfaction, and patient safety.

2.2 Improve 2022/2023 to 2023/24 data as detailed in the table below.

2.3 Racial equity is a process of eliminating racial disparities and improving outcomes for everyone.

The table below shows the Trust's 2023/24 performance against each of the nine WRES indicators, compared to 2022/23 data at national, and Trust level.

Green or red in the right-hand column indicates the Trust's improvement since 2022/2023. The Trust has maintained or improved its performance against 6 of the 9 WRES indicators. The table also shows the direction of the internal and external racial equity gap.

Indicator	National average 2022 /2023	COCH 2022 /2223	COCH 2023 /2204	Progress Indicator	Internal Racial Equity Gap 2022/2023 2023/2024	External Racial Equity Gap 2022/2023
1. Percentage of staff from racially minoritised groups.	26.4	16	16.6		0.6	9.8
2. Relative likelihood of white applicants being appointed from shortlisting compared to applicants from ethnic minority groups	1.59	0.82	1.47		0.65	0.12
3. Relative likelihood of staff from ethnic minority groups entering the formal disciplinary process compared to white staff	1.03	0.59	0.29		-0.3	0.74
4. Relative likelihood of white staff accessing non-mandatory training and CPD compared to staff from ethnic minority groups.	1.12	1.11	1.02		-0.09	0.01
5. Percentage of staff from ethnic minority groups experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	30.5	33.9	34		-0.1	-3.5
6. Percentage of staff from ethnic minority groups experiencing harassment bullying or abuse from staff in the last 12 months.	27.5	34.6	30.2		-4.4	-2.7

Indicator	National average 2022 /2023	COCH 2022 /2223	COCH 2023 /2204	Progress Indicator	Internal Racial Equity Gap 2022/2023 2023/2024	External Racial Equity Gap 2022/2023
7. Percentage of staff from ethnic minority groups believing the Trust provides equal opportunities for career progression or promotion	46.7	30.6	35.1		4.5	11.6
8. Percentage of staff from ethnic minority groups experiencing discrimination at work from manager/team leader/other colleagues in the last 12 months	16.4	24.0	27.5		3.5	11.1
9. Percentage difference in global majority representation between the Trust's Board membership, voting rights and its overall workforce	15.6	-10.1	-17.0		6.9	-32.6

2.4 Action taken

The Trust's 2022/23 WRES report set out six specific actions taken to tackle disparities in workplace experience:

1. **A Board member to be nominated as sponsor to BAME Staff Network.** Director of Finance, appointed December 2023

2. **Embed EDI training across the Trust Leadership Development, Skills and Talent Framework and ensure effective training delivery.** Commenced July 2024 On-going.

3. **Widening participation in the delivery of Trust services for our local community by increasing employment opportunities across all protected characteristics**.On track and reflected as an improvement against WRES indicator 2.

4. **Continue with the success of the ethnically diverse leadership course (The Elevate Programme).** Recruited and trained new cohort between August to November 2023. This is reflected in improvement to WRES indicator 4.

5. **Promote the role of Freedom to Speak Up Guardian (FTSU) and actively encourage reporting concerns. Ongoing Promotion via staff induction, internal communications and BAME network.** Promotion commenced in 2023 via staff induction, internal communications and BAME network.

6. **Develop and launch a Civility Charter alongside the Equality Strategy and Wellbeing via a Civility Roadshow**. Civility roadshows commenced in November 2023 and a cilivility pocket booklet has been provided to all staff in October 2024. Our Civility statement now reads as follows:

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

In addition, the Zero Tolerance campaign commenced in October 2024 to ensure incidents of abuse to our staff from patients and other staff are dealt with appropriately.

3 Implications

The actions planned are part of the Trust's Equality, Diversity and Inclusion Improvement Plan 2023-25. The table below sets out each action alongside its responsible lead and the WRES indicators it is designed to impact.

S/N	Action	Accountable	Responsible lead	Target WRES indicators								
				1	2	3	4	5	6	7	8	9
1.	Development of EDI and Human Rights Policy (EDIHR)	Chief People Officer	Head of HR and EDI Lead-Business Partner	X	X	X	X	X	X	X	X	X
2.	Development of specific and measurable EDI objectives by all Trust Board members, to be reviewed annually. including a specific objective on developing and embedding anti-racist framework and practice consistently.	Board Members	Chief People Officer and Chief Executive	X	X					X		X
3.	Introduction of enhanced Staff Network Framework to improve the efficacy and reach of the Ethnic Minority Staff Network and other network groups	Chief People Officer & Head of HR	EDI Lead-Business Partner and EDI Coordinator					X	X	X	X	

S/N	Action	Accountable	Responsible lead	Target WRES indicators								
				1	2	3	4	5	6	7	8	9
4.	Prepare Equality Impact Assessment Schedule for EDI related Policies and support completion of EIA's, including training managers on how to conduct EIAs'	Head of HR	EDI Lead- Business Partner and EDI Coordinator	X	X	X	X	X	X	X	X	
4	Publish annual Ethnicity Pay Gap report	Chief People Officer	Workforce Lead EDI Coordinator							X	X	X
5.	Develop EDI training, to improve staff understanding of EDI principles, inclusive leadership,tailored and active Bystander training, anti-racism, discrimination and harassment etc.		Senior OD Practitioner EDI Lead - Business Partner Lead for Service Users and Carers, EDI Coordinator	X	X	X	X	X	X	X	X	X
6	Review and relunch Recruitment and Selection Policy, review recruitment data quarterly and launch of Inclusive Recruitment training for recruiting managers, to improve race equality in recruitment processes.	Chief People Officer and Head of HR	Workforce Lead, Recruitment Lead, EDI-Business Partner and EDI Coordinator	X	X					X		X
7	Request expansion of induction and onboarding for internationally recruited staff, e.g. offering Cultural Competence training to teams welcoming internationally educated colleagues. This is aimed to enhance talent management practices	Deputy Chief People Officer	Senior OD Practitioner and EDI Lead-Business Partner and EDI Coordinator				X	X	X	X	X	

S/N	Action	Accountable	Responsible lead	Target WRES indicators								
				1	2	3	4	5	6	7	8	9
8	Request quarterly update on health and wellbeing initiatives for marginalised staff.	Workforce EDI Lead	EDI- Business Partner and EDI Coordinator				X	X	X	X	X	
9.	Monitor and report to the board on disciplinary, grievance, bullying and harassmernt case gap between ethnic minority staff and white staff.	Chief People Officer and Deputy Chief People Officer	Head of HR EDI Lead- Business Partner and EDI Coordinator				X	X	X	X	X	

Planned completion dates for the above actions are due to be discussed and agreed at the People Committee to be held on 10th December 2024.

4. Conclusion:

The Trust is dedicated to becoming an inclusive employer of choice for candidates from ethnic minority groups, and to improving the workplace experience of ethnic minority colleagues.

The actions planned, outlined in section 3, are part of the Trust's overarching Equality, Diversity and Inclusion Strategy 2023- 2026 aligned to the NHS Improvement Plan 2023 with the aim of improving the Trust's performance against the nine statutory WRES indicators.

Timelines against these actions will be agreed in December 2024 and progress monitored through the People Committee in 2025.

PUBLIC – Board of Directors
26th November 2024

Report	**Agenda Item 25.***	**Estates and Facilities Annual Report 2023/24**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Karen Edge Cathy Chadwick			Chief Finance Officer Chief Operating Officer				
Author(s)	Ian Miller			Associate Director of Estates				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X**	BAF impact is assurance in respect of the environment including potential impact on the quality of care and would result in poorer patient & family experience.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Not applicable.							
Executive summary	The purpose of this paper is to provide Board of Directors with an annual update on the Trust's Estates and Facilities services. The paper aims to outline progress over the last 12 months and to identify the challenges and risks, together with mitigations in place. The key updates include: • Facilities Services comprises of 14 critical support services that help underpin health care at the COCH and are an integral part of the NHS. • All estates policies, standard operating procedures, guidance documentation and permits to work have been reviewed and, in some cases, new ones generated and ratified at the appropriate compliance safety group. • Delivery of multiple Capital projects in 2024 including, new CT Room No.3, new IR Theatre, New Trust HQ, New Employee Wellbeing							

	Hub, new M&S and substantial works to address RAAC in the existing W&C Building. • After starting construction in June 2023, the build is progressing well for the new Women and Children's Building, and it remains on target for occupation during the summer of 2025
Recommendations	The Board of Directors is requested to: • Note the assurance provided within the report. • Note the key programmes of work for the next 12 months.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	Failure to maintain quality of care would result in poorer patient & family experience, risk included on strategic risk register
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	To be issued as part of the agenda pack.

Estates and Facilities Annual Report

1. Background

This Board of Directors are required to receive an annual report to update on delivery of services across Estates and Facilities.

2. Facilities

Facilities Management (FM) comprises of 14 critical support services that help underpin health care at the COCH and are an integral part of the NHS. They play a crucial role in ensuring Trusts can provide effective services for patients. As part of the wider healthcare system, they also have a role to play in supporting the NHS vision, priorities, and policies.

This paper sets out the current position in relation to Facilities Management and identifies risks and recommends action for improvement to ensure the Trust fulfils its statutory and non-statutory duties.

We employ a number of internal operatives and management staff members for the delivery of our FM services. With our current delivery standards considered to be good generally, we are working towards achieving outstanding levels of service provision. This requires targeted investment in our people and enhancing our ability to recruit and retain the highest quality expertise.

2.1 FM Service Delivery

We have given careful consideration to the areas requiring our focus and how best to improve these in conjunction with our wider strategy.

We have introduced a governance meeting for FM delivery which has responsibility for the managerial oversight of the Facilities Management functions within the Trust. The meeting provides assurance that the Facilities functions are being managed robustly from an operational, risk and compliance perspective.

Objectives of Group:

A. . To set the strategic direction and priorities for Facilities services
B. To set objectives in line with the respective corporate objectives and monitor performance against these
C. To review performance against targets and key performance indicators
D. To receive, review and approve business cases for service developments from the departments within Facilities Services.
E. To monitor the financial performance to ensure financial stability and robust budgetary management.
F. To review service planning and delivery
G. To ensure that the Facilities services comply with the Trust governance framework
H. To be appraised of Human Resource performance issues and agree future action
I. To review the local risk register for non-clinical services and identify risks for escalation to division
J. To ensure compliance with all statutory requirements relating to Facilities Services

2.2 In-Year Highlights

The list below details successes within Facilities Services over the last year:

- Domestic Services – Have focused on maintaining the 5* cleaning standards requirements in line with the Cleaning Standards in NHS Premises document 2021. Additional work and focus have seen a formal strategy document produced as well as substantial improvements in the PLACE Lite events through the year. November 2024 saw the formal main PLACE event undertaken with the largest ever team of external patient representatives at all three hospitals as part of COCH NHS FT. The results will be entered onto the NHS digital platform when it opens on 22nd November with much confidence that the results are exactly where we should be as a Trust. The Rapid Response Team supports the continued provision of bed and bed space servicing and have maintained an average of 350 hours per month given back to our nursing colleagues in the ownership of this critical task.
- Waste & Environment Services – Continuation of zero healthcare associated waste to landfill for over ten years, work continues actively on a solution for processing healthcare associated waste on site which has the capacity to save considerable costs from today's revenue budget (in line with new HTM 07-01) that has real potential for significant regional cost benefits if a collaborative approach is adopted.
- Catering Services – Consistently achieves a 5* rating from EHO, both Chester & Ellesmere Port Hospitals. Work has continued in improving the key roles within the service via a new Head Chef post; whilst work in progress recruitment continues for 2 x Deputy Head Chef vacant positions. Financially the service has performed very well considering the costs of raw food produce and managed to achieve a continued positive revenue stream and new options for 24-hour Hot Food Vending choices.
- Retail Services – consistently meets its revenue target. The new 'Going Greener' café (Healthier Eating Retail unit, in line with regional 'Prevention Pledge') was opened first week in November 2023. The 'front of house' retail shop has increased its revenue stream with an uplift in fresh made daily 'take-out' options for staff and visitors alike.
- Transport Services – new SLAs established that show a revenue stream as part of promoting the service wider than COCH. The Transport Department provides non-patient transport services that predominantly collects specimens from GP Surgeries and other Hospitals in our catchment area. In addition, all post, medical records, and equipment to these surgeries are collected and delivered. We also provide an hourly shuttle service taking specimens from our Pathology Department to Microbiology which is situated off-site at Bassendale in Bromborough
- Security Services – has seen much challenge this year in maintaining the required staffing levels. We have made progress through recruitment and with assistance from a regional hospital with interim management support. The end of the service review will see a much-improved service with obvious focus on safety of patients, staff, visitors and Trust assets.
- SLAs established with neighboring GP practices that provide a revenue stream to assist in offsetting current operational revenue budget
- Portering Services – carry out over 12000 transfers per month. Tele-Tracking KPI's met consistently in patient or specimen transfer providing vital support to patient flow
- Chaplaincy Services – supporting staff, patients, and carers with any spiritual, pastoral or religious needs they may have in relation to their care
- Postal Services – processing up to 3500 items of outgoing mail per day. A much-improved service that actively challenges users to reduce spend and use other forms of patient communications.

- E&F Help Desk – maintains its strength-to-strength approach – approx. 260 active requests/jobs logged and delivered on per months for a wide and diverse customer base across the Trust. The service provides an instant response to the customer and high quality customer service and priorities requests to enable efficient use of resource.

2.3 Areas of Focus for the Year Ahead:

- The prime focus over the next twelve months will be to deliver on the formal Domestic services strategy document. The re-structure of some of the supervisory roles and appointment of some service critical roles will further bolster and support the service as a whole to the Trust's betterment.
- Linen Services – Contractual performance from the current supplier remains a real challenge. As part of the collaborative approach, Trusts within the Cheshire & Mersey region are working with our procurement colleagues to revisit the marketplace to resolve the 'Linen Service' needs of many Trust within the C&M region
- Catering Services – Recruitment is still a challenge, national Band 2 pay rate remains uncompetitive when comparing to external recruitment campaign resulting in recruitment gaps to fill vacancies, particularly Band 2 Catering Assistants and Chef positions at Band 3.
- Domestic Services – Recruitment is still a challenge; we will be more flexible with our offer and focus on candidates that want to work around the school hours. National Band 2 pay rate remains uncompetitive when comparing to external recruitment campaigns.
- Security Services – Deliver on the full service review to provide a Security Service that is patient centered and focused and their to support the Trust in all its ask with staffing levels that are commensurate to the risk.
- Waste & Environment Services – Work underway to attempt to progress the in-house on-site waste processing solution, which if successful, will see a substantial reduction in current revenue costs.

3. ESTATES

3.1 Current Position

This section of the paper sets out the current position in relation to Estates Compliance and action to ensure the Trust fulfils its statutory and non-statutory duties to comply with legislation and guidance in relation to the estate.

Historic under-investment in maintaining the Estate on an ongoing basis has resulted in degradation of the physical buildings and mechanical and electrical infrastructure essential to the delivery of clinical services. The Estates Strategy makes reference to an in-depth 6-Facet survey conducted in 2021 by NIFES. At this time, the capital backlog categorised as 'High' and 'Significant' accounted for approximately £20m, however, this figure is for like-for-like replacement and does not include for any uplift for decant, professional fees, project management and VAT etc. In order to eliminate this backlog within the next 10 years, it is estimated that investment to the tune of £3m per year will be required.

An asset replacement program linked to a 5 -year plan has been established with a clear and targeted process based on the Estates 6-facet survey, a robust asset register focused on age, condition, and criticality.

The formal operational compliance structure with external Authorising Engineers (AEs) and Authorised Persons (APs) continues to grow and improve. This covers disciplines of Low Voltage

Electrical, High Voltage Electrical, Water, Medical Gas, Specialist Ventilation, Fire, Asbestos, and now Lifts. The current position is 100% of AE and AP posts are filled.

The restructuring of the operational side of the department (started in late 2023) has proved to be successful in ensuring that the department is more capable of supporting its compliance obligations. The Estates Officers are now aligned to specific responsibilities, namely Building infrastructure, Mechanical infrastructure and Electrical. In addition, the respective Estates Officers now have clear and direct relationships to their specific specialist sub-contractors to ensure better ownership of compliance and follow-up actions.

All department policies, standard operating procedures, guidance documentation and permits to work have been reviewed and, in some cases, new ones generated and ratified at the appropriate compliance safety group. The 'review status' of our Policies is discussed at every E&F Group.

A review of all service contracts has been completed to ensure best value for money, and assurance that all critical and non-critical plant is being maintained, thus ensuring that the Trust meets all statutory and mandatory requirements.

Following the investment into a new Computer-Aided Facilities Management (CAFM) system called Limble™ in late 2023, the system is now being actively used to manage reactive 'Helpdesk' requests across Estates and Facilities and is also used as a planning and tracking tool for our planned preventative maintenance (PPMs). As of October 2024, the system has 3,343 Estates maintenance assets entered, and individual 2,416 maintenance schedules.

The feedback from our customers across the hospital is that the new system is much better than what previously existed. Not only does it allow for much easier escalation of reactive tasks, but it also provides updates on progress. Typically, the Estates Team receive c30-35 reactive jobs per day.

3.2 In-Year Investment Highlights

The list below details some of the successes within Estates Department over the last year:

- Official opening of the new Trust HQ
- Official opening of new Employee Wellbeing Hub
- Creation of third CT room in Radiology (former Nuclear Med)
- Development of a brand-new Interventional Radiology (IR) Theatre, with a second theatre prepared for subsequent equipping.
- Opening of a new Marks & Spencer's Food outlet in the hospital's main entrance
- Creation of a new Clinical Research Facility in Moston Lodge, with further satellite locations identified for Ellesmere Port Hospital and Tarporley War Memorial Hospital.
- Construction of a new mains incoming sub-station which has been designed to be capable of supporting a dedicated 33kV high voltage electrical supply in the future.
- The site's electrical capacity has been increased to 4MVA to support the energisation of the new Women & Children's building.

- RAAC remediation works completed in Ward 32 (installation of fail-safes structures and end-bearing supports). Works now on-going to refurbish the ward for a re-opening in early January 2025.
- Securing of £7m of UEC Actif funding (via NHSe) to make improvements within the Emergency Department (ED) that will reduce patient waiting times.
- Works started on the development of a brand-new dedicated Therapies Unit building (anticipated completion and handover February 2025).
- Significant design works have been progressed for the development of a new 24 bed ward within the main hospital building. Construction works planned to commence February 2025.

3.3 Areas of Focus for the Year Ahead:

- On-time completion and handover of the new Women & Children's Hospital building (summer 2025).
- Ensure robust maintenance contracts are in-place for the new Women & Children's building to provide seamless assurance of Estates compliance.
- Delivery of UEC Actif projects to support the reduction in A&E waiting times.
- Progress design development of new IR day-ward/ recovery area in order to realise enhanced operational efficiencies and better patient experience.
- Delivery of the new 24 bed ward (to coincide with the vacating of the existing Women & Children's building).
- Approved accommodation strategy in-place for all services that will not be transferring into the new Women & Children's hospital building.
- Clear plan and schedule developed to demolish the existing W&C Building in 2025.
- Clear decision made regarding the re-purposing of the existing Neonatal Building, and any necessary architectural changes required are designed and costed.
- Firm-up a clear strategy for carparking on the Countess of Chester Healthpark (coupled to the Trusts Travel & Transport plan).
- Complete organisational review and redesign of Estates Capital Team to ensure it is fit for purpose moving forward.

4 Recommendations

The Board of Directors is requested to**:**

- Note the assurance provided within the report.
- Note the key programmes of work for the next 12 months.