PUBLIC – Board of Directors
28th January 2025

Report	**Agenda Item 13.**	**Care Quality Commission (CQC) Improvement Plan including Well Led**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	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	Executive Directors Group – 15th January 2025							
Executive summary	The purpose of this report is to provide assurance on progress with the Trusts Improvement Plan, including Well Led, in response to the regulatory breaches identified within the CQC's report and reflected within the subsequent CQC ratings. Areas identified as complete to transition to BAU are: • EPR optimisation and prioritisation processes in place. • Improved Board and committee reporting and ongoing work to continue to embed quality of reports. • Identification, reporting, investigation and learning from incidents. • Safeguarding arrangements and supporting reasonable adjustments for patients with complex needs. • Transparency of coronial cases, good communication with legal team and oversight through safety surveillance.							

	• Staff survey feedback, engagement and delivery of actions along with capturing and responding to staff feedback on an ongoing basis. • Divisional performance reporting and Divisional reviews. • Quality and safety Ward to Board reporting. • Clarity of Non Executive Director and Governor roles. The consolidated Improvement Plan progress will continue to be updated monthly to reflect reported progress, any changes to timescales and owners. This is reported via Executive Directors Group and to each Board of Directors meeting.
Recommendations	The Board of Directors is asked to: • **Note** the assurance on the progress of the consolidated CQC Improvement Plan. • **Note** that progress against this action plan will continue to be tracked through the Executive Directors Group and reported to the Board of Directors, together with outcomes also being reported going forward.

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

NHS
Countess of Chester Hospital
NHS Foundation Trust

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

Updated: 14th January 2025

Completed	On track	Behind schedule	Not achieved

Summary of actions progressing

Countess of Chester Hospital NHS Foundation Trust

Actions progressing

- Draft Quality and Safety Strategy developed.
- EPR optimisation as BAU includes a prioritised approach. The Trust is also participating in the national EPR survey.
- UEC and flow improvements continue to be progressed.
- The development of the clinical strategy is progressing.
- Accountability Framework drafted to replace the Governance Handbook. Work also planned to ensure all key Governance documentation to be available on the Internet to include a summary and link to each document e.g. Trust Constitution, Sub-committee Terms of Reference etc.
- Work continues on the full committee organogram and collation of Terms of Reference and workplans to support this.
- SARD capacity and demand review to support job planning is underway.
- Progress is being made against the risk management improvement plan. The Trust is also working to improve the Datix system, automated alerts and reporting of risks.
- Processes continue to be developed to support the future reviews of policies and the policy recovery programme is being progressed via the Executive Directors and leads.
- Early feedback received from 2024 staff survey and awaiting full feedback.
- EDI priorities being reviewed for 2025/26.
- Development sessions held and further work progressing with the Council of Governors.
- Governance, assurance and report writing awareness raising and development sessions continue.
- Organisation learning policy being developed to reflect range of learning activities and forums.

CQC 23/24 Reinspection: Improvement Areas Identified

Countess of Chester Hospital NHS Foundation Trust

Improvement Area 1 – Chief Operating Officer

- Emergency Department Improvement Plan

Improvement Area 2 – Chief People Officer

- Appraisal
- Training
- Mandatory Training
- Conflict Resolution
- Resuscitation
- Safeguarding

Improvement Area 3 – Director of Nursing

- Infection Prevention

Improvement Area 4 – Director of Governance, Risk and Improvement

- Governance

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

- Risk Management

Improvement Area 5b – Medical Director

- Clinical Audit

Improvement Area 5c – Chief Finance Officer

- Environment
- Estates
- Health & Safety

Improvement Area 6 – Chief Operating Officer

- Performance
- RTT
- Patient Flow

Improvement Area 7 – Chief People Officer

- Staff Experience
- Staff Engagement

Improvement Area 8 – Director of Nursing

- Learning from Incidents
- Restraint
- Safeguarding
- Patient Safety

Improvement Area 9 – Medical Director & Director of Nursing

- Safe Staffing Nursing & Medical ED

Improvement Area 10 – Medical Director

- Safe Medications

Improvement Area 11a – Director of Nursing

- Stroke Practitioners
- Reporting of Mix Sex Breaches
- Dignity & Respect
- Maternity Theatres
- Nutrition Assessments
- Patient Engagement
- Patient Information – Health Promotion & Children
- Complaints

Improvement Area 11b – Medical Director

- O2 Prescribing
- Sepsis

Improvement Area 11c – Chief Digital Officer

- Record Keeping & EPR

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

- Policies

Improvement Area 11e – Board Lead & Lead for Strategy

- Mental Health & Learning Disabilities

Improvement Area 11f – Chief Digital Officer

- Information Governance

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

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M1	Patient Experience & Staff Feedback	TW	The trust must assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service in line with the regulations.	SP	March 25	• Patient and Family Experience Strategy Launch Quality & Safety Strategy	• Improvement programme (Harms) demonstrating improvements • Quality and Safety strategy being developed and planned for completion in December 2024.This is in draft. Engagement with divisions regarding their priorities – awaiting feedback. Plan completion in March. In line with PSIRF plan and review of policy for 2025/26. • Monthly Harms Oversight Group commenced – quarterly reports and annual reports planned for QGG. In August 2024, 3 progress projects were presented at each meeting. • Patient Experience Vision posters available on all ward areas, vision embedded. • Monitoring outlines previously • Patient Experience included in ward accreditation process • Two patient experience engagement undertaken where patients attended the hospital. • Achieving 6 out of 9 Quality priorities for the year to date, actions for 3 areas remain underway. • The Six Steps Patient Experience survey link is sent to every patient who receives the Friends and Family via SMS text (this is inpatients, outpatients, ED and Maternity patients) . Also monitored through ward accreditation.	• Inpatient Survey Results • Patient Experience results • Complaints • Concerns • FTT • PFE launched • Patient and Family Experience Strategy launched • Quality Account published	• Q&S Committee	• Patient and Family Strategy • Quality & Safety Strategy • Quality Account • SOF dashboard
M6	Registration	TW	The trust must implement effective systems to comply with the requirements of CQC registration. The system must ensure services are provided from locations which have appropriately added to the trust's registration.	SP	Review March 25	• Update SRO and include registration of Tarporley Hospital. • Review if action has been complete.	• Identified lead for CQC – DON • Change to the statement of purpose submitted to the CQC confirming that Tarporley War Memorial Hospital is a satellite of the Countess of Chester Hospital NHS Foundation Trust for the provision of Outpatients and a Community base. • Request in Jan 2025 to complete a different form to remove a location (in progress)	Awaiting confirmation from CQC.	• Q&S Committee	• CQC Registration Documentation

Action Plan:

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

NHS Countess of Chester Hospital NHS Foundation Trust

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

Action Plan:

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

NHS Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M12 M13 S8	Patient Assessment	TW UEC	The trust must ensure service user records are audited appropriately to evidence that reasonable adjustments are in place to meet the needs of patients living with complex needs such as dementia, learning disabilities and mental health and to identify missed opportunities to safeguard patients and ensure ongoing compliance (e.g. Mental Health Capacity Act).	SP	**Complete – move to BAU**	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Develop strategy for patient with additional needs - In draft • Safeguarding EPR tool (admission screening tool) devised awaiting input into EPR • Relaunch Complex Care Passport.	• Reasonable Adjustment strategy in Draft awaiting approval (date TBC) • Introduction of 'This is me', using volunteers to support family to complete documentation. • All patients subjected to DoLS are reviewed by adult complex care team to ensure personalised care plans are in place – all patients recognised as having reasonable adjustments are referred to safeguarding and complex care team. The safeguarding team visits each patient to ensure a personalised approach is taken to meeting their needs. Safety net now in place for if referral is not made – an automated notification for any patient admitted with a LD flag is sent to the safeguarding and complex care team daily. • Safeguarding admission screen has now gone live in the EPR+ which identifies if patients lack capacity and prompts onward actions for completing MCA assessments, best interest meetings and DoLS applications. Safeguarding and complex care team now visit all patients that have a DoLS application to ensure personalised plans are in place, this process change is being audited. • Strategy for vulnerable patients has been approved at Safeguarding Assurance Committee, this is being worked up into the 6 step approach. • Outstanding action for completion by March 2025 – easonable adjustments need to be added to the safeguarding screening tool and care plans need to be developed in the EPR+.	• Safeguarding Task & Finish Group • Incidents • Complaints • Inpatient Experience Results • Complex Care Assessments • Think Family Meetings • Learning Disability Standards • Mental Capacity Assessment Compliance	• Q&S Committee	• Safe-guarding Quarterly Assurance Reports to BoD • National Inpatient Survey Results
M21	Risk & Complaints Manage-ment	MED	The trust must ensure the risks presented by gaps in the out of hours stroke service are effectively assessed and mitigated.	SP	**Further Review Mar 25**	• Develop business case to mitigate risks and submit to EDG for review	• Business case to mitigate against risks has been collated. • Trial of service till midnight 7 days • Collaborative venture re regional stroke service.	Service provision has been extended until midnight as a pilot	• Q&S Committee	• EDG for Decision-addressed internally by division

Action Plan:

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

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M47 S11	Patient Assessment	CYP MED	The trust must ensure that appropriate nutritional risk assessments are completed for anyone with specific dietary requirements or anyone with social, religious, or cultural needs. That there is a nationally recognised screening tool to monitor patients at risk of malnutrition within clinical audit.	SP	Review Mar 2025	• MUST screening to be launched in July 24 in ED.	• Scales purchased for ED • Mealtime coordinators in place across all wards. • Nutritional risk assessments should be undertaken for all patients – this needs improvement as compliance is low. The compliance and outcomes for this are monitored at the Nutrition and Hydration Steering Group. • When assessing the current food provision against the British Dietetic Association standards the Trust recognised itself as partially compliant in this area. Work is underway to review the establishment within the dietetic team to address how these areas of non-compliance can be addressed. • The Trust has yet to fully demonstrate the BDA standard of "Existence of a menu planning working group, meeting minutes and/or project planner. Evidence must show involvement of Registered dietitian throughout the process. Patient satisfaction surveys and patient involvement. • MUST risk assessments – trust has reviewed and updated MUST policy, expectations regarding timeliness of MUST assessments has been changed (national standard within 24 hours of admission and thereafter every 7 days, trust standard is now within 6 hours of admission and thereafter every 7 days). • MUST compliance is now visible to ward managers on the EPR+ whiteboard allowing oversight at ward level of compliance by patient. • MUST compliance is now built into ward accreditation programme and wards have introduced mealtime coordinators. • Compliance against the MUST KPIs is now available at organisational , divisional and ward level, this is now shared on a KPI report at Executive Directors Group, Senior Nursing and Quality Governance Group. • Outstanding actions for completion by March 2025 – (1) whiteboard to only show compliance when all 10 fields of MUST are completed (currently shows compliance when assessment started), (2) raise awareness with RN workforce that previous weight must be completed to complete assessment, where this is not available use today's weight.	• Nutrition Support Group • Senior Nurse Meetings • Must Assessment Compliance • Patient Survey Results • Patient Experience Strategy • Complaints	• Q&S Committee	• OMB • QGG • SOF • Nutrition Annual Report to BoD

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

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S3	Patient Experience & Staff Feedback	TW	The trust should implement effective patient engagement in the development of the trust's services.	SP	Propose to remove as covered in M1	• Planned engagement sessions for 2024 • Launch Patient and Family Experience Strategy (Apr-24) • Launch Quality & Safety Strategy (Sep-24)	*Linked with M1.*	• Patent Survey Results • Patient Experience Six Steps Monitoring • Healthwatch Feedback • Complaints and concerns • Friends and Family Test	• Q&S Committee	• Patient and Family Strategy • Quality & Safety Strategy • National Inpatient Survey Results
S9 S20	Patient Experience & Staff Feedback	MED CYP	The trust should ensure that health promotion and information is available in all departments is available in languages other than English, in child friendly versions, and in alternative formats.	SP	Mar-25	• Review of all information available to patients and ensure that they are all available in all languages.	• Review of translation services underway- update provided to the Quality & Safety Committee held in September 2024. Further update provided to the Quality & Safety Committee held in November 2024, action plan is in place and is progressing. • The specification for the spoken and non-spoken languages has been completed as is with the budget holders for agreement . The intention is to award spoken language interpretation and translation via the NHS Cheshire & Merseyside framework agreement. For non-spoken languages, the intention is to make a direct award via the NHS SBS Framework for Interpretation & Translation Services (ITS). This will result in one supplier. Once the contract is agreed, an implementation plan with the supplier will be completed	• Patient Experience Operational Group	• Q&S Committee	• Q&S Assurance Report to BoD

Action Plan:

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

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S13	Environment inc. Equipment	MED	The service should ensure that patients' privacy, dignity and confidentiality is maintained in the reception area.	SP	Mar-25	• Staff need to ensure that the privacy and dignity for patients is maintained within the reception area at all times.	• Nurse allocated to waiting room in ED in all shifts to oversee the care of patients • Interim national inpatient survey results are improved in relation to privacy and dignity of care for patients . • Capital funding has been allocated to extend the ED footprint; one initiative will be to provide designated spaces in the wait area for personal conversations. • Improving privacy and dignity. • January 2025. New build with improved waiting room facilities (with rooms identified for conversations and observations) will be in place by March 2025.	• Complaints • Friends and Family Test • Inpatient Survey Results • Concerns • Matron Audits	• Q&S Committee	• Patient and Family Experience Assurance Report to BoD • National Inpatient Survey Results
S16	Patient Assessment	MAT	The trust should continue to embed the changes made to the post-operative care of women and birthing people following obstetric surgery.	SP	Mar-25	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan	• AFPP review conducted June 2024 – this involved reviewing maternity theatres – Draft report received and to be presented to EDG, OMB (to be held in October 2024) and the Board of Directors to be held in November 2024. • As at January 2025, the Board of Directors and Quality and Safety committee have both received the report and action plan which is in progress. This will be monitored through the QGG and Q and S assurance committees.	• Report expected August/September 2024	• Q&S Committee	• Quarterly Maternity Assurance Reports to BoD

Action Plan:

Owner: Cathy Chadwick – Chief Operating Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M20 M54	Patient Flow & Perfor-mance	MED EPH	The trust must ensure that effective and timely care is provided; to improve patient access and flow through the hospital to safe discharge or transfer to other appropriate services.	CC	**Next Review Mar-25**	• See Patient Flow / UEC Improvement Plan	A system discharge summit was held between partners and it was agreed there is a need for an additional P2 beds in CWaC whilst longer terms plans are worked through. The beds have been identified and the ICB are identifying funding. The revised UEC improvement plan has a focus on improving ward processes, which the Deputy Director of Nursing is leading on. ECIST, GIRFT and AQUA all gave improvement ideas which have been added to the plan. The Trust is being supported by NHSE to further engage with BCUHB and Flintshire LA, and we have started to see additional discharges.	• Complaints • Patient Flow Working Group • KPIs / UEC Dashboard • System Improvement Board • OPELG	• F&P Committee	• EDG • OMB • SOF • SIB Exit Criteria

Action Plan:

Owner: Jason Bradley – Chief Digital & Data Officer

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring	Committee	Assurance
M50	Risk and Complaints Manage-ment	CYP	The trust must assess and manage the risks relating to the electronic patient record system and transcription services. The trust must improve the quality of the services provided and ensure this did not impact on delays to patients care and treatment.	JB	Next Review Mar-25	• Develop eDischarge Summary Task & Finish Group. • Review the eDischarge process and develop an optimum pathway and SOP to support the newly revised discharge process. • Review current transcription services and monitoring of typing timeframes. • Review current monitoring arrangements and revise where appropriate. • Meet the National Access Standards.	• A process review of the eDischarge process has taken place. The review found no system based delays. Users have been retrained on the process where necessary. Enhanced reporting is being developed to aid with operational monitoring. • Progress monitored via Operations and Performance Executive Led Group and Operational Management Board. • Completeness of discharge summaries has improved significantly during 2024 – the trust recognises that timeliness of discharge summaries is still an issue that is actively being worked on. • The trust is reviewing Voice Recognition (VR) solutions. VR is a key enabler to reducing letter turnaround time. Following review, a business case will be formulated in 2025.	• eDischarge Summary Task & Finish Group • Divisional Governance Meetings • Divisional Typing Figures / KPIs • Progress monitored via Operations and Performance Executive Led Group and Operational Management Board.	• Q&S Committe e • F&P Committe e	• Q&S plus F&P Assuranc e Report to BoD

Action Plan:
Owner: Jon Develing – Director of Strategy & Partnerships

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M7	Strategy	TW	The trust must ensure strategies designed to support the delivery of the trust's new overall strategy are completed, implemented, and monitored to ensure their effectiveness.	JD	Mar-25	• Enabling strategies in support of the overall Trust strategy will be developed during 2024/25. These will align with the 6 strategic goals to provide a golden thread ensuring that all parts of the organisation are supporting the same direction of travel	The Trust strategy has been approved and prepared for wider consultation and launch. The Trust strategy has been socialised with dedicated Team Brief sessions for Day and Night Staff. The strategy has also been an integral part of developing the Trust clinical strategy and has been shared with internal and external stakeholders. Clinical strategy day was held on 24th October 2024. Some 50 operational and clinical leaders from across the Trust were in attendance. A thematic update was prepared and feedback to Clinical Leads in December 2024.	• Delivery of the strategic goals and objectives within the overall Trust are a core component of respective executive Director portfolios and will be reported to the Board of Directors on a quarterly basis. • Trust Strategy approved in June 2024. • Launch of the women & children's strategy in July 2024. • **The strategic themes within the strategy are part of all staff appraisals** • **The delivery goals and objectives within the Trusty strategy are aligned with the Board Assurance Framework and reported as a single integrated report.**	• BoD	• BoD • OMB • EDG
M10	Auditing	TW	The trust must ensure there is effective oversight of the quality and safety of care provided to patients with mental health needs.	JD	Dec-24	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Review and refresh the Mental Health Group. • Develop a Trust Wide Mental Health Strategy.	• The Director of Strategy & Partnerships is now part of the Mental Health and Community services collaborative. • Mental Health review completed by a member of the psychiatric liaison service on secondment from CWP for 6 weeks. An interim report was reviewed at EDG in December 2024 with recommendations to be presented (Jan 2025). Recommendations arising from the review are to be taken to Joint committee with CWP with progress being monitored though the Mental health group	• Mental Health Steering Group • Datix Reporting • Learning Outcomes from Complaints • ED Safety & Quality Update	• Safe-guarding Committee • Q&S Committee	• Safe-guarding Quarterly Assurance Reports to BoD • Q&S Assurance report to BoD

Action Plan:

Owner: Jon Develing – Director of Strategy & Partnerships

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S1	Strategy	TW	The trust should implement effective systems to identify and plan services to address health inequalities.	JD	Nov-24	• Health Inequalities is a specific objective within the Trust strategy and part of the Director of Strategic Partnerships portfolio. • A bespoke approach will be developed in the first quarter of this year – this will include use of CIPHA/PHE Fingertips/Trust PTL/JSNA and NHS Benchmarking tools.	• A health inequality framework and awareness raising / training workshop was held for Board Directors 29/10/2024. • Draft framework has been developed and co-produced with local authority public health colleagues	• Waiting list Performance Reporting • Cheshire West Partnerships Board	• F&P Committee • External Cheshire West Partnership Board	• BoD • OMB • EDG

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Out comes	Committee	Assurance
M28 S19	Environ-ment inc. Equipment	UEC CYP	The trust must ensure that there is sufficient equipment that is maintained to keep patients safe including but not limited to resuscitation equipment.	KE	Next review Mar 2025	• Trust wide review of all equipment used to ascertain that it is fit for purpose and that there is satisfactory levels of equipment required across all areas and incorporate how medical equipment is checked and maintained.	• Assurances received at the Trust Medical Devices Group held in July 2024 for the medical devices maintained by the Clinical Engineering Dept (EBME) • Risk Assessment and action plan agreed through Deputy Medical Director and Deputy Director or Nursing & Quality Governance around limited Medical Device assurances . • Position statement regarding the management and assurance regarding medical devices and equipment, including an action plan with responsible persons and timeframes, presented to the Quality Governance Group held in October 2024. It has been agreed for this to monitored via QGG quarterly. • Medical Devices Officer appointed to commence at the Trust in December 2024.	• Asset register and report to F&P Oct-24 and then monitoring quarterly	• F&P Committee • Quality Governance Group	• Resuscitation Assurance Reports • F&P Assurance Report to BoD

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring	Committee	Assurance
M32	Environ-ment inc. Equipment	UEC	The trust must ensure that patients identified with a mental health condition are cared for in a safe ligature free environment and have appropriate risk assessments completed.	KE	March 2025	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Trust wide review of ligature risks to be conducted to ensure the environment is safe for patient care • Development of an Estates Strategy	• Clinical SoP in-place to identify and risk assess patients entering ED that present a potential self-harming risk. • Anti-baracade door systems fitted to all WC doors in ED to enable rapid access should a patient be suspected of self-harming inside. • New and improved Anti-Ligature Policy now developed and ratified. First two assessments (ED and AMU) were conducted on 05/11/2024 and were led by the Deputy Director of Nursing & Quality Governance, Health & Safety and Estates representation. It has been agreed that the champion for this Policy to be enacted across the Trust will be the newly appointed Health & Safety Manager (start date currently awaited). • Upon successful award of UEC ACTIF Funds - a new Mental Health Equalities Area to be created within the ED footprint to provide improve care and support to people with mental health issues (to be implemented before the end of the 2024-25 financial year).	• EDG • OMB	• Q&S Committee • F&P Committee	• Safe-guarding Assurance Report to BoD • Estates Strategy

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M40 M48 S4 S22	Environ-ment inc. Equipment	MAT CYP MED EPH	The trust must ensure that a robust system is in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and ensuring premises are safe and for their intended purpose.	KE	Next review Mar 2025	• UEC Improvement plan • Full review of the trust premises to ensure fit for purpose in line with best practice guidance.	• H&S action plan to be progressed further by the newly appointed Health & Safety Manager (start date currently awaited). • The Trust have employed Nifes to undertake a 6 Facet Survey of the acute estate and the final version of the survey has now been received. • H&S monitoring to be reported via the Risk Management Committee.	• Health Safety Audits • Patient Flow Working Group • KPIs / UEC Dashboard • System Improvement Board • Outcomes?	• F&P Committee • Q&S Committee	• EDG • OMB • F&P and Q&S Assurance Reports to BoD

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M46	Infection Prevention Control	CYP	The trust must ensure the premises and environment are clean and maintained to prevent the spread of infection. This includes but is not limited to repairs to flooring, walls and door frames, plumbing / drainage, and food storage within patient's fridges.	KE	Next review March 2025	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Development of an Estates Strategy	• The adoption of the NHS National Cleaning Standards assessment has been extended to include a multi-disciplinary team (MDT) approach, that includes stakeholders from outside of the Domestic Services organisation to provide an honest and independent assessment for assurance purposes. • (Items identified as failing to meet the required standards are logged and escalated to the appropriate 'resolution owner' (Nursing, Estates, Facilities etc. • PLACE (Full) and PLACE (Lite) assessments also utilise an MDT approach in addition to feedback from patient representatives to provide observations of where standards require improvement. • The Catering Department receive external compliance audits by the independent Environmental Health Officer (EHO), and is subsequently awarded a food standards rating accordingly. The CoCH Catering Service has maintained its 5-Star rating. • As the Clinical Strategy approaches finalisation, the Estates strategy will be refined to accommodate the needs defined within, and then be subsequently ratified. • Estates issues raised through IPC audits are fed-back to Estates via the Limble helpdesk system. The closure of items is tracked by both Estates and the area inspected (Ward/ department).	• PLACE Assessments • Incidents • National Cleaning Standards	• F&P Committee • Q&S Committee	• Estates Strategy • PLACE Annual Assurance Assessment Report to BoD • F&P and Q&S Assurance Reports to BoD

Action Plan:

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

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M2 M4	Risk & Complaints Management	TW	The trust must ensure risks in services are appropriately recorded, assessed, escalated to the trust's board where required, and regularly reviewed.	KW	**Next update Mar-25**	• Review and update risk management strategy • Review structures, roles and responsibilities to ensure robust risk management across the Trust. • Confirm escalation processes • Provide high risk reports to OMB, Board and Committees	• All risks are reviewed monthly at each Divisional Governance meeting and also by the Executive Directors' Group. • A report of high risks is also provided bi-monthly to the Board of Directors, monthly to OMB and relevant extracts are also provided to each of the sub-committees. Risk Management Policy revised and approved. • Introduction of a Risk Management Committee with the first meeting held in shadow format on 12/11/24. TOR formally approved at QGG held on 05/12/24. • Datix developments progressing.	• EDG • OMB • BoD • Sub-committees • Divisional Governance Meetings	• Audit Committee	
M3	Risk & Complaints Management	TW	The trust must ensure effective action is taken to address risks in services including areas of low compliance highlighted through internal governance systems.	KW	**Next update Mar-25**	• Review and update risk management strategy • Review structures, roles and responsibilities to ensure robust risk management across the Trust. • Confirm escalation processes • Provide high risk reports to OMB, Board and Committees	• All risks are reviewed monthly at each Divisional Governance meeting and also by the Executive Directors' Group. • A report of high risks is also provided bi-monthly to the Board of Directors, monthly to OMB and relevant extracts are also provided to each of the sub-committees. **Risk Management Policy reviewed and approved.** • **Introduction of a Risk Management Committee with the first meeting held in shadow format on 12/11/24. TOR formally approved at QGG held on 05/12/24** • **Datix developments progressing.**	• EDG • OMB • BoD • Sub-committees • Divisional Governance Meetings	• Audit Committee	

Action Plan:

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

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M43	Policy Management	MAT	The Trust must ensure that policies and procedures are reviewed and follow national guidance.	KW	Next Review Mar-25	• Review of all documents on SharePoint as policies. • Revise internal process for updating / removing / amending documents on SharePoint. • Further communications across the Trust to embed the processes.	• The Continuous Improvement Team have commenced the cleanse of policy documents on Sharepoint with an initial position statement reported via EDG. • A process has been established to monitor progress and escalate the position through EDG. • Further work is required to deliver these improvements. • Progress updates provided via the Audit Committee (last held in October 2024).	• Board of Directors • Sub-committees	• Via the relevant Committee dependant on the policy document	• EDG • Audit Committee

Action Plan:

Owner: Vicki Wilson– Interim Chief People Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M8	Patient Experience & Staff Feedback	TW	The trust must ensure staff feedback is captured and responded to appropriately to identify risks and drive improvement in services.	VW	**Complete – now part of BAU processes**	• To design a staff experience strategy/ cultural development programme that improves staff satisfaction and supports staff in the delivery of high-quality services. Its focus will be to: • Embed all elements of the NHS People Promise • Embed the Trust values & behaviours (Civility Charter) • Support all aspects of the employee lifecycle	Changes implemented since 2023 staff survey have been extensively communicated ahead of the launch of the 2024 survey which is open until end of November 2024. Zero tolerance campaign and posters showing our staff now produced and displayed across the trust. Comms re action taken when patients/staff abuse staff underway to build confidence in raising concerns. Bystander training in place setting out what is expected from staff and managers to actively support any colleagues suffering abuse. People Promise measures incorporated into People Strategic Plan. 2024 staff survey response rate increased 3% from previous year.	• Paper to EDG outlining actions and next steps including the development of a Civility Charter and training modules • Monitoring to take place at Divisional level, also at EEWG, OMB, POD according to meeting schedules • People Pulse	• POD	• EDG • OMB • Partnership Forum • EDG • Engagement as standing item at POD Reporting calendar established linked monitoring process Escalation of issues to EDG (on-going) • Staff Survey Results / Action Plan
M15 M35 M36 M51	Training	ME D UEC EPH	The trust must implement an effective system to ensure that all staff have the skills, knowledge, experience, and appraisal to care for and meet the needs of patients within their service area.	VW	Next update Mar 2025	Review induction programme and content. Review local induction process and format. Develop minimum competencies for staff groups. Align competency set to ESR and staff groups. Review training provision and capacity. Appraisal paperwork under review.	• New induction process now BAU • New appraisal implemented fully backed by high levels of training and support • TNA for 2025/26 underway • Requirements for training aligned to national programme. • Development of local oversight group in Jan 24 to optimise national and locally mandated learning. • Sub board level succession planning exercise underway. Return to region completed Nov 24.	• New welcome induction event • Training capacity reviewed and increased • New appraisal paperwork launched • Appraisal KPI – achieved Trust target in Nov 24	• POD	• SOF • OMB • Staff Survey Results / Action Plan

Action Plan:
Owner: Vicki Wilson– Interim Chief People Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M22	Training	MED	The trust must ensure that staff receive conflict resolution training in a timely manner, as is necessary to enable them to carry out the duties they are employed to perform.	VW	Next review March 2025	Undertake TNA with SME. Liaise with external trainer regarding training dates and capacity for F2F training. Link competency to relevant staff on ESR. Increase communication to divisions on compliance through OMB and HRBPs.	• TNA completed • Additional dates added on ESR to increase capacity. • Monthly alerts to divisions • Revised aim to reach Trust compliance target of 90% by end of Feb 2025.	• Monthly compliance reports sent to all divisions and accessible on 'S' drive. • Current compliance is at 75% (from 65% in sept 24)	• POD	• SOF • EDG • OMB
M44	Training	CYP	The trust must ensure that mandatory training (including safeguarding) compliance meets the trust target.	VW	**Next review March 2025**	• Review TNA for level 3 safeguarding • Review capacity meets demand for all face-2-face sessions. • Provide additional sessions for basic life support. • Provide enablers for those staff with limited access to PCs to undertake eLearning. • Increase communication to divisions on compliance through OMB and HRBPs.	Level 3 compliance still an issue across medical workforce. Date in place CPO, Chief Nurse and MD to review mandatory training competencies and denominators to ensure correctly applied and review delivery methods. Additional capacity provided to ensure enough places Staff provided with face to face training option where PC access limited and use of library and additional support to complete online as needed.	• Monthly compliance reports sent to all divisions and accessible on 'S' drive. • Latest overall Trust compliance is 88.48% (as at 13/09/24) • Divisions have been provided detailed reports on areas that need compliance improvement. • **Safeguarding level 1 &2 is at or above 90% target. We are now focusing on an improvement in trajectory for level 3.**	• POD	• SOF • EDG • OMB

Action Plan:

Owner: Nigel Scawn – Medical Director

NHS Countess of Chester Hospital NHS Foundation Trust

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

Action Plan:
Owner: Nigel Scawn – Medical Director

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M26	Safe Staffing	UEC	The trust must ensure that medical staffing levels, with the right qualifications and competencies, are safe for the numbers of patients in the department.	NS	**Review Mar-25**	• See Patient Flow / UEC Improvement Plan (Nursing and Medical). • Case for expansion of medical staff numbers to be developed. • Review roles and responsibilities of allied professionals to support triage and UTC.	• Linked to Well Led 7.2 • Case presented and agreed to EDG and OMB. • Additional consultant appointments made and planned further vacancy to recruit to in April 2025. • Additional medical lead for UTC in post. • UTC & minors now moved to upstairs within SDEC to improve numbers and flow. • Review of AHP workforce and medical staffing currently being progressed. • SARD work commenced on capacity demand modelling for medical staff in 15 biggest specialities. Aim for revised job plans by the end of March 2025.	• Patient Flow Working Group • Streaming Task & Finish Group • KPIs / UEC Dashboard • System Improvement Board	• F&P Committee • POD Committee	• EDG • OMB • SOF

Action Plan:

Owner: Nigel Scawn – Medical Director

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S6	Medica-tions	MED	The trust should review the prescribing of medicines that control distressed behaviour to ensure the policy is followed and monitoring is completed.	NS	Feb-25	• Review the policy and education for relevant teams	• The non-urgent and rapid tranquilisation policy was approved at D&T pending 2 points, firstly that safeguarding were consulted on its contents and secondly that reporting and monitoring requirements were reviewed, clarified and strengthened. Education for relevant teams to be delivered by end January 2025.	• Incident Reporting • Mental Health Steering Group	• Q&S Committee	• Q&S Assurance Report to BoD
S21	Patient Assessment	CYP	The trust should ensure staff improve the compliance of completing the sepsis screening tool on the electronic patient record.	NS	Next Review Mar-25	• Harms • Acquire new blood gas analyser to measure lactate within ED • Focus on compliance of prescribing antibiotics within 1 hour of diagnosis of Sepsis.	• Blood gas anaylser in situ.. • Regular monitoring through the Sepsis Improvement Group. • Sepsis care plans have been devised to be recorded within EPR, these are in draft form and work is underway with pharmacy/ microbiology re treatment options. Monitoring of sepsis screening collated monthly and discussed at monthly sepsis improvement group.	• Sepsis improvement programme (Harms) participating within the Harms Showcase (Mar-24) • AQ Compliance • Sepsis Screening Audits	• Q&S Committee	• Sepsis Assurance Report to BoD

Well Led Action Plan – KLOE 1

KLOE 1	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
1.4	• Develop a quality and safety strategy	Director of Nursing & Quality /Medical Director	**Proposal to remove as covered in M1**	This is being progressed for Q4.		High
1.8	• Continue to embed quarterly divisional performance meetings (FM Governance report 2019 REC 18) • Review format and timing for divisional performance meetings alongside the Operational Board agenda	Director of Governance, Risk & Improvement / Chief Operating Officer	**Proposed complete as now BAU process**	Performance reporting has been established to each OMB. The COO is also developing an approach to reintroduce Quarterly Divisional Reviews. The proposed approach was agreed at EDG and quarterly reviews are taking place with Divisions.		High

Action Plan – KLOE 2

KLOE 2	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
2.2	• All divisions to work towards the development of their respective strategies	Director of Strategic Partnerships	**Further update March 2025**	Discussions with the Clinical Directors and Divisional leads has taken place. Strategy day took place with Clinical Leads for October 2024 to drive forward the development of the Clinical Strategy. Specialty proposals were developed to support this and quarterly clinical leads strategy days planned to drive this forward. Further Trust wide workshop and discussion held in December and now built as BAU every quarter. Board report to be presented in January by way of progress	Trust Strategy was approved in June 2024. Women's and Children's Division strategy was launched in June 2024.	Medium
2.3	• Develop a five year financial strategy	Director of Finance	**March 2025**	Final 24/25 financial plan submitted in May 2024 in line with national deadlines. The financial plan has been co-ordinated with Cheshire & Merseyside ICB and national financial planning. Further work is to be undertaken on the 5-year financial plan to provide more detailed financial plan following completion of the Trust strategy and Clinical Services strategy. Work is commencing to develop the strategy with engagement with F&P in January	Final 24/25 financial plan submitted in May 2024 in line with national deadlines.	High
2.5	• Review and rationalise the divisional governance arrangement to allow for a single operational approach to divisional governance to provide consistency and uniformity in the meeting and reporting arrangements • (FM Governance report 2019 REC 16)	Director of Governance, Risk & Improvement	**March 2025**	A map of sub-committee groups is currently being developed which has been shared with EDG and is currently being finalised. Governance and assurance slides being used in a range of forums. New report template and guidance has been developed and circulated Trust Wide. Work continues to focus on improving report writing. Draft accountability framework developed (Dec 24) for implementation for 2025/26.	Map of sub-committees (Draft). New report template & guidance.	Medium
2.6	• Develop supportive strategies mental health, E and I and estates and facilities, well being	Medical Director Chief Operating Officer Director of HR	June 2023 – well-being strategy Mental health – tbc EDI I - completed Estates and facilities – tbc ***Revised dates for all strategies to be confirmed.***	• Wellbeing Hub now open. Wellbeing annual report that reviewed activity against wellbeing strategy objectives, including mental health support was submitted to POD Committee April 2024. • Further supporting strategies in progress. • The Trust strategy has been socialised with dedicated Team Brief sessions for Day and Night Staff. The strategy has also been an integral part of developing the Trust clinical strategy and has been shared with internal and external stakeholders.		Medium

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
3.2	• Staff survey feedback needs full analysis and clarity required on the key changes that need to happen as a result. Trust wide engagement sessions need to be held within April/May to meet face to face with all staff to demonstrate that the Trust is listening and taking on board their feedback. • Delivery of staff survey action plans	Chief People Officer	**Complete – now part of BAU processes for 2024 results**	• Trust wide engagement sessions held. • Civility handbook produced and rolled out across trust. All new starters are provided with a copy. • Zero abuse promotional programme commenced Autumn 2024. • Employee of the Month, Team of the month now fully implemented with high engagement levels. • Improvements have been made following the 2023 staff survey and there was a strong campaign to support engagement with the 2024 staff survey. • Listening events held locally in response to staff feedback.	Staff awards now in place Launch of Culture & Civility handbooks Further training in place	High
3.3	Implement the recommendations from the recent risk management review March 2023	Director of Governance, Risk & Improvement	**March 2025**	Monthly reports are now shared with EDG and then feedback provided to the Divisions in relation to their risks. Risk updates also continue to be updated via the Operational Management Board. A High Risks report is provided to the Board of Directors and sub-committees. The Trust's Risk Management Policy and Procedure has been reviewed and approved together with a review of the Trust's approach to Risk Management training. A process is also being developed for regular reviews of the risk register and to develop assurance reports via the relevant governance structures. Workshops held to agree priorities for Datix development (October and December 2024) and Risk Management Committee held in shadow format on 12/11/24. TOR formally approved at QGG held on 05/12/24. Datix developments progressing.	Risk policy compliance	High
3.5	• Provide a trajectory plan trust wide (supported by divisions) for all areas to achieve trust targets for all of mandatory training. To be monitored through Operational Management Board. • Mandatory training performance to achieve target	Chief People Officer	**Next review March 2025**	• Level 3 compliance still an issue across medical workforce. • Date in place CPO, Chief Nurse and MD to review mandatory training competencies and denominators to ensure correctly applied and review delivery methods. • Requirements for training aligned to national programme. • Development of local oversight group in Jan 24 to optimise national and locally mandated learning. • Additional capacity provided to ensure enough places.	Mandatory training compliance improved to 89% (as at Dec 24).	High

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact Rating
3.6 (moved from KLOE 8 Ref: 8.4)	A plan needs to be in place to ensure there is review of all out-of-date policies and procedures and that these are reviewed annually or as otherwise stated (FM Governance report 2019 REC 17)	Director of Governance, Risk & Improvement /Director of Nursing	**Next update March 2025**	Update provided to the Audit Committee in October 2024 which included a forward look to policies that will become due for review in 2024/25. Processes continue to be developed to support the future reviews of policies and the policy recovery programme is being progressed via the Executive Directors and leads (monthly reports provided via EDG).	Up to date policies accessible to all	High
3.7 (NEW)	Establish quality improvement priorities, learning and outcomes.	Director of Nursing	*To be completed in conjunction with the quality and safety strategy* **Next update March 2025**	Quality priorities agreed and Quality account published with stakeholder involvement Scrutiny panel undertaken of part of Quality Account process in July 2024. The Trust is achieving 6 out of 9 quality priorities as at the end of Quarter 2 2024/25. Actions are in place for the delivery of the remaining 3 priorities and an update was presented to the Quality Governance Group held in October 2024.	Quality priorities agreed and established as part of quality account . Monitored through QGG Linked with Quality Strategy.	High
3.10 (NEW)	EDI work	Chief People Officer	**Next update March 2025**	• WRES and WDES published with one consolidated improvement plan. • New EDI coordinator started. • Each network has active exec champion • Focus each month at Team brief on work of one network and feedback. • Neuro diversity and disability networks now brought together for additional coverage. Renamed Enabled Network • Sexual Misconduct education sessions organised for COCH senior leaders to ensure meeting new framework requirements. • Dual new medical and nursing Chairs for BAME network group. • Additional specialist temporary EDI resource brought in Jan-Mar 25 to support development and integration of EDI action planning.	Executive Champion roles identified. Ongoing network meetings. Progress on EDI priorities	High

Action Plan – KLOE 4

KLOE 4	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
4.3	• Develop a meeting map to incorporate Board, operational and management meetings focusing on attendees, membership, terms of reference and roles and responsibilities • (FM Governance report 2019 REC 13)	Director of Governance, Risk & Improvement	**Next update March 2025**	Work progressing on the full committee organogram and collation of Terms of Reference and workplans to support this. Governance and assurance slides have been developed and are being used in different forums to increase understanding and expectations.	Clear and effective governance structure	High
4.5	• Develop a governance handbook and accountability framework so that individual roles and committee responsibilities and accountabilities are clearly documented. • Raise awareness and embed governance framework and expectations (FM Governance report 2019 REC 14)	Director of Governance, Risk & Improvement	**Next update March 2025**	Draft Accountability Framework being reviewed to replace Governance Handbook. Also looking to ensure all key Governance documentation is available on the Internet to include a summary and link to each document e.g. Trust Constitution, Sub-committee TORs etc. Work has commenced on the full committee organogram and collation of Terms of Reference and workplans to support this. Governance and assurance slides have been developed and are being used in different forums to increase understanding and expectations.	Clear accountability and expectations	Medium

Action Plan – KLOE 4

KLOE 4	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
4.6	• Develop a ward to Board framework so that the Board receives assurance of its quality and safety to allow for clear and effective flows of information from ward to Board. • Subcommittee structure and workplans to be devised (FM Governance report 2019 REC 15)	Director of Nursing & Quality Director of Governance, Risk & Improvement	**Proposal to remove as complete and deliver remaining actions as part of 4.2 and 4.3**	Integrated reports are provided quarterly to the Quality & Safety Committee and Board of Directors- **Completed.** This is being actioned as part of 4.2 & 4.3.	Ward accreditation plan in progress following piloting of the farmwork IICC report presented to Board Risk and Issues report from QGG to quality and safety committee	High
4.7	A review of 7 day services needs to be undertaken to understand any risks and gaps in care delivery and support for patients and staff	Medical Director	**Next update March 25**	Review of 7 day services being revisited. Current risk remains that weekend discharge ward rounds covered on a voluntary overtime basis. AMD (Urgent Care) to present to EDG (end Jan 25).		Medium
4.11	• Review of Non-Executive Directors portfolio and development needs to ensure that there is a good understanding of their roles and responsibilities as a Non-Exec Director. • Review governor roles and expectations and understanding of roles. (FM Governance report 2019 REC 2)	Director of Governance, Risk & Improvement. Director of Governance, Risk & Improvement.	**Complete – now part of BAU processes**	NWLA run open programmes for NEDs which anyone can book on to by going onto via their website. NED inductions now in place and new NEDs invited to attend the NHS Employers events. Review of NED responsibilities undertaken and shared with Council of Governors. Board development programme finalised for 2024/25. Workshop held with the Council of Governors in October 2024 to reconfirm roles and reset the role of the COG going forward, with the support of the Trust Chair and Lead Governor. Following this, there is a clear action plan in place to support Governors to fulfil their roles and further workshop sessions are planned.	COG workshop to be held in October 2024. NED inductions in place. Details of NWLA training shared with NEDs.	Medium

Action Plan- KLOE 5

KLOE 5	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
5.1	The process for reviewing and assessing risk needs to be strengthened to allow for transparency of risks to ensure the Board are fully sighted on risks to patients and services (to include embedding risk management and review of BAF)	Director of Governance, Risk & Improvement	**March 2025**	This is linked to 3.3 also. Monthly reports are now shared with EDG and then feedback provided to the Divisions in relation to their risks. Risk updates also continue to be updated via the Operational Management Board. A High Risks report is provided to the Board of Directors and sub-committees. The Trust's Risk Management Policy has been revised together with a review of the Trust's approach to Risk Management training. A process is also being developed for regular reviews of the risk register and to develop assurance reports via the relevant governance structures. Introduction of a Risk Management Committee with the first meeting held in shadow format on 12/11/24. TOR formally approved at QGG held on 05/12/24.	Monthly reporting to EDG and OMB. High Risks report to the Board of Directors.	Medium
5.5	The Trust must implement quality improvement systems and processes such as regular audits of the services provided and must assess, monitor and improve the quality and safety of services. The Trust needs to develop an improvement strategy	Director of Governance, Risk & Improvement	**March 2025**	The Trust has a continuous improvement team in place, as well as a number of other teams that deliver improvement work. A session has been held with the Continuous Improvement Team in May 2024 to align team priorities to strategic priorities. Wider picture across all improvement activity to be developed. For 2024/25, a set of agreed improvement priorities has been developed and is currently being reset to include the Cost Improvement Programme and a number of other strategic priorities. An improvement strategy is required for 2025/26.		Medium

Action Plan- KLOE 5

KLOE 4	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
5.6	The governance of coronial cases needs to improve which will be underpinned by the improvement in governance of all incidents to ensure that patients families and carers are involved in investigations, communicated with frequently and have their questioned answered and receive investigatory reports at least 28 days prior to any inquest. The investigatory reports need to be shared with the coroner 28 days prior to hearings also.	Director of Nursing and Quality	**Propose to close and move to BAU**	Database of coronial inquest developed. Legal team included in Safety Surveillance and learning steering group. Plan to monitor 28-day compliance with investigation reports to coroner. Evidence of patient and family involvement in investigations documented.	Transparency of all coronial cases. Good communication with legal team Further work re oversight and improved timeframes for report submission.	High
5.8	The Trust must review all training needs across all disciplines and prioritise mandatory training, EPR training and education regarding investigation reports, complaints responses, coroner cases and risk management.	Chief People Officer	**Next update March 2025**	New appraisal process and leadership development programme implemented. Revised Training Needs Analysis to take place in Q4 once 2024 appraisals have taken place.	Launch of new appraisal process & paperwork.	High
5.13 (NEW)	Improved Board and Committee reporting: Quality of reports, report writing and presentations.	Director of Governance, Risk & Improvement	**Propose to close and move to BAU**	Revised Report & cover sheet template in place. Governance and assurance slides are being used in different forums to increase understanding and expectations. Continue to drive improvements through BAU committee meetings, QA of reports, feedback etc.	Revised Report & cover sheet template. Governance awareness sessions being provided.	Medium

Action Plan – KLOE 6

KLOE 6	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
6.4 (NEW)	Deliver plan to optimise Cerner Full optimisation	Chief Digital and Information Officer	**Proposed complete as now BAU processes**	EPR upgrade took place in Sept 2024, without any significant issues. The digital team have worked with trust colleagues to agree a list of EPR optimisations. A programme of work is now under way to deliver the optimisations. Monthly Clinical Digital Design Authority meetings take place (chaired by CCIO) to review optimisation list and agree new work packages. Next EPR upgrade will take place in Q1 of 2025/26, this will bring additional functionality. The upgrade is part of a 4 year programme to ensure the trust EPR is upgraded to the latest version when the version is released. Clinical Digital Design Authority process is now embedded and optimisation work is reviewed and prioritisation is agreed with all stakeholders on a monthly basis.	Trust EPR upgrade (Sept 2024) Prioritised EPR optimisation list agreed (Oct 2024).	Medium

Action Plan – KLOE 7

KLOE 7	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
7.1	A review of all engagement with staff and patients needs to be undertaken to understand what is working well, what needs to improve, what else is required? From this priorities for engagement need to be discussed at exec group initially and then trust wide. (Patient engagement events, well being events (well-being group), carers forums, quality events, patient expert groups?	Chief People Officer/ Director of Nursing	**Proposed complete as now BAU processes**	Feedback from staff survey 2023 used to highlight areas where action has been taken, including: • Wellbeing hub • Civility charter • New appraisal process focussed on wellbeing • Strengthened FTSU and champions • Focus on championing and strengthening the Diversity Networks • Recognition EoM, ToM, more thank yous, larger -CoA event • New leadership programmes at all levels • Nursing new staffing levels • Zero tolerance to violence and aggression • Improved staff comms • Visibility of board out and about • Areas where more focus required include fairness of car parking and access to flexible working. • Execs sighted on priorities and updates. High level staff survey data for 2024 available to review – trust improved in 6 out of 7 people promise themes. Awaiting release of further data to support develop action plans.	Programme of patient engagement events commenced and a plan for the year ahead.	High

Action Plan – KLOE 7

KLOE 7	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
7.2	The Trust must be assured that they have the right numbers of staff with the right skills across all disciplines – focus on medical. Nursing and therapy staff Workforce plan submitted to NHSE May 2023 ***Actions outstanding – review of AHP workforce and review of medical staffing***	Chief People Officer/ Director of Nursing/ Medical Director	**Nursing- Completed** **Medical – March 2025**	Nurse staffing review completed using the safer nursing tool. Review of maternity staffing also. **Completed.** Medical staffing - Review of AHP workforce and medical staffing currently being progressed. SARD commissioned to undertake a capacity demand modelling for medical staff in 15 biggest specialities. Aim for revised job plans by the end of March 2025.		High
7.5 (NEW)	Continue to build upon system understanding and engagement with external partners, stakeholder mapping.	Director of Strategic Partnerships	**Next update March 2025**	New Anchor Institution oversight group established (June) which will meet bimonthly. New reporting framework adopted. Revised terms of reference. Board report presented in July 2024. Anchor Institute Oversight Group has now expanded membership to CWP and Chester University sustainability department. The group has now also engaged with the Country Park.	System engagement in place.	Medium

Action Plan – KLOE 8

KLOE 8	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
8.1	The Trust need to establish a Board Lead for organisational learning. This will then allow a strategic review of where all learning takes place, who by and outcomes. This then needs to result in the development of an organisational learning policy which is inclusive of all disciplines and services. • Review policy to ensure comprehensive coverage of organisation learning. • Establish mechanisms (as required) and embed organisation learning across the Trust	Director of Governance, Risk & Improvement	**March 2025**	Organisational Learning Policy being progressed to reflect the mechanisms and learning forums in place which are attended Trust wide. Head of Legal Services, Deputy Medical Director and Deputy Director of Nursing & Quality Governance also working more closely to align organisational learning. Early draft shared with Deputy Director of Nursing, Quality and Governance and Deputy Medical Director (Dec 2024).	Clear arrangements in place to demonstrate systematic learning	High
8.4 (NEW)	Continuous improvement • workstreams to be aligned to strategic priorities. • Consider opportunities to involve patients • Board development and NHS IMPACT assessment (including action plan) • Transformation programme priorities and approach to be confirmed and aligned to strategy	Director of Governance, Risk & Improvement	**Next update March 25**	The Trust has a continuous improvement team in place, as well as a number of other teams that deliver improvement work. A session has been held with the Continuous Improvement Team in May 2024 to align team priorities to strategic priorities. Wider picture across all improvement activity to be developed. For 2024/25, a set of agreed improvement priorities has been developed and is currently being reset to include the Cost Improvement Programme and a number of other strategic priorities. Priorities and an improvement strategy is required for 2025 and beyond.	Measurable improvements	Medium

Action Plan – KLOE 8

KLOE 8	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
8.5	The emergency department needs a robust improvement plan across all domains, care, culture, operational polices and flow. The Trust needs to improve that patients receive care in a timely way and work to improve performance against national standards (from arrival to assessment in the emergency department) Improve data capture and process of 12 hour DTA breach data Improve time to initial assessment using Manchester Triage System Deteriorating Patients and Reduction in Incidents: • Full review of the nurse and health care support workers • Roles and responsibilities in across the nursing workforce have been re-affirmed • An accountability framework is being introduced • Matron does regular drop in sessions and a department news letter is produced. • Weekly audit in place via Tendable and additional PDN training. • Twice daily Consultant in-reach sessions supporting review of NEWS and an ED specific NEWS addendum developed for Trust policy Maximise SDEC • Aim for over 1000 attendances per month • Direct conveyance from NWAS • Open 12 hours per day 7 days per week Introduce an Urgent treatment Centre outside the ED footprint	Chief Operating Officer	**Next Review March 25**	Nurse staffing review completed. SDEC has been repurposed. Five Trusts in Cheshire and Merseyside have been placed into Tier 1 for their Urgent and Emergency Care (UEC) services and this includes our Trust. Intensive support for all organisations in Tier 1 has been allocated from the Emergency Care Intensive Support Team (ECIST) via NHS England (NHSE). The Trust has asked for targeted support with triage, new models of working and day to day clinical leadership of the Emergency Department. The Chief Operating Officer is working closely with the Integrated Care Board (ICB)/NHSE/ECIST to finalise the offer and also having an increased focus on breaches of the 4 hour target that are within the control of our Emergency Department. Further work to be co-ordinated internally to link to wider improvements to patient flow. UEC actions completed and new actions to be captured on the plan.	Improved performance against KPIs Improved patient experience	High

NHS
Countess of Chester Hospital
NHS Foundation Trust

Appendices

Summary of Improvement Outcomes

Countess of Chester Hospital NHS Foundation Trust

Urgent & Emergency care

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

Quality, Safety & Harms Improvement

1. Closure of serious incident backlog
2. Oversight and action regarding incidents through a range of daily and weekly meetings including the embedding of daily incident review meetings and a patient safety oversight meeting with Executive attendance
3. Development of the 6 steps patient and family experience across all clinical areas
4. Safe nurse staffing reviews completed across all wards and the emergency department
5. Improved timeliness in response to complaints
6. Implementation of the triage process in Maternity
7. Changes made to the post-operative care of women's & birthing people following obstetric surgery
8. Reasonable adjustments strategy completed and due to be launched Q4 2024/25
9. Transparency of all coronial cases, good communication with legal team and oversight through safety surveillance

Summary of Improvement Outcomes

Countess of Chester Hospital NHS Foundation Trust

Board Governance & assurance

1. Fully established Executive Team with clear visibility and a schedule for visits trust wide implemented.
2. Committee effectiveness improvements and compliance with Code of Governance
3. Clear Board development plan, appraisals and objectives
4. Awareness raising in respect of developing a strong culture of Governance and Risk Management

People & OD

1. A wide range of engagement activities covering inclusivity, behaviours, wellbeing and appraisal and career conversations, and visibility of FTSU.
2. Improvements have been made following the 2023 staff survey

Digital

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

Summary of completed actions (to date)

Countess of Chester Hospital NHS Foundation Trust

Completed Actions

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

NHS
Countess of Chester Hospital
NHS Foundation Trust

PUBLIC – Board of Directors
28th January 2025

Report	**Agenda item 14.**	**Clinical Strategy**							
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**	
Accountable Executive	Dr Nigel Scawn			Medical Director					
Author(s)	Jonathan Develing			Director of Strategy and Partnerships					
Board Assurance Framework	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**	BAF Impact is positive assurance when designing in sustainability and future service development.						
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	Board of Directors received an update on progress in October 2024. Operational Management Board has received an update.								
Executive Summary	The purpose of this report is to provide an update on the development of clinical strategies within the Trust.								
Recommendations	The Board of Directors are asked to note the development of the clinical strategy.								

Corporate Impact Assessment	
Statutory / Regulatory Requirements	It is a requirement that Trusts have up to date clinical strategy
Risk	BAF Impact is positive assurance when designing in sustainability and future service development.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

CLINICAL STRATEGY

1. INTRODUCTION

This paper provides an update on that presented in October 2024 in respect of developing a new clinical strategy for the Trust.

2. BACKGROUND

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

3. PURPOSE

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

4. CLINICAL STRATEGY DEVELOPMENT

To facilitate the development of the clinical strategy a series of workshops (October and December 2024) have been held collating inputs from clinical and operational leaders. This has seen more than 60 leaders across the organisation offering a multi-disciplinary input into a future direction of how services can be best developed and delivered.

Time for this strategic thinking has not been offered for many years and the approach has been widely welcomed, culminating in an overwhelming consensus that we want to see the Countess of Chester achieving excellence, becoming an outstanding hospital and meeting the needs of the population.

5. PROGRESS

The two workshops have already had a positive impact in terms of an engaged clinical and operational community with specific objectives to:

- Set time to aside to reflect, plan, identify trends and determine where to allocate resources
- Identify a specific target, outcome or objective that will add value or lever an opportunity
- Seek information from subject matter experts and key opinion leaders (facilitated guest speakers' sessions)
- Coproduction of ideas that are inquisitive not judgemental.
- Co-creation of a shared purpose.
    - Why does the Countess of Chester exist?
    - What is its purpose?
    - How does the Trust go about meeting the needs of the population?

  We want **`WHY`** to become
    - To support our population to the live healthiest life possible
    - Care for them in a positive way
    - Improve quality of life for patients and staff
    - Our community deserve high quality safe care
    - Promote health and wellbeing of population and staff

- Make the most difficult times of people's lives the best it can be
- Be part of the team and a team with similar values
- Be kind to patients and each other
- Support healthy populations
- Sustainability of the health and care system
- Do the right things for the right person at the right time -effective

`What` we want to be known for

- Provide a wide range of medical and surgical services and diagnostic services
- Multidisciplinary team decision making
- Provide services from cradle to grave
- Provide services that meet the needs of the population NOT the organisation
- Delivering excellent clinical care
- Attracting the best people
- Work in partnerships and networking
- Create trust for local people - rely `on us to look after them
- A Health promoting, health and wellbeing hospital
- Continuous learning
- Clinical excellence
- High quality teaching and student experience
- Be a great place to work

`How` we will do things in the future

- Provide high quality clinically effective and safe care
- Provide cost effective and evidence-based care
- Provide more convenient care closer to home
- By being kind to patients and each other
- Match demand with the needs of the population
- Provide patient and family centered whole patient care
- Align our `why` to build a culture of change and trust
- Supporting each other
- Embracing innovation and new technologies
- Make better use of data
- By being closer to primary care, coproduce solutions now and for the future

Whole Patient and Whole Life Course

Rather than looking at single episodic care there is an overwhelming consensus that we would wish to consider whole patient care and the whole life course of an individual's experience.

- **Whole patient care** is an approach to healthcare that focuses on treating the patient as a whole person, rather than just addressing a specific illness or condition. This concept emphasizes the physical, emotional, social, and spiritual aspects of a person's well-being, recognizing that health is influenced by many factors beyond just the biological or clinical symptoms.
- **The whole life course** refers to the entire span of an individual's life, from birth to death, and the various stages, experiences, and transitions that occur over this period. It is an

interdisciplinary concept that is often used in social sciences, public health, psychology, and sociology to understand how different life events and circumstances shape individuals' physical, mental, social, and economic well-being.

6. STRAGIC OUTPUTS

Affording this dedicated time to consider the roll of an acute Trust within a changing provider landscape and a changing demographic has allowed us to consider the factors above and focusses on several key areas each supported by `We Will` Statements. These statements will be translated into specific service strategies which are currently being developed by respective clinical divisions.

Key areas for our strategy

1. Improve outcomes for patients
2. Resources management
3. Team collaboration and leadership
4. Adapting to change
5. Patient centred approach
6. Technology and innovation
7. Developing resilience

Example – Improving outcomes for patients

In adopting a whole patient care and whole patient life course approach we will consider the long-term health outcomes for patients, not just the immediate issue at hand.

We will - Working with multidisciplinary teams to manage complex conditions. This will involve coordinating long-term treatment plans, preventive care, and palliative care. Outcome - more people dying in place of choice.

Example – Resource Management

We want to understand how to reduce waste and optimise resource use, which can lower costs while maintaining quality care.

We will - introduce service line reporting, develop an approach for innovation and share best practice. Outcome, improved insight into costs and expenditure and how each service line could become more efficient

7. CONCLUSION

The two workshops have provided significant insight into the development and delivery of services for the future. This time for strategic thinking, learning and leadership is now in hand and will now occur on a regular quarterly basis.

The outputs from this work will now facilitate a draft strategy for operational and clinical leads consideration by February 2025, and a final draft for Board consideration in March in time for an April launch and publication.

8. RECOMMENDATIONS

The Board of Directors are asked to note the development of the clinical strategy.

Committee Chair's Report

Thursday 9th January 2025 at 2.15pm – 4.15pm, Boardroom 1829 Building

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

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

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

- Escalation beds and pressures on staffing are impacting sickness absence and morale, with actions being taken to try to reduce redeployment of staff whilst ensuring a continued focus on safe staffing levels.
- E'discharge compliance and actions required to demonstrate improvement.
- Emergency Department (ED) remains a concern, and the ward accreditation process shows a decline, notwithstanding the challenges and pressures faced. UEC patient experience results were triangulated, recognising actions are aligned to the patient experience strategy actions. ED and flow remains a concern, and the focus remains on the improvement actions needed including the visibility and strength of leadership, and the support of Place colleagues.

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

- Update progress against the internal audit actions in respect of consultant job planning, bank and agency, discharge planning, legal services and medical staffing review. To note a number of actions, remain in progress including SARD job planning, discharge policy embedding (incl. Estimated Discharge Dates), and legal services policy.
- Reviewed quality and safety Key Performance Indicator (KPI) performance within the System Oversight Framework (SOF). Key areas of focus were increased numbers of concerns, patient flow and ED performance, sickness absence and staffing moves, improving risk assessment recording and compliance, and pressure ulcers. Assurance sought on actions being taken on Malnutrition Universal Screening Tool (MUST) risk assessments.
- Wide range of assurance provided through the work of Quality Governance Group (QGG), including learning from deaths, Infection Prevention & Control (IPC), harms improvement, safeguarding compliance, mortuary assurance, Acute Kidney Injury (AKI) report, organ donation, Place, safety surveillance, resuscitation report, hydration and nutrition. The only area for escalation being e'discharge compliance and assurance sought on improvement plans.
- Organ donation report provided positive update on the approach and contribution made.
- Quality Impact Assessment (QIA) update on process and approvals. Request to add educational impact assessment back in to QIA process.
- Compliance benchmark with Neonatal critical care service standards at level 1 and level 2.
- Resuscitation annual report providing assurance on compliance with resuscitation training, emergency trolley checks, did not attend (DNA)

cardiopulmonary resuscitation (CPR), and National cardiac arrest audit. Action plan focussed on improving training compliance levels in specific areas and staff groups (e.g. medical), specific areas with low trolley check compliance, and sustaining the improvement in DNA CPR audit outcomes.
- National safety standards for invasive procedures (NATSSIPs) work progressing including harmonisation of World Health Organisation (WHO) checklists and audits.

Advise *(items presented for the Board's information)*

- Received a patient story on feedback of impact of the play therapist on a child's journey with our health services.
- SOF development progressing so we have clarity of targets and KPIs.
- Two significant coroner's inquests including significant learning in December 2024. Whilst Regulation 28 not given there were some areas for concern and action including reference to neglect. The Trust has provided detailed learning statements (one was a joint statement with Cheshire Wirral Partnership NHS Foundation Trust). We have also had a review of mental health to support us in developing a wider action plan.
- The Medical Director raised an issue with the committee regarding potential for missed radiology results, with a paper subsequently circulated but the risk and actions needs to be further understood.

Risks discussed and new risks identified

- Board Assurance Framework (BAF) and high risks presented to the Committee and consideration of triangulation with the committee agenda, and discussion on
- Assurance sought that mandatory training compliance and releasing medical staff is included on the risk register.

Committee Chair's Report

Thursday 28th November 2024, 8.00am – 1.00pm, Boardroom – 1829 Building

Committee	Operational Management Board
Chair	Ms Jane Tomkinson OBE, Chief Executive Officer

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

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

- Nothing to alert to the board, all areas were aligned to the wider SOF reporting.

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

- UEC and Maternity CQC survey results show some great improvements and work continues to focus on the areas of feedback.
- Clinical strategy progress and plans for quarterly Clinical leads strategy days (next one planned 19th December 2024).
- Risk management action plan update including Risk Management Committee held, reference group being established to support Datix developments, training and awareness raising, and divisional risk maturity workshops to be planned for Q4 facilitated by MIAA.
- Divisional risk and performance reports received with a range of assurances across all areas of quality, people, operational performance and finance. A lot of work is taking place across Divisions on the quality improvement workstreams (including pressure ulcers, falls, IPC, risk assessment), mandatory training compliance (including safeguarding and resuscitation), E'discharge completion, finance performance including CIP and forecast, thematic reviews being undertaken and PSIIs progressing. Specific areas of action: mandatory training action plans, ACA approval processes, Emergency Department flow, stroke coordinators, sickness absence and reducing staff moves.

Advise
(items presented for the Board's information)

- OMB received updates on healthcare associated infections, annual planning, and the financial position.

Risks
(discussed and new risks identified)

- Risk updates were provided within the papers.
- The risk management improvement plan work will continue to strengthen risk management within the Trust.

Research matters

Research and Innovation Update

Peter Bamford

Director of Clinical Research

CRU and MRU Opening

Our new Clinical Research Unit (CRU) and Mobile Research Unit (MRU) officially opened in December.

Part of our trust strategy to increase our local research infrastructure providing patients with access to a dedicated clinical space.

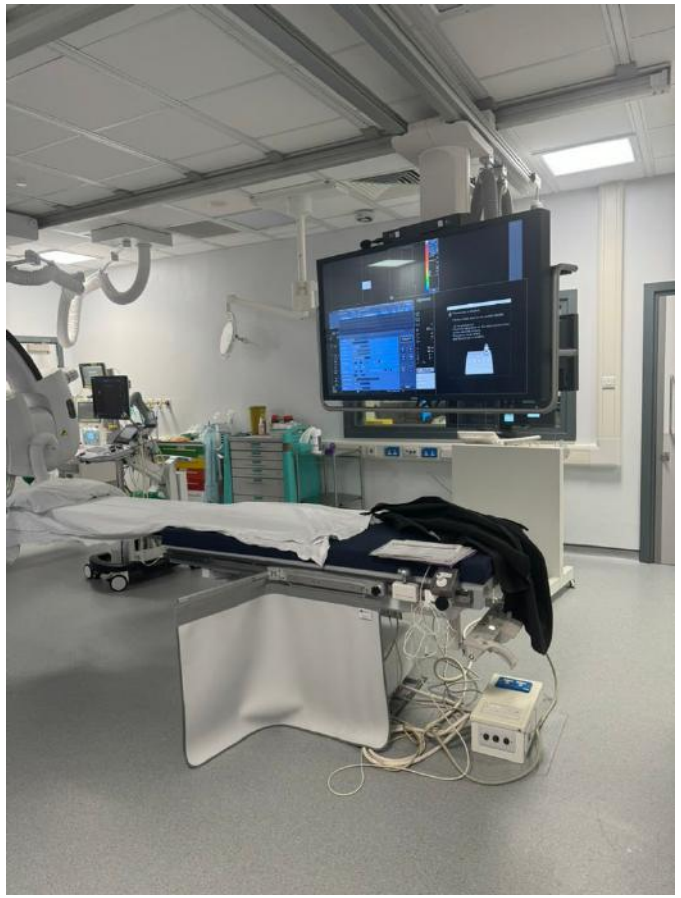
The CRU will enable us to conduct a broader range of research studies and trials, increasing our capacity.

Our research bus ensures we can take research into local communities, reducing inequalities in access across our region

The two facilities mark a £300,000 investment in our Trust

We want to research to be at the heart of what we do...We have already started work on 2 new facilities at EPH and Tarporley

Our successes: Capital Funding



£535k awarded in 2024 National NIHR Capital Program
To support :

1. Histopathology
2. Portable Radiology
3. Ultrasound
4. Pharmacy

£400k for infrastructure projects CRU, MRU, Community Hubs

Additional £1.2 million NIHR bid for new IR suite

2023 NIHR Capital Bid
£230k CRV equipment

Partnership development 2025

NHS
Countess of Chester Hospital
NHS Foundation Trust

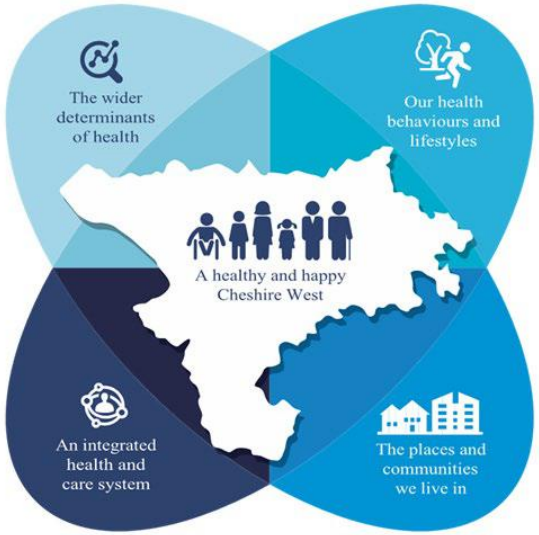
Bilateral Working Agreement

Medical School
Joint Research Office
Academic Posts

University of Chester

Primary Care Research Hubs

Areas of deprivation
Rural communities



Cheshire and Mersey Commercial Research Bid

R&D Finance update

- Recurrent staffing commitments - £181k above funding - cover for 24/25 from current income levels
- 24/25 Oct-Mar allocations now received

Year	2024/25 Oct-Mar	2024/25 April-Sept only2	2023/24	2022/23	2021/22
Allocation - AFP	£ 269,618	£ 279,257	£ 467,052	£ 496,636	£ 498,552
Additional/Contingency/Adjustments/RCF	£ 48,500	£ 158,388	£ 97,611	£ 54,078	£ 118,440
Total	**£ 318,118**	**£ 437,645**	**£ 564,663**	**£ 550,714**	**£ 616,992**
Breakdown:					
Base Delivery Budgets	£ 267,118	£ 271,757	£ 463,552	£ 463,552	£ 463,552
Cost pressure (inflation)				£ 13,282	
Specialty Group Leads	£ -	£ 5,000	£ 10,000	£ 14,584	£ 35,000
HSRC Lead	£ 2,500	£ 2,500	£ 5,000	£ 5,000	
National Specialty Lead	0	0	£ 13,500	£ 13,500	
Managed Recovery					£ 47,537
Commercial managed recovery					£ 49,732
Commercial Incentive Funding (RTT)			£ 5,000		
Short Turnaround funding				£ 20,094	
Life Sciences funding	£ 33,500	£ 33,500	£ 67,611		
Contingency Funding		£ 20,000			
Secondary Care Infrastructure Hub Funding		£ 89,888			
ETC				£ 702	£ 1,171
RCF	£ 15,000	£ 15,000	£ 25,000	£ 20,000	£ 20,000
	£ 318,118	**£ 437,645**	**£ 564,663**	**£ 550,714**	**£ 616,992**

Non NIHR Income Generation By year, study & allocation

Category	2024/25 M9	2023/24	2022/23	2021/22	2020/21	2019/20	2018/19
Commercial	£ 93,488	£ 161,624	£ 87,279	£ 20,882	£ 39,202	£ 165,096	£ 77,238
Non Commercial	£ 50,606	£ 49,607	£ 62,725	£ 106,924	£ 83,519	£ 26,951	£ 51,459
Total	**£ 144,094**	**£ 211,231**	**£ 150,004**	**£ 127,806**	**£ 122,721**	**£ 192,047**	**£ 128,697**

Study	Commercial	Non-commercial	Grand Total
REDEFINE 1	£51,371		£51,371
REDEFINE 3	£22,174		£22,174
ASCEND-PLUS		£16,249	£16,249
SPEAK	£12,449		£12,449
RESPOND WP4		£8,477	£8,477
OCEANIC-AF	£5,679		£5,679
OTHER	£1,815	£25,880	£27,695
Grand Total	**£93,488**	**£50,606**	**£144,094**

Period	Central	Specialty	Support	Total
2023/24	£55,882	£141,934	£13,415	£211,231
2024/25 M9	£39,541	£89,138	£15,415	£144,094

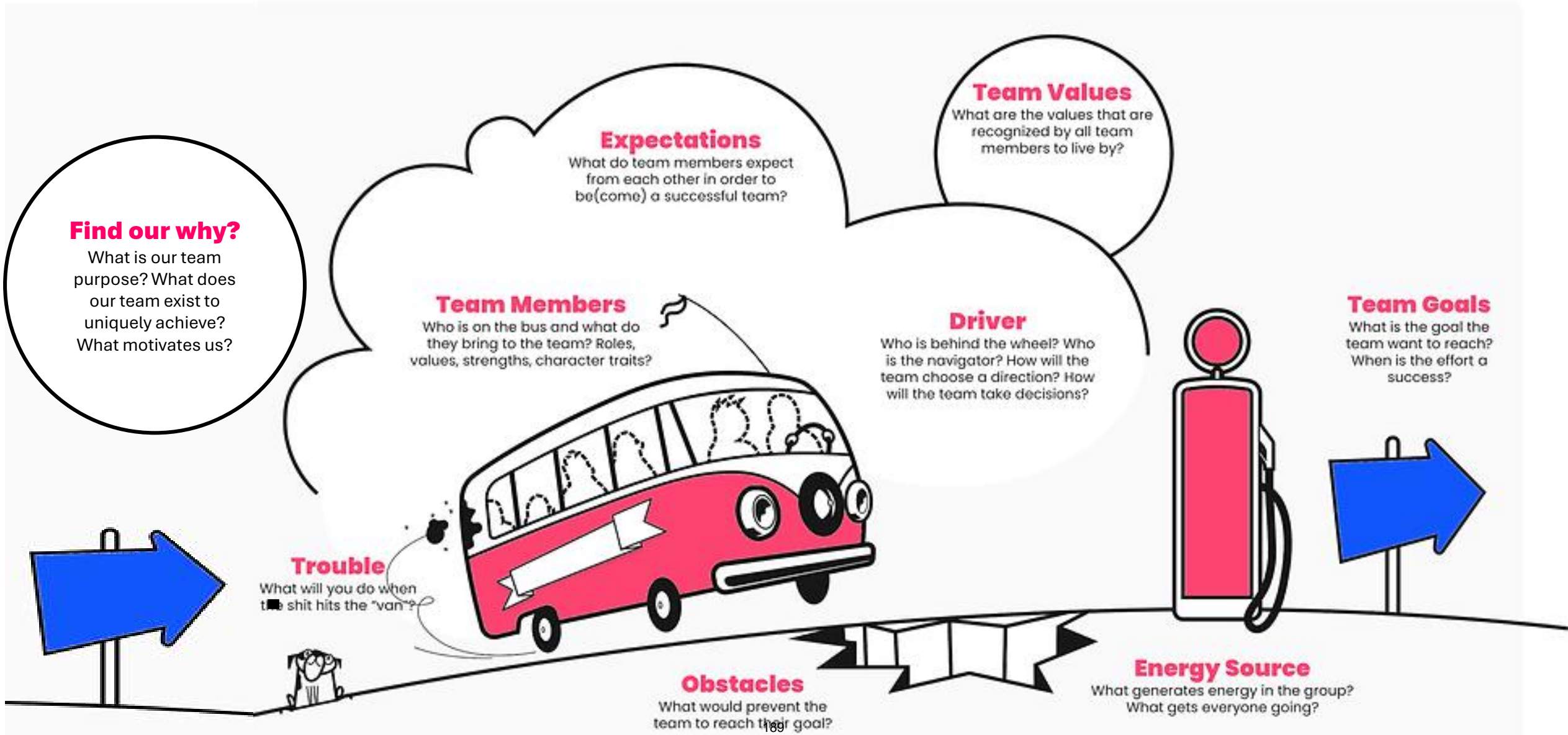
- Current income Forecast £19k, lower than 23/24 levels
- Highest income earned from Redefine 1, 3 & Ascend-plus trials
- 44% income earned attributed to specialty pots
- 50% to central R&D, this includes 30% contribution and studies linked to delivery by central team
- 6% allocated to support services (mainly pharmacy)

Priorities Locally

Mandatory Training - 97%
Retention – Turnover 2 recently resigned
Appraisals – 13/16 complete
Sickness – 9%

- Development of a Team Charter
- Regular appraisal and Development of staff
- Ensuring a complete complement of staff
- Celebration of achievements and success
- Development of activity around CRF and MRU
- Increasing commercial activity and income
- Communications strategy

Developing our Team Charter



Looking forwards to 2024-25: Reducing risks

No Dedicated Research Space:

Clinical Research Facility Opened

Mobile Research Vehicle Received

Financial Risk with predicted overspent for 2024/25:

Increase Commercial and Life Sciences Research

Utilisation of digital platform to track income

Appoint Research Accountant

Developing research activity around our successful funding bids

CPEX

Cardiology

Cardiac Rehab

Prehabilitation

Interventional Radiology

Need up to date research strategy:

Complete 5-year strategy for department in line with trust strategy refresh (Summer 2025)

Increasing Partnerships with surrounding heathcare providers and research institutions

University of Chester

West Cheshire PCNs

CWP

Clatterbridge

Currently at limits of delivery capacity

Aim to increase staff numbers

Establishing and embedding research within the divisional team structure across the organization

Minimal Governance support within the Team

Team charter has looked at new process for ensuring governance achieved in timely manner

IT issues

Plan for reconnecting Bache to hospital Wifi

Identification of research patients in Cerner

Implementing EDGE capability and digital tracking of performance

NHS
Countess of Chester Hospital
NHS Foundation Trust

Research matters

Updating Communication Strategy

Countess of Chester Hospital NHS Foundation Trust

Patient story: Matthew’s story

- Matthew lost 7 stone and “got my life back” thanks to our 'incredible’ Clinical Research Trial
- “The whole process was so well laid out and from the start I knew exactly what to expect.”
- "The team provided me with a detailed document outlining every objective and procedure. Dates for my appointments were clearly scheduled, which made it easy to manage my work and personal commitments and each upcoming step was always explained so I felt completely informed.”
- "Their support and encouragement were key to my success. They were always there when I needed them. I couldn't have done it without them.“
- To others considering a clinical trial, Matthew's message is to 'just do it'.

Patient story: Matthew's story

- Matthew helped us celebrate the opening of the CRU and the MRU by sharing his story with local media.
- We welcomed Granada Reports into the CRU and the bus and Matthew talked about his experience of being part of a research trial at our Trust

- **Dr Peter Bamford, Director of Clinical Research, said: "Patients involved in clinical research generally have better health outcomes and that's something we want for all our patients. So for us, these new facilities will allow us to expand the amount of research we can do for our patients."**

Committee Chair's Report

17th January 2025 / Bache Hall

Committee	Research and Innovation Committee
Chair	Director of Clinical Research, Peter Bamford

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

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

- New Clinical Research Unit (CRU) opened and trust taken receipt of mobile research unit (MRU) in December 2024. Opening event resulted in regional news coverage of the opening.

- Work started on two new research hubs at Ellesmere Port Hospital (outpatients) and Tarporley Memorial Hospital. Hoping to have these finished by the end of this financial year. These facilities will enable us to see patients closer to their homes during trial follow up but also encourage collaboration with primary care partners.

- Board level meeting took place between University of Chester and Countess regarding the potential relationship that we are looking to develop. In the first instance we will be hosting a 'sandpit' event with interested partied from both parties coming together to discuss the next steps. (March 2025)

    - Joint research office in Bache Hall
    - Specialty interest groups (akin to CWP)
    - Sustainability/Innovation group
    - Educational Developments
    - Service evaluation teams working with QI.

- Development of closer working relationship with PCNs also been an area of focus with a view to creating a collaboration between Primary, secondary care, universities and the community/voluntary sectors.

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

- Process of developing and updating the departments SOP library has begun – developed Expression of Interest SOP, Archiving SOP. These will be put through the Q&S committee for ratification.

- Activity for 2023-24 remained excellent with >1000 recruits for the 5th successive year. That has fallen this year however for several reasons:

    - Staff sickness and reduction in capacity
    - Difficulty in recruiting to band 6 vacancies
    - Concentration on building of infrastructure rather than delivery

- Reduction in the number of large observational studies (similar reduction seen across the region)
- Focus needs to be on increasing commercial opportunities and identifying high recruiting studies.

- Results of TED tool suggested morale was low across the team – this has been addressed through the ongoing development of a team charter which was supported by Lizzie Shevlin.

- Work continues on the development of an updated trust research strategy

Advise *(items presented for the Board's information)*

- Trust awarded £530k in the 2024 NIHR Capital bid which has been accepted by the trust. The funds will contribute towards developing our research support services. Specifically supporting ultrasound, radiology (C-arm and portable xray machine) and histopathology (with an immunostainer, microscope and microtome). First installment received for pharmacy and histopathology upgrades.

- Secured £1.2 million in funds from NIHR towards the newly developed IR suite

- 2023 NIHR Capital allocation fully received, and all allocated for capital projects.

Risks discussed and new risks identified

- Unclear whether all funds attributable to research activity are being brought in in their entirety – discussed increased utilization of research software package Edge to achieve this.

- The new CRU and MRU need fully up to date SOPs for when we become fully operational – they are in the pipeline however risk assessments need to be completed before we can start to use them to their full capacity

- IT – department setting up CRU clinics within Cerner so that activity can be planned and coordinated

- Lack of an appropriate parking bay for the MRU – taken to Capital Management Group and approved in December 2024. Work starting next week

- Wi-fi connection to Bache – options appraisal ongoing

NHS
Countess of Chester Hospital
NHS Foundation Trust

Committee Chair's Report

10th December 2024, 1pm – 4.30pm, Boardroom, 1829 Building

Committee	People Committee
Chair	Non-Executive Director, Ms W Williams

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

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

- Band 2/3 update on the challenges and unison grievance now raised. Work ongoing to review implications, costs and agree next steps.
- Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) action plans received and will be incorporated into a combined Equality, Diversity and Inclusion (EDI) plan. Significant actions needed and requires a clear focus on the impact of actions.
- Director of Medical Education Annual Report, recognising areas for improvement aligned with General Medical Council (GMC) survey feedback, University feedback and NHS England Education Quality Self-Assessment. Deanery intervention risk highlighted in relation to training and experience of Emergency Department trainees, and the Committee asked for this to be discussed, and actions agreed as a matter of priority including improvements in rostering processes.

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

- Progress on internal audit action log in relation to consultant job planning, bank and agency, and medical staffing reviews.
- Workforce metrics performance and areas where action is being taken to improve the position including overall workforce numbers, sickness absence, mandatory training, overtime and agency use. Committee requested further information on the establishment position.
- Appraisal compliance has achieved target and work ongoing to explore gaps, as well as assess effectiveness of appraisal processes and experience.

Advise *(items presented for the Board's information)*

- Nursing establishment and workforce challenges including sickness absence and impact of moving staff to the Emergency Department (ED). Actions being taken to recruit and strengthen ED workforce to reduce the need to move staff. Risks are being managed and mitigated throughout the day.
- Agreed a new governance structure to be established beneath the People Committee to strengthen the sub committee structures and assurance.
- Importance of the Trust ensuring that the workforce plan, operational plan and finance plan are aligned for 2025/26.
- Management training programme being developed.

Risks discussed and new risks identified
• Received the Board Assurance Framework (BAF) and high risk report including mitigations, and triangulated to the Committee agenda. • Risks to be reviewed in light of discussion regarding medical education (see Alert).

PUBLIC – Board of Directors
28th January 2025

Report	**Agenda Item 21.***	**Annual NHS England Quality Self-Assessment Education Report**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Vicki Wilson			Acting Chief People Officer				
Author(s)	Sallie Kelsey			Head of Education				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X**	Failure to maintain contractual requirements with the NHSE Education contract could result in the removal of students from the Trust. This would impact on the income brought into the Trust via the student tariff, affect the Trust reputation and impact on the future workforce pipeline.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X**
Previous considerations	Submission signed off by Chief Executive Officer, Jane Tomkinson - 30th October 2024 People Committee – 10th December 2024							
Executive summary	The purpose of this report is to highlight the responses to the annual self-assessment as a placement provider for both undergraduate and post graduate healthcare programmes. This report covers both the challenges and achievements within education and training. The challenges raised include training space and facilities, placement management/capacity and the increase in resident doctors working less than full time The achievements raised include collaboration/partnerships, learner/trainee support or wellbeing and supervisors/educators' investment The next steps are to develop an action plan to address the challenges raised.							

Recommendations	The Board of Directors is asked to acknowledge the achievements recorded within the self-assessment report and give consideration to the challenges relating to space and facilities within the Education Centre footprint.

Corporate Impact Assessment	
Statutory/regulatory requirements	NHSE education contract
Risk	Risk included on local 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 as part of the agenda pack.

Annual NHS England Quality Self Assessment Education Report

1. Introduction

The Trust is required to submit an annual self-assessment (SA) as a placement provider for both undergraduate and post graduate healthcare programmes, it is a process by which organisations carry out their own quality evaluation against a set of standards.

The NHS England Education Quality Framework identifies the standards that organisations are expected to meet to provide high quality learning environments. The NHS Education Funding Agreement (2024) requests all providers to fulfil the obligations of their roles and responsibilities set out in the NHS England Education Quality Framework and to submit a return to NHS England on their compliance with the agreement. There is the requirement, via the NHS Education Funding Agreement that organisations will undertake this annually.

2. Background

During 2024, NHS England reviewed the SA question set to ensure it was fit for purpose. Whilst the majority of SA questions remained unchanged and mapped to the education quality framework standards; they reviewed and updated the question set and language in line with the NHS Education Funding Agreement 2024 – 2027 as follows:

1. Section 3: NHS Education Funding Agreement

   - We are compliant with all applicable requirements of the Data Protection Legislation and with the requirements of Schedule 5 of the NHS Education Funding Agreement.
   - We have collaborative relationships with our stakeholders (e.g. education providers) which provide robust mechanisms to deliver agreed services.

2. Section 4: Education Quality

   - We are reporting and engaging with the requirements and process to escalate issues, in line with NHS England's education concerns process.
   - 2024's NETS will be open from 1 October 2024 until 26 November 2024. How will your organisation increase their NETS response rate for 2024?

3. Purpose

The purpose of the report is to highlight that the Trust meets all the statutory requirements of the NHS Education Funding Agreement except for being able to guarantee that the funding provided to support education and training is used explicitly for this purpose. The report highlights three areas of challenges and three areas of achievements and was completed by the Director of Medical Education and Head of Education.

4. Structure of the Self-Assessment and Information Submitted

The SA is divided into several main sections:

- Section 1. Challenges within education and training.
- Section 2. Achievements within education and training.
- Section 3. Compliance with the obligations and key performance indicators of the NHS Education Funding Agreement.

- Section 4. Compliance with the quality, library, reporting concerns and patient safety training obligations and key performance indicators of the NHS Education Funding Agreement.
- Section 5. Our policies and processes in relation to Equality, Diversity and Inclusion.
- Sections 6 - 11. Consider NHS England's Education Quality domains and standards and declare any areas, by exception, where standards are not met for each main professional group.
- Section 12. Sign off and submission.

The self-assessment report submitted covers the following professional groups that the Trust currently trains.

- Advanced Practice
- Allied Health professionals
- Dental
- Healthcare Science
- Medical Associate Professions
- Medicine Postgraduate
- Medicine Undergraduate
- Midwifery
- Nursing
- Pharmacy

Placement Provider Challenges

Increase in less than full time (LTFT) – The GMC national training survey has shown that the proportion of LTFT resident doctors working in the Northwest deanery has more than doubled since 2019 to 2024 from 12% to 25%. It currently stands at 35% in our Trust. This is challenging to cover curriculum requirements for the LTFT trainees and also impacts on the training of the full-time trainees.

Training space/facilities – It is becoming challenging to meet all learners needs in relation to space and facilities in the Education Centre due to the recent and ongoing increase in the number of learners. Specific areas include; simulation suite, medical student mess, library, IT facilities and meeting rooms. In clinical areas, space in some clinic rooms is tight to accommodate a learner.

Placement Management/Capacity – The multiprofessional workforce supervision ask is challenging in many specialties. The challenge is to find placement capacity and supervisors in areas that take nursing students, midwifery students' trainee ACPs, student doctors' core and specialty trainees and GP trainees. Pharmacy has similar issues where NHSE funding does not adequately cover the training requirements in the department. The increase in flexible working and reasonable adjustments from undergraduate students also puts challenges on placement capacity.

Placement Provider Achievements and Good Practice

Collaboration/partnerships – collaboration with University of Chester as they develop their MB ChB programme (Bachelor of Medicine). Supporting interview process for prospective medical students and supporting the transition of student nurses into employment with application and interview techniques. Continued working with Liverpool University and Trusts across the region to support the MB ChB programme and supporting both the local and central university OSCE exams. Pharmacy department have secured a partner organisation to work alongside the requirement of a split sector trainee pharmacist year. Co-designing the programme with Day Lewis Pharmacies.

Learner/Trainee Support or Wellbeing – Reported on the improved wellbeing offering and the Hub which is accessible to staff and learners. Also reported on the relaunch of Freedom to Speak Up, relaunch or staff networks and the creation of policies e.g. menopause.

Supervisors/Educators (investment) – Reported on the Trust wide job planning review and implementation of a new electronic planning system in conjunction with an updated job planning policy which clearly defines educational job planning requirements. This will allow time to be defined for supervision rather than being lost in “SPA” time. Pharmacy department also reported that for the first time the department is supporting two Clinical Scientist Graduate Programme students within the aseptic unit. They will review and improve processes whilst learning about quality control and pharmaceutical production.

In addition to the challenges and achievements mentioned above examples of good practice were submitted for other areas of the report. One area key achievements were reported on referred to developing and supporting learners. The self-assessment reported on an audit undertaken by the Practice Education Facilitators in repose to student nurses feeling they were not supernumerary in practice. The audit that covered students on both day and nights demonstrated that although a small number of students felt their supernumerary status had not been upheld, they were still able to access appropriate learning opportunities to meet their practice outcomes. It was also reported that the Pharmacy department developed a planning document for trainees that listed all learning outcomes and the level at which they needed to be achieved, providing space for learners to include agreed activities which would aloe demonstration of competence. This was aimed to aid trainees and supervisors through rotations, and it is hoped that the document will make the transition between sectors smoother.

Next Steps

The Head of Education along with the Director of Medical Education will develop an action plan to reduce areas of risks reported within the self-assessment. The main priority will be looking at capacity and facilities within the Education Centre and how the space available can be best utilised whilst also looking at capital bids to improve the facilities and make general repairs.

5. Conclusion

The self-assessment report submitted did not declare any areas of non-compliance. Areas of good practice and challenges were openly reported. It is acknowledged that some areas of challenge are a national challenge, specifically the less than full time working of resident doctors. The Education Department will continue to grow collaborative working with both the University of Chester and Liverpool University to ensure all learners have a positive and supportive learning experience at the Trust making us their future employer of choice.

An action plan will be developed to address the challenges in particular looking at the capacity and facilities within the Education Centre.

6. Recommendations

The Board of Directors is asked to acknowledge the achievements recorded within the self-assessment report and give consideration to the challenges relating to space and facilities within the Education Centre footprint.

Countess of Chester Hospital NHS Foundation Trust

PUBLIC - Board of Directors
28th January 2025

Report	**Agenda Item 22.**		**Council of Governors Report – Nov 2024**					
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**	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 update from the Council of Governors meeting. The general duties of the Council of Governors include: • To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and • To represent the interests of the members of the Trust as a whole and the interests of the public.							
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.

Council of Governors Report

1. PURPOSE

This report provides a summary update of recent activity related to the Council of Governors.

2. BACKGROUND

The Council of Governors meetings are held on a quarterly basis. In between, a less formal Governor Development Session is held, which features guest speakers from specific areas of the Trust.

3. CURRENT POSITION

3.1 Council of Governors Meeting

The Council of Governors met on the 21st November 2024 and key items included the following:

- A patient story was presented
- An update was provided from the Chair and the Chief Executive Officer on key matters.
- Chair's reports were received from the People Committee and Quality & Safety Committee.
- Lead Governor update.
- The CQC In Patient Survey results were presented.
- A summary of the Governors workshop and action plan was reviewed.
- The Trust SOF was provided setting out the Trust's performance in key areas from the NHS Oversight Framework Report including; Operational Performance, Quality, Safety, Finance and People.

Governors also provided updates and feedback in relation to their attendance at the Board of Directors, Sub-Committees and other Trust meetings / groups. Governors are invited to Public Board meetings and have an opportunity to ask questions at the end of the meeting on any matters on the agenda. Governors had also attended a number of walkabouts with Non Executive Directors.

Following the Council of Governors meeting held in public, a private meeting was held. The Council of Governors approved the extension to the External Audit contract, and a further term of office for Non Executive Director, Mrs Pam Williams, which will commence 1st March 2025.

3.2 Council of Governors Workshops

A workshop was held on 17th October 2024 focusing on the role of the Council of Governors, and exploring opportunities to enhance how we support Governors to fulfil their roles. An action plan was developed and progress will be monitored through the Council of Governors meetings.

A further workshop to engage on the Trust Strategy was held on 12th December 2024.

The next workshop on the role of Non Executive Directors is planned for 20th March 2025.

4. RECOMMENDATIONS

The Board of Directors is asked to note the report and the activity during this period.

PUBLIC - Board of Directors
28th January 2025

Report	**Agenda Item 23.**	**Freedom to Speak Up Vision and Strategy 2025-28**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Cathy Chadwick			Chief Operating Officer				
Author(s)	Helen Ellis			Freedom to Speak Up Guardian				
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**	The impact on the relevant BAF risks is that the Freedom to Speak Up (FTSU) Vision and Strategy offers a supportive framework to 'speak up' about issues in the workplace. This will contribute to the Trust's work to improve culture, morale and provide learning on how the trust can improve services.			
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	Executive Directors Group – 13th November 2024							
Executive summary	The purpose of this report is to seek approval for the revised and updated Freedom to Speak Up Vision and Strategy an action plan that supports the delivery of the strategy. This identifies three key aims that support a culture whereby colleagues feel able to speak up, leaders are responsive and act on the concerns raised, and that learning is shared to improve patient safety and staff experience. A new Standard Operating Procedure: 'Raising Concerns' is included in the report at appendix 1. This is based on best practice and supports a consistent approach across the organisation, regardless of who or to whom the concern is raised.							
Recommendations	The Board of Directors is asked to consider the contents of the refreshed Strategy, the action plan and the updates to the Freedom to Speak Up reporting Standard Operating Procedure. The Board of Directors is asked for agreement to use the documents to assist moving the service forward.							

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC – Well Led
Risk	The impact on the relevant BAF risks is that the Freedom to Speak Up (FTSU) Vision and Strategy offers a supportive framework to 'speak up' about issues in the workplace. This will contribute to the Trust's work to improve culture, morale and provide learning on how the trust can improve services.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

FTSU Vision and Strategy Update

1. Introduction

The Trust FTSU Guardian and FTSU Executive lead have reviewed the current FTSU vision and strategy as an update was due in 2025. In addition to this review a new action plan (appendix 1) has been produced to ensure delivery of the new vision and strategy.

The new Standard Operating Procedure (SOP), to support colleagues to raise concerns (appendix 2) also supports our aims with the FTSU strategy

2. Background

The current vision and strategy for FTSU is now out of date and this report contains the new vision and strategy for the service for the next three years.

3. Purpose

The purpose of this report is to ensure the Board of Directors are fully aware and agreeable to the revised vision and strategy which covers the service for the next three years.

4. Freedom to Speak Up Vision and Strategy 2025-2028

The concept of Freedom to Speak Up was derived from a review undertaken by Sir Robert Francis, which concluded in February 2015. The aim of the review was to assess the processes, mechanisms and cultures in place regarding speaking up across the NHS: this identified five key themes for improvement:

- Culture change
- Improved handling of cases
- Measures to support good practice
- Measures to support vulnerable groups
- Extending legal powers

These were underpinned with twenty identified principles and subsequent recommendations for all NHS organisations. This included the mandate for all NHS Trusts to have an appointed Freedom to Speak Up Guardian with the aim of promoting a consistent approach across the NHS and ensures that staff are encouraged and supported to raise concerns, free from detriment.

As part of the Care Quality Commission (CQC) inspection framework for the ‘Well Led’ domain every NHS Trust is assessed in relation to its ‘Speaking up Culture’, under Key Line of Enquiry (KLOE 3). It examines the leadership, management and governance that assure the delivery of high quality and person-centred care, supports learning and innovation and promotes an open and fair culture.

Our vision is to ensure that raising concerns becomes business as usual within the Trust, with staff feeling able to raise concerns and being confident that concerns will be addressed appropriately whilst always keeping the patient at the centre of everything we do. Equally we want to learn from our mistakes and promote a culture of openness and transparency that ensures the positive experiences of patients and staff.

This document should be read in conjunction with the Trusts Freedom to Speak Up policy which can be accessed through the Trusts intranet site.

5. Our Values

The Trusts values of **Safe**, **Kind** and **Effective** are linked to the ethos of Freedom to Speak Up – creating a culture of continuous improvement, delivering high quality care and services for patients and ensuring that staff experiences are positive. We are committed to promoting an open and transparent culture across the organisation to ensure that all staff feel safe and confident to speak up.

6. Current Context: What We Know

The NHS staff survey provides an important indication on whether staff understood how to raise concerns, feel able to do so and feel that concerns are taken seriously. It is recognised that this is not a perfect indicator for Freedom to Speak Up as the staff survey questions include raising concerns through other mechanisms including speaking to managers and incident reporting.

The 2023 Trust NHS staff survey results indicate that only 50.82% of staff would feel safe to speak up about anything that concerned them (national average 60.89%) and with only 35% believing that these concerns would be addressed (national average 48.65%).
This demonstrates that actions are needed to improve both the confidence of staff to raise concerns and the actions taken when concerns are raised.

This strategy will require flexibility in its delivery in order to respond to both national and local drivers during its period prior to review.

7. Our Strategy: Our Aims

To create a culture where all staff feel safe to raise concerns

We will:

- Ensure all staff are aware of Freedom to Speak Up and the Trusts Guardian
- Encourage Speaking Up and thank and support those that do
- Challenge poor behaviour when these do not align with our vision and values
- Actively encourage an open and transparent learning culture in all that we do
- Self-assess as a Board to reflect on our commitment to speaking up and identify any required improvements

Enable leaders to be responsive to concerns and act on these promptly and in the right way.

We will:

- Work to embed the vision, values and behavioural expectations across the leadership team
- Strengthen training opportunities in order to further develop leadership skills
- Work collaboratively with colleagues across all departments to resolve concerns
- Create the appropriate structures for concerns to be managed and escalated including regular meetings between Guardian and Executive Lead connecting the Board to the frontline
- Continue to ensure that all staff have access to the Freedom to Speak Up Guardian
- Monitor the concerns raised at senior management level and the progress made on these to ensure they are addressed promptly
- Share learning from these concerns to demonstrate our responsiveness and the actions taken to make positive change

Recognition of colleagues who speak up and sharing the learning to improve patient safety and staff experience.

We will:

- Actively share and celebrate improvements made as a result of speaking up
- Report nationally on our concerns raised and benchmark against other trusts so that learning can be shared.
- Share results from the feedback received from those that have accessed the Freedom to Speak Up Guardian/process
- Support all of those involved in raising a concern
- Measure our success using feedback mechanisms such as the NHS Staff Survey to assess improvements in raising concerns.

8. Monitoring

The Board will be appraised twice yearly of the Freedom to Speak Up activity, with updates provided at People and Organisation Development Committee twice a year as a minimum and annually to the Audit Committee. This will be built into cycles of business with each providing feedback to the Guardian and Executive Lead on quality and content of the reports.
The reports will include:

1. An overview of the cases reported and the themes identified.
2. Evidence that data has been triangulated with other key cultural, workforce and quality metrics within the Trust.
3. Bench marking data to evidence how the Trust compares to other trusts nationally.
4. An overview of how the strategic outcomes are being achieved, including risks in respect of achievements.

In addition, reports produced by the National Guardians Office will be shared with the Board as appropriate.

9. Reviews

This strategy will be reviewed as an ongoing activity in order to ensure it is aligned to the overarching Corporate Strategy of the Trust.

10. Recommendations

The Board of Directors is asked to consider the contents of the refreshed Strategy, the action plan and the updates to the Freedom to Speak Up reporting Standard Operating Procedure.

The Board of Directors is asked for agreement to use the documents to assist moving the service forward.

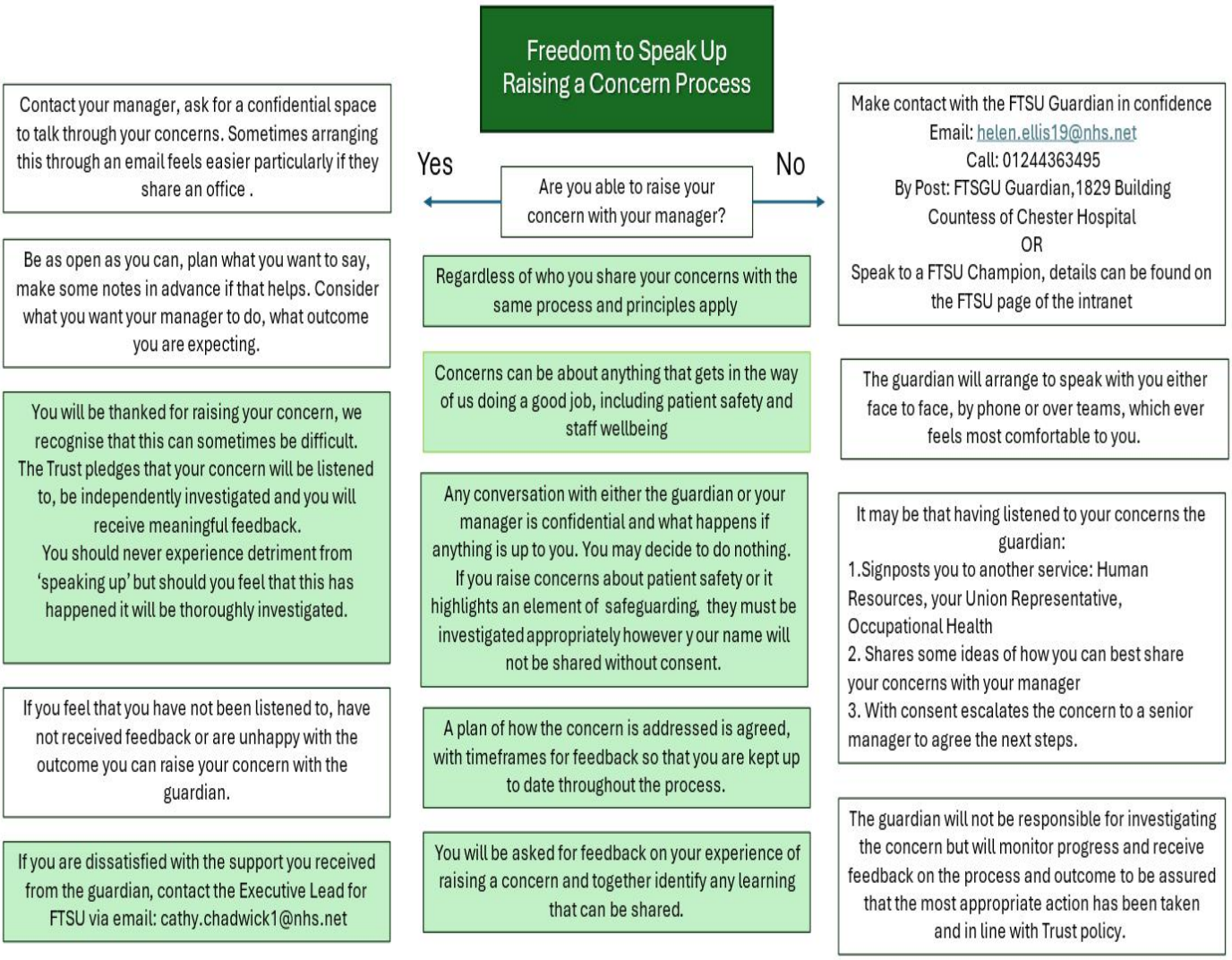
Appendix 1

Freedom to Speak Up: Action Plan: 2025

FTSU Ethos - Preventing Barriers to Speaking Up		
Action	BRAG status	Owner
Promote FTSU as an 'ethos' as opposed to a 'process' and align to the Trust Civility Charter		All Leaders
Raise awareness and profile of FTSU/Guardian and Champions through regular all staff communication		Guardian/ Comms Team
Increase staff engagement through induction sessions/listening groups/team meetings		Guardian/All managers/Education Lead
Maintain a relevant and up to date FTSU Intranet page for all staff		Guardian
Adoption of a FTSU policy that is in line with national recommendations		Guardian/Trust Board
Link FTSU with ED&I to remove barriers to speaking up for vulnerable groups	June 2025	Guardian/EDI Lead
Develop a standard process for responding to concerns raised including meaningful feedback	Feb 2025	Guardian
Promote a proactive rather than a reactive culture to speaking up		All Leaders
Mandate 'speak up' and 'listen up' e-learning for all staff with compliance of 90% as a minimum	May 2025	Guardian/Trust Board
Mandate 'follow up' e-learning for all members of the Trust Board with 100% compliance	May 2025	Guardian/Trust Board
Celebrate FTSU month through increased visual activities across the Trust		Guardian/Comms Team/All Leaders
Develop a network of trained and effective champions that reflects the workforce community		Guardian
Contribute to the boarder work that promotes a 'just culture'		Guardian/All Leaders/Trust Board
Leadership		
Action	BRAG status	Owner
Identify Executive and Non-Executive lead for FTSU		CEO/Trust Chair
Undertake a bi-annual FTSU Board Review		Trust Board
Develop and implement action plan and its recommendations based on outcome of the FTSU Board Review		Exec-Non-Exec FTSU Lead
Present FTSU Board Report twice yearly as a minimum		Guardian
Present FTSU People and Organisation Development (POD) Committee Report twice yearly as a minimum		Guardian
Review progress of FTSU Action Plan quarterly and update POD twice yearly		Guardian/Exec/Non-Exec FTSU Leads
Present FTSU Report to Audit Committee annually		Guardian

Training for Leaders on how to conduct facilitated conversations	Oct 2025	Chief People Officer
Review grievance /investigation processes to promote speaking up and limit opportunities for detriment	Oct 2025	Chief People Officer
Promote Compassionate Leadership		Chief People Officer
Adoption of zero tolerance to poor behaviours /bullying across all areas		All Leaders
Promotion of Trust Values/Civility Charter through role modelling		All Leaders
Development of a module for inclusion in Leadership Training on Speaking Up	Mar 2025	Guardian/ Education Lead
Learning and Improvement		
Action	BRAG status	Owner
Collect data on all FTSU concerns raised in line with national guidance		Guardian
Identify common themes and trends from FTSU concerns		Guardian/Exec/Non-Exec FTSU Leads
Share FTSU data that supports wider data triangulation Trust wide		Guardian
Develop mechanisms for responding to national and local staff surveys that explore speaking up	June 2025	Chief People Officer/Trust Board
Seek feedback from colleagues who speak up about their experiences to ensure best practice		Guardian

Appendix 2


Freedom to Speak Up
Raising a Concern Process
Are you able to raise your concern with your manager?
Yes
No
Contact your manager, ask for a confidential space to talk through your concerns. Sometimes arranging this through an email feels easier particularly if they share an office .
Be as open as you can, plan what you want to say, make some notes in advance if that helps. Consider what you want your manager to do, what outcome you are expecting.
You will be thanked for raising your concern, we recognise that this can sometimes be difficult. The Trust pledges that your concern will be listened to, be independently investigated and you will receive meaningful feedback.
You should never experience detriment from 'speaking up' but should you feel that this has happened it will be thoroughly investigated.
If you feel that you have not been listened to, have not received feedback or are unhappy with the outcome you can raise your concern with the guardian.
If you are dissatisfied with the support you received from the guardian, contact the Executive Lead for FTSU via email: cathy.chadwick1@nhs.net
Regardless of who you share your concerns with the same process and principles apply
Concerns can be about anything that gets in the way of us doing a good job, including patient safety and staff wellbeing
Any conversation with either the guardian or your manager is confidential and what happens if anything is up to you. You may decide to do nothing. If you raise concerns about patient safety or it highlights an element of safeguarding, they must be investigated appropriately however y our name will not be shared without consent.
A plan of how the concern is addressed is agreed, with timeframes for feedback so that you are kept up to date throughout the process.
You will be asked for feedback on your experience of raising a concern and together identify any learning that can be shared.
Make contact with the FTSU Guardian in confidence
Email: helen.ellis19@nhs.net
Call: 01244363495
By Post: FTSGU Guardian,1829 Building
Countess of Chester Hospital
OR
Speak to a FTSU Champion, details can be found on the FTSU page of the intranet
The guardian will arrange to speak with you either face to face, by phone or over teams, which ever feels most comfortable to you.
It may be that having listened to your concerns the guardian:
1.Signposts you to another service: Human Resources, your Union Representative, Occupational Health
2. Shares some ideas of how you can best share your concerns with your manager
3. With consent escalates the concern to a senior manager to agree the next steps.
The guardian will not be responsible for investigating the concern but will monitor progress and receive feedback on the process and outcome to be assured that the most appropriate action has been taken and in line with Trust policy.