Countess of Chester Hospital NHS Foundation Trust

Public meeting of the Board of Directors Agenda
(published items)
Tuesday 29th July 2025, 8.30 – 12.30
Boardroom, 1829 Building

Chair	Mr N Large, Trust Chair
Apologies	Dr N Scawn, Medical Director, Mr M Guymer, Non-Executive Director and Mr D Williamson, Non-Executive Director
In attendance	Dr I Benton, Deputy Medical Director, Ms R El Boukili, Maternity and Neonatal Voices Partnership Lead (Item 4) and Ms K Adams, Director of Pharmacy and Medicines Optimisation and Controlled Drugs Accountable Officer (CDAO) (Item 14)

Time	Agenda No.	Agenda item	Lead	Page No.	Decision Required
8.30	1.	Welcome, apologies and Chair's opening remarks (verbal)	Trust Chair		For noting
8.33	2.	Declarations of Conflicts of Interest with agenda items (verbal)	Trust Chair		For noting
8.35	3.	Patient Story (to be presented on the day)			
9.05	4.	Service Showcase (to be presented on the day)			
9.35	5.	Minutes of the previous meeting held on 20th May 2025 (attached)	Trust Chair	5 - 18	For approval
9.40	6.	To consider any matters arising and action log (attached)	Trust Chair	29 - 32	For noting
9.43	7.	Chief Executive Officer's Report (attached)	Chief Executive Officer	33 - 39	For noting
9.50	8.	Chair's Update (verbal)	Trust Chair		For noting
9.55	9.	a) Board Assurance Framework 2025/26 including Risk Appetite Statement (attached)	Director of Governance, Risk & Improvement	40 - 62	For decision & assurance
		b) High Risks Report (attached)	Director of Governance, Risk & Improvement	63 - 73	For noting
Quality of Care					
10.05	10.	Quality, Safety & Experience Strategy (attached)	Director of Nursing & Quality / Deputy Chief Executive	74 - 101	For decision

10.15	11.	Safety Surveillance and Learning Report – Quarter 4 (attached)	Director of Nursing & Quality / Deputy Chief Executive	102 - 115	For noting & assurance
10.25	12.	Quarter 1 2025-2026 Mortality Surveillance Report (learning from deaths) (attached)	Deputy Medical Director	116 - 124	For assurance
10.30	13.	Care Quality Commission (CQC) Improvement Plan including Well Led (attached)	Director of Nursing & Quality / Deputy Chief Executive	125 - 157	For assurance
10.35	14.	Quality & Safety Committee Chair's Report – 21st May 2025 and 3rd July 2025 (attached)	Chair Quality & Safety Committee	158 - 159	For assurance
10.40	15.	2024/25 Controlled Drugs (CDs) Annual Report (attached)	Director of Pharmacy and Medicines Optimisation and Controlled Drugs Accountable Officer (CDAO)	160 - 166	For assurance
Comfort Break (10.50 – 11.00)					
Operational Performance					
11.00	16.	Integrated Performance Report (IPR) – June 2025 (attached) Operational Performance Quality Safety Finance People	 Chief Operating Officer Director of Nursing & Quality Deputy Medical Director Chief Finance Officer Chief People Officer	167 - 211	For assurance

11.20	17.	Operational Management Board Chair's Report – 22nd May 2025 (attached)	Chief Executive Officer	212 - 213	For assurance
Finance, Use of Resource and Performance					
11.25	18.	Audit Committee Chair's Report – 15th July 2025 (attached)	Chair Audit Committee	214	For assurance
11.30	19.	Finance & Performance Committee Chair's – 20th May 2025 and 25th June 2025 (attached)	Chair Finance & Performance Committee	215 - 217	For assurance
Strategic Change					
11.35	20.	Annual Health & Safety Report 2024/25 (attached)	Chief Finance Officer	218 - 232	For assurance
11.40	21*.	Digital and Data Strategy Update (attached)	Chief Digital & Data Officer	233 - 244	For assurance
Leadership, Improvement Capability, Organisation Development and People					
11.43	22.	People Committee Chair's Report – 10th June 2025 (attached)	Chair People Committee	245 - 246	For assurance
11.48	23*.	Council of Governors Summary Report – 17th July 2025 (attached)	Director of Governance, Risk, and Improvement	247 - 249	For noting
11.50	24.	People Strategy – 2025 – 2028 (attached)	Chief People Officer	250 - 268	For decision
Governance					
12.00	25.	Terms of Reference Updates – Assurance Committees (attached) a) Audit Committee b) Finance & Performance Committee c) Quality & Safety Committee d) People Committee	Director of Governance, Risk & Improvement	269 - 293	For approval
12.10	26.	Use of Trust Seal: Women & Children's Build – Sub-Contractor Collateral Warranties (attached)	Director of Governance, Risk & Improvement	294 - 295	For decision
Items for noting					
12.15	27.*	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 1st May 2025 and Extraordinary 21st May 2025 (attached) b) Approved minutes of the People Committee – 8th April 2025 (attached)	Trust Chair		For noting

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		c) Approved minutes of the Finance & Performance Committee – 30th April and 20th May 2025 (attached) d) Approved minutes of the Operational Management Board – 24th April 2025 (attached) e) Approved minutes of the Audit Committee – 22nd April 2025 and Extraordinary 24th June 2025 (attached) f) Research and Innovation Committee Chair's report 16th July 2025 and approved Minutes 9th May 2025 (attached) **Other items:** g) Board of Directors Workplan 2025/26 (attached)			
Other items					
12.18	29.	Any Other Business (verbal)	Trust Chair		For noting
12.20	30.	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 24th July 2025*** **Future Dates:** 30th September 2025 25th November 2025 27th January 2026 31st March 2026	Trust Chair		For noting
12.30	31.	Closing remarks (verbal)	Trust Chair		For noting

Next Meeting: Tuesday 30th September 2025

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

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MINUTES OF THE PUBLIC BOARD OF DIRECTORS

Tuesday 20th May 2025, 8.30am – 13.00pm, Boardroom – 1829 Building

Members	20/05/25					
Interim Trust Chair, Mr N Large	☑					
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 Strategy and Partnerships, Mr J Develing	☑					
Chief Digital & Data Officer, Mr J Bradley	☑					
Chief Finance Officer, Mrs K Edge	☑					
Director of Governance, Risk & Improvement, Mrs K Wheatcroft	☑					
Acting Chief People Officer, Ms V Wilson	☑					

Members	20/05/25					
In (regular) attendance						
Head of Corporate Governance, Mrs N Cleuvenot	☑					

Agenda No.	Agenda item	Lead
1.	**Welcome, apologies and Chair's opening remarks** The Chair opened the meeting and members of the Board introduced themselves. There were no apologies to note.	
2.	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest raised in relation to agenda items.	
3.	**Service Showcase: Artificial Intelligence (AI) in Dermatology** Dr Eva Domanne (ED), Consultant Dermatologist/Skin Cancer Lead and Maria Facer (MF), Healthcare Assistant were in attendance to present the service showcase. ED provided data on skin cancer demographics in our population, indicating that higher UV exposure raises the risk of skin cancer, particularly amongst certain groups. A benchmarking exercise in 2021 analysed the trends in number of suspected cancer referral compared to diagnoses, predicting that the number of referrals would be likely to increase in the next 10-15 years. With the ongoing staffing challenges and increased pressure on the service it would be crucial to explore new ways of working. NICE has established an Early Value Assessment for using Artificial Intelligence to assess and triage skin lesions in the urgent suspected skin cancer pathway. The AI algorithm, which currently uses a fixed approach to analyse images, will require training with new data. If the Deep Ensemble for Recognition of Malignancy (DERM) identifies a lesion as benign, the patient is discharged from the urgent suspected skin cancer pathway. Conversely, if DERM categorises the lesion as pre-cancerous or malignant, an NHS dermatologist will review the case and determine an appropriate management plan for the patient. NICE's review found that DERM matches the performance of experienced dermatologists, with a sensitivity rate of 94.9% for all skin cancers. AI pathway performance as at 19/5/25: 802 cases assessed, 28% discharges and 226 initial dermatology appointments at the Trust have been avoided. Benefits include reduced waiting time, freeing up dermatology capacity, improved patient safety, enhanced patient experience and contribution to research.	

	Dr N Scawn (NS), Medical Director, asked how confident we are in AI and if there have been any instances where AI has been wrong. ED disclosed that all cases referred to the dermatologist are reviewed. The collected data and histological information are then provided to the AI company to further train their algorithm. She highlighted that increased usage would improve the system's performance, with the objective to implement this technology in primary care to preclude initial referrals. Ms J Tomkinson (JT), Chief Executive Officer, asked how the dermatology and plastics departments are working together. ED confirmed that, due to a shortage in dermatology capacity, some cases are being managed by the plastic surgery department. However, it was acknowledged that the plastic surgery department should primarily handle more complex cases. The use of AI to differentiate between these cases would, therefore also help optimise the capacity of the plastic surgery department. Ms W Williams (WW), Non-Executive Director, asked if GPs could take photos of the lesions themselves and send them to the AI company. ED shared that this had been trialed, but the quality of photos had been inconsistent. The Trust had highly trained staff to ensure high quality photos and therefore reduce the rejection rate from AI. MF presented the dermatoscope to the Board and shared the process for taking the images. Mr. N Large (NL), Interim Trust Chair, shared his personal experience with the dermatology department, praising the exceptional care and compassion provided by the team. Additionally, he had recently attended their away day and commended the collective vision demonstrated by all members. NL thanked the team for attending and sharing the excellent advancements in care. *ED and MF exited the meeting.* NL asked Mrs K Edge (KE) Chief Finance Officer, to consider the impact AI could have on finances. It was noted the pilot was ending soon and to recognise what financial impact this may have. The Board **noted** the Service Showcase.	
4.	**<u>Patient Story</u>** Ms S Pemberton (SP), Director of Nursing and Quality/ Deputy Chief Executive, read out a letter from a patient's fiancé. The patient was admitted to the Countess of Chester Hospital's A&E on the night of 28th December with severe flu symptoms, which rapidly worsened, leading to her immediate transfer to the I.C.U where she stayed until the 21st of January, receiving treatment for flu, pneumonia, an infection, and heart failure. The staff at the hospital provided exceptional care and support throughout her stay, demonstrating remarkable professionalism and compassion and communication that greatly reassured her fiancé. After	

	being moved to a Respiratory ward, the patient was discharged on 23rd January and is now recovering well at home. The patient and fiancé are profoundly grateful for the tireless efforts and dedication of the medical team, who made a significant positive impact on their lives, and they recently revisited the unit to express their heartfelt thanks. The Board **noted** the patient story.	
5.	**Minutes of the previous meeting held on 25th March 2025** The minutes of the previous meeting held on the 25th March 2025 were **approved** as a true and accurate record of the meeting.	
6.	**To consider any matters arising and action log** Updates for the following actions had been added to the action log and proposed for closure: **5. Align committee workplans to enable FTSU to report to the People Committee then Board of Directors.** Workplans are being reviewed and updated to ensure appropriate timing for reporting. **6. People Committee to receive FTSU benchmarking data (number of concerns and themes).** This will be managed through the People Committee. Mrs K Wheatcroft (KW), Director of Governance, Risk and Improvement provided brief updates against the open actions on the log which were progressing but not due until later in the year. The Board **noted** the updates and confirmed closure of the above actions.	
7.	**Chief Executive Officer's Report** Ms J Tomkinson (JT), Chief Executive Officer provided the CEO update and highlighted the following points: • Mandy Nagra has been appointed as the interim Director of Improvement at the ICB. • The Cheshire & Merseyside Provider (CMPC) Leadership Board met on Friday 2nd May. JT highlighted the potential for improved service delivery and cost efficiencies across the system. • Employee and Team of the Month – JT noted how well received this initiative has been and how important it is to recognise the good work of our staff and teams. • The North Wales Neonatal Network Donor Milk Hub (a collaboration of organisations including The Milk Bank at Chester – which serves 60 areas across the UK) has been shortlisted for the NHS Wales Sustainability Awards in the Sustainability Network or Community	

	category. The Trust is also looking to open a Milk Bio Bank which will support our innovation objectives. • Dr Theresa Barnes was recognised for her contributions to national policy changes in transforming outpatient care and improving patient experience. • The Trust have been placed in Tier 1 for Quarter 1 2025/26 for elective performance. Ms C Chadwick (CC), Chief Operating Officer, shared that the Trust has been tiered in the past and this had been supportive process. However, the Trust will be working to swiftly exit this and have requested the Exit Criteria. Mr N Large (NL), Interim Trust Chair asked for clarity on tiering and which areas this had been applied. It was agreed that this would be clarified in the performance section. JT shared that following the publication of the CEO report, she had met with the Royal College of Nursing (RCN) Foundation Charity. This had been a very positive meeting, and they are seeking to pilot their compassionate leadership programme. Ms S Pemberton (SP), Director of Nursing & Quality/Deputy Chief Executive shared that the Trust are currently undertaking a programme of competencies and working alongside the university. Prof A Hassell (AH), Non-Executive Director asked if the urgent care resource centre in Upton Lea would be able to see patients with mental health issues. Mr J Develing (JD), Director of Strategy and Partnerships stated that fundamentally the patient pathway will be changed and that mental health patients will be directed to Upton Lea rather than the COCH emergency department. This collaboration with Cheshire & Wirral Partnerships is scheduled to commence in December 2025. The Board **noted** the CEO report.	
8.	**<u>Chair's Update</u>** Mr N Large (NL), Interim Trust Chair congratulated Lucy Liang (LL), Governor and for running the Chester half marathon and the London marathon, Ms J Tomkinson (JT) for running the Chester half marathon and Mrs K Wheatcroft (KW), Director of Governance, Risk and Improvement and Ms V Wilson (VW), Acting Chief People Officer for completing the Anfield Abseil for the Countess Charity. NL reported attending the Plastics Away Day and praised the contributions from Mr J Develing (JD), Director of Strategy and Partnerships. He mentioned that he continues to participate in walkabouts around the hospital with Ms C Chadwick (CC), Chief Operating Officer, and noted that the complex needs of the patients keep our teams extremely busy. NL noted the upcoming Governor elections and asked the Board to encourage people in the community to participate. He also noted that the recruitment for the substantive Chair is progressing.	

	The Board **noted** the Chair's update.	
9.	**a) Board Assurance Framework (BAF) 2025/26** Mrs K Wheatcroft (KW), Director of Governance, Risk, and Improvement, stated that the BAF has been included in the meeting pack as a reference point against the papers. A comprehensive review of the BAF for Q1 will be conducted with Executive colleagues and reported in July. Mr M Guymer (MG), Non- Executive Director noted the positive progress under BAF 8 – Governance. He shared that he would be comfortable to see the residual risk score reduced when this was next reviewed. Mrs S Corcoran (SC), Non-Executive Director, commented that the achievement date remains as March 2025 for many of the risks and asked if this would be updated in the Q1 review. KW confirmed that the achievement dates will be updated during the review. Additionally, the Trust has exercised caution in adjusting risk scores or review dates until there is certainty that the actions have been fully implemented and embedded with clear results. The Board **noted** the BAF. **b) High Risks Report** KW gave an overview of the high risks report and confirmed the risk management improvement plan is progressing to strengthen risk management across the Trust. The report reflects risks on Datix with a residual risk rating of 15 and above. There are continued efforts to build risk management awareness across all levels of the organisation. The challenge lies in ensuring consistent scoring and identification of risks, but the Risk Management Committee is addressing this through the Divisions and with oversight from the Operational Management Board. Plans are in place to enhance the use of the Datix system for improved automation and real-time alerts. KW acknowledged that the report does not yet provide assurance, and efforts are being made to achieve that. Mr P Jones (PJ), Non-Executive Director, suggested the inclusion of timelines to monitor progress. SC agreed that governance processes are improving. She referred to the out of date policies and asked if this should be included in the high risk register. KW concurred that this could be a collective risk and would check if this was included on the risk register. **Action: KW to check if out of date policies is on the risk register and if it should be considered a high risk.** Mr N Large (NL), Interim Trust Chair, noted that the waiting list backlog in ophthalmology is being monitored by the Finance and Performance	**KW**

	Committee. He inquired whether this backlog also poses a clinical risk and should be within the remit of the Quality and Safety Committee. KW confirmed that multiple risks will cross over committees and that these are reported to all relevant committees. NL commented that Chairs of the assurance committees should review and cross reference the high risks they receive. SP indicated that the Quality and Safety Committee will review the safety risks associated with the Emergency Department but does not have sight of performance related risks, which could correlate to this. Ms J Tomkinson (JT), Chief Executive Officer, stated that Execs would discuss how to gain better assurance from the committees without diluting the role of the Board. NL acknowledged the measures taken to support staffing shortages in clinical pharmacy but noted that a long-term solution has not yet been identified. JT emphasised that future decisions necessary for achieving CIP delivery might make the content of the report less favourable. She indicated that there would need to be a clear focus on delivering CIP and ensuring safety, recognising the potential impact on our risks. Mrs P Williams (PW), Non-Executive Director, suggested adjusting the risk appetite to reflect this. Dr N Scawn (NS), Medical Director stated that there would be a need for increased risk management. However, it was important to recognise that mitigation does not eliminate the risk. KW responded that adjusting the risk appetite could be helpful, however where there are multiple elements e.g. financial and clinical, there may be different risk appetites. JT agreed that boundaries have been established for delivering CIP, and in light of this, the risk appetite may need to be reassessed. NL asked if the risk appetite is reviewed annually. KW confirmed that it is, however in light of the new financial landscape it would be good to review this again in more depth with the Board. **Action: Board to discuss risk appetite alongside BAF (including medium term financial plan) at a Board Development Day.** The Board **noted** the current high level risks and the work to strengthen risk management across the Trust to ensure risk registers reflect the risks faced, mitigations and actions.	**ALL**
10.	**<u>2024 Patient-Led Assessment of the Care Environment (PLACE) Report</u>** Mrs K Edge (KE), Chief Finance Officer presented the PLACE report, confirming that this had been reviewed at the Quality Governance Group. The PLACE assessment took place in October and November 2024 at The Countess of Chester Hospital NHS Foundation Trust, which includes The Countess of Chester Hospital, Ellesmere Port Hospital, and Tarporley War Memorial Hospital. It evaluated cleanliness, food quality, dignity, dementia support, and disability access. Comprehensive action plans, both trust-wide	

	and site-specific, have been formulated. The PLACE Committee and the PEOG are responsible for overseeing their implementation. Mr P Jones (PJ), Non-Executive Director commented positively about the action plans and asked where this would be reported for assurance. He also advised caution in combining scores for different sites. KE confirmed that the Quality Governance Group would monitor the action plans. She noted the scores are separated for each site and are only combined for national benchmarking purposes. Prof A Hassell (AH), Non-Executive Director asked why Ellesmere Port Hospital had received particularly poor outcomes. Mrs S Pemberton (SP), Director of Nursing and Quality/ Deputy Chief Executive shared that this had been due to signage, accessibility and cleanliness. It was noted that Cheshire and Wirral Partnership Trust manage some of these contracts and that the Trust would need to address their concerns with them. AH asked if additional checks will be made before the next PLACE assessment. KE confirmed that once all the actions in the plan have been implemented, another check will take place. SP shared that the Trust also conducts its own quarterly PLACE checks. Ms J Tomkinson (JT), Chief Executive Officer, raised concern about the results for Ellesmere Port Hospital especially considering their last CQC rating. She encouraged colleagues to visit the hospital for walkabouts, noting it is an excellent facility but is over capacity. SP noted that many of the issues are related to Estates. JT referred to the reduction in headcount ask across corporate departments, recognising the impact reducing resources could have on achieving high scores. SP responded that we would need re-evaluate how we best utilise the resources available to us. Ms W Williams (WW), Non-Executive Director commented on the challenges with managing consistent cleaning standards across remote locations. Mr M Guymer (MG), Non-Executive Director also suggested evaluating the practices of another hospital which had been rated No 1 cleanest hospital for five years. Dr N Scawn (NS), Medical Director noted that hospitals are 30% fuller now and that the estate has challenges that did not exist previously. The Board of Directors: • **Noted** the formal completion and outcomes of the 2024 PLACE assessment process • **Acknowledged** the positive trajectory and progress made against 2023 results • Took **assurance** from the improvement strategies in place to address underperforming areas • **Supported** the ongoing monitoring and delivery of PLACE action plans through Trust governance channels.	
11.	**<u>Maternity Service Quarterly Update – Quarter 4</u>**	

	Ms N Macdonald (NM), Director of Midwifery, presented the maternity services update. The report has been received at the Quality and Safety Committee. The service is continuing with year 7 of MSSP, is compliant for year 6 and maintains safety standards. An update against safety actions indicates compliance with saving babies' lives. There are fluctuations in quarters, but overall compliance is maintained. A new risk regarding baby abduction has been added to the Divisional risk register, and it is currently under review with a number of mitigations in place and discussion taking place at divisional level. There are no emerging themes from risks. Mrs P Williams (PW), Non-Executive Director enquired about the reference to term admissions in the report. NM responded that all were reviewed at MDT meetings, with no identified causes or themes. There had been a spike in admissions, but no term admissions occurred in April. The Board **noted** the update.	
12.*	**a) Bi-annual Safer Maternity and Neonatal Staffing Report – July 2024 to December 2024** Ms N Macdonald (NM), Director of Midwifery, presented the bi-annual Safer Maternity and Neonatal Staffing Report. This report is part of the maternity standards that must be submitted bi-annually. The report confirms compliance with year 7 standards, and discussions are ongoing with Birthrate Plus to reassess the midwife-to-birth ratio. Proper escalation processes are in place, and an on-call system for inpatient midwives has recently been implemented. Management changes for both inpatient and community midwives have been made, ensuring management activity during periods of high demand. Mutual aid is requested from other wards when necessary, and no poor outcomes have resulted from delays. Ms J Tomkinson (JT), Chief Executive Officer raised a question regarding the schedule of specialist midwives, noting that it appears there are a significant number of these roles with an increase in non-clinical work. NM responded that they are considering changing to a 70-30 clinical to non-clinical split, depending on the roles, and are looking at moving 5 WTE to this split, including the peri-natal mental health midwife. Mrs S Corcoran (SC), Non-Executive Director enquired about efforts to reduce sickness and absence rates. NM explained that they are working on wellbeing and positive mental attitude to offer staff support and proper return-to-work procedures. December data indicates definite improvement. The Chair asked about tackling inequalities in maternity, referencing the NHS Provider's report. NM confirmed they do review who is disadvantaged and participate in a national project to address inequalities in access to services and identify areas for change.	

	Ms S Pemberton (SP), Director of Nursing and Quality/ Deputy Chief Executive mentioned that the maternity services neonatal partnership (MNVP) is doing work on this and will update the Board in July. The committee agreed that continuity is favourable, and it is necessary to get into the new build before looking at new models of care. **Action: SP to provide update on maternity services neonatal partnership (MNVP) work on addressing health inequalities in maternity services.** The Board **noted** the update and thanked NM for attending. *NM exited the meeting.* **b) Bi-annual Safer Nurse Staffing Report - year-end establishment review and July 2024 to December 2024** SP confirmed that we are compliant with safer staffing standards, and detailed assurance is provided in the report. There are challenges with band 2/3 work, but it is hoped that this will be resolved by Q1 with discussions with the union ongoing. We are not struggling with recruitment of registered nurses. Students will require roles that we currently do not have, but we need to review this and consider incorporating this into apprenticeship schemes and career development for healthcare support workers. JT stated that it is very helpful to see the analysis of safety indicators in correlation to establishment. The Board **noted** the update and assurance provided.	**SP**
13.	**Quarter 4 2024-2025 Mortality Surveillance Report (Learning from Deaths)** (taken after item 10 as ahead of time) Dr N Scawn (NS), Medical Director presented the Mortality Surveillance report, noting that historically this had been reported through the Private Board meeting. The following points were highlighted: • All mortality indicators remain in the expected range. • A total of 320 patients died between January and March 2025, with all cases being scrutinised. Forty-six of these were referred for a fuller mortality review. • Four deaths were reported under the Learning from Lives and Deaths (LeDeR) criteria. • Themes for learning were reviewed under multiple forums. • The Mortality Surveillance Group examined Telstra Health data, which showed outlier deaths. • Each death in these outlier groups was scrutinised, and no concerns were raised. • Stroke has triggered the early warning tool twice and was reviewed again in January 2025. There is no cause for concern as to why there is a higher incidence of stroke.	

	Mr D Williamson (DW), Non-Executive Director stated that it is great to see that indicators are within range and asked if we could use health inequalities data to link to patient pathways. NL responded that it would be a large piece of work and that currently, Telstra Health is being used, which looks at national data. DW suggested that it might be something to take away since health inequalities are a key objective and a potential area to explore. Prof A Hassell (AH), Non-Executive Director asked if we could be assured that cerebrovascular disease numbers would not have been affected if we had a 24-hour service. NS confirmed that this is correct. AH commented positively on the presentation of the data tables and asked how we can be assured that there is learning from this and significant change in what we do. NS responded that a lot depends on the forums where this information is presented and how we capture learning from those. AH suggested that the process should be included in the report on how learning is monitored and implemented. NS mentioned that there is not a trust-wide repository for learning and stated that in 12 months we would need to be confident that these things do not re-occur. Ms S Pemberton (SP), Director of Nursing and Quality/ Deputy Chief Executive reflected on how we can evidence learning, noting that it is discussed at the patient oversight meeting and many other forums, but it is unclear how to definitively embed this. There was a walkabout following a review in maternity last September, where staff at every level were spoken to about an incident, and they all knew about it and the learning from it. It is recognised that this is difficult in a big organisation, and a follow-up will be done in 3 months to review. The only way to change what we do is through these efforts. Ms W Williams (WW), Non-Executive Director, emphasised the great learning opportunities and enquired about staff involvement in identifying problems and encouraging this process. NS mentioned that Datix reporting is good, and the 8am meeting receives an overview of all incidents aligned to levels of harm. Linking this data to data from the mortality report is crucial. WW emphasised encouraging Freedom to Speak Up (FTSU) and empowering staff to speak up if something is wrong. Mrs S Corcoran (SC), Non-Executive Director noted good examples of systems used at other hospitals that record all incidents related to patients. There is a need for context for the table on page 146 and to potentially present it as SPC. NS clarified that there is a numerical value for HSMR. Mr N Large (NL), Interim Trust Chair questioned why the SHMI is improving so much. Mr M Guymer (MG), Non- Executive Director attributed it to better coding practices. The Chair suggested that it was worth investigating the cause of the improvement. MG proposed comparing the depth of coding with other organisations, and this was assigned as an action for Mr J Bradley (JB), Chief Digital and Data Officer.	

	Action: JB to compare depth of coding (SHMI) data with other organisations. The Board **noted** the update.	**JB**
14.	**<u>Care Quality Commission (CQC) Improvement Plan including Well Led</u>** Ms S Pemberton (SP), Director of Nursing and Quality/ Deputy Chief Executive presented the CQC improvement plan. She highlighted some of the areas that have been proposed for closure and moved to BAU. It was noted that the previous Urgent and Emergency Care (UEC) action plan has been completed and is superseded with a new action plan. Ms W Williams (WW), Non-Executive Director mentioned that sepsis has been on our agenda for a year and enquired about what is needed to address this issue. Dr N Scawn (NS), Medical Director responded that it was part of the well-led and CQC report, so a lot has been put in place. The Sepsis Improvement Group lead has been changing processes for getting patients assessed more quickly. Additionally, CERNER is used to pick up when patients need antibiotics with the help of the CERNER screening tool. Robust processes are in place, and so far, the data is improving. NS mentioned that they are working towards having the evidence ready by 31st July 2025 and that the action plan is included in the UEC update going to the Extraordinary Quality & Safety (Q&S) Committee tomorrow. Whenever sepsis death rates are reviewed through Telstra Health, it is found that they actually perform below the number of expected deaths for sepsis. Although the 3 to 4-hour detection is not where it should be, there is no increased death from sepsis. WW asked if staff are confident in picking up signs of sepsis. NS stated that it is about judgment. WW asked what should be expected to see, and NS replied that the big metric is antibiotics within the required time. WW enquired if this is on the Q&S Committee agenda, and Prof A Hassell (AH), Non-Executive Director confirmed that it is definitely on the agenda. Mrs P Williams (PW), Non-Executive Director asked about the UEC action plan. Ms C Chadwick (CC), Chief Operating Officer confirmed that items from the original action plan had been completed and superseded by a new UEC action plan. Mr D Williamson (DW), Non-Executive Director commented that there is a lack of reporting form the Continuous Improvement Team demonstrating the embedding of the methodology and capability. Mrs K Wheatcroft (KW), Director of Governance, Risk, and Improvement responded that whilst a number of staff have undergone training over the years, there has not been adequate reporting on the impact and improvements from this historically within the organisation. For 2024/25 the Continuous Improvement Team has been focused on delivering improvements. The Executive Director Group are due to review the improvement team resources and priorities this week. The Continuous Improvement Team is divided between program delivery and continuous improvement, with significant focus been given to Cost Improvement Programme (CIP) and Quality Impact Assessment (QIA), as	

	well as UEC. Improvements are becoming evident through actual delivery but there is more to do to align improvement across the Trust. The Chair asked if the Quality and Safety Committee felt like they were receiving assurance on progress against the CQC Improvement Well. Prof A Hassell (AH), Non-Executive Director/ Chair of Quality & Safety Committee confirmed that these are areas of significant scrutiny, and the Committee is receiving assurance. The Board **noted** the progress updates against the CQC Improvement Plan.	
15.	**Quality & Safety Committee Chair's Report – 1st May 2025** Prof A Hassell (AH), Non-Executive Director/Chair of Quality & Safety Committee presented the Quality and Safety Chair's report which included areas to Alert the Board to, areas where Assurance had been received, areas to Advise to Board and any new risks discussed. The following points were highlighted: • Positive patient story demonstrating excellent and rapid care in our Emergency Department and Intensive Care Unit. • The Committee had requested further information for assurance regarding the quality and safety risk rating for 29 QIAs. • Mattress replacement process has been overhauled with 250 mattresses recently replaced. There was brief discussion regarding the process and focus of a QIA. The Board **noted** the Chair's Report.	
16.	**Strategic Oversight Framework (SOF) – March 2025** The system oversight framework demonstrated positive assurance across all executive portfolios. Ms C Chadwick (CC), Chief Operating Officer highlighted the following with regards to Operational Performance: • Improved ambulance handover time metrics in February • FDS delivering above planned trajectory • Decrease in 4 hour performance • Deterioration in DM01 performance CC highlighted the impact of the high level of Non Criteria to Reside (NC2R) patients on performance and flow. The call-before-convey protocol has been effective in is use to date, with a pilot program for patients over 65, demonstrating that 50% of the participants did not need to come to the hospital. Another pilot program for individuals over 18 is currently underway, and data is being gathered for this initiative. There has been positive collaboration with NWAS, and it is expected that a senior paramedic will be onsite going forward, which is promising news. There will be a change in elective planning targets reported to the next Board meeting. The organisation is moving into tiering for elective performance and	

	is awaiting confirmation of the exit criteria. Thorough planning is required for dermatology and gynaecology, and there are challenges with vascular, ENT, and cardiology, with focussed efforts are being made to ensure RTT compliance. The initial elective planning was based on increasing productivity on a set of measures providing advice, and it was progressing well. An additional £3million has been allocated to help specialties with their backlog. ENT and vascular constitute a significant percentage of the Trust's backlog. Referral management support from colleagues in the Cheshire and Merseyside Integrated Care System (ICS) is needed. Mr N Large (NL), Interim Trust Chair asked what could be done to support the vascular service. CC shared that we recently received a visit from the national team. We are compliant with NICE guidelines and treat the third highest number of varicose vein cases across the country. We are currently evaluating the possibility of introducing criteria or limitations on the number of cases we accept, considering whether these should be based on clinical factors or a first-come, first-served basis. NL asked, as a sub-region service is there funding for this. CC responded that vascular required external support and that the ICS needs to consider evidence based intervention. Ms W Williams (WW), Non-Executive Director noted that NC2R is a significant obstacle in the current situation and enquired about potential alternative approaches. CC acknowledged that some delays are internal and emphasised the importance of ensuring that own operations are running smoothly. She mentioned that medical resources are stretched and we are currently reviewing discharge processes. Additionally, they will seek support to assist with the discharge of Welsh patients, including assistance from Mandy Nagra to address the NC2R issue. NL concluded by stating that once everything within their control has been addressed, external parties will need to take action. Prof A Hassell (AH), Non-Executive Director mentioned that there have been reports suggesting GPs might be incentivised to seek advice and guidance prior to referral and asked if the necessary infrastructure is in place for this. CC commented that it seems like a reasonable approach, with £20 being the suggested amount. However, colleagues in the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) expressed uncertainty about the effectiveness of this incentive and did not anticipate a significant increase in demand. An external company that provides advice and guidance for ENT cases has previously achieved a 40% success rate. Dr N Scawn (NS), Medical Director commented that whilst GPs had been incentivised, Providers have not. Review of job plans revealed a significant amount of time is spent on advice and guidance. There is still a large number of referrals to manage so this is an addition to the workload.	

	Mrs S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO shared the highlights related to Nursing Quality of Care indicators: • Reduction in overall incidents in March • Reduction in CDIFF rates in March • All wards and departments working towards 'Striving for Excellence' accreditation • Areas of concern include sepsis screening and e-discharge compliance • Patient flow and Emergency Department (performance and quality indicators) • Category 2 pressure ulcers (weekly review and actions) • Timely closure of complaints and concerns (although improvements have been made) SP noted that patient flow, waiting times in the Emergency Department and car parking were all factors that impacted the patient experience and Friends and Family Test (FFT) results. A Quality, Safety and Experience Strategy has been drafted and is being reviewed by the Executive Directors this week. Accountability will be maintained by holding monthly meetings. The quality account is in draft and will go out for consultation. SP also noted that the newly appointed Medical Devices Safety Officer (MDSO) is undertaking a gap analysis. AH commented that the inpatient FFT survey results will be affected by ED performance as inpatients often come through ED. NS confirmed there has been a decrease in HSMR scoring. SHMI remains sub 100 and remains within the expected range. Mrs K Edge (KE), Chief Finance Officer presented Finance highlights: • Delivery of a £9.5 million deficit against planned deficit of £9.5million at month 12 • CIP is £7.9 million being plan at month 12 but excellent progress is being made • Capital expenditure in line with plan • The Trust is maintaining better payment practice code KE raised that the forward look is being discussed at many forums. It is widely recognised that 2025/26 poses an extremely challenging financial position. This means that the additional grip and control measures introduced in 2024/25 will be reviewed and enhanced to ensure they remain fit for purpose. Mrs P Williams (PW), Non-Executive Director commented that we are focussed on the challenge ahead, but it was still important to recognise the	

	achievement in delivering month 12 for 2024/25. NL concurred and commended the month 12 position. Ms V Wilson (VW), Acting Chief People Officer presented the People and Organisational Development highlights: • Turnover continues to be below the 10% target. • Sickness absence is still above target but has significantly reduced in March 2025. • Appraisal compliance is on target and further analysis is underway to identify the key areas of non-compliance. • Agency shifts for Nursing, Medical & Dental have increased from last month, however YTD spend is £189k less than last year. • Mandatory training compliance is just below target. Ms W Williams (WW), Non-Executive Director commended the work gone into supporting managers to manage their people better. It was noted that embedding this is not solely the responsibility of HR, and Divisions must also continue to lead and integrate this work. The Board **noted** the contents of the report.	
17.	**Operational Management Board Chair's Report – 24th April 2025** Ms J Tomkinson (JT), Chief Executive Officer presented the Operational Management Board Chair's report including areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed. There were no issues to highlight and the positive engagement and contribution from clinical leads continues. There were no further questions. The Board **noted** the report.	
18.	**Audit Committee Chair's Report – 22nd April 2025** Mr M Guymer (MG), Non-Executive Director presented the Audit Committee Chair's report which included areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed. MG noted that the new committee effectiveness review process was very successful and plans agreed for updates from Committees going forward. The Committee had also received and reviewed the Value for Money risk assessment. There were no further questions. The Board **noted** the report.	
19.	**Finance & Performance Committee Chair's – 30th April 2025** Ms P Williams, Non-Executive Director presented the Finance and Performance Committee Chair's report which included areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed.	

	Urgent Emergency Care (UEC) performance continues to be an area of concern. The deliverability of the 2025/26 Financial Plan and CIP programme remain a concern, and this will remain a focus for the Finance and Performance Committee. PW congratulated the Digital and Data team, for achieving the level 3 accreditation in the National Towards Excellence in Digital Standards. There were no further questions. The Board **noted** the report.	
20.	**<u>Equality, Diversity and Inclusion (EDI) Annual Report 2024/2025</u>** Ms V Wilson (VW), Acting Chief People Officer presented the EDI annual report. The annual report ensures compliance with public sector requirements. It presents workforce data and highlights changes over time. The report covers not only workforce diversity but also their experiences. Additionally, the paper has been reviewed by the People Committee. Ms W Williams (WW), Non-Executive Director noted the significant amount of work behind this, and the level of data and detail now included. She thanked the new EDI team members for their efforts. Mr N Large (NL), Interim Trust Chair, enquired about how we correlate this with the staff survey results. VW replied that the analysis of the staff survey results is also evaluated based on protected characteristics, which subsequently informs the Trust's actions. NL noted that we are below the community average in terms of disability and asked if there was analysis in relation to working age. VW confirmed that this data can be analysed in more depth. Prof A Hassell (AH), Non-Executive Director noted that there was an increased number of staff identifying themselves with a disability on the national staff survey. VW confirmed this was correct and that they are encouraging staff to declare their disabilities. It was noted that that the annual staff survey is more up to date and that staff are more likely to declare their disability through the survey than updating this on ESR. WW raised a possible typo in the document regarding the percentage of heterosexual staff. Mrs S Corcoran (SC), Non-Executive Director referred to the age profile with there being just under 30% of staff aged 51-70. She asked if this was similar across the NHS. VW shared that there has been an increase in older staff within the last year, although this is high we are not a significant outlier. Subject to the amendment above, The Board: • **Noted** the contents of the report and identified actions. • **Received** assurance that in producing the report, the Trust has complied with its obligations in respect of the Public Sector Equality Duty. • **Approved** publication of the report on the Trust's website.	

21.	**2025/26 Annual plan** Mrs K Edge (KE) Chief Finance Officer presented the 2025/26 Annual Plan update. The previous paper could not be formally signed off, as the ICB was not compliant with the control total. The ICB has now submitted a compliant plan. The £84million gap has been distributed on a fair share plan to all providers. Our plan now shows a £34million deficit, which has increased by £3million. Work is underway to identify opportunities that can be delivered at a system level to close this gap. The issue was discussed at the recent Finance & Performance Committee, highlighting the risk of not signing up to the control total, which would impact cash flow, intervention, and access to capital. There has been a change in the allocation of system support funding, which has increased from £14.4million to £19.4 million. This distribution of cash is non-recurrent, and there is a need to focus on the underlying deficit of £34million. We were also not compliant with RTT performance in the 2025/26 annual plan. We were encouraged to make significant improvements to achieve the expected RTT compliance and an additional £3 million has been allocated to improve the RTT trajectory. There has been a change in the report, including the additional £3million for RTT compliance, and the updated deficit number. The Board recognised the high risk trajectory associated with achieving the RTT targets and this would continue to be monitored. Ms C Chadwick (CC), Chief Operating Officer confirmed this would be included in the SOF. Mr M Guymer (MG), Non- Executive Director commented that a clear plan has been developed to meet financial and clinical performance targets despite the challenges. Mrs P Williams (PW), Non-Executive Director highlighted the importance of recognising the varying levels of risk within the plan. Mr D Williamson (DW), Non-Executive Director asked what mitigations we will monitor. CC responded that actions will be set out and progress updates would return to the Board. In summary the key risks include delivery of the CIP programme, delivery of RTT and emergency care performance standards. It was noted that the detail will be managed through assurance committees, but updates should also be reported to the Board via the SOF. The Board of Directors: • **Approved** the 2025/26 Annual Plan and key assumptions. • **Noted** the risks and mitigations.	
22.	**2024-25 National Cost Collection (NCC) Pre-Submission Board Assurance Report**	

	Mrs K Edge (KE), Chief Finance Officer presented the National cost collection assurance report for Board sign-off. KE updated that we have the plan and resources needed, and prior to submission the outputs will be reviewed by the Finance & Performance Committee. Mr M Guymer (MG), Non- Executive Director noted that we previously had non-submission of data, and it is good that we have restarted this practice. Dr N Scawn (NS), Medical Director questioned why, if we know the costs, we are not very good at service line reporting. KE explained that NCC focuses on costs, while service line reporting looks at income and other factors. NCC is nationally mandated and underpins a tariff. The Reference Cost Index compares our relative costs to other providers across England and provides some assurance around efficiency. However, it does not cover everything we deliver and does not really show affordability. Mr D Williamson (DW), Non-Executive Director asked if we have the resources for data collection but not for review. KE confirmed that we will deliver in line with national standards and guidelines but do not have the resources to review every service line. DW further enquired if there is a risk that NCC data might not be as valid as it could be due to the lack of review. KE acknowledged that this could be the case, as the usefulness of the data diminishes the longer it takes to validate it. The Board **Approved**: • The plan in Appendix A is sufficient to meet the requirements to produce the 2024/25 NCC submission by the deadline date. The plan includes: ▪ senior review and sign off to ensure the return has been prepared in accordance with the Approved Costing Guidance ▪ an information gap analysis and costing standards gap analysis will both be completed and any issues addressed as part of the planning process ▪ The costing and other teams involved in the submission are sufficiently resourced to produce and validate the submissions with the planned timeline.	
23.	**a) Research & Innovation Committee Chair's Report – 9th May 2025** Dr Peter Bamford (PB), Director of Clinical Research presented the Research and Innovation Committee Chair's report which included areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed. The Board **noted** the Research and Innovation Committee Chair's report. **b) Research Update** PB shared that the new Clinical Research Unit (CRU) and Mobile Research Unit (MRU) had official opened in December 2024. Since the end of April 2025, we have been able to see patients. The mobile research unit is operational but will require time to gain traction. By the end of summer, three	

	trials will be running. We have also participated in career fairs and received funding for research education. PB updated on partnership development with the University of Chester, Primary Care Research Hubs, Cheshire and Mersey Commercial Research delivery collaboration. Funding of £7million has been secured from the government, with commercial income anticipated to follow. New research hubs are being established at Ellesmere Port and Tarporley. There is also income designated for equipment and Interventional Radiology (IR) suite. It has been identified that we have not pursued grants adequately in the past. The Innovation Grant Scheme offers £110 million for AI initiatives aimed at reducing waiting lists. We are exploring the expansion of this scheme and pre-habilitation for patients on the waiting list. There are numerous funding streams available for the "Hospital at Home" program. Regarding our own finances, we are currently in a good position, with income from trials. This year, we have identified eight more commercial trials, and we aim to have a dedicated commercial trials team within two years. We plan to maintain a small surplus to support staffing costs and hope to increase income, which will allow for an increase in staffing. Positive feedback from the Postgraduate Research Experience Survey (PRES) survey highlights the quality of our staff. Professor A Hassell (AH), Non-Executive Director, enquired about our goals for the partnership with the University of Chester. PB confirmed that we aim to achieve university hospital status, which could be attainable in 10 years, noting that it will take time to develop. AH remarked on the importance of partnering around specific grant applications, stating that the University has much to gain from the Trust and urging collaboration on ad hoc projects as a starting point. Mr P Jones (PJ), Non-Executive Director offered to connect PB with the Director of Partnerships at the University of Salford. Ms J Tomkinson (JT), Chief Executive Officer, stated that she meets regularly with PB, who is working hard to drive progress despite having a limited team and recruitment restrictions. Funds need to be ringfenced for research to ensure continuous progression at COCH. The next steps involve preparing grant applications and exploring available funding opportunities. While some funds are allocated to research, they remain limited. There is no dedicated personnel for innovation, despite numerous funding opportunities. It would be beneficial to appoint someone to fulfil a role in the future. Mr D Williamson (DW), Non-Executive Director, Enquired about C2AI and whether procurement with that supplier is being optimised. Ms C Chadwick (CC), Chief Operating Officer stated that the access we have through the ICB is free. Mr N Large, Interim Trust Chair noted that, traditionally, research activity was documented through papers. However, modern advancements have led to	

	significant developments, which need clear communication to be understood by the audience. AH noted that statistically, patients treated in Trusts involved in research tend to have better outcomes. The Board thanked PB for the presentation. *PB exited the meeting at 12.20pm.* The Board **noted** the update.	
24.	**Clinical Strategy** Mr J Develing (JD), Director of Strategy and Partnerships, presented the Clinical Strategy following feedback from the Board development day. The appendices also included divisional objectives and outcomes. Ms W Williams (WW), Non-Executive Director, commented that she enjoyed reading about how Divisions will deliver. WW asked how long it would be before the indicated changes would be seen, enquiring specifically about robotic surgery and the operations it would perform, presuming that the plans behind that are divisional plans. JD explained that the strategy is also about vision, noting that the robot costs £1.5million. We are aware this is a fundamental part of surgery for the future. He mentioned that some of the details behind some ambitions are not included, but this is purposeful. He referred to the page on objectives, noting that some are ambitions and not fully costed, giving the reader an understanding of the vision. He emphasised the focus on culture, improvement and innovation, referencing the milk bank and AI in dermatology. Prof A Hassell (AH), Non-Executive Director, expressed that he really liked the document, appreciating the specific and measurable commitments and the inclusion of Divisional commitments. JD stated that the document has shifted to "We will" statements rather than "We hope," aiming to inspire people to think differently. Mr N Large, Interim Trust Chair commented that developing plans to underpin a strategy is different from the strategy itself and enquired about the next steps. JD outlined the next steps, which include producing a final publication in-house and running workshops in June 2025, followed by a public consultation to share with stakeholders. Mr D Williamson (DW), Non-Executive Director, mentioned various strategies and noted that Health and Safety is waiting for the clinical strategy. The Board discussed formulating a plan for monitoring how strategies dovetail with each other. Ms. J Tomkinson (JT), Chief Executive Officer, noted the missing three-year financial sustainability strategy and stated that another session with the Board is needed. The Chair stated that mapping all the strategies is necessary. It was agreed that these could continue to a focus for the Board development days and agendas.	

	The Board **approved** the Clinical Strategy.	
25.	**People Committee Chair's Report – 8th April 2025** Ms W Williams (WW), Non-Executive Director/Chair of the People Committee presented the People Committee Chair's report which included areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed. It was noted that there were no alerts raised but this did not indicate there were no issues. The Committee has focused on progressing the establishment of the foundations to support the People related issues. The Committee has approved the Terms of Reference for their new subsidiary groups and emphasised the importance of the operational work they are responsible for. The Committee has reviewed the People related High Risks and these have now been reduced where appropriate. It was agreed that the Workforce Sub-Committee will monitor the High Risks going forward. Ms V Wilson (VW), Acting Chief People Officer confirmed that risks relating to staffing will be managed through the Workforce sub-committee and that the sub-committee will provide assurance in a way we have not received before. The Committee has also reviewed and refreshed their workplan to ensure this underpins the People Strategy. Mr M Guymer (MG), Non- Executive Director queried how we monitor ongoing alerts without this becoming repetitive to the Board. Mrs K Wheatcroft (KW), Director of Governance, Risk, and Improvement confirmed that it was correct to continue to alert the Board to ongoing challenges but what would differ is the actions the Committee was taking and the request to or from the Board. The Board **noted** the update.	
26.	**Fit and Proper Persons (FPPT) Report** The Board received a report confirming that the annual Fit and Proper Persons Checks have been conducted and that all Board members remain compliant. Mrs K Wheatcroft (KW), Director of Governance, Risk, and Improvement noted that a standard DBS check is conducted for all Board member and an enhanced one is conducted only where required. KW also shared that MIAA are currently conducting a review of the Trust's FPPT processes and the outcomes of this will be reported to the Board via the Audit Committee. We will also look to continue to improve the presentation of this report going forward. The Board **noted** the report.	
27.*	**Council of Governors Summary Report**	

	The report summarised the key topics presented and discussed at the last Council of Governors meeting in April 2025. The Board **noted** the Council of Governors Summary Report.	
28.*	**Annual Committee Effectiveness Review 2024/25:** **a) Finance and Performance** **b) Audit Committee** **c) Quality & Safety Committee** **d) People Committee** It was noted that the reports had also been reviewed at the Audit Committee. Ms S Pemberton (SP), Director of Nursing and Quality/ Deputy Chief Executive thanked Mrs K Wheatcroft (KW), Director of Governance, Risk, and Improvement and Mrs N Cleuvenot, Head of Corporate Governance for their work in conducting the annual committee effectiveness reviews. The Board **noted** the reports and confirmed ongoing committee effectiveness for 2024/25.	
29.*	**Review of Register of Interests** The Board received the Register of Interests for the Board of Directors and Governors. It was noted that Mr J Bradley (JB), Chief Digital and Data Officer had been omitted from the register. This would be updated and re-published on the Trust website. The Board **noted** the Register of Interests.	
30.*	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 6th March 2025 (attached) b) Approved minutes of the People Committee – 11th February 2025 (attached) c) Approved minutes of the Finance & Performance Committee – 7th March 2025 (attached) d) Approved minutes of the Operational Management Board – 27th February 2025 (attached) e) Approved minutes of the Audit Committee – 13th February 2025 (attached) **Other items:** Draft Board of Directors Workplan 2025/26 (attached)	
31.	**Any Other Business** There was no other business to note.	
32.	**Questions from Governors and members of the Public relating to items on the meeting agenda** No questions had been received.	

33.	**Closing remarks** The Chair asked if everyone was happy with the conduct of the meeting. No issues were raised and the Chair thanked everyone for their attendance.	

Next Meeting: Tuesday 29th July 2025

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

Countess of Chester Hospital NHS Foundation Trust

Public Board of Directors Action Log

Updated July 2025

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
1	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.	The Trust reports national data yearly to NHS England (KO41) the data of number of requests. This data is currently being uploaded with a submission date of June 25. The report will then be available publicly in August 25 and the results will be included in the Safety Surveillance Committee Paper. Previous years the Countess of Chester have been in the middle of the national tables. In 2023/24 the Countess were flagged as the trust that had seen the biggest reduction in complaints. This was due to a variety of reasons – mainly the Trusts Improvement plan, which included the utilisation the PALS and concerns process more. This is turn did show	Sept-25	**Open**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
						an increase in the number of concerns raised and a deep dive of concerns has been completed and presented.		
2	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 Directors meeting to detail the new governance arrangements.	Updates are being provided through the CEO report. Further report to be provided following update to joint working arrangements and Leadership Board terms of reference. Confirmation from CMPC that TORs and working agreement will be ready for Board approvals in September 2025.	July-25	**Open**
3	25th March 2025	Chair of Finance and Performance Committee/ Director of Finance	PB9/ 03/25	Board Assurance Framework – Quarter 4 2024/25	Finance and Performance Committee to consider how the delivery of medium-term financial stability is reflected on the BAF.	This has been considered in the BAF (July 2025).	July-25	**Closed**
4	25th March 2025	Director of Nursing & Quality / Deputy Chief Executive	PB12/ 03/25	Care Quality Commission (CQC) Improvement Journey	SP to chase up CQC for feedback on value for money assessment		Sept -25	**Open**
5	20th May 2025	Director of Governance,	9b	High Risks Report	KW to check if out of date policies is on the	Out of date policies added to datix as moderate risk.	July-25	**Open**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
		Risk & Improvement			risk register and if it should be considered a high risk.			
6	20th May 2025	Board of Directors	9b	High Risks Report	Board to discuss risk appetite alongside BAF (including medium term financial plan) at a Board Development Day.	**Updated 9th June 2025 –** added to 24th June development day agenda.	July-25	**Closed**
7	20th May 2025	Director of Nursing & Quality / Deputy Chief Executive	12a	Bi-annual Safer Maternity and Neonatal Staffing Report – July 2024 to December 2024	SP to provide update on maternity services neonatal partnership (MNVP) work on addressing health inequalities in maternity services.	**Updated 9th June 2025-** Update on agenda as part of Service Showcase.	July-25	**Closed**
8	20th May 2025	Chief Digital and Data Officer	13	Quarter 4 2024-2025 Mortality Surveillance Report (Learning from Deaths)	JB to compare depth of coding (SHMI) data with other organisations.	**Update 21st July 2025** – Using data from Dr Foster (Telstra Health) for comparison, our coding depth matches the national average of 4.5 codes per record and is below the national average for records with no comorbidity recorded (34.7% for CoCH, 43.2% national i.e. a positive position). The coding depth has shown an improvement from 4.2	July-25	**Closed**

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
						average codes per record in 23/24 to 4.5 in 24/25. The Dr Foster data is used to identify specialties where there is variation from national figures and work then undertaken with the specialty to review recording of comorbidities.		

PUBLIC - Board of Directors
29th July 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 (July 2025)

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

1. 10 Year Health Plan

The Government's 10-Year Health Plan for England was unveiled on Thursday 3rd July 2025, setting a new course for the NHS. It marks a significant turning point for the NHS and for all of us who work within it.

The plan focuses on three main shifts which are areas we have been firmly focused on for some time with our approach set out in our five-year strategy - Transforming Care Together. This focus of the 10 Year Health Plan is:

- **From hospital to community:** a new Neighbourhood Health Service will bring care into the places people live, transforming access to general practice and preventing unnecessary hospital admissions.
- **From analogue to digital:** creating a digitally accessible health system where patients have a 'doctor in their pocket' providing 24/7 advice and guidance.
- **From sickness to prevention:** emphasising prevention and tackling the wider factors that affect health, reducing the burden of illness before it begins.

This is a comprehensive plan which sets out a very different approach to healthcare, shaped by the experiences and expectations of the public, patients, and health staff across the country. The goal is to make the NHS the very best place to work and to provide the highest standard of care. The plan includes:

<u>Improving Health and Wellbeing</u>

a. Focus on prevention and tackling health inequalities.
b. More support for mental health services, including children and young people.
c. Increased investment in primary care to provide better community and general practice services.

<u>Enhanced Patient Care</u>

a. Faster access to diagnostics and specialist care.
b. Expansion of personalized care and support for people with long-term conditions.
c. Improving cancer outcomes through earlier diagnosis and better treatments.

<u>Digital Transformation</u>

a. Significant expansion in digital services, including online GP consultations and digital records.
b. Use of data and AI to improve care planning and management.

<u>Workforce Development</u>

a. Addressing workforce shortages by recruiting and retaining staff.
b. Better training and support for NHS workers.

Sustainability and Efficiency

a. Improving NHS efficiency through new models of care.
b. A stronger focus on integrating health and social care services.
c. Tackling the environmental impact of healthcare.
d. Investment
e. Committing to increased funding to support these initiatives.
f. Leveraging technology and innovation for improved outcomes.

2. Cheshire & Merseyside Provider Collaborative (CMPC) Leadership Board meeting

The CMPC Leadership Board met on Friday 4th July and discussed a number of system wide issues currently in focus.

A significant portion of the meeting was handed over to a shared discussion with the ICB and NHSE colleagues and Trust Chairs for the Cheshire and Merseyside system to receive a summary of the outputs from the system wide rapid diagnostic review, led by Stephen Hay and supported by a team from PwC.

Individual Trust specific reports are expected to follow in month. Discussions are ongoing about how the system will respond to the recommendations arising from the review. Trusts have been notified of further in-depth discussions and exploration of month 3 positions imminently.

Next the Leadership Board received an update on the Efficiency at Scale Programme, specifically with relation to corporate back office and at scale opportunities.

CEOs reflected on the system agreement and position in respect of bank rates and next steps.

Update papers were also provided on the following areas:

- System financial report
- System performance update

3. Cheshire, Warrington and Wirral

The combined NHS Trusts of Cheshire, Warrington and Wirral have met to discuss how we as a collaborative we:

- Harness our collective influence to create a positive change and strategic influence for CWW within the C&M system.
- Maximize the opportunity presented in our three elective care centres in Wirral (Clatterbridge), Halton (Sir Tom More Unit) and Northwich (Victoria Infirmary).
- Map through priority pathways to explore opportunities.
- Adopt and adapt any clinical pathways currently within the CMAST program that may require executive support to expedite
- Determine other collaborative opportunities, if the footprint is not at C&M and develop a commercial workstream to consider new partnership investments.
- Explore digital opportunities.
- Establish governance arrangements within the group

Over the coming months we will be reviewing our plans to ensure alignment with the new approach.

4. Cheshire West

Cheshire West and Chester Council is consulting on issues and options for a new Local Plan that will update and replace all policies in the current Local Plan (Part One) and Local Plan (Part Two). The consultation will run for eight weeks beginning on Friday 4 July and ending at 23:59 on Friday 29 August 2025.

The new Local Plan will identify how much development is required in Cheshire West, including for housing, retail and employment uses and the plan will need to allocate sites to deliver the development needed.

This consultation is the first formal stage of producing a new Local Plan, and we are seeking views on how and where to accommodate new development, including identifying potential growth areas around settlements. The consultation sets out possible policy approaches across a range of subject areas including transport, protection of the environment and infrastructure. We are also seeking views on supporting documents including a Sustainability Appraisal (SA); and a Habitats Regulations Assessment (HRA).

To view all documents and supporting information and submit your comments online, visit: https://www.cheshirewestandchester.gov.uk/localplan

5. Employee and Team of the Month

May

Our Employee of the Month for May was Kev Harrower. Kev is a Digital Desktop Support Team Leader who was recognised for his outstanding commitment, problem-solving, and support during recent office moves within the People Services department. His proactive approach, attention to detail, and willingness to go the extra mile – completing work over the weekend to avoid disruption – made a real difference.

Our Team of the Month for May was the Pharmacy Homecare team who were recognised for supporting nearly 2,500 patients with direct-to-home medicine deliveries – improving convenience, reducing hospital visits, and easing pressure on pharmacy services. Their smart medication switching, including a major cost-saving on ustekinumab, helped to save around £1 million in the past year.

June:

Our Employee of the Month for June was Outpatients 1 Receptionist Emily Machin. Emily consistently demonstrates exceptional customer service and a dedication to excellence that exceeds expected standards. Recently she has inspired the development of customer service standards, and this is now being rolled across the team. She possesses a unique ability to connect with patients, making each individual feel valued and understood even when it comes to tricky situations and conversations.

Our Team of the Month for June was the Catering team. They are some of the hardest working, loyal, resourceful, and respectful individuals. They consistently strive to meet all their

daily targets to ensure all our patients and staff receive the best fresh food service within the northwest. They all have individual roles, but the Team can and does step up to any new challenges or daily deadlines especially within this busy environment that they all work in.

6. Patient Choice Award

In June we presented our inaugural Patient Choice Award. This is a new award that will be presented quarterly with winners picked from nominations made by our patients and their families or visitors to the Trust. The first winners were Tom Taylor and Hannah Truman:

'Tom and Hannah assessed me within minutes of attending ED when my speech wouldn't work and my arm went numb. They were calm, patient and extremely supporting of my situation. I was frightened. Tom and Hannah organised everything to happen in a timely manner with minimal distress and delays. Every member of staff I came into contact with in ED that day were amazing, but Tom and Hannah, and the team they represent were phenomenal. What a service they provide! I had a follow up MRI head booked later that week and Stroke appointment the following day. Unfortunately, i was diagnosed with a stroke, but the residual effects of this are minimal, and I put that down to the speed Tom and Hannah worked. They were efficient, but more importantly, kind and considerate.'

7. Celebration of Achievement

Our Celebration of Achievement event takes place on the 19th September 2025. Award nominations are now open for the following categories:

- Quality/Safety Improvement of the Year
- Digital Innovation of the Year
- Commitment to Learning Award
- Volunteer of the Year Award
- The Award for Inspirational Leadership
- Countess Cornerstone Award
- Countess Unsung Hero Award
- Living the Values Award

8. Pharmacy Aseptic Unit audit success

The pharmacy aseptic services unit was externally audited in June 2025 and I am delighted to report that the audit findings are positive. The auditor found that the service is delivered by a dedicated and capable team who demonstrated a culture of continuous improvement, and that systems and processes were robust and meet the required quality standards.

The overall risk rating was judged to be low which means the next audit will take place in two years' time – the best possible outcome. The aseptic services team work hard to deliver the highest quality standards and ensure that patient safety is maintained.

9. Children and Young Peoples Survey Results 2024

I'm proud to share that we've been ranked 9th out of 54 NHS Trusts in England for children's patient experience in the 2024 Children and Young Person National CQC Survey.

The survey, run by Picker for the CQC, reflects family feedback. We performed strongly in areas including pain management, staff introductions and communication. While we celebrate this, we're also acting on feedback to improve parental access to food, Wi-Fi quality, and staff awareness of children's medical needs.

10. Open days at the new Women and Children's Building

As we prepare to open the doors of our new Women and Children's Building, we have arranged a series of open days. These events are a significant milestone for our organisation and an exciting opportunity for us all to explore the building before it becomes a clinical environment.

There is no need to book, the dates are:

- Wednesday 23 July: 1pm to 4:30pm
- Wednesday 30 July: 3pm to 8:30pm
- Thursday 7 August: 5pm to 8:30pm

11. Reconditioning Revolution: working with Healthbox CIC

As part of our reconditioning revolution, we're working with local Community Interest Company Healthbox to help embed movement into everyday ward care – from simple exercises to encouraging patients to get up and dressed. Healthbox is sharing their specialist knowledge to build confidence and skills so we can better support activity which is key to preventing deconditioning and speeding up recovery and discharge for our patients.

This summer, we'll also support the Joyful Movement campaign with the council – encouraging people to move more in everyday ways, like walking to the shop or playing with their children.

12. Countess Charity launches new 'Extra Mile' Appeal

The Countess Charity has now launched our new appeal – the Extra Mile Appeal – a staff-led initiative aiming to raise £250,000 for additional equipment across our hospitals.

While the NHS provides essential equipment, your feedback - particularly from the Acute Medical Assessment Unit, which helped develop the idea for the appeal - shows that more resources like bladder scanners, ECG machines and blood pressure monitors would improve efficiency and patient care. Dedicated equipment on every ward means quicker diagnoses, reduced delays, better infection control, and more time for patient care.

13. The 1829 building update

NHS Property Services have confirmed that following discussions regarding organisation's plans on the use of the 1829 building, the Cheshire and Merseyside Integrated Care Board have given the instruction to declare the building surplus to requirements. As such NHS Property Services have given notice period that the official vacation date of the site will be 31st March 2026.

As a Trust we were already developing plans to vacate the building and these will be progressed in the timeframes set out.

14. Industrial Action: Resident Doctors Strikes

The British Medical Association (BMA) has announced new strike dates for resident doctors in England. Resident doctors, (formerly known as junior doctors) will walk out from 7am on 25th July until 7am on 30th July 2025.

This follows the renewed mandate for industrial action by the BMA. The ballot saw a turnout of 55 per cent of those eligible to vote, with 90 per cent of those voting in favour of taking action. The result grants the BMA a six-month mandate for industrial action, covering the period from 21st July 2025 to 7th January 2026.

The Trust is developing robust plans to respond to the strikes and ensure staff are supported and our services remain safe during this period.

15. Ongoing Media coverage

Cheshire Police and the Crown Prosecution Service (CPS) have issued statements in relation to the ongoing police investigations related to the case of Lucy Letby, a former employee. It is not appropriate for the Trust to comment whilst these investigations and the Public Inquiry are ongoing.

It is important to note that the latest developments – the arrests of three former senior leaders and the announcement that the CPS is considering further charges - are matters for the police and the CPS.

Whilst there is huge public interest in the story, I am keen that we do not let it overshadow our focus on providing high-quality care and treatment to our patients.

16. Board Leadership update

Following a thorough and robust recruitment process, Neil Large MBE has been appointed as the new Chair of the Board.

I would also like to thank our Governors who led and supported the recruitment process.

PUBLIC – Board of Directors
29th July 2025

Report	**Agenda Item 9a.**	**Board Assurance Framework 2025/26 including Risk Appetite Statement**						
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 for 2025/26 along with a refresh to the Board Risk Appetite Statement. This paper provides an update to the Board of Directors along with the full BAF, revised Board Risk Appetite Statement and progress against strategic objectives. 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 infrastructure 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. Whilst the risk appetite levels remain the same, the revised Board Risk Appetite Statement wording now references the context of organisation and system risk as well as specifically noting cyber risk. The report demonstrates the progress being made against key actions aligned to BAF risks and strategic objectives including: • Development and delivery of RTT plans to drive delivery of NHS planning standards. • Integrated UEC action plan. • Delivery and monitoring of staff survey action plans, and consistency of application of values. • Clinical strategy engagement events (July 2025) • Leadership of Place CVD events • Risk management improvements continuing to progress • Finance strategy development • Anchor Institute accreditation received • Green plan refresh in progress • Continued development of the partnership with the University of Chester. • Collaborative models at Cheshire & Merseyside, pan provider and local levels. Some objectives have moved to BAU and a review of objectives will be undertaken in Q2.
Recommendations	The Board of Directors is asked to: (i) **approve** the updates to the 2025/26 Board Assurance Framework (ii) **note** the update on progress in delivering strategic objectives (iii) **approve** the revised Board Risk Appetite Statement

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	Not confidential

Board Assurance Framework (BAF) 2025/26

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 2025/26 BAF was considered alongside the risk appetite statement during the Board development session in June 2025. The BAF is aligned to the 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 2025/26 BAF, including actions to mitigate and manage strategic risks, delivery of the 2025/26 strategic objectives and the revised risk appetite statement for approval.

2. BAF RISKS ALIGNED TO STRATEGIC GOALS

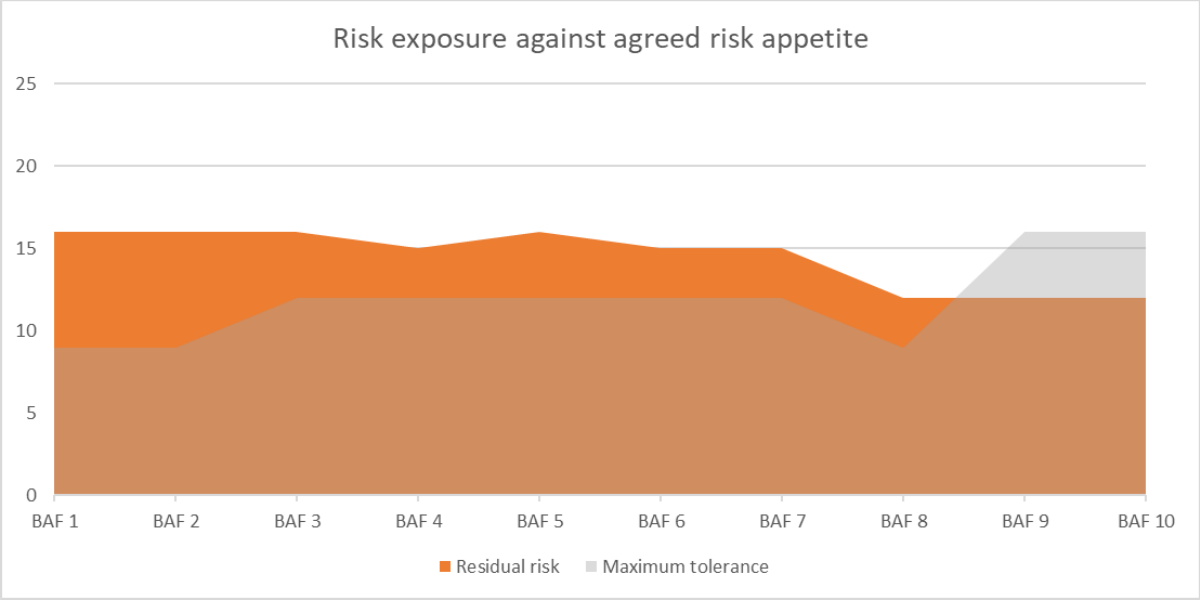
Alignment to strategic goals and objectives has been included within the BAF, with strategic objectives shaded within the key controls. The current risk exposure against the strategic goals is summarised below.

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 and culture** 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 deliver transformative **digital and data** solutions and performant, secure and resilient infrastructure could impact on patient and staff experience and organisational productivity						
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 infrastructure 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

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

- Development and delivery of RTT plans to drive delivery of NHS planning standards.
- Integrated UEC action plan.
- Delivery and monitoring of staff survey action plans, and consistency of application of values.
- Clinical strategy engagement events (July 2025)
- Leadership of Place CVD events
- Risk management improvements continuing to progress
- Finance strategy development
- Anchor Institute accreditation received
- Green plan refresh in progress

- Continued development of the partnership with the University of Chester.
- Collaborative models at Cheshire & Merseyside, pan provider and local levels.

Strategic objectives will be updated for 2025/26 in Q2.

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

5. BOARD RISK APPETITE STATEMENT

The Board Risk Appetite Statement has been revised following discussion at the Board development day (June 2025). The proposed changes are:

- Reference to organisation and system context.
- Specific reference to cyber in the context of digital and data risk appetite.

The full Board Risk Appetite Statement is provided in Appendix C.

6. RECOMMENDATIONS:

The Board of Directors is asked to:

(i) **approve** the updates to the 2025/26 Board Assurance Framework

(ii) **note** the update on progress in delivering strategic objectives

(iii) **approve** the revised Board Risk Appetite Statement

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	• Continued focus on consistency of application of standards • IPC compliance • UEC CQC response and action plans
BAF2. Failure to **maintain safety and prevent harm** would result in poorer patient care and outcomes	**16**	**9**	Partial	• Harms improvement programme outcomes • Sepsis compliance • Organisation learning policy • Clinical Strategy engagement events • Mental health provision
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	• 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 and culture** would affect our ability to deliver patient care	**15**	**12**	Partial	• E'rostering roll out • Workforce planning • Staff survey results and actions • Consistency of wellbeing offer • Delivery of integrated EDI action plan • Succession planning • Training needs analysis • Action plan development for NETS
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 and 5 year plan • Continuing to work with C&M ICB • Delivery of CIP schemes • Establishment and embedding of cash management mechanisms
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 level estates work • Capital plan delivery • Capital bids (TIF) • Continued RAAC failsafe and inspections continuing until decant
BAF7. Failure to deliver transformative **digital and**	**15**	**12**	Partial	• Digital and data strategy refresh and audit

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing
data solutions and performant, secure and resilient infrastructure could impact on patient and staff experience and organisational productivity.				• Cyber assessment framework and cyber security protection plans • Infrastructure developments • EPR optimisation programme • Data quality framework • National competency framework reporting • Team workforce plan and capabilities
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 (Divisional and sub committee) • Regulatory compliance and assurance map • CWP/COCH committee developments • Corporate Records Management policy refresh and review • Response to Inquiry report (Q4)

(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

The progress against strategic objectives is set out in the tables below. The strategic objectives will be reviewed and updated for 2025/26 in Q2.

Strategic Objectives	Lead	Progress
SG1 Patients and Family		
Systematic approach to improving quality and safety and reducing harm	SP	Complete - BAU
Delivery of NHS planning standards	CC	The Trust continues to meet the elective long waiting targets, the reduction in suspected long waiting cancer patients, however compliance to the operational standards relating to RTT remain challenged. There is a plan for a significant improvement in RTT compliance by the end of September 2025. 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 hours, 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 has an option to extend UTC opening hours however revenue funding would be required. Flow improvement plan being aligned with UEC improvement plan to ensure clear priorities and a focus on assessing the impact of the actions taken.
Development of a patient and family care model	SP	Complete - BAU
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 being updated by the Deputy Director of Nursing and Quality Governance.

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.Current focus includes zero tolerance and tackling poor behaviours.High level staff survey results 2024 received and development of action plans (March 2025). Progress being reviewed at sub committee level.
Develop an approach for recruitment, development and retention	VW	Complete - BAU
Improve the health and wellbeing of our staff	VW	Staff hub opened (2024/25) and wellbeing offer includes 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 as well as consistency of offer across the Trust.

SG3 Leadership		
Development of clinical strategy	NS	Clinical Strategy approved and launched. External engagement events to be led by the Director of Strategy and Partnerships (July 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 took place in April focussing 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 launched in Q1 2025/26. Training needs analysis to be progressed (Q2 25/26).
Ensuring governance is in place across the organisation	KW	Committee organagram developed and further review of sub committee structures including Divisions underway. Governance presentations continue to be delivered in various forums. Risk management improvement plan actions progressing, risk management policy approved and Risk Management Committee in place. Datix developments being implemented.

SG4 Adding Value		
Development of a new financial plan and strategy	KE	Conclusion of 2025/26 annual planning process (May 2025). Development of deficit drivers underway. Closed 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 clinical strategy and people strategy. Consideration of financial strategy approach Board strategy day (Jun 25).
Advance digital solutions in support of transforming care	JB	Strategy presented at Board Development day in June 2025. MIAA strategy audit follow up to take place in Q2. Draft Digital and Data Strategy to be aligned with objectives of 10 year plan. Digital Maturity Assessment 2025 was submitted in June 2025 following peer review.
Achieve anchor institution status. (green / social value / prevention)	JD	Anchor Institution Accreditation received July 2025. National guidance published in February 2025 will require Trust to refresh Green strategy. This has been overseen by the Anchor Institution Group and will be reported to Board in Q2.

SG5 Partnership		
Develop a bespoke research, education and innovation strategy	NS	Research ambitions to support strategy development being aligned to the clinical strategy. Research Strategy being drafted for Board in Sept. 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.
Collaborative Models	JD	Director of Strategy and Partnerships leading work with Cheshire, Warrington and Wirral to explore opportunities. Continued discussions with WUHFT following Board to Board. There are

		several pieces of work with Wirral including the Pathology and Renal reviews.
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 (UoC) 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). Increase in academic appointments mostly teaching through UoC medical school. Research appts to continue to be explored. Discussions ongoing to develop teaching programmes with UoC.

SG6 Populations		
Develop a Trust approach to health inequalities and prevention, and population health	JD	Board development session was 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 were 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.
Further develop our integrated care approach	CC	An exec to exec group has meet to discuss the formation of a joint committee with CWP to help with the strategic direction of developing community services and the neighbourhood model as well as wider collaboration opportunities.

Appendix C – Board Risk Appetite Statement (2025/26)

The progress against strategic objectives is set out in the tables below. The strategic objectives will be reviewed and updated for 2025/26 in Q2.
We will continue to protect the Quality and Safety of Care, being cautious of risks that may have a detrimental effect on the Patient and Family Experience and outcomes.

We have an open attitude to risk in relation to Operational Effectiveness and Finance. We acknowledge that there are significant financial and operational challenges across our healthcare system and within the Trust, and we need to look at innovative ways to support delivery and strengthen our financial position.

Transforming services to ensure sustainability and productivity will require changes in staffing models and an agile, resilient workforce. We have an open risk approach to our workforce challenges as we look at new and innovative ways to recruit, retain and support our people, whilst we maintain a strong focus on engagement and culture.

We have an open attitude to the digital agenda underpinning clinical innovation and optimization of our digital systems to become more efficient and effective. Whilst we are prepared to accept some level of risk to implement changes for longer term benefit, we will ensure that information governance and data security remains a priority and cyber risks are mitigated to appropriate levels.

Strong governance must underpin decision making at a system and organisation level, and we will be cautious about risks relating to governance.

Recognising the need for new ways of working we have a risk-seeking approach to research, innovation, strategic partnerships and system working. Delivering our clinical strategy, research and innovation ambitions we accept that there will be a need to accept a higher level of inherent risk. We will seek opportunities to work collaboratively with partners, contribute to the delivery of system and organisation priorities and develop new ways of working through a range of partnerships.

Risk appetite has been set as follows:

Risk domain	Risk appetite level	Risk score upper tolerance limit
Quality, Safety, and Patient Experience	Cautious	9
Operational Effectiveness	Open	12
Workforce	Open	12
Finance	Open	12
Digital	Open	12
Governance	Cautious	9
Research and Innovation	Seek	16
System working and Strategic Partnerships	Seek	16

Our Risk Appetite Descriptors are:

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	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 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**

NHS
Countess of Chester Hospital
NHS Foundation Trust

Board Assurance Framework 2025 - 26

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:** July 2025	**Causes:** - Longer patient waiting lists - Inconsistent compliance with standards - Hospital 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 - Quality and Safety Strategy and reporting	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**	Consistency of application of standards.			***9***	***Mar-26***
			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*							
			C3) Infection Prevention and Control. **Control Owner:** Director of Nursing and Quality	- IPR - Infection, Prevention & Control Quarterly Report via Q&S Committee - Quality Governance Group via Q&S Committee - Annual Quality Account (featuring IPC section re objectives) - PLACE inspection reports	CQC reports	*Partial*			Consistency of cleaning standards. IPC compliance assurance and improvements.				
			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*			UEC CQC inspection findings and response.	(i) To deliver the warning notice action plan. **Action owner:** Director of Nursing and Quality **Due date:** Q2 (ii) To respond to the findings of the CQC report. **Action owner:** Director of Nursing and Quality Due date: Quarterly updates	Comprehensive action plan developed and progress monitored weekly. Deep dive through the Q&S Committee. Bi-monthly progress report to Q&S Committee and update to Board of Directors (July 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:** July 2025	**Causes:** - Longer patient waiting lists. - Underdeveloped partnership working arrangements to support clinical strategy delivery. - Lack of reciprocal engagement in the wider health system. - 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	- IPR - 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 (falls, pressure ulcers). **Action owner:** Medical Director **Due date:** Quarterly updates	Continued updates to Quality Governance Group and presentations through Harms Improvement Oversight meeting.	***9***	***Mar-26***
									Consistent application of standards,	To deliver improvements in Sepsis complicance. **Action owner:** Medical Director **Due date:** Quarterly updates	New cerner processes implemented. Work ongoing to embed consistency of compliance with screening process and actions. Audit data being collated and reviewed. Updates provided to Q&S Committee.		
			C2) Organisational learning **Control Owner:** Medical Director/ Director of Governance Risk and Improvement	- Safety Surveillance Quarterly report to Q&S Committee and Board - 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:** Q3	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 being updated by the Deputy Director of Nursing and Quality Governance.		
			C3) Review of deaths **Control Owner:** Medical Director	- Quarterly Learning from Deaths report and annual mortality report via Q&S Committee and Board - Quality and Safety Committee	Telstra Health (Dr Foster) benchmarking	*Acceptable*							
			C4) Delivery of the Clinical Strategy **Control Owner:** Medical Director			*Partial*			Delivery of the Clinical Strategy and assurance reporting.	Develop approach to providing assurance on the progress of delivery of the Clinical Strategy through OMB. **Action owner:** Medical Director **Due Date:** Q4	Clinical Strategy approved and launched. External engagement events to be led by the Director of Strategy and Partnerships (July 2025).		
			C5) Mental Health service provision **Control Owner:** Director of Strategy and Partnerships	Exec to exec meetings with CWP.		*Partial*			Response to CQC Warning notice. Delivery of mental healtjh review action plan. Clear governance for collaboration and partnership working.	Ensuring improvements in setting expectations, clarity of accountability, and consistent application. **Action owner:** Director of Strategy and Partnerships **Due Date:** Quarterly updates	Actions included in the CQC action plan. Ongoing monitoring of standards. Exec to exec planned to discuss position and agree action. Further work progressed on TOR for a Joint Executive led Committee.		

Risk Theme: Operational Effectiveness

RISK APPETITE: OPEN - Upper tolerance limit 12

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

Risk description & information	Causes & consequences	Inherent risk score (C x L)	Key controls	Board Assurance			Residual risk score (C x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score	Estimated date of achievement of target score
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update		
BAF3 Inability to deliver operational planning standards, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust. **Executive Risk Lead:** Chief Operating Officer **Assurance Committee:** Finance and Performance Committee **Last Update:** July 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	- IPR 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 elective long waiting targets, the reduction in suspected long waiting cancer patients, however compliance to the operational standards relating to RTT remain challenged. There is a plan for a significant improvement in RTT compliance by the end of September 2025 . 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 hours, 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 has an option to extend UTC opening hours however revenue funding would be required. Flow improvement plan being aligned with UEC improvement plan to ensure clear priorities and a focus on assessing the impact of the actions taken.	*12*	***Mar-26***
			C2 Performance management framework and Governance Structure **Control Owner:** Chief Operating Officer	- IPR 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 report through OPELG. The AI validation tool is now at the point of being procured and will be implemented by Q4.		

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 and culture would affect our ability to deliver patient care. **Executive Risk Lead:** Chief People Officer **Assurance Committee:** People Committee **Last Update:** July 2025	**Causes** - Poor staff morale and culture - 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 - Lack of accountability **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 - Poor behaviours - Silo working, lack of collaboration and innovation, ownership of performance and delivery	*5 x 4 = 20*	C1) Workforce Plan **Control Owner**: Chief People Officer	- IPR (to every Board) - Staffing monitored via Strategic Workforce Group and chair's report to People Committee - Vacancy Control Panel reporting to EDG	Annual plan submitted to ICB. Monthly monitoring at ICB level	*Partial*	*5 x 3 = 15*	**NO**	Lack of digital workforce systems, processes and reporting. Greater scrutiny at system level and review of controls.	(i) Continue to ensure vacancy control measures are aligned to ICS headcount expectations and reporting. (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 and Pay Control Group in place. Plan being developed to roll out e'rostering for AfC staff to commence feb 2025. Medical e'rostering procurement underway with phased implementation from Q2 25/26.	*12*	*Mar-26*
									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 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	- IPR - Workforce dashboard/ SOF via People Committee - GMC Survey via People Committee - Preceptorship survey via People Committee - Staff survey action plan updates via People Committee - FTSU Bi-annual update and via People Committee - Employer relations report via People Committee - People promise report via People Committee	NHS Staff Survey results Pulse 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. Current focus includes zero tolerance and tackling poor behaviours. High level staff survey results 2024 received and development of action plans (March 2025). Progress being reviewed at sub committee level.		
									Consistency of wellbeing support.	Improving the consistency of the Trust wellbeing offer. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	Staff hub opened (2024/25) and wellbeing offer includes 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 as well as consistency of offer across the Trust.		
			C3) Equality, Diversity and Inclusion **Control Owner:** Chief People Officer	- Staff survey - WRES/ WDES and gender pay gap reports via People Committee - CPO report to People Committee - integrated EDI action plan updates to People Committee - EDI annual report to People Committee - Equality Delivery System 2 reports.	NHS staff survey results. WRES/ WDES. Gender pay gap results. Equality Delivery System 2 stakeholder engagement.	*Partial*		Poor experience. Diversity of workforce at all levels.	(i) Delivery of the EDI action plan **Action Owner:** Chief People Officer **Due date**: Quarterly updates	Integrated EDI action plan and priorities in place.		
			C4) Recruitment and Retention **Control Owner:** Chief People Officer	- IPR - Workforce dashboard/ SOF via People Committee - assurances on staff experience (as above)		*Acceptable*			Delivery of talent and succession planning.	Delivery of talent and succession planning. **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 in 2025/26.		
			C5) Education and Development, including leadership and management capabilities **Control Owner:** Chief People Officer	- L&D Reports via People Committee - Guardian of Safe Working reports - GMC survey via People Committee - Preceptorship survey via People Committee - Apprenticeship Report to People Committee - Workforce dashbord to People Committee	NHS Staff survey results. GMC Survey results Preceptorship survey results National Education and Training Survey	*Acceptable*		Training needs analysis. Development and delivery of action plan in respect of NETS	(i) Training needs analysis to be developed aligned to national work. (ii) Action plan to be developed and delivered in respect of the National Education and Training Survey results. **Action Owner:** Chief People Officer **Due date:** Quarterly updates	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 launched in Q1 2025/26. 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:** July 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 bank and agency usage; - The Trust, as part of the Cheshire & Merseyside system has agreed a planned deficit for 2025/26. This is dependant on the Trust delivering efficiency savings of c7% whilst not investing in any further developments. - Identification and delivery of recurrent Cost Improvement Plan (CIP) - Block funding for non-elective, caps on elective income alongside challenging targets to deliver RTT improvement through additional activity - 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) - Low cash balances and need for cash preservation actions impacting on operational effectiveness - 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 Bi-Weekly ICB FCOG meeting 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 2025/26 annual planning process (May 2025). Development of deficit drivers underway. Closed 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 clinical strategy and people strategy. Consideration of financial strategy approach Board strategy day (Jun 25).	*12*	*Mar-26*
			C2) Annual Budget and systems of budgetary control including additional grip and control actions comprising pay and non-pay controls **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 Bi-Weekly FCOG meeting and returns to the ICB (via System Improvement Director) including forecasting	*Partial*			Uncertainty of impact and funding for the pay award. Inquiry costs awaiting confirmation of national funding Unfunded escalation costs to maintain patients safety in light of increased levels of NC2R patient numbers	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. Pay award funding and impact assessment underway. System work continues on levels of NC2R and subsequent impact on escalation costs.		
			C3) Cost Improvement Programme including Quality Impact Assessments **Control Owner**: Chief Finance Officer	Weekly CIP delivery group reporting to F&P. F&P Committee	Financial Plan NHSE Template Weekly returns to ICB and NHSE and provider benchmarking of progress	*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 February 2025 to engage teams and agree next steps. Programme structure and targets agreed. CIP Delivery Group continues 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 implemented and EDG working with Divisions to implement these.		
			C4) Cash Management **Control Owner**: Chief Finance Officer	F&P Committee	Financial Plan NHSE Template Weekly returns to ICB and NHSE	*Partial*			Approach needed to mitigate the new challenges regarding cash and deficit support.	Cash management mechanisms to be embedded, working with system to understand implications and action Cash Committee ToR being developed **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Cash risk associated with Q2 DSF withdrawal established Distressed Cash Funding applciation underway Cash preservation plan developed		
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:** Jul 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*	*Mar-26*
			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 2025/26. Successful bid for £7.5m national capital to support ED/ UEC improvements with completion expected late 25/26.. TIF bid submitted to support elective capacity (Dec 24) and outcome awaited but preparatory work underway. 25/26 capital planning complete and majority of business cases drawn up and approved following prioritisation meeting held Feb 25.		
			C4) Estates strategy **Control Owner**: Chief Finance Officer	- Health and Safety Committee reports via Finance and Performance Committee. - Capital Management Group via F&P Committee	Six Facet Survey. Regulatory and statutory assurance received ad hoc (e.g. fire safety, H&S etc).	*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 complete and inspection programme in place. Ac**tion Owner**: Chief Finance Officer **Due date**: Quarterly updates	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:** July 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, modern, sustainable digital infrastructure, systems, services and data to enable safe, effective clinical patient care and business operations (Consequence C1, C2) - Increasing cyber 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 adequately assess and take action regarding 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, impacting productivity and consequently service quality/patient experience. C2- Insecurities within the systems and infrastructure with vulnerabilities that could be exploited through a cyber-attack.C8 C3 - Data loss and regulatory sanctions if personal data is lost, financial consequences of losng access to systems and data. C4 - Reduced level of skills in workforce due to inability to develop or recruit staff to 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*	KC1) Digital and Data Strategy which aligns with internal, partner, ICS / ICB and National expectations **Control Owner:** Chief Digital & Data Officer	Updates into F&PC via Digital Strategic Programme Update Strategy update to Trust Board development session	MIAA Digital strategy audit (Jan-Mar 25)	*Partial*	*5 x 3 = 15*	**NO**	Strategy refresh required with regular consolidated programme / progress 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 (DMA). **Action Owner:** Chief Digital and Data Officer **Due date:** September 2025 (ii) MIAA to conduct audit of Digital and Data Strategy. **Action Owner:** Chief Digital and Data Officer **Due date:** Q1 25/26	Strategy presented at Board Development day in June. MIAA strategy audit follow up to take place in Q2 Draft strategy to be aligned with objectives of 10 year plan DMA 2025 was submitted in June 2025 following peer review	*12*	***Mar-26***
			KC2) Annual plans that deliver effective management of Cyber security threats and Digital Infrastructure health **Control Owner**: Chief Digital & Data Officer	- DSPT 24/25 presented to Finance and Performance Committee (F&PC) - SIRO report into F&PC	- Annual MIAA assurance audit on DSPT submission	*Partial*			Information Asset Owner responsibilities for "essential services". Completion of capital infrastructure investment including data centres. .	(i) Completion of action plan relating to DSPT and Cyber Assurance Framework (CAF) **Action Owner:** Chief Digital and Data Officer **Due date:** March 26	DSPT submission was completed on 30th June - action plan has been developed to address gaps and mitigate risks		
										(ii) Deliver plan to maintain infrastructure health **Action Owner:** Chief Digital and Data Officer **Due date:** Sep 2025 Phase 1 Mar 2026 Phase 2	SAN is now operational with full migration to be completed in August 25. New aircon system is in place DC2 is now online and is supporting critical network infrastructure.		
										(iii) Deliver Cyber Security protection plan **Action Owner:** Chief Digital and Data Officer **Due date:** March 2026	New SIEM is now operational Cyber action plan is being worked through and monitored at IG&IS committee		
			KC3) Annual plan for investment, upgrade and optimisation of digital applications (including EPR) **Control Owner**: Chief Digital & Data Officer	- clinical digital systems progress (including EPR) reported to Finance & Performance Committee - Contract in place with EPR supplier, for upgrades over the next 5 years	- MIAA EPR lessons learned review (reported to Audit Committee and F&P Committee) - NHSE EPR Readiness review (reported via F&P Committee)	*Acceptable*			Application (including EPR) optimisation structures, engagement and assurance reporting.	Undertake Optimisation programme. Participate in national EPR usability survey and develop action plan based on results. **Action Owner:** Chief Digital and Data Officer **Due date**: EPR Optimisation Phase 1 August 2025 EPR Upgrade September 2025 EPR Optimisation phase 2 Mar 2026 Ophthalmology EPR Mar 2026	EPR upgrade will take place in Sept 2025 eRS integration will be live in July. Business case being developed for procurement of new Ophthalmology system - Q2 25/26.		
			KC4) Continuous improvement plan for Data Quality and Analytics **Control Owner**: Chief Digital & Data Officer	- Annual report to F&P Committee	Clinical coding audit	*Acceptable*			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:** Phase 1 October 2025, Phase 2 March 2026	Further development of key DQAM metrics has taken place. A review of the IPR has taken place with key leads and several updates have been made.		
										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		
			KC5) Digital and Data workforce plan ensuring, professionalisation, capacity, capability, and sustainability **Control Owner**: Chief Digital & Data Officer	National staff survey	- National digital workforce survey (reported via F&P Committee)	*Partial*			Fit for the future workforce plan.	Workforce plan review, including data scientist capabilities. Target achievement of DSDN Level 3 accreditation. (April 2025) **Action Owner:** Chief Digital and Data Officer **Due date:** Workforce plan September 2025	Regional digital workforce plan in development, DSDN Level 3 was achieved in April 2025 National workforce survey was completed in June 2025		

Risk Theme: Governance

RISK APPETITE: CAUTIOUS - Upper tolerance limit 9

LINKS TO STRATEGIC GOALS: SG3: Leadership, SG4: Adding Value, 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
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:** July 2025	**Causes** - implementation of changes in legislation - effectiveness of governance structures - clarity of accountability, decision making and assurance reporting - new partnership arrangements developing - organisational learning and sharing **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**	Clarity of sub committee level and Divisional Governance. Deliver the risk management improvement plan.	(i) To further develop the Sub Committee/ Group and Divisional governance organogram and assess effectiveness and embedding of the Accountability Framework. (ii) To further develop and embed risk management. **Action Owner**: Director of Governance, Risk and Improvement **Due date**: Quarterly updates	Committee organagram developed and further review of sub committee structures including Divisions underway. Governance presentations continue to be delivered in various forums. Risk management improvement plan actions progressing, risk management policy approved and Risk Management Committee in place. Datix developments being implemented.	***9***	***Q3 25/26***
			C2) Compliance with relevant codes of governance, regulation 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.		
			C3) Partnership Governance **Control Owner:** Director of Governance, Risk and Improvement	- CEO report	- CMPC updates	*Partial*			Clairity of governance for emerging partnerships and collaborations. New CMPC governance to be confirmed. Governance to support local collaboaration.	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 Joint Committee TOR beign reviewed. Support provided on discreet projects/ developments (e.g. Pathology South Hub). 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. Inquiry Report to be published (Jan 2026).	(i) Corporate records management policy to be updated and work to support embedding and improvement. (ii) Response to the Inquiry report. **Action Owner**: Director of Governance, Risk and Improvement **Due date:** Quarterly updates	Corporate records management added to Information security and information governance committee, with corporate records management policy re-draft in progress. We continue to understand, share and embed learning from the Inquiry.		

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:** July 2025	**Causes** - Clarity of system leadership and management roles - Maturity of the ICS and Place - Further development of Provider Collaborative - Changes in commissioning process - Unclear system clinical priorities - 10 year health plan implications **Consequences** - Potential conflicting priorities between organisations and systems - 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 Officer 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 CVD events	*Acceptable*	*4 x 3 = 12*	YES	Clarity of assurance reporting to Board (including cheshire work, CVD prevention and wider partnership work).	Director of Strategy and Partnerships report to be developed. **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 took place in April focussing on CVD and the management of diabetes.	*16*	***Target Score Achieved***
			C2) Develop a Trust approach to health inequalities and prevention, and population health **Control Owner:** Director of Strategy & Partnerships		Cheshire West Partnership Group	*Partial*			C2AI and Cipha into action reporting.	Develop a population health and health inequalities strategy. **Action Owner:** Director of Strategy & Partnerships **Due date:** Q3	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) Anchor institution workstreams (green / social value / prevention) **Control Owner:** Director of Strategy & Partnerships	Anchor Institute Group Chairs report to Finance & Performance Committee	ICB Net zero Group ICB Prevention Pledge Group Population Health Board National quarterly data collection via Foundary platform Anchor Institute Accreditation	*Partial*			Revised green plan to reflect National guidance.	Review and revise the Trust's Green Plan to reflect new National guidance. **Action Owner:** Director of Strategy & Partnerships **Due date:** Q2	Anchor Institution Accreditation received July 2025. National guidance published in February 2025 will require Trust to refresh Green strategy. This has been overseen by the Anchor Institution Group and will be reported to Board in Q2.		
			C4) Commerical Partnerships **Control Owner**: Director of Strategy & Partnerships	Operational Board Finance & Performance Committee Weekly Executive Group Theatre redevelopment Group (bi-weekly)	NHS Supply Chain Hill Dickson - legal advice	*Partial*			Developed approach for commercial partnerships. FBC development for Hybrid theatres.	FBC to be developed for Hybrid theatres. Approach to incldiue cabinet office approval, and tender documents. **Action Owner:** Director of Strategy & Partnerships **Due date:** Quarterly update	OBC approved by Finance and Performance Committee and Board (June 2025). Work progress with pipeline submission to Cabinet Office. Paper to be discussed at EDG including PMO support.		
			C5) Collaborative models **Control Owner**: Chief Operating Officer/ Director of Strategy & Partnerships	CEO Report to Board. COCH/CWP Community Services updates through OMB.	CMPC reporting.	*Partial*			Future vision and defined operating model.	To develop a joint COCH/CWP committee. **Action Owner:** Director of Strategy & Partnerships **Due date:** Q3	An exec to exec group has meet to discuss the formation of a joint committee with CWP to help with the strategic direction of developing community services and the neighbourhood model as well as wider collaboration opportunities.		
									Clarity of assurance reporting on collaborative work (level 1: local, level 2: pan providers, and level 3: C&M).	Director of Strategy and Partnerships report to be developed. **Action Owner**: Director of Strategy & Partnerships **Due date**: Quarterly updates	Director of Strategy and Partnerships leading work with Cheshire, Warrington and Wirral to explore opportunities. Continued discussions with WUHFT following Board to Board. There are several pieces of work with Wirral including the Pathology and Renal reviews.		

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:** July 2025	**Causes** - Lack of leadership capacity and succession planning - Funding sources - Early stages of partnerships and strategic focus - Lack of capacity and focus on Innovation opportunities - Capacity and capability to deliver commercial research activity in the CRU **Consequences** - Ability to maintain R&I function - Aligment of R&I activity - Ability to secure funds - Future leadership plans	***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**: Q2	Research ambitions to support strategy development being aligned to the clinical strategy. Research Strategy being drafted for Board in Sept. 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. Leadership resource.	To agree and communicate the development offer for research staff. **Action Owner:** Medical Director **Due date**: Quarterly update	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. Stronger culture within the team and development discussions happening with individuals.		
									Strengthening of governance and SOPs.	Review governance and SOPs (including CRF and Trust vehicle). **Action Owner:** Medical Director **Due date:** Q3	An agreed structure for research governance and processes developed for expression of interest, feasilibility and approval. This ensures 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. 5 new SOPS ratified at Research Board in July 2025. Priorities are now to update consent SOP, and manuals for Mobile Research Unit and Clinical Research Unit.		
									Lack of financial expertise embedded in the team.	To discuss financial support needs and resolve gap. **Action Owner:** Medical Director **Due date:** Q3	Meeting to take place with Finance Business Partner.		
			C3) Funding including RRDN (Regional Research delivery network) Arrangements **Control Owner**: Medical Director			*Partial*			Funding levels and income streams.	Continued focus on funding streams, including securing grants and commercial funding. **Action Owner :** Medical Director **Due date:** Quarterly updates	Assurance received that funding for 2025/26 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. Work ongoing with the Universities on grant opportunities. Clinical Research unit opened (Dec 24 but operationalised for clinical use from May 2025) and research bus received. Income remains similar and continued focus on opportunities. 2025/26 funding confirmed. Commercial Delivery network invovlement live from April 2025.		
			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 (UoC) 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). Increase in academic appointments mostly teaching through UoC medical school. Research appts to continue to be explored. Discussions ongoing to develop teaching programmes with UoC.		
			C5) Innovation Strategy **Control Owner**: Medical Director			*Partial*			Innovation strategy. Capacity and leadership to drive innovation.	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. Exploring innovation funds through grant applications.		

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
29th July 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)	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**	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	Not applicable						
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 is now established and is working to drive risk management improvement plan actions. The current focus is on Datix reporting and alerts and reviewing Risk Management Training for roll out across the Trust. 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 the 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						

	• Staffing levels and gaps in resources • Cyber Security • Estates and infrastructure • Cash management
Recommendations	The Board of Directors is asked to consider and **note** the current high risks and the work that continues to strengthen risk management across the Trust to ensure risk registers 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 High Risk Report 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 High Risk Register, there are currently 15 risks in total with a residual risk score of 15 and above that have been entered on to the Datix system. Risks scored 15 and over are scored in the following way:

Score	Count
15	8
16	7
Grand Total	**15**

The details of the high risks along with mitigations and actions are provided in appendix A. The risks have been manually updated 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
- Staffing levels and gaps in resources
- Cyber Security
- Estates and infrastructure
- Finance

Work is ongoing to further strengthen and embed risk management across the Trust, together with a refreshed Risk Management Policy. A Risk Improvement Plan is being progressed with Datix development priorities and reviewing Risk Management Training for roll out across the Trust. The Risk Management Committee continues to meet on a quarterly basis and has a key role in ensuring risk management is embedded.

3. RECOMMENDATIONS

The Board of Directors is asked to consider and **note** the current high-level risks and the work that continues to strengthen risk management across the Trust to ensure risk registers reflect the risks faced, mitigations and actions.

Appendix 1 – High Risks (as at 1st July 2025)

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
01/09/2022	2857	Backlog of overdue follow up appointments in: • Ophthalmology	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. The patient engagement portal will be used to contact patients as of May 2025. Investment in Ophthalmology diagnostics will facilitate more frequent measurement and virtual approach to follow ups. In addition failsafe officer employed to track most acute pathways.	March 2026	Cathy Chadwick	Finance & Performance Committee
24/02/2023	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.	August 2025	Cathy Chadwick	Finance & Performance Committee
23/07/2015	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.	October 2025	Sue Pemberton	Quality & Safety Committee
24/01/2025	3398	Multiple factors that could result in a Cyber Attack-	Digital and Data Services	5x3	15	This risk has been reviewed, and the score has been increased on	March 2026	Jason Bradley	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
		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.				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. Penetration test undertaken during June 2025, awaiting results. Password management strengthened with positive ID processes, system level accounts audited, and new strong password software to be deployed.	(in line with DSPT action plan)		

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
10/06/2024	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 and this has remained consistent. Work continues to reduce the waiting times for a bed to under 12 hours.	October 2025	Cathy Chadwick	Quality & Safety Committee
19/07/2019	2550	Risk to provision of Microbiology service due to insufficient resource in consultant microbiologist team	Diagnostics and Clinical Support	4x4	16	Job planning exercise completed which supports the need for extra resource Paper presented to EDG on 2nd July and approval given to recruit to a specialist doctor. Further meeting required to agree funding for the backfill. The risk score can be reduced if post is recruited to.	October 2025	Nigel Scawn	Quality & Safety Committee
19/01/2024	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 interview. SARD job planning exercise combined with	January 2026	Nigel Scawn	People Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
						capacity/demand modelling almost complete to guide future service needs.			
15/03/2023	2989	Lack of Interventional Radiology Resource for supporting the vascular service	Planned Care	3x5	15	Business case being developed for second IR suite, this will include the demand data and any build will require external funding.	TBC	Cathy Chadwick	Finance & Performance Committee
30/04/2024	3234	Inability to provide adequate IR service due to only having 1 IR theatre and no recovery ward	Diagnostics and Clinical Support	4x4	16	The current mitigation is to use the old IR suite for less complex procedures when staff are available. The long term solution is capital monies to convert the old IR suite and build a recovery space. Re-assessed & updated risk however score remains 16. Old suite has been serviced July 25 and no major issues. If service plan agreed (shared with COO and CFO), it will give us a year of an additional suite. This will reduce the risk slightly. External bids for funding continue to be completed, supported by GIRFT report	September 2025	Cathy Chadwick	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
06/04/2020	2385	Use of Siporex RAAC Planks in W&C's Building Roof	Corporate	3x5	15	Risk and mitigations being managed through Women & Children's Project Board. National RAAC board sign-off of current risk rating (reduced from 20). Move to new build in Summer 2025 will significantly reduce risk rating.	September 2025	Karen Edge	Finance & Performance Committee
24/10/2024	3346	Trust Fire Alarm System - Non-Compliance	Corporate	4x4	16	Prioritised for capital investment in 2025/26 capital programme. Business case approved and phased approach to replacement of high risk areas first commenced. Expected completion date Q3 25/26.	Q3 25/26	Karen Edge	Finance & Performance Committee
09/02/2023	2964	High numbers of Non-criteria to reside (NCTR) patients across both Trust sites	Therapies and ICC	4x4	16	Agreed to increase to a red risk of 16 at OMB due to affect of the high percentage of (NCTR) patients across the 3 adult bed owning divisions. Failing to reduce NCTR percentage of the acute bed base to 15% creates subsequent risk in patient flow resulting in delayed ambulance handover and increased number of patients being held in ED who should be transferred to ward areas.	Q3 25/26	Cathy Chadwick	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
						The number of NCTR patients also requires the Trust to maintain a high level of escalation capacity at additional cost. For individual NCTR Patients that are ready for discharge they risk higher chances of deconditioning and developing hospital acquired infections that could result in poorer outcomes. Trajectory for reduction of NCTR percentage of the acute bed base is from 21% (04/05/25) to 15% by end of March 2026. Challenge is now being supported from C&M ICB as well as ICB PLACE colleagues. Additional P1 and P2 community capacity funded through ICB discharge monies. Recruitment underway			
17/07/2024	3284	Non Achievement of Planned Care CIP Target 25/26 (£3.4million)	Planned Care	3x5	15	Additional weekly support regarding identification of cross divisional input into Surgery opportunities in place, with Exec led contributions.	July 2025	Cathy Chadwick/ Karen Edge	Finance & Performance Committee
05/06/2025	3477	High number of medical patients being managed	Urgent Care	4x4	16	Additional funding to support the management of Day2 patients across ED, SDEC and corridor.	October 2025	Cathy Chadwick	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
		outside of the Urgent Care bed base.				This includes junior and senior input 7-days a week. Expanded bed base on respiratory. Planned cohorting of NC2R patients from September 2025 in the medical bed base along with expanded medical bed base to reduce the number of medical patients outlying into surgical beds. Medical Take List moved to Cerner in July 2025 to reduce the administration and concerns with managing from an MS Teams list. Risk continues to remain not fully mitigated and poses significant concern with patients outside of the core bed base between 30-90x patients daily. Potential for worsening position due to closure of beds in September 2025. Highly reliant on reduction in NC2R position.			
21/07/2025	1869	Treasury Management	Corporate	3x5	15	The Trust is maximising debt collection, ensuring CIP plans are cash releasing and delaying payments to intra-system providers. There are Trust wide	March 2026	Karen Edge	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
						pay/non pay controls. Cash balance is reported to DoF daily and high level cash forecast is reported to DoF weekly. The Trust needs to extend its payment terms from 30 to 45 days, prioritise payroll and non pay spend critical to service delivery and delay/cease non PDC or grant funded capital spend.			

PUBLIC - Board of Directors
29th July 2025

Report	**Agenda Item 10.**	**Quality, Safety and Experience Strategy**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Sue Pemberton			Director of Nursing & Quality/Deputy Chief Executive				
Author(s)	Fiona Altintas			Deputy Director of Nursing, Quality and 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**	BAF positive impact to 1,2,3,4,8 and 9			
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	Quality and Safety Committee – 3rd July 2025							
Executive summary	A comprehensive Quality, Safety and Experience strategy is essential to build and embed a culture of improvement to continuously improve the lives of our population by providing safe, kind and effective care. The strategy has been developed through engagement with stakeholders, an extensive review of feedback and themes from patients and relatives and a comprehensive review of incidents, risk and the current position of the previous Harms Improvement Programme. Our Quality, Safety and Experience Strategy comprises three pillars of priorities: • Core Quality, Safety and Experience priorities • Divisional Quality, Safety and Experience priorities • Corporate (Trust Wide) Quality, Safety and Experience priorities							

	All which will embed our Patient and Family Experience vision. Through data collection and analysis of patient and staff surveys, complaints and concerns and patient safety incidents the Quality, Safety and Experience priorities for the next three years have been agreed through a variety of stakeholder events. The strategy describes enabling strategies and visions will support this new strategy and setting out behavioural standards and values that will support our Patient Safety Culture. This strategy will support our Culture of Listening and Learning and sets expectations and routes of measurement and monitoring of progress.
Recommendations	The Board is asked to **approve** the Quality, Safety and Experience Strategy.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	BAF 1,2,3,4,8 and 9.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

NHS
Countess of Chester Hospital
NHS Foundation Trust

WELCOME TO OUR

Quality, Safety and Experience Strategy

2025-2028

Safe **Kind** Effective

Contents

Foreword

We are pleased to introduce you to the Trust's Quality, Safety and Experience Strategy 2025-2028. Our strategy defines how we will use **insight** to understand our quality and safety; **involve** patients, staff and partners; and how we will **improve** our services.

The Trust is committed to improve its response when patient safety events or near misses occur and to learn from this is being strengthened through the implementation of the Patient Safety Incident Response Framework (PSIRF). PSIRF provides a real opportunity for the Trust to develop staff to be ambassadors of patient safety and provides nationally developed tools to understand where elements within our work systems require improvement or redesign.

To realise the NHS vision for patient safety, we will build on foundations for safer care – where we are now and where we need to go.

This strategy is part of a wider suite of strategies that work in tandem to support the Trust to achieve its overarching vision **to achieve outstanding care and experience for our patients and families.**

Introduction

A comprehensive Quality, Safety and Experience strategy is essential to build and embed a culture of improvement to continuously improve the lives of our population by providing safe, kind and effective care.

The strategy has been developed through engagement with stakeholders, an extensive review of feedback and themes from patients and relatives and a comprehensive review of incidents, risk and the current position of the previous Harms Improvement Programme.

Our Quality, Safety and Experience Strategy comprises three pillars of priorities:

- Core Quality, Safety and Experience priorities
- Divisional Quality, Safety and Experience priorities
- Corporate (Trust Wide) Quality, Safety and Experience priorities

All which will embed our Patient and Family Experience vision

The Strategy will have explicit lines of accountability and will identify measurable outcomes. Aligning to the Trusts **Transforming Care Together** strategy which sets out the Trusts purpose, with the following six goals:

1. Creating a positive patient and family experience
2. Develop our people and culture
3. Provide purposeful leadership
4. Adding value
5. Actively seeking partnership opportunities
6. Pro-active contribution to improving our population health

We want to build on your enthusiasm and drive for continuous safety improvement by strengthening how we understand, communicate, and learn from safety concerns across the Trust. As with any improvements we undertake, we will be reviewing and refining how we do this together with everyone. The Quality, Safety and Experience Strategy will set out our road map of Quality, Safety and Experience priorities over the next three years.

National context

The National Safety Strategy was published in 2019 and sets out how the NHS will support staff and providers to share safety insight and empower people – patients and staff with the skills, confidence and mechanisms to improve safety.

Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare. It is integral to the NHS's definition of quality in healthcare, alongside effectiveness and patient experience. It is human to make mistakes, so we need to continuously reduce the potential for error by learning and acting when things go wrong.

The NHS vision to continuously improve patient's safety will be built on two foundations:

- a patient safety culture
- a patient safety system

To support the development of the vision, three strategic aims have been developed:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information **(Insight)**
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(Involvement**)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas **(Improvement).**

Local context

The Independent regulators for health and social care, the Care Quality Commission, gave the Countess of Chester an overall rating of Requires Improvement.

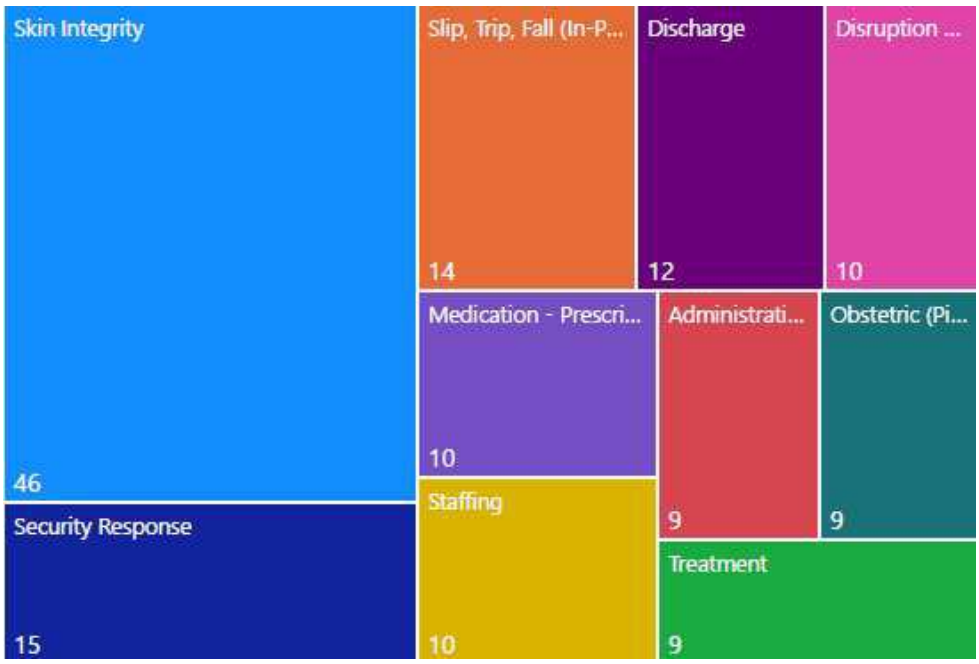
This strategy along with others will support the journey the Countess of Chester is on towards delivering outstanding care and an action plan formulated against findings from inspections.

We continue to work in collaboration with our local Integrated Care Board (ICB) Place team to be an active partner in several quality groups across Place and the wider health and social care system.

We have aligned our Quality, Safety and Experience Strategy with the Quality Priorities outlines in our Quality Account.

Our **quality**, **safety** and **experience** priorities

Through data collection and analysis of patient and staff surveys, complaints and concerns and patient safety incidents the Quality, Safety and Experience priorities for the next three years have been agreed through a variety of stakeholder events.



Complaints and concerns themes

- Time on waiting lists/delays
- Cancellations
- Communication
- Treatment

Harms Improvement Programme

- Deteriorating patient
- IPC – CDIFF and E-Coli
- Pressure Ulcers
- Sepsis
- Acute Kidney Injury
- Falls
- Medication Safety
- Emergency Department Improvement plan

The Quality, Safety and Experience priorities for the organisation are broken down into three workstreams of priorities, each with a rationale and measurable outcomes:

- Core (Previous harms improvement work now embedded as business as usual)
- Divisional (specific to each of the five divisions)
- Corporate (Trust wide priorities)

Core Quality, Safety and Experience Priorities (replacing Harms Improvement programme)		
Objective	*Rationale*	*Measurement*
IPC – CDIFF and E-Coli	• The Trust has seen an increase in healthcare associated infections and remains committed to improving patient safety	• Less than 10% of the C. difficile cases reported were inappropriately sampled • To achieve greater than 90% with antibiotic formulary prescribing • To achieve target for reported cases
Deteriorating Patient	• To improve training compliance in all aspects of the deteriorating patient • MET team	• Training compliance % – NEWS 2, ABCDE, Sepsis and AKI • Reduction of Incidents
Sepsis	• Early identification of the signs of sepsis is critical to averting organ failure and risk of death	• To achieve sepsis compliance • All patients presenting at hospital are assessed for the risk of sepsis • Patients with sepsis diagnosis receive antibiotics within the recommended timeframe
Reduce the number of inpatient falls	• Inpatient falls are one of the most frequent concerns to patient safety within the acute hospital environment.	• Reduce the number of inpatient falls by 10% from 2024/25 baseline
Pressure Ulcers	• Hospital-acquired pressure ulcers (HAPU) is one of the most common preventable complications of hospitalisation. HAPU significantly increases healthcare costs, including use of resources (dressings, support surfaces, nursing care time and medications).	• Reduction in HAPU by 20% from 2024/25 baseline • Meet all target from MUST and Braden

Acute kidney Injury	• To maintain compliance of AKI National Measures • Continuous education	• Compliance with National targets and compliance
Medication Safety	• Three areas • Medication Storage correct place as per Trust policy • Medication Administration • Prescribing Safely	• Increase in Incident reporting • Reduction of Medication incident with harm • Audit and Assurance reporting via Medicines Safety group
Emergency Department Improvement plan	• To improve the quality, safety and patient experience in the Emergency Department	• Audit and Assurance Reporting • Surveys • CQC

Corporate Quality, Safety and Experience Priorities		
Objective	*Rationale*	*Measure*
Violence and Aggression	• Violence and aggression are one of the highest numbers of reported incidents. This affects both patients, family and staff	• Reduction of incidents • Measure compliance against policy • Staff survey results •
National Safety Standards for Invasive Procedures (NatSSIPs)	• To implement NatSSIPs trust wide for all areas who undertake invasive procedures	• Audit compliance • Reporting to QGG and Q&S
Safe Management of Equipment and Patient Safety Alerts	• To provide assurance of process and compliance • Patient safety • Governance • Finance	• Gap analysis and action plan completion • Compliance of response to CAS alerts/NPSA • Audit and assurance Reporting
Education and Training	• To ensure all staff have the required training and competence to deliver care safely	• Mandatory Training compliance
Development and evolution of Patient Safety Incident Investigation Framework (PSIRF)	• To improve the knowledge and implementation of PSIRF • Patient Safety	• Audit (inc MIAA) • Assurance Reporting
Oliver McGowan Training compliance	• Mandatory training Nationwide • Positive Patient Experience	• Training compliance
Learning from Deaths	• Patient Safety	• Audit and Assurance Reporting

Divisional Quality, Safety and Experience Priorities		
Objective	*Rationale*	*Measure*
Wating List Management/harms (Planned Care)	• To reduce long waiters and harm on the waiting list	• RTT compliance • Implement robust process for identifying harms on the waiting list
Striving for Excellence Programme/Ward Accreditation (All Divisions)	• To improve all wards and departments ratings	• Ward accreditation programme
Rehabilitation and Reconditioning (All)	• To improve patient's condition	• Reduction in harm • Reduce length of stay • Positive patient experience
Home first/Hospital at Home (TICC)	• To aim to treat patients at home where appropriate	• Audit
Accreditations and inspections (e.g. UKAS, CQC, IR(ME)R, BS10008 etc) (DCSS)	• To maintain delivery of accreditation and inspections	• Achieve accreditation
To achieve a Stroke Coordinator 24/7 service (Urgent Care)	• To remove inequality in stroke care delay in review and treatment of stroke patients in ED out of hours • To measure Impact on SNAPP data outputs for COCH	• Data analysis • 24/7 cover achieved

Patient Experience Priorities		
Objective	*Rationale*	*Measure*
To further embed and monitor against the 6 Steps of the Patient and family Experience with the Countess of Chester Hospital	• To improve the patient and Family experience for all patients and their families	• FFT results • Patient Surveys • Ward Accreditation • PLACE
To improve scores from Inpatient Survey 2024 – review results and each area/department to identify areas of improvement	• To improve the patient and Family experience for all patients and their families	• Patient Surveys results
Introduction of Patient Safety Partners to support the Patient Safety Incidence Response Framework (PSIRF)	• The introduction of Patient Safety Partners will support the trust in ensuring the safety of both patients and carers	• The introduction of Patient Safety Partners will support the trust in ensuring the safety of both patients and carers
Implementation of Martha's Rule	• Martha's Rule is a major patient safety initiative providing patients and families with a way to seek an urgent review if their or their loved one's condition deteriorates, and they are concerned this is not being responded to	• Roll out of Call 4 Concern across the organisation to patients, carers and staff. • Introduction of Patient Wellness Questionnaire for all adult inpatient areas
Improve the overall improvement in maternity and children CQC survey	• The Trust remains committed to • providing the best possible experience for all the women and children using our services	• **Paediatrics:** Parent felt that ward was suitable for the child age group & Parents felt the room or ward was clean • **Maternity:** Found partner was able to stay with them as long as they wanted & noise on the postnatal ward at night

Supporting our strategy: **the enablers**

The Trust is committed to ensuring the services we provide are **safe**, **kind** and **effective**. Our patients and families are at the heart of all we do. No strategy can work in isolation, the following seven strategies will work in collaboration and enable the success of this Quality, Safety and Experience Strategy.

1. Patient and Family Experience Vision

Our new Patient and Family Experience Strategy marks a step change in our approach to patient experience.

We have listened to our patients, and they have told us that they want to be looked after, they want to feel safe, they want compassionate care, and they want to experience good hygiene and have their nutritional needs met. Seen through the eyes of our patients, these are some of the cornerstones of our new strategy.

2. Financial Strategy

The NHS has finite resources available and its essential these resources deliver value for money for the taxpayer and support the delivery of high quality, safe care for patients and their families. Our financial strategy will aim to deliver cost effective, innovative service delivery models.

3. Research Education and Innovation

The trust has a long history of embedding research and innovation. We will further embed and continue to develop an ambitious strategy that includes delivering on our aspiration to become a university teaching hospital.

4. People Plan

The NHS People Plan's aim is to have more people working differently, in a compassionate and inclusive culture within the NHS**.**

The Trust has an Anti-Racism Framework and Statement in place. As a Trust we commit to adopting a zero-tolerance approach to racism in all aspects of employment and service delivery. The principles are:

- Prioritise anti-racism
- Understand lived experience
- Grow Inclusive Leadership
- Act to tackle inequalities
- Review progress regularly

5. Clinical Strategy

The Trust is progressing a new clinical strategy that will focus the current and future needs of our population.

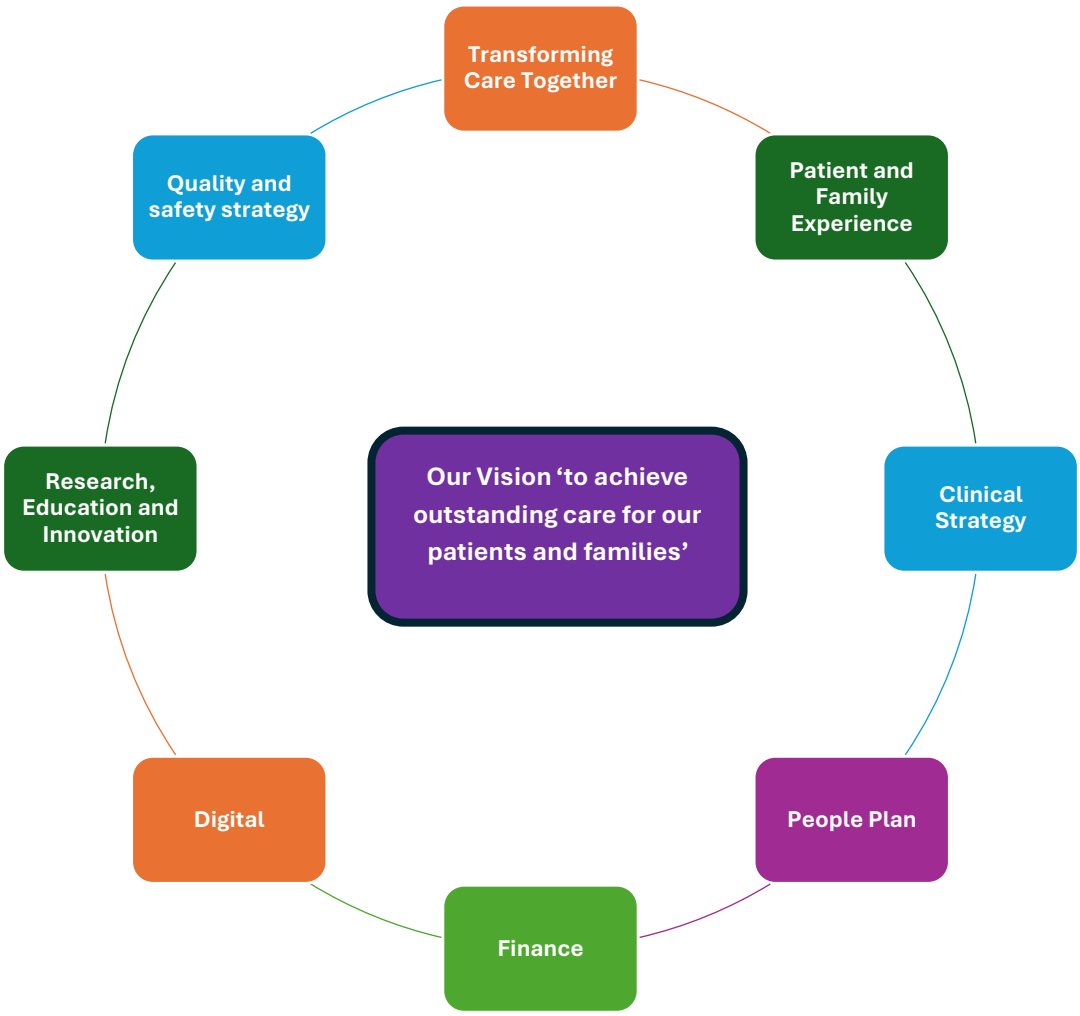
6. Digital Strategy

Digital technology plays a vital role in our lives and has the potential to revolutionise the way we care for patients, before they come into hospital, whilst they are in our care and in their ongoing care after they have been discharged. Digital developments and new technologies offer the potential for transformational improvements in safety. For example, electronic prescribing and medicines administration (EPMA) systems reduce medication errors and free up staff time for other activities.

7. Transforming Care Together

The Trust Vision, purpose and goals of the **'Transforming Care Together'** strategy provides the direction for this Quality, Safety and Experience strategy.

Enabling Strategies at the Trust



Patient and Family Experience Vision

A better patient and family experience is associated with improved patient safety, improved clinical outcomes and higher patient satisfaction scores. A positive patient experience can enable patients to fell more empowered to take a fuller role in their own healthcare.

The Patient and Family Experience Vision has been developed with our patients and their families and will shape and support our improvement work. The vision consists of six steps and are described in the three experience visions below, at our hospital, at our maternity unit and at our Emergency Department.

Team Countess

At the Countess of Chester, we are on a journey to become the very best organisation in which to work and to receive treatment. Our Trust Values are well established and provide direction for all that we do at the Trust. These are underpinned by our Trust Behavioural Standards. Both are reinforced by the Trusts Civility statement.

Our Values

Safe
Avoiding harm and reducing risk for all

Kind
Considerate and non-judgemental

Effective
Consistently maximising resources to deliver excellent and reliable care

Our Behavioural Standards

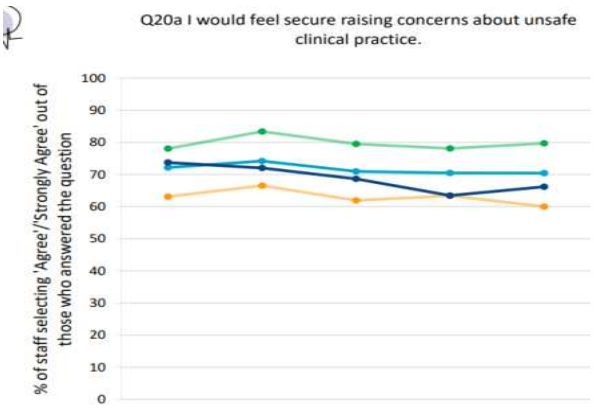
Defining a Patient Safety Culture

Patient safety culture is focused on the aspects of organisational culture that relate to patient safety. It is defined as a pattern of individual and organisational behaviour, based upon shared beliefs and values that continuously seeks to minimise patient harm.

The culture the trust is striving towards, and which promotes and embeds a patient safety culture are as follows:

- staff who feel psychologically safe
- valuing and respecting diversity
- a compelling vision
- good leadership at all levels
- a sense of teamwork
- openness and support for learning.

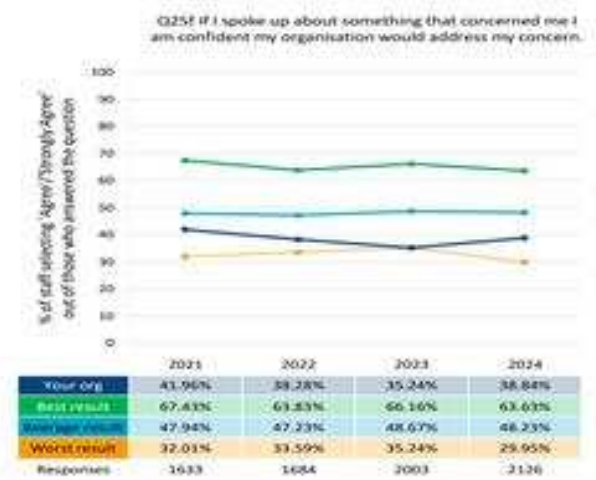
The 2024 NHS Staff Survey results have now been published and provide some insight into our safety culture. Although we have seen improvement compared to last year in all areas, it is evident compared to the best national result there is significant room for improvement, and this provides a baseline for measurement of progress.



	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

	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

	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



	2021	2022	2023	2024
Your org	41.96%	38.28%	35.24%	38.84%
Best result	67.43%	63.83%	66.16%	63.03%
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

1. Psychological safety for staff

To work at our best, we need to feel supported within a compassionate and inclusive environment. Psychological safety operates at the level of the group not the individual, with everyone knowing they will be treated fairly and compassionately by the group if things go wrong, or they speak up to stop problems occurring. It means staff do not feel the need to behave defensively to protect themselves and instead opens the space in which they can learn.

2. Diversity

Team psychological safety is characterised by a climate of inclusivity, trust and respect, where people feel able to thrive as themselves. Valuing diversity plays a critical role. Recognising how beneficial difference, be it in age, gender, ethnicity, power or diversity of thought, is for team working, communication and performance, is vital. These differences stimulate learning and creativity if harnessed in the right way.

3. Compelling vision

Before leadership can be practised well, there needs to be a vision of what we want to achieve. A good understanding of why we are doing something and where we want to get to, pervades the successful system.

4. Compassionate leadership and teamwork

Compassionate leadership creates psychological safety and encourages team members to pay attention to each other; to develop mutual understanding; to empathise and support each other. Such teams are also highly innovative. The way leadership is practised through the organisation is critical to its success, with clinical leadership being particularly important to safety.

5. Open to learning

To develop a culture of learning, the system must focus on what needs to change rather than punitive actions. An organisation that identifies, contains and recovers from errors as quickly as possible will be alert to the possibilities of learning and continuous improvement.

6. Kindness and civility

At its core, a positive culture requires kindness and civility. The importance of individuals' day-to-day behaviour in relation to safety is increasingly recognised. Studies have shown that where people are rude and disrespectful, safety is compromised.
To shift from incivility to a kinder culture everyone needs to counter the rudeness by role modelling the right behaviour, reward good behaviour and deal with bad behaviour.
Developing a patient safety culture requires us to:

- use existing culture metrics like those in the NHS Staff Survey to understand our safety culture and focus on staff perceptions of the fairness and effectiveness of incident management
- focus on the development and maintenance of a just culture by adopting the NHS Just Culture Guide and align this to the well-led framework

Culture of listening and learning

1. Sharing and Learning Forums

Our Sharing and Learning Forums support colleagues from across the organisation to come together to share their experiences and learning so that we can all work together to improve.

2. Safety Summits

Our Safety Summits have a different theme every month and are a place for staff to listen to experiences, explore, share and learn about all aspects of complex patient safety issues.

3. Safety Surveillance and Learning meeting

Focused on reviewing safety, checking progress and identifying learning, these meetings are open for divisional leads, Risk, Governance and Quality teams, Legal department and the PALs team and Heads of Nursing and Matrons.

4. Daily Trust Safety Huddles

Our daily trust Safety Huddles help us to prioritise patient safety issues by giving us time and space to talk about experiences, learning and problem-solving. The aim is for people and teams to feel empowered and supported to develop sustained solutions quickly.

Any member of staff is welcome and all clinical and non-clinical areas should be represented at the daily huddles, and we will talk through priority issues from the previous day and issues that may impact the day ahead. As a whole Trust team, we want to create a meeting environment where we all feel safe enough to speak up and know our perspectives will be respected.

5. Patient Safety Oversight meeting (PSOM)

Our incident oversight group meets weekly on a Friday and reviews all moderate and above incidents. The group agrees levels of harm, the PSIRF (Patient Safety Incident Response Framework) required, has executive approval of incident responses and provides a governance structure surrounding incidents and their responses. These meetings are open for divisional leads, Risk, Governance and Quality Lead (and their deputies when required)

6. Freedom to Speak Up

Freedom to Speak Up offers impartial and independent advice on all aspects of raising concerns including those relating to staff experiences whilst at work and is led by the Freedom to Speak Up Guardian. The service is confidential and without consent conversations will not be shared. Options of how best to manage any concern will be identified together, and feedback will always be provided should any investigation be undertaken.

Chief Executive Pledge

Jane Tomkinson OBE, Chief Executive Officer, has three pledges which are:

1. I actively encourage staff to speak up about any concerns
2. I will investigate fully, openly and transparently and will provide feedback wherever possible
3. I will keep you safe and ensure you suffer no detriment

How will we measure progress against our Quality, Safety and Experience Strategy and beyond?

- Monthly Quality and Safety meeting – leads to provide updates
- Quarterly update to Quality Governance Committee and Quality and Safety Committee
- Quality Account and Quality Priorities
- ICB reporting through Quality schedule where appropriate
- We will monitor our progress by improvements in FFT/staff and patient surveys
- Data analysis - SOF

The **Quality**, **Safety** and **Experience Strategy** serves to ensure the Trust delivers on its ambition. This has been co-created with our people who constantly strive to deliver their best for our patients.

Thank you

Sue Pemberton
Director of Nursing and Quality and Deputy Chief Executive Officer

Appendix 1

Quality, Safety and Experience Strategy 2025-28

Priority Title

Please outline the current key objectives for your respective area below (this needs to be the objectives for the three years of the strategy):

Please detail below the Key achievements what have you achieved over the course of the past year/starting position of priority:

Please outline your key priorities for the next three-month (insert date):

Appendix 2

Organisational Quality Priorities (Quality Account)

Proposed Quality Priorities 2025/26		
Patient Safety		
Objective	*Rationale*	*Measurement*
Reduce the incidence of Clostridium difficile and E coli Healthcare associated infections.	• The Trust has seen an increase in healthcare associated infections and remains committed to improving patient safety	• to achieve greater than 90% with antibiotic formulary prescribing • Less than 10% of the C.difficile cases reported were inappropriately sampled
Reduce the number of inpatient falls.	• Inpatient falls are one of the most frequent concerns to patient safety within the acute hospital environment	• Reduce the number of inpatient falls by 10% from 2024/25 baseline • 90% of patients to have a documented falls risk assessment within 6 hours of admission measured through quarterly audit of sample of patients
Reduce the incidence of Hospital Acquired Pressure Ulcers (HAPU).	• Hospital-acquired pressure ulcers (HAPU) is one of the most common preventable complications of hospitalisation. HAPU significantly increases healthcare costs, including use of resources (dressings, support surfaces, nursing care time and medications). They also have a significant impact on patients in terms of pain, worsened quality of life, psychological trauma and increased length of stay	• 90% of patients to have a skin integrity assessment within 6 hours of admission measured through a quarterly audit • Reduction in HAPU by 20% from 2024/25 baseline

Clinical Effectiveness		
Objective	*Rationale*	*Measurement*
All eligible patients are assessed for risk of developing deep vein thrombosis (DVT).	• Formal VTE risk assessment tools support the early identification of the and estimated probability of developing thrombosis	• Risk assessment within 14 hours of admission • Appropriate prophylaxis administered within 14 hours.
Ensure patients with suspected sepsis are assessed and diagnosed within recommended timeframes.	• Early identification of the signs of sepsis is critical to averting organ failure and risk of death	• All patients presenting at hospital are assessed for the risk of sepsis • Patients with sepsis diagnosis receive antibiotics within the recommended timeframe
Ensure patients in hospital remain hydrated.	• Effective hydration improves recovery times and reduces the risk of deterioration, kidney injury, delirium and falls	• All patients with National Early Warning score of greater than 5 are commenced on a fluid balance chart. • All patients diagnosed with Acute Kidney Injury are commenced on a fluid balance chart
Kind & Compassionate Care		
Objective	*Rationale*	*Measurement*
Introduction of Patient Safety Partners to support the Patient Safety Incidence Response Framework (PSIRF)	• The introduction of Patient Safety Partners will support the trust in ensuring the safety of both patients and carers. • someone who works with the NHS to make care safer for patients	• Appointment of Patient Safety Partners. • Patient Safety Partners becoming members of • groups that are in charge of safety and quality
Implementation of Martha's Rule	• Martha's Rule is a major patient safety initiative providing patients and families with a way to seek an urgent review if their or their loved one's condition deteriorates, and they are concerned this is not being responded to	• Roll out of Call 4 Concern across the organisation to patients, carers and staff. • Introduction of Patient Wellness Questionnaire for all adult inpatient areas.

Improve the overall improvement in maternity and children CQC survey	• The Trust remains committed to providing the best possible experience for all the women and children using our services	**Paediatrics:** • Parent felt that ward was suitable for the child age group • Parents felt the room or ward was clean **Maternity:** • Found partner was able to stay with them as long as they wanted • Noise on the postnatal ward at night

PUBLIC – Board of Directors
29th July 2025

Report	**Agenda 11.**	**Safety Surveillance and Learning Report – Quarter 4**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	**X**
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Fiona Altintas			Deputy Director of Nursing, Quality & Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X**	This assurance paper has a positive impact on BAF 1, 2 and 8			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Quality Governance Group – 6th June 2025 Quality & Safety Committee – 3rd July 2025							
Executive summary	The purpose of this paper is to inform and provide assurance that the Trust is a learning organisation and has robust governance and assurance structures in place to identify and highlight risk, identify themes and present changes in practice whose progress can be monitored and a forum for escalation of any concerns. The Trust continues in its journey with PSIRF, reviewing and changing processes as required. The engagement and attendance at the Safety Surveillance meetings has been extremely positive, with detailed presentations and engagement through which incidents and learnings are shared. Moderate assurance gained through the MIAA inspection and actions are being progressed. The Safety Surveillance meeting also provides an opportunity for the triangulation of complaints, concerns and incidents with learning and							

	actions also identified. The trust has several platforms trust wide to share learning. Process and governance surrounding coroners' inquests is improving, including preparation and oversight and several inquests have been converted to document only due to the standard and timely submission of investigations and learning responses. The newly developed Quality, Safety and Experience Strategy will further support the quality, safety and experience culture in the trust. The report details three Never Events that have been reported
Recommendations	The Boad of Directors is asked to: • **Note** the contents of the paper. • **Receive assurance** that the Trust is continuing to promote a learning culture with evident and measurable actions to improve patient safety. • **Note** the improvements in governance and oversight workstreams within the Countess of Chester Hospital.

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

Safety Surveillance and Learning Report – Quarter 4

1. Introduction

The Safety Surveillance meetings take place monthly with divisional representatives and relevant departments e.g. Tissue viability, PALs, Legal team. The Terms of Reference for the meeting are to triangulate themes and learning from incidents, complaints and coronial inquests. This paper will present data for quarter four and a year-end position.

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

Patient Safety Incident Investigations (PSII) are monitored through the weekly Patient Safety Oversight Group, with just two behind timescales, however, are now back on track.

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

2. Background

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

3. Purpose

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

4. Safety Surveillance Quarter Four 2024/25

Incident Analysis

In Quarter four, the Trust reported 3215 incidents. A reduction in moderate and above harm incidents compared to quarter two and three is reported.

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

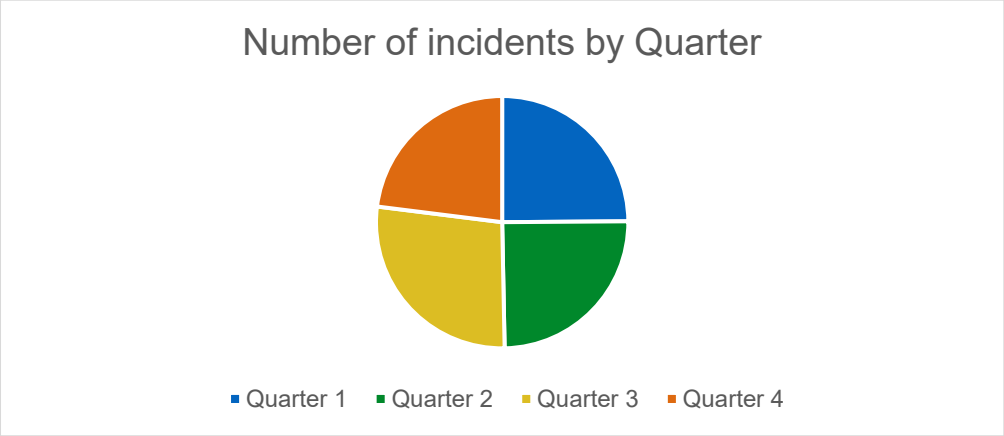
increase of moderate incidents mainly due to increased reporting of Present on Admission skin integrity incidents and an error in duplicate reporting following a new report received from Cheshire West Place (CWP).

The trends in levels of harm reported by quarter can be seen in graph 2.

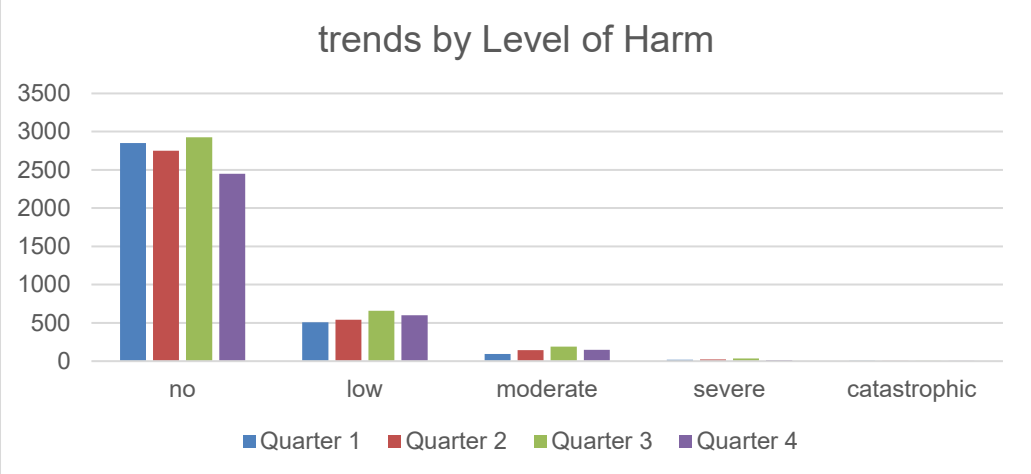
Table 1

Time frame	Catastrophic	Low	Moderate	None	Severe	Blank	Total
Quarter 1 24/25	6	506	95	2850	20		3477
Quarter 2 24/25	4	542	145	2749	24		3464
Quarter 3 24/25	4	658	189	2925	37	7	3813
Quarter 4 24/25	2	599	150	2450	14		3215
Total	16	2305	579	11620	95	7	13879

Graph 1



Graph 2



For quarter four, 95% of incidents were of no or low harm, with moderate harm incidents making up 4.6% and there were 14 severe and 2 catastrophic incidents reported. This is portrayed in graph 3 and table 2

Graph 3

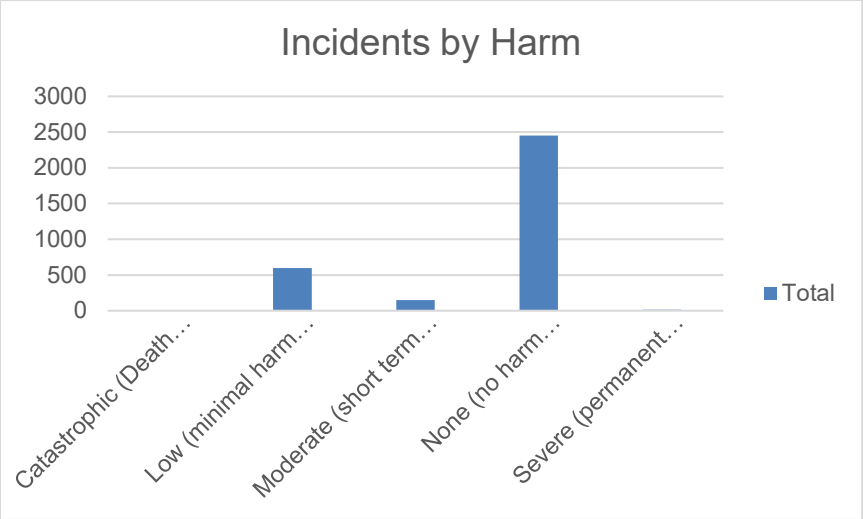
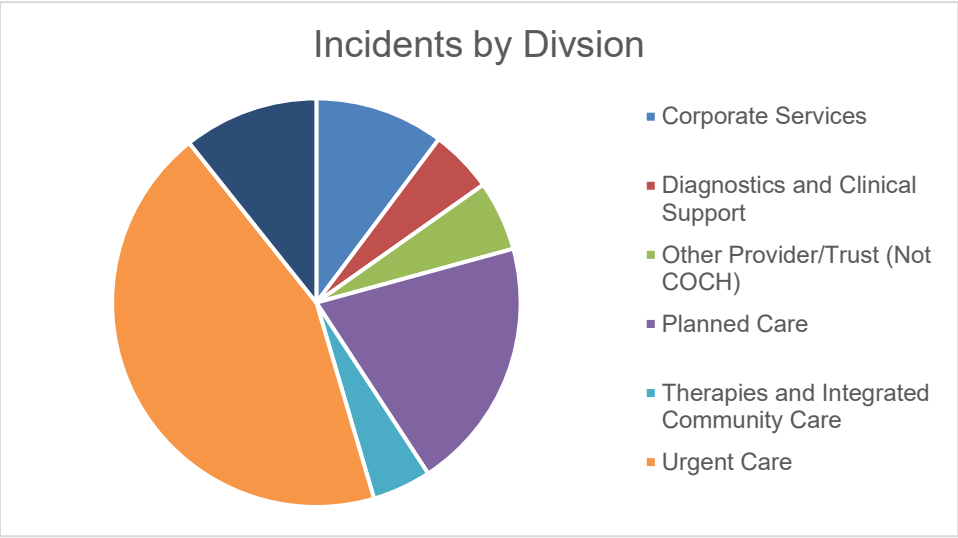


Table 2

Level of Harm	%of total incidents
no	76.2%
low	18.8%
moderate	4.66%
severe	0.43%
catastrophic	0.06%

Urgent Care is the highest reporter of incidents as seen in graph 4

Graph 4



Scrutiny and education are provided to ensure that we are reporting incidents at the correct level of harm. For an incident to be classed as moderate it must meet the following criteria.

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

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

Interrogation of moderate incidents in quarter four demonstrates that there were 20 categories of moderate harm were reported. There were 11 categories with 1-2 incidents reported for each category. The top 5 categories of moderate harm were:

1. Skin 65 incidents (43%)
2. Obstetrics 24 incidents (16%)
3. Healthcare Associated Infections (HCAI) 16 incidents (11%)
4. Treatment 11 incidents (7%)
5. Falls 7 incidents (5%)

These make up 82% of all moderate incidents reported and are consistent to previous reporting periods. The only addition is Health Care Associated Infections, and this is due to a change in trust reporting of bloodstream infections and Surgical Site infections, which is a positive change and allows for scrutiny, themes and learning to be derived. A similar process for the review of these is being established and is though the weekly divisional Infection Prevention meeting and then through Infection Prevention Committee.

Other categories of moderate harm include:

2 were for other providers
3 delays in outpatients
3 surgery related
1 delay in admitting to hospital
2 sub optimal treatment (both Acute Kidney Injury))

Quarter four saw 2 catastrophic incidents and 14 severe incidents. The two catastrophic incidents were reported as follows:

1 was a patient death during surgery – high risk procedure – AAR undertaken
1 where a patient arrived from home with necrotising fasciitis

The 14 severe incidents are made up of seven categories.

4 were skin integrity – all Present on Arrival (POA)
1 delay in ambulance
3 delays in diagnosis
1 Information Governance
1 staffing (affecting clinic)
2 treatment (1 external provider, 1 inappropriate treatment)
2 unexpected events (1 historic never event, 1 external provider)

All moderate and above incidents are managed through the weekly Patient Safety Oversight Group, with appropriate learning responses agreed and actions monitored.

Overall Incident Themes:

The top 5 consistently reported incidents are:

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

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

A trust wide mattress audit was undertaken with over 200 mattresses replaced. Focus and a priority is the Emergency Department (ED) and a newly formed ED Pressure Ulcer Improvement group has convened alongside a market review of mattresses that would be suitable for patients whilst in the ED.

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

Falls remain a concern and monitored and improvements measured through the Safer Mobility Group with several initiative to improve patients' mobility such as

- Sit out, get dressed, keep moving
- Value patients time and prevent deconditioning
- Decaf trial

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

An action plan has been developed which includes education and training for staff, the review and development of the Managing Violence and Aggression policy and an enhanced process and offer for staff support for any staff member subjected to violence and aggression.

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

Complaints and Concerns

The trust receives on average two new complaints a week and on average 70 concerns a week. Most complaints differ considerably in content/speciality, but some small perceived themes are emerging delays in diagnosis, medical harm, poor nursing care and lack of pain relief. The trends can be seen in Table 3.

Most concerns are typically queries about their treatment / appointment. There is a theme is patients getting frustrated with cancellations, patients enquiring where they are on the waiting list, patients chasing results, patients asking for updates. They typically come to PALS when they have

been unable to obtain this information from the service. A change to letter templates supporting the direction of where patients should seek advice is underway. The Patient Experience Portal (PEP) has now been introduced which allows patients to track their appointment status, however it should be noted that those patients who cannot access the digital platform are not disadvantaged and original access to information continues. Despite this, appointment related queries continue to be a main theme for PALS.

Table 3

Complaints	27/01/2025	03/02/2025	10/02/2025	17/02/2025	24/02/2025	03/03/2025	10/03/2025	17/03/2025	24/03/2025	Variance	Trend
Overdue	9	8	6	8	11	13	9	12	11	-1	
At risk of be overdue (within 4 weeks)	8	9	8	7	9	8	7	4	2	-1	
Within timescale	7	8	7	6	3	2	4	6	6	0	
New Complaints Received	2	2	1	1	1	1	2	3	0	-3	
New Complaints Received - % acknowledged within 3 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	0	
Open	24	25	21	21	23	23	20	22	20	-2	

Concerns	27/01/2025	03/03/2025	10/02/2025	17/02/2025	24/02/2025	03/03/2025	10/03/2025	17/03/2025	24/03/2025	Variance	Trend
Open for more than 40 working days	10	9	10	11	11	13	18	20	21	1	
Open for 20-39 working days	20	14	29	20	17	27	23	31	30	-1	
Open for under 19 working days	71	86	53	59	75	87	80	72	72	0	
New Concerns received in week	56	75	62	54	69	58	58	59	29	-30	
Concerns closed in week	59	73	81	59	60	45	81	57	38	19	
Open Concerns	101	109	92	90	103	127	121	123	123	0	

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

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

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

The timeliness of discharge letters has also been a theme and compliance of this is monitored weekly and improvement plans are in place, an E-Discharge task and finish group led by the Deputy Medical Director, not only to improve compliance of e- discharge letters within 24 hours, but to drive improvements in the quality of the discharge letters.

Urgent Care Division also focused on skin integrity leaning, including medical photography, safeguarding, body maps and risk assessments.

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

Within Women's and Children Division, Discharge safety netting advice to be standardized and consistent. Auto text has been incorporated into Cerner, to aid in standard documentation on discharge for 'safety netting'. Adhoc checklists to be used on discharge.

Leaflets have been provided by early pregnancy loss midwife to EPAU, GAU, ED, GOPD on Surgical, medical and expectant management of early pregnancy loss and ectopic pregnancy.

Medication safety was presented and described a change to DATIX reporting with new medication categories and subcategories allowing a more detailed approach to investigation, identifying

themes and learning. Continuous improvement is monitored through the Medicines Safety Group, specifically in areas of known high risk medicines/medicines classes:

- Oxygen
- VTE
- Anticoagulation
- Chemotherapy
- Insulin

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

Therapies and Integrated Care described learning from an After-Action review, it was identified that the to Rapid Response Team was sent to the incorrect email address (it was sent to the community care team - who the patient was also required referring to but not sent to Rapid Response Team). The patient therefore did not receive the therapy required on discharge. This was caused by human error. Subsequent actions are that the community response hub model has been developed prior to this review and launched on 03/02/2025. This should mitigate the risk as there will be one referral route for both the Rapid Response and Community Care Teams (Community Therapy).

- The referral would now be sent to the hub triage meeting and assigned to the correct teams and with the correct urgency.
- Training and support of new staff will be reviewed to ensure they are confident with the referral process.
- Learning has been shared with teams and through inpatient therapies governance meetings to disseminate learning from this case.
- Colleagues from the division have met with the patient's next of kin under duty of candour to offer apologies for the delay this error introduced in his care.

Diagnostics and clinical services discussed an increase in phlebotomy incidents, mainly due to staffing issues – plans in place for additional members of staff to be employed into the role. Extravasation incidents noted and have reduced but are being monitored and a report being developed.

Learning from Deaths/Coroner Inquests

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

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

This is also improving the preparation for coronial inquests ensuring investigations are received, reviewed and gone through a governance process in a timely fashion and a coroners database has been developed and is now in place, including a section for learning post inquest. This process has seen several coronial inquests being converted to document only rather than the Trust having to attend in person. No Regulation 28 (Prevention of Future Deaths) have been issued. Where a patient safety learning response has been written, for example and After-Action

Review we ensure that this is shared with the family prior to the inquest, and an offer of a family meeting to go through the report.

A weekly update is provided to the Executive Directors group of upcoming coroners inquests and outcomes of previous week coroners conclusions.

Examples of learning from deaths are:

- Handover to include oversight of risks including falls in ED - new handover sheet introduced to standardise approach to patient safety risks.
- Corridor Tagging is always in place when the corridor is in operation.
- Tagging enhances communication between nurses, especially when a nurse must leave an area, they will ‘tag’ a nurse who is then responsible for overseeing patients in the areas.
- Clear communication is shared trust wide in relation to documentation standards concerning the use of copy and paste function as part of medical documentation
- Develop a process with CWP (Cheshire and Wirral Partnerships) in relation to a patient’s medical status prior to a decision to proceed with the Mental Health Act
- Appropriate identification of patients entering End of life

Patient Safety Incident Response (PSII)

During 2024/25, 19 incidents requiring Patient Safety Incident Investigation (PSIIs) were reported including 2 Never Events. (Table 4). This includes 2 Maternity diverts that we are mandated to report to StEIS. The first never event was reported in April 2024 and a second never event that occurred historically in 2012, but which was identified in quarter 4 in 2024/25 have both had full investigations undertaken (PSII).

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

Progress of any PSII is managed through the weekly Patient Safety Oversight Meeting. Of the 19 PSII, 13 have had PSII completed and presented to the Oversight meeting with ICB oversight. Of the remaining 6, one is with the Trust to complete and it is acknowledged that there have been delays with achieving completion. The others are maternity PSII that are either going through the MNSI/SDUIC process or awaiting sign off by the LMNS, with one sitting with the Trust to provide feedback following LMNS feedback

Table 4 - The current position of the Trust PSIIs 2024/25

Incident and Steis Number	Lead Division	Incident report date	Status
Incident where the baby fell from mothers' bed	Women's and Children	22/4/24	Completed and closed
Never Event – retained swab following delivery	Women's and Children	4/10/24	Completed and closed from a trust – further LMNS feedback awaited
Missed opportunity to diagnose ophthalmic condition in ED	Urgent Care	26/4/24	Completed and closed
Delay in Treatment – Stroke	Planned Care	8/7/24	Completed and closed
Missed diagnosis of base of skull malignancy	Planned Care	15/4/24	Completed and closed
Missed colon cancer	Urgent Care	15/5/24	Completed and closed
Post partum hemorrhage and unplanned hysterectomy	Women's and Children	4/8/24	PSII completed – shared feedback from LMNS with Trust to review
Maternity Unit being placed on Divert	Women's and Children	25/9/2024	Closed no patients diverted
Maternity Unit being placed on Divert	Women's and Children	27/10/24	Closed
Delay in treatment/diagnosis – ED	Urgent Care	8/11/24	Near completion
Baby death	Women's and Children	1/11/24	SWARM completed/SUDIC 22/10/24
Baby transferred for cooling	Women's and Children	25/10/24	MNSI
Self-Discharge	Planned Care	6/9/24	Completed and closed
Ophthalmology – near miss Never event	Planned Care	23/10/24	Completed and closed
Patient Death while detained under Mental Health Act	Urgent care	11/12/2024	Completed and closed Statutory Notification of a death of a patient while detained under the Mental Health Act.
Patient Fall – Catastrophic Head Injury	Urgent Care	13/12/24	Completed and closed

Incident and Steis Number	Lead Division	Incident report date	Status
Missed discharge follow up following Elective Caesarean Section	Women's and Children	10/12/2024	Completed and presented to Oversight Group and ICB – awaiting feedback from the LMNS
Intrapartum Stillbirth during labour	Women's and Children	30/12/2024	Reportable to MNSI – investigation complete – awaiting formal report
Misplaced IVC filter – Never Event – Wrong Site Surgery	Planned Care	15/1/25	Completed and closed

The Trust is currently undertaking three thematic reviews:

- Sample management
- Patient absconding
- Surgical medical cover out of hours

Duty of Candour/ Family engagement with Investigations

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

An audit of Duty of Candour with respect to the Patient safety Incident Investigations has been conducted. The results show for the following categories

Of the nineteen -incidents reported to StEIS, where duty of candour was applicable, the compliance is as shown in table 6.

Table 6

Mode of Candour	Compliance	Comments
Verbal Duty of Candour	95%	The 5 % discrepancy relates to one patient who passed away and had had no or estranged NOK. Several attempts have been made.
Apology Provided	95%	The 5 % discrepancy relates to one patient who passed away and had had no or estranged NOK. Several attempts have been made.
Written Duty of Candour	90%	The 5 % discrepancy relates to one patient who passed away and had had no or estranged NOK. The other 5% relates to no evidence in DATIX of written letter. This is being followed up.
Final duty of candour and sharing of outcome/learning	95%	The 5 % discrepancy relates to one patient who passed away and had had no or estranged NOK. Several attempts have been made.

MIAA Inspection

Mersey Internal Audit (MIAA) conducted an audit of Patient Safety Incident Response Framework at the Countess of Chester Hospital in Dec 2024 - Feb 2025. The overall audit objective was to evaluate the operating effectiveness of controls and level of consistency in place for the management, recording, monitoring and reporting of incidents following the adoption of PSIRF.

Overall, the audit found an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk. An overall assurance rating of Moderate was achieved. A management response and action has been identified for each that requires improvement

Quality, Safety and Experience Strategy

A Quality Safety and Experience Strategy (2025-2028) has been developed and is being presented at the Quality Governance Group in June. The strategy defines how we will use **insight** to understand our quality and safety; **involve** patients, staff and partners; and how we will **improve** our services

The strategy has been developed through engagement with stakeholders, an extensive review of feedback and themes from patients and relatives and a comprehensive review of incidents, risk and the current position of the previous Harms Improvement Programme. All pillars will embed our Patient and Family Experience Vision

Our Quality, Safety and Experience Strategy comprises three pillars of priorities:

- Core Quality, Safety and Experience priorities
- Divisional Quality, Safety and Experience priorities
- Corporate (Trust Wide) Quality, Safety and Experience priorities

We have also aligned our Quality, Safety and Experience Strategy with the Quality Priorities outlines in our Quality Account.

5. Conclusion

The Trust continues in its journey with PSIRF, reviewing and changing processes as required. The engagement and attendance at the Safety Surveillance meetings has been extremely positive, with detailed presentations and engagement through which incidents and learnings are shared.

Moderate assurance gained through the MIAA inspection and actions are being progressed.

The Safety Surveillance meeting also provides an opportunity for the triangulation of complaints, concerns and incidents with learning and actions also identified. The trust has several platforms trust wide to share learning.

Process and governance surrounding coroners' inquests is improving, including preparation and oversight and several inquests have been converted to document only due to the standard and timely submission of investigations and learning responses.

The newly developed Quality, Safety and Experience Strategy will further support the quality, safety and experience culture in the trust.

Further plans in place to provide increased scrutiny and oversight of mortality reviews, led by Deputy Medical Director and Deputy Director of Nursing of Quality and Governance

6. Recommendations

The Board of Directors is asked to:

- **Note** the contents of the paper.
- **Receive assurance** that the Trust is continuing to promote a learning culture with evident and measurable actions to improve patient safety.
- **Note** the improvements in governance and oversight workstreams within the Countess of Chester Hospital.

PUBLIC – Board of Directors
29th July 2025

Report	**Agenda Item 12.**	**Quarter 1 2025-2026 Mortality Surveillance Report (learning from deaths)**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Dr Nigel Scawn			Medical Director				
Author(s)	Dr Ian Benton			Deputy Medical 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**	Failure to maintain safety and prevent harm would result in poorer patient care and outcomes 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							
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X**
Previous considerations	Not applicable							
Executive summary	The purpose of this report is to provide assurance as to the Trusts structures, processes and oversight of mortality. This report confirms that Mortality Indicators continue to remain within 'as expected' range • SHMI for Mar 24 - Feb 25 is 91.0 ('as expected' range) • HSMR for Mar 24 – Feb 25 is 93.5 ('as expected' range) • SMR for Mar 24 – Feb 25 is 94.4 ('as expected' range) Further work is being undertaken to improve the reporting and capturing of quality care and avoidability of death assessments within mortality reviews							
Recommendations	The Board of Directors is assured by the contents of this paper and that learning from mortality and morbidity is improving across the organisation within the learning and safety meeting structures / groups reaching multiprofessional audiences.							

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	Failure to maintain safety and prevent harm would result in poorer patient care and outcomes and failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation, and our reputation.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

Mortality Dashboard Quarter 1 2025-6

Mortality Review	Mortality Rate (SHMI / HSMR)
• 240 patients died (inpatient) in the Trust between 1st April 2025 – 30th June 2025 • 100% were scrutinised by the Medical Examiner's Office • 62 patients were identified by the ME's for further mortality review (HM Coroner referral, learning, family/staff concern or Governance) • There were 3 reported deaths under LeDeR criteria	• SHMI for Mar 24 - Feb 25 is 91.0 ('as expected' range) • HSMR for Mar 24 – Feb 25 is 93.5 ('as expected' range) • SMR for Mar 24 – Feb 25 is 94.4 ('as expected' range) • All mortality measures have consistently been within expected range.

Medical Examiners Activity

Month	Total Adult (inpatient) Deaths	Number reviewed	Mortality review requests	HM Coroner referral	Deaths that occur in patients with a Learning Disability
April 2025	77	77	10	12	1
May 2025	76	76	7	10	1
June 2025	87	87	8	8	1

Mortality Dashboard Quarter 1 2025-6

Medical Examiners Updates

Since legislation came into effect on 9.9.24 the Medical Examiners continue to review 100% of all hospital and community-based deaths.
The office is staffed to 1 WTE Medical Examiner, also providing on call cover over a weekend to accommodate faith deaths

Examples of reasons for escalation for further mortality review from Medical Examiners

Early readmission with respiratory failure / heart failure. Could these have been predicted on discharge?
Missed opportunity for senior decision-making support
Review of IR procedure
Compliments to the Surgical ST5 and Anaesthetic fellow for clear documentation and levels of treatment
Review handover process between ED and Ward
Prior to admission no evidence of Advanced care planning (forwarded to primary care – Wales)
Review necessity of Ryles tube
Concerns raised that remained Medical Fit for Discharge for approx. 2.5 months succumbing to a hospital acquired infection.
Late presentation to hospital. Could primary care review aspects leading to admission.
Clarity of nurse confirmation of death at EPH (Policy has subsequently been amended and new guidance produced)

Learning themes from Mortality reviews

Since February 2024, the themes for learning are reviewed monthly and themes /areas for learning are chared at the various safety and learning fora.

Themes for learning have been shared at the various Trust safety and learning meetings, safety summits, 9.30 am daily safety briefing, weekly learning bulletins and via direct communications from the deputy Medical Director and Medical Director. Since the successful implementation of PSIRF and changes to the learning and oversight meetings we also present monthly (from August 2024) the learning themes from mortality reviews. There is a significant overlap in aspects of care identified by the medical examiners, mortality reviews, clinical incidents and complaints.

Mortality Dashboard Quarter 1 2025-6

Good care	Gaps in care / Learning identified
Appropriate escalation Excellent out of hours care, 2 off site consultants attending within 30 mins for emergency procedure Timely ED and Stroke team assessment, investigations and transfer. Quick response by H@H team, advice from microbiologist, timely End of Life care. Recognition of drug reaction Prompt ED and ICU assessment Assessment as to ceilings of care and frailty made on current admission prior to death. Thorough clerking and summary of previous care Timely review, Involvement of palliative care team. Effective communication with patient and family Complex case and involvement of many specialists in 3 different hospitals. Microbiology involvement. Ceiling of care established early, regular updates to family. Daily consultant review Pragmatic discussions with family Proceeded to organ donation Early recognition of ceiling of care	Ideally re-consent would be appropriate for second emergency procedure however clear that undertaken under ‘best interest’. Ensure ID wrist bands are attached to patients Identification and referral to safeguarding in early part of patient’s journey. Update to radiology regarding change in organ donation criteria and imaging requirements. Shared decision making with Primary care team and H@H teams. Early discussion by primary care prior to referral regarding End-of-Life discussions. More could have been done to involve family in prognosis discussions. Missed opportunity to involve family as to frailty and future limitations of treatment, which would have guided decision making on preferred priorities / location of care. Elements of documentation could be improved. Were family / NOK informed of ward location on moving from ED? Incomplete edischarge Transfer of care from Flintshire community and N Wales Hospitals and multiple providers of care, incomplete health records.

Good team work between medical and surgical teams.	

Outlier diagnosis groups

As part of the monthly Mortality Surveillance Group we track diagnosis groups that have either reached statistical significance or those that statistical modelling (CUSUM) suggests impending outlier indices. The Mortality Surveillance Group reviews these diagnosis groups with targeted case reviews.

In this quarter we have reviewed the following diagnostic groups that have appeared on the Telstra Health HSMR outlier tool (reported deaths in rolling 12 month period). We have undertaken reviews for the diagnosis groups: **Fracture of upper limb** (observed 8, expected 3.1), **Joint disorders and dislocations** (observed 3, expected 0.5), **diabetes with complications** (observed 10, expected 4.3) (repeated as featured in 2024-5) and **leukaemia** (observed 10, expected 4.3). The groups contained low numbers so are strongly influenced by a small number of observed deaths than expected. There were no significant concerns raised from these reviews.

Cerebrovascular Disease remains on the Mortality Surveillance review list as a significant increase in mortality in Feb and March 2024 will continue to influence the statistics until the 12-month rolling period expires. A second review of mortality was undertaken in January 2025 (period up to November 2024) and similar to that done in mid-2024 did not find any cause for concern to account for the higher than expected mortality. It is not expected to return to normal until after March 2025, due to the passing of the 2 months that are thought to be influencing the statistics (February and March 2024). A further review will be undertaken in Quarter 2 as the current HSMR data is only up to the end of March 2025.

The Trust is a positive outlier across several diagnoses' groups:

Aortic and peripheral arterial embolism or thrombosis (observed 8, expected 20.1 Relative risk 39.7), as well as **septicaemia** (observed 128, expected 167.8 Relative Risk 76.3)

Data Quality:
The Trust has fewer coded spells within signs and symptoms chapter 4.5% vs national average 7.4%. This is a positive position as there are fewer signs and symptoms coded episodes with more accurate diagnostic coded episodes which then has the appropriate proportional expected mortality assigned.

Mortality Dashboard Quarter 1 2025-6

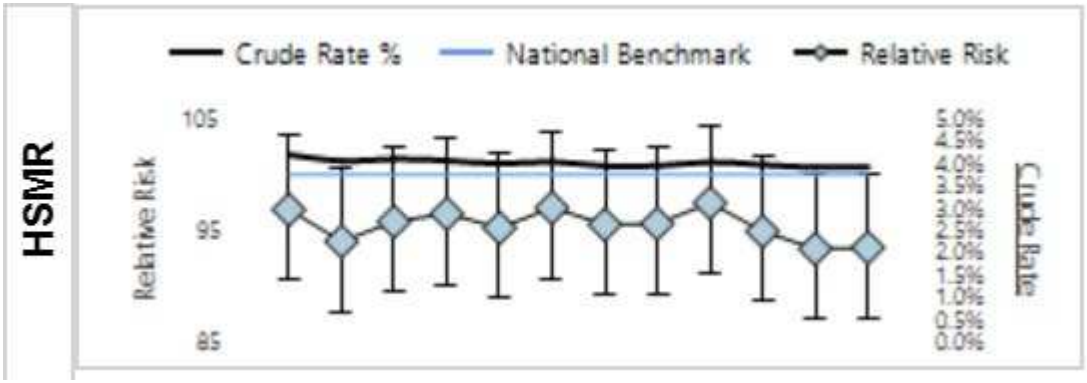
Mortality Data

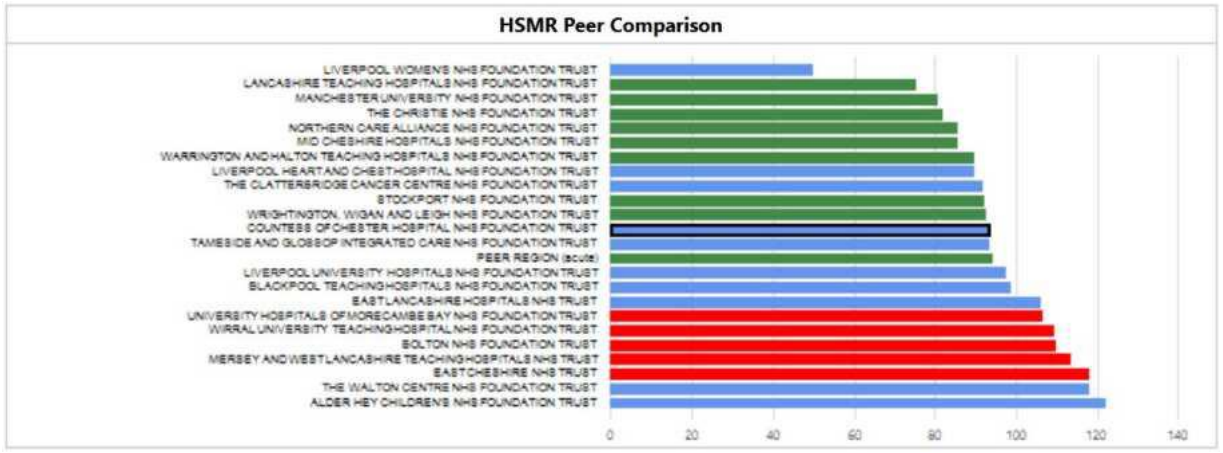
SHMI for Mar 24 – Feb 25 = as expected
HSMR for Mar 24 – Feb 25 = as expected
SMR for Mar 24 – Feb 25 = as expected

	Sept 22 - Aug 23	Oct 22 - Sept 23	Nov 22 - Oct 23	Dec 22 - Nov 23	Jan 23 - Dec 23	Feb 23 - Jan 24	Mar 23 - Feb 24	Apr 23 - Mar 24	May 23 - Apr 24	June 23 - May 24	July 23 - June 24	Aug 23 - July 24	Sept 23 - Aug 24	Oct 23- Sept 24	Nov 23 - Oct 24	Dec 23 - Nov 24	Jan 24 - Dec 24	Feb 24 - Jan 25	Mar 24 - Feb 25	
SHMI (Summary Hospital Level Mortality Indicator)	96.7	98.7	98.9	96.7	97.0	97.0	96.5	95.5	94.7	93.9	94.3	94.4	92.8	92.9	91.7	90.9	91.5	90.0	91.0	'as expected'
HSMR (Hospital Standardised Mortality Ratio)	101.1	100.3	99.2	97.3	95.7	93.9	95.5	98.0	97.2	94.5	96.9	97.7	95.3	96.2	94.6	94.1	95.7	93.5	93.5	'as expected'
SMR (Standardised Mortality ratio)	98.2	98.7	-	-	-	-	-	-	95.3	93.5	95.8	-	95.9	-	95.1	94.7	-	94.2	94.4	'as expected'

Mortality Dashboard Quarter 1 2025-6

Rolling 12 months trend (rolling 12 months to March 2025)





Summary Hospital-level Mortality Indicator (SHMI) v Hospital Standardisation Mortality Ration (HMSR)

Both methods are valid statistical models representing the mortality data in slightly different ways. SHMI is produced by NHS Digital and includes all deaths and those 30 days from discharge (approximately 30% or attributed deaths). HSMR+ is calculated by Telstra Health, but only includes 41 (was 56) diagnostic groups accounting for 80% of all deaths. This allows more details statistical analysis for us to review and track trends in mortality.

The HSMR+ is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in hospital deaths (multiplied by 100) for **41 specific diagnostic groups** (accounting for 80% of all activity). The expected deaths are calculated from logistical regression models taking into account and adjusting for a case-mix of 12 factors: admission type, age, year of discharge, IMD deprivation (new), diagnosis subgroup, sex, Elixhauser/Bottle comorbidity score (new), frailty (new), emergency admissions in the last 12 months, month of admission, source of admission, interaction between age on admission group and comorbidity.

Although a score of 100 indicates that the observed number of deaths matched the expected number, it is the presentation of statistical results that identify it outliers beyond what is expected is seen. A CUSUM statistical model tracking monthly change is in use (this allows early identification of possible trends towards statistical significance).

CUSUM analysis (Cumulative Sum) is a statistical technique used to monitor change detection and deviation from standard performance. It analyses the cumulative sum of differences between data points and a reference value, identifying trends in data over time

PUBLIC – Board of Directors
29th July 2025

Report	**Agenda Item 13.**	**Care Quality Commission (CQC) Improvement Plan including Well Led**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	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**	Linked to all BAF areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Executive Directors Group – 16th July 2025							
Executive summary	The purpose of this report is to provide assurance on progress with the Trusts Improvement Plan, including Well Led, in response to the regulatory breaches identified within the CQC's report and reflected within the subsequent CQC ratings. Areas identified as complete to transition to 'business as usual' are: • Association for Perioperative Practice (AfPP) revisit in June 2025 – accreditation received and positive feedback from AfPP • Maternity theatre staffing plan agreed • Clinical strategy approved and launched within organisation • New Mental Health equalities area completed in April 2025 and in use • Staff with limited access to PCs provided with face to face options and library access to support completion of mandatory training • Datix developments progressed and reports, notifications and training being developed.							

	• Organogram developed, new Accountability Framework in place and planned work on Divisional governance 2025/26. • New People Strategy which includes Equality, Diversity & Inclusion, Health & Wellbeing (with current people strategy, EDI & HWB strategies run to 2026) approved at People Committee. • Staff networks developed to support equality and inclusion. The consolidated CQC Improvement Plan progress will continue to be updated monthly to reflect reported progress, any changes to timescales and owners. This is reported via Executive Directors Group and to the Board of Directors.
Recommendations	The Board of Directors is asked to: • **Note** the assurance on the progress of the consolidated CQC Improvement Plan. • **Note** that progress against this action plan will continue to be tracked through the Executive Directors Group and reported to the Board of Directors.

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	Not confidential.

NHS
Countess of Chester Hospital
NHS Foundation Trust

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

Updated: July 2025

Completed	On track	Behind schedule	Not achieved

Summary of actions complete (since last update)

Actions complete (proposal to move to BAU)

- AfPP revisit in June 2025 – accreditation received and positive feedback from AfPP
- Maternity theatre staffing plan agreed
- Clinical strategy approved and embedded within organisation
- New Mental Health Equalities area completed in April 2025 and live in clinical occupation
- Staff with limited access to PCs provided with face to face options and library access to support completion of mandatory training
- Datix developments progressed and reports, notifications and training being developed.
- Committee organogram developed, new Accountability Framework in place and planned work on Divisional governance 2025/26.
- New People Strategy which includes EDI, HWB (current people strategy, EDI & HWB strategies run to 2026) approved at People Committee.
- Staff networks developed to support equality and inclusion.

Summary of actions progressing

Actions progressing

- Draft Quality and Safety Strategy developed and outline shared with Q&S Committee.
- New combined UEC action plan continues to be progressed.
- SARD capacity and demand review to support job planning is progressing with consistency panels now held. SARD in process of feeding back to specialities.
- Policy recovery programme continues to progress via Executive Directors and leads.
- 2024 staff survey action plans being developed.
- EPR, prioritisation with Divisions and corporate team now embedded into the Digital and Data programme planning. National EPR usability survey and results being published by NHSE. Upgrade programme now BAU, with next upgrade due September 2025. Regular meetings in place to support ED process improvement.
- Digital and Data Strategy being refreshed in line with corporate and clinical strategies and 10 year plan.
- Business case for VR solutions being developed to support letter turnaround time.
- New mental health action plan being developed
- Environment improvements being carried out in ED (painting, fire door replacement, ceiling grid and tile replacement etc.)
- Grant application being submitted with proposal to use predictive tools on RTT.
- New Sepsis screening action plan developed and reported to Q&S Committee
- 5 year financial plan progressing following finalisation of Trust and Clinical Services Strategies

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

Action Plan:

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

NHS Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M21	Risk & Complaints Manage-ment	MED	The trust must ensure the risks presented by gaps in the out of hours stroke service are effectively assessed and mitigated.	SP	Sept -25	• Develop business case to mitigate risks and submit to EDG for review	• Business case to mitigate against risks has been collated. • Trial of service till midnight 7 days • Collaborative venture re regional stroke service. • The urgent care division has confirmed that the out of hours stroke service has been extended to midnight and is funded. The division are currently reviewing if they are able to extend the service to cover 24/7. • The service has been recurrently funded until midnight.	Service provision has been extended until midnight as a pilot	• Q&S Committee	• EDG for Decision-addressed internally by division
S9 S20	Patient Experience & Staff Feedback	MED CYP	The trust should ensure that health promotion and information is available in all departments is available in languages other than English, in child friendly versions, and in alternative formats.	SP	Sept-25	• Review of all information available to patients and ensure that they are all available in all languages.	• Review of translation services underway-update provided to the Quality & Safety Committee held in September 2024. Further update provided to the Quality & Safety Committee held in November 2024, action plan is in place and is progressing. • The specification for the spoken and non-spoken languages has been completed as is with the budget holders for agreement . The intention is to award spoken language interpretation and translation via the NHS Cheshire & Merseyside framework agreement. For non-spoken languages, the intention is to make a direct award via the NHS SBS Framework for Interpretation & Translation Services (ITS). This will result in one supplier. Once the contract is agreed, an implementation plan with the supplier will be completed • Paper presented to QGG in June 25 – new leads identified – regional review of services being undertaken and COCH are part of regional review	• Patient Experience Operational Group	• Q&S Committe e	• Q&S Assurance Report to BoD

Action Plan:

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

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S16	Patient Assessment	MAT	The trust should continue to embed the changes made to the post-operative care of women and birthing people following obstetric surgery.	SP	**Complete**	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan	• AFPP review conducted June 2024 – this involved reviewing maternity theatres – Draft report received and to be presented to EDG, OMB (to be held in October 2024) and the Board of Directors to be held in November 2024. • As at January 2025, the Board of Directors and Quality and Safety committee have both received the report and action plan which is in progress. This will be monitored through the QGG and Q and S assurance committees • .The Planned care division updated the Operational Management Board in April 2025 on the progress made against the AFPP report and provided assurance that they on schedule to be reinspected at the end of May and a date is being arranged currently. The reinspection report will be received at the quality and safety committee when completed. • AfPP revisit in June 25 – accreditation received and positive feedback from AfPP • Maternity theatre staffing plan agreed	• Report expected August/September 2024	• Q&S Committee	• Quarterly Maternity Assurance Reports to BoD

Action Plan:

Owner: Cathy Chadwick – Chief Operating Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M20 M54	Patient Flow & Perfor-mance	MED EPH	The trust must ensure that effective and timely care is provided; to improve patient access and flow through the hospital to safe discharge or transfer to other appropriate services.	CC	**Next Review June-25**	• See Patient Flow / UEC Improvement Plan	A revised System Improvement Plan for UEC has been agreed and progress is monitored at Patient Flow Steering Group and System Oversight Group. One of the main areas of focus is improving ward processes, which the Deputy Director of Nursing is leading on. ECIST, GIRFT and AQUA all gave improvement ideas which have been added to the plan. The Trust is being supported by NHSE National colleagues to further engage with BCUHB and Flintshire LA, and we have started to see additional discharges. The number of days NCTR patients are delayed is reducing however the total number of patients delayed still needs further work.	• Complaints • Patient Flow Working Group • KPIs / UEC Dashboard • System Improvement Board • OPELG	• F&P Committee	• EDG • OMB • SOF • SIB Exit Criteria

Action Plan:

Owner: Jason Bradley – Chief Digital & Data Officer

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring	Committee	Assurance
M50	Risk and Complaints Manage-ment	CYP	The trust must assess and manage the risks relating to the electronic patient record system and transcription services. The trust must improve the quality of the services provided and ensure this did not impact on delays to patients care and treatment.	JB	Next Review Sept 25	• Develop eDischarge Summary Task & Finish Group. • Review the eDischarge process and develop an optimum pathway and SOP to support the newly revised discharge process. • Review current transcription services and monitoring of typing timeframes. • Review current monitoring arrangements and revise where appropriate. • Meet the National Access Standards.	• A process review of the eDischarge process has taken place. A further review is underway led by our CCIO to see if any additional enhancements to the EPR process can be deployed. Enhanced reporting is in place to aid with operational monitoring. • Progress monitored via Operations and Performance Executive Led Group and Operational Management Board. • Completeness of discharge summaries has improved significantly during 2024 – the Trust recognises that timeliness of discharge summaries is still an issue that is actively being worked on. • The trust is reviewing Voice Recognition (VR) solutions. VR is a key enabler to reducing letter turnaround time. Following review, a business case will be formulated in 2025. Specification is in development.	• eDischarge Summary Task & Finish Group • Divisional Governance Meetings • Divisional Typing Figures / KPIs • Progress monitored via Operations and Performance Executive Led Group and Operational Management Board.	• Q&S Committe e • F&P Committe e	• Q&S plus F&P Assuranc e Report to BoD

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

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M7	Strategy	TW	The trust must ensure strategies designed to support the delivery of the trust's new overall strategy are completed, implemented, and monitored to ensure their effectiveness.	JD	Sept-25	• Enabling strategies in support of the overall Trust strategy will be developed during 2024/25. These will align with the 6 strategic goals to provide a golden thread ensuring that all parts of the organisation are supporting the same direction of travel	The Trust strategy has been approved and prepared for wider consultation and launch. The Trust strategy has been socialised with dedicated Team Brief sessions for Day and Night Staff. The strategy has also been an integral part of developing the Trust clinical strategy and has been shared with internal and external stakeholders. Clinical strategy, leadership and learning events held in October 2024, December2024 and February 2025. Part of a culture and strategy reset these sponsored events have helped develop the Trust corporate and clinical strategy both now produced, and embedded within the organisation.	• Delivery of the strategic goals and objectives within the overall Trust are a core component of respective executive Director portfolios and will be reported to the Board of Directors on a quarterly basis. • Trust Strategy approved in June 2024. • Launch of the women & children's strategy in July 2024. • The strategic themes within the strategy are part of all staff appraisals • The delivery goals and objectives within the Trust strategy are aligned with the Board Assurance Framework and reported as a single integrated report. • Clinical Strategy has been approved and public engagements events planned I July 20025 to coincide with the launch of the ten-year plan.	• BoD	• BoD • OMB • EDG
M10	Auditing	TW	The trust must ensure there is effective oversight of the quality and safety of care provided to patients with mental health needs.	JD	Next review – Sept 25	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Review and refresh the Mental Health Group. • Develop a Trust Wide Mental Health Strategy.	• Mental Health review completed by a member of the psychiatric liaison service on secondment from CWP for 6 weeks. An interim report was reviewed at EDG in December 2024 with recommendations to be presented (Jan 2025). Recommendations arising from the review have been taken to Joint executive committee with CWP. • Progress being monitored though the Mental health group. • New action plan developed as result of CQC visits	• Mental Health Steering Group • Datix Reporting • Learning Outcomes from Complaints • ED Safety & Quality Update • New action plan • Raised at executive joint board level to ensure oversight of action plan	• Safe-guarding Committee • Q&S Committee	• Safe-guarding Quarterly Assurance Reports to BoD • Q&S Assurance report to BoD

Action Plan:

Owner: Jon Develing – Director of Strategy & Partnerships

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S1	Strategy	TW	The trust should implement effective systems to identify and plan services to address health inequalities.	JD	Next review – Sept 25	• Health Inequalities is a specific objective within the Trust strategy and part of the Director of Strategic Partnerships portfolio. • A bespoke approach will be developed in the first quarter of this year – this will include use of CIPHA/PHE Fingertips/Trust PTL/JSNA and NHS Benchmarking tools.	• A health inequality framework and awareness raising / training workshop was held for Board Directors 29/10/2024. • Draft framework has been developed and co-produced with local authority public health colleagues. • Health inequalities has been built into the clinical strategy. • Trust is leading on CVD Prevention across the local system and has arranged 4 clinical symposium s on CVD and cardiometabolic disease.	• Waiting list Performance Reporting • Cheshire West Partnerships Board	• F&P Committee • External Cheshire West Partnership Board	• BoD • OMB • EDG

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Out comes	Committee	Assurance
M28 S19	Environ-ment inc. Equipment	UEC CYP	The trust must ensure that there is sufficient equipment that is maintained to keep patients safe including but not limited to resuscitation equipment.	KE	Next review Sept 2025	• Trust wide review of all equipment used to ascertain that it is fit for purpose and that there is satisfactory levels of equipment required across all areas and incorporate how medical equipment is checked and maintained.	• Assurances received at the Trust Medical Devices Group held in July 2024 for the medical devices maintained by the Clinical Engineering Dept (EBME) • Risk Assessment and action plan agreed through Deputy Medical Director and Deputy Director or Nursing & Quality Governance around limited Medical Device assurances . • Position statement regarding the management and assurance regarding medical devices and equipment, including an action plan with responsible persons and timeframes, presented to the Quality Governance Group held in October 2024. It has been agreed for this to monitored via QGG quarterly. • Medical Devices Officer appointed to commence at the Trust in December 2024. • Medical Devices Safety Officer (MDSO) commenced in post and completed a full gap analysis of equipment to provide full oversight of control and potential areas for improvement. Action plan developed. Capital and minor equipment bids in progress for high risk items. • Medical Devices Purchasing Group to be established to provide future assurance on medical device equipment fit for purpose and replacement programme oversight. In addition, we monitor action plan.	• Asset register and report to F&P Oct-24 and then monitoring quarterly	• F&P Committee • Quality Governance Group	• Resuscitation Assurance Reports • F&P Assurance Report to BoD • Action plan following completion of gap analysis to track improvement for assurance. • Medical Device Purchasing Group

Action Plan:

Owner: Karen Edge – Chief Finance Officer

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

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M40 M48 S4 S22	Environ-ment inc. Equipment	MAT CYP MED EPH	The trust must ensure that a robust system is in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and ensuring premises are safe and for their intended purpose.	KE	Next review Sept 2025	• UEC Improvement plan • Full review of the trust premises to ensure fit for purpose in line with best practice guidance.	• H&S action plan to be progressed further by the newly appointed Health & Safety Manager (start date currently awaited). • The Trust have employed Nifes to undertake a 6 Facet Survey of the acute estate and the final version of the survey has now been received. • H&S monitoring to be reported via the Risk Management Committee. • Environment improvements via UEC ACTIF project to reduce environmental risks to patients and staff, including delivery of a HCI area. • Substantive H&S manager in post and improvements made in processes and systems across the organisation. • Detailed reports on risk, mitigation and assurances being provided regularly to RMC and other assurance committees.	• Health Safety Audits • Patient Flow Working Group • KPIs / UEC Dashboard • System Improvement Board • Outcomes?	• F&P Committee • Q&S Committee	• EDG • OMB • F&P and Q&S Assurance Reports to BoD

Action Plan:

Owner: Karen Edge – Chief Finance Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M46	Infection Prevention Control	CYP	The trust must ensure the premises and environment are clean and maintained to prevent the spread of infection. This includes but is not limited to repairs to flooring, walls and door frames, plumbing / drainage, and food storage within patient's fridges.	KE	Next review Sept 2025	• Refer to CQC response to safety concerns raised at inspection (19.10.23) Immediate and Long-term Action Plan • Development of an Estates Strategy • Carry out environment improvements in ED to improve patient experience, staff morale and IPC standards.	• The adoption of the NHS National Cleaning Standards assessment has been extended to include a multi-disciplinary team (MDT) approach, that includes stakeholders from outside of the Domestic Services organisation to provide an honest and independent assessment for assurance purposes. • (Items identified as failing to meet the required standards are logged and escalated to the appropriate 'resolution owner' (Nursing, Estates, Facilities etc. • PLACE (Full) and PLACE (Lite) assessments also utilise an MDT approach in addition to feedback from patient representatives to provide observations of where standards require improvement. • The Catering Department receive external compliance audits by the independent Environmental Health Officer (EHO), and is subsequently awarded a food standards rating accordingly. The CoCH Catering Service has maintained its 5-Star rating. • As the Clinical Strategy approaches finalisation, the Estates strategy will be refined to accommodate the needs defined within, and then be subsequently ratified. • Estates issues raised through IPC audits are fed-back to Estates via the Limble helpdesk system. The closure of items is tracked by both Estates and the area inspected (Ward/ department). • Regular dept reviews in place (every 2 weeks) between clinical and estates leads to review issues for action within ED. • Estates lead ensuring continual review and improvement of wider ED footprint with Estates Team. • Environment improvements being carried out in ED (painting, fire door replacement, ceiling grid and tile replacement etc.) to improve – works commenced April 2025 and due to complete end July.	• PLACE Assessments • Incidents • National Cleaning Standards	• F&P Committee • Q&S Committee	• Estates Strategy • PLACE Annual Assurance Assessment Report to BoD • F&P and Q&S Assurance Reports to BoD

Action Plan:

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

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M2 M4	Risk & Complaints Management	TW	The trust must ensure risks in services are appropriately recorded, assessed, escalated to the trust's board where required, and regularly reviewed.	KW	Proposal to move to BAU Sept 25	• Review and update risk management strategy • Review structures, roles and responsibilities to ensure robust risk management across the Trust. • Confirm escalation processes • Provide high risk reports to OMB, Board and Committees	• All risks are reviewed monthly at each Divisional Governance meeting and also by the Executive Directors' Group. • A report of high risks is also provided bi-monthly to the Board of Directors, monthly to OMB and relevant extracts are also provided to each of the sub-committees. • Risk Management Policy revised and approved. • Risk Management Committee in place. • Datix developments progressed. • Reports, notifications and training being developed. (Some delays noted to progressing this)	• EDG • OMB • BoD • Sub-committees • Divisional Governance Meetings	• Audit Committee	
M43	Policy Management	MAT	The Trust must ensure that policies and procedures are reviewed and follow national guidance.	KW	Next Review Sept-25	• Review of all documents on SharePoint as policies. • Revise internal process for updating / removing / amending documents on SharePoint. • Further communications across the Trust to embed the processes.	• The Continuous Improvement Team have commenced the cleanse of policy documents on Sharepoint with an initial position statement reported via EDG. • A process has been established to monitor progress and escalate the position through EDG. • Further work is required to deliver these improvements. • Progress updates provided via the Audit Committee. • Progress continues to be made but action to remain open until significant reduction in out of date policies is evident and work on other documents is progressing.	• Board of Directors • Sub-committees	• Via the relevant Committee dependant on the policy document	• EDG • Audit Committee

Action Plan:
Owner: Vicki Wilson– Chief People Officer

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M22	Training	MED	The trust must ensure that staff receive conflict resolution training in a timely manner, as is necessary to enable them to carry out the duties they are employed to perform.	VW	Next review Sept 2025	Undertake TNA with SME. Liaise with external trainer regarding training dates and capacity for F2F training. Link competency to relevant staff on ESR. Increase communication to divisions on compliance through OMB and HRBPs.	• TNA completed • Additional dates added on ESR to increase capacity. • Monthly alerts to divisions • Revised aim to reach Trust compliance target of 90% - **trajectory for 90% at Sep 25.**	• Monthly compliance reports sent to all divisions and accessible on 'S' drive. • Current compliance is **steadily increasing and has increased (from 65% in sept 24, 75% in Dec, 80% in March 25). Currently 83% in June 2025.**	• POD	• SOF • EDG • OMB
M44	Training	CYP	The trust must ensure that mandatory training (including safeguarding) compliance meets the trust target.	VW	**Next review Sept 2025**	• Review TNA for level 3 safeguarding • Review capacity meets demand for all face-2-face sessions. • Provide additional sessions for basic life support. • Provide enablers for those staff with limited access to PCs to undertake eLearning. • Increase communication to divisions on compliance through OMB and HRBPs.	Level 3 compliance still an issue across medical workforce. Date in place CPO, Chief Nurse and MD to review mandatory training competencies and denominators to ensure correctly applied and review delivery methods. Additional capacity provided to ensure enough places Staff provided with face to face training option where PC access limited and use of library and additional support to complete online as needed.	• Monthly compliance reports sent to all divisions and accessible on 'S' drive. • Latest overall Trust compliance is 89% (as at 13/09/24) • Divisions have been provided detailed reports on areas that need compliance improvement. • **Safeguarding level 1 &2 is at or above 90% target. Level 3 is continuing to improve and reached 89% in March 25%.**	• POD	• SOF • EDG • OMB

Action Plan:

Owner: Nigel Scawn – Medical Director

Countess of Chester Hospital NHS Foundation Trust

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M5	Patient Flow & Perform-ance	TW	The trust must ensure patients waiting to receive treatment after a referral are clinically reviewed and validated	NS	Further update Sept 25	• Refer to Section 29a Reg 17 Governance Action Plan. • Representation at the Surgical Risk Programme Group. • Any patient seen in outpatients who appears to have come to harm due to their wait should be recorded within Datix and investigated. • Any patient who attends ED for harm consequently for the condition that they are awaiting treatment should be recorded within Datix and investigated. • Implement C2AI (prediction tool) to prioritise surgical patients.	• Datix reporting. • Regular submission of data to C2AI commenced and first cohort (orthopaedics) of patients of increased risk is now received. Process rolling out to further specialities across the Trust. • The quality team are reviewing 100 patients per month who are on wating list to see if it corresponds with the reason for ED attendance. Where there could be a link, they are contacting the clinician to request review and if potential harm – requesting a Datix be submitted. • Data quality issues remain for patients particularly on the non RTT list and actions to address this is being explored. • Grant application being submitted with proposal to use predictive tools on RTT.	• Daily Safety Huddles • Divisional Governance Groups • Incidence Report • Serious Incident Reports	• Q&S Committee • F&P Committee	• Integrated Incident, Complaints & Claims Report • Q&S and F&P Assurance Reports to BoD

Action Plan:
Owner: Nigel Scawn – Medical Director

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
M26	Safe Staffing	UEC	The trust must ensure that medical staffing levels, with the right qualifications and competencies, are safe for the numbers of patients in the department.	NS	Review Sept-25	• See Patient Flow / UEC Improvement Plan (Nursing and Medical). • Case for expansion of medical staff numbers to be developed. • Review roles and responsibilities of allied professionals to support triage and UTC.	• Linked to Well Led 7.2 • Case presented and agreed to EDG and OMB. • Additional consultant appointment made and further vacancy recruited to in June 2025. • New medical lead for ED and a medical lead for UTC in post. Weekly ED leadership team meeting. • UTC & minors now moved to upstairs within SDEC to improve numbers and flow. • SARD work commenced on capacity demand modelling for medical staff. Job plan consistency panels taken place. SARD in process of feeding back to specialities.	• Patient Flow Working Group • Streaming Task & Finish Group • KPIs / UEC Dashboard • System Improvement Board	• F&P Committee • POD Committee	• EDG • OMB • SOF

Action Plan:

Owner: Nigel Scawn – Medical Director

CQC Ref	Theme	Area	Milestone	Action Owner	Time Frame	Actions	Progress	Monitoring/ Outcomes	Committee	Assurance
S6	Medica-tions	MED	The trust should review the prescribing of medicines that control distressed behaviour to ensure the policy is followed and monitoring is completed.	NS	Sept-25	• Review the policy and education for relevant teams	The non-urgent and rapid tranquilisation policy was approved at June 2025 D&T meeting pending 2 points, firstly that it is made clear in the document that a record needs to be made following rapid tranquilisation on Cerner/Datix and secondly that there is an update to the monitoring section to indicate pharmacy will complete the audit to monitor compliance.	• Incident Reporting • Mental Health Steering Group	• Q&S Committee	• Q&S Assurance Report to BoD
S21	Patient Assessment	CYP	The trust should ensure staff improve the compliance of completing the sepsis screening tool on the electronic patient record.	NS	Next Review Sept-25	• Harms • Acquire new blood gas analyser to measure lactate within ED • Focus on compliance of prescribing antibiotics within 1 hour of diagnosis of Sepsis.	• Regular monitoring through the Sepsis Improvement Group. • A new sepsis screening tool has been introduced onto Cerner. This is now linked to sepsis care plans that have been devised within EPR. • Monitoring of sepsis screening collated monthly and discussed at monthly sepsis improvement group. • New action plan developed and reported to Q&S Committee	• Sepsis improvement programme (Harms) participating within the Harms Showcase (Mar-24) • AQ Compliance • Sepsis Screening Audits	• Q&S Committee	• Sepsis Assurance Report to BoD

Action Plan – KLOE 2

KLOE 2	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
2.2	• All divisions to work towards the development of their respective strategies	Director of Strategic Partnerships	**Further update Sept 2025**	Discussions with the Clinical Directors and Divisional leads has taken place. Strategy day took place with Clinical Leads for October 2024 to drive forward the development of the Clinical Strategy. Specialty proposals were developed to support this and quarterly clinical leads strategy days planned to drive this forward. Further Trust wide workshop and discussion held in December and now built as BAU every quarter. Board report to be presented in January by way of progress. Final draft clinical strategy for Board approval in May. Bespoke support provide to respective divisions in developing service specific strategies that align with that of the organisation	Trust Strategy was approved in June 2024. Women's and Children's Division strategy was launched in June 2024.	Medium
2.3	• Develop a five year financial strategy	Director of Finance	**Oct 2025**	Final 24/25 financial plan submitted in May 2024 in line with national deadlines. The financial plan has been co-ordinated with Cheshire & Merseyside ICB and national financial planning. Further work is to be undertaken on the 5-year financial plan to provide more detailed financial plan following completion of the Trust strategy and Clinical Services strategy. Work is commencing to develop the strategy with engagement with F&P in January with national guidance on medium term planning to be issue over summer 2025.	Final 24/25 financial plan submitted in May 2024 in line with national deadlines.	High
2.6	• Develop supportive strategies mental health, E and I and estates and facilities, well being	Chief People Officer/ Chief Finance Officer	**Complete – proposal to remove as will be monitored by People Committee.**	• Wellbeing Hub now open. Wellbeing annual report that reviewed activity against wellbeing strategy objectives, including mental health support was submitted to POD Committee April 2024. • Further supporting strategies in progress. • The Trust strategy has been socialised with dedicated Team Brief sessions for Day and Night Staff. The strategy has also been an integral part of developing the Trust clinical strategy and has been shared with internal and external stakeholders. • New People Strategy which includes EDI, HWB (current people strategy, EDI & HWB strategies run to 2026) approved at People Committee. • Staff networks developed to support equality and inclusion.	Draft People Strategy presented to people Committee in April 25 (incorporates EDI & wellbeing), final strategy to be signed off in June 25.	Medium
			Estates and facilities – March 2026	Estates strategy to be developed by end of 2025/26, engagement with F&P and alignment with Clinical Service Strategy underway.		

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
3.3	Implement the recommendations from the recent risk management review March 2023	Director of Governance, Risk & Improvement	**Proposal to move to BAU June 25**	• All risks are reviewed monthly at each Divisional Governance meeting and also by the Executive Directors' Group. • A report of high risks is also provided bi-monthly to the Board of Directors, monthly to OMB and relevant extracts are also provided to each of the sub-committees. • Risk Management Policy reviewed and approved. • Risk Management Committee in place. • Divisional Risk Maturity self assessments complete. • Datix developments progressed. • Reports, notifications and training being developed.	Risk policy compliance	High
3.5	• Provide a trajectory plan trust wide (supported by divisions) for all areas to achieve trust targets for all of mandatory training. To be monitored through Operational Management Board. • Mandatory training performance to achieve target	Chief People Officer	**Next review Sept 2025**	• Level 3 compliance still an issue across medical workforce. • Date in place CPO, Chief Nurse and MD to review mandatory training competencies and denominators to ensure correctly applied and review delivery methods. • Requirements for training aligned to national programme. • Development of local oversight group in Jan 24 to optimise national and locally mandated learning. • Additional capacity provided to ensure enough places. • Continued focus on conflict resolution and resus which remain lower – although predominantly in A&C / E&F workforce. Revised trajectory plans requested from any non-compliant areas to ensure compliance by Sept 25.	Mandatory training target achieved - 91% against 90% target (as at June 25).	High
3.6 (moved from KLOE 8 Ref: 8.4)	A plan needs to be in place to ensure there is review of all out-of-date policies and procedures and that these are reviewed annually or as otherwise stated (FM Governance report 2019 REC 17)	Director of Governance, Risk & Improvement /Director of Nursing	**Next update Sept 2025**	• The Continuous Improvement Team have commenced the cleanse of policy documents on Sharepoint with an initial position statement reported via EDG. • A process has been established to monitor progress and escalate the position through EDG. • Further work is required to deliver these improvements. • Progress updates provided via the Audit Committee. • Progress continues to be made but action to remain open until significant reduction in out of date policies is evident and work on other documents is progressing.	Up to date policies accessible to all	High

Action Plan- KLOE 3

KLOE 3	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact Rating
4.3	• Develop a meeting map to incorporate Board, operational and management meetings focusing on attendees, membership, terms of reference and roles and responsibilities • (FM Governance report 2019 REC 13)	Director of Governance, Risk & Improvement	**Proposal to move to BAU June 25**	• Committee organogram developed and work progressing to collate of Terms of Reference and workplans to support this. • Governance and assurance slides are being used in different forums to increase understanding and expectations. • New Accountability Framework in place. • Planned work on Divisional Governance in 2025/26.	Clear and effective governance structure	High

Action Plan- KLOE 5

KLOE 5	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
5.1	The process for reviewing and assessing risk needs to be strengthened to allow for transparency of risks to ensure the Board are fully sighted on risks to patients and services (to include embedding risk management and review of BAF)	Director of Governance, Risk & Improvement	**Proposal to move to BAU Sept 25**	• BAF in place. • All risks are reviewed monthly at each Divisional Governance meeting and also by the Executive Directors' Group. • A report of high risks is also provided bi-monthly to the Board of Directors, monthly to OMB and relevant extracts are also provided to each of the sub-committees. • Risk Management Policy revised and approved. • Risk Management Committee in place. • Datix developments progressed. • Reports, notifications and training being developed. Some delays in progressing.	Monthly reporting to EDG and OMB. High Risks report to the Board of Directors. Effective BAF in place.	Medium
5.5	The Trust must implement quality improvement systems and processes such as regular audits of the services provided and must assess, monitor and improve the quality and safety of services. The Trust needs to develop an improvement strategy	Director of Governance, Risk & Improvement	**Further update – Sept 2025**	• The Trust has a continuous improvement team in place, as well as a number of other teams that deliver improvement work. • A session was held with the Continuous Improvement Team in May 2024 to align team priorities to strategic priorities. • For 2024/25, a set of agreed improvement priorities has been developed and has been reset for 25/26 to include the Cost Improvement Programme and a number of other strategic priorities. • Wider picture across all improvement activity to be developed • An improvement strategy is required for 2025/26. • Q&S strategy also defines the quality improvement priorities. • Work to do to bring this all together.	Clear improvement Strategy/ Plan.	Medium

Action Plan – KLOE 7

KLOE 7	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
7.2	The Trust must be assured that they have the right numbers of staff with the right skills across all disciplines – focus on medical. Nursing and therapy staff Workforce plan submitted to NHSE May 2023 ***Actions outstanding – review of AHP workforce and review of medical staffing***	Chief People Officer/ Director of Nursing/ Medical Director	**Nursing- Completed**	Nurse staffing review completed using the safer nursing tool. Review of maternity staffing also. **Completed.**		High
			Medical – Next Review Sept 2025 **AHP – Nov 2025**	Medical staffing - currently being progressed. SARD undertaken a capacity demand modelling for medical staff in 16 biggest specialities. Revised job plans drafted and subject to consistency panels. Current review of job plans matched to capacity/demand work by specialities. Review of AHP workforce - A review of the AHP workforce has been completed by the TICC division. AHP review remains outstanding and is been led by Lead for therapies.		
7.5 (NEW)	Continue to build upon system understanding and engagement with external partners, stakeholder mapping.	Director of Strategic Partnerships	**Next update Sept 2025**	New Anchor Institution oversight group established (June) which will meet bimonthly. New reporting framework adopted. Revised terms of reference. Board report presented in July 2024. Anchor Institute Oversight Group has now expanded membership to CWP and Chester University sustainability department. The group has now also engaged with the Country Park. The Trust	System engagement in place.	Medium

Action Plan – KLOE 8

KLOE 8	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
8.1	The Trust need to establish a Board Lead for organisational learning. This will then allow a strategic review of where all learning takes place, who by and outcomes. This then needs to result in the development of an organisational learning policy which is inclusive of all disciplines and services. • Review policy to ensure comprehensive coverage of organisation learning. • Establish mechanisms (as required) and embed organisation learning across the Trust	Director of Governance, Risk & Improvement	**Next update June 25**	Organisational Learning Policy being progressed to reflect the mechanisms and learning forums in place which are attended Trust wide. Head of Legal Services, Deputy Medical Director and Deputy Director of Nursing & Quality Governance also working more closely to align organisational learning. Early draft shared with Deputy Director of Nursing, Quality and Governance and Deputy Medical Director (Dec 2024). Further review required.	Clear arrangements in place to demonstrate systematic learning	High
8.4 (NEW)	Continuous improvement • workstreams to be aligned to strategic priorities. • Consider opportunities to involve patients • Board development and NHS IMPACT assessment (including action plan) • Transformation programme priorities and approach to be confirmed and aligned to strategy	Director of Governance, Risk & Improvement	**Next update Sept 25**	• The Trust has a continuous improvement team in place, as well as a number of other teams that deliver improvement work. • A session was held with the Continuous Improvement Team in May 2024 to align team priorities to strategic priorities. • For 2024/25, a set of agreed improvement priorities has been developed and has been reset for 25/26 to include the Cost Improvement Programme and a number of other strategic priorities. • Wider picture across all improvement activity to be developed • An improvement strategy is required for 2025/26.	Measurable improvements.	Medium

Action Plan – KLOE 8

KLOE 8	Development Areas	Responsibility	Timeframe	Progress	Outcomes	Impact rating
8.5	The emergency department needs a robust improvement plan across all domains, care, culture, operational polices and flow. The Trust needs to improve that patients receive care in a timely way and work to improve performance against national standards (from arrival to assessment in the emergency department) Improve data capture and process of 12 hour DTA breach data Improve time to initial assessment using Manchester Triage System Deteriorating Patients and Reduction in Incidents: • Full review of the nurse and health care support workers • Roles and responsibilities in across the nursing workforce have been re-affirmed • An accountability framework is being introduced • Matron does regular drop in sessions and a department news letter is produced. • Weekly audit in place via Tendable and additional PDN training. • Twice daily Consultant in-reach sessions supporting review of NEWS and an ED specific NEWS addendum developed for Trust policy Maximise SDEC • Aim for over 1000 attendances per month • Direct conveyance from NWAS • Open 12 hours per day 7 days per week Introduce an Urgent treatment Centre outside the ED footprint	Chief Operating Officer	**Next review – Sept 2025**	A revised System Improvement Plan for UEC has been agreed and progress is monitored at Patient Flow Steering Group and System Oversight Group. Additional support from the ICB to address the high number of patients that do not meet the criteria to reside (NCTR) has meant the trust has seen a reduction in delay days, but we are yet to see movement on the total number of patients The Trust has had a leadership away day hosted by NHSE. This will focus the team on roles/responsibilities, SOP's and Inter professional Standards. We have introduced an SOP to reduce the length of time patients spend in the department which has successfully started to reduce long waits to under 24 hours and has significantly reduced ambulance turnaround times. All original actions are now completed. Including: UTC fully open and taking 30-25% take each day SDEC taking well over 1200 patients per month and direct conveyance from NWAS Call before convey for all non-resus ambulances for over 18 years old also in place.	Improved performance against KPIs Improved patient experience	High

NHS
Countess of Chester Hospital
NHS Foundation Trust

Appendices

Summary of Improvement Outcomes

Urgent & Emergency care

1. Improved performance in type 3 performance
2. Increased use of Same Day Emergency Care (SDEC)
3. Reduction in long waiting patient and significantly improved ambulance turnaround times

Quality, Safety & Harms Improvement

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

Summary of Improvement Outcomes

Board Governance & assurance

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

People & OD

1. A wide range of engagement activities covering inclusivity, behaviours, wellbeing and appraisal and career conversations, and visibility of FTSU.
2. Improvements have been made following the 2023 staff survey
3. Clear EDI priorities and oversight of progress
4. Induction, appraisal and leadership programmes embedded to support People development
5. Improved compliance for mandatory training

Digital

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

Summary of completed actions (to date)

Countess of Chester Hospital NHS Foundation Trust

Completed Actions

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

Summary of completed actions (to date)

Completed Actions

- Daily review of incidents implemented, risk management committee established and Organisational Learning Policy reviewed.
- Complex Care passport relaunched. Safeguarding EPR tool.
- People Promise measure incorporated into People Strategic Plan
- Performance reporting has been established to each OMB.
- Trust wide engagement sessions and local Listening events held in response to staff feedback.
- Integrated reports are provided quarterly to the Quality & Safety Committee and Board of Directors.
- NED responsibilities reviewed and NED inductions now in place.
- Governor workshop held to reconfirm roles and reset the role of the CoG. Action plan in place to support governors in fulfilling their roles and further workshops scheduled.
- Database of coronial inquest developed.
- Revised reporting and cover sheet template in place.
- EPR upgrade has taken place and part of 4 year programme to ensure latest version is installed when released.
- Clinical Digital Design Authority process embedded.
- Feedback from staff survey 2023 has been collated and highlighted areas of action and high-level data from 2024 survey being reviewed to support and develop action plans.
- Harms improvement programme in place and embedded.
- MUST assessment implementation and monitoring.
- Risk management policy revised, Risk Management Committee established and regular review of risk registers. Divisional risk maturity self assessments complete.
- Induction and appraisal processes embedded.
- Leadership development programmes implemented.
- Committee organogram developed.
- New accountability framework in place.
- EDI workstreams and priorities and developed and governance in place to assure progress.
- Previous UEC action plan complete and superseded by new combined UEC action plan.
- The trust has notified the CQC that Tarporley Hospital no longer needs to be registered separately.

Committee Chair's Report
Wednesday 21st May 2025 at 13.30 – 15.00, Boardroom, 1829 Building

Committee	Extraordinary Quality & Safety (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)

- The Board of Directors is aware of the recent Care Quality Commission (CQC) Section 29a notice regarding Urgent and Emergency Care at the Countess of Chester Hospital NHS Foundation Trust. This extraordinary Q&S meeting was to understand and seek assurance regarding the Trust response.

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

- Immediate, required actions have been implemented in response to the notice.

Advise
(items presented for the Board's information)

- The Committee reviewed the notice, including discussing any areas in which the Committee might have sought further assurance previously.
- Actions and progress on each specific CQC concern were presented and discussed.
- Agreement was reached on the nature of information to be provided to the Committee in future meetings as assurance in these areas.

Risks discussed and new risks identified

- No new risks were identified

Committee Chair's Report
Thursday 3rd July 2025 at 10.00 – 12.25, Boardroom, 1829 Building

Committee	Quality & Safety (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)

- Progress update Care Quality Commission (CQC) Section 29(a) notice. Generally good progress but:
  - Worsening position on sepsis performance in the Emergency Department (ED) – Committee requested more information on the effectiveness of current plans, and this will remain on the agenda.
  - Six other areas with remaining risk - Portable Appliance Testing (PAT) Testing/equipment servicing, some Infection, Prevention & Control (IPC) metrics, patient experience, Resus capacity, aspects of culture.
- Request for risk assessment in relation to current and planned resuscitation capacity in ED (cognisant of national recommendations).

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

- Some solid assurance on improvements in the ED, in the form of audits and operational metrics including but not limited to – falls, Malnutrition Universal Screening Tool (MUST) and Braden screening.
- Improved assurance on learning and improvements from Patient Safety Incident Investigation (PSII), Coroners Reports, Mortality Review etc.
- Annual Mortality Review Report received.
- Assurance presented on improvements to the process on the management of National Institute for Health and Care Excellence (NICE) guidance. Significantly improved position on guidance closed.
- Clinical Audit capacity and governance arrangements, including Surgical, Medical, and Radiological Technology (SMART) action planning (partial assurance given). National audit compliance in place but risks associated with numbers of local audits overdue (55/158) - linked to capacity and Divisional governance arrangements
- Assurance noted on the Striving for Excellence programme.
- Assurance presented on improved cleaning standards with supporting verbal information on multi-disciplinary approach.
- Assurance noted on the Complaints process.

Advise
(items presented for the Board's information)

- Care and compassion training now in place for Nurses in the ED – Committee stressed the requirement to roll this out to all disciplines.

Risks discussed and new risks identified

- Global risk on the ED under review.
- Clinical Audit capacity and governance.

PUBLIC – Board of Directors
29th July 2025

Report	**Agenda Item 15.**	**2024/25 Controlled Drugs (CDs) Annual Report**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Nigel Scawn			Medical Director				
Author(s)	Karen Adams			Director of Pharmacy and Medicines Optimisation and Controlled Drugs Accountable Officer (CDAO)				
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). Risk register ID 3470 Medicines Optimisation: Safe and Secure Management of Controlled Drugs			
Strategic goals	Patient and Family Experience Purposeful Leadership							**X** **X**
CQC Domains	Safe Effective Responsive Well led							**X** **X** **X** **X**
Previous considerations	Quality Governance Group (QGG) June 2024 - 2023/24 Controlled Drugs (CD) Annual Report Public Board of Directors March 2025 - Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2025							
Executive summary	The purpose of this report is to provide assurance through an overview of controlled drugs activity during 2024/25 and sspecific issues and improvement actions that have been undertaken during 2024/25 are detailed. The report provides positive assurance that the trust has systems and processes in place to safely manage controlled drugs which are sufficient to meet the requirements of the controlled drugs regulations and adeptly highlight areas for improvement. One significant incident of staff diversion occurred during 2024/25 and the Trust was commended on the management of the incident by NHS England.							
Recommendations	The Board of Directors is asked to note the assurance provided within the report with regards to the safe management of controlled drugs within the organisation							

Corporate Impact Assessment	
Statutory/regulatory requirements	Controlled Drugs Regulations 2013 & 2020 (as amended) CQC
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 – Document to be shared with commissioners and regulators on request

2024/25 Controlled Drugs (CDs) Annual Report

1. Introduction

The statutory requirements for the safe management of controlled drugs for designated bodies are outlined in the Controlled Drugs (Supervision of Management and use) Regulations 2013. One of the requirements is the appointment of an accountable officer who has responsibility for all aspects of controlled drugs management within their organisations. The controlled drugs accountable officer (CDAO) quality assures processes for managing controlled drugs in line with legislation. They must report to the board and NHS England to provide assurance that controlled drugs are used and handled appropriately and advise of gaps in systems and behaviours and the consequences of these. At the Countess of Chester Hospital NHS Foundation Trust, the CDAO is the Director of Pharmacy and Medicines Optimisation.

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 provide assurance of organisational compliance with the CD regulations through an overview of controlled drugs activity during 24/25

4. 2024/25 Controlled Drugs Annual Report

4.1 Controlled Drugs Governance and assurance reporting processes

Quarterly CD reports are received by the Medication Safety group detailing incident reporting themes, levels of compliance, improvement activities and regulatory/ legislative updates. Areas of concern are escalated via chairs reports to Quality Governance Group (QGG) and to Quality and Safety (Q&S) committee where warranted. Additionally, the CDAO submits a designated body occurrence report to NHS England regional CD team on a quarterly basis and an annual self assessment in line with the Designated Body CDAO Improvement Framework. From 25/26 the latter must gain Trust Board approval prior to submission.

Processes related to controlled drugs are primarily managed through the following documents:

- Safe Management of controlled drugs policy
- Ward controlled drugs SOPs
- Theatre and Radiology controlled drugs SOPs
- Endoscopy controlled drugs SOPs

• Pharmacy controlled drugs SOPs

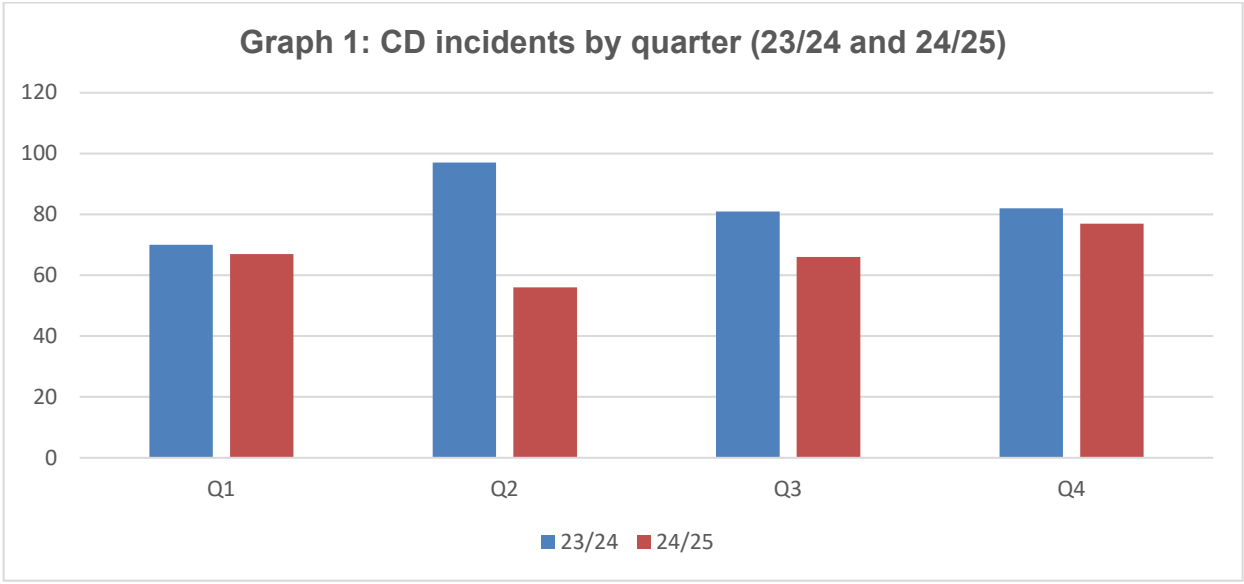
4.2 Incidents

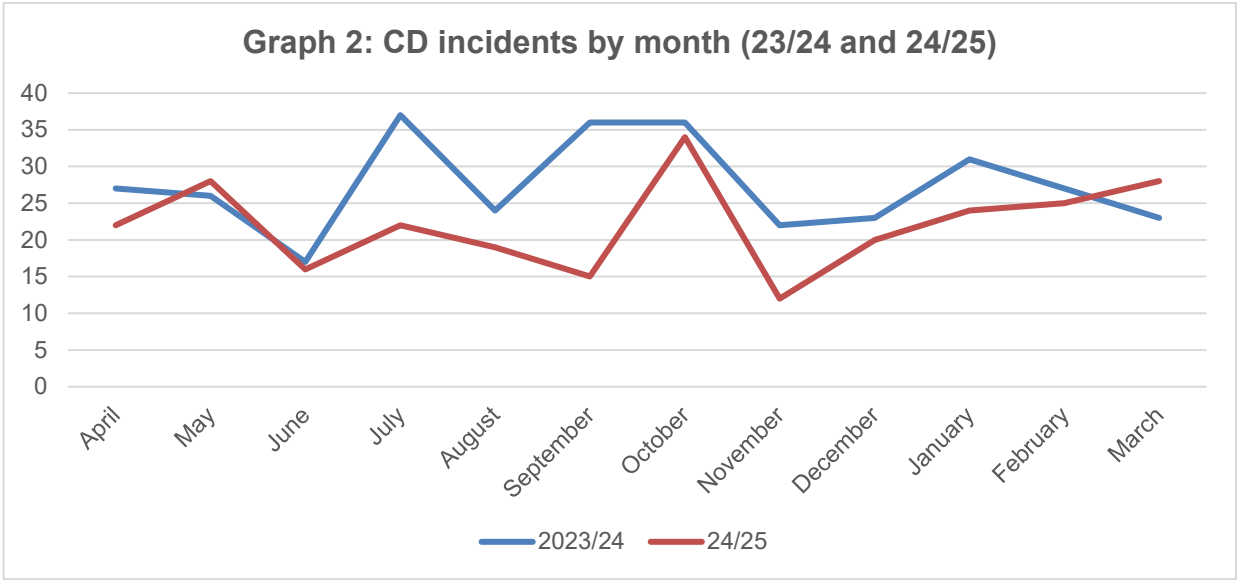
4.2.1 Internal reporting

A total of 265 CD incidents were reported during 2024/25, a reduction of 20% from 2023/24 reporting figures. Trends relating to reporting activity can be seen in Graphs 1 and 2.

Thematic reviews are undertaken quarterly in terms of drug, area and category with further analysis of trends in unaccounted for losses. During 2024/25 this highlighted the following:

- The highest reporting areas are ED and AMU
- The greatest number of incidents reported are to patient related incidents and governance issues
- ED reports the greatest number of unaccounted for losses (a notable rise was highlighted in Q4). Steps implemented to improve management and oversight.
- Trends of increased issues of schedule 3,4 and 5 CDs (irreconcilable increases in 2 areas retrospectively linked to case of staff diversion)





4.2.2 External reporting

CD incidents reported to external bodies during 24/25 are listed in Table 1.

Table 1

External organisation	Incidents reported
NHSE*	3 Professional or Employee of concern- Safeguarding issue Professional or Employee of concern- Stolen or Diversion Professional or Employee of concern-Illicit use-Illicit drugs
CQC	0
Police	1

** From December 2022, incidents reported meeting the following criteria must be reported directly to NHSE within 48 hours.*

- *Persons, professional or staff of interest or concern*
- *Actual or suspected diversion of controlled drugs*
- *Incidents classified as Severe or Fatal Patient Harm, either physical or psychological harm*
- *Any other incidents considered to be significant by the Designated Body Controlled Drug Accountable Officer*

One significant incident of staff diversion of schedule 3 and 5 CDs was reported during Q3 and subsequently a proposal for enhanced controls of lower CD schedules was approved for implementation. The Trust was commended on its management of the incident by NHSE.

4.3 Compliance

4.3.1 Safe and secure storage

Compliance with safe and secure storage standards audited quarterly are listed in Table 2. The themes and associated improvement actions for 24/25 are:

- Sustained improvement in expired/fit for purpose products
- Serious breaches of key security highlighted in one area in Q3 and Q4. Improvements put in place following breech in Q3 but failed to sustain compliance. Urgent remedial action instructed and progressed in Q4.
- Repeatedly low compliance with signing of ‘received requisitions’. Change in pharmacy process implemented in Q4 to mandate a signature on receipt.
- Repeatedly low compliance with crossings out and alterations. Local feedback delivered quarterly; compliance shared with divisions for further targeted actions.
- Decline in compliance with separation of CD keys. Non-compliance due to combination with medicines keys and limited to a small number of areas. Support and education delivered to areas in question (Q4)
- All quarterly reports have included an area heatmap to allow divisions to address area specific non-compliance.

Table 2

Pharmacy CD assurance quarterly audit	Positive response	Q1	Q2	Q3	Q4
Are the CD keys kept as a separate bunch, that is, not combined with other keys, e.g. for medicines cupboards?	Yes	82%	60%	60%	67%
Was the CD cupboard securely locked?	Yes	100%	100%	100%	98%
Was the CD register locked away?	Yes	96%	90%	92%	98%
Was the CD order book locked away?	Yes	98%	96%	94%	98%
Was the grade of staff in possession of the CD keys appropriate (qualified staff)?	Yes	100%	100%	96%	94%

Was all medication in date and fit for use?	Yes	63%	89%	82%	80%
Was the stock check correct and free from any discrepancies?	Yes	90%	83%	94%	82%
Was the CD cupboard free from other items other than CDs?	Yes	90%	92%	96%	94%
Were all 'received requisitions' signed?	Yes	49%	53%	54%	65%
Are requisitions checked and confirmed as being present in the CD register? (sample of 5 per area)	Yes	94%	100%	98%	92%
Is the list of authorised signatories in the CD order book 'live' and up to date?	Yes	88%	92%	92%	86%
Are the registers legible, free from crossing out or alterations and in line with SOPs?	Yes	57%	70%	65%	59%
Is naloxone a ward stock item available and in date on the day of inspection?	Yes	98%	98%	98%	96%
If midazolam is stocked on the ward, is flumazenil available and in date on the day of inspection?	Yes	100%	100%	100%	100%
Where breakages or spillages have been recorded in the register, is the same individual's name repeatedly involved in the breakages or spillages?	No/NA	86%	100%	100%	90%
Are CD cupboards appropriate in size for the amount of stock used?	Yes	96%	100%	96%	98%
Is the CD cupboard made of metal?	Yes	100%	100%	100%	100%
Are all the entries in the Patients' Own CD Register up to date and correct?	Yes	86%	86%	73%	88%

4.3.2 Local intelligence network (LIN)

A legal duty of collaboration between specific organisations (responsible bodies) is outlined in the Health Act 2006, which is described in detail in the Controlled Drugs (supervision of management and use) regulations 2013. ‘Local intelligence networks’ are formed from these organisations and there is a legal duty for members to share information and intelligence relating to concerns in connection with the management and use of controlled drugs.

The trust is fully compliant with all requirements of LIN participation including:

- 100% attendance at network meetings
- 100% occurrence reports submitted
- All alerts related to ‘Relevant Individuals’ actioned as required
- All incidents meeting the criteria for direct reporting, reported to NHS England

4.3.3 Home Office Licence

The Trust holds a Home Office controlled drugs licence to allow it to supply controlled drugs to external legal entities (primarily the Hospice of the Good Shepherd). The current licence renewal is still pending despite a compliance inspection by the Home Office in May 2024.

Feedback from the compliance inspection highlighted the following improvements which have both been completed within agreed timeframes.

- CCTV installation into the pharmacy CD area
- Installation of the CD Omnicell to comply with BS2881 Level 2 CD storage

The delay in issuing the license has been repeatedly raised with the Home Office, and NHS England North West CD team have also escalated concerns to the Home Office as a number of Trusts in the NW are in the same position.

A risk related to Home Office activity and associated authorisation of witnesses for CD destruction is recorded on the pharmacy risk register (ID 3077).

5. Conclusion

This report provides assurance that the trust has systems and processes in place to safely manage controlled drugs which are sufficient to meet the requirements of the controlled drugs regulations and adeptly highlight areas for improvement.

6. Recommendations

The Board of Directors is asked to note the assurance provided within the report with regards to the safe management of controlled drugs within the organisation.