NHS
Countess of Chester Hospital
NHS Foundation Trust

Public meeting of the Board of Directors Agenda
(published items)
Tuesday 25th March 2025, 8.30 – 13.00
Boardroom, 1829 Building

Chair	Mr N Large, Interim Trust Chair
Apologies	
In attendance	Ms N Macdonald, Director of Midwifery (Item 11), Ms H Ellis, FTSU Guardian (Item 13) and Ms K Adams, Director of Pharmacy and Medicines Optimisation/Controlled Drugs Accountable Officer (Item 15)

Time	Agenda No.	Agenda item	Lead	Page No.	Decision Required
8.30	1.	Welcome, apologies and Chair's opening remarks (verbal)	Interim Trust Chair		For noting
8.33	2.	Declarations of Conflicts of Interest with agenda items (verbal)	Interim Trust Chair		For noting
8.35	3.	Service Showcase (to be presented on the day)			
9.05	4.	Patient Story (to be presented on the day)			
9.25	5.	Minutes of the previous meeting held on 28th January 2025 (attached)	Interim Trust Chair	5 - 20	For approval
9.30	6.	To consider any matters arising and action log (attached)	Interim Trust Chair	21 - 25	For noting
9.35	7.	Chief Executive Officer's Report (attached)	Chief Executive Officer	26 - 36	For noting
9.45	8.	Chairs Update (verbal)	Interim Trust Chair		For noting
9.55	9.	a) Board Assurance Framework – Quarter 4 2024/25 (attached)	Director of Governance Risk & Improvement	37 - 56	For assurance & decision
		b) High Risks Report – February 2025 (attached)	Director of Governance, Risk & Improvement	57 - 67	For noting
Quality of Care					
10.05	10.	Quarterly Report on Safe Working Hours (attached)	Medical Director	68 - 81	For noting
10.15	11.	Maternity Services Quarterly Update – Quarter 3 (attached)	Director of Midwifery	82 - 132	For assurance
Comfort Break (10.25 – 10.40)					
10.40	12.	Care Quality Commission (CQC) Improvement Journey (attached)	Director of Nursing & Quality /	133 - 156	For assurance

			Deputy Chief Executive		
10.50	13.	Freedom to Speak Up Update Report (attached)	Chief Operating Officer / FTSU Guardian	157 - 165	For assurance & noting
11.00	14.	Quality & Safety Committee Chair's Report – 6th March 2025 (attached)	Non-Executive Director	166 - 167	For assurance
11.05	15.	Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2025 (attached)	Director of Pharmacy and Medicines Optimisation/ Controlled Drugs Accountable Officer	168 - 174	For ratification
Operational Performance					
11.15	16.	System Oversight Framework (SOF) – February 2025 (attached separately) Operational Performance Quality Safety Finance People	 Chief Operating Officer Director of Nursing & Quality Medical Director Chief Finance Officer Acting Chief People Officer		For assurance
11.45	17.	Operational Management Board Chair's Report – 27th February 2025 (attached)	Chief Executive Officer	175 - 176	For assurance
Finance, Use of Resource and Performance					
11.50	18.	Audit Committee Chair's Report – 13th February 2025 (attached)	Non-Executive Director	177 - 178	For assurance

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11.55	19.	Finance & Performance Committee Chair's – 7th March 2025 (attached)	Non-Executive Director	179	For assurance
Strategic Change					
12.00	20.*	NHS Green Plan Guidance Update (attached)	Director of Strategic Partnerships	180 - 181	For noting
Leadership, Improvement Capability, Organisation Development and People					
12.03	21.	People Committee Chair's Report – 11th February 2025 (attached)	Non-Executive Director	182	For assurance
12.08	22.	Standing Financial Instructions (SFIs) Review 2025 (attached)	Chief Finance Officer	183 - 184	For ratification
12.18	23.*	Gender Pay Gap Report (attached)	Acting Chief People Officer	185 - 191	For assurance & noting
12.20	24.	NHS Staff Survey 2024 – Results and High-Level Actions (attached)	Acting Chief People Officer	192 - 199	For assurance & noting
12.30	25.*	Equality Delivery System (EDS) Assessment Report 2024/25 (attached)	Acting Chief People Officer	200 - 210	For assurance & noting
12.33	26.*	Council of Governors Summary Report (attached)	Director of Governance, Risk, and Improvement	211 - 212	For noting
Governance					
12.35	27.*	Code of Governance Compliance 2024/25 (attached)	Director of Governance, Risk, and Improvement	213 - 216	For assurance & noting
12.38	28.*	Provider Licence Compliance 2024/25 (attached)	Director of Governance, Risk, and Improvement	217 - 220	For assurance & noting
12.40	29.	Use of Trust Seal: Renewal of Lease for Tarporley War Memorial Hospital and Countess of Chester Hospital (attached)	Director of Governance, Risk & Improvement	221 - 222	For decision
Items for noting					
14.43	30.*	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 9th January 2025 (attached) b) Approved minutes of the People Committee – 10th December 2024 (attached)	Interim Trust Chair		For noting

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		c) Approved minutes of the Finance & Performance Committee – 21st January 2025 (attached) d) Approved minutes of the Operational Management Board – 28th November 2024 and 23rd January 2025 (attached) e) Approved minutes of the Audit Committee – 15th October 2024 (attached) **Other items:** f) Board of Directors Workplan 2024/25 (attached)			
Other items					
12.45	31.	Any Other Business (verbal)	Interim Trust Chair		For noting
12.50	32.	Questions from Governors and members of the Public relating to items on the meeting agenda - ***Questions to be submitted in writing in advance of the meeting to:*** coch.membershipenquiriescoch@nhs.net ***by Thursday 20th March 2025*** **Future Dates:** 20th May 2025 29th July 2025 30th September 2025 25th November 2025 27th January 2026 31st March 2026	Interim Trust Chair		For noting
13.00	33.	Closing remarks (verbal)	Interim Trust Chair		For noting

Next Meeting: Tuesday 20th May 2025

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

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MINUTES OF THE PUBLIC BOARD OF DIRECTORS

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

Members	04/06/24	30/07/24	24/09/24	26/11/24	28/01/25	
Trust Chair, Mr I Haythornthwaite	☑	☑	☑	☑	☑	
Chief Executive Officer, Ms J Tomkinson OBE	☑	☑	☑	☑	☑	
Non-Executive Director, Mr D Williamson	☑	☑	☑	☑	☑	
Non-Executive Director, Mr P Jones	☒	☑	☑	☑	☑	
Non-Executive Director, Mr M Guymer	☑	☑	☑	☑	☑	
Non-Executive Director, Mrs P Williams	☑	☑	☑	☑	☑	
Non-Executive Director, Professor A Hassell	☑	☑	☑	☑	☑	
Non-Executive Director, Mrs W Williams	☑	☑	☑	☑	☑	
Non-Executive Director, Mrs S Corcoran	☒	☑	☑	☑	☑	
Chief Operating Officer, Ms C Chadwick	☑	☑	☑	☑	☑	
Medical Director, Dr N Scawn	☑	☑	☑	☑	☑	
Director of Nursing & Quality/Deputy Chief Executive , Ms S Pemberton	☑	☑	☑	☑	☑	
Director of Strategic Partnerships, Mr J Develing	☑	☑	☒	☑	☑	
Chief Digital & Data Officer, Mr J Bradley	☒	☑	☑	☑	☑	
Interim Chief People Officer, Mrs D Herring	☒	☑	☑	☑	N/A	
Chief Finance Officer, Mrs K Edge	☑	☑	☑	☑	☑	

Director of Governance, Risk & Improvement, Mrs K Wheatcroft	☑	☑	☑	☑	☑	
Acting Chief People Officer , Ms V Wilson	N/A	N/A	N/A	N/A	☑	
In attendance	**04/06/24**	**30/07/24**	**24/09/24**	**26/11/24**	**28/01/25**	
Deputy Director of Governance & Risk, Mrs L Leadsom *(Minutes)*	☑	☑	☑	☑	N/A	
Senior Project Administrator , Mrs R Butterworth *(Minutes)*	N/A	N/A	N/A	N/A	☑	
Director of Midwifery, Ms N Macdonald	☑	☑ (items 6b & 10)	☑ (item 10)	☑ (item 10)	☑ (item 10)	
Development Non-Executive Director, Mr M Smith	☒	☑	☒	N/A	NA	
Development Non-Executive Director, Mrs L Liang	☒	☑	☑	☑	☑	
Business Performance Manager - Diagnostics and Clinical Support Services Division, Ms. EJ Punter,	N/A	N/A	N/A	☑ (item 3)	N/A	
Specialist Neurological Occupational Therapist, Ms K Cottrell	N/A	N/A	N/A	☑ (item 7)	N/A	
Associate Director of Nursing – Corporate, Mrs S Edwards	N/A	N/A	N/A	☑ (item 11)	N/A	
Head of Nursing – Urgent & Emergency Care, Mrs E Maxwell	N/A	N/A	N/A	☑ (item 11)	N/A	
Associate Medical Director – Women's and Children's, Dr S Brigham	N/A	N/A	N/A	N/A	☑ (item 10)	
Diabetes Team Lead - Dr S Williams	N/A	N/A	N/A	N/A	☑ (item 3)	
LMNS SRO, Ms C McClennan via Microsoft Teams.	N/A	N/A	N/A	N/A	☑ (item 11)	
Qi & Safety Lead LMNS, Ms D Gould via Microsoft Teams.	N/A	N/A	N/A	N/A	☑ (item 11)	
Freedom to Speak up Guardian, Mrs H Ellis	N/A	N/A	N/A	N/A	☑ (item 23)	

Formal Business		
Agenda Item Number	Item	Lead
PB1/ 01/25	**Welcome, apologies and Chair's opening remarks** The Trust Chair, Mr Ian Haythornthwaite, welcomed members to the meeting.	
PB2/ 01/25	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest raised in relation to agenda items.	
PB3/ 01/25	**Service Showcase – Diabetes Services** The Diabetes Services team led by Dr S Williams attended the meeting to give a presentation to the Board of Directors on the Trusts Insulin Pump service. The presentation covered information about the service, how it compares to other Trusts in the region and patient feedback for the Service. The team also shared their vision of how the service could grow. Non-Executive Director, Prof A Hassell thanked the team remarking that it was a fantastic service and asked how the team got so good at providing this service. The team advised that Chester always had a good pump service and that the service just needed to have a more streamlined approach and sourcing experts in the insulin pumps to improve the service further adding that they are always looking for ways to improve. The Chief Executive Officer, Ms J Tomkinson asked if there are robust plans to extend the numbers. The Team advised that currently there is reliance on good will in the team and highlighted some of the barriers to growth. The team added that they had applied for funding for an administrative post, but this had not been approved. Non-Executive Director, Mrs P Williams asked if they had been told the reason why the funding had not been approved, but the team did not know. **ACTION:** Chief Operating Officer, Ms C Chadwick said she would pick the business case up with the team. The Medical Director, Dr N Scawn advised the Board that the Trust had just appointed a well-established endocrine specialist who would work alongside Consultant Endocrinologist, Prof F Joseph. The Director of Strategic Partnerships, Mr J Develing advised the team that the Trust was running at cardiometabolic disease programme and asked if the Team would participate. **ACTION:** It was agreed for Mr J Develing to share details regarding the Cardiometabolic Disease Programme outside of the meeting Mr I Haythornthwaite thanked the team for attending.	**CC** **JD**
PB4/ 01/25	**Patient/Staff Story**	

	The Director of Nursing & Quality/Deputy Chief Executive, Mrs S Pemberton introduced the patient story which was a video previously shared at the Quality and Safety Committee. The video told the story of a patient and her twin sister who were born prematurely and their story of the medical interventions they have received since a young age and the Play Assistant supporting them to overcome any fears or anxieties with interventions undertaken. The Trust Chair, Mr I Haythornthwaite thanked Mrs Sue Pemberton for sharing and asked her to pass on the Board of Directors thanks to the team and the patient's family for allowing the story to be shared.	
PB5/ 01/25	**Minutes of the previous meeting held on the 26th November 2024** The minutes of the previous meeting held on the 26th November 2024 were formally **approved** as a true and accurate record. This was subject to a request for changes to the maternity section by the Director of Nursing & Quality/Deputy Chief Executive, Mrs S Pemberton. **ACTION:** It was agreed for Mrs S Pemberton to pick these up outside of the meeting with the Director of Governance, Risk & Improvement, Mrs K Wheatcroft.	**SP/ KW**
PB6/ 01/25	**To consider any matters arising and action log** **Action 41 – Safeguarding and Complex Care Training compliance for medical staff Update** The Medical Director, Dr N Scawn updated the Board of Directors with the latest performance adding that there had been an increase in training through December 2024 and the score had increased to 73% for adult training and 78% for children's training. Dr N Scawn added that there are more doctors booked on to the training throughout January. He also brought to the Board of Director's attention the Trust being in OPEL 4 all but one day so far in January 2025 and therefore all training was stepped down as per the process in OPEL 4. Dr N Scawn advised the Board that the projected figures are 80% for children's training and 78% for adults training. **Action 30** – Update provided within the action log and the Deputy Director of Nursing & Quality, Governance, Ms F Altintas is reviewing the benchmarking data, action to remain open. **Item 42** – There is a paragraph in Chief Executive Officer's Report as an update, action to remain open.	
PB7/ 01/25	**Chief Executive Officer's Report** The Chief Executive Officer, Ms J Tomkinson highlighted the following from the Chief Executive Officer's Report: • Cheshire West Health and Care Partnership reset, Ms J Tomkinson advised that she and the Director of Strategic Partnerships, Mr J Develing both attended the meeting and noted the closely aligned objectives for next year.	

	• Urgent and Emergency Care patient survey results. Noting that the scores have improved and some of the scores were the highest in the region but added there is still work to be done in the Trusts Urgent and Emergency care services. • Trauma Unit accreditation, confirming position as a key provider in the region. • Innovating and developing new services based on patient experience, Ms J Tomkinson highlighted that the Trust is one of the first in the region to launch a new heart failure virtual ward. • A Member of Parliament (MP) engagement visit took place with Justin Madders, MP for Ellesmere Port and Bromborough, and Aphra Brandreth MP for Chester South and Eddisbury. Mark Tami, MP for Alyn, and Deeside had been unable to attend. Sam Dixon, MP for Chester North, and Neston had visited the Trust in December 2024. • The Thirlwall Inquiry oral hearings have finished, and the closing statements are being drawn up. The Trust has collected learning from the hearings that will continue to be shared. • Duty of Candour and Manager regulation consultations are live. Ms J Tomkinson advised that this has been shared with the Executive Directors and the Trust Chair, Mr I Haythornthwaite confirmed that this had been circulated to Non-Executive Directors. The Cheshire and Merseyside Acute and Specialist Trust (CMAST) provider collaborative were planning on submitting a collective response on behalf of Trusts. • Executive Team update, Ms J Tomkinson welcomed the Acting Chief People Officer, Mrs V Wilson to her first Board of Directors meeting in her role, and also confirmed Director of Nursing & Quality/Deputy Chief Executive, Mrs S Pemberton had taken up the Executive role as Children's Champion. The Board **noted** the contents of the Report.	
PB8/ 01/25	**<u>Chairs Update</u>** The Trust Chair, Mr I Haythornthwaite recognised the significant effort from the Emergency Department and wider areas of the Trust following the burst pipe in the Emergency Department. The feedback has been that the evacuation was coordinated in a calm manner, and the Trust was able to step up services quickly overnight. Mr I Haythornthwaite clarified to the Non-Executive Directors the process for feedback on the ward walkarounds, confirming that if there are issues that arise on the walk arounds , they should take up with the Executive Director responsible for that area. If there are still concerns, then this should be raised with Mr I Haythornthwaite so that it can be brought back to the Board with time scheduled to discuss the issue.	
PB9/ 01/25	**a) <u>Board Assurance Framework – Quarter 3 2024/25</u>**	

	The Director of Governance, Risk & Improvement, Mrs K Wheatcroft advised the Board that the BAF for Quarter 3 has been through a full review by the Executive Team. Mrs K Wheatcroft advised that the risks remain at the same level as the Quarter 2 update reminding the Board that the risks are strategic risks and that the actions are going to take time to be fully implemented and for the impact of the actions to be seen. The paper also provided a progress update against strategic objectives. The Board of Directors: • **approved** the updates to the Board Assurance Framework at Quarter 3. • **noted** the progress in delivering the 2024/25 strategic objectives **b) <u>High Risks Report – January 2025</u>** The Director of Governance, Risk & Improvement, Mrs K Wheatcroft gave an overview of the high risks report and confirmed the risk management improvement plan is progressing to strengthen risk management across the Trust. Non-Executive Director, Mr Paul Jones commented on the improvement in the report and referred back to a discussion from the Finance and Performance Committee requesting a column to track mitigation timeframes, Mrs K Wheatcroft recognised the importance of this and advised that there is a lot of work within the Datix system needed before this can be done easily. Non-Executive Director, Mr M Guymer asked if there was a plan to educate colleagues on how to reduce scores given the medical photography and mortuary freezer risks that were appearing on the high risk report and that there should be a fix found for these. A discussion took place around the Trust having confidence that systems are in place and the need for education on scoring risks and putting fixes in place where required following comments from Non-Executive Director, Mrs S Corcoran, and Mr M Guymer Following a question from Mr P Jones around whether limited assurance could be taken from the report, a discussion took place around assurance with Mr M Guymer adding that he takes assurance that it is showing that the organisation is getting better, and the report shows positive messages The Trust Chair, Mr I Haythornthwaite thanked the Board for the interesting discussion around the report and raised the need for the Executive team to note the issues that have arisen around balancing operational risks and resources. The Board of Directors **considered** the current high-level risks and continue to work on local risk registers to ensure these reflect the organisation's risk profile.	
PB10/ 01/25	**<u>Maternity Survey 2024: Management Report January 2024</u>**	

	The Director of Midwifery, Ms. N McDonald and the Associate Medical Director for Women's and Children's, Dr S Brigham, joined the meeting for this item. Ms N McDonald updated the Board on the highlights of Maternity Survey Results including positive feedback and areas for improvement and noted where the Trust ranked twenty out of fifty six Trusts which is a significant improvement from thirty eighth back in 2022 and twenty six in 2023. Ms N McDonald told the Board that many of the areas for improvement will be addressed when the department moves over to the new building. The Medical Director, Dr N Scawn, asked if the single rooms would result in a requirement for extra staff. Ms N McDonald confirmed that the department would change some ways of working and following benchmarking with other Trusts on how to operate it would need around one extra Heath Care Assistant. Non-Executive Director, Prof A Hassell asked for clarification on one of the negatives around partners being able to stay. Ms N McDonald explained the current process on the ward for partners and the issues with space and privacy which prevented partners from being able to stay on the ward in the current building during the night, however assured the Board that this would be addressed in the new building with single rooms and pull down beds. Non-Executive Director, Mrs P Williams asked for further information on another area of improvement around medical history and whether this is exposing the Trust to any risks in service delivery. Dr S Brigham advised the Board that there was an education piece in place with the teams around how to ask questions and rather than asking open questions, speaking to patients with the facts from the medical record. The Board of Directors **noted** the results and ongoing work to progress the action plan, which will continue to be monitored by the Patient Experience Oversight Group.	
PB11/ 01/25	**<u>Maternity Incentive Scheme Year 6 Compliance and Assurance Report</u>** The Director of Midwifery, Ms N McDonald and the Associate Medical Director for Women's and Children's, Dr S Brigham, were joined by external stakeholders Ms C McClennan (LMNS SRO) and Ms D Gould (Qi & Safety Lead LMNS) who joined via MS teams. Ms N McDonald led the presentation to the Board and explained that a meeting had already taken place with the Director of Nursing & Quality/Deputy Chief Executive, Ms S Pemberton and Non-Executive Director, Mrs S Corcoran as safety champions to thoroughly review the report. Ms S Pemberton and Mrs S Corcoran provided assurance to the Board by confirming that all of the standards had been reviewed and evidence seen in both paperwork and in practice as visible during walk arounds.	

	Ms N McDonald brought safety action 10 to the Boards attention as previous reports did not show all the requirements has having been met as good governance. Ms C McClellan advised the Board that there has been an extraordinary Local Maternity & Neonatal System (LMNS) board on 27th Jan and therefore the minutes from this Board will be provided for evidence of sign off and thanked and recognised the team effort. Non-Executive Director, Prof A Hassell raised a point about how the Lavendar midwife was the bereavement midwife and how it referred to as the bereavement midwife in the letter to bereaved parents and this may cause some confusion, this was accepted by the team and would be reviewed. The Chief Executive Officer, Ms J Tomkinson queried the correlation between this and exiting the maternity safety surveillance program. Ms N McDonald advised that this is a completely separate scheme and noted that the department has been asked to share some of the best practice with the national team. The Trust Chair, Mr I Haythornthwaite thanked the team for attending and providing the update. The Board of Directors: • **Approved** the final compliance position for MIS Year 6. • **Authorised** the CEO to sign the Board Declaration Form for submission to NHS Resolution. • **Noted** the importance of sustained efforts to maintain the MIS standards.	
PB12/ 01/25	**<u>Safety Surveillance and Learning Report – Quarter 3</u>** The Director of Nursing & Quality/Deputy Chief Executive, Ms S Pemberton advised the Board that this is the Quarter 3 report. Ms S Pemberton highlighted the following from the Safety Surveillance and Learning Report – Quarter 3: • The increase in moderate incidents detailed in the report is down to the Trust now accurately recording all incidents that present with pressure ulcers, and that in cases where the Trust had not caused these the Trust are working with partners on how to prevent them. It was also noted that a report has been received from Cheshire West which indicated that there was some duplication in the numbers, and this is also reflected in the report. • The Patient Safety Incident Investigations (PSIIs) and how they are monitored weekly through the oversight group. The Integrated Care Board are invited to attend the Patient Oversight Group. • The breakdown of incidents by harm. • Learning which has taken place to ensure incidents are reported and classified correctly along with where duty of candour process needs to be done. • It was noted that in November 2024 there were no catastrophic incidents but that the Trust had two in December 2024, both of which have been reported through the relevant channels and investigations are under way.	

	• Violence and aggression incidents are being reviewed and it is shown that 70% of incidents are related to patients with limited capacity and the safeguarding team are involved in the process. • A thematic review has taken place of complaints and concerns by division and assurance reviews carried out with departments as required. • The Emergency Department is being supported by a secondment post for clinical leadership. To strengthen quality and safety there is now a weekly meeting with the team. • Work is being done by the Deputy Director of Nursing & Quality, Governance, and the Deputy Medical Director to strengthen the Learning from Deaths Group. • The improvement in the process for coroner inquests and working with the legal team, staff support, and report submissions was noted. Non-Executive Director, Mr D Willamson commented that it was a joined-up report but referred to the missing information in table 1 stating that it does not give assurance and asked if there are plans to update. Mrs S Pemberton informed the Board that this is being addressed as part of the education around harm classifications. The reporting will also be updated following the Mersey Internal Audit Agency (MIAA) Patient Safety Incident Response Framework (PSIRF) audit. Non-Executive Director, Ms S Corcoran asked if the figures in the report have been validated. Ms S Pemberton advised that the scores are scrutinised by the Executive Team and governance groups in the harms discussions. The Integrated Care Board (ICB) are in attendance at meetings and have approved the way that the Trust is assessing and grading harm. Following a further question from Mrs S Corcoran around plans within the PSIRF meetings to look at areas which have gone well, a discussion took place about this being done informally and the benefit of having this reported at Board level. A query was raised by Non-Executive Director, Prof Andrew Hassell around the timings of the Committee meetings in relation to the Board meetings and that Mrs S Pemberton had updated that an exercise was underway to review this. The Director of Governance, Risk and Improvement, Ms K Wheatcroft added that the quality and content of this report demonstrates the improvement since the well led peer review 18 months ago and that the Board needed to recognise that the Trust was in an improved and different place from then. The Board of Directors: • **Noted** the contents of the paper. • **Noted** the assurance that the Trust is continuing to promote a learning culture with evident and measurable actions to improve patient safety • **Noted** the improvements in governance and oversight workstreams • **Noted** further improvement workstream regarding Learning from Deaths and Mortality Review.	
PB13/ 01/25	**<u>Care Quality Commission (CQC) Improvement Plan including Well Led</u>**	

	The Director of Nursing & Quality/Deputy Chief Executive, Ms S Pemberton advised the Board the report provided further assurance this month with a number of the actions being closed and drew the Board's attention to the areas that would be transferred to business as usual. Following comments from the Chief Executive Officer, Ms J Tomkinson and Non-Executive Director, Mrs S Corcoran regarding questions raised from the Thirlwall Inquiry, Ms S Pemberton provided assurance to the Board that the learning points were followed up as key lines of enquiry and that there were no points that Ms J Tomkinson raised at the Inquiry that the Trust were not already progressing. Ms J Tomkinson also reminded the Board that the Executive Team was a fairly new team and recognised the growth in such a short period of time. Following a question from Non-Executive Director, Mr D Williamson around health inequalities, the Director of Strategic Partnerships, Mr J Develing advised the Board that a Framework was being established and that further work would need to be completed at a Board of Director's Development Day. The Board of Directors: • **Noted** the assurance on the progress of the consolidated CQC Improvement Plan. • **Noted** that progress against this action plan will continue to be tracked through the Executive Directors Group and reported to the Board of Directors, together with outcomes also being reported going forward.	
PB14/ 01/25	**<u>Clinical Strategy</u>** The Director of Strategic Partnerships, Mr J Develing updated the Board on the engagement events in the form of workshops with clinical leads. Mr J Develing told the Board that the paper detailed the Trust's activities and explained how the Trust wanted to be a health providing hospital as well as an acute hospital and how to the Trust would deliver the strategy to work towards this. Mr J Develing highlighted areas of excellence within the Trust and mentioned the Milk Bank, the Breast Surgery Team, and the Diabetes insulin pump team, all of which had presented to the Board of Directors. Non-Executive Director, Mr M Guymer raised a concern that the paper does not include capital and finance and whether there was a danger that this may not be able to be delivered or achieved. Mr J Develing led a discussion on how the Trust would achieve the strategy by linking in with partnerships in the community and broader patient engagement sessions to achieve this. Following a question around the risks to partnerships from Non-Executive Director, Mrs S Corcoran, Mr J Develing noted that he had feedback from existing partnerships such as Health Watch, but that work needed to be done around the business sector.	

	Non-Executive Director, Mrs W Williams commented that she found the key areas of the strategy and the engagement with clinicians very positive and asked around timescales for achievement. Mr J Develing advised that it was a 5-year strategy and gave more information to the Board on the expected milestones and organisations that the Trust will need to work with. The Medical Director, Dr N Scawn reminded the Board of the increased link with the Chester medical school and how if the Trust can get the primary prevention message in place that students will have this as part of their medical knowledge and training. The Board of Directors **noted** the progress and approach to developing the Clinical Strategy.	
PB15/ 01/25	**<u>Quality & Safety Committee Chair's Report – 9th January 2025</u>** Non-Executive Director, Prof A Hassell advised the Board of the three alerts that were detailed within the Quality & Safety Committee Chair's Report – 9th January 2025: • E-discharge compliance – Prof A Hassell told the Board that while there has been improvement the Trust was at 68% for the 24-hour target. The Medical Director, Dr N Scawn gave an update on information that was available from Cerner which showed correlation between discharge times for patients and non-completion of E-discharge paperwork. There was a discussion following an observation from Non-Executive Director, Mr M Guymer who advised that E-Discharge had also been raised as an alert at the Audit Committee. Dr N Scawn advised the Board that the work is being done on the information in the report would be shared at the next Quality and Safety Committee meeting. There was a discussion held around the protocol of raising alerts the Board of Directors following a point raised by the Trust Chair, Mr I Haythornthwaite around the level of detail shared at the Board meetings. • Escalation beds and pressures impacting on staff absence – Prof A Hassell advised the Board the issue is actively being addressed but will take time. Therefore, the Committee were not yet assured on this issue. • Issues within the Emergency Department – Prof A Hassell highlighted the areas of concern and noted that the Director of Nursing & Quality/Deputy Chief Executive, Ms S Pemberton had already referred to the actions in place earlier in the meeting. Non-Executive Director, Mrs P Williams added that this triangulates with the alert from the Finance and Performance Committee in relation to the Emergency Department. It was noted that currently the Committees do not have assurance on this issue. Non-Executive Director, Prof A Hassell also shared an area of assurance from the Committee, highlighting the impact of the Organ Donation Service, adding that the Committee was assured that it is an area of really good work that enhances the well-being of the patients. The Board of Directors **noted** the Chair's report of the above Committee.	

PB16/ 01/25	**System Oversight Framework – December 2024** Chief Operating Officer, Ms C Chadwick highlighted to the Board the areas identified as positive assurance and others that require improvement. Ms C Chadwick highlighted the following from the System Oversight Framework – December 2024: • Emergency Department performance including patient wait times, ambulance wait times and length of stays within the department. • The Emergency Department re-set exercise in conjunction with external partners and the outcomes from this exercise, adding that the feedback would be available in the coming weeks. • The support from the national team in relation to conversations with Flintshire to expedite discharge for Welsh patients. • A new process of call before convey for ambulances to call before they bring in a patient over sixty five unless it is a resus case advising that in some cases patients arrive by ambulance who did not need to attend the Emergency Department. • Activity included in the report resulting from the Wirral University Teaching Hospital cyber-attack. Following a question from Non-Executive Director, Prof A Hassell, Ms C Chadwick outlined the full process of the call before convey initiative The Director of Nursing & Quality/Deputy Chief Executive, Ms S Pemberton, highlighted the Friends and Family Testing and the actions taken to improve this. The Medical Director, Dr N Scawn also advised that the Mortality overview was on track. Non-Executive Director, Mrs S Corcoran raised a concern that the sepsis data was over six months old, and a discussion was held around the systems used for this and the plans in place for the Trust to produce this data internally. Chief Finance Officer, Mrs K Edge summarised the Trust's Financial performance against plan and shared with the Board that the Thirlwall Inquiry funding had now been confirmed and that the main areas for concern in the Trust was the Capital Improvement Programme slippage but that this was covered in the Private Board papers along with the mitigations that have been put in place. Non-Executive Director, Mr M Guymer expressed concern around the deficit position despite the efforts made and Non-Executive Director, Mr P Jones highlighted areas for improvement and a discussion followed around the plans to address these. Acting Chief People Officer, Ms V Wilson gave a summary of the People and Organisational Development metrics stating the main areas for concern were sickness absence and mandatory training compliance. Following a question from Chief Executive Officer, Ms J Tomkinson, Ms V Wilson also gave an update on the headcount reduction plans.	

	The Board of Directors **considered and noted** the contents of the Report.	
PB17/ 01/25	**Operational Management Board Chair's Report – 28th November 2024** Chief Executive Officer, Ms J Tomkinson advised the Board that the Operational Management Board (OMB) had met the previous week, and along with the November 2024 report the January 2025 Chair's report had also been circulated. The AAA reports highlighted the key areas and advised that there were no alerts to share. For consistency it had been agreed with the Director of Governance, Risk and Improvement, Mrs K Wheatcroft that an OMB AAA report should be produced in the same way as the other Assurance Committees. Trust Chair, Mr I Haythornthwaite thanked Ms J Tomkinson for bringing the report to the Board commenting that is useful to be included. The Board of Directors **noted** the Chair's reports of the Operational Management Board.	
PB18/ 01/25	**Finance & Performance Committee Chair's Report – 21st January 2025** Non-Executive Director, Mrs P Williams advised the Board of the following alerts from the Finance & Performance Committee Chair's Report – 21st January 2025: • Urgent Emergency Care performance which has been discussed previously in the meeting • The Trust Financial position, remains on the report as an alert due to the ongoing challenges and need for assurance There were no questions in relation to the Chair's report. The Board of Directors **noted** the Chair's report of the Finance & Performance Committee.	
PB19/ 01/25	**Research & Innovation Update** The Director of Clinical Research, Mr P Bamford was unable to attend the meeting to present to the Board due to clinical pressures on the day, therefore the Chief Executive Officer, Ms J Tomkinson shared the presentation. Ms J Tomkinson highlighted the Trust's ambition to become a University Teaching Hospital, and the need to work through the criteria needed to achieve this. Non-Executive Director, Prof A Hassell asked if there was potential for a Board seminar, Ms J Tomkinson suggested it could be included in one of the Board of Directors Development Days. The Trust Chair, Mr I Haythornthwaite agreed, adding that it would be useful to include to work on then criteria needed the Trust aspirations. **ACTION:** Criteria to become a University Teaching Hospital to be included on a future Board Strategy day agenda. **a) Research & Innovation Committee Chair's Report – 17th January 2025**	**JT**

	The Board of Directors **noted** the Chair's report of the above Committee.	
PB20/ 01/25	**<u>People Committee Chair's Report – 10th December 2024</u>** Non-Executive Director, Mrs W Williams advised the Board of the following alerts from the People Committee Chair's Report – 10th December 2024: • Band 2/3 update - a discussion took place around the submitted grievance, training plans and cost implications. Non-Executive Director, Mr M Guymer raised a concern that this may pose a significant risk to year end provisions • Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) significant actions required to coordinate activity in the Trust and that it is not moving at the pace we would like it to. • Director of Medical Education Annual Report, the general medical council survey has highlighted areas that need to be improved upon. An integrated action plan is to be shared at the next Committee meeting. Mrs W Williams also drew the Board's attention to the management training programme adding that the focus is kept on this in the Committee meetings. The Board of Directors **noted** the Chair's report of the People Committee.	
PB21/ 01/25	**<u>Annual NHS England Quality Self-Assessment Education Report</u>** This item was for information only and there were no questions relating to it but was noted that Education should be included as part of the enabling strategies work to be considered at the forthcoming Board of Directors Strategy day. The Board of Directors **acknowledged** the achievements recorded within the self-assessment report and considered to the challenges relating to space and facilities within the Education Centre footprint.	
PB22/ 01/25	**<u>Council of Governors Report</u>** Director of Governance, Risk & Improvement, Mrs K Wheatcroft highlighted the key points of the report to the Board and advised that the workshops and engagement continued with the Governors. The Board of Directors **noted** the contents of this report.	
PB23/ 01/25	**<u>Freedom to Speak Up Vision and Strategy 2025-28</u>** Freedom to Speak up (FTSU) Guardian, Mrs H Ellis attended for this item with was presented along with the FTSU Executive Lead and Chief Operating Officer, Ms C Chadwick. Ms C Chadwick introduced the paper explaining that it was as a result of the Trust revisiting the vision and strategy advising the paper also contains an action plan and the procedure for reporting concerns.	

	Mrs H Ellis advised that the team had followed national guidance when reviewing and updating the document. The Director of Nursing & Quality/Deputy Chief Executive, Ms S Pemberton asked if the Trust FTSU policy includes how staff can raise a concern about other members of staff in line with the query from the Thirlwall Inquiry. Mrs H Ellis will check the exact wording of the policy. Discussions took place following questions from a number of the Executives and Non-Executive Directors. • Whether the Chief Executive Officer pledge on Freedom to Speak Up should appear in the strategy. It was agreed this would be added. • Whether the actions raised from the previous peer review were reflected in the strategy. Director of Governance, Risk, and Improvement, Mrs Karan Wheatcroft had completed the peer review prior to joining the Trust and confirmed that these actions had largely been derived in the last twelve months building the foundations of the policy, report, Board self-assessment and increased Champion network. • The need for the Trust to have a clear policy on detriment. This was included in the CEO pledge and FTSU policy and more work was planned as part of the strategy aligned to the National Guardians Office priorities. • The importance of working together in line with other activity which is happening within the Trust. Non-Executive Director, Mr. D Williamson raised concerns of the Clarity of the flowchart as there weren't clear arrows or connections between the boxes. **ACTION:** It was agreed that clear arrows and connections would be added to the raising concerns flowchart. The Board of Directors **approved** 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 **agreed** to use the documents to drive forward the FTSU work.	**HE/ CC**
PB24/ 01/25	**<u>Items for noting and receipt</u>** The Board of Directors noted the following minutes which had been approved by the relevant Committees: a) Approved minutes of the Quality & Safety Committee – 7th November 2024 b) Approved minutes of the People Committee – 8th October 2024 c) Approved minutes of the Finance & Performance Committee – 25th September 2024 d) Approved minutes of the Operational Management Board – 26th September 2024 e) Approved minutes from the Research Executive Meeting – 11th October 2024	

	The Board of Directors noted the following item: f) Board of Directors Workplan 2024/25.	
PB25/ 01/25	**Any other business** The Chief Operating Officer, Ms C Chadwick raised whether the Board wanted to sponsor a duck in the annual duck race as per previous years at a cost of £17 each, and it was agreed that this would be supported personally by the Directors.	
PB26/ 01/25	**Questions from Governors and members of the Public relating to items on the meeting agenda** Trust Chair, Mr I Haythornthwaite explained that no questions had been raised in advance of the meeting and invited questions from those in attendance. No questions were raised.	
PB27/ 01/25	**Closing remarks** The Trust Chair, Mr I Haythornthwaite thanked the Board of Directors, the Governors, and the visitors for attending the meeting.	
	Date & Time of next meeting The next meeting will be held on Tuesday 25th March 2025 (timings to be confirmed).	

Countess of Chester Hospital NHS Foundation Trust

Public Board of Directors Action Log

2024/25 - Updated March 2025

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
30	4th June 2024	Director of Nursing & Quality / Deputy Chief Executive and Director of Governance, Risk & Improvement	PB9/06/24	Integrated Incidents, Complaints, Claims and Inquests Quarter 4 2023/24 - The Trust Chair, Mr I Haythornthwaite, also acknowledged the improvements to date, however, queried how the figures reported compare to other Trusts.	Ms S Pemberton explained that the Trust needs to further understand the data being collated and provided to enable this to be benchmarked against other Trusts, noting this also links to the requirements for the targeted improvement for concerns. It was agreed this reporting would be discussed with the Director of Governance, Risk & Improvement, Mrs K Wheatcroft, for a future report.	**Update 17th September 2024** - This will be reflected within the next quarterly report. **Update 26th November 2024** – Acton agreed to remain open until actions are fully implemented. **Update 20th January 2025** - The deputy director of nursing and governance is exploring if there is any benchmarking data against all the data the trust has. This is proving challenging however we will continue to explore if possible.	Jan-24	**Open**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
						Update 28th January 2025 - Deputy Director of Nursing & Quality, Governance, Ms F Altintas is reviewing the benchmarking data, action to remain open. **Update 12th March 2025** - Work is ongoing to ascertain benchmarking data for numbers of complaints by the Deputy Director of Nursing and Governance.		
41	4th Sept 2024	Medical Director	PB24/ 09/24	Safeguarding and Complex Care Annual Report 2023/24	Training compliance for medical staff remains a challenge The Medical Director, Dr N Scawn, acknowledged this ongoing issue and agreed for this to be discussed further following the meeting.	**Update 19th November 2024 –** The Medical Director has requested the latest compliance figures. **Update 26th November 2024**– Action remains on-going with update to be provided at the January 2025 Board	Jan-25	**Closed**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
						of Directors **Update 20th January 2025** – Dr N Scawn to verbal update at the January 2025 Board of Directors. **Update 28th January 2025** – Dr Scawn updated that training has increased to 73% for adult training and 78% for children's training noting the Trust OPEL 4 position for January 2025 and the step down in training. The projected figures are 80% for children's training and 78% for adults.		
42	26th Nov 2024	Director of Strategic Partnerships	PB7/ 11/24	Chief Executive Officer's (CEO) Report	The Director of Strategic Partnerships, Mr J Develing, is representing the Trust on the reset of a new collaborative and a paper will be provided to a future Board of	**Update 13th March 2025** – updates are being provided through the CEO report.	TBC	**Open**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
					Directors meeting to detail the new governance arrangements.			
44	28th January 2025	Chief Operating Officer / Director of Strategic Partnerships	PB3/ 01/25	Service Showcase – Diabetes Services	Chief Operating Officer, Ms C Chadwick said she would pick the administrative post business case up with the team. Director of Strategic Partnerships, Mr J Develing to share details regarding the Cardiometabolic Disease Programme outside of the meeting	**Update 4th March 2025** – Ms C Chadwick to meet with the Diabetes team on the 5th March 2025. **Update 17th March 2025** – Mr J Develing and Ms C Chadwick met with the team and action is complete.	Mar-25	**Closed**
45	28th January 2025	Director of Nursing & Quality/Deputy Chief Executive / Director of Governance, Risk & Improvement	PB5/ 01/25	Minutes of the previous meeting held on the 26th November 2024	Mrs S Pemberton to pick up changes to the Maternity section outside of the meeting with the Director of Governance, Risk & Improvement, Mrs K Wheatcroft.	**Update 6th February 2025** – Update received and approved set of minutes saved.	Mar-25	**Closed**
46	28th January 2025	Chief Executive Officer	PB19/ 01/25	Research & Innovation Update	Ms J Tomkinson to share the criteria to become a University Teaching	**Update 4th March 2025** – Action completed at the	Mar-25	**Closed**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/Outcome	Due Date	Status
					Hospital at a future Board Strategy day.	February 2025 Board Development Day.		
47	28th January 2025	Chief Operating Officer / Freedom to Speak Up Guardian	PB23/ 01/25	Freedom to Speak Up Vision and Strategy 2025-28	It was agreed that clear arrows and connections would be added to the raising concerns flowchart.	**Update 4th March 2025** – Action complete and the document is on the intranet.	Mar-25	**Closed**

PUBLIC - Board of Directors
25th March 2025

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

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

Chief Executive Officer's Report (March 2025)

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

1. National Updates

The closer relation between NHSE and the Department of Health continue to develop with changes in NHSE leadership and an expectation of further reform.

This was reinforced on the 13th of March when the government announced that they will legislate to abolish NHS England and make it "fully integrated" into the Department of Health and Social Care. This announcement was proceeded in the same week with Integrated Care Boards being told to reduce running costs by 50%, and a call for Trusts to create wholly owned subsidiaries to support service and reduce corporate departments.

The NHS Ten-Year Plan consultation period has now concluded, and the final report expected in Spring. The Trust contributed and included comments from our Council of Governors workshop held in February 2025.

2. Regional Updates

The Trust Board is asked to note that Cathy Elliott has been appointed as the next Chief Executive of Cheshire and Merseyside Integrated Care Board.

3. CMAST Leadership Board meeting

Key highlights to note from the March 2025 meeting of the CMAST Leadership Board include:

- Progress on an options appraisal for the configuration of catheter laboratories.
- Medicine Optimisation program. This at scale program is delivering significantly more savings than the forecast. Utilising a rapid discussion making, web-based platform the program is now focussing on high-cost drugs that are ICB commissioned with an initial focus on Rheumatology.
- Planning assumptions. Submitted plans were significantly beyond the Cheshire and Merseyside overall financial allocations, and all Trusts are reviewing their submissions, reconciling activity, out turn and additional activity to deliver a range of scenarios as well as ensuring the delivery of urgent care.

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

Key highlights to note from the March meeting of MHLDC include:

- 2025/26 Work programme will include admissions avoidance at scale and the development on enhancing Community Services in line with planning guidance and the expectations of the 10 Year Plan.
- It was noted that successful initiatives such as virtual wards and Community based Intra venous (IV) antibiotics are funded non recurrently by the ICB and that the collaborative has

asked for these to be included within the ICB commissioning intentions to ensure continuity of care and services.

5. Local Pathology Hub Working Group: South

In 2023 the Pathology Target Operating Model (TOM) high level design and delivery plan received endorsement from Cheshire and Merseyside Acute & Specialist Trusts (CMAST), Chief Executive Officers and the Cheshire & Merseyside Diagnostic Delivery Board (DDB). The Countess of Chester Hospital NHS Foundation Trust and Wirral University Teaching Hospitals NHS Foundation Trust will deliver a single pathology service to be known as the South Hub. This approach is being replicated in other parts of Cheshire and Merseyside.

A project team with colleagues from both Trusts and from the diagnostic arm of CMAST was formed last year working through the 6 possible operating models and the implications on both the delivery of service and the staff. Currently the project group is working on finalising the operating model and planning the phases of integration, and approval for the final recommended model to be presented to Trust Boards in May 2025.

6. Cheshire and Wirral Partnership Trust and Countess of Chester Collaborative

This local collaborative has been established to facilitate the delivery of an integrated community service, with the two Trusts working together through a single delivery model.

Executive teams meet on a regular basis with further collaborative opportunities being identified. A workplan is being developed that brings together all joint opportunities that may be governed through a joint committee structure.

7. Cheshire Review

As part of ICB/ICS financial recovery, planning discussions around additional Cheshire opportunities commenced during the early part of 2024.

This work included a review of the significant work already underway including Cheshire and Merseyside wide programmes on system and provider efficiency through the ICB, providers and CMAST; the conclusion of this was:

- Several of the high priority NHS “financial recovery” areas already are operating through Cheshire wide arrangements within an overarching Cheshire and Merseyside Programme, including medicines optimisation and continuing healthcare
- Other key areas were operating through NHS Provider Collaboratives at a Cheshire and Merseyside level such as efficiency at scale, diagnostics and elective recovery and adding a Cheshire layer would not add value to working on the broader footprint
- Some areas were being managed by the ICB at a Cheshire and Merseyside level already and would not add value adding a Cheshire layer including programmes on unwarranted variation, or independent sector optimisation
- Local Authority representatives clearly articulated the need to recognise the emerging status of devolution in Cheshire and Warrington and that for some delegated functions this footprint will be more relevant going forward

8. National Staff Survey

The National Staff Survey 2024 results were published on the 13th March 2025 with two Team Briefs held for staff. Full reports can be accessed at www.nhsstaffsurveys.com.

Our results show we are making steady improvements across 6 of the 7 People Promise themes. We have seen a decline in the 'we are safe and healthy' theme, linked to the experiences of colleagues around violence and aggression and sexual safety from patients and the public, both areas that we have already begun working to improve. The results show we are heading in the right direction, and they reaffirm that collective efforts to create a better workplace are making a difference. We have identified further actions to address those areas for development and to build upon areas where we have already seen improvement. Updates on progress will be reported via the People Committee.

9. Employee and Team of the Month

Our Employee of the Month for January 2025 was Baki Kose, Domestic. Baki received multiple nominations and was described as "a breath of fresh air" in Moston Lodge. He is known to all the teams in the building and always goes above and beyond with his work.

Our Team of the Month for January 2025 was our Legal Team. "The Legal Team are always there to support staff, provide guidance and are truly experts in their field". The Team were nominated for their exceptional work ethic, in what can be extremely difficult, challenging and sometimes emotive situations.

10. Call 4 Concern – Martha's Rule

The Trust has been preparing for the launch of Call 4 Concern to further improve patient safety. The initiative will launch across the Trust on 7th April and will help us to act on concerns about deterioration that are raised by patients and their families.

Call 4 Concern forms part of the Trust's response to *Martha's Rule* which was developed following the death of Martha Mills, a 13 year old in 2021. Martha died from sepsis after concerns about deterioration raised by her parents were not responded to.

The introduction of Call 4 Concern provides patients and their families with a way to ask for a different team to urgently review a patient if they have ongoing concerns.

11. Discharge lounge re-opening

In early February 2025, the discharge lounge re-opened to patients following extensive upgrade and refurbishment work.

The discharge lounge is now much brighter, more spacious and a more comfortable space with additional facilities to improve patient experience and to better meet the needs of patients and their families. A designated pharmacy hub means staff can prepare prescriptions for patients more efficiently.

12. New Aseptic Unit Opening

In March 2025, the Trust's aseptic suite, which forms part of the Pharmacy Department, in Martindale House, reopened following an extensive refurbishment. The aseptic suite manufactures injectable medicines, therefore it is vital that the facility meets the standards as set out by the Medicines and Healthcare products Regulatory Agency (MHRA). All of the medicines made in the unit need special precautions due to their complex and high-risk nature.

13. CQC unannounced inspection of UEC

The CQC undertook an unannounced inspection of our Urgent and Emergency Care Services between 24th – 26th February 2025. Following the onsite inspection we provided a range of documents in response to the request from the Inspection Team. We are now awaiting formal feedback.

14. Thirlwall Inquiry update

The Trust has submitted its' closing statement to the Thirlwall Inquiry. The oral hearings for closing submissions are being held at Liverpool Town Hall on the 17th-19th March 2025. It is anticipated that the Inquiry will publish its' report in late Autumn 2025.

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

15. Board Leadership update

The Trust welcomed Neil Large, MBE as he commenced in his role as Interim Chair on the 1st March 2025 with support from Cheshire and Merseyside Integrated Care Board, and approval through the Trust's Council of Governors.

Neil brings significant experience working at board level across a variety of public sector organisations, holding positions of Chief Executive, Chair and more recently Non-Executive Director. He has held various leadership roles and has a proven track record in transformation and organisational change. Neil lives locally and has a good understanding of our hospitals and the challenges we face.

Over the next six months, Neil will lead the Board of Directors, working closely with the Executive team, Non-Executive Directors and Governors to focus on our continued improvement journey.

NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

CMAST BULLETIN

Welcome message

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

CMAST Leadership Board met on Friday 7th February and discussed several system wide issues.

The Leadership Board heard an update on, and discussed, the system's response to this year's NHS Planning Guidance. Several actions are already underway, and the necessity for a system wide, multi-year strategic response was also considered.

An update was presented on the management arrangements, procedures and methodologies for specialised commissioning across Cheshire and Merseyside. There was also an update on the national nursing role profile review, and recommendations presented regarding a collective system wide approach.

The board heard a summary of ongoing discussion and progress on the move to a single Cheshire and Merseyside provider collaborative. Subject to further discussion, and agreement on governance arrangements, potential commencement dates are under consideration.

Elective Recovery

Senior Responsible Officer: Janelle Holmes
Programme Director: Jenny Briggs

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End of December 2024:
1,153
65-week patients
of which, 680 were capacity, 326 choice, 138 complex/unit and 9 corneal grafts.

The 52 week wait total cohort position (up to March 2025) has reduced from
177,377
in July 2024 to
46,094
in January 2025.

Validation improvement plans and trajectories continue to report positive increases of **8.93%** improvement for 12-weeks, **16.98%** for 26-weeks and **15.05%** for 52-weeks.

Outpatients

C&M **Specialist Advice Diversion** rates are performing above the national value in MHS at 20.2%.

Remote Consultations continue to achieve the national value of 18% in C&M year to date (April to October 2024).

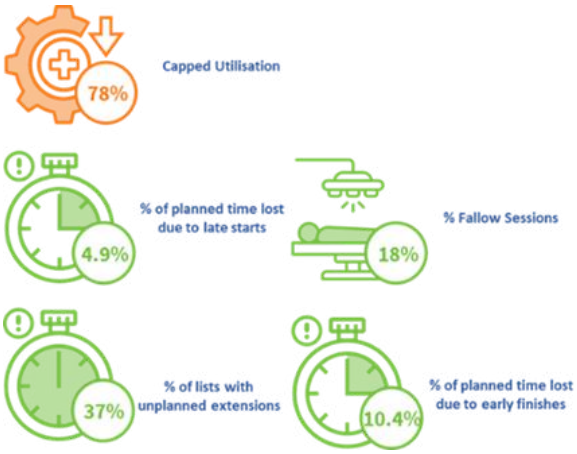
E-Referral System (ERS) current state analysis has commenced with a plan to share with providers to develop an improvement project.

Provider Further Faster Support 1-1's are continuing to develop priority project plans for the next phase. A proposal to establish the three sub-groups focused on outpatient/clinic improvement has been shared with Trust leads.

Theatres

82% of theatre sessions were cross covered in November which is the highest achievement to date.

Launch of **'Marketing' Group** to increase direct referrals to Clatterbridge Hub.



Clinical Pathways (CPP)

Senior Responsible Officer: Jan Ross
Programme Director: Jenny Briggs

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Gynaecology

Wirral University Teaching Hospital **pathway improvement** scope has been defined with a focus on five key areas including Menopause, Urinary Incontinence and Post Coital Bleeding.

Liverpool Women's Hospital **Menopause clinics** in the community to launch in February 2025 in Sefton. 72 additional appointment slots will be in place at this time. This will increase within three months following launch.

Reason for Referral evaluation summary is complete; findings are to be formally published in February 2025.

Community based menopause clinics: Providing access to menopause support and reducing waiting times - NHS Cheshire and Merseyside

Cardiology

Phase 1 of the C&M **Cardiology Cath Lab options appraisal** (November 2024) concluded that a 2 site percutaneous coronary intervention (PCI) service model is the preferred option for the region.

Phase 2 of the options appraisal, which aims to identify the preferred site to receive the PCI service upgrade, is currently underway and progressing well.

Ophthamology

C&M has been selected to participate in a funded pilot to test an **AI powered patient consultation summary tool**, **CLEARnotes**. Expressions of interest from Trusts and Local Optical Committees were received throughout January and a decision on participation will be made in the coming weeks.

As of 1st January 2025, the **Single Point of Access** pilot, currently live in East Cheshire, West Cheshire, St Helens, Halton and Knowsley, was formally extended for the second 6-month period, taking the pilot end date to 30th June 2025.

Quality cataract care for patients across Cheshire and beyond :: Mid Cheshire Hospitals NHS Foundation Trust

ENT

Age threshold for Audiology pathways at COCH has been removed in a pilot aiming to reduce waiting times. Outcomes of this pilot will be reviewed in Spring 2025 and review to scale across C&M will be completed at this time.

Diagnostics

Senior Responsible Officer: Liz Bishop
Programme Director: Tracey Cole

NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

93.1%
of patients have been waiting 6 weeks or less (0.3% increase from the previous month).

#2
ICS ranking previous was 3rd out of 42 ICSs.

Total number of patients waiting decreased to **62,038** and total activity was **104,771**, a decrease of **6.9%** compared to October.

Clatterbridge patient features in NHS announcement about diagnosis figures :: The Clatterbridge Cancer Centre

Endoscopy

Additional **Cystoscopy procedures** funded at Warrington and Halton Hospital, Countess of Chester Hospital and Mid Cheshire Hospital have seen a significant reduction in the waiting list backlog (**348** procedures in total).

Digital - working with all trusts to secure a safe and effective transition to SOLUS V2.

Transformation - Alternatives to Endoscopy has services operational at East Cheshire Trust, Warrington and Halton Hospital and Countess of Chester Hospital.

https://www.mcht.nhs.uk/news-and-events/news/mid-cheshire-hospitals-endoscopy-team-achieves-national-accreditation

Pathology

Monthly submission to NHSE on **Whole Slide Images (WSI) digital reporting** commenced against NHSE target of 50% digital reporting. Supplier site visits have taken place to understand current stage and inform next steps.

LIMS
Initiation activity continues, central team partially in post. Initial deliverables now in draft form including, data mitigation strategy, Master Patient Index (MPI) and numbering strategies, draft order catalogue and harmonisation.

Innovative HIV testing expanded in Liverpool :: NHS University Hospitals of Liverpool Group

Warrington and Halton Hospitals NHS Trust - Mum who received 65 units of lifesaving blood products supports blood appeal

Cheshire and Merseyside Pathology Network (CMPN) **Partnership Board** commenced 25th October 2024. This is a significant step towards achieving maturing status on the Pathology Maturity Matrix.

Diagnostics

NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

Physiological Sciences

Self-assessment against the national Physiological Sciences (PS) maturity matrix is in progress.

Expansion of sleep studies, echo, spirometry and audiology tests continues at CDCs.

Communications toolkit completed for Audiology, Respiratory Physiology, Sleep Studies, Cardiac Physiology, Neurophysiology, Vascular Science and Gastrointestinal Physiology.

Enhanced GP Direct Access for COPD, asthma and heart failure
Report presented at the January Urgent and Emergency Care board.

Countess of Chester Hospital marks successful year of new urology clinic where patients are now being seen and treated quicker | Countess of Chester Hospital

Radiology/Imaging

AI Prostate - Siemens to add a DICOM note to their MR scanners in University Hospitals of Liverpool Group (pending approval from their Radiology department) to enable auto-forwarding from these scanners and reduce the workload on Picture Archiving and Communication System (PACS) teams.

Interventional Radiology (IR) - First report for review submitted 17th January 2025 that summarises the current state of IR services in C&M and will play a key role as a driver for change in services.

State-of-the-art camera will improve patient experience :: NHS University Hospitals of Liverpool Group

Community Diagnostic Centres (CDCs)

Sustainability Project
Updated sustainability Project for 2024/25 (to date and forecasted out-turn) and 2025/26 (planned delivery) was approved at November's Diagnostic Steering Group. Data is currently being worked through, and the final report will be delivered at Diagnostic Steering Group in February 2025.

Delivery is above plan by
18,015
tests year to date
300,851 total tests for the year to date (29th December 2024 data).

VIN & Shopping City's Letters of Access (LOAs) received and accepted.

Final briefing pack for 2024/25 International Recruitment has been sent to sites who are interested. Interest to be sent to Programme Lead.

Demolition work officially breaks ground on new £5 million Community Diagnostic Centre at Congleton War Memorial Hospital :: East Cheshire NHS Trust

Contact us for more information regarding the latest news!

ccf-tr.candmdiagnosticprogramme@nhs.net

Efficiency at Scale (E@S)

Senior Responsible Officer: Ged Murphy
Programme Director: Nina Russell

NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

The 2023/24 corporate services benchmarking has been produced for all the integration areas.

Risk, Governance and Legal Services

The C&M **Infection Prevention and Control (IPC)** Reducing C. Difficile Toolkit has been formally launched across providers.

Medicines Optimisation

The QIPP 2024/25 target is forcast to deliver

£20.85m

in primary care and

£9.6m

has been delivered year to date.

After commencing in H2, the high-cost drug scheme has delivered

£5.2m

year to date against a financial year end target of

£9.8m.

Procurement

The procurement programme remains on track to deliver the

£7.1m

target with

£5.4m

delivered year to date.

PUBLIC - Board of Directors
25th March 2025

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

	• BAF9 - system working (12) • BAF10 - research and innovation (12) 8 of the 10 risks on the BAF remain above risk appetite level. Actions are progressing, but given the strategic nature of these risk it is recognised that it will take time to fully implement and embed the improvements needed, along with ensuring clear evidence of assurance that the risks are being mitigated. The report demonstrates the progress being made against key actions aligned to BAF risks and strategic objectives including: • Quality and Safety strategy refresh in progress • Implementation of 6 steps for family and patient experience across all areas, and approach to seek feedback as part of family and friends tests • Final operational planning guidance published and activity, finance and workforce planning progressing • Staff survey results received and action plans being developed • Clinical strategy progressing and quarterly operational and clinical leads strategy days taking place • Leadership of Place CVD events • Risk management improvements progressing • Finance strategy principles discussed at Finance & Performance Committee and Board strategy day • Digital pilots progressing • Continued development of partnership with the University of Chester
Recommendations	The Board of Directors is asked to (i) **approve** the updates to the Board Assurance Framework at Q4 (ii) **note** the progress in delivering the 2024/25 strategic objectives

Corporate Impact Assessment	
Statutory/regulatory requirements	Trust compliance with the CQC regulatory framework, Provider 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.

Board Assurance Framework (BAF) Quarter 4 2024/25

1. BACKGROUND

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

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

The Board of Directors receives the BAF each month with a full update completed on a quarterly basis. The purpose of this paper is to provide an overview of the BAF Q4 update, including actions to mitigate and manage strategic risks, and delivery of 2024/25 strategic objectives.

2. BAF RISKS ALIGNED TO STRATEGIC GOALS AND OBJECTIVES

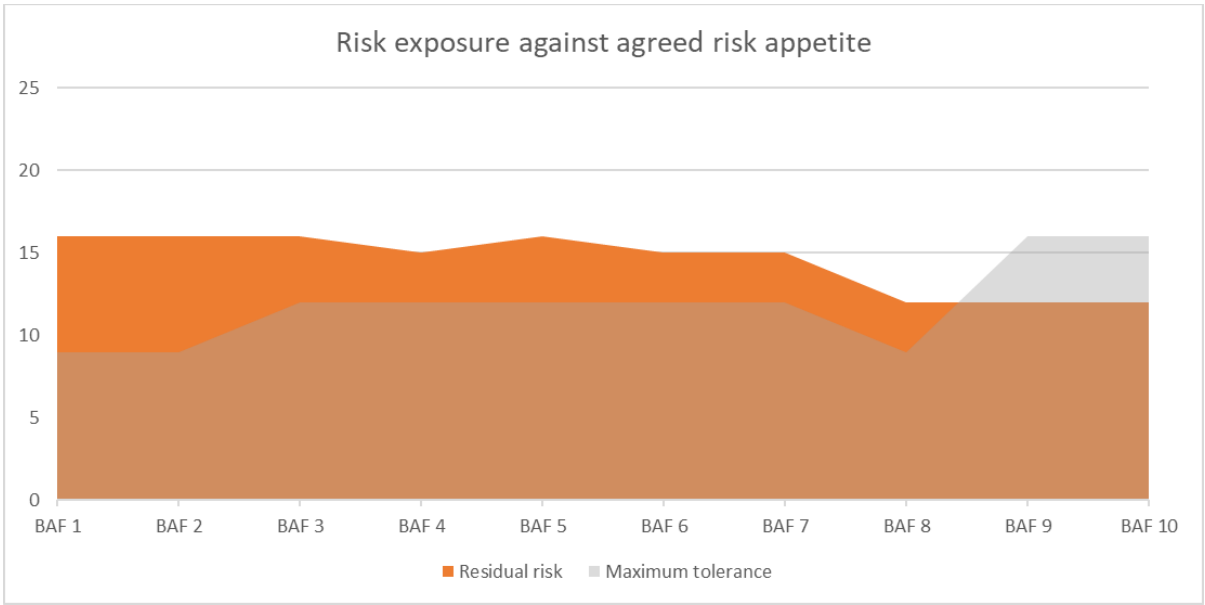
Alignment to strategic goals and objectives has been included within the BAF, with strategic objectives shaded within the key controls. The current risk exposure against the strategic goals is summarised below.

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

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

3. CURRENT RISK SCORE AGAINST TARGET SCORE

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



Key:

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

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

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

4. PROGRESS AGAINST STRATEGIC OBJECTIVES AT Q4

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

- Quality and Safety strategy refresh in progress
- Implementation of 6 steps for family and patient experience across all areas, and approach to seek feedback as part of family and friends tests
- Final operational planning guidance published and activity, finance and workforce planning progressing
- Staff survey results received and action plans being developed
- Clinical strategy progressing and quarterly operational and clinical leads strategy days taking place
- Leadership of Place CVD events
- Risk management improvements progressing
- Finance strategy principles discussed at Finance & Performance Committee and Board strategy day
- Digital pilots progressing
- Continued development of partnership with the University of Chester

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

5. RECOMMENDATIONS:

The Board of Directors is asked to:

(i) **approve** the updates to the Board Assurance Framework at Q4

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

Appendix A – Summary of strategic risks above risk appetite

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

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing
BAF1. Failure to maintain **quality of care** would result in poorer patient & family experience	**16**	**9**	Partial	• Developing new Quality and Safety Strategy • Feedback on patient and family experience strategy through Friends and Family test • C'Diff improvement priorities being developed for 25/26
BAF2. Failure to **maintain safety and prevent harm** would result in poorer patient care and outcomes	**16**	**9**	Partial	• Harms improvement programme outcomes • Organisation learning policy • Clinical Strategy (draft) • Learning from deaths reporting • Mental health review action plan
BAF3. Inability to deliver **operational planning standards**, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust.	**16**	**12**	Partial	• Operational planning 25/26 • Integrated flow and UEC improvement plans • Non RTT validation (including use of AI)
BAF4. Challenges in ensuring a high quality, engaged, diverse and inclusive **workforce** would affect our ability to deliver patient care	**15**	**12**	Partial	• E'rostering roll out • Workforce planning • Staff survey results and actions • Understanding wellbeing needs • Integrated EDI action plan • Succession planning • Training needs analysis
BAF5. Failure to deliver **financial plan** and underlying financial position could impact long term financial sustainability for the Trust and system partners	**16**	**12**	Partial	• Financial Strategy • Continuing to work with C&M ICB for 25/26 plan • CIP planning 25/26
BAF6. Inability to achieve the **capital programme** within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of our services	**15**	**12**	Partial	• Engagement in system estates work • Capital plan delivery • Capital bids (TIF) • Continued RAAC failsafe and inspections continuing
BAF7. Failure to ensure **digital transformation and IT resilience** could impact the delivery of services for patient and our workforce	**15**	**12**	Partial	• Digital strategy refresh and audit • Cyber assessment framework audit • Infrastructure developments • EPR optimisation programme

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing
				• Data quality assurance • National competency framework workstreams • Team workforce plan and skills development accreditation planned
BAF8. Failure to ensure effective **corporate governance** could impact our ability to comply with legislation and regulation.	**12**	**9**	Partial	• Risk management improvements • Governance organogram (draft) • Regulatory compliance and assurance map (into 25/26) • CWP/COCH collaboration Exec to Exec and next steps • Corporate Records Management policy refresh and review

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

Appendix B – Progress against Strategic Objectives Q4

The progress against strategic objectives at Q4 is set out in the tables below.

Strategic Objectives	Lead	Progress
SG1 Patients and Family		
Systematic approach to improving quality and safety and reducing harm	SP	Work commenced on overarching Quality and Safety Strategy refresh and update provided at the Board Strategy Day Feb 2025.
Delivery of NHS planning standards	CC	The Trust continues to meet the long waiting RTT targets and the reduction in suspected long waiting cancer patients. Access to UEC services remains as above and is challenged due to high ED attendances and lack of progress with the reduction of patients that no longer have the criteria to reside. There is a full UEC improvement programme in progress with improved metrics of 12 hour DTAs, ambulance handover delays and time to triage. The Trust continue to work with the wider systems and local authorities to enable an improved number of complex discharges. The Trust continues to explore options to extend SDEC opening hours. Flow improvement plan being aligned with UEC improvement plan to ensure clear priorities and a focus on assessing the impact of the actions taken. Final operational planning guidance for 2025/26 published and activity planning underway with finance and workforce.
Development of a patient and family care model	SP	Patient and family experience strategy being implemented with local consideration of actions needed to embed. All areas have now implemented 6 steps for patient and family experience, and we are developing an approach to seek feedback on these steps through the family and friends test. ED and UEC, and Maternity inpatient survey results received and shared with the Board.
Adoption of continual improvement and learning	KW	The Trust has developed a range of organisational learning through PSIRF, learning from deaths, national inquiries, clinical audit, patient safety summits etc. The policy is being developed to capture all these opportunities, and consider how sharing of learning can continue to be maximised. Early draft shared with Deputy Medical and Nursing Directors for feedback (Jan 25).

SG2 People and Culture		
United shared values, goals, mindset and behaviours	VW	Civility statement developed through wide engagement, approved by the Board (May 24). And rolled out.New staff survey launched along with a you said we did timeline. Current focus includes zero tolerance and tackling poor behaviours. High level staff survey results 2024 received and development of action plans (March 2025).
Develop an approach for recruitment, development and retention	VW	Onboarding welcome event improved for all staff groups. Evaluation of event ongoing to look at further opportunity to enhance. Also improving TRAC experience for candidates (Q2 25/26).
Improve the health and wellbeing of our staff	VW	Staff hub opened (Q1) and wellbeing offer developing to include physical, mental and financial. Continuing to understand the wellbeing needs within the Trust and improve specific wellbeing support. Focus is also on the underlying challenges and improving working arrangements.

SG3 Leadership		
Development of clinical strategy	NS	Discussions with the Clinical Directors and Divisional leads has taken place. Strategy days took place with Clinical Leads in October and December 2024 to drive forward the development of the Clinical Strategy. Specialty proposals were developed to support this and quarterly clinical leads strategy days planned to drive this forward. Clinical strategy update to Board (Jan 25). Further Clinical Leads day planned March 2025.
Take a leadership role within Cheshire West	JD	Representation and engagement continues across a range of forums. Director of Strategy facilitated, arranged and chaired the first of a series of prevention conference across Place focused on CVD Prevention. A second conference aimed at admission avoidance / specifically CVD-R (respiratory) was held in October with circa 55 primary care colleagues present. A third leadership event is planned in for April 1st which will focus on CVD and the management of diabetes.
Develop our leadership teams	VW	Leadership framework established and programmes rolled out for clinical leaders, aspiring leaders (band 2-4) and lead managers. Basic skills for manager training developed for all managers and update on outline programme provided through People Committee, with launch in Q1 25/26. Training needs analysis to be progressed (Q2 25/26).
Ensuring governance is in place across the organisation	KW	Significant progress made against well led action plan including assurance committee effectiveness, BAF and risk appetite reset for 2024/25. Risk management improvement plan actions progressing, risk management policy approved and Risk Management Committee in place. Datix developments being implemented. Committee organagram developed and further review of sub committee structures including Divisions underway. Governance presentations continue to be delivered in various forums.

SG4 Adding Value		
Development of a new financial plan and strategy	KE	Conclusion of 2024/25 annual planning process (June 2024). Development of deficit drivers underway. Revisited PWC action plan and HfMA financial control checklist, reported to F&P Committee and prioritised action plan will continue to be reported. Financial strategy will need to align with the emerging clinical strategy and people strategy. Initial consideration of financial strategy at F&P Committee and Board strategy day (Feb 25).
Advance digital solutions in support of transforming care	JB	Microsoft Co-pilot trial is being developed with access to 500 licenses. MIAA strategy audit Q4 2025. Ambient voice solutions are currently being reviewed with view to pilot in Q1 25/26.
Achieve anchor institution status. (green / social value / prevention)	JD	New Anchor Institution oversight group established (June) which meets bi monthly. New reporting framework adopted. Revised terms of reference. Board report presented in July 2024. Anchor Institute Oversight Group has now expanded membership to CWP and Chester University sustainability department. The group has now also engaged with the Country Park. National guidance published in February 2025 will require Trusts to refresh Green strategies by July 2025. This will be overseen by the Anchor Institution Group and is on target for delivery.

SG5 Partnership		
Develop a bespoke research, education	NS	Early discussions to establish research ambitions to support strategy development. This will be aligned to the clinical strategy approach.

and innovation strategy		A research nurse attends Divisional Boards to increase visibility of research studies and opportunities as well as provide feedback. Research sandpit being planned with the University.
Explore new models of care for In Reach, Out Reach and Networked services.	CC	Continued discussions with WUHFT following Board to Board. There are several pieces of work coming to a conclusion including the Pathology and Renal reviews which will be subject to an exec to exec meeting in Q1 this 2025/26.
Increase academic appointments	NS	Communication strategy developed to support awareness for partner organisations. Current focus on building relationships and developing collaboration opportunities. Framework agreed between COCH and the University of Chester to progress partnership arrangements. Also building relationships with Primary Care Networks (PCNs) to develop a primary care research network. Trust Consultant (and Dir. of Medical Education) appointed as Acting Clinical Dean at the University of Chester. Steps to Teaching and University Hospital status explored with the Board (February 2025).

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

Countess of Chester Hospital
NHS Foundation Trust

Board Assurance Framework 2024 - 25

Risk Theme: Quality & Patient Experience

RISK APPETITE: CAUTIOUS - Upper tolerance limit 9

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

Risk description & information	Causes & consequences	Inherent risk score (C x L)	Key controls (Actions taken to manage the risk)	Board Assurance (The mechanisms we know the controls are working - reports, scrutiny meetings, committees, internal & external audits and reviews)			Residual risk score (C x L)	Within risk tolerance?	Gaps in Control / Assurance (Identified weaknesses in current management arrangements/ how we assure ourselves - or not enough information or lack of scrutiny	Actions		Target risk score	Estimated date of achievement of target score
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update		
BAF1 Failure to maintain quality of care would result in poorer patient & family experience **Executive Risk Lead:** Director of Nursing and Quality **Assurance Committee**: Quality and Safety Committee **Last Update:** March 2025	**Causes:** - Longer patient waiting lists - Inconsistent compliance with standards - Emergency Department capacity not supportive of the high volume of patients presenting to the Emergency Department. - Lack of clinical engagement.. **Consequences:** - Quality of care - Unintended harm - Poor patient experience - Regulatory compliance	*4 x 5 = 20*	C1) Quality and Safety Strategy priorities. **Control Owner:** Director of Nursing and Quality	- Safety Surveillance Quarterly report - Quality and Safety Committee reports - Quality Governance Group via Q&S Committee - Patient Experience Operational Group via Q&S Committee - Operational Management Board	National inpatient survey results. Healthwatch reports. Internal audit reviews. NHS Staff survey results. CQC Inspection Outcomes. Family and friends test results.	*Partial*	*4 x 4 = 16*	**NO**	Quality & Safety Strategy refresh.	Quality and Safety Strategy to be refreshed in 2024/25. Patient and Family experience startegy to be embedded. **Action Owner**: Director of Nursing and Quality **Due date:** Q4	Work commenced on overarching Quality and Safety Strategy refresh and update provided at the Board Strategy Day Feb 2025. Patient and family experience strategy being implemented with local consideration of actions needed to embed. All areas have now implemented 6 steps for patient and family experience, and we are developing an approach to seek feedback on these steps through the family and friends test. ED and UEC, and Maternity inpatient survey results received and share with the Board.	*9*	*Mar-25*
			C2) Quality Governance Structures **Control Owner:** Director of Nursing and Quality	- Consolidated CQC and Well Led Action Plan reported to each Board of Directors - Quality and Safety Committee - Quality Governance Group via Q&S Committee	Commissioner reviews of quality (quarterly). CQC reports.	*Acceptable*			Review of work plans of reporting sub committees/ groups to strengthen assurance coverage.	To review sub committee/ group reporting structures and workplans for Q&S Committee. **Action owner**: Director of Nursing and Quality **Due Date:** Update Q4	Full review of Quality Governance Structures completed. Comprehensive combined CQC action plan in place and progressing with updates provided to Executive Directors Group monthly and to each Board of Directors. Sub committee reporting to Quality and Safety Committee is now embedded from Quality Governance Group. QGG Workplan reviewed for 2025/26. Q&S Committee effectiveness review in progress.		
			C3) Infection Prevention and Control. **Control Owner:** Director of Nursing and Quality	- SOF - Infection, Prevention & Control Quarterly Report via Q&S Committee - Quality Governance Group via Q&S Committee - Annual Quality Account (featuring IPC section re objectives)	CQC reports	*Partial*			Assurance gap re cleaning standards. IPC compliance assurance and improvements. Infection rates are exceeding the expected targets.	(i) To improve compliance assurance through harms improvement (ecoli and cdiff), and campaigns (e.g. Gloves off). (ii) To establish assurance reporting on cleaning standards. **Action Owner:** Director of Nursing and Quality **Due date:** Quarterly updates	Harms improvement priorities agreed for 2024/25 and programmes progressing. Gloves off campaign established and successful outcomes demonstrated. Concerns regarding C Difficile sampling processes and practices, with an improvement plan in place and progressing. Good progess on joint working with the Facilities Team regarding cleaning standards with an update reported to Quality and Safety Committee in November 2024. Improvement priorities being developed for 2025/26.		
			C4) CQC regulatory compliance **Control Owner:** Director of Nursing and Quality	- Consolidated CQC and Well Led Action Plan reported to each Board of Directors - Quality and Safety Committee - Quality Governance Group via Q&S Committee - Ward accreditation reporting via Q&S	Commissioner reviews of quality (quarterly). CQC reports.	*Acceptable*				To deliver the programme of ward accreditation across the Trust. **Action owner:** Director of Nursing and Quality **Due date:** Complete	Good progress with new ward accreditation programme roll out, with all wards planned to be completed in 2024/25 and a full report to the Board of Directors at the end of Q4. Update provided at the Board Strategy Day Feb 2025.		
BAF2 Failure to maintain safety and prevent harm would result in poorer patient care and outcomes **Executive Risk Lead:** Medical Director **Assurance Committee**: Quality and Safety Committee **Last Update:** March 2025	**Causes:** - Longer patient waiting lists. - Underdeveloped partnership working arrangements to support clinical strategy delivery. - Lack of reciprocal engagement in the wider health system (including ICB, Place). - Need to review of mental health service provision in A&E and across all Trust sites **Consequences:** - unintended harm - Extended length of stay - De-conditioning of patients	*4x 5 = 20*	C1) Safety priorities. **Control Owner:** Medical Director	- SOF - Quality Governance Group via Quality and Safety Committee	CQC Inspection Outcomes	*Partial*	*4 x 4 = 16*	**NO**	Delivery of quality improvement outcomes.	To deliver harms improvement programme outcomes. **Action owner:** Medical Director **Due date:** Quarterly updates	Reviewed 23/24 acheivements, and revised programme for 24/25. Continued updates to Quality Governance Group and presentations through Harms Improvement Oversight meeting.	*9*	*Mar-25*
			C3) Organisational learning **Control Owner:** Medical Director/ Director of Governance Risk and Improvement	- Safety Surveillance Quarterly report - Quarterly Mortality report via Q&S Committee - Quality Governance Group via Q&S Committee		*Partial*			Organisational Learning Policy and embedding of approach.	The production of an Organisational Learning Policy, including range of activity, forums and reporting. **Action Owner:** Director of Governance, Risk and Improvement **Due date:** Q4	The Trust has developed a range of organisational learning through PSIRF, learning from deaths, national inquiries, clinical audit, patient safety summits etc. The policy is being developed to capture all these opportunities, and consider how sharing of learning can continue to be maximised. Early draft shared with Deputy Medical and Nursing Directors for feedback (Jan 25).		
			C4) Review of deaths **Control Owner:** Medical Director	- Quarterly Learning from Deaths report and annual mortality report via Q&S Committee - Quality and Safety Committee - Quality Governance Group via Q&S Committee	Telstra Health (Dr Foster) benchmarking	*Partial*				Continued improvement to learning from deaths reporting **Action Owner:** Medical Director **Due date:** Quarterly updates	Work ongoing to develop improved reporting		
			C5) Development and implementation of Clinical Strategy **Control Owner:** Medical Director			*Partial*			Refresh of the Clinical Strategy aligned to the Trust Strategy.	The Medical Director will work closely with the Director of Strategic Partnerships and Clinical leaders to ensure the Clinical Strategy is aligned to the Trust Strategy and reflective of the new clinically led divisional infrastructure. **Action owner:** Medical Director **Due Date:** Q4	Discussions with the Clinical Directors and Divisional leads has taken place. Strategy days took place with Clinical Leads in October and December 2024 to drive forward the development of the Clinical Strategy. Specialty proposals were developed to support this and quarterly clinical leads strategy days planned to drive this forward. Clinical strategy update to Board (Jan 25). Further Clinical Leads day planned March 2025.		
			C6) Mental Health review **Control Owner:** Director of Strategy and Partnerships	CEO Report to Board.	Mental Health, Learning Disability and Communuty collaborative updates	*Partial*			Education and training in mental health awareness and mental health first aid training. An understanding of the roles and responsibilites of a 136 place of safety and continuity of care when handing over between acute and mental services.	Action Plan developed including reintroducing the mental health collaboative between CWP and the Trust for liasion psychiatry services, with an aim to reduce delays in the process for people with MH crisis in ED, and supporting Children and Young People with Mental Health needs in an Acute Paediatric Setting. **Action owner:** Director of Strategy and Partnerships **Due Date:** Quarterly updates	Ligature risk well embedded in A&E and being rolled out across ward areas. Plan in place for every patient to have a safegaurding risk assement. Workplan for 2024/25 developed. Mental Health review has been completed by a member of the psychiatrict liaison service on secondment from CWP for 6 weeks. An interim report was reviewed at EDG in December and further update including action plan expected March 2025.		

Risk Theme: Operational Effectiveness

RISK APPETITE: OPEN - Upper tolerance limit 12

LINKS TO STRATEGIC GOALS: SG4: Adding Value

Risk description & information	Causes & consequences	Inherent risk score (C x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (C x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF3 Inability to deliver operational planning standards, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust. **Executive Risk Lead:** Chief Operating Officer **Assurance Committee**: Finance and Performance Committee **Last Update:** March 2025	**Cause:** - Unable to meet the demand for services within available resources - Increased demand in suspected cancer referrals and ED attendances - Increased number of patients that do not meet the criteria to reside **Consequences:** - Increased patient waits for access to services impacting on patient safety, potential harm and patient experience. - Failure to meet key targets and regulatory requirements in some areas - Sub-optimal service provision - Increased ambulance handover delays - Potential increase in complaints from family, friends and carers.	*4 x 5 = 20*	C1) Annual plan with clear activity and performance reporting against trajectories and focussed improvement plans as required. **Control Owner:** Chief Operating Officer	- System Oversight Framework to Board (each meeting), including enhanced reporting on RTT. - Finance and Performance Committee - Divisional Performance via Operational Management Board - Operations and Performance Executive Led Group via OMB - Quarterly Divisional Performance Reviews - Bi-weekly patient flow meetings.	North West performance report overseen by ICB. Contract review meetings. System Oversight Group.	*Partial*	*4 x 4 = 16*	NO	Management of flow, consistent application of discharge requirements and significant NC2R patients requiring wider system response. UTC/ SDEC restricted opening hours.	(i) ED - Whole system approach to hospital avoidance and supported primary care function. Continued focus at SOG. (ii) ED - Continued MADE (weekly) super MADE (bi-monthly) multidisciplinary discharge events. (iii) Explore options to extend Same Day Emergency Care Unit opening hours. (iv) Flow improvement plan integrated with UEC imporvement plan to drive forward clear priority actions and assess the impact. **Action Owner:** Chief Operating Officer **Due date:** Quarterly updates	The Trust continues to meet the long waiting RTT targets and the reduction in suspected long waiting cancer patients. Access to UEC services remains as above and is challenged due to high ED attendances and lack of progress with the reduction of patients that no longer have the criteria to reside. There is a full UEC improvement programme in progress with improved metrics of 12 hour DTAs, ambulance handover delays and time to triage. The Trust continue to work with the wider systems and local authorities to enable an improved number of complex discharges. The Trust continues to explore options to extend SDEC opening hours. Flow improvement plan being aligned with UEC improvement plan to ensure clear priorities and a focus on assessing the impact of the actions taken. Final operational planning guidance for 2025/26 published and activity planning underway with finance and workforce.	*12*	***Mar-25***
			C2 Performance management framework and Governance Structure **Control Owner:** Chief Operating Officer	- System Oversight Framework to Board (each meeting), including enhanced reporting on RTT. - Finance and Performance Committee - including System Oversight Framework - Divisional Performance via Operational Management Board - Operations and Performance Executive Led Group via Finance and Performance Committee - Quarterly Divisional Performance Reviews		*Acceptable*			Some gaps in validation (non RTT) and data quality issues remain.	Increased focus on Non RTT follow up data quality, clinical validation and delivery **Action Owner:** Chief Operating Officer **Due date:** Quarterly updates	CMAST resources secured and have supported validation. Continue to focus on non RTT follow up and progressing opportunity to use AI solution at final stages for EDG sign off March 2025.		

Risk Theme: Workforce

RISK APPETITE: OPEN - Upper tolerance limit 12

LINKS TO STRATEGIC GOALS: SG2: People and Culture

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF4 Challenges in ensuring a high quality, engaged, diverse and inclusive workforce would affect our ability to deliver patient care. **Executive Risk Lead:** Chief People Officer **Assurance Committee:** People and Organisation Development Committee **Last Update:** March 2025	**Causes** - Poor staff morale - Staff burn-out - Lack of health and wellbeing support - Increased pressures in the hospital - External scrutiny - Failure to engage staff, listen to feedback and act - lack of effective systems and processes **Consequences** - Loss of goodwill and staff engagement - Short term sickness absence - Turnover hotspots - A deterioration in the physical and mental wellbeing of our workforce - Increased bank/ temp staff hours - Erosion of skills and knowledge - Reduced leadership capacity and capability	*5 x 4 = 20*	C1) Workforce Plan **Control Owner**: Chief People Officer	- System Oversight Framework Report (bi-monthly) - Staffing monitored via Strategic Workforce Group and chair's report to People and Organisation Development Committee	Annual plan submitted to ICS.	*Partial*	*5 x 3 = 15*	**NO**	Enhanced workforce controls required, including vacancy control measures, and pay controls aligned to system oversight expectations. Lack of digital workforce systems, processes and reporting.	(i) Establish and embed enhanced vacancy control measures aligned to ICS headcount expectations. (ii) Continue to explore and progress digital systems **Action owner:** Chief People Officer **Due date:** Quarterly updates	Executive led vacancy control group including variable pay measures established in Q1. Pay Control Goup in place. Plan being developed to roll out e'rostering for AfC staff to commence feb 2025. Medical e'rostering procurement underway with demos planned Jan 2025 and implementation Q1 25/26.	***12***	***Mar-25***
									Workforce plan underpinned by professional group workforce reviews and plans.	Professional group workforce plans to be developed and reviewed. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	Review of nurse staffing complete and actions agreed. Workforce planning session at People Committee and Board development day in October 2024. Workforce planning will need to be aligned to 2025/26 operational planning as well as the Clinical Strategy. Band 2/3 and apprenticeships work continuing to progress.		
			C2) Staff experience, engagement, morale and culture **Control Owner**: Chief People Officer	- SOF - Workforce dashboard/ SOF via POD - GMC Survey via POD - Preceptorship survey via POD - Staff survey action plan updates and Pulse surveys via POD - FTSU Bi-annual update and via POD - Quarterly employer relations report via POD	NHS Staff Survey results	*Partial*			Staff survey action plan delivery and assurance on delivery of Divisional action plans.	Delivery of staff survey action plan including listening channels, respect and civility work, and engagement strategy. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	Civility statement developed through wide engagement, approved by the Board (May 24). And rolled out. New staff survey launched along with a you said we did timeline. Current focus includes zero tolerance and tackling poor behaviours. High level staff survey results 2024 received and development of action plans (March 2025).		
									Clear and comprehensive wellbeing offer.	Improving the Trust wellbeing offer. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	Staff hub opened (Q1) and wellbeing offer developing to include physical, mental and financial. Continuing to understand the wellbeing needs within the Trust and improve specific wellbeing support. Focus is also on the underlying challenges and improving working arrangements.		
			C3) Equality, Diversity and Inclusion **Control Owner:** Chief People Officer	- Staff survey - WRES/WDES Reports via POD - CPO report to People Committee	NHS staff survey results. WRES/ WDES.	*Partial*			Well established staff networks and feedback. Poor experience. Diversity of workforce at all levels. Lack of clear metrics for improvement.	(i) Establish and develop staff networks. **Action Owner:** Chief People Officer **Due date**: Complete (ii) Data analysis to understand postion and set improvement targets. **Action Owner:** Chief People Officer **Due date:** Q4 2024/25	Executive leads identified for staff networks and initial meetings taking place.New EDI lead appointed and active work being done across the networks. EDI also a key part of the strategy, staff survey, wellbeing, and development plans. Data analysis being undertaken to understand position and set future improvement targets. Additional specialist resource to be used in Q4 to support development of an integrated EDI action plan.		
			C4) Recruitment and Retention **Control Owner:** Chief People Officer	- SOF - Workforce dashboard/ SOF via POD		*Acceptable*			Delivery of talent and succession planning including scope for growth.	Delivery of talent and succession planning including roll out of Scope for Growth. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	New appraisal framework developed and being used for appraisals. Reviewing use of talent conversations. Board level succession plan being further developed and return made to NHS Leadership Academy Q3.		
									Enhanced onboarding process and experience.	Redesign of onboarding processes and improve experience. **Action Owner:** Chief People Officer **Due date:** Complete	Onboarding welcome event improved for all staff groups. Evaluation of event ongoing to look at further opportunity to enhance. Also improving TRAC experience for candidates (Q2 25/26).		
			C5) Education and Development, including leadership and management capabilities **Control Owner:** Chief People Officer	- L&D Reports via POD - Guardian of Safe Working reports - GMC survey via POD - Preceptorship survey via POD	NHS Staff survey results. GMC Survey results Preceptorship survey results	*Acceptable*			Training needs analysis. Delivery of leadership and management development.	Leadership and management programmes to be rolled out at all levels. Training needs analysis to be developed following appraisals. **Action Owner:** Chief People Officer **Due date:** Q4 2024/25	Leadership framework established and programmes rolled out for clinical leaders, aspiring leaders (band 2-4) and lead managers. Basic skills for manager training developed for all managers and update on outline programme provided through People Committee, with launch in Q1 25/26. Training needs analysis to be progressed (Q2 25/26).		

Risk Theme: Finance & Capital

RISK APPETITE: OPEN - Upper tolerance limit 12

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

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF5 Failure to deliver financial plan and underlying financial position could impact long term financial sustainability for the Trust and system partners. **Executive Risk Lead:** Chief Finance Officer **Board Committee**: Finance and Performance Committee **Last Update:** March 2025	**Cause:** The Trust operates in an increasingly challenging financial environment in line with the national position for acute providers. This is driven by: - Increase in non elective activity delivered at premium costs; - High numbers of medically optimised and delayed transfers of care for which costs are not fully reimbursed; - Costs associated with medical and nurse agency usage; - The Trust, as part of the Cheshire & Merseyside system has agreed a planned deficit for 2024/25. This is dependant on the Trust delivering efficiency savings of 5% whilst not investing in any further developments. - Identification and delivery of recurrent Cost Improvement Plan (CIP) - Return to Payment by Results (PbR) for elective and outpatient activity and block funding for non-elective activity alongside activity target requirements and potential clawback of income through Elective Recovery Fund (ERF) if activity targets are not delivered - Lack of internally generated Capital resource **Impact:** - The Trust is unable to achieve a sustainable financial balance & achievement of recurrent efficiencies & deliver its strategic objectives. This will result in the requirement to borrow cash from DHSSC (with a cost associated with borrowing cash) - Inability to maintain safe and effective local services. - Increased external scrutiny from NHSE and Integrated Care Board (ICB) - The Trust's inability to deliver financially would also impact on the financial position of the Cheshire & Merseyside System.	*4 x 4 = 16*	C1) Finance Strategy and underlying sustainability **Control Owner**: Chief Finance Officer	- Trust board report (monthly) - Finance & Performance Committee - Divisional Boards via Operational Management Board (Monthly) - Capital Steering Group via F&P Committee (Monthly) - Operational Performance Executive Led Group reporting to OMB	System Financial Plan ICB submissions ICB monthly expenditure controls group NHSE monitoring returns	*Partial*	*4 x 4 = 16*	**NO**	Long term financial plan aligned to strategy. Sustainable plan for C&M under development.	A more detailed 5 year financial plan is in the process of being prepared. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Conclusion of 2024/25 annual planning process (June 2024). Development of deficit drivers underway. Revisited PWC action plan and HfMA financial control checklist, reported to F&P Committee and prioritised action plan will continue to be reported. Financial strategy will need to align with the emerging clinical strategy and people strategy. Initial consideration of financial strategy at F&P Committee and Board strategy day (Feb 25).	*12*	***Mar-25***
			C2) Annual Budget and systems of budgetary control **Control Owner**: Chief Finance Officer	- Financial Plan (approved) - Finance Report to Board - F&P Committee - Forecast processes and reporting within finance reports	Financial Plan ICB submissions Internal Audit reviews Weekly FICC returns to the ICB (via FICC) including forecasting	*Partial*			Uncertainty of impact and funding for the pay award.	Continue to work with the C&M ICB. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Ongoing discussions with the ICB and NHSE CFOs re Inquiry funding. NHSE review of impact of the pay award funding has been completed and position agreed however no further funding will be provided. Formal confirmation of Inquiry funding received (Jan 2025). 25/26 position being reviewed. 25/26 planning guidance introduces uncertainty and increased risk over ERF/ funding flows and system funding. Continued discussion with the ICB for 25/26 contract value (Q1).		
			C3) Cost Improvement Programme including Quality Impact Assessments **Control Owner**: Chief Finance Officer	CIP delivery group reporting to F&P. F&P Committee	Financial Plan NHSE Template FICC returns to the ICB (via PWC)	*Partial*			Delivery phase of CIP Programme, low levels of maturity and to be underpinned by productivity expectations. Slippage and risk in converting CIP opportunities to identified schemes.	Development of schemes and further movement of opportunities into identified schemes which can be transacted. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Workstreams identified and Executive Leads assigned. Workshop held in April 2024 to engage teams and agree next steps. CIP Delivery Group established with CEO as Chair, and reporting into F&P Committee. Workstreams reporting into EDG, with scheme maturity levels moving positively. Consideration of acceleration of CIP opportunities supported by the Continuous Improvement Team. Additional financial control measures being implemented and EDG working with Divisions to implement these. Action complete for 24/25 and focus on 25/26. CIP planning for 25/26 commenced with workshop Jan 25. CIP structured agreed, opportunities identifed and residual gap. Further development of programme underway through EDG. National benchmarking/ productivity assessment under review for additional opportunities.		
BAF6 Inability to achieve the capital programme within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of our services **Executive Risk Lead:** Chief Finance Officer **Board Committee:** Finance and Performance Committee **Last Update:** Jan 2025	**Causes** - Implications of ICS capital envelope with undetermined ICB estates strategy and capital prioritisation process - Ageing estate and challenging backlog maintenance risks - Womens and Childrens building major capital scheme - limited development opportunities due to space constraints **Consequences** - Impact on delivery of capital plan - insufficient progress on backlog maintenance - Inability to invest in innovations not currently identified in the Trust's five year financial plan - Having to re-prioritise the programme if an unidentified need arises - Disruption to operational services during a complex capital programme	*5 x 4 = 20*	C1) Robust governance arrangements for Capital Management. **Control Owner**: Chief Finance Officer	- Finance and Performance Committee reporting to Board. - Capital Management Group via F&P Committee	ICB returns	*ACCEPTABLE*	*5 x 3 = 15*	**NO**	Uncertainty of the ICS approach to capital, estates strategy and capital prioritisation process.	Engagement in ICS Estates Strategy development. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Member of efficiency at scale workstream overseeing system estates work.	*12*	***Jul-25***
			C2) Management of new Women's and Children's Build **Control Owner**: Chief Finance Officer	W&C Project board governance - monthly risk review undertaken and assurance report provided to Project Board with escalations to Board of Directors via Finance and Performance Committee.		*Acceptable*							
			C3) Capital planning and prioritisation **Control Owner**: Chief Finance Officer	Quarterly update to the Finance and Performance Committee. Estates Strategy.		*Partial*			Exploring opportunities for contingency and system capital funding,	Continue to explore opportunities for system capital **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Capital allocation confirmed and prioritised plan in place for 2024/25. Successful bid for £7.5m national capital to support ED/ UEC improvements with completion expected early 25/26.. TIF bid submitted to support elective capacity (Dec 24) and outcome awaited but preparatory work underway. 25/25 capital planning underway. Prioritisation meeting held Feb 25 with BAU allocation and contingency proposal.		
			C4) Estates strategy **Control Owner**: Chief Finance Officer	- Health and Safety Committee reports via Finance and Performance Committee. - Capital Management Group via F&P Committee	Six Facet Survey. Regulatory and statutory assurance received ad hoc (e.g. fire safety, H&S etc).	*Partial*			RAAC remediation plan .Risk and management of RAAC is guided by the most up to date professional guidance as issued by NHSE	RAAC failsafe works to continue with expected completion now at the end January 2025. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	At end of January 2024 Regional RAAC Board agreed additional funds to support the remaining failsafe works to the existing building, with advance of £2m to support the development options to re-provide bed capacity. New contractor has commenced failsafe works in July 2024. Additional funding agreed to support increased costs. Annual assessment completed Jan 2025. No further exceptional work required, with failsafe and inspections to continue until decant.		

Risk Theme: Digital & Data

RISK APPETITE: OPEN - Upper tolerance limit 12

LINKS TO STRATEGIC GOALS: SG4: Adding Value

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF7 Failure to deliver transformative digital and data solutions and performant, secure and resilient infrastructure could impact on patient and staff experience and organisational productivity. **Executive Risk Lead:** Chief Digital & Data Officer **Assurance Committee**: Finance and Performance **Last Update:** March 2025	**Cause:** - Failure to review and adopt innovative solutions to deliver value added digital transformation - impacting ability to support CoCH, ICB and NHSE strategies (Consequence C1) - Failure to invest sufficiently in secure digital infrastructure, systems, service and data to enable safe, effective clinical patient care and business operations (Consequence C1, C2) - Increasing risk profile with more attacks evident, including ransomware and phishing. (Consequence C3) - Failure to identify, develop and maintain the required Digital & Data Services people capability (internal plus partnerships/third parties) (Consequence C4) - Failure to adequately train Trust wide staff in cyber security awareness (Consequence C5) -Failure to adaquately assess the quality of data within the Trust digital clinical systems (Consequence C6) - Increasing support and licence costs for key systems (Consequence C7) **Consequence:** C1-Trust will be reliant on systems that are not fit for purpose which will impact productivity and consequently service quality/patient experience - the Trust will not be able to adopt innovative solutions. C2- Insecurities within the systems and infrastructure with vulnerabilities that could be exploited through a cyber-attack. C3 - Data loss and regulatory sanctions if personal data is lost C4 - Reduced level of skills in workforce due to inability to recruit staff at required level C5 - Compromised systems and infrastructure would result in business continuity measures being put in place for staff and patients. C6 -Poor data quality could lead to Trust staff making ill-informed decisions and inaccurate external reporting C7 - Increasing license costs will impact on Trust financial position and may prevent the Trust renewing contracts and lead to removal of digital solutions	*5 x 4 = 20*	C1)Digital and Data Strategy which aligns with ICB and National expectations **Control Owner:** Chief Digital & Data Officer	Updates into FnP via Digital Strategic Programme Update	MIAA Digital strategy audit (Jan-Mar 25)	*Partial*	*5 x 3 = 15*	**NO**	Strategy refresh required with regular consolidated reporting to F&P Committee. Green policy is being updated in 2025 - Digital & Data Services are represented at the anchor institution steering group	(i) Refresh Digital and Data Strategy informed by National digital maturity assessment. **Action Owner:** Chief Digital and Data Officer **Due date**: Quarterly update (ii) MIAA to conduct audit of Digital and Data Strategy. **Action Owner:** Chief Digital and Data Officer **Due date:** Q1 25/26	Microsoft Co-pilot trial is being developed with access to 500 licenses. MIAA strategy audit Q4 2025 Ambient voice solutions are currently being reviewed with view to pilot in Q1 25/26	*12*	*Mar-25*
			C2)Annual plans that deliver effective management of Cyber security threats and Digital Infrastructure health **Control Owner**: Chief Digital & Data Officer	- DSPT annual audit via Audit Committee - DSPT 23/24 presented to Finance and Performance Committee (F&PC) - SIRO report into F&PC	- Annual MIAA assurance audit on DSPT submission	*Partial*			SIRO report for F&P Committee. Information Asset Owner responsibilities. Completion of capital infrastructure investment including data centres. New DSPT toolkit for completion in 2024/25.	(i) SIRO Report to be developed **Action Owner:** Chief Digital and Data Officer **Due date:** Complete	SIRO report developed and submitted to F&P Committee (Completed). Creation of new AI steering group – regular meetings now taking place (Completed)		
										(ii) DSPT and Cyber Assurance Framework (CAF) initial audit evidence to be submitted December 2024 **Action Owner:** Chief Digital and Data Officer **Due date:** June 2025	DSPT/CAF audit report expected by end of March 25.		
										(iii) Deliver plan to maintain infrastructure health **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	SAN order completed and delivery expected in Mar 25 New air conditioning system to come online in March 25		
										(iV) Deliver plan Cyber Security protection plan (V) Targeted action on Information Asset Owners process including business continuity plans and their party supplier management **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	Complete Lessons learnt review following recent regional Cyber attacks (Q4 24//25) New SIEM solution has been ordered - following successful funding bid.		
			C3)Annual plan for investment, upgrade and optimisation of digital Applications (including EPR) **Control Owner**: Chief Digital & Data Officer	- EPR update reported to Finance & Performance Committee - Contract in place with EPR supplier, for upgrades over the next 5 years	- MIAA lessons learned review (reported to Audit Committee and F&P Committee) - NHSE Readiness review (reported via F&P Committee)	*Partial*			Application (including EPR) optimisation structures, engagement and assurance reporting.	New prioritisation process for digital applications to be introduced, including clincially led group to drive EPR optimisation programme. **Action Owner:** Chief Digital and Data Officer Due date: Complete Under taken optimisation programme and encourage participation in national EPR usability survey **Action Owner:** Chief Digital and Date Officer **Due date:** Quarterly udpate	Prioritisation process now established with updates into F&P Committee. EPR usability survey was conducted in Q3 24/25 results due in Q4 24/25 Project underway to enable integration of primary care electronic referrals (eRS) into EPR. Solution due to be tested Mar 25. Business case being developed for procurement of new Ophthalmology system - Q1 25/26.		
			C4) Continuous improvement plan for Data Quality and Analytics **Control Owner**: Chief Digital & Data Officer	- Annual report to F&P Committee		*Partial*			Clear data quality framework and assurance reporting.	Develop and deploy data quality framework with enhanced assurance reporting. **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	Annual report to F&P Committee (Nov 2024). Data Hub will launch in Jan 2025 Data Quality Assurance Mark (DQAM) - resource prioritisation within Data and Analytics team is under way Feb 2025		
										Adopt NCF Framework for internal reporting **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	National Competency Framework (NCF) workstreams in progress to support recruitment, retention and professional development within Analytics team		
			C5) Digital and Data workforce plan ensuring, professionalisation, capacity, capability, and sustainability **Control Owner**: Chief Digital & Data Officer		- National digital workforce survey (reported via F&P Committee)	*Partial*			Fit for the future workforce plan.	Workforce plan review, including data scientist capabilities. Target acheivement of DSDN Level 3 accreditation. (April 2025) **Action Owner:** Chief Digital and Data Officer **Due date:** Quarterly update	Regional digital workforce plan in development, Data science development plan in place. C&M EPR resourcing plan in development. Digital SDN (Skills Development Network) level 3 accreditation initial assessment Jan/Feb 2025. Full assessment on 1st April 25		

Risk Theme: Governance

RISK APPETITE: CAUTIOUS - Upper tolerance limit 9

LINKS TO STRATEGIC GOALS: SG3: Leadership

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF8 Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation. **Executive Risk Lead:** Director of Governance, Risk and Improvement **Board Committee**: Audit Committee **Last Update:** March 2025	**Causes** - implementation of changes in legislation - effectiveness of governance structures - clarity of accountability and assurance reporting - new partnership arrangements developing **Consequences** - legal and regulatory action - Board effectiveness	***4 x 3 = 12***	C1) Effective Governance Structures **Control Owner:** Director of Governance, Risk and Improvement	- Well led action plan. - Annual report. - Committee effectiveness annual reports via Audit Committee.	Head of Internal Audit Opinion (via Audit Committee). VFM opinion (via Audit Committee). CQC Reports.	*Partial*	***4 x 3 = 12***	**NO**	Well led action plan delivery.	Continued delivery of actions within the Well Led action plan including strengthened reporting and Sub Committee/ Group organogram. **Action Owner**: Director of Governance, Risk and Improvement **Due date**: Quarterly updates	Significant progress made against well led action plan including assurance committee effectiveness, BAF and risk appetite reset for 2024/25. Risk management improvement plan actions progressing, risk management policy approved and Risk Management Committee in place. Datix developments being implemented. Committee organagram developed and further review of sub committee structures including Divisions underway. Governance presentations continue to be delivered in various forums.	***9***	***Q4 24/25***
			C2) Compliance with relevant codes of governance and legislative requirements **Control Owner:** Director of Governance, Risk and Improvement	- Annual report - code of governance compliance (via Audit Committee) - Provider licence compliance (via Audit Committee)		*Acceptable*			Comprehensive map of regulatory compliance and assurance reporting.	Regulatory compliance and asurance map to be developed. **Action Owner:** Director of Governance, Risk and Improvement **Due date:** Q4	Regulatory compliance map being developed to be populated by Divisions and teams. Likely to be developed into 2025/26. Compliance with NHS Constitution to be reported in Q4. Provider licence and code of governance compliance reported to Audit Committee (Feb 25) and summary to Board (Mar 25).		
			C3) Partnership Governance **Control Owner:** Director of Governance, Risk and Improvement	- CEO report	- CMAST CiC updates - Mental health and learning disabilities collaboration updates	*Partial*			Clairity of governance for emerging partnerships and collaborations.	To take stock of current partnerships and support emerging partnerships with effective governance. **Action Owner:** Director of Governance, Risk and Improvement **Due date:** Quarterly updates	Continued development of governance for CWP/COCH collaborative community services with an update to the Board strategy day (Oct 24). Joint Committee TOR drafted for Board approval. Exec to Exec meeting took place in Feb 2025. Further work to identify and engage as partnerships develop.		
			C4) Public Inquiry **Control Owner:** Director of Governance, Risk and Improvement	- Thirlwall Inquiry Updates - Legal cost updates (via F&P Committee)		*Acceptable*			Corporate records management lessons learned.	Decision log and corporate records management lessons learned being developed for action. **Action Owner**: Director of Governance, Risk and Improvement **Due date:** Quarterly updates	Continue to understand and share learning including Board development session (October 2024). Decision log in place. Corporate records management added to Information security and information governance group, with corporate records management work commencing with plicy re-draft.		

Risk Theme: System Working and Collaboration

RISK APPETITE: SEEK - Upper tolerance limit 16

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

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF9 System working and provider landscape changes may present challenges in ensuring COCH is positioned as a strong system partner, with priorities aligned to system partners across Cheshire & Merseyside. **Executive Risk Lead:** Director of Strategy & Partnerships **Board Committee**: Board of Directors **Last Update:** March 2025	**Causes** - Primary Legislative Changes as per the Health and Care Act 2022 - Maturity of the ICS and Place - Further development of Provider Collaboratives - Changes in commissioning process - Unclear clinical priorities - Newly defined system strategy/ plans **Consequences** - Conflicting priorities between COCH and ICS - Diversion of COCH leadership capacity - Loss of autonomy - Disruption to established clinical networks	*4 x 4 = 16*	C1) Take a Leadership role in Cheshire West **Control Owner:** Director of Strategy & Partnerships	Chief Executive reports to Board.	Regular reporting from CMAST CiC Regular reporting from Mental Health, Learning Disabilities and Community Servcies CiC Cheshire West Health and Well Being Board Cheshire West Partnership Group	*Acceptable*	*4 x 3 = 12*	**YES**	Uncertainty regarding delegation and decision making.	Ensure the Trust has appropriate representation at the ICS, CMAST, MHLDC and other Provider collaboratives, specialised commissioning and local place based forums. **Action Owner**: Director of Strategy & Partnerships **Due date**: Quarterly updates	Representation and engagement continues across a range of forums. Director of Strategy facilitated, arranged and chaired the first of a series of prevention conference across Place focused on CVD Prevention. A second conference aimed at admission avoidance / specifically CVD-R (respiratory) was held in October with circa 55 primary care colleagues present. A third leadership event is planned in for April 1st which will focus on CVD and the management of diabetes.	*16*	***Target Score Achieved***
			C2) Develop a Trust approach to health inequalities and prevention **Control Owner:** Director of Strategy & Partnerships	Reports to People and Organisation Development Committee (bi-monthly)	Cheshire West Partnership Group	*Partial*			Internal and external availbility of data and the intelligence to join up data sets in order to better infom our approach and target popultions in greatest need.	Embark on a dedicated data collection. Attendance at the ICB Population Health Board. Enroll in the ICB Population Health Academy. **Action Owner:** Director of Strategy & Partnerships **Due date:** Quarterly updates	Board development session held in October - raising education and training awareness of health inequalities at a national, Core20plus5, regional (Marmot) and local level using CIPHA data. Roles and responsibilities of Board members discussed and self assessment undertaken. An outline approach to Health Inequalities was discussed and has also been shared with local stakeholders who have endorsed the approach.		
			C3) Purposeful shift from traditional provision to a population health approach **Control Owner:** Director of Strategy & Partnerships	Reports to People and Organisation Development Committee (bi-monthly)	Cheshire West Partnership Group	*Partial*			Clnical strategy	Develop a framework by which clinical strategies can be developed. Seek sponsorships to fund dedicated clinical startegy development day. Program manage Clinical summit, 24th October 2024. **Action Owner:** Director of Strategy & Partnerships **Due date**: Q4	Clinical Strategy day was held as planned in October with over 60 colleagues in attendance. Videos of the event are now in SharePoint. The event was highly productive with colleagues asking for more events of this nature. Series of operational and clinical leads strategy sessions to be undertaken on a Quarterly basis. Further Trust wide workshop and discussion held in December and now built as as BAU every quarter. Board report presented in January by way of progress.		
			C4) Achieve anchor institution status. (green / social value / prevention) **Control Owner:** Director of Strategy & Partnerships	People and Organisation Development Committee (bi-monthly) Finance & Performance Committee	ICB Net zero Group ICB Prevention Pledge Group Population Health Board National quarterly data collection via Foundary platfrom	*Partial*			Aligned assurance.	Align the three former workstreams into one overight function : NHS Prevention Pledge; Social Value; Progress against the Trust green net zero plan **Action Owner:** Director of Strategy & Partnerships **Due date:** Quarterly update	New Anchor Institution oversight group established (June) which meets bi monthly. New reporting framework adopted. Revised terms of reference. Board report presented in July 2024. Anchor Institute Oversight Group has now expanded membership to CWP and Chester University sustainability department. The group has now also engaged with the Country Park. National guidance published in February 2025 will require Trusts to refresh Green strategies by July 2025. This will be overseen by the Anchor Institution Group and is on target for delivery.		
			C5) Commerical Partnerships **Control Owner**: Director of Strategy & Partnerships	Operational Board Finance & Performance Committee Weekly Executive Group Theatre redevelopment Group (bi-weekly)	NHS Supply Chain Hill Dicksion - legal advice	*Partial*			Developed approach for commercial partnerships.	Development of a MDT stakeholder Group Development of scope and specification for a hybrid theatre Develop a long term vision for main theatres **Action Owner:** Director of Strategy & Partnerships **Due date:** Quarterly update	MDT Project Group established. Scope and specification development. Outline Business Case for hybrid theatres developed for July Board consideration. Market testing via Capability framework commenced with 3 potential suppliers identified, hence a mini competition is now indicated. Trust open day with potential suppliers by way of engagement. CCL now onboarded to help develop options appraisal and OBC. OBC is on track for completion for April Finance and Performance Committee pior to Board later that month		
			C6) Integrated Care approach **Control Owner**: Chief Operating Officer/ Director of Strategy & Partnerships	COCH/CWP Community Services updates through OMB.		*Partial*			Future vision and defined operating model.	To build on the work to date to develop the Community Services Collaboration, to agreed a clear vision and future operating model. **Action Owner:** Chief Operaitng Officer/ Director of Strategy & Partnerships **Due date:** Q4	MOU in place. Discussions underway and paper being developed for COCH/CWP Community Services collaboration vision and future operating model. Update provided at the Board strategy day (October 2024). An exec to exec group has meet to discuss the formation of a joint committee to help with the strategic direction of developing community services and the neighbourhood model.		
			C7) Models of care for in reach, out reach and networked services **Control Owner:** Chief Operating Officer/ Director of Strategy & Partnerships			*Partial*			Development of partnership models.	Continued discussions with WUHFT and other partners to develop models of care. **Action Owner:** Chief Operating Officer/ Director of Strategy & Partnerships **Due date:** Quarterly updates	Continued discussions with WUHFT following Board to Board. There are several pieces of work coming to a conclusion including the Pathology and Renal reviews which will be subject to an exec to exec meeting in Q1 this 2025/26.		

Risk Theme: Research and Innovation

RISK APPETITE: SEEK - Upper tolerance limit 16

LINKS TO STRATEGIC OBJECTIVES: SG5: Partnerships

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF10 Inability to deliver the Research and Innovation agenda to exploit future opportunities **Executive Risk Lead:** Medical Director **Board Committee**: Board of Directors **Last Update:** March 2025	**Causes** - Leadership capacity - Funding sources - Early stages of partnerships **Consequences** - Ability to maintain R&I function - Aligment of R&I activity	***4 x 3 = 12***	C1) Research Strategy **Control Owner**: Medical Director	Quarterly Board reports Updates via OMB	Annual report to CRN	*Partial*	***4 x 3 = 12***	**YES**	Strategy needs to be updated to reflect our ambition.	Refresh our Research Strategy to align to new Trust Strategy. **Action Owner:** Medical Director **Due date**: Q4	Early discussions to establish research ambitions to support strategy development. This will be aligned to the clinical strategy approach. A research nurse attends Divisional Boards to increase visibility of research studies and opportunities as well as provide feedback. Research sandpit being planned with the University.	***16***	***Target Score Achieved***
			C2) Team structure, SOPs and expertise **Control Owner:** Medical Director		MHRA inspections GPC inspections HTA inspections	*Partial*			Staff development and retention.	To agree and communicate the development offer for research staff. **Action Owner:** Medical Director **Due date**: Q4	Team charter developed with the team. Appraisals and development discussions have taken place, and individual objectives clearly aligned. The team continue to explore apprenticeships, career paths and progression opportunites.		
									Strengthening of governance and SOPs.	Review governance and SOPs (including CRF and Trust vehicle). **Action Owner:** Medical Director **Due date:** Q4	An agreed structure for research governance and processes to include expression of interest, feasibility and approval. This will ensure formal structures, processes and documentation are in place to support timely mobilisation of research studies. List of Standard Oprating Procedures (SOPs) in place and team engaged in further review and development in Q4.		
			C3) CRN Arrangements **Control Owner**: Medical Director			*Partial*			Funding levels and income streams. Changes to CRN anticipated in 24/25.	Continued focus on funding streams, including securing grants and commercial funding. **Action Owner :** Medical Director **Due date:** Quarterly updates	Assurance received that funding for 2024/25 will remain. Future year funding yet to be confirmed but likely to be built focussing on opening studies, recruitment, time and target which are areas the team are strengthening in preparation. COCH are involved in the Cheshire and Merseyside ICB bid to create a commercial delivery network, with the outcome of the bid yet to be confirmed. Work ongoing with the University of Chester on grant opportunities. Clinical Research unit opened (Dec 24) and research bus received.		
			C4) Partnership Arrangements (including academic appts) **Control Owner:** Medical Director	Updates through OMB		*Partial*			Increasing academic appointments. Partnership agreements and governance.	To continue to develop our partnership arrangements, inlcuding education institutes and commercial. **Action Owner:** Medical Director **Due date:** Quarterly updates	Communication strategy developed to support awareness for partner organisations. Current focus on building relationships and developing collaboration opportunities. Framework agreed between COCH and the University of Chester to progress partnership arrangements. Also building relationships with Primary Care Networks (PCNs) to develop a primary care research network. Trust Consultant (and Dir. of Medical Education) appointed as Acting Clinical Dean at the University of Chester. Steps to Teaching and University Hospital status explored with the Board (February 2025).		
			C5) Innovation Strategy **Control Owner**: Medical Director			*Partial*			Innovation strategy.	Partnership with University of Chester to be explored to support Innovation ambitions. **Action Owner:** Medical Director **Due date**: Quarterly updates	Current focus on building relationships and developing partnership opportunities. This will require leadership and resource to drive forward.		

Board Assurance Framework

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

5x5 risk scoring matrix:

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

Risk Appetite Levels

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

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 9b.**	**High Risks Report**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft		Director of Governance, Risk & Improvement				
Author(s)	Karan Wheatcroft		Director of Governance, Risk & Improvement				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research		**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Potential to link to all BAF risk areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led						**X** **X** **X** **X** **X**
Previous considerations	-						
Executive summary	Work is ongoing to further strengthen and embed risk management across the Trust, together with a refreshed Risk Management Policy. The Risk Management Committee has now met twice and started to progress the risk management improvement plan actions. Whilst the improvement plan is progressing, the reporting of high risks continues as per the Datix system with review and update by Executive Directors. This paper sets out a range of risks with a residual score of 15 or over and these risks include: • RAAC • Waiting lists and overdue follow ups • Equipment and assets • Radiology capacity and demand • CIP						

	• Staffing levels and gaps in resources • Cyber Security
Recommendations	The Board of Directors is asked to consider and note the current high level risks and the work that continues on local risk registers to ensure these reflect the risks faced, mitigations and actions.

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

High Risks Report

1. BACKGROUND

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

2. DATIX RISK REGISTER

On the Corporate Risk Register, there are currently 29 risks in total with a residual risk score of 15 and above that have been entered on to the Datix system (note: this number varies significantly as we are increasing our focus on the risk registers with an aim to improve accuracy and completeness). The risk to cyber security has been added since the last report in January 2025.

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

Score	Count
15	15
16	14
Grand Total	**29**

The details of the 29 high risks are provided in appendix 1. The risks have been manually adjusted whilst work is ongoing to improve our risk management processes. The risk themes include:

- RAAC
- Waiting lists and overdue follow ups
- Equipment and assets
- Radiology capacity and demand
- CIP (planned care)
- Safe staffing levels and gaps in resources
- Cyber Security

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

3. RECOMMENDATIONS

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

Appendix 1 – High Risks (as at 3rd March 2025)

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
2857 2004	Backlog of overdue follow up appointments in: • Ophthalmology • Urology	Planned Care	4x4	16	Waiting lists being validated and monitored through the Divisions and through OPELG. AI validation software has been agreed and we have started the procurement process.	Cathy Chadwick
3413 3412	E.D.F washers endoscopy decontamination unit life span Endoscopy decontamination F.D.(8) discontinuation of spare parts	Planned Care	5x3	15	Agreed to replace from capital slippage 24/25 – order placed and new washer will be in place before the end of March 2025.	Cathy Chadwick
3406	Ovens beyond repair - ovens range from 16 to 19 years old and are costing large amounts of money to repair with less guarantee of whether the repair would last.(12.5k for repairs 2023/2024)	Corporate	5x3	15	Considered and provisionally agreed for 2025/26 capital programme.	Karen Edge
3425	Failure of Siemens Fluoroscopy Equipment in Radiology - Siemens Artis Zee Fluoroscopy equipment is in excess of 10 years old (expected life span of 8 years), with limited parts available for continued maintenance, the equipment is now deemed 'end of life'. There is no back-up equipment to perform these examinations if this equipment fails and patients would	Diagnostics and Clinical Support	5x3	15	Considered and provisionally agreed for 2025/26 capital programme.	Karen Edge/Cathy Chadwick

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
	require transfer to other hospitals outside of this trust for examinations.					
3429 3416	Inability to deliver a Sentinel Lymph Node Service at CoCH due to upcoming changes to Radiopharmaceutical Preparation & Supply	Women and Children/ Diagnostics and Clinical Support	5x3 4x4	15 16	Agreement reached with Clatterbridge Hospital for the radioisotope to be administered at there site before patients then attend COCH for the imaging process.	Nigel Scawn
2971	Inability to deliver timely care to patients on a urology cancer pathway	Planned Care	4x4	16	Case presented to and approved at EDG for additional clinical staff and recruitment underway. Urology included in the TIF bid and will gain a lot more capacity once the build is finalised.	Cathy Chadwick
3298	The single lift that links the JDSC building is an aging asset and consequently much of the original lift control system is obsolete from a maintenance and repair perspective. Given the age and condition of the lift, the probability of breakdown is increasing and reliability issues are being witnessed more frequently.	Corporate	4x4	16	On-call service from lift maintenance service provider. Trained staff in lift release. Asset log being used to record breakdowns. Ordered replacement of control panel (significant component in operational functionality).	Karen Edge
1246	Lack of second theatre on Central Labour Suite	Women and Children	4x4	16	New Women's and Children's build under construction and due to open Summer 2025. Risk will be removed once the move has taken place.	Sue Pemberton
3348	Loss of postal function for Trust internal and external mail. - Post Room is currently based in the Maternity	Corporate	5x3	15	Review of options ongoing.	Karen Edge

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
	building. Following the transition to the new Women and Children's Building in the middle of 2025 the old building will need to be vacated and there is currently no provision for the re-siting of the Post Room facility.					
3398	Multiple factors that could result in a Cyber Attack- several separate areas of risk that could contribute to a Cyber attack. Separate risks have been raised for these areas and this risk is to hold the overarching risk of a Cyber attack.	Digital and Data Services	5x3	15	This risk has been reviewed, and the score has been increased on the basis of recent cyber-attacks in Cheshire and Merseyside. Controls are in place covering MFA, patch management and national cyber alert responses. Active programmes of work to mitigate risk include implementation of a SIEM solution, completion of DSPT/CAF audit, and acting upon regional lessons learnt from recent events. Oversight is provided by IG & IS committee with SIRO report into F&P Committee at each meeting. There is a concern regarding Information Assets Owners and 3rd party asset management – with plans being developed to address concerns. Annual Cyber work plan for 25/26 is actively being developed.	Jason Bradley

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
3284	Non Achievement of Planned Care CIP Target.	Planned Care	4x4	16	Increased grip and control measures in place across the Trust, Divisional updates to CIP Review Group and focused review meetings taking place. The Division will meet there 1% but not the additional income target. Score to be re-reviewed now mitigations in place.	Cathy Chadwick
3118	Not enough dedicated provision of ultrasounds for anaesthetic use within Theatres including Maternity	Planned Care	4x4	16	Jubilee Ultrasound - replacement has been ordered after securing capital slippage funding Maternity Ultrasound – In use Existing theatres ultrasound – Now operational Additional Ultrasound - added to capital list Score to be re-reviewed now mitigations in place	Cathy Chadwick
2678	Insufficient clinical pharmacy staff to undertake patient facing services across all areas resulting in a risk of medication related harm incidents , reduced patient flow, increased medication costs, increased incidence of antimicrobial resistance, breaches of legislation	Diagnostics and Clinical Support	5x3	15	Medicines information department and on-call pharmacist available for clinical advice. In areas without a full clinical service, supplies maintained through dispensary team and	Nigel Scawn

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
	and regulatory standards related to the use of medicines				discharge team available to support patient flow.	
3426	Replacement of Baxter pressure infuser to Belmont RI 2 Fluid management system - 3M Ranger system in use within the trust does not supply high-volumes and is cumbersome to set up. A fluid warmer is required to safely resuscitate patients and prevent hypothermia especially in the event of utilisation of the Massive Haemorrhage Pathway (MHP) where blood products are used directly from cold storage.	Planned Care	4x4	16	Considered and provisionally agreed for 2025/26 capital programme	Cathy Chadwick/Karen Edge
3309	Risk of out of hours work for CT becoming unmanageable for the staff working and mistakes being made	Diagnostics and Clinical support	4x4	16	Additional cover provided through rota to 8pm. New process introduced to outsource bookings after 5pm (covered by vacancies underspend). Some cover in place for vacancies. Score to be re-reviewed now mitigations in place.	Cathy Chadwick
3303	Medical Photography - Risk of the Trust having no clinical photographer in core business hours additional Risk around the correct governance processes	Diagnostics and Clinical Support	4x4	16	Processes in place to schedule patients and local agreements in place with some specialties. Adhoc admin support provided by radiology teams.	Cathy Chadwick

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
	being followed for loan cameras.				SOPS developed for usage of loan camera. Score to be re-reviewed now mitigations in place .	
2522	Risk of treatment delays and patient management for cancer patients who have not come via the fast track pathway (clinical risk) due to it not being possible to accurately code cancer diagnoses in Cerner or perform searches for this information	Diagnostics and Clinical support	4x4	16	This issue relates to potential delays in Pathology in isolation. Post EPR implementation review of mTuitive in progress and this should have resolved some of the issues. Priority for resolution but there are competing divisional priorities and limited digital and data resource to support. Score to be re-assessed as even though there is a risk there is no evidence this has caused an issue to delay in treatment.	Cathy Chadwick/ Jason Bradley
3260	Risk to patient safety due to lack of adherence to NHSE 4 hour Emergency Department standard	Urgent Care	3x5	15	Continued focus on flow and UEC improvement plan, which had been reviewed and is now a full system improvement plan. Long waiting times in the Emergency Department have significantly improved during February 2025.	Cathy Chadwick

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
2550	Risk to provision of Microbiology service due to insufficient resource in consultant microbiologist team	Diagnostics and Clinical Support	4x4	16	Locum and agency arrangements in place for the 0.6 wte vacancy and any a/l or absence gaps. Calls from clinical teams limited to consultant only to manage the workload. Permanent band 7 appointed Sep 24.	Nigel Scawn
3159	Risk to service provision and staff burnout due to reduction in Obstetric and Gynaecology Consultant workforce	Women's and Children's	5x3	15	Long term agency locum in place, distribution of role across service to ensure focus on maternity services. Executive discussion on recruitment plans. One new appointment made at recent interviews Further role advertised in January 2025 – aim for over recruitment into O&G roles to support the service. Support offered from LWH for fetal medicine	Nigel Scawn
3435	Shortage of Lidocaine -national shortage of Lidocaine spray which is necessary for undertaking OGDs. Endoscopy have used lidocaine 5% + phenylephrine 2.5% spray (TNE) as an alternative in the meantime but there is a significant cost implication. Lidocaine is costed at	Urgent Care	5x3	15	Lidocaine 10% spray now available again and back in stock. Risk to be closed.	Nigel Scawn

Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Executive Lead
	£7:18 per patient and lidocaine 5% + phenylephrine 2.5% spray at £23.					
3427	Single Point Of Failure - One person coordinating AAA pathways including surveillance, ordering of grafts and stents. Availability of stents crucial for emergency cases. Additional risk is the lack of a CLTI / Carotid Coordinator for the SMART Centre.	Planned Care	5x3	15	The risk is in holding and needs to be reviewed by divisional leadership to clarify the risk rating.	Cathy Chadwick
2989	Lack of Interventional Radiology Resource for supporting the vascular service	Diagnostics and Clinical Support	3x5	15	Business case being developed for second IR suite, this will include the demand data and any build will require external funding.	Cathy Chadwick
3297	SMART Vascular - AAA waiting times	Planned Care	3x5	15	Working with WHH and WUTH to audit the pathway and develop an action plan to reduce the wait times to meet the 8 week target.	Cathy Chadwick
3234	Inability to provide adequate IR service due to only having 1 IR theatre and no recovery ward	Diagnostics and Clinical Support	4x4	16	Business case being developed for second IR suite, this will include the demand data and any build will require external funding.	Cathy Chadwick
2385	Use of Siporex RAAC Planks in W&C's Building Roof	Corporate	3x5	15	Risk and mitigations being managed through W& C project Board. National RAAC board sign-off of current risk rating (reduced from 20)	Karen Edge

PUBLIC – Board of Directors
25 March 2025

Report	**Agenda Item 10.**	**Quarterly Report on Safe Working Hours**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Dr Nigel Scawn			Medical Director				
Author(s)	Dr Rebecca Gale			Guardian of Safe Working				
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**	Failure to maintain safety and prevent harm would result in poorer patient care and outcomes, inability to deliver operational planning standards, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust, Challenges in ensuring a high quality, engaged, diverse and inclusive workforce would affect our ability to deliver patient care and failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation, and our reputation.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							 **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X**
Previous considerations	Not applicable							
Executive summary	The purpose of this report is to provide assurance to the Board that the doctors' working hours within the Trust are being monitored and managed appropriately. The safeguards built into the 2016 Junior doctors' contract are designed to ensure risk of fatigue is effectively mitigated thereby minimising any risk to patient safety. The role of the Guardian of Safe Working (GOSW) is to ensure that compliance with safe working hours is addressed both by the doctors themselves and the Trust hosting them.							

	This quarterly report includes data relevant to the safe working hours of resident doctors including but not limited to, exception reports, vacancies and information obtained from the resident doctor's forum held on the 22nd January 2025. The key message from this quarter is ongoing good engagement with the exception reporting process by the resident doctors and an improvement in the time taken for agreement of reports by the supervisor. The current main issue is the number of fineable breaches in hours that have been identified and the lack of a system in place at COCH to allow those fines to be administered, thereby delaying payment for the resident doctors and reducing the visibility of the issues. Actions to be taken include: • The need for a system to allow fines to be administered needs to be urgently resolved as it is causing delays in the resolution of reports and the payment for those doctors involved. This risks disengagement with the exception reporting system if the resident doctors do not feel their concerns are being adequately addressed. • A clear system for reporting the individual specialties exception reporting data at their departmental governance meetings is needed so all specialties can clearly see the trends and issues raised. This is particularly important for those breaches that have incurred a fine as all efforts need to be made to minimize these occurrences. • General surgery and urology rotas need to be reviewed with a consideration to reduce the maximum shift length as there have been a high number of breaches resulting in a fine identified in the last quarter.
Recommendations	The Board of Directors is asked to note the report and actions required.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	Risks related to the medical workforce and the governance around this.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential.

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

QUARTERLY REPORT ON SAFE WORKING HOURS:
DOCTORS AND DENTISTS IN TRAINING

PERIOD 01/10/2024 TO 31/12/2024

Executive summary

The key message from this quarter is ongoing good engagement with the exception reporting process by the resident doctors and an improvement in the time taken for agreement of reports by the supervisor.

The current main issue is the number of fineable breaches in hours that have been identified and the lack of a system in place at COCH to allow those fines to be administered, thereby delaying payment for the resident doctors and reducing the visibility of the issues.

Introduction

The purpose of this report is to provide reassurance to the board that the doctors working hours within the Trust are safe. The safeguards built into the 2016 Junior doctors' contract are designed to ensure risk of fatigue is effectively mitigated thereby minimising any risk to patient safety. The role of the Guardian of Safe Working (GOSW) is to ensure that compliance with safe working hours is addressed both by the doctors themselves and the trust hosting them.

This quarterly report includes data relevant to the safe working hours of resident doctors including but not limited to, exception reports, vacancies and information obtained from the resident doctor's forum held on the 22nd of January 2025.

High level data

Number of doctors / dentists in training on 2016 T&Cs (total):	186 (LE)
Amount of time available in job plan for guardian to do the role:	1 PA per week
Admin support provided to the guardian (if any):	4 hours per week.
Amount of job-planned time for educational supervisors:	0.25 per trainee

a) Exception reports (with regard to working hours)

Grade	Specialty	Exceptions Jul-Sept	Exceptions Oct-Dec
F1	Gastro	6	7
F1	Ortho	8	5
F1	AMU	13	5
F1	ED	4	8
F1	COTE	10	11
F1	General surgery	4	1

F1	Psychiatry	2	0
F1	Urology	19	15
F1	Vascular	2	0
F1	Respiratory	1	5
F1	Plastics	0	1
IMT	COTE	4	5
IMT	AMU	4	4
IMT	Haematology	6	2
ST1	Plastics	1	0
CT1	General Surgery	3	6
ST3	Plastics	3	2
CT3	Surgery	0	1
CT3	Urology	0	1
ST6-8	Plastics	5	1
ST6-8	Ophthalmology	1	0
ST6-8	Vascular	1	0
Unknown	Unknown	2	

For the 2 reports flagged as immediate safety concern in the July-Sept quarter, I have had further confirmation from the doctors involved that the safety concern was selected in error, so those reports have been closed. For this quarter there were no reports with safety concerns flagged.

b) Work schedule reviews.
The F1 doctor tier remain the highest reporting group spread across a range of specialties but with clear outliers in Urology given the size of the specialty, and care of the elderly.

Urology- The issue with the high number of exception reports in urology had been identified by the doctors themselves and via the exception reporting system in the last quarter. In discussion with the educational supervisors for Urology, they had highlighted particular issues around weekend cover with lack of senior ward round support for the F1 doctors. This understaffing of the urology rota has led to a fine for breaching the contract at the F1 level due to exceeding 25% of shifts with missed breaks. Unfortunately, the planned meeting to look at the causes for this did not occur but there has been recruitment to urology and the foundation tier during this reporting period which appears to have improved the situation. Of the 15 exception reports submitted by the F1 grade, only 3 were from the month of Dec following this recruitment.

General surgery- The work done to cover the rota gaps in surgery plus the recruitment to the F1 tier is reflected in the exception reports with only 1 in this quarter. However, the pressure appears to have moved to the Core Trainee (CT) tier of surgery as there was an increase in the number of reports received to 6 from 3 and a number of these included a lack of ability to take breaks as well as exceeding

shift length. The current shift time of 12.5 hours is being looked at due to the number of fines highlighted for exceeding the maximum shift length of 13 hours.

Care of the elderly (COTE) - Again COTE were an outlier in the number of exception reports submitted although they are the largest medical specialty. On in-depth review of the reports 3 of the 14 at F1 level were incorrectly attributed to COTE rather than the acute medical on call. I have been in contact with the rota coordinator and educational supervisors within COTE to ensure there is adequate senior support to support the foundation tier residents to allow them to leave the ward on time.

c) Fines

Type of Exceptions	
72 hours work in 168 hours	0
Difference in work pattern	**1**
Early start	0
Exceeded the maximum 13-hour shift length	**8**
Late finish	**70**
Minimum daily Working Time Rest of 11 hours reduced to less than 8 hours	0
Request a work schedule review	0
Teaching cancelled	0
Unable to achieve breaks	**26**
Unable to attend clinic/theatre/session	0
Unable to attend scheduled teaching/training	**2**

The main reason for exception reporting this quarter is for late finishes with 70 reports referencing this. There were 26 reports related to being unable to achieve breaks. The surgical specialties are over-represented particularly Urology.

Specialty	**Number of reports unable to take breaks**
Orthopaedics	3
General surgery	6
Urology	8
Acute medicine	0
Gastro	3
Resp	1
COTE	6

With regards to fines there were 8 fineable breaches identified for shifts exceeding 13 hours. The issues with the lack of a defined account that is allocated to the

GOSW for fines to be paid into has meant these fines have not been able to be addressed. This is an ongoing problem which has been previously raised at Joint Local Negotiating Committee (JLNC), the Resident Doctors Forum (RDF) and with medical staffing. Due to this, the fine for vascular due to an ST7 breaching the safe hours for a Non-Resident On call (NROC) shift has still not been resolved from the last quarterly report.

All the breaches this quarter were within general surgery which is a specialty that has been identified at the RDF as being significantly under pressure with larger than usual patient numbers and rota gaps at both F1 and CT level leading to concerns raised about doctors being unable to take leave. There is a work schedule review required as the current on call shift length in general surgery is 12.5 hours which is too close to the maximum allowable unless finish times can be guaranteed. If the shift time was reduced to 12 hours, then none of the shift overruns would have incurred a fine.

F1 doctors do not undertake overnight shifts at COCH which then puts additional staffing pressure on the CT and Specialist Trainee (ST) tiers. There is an option for additional foundation doctors to join COCH if additional rotation and out of hours funding can be found, and specialties are currently considering this. If additional foundation doctors were allocated it may then be possible to construct an overnight on call tier of the rota for both medicine and surgery.

Table of breaches of 2016 contract that have led to a fine and costings. (Vascular is carried over from previous quarter due to non resolution).

Exception ID	Grade	Specialty	Hours relating to breach	Drs Rateb (£)	Drs Payment (£)	GoSW Rate (£)	GoSW payment (£)	Total (£)
71	ST7	Vascular	8	65.01	**520.08**	108.33	**866.64**	**1,386.72**
139	ST3	General Surgery	0.5	41.38	**20.69**	68.94	**34.47**	**55.16**
146	F1	General Surgery	1	37.79	**37.79**	62.99	**62.99**	**100.78**
147	F1	General Surgery	1	37.79	**37.79**	62.99	**62.99**	**100.78**
171	F1	General Surgery	1	37.79	**37.79**	62.99	**62.99**	**100.78**
206	F1		1	37.79	**37.79**	62.99	**62.99**	**100.78**
207	F1	General Surgery	0.5	37.79	**18.90**	62.99	**31.495**	**50.39**

208	F1	General Surgery	1	37.79	**37.79**	62.99	**62.99**	**100.78**
Average breaks missed	F1	Urology	3	23.83	**71.49**	39.73	**119.19**	**190.68**
139	ST3	General Surgery	1	56.68	**56.68**	94.46	**94.46**	**151.14**

Issues arising

Issues relating to the introduction of the new software have been largely resolved but there remains some ongoing developments to improve the ease of use of the system, particularly with the planned changes to exception reporting by new resident pay deal.

System issues:

Editing exception reports: Resident doctors are now able to edit their reports until the point of supervisor agreement. This has helped with the delays incurred when the incorrect supervisor has been selected as they can now alter the report rather than resubmit it.

The function to edit the hours if they have been entered incorrectly is not available which the developers are working on as this would improve the ease of administering any additional payments required.

Delays in granting access to doctors to system on commencing work: There were some significant and unacceptable delays in doctors obtaining access to the exception reporting system in August due to a delay in uploading their information to the reporting system. There were no significant changeovers in this quarter, so I am awaiting the February rotation to see if this remains a problem.

Display of fineable breaches:

The current software dashboard does not specify which reports have incurred a fine without exporting the data set to excel. I have met with the developer to ask if this could be added to the dashboard to allow immediate identification at the time the report is submitted.

Education of residents to select correct specialty

There are still exception reports being attributed to the incorrect base specialty. This is mainly a problem with on call shifts for medicine. All residents receive a demonstration of the system at induction but going forwards I plan to liaise with the system developer to see if it would be possible to add a specific tick box to indicate if the report is related to an on-call shift.

Non software issues:

Urology

There is an ongoing concern with the workload in urology particularly as there has been a breach in resident doctors being unable to take 25% or more of their scheduled breaks which will incur a fine. The understaffing in urology has been partially resolved by the additional recruitment to a locally employed post. The number of exception reports has reduced to 3 for the month of December following this.

General surgery

There are significant concerns regarding the staffing in general surgery at both foundation and CT tier with a number of fines for breaching the total shift length. Concerns were also raised at the resident doctor forums for the high workload particularly on call. This has been discussed with the DME and medical staffing regarding modelling a more sustainable rota (potentially including a foundation tier on night shifts) and how this can be staffed going forwards, potentially with the addition of locally employed posts to support.

Care of the Elderly

Care of the Elderly continue to have the highest number of reports at both foundation and CT level relating to additional hours worked and missed breaks. I have contacted the rota coordinator, and the main issues raised are around the large ward footprint the resident doctors are required to staff (5 wards plus outliers), lack of support services e.g. phlebotomy and overall understaffing as a result of doctors working less than full time. From August COTE have been running at 80% WTE doctors for the ST grade and 60% for the CT grade. Locum positions have been appointed to but there was a delay in recruitment to starting which has caused staffing gaps. The Care of the Elderly team are currently undertaking a project to compare their resident staffing levels to the Royal College of Physicians recommendations.

Surgical work schedule timings

I received poor engagement with my request for the surgical specialties to highlight how they manage the difference in work schedule finish time of 5:30 with the scheduled end time of theatre lists of 15:45-18:00. I will continue to address this going forwards as it is important the work schedules reflect the actual hours the resident is expected to work.

Actions taken to resolve issues.

To resolve the issues relating to the lack of an ability to administer fines I have highlighted this at the JLNC in Oct, the resident doctors forum in Oct and Jan, spoken with manager in HR and finance and held a meeting in Jan 25 to talk through the need for a designated GOSW account so that fines can be levied against departments whose resident doctors are exceeding hours. I am now writing a finance report to detail what the requirement is for this system so it can be taken forwards.

There have been further meetings between the software developer and myself with some new changes introduced to allow the exception reports to be editable by the resident doctors after submission. There is now a mobile phone app available to allow ease of exception reporting which has been publicized to the resident doctors.

Action plan:

Action required	Timescale for delivery	Responsible for delivery
Finance paper explaining need for fine account	20th March 2025	GOSW (R Gale)
Account set up for GOSW to allow fines to be administered	End April 2025	Paul Marston (HR)/ Finance business partners
System for reporting individual specialties ER data	April 2025	Clinical leads to supply details of monthly specialty business/governance meetings for dissemination of data.
Review of general surgical rota staffing	April 2025	Will Stockton (Surg rota lead) Chris McFaul, Jenna Roberts, Ellen Strudwick.
Review of F1 doctor staffing with aim to increase F1 numbers	July 2025	Jennie Grainger/Richard Hay as Foundation program team.

Summary

The majority of the issues relating to the introduction of the new exception reporting system were resolved in Q3 and there is a plan for ongoing presentation and education at trust induction for all doctors joining the organization. Engagement with the exception reporting system has continued to be good but is still skewed towards the foundation grades. The resident doctors' forums are occurring and provide a valuable resource to investigate further into trends seen emerging in the exception reports but engagement with these remain poor. There is a planned medicine specific meeting due to take place in March and this will then feed into the next RDF in April. We are planning to hold the next meeting within the hospital instead of the education center to try and improve attendance. The plan for specialty representatives generated little response from the resident doctors.

Questions for consideration

The need for a system to allow fines to be administered needs to be urgently resolved as it is causing delays in the resolution of reports and the payment for those doctors involved. This risks disengagement with the exception reporting system if the resident doctors do not feel their concerns are being adequately addressed. A clear system for reporting the individual specialties exception reporting data at their

departmental governance meetings is needed so all specialties can clearly see the trends and issues raised. This is particularly important for those breaches that have incurred a fine as all efforts need to be made to minimize these occurrences.

Appendices

Exceptions Reports by Department

Exceptions Reports by Department	
Acute	**18**
Gastro	*5*
Gen Surg	*4*
COTE	*12*
T&O	*1*
A&E	*3*
Resp	*3*
Plastics	*3*
Urology	*10*
Vasc	*0*
Haem	*2*
Diab	*0*
Ophthal	*0*
Cardio	*1*
Med O/C	*7*
Surg O/C	*11*
	0
	0

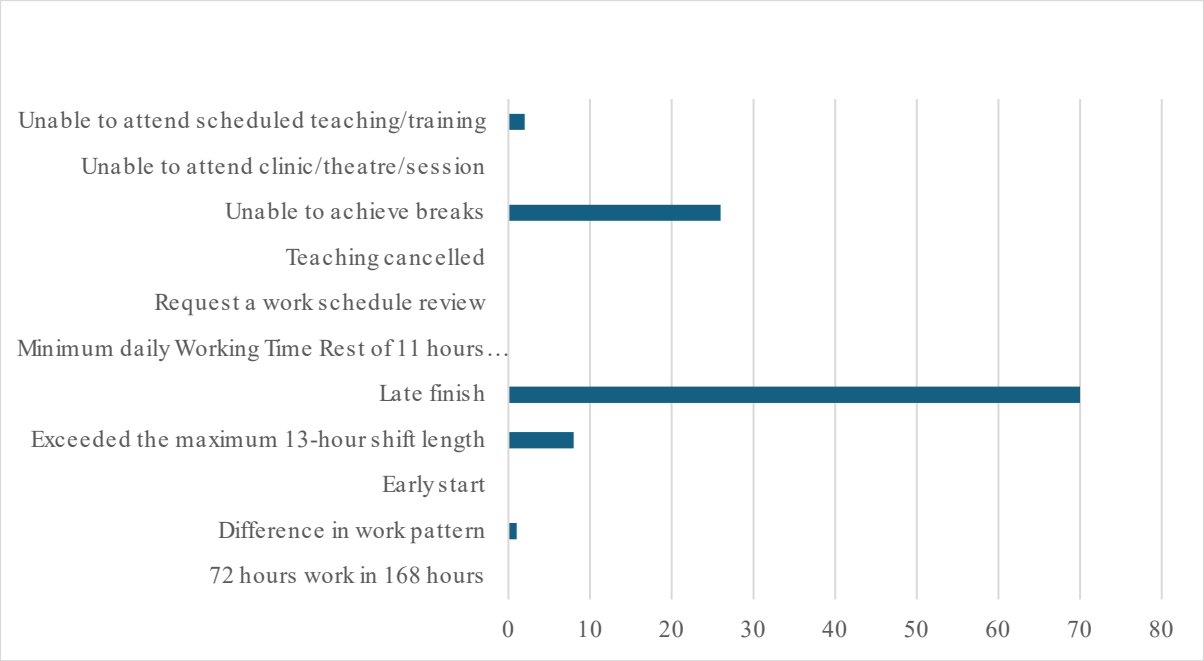
Exception reports by Grade

Grade	
F1	58
F2	0
ST1-2	16
ST3-5	4
ST6-8	1

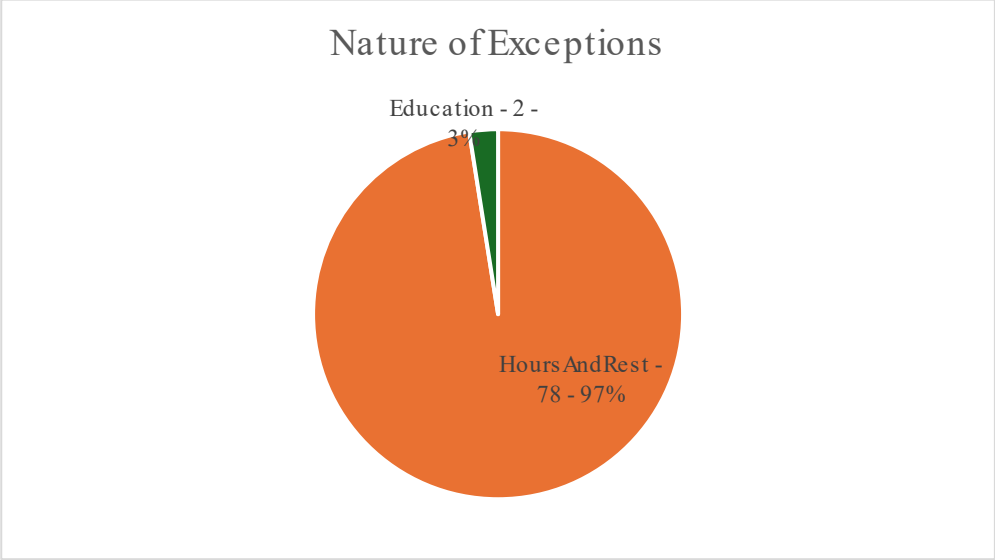
No of Exception Reports by Division

No of Exception Reports by Division	
Urgent Care	51
Planned Care	29
Womens & Childrens	0
Diagnostics	0

Nature of Exceptions



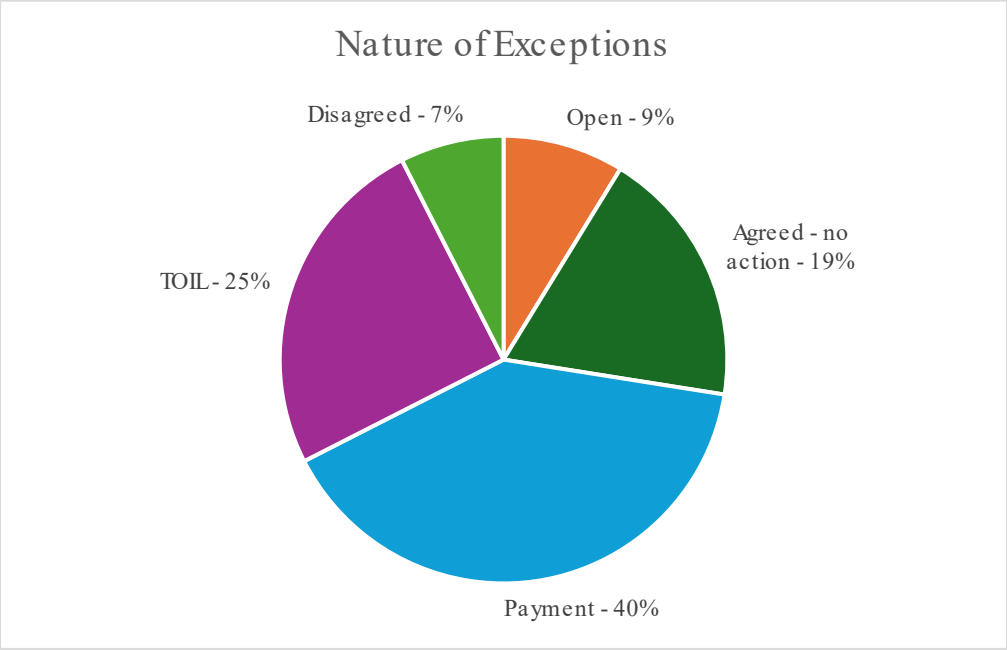
Type of exceptions



Resolution of Exception Reports

There are 6 outstanding reports from quarter 3. One of these is due to an inability to pay the fine the doctor is due for breaching hours. The other 5 are still awaiting supervisor sign off.

For quarter 4:



There are been a big improvement in the number of reports still remaining open. This stood at 48% for the previous quarter but with improved engagament by supervisors and changes to the system this has been reduced to 9%. This should improve further when the change to exception reporting (all additional time of less than 2 hours can be automatically authorised without educational supervisor sign off) as agreed by the new resident doctors deal comes into effect. There were a number of reports which were incorrectly marked as “agreed, no action” by the supervisors so reports marked as this are manually reviewed and modified for payment at a meeting between GOSW and Med staffing at the end of the quarter.

Time taken to resolve:

Average time taken to resolve	21
Shortest	0
Longest	113

The aim is to have all reports resolved within 2 weeks of submission. The 113 days is due to the ongoing issue with inability to administer a fine which has been detailed previously in the report.

The Board of Directors is asked to note:

- The need for a system to allow fines to be administered needs to be urgently resolved as it is causing delays in the resolution of reports and the payment for those doctors involved. This risks disengagement with the exception reporting system if the resident doctors do not feel their concerns are being adequately addressed.
- A clear system for reporting the individual specialties exception reporting data at their departmental governance meetings is needed so all specialties can clearly see the trends and issues raised. This is particularly important for those breaches that have incurred a fine as all efforts need to be made to minimize these occurrences.
- On call surgery rotas need to be reviewed with a consideration to reduce the maximum shift length as there have been a high number of breaches resulting in a fine identified in the last quarter.
- The action plan.

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 11.**	**Maternity Service Quarterly Update Quarter 3**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Natasha Macdonald Sara Brigham Pippa Scott-Heale			Director of Midwifery Associate Medical Director Divisional Director				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X**	BAF 1 – Failure to maintain quality of care would result in poorer patient & family experience. BAF2 - Failure to maintain safety and prevent harm would result in poorer patient care and outcomes. BAF 3 – Inability to deliver operational planning standards, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Perinatal assurance and improvement board – 13th February 2025 Quality and Safety Committee – 6th March 2025							
Executive summary	This report updates the Board of Directors on maternity and neonatal services at The Countess of Chester Hospital NHS Foundation Trust, covering key performance metrics, safety concerns, and compliance with the Maternity and Neonatal Incentive Scheme (MIS). Key highlights: • Ongoing monitoring through the Perinatal Surveillance Tool and improvements in the Saving Babies' Lives Care Bundle (SBLv3). • Review of serious incidents, lessons learned, and actions to enhance patient safety. • Focus on leadership visibility, staff engagement, and addressing concerns raised through Freedom to Speak Up (FTSU).							

	• Strengthened collaboration with the Maternity and Neonatal Voices Partnership (MNVP) to improve service user involvement. • Governance structures ensuring continued oversight and reporting to the Trust Board.
Recommendations	The Board of Directors is asked to note the assurance provided.

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

Maternity Service Quarterly Update

1. Introduction

The quality and safety of maternity and neonatal services remain a priority for the Trust, aligning with national expectations and the Ockenden Report (2020). This report provides a comprehensive update on performance, safety concerns, and improvements, focusing on progress with the Maternity Incentive Scheme (MIS) and compliance with CNST safety actions. It also addresses serious incidents, cultural challenges, and service developments, enabling the Board to fulfil its governance responsibilities and ensure excellence in care for mothers, babies, and families.

2. Background

Maternity and neonatal services have faced increasing scrutiny following national reviews, including the Ockenden Report (2020), highlighting the need for enhanced oversight and improvement in NHS maternity care. The Maternity Incentive Scheme (MIS), now in its sixth year, drives these improvements by incentivising Trusts to meet safety actions through the Clinical Negligence Scheme for Trusts (CNST). This report addresses MIS Year 6 requirements, updates on key initiatives like the Saving Babies' Lives Care Bundle Version 3, compliance with the Maternity Services Data Set (MSDS), and insights from serious incidents and perinatal reviews. Regular updates to the Women and Children's Board ensure transparency and continuity.

3. Purpose

Assurance: This report provides assurance to the Board on the safety, quality, and compliance of Maternity and Neonatal services with the Maternity Incentive Scheme (MIS).

Maternity (and Perinatal) Incentive Scheme (MIS) An update on the Maternity (and Perinatal) Incentive Scheme (MIS) is provided as part of the Maternity Services report. While Year 6 of the MIS has concluded, its principles and requirements have now become business as usual, embedding safety and quality improvements into standard practice.

Compliance with MIS standards is maintained through the monthly Divisional Perinatal Assurance and Improvement Board, which continues to review and gather evidence aligned with the MIS Technical Guidance to ensure sustained adherence.

MIS Progress Update.

The Trust has embedded the ten safety actions from MIS Year 6 into routine operations.

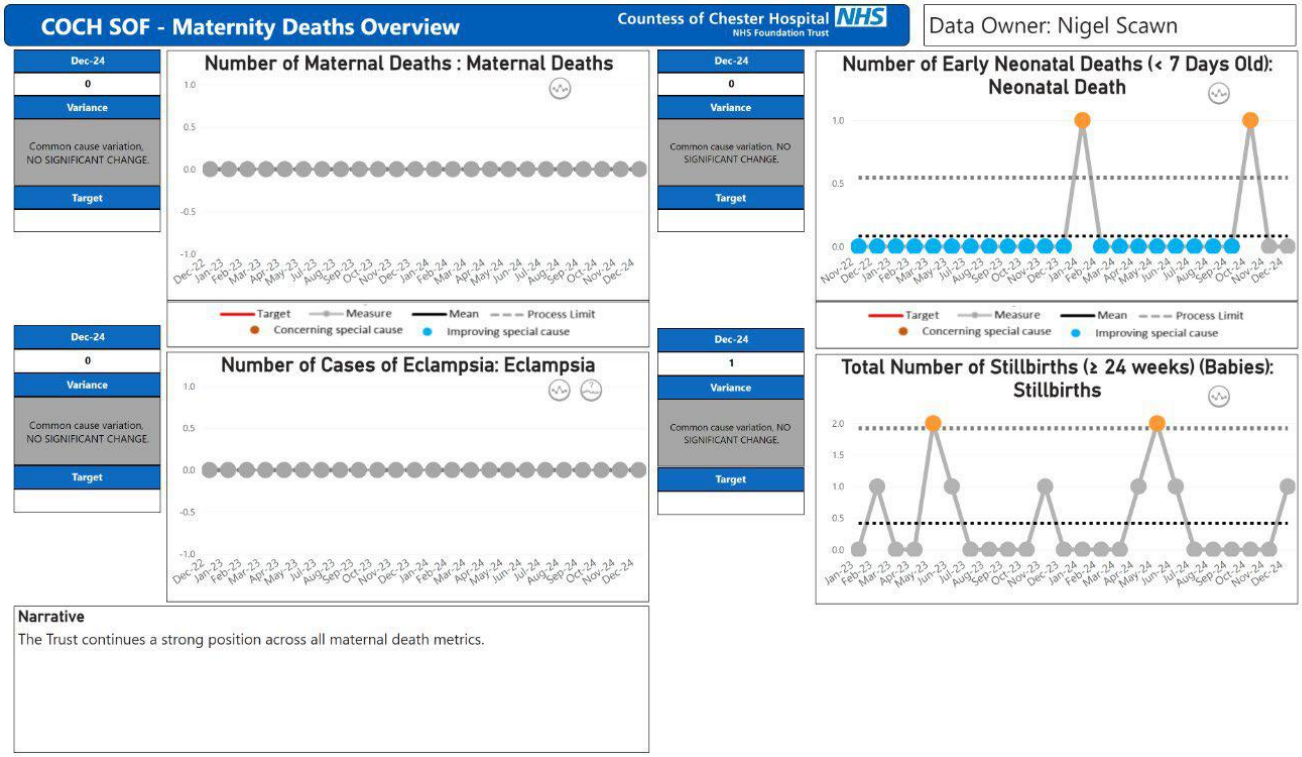
Safety Action		Assurance	
1	**Safety action 1:** Are you using the National Perinatal Mortality Review	Q3 report provided to Board of Directors January 2025	Full compliance

	Safety Action	Assurance	
	Tool (PMRT) to review perinatal deaths		
2	**Safety action 2:** Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	July 2024 Scorecard passed submission. This safety action is now complete.	Full compliance
3	**Safety action 3:** Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimize separation of parents and their babies?	Quality improvement project launched to further the attain work overseen by safety champions. Transitional care is provided in full alignment with the comprehensive specifications outlined in BAPM (British Association of Perinatal Medicine) guidance.	Full compliance
4	**Safety action 4:** Can you demonstrate an effective system of clinical workforce planning to the required standard?	Included at **Appendix 1** is the Obstetric and Anaesthetic workforce report along with the neonatal medical and nursing workforce paper reported in line with British Association of Perinatal Medicine (BAPM) providing an update on the Trust's position from July 2024-December 2024. The report confirms full adherence to this standard.	Full compliance
5	**Safety action 5:** Can you demonstrate an effective system of midwifery workforce planning to the required standard?	The biannual staffing report, covering the period from July to December 2024 to People Commtitee April 2025	Full compliance
6	**Safety action 6:** Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Saving Babies Lives, noting the Trust achieved compliance against the 6 elements based on evidence submitted in December 2024 next review February 2025.	Full compliance

Safety Action		Assurance	
7	**Safety action 7:** Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	The Maternity and Neonatal Voices Partnership MNVP lead is working within our services. Listening to families continues to be high priority using the Trusts six steps model.	Full compliance
8	**Safety action 8:** Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	All staff group compliant	Full compliance
9	**Safety action 9:** Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	We have established a clear oversight mechanism to provide assurance to the Board on maternity and neonatal safety and quality issues. These meetings ensure continuous monitoring, evaluation, and improvement of safety and quality standards within our maternity and neonatal services. Strategic oversight framework presented by chief operating officer	Full compliance
10	**Safety action 10:** Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Q3 report provided to Board of Directors January 2025	Full compliance

Learning from deaths

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



Learning Extract: October to December 2024

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

Cases Meeting Inclusion Criteria for Reporting to MBRRACE-UK (Q3 2024/25)

Neonatal Death
A neonatal death occurred at three days of age in the community and was brought into the Emergency Department. A joint agency response was initiated.
This case is under review by the MNSI and is subject to PMRT review.
Learning identified included an independent practitioner to confirm the correct ET tube placement, balancing current guidance with best practice, and clarifying the timeframe for transferring the body to the mortuary.
Updated child death guidance was ratified and circulated in January 2025, providing explicit process instructions.

Lessons learned during PMRT meetings have been disseminated internally via communication from the Bereavement Midwife and the Practice Development Midwife. These lessons are shared during rolling half-day training sessions, Perinatal Mortality and Morbidity meetings, and the Safety Huddle.
Wider learning has been shared with the Northwest Coast Network Special Interest Groups. Feedback and evaluations from presentations and discussions have been consistently positive.

Key Learning Points

Miscommunication: An ambulance service error led to a patient being transferred to the bereavement suite while the baby was still alive. Staff have been reminded to verify information accurately before patient arrival.

Missed On-Call Obstetrician Opportunity: Earlier contact with the on-call obstetrician could have facilitated a more timely examination and MDT discussion, reducing psychological distress for the family and clarifying the poor prognosis sooner.

Documentation: Community midwifery staff have been reminded to ensure documentation is contemporaneous.

Connectivity Issues: Community midwives are advised to use patient home Wi-Fi, where available, as it does not require a password.

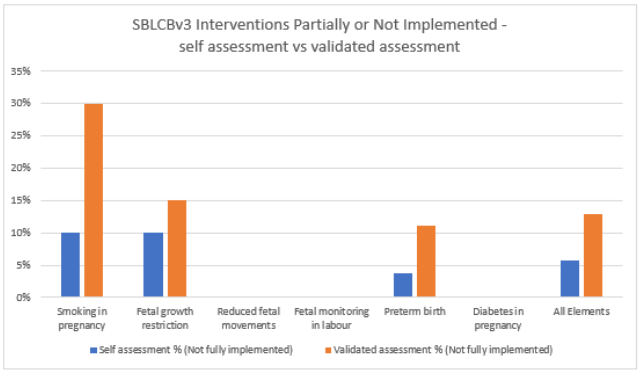
Feeding Assessment Guides: Laminated guidance for breast and bottle-feeding assessments is now available in key areas to support staff during calls and assessments.

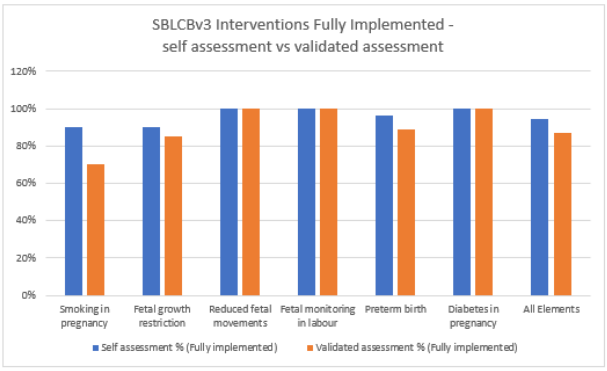
Saving Babies' Lives Care Bundle (SBLv3)

SBLv3 is a structured programme designed to reduce perinatal mortality by improving care in five key areas: smoking cessation, risk assessment and surveillance for fetal growth restriction, reduced fetal movement awareness, effective fetal monitoring, and preterm birth optimisation.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	90%	Partially implemented	85%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	89%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	87%	CNST Met





Summary of Areas for Improvement & Suggested Actions – SBL Compliance

1. Junior Staff Training
   - Issue: Junior staff have not completed the required brief advice training.
   - Action: Ensure all junior staff complete the very brief advice training, with oversight to track and support completion.
2. Recording of Quit Dates
   - Issue: There is a need for accurate input of quit dates to reflect smoking cessation efforts.
   - Action: Provide support for lead Midwife to ensure quit dates are consistently recorded and reported.
3. Optimisation Work & Performance Clarity
   - Issue: Lack of clarity on whether optimisation performance issues are due to data entry errors or actual underperformance.
   - Action: Conduct a review of data entry processes and performance outcomes to determine the root cause and implement targeted improvements.

4
. Leadership & Governance
   - Issue: Need for clear leadership to drive improvements in SBL compliance.
   - Action: Identify the medical lead for SBL, with midwifery oversight provided by Director of Midwifery, ensuring alignment between clinical and operational leadership.

Next Steps
   - Confirm the medical lead for SBL.
   - Implement monthly oversight meetings, with first report to PAIB within the next reporting cycle.
   - Develop an action plan for junior staff training and quit date data entry improvements.
   - Review optimisation data and performance to identify specific areas for improvement.

This structured approach will enhance compliance, drive meaningful improvement, and ensure alignment with strategic priorities.

Summary:
We have achieved 94% self-assessed implementation and 87% LMNS validation, demonstrating strong overall performance. However, targeted improvements are required to address remaining gaps, strengthen compliance, and ensure sustained progress towards the full implementation of Saving Babies' Lives Care Bundle v3**.**

Maternity neonatal voice partnership

The MNVP remains committed to strengthening community engagement and improving service user feedback to enhance maternity and neonatal care. Recent efforts have focused on building strategic partnerships with local organisations to ensure diverse voices shape service improvements.

Key collaborations have supported initiatives in inclusive maternity education, improved accessibility for marginalised groups, and enhanced patient engagement. Partnerships with healthcare professionals and community networks continue to inform service development, prioritising cultural sensitivity, trauma-informed care, and equitable access.

Moving forward, the MNVP will refine feedback processes, expand digital engagement, and work closely with healthcare teams to embed user-led improvements into service delivery. These initiatives align with the Trust's strategic priorities, reinforcing a patient-centred approach to maternity and neonatal care.

Maternity Incidents

Serious Incidents Reports – 5

- Term baby transferred for cooling
- 3-day old baby RIP
- Unit closure 15 hours – 5 service users diverted
- Missed postnatal discharge visit – baby readmitted with severe jaundice
- Intrapartum stillbirth

PSII in progress 4. 3 awaiting Integrated care board (ICB) sign off and 1 being written.

- Never event (retained swab);
- PPH 4.9L, hysterectomy
- Baby fall
- Missed postnatal discharge visit – baby readmitted with severe jaundice

AAR: 33
Swarm: 3

Thematic review: **1**

- Post Partum haemorrhage >1,500ml

Number of moderate and above incidents

Total reported: **50** (x5 incidents are linked to 2 requiring only 1 learning response each) of these 3 severe, and 1 fatal.

Open currently of Q2: **20** (3 severe and 1 fatal)

Closed: **30**

CQC escalations There were no CQC escalations received in this quarter

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

Maternity safety support program update

A letter was received from the regional team confirming an additional exit criterion.
'*When exiting Countess of Chester Hospital NHS Trust from the MSSP, it must be recognised that the findings and recommendations from the Thirlwall enquiry are due to publish next year. Although this primarily relates to neonatal services, cultural aspects, governance systems and processes and multidisciplinary working are inter-dependable with maternity services. It has been*

agreed that following the publication of the Thirlwall enquiry, there will be a multi stakeholder Rapid Quality Review led by the region, which the MSSP team will be part of for completeness and ongoing support if required.'

Maternity and neonatal culture improvement plan

Report Summary: Postpartum Haemorrhage (PPH) Thematic Analysis

A thematic review of 40 PPH cases (>1500 mls) from January to July 2024 highlighted the following key findings:

Risk Identification:

Inconsistent identification and documentation of PPH risk factors during antenatal and intrapartum periods.
Lack of personalised care planning for high-risk cases.

Clinical Management:

Delays in administering critical interventions such as Tranexamic Acid (TXA) and Oxytocin.
Major Obstetric Haemorrhage (MOH) protocol was not activated in all relevant cases, though women recovered well.

Documentation and Tools:

Incomplete use of the OBS Cymru checklist and gaps in documenting medication administration.
Proactive use of tools like ROTEM and cell salvage showed potential but lacked consistent implementation.

Good Practices:

Majority of cases managed effectively with appropriate settings and staffing.
Strong outcomes with no fatalities and most women discharged within three days.

Recommendations:

Improve risk identification and personalised care planning.
Ensure timely administration of interventions like TXA.
Strengthen documentation standards and scribe roles during emergencies.
Reinforce the importance of the labour ward coordinator's role in managing emergencies.
A SMART safety action plan is underway to address these findings and embed proactive measures, anticipating a reduction in PPH cases and improved outcomes for patients.

Freedom to Speak Up Response
Following a concern raised to the FTSU Guardian in December 2024, an action plan has been developed and shared with the Maternity Safety Champions. The concern has now been closed by the FTSU Guardian, with steps taken to address underlying issues and improve staff engagement.
Summary of Key Issues

Concerns raised through FTSU channels highlighted challenges in leadership visibility, staffing shortages, communication gaps, workplace culture, and patient safety risks. Staff have reported feeling undervalued, disconnected from management, and hesitant to voice concerns due to fear of negative responses. Chronic understaffing and unclear management structures have contributed to increased stress, burnout, and concerns from staff in relations to safe staffing.

Actions Taken

To address these concerns, a number of initiatives have been implemented:

- Staff Engagement: A unit meeting was held to openly discuss concerns, reinforce management support, and encourage staff participation in solutions.
- Governance & Leadership: A dedicated working group has been established to focus on improving leadership visibility, with all managers now undertaking regular clinical shifts.
- Communication & Transparency: Increased promotion of the FTSU role through newsletters and staff forums, alongside structured leadership development to enhance responsiveness to concerns.
- Workforce Wellbeing: Measures introduced to ensure staff are taking breaks and are properly compensated for additional hours worked. Recruitment efforts are ongoing to address persistent staffing shortages.
- Retention & Culture Improvement: Team-building activities have been organised to enhance workplace culture and foster a more supportive environment for new and experienced staff alike.

Monitoring & Next Steps

Progress will be closely monitored through regular staff feedback sessions and governance oversight at safety chmapiosn meetings. A quarterly FTSU report will track ongoing improvements to ensure continued commitment to fostering a positive, safe, and communicative working environment.

These actions reflect a sustained effort to address concerns raised through FTSU, ensuring staff feel supported, valued, and empowered to speak up without fear of repercussions.

Maternity Risk Register Update – Q3

Two new risks were added in Q3:

1. **EPR System Issue** – The system is unable to open a pregnancy episode for male patients, impacting maternity data recording. IT and system providers are working on a resolution.
2. **Central Labour Suite Ventilation** – The supply and extract system does not meet the required 10 air changes per hour. Estates and infection control teams are assessing remedial actions. These standards will be met in the new W and C building.

A high-risk remains:

- **Lack of a Second Theatre in Central Labour Suite** – Continues to impact timely access to emergency obstetric surgery. Mitigations include escalation protocols and capital investment planning.

Learning from Concerns and Complaints

1 New Complaint received in Q3.

1 New Concern received Q3.

Themes identified are around requests for appointments and staff behaviour.

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

Friends and Family Test (FFT) Maternity Services Feedback Q3 2024/2025

Overview

Friends and Family Test (FFT) data shows high patient satisfaction across maternity services, with staff professionalism and compassionate care consistently praised. Key areas for improvement include communication, waiting times, and visitor policies.

Key Findings

- Antenatal Services: 90.0% positive feedback. Staff praised, but long waits (up to 2.5 hours) and unclear test result communication highlighted.
- Birth Services:
  - Obstetric Unit – 95.54% positive. Excellent midwifery and theatre care. Concerns raised over food quality and visiting policies.
  - Alongside Midwifery Unit – 100% positive (low response rate).
- Postnatal Services:
  - Ward – 90.6% positive. Strong appreciation for midwifery support.
  - Community – 77.5% positive Limited data but overall positive feedback.

Response Rate Analysis

- Antenatal: 9%, Birth: 29%, Postnatal: 23%. Postnatal community 10%
- Obstetric Unit exceeded the NHS 15% benchmark, while antenatal and postnatal wards were slightly below.
- Actions to Improve: Promote real-time feedback, enhance digital engagement, and increase awareness of impact.

Recommendations

1. Improve communication – Reduce waiting times and enhance test result clarity.
2. Enhance birth experience – Review visitor policies and improve food quality.
3. Strengthen postnatal support – Maintain high staff engagement and explore additional community support.

Maternity services remain well-rated, with staff dedication a key strength. Addressing these areas will further improve patient experience and response rates.

Maternity & Neonatal Safety Champions Walkaround Feedback

Date: 14th January 2025

The Maternity & Neonatal Safety Champions Walkaround on 14th January 2025 provided assurance regarding safety, staff engagement, and patient experience. One immediate safety concerns were identified during the visit, a staffing issue was raised separately and promptly addressed by the Director of Midwifery.

Key observations included a clean, well-organised postnatal ward, positive staff feedback on escalation processes, and clear information displays. Patient feedback was overwhelmingly positive, particularly regarding staff support and communication. The MNVP proposed renaming the bereavement trolley the "Lavender Trolley" to align with the Bereavement Suite, which was well received.

Recommendations include enhancing junior medical staff involvement in learning events and exploring alternative formats for future walk rounds.
Overall, the visit reinforced compliance with safety protocols, adherence to national guidelines, and a strong culture of learning and improvement within maternity and neonatal services.

Conclusion

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

Recommendations

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

Appendix: Glossary of Terms and Acronyms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1

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

	Compliance
a) Obstetric Medical Workforce	
b) Anaesthetic Medical Workforce	
c) Neonatal Medical Workforce	
d) Neonatal Nursing Workforce	

Dr Sara Brigham
January 2025
Associate Medical Director Women and Children's Division

Maternity Incentive Scheme year 6

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Obstetric medical workforce

	Compliance
1) NHS Trusts/organisations should ensure that they meet the criteria for employing short-term locums	
2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums	
3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest	
4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document "Roles and Responsibilities of the consultant providing acute care in Obstetrics and Gynaecology"	

Dr Sara Brigham
January 2025
Associate Medical Director Women and Children's Division

Obstetric medical workforce

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

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

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

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

Minimum Evidence required

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

Results

	Compliance/Evidence
During the period July 2024 – December 2024 inclusive, 34 shifts were covered by locum doctors on the tier 2/ 3 rota. All of the shifts were covered by Drs who were currently working at CoCH	

Actions

1.Continue

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

Results

	Compliance/ Evidence
Audit of all locum shifts undertaken during the period July 2024 – December 2024. 1 long term locum was employed until August 2024 (15/4/24-8/8/24). They held the Certificate of eligibility for locums and received induction and appropriate supervision as per RCOG guidance	

Actions

1.Continue

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

Minimum Evidence required

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

Results

	Compliance/ evidence
All job plans in O&G at COCH do not have clinical activity following the day after on call. COCH guidance and SOP on Compensatory rest developed in July 2023	

Evidence

Example job plan

Job Plan			8.5 DCC	1.5 SPA				
		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Week 1	am	Colp		ANC		RAC		
	pm		TH	Colp		Em Gyn		
	o/call							
Week 2	am	OGW	OGW	OGW	OGW			
	pm	OGW	OGW	OGW	OGW			
	o/call							
Week 3	am	Colp	Colp	ANC		TH		
	pm		GOPD	Colp				
	o/call			OC				
Week 4	am	Colp	Colp	ANC				
	pm		GOPD	Colp		Em Gyn		
	o/call			OC				
Week 5	am	Colp	Colp	TH		OC 20:30-8:30		
	pm		GOPD	TH				
	o/call							
Week 6	am			TH		GOPD		
	pm			TH				
	o/call							
Week 7	am	Colp		TH				
	pm		GOPD	Colp		Em Gyn		
	o/call							
Week 8	am	Colp		ANC		GOPD		
	pm		GOPD	Colp				
	o/call							
Week 9	am	Colp		ANC		TH		
	pm		GOPD	Colp		Em Gyn		
	o/call			OC				
Week 10	am	Colp	Colp	ANC				
	pm		GOPD	Colp		Em Gyn		
	o/call			OC				
Week 11	am	Colp		ANC		OGW	OC 8:30-20:30	
	pm		TH	Colp		OGW		
	o/call							
Week 12	am			ANC	CS			
	pm			TH	CS			
	o/call							

Actions

1. Continue

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

Results

	Compliance/ Evidence
6 monthly report produced by Labour ward lead July – December 2024 audit showed 100% Consultant attendance for all scenarios as listed in the RCOG workforce document	

Actions

1. Continue with 6 monthly audit of consultant attendance

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

Anaesthetic Medical workforce

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

Dr Jo Fawkner-Corbett
January 2025
Clinical Lead for Obstetric Anaesthesia

Anaesthetic medical workforce

Standard

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

Evidence required

The rota should be used to evidence compliance with ACSA standard 1.7.2.1. This can be a representative month of the rota

Methods

CoCH have a dedicated Anaesthetist covering the maternity Unit 24 hours per day 7 days per week

A review was undertaken of the anaesthetic rota – August 2024 to December 2024 inclusive

Results

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

July 100%
August 100%
September 100%
October 100%
November 100%
December 100%

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

In summary, COCH was 100% compliant with the staffing standard as set by the Royal College of Anaesthetists for immediate anaesthetist availability for the obstetric unit between July 2024 - December 2024. There are clear lines of communication to the oncall or supervising consultant at all times.

ACTION

Continue to audit the anaesthetic rotas to ensure a dedicated Anaesthetist is covering the maternity Unit 24 hours per day 7 days per week

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

Neonatal Medical workforce

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

Dr Victoria Guratsky
Neonatal and paediatric Clinical Director
January 2025

Neonatal medical workforce

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

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

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

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

Background:

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

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

Since June 2016 COCH the Neonatal Unit at CoCH has functioned between an LNU and SCU. COCH data for 2024 (to end of Nov) shows 16 infants admitted with admission weight < 1500 grams and 283 RCDs (Respiratory care days) were recorded. These figures are in keeping with a SCU rather than an LNU.

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

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

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

As described above the unit is currently working somewhere between an LNU and SCU and figures for 2024 are in keeping with a SCU. However, the unit is referred to by the North West Neonatal Operational Network as an LNU and it is the vision for our perinatal services that the unit will return to level 2. We therefore include staff planning based on getting back to LNU workload as this is the long-term vision for our services.

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

BAPM Recommendations for Medical Staffing of LNUs and SCUs:

Tier One (F2/ST1/2 equivalent)

Local Neonatal Units

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

Special Care Units

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

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

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

Tier Two (ST3+ or equivalent)

Local Neonatal Units

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

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

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

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

Special Care Units

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

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

Tier Three (consultant level)

Local Neonatal Units

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

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

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

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

Special Care Units

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

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

Tier 1

Tier 1 rota consists of 9 doctors. This includes paediatric ST1&2, GP ST1&2 and F2. There is an additional 'trust grade' doctor who contributes to the rota.
Two ANNP's are each working 3 long days a week. This equates to 08:30-21:00 6 days a week. Some weeks this will be across Monday-Friday and two weeks a month will include Saturday-Sunday.
A mixture of normal working days (08.30 – 16.30h); long days (08.30 – 21.00h); twilight shifts (16.00 – 00.00h) gives dedicated tier one cover to the neonatal unit during these hours:
Monday – Friday 08.30 – 00.00h
Saturday and Sunday 08.30 – 21.00h

Tier 2

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

Tier 3

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

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

Changes implemented so far since publication of framework November 2018

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

- Over-establishment of the Tier 1 level staffing – initially by employing 2x trust grade level doctors. Currently we have funding for 1x trust grade level doctor. This ensures better cover for sickness/annual leave/study leave, improves staffing in normal working hours and allowed implementation of the twilight shift.

- Introduction of the twilight shift Monday – Friday at Tier 1 level. This extended the dedicated tier 1 NNU cover from 21.00 to 00.00h.
- Two qualified ANNP now contribute to the Tier 1 neonatal rota (covering weekday and weekend long day shifts). A third ANNP is due to complete training in the next six months and will also add to the regular tier 1 cover.
- Substantive staff grade Tier 2 level created and in post from March 2021.
- Two new consultants now in post
- Increase in enhanced neonatal nurse practitioner roles – two senior neonatal nurses are on the non-medical prescribers register. Along with enhanced skills, such has cannulation, this allows supplementation to tier one rota in managing infants requiring eg septic screens.
- FY1 on rotation to paediatrics now provides out-of-hours cover as part of their rota. Currently this practitioner is supernumerary to tier 1 rota and only covers paediatrics.
- APNP now established in covering seven days a week, 08:30-21:00

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

Recommendations to increase dedicated medical staffing for NNU

The number of tier 1 & 2 level doctors is limited by the number of paediatric and GP trainees. In 2022, national recruitment in paediatrics has improved. However, vacancy rates across paediatric rotas are increasing due to increased dropout and increased less-than full time working.
Whilst a case can be made to improve out of hours staffing with more trust grade doctors at tier 1 and tier 2 level, it should be noted that training opportunities will be diluted and careful consideration should be taken as to whether it is appropriate for there to be dedicated tier 1 level cover overnight at current capacity and workload.

Taking NIPE examinations out of routine workload would allow five 8 hour shifts on the tier 1 rota to be re-distributed to improve out of hours staffing.
ANNPs and APNPs further contributing to the out of hours rota should be strongly considered. These practitioners could only contribute to either paediatrics or neonates. ANNP posts are already established and part of their job plan is to cover the tier 1 rota. A precedent has been set. APNPs have been in place on the paediatric ward for >10 years. They cover the tier 1 rota ad hoc in case of illness or unexpected under staffing.
Most of the tier 1 rota is covered by medical staffing monies. Funding for the advanced nurse practitioners has been varied; one ANNP was financed by corporate and one from medical staffing, our APNPs are financed within nurse staffing.

References:

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

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

Neonatal Nursing staff

	Compliance
The neonatal unit meets the BAPM neonatal nursing standards	

Anne McGlade
Head of Neonatal and Paediatric nursing
January 2025

Neonatal nursing workforce
Each Neonatal Unit must implement or work towards an agreed plan with commissioners for nurse staffing levels based on the following staff to baby ratios for direct patient care, as described in the Toolkit for High Quality Neonatal Services (2009) and recommended by the British Association of Perinatal Medicine (BAPM) and the Neonatal Nurses Association (NNA).
The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN

Results
Neonatal Nursing Workforce
Evidence supports a higher nurse: baby ratio, especially of nurses with a neonatal Qualified in Specialty (QIS) qualification, for the delivery of high-quality neonatal care. National safe neonatal nurse staffing requirements are clearly defined by British Association of Perinatal Medicine (BAPM) and Department of Health Toolkit for Neonatal Services (2010) and state that nurse to baby staffing levels on neonatal units should equate to 1:1 or Intensive Care, 1:2 for High Dependency and 1:4 for Special Care. We have continued to maintain our BAPM compliance and currently have recruited/recruiting into current vacancies and have invested in nurse training to gain QIS qualification. The unit remains committed to maintain BAPM compliance.

Action
Continue

Action plan

Area for Review	Recommendation/ Action	Action Lead	Target date	Date of completion/ update
Monitoring of compliance for all short and long term locums	O&G rota co-ordinator to ensure that for every locum, the RCOG Compliance table is completed to provide on going evidence	Rota Co-ordinator/ Clinical Director	Ongoing	Ongoing
Compensatory rest	Continue to ensure all job plans have no clinical activity following on call	Clinical Director	Ongoing	Ongoing
Consultant attendance for all scenarios as listed in the RCOG workforce document	Continue with 6 monthly audit of attendance	Labour ward Lead	Ongoing	Ongoing

Neonatal medical staffing options appraisal	Review of workforce to ensure additional tier one rota. Options appraisal to be developed which includes review of APNP and ANNP workforce.	Paediatric and Neonatal Directorate Manager		Discussions ongoing at regional and national level to decide level of units within NW region
APNP job plan & roles	Review of APNP job plan & roles	Head of Paediatrics	Jan 2025	Progress has been made with agreement that ANNP's will be responsible for set out-of-hours evening work to allow further flexibility within the tier one rota.
NIPE examinations	Review midwifery ways of working to look at NIPE examinations becoming part of normal postnatal care.	Director of Midwifery	Jan 2025	Further training of midwives ongoing
Neonatal Consultant CPD	Consultants are to maintain minimum of 8 hours neonatal CPD	Neonatal lead	September 2023	Complete and demonstrating through appraisal
Monitoring of compliance	This report and action plan to be signed off by the Trust Board, Trust Board level safety champions and LMNS	Associate Medical Director	January 2025	

NHS
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Clinical Audit Report

Obstetrics and Gynaecology Consultant Attendance
Maternity and Perinatal Incentive Scheme (MIS) – year 6
Assurance report Safety Action 4

Clinical audit number (DATIX ID): ID 25799

Audit cycle number: 3

Division: Women and Children

Specialty- Obstetrics

Project lead Name/ Designation	Dr Melisa Thomas - Obstetrics and Gynaecology consultant, Labour ward Lead
Name	Dawn Picken Midwife Audit and Guideline Lead
Name	La'Raib Wayn Business intelligence analyst
Data Period	July – December 2024
Report Completion	January 2025

1. **Background and rationale:**

   Consultants play a crucial role in being key clinical decision makers, maintaining standards, reducing variation in patient care and role modelling professional behaviour[1].
   The RCOG and maternity incentive scheme acknowledges that consultants and their teams are often working to the best of their ability in extremely testing circumstances and under increasing scrutiny.
   Whilst recognising the general principles of a need for effective leadership, the RCOG has recommended standards to define when consultants need to be involved in discussions about patient care and when they should attend in person[1].

2. **Aims and objectives:**
   Evidence compliance with safety action 4 of the maternity incentive scheme year 6 which will lead to assurance in consultant attendance.

   We aim to identify any noncompliance in consultant attendance and will implement actions for improvement where required.

3. **Standards/guidelines/ evidence base:**
   Maternity incentive scheme Year 6 April 2024 Safety action 4.

RCOG Roles and Responsibilities of the Consultant providing Acute Care in Obstetrics and Gynaecology 2021.

Roles and Responsibilities of the Consultant providing Acute Care in Obstetrics and Gynaecology – Summary of Workforce Report. June 2021 (Updated May 2022). W+C Directorate. Sara Brigham. Consultant Obstetrician and Gynaecologist and Clinical Lead for Obstetrics

4. **Sample:**
All clinical situations requiring consultant attendance as per the RCOG guideline between July and December 202.

5. **Data source:**
   - Data taken from business intelligence reports i.e EPR
   - Reports from the incident reporting system (Datix)
   - Discussion with staff

6. **Methodology:**
A data report was pulled from EPR and our incident reporting system by the business intelligence and risk team. This was manually analysed to assess the presence of an on-call consultant if required as per the RCOG Roles and responsibilities of the consultant providing acute care in Obstetrics and Gynaecology.

The data was collected and summarised on an excel spread sheet then compared to the data from July 23-July 2024.

We have omitted elective caesarean sections as these are performed and delivered by consultants on consultant led caesarean section lists.

7. **Findings:**
A consultant was present at all clinical situations required, please see results below. Our results replicate the previous 12 months. The data collection tool was amended from January 2024 to include all the situations as specified in the RCOG work force document and we have continued with this tool to ensure consistency.

No clinical incidents were submitted within this time in relation to nonattendance by consultants for clinical scenarios as described within the RCOG workforce document.

MUST ATTEND	July - Dec 2023		Jan-June 2024		Jul-Dec 2024	
General	Num	%	Num	%	Num	%
High level of acuity- i.e second theatre			3	100	2	100
ANY return to theatre			2	100	3	100
Team debrief request			0	0	1	100
If asked			0	0	0	0

Obstetrics						
Critical deterioration requiring HDU/ITU	3	100	2	100	2	100
Major Placenta Praevia	5	100	2	100	0	0
c/s BMI>50			4	100	1	100
C/S <28/40			0	0	0	0
Premature twins <30/40			0	0	1	100
4th degree perineal tears	0	0	1	100	0	0
Unexpected Intrapartum stillbirth	0	0	0	0	1	100
Eclampsia	0	0	0	0	0	0
Maternal collapse			0	0	0	0
PPH >2L bleeding continuing			14	100	8	100
Gynae						
any laparotomy	2	100	0	0	2	100
Must attend unless most senior doctor competent						
General						
Any patient in O or G with EBL >1.5l and ongoing bleeding	70	100	28	100	3	100
Obstetrics						
Trial of Instrumental delivery	36	100	32	100	16	100
Vaginal twin delivery	0	0	2	100	3	100
Full dilatation CS	21	100	10	100	11	100
C/S BMI >40	15	100	0	0	3	100
CS transverse lie	2	100	0	0	1	100
cs less than 32 weeks			4	100	1	100
vaginal breech			0	0	5	100
3rd degree perineal tears	10	100	4	100	5	100
Gynaecology						
diagnostic laparoscopy			1	100	2	100
Ectopic Pregnancy needing surgical management	15	100	22	100	17	100

8. Findings Presented: where/ when

As part of staffing report to the executive Board MIS update

Part of CNST update presented at PAIB

9. **Recommendations**
   Continue the audit to ensure compliance

10. **Action plan (Appendix 1) –**
    Continue to ensure all staff are aware of the guidance for when to call a consultant by displaying the RCOG guidance list on the doctor's information board near the hand over room on labour ward.

    Continue to provide a list of competencies for each trainee rotating through labour ward which is shared with the consultant team and available for the shift leaders. This will also be the case for locum colleagues.

11. **Has there been any lessons Learned?**
    None identified

12. **Any changes in practice**
    Not required at present

13. **Any improvement in patient care**

Assurance level key:

Assurance Level RAG	Calculation of assurance and rationale
Full	To be used 90-100% of standards achieved a score of 90% or above and rated Green
Significant	To be used when 65%-89% of standards have achieved a score of 90% or above and rated Green.
Limited	To be used when 35-64% of standards have achieved a score of 90% or above and rated green
Very Limited	To be used when 0-34% of standards have achieved a score or 90% or above and rated green.

KEY: An assurance rating statement is made based on the percentage compliance with the audited standards. It is intended to provide an indicator of assurance and risk only as it is recognised this is not the sole measure of quality.

Assurance statement

Previous year Overall Assurance Level RAG	Overall Current Year Assurance Level RAG	Rationale
Full	**Full**	

Appendix 1

Review of previous action plan and on-going actions

Area for Review	Recommendation/Action	Action Lead	Target date	Date of completion	Action review- July 2024
Clear identification of scenarios in which Consultant should attend to be made available for all staff	Poster display on CLS in handover area	Caroline Edwards	14/12/2022	14/12/2022	Reinstated July 2024 – Dr M Thomas
Trainee competency tracker	To update 6 monthly	L Canavan /RCOG Tutor	Change of roles for college tutor, Updates done on daily basis during handover.	To obtain a formal report from current trainees by 31/1/2024	On going – August report complete and sent to team Also on the trust 'S' drive and accessible to staff if required
Electronic consultant attendance for scenarios within Cerner EPR system.	Trigger list embedded within CERNER system. Electronic audit tool developed.	Lucy Davies	14/03/2023	30/04/2023	
Clinical incident reporting of consultant non-attendance for scenarios	Continue to Datix any cases of consultant non attendance	S Brigham	Ongoing	Ongoing	On going- Dr M Thomas
Continuous audit of compliance of consultant attendance for the clinical situations listed in this document when a	Produce monthly ongoing audit report of all scenarios as described in appendix 2 to show continuing compliance	Labour Ward Lead	Ongoing	Ongoing	On going – Dr M Thomas

consultant is required to attend in person					
Monitoring of compliance	Produce six monthly report to trust board and LMNS	Labour Ward Lead/ S Brigham	Ongoing	Ongoing	On going- Dr M Thomas

Reference

1. RCOG Roles and Responsibilities of the Consultant providing Acute Care in Obstetrics and Gynaecology 2021.
2. Maternity incentive scheme Year 6 April 2024 Section 4.
3. Roles and Responsibilities of the Consultant providing Acute Care in Obstetrics and Gynaecology – Summary of Workforce Report. June 2021 (Updated May 2022). W+C Directorate. Sara Brigham. Consultant Obstetrician and Gynaecologist and Clinical Lead for Obstetrician

C&M Maternity Provider standardized Quarterly Perinatal Board report.

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

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

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

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

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Cheshire and Mersey Maternity Provider Quarterly Perinatal Board Report

Oct - Dec 2024

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

1. **EXECUTIVE SUMMARY:** Key findings section at the start of report to include.

	Q1 JAN – MAR 24	Q2 APR – JUN 24	Q3 JULY – SEP 24	Q 4 OCT – DEC 24
SB > 24 WEEKS	Rate 0 /1000	Rate 8.56/1000	Rate is 0/1000	Rate is 2.02/1000
NN mortality rate	Rate 2/1000	Rate 0/1000	Rate 2.01/1000	Rate is 2.02/1000
Add any other key findings progress on action plans, PMRT highlight themes, no. of StEIS reports	Coroner Informed no action			Intrapartum SB . Coroner informed

2. **DASHBOARD AND BENCHMARKING**

Table. 1 Stillbirths and neonatal death dashboard

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Total
Total stillbirths	0	0	0	1	2	1	0	0	0	0	0	1	**5**
Stillbirths (excluding terminations)	0	0	0	1	2	0	0	0	0	0	0	1	**4**
Births	162	166	165	149	163	155	182	147	172	183	168	144	**1956**
SB Rate	0	0	0	6.7 /1000	12.2 /1000	6.45 /1000	0	0	0	0	0	6.9 /1000	**2.56 / 1000**

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Total
Total Neonatal Mortality	0	1	0	0	0	0	1	0	0	1	0	0	**3**
Deliveries	162	166	165	149	163	155	182	147	172	183	168	144	**1956**
Neonatal Mortality Rate/1000 deliveries	0	6/1000	0	0	0	0	5.5 /1000	0	0	5.5 /1000	0	0	**1.53 /1000**

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

Quarter	Stillbirth Rate	NMR
Q1 Jan – Mar 24	0	2.02 /1000
Q2 Apr – Jun 24	6.42/ 10000	0/1000
Q3 Jul – Sep 24	0	2.01/1000
Q4 Oct – Dec 24	2.02/1000	2.02/1000

Table 3: Stillbirth and NN Mortality by cause

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

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

Table 4. PMRT review panel grading of care provided.

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

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

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

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

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

PMRT grade C	**1**	**1**
PMRT grade D		
Total cases	**2**	**2**

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

PMRT grading	**Care provided to the mother up to the point that the baby was confirmed as having died**	**Care provided to the mother following confirmation of the death of her baby**
PMRT grade A	**1**	**2**
PMRT grade B	**1**	
PMRT grade C	**1**	**1**
PMRT grade D		
Total cases	**3**	**3**

Table 5. Reasons for review panel grading C&D

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

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

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

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

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

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

				Review and update the management of perinatal diabetes guideline, to include elevated HbA1c and time out of range management Complete the learning response for the linked incident – wrong dose potassium post-delivery		

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

Review panel grading	Reason for grading	Level of investigation (StEIS/Level 2/Level	MNSI (yes/no)	Learning	QI plan aligned to theme	*Inform forward audit plan/implement QI project
C	Insensitive communication when referring to the twin pregnancy as a singleton following the death of baby Parents informed of incorrect location when Baby transferred from Claire House due to the	PMRT	NO			

	funeral home having multiple sites Mode of birth documented as 'other' due to manual removal of placenta caused parental distress					
C	Psychological impact of being taken into lavender Suite when baby alive	PMRT	NO			

6 INTRAPARTUM & TERM STILLBIRTHS

	Q1 Jan – Mar24	Q2 Apr – Jun 24	Q3 Jul – Sep 24	Q4 Oct – Dec 24
INTRAPARTUM SB	0	0	0	1
TERM SB	0	0	0	0

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

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

8. SAFEGUARDING/UNBOOKED AND LATE BOOKERS

	Q1 Jan – Mar 24	Q2 Apr – Jun 24	Q3 Jul – Sep 24	Q4 Oct – Dec 24
NND – Late Booking/ Safeguarding Issues	BBA booked at Wrexham	NO	NO	NO

9. LANGUAGE BARRIERS

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

10. SMALL FOR GESTATIONAL AGE

	Q1 Jan – Mar 24	Q2 Apr – Jun 24	Q3 Jul – Sep 24	Q4 Oct – Dec 24

Was small for gestational age a contributing factor	NO	NO	NO	NO

11. LEARNING FROM DEATHS

	Learning from deaths	Progress on previous actions
Q1 Jan – Mar 24	All learning applicable to Wrexham maternity – They have been informed	Completed
Q2 Apr – Jun 24	**SB 29 weeks.** SFH measurements for Low-risk patients at every scheduled antenatal appointment from 24/40. High risk patients with a normal UAD to have SFH measurements at every scheduled appointment from 24/40 until USS commences at 32/40. May – 36/40 IUD. Not seen in medical disorders clinic following anatomy scan and growth ultrasound scans not commenced until 32/40 (although would not have changed the outcome) – work in progress for the streamlining of appointments.	Completed
Q3 Jul – Sep 24	Consider the benefits to introducing a preconceptual 'school' for all type 1 diabetics (to facilitate women who go on to have unplanned pregnancies). This will consist of sharing information and counselling to ensure women are fully informed of the risks of poor diabetic control. Review and update the management of perinatal diabetes guideline, to include elevated HbA1c and time out of range management. Complete the learning response for the linked incident – wrong dose potassium post-delivery	

Q4 Oct – Dec 24	Miscommunication between the ambulance service and central labour suite meant the patient was transferred directly into the bereavement suite when the baby was still alive. The importance of establishing accurate information prior to the patient's arrival has been shared with staff. Missed opportunity to contact the on-call Obstetrician earlier. This would have enabled a speculum examination to be completed sooner and therefore prior to the MDT discussion. The initial BAPM grading was classified as high risk of a poor outcome for baby born at 23/40, which changed to a BAPM grading of extremely high risk following the outcome of the speculum examination. This prompted further conversations with the family as the prognosis was then poorer – further psychological distress. Documentation from Community Midwifery staff was not always contemporaneous. Internet connectivity for Community Midwives laptops is not always good. Community staff have been advised to utilise Wi-Fi in patient's homes. This is possible without needing to input a password. New laminated staff guidance for both breast and bottle-feeding assessments have been produced and are kept in key areas where all midwives access (community midwives office, ward 33, central labour suite and triage). This provides all staff with a reference guide when taking phone calls and undertaking feeding assessments. SBAR's for transfer of care not completed in the intrapartum stillbirth. Urgent safety memo sent to all staff ensuring that SBAR's are completed as appropriate. Urgent safety memo to all staff recommending that during the induction of labour process an immediate clinical assessment is performed and CTG commenced immediately.	

12. HORIZON SCANNING

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

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 12.**	**Care Quality Commission (CQC) Improvement Journey**						
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	CQC Engagement Meeting – 5th March 2025							
Executive summary	The purpose of this report is to provide an update on the CQC improvement journey. The paper sets out the historic gaps, current position and future priorities covering: • Quality and Safety • Leadership and Governance • People and Culture • Finance and Performance • Digital and Systems • Strategy • Emergency Department / Urgent & Emergency Care • Maternity							

	The full CQC action plan was presented to the Board of Directors in January 2025. This 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 the Board of Directors meeting.
Recommendations	The Board of Directors is asked to: • **Note** the Improvement Journey. • **Note** that progress against this action plan will continue to be tracked through the Executive Directors Group and reported to the Board of Directors.

Corporate Impact Assessment	
Statutory/regulatory requirements	Trust compliance with the CQC regulatory framework.
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.

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COCH CQC Improvement Journey

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 and Data 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 and Data Officer
- Information Governance

Improvement Areas

Leadership and Governance

- Exec and Senior Leadership Visibility
- Leadership Strategy and Succession Plan
- Organisation structure and clinical leadership
- Board and Committee effectiveness review (incl. TORs, papers, meeting management)
- Board and Divisional Governance
- Meeting map, Governance Handbook
- Board Assurance Framework
- Review of NED roles
- Review of Exec Portfolios
- Out of date policies and procedures

Strategy

- Trust Strategy
- Divisional Strategies

Quality and Safety

- Quality and Safety Strategy
- Patient and Family experience strategy
- Patient engagement
- Leadership roles for dementia, learning disabilities, delirium and mental health
- Integrated safety, risk and quality
- Introduce HALT
- Risk Management
- Ward to Board quality and safety assurance
- Incident management (processes, escalation and training)
- Serious Incidents (backlog and learning)
- Quality Improvement and audit
- Coroners cases
- Duty of Candour
- Learning from deaths
- Safe staffing and skill mix
- Reducing Harm
- Complaints management

Finance and Performance

- Divisional Performance Meetings
- financial strategy
- Mandatory training performance
- Review of 7 day services
- Emergency Department Improvement Plan

Culture and People

- Staff survey response and action plan
- Cultural and behaviour organisation review
- Staff engagement (incl. Trust values and vision)
- FTSU
- Development programme for senior operational leaders
- Organisational Learning
- mental health, E and I and estates and facilities, well being and E and I

Digital and Systems

- Independent Digital Review (incl. systems, information etc.
- Cerner developments, training and improvement plan

Quality & Safety Improvement Journey

NHS Countess of Chester Hospital NHS Foundation Trust

Historic gaps….

- Quality and Safety Strategy
- Patient and Family experience strategy
- Patient engagement
- Leadership roles for dementia, learning disabilities, delirium and mental health
- Integrated safety, risk and quality
- Introduce HALT
- Risk Management
- Ward to Board quality and safety assurance
- Incident management (processes, escalation and training)
- Serious Incidents (backlog and learning)
- Quality Improvement and audit
- Coroners cases
- Duty of Candour
- Learning from deaths
- Safe staffing and skill mix
- Reducing Harm
- Complaints management

Current position….

- **Patient and Family experience** strategy embedded across the Trust
- **PSIRF** implemented with new governance structures, tools and sharing learning
- **Integrated safety, risk and quality** with Nursing leadership including Deputy Directors
- **Safety systems** enhanced with HALT, MET in place and Marthas Law pilot
- Ward to Board **quality and safety assurance** strengthened, including governance forums and reporting
- **Strengthened PALs**, complaints and concerns processes
- New **Ward Accreditation Framework** rolled out and driving improvements in standards
- **Harms reduction** programmes
- Improved position and coordinated approach to **Coroners cases** including strong focus on learning
- **Backlogs recovered** and timely processes established for incidents, complaints, CQC concerns etc.
- **Safe nurse staffing** assurance and management
- **IPC** developed and embedded, including Quality Improvement
- **Safeguarding** strengthened

Future….

- Quality and Safety Strategy
- Patient engagement
- Leadership roles for dementia, learning disabilities, delirium and mental health
- Restraint
- Marthas Law pilot to be rolled out
- Risk Management Improvement Plan continues to be delivered
- Quality Improvement and audit
- Duty of Candour
- Mortality review and learning from deaths processes being enhanced
- Clinical staffing and skill mix being reviewed through SARD job planning and roster system developments
- Organisation learning policy to be finalised
- MUST and nutrition assessments compliance
- Translation services
- E’discharge and improvement in discharge journey

ng for ence Ward ditation amme

NHS
Countess of Chester Hospital
NHS Foundation Trust

Striving for Excellence Ward Accreditation….current position

Countess of Chester Hospital NHS Foundation Trust

23 ward visits and presentations completed

21 presentations (Stroke Rehab and Jubilee to present)

Certificates to wards on achievement (Poppy, CCU,44, Stroke Rehab and ED to present)

Achieving 8 Gold, 10 Silver and 3 Bronze

Plans made for all CAF'S for areas including Outpatients, Maternity, Neonates, Paediatrics, theatres by February 2025

36 areas in total

Plan for CRV, radiology, pharmacy, endoscopy in 2025

Possible extension into Community Services in future

Summary of IPC related actions

Countess of Chester Hospital NHS Foundation Trust

Governance

- Strengthened governance structure from ward to board
  - IPC Assurance committee – updated terms of reference, group membership and engagement
  - Divisional IPC groups developed and sustained to provide focus on the IPC agenda at divisional level
  - Antimicrobial Stewardship Committee – updated and revised terms of reference, enhanced group membership with divisional representation. Procurement of antibiotic app to host the formulary.

Healthcare Associated Infections

- IPC embedded within the Trusts ' Harms Improvements Programme' focusing work to reduce risks relating to *C.difficile* infections and *E.coli* blood stream infections
  - Strengthening processes relating to appropriate microbiology (faeces) sampling
  - Targeting work on UTI prevention and management (hydration, microbiology sampling and antimicrobial stewardship)

Compliance Monitoring

- Sustained programme and cycle of IPC audit and compliance monitoring
  - Ward/Departmental IPC audit programme completed for 2024/25
  - Hand Hygiene monitoring (driven by the IPC team)
  - MRSA screening compliance
  - IPC clinical practice monitoring (IV-line care, urinary catheter care, commode cleanliness)
  - Escalation of enhanced monitoring based on clinical risk assessment

Infection Prevention and Control Team

- Maintenance of onsite 7-day service
- Robust real time surveillance (Teletracking) and risk assessment optimising bed capacity and single room utilisation
- Continued programme of policy development, review and update
- Development of sustainable and resilient process for FFP3 mask fit testing (RPE Co-ordinator)

Training and Education

- Continued delivery of the IPC Educational Framework for induction and mandatory training.
- Roll out of ANTT eLearning programme

Cleaning Standards

- Strengthened process of monitoring of national cleanliness standards
- MDT approach
- Updated Functional Risk categorization
- Development of proposal for restructuring and reorganisation of the facilities service to provide sustainability and resilience to provision of cleaning services.
- PLACE assessments – IPC working as a key stakeholder in sustaining and maintaining the PLACE programme.

Falls and Safer Mobility

Safer Mobility and Reconditioning

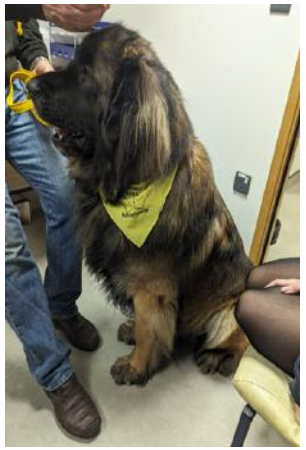
Countess of Chester Hospital NHS Foundation Trust

Aim to reduce total falls & unwitnessed falls by 20%

- Current falls reduction organisationally of ↓**9.2%**
- Current unwitnessed falls reduction of ↓**6%**

Actions

- Bay tagging, staffing models in bays & visibility
- Meaningful intentional rounding (toileting, available aids)
- Decaf trial and move to Trust Wide change
- Divisional review of HCSW roles and future models
- Induction updated to include expectation of preventing deconditioning
- B2 JD updated to include prevention of deconditioning, activity and mobility
- Ward accreditation updated to include deconditioning
- Activities purchased via charitable funds
- ‘Activity volunteers’ supported by the volunteer team
- Divisionally led activity programmes
- Daily activities programme covering urgent and planned care
- Twice weekly events off the ward
- Run by ward team and supported by volunteers
- Family inclusion



Countess of Chester Hospital NHS Foundation Trust

Patient Safety Incident Response Framework

Incident Management

- The Deputy Director of Nursing receives every single incident reported in real time, regardless of the level of harm for scrutiny and oversight.
- A database of all incidents reported in the previous 24 hours is circulated to Executive Directors, Divisional Leads, Deputy Medical Director and Deputy Directors of Nursing and Heads of Departments.
- A daily 8 am Executive-led meeting occurs that includes scrutiny of the previous 24 hours incidents reported, with any incidents of immediate concern or themes of incidents escalated and actions undertaken.
- A daily incident meeting with the divisional risk leads, for planned and urgent care, the Deputy Director of Nursing and the Head of Nursing for Risk and Quality is undertaken. Each incident is reviewed, initial level of harm grading reviewed, and the investigating officer allocated. An initial indication of the level of response is agreed, i.e. SWARM, After Action review, Patient Safety Incident Response (PSII) etc.
- The Women's and Children's and Diagnostic and Therapy and Integrated Care also hold daily meetings with the same agenda as above.
- Weekly divisional risk and incident meetings are held with the divisional triumvirates and risk leads to ensure divisional oversight, timely investigations and preparation for the weekly Trust Oversight Meeting.

Patient Safety Incident Response Framework

For incidents classed as Moderate and above the additional scrutiny and oversight is as follows:

- A weekly Patient Safety Oversight Meeting-led by Deputy Medical Director and Deputy Director of Nursing and Governance.
- Membership includes the Medical Director and Director of Nursing, Divisional Triumvirate team, Risk and Governance leads, Head of Quality and Head of Complaints.
- The meeting provides:
    - Oversight of incidents over 28 days
    - Review of investigations and assurance of timely investigations and escalation of barriers
    - Approval of Level of Harm
    - Development of Trust Learning Response Database
    - Approval of Patient Safety Incident Investigation (Multi-disciplinary check and challenge)
    - Oversight of Patient Safety Incident Investigation (PSII) actions plans and their completion
    - Learning from previous weeks incidents by division
    - Identification and Sharing of Organisational learning
    - Escalation of concerns
    - Transparency of incidents and investigations
    - Triangulation of incidents and complaints

Monthly Safety Surveillance Group

As the Trust progresses and develops PSIRF, improved governance and assurances frameworks have been developed, with one being the development of a monthly Safety Surveillance and Learning Meeting. The aim of this meeting is to articulate themes of incidents, complaints and concerns, learning from deaths and coroners' inquests. Learning responses are shared which guide and provide direction to changes in practice that will promote patient, families and carers and staff safety and overall experience and in turn, reduce patient and staff safety risk. It also provides a Trust-wide forum for learning to be shared.

Safeguarding and Complex Care Key Issues

Countess of Chester Hospital NHS Foundation Trust

Safeguarding Training (Trustwide)

L1- adults (91%) Children (88%)

L2- adults (91%) children (92%)

L3 adults (89%) children (89%)

Oliver McGowan (87%)

Safeguarding strategy in place

Electronic Patient Record

Mandatory safeguarding screening tool in Paediatric Emergency Department and on all inpatient wards

Electronic referral form generates valuable assurance data.

Electronic referral forms for DoLS (under development), MCA, ligature risk assessment and MARAC.

Flagging system to highlight all safeguarding and complex care issues

External Assurance

Compliance with Safeguarding Commissioning Standards.

Active Participation at Multiagency safeguarding boards

Trust safeguarding strategy aligns to safeguarding partnership boards.

Named Staff in place.

Robust relationships with external safeguarding partners at executive and operational level.

Reporting structure in place for all required returns.

Internal Assurance

Safeguarding and Complex Care Audit Programme Established.

DoN and ADoN (Safeguarding and Complex Care) formalised 1-1 sessions monthly

Internal Governance and reporting structures in place

Action plans created for key areas such as self-neglect, domestic abuse and children in care

Clearly defined role of the Safeguarding Team with enhanced visibility throughout hospital.

Allegation and Staff Concern Processes

Strong processes are in place for managing allegations and concerns

Senior oversight provided by the Director of Nursing (DoN) / Deputy Director of Nursing (DDoN)

Coordination led by the Associate Director of Nursing (ADoN) for Safeguarding and Complex Care

Standardised documentation used throughout the process

Established, collaborative relationships with the Local Authority Designated Officer (LADO) and the Local Authority for the PIPOT process

•A robust process is in place to monitor all DoLS applications, with all patients under a DoLS reviewed by the Complex Care Team regularly.

•*Completion of This is Me* and Patient Passports are monitored for all complex patients.

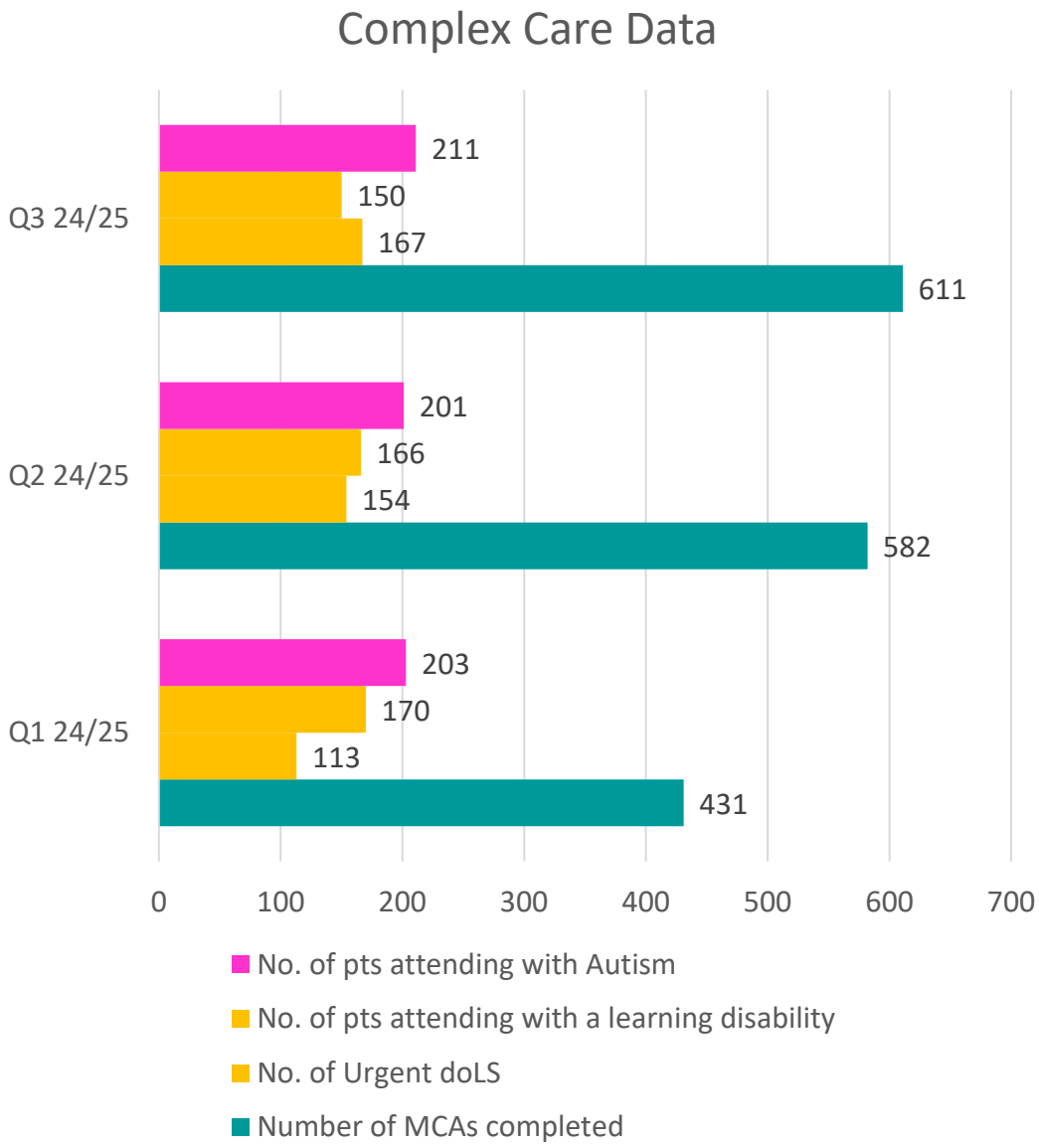
•MCA and DoLS forms are now electronic and accessed via patient electronic record.

•MCA assessments and consideration of required reasonable adjustments are integrated into the mandatory screening tool during inpatient admission.

•A daily list of patients flagged for Autism and/or Learning Disabilities is generated for the team to review.

•A flagging system is in place for all patients subject to DoLS who require reasonable adjustments.

•The implementation plan for Oliver McGowan Mandatory Training is in progress



Leadership & Governance Improvement Journey

NHS Countess of Chester Hospital NHS Foundation Trust

Historic Gaps.....

- Exec and Senior Leadership Visibility
- Leadership Strategy and Succession Plan
- Organisation structure and clinical leadership
- Board and Committee effectiveness review (incl. TORs, papers, meeting management)
- Board and Divisional Governance
- Meeting map, Governance Handbook
- Board Assurance Framework
- Review of NED roles
- Review of Exec Portfolios
- Out of date policies and procedures

Current Position.....

- **Board stability**, leadership and visibility
- Operational Management Board established and greater engagement and involvement with **Senior Leadership**
- Engagement and involvement of **Clinical Leads** (including strategy days)
- Effective **Board and Committees**
- **Reporting** guidelines, templates, QA and awareness
- **Divisional Reviews** introduced
- **Committee organogram** developed
- Effective **Board Assurance Framework** in place
- **NED roles** reviewed and aligned to national guidance
- **Executive portfolios** established, with clear objectives aligned to Trust strategy and improvement priorities
- Strengthened understanding of the role of **Governors**
- **Risk Management improvement** plan, updated Policy and Risk Management Committee established to drive forward improvements
- **MP engagement** and relationships
- **Code of Governance** and **Provider Licence** compliance

Future.....

- Board and sub-board succession Plans to be further developed
- Accountability Framework to be finalised
- Out of date policies and procedures work progressing to close the backlog and establish an effective process
- Regulatory compliance matrix being populated
- Thirlwall report, learning and corporate records management
- NHS Constitution compliance assessment
- COG development plan delivery

People & Culture Improvement Journey

Countess of Chester Hospital NHS Foundation Trust

Historic Gaps.....

- Staff survey response and action plan
- Cultural and behaviour organisation review
- Staff engagement (incl. Trust values and vision)
- FTSU
- Development programme for senior operational leaders
- Essential training for managers
- Organisational Learning
- Mental health, EDI and estates and facilities, well being and EDI strategies
- Appraisal and mandatory training compliance

Current Position.....

- A wide range of engagement activities covering inclusivity, behaviours, wellbeing.
- Wellbeing Hub has opened which is accessible to all staff with dedicated wellbeing practitioner - .
- Refreshed appraisal documentation launched and evaluation of quality of appraisal incorporated into process. Appraisal training for managers and career conversations. Appraisal target reached in Oct 24.
- Listening events held and civility statement agreed. Civility and zero tolerance campaigns launched
- Visibility of FTSU, Board assessment and extensive Champion network developed.
- Expanded staff networks with executive sponsorship
- Launch of Employee of Month and team of Month Awards with representation from Staff Side and EDI/Staff Networks on the judging panel.
- People Promise exemplar programme
- Improvements have been made following the 2023 staff survey

Future.....

- Staff survey 2024 feedback response
- Further focus on zero tolerance, civility, culture and behaviours
- Triangulation of FTSU
- Organisation Learning policy
- Development of future People Strategy and embedding of People Promise
- Improving comparative experience of underrepresented groups
- Achievement of mandatory training compliance
- Focus on reducing long term sickness absence and stress/anxiety related absence
- Flexible working – enhanced use of rostering and digital solutions
- Increased use of apprenticeships – new roles, career development and widening access
- Further improve Welcome event

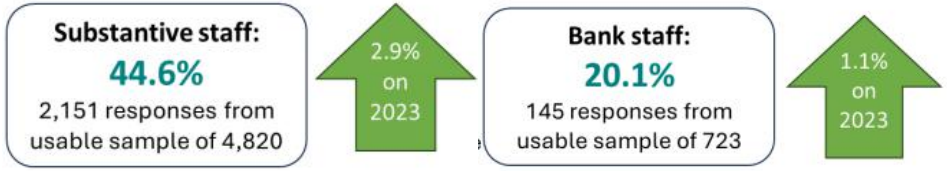
Staff Survey 2024

Countess of Chester Hospital NHS Foundation Trust

Significant question results: 2023 compared to 2024

Significantly better scores Question	Difference compared to 2023 results
4b I am satisfied with the extent to which my organisation values my work.	↑
11a My organisation takes positive action on health and well-being.	↑
20a I would feel secure raising concerns about unsafe clinical practice.	↑
21 I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).	↑
23a In the last 12 months, I have had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review.	↑
25a Care of patients / service users is my organisation's top priority.	↑
25b My organisation acts on concerns raised by patients / service users.	↑
25e I feel safe to speak up about anything that concerns me in this organisation.	↑
25f If I spoke up about something that concerned me I am confident my organisation would address my concern.	↑

Reminder of our 2024 return rates



Significantly worse scores Question	Difference compared to 2023 results
13a In the last 12 months, I have personally experienced physical violence at work from patients / service users, their relatives or other members of the public.	↓
17a In the last 12 months, I have personally been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public.	↓

Finance and Performance Improvement Journey

NHS Countess of Chester Hospital NHS Foundation Trust

Historic Gaps.....

- Divisional Performance Meetings
- Financial strategy
- Financial awareness
- Reliance on non-recurrent and Divisional CIP
- Accountability
- Mandatory training performance
- Emergency Department Improvement Plan
- Long waiting elective position challenged
- All cancer indicators not met
- Endoscopy performance impacting DM01 performance
- Lack of oversight and grip on performance.

Current Position.....

- Reset of budgets to represent the resources required to deliver services
- Budget holder training and budget sign off ensuring skills to manage budget and budget holder accountability
- Divisional reporting packs introduced, and Finance included in Divisional board updates
- Recurrent CIP identification, cross divisional lens, programme management and oversight
- Delivery of agreed system control total, except impact of exceptional items (pay award, ET)
- FSD Level 2 re-accreditation
- Long waiting elective position improved
- Theatre performance improved and FDP platform gave us sight of our data
- Introduction of a corporate cancer team, all areas significantly improved, and performance sustained.
- Extensive work on Endoscopy post EPR implementation, lists are now productive and backlog reducing
- Over performance eon total activity
- Operations and Performance Executive Led Group (OPELG) in place that reports into Finance and Performance Committee

Future.....

- Day 1 reporting
- Improved engagement and communication
- FSD level 3
- Financial strategy
- HFMA value-based costing
- Improvements in total RTT compliance (minimum of 10%) as well as long waits.
- Introduction of AI validation software to support RTT and Non-RTT waiting list cleansing
- Additional clinical workforce that will increase Endoscopy capacity
- Clinical Lead appointed for Cancer to ensure innovation and pathway improvements continue and are strengthened
- Continue with robust annual planning with finance, activity and workforce triangulation

Digital & Systems Improvement Journey

Countess of Chester Hospital NHS Foundation Trust

Historic Gaps.....

- Independent Digital Review (incl. systems, information etc.) Review completed July 2023)
- Cerner developments, training and improvement plan.

Current Position.....

- Successful **EPR upgrade**
- **Digital and Data prioritisation** process in place led by CCIO and CNIO, incorporating EPR optimisation
- New EPR training management system in place Dec 2024

Future.....

- Further EPR upgrades planned 2025-2027
- Digital and Data Strategy refresh April 2025
- Review national EPR usability survey outcomes

Strategy Improvement Journey

Historic Gaps.....

- Trust Strategy
- Clinical Strategy
- Divisional Strategies
- Enabling Strategies
- Partnership and systems engagement

Current Position.....

- New Transforming Care Together Trust Strategy launched
- Strategic objectives delivery and progress aligned to BAF reporting
- Women's and Children's 5 year Strategy
- Anchor Institution Group formed
  - Prevention
  - Social Value
  - Green (Net zero)
- Heatlh Inequalities framework developed
- Use of C2AI tools to target inequalities on the waiting list
- Operational and clinical leader's forum established and planned for on a quarterly basis throughout the year
- Member of the Health and Well Being Board
- Member of the Cheshire West leadership Gropu
- Member of the Cheshire business Advisory Board

Future.....

- Clinical Strategy to be finalised
- Enabling strategy priorities
- Divisional Strategies
- University Teaching Hospital ambitions and timeline to deliver
- Partnerships
- Health Inequalities
- Anchor Institution
- Knowledge Transfer Partnership with Hope University, Innovate UK and NHS Charities.

ED/ UEC Improvement Journey

Countess of Chester Hospital NHS Foundation Trust

Historic Gaps.....

- Lack of space to see Type 3 patients
- Triage variable
- Extended Length of Stay (regional outlier)
- Ambulance turnaround time extended (regional outlier)
- Lack of 'see and treat space' when busy
- Long length of stay for mental health patients
- Discharge lounge unable to accommodate patients on stretchers
- Multiple internal actions plans that needed partner actions adding
- System escalation meetings not called until
- Increasing numbers of NCTR

Current Position.....

- Top floor of SDEC is now a UTC and see Type 3 patients and 30-35% of the daily attendances
- Additional MTS training and additional nursing numbers
- Trialling 'doctor/ANP' at the front door
- Regular Exec meetings with NWAS and HALO always on site
- Call before Convey pilot underway
- SDEC being used overnight to give ED space and improve ambulance handover time
- See and treat cubicles protected and ED cons in-charge of Type 1 non-admitted
- New area in ED for patients with additional needs to be finished by end of March 2025
- Additional escalation space opened
- Increased use of Same Day Emergency Care (SDEC)
- Discharge lounge capital works complete with stretcher space
- Discharge summit held with system partners invited to join and actions added to a condensed plan (see next two slides)
- NCTR reached an all-time high of 152 20.02.2025

Future.....

- Atrium to join ED and SDEC together and create a triage and streaming hub
- E-triage/streaming software
- Additional space in ED when more patients directly streamed off site/SDEC/UTC
- Reduced number of ambulance conveyances
- Initial actions on the plan complete and embedded
- All inpatients to have an EDD
- Trust and LAs to work together on processes for prescribing care and delays causing deconditioning and increased care needs when leaving hospital
- System partners to have OPEL action cards (AQUA)
- Trust suggesting another re-set event
- System plans to reduce NCTR (celling of 58)

UEC Improvement Plan

Drivers	Action	Next Steps
Attendance / Admission Avoidance	• Call before Convey (West), started on 20th January; approx. 4 calls per day to SPA and good deflection rates.	• Regular touch point meetings with C&M Steering Group. Ongoing monitoring of impact / effectiveness via locality tactical group
	• Frailty (Care Homes) Improvement Plan to roll out frailty specific pathways and associated support into CW Care Homes (i.e., head injury and long lie pathways, hydration, personalised care plans inc DNACPR)	• Co-delivered with Quality Team. Head Injury pathway rolled out Dec 2024. Review progress at next Admissions Avoidance group and take forward plans for roll out of long-lie pathway
	• Admission avoidance dashboard under development to assess impact of work being taken forward.	• Progress update at next Admissions Avoidance Group.
Emergency Department	• Implement RAT model	• Agree roles and responsibilities Allocation of ED Consultants
	• Ensure clear roles and responsibilities in place across all staff groups at all levels	• Follow through induction programme for newly recruited teams Ensure that new workforce enabling senior teams to take on more extended roles
	• Implement new ED huddle format	• Review and identify best practice
Wards	• Ensure compliance of EDD and CDD for all patients	• Agree ward based flow improvement plan (workshop 28.02.25) Agree roles and responsibilities Monitoring of compliance and quality via Divisional Operational Performance Meeting
	• Implement Daily Discharge Huddle approach developed at WHH	• Agree roles and responsibilities Monitoring of compliance and quality via Divisional Operational Performance Meeting
	• Introduce LLOS management oversight meeting to systematically review LOS >21 days	• Implement ward based LLOS meeting Monitoring via Patient Flow Steering Group

UEC Improvement Plan

Drivers	Action	Next Steps
Community & NC2R	• Reduce variation in discharge delays through RRT-First service model	• Review P1 provision across providers
	• Increase P2 capacity	• Case completed for capital investment Gain approval via Cheshire West Place
	• Implement trusted assessment model (Flintshire)	• Develop SOP
Escalation Management & Flow	• Implementation of new escalation process for the management of LLOS within ED >48 hours	• Continued monitoring via Patient Flow Steering Group
	• Ensure consistent senior oversight at site meetings	• Agree roles and responsibilities Review current site meetings
	• Implement new Full Capacity Protocol (FCP)	• Review FCP documentation
	• Implementation of new system escalation to convene 'silver control'	• Develop clear CoCH operational triggers
	• Clarify specific improvement work being supported by external improvement teams	• Align ECIST & AQUA resource to maximise delivery potential
	• Clarify UEC, flow management, accountability and oversight arrangements through directorates, divisions, to board and the wider system	• Share with System Oversight Group
	• Articulate shared system goals; consider use of a concordat, MOU or similar document	• Agree a system wide UEC Improvement plan

Maternity Improvement Journey

Countess of Chester Hospital NHS Foundation Trust

Historic Gaps.....

•Lack of robust board oversight and reporting
•BSOTS triage process paused
•Limited digital capability, restricting metric capture
•Gaps in theatre staffing and processes
•Increased number of hysterectomies

Current Position.....

- Triage Process: Successfully implemented in maternity services
- Post partum haemorrhage full implementation of OBS Cymru
- Post-Operative Care: Improvements for women and birthing people following obstetric surgery
- Governance: Exited Maternity Safety Support Programme (MSSP) with strengthened oversight
- Engagement: Enhanced MNVP recruitment and joint oversight Systems
- Service Feedback: Demonstrated improvements in maternity service survey results achieved a ranking of 20th out of 56 organisations, a significant improvement from 38th in 2022 and 26th in 2023.
- Compliance & Strategy: Achieved 10/10 in Maternity Incentive Scheme (MIS) Year 6; integrated into Women & Children's Divisional five-year strategy, including maternity strategy
- Collaboration:
- Active participation in regional and national working groups
- Bereavement Support: Expanded services, including a dedicated lead for early pregnancy loss
- Leadership & Culture: Continued focus on strengthening team culture and leadership

Future.....

- Infrastructure: New W and C build
- Regulatory Response: Post-Thirlwall review with Maternity Improvement Adviser (MIA)
- Service Enhancements: Further improvements to triage and day unit care
- Quality Assurance: Preparation for repeat inspection

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 13.**		**Freedom to Speak Up Update Report**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	**X**
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	Not applicable							
Executive Summary	This report is intended to provide: • Comparative data outlining on the number of concerns raised and by staff groups, themes and trends, status and learning. • An update on the development of an FTSU Champions Network • Governance assurance • Mandatory Training Compliance • Results relating to raising concerns from the NHS Survey 2024 • Feedback from the first FTSU Managers Training • Service Development							
Recommendations	The Board of Directors is asked to note the report and receive assurance that local FTSU arrangements are in place and continue to meet best practice.							
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

Freedom to Speak Up

Freedom to Speak Up Report to: Trust Board (March 2025)

1. Introduction

This paper provides the Trust Board with an update of the work of the Freedom to Speak Up (FTSU) Guardian and Champions in supporting the safety culture within the Trust, reflect on the progress made by the FTSU Network in empowering staff to speak up freely and to encourage ongoing positive cultural change. Concerns raised in Q1, Q2 and Q3 with comparison of figures for previous quarters will be provided in line with National Guardians Office (NGO) recommendations. New guidance on Detriment published in January by the NGO will me outlined in addition to reviewing the finding from the 2024 NHS Staff Survey in relation to raising concerns.

2. Background

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-centered 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.

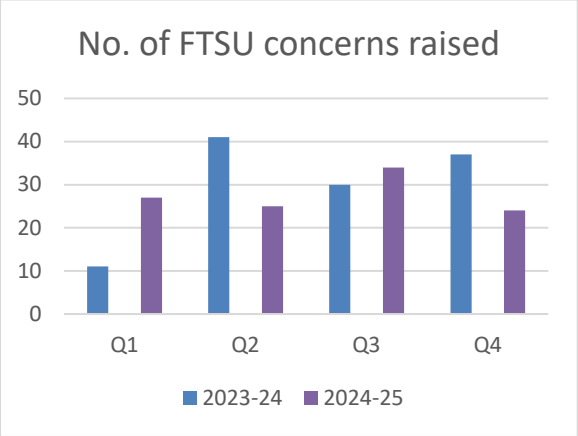
This document should be read in conjunction with the Trusts Freedom to Speak Up policy which can be accessed through the Trusts intranet site.

3. Purpose

The Executive Board is asked to review the report and receive assurance that the FTSU arrangements in place continue to meet best practice and supports staff to raise concerns. This is done in the context of an evolving and maturing national agenda, that is learning from the collective experiences of FTSU Guardians, their champion networks and those at the National Guardian Office.

4. Assessment of FTSU Concerns 2024-25

The trust has several safety reporting channels such as speaking directly to line managers, incident reporting and team and trust safety huddles. Issues raised in other channels are not logged as FTSU unless referred to or raised directly to the FTSU Guardian or champions. Please note data for Q4 of this year does not include 18-31st March 2025.



A total of five concerns were raised anonymously during this period, four of which related to one particular concern. This is below the national average as published by the NGO.

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

Table A: Comparative Themes

Themes of concerns	Q1 (2023/24)	Q2	Q3	Q4	Q1	Q2	Q3
Patient safety or quality	4	2	10	17	8	17	13
Worker safety or wellbeing	9	19	20	23	14	21	16
Bullying or harassment	5	19	10	18	6	4	1

Poor attitudes and behaviours	10	28	21	29	19	18	21
Detriment from speaking up	0	1	2	4	0	0	0

The report submitted in September 2024 highlighted that in Q1 an increase in the number of colleagues with some level of managerial responsibility raised concerns. This percentage has reduced to a level reflected over previous years.

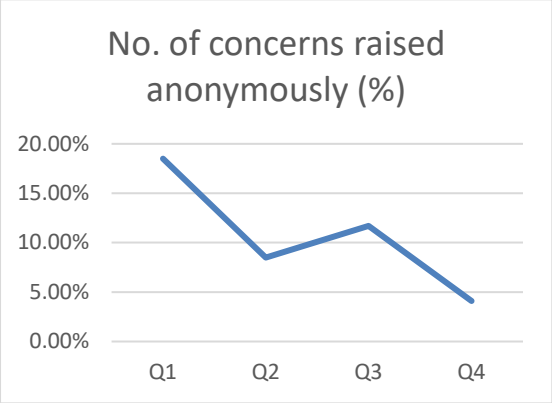


Table B: Comparison of concerns raised by different professional groups:

Professional Group	Q1 (23/24)	Q2	Q3	Q4	Q1 (24\25)	Q2	Q3
Facilities and Estates	1	5	1	5	1	4	3
Registered Nurses/ Midwives/ ANP	3	1 3	1 3	1 6	7	1 7	2 1
Nursing Assistants & Support Staff	0	7	5	1	4	0	2
Corporate Service Staff	0	1	1	4	1	4	3
Administrative/ Clerical	0	1 1	2	4	7	3	2
Doctors/Dentists	2	0	1	2	4	2	0
Allied Health Practitioners	2	4	7	5	2	5	3
Other	3	0	0	0	1	0	0

Analysis of FTSU Concerns, Actions, Status and Learning:

One concern remains open from Q1, Q2 and Q3, which will soon be resolved.

There is a significant decrease in colleagues citing Bullying and Harassment as part of the concern raised during 2024-25 and with none citing detriment.

Poor attitudes and behaviours continue to be the largest cause for concern, with poor communication being identified as a contributory factor in all.

Limited feedback from managers is the sole reason for reaching out to FTSU when concerns have previously been discussed at department/ward level. It can be difficult to give feedback without breaching confidentially however more work needs to be done on sharing learning and themes with all staff.

Initially when some colleagues approach with concerns the fear of detriment has prevented further escalation in some of these cases, however this is often resolved through discussion with the Guardian and we haven't had any concerns of detriment raised this year.

It is hoped that the Managers FTSU Workshop will go some way to addressing the process by which concerns are managed and feedback provided. The continued work to improve civility and respect at work together with a zero tolerance of poor behaviours will also contribute to cultural improvement.

5. Progress on Internal Assessments and Governance

Cathy Chadwick, Chief Operating Officer and Paul Jones Non-Executive Director continue to have executive leadership for FTSU. The Executive lead, Chief People Officer and the Guardian convene triangulation meetings when cases of concern involve HR services. Support and service review meetings between the Executive lead and Guardian are held monthly as a minimum. The Trust Board approved an updated FTSU Action Plan in January 2025 and will act as a driver for further service development and improvement. This will be reviewed quarterly as a minimum and presented to the People and Organisation Development Committee bi-annually. Progress will be communicated within the next Board Report. FTSU reports are also submitted to the Audit Committee and Quality and Safety Committee annually.

6. National Guardian Office Guidance on Detriment

This guidance refers to detriment, disadvantageous or demeaning treatment by colleagues, line managers or leaders towards a colleague because of the act of speaking up, rather than the specifics of the matter raised by speaking up. This can be a deliberate act or a failure to act or omission. While these behaviours might not be intentional, the impact can still be significant if a person believes they are being treated poorly or differently. The guidance outlines best practice in preventing detriment. These include:

A. An FTSU policy adopted in line with the national policy should clearly state that speaking up is welcomed and outline the different routes available for colleagues.
B. The Executive Lead should take responsibility for ensuring the completion the Freedom to Speak Up self-reflection and planning tool, at least every two years.
C. Managers should undertake the Listen Up training to ensure they listen well and foster an environment that encourages and supports speaking up. Managers should be trained to understand what detriment can look like, how best to respond to it and ensure people receive the appropriate support. Leaders should complete Speak Up, Listen Up and Follow Up training.
D. Confidentiality when requested by a colleague is protected wherever possible, and information will be kept strictly confidential, only shared on a need-to-know basis.

Within our organisation all the above are embedded and reflect best practice.

In addition, the guidance recommends that organisations and Freedom to Speak Up Guardians should consider completing a risk assessment when a colleague speaks up and voices fear of perceived detriment. This will assess the likelihood of detriment and propose measures to reduce this risk. A 'checklist' has been devised for use for when detriment is reported. Both these recommendations now need to be considered and if agreed implemented into the FTSU framework.

7. FTSU Mandatory Training

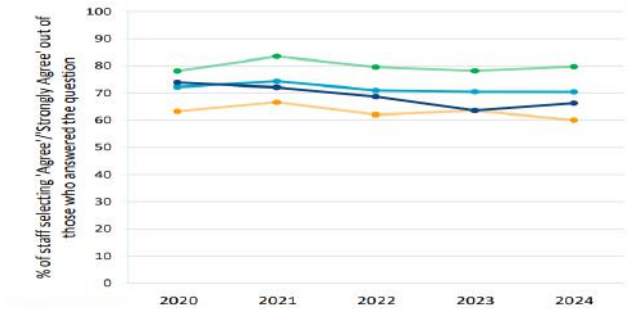
'Speak Up' is now at 92.43% with 'Listen Up' at 83.52% (an increase from 69.12%, from September 2024). The FTSU Action Plan indicates 90% compliance required.
'Follow Up' mandated for Board members currently stands at 100% compliancy.

Staff Group	Speak Up Compliance %	Listen Up Compliance %
Add Prof Scientific and Technic	97.08%	89,05%
Additional Clinical Services	94.46%	85.69%
Administrative and Clerical	95.93%	89.82%
Allied Health Professionals	98.18%	91.52%
Estates and Ancillary	60.79%	42.92%
Healthcare Scientists	94.90%	81.63%
Medical and Dental	88.94%	76.14%
Nursing and Midwifery	97.77%	90.71%

8. NHS Staff Survey

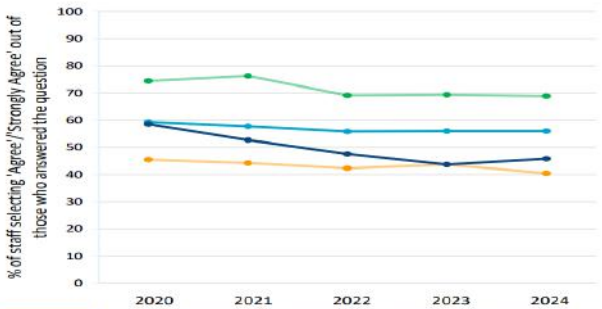
The 2024 NHS Staff Survey results were published and although the four questions within the survey do not specifically relate to Freedom to Speak Up, they do provide some insight into staff perception and therefore a valuable tool in which to consider how we might best improve speak up culture.

Q20a I would feel secure raising concerns about unsafe clinical practice.



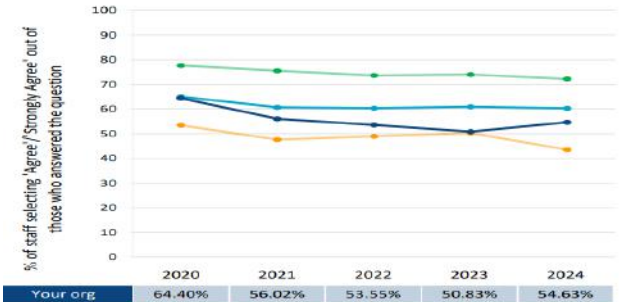
	2020	2021	2022	2023	2024
Your org	73.73%	72.02%	68.67%	63.46%	66.19%
Best result	78.06%	83.39%	79.51%	78.11%	79.71%
Average result	72.16%	74.20%	70.96%	70.47%	70.44%
Worst result	63.08%	66.55%	61.96%	63.38%	60.03%
Responses	1698	1634	1688	2007	2136

Q20b I am confident that my organisation would address my concern.



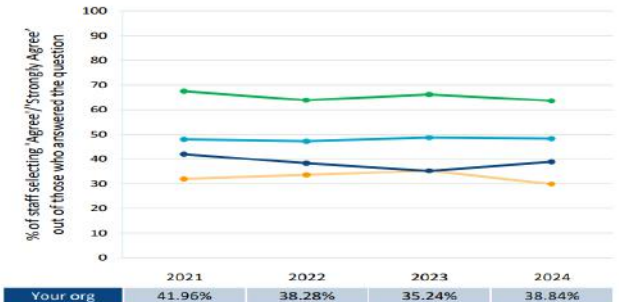
	2020	2021	2022	2023	2024
Your org	58.49%	52.61%	47.54%	43.61%	45.71%
Best result	74.37%	76.20%	69.10%	69.35%	68.85%
Average result	59.29%	57.68%	55.79%	55.93%	55.91%
Worst result	45.38%	44.13%	42.28%	43.61%	40.42%
Responses	1697	1627	1684	1999	2134

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022	2023	2024
Your org	64.40%	56.02%	53.55%	50.83%	54.63%
Best result	77.65%	75.50%	73.58%	74.00%	72.15%
Average result	65.01%	60.68%	60.37%	60.93%	60.29%
Worst result	53.44%	47.61%	48.97%	50.33%	43.56%
Responses	1697	1630	1682	2005	2128

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023	2024
Your org	41.96%	38.28%	35.24%	38.84%
Best result	67.43%	63.83%	66.16%	63.63%
Average result	47.94%	47.23%	48.67%	48.23%
Worst result	32.01%	33.59%	35.24%	29.95%
Responses	1633	1684	2003	2126

These results are extremely encouraging and suggest a more open and supportive culture is developing.

9. Freedom to Speak Champions Network

Since last reporting the network has increased by a further 25 champions, now totally 70. A total of 80 colleagues have completed the training since January 2023, however some have left the trust whilst others for either personal or work commitments have opted out. The overall retention and engagement continue to significantly exceed the 50% expectation rate.
Champions are required to have completed their mandatory training for FTSU, undertaken pre training reading, gained support from their line manager through receipt of a signed 'Managers Pledge', attended a three-hour face to face group training session and be committed to the values of the Trust. There is then a requirement to attend bi-monthly network meetings and engage in bi-annual support one to one meetings with the guardian.

Having such a large and diverse network of champions supporting the work of the guardian provides an even greater choice for colleagues who are unsure who or how to raise a concern. Champions are a voice within their own teams, taking time to share information at team meetings and during new staff inductions.
During 2024 champions made 359 individual contacts with colleagues and undertook 51 activities that supported and promoted speaking up. In total these reached over 1,000 colleagues.

10. Workshops for Managers

In February the first FTSU workshop for managers was held. The FTSU Process Chart underpinned the learning with particular focus on listening, supporting, action and feedback. A further four sessions are planned for May/June at Ellesmere Port Hospital and will include managers from nursing and therapies.

11. Conclusion

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

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

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

The FTSU guardian will continue to provide quarterly and annual reports on the number of concerns raised through the FTSU Network and any common themes to the Board of Directors and the National Guardian's Office. Learning from cases will continue to be reviewed and shared appropriately. The FTSU guardian will continue to maintain engagement with the national office and regional networks to ensure that national updates are cascaded and implemented.

12. Recommendations

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

Committee Chair's Report

Thursday 6th March 2025 at 2.15pm – 4.30pm in the Boardroom, 1829 Building

Committee	Quality & Safey (Q&S) Committee
Chair	Non-Executive Director, Prof A Hassell

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)*

- Hospital acquired pressure ulcer numbers have increased and significant work being done in particular in the Emergency Department (ED) to identify those present on arrival and support early management.
- Friends & Family Test 90% for inpatients discussed against national average of 94% with ongoing work on the 6 steps for family and patient experience. Examples provided and analysis to be undertaken and reported back to the Committee.
- Specialised palliative care and end of life service review providing assurance on compliance with standards including gaps and action. Committee requested an update in 6 months.

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

- Temporary staffing compliance with mandatory training.
- Q&S metrics in the System Oversight Framework (SOF) were reviewed. Discussion took place on timeliness of some of the data recognising some of the mortality data is historic due to timing and there was an error noted in neonatal data which will be picked up with the team.
- Quality Governance Group (QGG) report updated on a wide range of items with a range of assurance levels given (discussions included: point of care testing; medical devices safety officer in post and undertaking a baseline assessment; emergency department improvement plan; consent; and e'discharge). Significant assurance on radiology reporting discrepancy in terms of action taken and learning. Committee requested ED improvement plan including range of actions across the Trust and system to be shared. Further discussion planned through committee effectiveness workshop on reporting and assurances from QGG.
- Maternity and Neonatal Incentive Scheme compliance (Q3).
- Assurance on implementation on Patient Safety Incident Framework (PSIRF), with a draft internal audit report received with Moderate Assurance demonstrating the progress in implementing PSIRF and the strength of focus on patient safety and learning.
- Safety surveillance and learning report included Incident reporting, completion of reviews and learning including Patient Safety Incident Investigation (PSIIs); Themes from complaints and concerns and action being taken; improvement work being undertaken on mortality reviews and learning from deaths; update on Coroners inquests.

- Assurance on progress with NICE guidance review and closure of actions.
- Assurance on Cancer harm review completion, waiting times and performance.
- Radiology GP results action plan progress.
- Ionising Radiation (Medical Exposure) Regulations (IRMER) quarterly update including assurance on incident reporting, benchmarking and actions taken.

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

- The Trust are establishing a patient nominated staff award from next month to recognise the patient feedback we get for individuals.
- Committee received a brief verbal update on the initial feedback from the unannounced Care Quality Commission (CQC) inspection of Urgent and Emergency Care (UEC) including immediate actions taken during the visit.
- Maternity Safety Support Programme (MSSP) letter which now states that whilst the Trust has successfully exited the programme, a further service review will be undertaken later in the year following the publication of the Thirlwall Public Inquiry.
- Maternity update paper included review and early learning from two serious incidents which have been reported to Maternity and Newborn Safety Investigations (MNSI) and will undergo Perinatal Mortality Review Tool (PMRT) including external representation. Support being provided to the families.
- Stroke services update, with recurrent investment agreed to improve patient care and experience, and exploring further opportunities to expand stroke coordinator cover.
- Sepsis annual report with action plan for changes to processes, data and compliance improvement.

Risks discussed and new risks identified

- High risks in relation to Q&S were received, key areas highlighted were the appointment of the Medical Devices Safety Officer (MDSO) which will reduce the risk; the lack of medical photography cover with work being undertaken to implement mitigations. It was noted that the consistency in risk scoring is still an area for focus.
- Reviewed Board Assurance Framework (BAF) to ensure consistency with Committee agenda, assurances and risks.

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 15.**	**Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2025**						
Purpose of the Report	Decision		Ratification	**X**	Assurance		Information	
Accountable Executive	Dr Nigel Scawn			Medical Director				
Author(s)	Karen Adams			Director of Pharmacy and Medicines Optimisation Controlled Drugs Accountable Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X**	The impact on the BAF is assurance around the legislative requirements for Boards of Designated Bodies to meet their duties under the Controlled Drugs Regulations 2013 & 2020 (as amended)			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X**
Previous considerations	Not applicable							
Executive summary	The trust (as a designated body) is required to complete and submit a self-assessment via their CDAO, of their systems and processes for handling controlled drugs. The self-assessments allow a regional assessment of current state and improvements. As of 2025, CDAOs are required to obtain board sign off prior to submission. The answers proposed for submission show that systems and processes in place to safely manage controlled drugs at the trust are sufficient to meet the controlled drugs regulations and highlight areas for potential improvement.							
Recommendations	The Board of Directors is asked to approve the proposed answers for submission.							

Corporate Impact Assessment	
Statutory/regulatory requirements	Controlled Drugs Regulations 2013 & 2020 (as amended)
Risk	Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation (BAF8)
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2025

1. Introduction

The Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework was introduced in 2022 to support organisations to continually improve their systems and processes for handling controlled drugs. Following the national CQC webinar held in November 2024, “Board Accountability (designated bodies) for safe use of Controlled Drugs”, Boards are now asked to sign off the submission alongside the CDAO.

2. Background

The Controlled Drugs Regulations were first introduced in 2007 to strengthen governance arrangements for the use and management of controlled drugs in response to the Shipman Inquiry.
The key principles of the regulations include:

- A requirement for designated bodies to appoint and resource a CDAO, who may be appointed into this role and the registration requirements
- Systems for safe management and use are in place and must comply with Misuse of Drugs legislation
- CDAOs must participate in the Local Intelligence Network (LIN) where partner organisations including designated bodies, commissioners, local authorities, regulators and the police are able to share intelligence

3. Purpose

The purpose of this report is to share the proposed responses of the CDAO for the Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework self assessment 2025 with Board members to see approval for submission to NHS England. Answers proposed for submission are indicated in boxes highlighted.

4. Proposed submission

4.1 Systems and processes to handle concerns

How confident is the DB CDAO that all relevant areas know how to report CD-related concerns, including suspected diversion and misuse of CDs by colleagues? (1= not confident to 5 = fully confident)	
Answer: 5	

How confident is the DB CDAO that all relevant areas of the organisation are reporting CD concerns including suspected diversion and misuse of medicines by colleagues? (1= not confident to 5 = fully confident)	
Answer:5	

4.2 Workforce Knowledge and Skills

	Yes	Somewhat	No	Don't know	No recruitment in past 24 months
Can the DB provide evidence (in past 24 months) that relevant staff are trained on induction about vigilance and reporting concerns about unsafe behaviour and systems?		✓			
Rationale for answer: • Nurse induction attendance log • Pharmacy staff CD SOPs log • F2SU					
Can the DB provide evidence that relevant staff receive training on SOPs for handling CDs and reporting concerns?		✓			
Rationale for answer: • Nurse induction attendance log • Pharmacy staff CD SOPs log					
Can the DB provide evidence that relevant staff are updated following SOP/policy reviews for reporting concerns and handling CDs?		✓			
Rationale for answer: • Training following pharmacy SOP update (pre-home office inspection) • No other reviews undertaken pre-July 2023					
Can the DB provide evidence that relevant staff are updated on learning from incidents related to CDs?		✓			
Rationale for answer: • Weekly learning • Quarterly CD report (including improvement actions)					

4.3 Systems in place to investigate CD related incidents

	Yes	Somewhat	No	Don't know	No incidents in past 24 months	Agree	Strongly agree
Can the DB provide evidence (from the past 24 months), that a systems improvement methodology is used to examine the cause of CD-related incidents?		✓					

Rationale for answer:

- Multi-disciplinary, trust wide review
- Triangulation of information from incidents, audit and practice

Can the DB provide evidence (from the past 24 months), that lessons from CD-related incidents are implemented?	✓						

Rationale for answer:

- Process change for receipt signature for audit trail
- Local changes in storage arrangements eg ICU, ED

How frequently are low impact incidents involving controlled drugs reviewed to identify themes*?

- Never
- Annually
- Twice yearly
- Quarterly
- More frequently than quarterly
- This Organisation has not had any incidents in the past 24 months

Answer: Quarterly

Information sharing with responsible bodies
Is there a policy that makes clear the requirement for the CDAO to share personal identifiable information with police, professional regulators, NHS England CDAO?

- Yes
- Somewhat
- No
- Don't know

Answer: Somewhat

Can the designated body provide evidence of sharing concerns and information related to controlled drugs with any of the following in the past 24 months
Select all that apply

- ✓ Medical Director
- ✓ Director of Nursing
- ✓ Human Resources/Organisational Development
- ✓ Pharmacist(s)
- ✓ Medicines Safety Officer
- Medical Examiner
  - ✓ Safeguarding
  - ✓ Security/Fraud
- Estates
  - ✓ Commissioner (CCG medicines optimisation or quality and safety)
  - ✓ Professional regulator (e.g. GPhC, NMC, GMC, HCPC)
- CQC
  - ✓ Police
- Organisation has not had concerns/incidents in past 24 months

Externally shared incidents (during 2024)

- Professional or Employee of concern-Illicit use-drug dealing/illicit drugs
- Professional or Employee of concern- Safeguarding issue
- Professional or Employee of concern- Staff diversion
- Professional or Employee of concern-Illicit use-illicit drugs

4.4 Prescribing, clinical monitoring and taking action

	Yes	Somewhat	No	Don't known	Not applicable
The designated body has systems in place for identifying unusual prescribing of CDs (Schedules 2-5) in relevant areas	✓				
Evidence (from the past 24 months) can be provided that all unusual prescribing of Sch 2-5 CDs in relevant clinical areas has been/is being investigated.					✓ No unusual prescribing detected
Rationale for answer: • Ward based pharmacy review for inpatients • Pharmacy clinical check for outpatients • Quarterly usage review of Schedule 4 and 5 • Review of FP10 data in place					

Does the DB have any evidence (from the past 24months) that there have been changes in process(es) from the outcome of a CD investigation?

	Yes	No	Don't know how / no capacity
The designated body has support available for staff well-being including substance misuse support	✓		
Evidence (from the past 24 months) can be provided that all identified alleged diversion of drugs liable to misuse (including CDs), have been investigated.	✓		
Rationale for answer: • Wellbeing hub and resources, Employee assistance program • Evidence of investigations held on datix			

4.5 The CDAO is set up for success: suitably experienced and resourced

Does the Designated Body CDAO either sit on the Board, or report directly to a Board member?

Please select at most 2 options.

- the CDAO is a Board member
  - ✓ the CDAO has regular "catch-ups" with a Board member to discuss CDAO specific risks and mitigations
  - ✓ the CDAO reports to the Board via written reports that are distinct from Pharmacy/ Medicines management reports
- the CDAO does not report into the Board
- Other (provide further information)

Is the DB CDAO adequately resourced to carry out responsibilities on behalf of the Board?

- Yes
- Somewhat
- No
- Don't know

Proposed answer: Somewhat	

Have you or your organisation contributed to the North West Controlled Drug LIN in the past 24 months through one or more of the following:

- ✓ Attended a LIN meeting
- Led a break-out room discussion at a LIN meeting
- Provided feedback from a break-out room discussion
- Participated in an Action Learning Set related to safe use of CDs
- Presented case study related to safe use of CDs (for example at the LIN meeting or to your organisation)
- Buddying with another CDAO
- Short Life Working Group member
- ✓ Other (provide further information)- provided feedback and suggested future topics

5. Conclusion

Systems and processes in place to safely manage controlled drugs at the trust are sufficient to meet the controlled drugs regulations. Mechanisms to identify areas to improve these processes are well embedded and changes implemented in this regard shall continue to be communicated via the quarterly controlled drugs reports. The report will include an action plan which is received and monitored by the Medication Safety Group with any identified risks being escalated to the Quality Governance Group.

6. Recommendations

The Board of Directors is asked to approve the proposed answers for submission.

Committee Chair's Report
Thursday 27th February 2025, 8.00am – 1.00pm
Boardroom, 1829 Building

Committee	Operational Management Board (OMB)
Chair	Ms Jane Tomkinson, 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 System Oversight Framework (SOF) and wider Board reporting.

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

- Trust operational performance with reference to Cheshire and Merseyside system performance, including cancer, diagnostics and waiting times, and Urgent Emergency Care (UEC) with the Trust focus on 72 hour Emergency Department (ED) breaches demonstrating improvements in reducing breaches and this needs to be maintained.
- Review of Quality & Safety performance, incidents, falls, pressure ulcers, PSIIS, complaints and concerns, and a deep dive into IPC highlighting areas with the highest and lowest compliance.
- Financial performance with current position £2.6M under performance against planned deficit with the plan adjusted to reflect non recurrent cash support. There are risks around delivery of the plan unless mitigations and additional CIP are identified and delivered.
- People update on workforce plan monitoring, people related Key Performance Indicators (KPIs), sickness absence, appraisals, mandatory training, staff survey results, and continued focus on culture in terms of tackling bullying, harassment and incivility.
- Annual Planning update including national priorities, activity assumptions, activity plans, productivity and efficiency opportunities, and plan submission requirements.
- Divisional risk and performance reports received with a range of assurances across all areas of quality, people, operational performance, and finance. Updates demonstrated a lot of work taking place across Divisions on the quality improvement workstreams (including pressure ulcers, falls, Infection Prevention & Control (IPC), risk assessment), mandatory training compliance (including safeguarding and resuscitation), e'discharge completion, financial performance (including CIP), operational performance, thematic reviews, and Patient Safety Incident Investigation (PSIIs).

Advise
(items presented for the Board's information)

- OMB supported the gastroenterology business case which included investment in additional consultant capacity and nurse consultant with planned income exceeding the costs.
- OMB supported the plastics business case which included investment in consultant capacity to address on call rota gaps, improve service resilience and reduce extra duty cost. Additional administrative hours were also supported to replace the on-going spend on overtime and bank.
- OMB supported the Dexa (bone density) service business case to introduce a new service with the identified capital (successful NHS England bid) and revenue linked to the Community Diagnostic Centre plan.
- Updates received on preventing deconditioning, and the therapies ward plan.

Risks
(discussed and new risks identified)

- Risk Management improvement plan update. Making progress but significant work still to do and request for further engagement with the Datix reference group to support system developments.
- Impact of planning guidance is being reviewed, including income linked to business case investment decisions.

Committee Chair's Report

Thursday 13th February 2025, 9.30am – 12.30pm, Boardroom, 1829 Building

Committee	Audit Committee
Chair	Non-Executive Director, Mr M Guymer

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)*

- No areas to alert to the Board of Directors.

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

- Risk Management improvement plan progress, notwithstanding more to do in terms of Datix developments and implementation to support this
- Anti-Fraud plan progress report including awareness raising, referrals and ongoing cases.
- Review of the Draft Annual Governance Statement 2024/25.
- Provider Licence Compliance 2024/25.
- Code of Governance Compliance 2024/25.
- Internal Audit Plan Progress report including substantial assurance for financial systems key controls. The medical staffing review didn't include an assurance level but did highlight a number of issues and the Acting Chief People Officer attended to explain how this aligned to work already progressing e'roster which will be followed up through the People Committee.
- Assurance on follow up progress against Internal Audit recommendations.

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

- New Failure to Prevent Fraud guidance supporting a new statutory instrument which will bring this offence into effect from Sept 2025. NHS Counter Fraud Authority reviewing this alongside their counter fraud standards and we will need to consider this with our Anti-Fraud Specialist.
- Out of date policies continue to be a focus but significant work still needed in terms of updates and accuracy of reporting information.
- Thorough review and update of proposed changes to Standing Financial Instructions (SFIs) for Board approval.
- Recovery and Bad debt write off for 2024/25 £199K which included significant debt of £136K in relation to the liquidation of a maternity services provider in 2020 (noting there was a provision for this in prior years). Also, a number relating to an overseas supplier and overseas patients. Audit Committee requested historic timeline on reporting within the Trust of the liquidation of a maternity services provider.
- Concerns on salary overpayments causes with an action plan in place to improve systems and processes to mitigate the risk going forward, recognising the risk of financial recovery on historical overpayments.

• Approved the Indicative External Audit Plan 2025, Draft Anti-Fraud plan 2025/26 and the Draft risk based Internal Audit Plan 2025/26.
Risks discussed and new risks identified
• The risks and assurance for the transition of payroll services to be considered through the People Committee.

Committee Chair's Report

Friday 7th March 2025 at 1.30pm – 2.30pm via Microsoft Teams

Committee	Finance & Performance Committee
Chair	Non-Executive Director, Ms P 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)*
• Financial position for 2025/26 annual planning is challenging. CIP delivery for 24/25 and 25/26 is a key risk. Consideration needs to be given to larger scale change and transformation initiatives. • UEC performance continues to be an area of concern. Significant focus and improvement work has been undertaken but progress is being hampered by large increases in NCR.
Assure *(matters in relation to which the Committee received assurance)*
• Month 11 finance update indicates that the planned position for 2024/25 should be achieved. • SOF performance standards received • Alert, Assure and Advice Chair report from Operations and Performance Executive Led Group (OPELG) • Funding received for staff pay award and industrial action.
Advise *(items presented for the Board's information)*
• Medical staffing overspend of £1.2m due to sickness, vacancies and workload pressures.
Risks discussed and new risks identified
• CIP underdelivered by £7.4m. Workshop held in January 2025 and CIP delivery groups assessing opportunities for CIP identification. • Increased Band 2-3 recurrent costs (backpay costs will be within 24/25 position). • NC2R consistently above agreed projections. • RAAC in Women's and Children's: risk assessment being done and actively managed

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 20.***	**NHS Green Plan Guidance Update**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Jonathan Develing			Director of Strategic Partnerships				
Author(s)	Jonathan Develing Russ Morrow			Director of Strategic Partnerships Head of Facilities				
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**	As new guidance expands the strategic intent of the green agenda, the development of a refreshed plan will need to take into account all elements of the Trust Board Assurance Framework (BAF)			
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	Anchor Institution Group February 2025.							
Executive summary	The purpose of this report is to brief the Board on refreshed net zero guidance published by NHS England in February 2025.							
Recommendations	The Board of Directors is asked to note that the Anchor Institution Group will oversee the development of a new green plan, referring to this guidance, by July 2025, in line with National requirements.							

Corporate Impact Assessment	
Statutory/regulatory requirements	Trust compliance with national guidance.
Risk	Risk to compliance and meeting net zero expectations.
Equality & Diversity	Meets Equality Act 2010 duties & Public Sector Equality Duty 2 aims and does not directly discriminate against protected characteristics.
Communication	Not confidential.

NHS Green Plan Guidance Update

Introduction

In February 2025 NHS England published new guidance relating to the NHS Greener programme.

This statutory guidance has been developed to support NHS organisations develop robust plans to improve health outcomes, reduce costs, and minimise waste – continuing the NHS' journey to achieving net zero.

Background

Lord Darzi highlighted the urgency of this agenda last November,

'The World Health Organisation has described the climate crisis as the "single biggest threat facing humanity". Given the global health imperatives, the NHS must stick to its net zero ambitions. There is no trade-off between climate responsibilities and reducing waiting lists. Indeed, often health and climate are mutually reinforcing goals: cleaner air is good for the environment and good for respiratory health.'

In summary, guidance calls for a refresh of provider plans with a focus not just on achieving net zero targets but also new opportunities to deliver outcomes that are best for our patients, financially beneficial, and better for our planet.

There are three principal aims

1. Prioritising interventions that support world-leading patient care and population health, reduce inequalities, and tackle climate change and broader sustainability issues.
2. Supporting organisations to plan and make considered investments while increasing efficiencies and delivering value for taxpayers.
3. Ensuring every NHS organisation supports the NHS-wide ambition to reach net zero carbon emissions, reflecting on the learning from delivery to date.

Recommendation

At the Countess of Chester Hospital NHS Foundation Trust, we have a well-developed Green Plan "We're Going Greener 2021-25" first published in April 2021.

The Board of Directors is asked to note that the Anchor Institution Group will oversee the development of a new green plan, referring to this guidance, by July 2025, in line with National requirements.

Committee Chair's Report

11th February 2025

Committee	People Committee
Chair	Non-Executive Director, Ms W Williams (this meeting Chaired by Non-Executive Director, Ms P 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)*

- No items to alert.

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

- Education action plan developed to focus on addressing the themes from a range of national surveys including General Medical Council (GMC). A number of actions complete and others progressing with deadlines of April and September 2025.
- Equality Delivery System assessment compliance demonstrating positive progress, agreed for publication.
- People promise exemplar programme delivery with a closedown report to be produced for NHS England to be reported to the Committee in April 2025.
- Update on management development, leadership and appraisals with continued roll out of training and review of qualitative impact of appraisals.

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

- Paper on apprenticeship levy which is underutilised. Further work being undertaken to explore opportunities to maximise number of apprentices and use of the levy.
- Early update on staff survey results which remain embargoed, including improved response rates, timeframes for data release, communication and development of action plans. Further update planned April 2024.
- People Key Performance Indicators (KPIs) with information, actions and assurance to be considered through governance structures and future reports.
- Equality, Diversity & Inclusion progress noted and integrated action plan to be developed.
- Gender pay gap report received and approved for publication, noting reduction in gender pay gap and further actions to be taken.
- Out of date policies and planned review dates provided to the Committee, recognising further extensions to dates based on a risk priority basis (Committee requested further commentary to support this).
- Update on governance structure underpinning the work of the People Committee with draft Terms of References (TOR) developed. To be established and final TOR to come back for approval.

Risks discussed and new risks identified

- Reviewed BAF and high risk report triangulating with the agenda.

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 22.**	**Standing Financial Instructions (SFIs) Review 2025**						
Purpose of the Report	Decision		Ratification	**X**	Assurance		Information	
Accountable Executive	Karen Edge			Chief Finance Officer				
Author(s)	Rose Garrod			Chief Financial Accountant				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			 **X** **X** **X**	BAF impact is compliance with our governance arrangements.			
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	Audit Committee February 2025.							
Executive summary	The Audit Committee has reviewed the proposed amendments and recommended approval to the Board. Once approved by the Trust Board the new version of the SFI and VPP are uploaded onto the intranet. A mini guide will be updated and circulated to managers.							
Recommendations	The Board of Directors is asked to: • Note the changes to Standing Financial Instructions (SFI's) and Variable Pay Policy (VPP) • Ratify the revised SFI's							

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the Trust compliance with Foundation Trust Status
Risk	Ensures compliance of Trust rules and regulations by staff
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

Standing Financial Instructions Review 2025

1. Introduction

Standing Financial Instructions (SFI's) set out the financial governance rules for the Trust and as such the Trust is required to review the Standing Financial Instructions on a regular basis to ensure that they remain current and relevant. SFI's have to be ratified and approved by the Trust board, based on the recommendations from the audit committee.

Once approved and ratified by the Board the SFI's are updated on the Intranet to ensure that all staff can access. Training is delivered to all budget holders on a regular basis through the Finance Awareness Training and Finance for 1st Line Leaders Programme in which the key elements and importance of the SFI's are provided.

2. Background

The review is conducted by consulting with a number of stakeholders including Internal Audit and External Audit Trust senior managers and Directors. The review also takes account of latest legislation and national guidance and internal audit recommendations.

3. Purpose

The purpose of the review is to ensure that the correct legislation is reflected throughout the document, that the correct roles and responsibilities are up to date and that all issues of financial governance are set out as to who is responsible and at what level.

4. Key changes within the SFI's and VPP

The key changes to note are:

SFI's

- The latest Terms of Reference for Audit Committee and Remuneration Committee are now reflected in the document;
- Changes have been made throughout the document to reflect latest changes in Procurement legislation;
- Internal audit recommendations have been incorporated;
- Where possible the document points to the relevant policies and procedures;
- Change of processes;
- Introduction of the Provider Selection Regime
- Change of Procurement legislation
- Job title changes

VPP

- Introduction of the Pay Control Panel
- Change of processes
- Job title changes

The Audit Committee considered the review and recommendations at its meeting in February and recommend approval of the updated SFI's to the Board.

5. Recommendations

The Board of Directors is asked to:

- Note the changes to Standing Financial Instructions (SFI's) and Variable Pay Policy (VPP)
- Ratify the revised SFI's

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 23.***	**Gender Pay Gap**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	**X**
Accountable Executive	Vicki Wilson			Acting Chief People Officer				
Author(s)	Vicki Wilson			Acting Chief People Officer				
Board Assurance Framework	BAF 1 Quality, BAF 2 Safety BAF 3 Operational, BAF 4 People BAF 5 Finance, BAF 6 Capital BAF 7 Digital, BAF 8 Governance BAF 9 Partnerships, BAF 10 Research			**X**	BAF impact is the challenges in ensuring a high quality, engaged, diverse and inclusive workforce would affect our ability to deliver care.			
Strategic goals	Patient and Family Experience, People and Culture, Purposeful Leadership Adding Value, Partnerships, Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	People Committee 11th February 2025							
Executive summary	The paper provides an overview of the Trust's Gender Pay Gap (GPG) report for 2024. It includes data insights and demonstrates that the Trust understands the need to reduce workplace gender inequalities, promote equality and work to eliminate discrimination. There has been a decrease in both the mean and median pay in this year's gender pay gap figures. Despite the positive decrease there is still more work to be done as we are still seeing more male employees represented within the upper earning quartiles then women. The Trust acknowledges that the gender pay gap is the result of the roles in which men and women work within the Trust. The GPG report will be published on the Trust website, following People Committee, and in advance of the 31 March deadline. The EDI coordinator will progress the actions identified above and progress against these will be monitored through the People & Culture sub-committee and reported up to People Committee.							

Recommendations	The Board of Directors is asked to: • Note the contents of the COCH Gender Pay Gap report and identified actions. • Note the publication of the Gender Pay Gap report on the Trust's website.

Corporate Impact Assessment	
Statutory/regulatory requirements	Workforce regulation and legislation.
Risk	Poor staff experience (BAME and staff with disabilities) risk included on strategic risk register
Equality & Diversity	Meets Equality Act 2010 duties & PSED
Communication	Not confidential

Gender Pay Gap

1. Introduction

The paper provides an overview of the Trust's Gender Pay Gap (GPG) report for 2024. It includes data insights and demonstrates that the Trust understands the need to reduce workplace gender inequalities, promote equality and work to eliminate discrimination. It also sets out the actions identified as a result of the GPG report 2024.

2. Background and context

Under the Gender Pay Gap Regulations 2017, the Trust is required to report annually on gender pay gap, utilising a reporting framework set out by the Government Equalities Office (GEO) and to register with the GEO and submit its annual Gender Pay Gap Report (GPGR).

3. Purpose

The purpose of this paper is to provide the Gender Pay Gap 2024 data in compliance with the Government Gender Pay Gap Regulations 2017. The Trust is required to submit the statistical data within the report to the Department of Work and Pensions by 31st March 2024 and must publish this information on its Trust website by 31st March 2023.

4. Gender Pay Gap 2024

4.1. Gender Pay Gap Definition

The gender pay gap is a figure that shows the difference in the average pay between all men and women in a workforce. The gender pay gap is the difference between women's and men's average salary earnings, expressed as a percentage of men's earnings. It is a measure of women's overall position in the paid workforce and does not compare like roles. Gender pay gap is different to 'equal pay' which is a more specific legal concept that deals with the pay differences between men and women carrying out comparable jobs. While the gender pay gap focuses on an average across the whole organisation across a variety of different role and pay bands. A large difference in the gender pay gap does not necessarily indicate unequal pay, which is determined by what people earn in comparable jobs.

The gender pay gap can indicate that there is some practice to address with regards to if women are in roles that are paid less than men, and potentially, the reasons for this. This may be due to varied reasons, for example, women and men working in different roles, with female-dominated roles attracting lower wages, women's disproportionate share of unpaid caring and domestic work, lack of workplace flexibility to accommodate caring and other responsibilities, especially in senior roles, women's greater time out of the workforce impacting career progression and opportunities, lack of confidence among female staff seeking pay increases/leadership roles.

The range of reasons as to why gender pay gap exists across different organisations in all the workforce sectors is a complex issue. It is important to note that a gender pay gap does not equate to the existence of an equal pay problem, though a gender pay gap may be a catalyst for organisations to look into any reasons as to why the gap exists.

4.2. COCH Gender Pay Gap Report 2024

The data tables in Appendix 1 provide analysis on the Mandatory Gender Pay Gap Reporting for the 2023/24 financial year with the data as of 31st March 2024.

The 2024 the mean (average) difference in hourly rate by gender and determines that women are paid £5.26 per hour less than their male colleagues, which is equivalent to a pay gap of 22.49%. This is a decrease in the GPG of 2023 by £1.52 per hour, and a reduction in the pay gap of 6.13%.

The gender pay gap report also looks at gender make-up by quartile, of the whole workforce establishment. Quartile 1 represents staff paid on lower salaries, with Quartile 4 representing the highest paid cohort of employees. Women account for 70.93% in quartile 4. The total percentage of women across the whole organisation is 79.86%, so quartile 4 shows an underrepresentation of women, and quartile 1 shows an overrepresentation of women at 83.92%.

A number of actions have been identified following review of the GPG report which are set out below. We will work with colleagues across the organisation, including through our Women's Staff Network to explore the potential for additional actions which could help to improve gender equality in the workplace.

Action 1	Undertake thorough analysis of workforce data especially where there is a gender pay gap, to better understand who is applying for and being appointed to roles and take steps to spot and address any patterns identified.	April 2025.
Action 2	Undertake thorough analysis of training data to better understand who is applying for and being accepted onto leadership development training and take steps to spot and address any patterns identified.	April 2025.
Action 3	Establish a mechanism to inform and support activities of the Women's Staff Network on gender specific HR issues.	February 25

These actions will be incorporated into the integrated EDI action plan and progress against these will be monitored through the People & Culture sub-committee and reported up to People Committee.

5. Conclusion

There has been a decrease in both the mean and median pay in this year's gender pay gap figures. Despite the positive decrease there is still more work to be done as we are still seeing more male employees represented within the upper earning quartiles then women. The Trust acknowledges that the gender pay gap is the result of the roles in which men and women work within the Trust. There are societal and structural factors which go some way to explaining the gender pay gap within the Trust, including over-representation of women in the traditionally care-giving profession of nursing, which is a major factor common to all NHS Trusts.

Supporting women to succeed in leadership roles is a key focus for the Trust and we recognise that flexible working is a critical part of enabling women to maintain their careers. Increasing

flexible working opportunities across our organisation is a key area of focus for the Trust. We will continue to listen to our female colleagues through our variety of listening mechanisms, including our Women's Staff Network, and be open to considering any proposals to further gender equality in the workplace.

6. Next Steps & Actions

The GPG report will be published on the Trust website, following People Committee, and in advance of the 31 March deadline.

The EDI coordinator will progress the actions identified above and progress against these will be monitored through the People & Culture sub-committee and reported up to People Committee.

7. Recommendations

The Board of Directors is asked to:

- Note the contents of the COCH gender Pay Gap report and identified actions
- Note the publication of the GPG report on the Trust's website

Appendix 1 - COCH Gender Pay Gap Report 2024

Employee Headcount	5577

Percentage of Men & Women in each Hourly Pay Quarter	Male	Female	Male %	Female %
Upper Hourly Pay Quarter	407	993	29.07%	70.93%
Upper Middle Hourly Pay Quarter	205	1185	14.75%	85.25%
Lowe Middle Hourly Pay Quarter	287	1107	20.59%	79.41%
Lower Hourly Pay Quarter	224	1169	16.08%	83.92%
All Pay Quarters	**1123**	**4454**	**20.14%**	**79.86%**

Average & Median Hourly Rate	Mean Hourly Rate	Median Hourly Rate
Male	£23.40	£17.68
Female	£18.14	£16.63
Difference	£5.26	£1.06
Pay Gap %	22.49%	5.99%

The table below provides a pay band-based representation of the workforce establishment, to adhere to GDPR, headcounts less than 6 are not displayed.

Grade	Male		Female		Difference in Hourly Rate	Percentage Difference
	Employee Headcount	Average of Hourly Rate	Employee Headcount	Average of Hourly Rate		
Apprentice		£10.42	17	£11.04	-£0.62	-5.95%
Band 1	14	£14.94	38	£16.95	-£2.01	-13.46%
Band 2	278	£13.79	1311	£13.59	£0.20	1.46%
Band 3	115	£13.17	484	£12.68	£0.49	3.72%
Band 4	53	£14.23	242	£13.83	£0.40	2.83%
Band 5	168	£17.02	1061	£17.99	-£0.97	-5.70%
Band 6	87	£20.39	564	£21.28	-£0.88	-4.33%
Band 7	79	£23.81	373	£24.23	-£0.41	-1.74%
Band 8a	39	£27.04	128	£26.98	£0.06	0.22%
Band 8b	14	£32.09	33	£31.79	£0.30	0.93%
Band 8c	6	£36.22	15	£39.66	-£3.44	-9.50%
Band 8d		£45.45	8	£43.06	£2.40	5.28%
Band 9		£51.45		£51.08	£0.37	0.71%
M&D - Consultant	153	£54.07	78	£52.48	£1.59	2.95%
M&D - Other	102	£28.59	90	£26.03	£2.57	8.98%
Executive Director		£74.62		£86.85	-£12.23	-16.39%
Non-Executive Director		£10.43		£6.94	£3.50	33.51%
Grand Total	**1123**	**£23.40**	**4454**	**£18.14**	**£5.26**	**22.49%**

Staff Group	Male		Female		Difference in Hourly Rate	Percentage Difference
	Employee Headcount	Average of Hourly Rate	Employee Headcount	Average of Hourly Rate		
Add Prof Scientific and Technic	25	£24.15	129	£21.43	£2.73	11.29%
Additional Clinical Services	163	£14.08	1174	£13.94	£0.14	1.00%
Administrative and Clerical	222	£18.91	802	£14.87	£4.05	21.39%
Allied Health Professionals	77	£20.37	296	£21.16	-£0.78	-3.85%
Estates and Ancillary	217	£14.04	290	£13.73	£0.31	2.24%
Healthcare Scientists	32	£21.05	74	£21.90	-£0.85	-4.03%
Medical and Dental	256	£44.01	168	£38.31	£5.70	12.95%
Nursing and Midwifery Registered	131	£20.04	1521	£20.67	-£0.63	-3.15%
Grand Total	**1123**	**£23.40**	**4454**	**£18.14**	**£5.26**	**22.49%**

GENDER PAY GAP BY BONUSES

Percentage of Men & Women who received Bonus Pay	Male	Female	Male %	Female %
Staff Receiving Bonuses	133	74	64.25%	35.75%

Average & Median Hourly Rate	Mean Bonus Pay	Median Bonus Pay
Male	£7,249.82	£4,720.72
Female	£6,520.51	£4,720.72
Difference	£729.31	£0.00
Pay Gap %	10.06%	0.00%

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 24.**	**NHS Staff Survey 2024 – Results and High-Level Actions**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Vicki Wilson			Acting Chief People Officer				
Author(s)	Liz Pritchard			Deputy Chief People Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X**	BAF impact is BAF 4 – People Failure to focus on creating a positive staff experience and higher levels of engagement are known to impact on the recruitment, retention and advocacy of staff. Poorer staff experience is known to have a negative impact on patient outcomes and experience. The Trusts assessment by the CQC under the Well Led domain may also be negatively impacted.			
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
Previous considerations	People Committee January							
Executive summary	This paper provides a summary of the Trust 2024 Staff Survey outcomes, including national benchmark data. It analyses data via People Promise theme as well as the measures of engagement and morale and In 2024, the Trust achieved a 46% response rate, it's highest in 11 years. Whilst the Trust continues to be below the average for our comparator group across all People Promise elements and themes, our 2024 results show that we have improved our position across 8 out of 9 elements/ themes. This is a significantly improved benchmarking position from 2023 results where we were aligned to the worst performing Trusts for 7 out of 9 elements/ themes. The Trust improved against a national average downward trend in the following areas: • Compassionate Culture							

	• Diversity & Equality • We each have a voice that counts • Raising concerns • Involvement • Advocacy The areas of deterioration or lowest performance include: • Physical violence from patients/public • Unwanted behaviour of a sexual nature from patients/public. • Flexible working In terms of workforce equality indicators the experience of staff with a long-term condition is less favourable when compared with staff without a long-term condition however improvements have been made since the 2023 report for staff with a long-term condition across 8 of the 9 indicators included in the report. A number of high-level priority actions are identified below. Divisional level action planning supported via the HR Business Partners, is ongoing. Reporting and oversight will be maintained via divisional and people governance structures and the overarching action plan will initially be reported to People Committee in April.
Recommendations	The Board of Directors is asked to: • Note the Trust's Staff Survey 2024 results • Note the analysis undertaken and areas for action identified. • Take assurance that the Trust continues to engage its staff in the completion of the staff survey, has undertaken an analysis of the 2024 survey results, and has identified appropriate actions and will monitor progress via People Committee.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	Poor staff experience (BAME and staff with disabilities) risk included on strategic risk register
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

NHS Staff Survey 2024 – Results and High-Level Actions

1 Introduction

The NHS Staff Survey provides an opportunity for NHS organisations to survey their staff in a consistent and systematic way. This makes it possible to build up a picture of staff experience and, with care, to compare and monitor change over time and to identify variations between different staff groups. The Trust recognises the importance of positive staff experience and the impact this has for patients. Our staff survey results provide valuable insight into the experience of staff working within our Trust and supports us in identifying priorities for improvement. The data from our staff survey is available in the public domain and is used by organisations such as the CQC as part of a wider suite of metrics to review and monitor performance.

2 Background

The survey was made available to all staff (including Bank Staff) for completion during the period September to November 24 using a mixed survey mode of electronic and paper based. To maintain confidentiality, all Trusts are required to use an external survey provider, with the Trust continuing to use IQVIA for the 2024 survey. The results are subject to a national embargo that was lifted on 13th March 25, with benchmarking available for substantive staff results available for sharing from this date. Benchmarking data for Bank Staff is not expected to be available till later in spring 2025.

Since 2022, Staff Survey results have been mapped against the NHS People Promise, the promise that all NHS organisations and staff working within them make to each other to work together to improve the experience of working in the NHS for everyone. The people promise includes the following 7 elements, with the staff survey also mapped to two additional measures or engagement and morale.

Figure 1 – Visual summary of the NHS People Promise and the additional NHS Staff survey measures of Staff Engagement and Morale

3 Purpose

The purpose of the report is to highlight key observations from analysis of the Trust's staff survey results and benchmark data, and to provide assurance that the Trust continues to engage its staff in the completion of the staff survey and has identified appropriate actions with the aim of further improving staff experience.

4 NHS Staff Survey 2024 Results

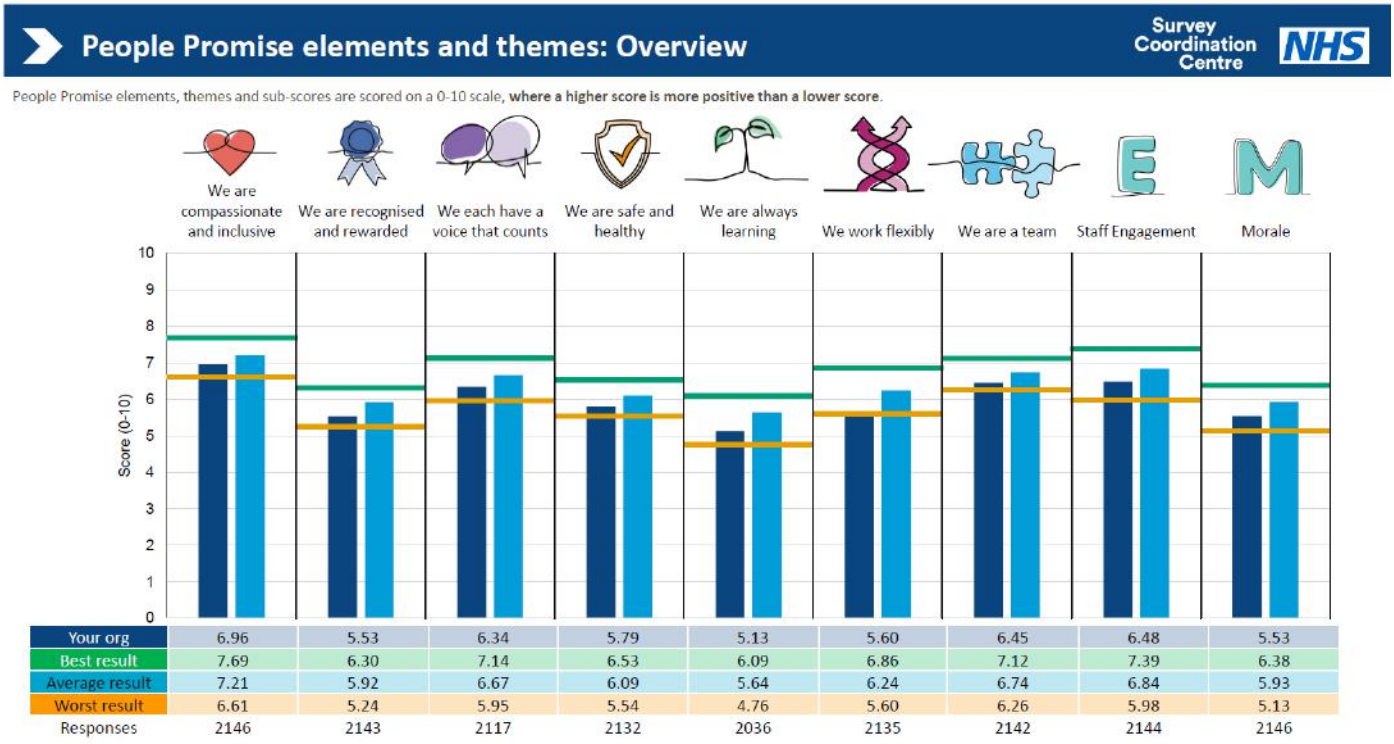
The following section provides a high-level summary of results, and a full copy of the Trust Breakdown and Benchmark Reports are provided in the below links.
https://cms.nhsstaffsurveys.com/app/reports/2024/RJR-breakdown-2024.pdf
https://cms.nhsstaffsurveys.com/app/reports/2024/RJR-benchmark-2024.pdf

4.1 Completion Rates

In 2024, the Trust increased completion of the Staff Survey for both substantive and bank staff, increasing the response rate for substantive staff to 45% (3% increase from 2023) and for Bank Staff to 20% (1% increase from 2023). This was the highest response achieved in 11 years and was enabled by a Staff Survey communication plan that was launched in September 24 and ran throughout the completion window.

4.2 Benchmarking with Comparator Group

For the purposes of national benchmarking the Trust is compared with 121 other organisations that are categorised as Acute and Acute and Community Trusts.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.96	5.53	6.34	5.79	5.13	5.60	6.45	6.48	5.53
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	2146	2143	2117	2132	2036	2135	2142	2144	2146

Figure 2. below provide a visual overview of Trust results against our comparator group.

Whilst the Trust continues to be below the average for our comparator group across all People Promise elements and themes, our 2024 results show that we have improved our position across 8 out of 9 elements/themes. This is a significantly improved benchmarking position from 2023 results where we were aligned to the worst performing Trusts for 7 out of 9 elements/themes.

In addition, a number of sub score results show an increase in scores, against a national average downward trend in the following areas:

- Compassionate Culture
- Diversity & Equality
- We each have a voice that counts
- Raising concerns
- Involvement
- Advocacy

That the Trust has made positive improvements in relation to these scores, despite the national trend deteriorating, is testament to the focus and hard work that has been undertaken in these areas.

The sub-score area where the Trust has deteriorated, despite a positive national trend relates to ‘Negative Experience’. This includes questions that relate to staff experiencing physical violence/ bullying, harassment or abuse and unwanted behaviour of a sexual nature from patients/public. We know that staff are currently experiencing violence and aggression from patients and have established a violence and aggression group to help address this, along with the zero-tolerance

campaign. It is clear that more must be done to ensure staff understand what we are doing to address this, and that our interventions are impactful.

The People Promise Theme where the Trust scores worst in comparator group is We Work Flexibly. Sub-scores for both 'Support for work-life balance' and 'flexible working' as part of this theme are aligned to worst results in the comparator group. We know that there is more we can do around supporting flexible working, particularly in our clinical divisions who report lower levels of flexible working than corporate colleagues. Review of policy, development of line manager capability and rollout of electronic rostering systems will all support improvements in this area.

The sub-score of Line Management within the theme of 'We are a Team' is also aligned to worst results in the comparator group. This includes questions that relate to staff experience of their immediate managers. Development of line manager capability through the managers essentials programme and wider leadership programmes will help to improve this.

In relation to the engagement and morale elements, prevalence of stress, anxiety & burnout amongst staff is contributing to lower scores. Further work is needed to understand and tackle root causes of stress, anxiety and burnout.

4.3 Trust performance compared with 2023 results

Whilst it is important to understand and acknowledge benchmarking, the Trust continues to focus on a year-on-year analysis of results to drive our continuous improvement of staff experience.

Direct comparison of People Promise theme/element results, show that all People Promise themes have improved or remained the same since 2023, with no significant decline in experience reported. 'We each have a voice that counts' has seen a significant improvement, indicating that work undertaken, particularly in relation to raising concerns (including Freedom to Speak Up), is becoming embedded.

In relation to question level results, the Trust has 9 questions where a statistically significant improvement has been achieved, 96 questions that have seen no significant movement and 2 questions that have seen a significant decline. These are summarised as follows.

Question types that have seen a statistically significant improvement.	Question types that have seen a statistically significant decrease
• Feeling valued by the organisation • Wellbeing • Raising concerns and speaking up • Respect for individual difference • Appraisal completion • Care of patients being organisations top priority	• Physical violence from patients/public • Unwanted behaviour of a sexual nature from patients/public.

4.4 Trust Performance – Breakdown

Divisional response fluctuates across question types however scoring for 'Your Organisation' has seen a consistent improvement across all Divisions, showing that there has been a positive impact of the work being done to improve culture & experience.

Question Type	2023 Overall %	2024 Overall %	% Change
YOUR JOB	52.48%	52.80%	0.33%
YOUR TEAM	65.34%	65.24%	-0.10%
PEOPLE IN YOUR ORGANISATION	61.82%	63.90%	2.09%
YOUR MANAGERS	62.80%	62.67%	-0.13%
YOUR HEALTH, WELL-BEING & SAFETY AT WORK	33.78%	34.36%	0.57%
YOUR PERSONAL DEVELOPMENT	48.98%	49.45%	0.47%
YOUR ORGANISATION	42.35%	44.91%	2.56%
OVERALL	**46.06%**	**46.70%**	**0.64%**

From a divisional perspective, the best staff experience (as measured by the 30 themes) is within Corporate non-clinical, IM&T and Finance & Performance. It is of note that the best performing areas are all non-patient facing divisions, mirrored by breakdown data for Staff Groups where A&C staff have the highest average across all areas (with Estates & Facilities the lowest)

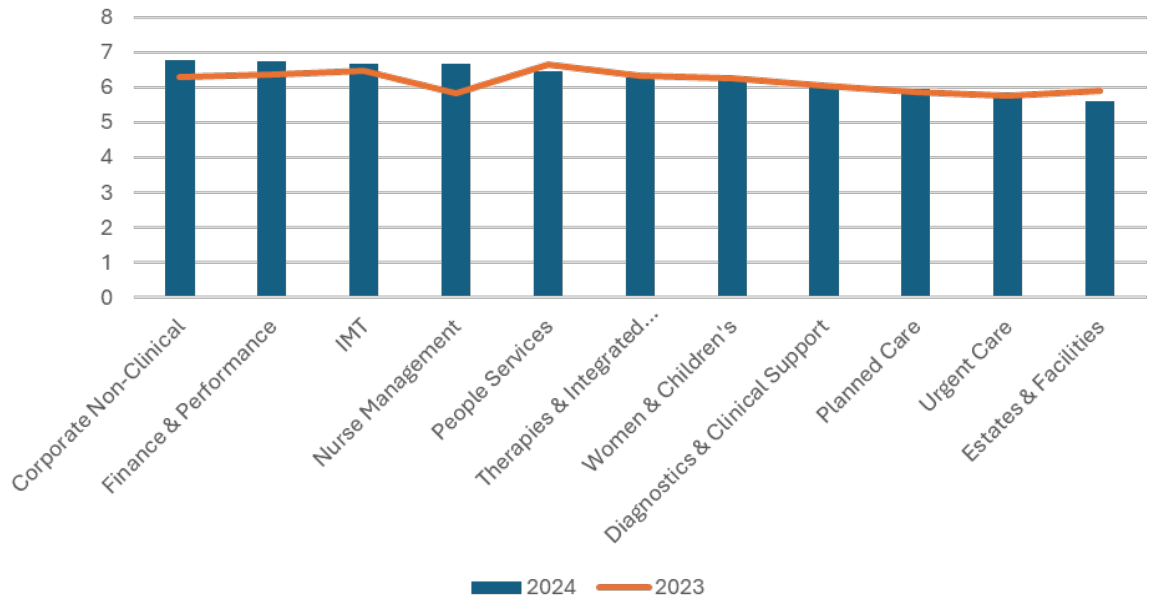


Figure 3.above provides a visual overview of Trust results by Division in 2023 and 2024. .

There is a significant difference in staff experience across divisional areas. The table below shows the number of themes by area that are above the Trust average score for that theme.

- People Services 9
- IMT 9
- Finance and Performance 9
- Nurse Management 9
- Therapies and Integrated Community Care 8
- Women and Children's 8
- Corporate Non-Clinical 8
- Diagnostics and Clinical Support 2
- Estates and Facilities 1
- Planned Care 1
- Urgent Care 1

4.5 Workforce equality indicators

Staff survey reporting also provides data for workforce equality indicators.

In relation to Workforce Race Equality Standards (WRES) key findings include:	In relation to Workforce Disability Equality Standards (WDES), key findings include:
• Bullying & harassment / discrimination levels from colleagues / managers has reduced significantly amongst staff in ethnic groups • Harassment and abuse levels from patients/public are rising in both groups, faster amongst white staff • Less staff in ethnic groups than white staff feel that there are opportunities for career progression	• that the experience of staff with a long-term condition is less favourable when compared with staff without a long-term condition • improvements have been made since the 2023 report for staff with a long-term condition across 8 of the 9 indicators included in the report.

4.6 Summary of findings

In summary, benchmarking against our comparator group illustrates that there is a significant amount of further work required to improve staff experience at the Trust however, both benchmarking results and Trust year on year comparison of results would indicate that the Trust is continuing to make positive steps in improving staff experience.

5 NHS Staff Survey 2024 – High Level Priority Actions

A number of high-level priority actions are identified below. Divisional level action planning supported via the HR Business Partners, is ongoing. Reporting and oversight will be maintained via divisional and people governance structures and the overarching action plan will initially be reported to People Committee in April.

People Promise Theme/Element	Sub-score trends and specific focus	Action to be taken
We are Safe and Healthy	Negative experiences • Violence and Aggression from patient/public • Sexual Safety from patient/public	Further action planning and implementation via the Trust Violence and Aggression Group. • Review of incidents of patient violence and aggression to understand causes, hotspots and identify relevant actions. • Develop clear and robust processes to address violence and aggression from patients and public, in accordance with the Zero Tolerance campaign approach. Continue to embed work practices that support improved sexual safety in line with Sexual Safety Charter. Review and monitoring of reporting.
We are a Team	Line management	Launch of Trust Manager Essentials programme in Q1 24/25. Review of current management development offers to identify further targeted management development opportunities. Q1/2
We work flexibly	Support for work-life balance Flexible working	Review of current Trust approach to flexible working and development of guidance and support for managers (linked to manager essentials prog).Q1 Rollout of rostering to support flexible working opportunities (eg. potential for self/team rostering etc) (Ongoing throughout 2025/26)
Engagement & Morale	Reduce stress, anxiety & burnout	Understand and tackle root causes of stress, anxiety and burnout. Manager essentials prog. Targeted HWB support

6 Conclusion

This report demonstrates the Trust's ongoing commitment to improving staff experience, supporting its staff to participate in the staff survey, analyse the results and identify and implement actions with the aim of continually improving staff experience.

In support of this, the analysis of Trust level results finds that staff engagement with the survey (completion of the survey) has improved in 2024. Benchmarking against our comparator group illustrates that there is a significant amount of further work required to improve staff experience at the Trust however, both benchmarking results and Trust year on year comparison of results would indicate that the Trust is continuing to make positive steps in improving staff experience. High level actions identified are linked to the analysis undertaken in section 4 of the report. Reporting and oversight will be maintained via divisional and people governance structures and the overarching action plan will initially be reported to People Committee in April.

7 Recommendations

The Board of Directors is asked to:

- Note the Trust's Staff Survey 2024 results
- Note the analysis undertaken and areas for action identified.
- Take assurance that the Trust continues to engage its staff in the completion of the staff survey, has undertaken an analysis of the 2024 survey results, and has identified appropriate actions and will monitor progress via People Committee.

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 25.***	**Equality Delivery System (EDS) Assessment Report 2024/5**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	**X**
Accountable Executive	Vicki Wilson Sue Pemberton			Acting Chief People Officer Director Of Nursing and Quality / Deputy Chief Executive				
Author(s)	Samantha Edwards Funbi Mathew			Associate Director of Nursing, Corporate Human Resources Business Partner, Corporate				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X**	BAF impact is Quality. The Trust has responsibility to meet its public sector duty under the Equality Act 2010. BAF Impact is People. The Trust must ensure a high quality, engaged, diverse and inclusive workforce.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							 **X** **X**
Previous considerations	People Committee 11th February 2025 Quality and Governance Group 6th February 2025							
Executive summary	The report highlights the Trust's commitment to Equality, Diversity, and Inclusion (EDI) and provides a comprehensive summary of the annual EDS assessment for 2024. The Trust has made significant progress, with 10 outcomes rated as "Achieving" and one outcome rated as "Developing," compared to the previous year when 7 outcomes were rated as "Developing" and 4 as "Underdeveloped" Despite scoring ''Achieving'' grades across 10 outcomes, our overall score is 21 based on a lower score in 1 outcome (staff experience and advocacy being rated as ''Developing'' under Domain 2). This means that the Trust is rated overall as ''Developing''. Wee have progressed from being rated overall as ''Underdeveloped'' in the previous year to ''Developing'' with 1 score below (22) which is the overall score for Achieving organisations.							

	A number of positive areas were highlighted through the assessment. While wellbeing initiatives have been strengthened, staff survey responses highlight areas needing further attention. Leadership efforts were evaluated across three outcomes, with an overall score of 6 (2 out of 3 for each outcome). Improvements in leadership visibility and accountability were noted as key contributors to this score. The assessment also identified critical areas requiring further attention, particularly in data collection and staff experience. Less than 45.38% of staff would recommend the Trust as a place to work, and only 51.38% would recommend it as a place for care. To address these challenges and build on progress a number of actions have been identified.
Recommendations	The Board of Directors is asked to: • Note the contents of the report. • Note the recommendations outlined which were approved at People Committee in February. • Note the publication of the Trust's annual Equality Delivery System Action Plan, approved by People Committee in February, to the Trust website on 28th February 2025.

Corporate Impact Assessment	
Statutory/regulatory requirements	Requirement of commissioned Trusts by NHS England and Improvement to undertake an annual Equality Delivery System assessment.
Risk	BAF impact is Quality. The Trust has responsibility to meet its public sector duty under the Equality Act 2010. BAF Impact is People. The Trust must ensure a high quality, engaged, diverse and inclusive workforce.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published on Trust website

Equality Delivery System (EDS) Assessment Report 2024/5

1. Introduction

The Equality Delivery System (EDS) serves as a cornerstone for NHS organisations, enabling them to assess and enhance their approaches to equality, diversity, and inclusion (EDI). Grounded in the Public Sector Equality Duty as outlined in the Equality Act 2010, the EDS provides a structured framework for addressing health inequalities through three pivotal domains:

1. Commissioned or Provided Services
2. Workforce Health and Wellbeing
3. Inclusive Leadership

This report to the People Committee includes reference to Domains 1, 2 and 3. Domains 2 and 3 relate to the workforce agenda and this report presents a detailed overview of the Trust's achievements in enhancing workforce health and wellbeing and fostering inclusive leadership. It should be noted that the report is also being presented to Quality and Governance Group on 6th February 2025 in respect of Domain.

2. Background

The Equality Delivery System (EDS), published by NHS England and Improvement in 2022, serves as an essential framework for NHS organisations to assess and enhance their performance in relation to equality, diversity, and inclusion (EDI) as well as addressing health inequalities. By collating evidence against various outcomes, NHS organisations can evaluate their practices and policies in a structured way.

In 2023/24 the Trust received an overall rating of 'Underdeveloped'. When looking at ratings against individual outcomes, 7 were rated as 'developing', and 4 were rated as 'underdeveloped'. Key findings suggested that the way the Trust collects and uses Equality, Diversity and Inclusion (EDI) data provides great scope for improvement. The consideration of equality impacts in Trust decision-making was limited with many papers viewed at senior committees not identifying equality-related issues.

3. Purpose

The EDS assessment process involves several key outcomes that organisations must meet, focusing on ensuring equitable access to services, improving patient experience, enhancing workforce diversity, and fostering an inclusive organisational culture. This strategic approach encourages NHS organisations to embed EDI principles into their operations and decision-making processes, ultimately leading to better health outcomes and experiences across diverse populations. The report seeks to:

- Summarise the process undertaken to deliver on the Equality Delivery System (EDS) for this reporting year.
- Report on the EDS Ratings that have been achieved.
- Outline actions that will be taken to improve EDS Ratings.

4. Overview of the EDS 2024 Assessment Process

Stakeholders, including staff, patients, and community representatives play a crucial role in grading the evidence collected. This collaborative assessment not only helps identify areas of strength but also highlights opportunities for improvement. The EDS aims to ensure that NHS organisations are not only compliant with equality legislation but are also actively working to reduce health disparities and promote inclusive practices for all individuals they serve.

The Equality Delivery System (EDS) assessment process was overseen by the Trust's HR Business Partner and the Associate Director of Nursing for Corporate Services and involved collaboration with relevant colleagues to ensure a comprehensive evaluation. The table below shows a summary of the Domain areas, evidence and outcomes and ratings for each.

Domain		Evidence and Key Outcomes:	Rating
Domain 1: Commissioned or Provided Services	a) **Access to Services**: Ensuring patients have the required levels of access.	Relevant evidence was gathered from Trust resources, including committee reports, audits, policies, and the Datix system. Protected characteristic data collection was scrutinised for gaps and trends. National benchmarks and current research contextualised the findings, enabling an in-depth assessment of accessibility, responsiveness, harm-free care, and patient experience.	**2**
	b) **Meeting Health Needs**: Evaluating how well individual patients' health needs are met.		**2**
	c) **Safety**: Ensuring patients are free from harm when using services.		**2**
	d) **Experience**: Capturing positive patient experiences.		**2**
Domain 2: Health and Wellbeing Workforce	a) **Support for Managing Health Conditions**: Targeted initiatives for conditions such as obesity, diabetes, asthma, COPD, and mental health.	○ Delivered health checks, benefiting 256 staff members. ○ Conducted 1,210 wellbeing event attendances and 479 individual support sessions. ○ Enhanced mental and physical wellbeing through partnerships with external organisations.	**2**
	b) **Freedom from Abuse and Harassment**: Promoting a zero-tolerance culture.	○ Launched the Zero Tolerance Campaign in November 2024. ○ Resolved formal harassment cases, ensuring accountability and fostering a respectful workplace.	**2**
	c) Access to Independent Support: Strengthening confidential support mechanisms.	○ Supported over 600 Employee Assistance Program (EAP) calls. ○ Achieved 90% compliance with Freedom to Speak Up (FTSU) training.	**2**
	d) Staff Recommendations: Capturing staff perceptions of the Trust as an employer and care provider.	○ Highlighted challenges with staff advocacy (45.36% recommended the Trust as a workplace).	**1**

Domain 3: Inclusive Leadership	a) **Leadership Commitment to Equality**: Demonstrating visible advocacy and sponsorship of inclusive initiatives.	• Executive sponsorship of six active staff networks. • Relaunched the Elevate Program to support ethnically diverse leadership.	**2**
	b) **Equality Impact in Decision-Making**: Ensuring equality considerations are integrated into governance.	• Developed EIA guidance for managers and advocated for Equality Impact Assessments (EIAs) for policies and programs. • Used workforce and patient data to identify and address inequalities.	**2**
	c) **Performance Monitoring and Progress**: Tracking advancements in EDI objectives.	• Achieved 93.6% compliance in EDI training. • Expanded Freedom to Speak Up Champion network with diverse representation. • Improved staff engagement through civility road shows and targeted leadership development sessions.	**2**

5. Scoring Approach Across Domains 1, 2 and 3

The identification of potential graders was based on the list of required stakeholders as outlined in the EDS Technical Guidance. All relevant stakeholders were involved in the grading process, with additional details provided in Appendix 1.

To ensure alignment and understanding, two internal stakeholder briefing events were conducted in December 2024 and January 2025. The first event focused on Domain 1, while the second addressed Domains 2 and 3 collectively. These sessions provided an opportunity to review the evidence and reach consensus on prospective scores, as well as to discuss future action plans based on identified gaps. The scoring process itself was carried out with stakeholders reviewing the evidence packs at their own pace. The review period for Domain 1 ran from 13th December 2024, while the review for Domains 2 and 3 took place until 22nd January 2025. During this process, participants were asked to assign a score of 0, 1, 2, or 3 to each outcome, with guidance provided by the EDS Ratings and Scorecard Guidance 2022 to support their evaluations.

6. Overall Score

The Trust received an overall score of 21, with a score of 2 awarded across 10 outcomes and a score of 1 for the 11th outcome. To determine the overall rating, the scores provided by graders were averaged for each outcome and rounded to the nearest whole number. These average scores were then summed, with the total score corresponding to the grade as per the EDS2022 Scorecard and Ratings Guidance.

Despite scoring ‘’Achieving’’ grades across 10 outcomes, our overall score is 21 based on a lower score in 1 outcome (staff experience and advocacy being rated as ‘’Developing’’ under Domain 2). This means that the Trust is rated overall as ‘’Developing’’ and has progressed from being rated overall as ‘’Underdeveloped’’ in the previous year. The score of 21 is just 1 point below the overall

score for Achieving. Further details on how to interpret the ratings, the individual scores for each outcome can be found in Appendix 1.

7. Next Steps

To address these challenges and build on progress, the Trust will:

1. Refine data collection processes for protected characteristics within the complaints service.
2. Publish the Equality Impact Assessment (EIA) for the Complaints Policy to enhance transparency.
3. Triangulate and analyse patient safety incidents to identify trends among individuals most adversely affected.
4. Commission patient-centered translation and interpretation services.
5. Expand data collection in Occupational Health.
6. Strengthen mechanisms for gathering and analysing exit interview feedback.
7. Provide evidence of union support initiatives for staff.
8. Promote the Leadership Framework for Health Inequalities Improvement, ensuring the Board actively champions this approach.
9. Demonstrate tangible improvements in staff experience, encouraging advocacy for the Trust as an excellent place to work.

By implementing these steps, the Trust aims to address gaps, enhance performance, and ensure sustained progress in EDI outcomes. The Board is invited to approve these recommendations and provide assurance that the organisation is on a robust trajectory toward achieving its EDI goals

8. Conclusion

The assessment results for 2024/25 demonstrate good progress across the EDS framework's 3 domains and 11 outcomes, with 10 outcomes rated as "Achieving" and 1 as "Developing." Notable strides have been made in refining the Trust's capacity to understand, collect, and apply EDI data critical tools for uncovering disparities and driving improvements for both patients and staff. However, opportunities remain to further embed Equality Impact Assessments (EIAs) and leverage EDI data in decision-making processes. Strengthening these practices will be pivotal in refining outcomes for those who receive care and for those who provide it, ensuring the Trust remains at the forefront of addressing health inequalities.

Domain 1: The Trust achieved a score of 2 across all four outcomes, indicating that it is "achieving activity" in these services. Patient satisfaction, particularly among those with protected characteristics, remains high, reflecting strong access to services. The Trust demonstrates an effective approach to personalised care, particularly for those at higher risk, and fosters a culture of continuous improvement. Both staff and patients feel empowered to report near misses and incidents, which contribute to an environment prioritising equality and addressing health inequalities within patient safety. The recognition of the vital link between staff experience and patient care is also a strength, driving positive outcomes.

Domain 2: The Trust scored 2 for three outcomes and 1 for one outcome. While considerable efforts have been made to improve staff health and wellbeing, the evidence suggests that these efforts have not fully aligned with staff experience ratings, particularly in the staff survey and pulse survey's outcomes. This discrepancy led to the rating of 2D (staff recommendation) as "Developing." The Trust has made progress as outlined in the WRES and WDES reports, but key areas require attention. The panel anticipates that the Trust will implement an action plan to close the identified gaps.

Domain 3: The Trust scored 2 across three outcomes, indicating "Achieving Activity" in this domain. This represents significant improvement compared to the 2023/2024 rating, where the Trust scored zero. The progress in leadership commitment to equality, equality impact in decision-making, and performance monitoring is particularly notable, demonstrating a shift from underdeveloped activity to achieving status.

While external stakeholders acknowledged the Trust's progress and commitment to its improvement work, inconsistencies in the use of equality impact assessments across the Trust were identified. Specifically, in Domain 1, not all services routinely consider the equality impact of their procedures and policies. When assessments have been conducted, there has often been limited engagement with groups at higher risk due to protected characteristics. Furthermore, the collection of data on protected characteristics for both patients and staff, particularly in relation to health and wellbeing services, is insufficient and requires improvement. Data gaps exist in areas such as staff protected characteristics and those impacted by moderate or severe patient safety incidents.

The Trust is committed to addressing these gaps through the development of detailed action plans aimed at improving processes, enhancing data collection, and ultimately improving service quality and staff experience.

9. Recommendations

The Board of Directors is asked to:

- Note the contents of the report.
- Note the recommendations outlined which were approved at People Committee in February.
- Note the publication of the Trust's annual Equality Delivery System Action Plan, approved by People Committee in February, to the Trust website on 28th February 2025.

Appendix 1 - NHS Equality Delivery System (EDS)

EDS Lead	Funbi Matthew	**At what level has this been completed?**	
EDS engagement date(s)	13th December 2024 to 22nd January 2025	**Individual organisation**	Countess of Chester Hospital NHS Foundation Trust

Date completed	22nd January 2025	**Month and year published**	28 February 2025
Date authorised		**Revision date**	

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Domain	Outcome	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	2	Jodie McIlwain Head of Complaints Fiona Altintas Deputy Director of Nursing
	1B: Individual patients (service users) health needs are met	2	Samantha Edwards Associate Director of Nursing Fiona Altintas Deputy Director of Nursing
	1C: When patients (service users) use the service, they are free from harm	2	Fiona Altintas Deputy Director of Nursing Jill Cooper Lead Nurse for Safeguarding
	1D: Patients (service users) report positive experiences of the service	2	Samantha Edwards Associate Director of Nursing Fiona Altintas Deputy Director of Nursing

Domain 2: Workforce health and well-being

Domain	Outcome	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	2	Vicki Wilson, Chief People Officer (Acting) Emma Taylor, Head of Human Resources Funbi Matthew, EDI Lead, HR Business Partner Gareth Siggee, Employee Wellbeing Lead Ashley Vaughan-Pearson, EDI Coordinator
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	2	Vicki Wilson, Chief People Officer (Acting) Emma Taylor, Head of Human Resources Funbi Matthew, EDI Lead, HR Business Partner Gareth Siggee, Employee Wellbeing Lead Ashley Vaughan-Pearson, EDI Coordinator
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	2	Vicki Wilson, Chief People Officer (Acting) Emma Taylor, Head of Human Resources Funbi Matthew, EDI Lead, HR Business Partner Gareth Siggee, Employee Wellbeing Lead Ashley Vaughan-Pearson, EDI Coordinator
	2D: Staff recommend the organisation as a place to work and receive treatment	1	Vicki Wilson, Chief People Officer (Acting) Emma Taylor, Head of Human Resources Funbi Matthew, EDI Lead, HR Business Partner Ashley Vaughan-Pearson, EDI Coordinator

Domain 3: Inclusive leadership

Domain	Outcome	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	2	Vicki Wilson, Chief People Officer (Acting) Sue Pemberton, Director of Nursing & Quality Jason Bradley, Chief Digital and Data Officer Emma Taylor, Head of Human Resources Funbi Matthew, EDI Lead,HR Business Partner
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	2	Vicki Wilson , Chief People Officer (Acting) Emma Taylor, Head of Human Resources Sam Edwards, Associate Director of Nursing, Corporate Nursing Funbi Matthew, EDI Lead,HR Business Partner
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	2	Vicki Wilson, Chief People Officer (Acting) Hollie Salisbury, Head of Continuous Improvement Emma Taylor, Head of Human Resources

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): Alex Moss (Internal Staff Chair)	**Independent Evaluator(s)/Peer Reviewer(s):** **Amanda Sproson, Healthwatch Cheshire** **Mark Groves – Represented by** Louise **Barry, Healthwatch Cheshire** **Robert Jones , Equality and Diversity Manager**

PUBLIC - Board of Directors
25th March 2025

Report	**Agenda Item 26.***		**Council of Governors Report – February 2025**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk & Improvement				
Author(s)	Nusaiba Cleuvenot			Head of Corporate Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **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	Not confidential.

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 13th and 19th February 2025 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 Finance & Performance Committee.
- Lead Governor update.
- The Maternity Survey and Urgent & Emergency Care Patient Experience results were presented.
- Anchor Institution and NHS 10 Year Health Plan consultation discussion.
- 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 received papers detailing the Chair's Appraisal Process and Non-Executive Director Appraisal Process, whilst supported this was not formally approved as the meeting was not quorate. The papers would be re-circulated to all governors again to seek approval.

At the private meeting on 19th February, the Council of Governors approved the appointment of an interim Chair for a 6-month period.

3.2 Council of Governors Workshops

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
25th March 2025

Report	**Agenda Item 27.***		**Code of Governance Compliance 2024/25**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	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**	BAF impact – Linked to all areas of the BAF but specifically the actions within BAF 8.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	Reported to Audit Committee on 13th February 2025.							
Executive summary	The assessment sets out compliance with the Code of Governance for NHS Foundation Trusts, including: • Board leadership and purpose • Division of responsibilities • Composition, succession and evaluation • Audit, risk and internal control • Remuneration The Trust remains compliant with the majority of the areas set out within the code.							
Recommendations	The Board of Directors is asked to note the Trust's current compliance against each of the Code of Governance provisions.							

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the requirements of the Health and Social Care Act 2008 and in line with the Trust's Constitution, Code of Governance and regulatory requirements.
Risk	As outlined within the risk management policy document.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	To be communicated through a summary report to the Board of Directors and referred to in the Annual Report.

Code of Governance Compliance 2024/25

1. Executive Summary

The purpose of this paper is to provide assurance on compliance with the Code of Governance for 2024/25.

The assessment confirms ongoing compliance with the Code of Governance in 2024/25. A number of actions have been identified to further strengthen compliance in some areas.

The Board is asked to note the reported compliance with the Code of Governance for 2024/25, and the actions to be taken forward.

2. Background

The updated code of governance for NHS providers was introduced on 1st April 2023.The code of governance sets out the framework for corporate governance for foundation and NHS trusts. The code is assessed on the basis of comply or explain against each provision.

3. Compliance

The Trust has declared partial compliance in 7 areas and there are mitigations and actions in place. The Senior Independent Director continues to chair the Audit Committee with mitigation of 2 NEDs also members of the Committee.

The main changes from the prior year assessment include:

- (A.2.2) moved from partial to full compliance following the launch of the Trust Strategy.
- (A.2.8 and App B 2.12) moved from full to partial compliance with an action to re-establish the Membership Engagement Group.
- (D.2.3) moved to partial compliance following the extension of the External Audit contract which will exceed 10 years (this was an informed decision with clear advice and assessment of risks).
- (App B 2.6) moved to compliant as Council of Governors (COG) engagement with the Board in areas of concern is set out in the Trust Constitution.
- Additional narrative on engagement with Mental Health and Learning Disabilities provider collaborative; reference to clinical strategy; focussed work on culture; Board Freedom to Speak Up
- (FTSU) Self-Assessment; workshops with the COG; and approval of Trust Chair second term of office.
- Identified actions include:
- (A.2.1) Continued system working and alignment of objectives including clinical strategy.

- (A.2.5) to explore the opportunity to include ethnicity and deprivation data for relevant metrics within future SOF reports.
- (A.2.8 and App B 2.12) Membership Engagement Group led through the Council of Governors to be re-established.
- (C.4.13) To ensure Board diversity is part of the EDI action plans and priorities.

Subsequent to the review of the full Code of Governance compliance assessment at the Audit Committee, a procedural issue has come to light in respect of staff governor elections (relating to 2023) with action to be taken in 2025.

4. Recommendation

The Board of Directors is asked to note compliance with the Code of Governance for 2024/25 and actions in place.

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 28.***		**Provider Licence Compliance 2024/25**					
Purpose of the Report	Decision		Ratification		Assurance	**X**	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**	BAF impact – Linked to all areas of the BAF but specifically the actions within BAF 8.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	Reported to Audit Committee on 13th February 2025.							
Executive summary	The assessment sets out compliance with the Provider Licence conditions. Assurance is provided in the context that during 2024/25 the Trust has continued to manage the recovery of waiting lists, alongside the challenges of operational pressures. These areas continue to have strong oversight through the Executive Team, respective assurance committees and the Board of Directors. The assessment confirms ongoing compliance with the Provider Licence in 2024/25. The main changes from the prior year assessment include: • Exit from System Improvement Board in 2024/25 and move to System Oversight Group. • New approach to CIP implemented in 2024/25. • Governance and Committee effectiveness strengthened.							

	• Progress against strategic goals and objectives aligned to BAF reporting. • Examples of NHS Guidance considered in year including Chairs Appraisal, Board leadership competency framework, and Insightful Board. Identified actions to be progressed include: • Health inequalities and population health approach using C2AI • Delivery of Risk Management Improvement Plan • Continued development of the Committee Organogram • Continued focus on financial governance • Continued focus on improving the Trust's SOF/NOF rating. • Introduction of quarterly provider licence checklist review • Annual assessment against the NHS Constitution pledges • Review of Staff Governor elections (2023) and action to be taken.
Recommendations	The Board of Directors is asked to note the review of compliance with the provider licence for 2024/25 and associated actions.

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the requirements of the Health and Social Care Act 2008 and in line with the Trust's Constitution, Code of Governance and regulatory requirements.
Risk	As outlined within the risk management policy document.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	To be communicated through a summary report to the Board of Directors and referred to in the Annual Report.

Provider Licence Compliance 2024/25

1. Executive Summary

The purpose of this paper is to provide assurance on compliance with the Provider Licence for 2024/25.

The assessment confirms ongoing compliance with the Provider Licence in 2024/25. A number of actions have been identified to further strengthen compliance in some areas.

The Board is asked to note the reported compliance with the Provider Licence for 2024/25, and the actions to be taken forward.

2. Background

The Provider Licence sets out the obligations for providers of NHS services that will allow NHS England (NHSE) to fulfill its regulatory duties.

The licence has served as the main tool by which NHS England (NHSE) regulates providers of NHS services. The SOF is used to identify potential risk of a provider failing to comply with its licence.

A new licence was implemented from 2023/24 to take account of the establishment of Integrated Care Systems and the new obligations for Foundation Trusts (FT) linked to system reform, collaboration and partnership working. These reforms change the emphasis of FT regulation.

3. Compliance 2024/25

The Audit Committee conducted a detailed review of each condition within the licence and identifies, where relevant, the current controls that are in place to ensure compliance. Each licence condition is assigned to an accountable Executive Director (refer Appendix 1).

The assessment has identified a number of actions to be progressed.

Action	Responsibility	Timeframe
1. The use of C2AI health inequalities waiting list tool is being piloted in Orthopaedics.	Director of Strategic Partnerships	By the end of Quarter 4. 2025/26
2. Introduction of a quarterly checklist to provide in year assurance on compliance with key aspects of the licence to the Audit Committee.	Director of Governance, Risk & Improvement	Quarterly reviews to be included within workplans for Audit Committee
3. Consider an annual review against the NHS constitution.	Director of Governance, Risk and Improvement	To be completed in Q1 2025/26

Action	Responsibility	Timeframe
4. To continue to deliver the Risk Management Improvement Plan.	Director of Governance, Risk & Improvement	By end of Quarter 4 2025/26
5. Continue to develop the Committee Organagram.	Director of Governance, Risk & Improvement	By the end of Quarter 2 2025/26
6. Continued focus on enhanced financial control environment within the Trust.	Chief Finance Officer	By the end of Quarter 4 2025/26
7. Continued focus on improving the Trust's SOF/NOF rating.	Chief Finance Officer/ Chief Operating Officer/ Director of Nursing, Quality and Safety	2025/26
8. Staff Governor elections to be reviewed and action taken*	Director of Governance, Risk & Improvement/ Trust Chair	By the end of Quarter 2 2025/26

**Subsequent to the review of the full Provider Licence compliance assessment at the Audit Committee, a procedural issue has come to light in respect of staff governor elections (relating to 2023) with action to be taken in 2025.*

During 2024/25 the Trust has continued to manage the recovery of waiting lists, alongside sustained operational pressures. These areas continue to have strong oversight through the Executive Team, respective assurance committees and the Board of Directors.

The assessment confirms ongoing compliance with the Provider Licence in 2024/25.

The proposal remains to introduce a quarterly checklist to be completed by the relevant accountable Executive Directors and reported to the Audit Committee to provide assurance that the Trust is compliant with key licence conditions and / or to highlight emerging risks to regulatory compliance.

Regulatory risks are highlighted to the Board for consideration via the Board Assurance Framework (BAF) and regular cycle of Board assurance documents.

4. Recommendation

The Board of Directors is asked to note the review of compliance with the provider licence for 2024/25 and associated actions.

PUBLIC – Board of Directors
25th March 2025

Report	**Agenda Item 29.**		**Use of Trust Seal: Renewal of Lease for Tarporley War Memorial Hospital and Countess of Chester Hospital**					
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk & Improvement				
Author(s)	Nusaiba Cleuvenot			Head of Corporate Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X**	Aligned to Constitution requirements for application of the Trust Seal.			
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	To notify the Board of Directors on the use of the Trust Seal.							
Recommendations	The Board of Directors is asked to approve the use of Trust Seal in retrospect.							

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

Use of Trust Seal

1. Executive Summary

The purpose of this paper is to notify the Board of Directors on the Use of Trust Seal.

2. Background

As per the Constitution, the use of the Trust Seal must be approved by the Director of Finance or nominated officer and authorised in writing the Chief Executive Officer (CEO) or nominated officer. The Board will receive a report of all sealings for approval.

3. Use of Trust Seal

Date Seal Applied	Document	Signatories
10 February 2025	Counterpart Lease Between: Tarporley War Memorial Hospital Trust and Countess of Chester Hospital NHS Foundation Trust	Jane Tomkinson, Chief Executive Officer; Karan Wheatcroft, Director of Governance, Risk & Improvement*

**To note the Director of Finance is a Trustee for Tarporley War Memorial Hospital Trust and nominated the Director of Governance, Risk and Improvement to authorise the use of the seal.*

4. Recommendation

The Board is asked to approve the application of the Trust Seal in retrospect.