NHS
Countess of Chester Hospital
NHS Foundation Trust

Public meeting of the Board of Directors Agenda (published items)

Tuesday 28th January 2025, 8.30 – 13.00
Boardroom, 1829 Building

Chair	Mr I Haythornthwaite, Trust Chair
Apologies	
In attendance	Ms H Ellis, FTSU Guardian, Mr P Bamford, Director of Clinical Research, Ms N Macdonald, Director of Midwifery and Ms D Gould, Qi & Safety Lead, LMNS

Time	Agenda No.	Agenda item	Lead	Page No.	Decision Required
8.30	1.	Welcome, apologies and Chair's opening remarks (verbal)	Trust Chair		For noting
8.33	2.	Declarations of Conflicts of Interest with agenda items (verbal)	Trust Chair		For noting
8.35	3.	Service Showcase (to be presented on the day)			
9.15	4.	Patient/Staff Story (to be presented on the day)			
9.25	5.	Minutes of the previous meeting held on 26th November 2024 (attached)	Trust Chair	5 - 26	For approval
9.30	6.	To consider any matters arising and action log (attached) Action 41 - Safeguarding and Complex Care Training compliance for medical staff Update (verbal)	Trust Chair Medical Director	27-29	For noting
9.35	7.	Chief Executive Officer's Report (attached)	Chief Executive Officer	30 - 42	For noting
9.45	8.	Chairs Update (verbal)	Trust Chair		For noting
9.55	9.	a) Board Assurance Framework – Quarter 3 2024/25 (attached) b) High Risks Report – January 2025 (attached)	Director of Governance Risk & Improvement Director of Governance, Risk & Improvement	43-62 63-71	For noting For noting
Quality of Care					
10.10	10.	Maternity Survey 2024: Management Report January 2024 (attached)	Director of Midwifery	72-79	For assurance
10.20	11.	Maternity Incentive Scheme Year 6 Compliance and Assurance Report (attached)	Director of Midwifery /	80-118	For approval & assurance

			Qi & Safety Lead, LMNS		
Comfort Break (10.30 – 10.40)					
10.40	12.	Safety Surveillance and Learning Report – Quarter 3 (attached)	Director of Nursing & Quality / Deputy Chief Executive	119-131	For assurance & noting
10.50	13.	Care Quality Commission (CQC) Improvement Plan including Well Led (attached)	Director of Nursing & Quality / Deputy Chief Executive	132-174	For assurance
10.55	14.	Clinical Strategy (attached)	Medical Director / Director of Strategic Partnerships	175-178	For noting
11.05	15.	Quality & Safety Committee Chair's Report – 9th January 2025 (attached)	Non-Executive Director	179-180	For assurance
Operational Performance					
11.10	16.	System Oversight Framework – December 2024 (attached separately) Operational Performance Quality Safety Finance People	 Chief Operating Officer Director of Nursing & Quality Medical Director Chief Finance Officer Acting Chief People Officer		For assurance
11.35	17.	Operational Management Board Chair's Report – 28th November 2024 (attached)	Chief Executive Officer	181	For assurance
Finance, Use of Resource and Performance					
11.40	18.	Finance & Performance Committee Chair's Report – 21st January 2025 (to follow)	Non-Executive Director		For assurance
Strategic Change					

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11.45	19.	Research & Innovation Update (attached) a) Research & Innovation Committee Chair's Report – 17th January 2025 (attached)	Director of Clinical Research	182-193 194-195	For noting
Leadership, Improvement Capability, Organisation Development and People					
11.55	20.	People Committee Chair's Report – 10th December 2024 (attached)	Non-Executive Director	196-197	For assurance
12.00	21.*	Annual NHS England Quality Self-Assessment Education Report (attached)	Acting Chief People Officer	198-202	For noting
12.05	22.	Council of Governors Report (attached)	Director of Governance, Risk & Improvement	203-205	
12.15	23.	Freedom to Speak Up Vision and Strategy 2025-28 (attached)	Chief Operating Officer / FTSU Guardian	206-213	For approval
Items for noting					
12.25	24.*	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 7th November 2024 (attached) b) Approved minutes of the People Committee – 8th October 2024 (attached) c) Approved minutes of the Finance & Performance Committee – 25th September 2024 (attached) d) Approved minutes of the Operational Management Board – 26th September 2024 (attached) e) Approved minutes from the Research Executive Meeting – 11th October 2024 (attached) **Other items:** f) Board of Directors Workplan 2024/25 (attached)	Trust Chair		For noting
Other items					
12.35	25.	Any Other Business (verbal)	Trust Chair		For noting
12.45	26.	Questions from Governors and members of the Public relating to items on the meeting agenda - ***Questions to be submitted in writing in advance of the meeting to:*** coch.membershipenquiriescoch@nhs.net ***by Thursday 23rd January 2025***	Trust Chair		For noting

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		Future Dates: Tuesday 25th March 2025 20th May 2025 29th July 2025 30th September 2025 25th November 2025 27th January 2026 31st March 2026			
13.00	27.	Closing remarks (verbal)	Trust Chair		For noting

Next Meeting: Tuesday 25th March 2025

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

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MINUTES OF THE PUBLIC BOARD OF DIRECTORS

Tuesday 26th November 2024, 8.30am – 12.00pm, Boardroom – 1829 Building

Members	04/06/24	30/07/24	24/09/24	26/11/24		
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	**04/06/24**	**30/07/24**	**24/09/24**	**26/11/24**		
Deputy Director of Governance & Risk, Mrs L Leadsom *(Minutes)*	☑	☑	☑	☑		
Director of Midwifery, Ms N Macdonald	☑	☑ (items 6b & 10)	☑ (item 10)	☑ (item 10)		
Development Non-Executive Director, Mr M Smith	☒	☑	☒	N/A		
Development Non-Executive Director, Mrs L Liang	☒	☑	☑	☑		

Business Performance Manager - Diagnostics and Clinical Support Services Division, Ms EJ Punter,	N/A	N/A	N/A	☑ (item 3)		
Specialist Neurological Occupational Therapist, Ms K Cottrell	N/A	N/A	N/A	☑ (item 7)		
Associate Director of Nursing – Corporate, Mrs S Edwards	N/A	N/A	N/A	☑ (item 11)		
Head of Nursing – Urgent & Emergency Care, Mrs E Maxwell	N/A	N/A	N/A	☑ (item 11)		

Formal Business		
Agenda Item Number	Item	Lead
PB1/ 11/24	**Welcome, apologies and Chair's opening remarks** The Trust Chair, Mr Ian Haythornthwaite, welcomed members to the meeting. It was noted that Non-Executive Directors, Mr M Guymer and Ms W Williams were attending via MS Teams. The Interim Chief People Officer, Mrs D Herring, explained that the Interim Deputy Chief People Officer, Ms V Wilson, was unable to attend the meeting due to planned leave. It was noted that the Chief Executive Officer, Ms J Tomkinson, would need to leave the meeting at 11.00am to attend a meeting with Cheshire & Merseyside Integrated Care Board (ICB) meeting and would return as soon as this was finished. The Medical Director, Dr N Scawn, reported to the Board of Directors the sad news of the recent passing of colleague and friend, Dr Lawrence Wilson, acknowledging his contribution and the loss this brought to the Trust.	
PB2/ 11/24	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest raised in relation to agenda items. The Trust Chair, Mr I Haythornthwaite, updated that the Chief Executive Officer, Ms J Tomkinson, is now a member of the Board at the University of Chester, and the Board of Directors expressed their congratulations.	
PB3/ 11/24	**Service Showcase –Community Diagnostic Centre (CDC)** The Trust Chair, Mr I Haythornthwaite, welcomed Business Performance Manager - Diagnostics and Clinical Support Services Division, Ms EJ Punter, to the meeting. Ms EJ Punter provided an overview of the service noting that in 2023/24 and the first quarter of 2024/25 the Trust completed a total of 22,329 tests against a plan of 21,567, noting that the tariff for CDC tests is paid on a PBR model, incurring a revenue of close to £2 million during this time. Ms EJ Punter highlighted that in a recent sustainability review the Trust was found to be one of the top Trusts regionally who deliver under tariff. Ms EJ Punter shared some positive patient feedback received in relation to the service and outlined that the Trust has recently started a patient survey for	

	CDC to ensure that the service offered meets the needs of our patients and the outcome of this has been overwhelmingly positive with 97% of patients providing positive feedback. The Interim Chief People Officer, Mrs D Herring, referenced the recent CDC review of financial and maturity commissioned by NHS England with the element relating to overseas recruitment being scored as 'amber', suggesting that in essence this should be marked as 'green' as a metric given the service has not been in a position to require the support to date rather than it was a gap in compliance. Non-Executive Director, Professor A Hassell, thanked Ms EJ Punter for the great presentation and asked for further clarification of the lack of access to CRIS. Ms EJ Punter advised that work is progressing in relation to this and there is a contract in place until 2031, noting minimal impact to date. Mr I Haythornthwaite thanked Ms EJ Punter on behalf of the Board of Directors for providing the service showcase.	
PB4/ 11/24	**Minutes of the previous meeting held on the 24th September 2024** The minutes of the previous meeting held on the 24th September 2024 were formally **approved** as a true and accurate record.	
PB5/ 11/24	**Matters arising and action log** The Board of Directors received the updated action log. It was noted that actions 40 and 41 remain ongoing and an update will be provided to the next Board of Directors to be held in January 2025. Non-Executive Director, Mr D Williamson, queried if actions 29 and 30 should remain open until the actions are fully implemented and it was agreed for them to be re-opened on the action log. The Board of Directors **noted** the update and the remaining actions on the log.	
PB6/ 11/24	**Staff Story** The Trust Chair, Mr I Haythornthwaite, welcomed Specialist Neurological Occupational Therapist, Ms K Cottrell, to the meeting. Ms K Cottrell provided an overview of her Doctorate - An Ethnographic Study of Acquired Brain Injury (ABI) Survivors: Meaningful Occupation and Recovery in the Acute Setting. Ms K Cottrell outlined that a working group has now been established and the Trust is collating a Brain Injury Policy to support staff and patients. Non-Executive Director, Ms S Corcoran, thanked Ms K Cottrell for the excellent presentation and queried if any support could be provided by the Board of Directors. Ms K Cottrell explained that further work is required to filter down to staff for them to feel empowered to make person centred decisions and to further understand the impact of unintentional harm.	

	Non-Executive Director, Mrs W Williams, acknowledged the fantastic presentation and highlighted the learning regarding patient care and that this could be included in staff training and development. The Director of Nursing & Quality / Deputy Chief Executive, Mrs S Pemberton, highlighted the priority for the Trust is getting back to basics and referenced the work being led by John Bolton in the Emergency Department, noting the focus of personal care. Mrs S Pemberton acknowledged the excellent work to date which has been led by Ms K Cottrell in promoting good working across nursing and therapy led services. Non-Executive Director, Professor A Hassell, acknowledged the powerful study, querying the number of patients at the Trust who are inpatients for 3 months or more with an ABI. Ms K Cottrell explained that these patients are managed within non stroke wards and via stroke rehabilitation, dependant on the needs of the patient. The Chief Finance Officer, Mrs K Edge, thanked Ms K Cottrell for the overview and the fantastic learning identified and queried if there is an opportunity to share this wider across the system with other Trusts. Ms K Cottrell confirmed this could be shared wider following the completion and publication of her Thesus and Doctorate. The Chief Digital & Data Officer, Mr J Bradley, referenced the aforementioned lessons learned and the Task & Finish Group which has now been established and acknowledged it is positive to see this being taken forward for patients. The Chief Executive Officer, Ms J Tomkinson, highlighted this is of credit to Ms K Cottrell's leadership and queried if St Cyril's Neurological Rehabilitation Unit remains open. Ms K Cottrell confirmed that it is but as a private provider, noting nursing care is provided and they also provide some rehabilitation. Mr I Haythornthwaite expressed thanks to Ms K Cottrell on behalf of the Board of Directors for the update.	
PB7/ 11/24	**<u>Chief Executive Officer's Report</u>** The report included updates on a range of issues and was taken as read. The Chief Executive Officer, Ms J Tomkinson, provided an overview of the relevant local, regional, and national issues and highlighted the following: • The Director of Strategic Partnerships, Mr J Develing, is representing the Trust on the reset of a new collaborative and a paper will be provided to a future Board of Directors meeting to detail the new governance arrangements. It was noted that the ICB has also indicated a desire to develop a specification for community services by February 2025. • Flu and COVID-19 vaccines continue to be offered to all staff who have contact with patients as part of your work benefit package, noting this is the last week of the staff vaccination programme.	**JD**

	• The Trust continues to engage with local MPs including CEO meetings. A meeting was recently held with Mrs Samantha Dixon MP which included a visit to the new Women's and Children's building. • Since this report was collated, Ms J Tomkinson has formally withdrawn from her role on the Board at Liverpool John Moore's University (LJMU) and has been appointed at the University of Chester (UoC). There are significant opportunities for joint appointments and joint working. It was highlighted that there was a need for a robust strategy to include the use of the Bache Hall building noting this could be a thriving research and innovation hub for both organisations. Mr J Develing explained that Mr P Kingston from the UoC is also linked in with the Trust and will attend the Anchor Institution Group. • The key focus nationally is in relation to the urgent and emergency care agenda, noting the huge increases in attendances of late and that last week saw the highest level of attendances to date. It was noted that the Trust had a visit from the National Emergency Care Lead, Ms SJ Marsh, and this is also linked to the ongoing focus on system engagement to reduce the number of Non-Criteria to Reside Patients (NCTR). The Board of Directors **noted** the update provided.	
PB8/ 11/24	**Chair's Update** The Trust Chair, Mr I Haythornthwaite, updated that the Trust has successfully recruited 6 new Governors and work is progressing with the Director of Governance, Risk & Improvement, Mrs K Wheatcroft, Deputy Director of Governance & Risk, Mrs L Leadsom and Lead Governor, Mr J Jones, with regards to a series of development programmes for the Council of Governors and a re-set of the work programme for the formal COG meetings to support the Trust Governors to fulfil their roles. Mr I Haythornthwaite referenced the staff communication which had been issued the previous week relating to the upcoming Employment Tribunal which is due to begin on 25th November 2024 and that updates will be provided as they are available. It was noted that Mr I Haythornthwaite and the Interim Chief People Officer, Mrs D Herring would be attending the Employment Tribunal each day, noting it is currently scheduled to run until the 20th December 2024. The Board of Directors **noted** the update provided.	
PB9/ 11/24	**a) Board Assurance Framework 2024/25 – Quarter 2 2024/25** The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, outlined that the Board Assurance Framework (BAF) has been fully reviewed with Executive Leads at Quarter 2 2024/25 and this paper provides a cover paper on the update along with the full BAF. It was noted that 8 of the 10 risks on the BAF remain above risk appetite level. Actions are progressing, but given the strategic nature of these risks it is recognised that it will take time to fully implement and embed the improvements needed, along with ensuring clear evidence of outcomes in terms of mitigating the risks.	

The paper also provided an update on progress against the Trusts 2024/25 strategic objectives.

Mrs K Wheatcroft highlighted that the key areas of action include research and partnership working with the University of Chester, wider leadership partnership working which is being led by the Director of Strategic Partnerships, Mr J Develing, Trust behaviours and civility, and Urgent & Emergency Care action plans.

Non-Executive Director, Mr M Guymer, acknowledged the continued improvement in reporting, however, highlighted a typographical error with the reference to the risk tolerance level for BAF 8 and it was agreed this would be reviewed and updated following the meeting.

The Trust Chair, Mr I Haythornthwaite, acknowledged the excellent progress with this report and expressed thanks to Mrs K Wheatcroft and the team.

The Board of Directors:

- **Approved** the updates to the Board Assurance Framework at Quarter 2 2024/25
- **Noted** the progress in delivering the 2024/25 strategic objectives.

b) <u>High Risks Report – November 2024</u>

Mrs K Wheatcroft outlined that work is ongoing to further strengthen and embed risk management across the Trust, together with a refreshed Risk Management Policy. The first Risk Management Committee was held in shadow format on 12th November 2024. A Risk Management Improvement Plan, as presented to the Audit Committee on 15th October 2024, is being progressed to agree risk management Datix development priorities and to establish Risk Management Training to be developed and rolled out across the Trust.

Mrs K Wheatcroft confirmed that there are currently 22 risks in total with a residual risk score of 15 and above following review.

Non-Executive Director, Mr P Jones, acknowledged the good progress to date and queried if there is an indicative timescale for the Datix cleanse to be completed. Mrs K Wheatcroft advised that a Datix Reference Group is being arranged to be held by mid-January 2025 and this will include work with the Divisions to determine the priorities and approach to the data cleanse. It is important that the system is further developed to support effective recording and management of risks.

Mrs K Wheatcroft advised there is a Governance & Risk Management session planned with Operational Leads to continue to raise awareness and develop a stronger understanding of governance and risk management requirements. Mersey Internal Audit Agency (MIAA) are also going to support Divisions with regards to their risk maturity.

	Mr P Jones highlighted there are missing timescales for the high risks and Mrs K Wheatcroft explained this will be captured in Datix going forward, and in the interim that timescales will need to be agreed with the Executive Leads. Non-Executive Director, Mr M Guymer, welcomed the direction of travel with this but flagged the inconsistencies with how risks are being scored and assessed, noting some are not comparable currently which are scored with the same residual risk score. Mrs K Wheatcroft advised discussions are ongoing regarding consistency and recognised further work is required to further develop this. The Trust Chair, Mr I Haythornthwaite, queried if the data cleanse will be undertaken prior to reporting to the Board of Directors going forward and Mrs K Wheatcroft confirmed that this was the intention although it may continue to be a manual process in the short term. Non-Executive Director, Mr D Wiliamson, acknowledged the great progress to date and expressed thanks to Mrs K Wheatcroft and the team for including the mitigating actions within the report. Mr D Williamson suggested it would be beneficial for the report to also track the direction of travel, together with rationale for the increase or decrease of risk scores and Mrs K Wheatcroft confirmed that trend information will be developed for future reports. Mr D Williamson referenced that the RAAC risk score has increased and the Chief Finance Officer, Mrs K Edge, advised that this was discussed in detail at the Finance & Performance Committee. The RAAC Board have suggested the score should be 20. Whilst actions have progressed, the decision was taken to reflect the RAAC Board's advice and increase the score to 20 given that further work is required to manage the risk. Mrs K Edge highlighted that the Trust is under significant scrutiny by partners running the programme. The Trust Chair, Mr I Haythornthwaite, queried which Committee this risk is being monitored by and Non-Executive Director, Mrs P Williams, confirmed this is via Finance & Performance Committee, and is also referenced in the Chair's report provided as part of this agenda. Mrs P Williams explained that the issue has been identified, there is a workplan in place and it is recognised that this residual risk will remain until the end of the work programme. The Board of Directors **noted** the contents of this report and considered the current risks reported with a residual score of 15 and above.	
PB10/ 11/24	**<u>Maternity Service Quarterly Update</u>** *To note, this item was taken after item PB08/11/24.* The Director of Midwifery, Ms N Macdonald, explained this report was discussed in detail at the Quality & Safety Committee held in November 2024 and provided the following key highlights: • The Trust currently has the lowest home admission rate across Cheshire & Merseyside, and are continuing to work on family integrated care.	

	• The Trust is fully compliance with the metrics against the CNST standard. • Maternity and Neonatal Voices Partnership (MNVP) – Joined the Trust • The Trust is on track for all staff to be training compliant by the end of November 2024. • Maternity Champions process is underway, noting that the rates remain low. • There is 1 Patient Safety Incident Investigation (PSII) in progress with further detail included within the report, noting that the learning identified has been discussed at the Safety Champions meeting and Perinatal Board. • The Women's & Children's new 5 year Strategy was launched earlier this year which includes a culture and improvement plan. • The latest GMC survey results show a decline in comparison to the previous survey. Gaps remain within the obstetrics workforce but there are plans in place to improve the trainee experience. • Work continues with regards to social inclusion and the Trust is working with a local Kids Bank charity. • 3 new risks have been added to the Risk Register, further detail is provided within the report. • Following the last Safety Champion Walkabout the team are looking at increasing visibility for this role and Non-Executive Director, Mrs S Corcoran, is drafting an item for inclusion in the next Women & Children's newsletter. The Trust Chair, Mr I Haythornthwaite, acknowledged the great progress and expressed thanks to Ms N Macdonald for her leadership in driving this forward. Non-Executive Director, Mr D Williamson, asked what the top 3 things to improve within the Division were and Ms N Macdonald confirmed that the top priority is in relation to medical workforce and recruiting substantively to positions, noting the Trust are confident this will improve when the new build opens. Non-Executive Director, Mr M Guymer, referenced the trainee survey results within Appendix 4 and raised concerns that scores have decreased on all categories and requested further information relating to this. The Medical Director, Dr N Scawn, referenced that the GMC paper later on the agenda provides further details and that the Obstetrics and Gynecology service have a comprehensive action plan in place. Mr M Guymer queried what is being done to address this ahead of next year's results and also what is the route back via governance structures, including the opportunity for further assurance in the short term. Ms N Macdonald explained that the action plan together with the metrics are presented to the People Committee, noting that this is the GMC survey and is therefore not reflective of the whole Women & Children's Division.	

	The Interim Chief People Officer, Mrs D Herring, explained that she has met with the team to review the workforce plan, noting the highest spend on agency staff is in this area and that the Division is being proactive in recruiting for next year, recognising that less than 35% trainees are currently full time. Non-Executive Director, Ms S Corcoran, advised that this was discussed in great detail at the Safety Champions Meeting and the themes were already known, noting the impact of the Thirlwall Inquiry to the team, particularly in relation to morale and absence levels. Ms S Corcoran commended the report and the level of detail provided and noted the Division planning ahead is to aim to see a different position next year. The Trust Chair, Mr I Haythornthwaite, acknowledged the level of detail being reviewed via the sub-committees ahead of the Board of Directors. The Director of Nursing & Quality, Mrs S Pemberton, reiterated Ms S Corcoran's points and expressed thanks to Ms N Macdonald for the quality of the paper and Ms S Corcoran's rigorous chairing of the Safety Champions meeting to help to drive the standards forward. Non-Executive Director, Professor A Hassell, referenced the in-year appointments and the attractiveness of these positions to Junior Doctors and if this fits the increase in medical students. Mrs D Herring confirmed that all Trusts are in a similar position and require improvements in this area. Dr N Scawn referenced a National Medical Directors conference he has recently attended noting that the plan for NHS Health Education England is to recruit into part time roles, rather than WTE, with an aim for this to support Trusts in reducing the gaps. Mr I Haythornthwaite expressed thanks to Ms N Macdonald for this thorough update. The Board of Directors **noted** the assurance provided within the report.	
PB11/ 11/24	**<u>Urgent and Emergency Care Patient Experience Survey Results 2024</u>** *To note, this item was taken after PB08/11/24.* The Trust Chair, Mr I Haythornthwaite, welcomed the Associate Director of Nursing – Corporate, Mrs S Edwards and the Head of Nursing – Urgent & Emergency Care, Mrs E Maxwell to the meeting. Mrs S Edwards outlined that this report summarises the findings from the Urgent and Emergency Care Survey 2024 carried out by Picker, on behalf of Countess of Chester Hospital NHS Foundation Trust, with patients surveyed between February and March 2024. In the Type 1 survey, 55 questions were asked, of these 40 can be positively scored, with 19 of these which can be historically compared. In the Type 3 survey, 52 questions were asked of these 38 can be positively scored, with 16 of these which can be historically compared. Mrs S Edwards advised that the Trust has made an overall	

	improvement across rankings noting that overall the rest of England is in a similar position against the 11 sections of the survey. Mrs E Maxwell advised that since the survey was undertaken there have been a lot of improvements across Urgent & Emergency Care, noting the significant focus on UEC nationally, and highlighting that positive patient experience should be a golden thread throughout the Trust. Mrs E Maxwell referenced the positive improvements since the last survey but recognised further improvements are required. Mrs E Maxwell confirmed that clear actions are progressing in response to the results, that a 6 step vision has been developed for patient experience and that follow up calls are also undertaken for patients following their discharge. Non-Executive Director, Professor A Hassell, acknowledged that the commitment comes across very strongly and asked about the areas which can realistically be most improved over the next 12 months. Mrs E Maxwell confirmed that many of the operational pressures are improving and she is confident that the standards of care will also improve following this, referencing the capital funding for the UEC estate which the Trust has received which will also in turn assist with patient flow. The Medical Director, Dr N Scawn, reiterated the progress made to date and highlighted a message from the regional Medical Director that the CQC are planning to inspect 12 UEC's at Trusts. Mr I Haythornthwaite queried if we have any further indication when this will be and Dr N Scawn advised this is likely to be in the new year. Non-Executive Director, Mrs S Corcoran, highlighted if the Trust are inspected that this is an opportunity to focus on brilliant work and quality improvements across the UEC department. The Director of Nursing & Quality, Mrs S Pemberton, referenced the inter hospital transfer scheme and recognised there is a lot of work to do but we have moved positively from a ranking of 55 to 33. Mrs E Maxwell's leadership within UEC was highlighted, noting that the next steps are in relation to the infrastructure, operational flow and to address staffing issues. Non-Executive Director, Mr D Williamson, queried if the team are receiving the support required for the screens to display waiting times and Mrs E Maxwell advised this will be resolved as part of the new capital project. Mr I Haythornthwaite expressed thanks to Mrs S Edwards and Mrs E Maxwell for attending and providing this thorough update. The Board of Directors **noted** the contents of the report and the survey results.	
PB12/ 11/24	**<u>Safety Surveillance Report – Quarter 2 2024/25</u>** The Director of Nursing & Quality, Mrs S Pemberton, provided the following key highlights from the report: • This report is continuing to be developed to ensure learning is included for all areas throughout this report.	

	• The majority of incidents reported are of no and low harm and on average 79% of incidents relate to a number of categories. • There is a delay with one PSII which is being addressed. • Review of Post Partum Haemorrhage (PPH) is underway. • A robust review is held each Friday to discuss and review significant incidents. Regular meetings are held with the ICB and a number have been signed off as completed with the ICB praising the Trust for the investigations undertaken. • Complaints figures remain lower with an increased focus on concerns being received. These mainly relating to patients following up appointments and the Divisions are working hard to initiate a process for patients to contact them direct rather than via the PALs team. • It was noted an update would be provided during the private Board of Directors in relation to open corners inquests. The Chief Executive Officer, Ms J Tomkinson, acknowledged the outstanding progress made to date and agreed with the focus being on the learning culture, and ensuring this is embedded across the Trust including the medical workforce. Ms J Tomkinson referenced the ongoing Thirlwall Inquiry noting that learning from incidents is key. Non-Executive Director, Mrs S Corcoran, expressed thanks for the excellent report and also referenced the progress the Trust has made in relation to sharing of learning to prevent incidents from reoccurring. Non-Executive Director, Professor A Hassell, acknowledged the really good report and queried if there are any themes identified of the concerns received from patients following up appointments and issues. Mrs S Pemberton advised that the Head of Patient Experience is undertaking a deep dive of these concerns and this will be followed up via the Quality & Safety Committee. The Board of Directors: • **Noted** the contents of the paper. • **Noted** the assurance that the Trust is continuing to promote a learning culture with evident and measurable actions to improve patient safety. • **Noted** the improvements in governance and oversight workstreams within the Trust. • **Noted** 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). *To note, Ms J Tomkinson left the meeting.* *A comfort break was also held from 10.40am – 10.50am.*	

PB13/ 11/24	**Care Quality Commission (CQC) Improvement Plan including Well Led** The Director of Nursing & Quality / Deputy Chief Executive, Mrs S Pemberton, provided an update on progress against the consolidated CQC Improvement Plan, including Well Led. Mrs S Pemberton updated that progress has been noted, with the key areas of progress including: • Successful Electronic Patient Record (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 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. Mrs S Pemberton acknowledged that some dates had been revised noting they were over-estimated initially but provided re-assurance that the areas are progressing. Mrs S Pemberton referenced the significant amount of work being undertaken in relation to governance, the EPR upgrade and optimisation plans, the commencement of the Clinical Strategy and the policy review programme. Non-Executive Director, Mrs S Corcoran, queried the process for revising dates and Mrs S Pemberton explained that sections are updated by each Executive Lead and reviewed and agreed via the Executive Directors Group. The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, referenced the number of action plans currently in place across the Trust, noting actions will not be marked as completed until there is assurance in place to demonstrate embedding and outcomes within the Trust. Non-Executive Director, Mr M Guymer, referenced KLOE2 the 5 Year Financial Strategy and expressed his frustration in the delays in progress. MR M Guymer also referenced the governance organogram document which remains work in progress and requested for this to be circulared, even if this is for an earlier draft version to be provided. The Chief Finance Officer, Mrs K Edge, outlined that financial governance has been reviewed as a priority and the financial strategy is agreed to be reviewed for Quarter 4, to ensure this aligns to the system and national finances. Mr M Guymer highlighted that it is important for the Unitary Board to be involved in this and Mrs K Edge outlined this is a timing issue and the work will feed into the next steps. Non-Executive Director, Mrs P Williams, suggested for a discussed at a Board Development session to ensure full engagement of this and this was agreed.	

	Mrs K Wheatcroft agreed to circulate the governance organogram recognising this was work in progress. Non-Executive Director, Mr D Wiliamson, queried what is required to address the link to ICB and LA colleagues and further beds required. The Chief Operating Officer advised that the ICB have commissioned an external professional regarding complex discharge of Cheshire West patients, noting the work required in relation to patient assessment, with the main gap identified as Priority 2 (P2) beds. Ms C Chadwick explained that a meeting has been held with NHS England regionally and the ICB and discussions are ongoing to agree who will write the case regarding funding. Ms C Chadwick confirmed the Trust have escalated this as far as it can and noted that the NCTR split is predominantly Cheshire West and continues to be challenged with the main issue within its own Local Authority boundaries. Mr D Williamson suggested it would be beneficial for Health Inequalities to be discussed further at a future Board Development session and for a roadmap to be provided with specific actions. Mr J Develing explained that he is looking to develop this for health and inequalities, together with metrics to measure against, and this will be part of a wider engagement piece of work with staff. 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.	**KW**
PB14/ 11/24	**<u>Bi-annual Safer Nurse Staffing Report – August 2024</u>** It was noted that this paper is 'for information' unless any Board member requests a discussion. Non-Executive Director, Mr M Guymer, acknowledged the thorough and comprehensive report noting that some areas are identified as having higher establishments than required. Reference was made to wards 42, 48, 49 and Cardiology and it was agreed this would be reviewed outside of the meeting. The Director of Nursing & Quality / Deputy Chief Executive, Mrs S Pemberton, explained that Non-Executive Director, Mrs W Williams, had requested similar information via the People Committee and it was agreed for this to be covered as part of that report further down on the agenda. The Board of Directors **noted** the contents of the report.	
PB15/ 11/24	**<u>Quality & Safety Committee Chair's Report - 7th November 2024</u>** Non-Executive Director, Professor A Hassell, presented the Chair's report and highlighted the Committee had agreed for the following items to be brought to the attention of the Board of Directors:	

	• 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. The Trust Chair, Mr I Haythornthwaite, queried the requirements of the Board of Directors in relation to these areas of alert and highlighted that they are not reflective of current risks on the risk register and queried how this data is being triangulated. The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, explained that an email conversation was initiated with Professor A Hassell prior to this meeting to discuss the AAA report, and it would be good practice for Committees to query whether these are reflected on risk registers when risks are being discussed as this would help to ensure the embedding of risk management. The Board of Directors **noted** the Committee Chair's report.	
PB16/ 11/24	**<u>General Medical Council (GMC) National Trainee Survey Report 2024</u>** The Medical Director, Dr N Scawn, confirmed that this report was also presented to the People Committee held in October 2024 and acknowledged the engagement with trainees and trainers and that the two areas of concern relate to rota issues and the Trust's new Job Planning Policy. It was noted that the improvement plan is due to be presented to the People Committee in December 2024. The Board of Directors **noted** the contents of the report.	
PB17/ 11/24	**<u>System Oversight Framework Report</u>** 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 new 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 improvements in compliance with DM01 Sustained reduction in staff turnover Ms C Chadwick explained that the following areas require improvement: • Sepsis Treatment • Sepsis Screening • Emergency Medicine Performance • Sickness Absence Compliance • Financial Overspend Ms C Chadwick highlighted: • Performance within the Emergency Department (ED) remained average in October 2024, noting a spike of 304 attendances the previous week and there are several days where referrals into medicine are over 100. • Ambulance spikes continue and handover times remain higher which is linked to the number of patients within ED and the increase of Long Length of Stay (LLOS) patients. • The issue with NCTR patients remains at 100+ most days and this reached 123 earlier this month noting this also impacts on patient experience across the Trust. • Work is ongoing with nursing and operational teams to focus on actions for each of the areas of ED and a new Standard Operating Procedure (SOP) is being introduced for LLOS patients, which will also include actions for system partners. • The Trust is working with ECIST as part of a rapid improvement offer and supporting work with North West Ambulance Service 'call before convey'. Options are being explored for a Senior Consultant to be on the front door to provide a streaming service. ECIST are undertaking an audit when patients need admitting and Ms SJ Marsh, the National UEC Lead is due to visit the UEC on 2nd December 2024. • £7.5m of capital monies has been awarded to the Trust which will be used to revamp the discharge lounge, together with an area in the ED department specifically for mental health patients, and a separate area for pediatric mental health patients. • The cancer Faster Diagnosis Standards (FDS) remains an area for action, noting that the concern is with the first part of the urology pathway as compliance is lower and the Trust been asked to submit an improvement plan. • Radiology and diagnostics is already at 89% and the Trust is one of the highest performing Trusts in Cheshire & Merseyside for utilisation. The Trust Chair, Mr I Haythornthwaite, queried if there is sufficient time allocated on the agenda for this item and queried if a level of the discussion could be covered at sub-committee level. Ms C Chadwick outlined that the	

	operational and financial performance data is reported via the Finance & Performance Committee but certain data for example the elective and cancer information is reported via the Board of Directors. It was agreed that the timings of the agenda would be reviewed further outside of the meeting. Non-Executive Director, Mrs W Williams, commended the work undertaken in ED and referenced the link to positive patient experience. The Director of Nursing & Quality/Deputy Chief Executive, Mrs S Pemberton highlighted that areas relating to quality are reported to the Quality & Safety Committee and via other reports on this agenda. Ms S Pemberton highlighted that C Difficile cases and E'coli cases are higher than trajectory, and there is an improvement plan in place to address this, and that other Trusts in the region are also above trajectory. The Medical Director, Dr N Scawn, advised that a more detailed update in relation to mortality is included on the agenda for the Private Board of Directors meeting and that updates in relation to maternity were provided as part of the quarterly maternity update provided earlier on the agenda. The Chief Finance Officer, Mrs K Edge, updated that the Trust has received an allocation of cash from the ICB, however, this does not eradicate the planned deficit but does reduce the plan deficit to £9.56m in year. It was noted that the Trust is currently £6.3m off plan with is predominantly due to industrial actions earlier this year, the impact of the recent pay award and the costs of the Thirlwall Inquiry. Mrs K Edge updated that the Trust is in dialogue with the system with regards to delivering against plan and Non-Executive Director, Mrs P Williams, advised that this is highlighted as an item to alert the Board of Directors to, following the last Finance & Performance Committee. The Interim Chief People Officer, Mrs D Herring, highlighted that sickness absence levels have worsened with a significant number relating to stress and anxiety and the Trust is investing in 2 co-ordinators to help managers with sickness absence. It was noted that turnover is below 10%, however, there are some areas where this is higher and this variation is being monitored and discussed further via the People Committee. The Trust has surpassed its appraisal target. It was noted there has been an increase in agenda spend, however, there has been a significant reduction overall regarding agency spend in comparison to the previous year. Mr I Haythornthwaite acknowledged the positive progress in a number of areas and the need for the Trust to continue to celebrate improvements and achievements via positive communications mechanisms. Non-Executive Director, Mr D Williamson, referenced the pictorial timeline in relation to the staff survey and suggested this could be used for similar successes and positive stories. The Board of Directors **noted** the SOF performance and areas for action.	

PB18/ 11/24	**Winter Planning** The Chief Operating Officer, Ms C Chadwick, provided the following key highlights: • 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. Ms C Chadwick outlined that planning remains a challenge and that capacity plans will be tested in advance of winter with the real focus on not normalising corridor care and where this is necessary that the fundamentals of patient care are provided. Ms C Chadwick explained that the Trust is increasing Hospital@Home capacity, the increase of virtual wards, the Trust is looking to increase the rapid response offer and also reviewing how to use day case areas for creatively. Non-Executive Director, Professor A Hassell, highlighted the reference to Arthoscopy within the report and it was agreed this should be Arthroplasty. The Board of Directors **noted** the winter plan.	
PB19/ 11/24	**Core Standards Compliance (including EPRR update)** It was noted that this paper is 'for information' unless any Board member requests a discussion. Non-Executive Director, Mr M Guymer, referenced section 6 re ICB feedback and requested clarity. The Chief Operating Officer, Ms C Chadwick, explained that last year all Trusts across Cheshire & Merseyside were non-compliant and the ICB reviewed all self-assessments. The feedback was noted and it was agreed for the table to be updated to ensure this is clear. Ms C Chadwick updated that this year the Trust has self assessed as fully compliant in 48 areas and partial compliant in 14 areas, therefore recognising the improvements. Non-Executive Director, Mrs P Williams, explained that this was discussed at the Finance & Performance Committee and the members queried the value of the ICB review as only a small number of items were reviewed and this would not necessarily be key in delivery overall strategy and linked to policy and narrative changes. Non-Executive Director, Mrs S Corcoran, queried if there are any significant risks identified in relation to EPRR and if so, if they are reflected on the risk register and Ms C Chadwick advised this was raised at the Finance & Performance Committee too and an action agreed to ensure clarity on residual risk.	

	The Board of Directors **noted** the update provided.	
PB20/ 11/24	**Finance & Performance Committee Chair's Report – 25th September 2024 and 20th November 2024** Non-Executive Director, Mrs P Williams, outlined there has been a lot of progress between the meetings held in September 2024 and November 2024 and focussed on the latter. The Committee had agreed for the following items to be brought to the attention of the Board of Directors: • Financial position at Month 7 and forecast risks and actions (£6.3M off plan YTD) which includes Thirlwall Inquiry, impact from industrial action, pay award pressures and under delivery of CIPs of £4.8m). Mrs P Williams updated that progress has been made and there are workplans in place in relation to the health & safety action plan, EPRR core standards and the emerging risks from the new Women's & Children's Build including RAAC. It was noted that the Board of Directors would continue to be updated with each of these pieces of work. The Trust Chair, Mr I Haythornthwaite, clarified that the concerns in relation to RAAC had been sufficiently covered. Non-Executive Director, Mr D Williamson, highlighted this risk score of 20 and it was agreed this has been discussed earlier with this now in line with the RAAC Board recommendation. The Board of Directors **noted** the Committee Chair's report.	
PB21/ 11/24	**Audit Committee Chair's Report – 15th October 2024** Non-Executive Director, Mr M Guymer**,** confirmed that the Committee did not feel there were any areas of alert to be brought to the attention of the Board of Directors. Mr My Guymer explained that there had been 1 MIAA report received in relation to legal services which received 'limited assurance' and there is an action plan in place to address this. The Director of Governance, Risk & Improvement, Mrs K Wheatcroft, suggested for an update to be provided in relation to the Trusts External Auditors, KPMG. Mr M Guymer confirmed that the Trust has reviewed and recommended an extension to the contract with KPMG and that this was formally approved via the Council of Governors on 21st November 2024 with the Trust now concluding the process. The Board of Directors **noted** the Committee Chair's report.	
PB22/ 11/24	**People & Organisation Development Committee Chair's Report – 8th October 2024** Non-Executive Director, Mrs W Williams, highlighted the Committee had agreed for appraisal rates to be brought to the attention of the Board of Directors, noting that work is underway to understand why there remain difficulties with regards to completion in some areas and the Committee are keen to ensure there are mechanisms in place to support staff.	

	Non-Executive Director, Mr D Williamson, outlined that the previous paperwork used for appraisals was reviewed and reduced in an effort to support completion rates and the Interim Chief People Officer, Mrs D Herring, advised that following the staff survey results from 2023 a new form was designed and implemented, with input from staff and was launched in April 2024. Mrs D Herring confirmed that this form is being used and there has been positive feedback in relation to this, noting this also incorporates wellbeing and development and the Trust is hopeful that this will be reflected in this year's staff survey results. The Board of Directors **noted** the Committee Chair's report.	
PB23/ 11/24	**People Strategy 2021 – 2026 Progress Update** The Interim Chief People Officer, Mrs D Herring, provided a progress update on delivery of the Trust's 5-year People Strategy which commenced 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. 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 and this will be aligned to the 4 key areas in the national people plan. *To note, Ms J Tomkinson returned to the meeting.* Non-Executive Director, Mr P Jones, acknowledged the clear report and the commendable approach to refresh in 2025, a year ahead of required and expressed his support in relation to this. Non-Executive Director, Mrs W Williams, acknowledged the work undertaken to date led by Mrs D Herring, working with staff and understanding their requirements which stands the Trust in good stead for the revised strategy in 2025. Non-Executive Director, Mr D Williamson, queried the issue with staff overpayments and if the process improvements should be agreed as an objective for next year. Mrs D Herring advised that this will be managed as part of the migration of the payroll service to Mersey & West Lancashire NHS Trust which will include the tightening of processes and controls. The Board of Directors: • **Noted** the update received and the assurance provided against the 2021 – 2026 People Strategy priorities. • **Noted** the further priority actions set out in this paper with work commencing on the new People Strategy in 2025. • **Agreed** that progress against these priorities will be reported through the People Committee with an annual update to the Trust Board.	
PB24/ 11/24	**a) Workforce Disability Equality Standard (WDES) Action Plan**	

	The Interim Chief People Officer, Mrs D Herring, outlined that 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, noting disability equality is the protection of people from discrimination based on their disability. Mrs D Herring provided an update on the following key areas: • 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 Mrs D Herring acknowledged that there is further work to be progressed in this area and that this report together with an improvement plan will be presented to the People Committee to be held in December 2024. Non-Executive Director, Professor A Hassell, queried the reference to % of Board members with a disability and it was agreed that this wasn't clear and that the People Committee would review this detail further. The Board of Directors: • **Noted** the report and the actions to improve the Trust's position. • **Agreed** that updates on progress will be provided though the People Committee. **b) Workforce Race Equality Standard (WRES) Action Plan** Mrs D Herring provided an update on the following key updates: • 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. Mrs D Herring highlighted the increase in number of staff being abused by patients, including racial abuse, and the Trust has launched a zero tolerance campaign to address this via the usage of communications and posters. The Director of Nursing & Quality / Deputy Chief Executive, Mrs S Pemberton, acknowledged the challenge with patients who do not have capacity including dementia and this is being looked into further. Mrs D Herring explained that the Trust is looking to introduce bystander training in areas to ensure staff have the confidence to challenge and to raise concerns when instances occur. Non-Executive Director, Mr D Williamson, queried if this is reflective of the national picture and if the Trust has the right proportion of BAME and disabled staff for the local population. Mrs D Herring explained that a lot of this data is from the national staff survey which have our own results too and this is what is published. The Board of Directors: • **Noted** the report and the actions to improve the Trust's position. • **Agreed** that updates on progress will be provided though the People Committee.	
PB25/ 11/24	**Estates & Facilities Annual Report 2023/24** It was noted that this paper is 'for information' unless any Board member requests a discussion. The Board of Directors **noted** the report.	
PB26/ 11/24	**Items for noting and receipt** **The Board of Directors noted the following minutes which had been approved by the relevant Committees:** a) Approved minutes of the Quality & Safety Committee – 10th September 2024 b) Approved minutes of the People Committee – 10th August 2024 c) Approved minutes of the Audit Committee – 23rd July 2024 **The Board of Directors noted the following item:** d) Board of Directors Workplan 2024/25.	
PB27/ 11/24	**Any other business** There were no further items of business raised.	
PB28/ 11/24	**Questions from Governors and members of the Public relating to items on the meeting agenda**	

	No questions were raised.	
PB29/ 11/24	**Closing remarks** The Trust Chair, Mr I Haythornthwaite, acknowledged that this would be the last Board of Director's meeting for the Interim Chief People Officer, Mrs D Herring and the Deputy Director of Governance & Risk, Mrs L Leadsom's, as they are both due to leave the Trust in December 2024. Mr I Haythornthwaite expressed thanks to both individuals for their support to him as the Chair and also the Board of Directors during their time at the Trust and wished them both well for the future. *To note, the meeting was closed at 12.00pm.*	
	Date & Time of next meeting The next meeting will be held on Tuesday 28th January 2025 (timings to be confirmed).	

Countess of Chester Hospital NHS Foundation Trust

Public Board of Directors Action Log

2024/25 - Updated 20th January 2025

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 **Update 26th November 2024** – Acton agreed to remain open until actions are fully implemented. **Update 20th January 2025** – This report as changed to the Safety Surveillance Report, included on the 28TH January 2025 Board of Directors agenda.	Jan-24	**Closed**
30	4th June 2024	Director of Nursing & Quality / Deputy Chief Executive and	PB9/06/24	Integrated Incidents, Complaints, Claims and Inquests Quarter 4 2023/24 - The Trust Chair, Mr I Haythornthwaite, also	Ms S Pemberton explained that the Trust needs to further understand the data being collated and	**Update 17th September 2024** - This will be reflected within the next quarterly report.	Jan-24	**Open**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
		Director of Governance, Risk & Improvement		acknowledged the improvements to date, however, queried how the figures reported compare to other Trusts.	provided to enable this to be benchmarked against other Trusts, noting this also links to the requirements for the targeted improvement for concerns. It was agreed this reporting would be discussed with the Director of Governance, Risk & Improvement, Mrs K Wheatcroft, for a future report.	**Update 26th November 2024** – Acton agreed to remain open until actions are fully implemented. **Update 20th January 2025** - The deputy director of nursing and governance is exploring if there is any benchmarking data against all the data the trust has. This is proving challenging however we will continue to explore if possible.		
41	4th Sept 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. **Update 26th November 2024**– Action remains on-going with update to be provided at the	Jan-25	**Open**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
						January 2025 Board of Directors **Update 20th January 2025** – Dr N Scawn to verbal update at the January 2025 Board of Directors.		
42	26th Nov 2024	Director of Strategic Partnerships	PB7/ 11/24	Chief Executive Officer's Report	The Director of Strategic Partnerships, Mr J Develing, is representing the Trust on the reset of a new collaborative and a paper will be provided to a future Board of Directors meeting to detail the new governance arrangements.	**Update 20th January 2025** - System discussions ongoing, date tbc.	TBC	**Open**
43	26th Nov 2024	Director of Governance, Risk & Improvement	PB13/ 11/24	Care Quality Commission (CQC) Improvement Plan including Well Led	Mrs K Wheatcroft agreed to circulate the governance organogram recognising this was work in progress.	**Update 20th January 2025** - Draft organogram circulated	Jan-25	**Closed**

PUBLIC - Board of Directors
28th January 2025

Report	**Agenda Item 7.**		**Chief Executive Officer's Report**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Jane Tomkinson OBE			Chief Executive Officer				
Author(s)	Karan Wheatcroft			Director of Governance, Risk & Improvement				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Relevant across all BAF areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X**
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 (January 2025)

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

1. NHS England Plan to Reform Elective Care

On the 6th January 2025, NHS England published its plan to reform elective care for patients.

In terms of operational planning and as a first step, it is expected that by March 2026 the percentage of patients waiting less than 18 weeks for elective treatment will be 65% nationally. Every trust will need to deliver a minimum 5 percentage point improvement by March 2026.

Whilst we are still awaiting the national planning guidance, we are progressing our operational plan to align to these expectations.

2. CMAST Leadership Board meeting

CMAST Leadership Board met on 6th December discussing a number of system issues.

The Leadership Board were joined by Trust Chairs for a quarterly update on programme deliverables which covered outputs for the first half of the financial year. These updates were both noted and widely celebrated by those present.

The Board also received an update on recent system discussions and was asked to feedback, outside of the meeting, on the suggestion that there could be one provider collaborative within C&M. Board feedback was particularly sought on anticipated benefits and any areas which should be subject to wider exploration.

Update papers were also provided on the following areas:

- System financial report
- System performance

3. Cheshire West Health and Care Partnership

The Partnership met in January 2025 and received a report from the Local Authority public health function in relation to future production of strategic needs assessment across Cheshire West. To support, a new collaborative business intelligence board will be established with the aim of strengthening collaboration and create a unified process to generate actionable intelligence and insight that underpin and drive future system strategies, policies, and effective service delivery to advance the health and wellbeing of the Cheshire West and Chester population. The Trust is a member of the intelligence board and will support with executive input as appropriate.

The partnership also received updates on

- Children and young people improvement plan including revisions to safeguarding policy, noting the significant increasing costs and demand for services.
- Adult social care strategy `Enabling Great Lives `noting that CQC, using the new single assessment framework, will be undertaking an inspection in February 2025.
- Healthier Futures – reprovision of Leighton hospital as part of the new hospital program.

4. Mental Health, Learning Disability and Community services collaborative (MHLDC)

Future provider collaborative arrangements and relationships with the Integrated Care Board (ICB) and Cheshire and Merseyside Acute and specialist Trust collaborative (CMAST) continue to be explored.

Urgent Care: Planning is in hand to use `EPR onward referral` which will allow for ambulance crews to electronically refer to urgent care from attendance at scene.

Community services specification: As the offer of community services differs across Cheshire and Merseyside the ICB are developing a specification for a more standardised approach.

5. NHS England Letter re Undertakings

The Trust has now received formal confirmation from NHS England that enforcement undertakings have been discontinued. This is welcome news, reflecting the sustained improvement in the areas that were under scrutiny and the continued commitment to improving services for our patients.

6. Maternity patient survey results

The Care Quality Commission (CQC) released the National Maternity Survey findings for 2024, capturing the perspectives of women who gave birth in February 2024, providing a crucial snapshot into their experiences of the maternity care provided by the Trust. Families were asked questions about every aspect of their care.

Our results show yet another year-on-year improvement in the experiences of our service users and their families. Of the 58 acute NHS Trusts who use the same survey provider (Picker) as us, we are one of the most improved this year, which is a great achievement and reflects the efforts of everyone involved in these services and the continued focus on ensuring high quality patient care and experience.

7. Urgent and Emergency Care patient survey results

The CQC survey, conducted in February and March 2024, gathering feedback from over 400 patients about their experiences of emergency care at the Countess of Chester Hospital with the findings highlighting significant progress in key areas:

- 94% of patients reported that they had confidence and trust in doctors and nurses
- 30% more patients reported being able to access food and drink while in A&E.
- 17% more patients felt they could get help for their condition from a member of staff.
- Noticeable improvements were also reported in keeping patients informed about waiting times.

Some of the Trust's scores were amongst the highest in the region, including for care and treatment, information about recovery at home and the overall experience patients had of the department. The results demonstrate the success of the newly implemented six-step patient experience vision, which has been developed by frontline A&E staff to enhance care, compassion, and quality.

Closely monitored through an A&E Improvement Framework which tracks progress and identifies areas for further improvement, this approach has brought real and sustained improvements to patient care, including how care is provided, safety, and communication.

The results for our Urgent Treatment Centre also demonstrated improvements.

There is more work to do in our urgent and emergency care services and the survey also identified some key areas for further focus.

8. CWP and COCH Community Collaborative

The CWP and COCH Community Collaborative between the Trusts commenced on 1st May 2024 with the aim to integrate the CWP Neighbourhood Care Group and the COCH Therapies and Integrated Community care Division to improve and extend care delivered to patients in the community in Cheshire West. The Community Collaborative is underpinned by a Memorandum of Understanding (MOU) and an operational committee with various sub groups has been in place to support the developments. We are now looking to formally establish a Joint Committee to drive strategic decision making and ensure a clear line of assurance to both Trust Boards.

9. National Staff Survey

The final response rate for substantive staff completing the national NHS Staff Survey was 45% which continues to be an important improvement in ensuring we hear the voices of our staff. Bank staff also had a higher return rate with 20% completing their surveys. There remains more to do to increase submission rates further but this is a positive trajectory.

In early 2025, the Trust received a headline report from IQVIA, the independent company who administered the survey on behalf of the Trust. This will provide an overview of the survey results and will be followed by a much more detailed full report in the spring. Results will be published on the NHS Staff Survey website alongside results from previous years.

10. Staff Networks – ENABLED

The new ENABLED (Enhancing Abilities and Leveraging Disabilities) network launched in December 2024 with an event in the Wellbeing Hub at the Countess of Chester Hospital.

The network is a combination of the Disability Advice & Welfare Network (DAWN) and Neurodiversity Staff Networks and is for anyone working at the Trust who has a disability, neurodiversity or long-term health condition, as well as for allies. The aim is to help anyone who needs support and to work with other staff networks to help make the Trust a safer, happier, supportive and inclusive place to work.

The Trust's staff networks are engaging with colleagues and offering advice and support.

11. Employee and Team of the Month

Our Employee of the Month for December 2024 was Arthur Barrett, Health Records Assistant**.** Arthur was nominated for his outstanding positive attitude and unwavering commitment to excellence.

Our Team of the Month for December 2024 was our Endoscopy & Endoscopy booking team. Our Endoscopy booking team have transformed the way they work to ensure patients get the best possible experience and are now the leading booking team in the region and an example of best practice for others.

12. Women's and Children's Build update

The new Women and Children's Building is on track to open in summer 2025. Construction of the three-storey building began in June 2023 and is now 65% complete. The skeleton of the inside is taking shape and the building is now watertight.

The Project Team has facilitated many site visits to help clinical teams prepare for the relocation into the new building and plan for new ways of working.

Once complete, the new development will replace the current Women and Children's Building, which has been in use since 1971, and will accommodate maternity, neonatal, paediatrics and gynaecology wards and services. The facility will offer increased capacity, modern amenities and carefully designed spaces for patients, families and staff.

13. Clinical Research Unit and Mobile Research Bus

In December 2024, the Trust unveiled its new Clinical Research Unit (CRU) and Mobile Research Bus. The facility and bus are set to transform the Trust's research capabilities, providing patients with access to the latest treatments and trials.

Featuring two consultation rooms and an observation bay, the research unit, the first of its kind in West Cheshire, will enable the Trust to conduct a broader range of studies and additional trials, and further establish itself as a centre of research excellence.

One of only four research buses in the North West, which is designed to bring clinical trials and healthcare opportunities directly to populations across Cheshire West and beyond, including in rural and deprived communities that may have previously been under-represented in medical studies.

Both innovations mark a £300,000 overall investment into the Trust's research capabilities, including grants from the North West Coast Clinical Research Network where the Trust was one of five successful bids for funding.

Work has also begun on two more research hubs at Ellesmere Port and Tarporley Hospitals to create a research network within Cheshire.

14. Trauma Unit Accreditation

The Cheshire & Mersey Major Trauma Specialised Services Clinical Network (CMMTN) conducted a service review on the 4th of December 2024, as part of the network accreditation process for Trauma Unit status for acute trusts across Cheshire & Mersey.

The review concluded that the Countess of Chester Hospital has met the required standards for accreditation as a Trauma Unit (TU) for the period of 2024-2026.

An action plan is also being developed in response to the opportunities for improvement.

15. New trans-nasal endoscopy service launched

A new trans-nasal endoscopy service (TNE) launched in November to provide patients with a less invasive and safer, more comfortable experience.

The innovative new procedure allows the endoscopist to examine the oesophagus, stomach and upper part of the small intestine without the need for sedation, which offers a safer option with fewer side effects. It also uses a small, flexible tube equipped with a camera which is passed through a patient's nostril rather than through the mouth. By bypassing the gag reflex, the

procedure significantly reduces discomfort and allows patients to remain more relaxed. It typically lasts up to 15 minutes and is performed using local anaesthetic, without the need for sedative drugs.

Among the key benefits of the new service are faster recovery times, minimal gagging and the ability for patients to speak with the endoscopist during the procedure. These factors make TNE better tolerated for most patients, particularly those who may struggle with traditional endoscopy.

16. New heart failure virtual ward

We are proud to be one of the first Trusts in the region to launch a brand new Heart Failure virtual ward, bringing hospital-level care straight to our patients' homes.

This innovative service means patients can leave hospital sooner, or even avoid being admitted altogether, whilst still receiving expert care from the comfort of their own home. Using specialist monitors, patients record their symptoms and stats daily, which are send directly to our team, who then create a tailored treatment plan, ensuring quicker adjustments and earlier interventions.

17. New one-stop urology clinic

In November 2024, we launched a 'one stop' Urology clinic, which is helping patients with urinary tract issues get the care they need faster and more efficiently. Previously, patients often faced multiple appointments for different tests before treatment decisions could be made.

The new streamlined clinic offers all necessary tests, consultations and treatment discussions in a single visit, not only providing a more thorough and convenient experience for patients, but also reducing the waiting list so more people can be seen sooner.

18. MP Engagement

We continue to engage regularly with our local MPs, with a visit from Samantha Dixon, in November, and Aphra Brandreth and Justin Madders in January 2025. As well as sharing updates and discussing local issues, the visits involved a tour of the new Women's and Children's building.

19. Thirlwall Inquiry update

The Thirlwall Inquiry oral hearings are due to complete mid January, with closing statements to take place in March and the report expected in the Autumn 2025. The most recent witnesses have been given evidence in respect of part C of the inquiry focused on effectiveness of NHS management and governance structures and processes, and external scrutiny and regulation as well as NHS culture.

The Trust remains committed to supporting the Thirlwall Inquiry and ongoing police investigations.

20. Duty of Candour and Manager Regulation Consultations

The consultation process of the Regulation of Managers started with responses due by the 18th February. The Countess of Chester Hospital NHS Foundation Trust will participate in this via a CMAST collaborative response.

There is also a consultation on the Duty of Candour and a number of colleagues are currently reviewing this to support a Trust response.

21. Executive Team update

We have welcomed Vicki Wilson to the Executive Team, commencing in the role of Acting Chief People Officer from 1st January 2025.

22. Children's Champion

Sue Pemberton, Deputy CEO and Director of Nursing & Quality has taken on the role of the Children's Champion for the Trust. This will include advocating for children, young people and their families.

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CMAST BULLETIN

Welcome message

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

CMAST Leadership Board met on 6th December discussing a number of system issues as follows:

The Leadership Board were joined by Trust Chairs for a quarterly update on programme deliverables through the first half of the financial year. A summary of progress to date can be found here and was both widely noted and celebrated by those present.

The Board also received an update on recent system discussions and was asked to feedback, outside of the meeting, on the suggestion that there could be one provider collaborative within C&M. Board feedback was particularly sought on anticipated benefits and any areas which should be subject to wider exploration.

Update papers were also provided on the following areas:
· System financial report
· System performance update

Finally, we would like to wish you all a very Merry Christmas and Happy New Year.

Mersey and West Lancashire Teaching Hospitals NHS Trust - MWL NHS | News

Elective Recovery

Senior Responsible Officer: Janelle Holmes
Programme Director: Jenny Briggs

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In November 2024:
909
65-week patients
and
29
78-week patients.

Some Trusts are anticipating residual risks in delivering 65-weeks in December and the team are working closely with providers to ensure that all mutual aid and operational tactical measures are undertaken to support the position.

Validation improvement plans and trajectories have been completed, and the actual position is being tracked weekly which is reporting positive increases of up to
7%

Outpatients

Successfully relaunched the **C&M Operational Delivery Group** to capture Trust improvement plans across the **Further Faster** priorities with final Trusts reporting next month, and the format aligned to the revised regional reporting requirements.
Achievement of the national value against Further Faster metrics continues as a system for Remote Consultations and ERF Activity.

Urology Pathway mapping, capacity and demand modelling and clinic template variation review continuing with pilot Trust.

Completed agenda and session format for the Clinical Leads Workshop in December focused on the priorities, challenges and FF improvement metrics.

Theatres

79% **capped theatre** utilisation (improvement).

Liverpool Heart and Chest Hospital the second best performer in country for capped utilisation and Wirral University Teaching Hospital and East Cheshire Trust are in quartile 4.

Clinical Pathways (CPP)

Senior Responsible Officer: Jan Ross
Programme Director: Jenny Briggs

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Gynaecology

The reason for referral audit funded by Elective Recovery is now complete and is being summarised with recommendations.

Planning for expansion of Liverpool Women's Hospital (LWH) Menopause community clinics continues and expected to commence in February 2025 within Sefton. Modelling completed to understand freed up capacity within LWH.

Work to begin to support Wirral University Teaching Hosptial in PCN collaboration and with Endometriosis pathways.

Cardiology

The second part to the **Cardiology Cath Lab Options Appraisal Workshop** took place on 4th November – the group concluded the session by successfully scoring all 4 options against the outstanding scoring criteria.

The outcome of the scoring is to be presented and discussed at relevant forums, such as the CM Cardiac Leadership Group, the CMAST Cardiology Provider Alliance and the CMAST CPP Leadership Group to agree next steps for the Cardiology Provider Alliance.

Liverpool Heart and Chest Hospital | NEWS: Liverpool Heart and Chest Hospital Successfully Implants World's First Leadless Dual Chamber Pacemaker

Ophthamology

In November 2024, the **Advice and Guidance Pilot** went live with Mid Cheshire Hospitals NHS FT and Countess of Chester Hospitals NHS FT. As with the current pilot underway at East Cheshire NHS Trust, this will link community optometrists directly with consultant ophthalmologists for specialist advice and guidance. The pilots across all 3 Trust's will run until end of March 2025.

Following the successful **NHSE Eyecare Accelerator funding bid**, we are working closely with the C&M ICB on the procurement and commissioning requirements regarding the implementation of the Glaucoma Enhanced Case Finding service pilot.

ENT

Strategic discussions around improved C&M ENT **resilience and longevity** have begun; options to become more sustainable will be outlined for further discussion and sight by appropriate governance.

Dermatology

The Dermatology Alliance is focused on the roll out of Skin Analytics, with all trusts currently in the process of developing system and clinical pathways and completing key project milestones. The majority of trusts have set a target to go-live January 2025.

91.2%
of patients waiting 6 weeks or less (1.3% increase from the previous month)

#3
ICS ranking remained stable at 3rd out of 42 ICS

Endoscopy

Halton Endoscopy Hub is providing additional capacity for up to 400 slots of Colonoscopy or Gastroscopy per month. The Hub capacity has already been utilised by Warrington and Halton Hospital, Countess of Chester Hospital and University Hospitals of Liverpool Group.

List productivity – Utilisation of lists is at 112.45% (19th November).

Network is interviewing for **Deputy Clinical Lead** in December 2024, with a view to have a candidate in post by January 2025.

Midlands and Lancashire Digital Transformation team have been commissioned to support implementation of SOLUS V2

Countess of Chester Hospital NHS Foundation Trust launches new trans-nasal endoscopy service | Countess of Chester Hospital

Pathology

TOM
(3 Hub Target Operating Model)
East Hub outline business case (OBC) approved by Warrington and Halton Hospital board

LIMS
(Laboratory Information Management System) – Official programme launch held 11th and 12th November

Workforce workstreams established for South and East hubs to support delivery of future models.

Digital Pathology- In progress of securing £1.25m of revenue funding to support further adoption of DigiPath and to move towards NHSE targets of 50% of digital reporting.

Warrington and Halton Hospitals NHS Trust - National Pathology Week - 4 to 10 November

Diagnostics

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Physiological Sciences

Progressing work on expanding sleep studies, echo, spiro and audiology tests at CDCs

Artificial Intelligence (AI) in Echocardiology Clinics
Product demonstration and planning sessions held with Mersey and West Lancashire Teaching Hospital and University Hospitals of Liverpool Group.

Enhanced GP Direct Access for COPD, asthma and heart failure
Final proposal produced.

Service and financial models required to deliver additional tests developed at C&M and Place level.

Radiology/Imaging

PACS Based Reporting
A change to the report distribution issue was approved and made on behalf of all trusts. Tests have been undertaken and this has gone well to date.

CAMRIN Radiology Clinical Reference Group
Discussed new arrangements for Gynae clinical representative

AI For Chest X-rays
Go-live to be completed November 2024. CAMRIN waiting for data from C&M ICS to complete data return.

Workforce
CAMRIN Recruitment and retention policy written in conjunction with ICB R&R leads

Mersey and West Lancashire Teaching Hospitals NHS Trust - MWL NHS | News

First patient joins radiotherapy clinical research trial :: The Clatterbridge Cancer Centre

Community Diagnostic Centres (CDCs)

Sustainability Project
Following the success of the 23/24 sustainability review the project has been recommissioned to deliver another piece of work across C&M. The project is due for completion January 2025.

Re-profiling
H2 re-profiling has been approved and sites now working to re-profiled plans

Pathways
VIN & Shopping City's pathway bids have been approved and signed off.

Parking to be limited at Congleton War Memorial Hospital from 2nd to 13th December as work continues on new Community Diagnostic Centre :: East Cheshire NHS Trust

Contact us for more information regarding the latest news!

ccf-tr.candmdiagnosticprogramme@nhs.net

Efficiency at Scale (E@S)

Senior Responsible Officer: Ged Murphy
Programme Director: Nina Russell

NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

C&M has been selected as a key stakeholder in supporting the national additional indemnity insurances programme following the scoping work that has taken place within C&M over the past year.

Medicines Optimisation

The QIPP 24/25 target is forcast to deliver

£20.2m

in primary care

£7.6m

was delivered in September

Help reduce medication waste and support the NHS across Cheshire and Merseyside :: Liverpool University Hospitals NHS Foundation Trust

Procurement

The E@S Procurement Programme Director, Sue Colbeck, was awarded the **Procurement Excellence Award** at the national Healthcare Supplies Association Annual Awards (HCSA) for the C&M region.

Sue Colbeck and Nina Russell, E@S Programme Director both spoke at the **HCSA Annual Conference & Exhibition**.

76% of the 24/25 procurement workplan has been delivered. A saving of

£5.4m

has already been delivered against the

£7.1m

workplan.

PUBLIC - Board of Directors
28th January 2025

Report	**Agenda Item 9a.**	**Board Assurance Framework – Quarter 3 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 3 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 remain the same as at previous quarterly update: • 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: • ED and UEC, and Maternity inpatient survey results received • UEC and flow action plans • Additional financial control measures • Capital bids to support infrastructure and operational effectiveness • Draft Clinical Strategy • Planning for e'roster roll out • Progress being made to deliver risk management improvement plan, including establishment of Risk Management Committee • Digital maturity assessment • Cyber assurance framework • Mental health review completed and action plan being developed • Research developments including the opening of the Clinical Research Unit and the new Research Bus • Continued learning from the Inquiry
Recommendations	The Board of Directors is asked to (i) **approve** the updates to the Board Assurance Framework at Q3 (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 3 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 Q3 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

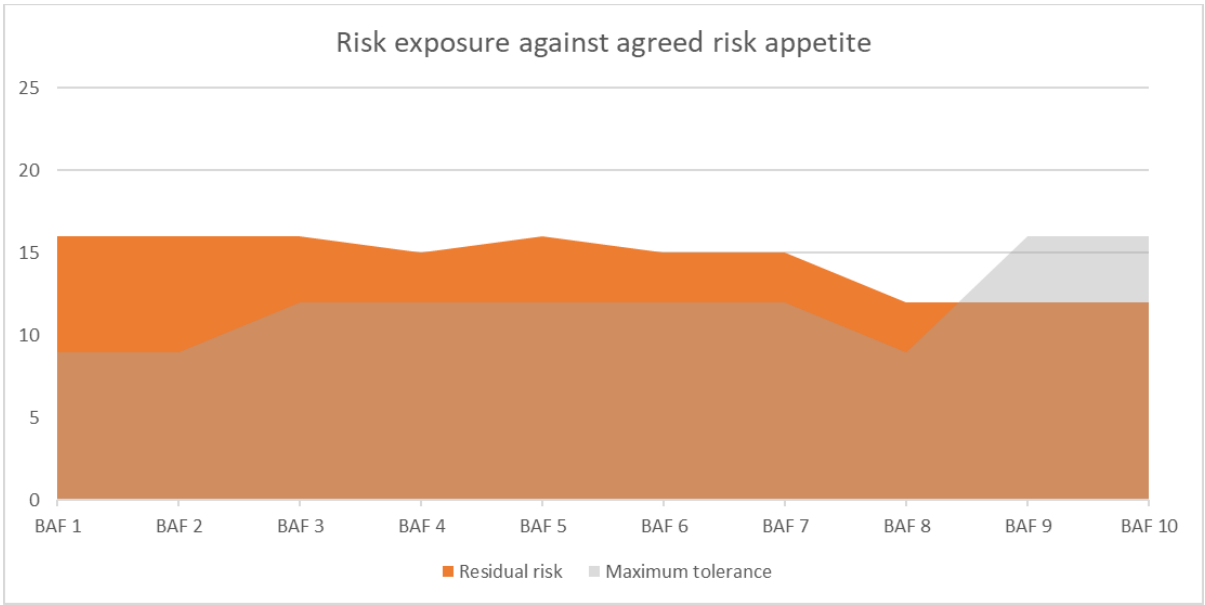
Alignment to strategic goals and objectives has been included within the BAF, with strategic objectives shaded within the key controls. The current risk exposure against the strategic goals is summarised below.

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 Q3

Progress against strategic objectives has been aligned to the BAF. Key updates at Q3 include:

- ED and UEC, and Maternity inpatient survey results received
- UEC and flow action plans
- Additional financial control measures
- Capital bids to support infrastructure and operational effectiveness
- Draft Clinical Strategy
- Planning for e'roster roll out
- Progress being made to deliver risk management improvement plan, including establishment of Risk Management Committee
- Digital maturity assessment
- Cyber assurance framework
- Mental health review completed and action plan being developed
- Research developments including the opening of the Clinical Research Unit and the new Research Bus
- Continued learning from the Inquiry

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 Q3

(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 - Feedback on patient and family experience strategy - C'Diff 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 (draft) - Mental health review action plan
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 (including use of AI)
BAF4. Challenges in ensuring a high quality, engaged, diverse and inclusive **workforce** would affect our ability to deliver patient care	**15**	**12**	Partial	- E'rostering roll out - Workforce planning - Staff survey results and actions - Understanding wellbeing needs - EDI priorities and plan - Evaluation of onboarding experience - Talent and succession planning - Training needs analysis
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 - Capital bid (TIF) - Annual RAAC Assessment
BAF7. Failure to ensure strong **digital transformation and IT resilience** could impact the delivery of services for patient and our workforce	**15**	**12**	Partial	- Digital strategy audit - Cyber assessment framework audit - Digital maturity assessment - Infrastructure developments - EPR optimisation programme

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing
				- Data quality assurance - National competency framework workstreams - 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	- Risk management improvement plan progress - Governance organogram (draft) - Regulatory compliance and assurance map (into 25/26) - CWP/COCH collaboration draft joint committee TOR and Exec to Exec planned - Corporate Records Management review

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

Appendix B – Progress against Strategic Objectives Q3

The progress against strategic objectives at Q3 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. ED and UEC, and Maternity inpatient survey results received.
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. Awaiting final operational planning guidance for 2025/26.
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. ED and UEC, and Maternity inpatient survey results received.
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. Early draft shared with Deputy Medical and Nusing Directors for feedback (Jan 25).

SG2 People and Culture		
United shared values, goals, mindset and behaviours	VW	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.High level staff survey results 2024 received and awaiting full access to results and feedback to support development of action plans (March 2025).
Develop an approach for recruitment, development and retention	VW	Onboarding welcome event improved for all staff groups. Evaluation of event ongoing to look at further opportunity to enhance. Also improving TRAC experience for candidates.

Improve the health and wellbeing of our staff	VW	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 days took place with Clinical Leads in October and December 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. Clinical strategy update planned for Board (Jan 25).
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	VW	Leadership framework established and programmes rolled out for clinical leaders, aspiring leaders (band 2-4) and lead managers. Basic skills for manager training developed for all managers and update on outline programme provided through People Committee, with dates being arranged. 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 actions progressing, risk management policy approved and Risk Management Committee in place. Committee organagram developed and further review of sub committee structures including Divisions underway. Governance presentations continue to be 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. Revisited PWC action plan and HfMA financial control checklist, reported to F&P Committee and priortised action plan will continue to be reported. 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 (Complete) Digital presentation at clinical strategy day (Complete). Co pilot workshop taking place in Jan 25 MIAA strategy audit Q4 2025 DMA results to be shared and briefing to go to Finance and Performance Committee (Mar 25) Revised programme reporting into F&P (Jan 25)

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). Joint Committee TOR drafted and Exec to Exec meeting planned.

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:** Jan 2025	**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. ED and UEC, and Maternity inpatient survey results received.	*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:** Update Q4	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. Workplans to be reviewed in Q4 for 2025/26.		
			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 and successful outcomes demonstrated. Concerns regarding C Difficile sampling processes and practices, with an improvement plan in place and progressing. 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:** Jan 2025	**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. Early draft shared with Deputy Medical and Nusing Directors for feedback (Jan 25).		
			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 days took place with Clinical Leads in October and December 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. Clinical strategy update planned for Board (Jan 25).		
			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 responsibilites 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 been completed by a member of the psychiatrict liaison service on secondment from CWP for 6 weeks. An interim report was reviewed at EDG in December and further update including action plan expected Jan 2025.		

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:** Jan 2025	**Cause:** - Unable to meet the demand for services within available resources - Increased demand in suspected cancer referrals and ED attendances - Increased number of patients that do not meet the criteria to reside **Consequences:** - Increased patient waits for access to services impacting on patient safety, potential harm and patient experience. - Failure to meet key targets and regulatory requirements in some areas - Sub-optimal service provision - Increased ambulance handover delays - Potential increase in complaints from family, friends and carers.	***4 x 5 = 20***	C1) Annual plan with clear activity and performance reporting against trajectories and focussed improvement plans as required. **Control Owner:** Chief Operating Officer	- 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. Awaiting final operational planning guidance for 2025/26.	***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 and have supported validation in Q3. Continue to focus on non RTT follow up and progressing opportunity to use AI in the future as a sustainable solution.		

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:** Jan 2025	**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. Plan being developed to roll out e'rostering for AfC staff to commence feb 2025. Medical e'rostering procurement underway with demos planned Jan 2025.	*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. High level staff survey results 2024 received and awaiting full access to results and feedback to support development of action plans (March 2025).		
									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. Additional specialist resource to be used in Q4 to support development of plans.		
			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 made to NHS Leadership Academy Q3.		
									Enhanced onboarding process and experience.	Redesign of onboarding processes and improve experience. **Action Owner:** Chief People Officer **Due date:** Complete	Onboarding welcome event improved for all staff groups. Evaluation of event ongoing to look at further opportunity to enhance. Also improving TRAC experience for candidates.		
			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 developed for all managers and update on outline programme provided through People Committee, with dates being arranged. 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:** Jan 2025	**Cause:** The Trust operates in an increasingly challenging financial environment in line with the national position for acute providers. This is driven by: - Increase in non elective activity delivered at premium costs; - High numbers of medically optimised and delayed transfers of care for which costs are not fully reimbursed; - Costs associated with medical and nurse 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. Revisited PWC action plan and HfMA financial control checklist, reported to F&P Committee and priortised action plan will continue to be reported. 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 NHSE CFOs re Inquiry funding. NHSE review of impact of the pay aware funding has been completed and position agreed however no further funding will be provided. Formal confirmation of Inquiry funding received (Jan 2025).		
			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 EDG, 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:** Jan 2025	**Causes** - Implications of ICS capital envelope with undetermined ICB estates strategy and capital prioritisation process - Ageing estate and challenging backlog maintenance risks - Womens and Childrens building major capital scheme - limited development opportunities due to space constraints **Consequences** - Impact on delivery of capital plan - insufficient progress on backlog maintenance - Inability to invest in innovations not currently identified in the Trust's five year financial plan - Having to re-prioritise the programme if an unidentified need arises - Disruption to operational services during a complex capital programme	*5 x 4 = 20*	C1) Robust governance arrangements for Capital Management. **Control Owner**: Chief Finance Officer	- Finance and Performance Committee reporting to Board. - Capital Management Group via F&P Committee	ICB returns	*ACCEPTABLE*	*5 x 3 = 15*	**NO**	Uncertainty of the ICS approach to capital, estates strategy and capital prioritisation process.	Engagement in ICS Estates Strategy development. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Member of efficiency at scale 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. TIF bid submitted to support elective capacity (Dec 24).		
			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 development options to re-provide bed capacity. New contractor has commenced failsafe works in July 2024. Additional funding agreed to support increased costs. Annual assessment due to be completed by end Jan 2025 to determine any further actions required for the remaining lifespan of the building.		

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: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF7 Failure to 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:** Jan 2025	**Cause:** -Failure to review and adopt innovative solutions to deliver value added digital transformation - 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** -Trust will be reliant on systems that are not fit for purpose which will impact productivity - 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. -Trust	*5 x 4 = 20*	C1)Digital and Data Strategy which aligns with ICB and National expectations **Control Owner:** Chief Digital & Data Officer	Updates into FnP via Digital Strategic Programme Update	MIAA Digital strategy audit (Jan-Mar 25)	*Partial*	*5 x 3 = 15*	**NO**	Strategy refresh required with regular consolidated reporting to F&P Committee. Green policy is being updated in 2025 - Digital are represented at the anchor institution steering group	(i) Refresh Digital Strategy informed by National digital maturity assessment. (ii) MIAA to conduct audit of Digital Strategy. (iii) Review programme reporting into F&P **Action Owner:** Chief Digital and Data Officer **Due date:** Q4	NHS Providers led Board session planned on Digital Maturity (Complete) Digital presentation at clinical strategy day (Complete). Co pilot workshop taking place in Jan 25 MIAA strategy audit Q4 2025 DMA results to be shared and briefing to go to FnP (Mar 25) Revised programme reporting into F&P (Jan 25)	***12***	***Mar-25***
			C2)Annual plans that deliver effective management of Cyber security threats and Digital Infrastructure health **Control Owner**: Chief Digital & Data Officer	- DSPT annual audit via Audit Committee - DSPT 23/24 presented to F&P committee	- Annual MIAA assurance audit on DSPT submission	*Partial*			SIRO report for F&P Committee. Information Asset Owner responsibilities. Completion of capital infrastructure investment including data centres. New DSPT toolkit for completion in 2024/25.	(i) SIRO Report to be developed **Action Owner:** Chief Digital and Data Officer **Due date:** Complete	SIRO report developed and submitted to F&P Committee (Completed). Creation of new AI steering group – regular meetings now taking place (Completed)		
										(ii) DSPT and Cyber Assurance Framework (CAF) initial audit evidence to be submitted December 2024 **Action Owner:** Chief Digital and Data Officer **Due date:** Jun 2025	CAF provisional submission completed. MIAA review to take place in (Feb 2025)		
										(iii) Deliver plan to maintain infrastructure health **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	Continue to maintain and upgrade the data centre infrastructure environment (ongoing) Key investments include: Air con system replacement taking place in Jan 2025 New SAN procurement will be awarded in Jan 2025		
										(iV) Deliver plan Cyber Security protection plan **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	Complete Lessons learnt review following recent regional Cyber attacks (Q4 24//25) £105k Cyber funding secured from ICB/National Upgrade of telephony system following capital funding support Feb 2025		
			C3)Annual plan for investment, upgrade and optimisation of digital Applications (including EPR) **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)	*Acceptable*			Completion of upgrade.	**Action Owner:** Chief Digital and Data Officer **Due date:** Complete	EPR Upgrade completed 25th Sept 2024 - closure report to F&P Committee (Complete) EPR upgrade contract in place to deliver yearly upgrades across the next 4 years.		
									Application (including EPR) optimisation structures, engagement and assurance reporting.	Delivery of EPR optimisation plan **Action Owner:** Chief Digital and Data Officer **Due date**: Quarterly update	Prioritisation process now established with updates into FnP EPR usability survey was conducted in Q3 results due in Q4 Funding secured for integration of primary care electronic referrals (eRS) into EPR. Project completion Mar 2025 Business case being developed for procurement of new ophthalmology system HIMSS assessment planned for Q4.		
			C4) Continuous improvement plan for 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. Data Hub will launch in Jan 2025		
										Adopt NCF Framework for internal reporting **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	National Competency Framework (NCF) workstreams in progress to support recruitment, retention and professional development within Analytics team		
			C5) Digital and Data workforce plan ensuring, professionalisation, 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. Digital SDN (Skills Development Network) level 3 accreditation initial assessment Jan/Feb 2025		

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:** Jan 2025	**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 - Board effectiveness	***4 x 3 = 12***	C1) Effective Governance Structures **Control Owner:** Director of Governance, Risk and Improvement	- Well led action plan. - Annual report. - Committee effectiveness annual reports via Audit Committee.	Head of Internal Audit Opinion (via Audit Committee). VFM opinion (via Audit Committee). CQC Reports.	*Partial*	***4 x 3 = 12***	**NO**	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**: Quarterly updates	Significant progress made against well led action plan including assurance committee effectiveness, BAF and risk appetite reset for 2024/25. Risk management improvement plan actions progressing, risk management policy approved and Risk Management Committee in place. Committee organagram developed and further review of sub committee structures including Divisions underway. Governance presentations continue to be 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. Likely to be developed into 2025/26. 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 (Oct 24). Joint Committee TOR drafted for Board approval. Exec to Exec meeting planned (Feb 2025). 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 scoping for corporate records management work drafted.		

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:** Jan 2025	**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:** Quarterly update	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. Trust open day planned for Monday 13th with potential suppliers by way of engagement. CCL now onboarded to help develop options appraisal and OBC		
			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). Joint Committee TOR drafted and Exec to Exec meeting planned.		
			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:** Jan 2025	**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. Clinical Research unit opened (Dec 24) and research bus received.		
			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.		

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
28th January 2025

Report	**Agenda Item 9b.**	**High Risks Report – January 2025**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
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**	Potential to link to all BAF risk areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led						**X** **X** **X** **X** **X**
Previous considerations	-						
Executive summary	Work is ongoing to further strengthen and embed risk management across the Trust, together with a refreshed Risk Management Policy. The Risk Management Committee has now met twice and started to progress the risk management improvement plan actions. Whilst the improvement plan progressing, the reporting of high risks continues as per the Datix system. This paper sets out a range of risks with a residual score of 15 or over and these risks include: • RAAC • Waiting lists and overdue follow ups • ED waiting times and performance • Equipment and assets • Radiology capacity and demand • CIP						

	• Staffing levels and gaps in resources • EDI • Payroll services
Recommendations	The Board of Directors is asked to consider the current high level risks and continue to work on local risk registers to ensure these reflect the risks faced, mitigations and actions.

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

High Risks Report – January 2025

1. BACKGROUND

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

2. DATIX RISK REGISTER

On the Corporate Risk Register, there are currently 29 risks in total with a residual risk score of 15 and above that have been entered on to the Datix system (note: this number varies significantly as we are increasing our focus on the risk registers with an aim to improve accuracy and completeness).

Risks scored 15 and over are scored in the following way:

Score	Count
15	12
16	16
20	1
Grand Total	**29**

The details of the 29 high risks are provided in appendix 1. The risk themes include:

- RAAC
- Waiting lists and overdue follow ups
- ED waiting times and performance
- Equipment and assets
- Radiology capacity and demand
- CIP (planned care)
- Safe staffing levels and gaps in resources
- EDI
- Payroll

Work is ongoing to further strengthen and embed risk management across the Trust, together with a refreshed Risk Management Policy. The first Risk Management Committee was held in shadow format on 12th November 2024 with a second meeting taking place on 14th January 2025. A Risk Improvement Plan is being progressed to agree risk management Datix development priorities and to establish Risk Management Training for roll out across the Trust.

3. RECOMMENDATIONS

The Board of Directors is asked to consider the current high-level risks and continue to work on local risk registers to ensure these reflect the risks faced, mitigations and actions.

Appendix 1 – High Risks (as at 13th January 2025)

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
2385	Use of Siporex RAAC Planks in W&C's Building Roof.	Corporate	4x5	20	This risk score has been increased following advice from the RAAC Board. Funding has been secured and actions are being supported through the RAAC Board.	Karen Edge
3298	The single lift that links the JDSC building is an aging asset and consequently much of the original lift control system is obsolete from a maintenance and repair perspective. Given the age and condition of the lift, the probability of breakdown is increasing and reliability issues are being witnessed more frequently.	Corporate	4x4	16	On-call service from lift maintenance service provider. Trained staff in lift release. Asset log being used to record breakdowns. Ordered replacement of control panel (significant component in operational functionality).	Karen Edge
2854	Lack of Medical Devices Safety Officer (MDSO) role in the Trust	Corporate	4x4	16	Discussions held at Medical Devices Group meeting and agreed as a risk to ensure focus at corporate level.	Nigel Scawn
3303	Medical Photography - Risk of the Trust having no clinical photographer in core business hours additional Risk around the correct governance processes being followed for loan cameras.	Diagnostics and Clinical Support	4x4	16	Processes in place to schedule patients and local agreements in place with some specialties. Adhoc admin support provided by radiology teams. SOPS developed for usage of loan camera.	Cathy Chadwick
3119	Mortuary freezer age and poor performance (4 Tier freezer).	Diagnostics and Clinical Support	4x4	16	Freezers are temperature monitored 24/7 by online monitoring company. APTs respond to any calls. Two separate freezer sections available.	Cathy Chadwick

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
3309	Risk of out of hours work for CT becoming unmanageable for the staff working and mistakes being made	Diagnostics and Clinical support	4x4	16	Additional cover provided through rota to 8pm. New process introduced to outsource bookings after 5pm (covered by vacancies underspend). Some cover in place for vacancies.	Cathy Chadwick
2522	Risk of treatment delays and patient management for cancer patients who have not come via the fast track pathway (clinical risk) due to it not being possible to accurately code cancer diagnoses in Cerner or perform searches for this information	Diagnostics and Clinical support	4x4	16	Post implementation review of mTuitive in progress as this should have resolved some of the issues. Priority for resolution but there are competing divisional priorities and limited digital and data resource to support.	Cathy Chadwick/ Jason Bradley
3234	Inability to provide adequate IR service due to only having 1 IR theatre and no recovery ward	Diagnostics and Clinical Support	4x4	16	Business case being developed for second IR suite, will require external funding.	Cathy Chadwick
2550	Risk to provision of Microbiology service due to insufficient resource in consultant microbiologist team	Diagnostics and Clinical Support	4x4	16	Locum and agency arrangements in place for the 0.6 wte vacancy and any a/l or absence gaps. Calls from clinical teams limited to consultant only to manage the workload. Permanent band 7 appointed Sep 24.	Cathy Chadwick
3326	Risk to safe staffing levels and potential for reliance on premium cost temporary staffing as a result of medical workforce gaps.	HR (Medical staffing)	4x4	16	Review of vacant posts and offer of additional support where hard to recruit vacancies exist. Improving attractiveness of roles to ensure issues don't prevent people from wanting to work at the Trust.	Vicki Wilson

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
					SARD job planning work to review capacity and demand.	
3322	Risk to payroll service, Small service which has lost clients (and therefore staff), resilience, poor morale and increasing pressure on payroll team increasing potential risk of pay errors.	HR (Payroll Service)	4x4	16	Additional interim resource and support to ensure delivery of critical processes. Planning to move payroll service from in house to a scaled up provider in line with national and system expectations.	Vicki Wilson
2857 2062 2004	Backlog of overdue follow up appointments	Planned Care	4x4	16	Waiting lists being validated and monitored through the Divisions and through OPELG. Pace of validation will increase when AI validation is in place.	Cathy Chadwick
2971	Inability to deliver timely care to patients on a urology cancer pathway	Planned Care	4x4	16	Case presented to and approved at EDG for additional clinical staff and recruitment underway.	Cathy Chadwick
3290	Requirement for additional Medtronic debridement hand pieces x 2 for ENT to carry out additional ENT lists.	Planned Care	4x4	16	Managing of booking ENT cases requiring Medtronic debridement.	Cathy Chadwick
3284	Non Achievement of Planned Care CIP Target.	Planned Care	4x4	16	Increased grip and control measures in place across the Trust, Divisional updates to CIP Review Group and focused review meetings taking place.	Cathy Chadwick
1246	Lack of second theatre on Central Labour Suite	Womens and Childrens	4x4	16	New Women's and Children's build under construction and due to open Summer 2025.	Cathy Chadwick

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
3386	OPD have the old style blood pressure monitors, that are now end of life, these machines can no longer be repaired as components are no longer stocked and made by the company. Some machines have already completely broken and so there is not enough to cover all OPD areas and through the day machines have to be moved locations to support clinical activity.	Diagnostics and Clinical Support	5x3	15	Current mitigations include moving monitoring machines around the department.	Cathy Chadwick
2989	Lack of Interventional Radiology Resource for supporting the vascular service	Diagnostics and Clinical Support	3x5	15	Business case being developed for second IR suite, will require external funding.	Cathy Chadwick
2678	Insufficient clinical pharmacy staff to undertake patient facing services across all areas resulting in a risk of medication related harm incidents , reduced patient flow, increased medication costs, increased incidence of antimicrobial resistance, breaches of legislation and regulatory standards related to the use of medicines	Diagnostics and Clinical Support	5x3	15	Medicines information department and on-call pharmacist available for clinical advice. In areas without a full clinical service, supplies maintained through dispensary team and discharge team available to support patient flow.	Cathy Chadwick
3247	The current multi-faith Spiritual Care Centre requires expansion in terms of operational footprint to accommodate the multi-faith denominations and include provision for washing facilities for female users who follow Islam.	Estates	3x5	15	Controls limited by size of footprint and numbers of attendees. For users who follow Islam, pre-prayer preparation facilities are not existent for female Muslims.	Karen Edge

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
3321	Failure to provide safe, cost effective medical cover as a result of ineffective, paper based work scheduling and rostering systems.	HR Medical Staffing	3x5	15	Additional resource and support to medical staffing team. Review of internal processes. Plan in place to implement electronic rostering system for medical staff.	Vicky Wilson
3323	Poor staff experience especially for BAME staff and those with disabilities resulting in poor levels of morale, high sickness levels, increased churn and impact on providing the best patient care.	HR HRBP	3x5	15	People promise manager in place with focus on staff experience. Focus on staff networks. Restructure of EDI team to enable greater focus on actions to support inclusion across the organization.	Vicki Wilson
3291	ENT Baha machine obsolete, requires new machine and handpieces.	Planned Care	5x3	15	Machine has been repaired but parts now obsolete so any further breakdown would result in the need for a replacement machine.	Cathy Chadwick
3297	SMART Vascular - AAA waiting times	Planned Care	3x5	15	Working with WUHFT and W&HFT to audit the pathway and develop an action plan to reduce the wait times to meet the 8 week target.	Cathy Chadwick
3304	Currently patients are transferred from theatre to recovery without full and safe monitoring. Lack of capnography monitoring in breach of national safety standards	Planned care	5x3	15	Efficacy of patient respiration is confirmed by monitoring saturations and patient respiratory effort. Portable monitoring devices which can show a capnograph trace would be required for all theatre areas to enable compliance with national standards.	Cathy Chadwick / Nigel Scawn
3260	Risk to patient safety due to lack of adherence to NHSE 4 hour Emergency Department standard	Urgent Care	3x5	15	Continued focus on flow and UEC improvement plan.	Cathy Chadwick

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
3159	Risk to service provision and staff burnout due to reduction in Obstetric and Gynaecology Consultant workforce	Women's and Children's	5x3	15	Long term agency locum in place, distribution of role across service to ensure focus on maternity services. Executive discussion on recruitment plans. Two roles to be advertised in January 2025 – over recruitment into O&G roles to support the service. Support offered from LWH for fetal medicine	Nigel Scawn

PUBLIC – Board of Directors
28th January 2025

Report	**Agenda Item 10.**	**Maternity Survey 2024: Management Report January 2024**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Claire Davies Natasha Macdonald			Head of Midwifery Director of Midwifery				
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 failure to maintain quality of care would result in poorer patient & family experience and 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**
Previous considerations	Safety Champions July 2024							
Executive summary	The Maternity Survey 2024 reveals significant progress in patient experience, with the Trust ranking 20th out of 56 organisations, a remarkable improvement from 38th in 2022 and 26th in 2023. Key highlights include: • **95%** of respondents felt treated with respect and dignity during labour and birth. • **96%** had confidence and trust in staff during labour and birth. • **92%** felt involved in decisions about their care. Areas identified for improvement include partner access, medical history awareness, and immediate assistance during labour. These are being addressed through a comprehensive action plan with measurable goals.							

Recommendations	The Board of Directors is asked to note the ongoing work to progress the action plan, which will continue to be monitored by the Patient Experience Oversight Group.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	BAF impact is failure to maintain quality of care would result in poorer patient & family experience and 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.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

Maternity Survey 2024: Management Report September 2024

1. Background

This report summarises the findings from the Maternity Survey 2024 conducted by Picker on behalf of the Countess of Chester Hospital NHS Foundation Trust.

A total of 89 questions were included in the 2024 survey. Of these, 59 questions received positive scores, with 49 questions offering historical comparison. The Trust's maternity service achieved a ranking of **20th out of 56 organisations**, a significant improvement from **38th in 2022** and **26th in 2023**.

The historical positive score demonstrates consistent progress, with the Trust being ranked as the **15th most improved service in 2024** (compared to **54th in 2022** and **23rd in 2023**).

This survey is part of the NHS Patient Survey Programme, benchmarking Trust performance nationally to drive improvements in care

2. Key Findings

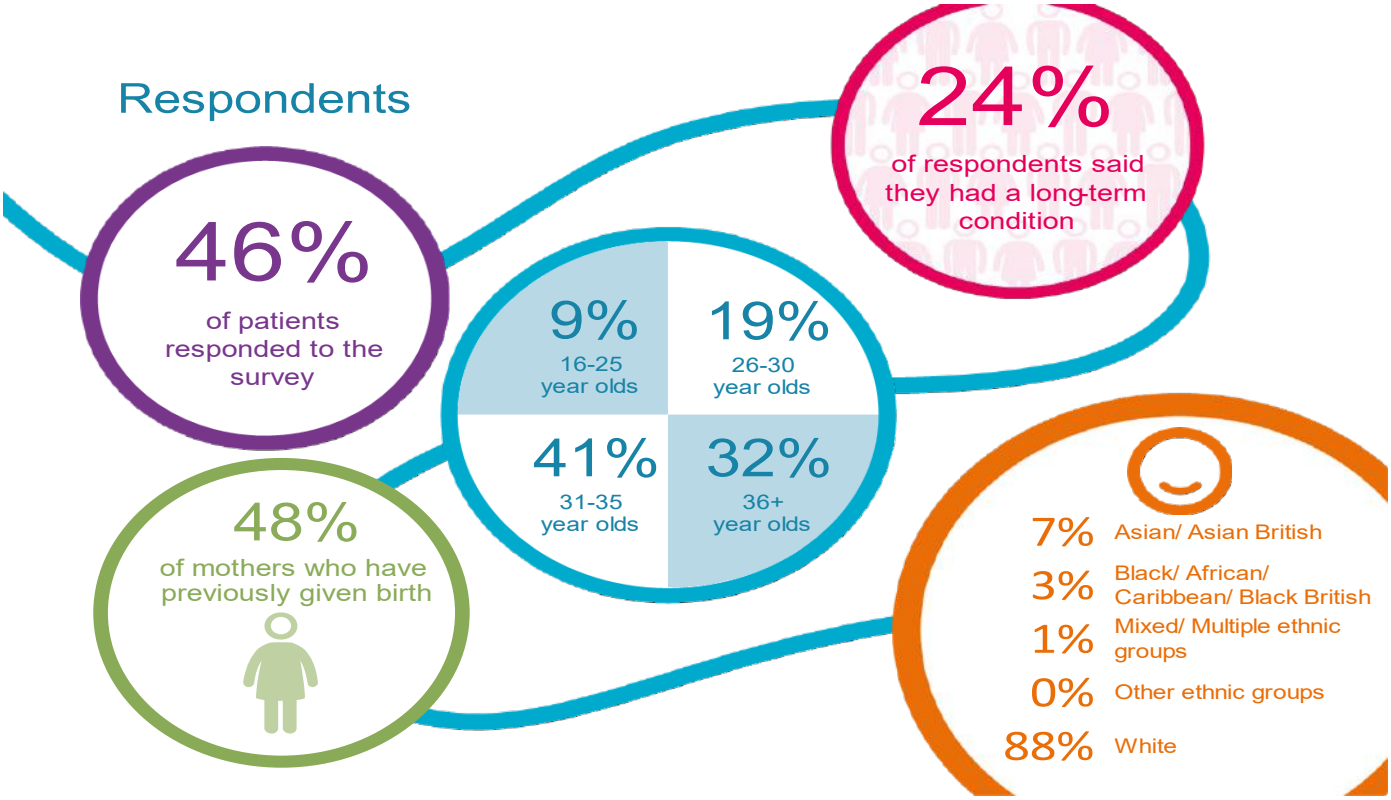
Positive Outcomes

- Exceptional care: Patients praised the kind, compassionate, and calm approach of the maternity team.
- Improved antenatal education: High scores for providing information about warning signs during pregnancy.
- Notable improvement in rankings: The Trust moved from 54th in 2022 to 15th most improved in 2024.
- Feeding support: Positive feedback on advice and support for feeding during the postnatal period.

Areas for Improvement

- Partner access (D6): Only 31% of respondents reported that their partner could stay as long as they wanted.
- Medical history awareness (B6): 77% of respondents felt midwives or doctors were aware of their medical history.
- Help during labour (C13): 89% of respondents reported they could get help when needed.
- Respect and dignity (C17): Opportunity to enhance patients' sense of respect and dignity during care.

Summary of Respondents



Survey Data Overview

- Invitations Sent: 285
- Eligible Respondents: 283
- Response Rate: 46% (previously 44%)
- Comparison to Peers: Slightly above the average response rate of similar organisations (41%).
- Demographic Insights:
  - Respondents included diverse age groups, with 41% aged 31-35 years.
  - 24% reported having a long-term condition, emphasising the need for personalised care.
  - 98% indicated English as their primary language.

Performance Trends

Bar graph demonstrating ranking improvement (38th in 2022, 26th in 2023, 20th in 2024).

Summary of Findings

- 95% (C.17) felt that they were treated with respect and dignity during labour and birth
- 96% (C.18) felt they had confidence and trust in staff during labour and birth
- 92% (C.16) felt they were involved enough in decisions about their care

Most improved scores	Trust 2024	Trust 2023
C4. Given information / advice on risks of induced labour	90%	70%
F18. Felt GP talked enough about mental health during postnatal check-up	78%	65%
F15. If needed it, received support or advice about feeding their baby during evenings, nights or weekends	78%	67%
F17. Felt GP talked enough about physical health during postnatal check-up	75%	66%
B11. Given the help needed by midwives (antenatal)	99%	91%

Most declined scores	Trust 2024	Trust 2023
D6. Found partner was able to stay with them as long as they wanted (in hospital after birth)	31%	49%
B6. Felt midwives or doctor aware of medical history (antenatal)	77%	94%
C13. Able to get help when needed (during labour and birth)	93%	99%
D2. Discharged without delay	64%	69%
C20. Felt midwives or doctor aware of medical history (during labour and birth)	89%	94%

Areas for Improvement

The areas for improvement have been identified as the Trust 2024 results had declined from the previous 2023 results.

1. D6 – found partner was able to stay with them as long as they wanted
2. B6 – felt midwives or Drs were aware of medical history (antenatal)
3. C13 – able to get help when needed (during labour and birth)

Patient Feedback

A total of 81 responses was feedback to the Trust through the PICKER survey, with a mixture of positive and negative comments.

Positive Responses

- Exceptional level of care
- Excellent care from start to finish
- Could not fault care
- Excellent continuity of care
- A kind, compassionate and calm team

Negative Responses

- Partner was unable to stay overnight
- Limited support for postnatal health
- Noisy on the postnatal ward at night
- A few too many staff in the postnatal period
- Birth plan ruined as needed a cannula

3. Next Steps

i. Action plan to be completed which has identified areas for improvement.
ii. Work in collaboration with the Maternity and Neonatal Voices partnership Lead.
iii. Communicate and share learning with the team.

4. Recommendations

The Board of Directors is asked to note the ongoing work to progress the action plan, which will continue to be monitored by the Patient Experience Oversight Group.

5. Conclusion

The Maternity Survey 2024 demonstrates the Trust's dedication to improving maternity services. While progress is evident, focused actions are in place to address identified challenges and sustain upward trends in patient satisfaction.

National Maternity CQC Survey 2024 Results – management report
Action plan commenced – November 2024

Executive Sponsor	Sue Pemberton: Deputy Chief Executive and Director of Nursing and Quality
Action Plan Lead	Natasha Macdonald: Director of Midwifery Claire Davies: head of Midwifery
Date shared at Governance Board	
Last updated	December 2024

Key	**RED - Project Experiencing or very likely to experience significant problems – urgent action required**	**AMBER - Project has potential for significant problems – action required**	**GREEN - Project on target and no significant problems anticipated**

Action	**Areas for Review**	**Recommendation/ Action**	**Lead Person**	**Target Date for completion**	**Progress of Actions**	**Date of Completion**	**Evidence**

D6	31% Found partner was able to stay with them as long as they wanted	Extend visiting hours for partner, friends and family Maternity Six Steps	Inpatient Matron MNVP Lead	January 2025	Inpatient Matron to ensure the appropriate communication has been shared with our service users and teams	Completed	Email
B6	77% Felt midwives or Drs were aware of medical history (antenatal)	Quality Improvement Group reviewing Antenatal Clinic and Personalised Care	Inpatient Matron Community Matron	March 2025	Antenatal QI working group in place.	Ongoing	
C13	89% Able to get help when needed (during labour and birth)	Highlight on safety huddles the importance of providing one to one care in the labour room Call bell to hand	Inpatient Matron Central Labour Suite manager	January 2025	Matrons to add to the safety huddle and discuss with their teams.	Completed	

PUBLIC – Board of Directors
28th January 2025

Report	**Agenda Item 11.**	**Maternity Incentive Scheme Year 6 Compliance and Assurance Report**						
Purpose of the Report	Decision	**X**	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** **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	Not applicable							
Executive summary	This report provides assurance to the Trust Board on compliance with the Maternity (and Perinatal) Incentive Scheme (MIS) Year 6 standards, as mandated by NHS Resolution. It outlines the Trust's actions to achieve the required 10 Safety Actions and highlights evidence demonstrating compliance. Key points include: • **Compliance Overview:** The Trust has met all 10 Safety Actions, ensuring alignment with MIS Year 6 requirements. These actions include enhanced data submission, multidisciplinary training compliance, and robust mechanisms for learning from incidents.							

	• **Quarter 3 Highlights:** From October to December 2024, three qualifying cases were reported to the Maternity and Newborn Safety Investigations (MNSI) programme. No qualifying cases required reporting to the Early Notification (EN) Scheme. • **Evidence of Family Support:** All families involved in qualifying incidents were informed of the role of MNSI and compliance with statutory duty of candour. Documentation has been provided through Datix system. • **Lessons Learned:** The Trust has implemented significant improvements based on lessons learned from PMRT reviews, including addressing communication errors, enhancing documentation practices, and issuing updated clinical guidance. • This report seeks approval from the Trust Board to ratify the final compliance position and authorise the CEO to sign the MIS Year 6 Board Declaration Form for submission to NHS Resolution. This compliance secures financial incentives and reinforces the Trust's commitment to delivering safe, high-quality maternity and neonatal care.
Recommendations	The Board of Directors is requested to: • Approve the final compliance position for MIS Year 6. • Authorise the CEO to sign the Board Declaration Form for submission to NHS Resolution. • Note the importance of sustained efforts to maintain the MIS standards.

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.

NHS
Countess of Chester Hospital
NHS Foundation Trust

Maternity Incentive Scheme Year 6 Compliance and Assurance Report

Introduction

This paper and accompanying presentation seek Trust Board approval for the CEO to sign the Board Declaration Form, confirming compliance with the Maternity (and Perinatal) Incentive Scheme (MIS) Year 6 standards as required by NHS Resolution. The Board should be assured by the robust evidence regularly provided and reviewed in dedicated evidence review meetings. The Local Maternity and Neonatal System (LMNS) has also reviewed the submitted evidence to ensure its validity.

As in previous years, Trusts that achieve all 10 Safety Actions will recover the portion of their contribution allocated to the CNST Maternity Incentive Fund (10% of their premium) and qualify for a share of any unallocated funds. To achieve compliance, the Trust must meet 10 Safety Actions comprising approximately 90 standards, many of which require external validation through electronic submissions to national and regional databases, including:

- Perinatal Mortality Review Tool (PMRT) (safety action 1)
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) (safety action1)
- Maternity Services Dataset (MSDS) (safety action 2)
- Saving babies' lives (safety action 6)
- NHS Resolution (safety action 10)

Background

The NHS Resolution Maternity Incentive Scheme (MIS) aims to improve safety in maternity and neonatal care by requiring Trusts to meet specific safety standards. Year 6 builds on previous successes by embedding improvements and introducing initiatives aligned with the national goal of halving stillbirths, neonatal deaths, maternal deaths, and brain injuries by 2025.

Participating Trusts must provide evidence of compliance with 10 Safety Actions, focusing on the following areas:

1. **Perinatal Mortality Review (PMRT):** Ensure perinatal deaths are reviewed using the National Perinatal Mortality Review Tool, including notifying deaths within seven working days and involving parents in the review process.
2. **Maternity Services Data Set (MSDS):** Submit data to MSDS to the required standard, ensuring at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) pass data quality criteria. Accurate ethnicity data must be provided for at least 90% of women booked in July 2024.

3. **Transitional Care:** Ensure transitional care services are in place for babies born between 34+0 and 36+6 weeks and demonstrate quality improvement to minimise separation of parents and babies.
4. **Workforce Planning:** Provide evidence of effective workforce planning for both clinical and midwifery staff, ensuring compliance with staffing standards and addressing any deficits with action plans**6 Saving Babies' Lives Care Bundle:** Demonstrate progress towards full compliance with the Saving Babies' Lives Care Bundle Version 3.
5. **Service User Engagement:** Engage with Maternity and Neonatal Voices Partnerships (MNVPs) to ensure user involvement in service development, including coproduction of services and action plans post-CQC survey reviews.
6. **Training Compliance:** Achieve at least 90% attendance for relevant staff in fetal monitoring, maternity emergencies, and neonatal life support training.
7. **Board Oversight:** Establish clear oversight and assurance mechanisms regarding maternity and neonatal safety, with evidence of ongoing monitoring and shared learning.
8. **Maternity and Newborn Safety Investigations:** Report all qualifying cases to MNSI and NHS Resolution's Early Notification Scheme, ensuring compliance with the duty of candour.

On 9 January, an extraordinary meeting was convened to review and critique the supporting evidence for each Safety Action. Attendees included Sue Pemberton, Director of Nursing, and Sarah Corcran, Non-Executive Director and Maternity Safety Champion.

Current Compliance Position

The Trust has successfully completed all 10 Safety Actions for MIS Year 6, demonstrating full compliance with approximately 90 required standards. Key achievements include:

- **Data Quality:** Timely and accurate submissions to MSDS, PMRT, MBRRACE, and NHS Resolution.
- **Training Compliance:** Multidisciplinary training completion rates exceed 90%, covering all mandated topics.
- **Serious Incident Learning:** Lessons from PMRT reviews are disseminated through internal forums, including rolling half-day training, Safety Huddles, and Perinatal Mortality and Morbidity meetings.
- **Service User Engagement:** Collaboration with MNVPs has enhanced pathways for diverse and hard-to-reach populations.

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

As no previous cases have met the criteria Quarter 3 evidence has been shared to enable board oversight prior to sign off.

In Quarter 3 September – December 2024, Three cases reported to MNSI

1. Term baby transferred for cooling. No evidence of hypoxic ischaemic encephalopathy (HIE) on MRI scan.
2. Early neonatal death at 3 days of age.
3. Intrapartum stillbirth at 38+4 weeks.

There were 0 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.

The Trust Board can be assured that the family have received information on the role of MNSI and NHS Resolution's EN scheme. **Evidence:** Documented on Datix and Cerner systems

Current Compliance Position
The Trust has achieved compliance with all required standards under the Maternity (and Perinatal) Incentive Scheme Year 6.

All eligible cases were notified to MBRRACE-UK within the required seven-day timeframe (Standard A). Surveillance for eligible cases was commenced within one calendar month, and parents were informed of the review process (Standard B). While all eligible cases met the timelines for initiating reviews under Standard C, 5 of the 6 eligible cases completed 13 of the 18 Factual questions.

Recommendations

The Board of Directors is requested to:

- Approve the final compliance position for MIS Year 6.
- Authorise the CEO to sign the Board Declaration Form for submission to NHS Resolution.
- Note the importance of sustained efforts to maintain the MIS standards.

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.

Countess of Chester Hospital NHS Foundation Trust

Appendix 1

Meeting			**Board of Directors**					
Report	**Agenda item**		**Maternity Incentive Scheme (MIS) Safety 10)**					
Purpose of the Report	Decision		Ratification		Assurance	x	Information	
Accountable Executive	Sue Pemberton				Director of Nursing			
Author(s)	Lorna McNulty Lesley Roe				Risk Midwife for Women's & Children's Services Bereavement Midwife			
Board Assurance Framework	1st October – 31st December (Y6, Q3)				Quality & Safety			
Strategic Aims	To deliver safe care and treatment							
CQC Domains	Safe, responsive, and well led							
Previous Considerations								
Executive Summary	The purpose of this report is to provide the trust board oversight qualifying cases to The Maternity and Newborn Safety Investigations programme (MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 1st October 2024 to 31st December 2024 to the required standard.							
Highlights	**MIS Safety Action 10** ▪ In Q3 24/25 three cases met the inclusion criteria for MNSI							
Recommendation(s)	The Board/Committee is requested to**: -** • Note the assurance provided within the report							
Corporate Impact Assessment								
Statutory Requirements								
Quality & Safety	Improved compliance with MIS year 6 Quality Standard 1 recommendations MBRRACE-UK Confidential Enquiry Audit Requirements							

Patient Involvement	As stipulated within the MIS Safety Action
Financial impact	Where Maternity services can demonstrate full compliance of all safety actions, they can regain their 10% contributions to MIS.

Safety action 10 of the maternity incentive scheme.
Have you reported 100% of qualifying cases to the Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Criteria for reporting to MNSI

Qualifying incidents are babies born ≥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 MNSI definition of labour:

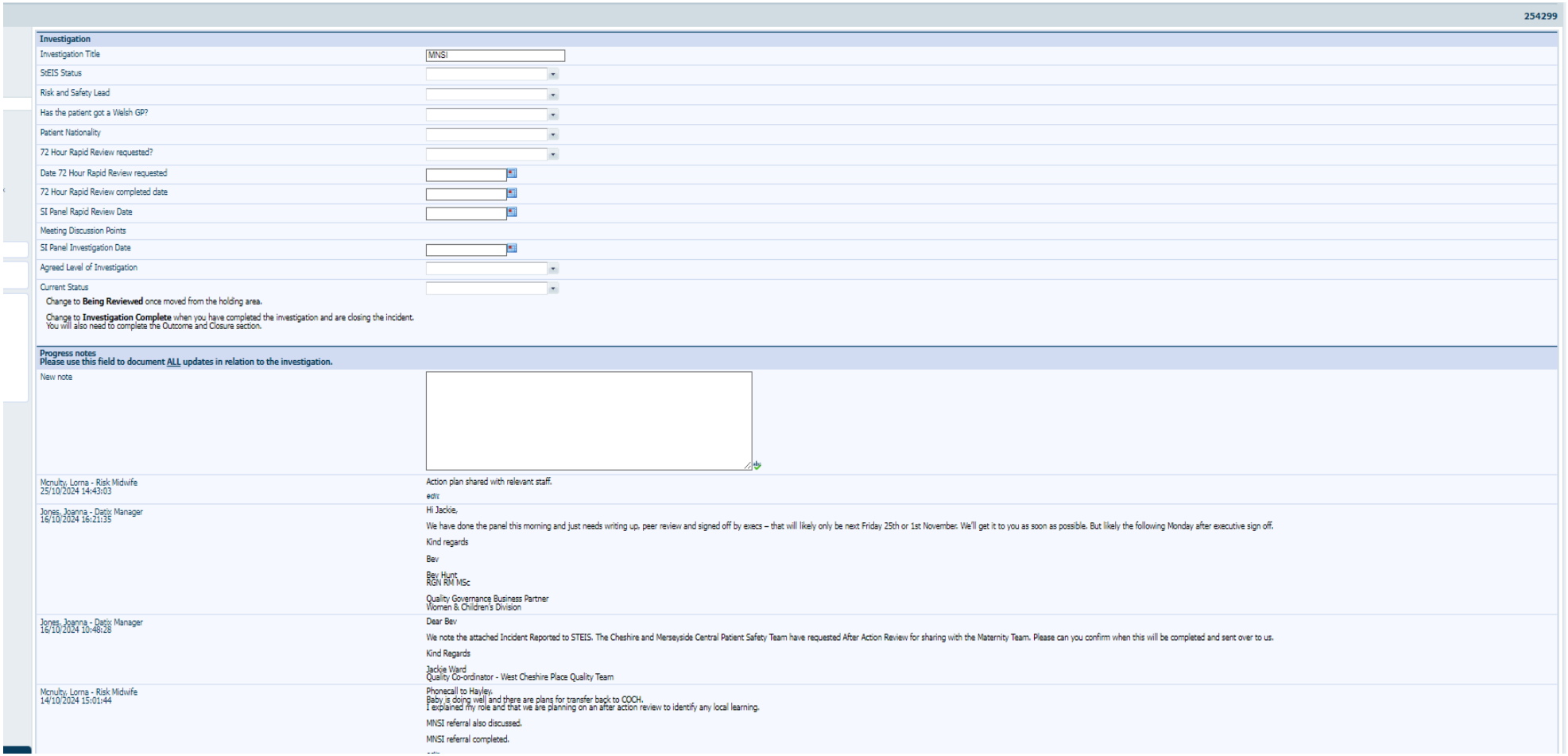
- Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation.
- When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured 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 October to 31st December 2024.	Three cases reported to MNSI: 1.Term baby transferred for cooling. No HIE on MRI scan. 2.Early neonatal death at 3 days of age. 3.Intrapartum Stillbirth at 38+4 weeks.	1.Maternity and Newborn Safety Investigations (MNSI) Case Log. 1.MI-038675 2.MI-038703 3.MI-039180
Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 1st October to 31st December 2024.	No qualifying cases.	N/A
For all qualifying cases which have occurred during the period 1st October to 31st December 2024 the Trust Board are assured that the family have received information on the role of MNSI and NHS Resolution's EN scheme.	Parents received the initial information about the role of MNSI on: 1.Verbal MNSI information provided on 14/10/2024 via a phonecall from the Risk Midwife. 2.Verbal MNSI information provided on 18/10/2024 by our Bereavement Midwife. 3.Verbal MNSI information provided on 27/12/2024 by our Bereavement Midwife.	1.Documented on Datix incident reporting system. 2.Documented on Cerner and Datix incident reporting system. 3.Documented on Cerner and Datix incident reporting system.
There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	1.Duty of Candour completed on 14/10/2024. 2.Verbal 18/10/2024 and letter provided 21/10/2024. 3.Verbal 27/12/2024 and letter provided 27/12/2024.	1.Documented on Datix incident reporting system. 2.Documented on Cerner. 3.Documented on Datix incident reporting system and Cerner.
Has Trust Board had sight of maternity clinical governance records of qualifying MNSI/EN incidents and numbers	Yes. This report will go to BOD in Jan 2025.	This quarterly report and MIS presentation.

reported to MNSI and NHS Resolution?		
Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes. This report will go to BOD in Jan 2025.	This quarterly report and MIS presentation.
Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes. This report will go to BOD in Jan 2025.	This quarterly report and MIS presentation.
Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	No qualifying cases.	N/A.

Term baby transferred for cooling



254299

Investigation

Investigation Title	MNSI
StEIS Status	
Risk and Safety Lead	
Has the patient got a Welsh GP?	
Patient Nationality	
72 Hour Rapid Review requested?	
Date 72 Hour Rapid Review requested	
72 Hour Rapid Review completed date	
SI Panel Rapid Review Date	
Meeting Discussion Points	
SI Panel Investigation Date	
Agreed Level of Investigation	
Current Status	

Change to **Being Reviewed** once moved from the holding area.

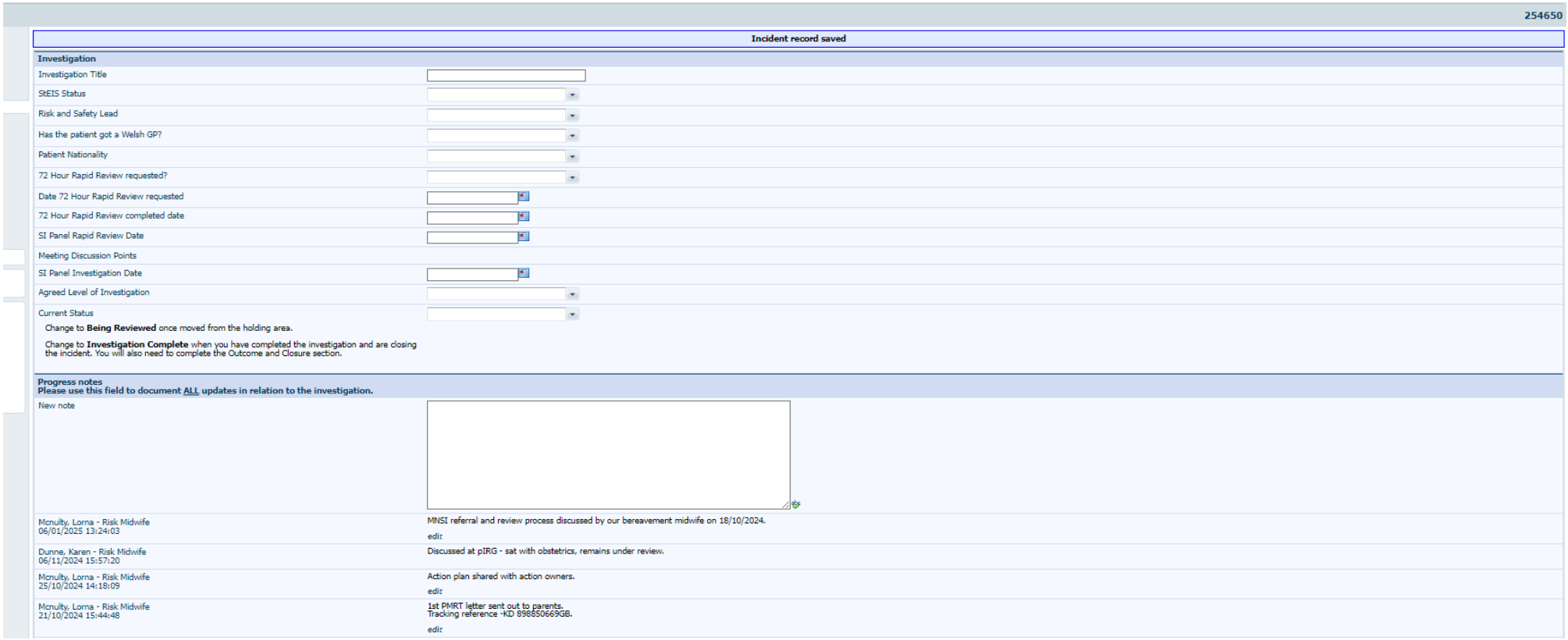
Change to **Investigation Complete** when you have completed the investigation and are closing the incident. You will also need to complete the Outcome and Closure section.

Progress notes
Please use this field to document ALL updates in relation to the investigation.

New note

Mcnulty, Lorna - Risk Midwife 25/10/2024 14:43:03	Action plan shared with relevant staff. edit
Jones, Joanna - Datix Manager 16/10/2024 16:21:35	Hi Jackie, We have done the panel this morning and just needs writing up, peer review and signed off by execs – that will likely only be next Friday 25th or 1st November. We'll get it to you as soon as possible. But likely the following Monday after executive sign off. Kind regards Bev Bev Hunt RGN RM MSc Quality Governance Business Partner Women & Children's Division
Jones, Joanna - Datix Manager 16/10/2024 10:48:28	Dear Bev We note the attached Incident Reported to STEIS. The Cheshire and Merseyside Central Patient Safety Team have requested After Action Review for sharing with the Maternity Team. Please can you confirm when this will be completed and sent over to us. Kind Regards Jackie Ward Quality Co-ordinator - West Cheshire Place Quality Team
Mcnulty, Lorna - Risk Midwife 14/10/2024 15:01:44	Phonecall to Hayley. Baby is doing well and there are plans for transfer back to COCH. I explained my role and that we are planning on an after action review to identify any local learning. MNSI referral also discussed. MNSI referral completed.

Early neonatal death at 3 days of age



254650

Incident record saved

Investigation

Investigation Title	
StEIS Status	
Risk and Safety Lead	
Has the patient got a Welsh GP?	
Patient Nationality	
72 Hour Rapid Review requested?	
Date 72 Hour Rapid Review requested	
72 Hour Rapid Review completed date	
SI Panel Rapid Review Date	
Meeting Discussion Points	
SI Panel Investigation Date	
Agreed Level of Investigation	
Current Status	

Change to **Being Reviewed** once moved from the holding area.

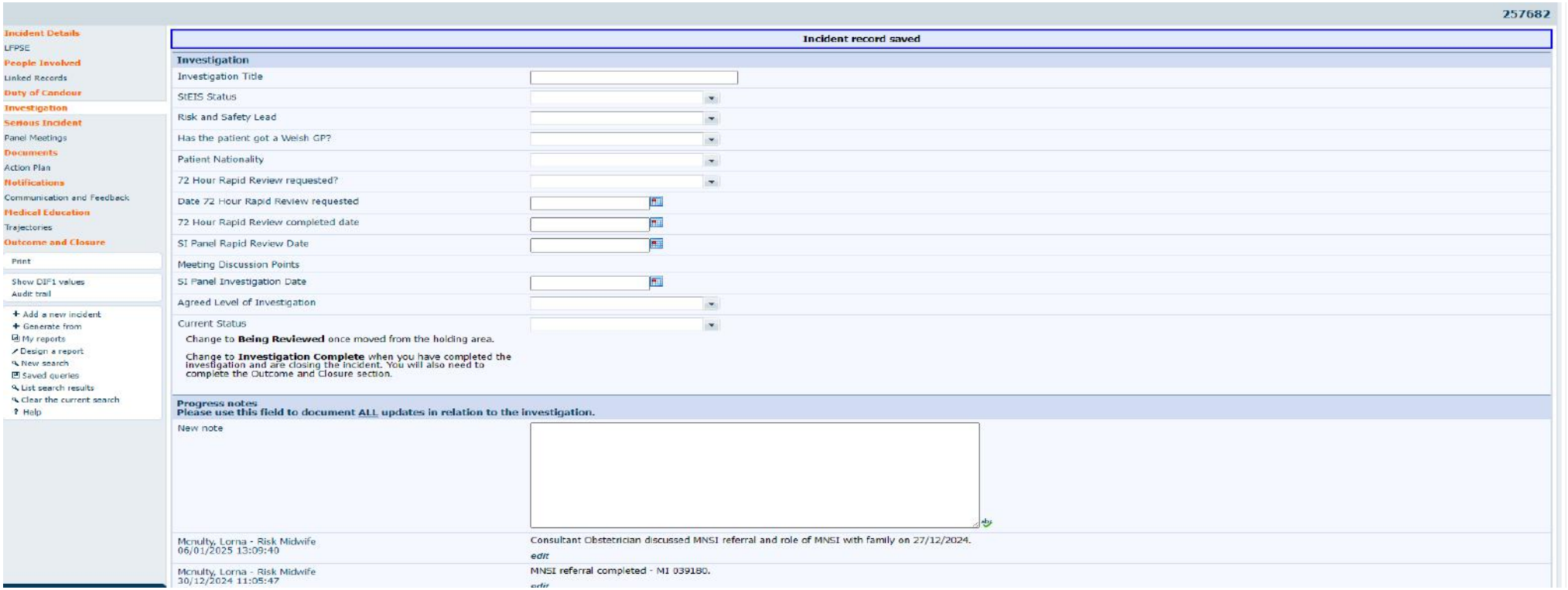
Change to **Investigation Complete** when you have completed the investigation and are closing the incident. You will also need to complete the Outcome and Closure section.

Progress notes
Please use this field to document ALL updates in relation to the investigation.

New note

Mcnulty, Lorna - Risk Midwife 06/01/2025 13:24:03	MNSI referral and review process discussed by our bereavement midwife on 18/10/2024. *edit*
Dunne, Karen - Risk Midwife 06/11/2024 15:57:20	Discussed at pIRG - sat with obstetrics, remains under review.
Mcnulty, Lorna - Risk Midwife 25/10/2024 14:18:09	Action plan shared with action owners. *edit*
Mcnulty, Lorna - Risk Midwife 21/10/2024 15:44:48	1st PMRT letter sent out to parents. Tracking reference -KD 898850669GB. *edit*

Intrapartum stillbirth at 38+4 weeks



Countess of Chester Hospital NHS
NHS Foundation Trust

Countess of Chester Health Park
Liverpool Road
Chester
CH2 1UL
Tel: 01244 365000
Email: coch.lavendermidwives@nhs.net
coch.maternitysafety@nhs.net

ADDRESS

Date

Dear NAMES,

Understanding What Happened

First, may we offer our sincere condolences for the loss of your baby girl, *****. We understand that this is a difficult time to be reading new information.

When a baby dies during pregnancy or within 28 days of birth, a review is performed of the care that both you and your baby received to understand as much as we can about what happened. All aspects of your care will be examined including your immediate post-delivery care. Your views are important, and it would be helpful if you could share your feelings and thoughts about your care, or any questions you have with us. To support you in doing this, we have provided you with key contacts: ***Bereavement Midwife: Lesley Roe – coch.lavendermidwives@nhs.net and Risk Midwife: Lorna McNulty – coch.maternitysafety@nhs.net.***

First, you have an opportunity to put forward any questions you may have about your care. The Lavender Midwife will aim to answer your questions quickly and thoroughly.

We have arranged for you to have a Pregnancy Risk Clinic appointment with Dr ****, (Consultant Obstetrician) on DATE/TIME. The Pregnancy Risk Clinic is a clinical appointment with Dr **** to see how you are, discuss events and results from any investigations. The appointment will also provide you with an opportunity to ask any further questions and a plan will be developed for if you decide to consider future pregnancies. It may seem a long time until this appointment, but this allows us to gather all the information and results required. We understand that this is a long and difficult time to wait and we will support you during this time, however, it is important to have as many results as possible for the review to be thorough.

Hopefully these two opportunities will have addressed your questions, concerns or feedback. Nevertheless, there is one final process called the Perinatal Mortality Review Tool (PMRT) that may address any further concerns or questions. The PMRT involves multiple health professionals and has been designed to standardize the review process and ensure a thorough, high quality review of the

Countess of Chester Hospital NHS
NHS Foundation Trust

Countess of Chester Health Park
Liverpool Road
Chester
CH2 1UL
Tel: 01244 365000

This will involve a hospital panel at The Countess of Chester Hospital (including external health professionals) holding a meeting and reviewing you and your baby's care using the specific Perinatal Mortality Review Tool process.

The review will:

- look at your medical records from the beginning of your pregnancy
- look at tests and results, including postmortem and placental reports if you have consented to either of these
- answer any questions you may have and address any concerns
- talk to staff involved
- look at guidance and policies to ensure the care you received was appropriate
- talk to you about the review process and your involvement
- support you to provide any questions or give your perspective of your care to the review team
- give you choices about how you might do this

The review may tell us that good and appropriate care was given to you and your family, or that we may need to change the way we do things.

Keeping you informed

Once the PMRT process is completed, we will discuss its findings with you. We will also provide a letter detailing the outcome, we can deliver this either in person with a home visit, discuss via the phone or we can also send by post or email if you would prefer.

If you have any questions about this process, please contact Lesley Roe or Lorna McNulty. Our Lavender Midwife will be in touch with you within 10 days and we will discuss this further.

Yours Sincerely,

Lesley Roe & Lorna McNulty

Lead Bereavement Midwife
Lead Risk Midwife

Recommendation

The minimum essential requirement is that:

The Trust Board has sight of Trust legal services and maternity clinical governance records and numbers of qualifying MNSI and EN incidents.

The Trust Board has sight of evidence 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.

We have complied with all reporting conditions as incidents have occurred. The Trust Board can be assured the Maternity service is committed to achieving the standards required of the Maternity Incentive Scheme.

Sign-Off Presentation for MIS NHS Resolution Incentive Scheme Assurance against the Maternity (and Perinatal) Incentive scheme Year 6 for Trusts

January 2025

NHS
Countess of Chester Hospital
NHS Foundation Trust

Overview of Maternity Services Compliance Maternity and Perinatal Incentive Scheme (MIS) – Year 6

NHS Countess of Chester Hospital NHS Foundation Trust

Launch Date: April 2024

- Purpose: Ensure robust compliance with all 10 Safety Actions, each subdivided into multiple elements
- Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion however it should ne noted COCH continue to have direct board reporting for perinatal services.

Evidence Review Process

- Ongoing monitoring and evidence review of all MIS requirements are now scheduled within the Perinatal assurance and improvement board annual work plan to ensure all safety actions are continuously reviewed. Escalation and assurance to Board within Maternity quarterly report.
- Comprehensive evidence review conducted by the CoCH maternity team, aligning with technical guidance and the Board Sign-Off Sheet.
- Evidence for Safety Actions 1–10 submitted to the Local Maternity and Neonatal System (LMNS) November 2024 via NHS futures platform.
- Reviewed by Debbie Edwards, Strategic Advisor for Maternity & Neonatal Services, and LMNS representatives awaiting confirmation. - No additional evidence requested post-review to date.

COCH Self-assessment CNST Compliance 2024

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
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?	Yes
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes

Safety Action 1

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

Safety action No. 1		
Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?		
From 8 December 2023 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
1	Have all eligible perinatal deaths from 2 April 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose NA)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2 April 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 60% of the reports published within 6 months of death?	Yes
5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews, any themes identified, and consequent action plans.	Yes
6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Evidence

Q1 Quality and safety September 2024

Q2 Board of directors November 2024

Safety Action 1

Evidence Highlights

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.
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
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
30/05/24	03/10/24	06/06/24	04/06/24	04/06/24	04/06/24 & 02/10/24	30/07/24	25/11/24	07/11/24	B & C
15/07/24	07/11/24	17/07/24	22/07/24	17/07/24	22/07/24	16/09/24	02/01/25		B & A
16/09/24	05/12/24	19/09/24	19/09/24	16/09/24	16/09/24 & 29/11/24	16/11/24	16/03/25		C & A
17/10/24	06/02/25	18/10/24	18/10/24	18/10/24	18/10/24	17/12/24	17/04/25		
26/12/24	06/03/25	27/12/24	27/12/24	27/12/24	27/12/24	26/02/25	26/06/25		

Safety Action 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?	Yes
2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Safety Action 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Organisation Name: COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

Reporting Period: July 2024

NHS England

Notes: The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	145			Passed
CQIMDQ14	180	180	100.0		Passed
CQIMDQ15	175	175	100.0		Passed
CQIMDQ16	165	175	94.3		Passed
CQIMDQ24	145	165	87.9		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	130	180	72.2	Passed
CQIMDQ08	180	180	100.0	Passed
CQIMDQ09	180	180	100.0	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	180	180	100.0		Passed
CQIMDQ11	70	180	38.9		Passed
CQIMDQ12	5	180	2.8		Passed
CQIMPPH	5	180			Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	180	180	100.0		Passed
CQIMDQ22	175	175	100.0		Passed
CQIMDQ23	165	175	94.3		Passed
CQIMPreterm	10	175		57	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	180	180	100.0		Passed
CQIMDQ15	175	175	100.0		Passed
CQIMDQ16	165	175	94.3		Passed
CQIMDQ18	100	175	57.1		Passed
CQIMDQ20	0	95	0.0		Passed
CQIMTears	0	95		0	Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	180	180	100.0	Passed
CQIMDQ15	175	175	100.0	Passed
CQIMDQ16	165	175	94.3	Passed
CQIMDQ18	100	175	57.1	Passed
CQIMDQ26	175	175	100.0	Passed
CQIMDQ27	200	200	100.0	Passed
CQIMDQ28	105	200	52.5	Passed
CQIMVBAC	5	10	50.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	180	180	100.0	Passed
CQIMDQ31	180	180	100.0	Passed
CQIMDQ32	165	180	91.7	Passed
CQIMDQ33	180	180	100.0	Passed
CQIMDQ34	105	180	58.3	Passed
CQIMDQ36	175	180	97.2	Passed
CQIMDQ37	85	175	48.6	Passed
CQIMDQ38	180	180	100.0	Passed
CQIMDQ39	180	180	100.0	Passed
CQIMRobson01	0	30	0.0	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	25	40	62.5	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	20	25	80.0	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	200	180	111.1	Passed
CQIMDQ04	185	200	92.5	Passed
CQIMDQ05	25	185	13.5	Passed
CQIMSmokingBooking	25	185	13.5	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	165	180	91.7	Passed
CQIMSmokingDelivery	10	165	6.1	Passed

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	185	200	92.5	Passed

Evidence

- Maternity Service Quarterly Update November 2024

Safety Action 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2024 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?	Yes
2	Or Is there a Transitional Care (TC) action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.		
3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	Yes
4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	Yes

Safety Action 3

Evidence highlights

Term Baby Respiratory Pathway

Caroline Bennion/Dr Jenny Loughnane

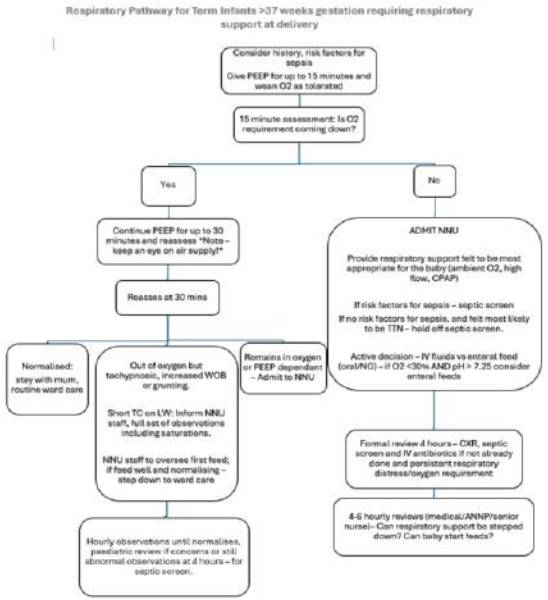
NHS Countess of Chester Hospital NHS Foundation Trust

Background
Reducing Term admissions to Neonatal Unit is an NHS improvement priority. There is overwhelming evidence that separation of mother and baby interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breast feeding, morbidity for mother and infant .

Respiratory problems are the most common reason for term admissions. Many require only a short period of CPAP but are routinely commenced on IV antibiotics and fluids, necessitating a period of establishing enteral feeds, further prolonging separation and exposure to broad spectrum antibiotics.

Aim
Decrease respiratory term admissions to the neonatal unit: and for those who are admitted decrease the duration of stay.

National/Local drivers
Although our term admission rates are low in 2023-2024 54% of term admissions were due to respiratory distress. This is replicated in the National figures within NHS England ATTAIN project (Reducing admissions of full- term babies to neonatal units.



Method
Infants ≥ 37/40 presenting with respiratory distress to follow the pathway to support newborn transition.

Data collection
Each case will be reviewed by the perinatal team, data captured via Badger. A PDSA approach to establish and embed the flow chart into practice. Further information will be collected on:

- Duration of CPAP and location
- Requirement for admission
- Requirement for a timing of septic screen

References

Collicot, N., Collier, J., Maitre, A. (2022). Reducing Term Admission to a level 2 Neonatal Unit with the introduction of a Pathway for Respiratory Management in the first Hour After Birth.
Newborn life Support Algorithm 2021.pdf (resus.org.uk
NHS England –Reducing admissions of full- term babies to neonatal unit

QI Project presentation to LMNS

Organiser	EDWARDS, Debbie (WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST)
Time	21 November 2024 11:15-11:30
Location	Microsoft Teams Meeting
Response	Accepted Change Response

Microsoft Teams Need help?

Join the meeting now

Meeting ID: 327 152 284 449

Passcode: 5GMjyV

Safety Action 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured 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 following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They 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 Progrssion (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance	Yes
3	Has the Trust monitored 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 https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person.	Yes
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	N/A
Do you have evidence that the Trust position regarding question 3 & 4 has been shared:		
5	At Trust Board?	Yes
6	With Board level safety champions?	Yes
7	At LMNS meetings?	Yes

Safety Action 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, 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) - Representative month rota acceptable.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	Yes
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	N/A
11	Was the above workforce action plan shared with the LMNS?	N/A
12	Was the above workforce action plan shared with the ODN?	N/A
d) Neonatal nursing workforce		
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing	Yes
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	N/A
15	Was the above workforce action plan shared with the LMNS?	N/A
16	Was the above workforce action plan shared with the ODN?	N/A

Evidence

- Maternity Service Quarterly Update November 2024 to board
- Safety champions November 2024

Safety Action 5

Can you demonstrate an effective system of Midwifery workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.	Yes
2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. If this process has not been completed due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.	Yes
3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Meeting midwifery staffing recommendations from Ockenden and evidence of the funded establishment being compliant with outcomes of birthrate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● Where deficits in staffing levels have been identified, the plan to address these findings must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.** An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
5	A workforce action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will NOT enable the Trust to declare compliance with this sub-requirement.**	N/A
6	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
7	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will enable the Trust to declare compliance with this sub-requirement.**	N/A

Evidence

- Midwifery and Maternity Safer Staffing Report – 1st January 2024 to 30th June 2024 to Board of Directors September 2024
- Birthrate Plus December 2021

Can you demonstrate an effective system of Midwifery workforce planning to the required standard?

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

Evidence

- Meeting scheduled Birthrate plus
- Midwifery staffing paper Papers to BOD sept 2024

Safety Action 6

Can you demonstrate that you are on track to compliance with all elements of Saving Babies' Lives Care Bundle Version 3?

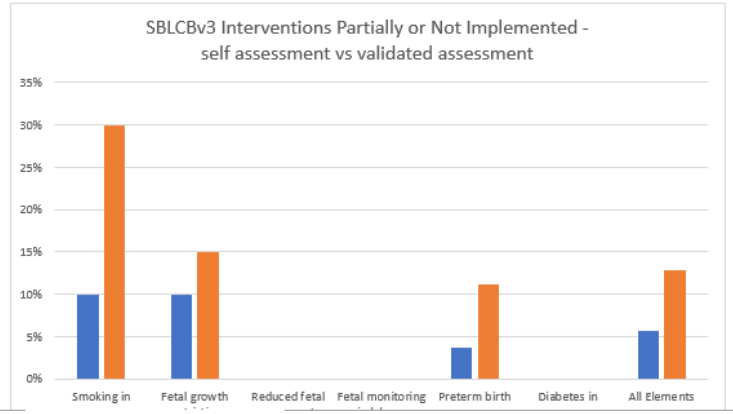
From 2 April 2024 until 30 November 2024

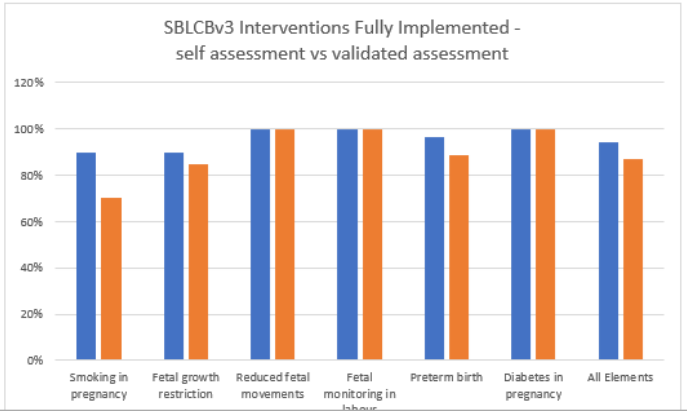
Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	Yes
2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**	Yes
3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Yes
4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	Yes
5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**	Yes
6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	Yes

Can you demonstrate compliance with all five elements of the Saving Babies Lives care bundle v3 ?

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	90%	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	96%	Partially implemented	89%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	87%	CNST Met





Safety Action 7

Listen to women, parent and families using maternity and neonatal service and coproduce with service users

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes
2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as:** •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Yes
3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: •Job description for MNVP Lead •Contracts for service or grant agreements •Budget with allocated funds for IT, comms, engagement, training and administrative support •Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	N/A
5	Show evidence of a review of annual CQC Maternity Survey data, such as the documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.	Yes
6	Has progress on the coproduced action above been shared with Safety Champions?	Yes
7	Has progress on the coproduced action above been shared with the LMNS?	Yes

Listen to women, parent and families using maternity and neonatal service and coproduce with service users

03 MEETING OUTCOMES

1. Chester Pride: Meets monthly and invited MNVP Lead to attend meetings or will share surveys/ documentation and are keen to be involved in future 15 steps or upcoming co-production projects

2. Chester Muslim Sisters Association: Invited to attend weekly mums group at the mosque. Added to whatsapp group and good response and dialogue around questions raised. It was highlighted that a discussion about cultural/religious considerations for labour and birth would be useful to have during the 36 week appointment. A prayer space within easier access of maternity/labour ward was raised as something that families would find extremely beneficial. We also discussed Quran cubes. These are speakers that play the Quran and there is a Muslim charity that can provide them to hospitals upon the hospital chaplain's request. The suggestion was that parents on the neonatal unit could play it next to their baby's cot which they believe would be comforting to both.

MNVP UPDATE // DEC 2024

03 MEETING OUTCOMES

3. CHAWREC (Cheshire, Halton and Warrington Race and Equality Centre); New BAME health inequality officer keen to work together. Met to share links and current goals which align well. Part of her role is to signpost asylum seekers/refugees to health services and assist them in understanding the system. We discussed whether she knew how to do this for maternity services and I proposed that a guide from the hospital would be helpful for her.

Safety Action 8

Can you evidence the following 3 elements of local training plans and ‘in-house’, one day multi professional training ?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2024?		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants	Yes
6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	Yes
7	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	Yes
9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.	Yes
12	For rotational anaesthetic staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff	Yes
	Neonatal basic life support (NBLS)	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births	Yes
16	For rotational medical staff that commenced work in neonatology on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of Neonatal nurses (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
19	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes

Evidence

- Fetal monitoring
- Maternity emergencies
- Neonatal basic life support

Safety Action 8

Can you evidence the following 3 elements of local training plans and ‘in-house’, one day multi professional training?

1. ROLLING COMPLIANCE FETAL SURVEILLANCE AND MONITORING TRAINING / SD C

FETAL MONITORING – CONSULTANT OBS
11 CONSULTANTS REQUIRED TO COMPLETE
10/11 COMPLIANT WITH FETAL MONITORING TRAINING = **91%**
CURRENTLY COMPLIANT WITH CNST / SBL / OCKENDEN REQUIREMENTS

FETAL MONITORING - JUNIOR DOCTORS OBS/GYN
12 JUNIOR DOCTORS REQUIRED TO COMPLETE
11/12 COMPLIANT WITH FETAL MONITORING TRAINING = **92%**
CURRENTLY COMPLIANT WITH CNST / SBL / OCKENDEN REQUIREMENTS

FETAL MONITORING - MIDWIVES
109 MIDWIVES REQUIRED TO COMPLETE
101/109 COMPLIANT WITH FETAL MONITORING TRAINING = **93%**
CURRENTLY COMPLIANT WITH CNST / SBL / OCKENDEN REQUIREMENTS

2. ROLLING COMPLIANCE MATERNITY EMERGENCIES (PROMPT / SD A)

MATERNITY EMERGENCIES - CONSULTANT OBS
11 CONSULTANTS REQUIRED TO COMPLETE
10/11 COMPLIANT WITH PROMPT TRAINING = **91%**
CURRENTLY COMPLIANT WITH CNST / OCKENDEN REQUIREMENTS

MATERNITY EMERGENCIES - 2023/24 JUNIOR DOCTORS OBS/GYN
18 JUNIOR DOCTORS REQUIRED TO COMPLETE
17/18 COMPLIANT WITH PROMPT TRAINING = **94%**
CURRENTLY COMPLIANT WITH CNST / OCKENDEN REQUIREMENTS

2. ROLLING COMPLIANCE MATERNITY EMERGENCIES (PROMPT / SD A)

MATERNITY EMERGENCIES - MIDWIVES
109 MIDWIVES REQUIRED TO COMPLETE
108/109 COMPLIANT WITH PROMPT TRAINING = **99%**
CURRENTLY COMPLIANT WITH CNST / OCKENDEN REQUIREMENTS

MATERNITY EMERGENCIES - MSWs
14 MSWs REQUIRED TO COMPLETE
13/14 COMPLIANT WITH PROMPT TRAINING = **93%**
CURRENTLY COMPLIANT WITH CNST / OCKENDEN REQUIREMENTS

MATERNITY EMERGENCIES - MA
22 MAs REQUIRED TO COMPLETE
22/22 COMPLIANT WITH PROMPT TRAINING = **100%**
CURRENTLY COMPLIANT WITH CNST / OCKENDEN REQUIREMENTS

MATERNITY EMERGENCIES – CONSULTANT ANAESTHETISTS
26 ANAESTHETIC CONSULTANTS REQUIRED TO COMPLETE
24/26 COMPLIANT WITH PROMPT TRAINING = **92%**
CURRENTLY COMPLIANT WITH CNST / OCKENDEN REQUIREMENTS

MATERNITY EMERGENCIES - ANAESTHETIC TRAINEES
15 ANAESTHETIC TRAINEES REQUIRED TO COMPLETE
14/15 COMPLIANT WITH PROMPT TRAINING = **93%**
CURRENTLY COMPLIANT WITH CNST / OCKENDEN REQUIREMENTS

3. ROLLING COMPLIANCE NEONATAL LIFE SUPPORT (M,N&P MANDATORY TRAINING / SD B)

NEONATAL LIFE SUPPORT – CONSULTANT OBS
11 CONSULTANTS REQUIRED TO COMPLETE
10/11 COMPLIANT WITH NLS TRAINING = **91%**
CURRENTLY COMPLIANT WITH TRUST REQUIREMENTS

NEONATAL LIFE SUPPORT - MIDWIVES
109 MIDWIVES REQUIRED TO COMPLETE
107/109 COMPLIANT WITH NLS TRAINING = **98%**
CURRENTLY COMPLIANT WITH CNST / OCKENDEN REQUIREMENTS

NEONATAL LIFE SUPPORT - MA
22 MAs REQUIRED TO COMPLETE
21/22 COMPLIANT WITH NLS TRAINING = **96%**
CURRENTLY COMPLIANT WITH TRUST REQUIREMENTS

NEONATAL LIFE SUPPORT – NEONATAL NURSE
27 NNs AND 2 ANNPs REQUIRED TO COMPLETE
27/29 COMPLIANT WITH NLS TRAINING = **93%**
CURRENTLY COMPLIANT WITH CNST / OCKENDEN REQUIREMENTS

NEONATAL LIFE SUPPORT – NEONATAL NURSE ASSISTANT
10 NNAs REQUIRED TO COMPLETE
10/10 COMPLIANT WITH NLS TRAINING = **100%**
CURRENTLY COMPLIANT WITH TRUST REQUIREMENTS

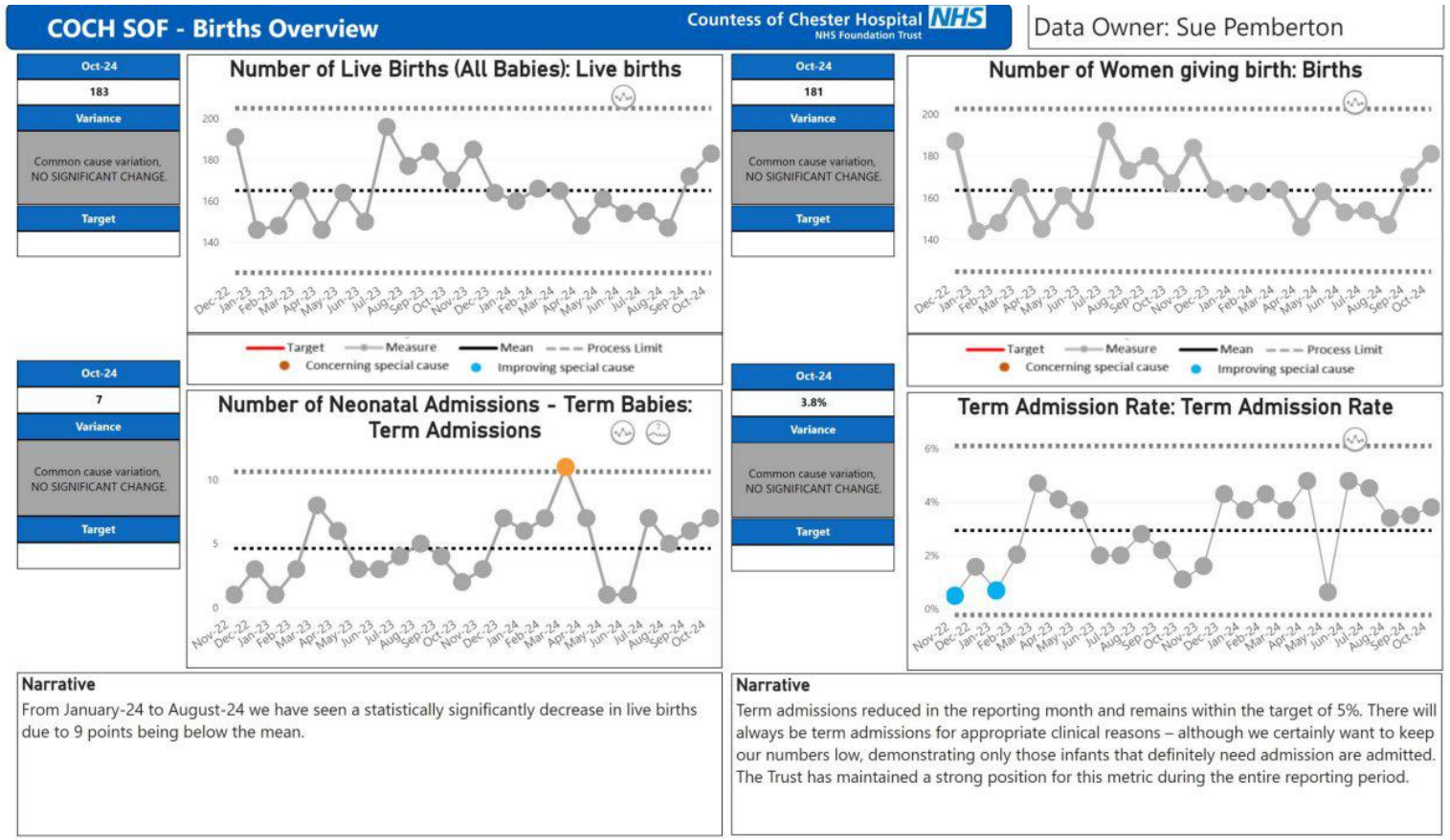
Safety Action 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	Yes
2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes
6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Yes
7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes
9	Evidence in 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.	Yes

Safety Action 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?



Safety Action 10

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

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes
2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	N/A
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Yes
4	Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Yes
6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes
7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	N/A

PUBLIC – Board of Directors
28th January 2025

Report	**Agenda Item 12.**	**Safety Surveillance and Learning Report – Quarter 3**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	**X**
Accountable Executive	Sue Pemberton			Director of Nursing and 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** **X** **X**	This assurance paper has a positive impact on BAF 1, 2 and 8			
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 – 6th December 2024 Quality and Safety Committee – 9th January 2025							
Executive summary	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. The report highlights an increase of moderate incidents and rationale for this was discussed, mainly due to increased reporting of Present on Admission skin integrity incidents and an error in duplicate reporting following a new report received from Cheshire West Place (CWP). The report confirms that Patient Safety Incident Investigations (PSII) are monitored through the weekly Patient Safety Oversight Group, with just two behind timescales, but are now back on track.							

	The next steps are to improve the process and systems for learning from deaths and mortality reviews and this piece of work is being led by the Deputy Medical Director and Deputy Director of Nursing and Quality Governance. An update on themes and learning from incidents, complaints and concerns is included. The Trust attended two significant coroner inquests in November with learning identified and shared in the paper.
Recommendations	The Committee 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 further improvement workstream regarding Learning from Deaths and Mortality Review.

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	Not confidential

Safety Surveillance and Learning

1. Introduction

The Safety Surveillance meetings take place monthly with divisional representatives and relevant departments e.g. Tissue viability, PALs, Legal team. The Terms of Reference for the meeting are to triangulate themes and learning from incidents, complaints and coronial inquests. As we transition to Safety Surveillance reporting, the timescales for reporting will adjust. This paper will present data for quarter three but noting that December's meeting was postponed due to the cycle falling on Christmas Day.

An overview of incidents and learning is presented by all divisions, learning from complaints, trust oversight and triangulation of themes, and an overview of medication incidents, learning and improvement workstreams. Examples of learning shared are included in the paper.

An increase of moderate incidents was identified and rational for this was discussed, mainly due to increased reporting of present on admission skin integrity incidents and an error in duplicate reporting following a new report received from Cheshire West Place.

Patient Safety Incident Investigations (PSII) are monitored through the weekly Patient Safety Oversight Group, with just two behind timescales, however are now back on track.
There were two significant corners inquests in November that identified further areas of learning that are described in the paper.

Identified areas of improvement are with respect to Learning from Deaths and mortality reviews, this piece of work is being led by the Deputy Medical Director and the Deputy Director of Nursing and Quality Governance.

The Trust is currently being reviewed by Mersey Internal Audit Agency (MIAA) regarding the Patient Safety Incident Response Framework (PSIRF), and the feedback will be shared once received. The review has included the submission of the following and a walkabout where MIAA talked to staff about PSIRF:

- Patient Safety Response Policy
- Report of Patient Safety Incidents for April 2024 to date
- Evidence of committee / Board briefings, staff training records and resources
- Committee minutes for the last 3 months where safety incidents are discussed.
- A review of random 20 incidents including the following:
- Evidence of decision making (updates / minutes of any relevant meetings / review panels etc)
- What the agreed timeframes were for each, how this was documented and shared with relevant parties
- If and how these timeframes were monitored and/or escalated if required
- How the incident was managed and how it progressed
- Reporting of the incident (internal and external)
- Any action plans
- Duty of candour
- Any involvement of patients, family, carers and staff in the investigation
- Any learning responses

2. Background

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. This 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.

3. 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.

4. Safety Surveillance Quarter 3 2024/25

Incident Analysis

In Quarter three, the Trust reported 3820 incidents with October being the highest reporting month with 1383 incidents reported.

A comparison of incidents reported demonstrate a consistent reporting culture and trends can be viewed in Table 1. There is, at most, a variance of 300 incidents per quarter. This is monitored and there are a variety of reasons that can be articulated to explain this variance, e.g. months with Bank Holidays, peaks of high annual leave (i.e. summer holidays) and there are some departments that submit many incidents at one time – e.g. pathology, catering which can all have an impact on overall reporting numbers.

Table 1

Time frame	Catastrophic	Low	Moderate	None	Severe	Blank	Total
Quarter 4 23/24	1	585	92	3078	9		3765
Quarter 1 24/25	6	506	95	2850	20		2477
Quarter 2 24/25	4	542	145	2749	24		3465
Quarter 3 24/25	4	658	189	2925	37	7	3820
Total	15	2291	521	11620	90	7	13527

Quarter two and Quarter three have seen an increase in the number of moderate harms reported.

Table 2

Level of Harm	Overall % of Incidents
No and Low harm	94%
Moderate	4.9%
Severe	1%
Catastrophic	0.1%

Table 2 demonstrates that moderate harms contribute to 4.9% of all incidents reported in quarter three. Several reasons have been identified to explain this rise. As described previously, the increased robustness of reporting pressure ulcers on admission (which are generally classed as a moderate harm) has seen an increase of incidents reported for other providers, rising from 7 per quarter to 34 per quarter, at its highest. There has also been a duplication of incidents reported in error in DATIX (n=32) from an Interface report sent by Cheshire West place in October.

Additionally, further scrutiny and education is required to ensure that we are reporting incidents at the correct level of harm. For an incident to be classed as moderate it must meet the following criteria.

Moderate harm is when at least one of the following apply:

- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
- has limited or is likely to limit the patient's independence, but for less than 6 months
- has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

Education is being provided in several forums and the production of a DATIX booklet is underway and a survey is being developed to support education and training for all staff in DATIX management and the sharing of learning. Recent training presentations have been provided to clinical leads, senior nurses and ward managers and at the Advanced Practice Conference.

Table 3 demonstrates that on average 70% of all moderate and above incidents consist of the same four themes – Skin integrity, Obstetric and Gynae, Falls and Infection Prevention. This is a consistent theme per quarter.

Table 3 Analysis of Moderate and above incidents Quarter three.

	October 24	November 24	December 24
Number of moderate and above incidents	101	56	73
Number of moderate and above Skin Integrity incidents	41	22	24

	October 24	November 24	December 24
Number of Obstetric/Gynae (PPH, ¾ degree tears etc)	20	10	15
Number of Falls	2	4	5
Infection Prevention	8	7	4
% of total moderate and above	70%	77%	66%

Quarter three saw 4 catastrophic incidents and 37 severe incidents. The four catastrophic incidents were reported as follows:

October – Two catastrophic incidents were due to unexpected death – a lady with a massive thyroid nodule developed a cough and due to massive nodule, stopped breathing and sadly passed away. She did have a DNAR in place. A full review was undertaken and incident downgraded. The second was a patient who self-discharged and was readmitted and sadly passed away. This has been reported and a Patient Safety Incident Investigation (PSII) is underway as significant learning identified.

November – No Catastrophic incidents reported

December – Two catastrophic incidents reported – one gentleman fell in the Emergency Department and sustained a catastrophic head injury. The second was an intrapartum foetal death. Both have been reported to StEIS and PSII underway.

The severe incidents are made up of a wide variety of categories, but themes identified are, delays in patient pathways/ follow up, wrong tooth removed (not a Never Event) and missed or delayed diagnosis. All moderate and above incidents are managed through the weekly Patient Safety Oversight Group, with appropriate learning responses agreed and actions monitored.

Overall Incident Themes:

The top 5 consistently reported incidents are:

- Skin Integrity
- Slips, trips and falls,
- Medication
- Staffing
- Security response

With respect to Skin Integrity – approximately 50% were pressure ulcer /skin integrity issues identified on admission to hospital. We are working with our external partners by completing Interface incidents where appropriate to ensure learning is identified and actioned in organisations external to the Trust.

Staffing incidents, generally consist of incidents relating to staffing number, staff redeployment and handovers of care. Staffing is reviewed at least three times a day, with timely escalations and actions to ensure safe staffing levels. Staff redeployment is monitored, and new ways of working are being trialled.

Falls remain a concern; however, a newly formed Safer Mobility Group has been formed with several initiative to improve patients' mobility such as

- Sit out, get dressed, keep moving

- Value patients time and prevent deconditioning
- Decaf trial

Security Incidents remain a concern for the Trust. A newly formed Violence and Aggression steering group has been convened, with clear terms of reference and membership. Initial interrogation of data has shown that the number of staff assaulted is increasing year on year, but also that just under 70% of those are from patients who are confused which has enabled the group to focus on the management and care of the confused patient, for example 'This is me' booklets, de-escalation techniques, reducing patient moves and inclusion of families and carers.

Medication Incidents are monitored and managed through the Medicines Management group and Harms Improvement group, but they do attend Safety Surveillance and share identified learning and themes.

Complaints and Concerns

The trust receives on average two new complaints a week and on average 70 concerns a week. Most complaints differ considerably in content/speciality, but some small perceived themes are emerging: delays in diagnosis, medical harm, poor nursing care and lack of pain relief. The trends can be seen in Table 4.

Most concerns are typically queries about their treatment / appointment. There is a theme is patients getting frustrated with cancellations, patients enquiring where they are on the waiting list, patients chasing results, patients asking for updates. They typically come to PALS when they have been unable to obtain this information from the service. A change to letter templates supporting the direction of where patients should seek advice is underway.

Table 4

Complaints	18/11/2024	25/11/2024	02/12/2024	09/12/2024	16/12/2024	23/12/2024	30/12/2024	06/01/2025	13/01/2025	20/01/2025	Variance	Trend
Overdue	1	1	3	3	4	4	5	8	7	7	0	
At risk of be overdue (within 4 weeks)	5	6	6	12	11	9	12	9	8	11	3	
Within timescale	10	12	14	8	9	10	7	7	6	4	-2	
New Complaints Received	2	2	4	0	3	2	2	1	2	2	0	
New Complaints Received - % acknowledged within 3 days	100	100	100	100	100	100	100	100	100	100	0	
Open	18	19	23	23	24	23	24	24	21	22	1	

Concerns	18/11/2024	25/11/2024	02/12/2024	09/12/2024	16/12/2024	23/12/2024	30/12/2024	06/01/2025	13/01/2025	20/01/2025	Variance	Trend
Open for more than 40 working days	6	7	10	8	8	4	7	7	5	11	6	
Open for 20-39 working days	10	14	7	8	10	16	17	21	21	16	-5	
Open for under 19 working days	69	61	65	73	77	63	59	58	71	80	9	
New Concerns received in week	76	68	73	61	64	56	29	45	76	75	-1	
Concerns closed in week	92	73	74	57	60	64	37	43	71	69	-2	
Open Concerns	85	82	82	89	95	83	83	86	97	107	10	

Examples of learning identified from complaints, concerns and incidents is demonstrated below:

A thematic review of complaints and concerns by division was presented outlining the following themes:

In Urgent care, themes included waiting times in the Emergency Department (ED), including care, comfort and availability of food and drink. Significant improvement work is being undertaken within the ED, including a nurse allocated to the waiting room, nurse rounding and the monitoring of compliance, food and drink trollies and communication to patients and their families.

The timeliness of discharges letters has also been a theme and compliance of this is monitored weekly and improvement plans are in place.

In Planned Care Division, themes include appointment waiting times, chasing results and cancellations. These main specialities that this relates to are ENT, Urology and Ophthalmology. The divisional leads have several improvement workstreams identified to improve services.

Within Women's and Children Division, a concern raised provided an opportunity to improve the chaperone process and work is ongoing to facilitate this.

TICC and DCSS Divisions had no new complaints, but there were some concerns raised regarding appointments.

Urgent Care Division presentation included immediate actions following an incident that has progressed to a PSII as:

- The new whiteboard functionality on firstnet gives immediate sight of all patients NEWS2, the Head of Nursing is able to review the whole department in less than one minute and all patients are up to date (other than those waiting for triage.) further improvements are to get this rag rated with IT for even better visibility
- One of the unit managers has been deployed as Safety oversight Nurse and the following role descriptor is in place for clarity
- Visible and on the department floor for the shift
- Touching base with all team members and reiterating roles and responsibilities, supporting and educating where needed
- Having a daily robust overview of risk assessment compliance and NEWs2 and report that to Matrons weekly, with explicit plans in place from the team to improve to be brought to monthly oversight meeting
- Undertaking risk assessments / NEWS2/Fluid Balance/ Care Planning alongside staff to ensure a) they are aware of what to do b) compliance is reached
- Reporting any concerns in relation to competence of any individuals to Matrons and the PDN, and holding 1:1s with these individuals
- Undertaking tendable audits daily to monitor and track compliance, e.g. one/two audits per day and ensuring the schedule is met – the importance of this is that we focus on learning and actions from each audit and share this with the team
- Bringing an update to biweekly governance meetings, complete with an overview of previous 2 weeks and plan for 2 weeks ahead
- Amongst the team, keep the ED Improvement Framework up to date with actions assigned to them

From the Women's and Children Division they shared some immediate learning following a severe incident which included appropriate feeding advice via Infant feeding team and immediate advice on syringe feeding advice shared. A syringe feeding task group set up – advice to provide to parents and triage forms for telephone advice. Following a moderate incident some Lightening learning was shared when a Standard bleep call for the Neonatal registrar was requested in isolation when a crash call was requested.

In Planned Care Division – learning was shared relating to patients who are admitted with airway problems, must have a swallow assessment on admission.

Planned care Division are also carrying out a thematic review on sampling incidents highlighting the main issues are:

- No clinical information recorded is highest issue reported
- Mislabeled specimens and Inappropriate requests are the next greatest volume reported

The current process has been mapped and highlighted areas for improvement – the new updated process is out for comments.

Medication safety was presented and described a change to DATIX reporting with new medication categories and subcategories allowing a more detailed approach to investigation, identifying themes and learning. Continuous improvement is monitored through the Medicines Safety Group, specifically in areas of known high risk medicines/medicines classes:

- Oxygen
- VTE
- Anticoagulation
- Chemotherapy
- Insulin

There are three ongoing medication harms improvement workstreams: Administration, Prescribing and Storage.

Therapies and Integrated Care described learning regarding the management of Clostridium and guidance if you suspect a patient has a Deep Vien Thrombosis.

Diagnostics discussed themes relating to the process of patients being transferred to the department and improvement required in communication.

Learning from Deaths

Every death in the Trust is now scrutinised by the medical examiner. Any death raising a concern or where learning has been identified a Mortality and Morbidity (M&M) or Structured Judgement Review is undertaken.

Learning from Deaths is an area that requires improvement; however, actions are being taken to improve visibility of escalations from the Medical Examiner, identified learning and mortality review oversight. This is being led by the Deputy Medical Director and Deputy Director of Nursing and Quality Governance. A weekly escalation from the Medical Examiner officer supports the proactive management of preparation and a weekly meeting with the Deputy Director of Nursing with the legal team, to maintain traction and oversight of the process.

This is also improving the preparation for coronial inquests ensuring investigations are received, reviewed and gone through a governance process in a timely fashion and a coroners database has been developed and is now in place, including a section for learning post inquest.

The database also has a claims section with a plan to provide updates and learning from claims in the next safety surveillance paper.

Coroner Inquests

November saw two significant coroner inquests, both Jury Inquests, where further learning has been identified and hence included in this report.

The first was regarding a patient who ligatured himself in the Emergency Department. A lengthy and robust lessons learned statement was presented at the inquest and the coroner was assured from this and did not issue a Regulation 28 on this basis, however, the conclusion of the inquest was suicide contributed to by neglect. The narrative surrounding this was in the main due to communication between the Mental Health Team and the Emergency Department with respect to his gatekeeping assessment, the provision of 1:1 supervision and the assessment of the risk associated. Eight recommendations were provided with additional improvements and actions including Ligature Risk assessments, Enhanced Supervision policy and mental Health rounding.

This was an extremely difficult inquest for the staff involved and wrap around support has been provided. The learning from this inquest is also being shared regionally at the System Quality Group in January 2025.

The second inquest has only recently concluded and was in respect to a patient who was restrained by both security team and the police. During this time, he suffered a cardiac arrythmia, respiratory arrest and required resuscitation. He was successfully resuscitated but suffered a hypoxic brain injury and died a few days later. The inquest focused on both the restraint and the resuscitation and expert witnesses were called for both subjects. The conclusion from the coroner was that the patient died as a consequence of irreversible brain damage following his cardiac arrest. His death was contributed to by neglect as outlined below:

> *The patient had a history of paranoid schizophrenia and prolonged Spice depending since 2009. On 20 November 2021 he was admitted to the Countess of Chester Hospital due to a rapid decline in his mental health and reported use of Spice on 19 November 2021. During his treatment between 04:17 and 04:37, a number of important medical checks and actions did not take place. Based on the balance of probability, this resulted in a rapid deterioration of his condition and subsequent cardiac arrest.*

No issues were raised regarding the level of restraint but learning regarding awareness of Acute Behavioural Disturbance (ABD) was highlighted. Actions are in place now regarding awareness and training of ABD. The coroner was satisfied with assurance and actions surrounding ABD and no Regulation 28 was issued for this.

There is further learning regarding resuscitation management, scribing and governance around incident management that the trust submitted further evidence and assurance prior to the coroner making his final decision regarding a Regulation 28. It is important to note that this incident occurred three years ago, and significant improvement have been made and can be demonstrated. Like the previous inquest, this was an extremely difficult inquest for staff involved and wrap around support has been provided.

To note the Trust has not received a Regulation 28 (or Prevention of Future Deaths – PFD) since 2019.

The Quality leads at Cheshire West Place share PFDs from other trusts and we review if there are any improvements required at the Countess as a result of learning from other Trusts. A recent PFD evoked on a Trust was regarding the deteriorating patient in the radiology department and we have reviewed the process here and are satisfied with our response.

Patient Safety Incident Response (PSII)

The Trust have reported twenty PSII's and one Never Event to StEIS in the year to date, the detail can be seen in Table 5 below. The investigations are monitored through the Patient Safety Oversight Meeting. Three are related to Maternity Diverts that we are mandated to report to StEIS. Out of the remaining thirteen, 7 are completed, 5 are on target for their completion dates and 2 are delayed (one for sickness and one awaiting information from an external trust), but back on track currently.

We have excellent engagement from Cheshire West Place with oversight of our completed PSIIs and they are invited to attend our weekly Patient Safety Oversight Meeting.

The Progress of any PSII is managed through the weekly Patient Safety oversight Meeting.

Table 5 - The current position of the Trust PSIIs

Incident and Steis Number	Lead Division	Incident report date	Status
Thematic Review of Stroke Incidents	Urgent Care	13/1/24	Completed
Thematic Review of Glaucoma Pathway Incidents	Planned Care	13/10/23	Completed
Incident where baby fell from mothers' bed	Women's and Children	22/4/24	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	26/4/24	Approved Oversight meeting 8/11/24
Delay in Treatment – Stroke	Planned Care	8/7/24	Completed – approved Oversight Meeting 27/12/24
Missed diagnosis of base of skull malignancy	Planned Care	15/4/24	Multi organisational review in progress – awaiting Walton
Missed colon cancer	Urgent Care	15/5/24	Completed
Post partum hemorrhage and unplanned hysterectomy	Women's and Children	4/8/24	PSII out for Peer review – on target for completion 30/11/24
Maternity Unit being placed on Divert	Women's and Children	25/9/2024	Opened and closed on StEIS – no patients diverted
Maternity Unit being placed on Divert	Women's and Children	27/10/24	
Delay in treatment/diagnosis – ED	Urgent Care	8/11/24	Tabletop completed – Due 10/1/25
Baby death	Women's and Children	1/11/24	SWARM completed/SUDIC 22/10/24

Incident and Steis Number	Lead Division	Incident report date	Status
Baby transferred for cooling	Women's and Children	25/10/24	MNSI
Self-Discharge	Planned Care	6/9/24	Agreed PSII 8/11/24
Ophthalmology – near miss Never event	Planned Care	23/10/24	Agreed PSII 8/11/24
Maternity Unit being placed on Divert	Women's and Children	25/11/24	
Patient Death while detained under Mental Health Act	Urgent care	11/12/2024	Statutory Notification of a death of a patient while detained under the Mental Health Act.
Patient Fall – Catastrophic Head Injury	Urgent Care	13/12/24	PSII commenced
Missed discharge following Elective Caesarean Section	Women's and Children	10/12/2024	PSII commenced
Intrapartum Stillbirth during labour	Women's and Children	30/12/2024	Reportable to MNSI

The Trust has also undertaken several thematic reviews where themes arriving from incidents have been identified and learning and changes in practice have been identified.

- Glaucoma pathway
- Stroke management
- Transfers of Care Cluster Review
- Post partum Haemorrhage
- Urology Cluster Review
- Blood Stream Infection Cluster Review

Duty of Candour/ Family engagement with Investigations

Families are actively encouraged to be part of any investigation and to ask questions. Families are at the heart of the PSIRF process. Investigations are shared with families/patients and often family meetings are arranged to allow explanations of reports and to answer any questions. We have facilitated this both face to face and on teams.

We are currently undertaking an audit of Duty of Candour and is due to be presented at Quality Governance Committee in February 2025.

5. Conclusion

The Trust continues in its journey with PSIRF, reviewing and changing processes as required. The engagement and attendance at the Safety Surveillance meetings has been extremely positive,

with detailed presentations and engagement through which incidents and learnings are shared. It is still in its infancy and there are still some improvements to be made, in particular learning from deaths.

The meeting also provides an opportunity for the triangulation of complaints, concerns and incidents with learning and actions also identified.

Process and governance surrounding coroners' inquests is improving, including the preparation and oversight.

6. Recommendations

The Board 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 further improvement workstream regarding Learning from Deaths and Mortality Review.